

# A career as ...

## — a psychiatric liaison pharmacist

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Specialist mental health pharmacy services are rarely developed within acute medical trusts. This can create a service gap if mental health service users are admitted to acute hospitals. This article describes a role created by two London trusts to fill the gap



Discussion with the community mental health team about a patient's drug history is sometimes required

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**A**mong the general population, one in six adults suffers from a form of mental illness.<sup>1</sup> Patients who are diagnosed with severe and enduring mental illness are more likely to suffer from diabetes, ischaemic heart disease, stroke, hypertension and epilepsy, than other patients.<sup>2</sup> Similarly, some chronic medical conditions are associated with mental illness (eg, diabetic patients are twice as likely to develop depression than non-diabetics). There is often a gap in pharmacy services for such patients, because specialist mental health pharmacists do not usually work in acute hospitals.

To address this gap, Guys and St Thomas' NHS Foundation Trust (GST) and South London and the Maudsley NHS Foundation Trust (SLM) introduced a psychiatric liaison pharmacist to work across both sites, who has been in post since 2005. This post is, as far as we are aware, the only one of its kind in the UK.

### Why was the post needed?

An audit undertaken at GST suggested that up to 25 per cent of inpatients were taking at least one psychiatric drug. Usually, this drug

was not the cause of the admission and did not require any alteration while the patient was in hospital. However, occasionally the reason for admission affected the psychiatric drug, or a treatment prescribed for another condition interacted with it. For a pharmacist to validate these changes, the advice of a specialist pharmacist was often required.

Before the introduction of the psychiatric liaison pharmacist, advice on mental health drug treatment was obtained from specialist pharmacists at the nearby mental health trust (SLM). The introduction of the post was intended to provide specialist mental health advice for pharmacists from within GST. This would be done through a referral service. The postholder is given approximately 7.5 hours per week to provide this service.

In addition, it was hoped that the postholder would contribute to the development and audit of guidelines that involve psychotropic drugs or manage psychiatric symptoms. These include alcohol withdrawal syndrome, Wernicke's encephalopathy, delirium and rapid tranquilisation.

### Maintaining knowledge

It was decided that clinical expertise in general medicine and mental health needed to be maintained to provide an effective and efficient referral service. Therefore, the post was divided between St Thomas' Hospital and the Maudsley Hospital.

To help maintain knowledge in general medicine, the postholder is part of the

pharmacy admissions team and attends general medical ward rounds once a week. This allows for clinical supervision of the postholder in general medicine.

To help maintain knowledge in mental health, the postholder is part of the Maudsley Hospital's medicines information team and provides clinical pharmacy services to a mental health ward at St Thomas' Hospital.

Both hospitals are large teaching hospitals, so there is an additional requirement to teach undergraduate and postgraduate pharmacy students, medical students, junior doctors, nurses, and consultants.

### An audit of referrals

To assess the workload of the referral service and the nature of referrals that were received, an audit was conducted on all referrals received over a 12 month period from October 2006 to October 2007.

A referral was defined as the postholder being paged or telephoned directly to be asked advice or to see a patient. The audit only included patients on the medical, cardiac or surgical wards at GST.

Referrals were not included if the postholder had been involved in the patient's care previously during the admission. Ad hoc queries (eg, discussed with the postholder in person without being paged or telephoned) or interventions carried out during ward rounds were not included.

The following data was recorded every time a referral was made:

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- The profession of the person making the referral
- The nature of the referral
- The drug(s) involved
- The time taken to complete the query
- The postholder's rating of the difficulty of the query

The latter was recorded to assess whether the postholder was being asked to give advice that was available in locally produced guidelines. GST has produced guidelines in collaboration with SLM for several conditions that require the use of psychotropic medicines. These include the management of alcohol withdrawal syndrome and Wernicke's encephalopathy, and the recognition and management of delirium.

A "difficult referral" was one that required the postholder to complete a full literature search and offer an opinion from professional experience after visiting the patient. Such situations occurred when trust guidelines could not be applied.

### Results of the audit

A total of 130 referrals were recorded during the twelve-month period. On average, it took 39 minutes to assess each patient and answer the query or suggest a treatment plan. Most referrals (55 per cent) took 30–60 minutes to complete.

**Who uses the service?** Pharmacists made 69 per cent of the referrals. This was expected, because the post constitutes part of the pharmacy team.

Towards the end of the time period, we observed fewer referrals coming from pharmacists, and more referrals coming from medical staff. We suggest three reasons for this:

- Presence of a mental health specialist within the pharmacy team increased the level of education, awareness and confidence among pharmacy staff in treating common psychiatric conditions
- Pharmacy staff became accustomed to the routine and the presence of the specialist, and would "pop by" for advice rather than paging or telephoning (this did not fall under our definition of a referral)
- Presence of the postholder on the general medical ward allowed direct promotion of the service to general medical consultants

**What is asked?** In total, 40 per cent of referrals were made to discuss treatment options before a drug was prescribed. These queries were often made in view of a new diagnosis or where treatment options were not specified by trust guidelines. An example of this is shown in Panel 1.

Referrals to discuss drug doses comprised 27 per cent of the total, usually because a

### Panel 1: Benefit of access to a psychiatric liaison pharmacist

A patient who is taking an antidepressant suffers a myocardial infarct (MI). This necessitates a review of the choice of antidepressant.

Traditionally, this review was done by the cardiologist or left for the GP to perform. Commonly, the antidepressant treatment would be discontinued.

When the referral was made to the psychiatric liaison pharmacist, the drug choice was made after discussion with the community mental health team about the patient's drug history and the safety profile of the drug post-MI.

medical condition altered the patient's renal or hepatic function. In these circumstances, when a psychotropic medicine was deemed necessary, the postholder was contacted to advise on a dose adjustment or alternative drug. If the patient was under the care of a psychiatrist or community mental health team, the postholder would usually take responsibility for communicating any change to the necessary parties. A breakdown of the classification of all referrals is shown in Panel 2.

On two occasions, a referral was made regarding the supply and administration of drugs that were unlicensed or were to be used for an unlicensed indication. For example, intravenous citalopram was required for a patient who had no enteral access and was receiving all medicines parenterally. The patient's mental state deteriorated to the extent that he became suicidal and threatened to withdraw consent for life-saving procedures.

It was decided that an antidepressant should be prescribed to improve the patient's mental state, in the hope of receiving consent for further medical and surgical

### Panel 2: Classification of referrals by the nature of the query

Nature of query	Number of queries
Choice of drug	52
Dose of drug	35
Side effects of drug	21
Therapeutic drug monitoring	7
Clarification of policy	6
Pregnancy or breastfeeding	5
Formulation	2
Supply	2

treatment. The psychiatric liaison pharmacist recommended the use of IV citalopram, ordered the product, educated nursing staff on its administration and monitored the patient's haemoglobin level, liver function and sodium level.

**Which drugs are referrals about?** Most referrals were about antidepressants, antipsychotics and chlordiazepoxide. Typical queries included:

- Antidepressant choice following a myocardial infarct
- Using antipsychotics for rapid tranquilisation or delirium
- Using chlordiazepoxide for alcohol withdrawal syndrome

**How difficult are the queries?** "Difficult referrals", all of which required a visit to the patient, accounted for 54 per cent of referrals. This highlights the difficulty of the previous system, where mental health advice was offered from outside the trust.

### Success of the post

Expert clinical practice requires the judicious use of evidence in combination with clinical experience and patient concordance. Guidelines alone will not accommodate individual complexities or provide the expert advice that can be necessary in these cases.

The time taken to complete the referrals was considerable — 130 referrals at an average of 39 minutes each. We suggest that this additional workload would be unmanageable by a pharmacist working at a different trust who was not granted a portion of their working hours to deliver the service.

The post was designed to provide on-site specialist advice on psychiatric medicines to the pharmacy team. The post's success in achieving this has been confirmed by the fact that the majority of referrals came from pharmacists.

In addition, an increasing number of referrals from non-pharmacy clinicians, many of which were made before a prescription was issued, reflects the added value of a psychiatric pharmacist providing advice within an acute trust.

Further data will be collected during the next 12 months to ensure the service continues to improve to meet trust and departmental needs.

### References

1. Department of Health. National service framework for mental health: modern standards and service models. London: the department; 1999.
2. Department of Health. Choosing health: Supporting the physical needs of people with severe mental illness — commissioning framework. London: the department; 2006.