

Practicalities of care closer to home: seven key questions for community psychiatrists

ARTICLE

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SUMMARY

This article aims to clarify what ‘care closer to home’ means to a community psychiatrist. Care closer to home can be operationalised as primary care liaison and the article reviews experience across England of how a liaison service can work with the recently organised primary care networks. Key competencies needed for liaising with primary care are discussed using seven questions, including bias mitigation, reducing bed-days, consultation skills, knowledge of emerging treatments and reducing administrative overheads while improving access.

LEARNING OBJECTIVES:

After reading this article you will be able to:

- comprehend available models on liaising with primary care networks
- understand the challenges for psychiatric services in primary care liaison
- review alternative consultation modes to enhance patient and carer contributions.

DECLARATION OF INTEREST

None.

KEYWORDS

Liaison psychiatry; bias in decisions; service development in community care.

above high street chemists. This provides ease of access and relative anonymity, compared with home or school visits or attendance at community mental health team (CMHT) clinics.

Care closer to home is also linked with the recent development of primary care networks (PCNs), which are collections of general practices covering populations of 30–50 000 (King’s Fund 2019). PCNs are expected first to focus on collaborative working, involving not just mental illness, but also frailty, cardiorespiratory disease and cancer. Examples of innovations include Skype access to consultants and employing pharmacists to review patients with complex conditions. The other objective of PCNs is cost-efficiency in chronic disease management by limiting hospital bed use.

Regarding the future consultant workforce in primary care, the three medical Royal Colleges (of Physicians, General Practitioners and Psychiatrists) are in negotiations to devise a hybrid curriculum involving competencies in all three specialties. Hybrid consultant roles were initially developed in paediatrics (Madhava 2010) to accommodate working directly with primary care. Essentially, a hybrid consultant would need skills in adult, old age and neurodevelopmental disorders (e.g. autism, attention deficit disorders), alongside competency in managing neurological conditions such as Parkinson’s disease and epilepsy.

Service models of primary care liaison

NHS England appears to have decided that the traditional mental healthcare delivery via CMHTs has become unfit for purpose, owing to long waits for specialist treatment (typically 2–3 months), difficulty communicating with primary care (a 2-week delay for letters) and patient safety issues (suicide and other untoward events post-discharge). Consequently, a series of pilot sites called vanguards were set up to inform alternative models of practice (NHS England 2016).

Model 1 – Prism

The Primary Care Mental Health Service (Prism), which is run by the Cambridgeshire and Peterborough NHS Foundation Trust (2017)

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Care closer to home via primary care liaison

The UK’s National Health Service (NHS) has been promised significant transformation funding over the next 3 years for mental healthcare providers to work directly with primary care (National Collaborating Centre for Mental Health 2019). The latest iteration is ‘care closer to home’ (NHS Improvement 2015), a core principle of the 10-year NHS Long Term Plan (NHS England 2019). The objective is to reduce hospital outpatient activity by locating staff at sites in town centres, including newbuilds (such as the Nelson Health Centre in London), unused council offices (suicide prevention centres in Liverpool, such as The Liverpool Light Centre) and office space

vanguard, involves mental health nurses promptly triaging all general practitioner (GP) requests for assistance and signposting to appropriate secondary care services, self-help groups or third-sector agencies. PRISM has shown a saving of at least £650 000 annually in reduced referrals to secondary mental health services in the first 2 years of operation, alongside high user and referrer satisfaction (Elliott 2018). Although cost savings have not been published, there appear to be equivalent reductions in administrative overheads, such as processing formal referrals, setting up appointments and typing letters. It is estimated by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust that 50% of the cost of a mental health referral (around £319) is spent on referral processing and other hospital overheads.

Model 2 – The Gold Standards Framework

This framework (Reynolds 2010) involves a team of GPs, district nurses and Macmillan nurses routinely reviewing all patients (irrespective of diagnosis) on the palliative care register and intervening when necessary. It has been suggested that community psychiatric nurses (CPNs) looking after patients with severe mental illness (SMI), intellectual disability and dementia could follow a similar regime, by attending Gold Standard meetings and seeing patients as needed, without a formal referral. The City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) (Parsonage 2019) has experience in collaboration with GPs in managing patients with SMI.

Model 3 – specialist consultancy teams

The third model, a consultancy team of skilled practitioners (occupational therapist, social worker and dementia nurse), was developed for complex dementia care by PMH Consultancy and Education, a private-sector company working in Cheshire (<https://pmhcande.com/ola/services/dementia-care-consultancy-1>). This team does not carry a case-load, but works alongside any team requesting help (including care homes) to manage behaviours that challenge and to avoid hospital admission. Consultative teams could focus on challenging behaviour and other complexities posed by people with dementia, autism, intellectual disability and personality disorders, with medication advice sought using an internet-based app such as Skype.

Opinion: questions pertinent to primary care liaison

What biases are likely in liaison work and how to mitigate them?

Liaison psychiatry involves rapid diagnostic formulations, risk mitigation and treatment planning; but this

can result in thinking errors (O'Sullivan 2018). Confirmation bias (often associated with overconfidence) is the most common problem, when a doctor – often under time pressure – looks for evidence confirming the initial impression, rather than seeking evidence to the contrary. There is a variant of confirmation bias called ‘diagnostic overshadowing’ (Jones 2008), when doctors (including psychiatrists) encountering patients with mental illnesses, conclude that their physical symptoms are part of their psychiatric syndrome and fail to investigate adequately.

In addition, trying to fit presentations to diagnostic codes and treat using previously learned ‘rules of thumb’ (heuristics) can also produce errors. An example of a heuristic error is assuming that ‘past risky behaviour predicts future behaviour’ without looking at recent changes in context. Affective bias (‘heart ruling the mind’) can influence risk management; for example, in Mental Health Act (MHA) assessments when assessors are excessively risk averse. As regards psychotropic selection, pharmaceutical promotions, unreplicated drug trials and perceived individual successes (or failures) with specific drugs can be potential biases.

Working as a multidisciplinary team (MDT) can also lead to biases such as groupthink (overconfidence in ‘group wisdom’) and escalation of commitment (‘throwing good money after bad’), particularly in the absence of clinical leadership. Sometimes MDT biases are due to lack of clearly stated objectives (‘mission creep’).

Increasing professional maturity should help a doctor to avoid or mitigate biases, and a clinical lead should assist subordinates in making unbiased decisions. However, in a busy clinical setting, self-regulated professionalism and proactive supervision can easily be lost. For a full discussion on bias see the Royal College of Psychiatrists’ CPD Online module (de Silva 2010).

How do we reverse rising admissions under Section 2 of the Mental Health Act in the context of reduced bed availability?

A consequence of increased investment to the primary–secondary care interface is less investment in mental health beds; these continue to reduce in number (McCartney 2017), partly owing to unsafe staffing levels (including staff preferring to work Monday to Friday in the community). Because of fixed commitments, it is rare for the patient’s care coordinator to be part of an MHA assessment, and this results in a loss of ‘soft’ knowledge about resilience factors.

Furthermore, despite being told that the assessment is ‘under the Mental Health Act’ it is rare for patients to appreciate that anything they voluntarily

disclose could be used as evidence for detention. All three assessors – the two doctors and the approved mental health practitioner (AMPH) – are under obligation to minimise risk, which potentially gives rise to affective bias and the ignoring of the patient's human rights (for example, privacy, right to family life). Indeed, MHA assessments are being legally challenged under the Human Rights Act.

Pragmatically, the best alternatives are to provide an advocate to maintain fidelity to the Human Rights Act; or to invite the relevant home treatment team to attend the assessment, with the sole purpose of providing alternatives to admission, for example utilising supervised 'safe flats': an initiative developed by South London and Maudsley NHS Foundation Trust in association with a local housing provider, Thames Reach. Furthermore, before the two doctors attend, the AMPH could carry out an initial review (not under the Act) with the assistance of the home treatment team, to ensure that all alternatives to hospital admission are considered with the patient and carers.

Lean working (de Silva 2018a) as practised in Middlesbrough (Tees, Esk and Wear Valleys NHS Foundation Trust), using daily ward reviews, early pre-discharge meetings and links with community providers, can assist early hospital discharge. Furthermore, in cases of prolonged admission (for example, of people with personality difficulties and risky behaviour), a visiting senior clinician (a 'trusted advisor') could be of value. This is currently in use in Newcastle (Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust) and can empower ward teams to discharge patients.

As regards patients with chronic psychoses or dementia, advance care planning (ACP) could help decision makers (such as ambulance crews) to avoid inappropriate admissions. ACP use is patchy around the country (Lund 2010). Some GPs provide admission avoidance documents, but these are not consistent with the algorithms used by ambulance crews. Furthermore, carers and families influence admissions in crisis, suggesting the need to seek agreement with the family and carers when preparing admission avoidance documents.

Is zero suicide among patients under mental healthcare realistic?

This aspiration is viewed as controversial by both clinicians and patients, as the implicit assumption is that suicide is equated to failure of psychiatric treatment and follow-up. Perhaps mortality due to suicide is better viewed as part of reduced life expectancy in people with mental illness generally (see the next section).

Although evidence over the past 10 years suggests that the number of suicides by patients under

secondary mental healthcare has gradually reduced (National Confidential Inquiry into Suicide and Safety in Mental Health 2018), suicides among younger women and among patients soon after hospital discharge have not (Haglund 2019). It is not known whether the rise in young women killing themselves is a result of pre-existing trauma: the inquiry has not collected these figures routinely. As regards post-discharge suicides, the high-risk period for suicide following a hospital admission is now recognised as the 3 days immediately after discharge. It is preferable for this follow-up visit to be carried out by a person already known to the patient; ideally a ward staff member.

Furthermore, information sharing between emergency services and mental health is patchy. With rapid transfer of patients between crisis teams, in-patient wards and CMHTs, patients and carers can have difficulty establishing a trusting relationship with any of the mental health staff they encounter during a single episode of care. Perhaps a patient-held chip and PIN card might be of value, similar to maternity cards from the past.

Standardised risk assessments have been largely ineffective in predicting completed suicide (Large 2016): they are mainly used as 'defensible documentation'. Despite the main remediable cause in suicide being the method selected, specific inquiry via carers is not always carried out owing to anxieties about patient confidentiality and loss of trust. The tool most accepted by patients and carers is the safety plan (Cole-King 2013), describing a succinct action list for the person if they are harbouring suicidal ruminations: who to ring, where to go and what to say when they get there.

On staff education, most NHS trusts have mandatory suicide awareness updates, although this should be an annual undertaking, with discussion of local trends in completed suicide. There is scope for closed-circuit television (CCTV) observation of local suicide 'hot spots', although there are resource implications. CCTV could be also used in ward settings (Warr 2005) instead of 'close observation', which is typically seen by patients as non-therapeutic, with exceptions for patients with persecutory delusions.

Should severe mental illness, intellectual disability and autism spectrum disorder be seen as life-limiting conditions, similar to dementia?

Actual figures suggest that people with these conditions have a reduction in life expectancy of around 15 years, possibly through poor diet, medication side-effects, loneliness, lack of purposeful activity and suicide. There is no evidence that psychiatric

treatments (pharmaceutical or otherwise) improve this situation. Furthermore, people who have experienced trauma early in life show shorter telomere length (Tyrka 2010), consistent with a shorter lifespan. Chronic stress, as experienced by most psychiatric patients independent of diagnosis, also speeds up the biological clock (Solanas 2017).

Research on preventing neurodegenerative conditions (such as Alzheimer's disease, Parkinson's disease and stroke) has moved away from specific disease-modifying treatments to extending healthy lifespan by triggering cell 'cleansing' called autophagy (Cuervo 2005). Specifically, patients could have their lifespan prolonged by reduced meal sizes (Martin 2007), intermittent fasts (Wei 2017), supplements such as resveratrol and nicotinamide adenine dinucleotide (NAD) boosters (Wang 2006) and exercise (Reimers 2012). These interventions will probably reduce morbidity rather than closing the mortality gap.

Clearly, viewing SMI, intellectual disability and autism as palliative conditions is controversial; however, this view fits the available evidence and dovetails with the Gold Standards Framework method of oversight (model 2 above) – which secondary mental health services cannot provide owing to their move to episodic care, typically a specialist assessment and two follow-up contacts. Primary care SMI management has been piloted in Whitby (the Whitby SMI monitoring project; de Silva 2018b), with a CPN rotating between 6 GP practices (population 26 000), working with practice nurses responsible for cardiovascular screening to cover all patients on antipsychotic medication (including clozapine). This approach had widespread staff and patient approval, leading to all patients on long-term depot antipsychotics being discharged from the CMHT, as well as pick up of previously undiagnosed hypertension, dyslipidaemia and glucose intolerance.

What key areas of emerging medical knowledge should community psychiatrists be aware of?

On physical health

Hyperinsulinemia associated with non-alcoholic fatty liver disease (NAFLD) is probably the main topic community psychiatrists need to be aware of, as this condition leads to systemic inflammation (Shoelson 2006) and to metabolic syndrome (a cluster involving visceral obesity, hypertension, dyslipidaemia and insulin resistance). Metabolic syndrome is the most common cause of mortality in psychiatric patients (Ho 2014). There is rodent evidence that atypical antipsychotics lead to NAFLD (Soliman 2013).

NAFLD is difficult to diagnose without liver imaging, but liver function tests can be suggestive. It is estimated that 40% of adults on a processed/high-sugar diet have this condition. Furthermore, symptoms of NAFLD can be mistaken for somatic anxiety and depression (Elwing 2006). There is emerging evidence linking NAFLD to breast and bowel cancers (Sanna 2016) and to cognitive deficits (Celikbilek 2018). Cognitive deficits (and hippocampal atrophy) are also associated with metabolic syndrome in adolescents (Yau 2012).

On pathogenesis (Lim 2010), unlike glucose (which the liver readily converts to rapidly usable glycogen), fructose (50% of sugar molecules) gets converted to fat (*de novo* lipogenesis), initially deposited in the liver, thereafter transported as low-density lipoprotein (LDL type B) to visceral fat stores. LDL-B can invade sub-endothelial sites of small blood vessels, risking intraluminal clots which can lead to cardiac infarcts and venous thromboembolism. Furthermore, arterial fat deposition can lead to vascular cognitive impairment (Dolan 2010). People with NAFLD are often hungry, as the effect of the satiety hormone leptin (released by fat stores) on the hypothalamus is reduced (Myers 2012). This leads to escalating obesity that is resistant to dieting.

There are no drugs to remedy fatty liver, but intermittent fasting regimes appear to be beneficial (Fuhrmeister 2016), alongside aerobic or resistance training, although weight loss is also necessary (Loomba 2015). The recent finding that middle-aged people consuming both sugary and artificially sweetened carbonated drinks have increases in obesity and mortality similar to those in NAFLD (Mullee 2019) is relevant in patient education, as a significant proportion of people with SMI or intellectual disability drink sweetened carbonated drinks.

On biomarkers

The key development has been cerebrospinal fluid (CSF) analysis of the ratio of short- to long-chain beta amyloid to predict the likelihood of developing Alzheimer's disease up to 20 years before clinical features become apparent (Janelidze 2018). Currently, this investigation is carried out among people with a family history of early-onset disease or when other investigations are equivocal. People with Alzheimer's are more likely to show insulin resistance (sometimes selectively affecting the brain) 20 years before symptoms, which alongside inflammatory markers and apolipoprotein E (*APOE*) allelic variations, can be robust biomarkers and inform risk mitigation via, for example, resistance training (Andersen 2003).

On addictive behaviours

An allelic variant of a gene called *CREM* (cAMP-responsive element modulator) has been linked with multiple addictive behaviour, with evidence of cross-sensitisation (Miller 2018), suggesting a gateway effect of highly sweetened carbonated drinks leading to opiate and stimulant addiction, as demonstrated in rodents (Rada 2005). As regards treating addictive behaviours, transcranial direct current stimulation is being trialled (Grall-Bronner 2014), along with cannabinoid 1 (CB1) receptor antagonists (de Vries 2001). In general, the endocannabinoid system might turn out to be as significant as the serotonergic, adrenergic and dopaminergic pathways in the remediation of some mental disorders (Parolaro 2010).

How do we encourage patients and carers to talk freely about difficulties?

Approaches to facilitate patient and carer input to assessments have included open dialogue (Freeman 2018) and trauma-informed mental healthcare (Sweeney 2016). Open dialogue involves helping the patient and carers to articulate their understanding of the presenting problem(s), to agree a joint narrative and to suggest solutions. Evidence from Finland with first-episode psychosis presentations suggests high patient approval coupled with earlier hospital discharges, reduced readmissions, reduced psychotropic prescriptions and increased employment (Bergström 2018). A trial of open dialogue is underway in England involving selected CMHTs working entirely using this approach (ODESSI trial with Principal Investigator Steven Pilling UCL (2017–2022)).

Trauma-informed care

Trauma-informed care (TIC) involves acknowledging a person's trauma history without causing re-traumatisation (Hopper 2010). The Adverse Childhood Experience questionnaire (ACE-10) can be used as a screening tool. The patient is thereafter encouraged to think of the future: learning to avoid similar experiences (such as bullying) and developing a meaningful life purpose. Occasionally, intrusive memories have to be treated, for example via eye-movement desensitisation and reprocessing (EMDR). A brief description of the trauma is retained on electronic notes, with a warning not to delve into details thereafter.

Transparent and honest consultations

There is a further issue, transparent and honest consultations – how to facilitate difficult discussions on anticipated disease progression in neurodegenerative disorders and on risks and benefits (numbers needed to treat versus needed to harm) when using

antipsychotic, antidepressant, stimulant and memory-enhancing psychotropics. These discussions naturally lead to (or follow from) conversations on physical health screening and advance care planning.

Competency in facilitating these discussions are key components of a community psychiatrist's toolkit, especially when working in collaboration with GPs. Unfortunately, the psychiatric curriculum examines only diagnostic interview skills in what is, by necessity, an inquisitorial type of interview that can leave patients feeling uncomfortable and 'not heard'.

What is the most cost-effective liaison psychiatry service in primary care for improving access and patient flow?

The simplest solution would be to transplant the established general hospital psychiatric liaison team (PLT) model to primary care. This has been recently piloted in Nottingham (O'Shea 2019), with an average annual saving of over £500 per patient on discharge. PLT staff triage all referrals within 1 day, independent of age and circumstances, including substance misuse, intellectual disability and dementia.

Instead of formal written referrals, an email including an 'intermediate summary' from GP records (consisting of a problem list, medication list and the last three consultations describing the presenting problems) would be sufficient to commence an assessment, saving referral processing costs. Typically, information is summarised in the 'situation, background, assessment and response' (SBAR) format recommended by NHS Improvement, upgraded for mental illness by adding in a 'risk' section (de Silva 2013). This summary is used thereafter as the core document when care is transferred to other mental health teams. Consultant supervision is available immediately, including the option of discussing short-term treatment using an app such as Skype.

Alternatively, a liaison service in primary care could use the Prism model for rapid triage, coupled with the Gold Standards Framework to monitor people with chronic mental health conditions, including psychosis, dementia and intellectual disability. Furthermore, consultancy teams can back up primary care PLTs on 'behaviours that challenge' and on optimising psychotropic medication prescription.

Clearly 24 h coverage in primary care is not required as GP surgeries generally operate Monday to Friday 'office hours'. However, there could be close working with the hospital liaison teams that cover accident and emergency departments where patients attend out of hours. A joint

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set of electronic records, including primary care, mental health and acute hospital (as operated in Sheffield at South Yorkshire and Bassetlaw Integrated Care System), would be ideal in facilitating seamless care.

Hospital liaison psychiatry services have demonstrated significant savings through rapid assessment and diversion (Bell 2018). This is consistent with the above-mentioned financial savings demonstrated by Prism. Rapid access will also limit unnecessary referrals of 'functional' patients to other specialties.

Concluding comments

Community care involving formal written referrals has been a core feature of the NHS since its inception. Transformation towards joint working with primary care will result in reduction of administration and management roles, which touches on the much larger debate as to whether the NHS is going to remain a large generic employer or can become a value-for-money health maintenance organisation such as Kaiser Permanente in the USA (Feachem 2002).

Perhaps the evidence that a primary care psychiatric liaison team can save time and money while providing additional help for patients with functional neurological disorders will gain acceptance among secondary mental health staff. It is hoped that patients, carers and third-sector voluntary agencies would be valuable allies to facilitate this process, if allowed to do so by the usual stakeholders.

Notwithstanding the focus on primary care liaison, similar emphasis needs to be placed on liaison with psychiatric in-patient services, including assisting in efforts to reduce bed use and collaborating with discharge of vulnerable patients potentially at risk of suicide and physical deterioration.

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MCQs

Select the single best option for each question stem

1 Common thinking errors in liaison psychiatry include:

- a delayed gratification
- b need for classification
- c confirmation bias
- d use of reflection
- e use of supervision.

2 Methods of avoiding excess psychiatric bed use involve:

- a reducing bed numbers
- b increasing ward staffing
- c defensible documentation
- d use of a patient advocate
- e lean working.

3 Actions to prevent suicide among psychiatric in-patients include:

- a courageous decision-making
- b reducing polypharmacy
- c within 7-day post-discharge follow-up
- d within 1-day post-discharge follow-up
- e flexible follow-up.

4 Non-alcoholic fatty liver disease (NAFLD) always involves:

- a excess fat intake
- b obesity
- c links to cancers
- d depression
- e fructose deposited as fat in the liver.

5 Trauma-informed care involves:

- a avoiding asking about trauma
- b using the ACE-10 as a screening tool
- c using trauma as an explanation of symptoms
- d regular use of EMDR
- e documenting the trauma in detail.