

# ROYAL COLLEGE OF PSYCHIATRISTS

## FACULTY OF LIAISON PSYCHIATRY

### NEWSLETTER



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#### Editors:

*Dr Sridevi Sira Mahalingappa*

*Dr Nora Turjanski*

Dear Colleagues,

Welcome to our new edition of the liaison psychiatry newsletter.

We have received many interesting submissions and we are very grateful to everyone who has contributed to this newsletter. The reports from the Chair and Vice Chair of the faculty provide a great overview of the position of this faculty and forthcoming developments. Our membership and general interest in liaison psychiatry continues to expand. We are very pleased to include submissions from other professionals, medical students and trainees and extend a particular welcome to our colleagues from the Paediatric liaison psychiatry network.

As you know, this is not a peer reviewed journal or a scientific publication but it is a good platform to share good practice, idea and a sensible dose of optimism! In the future, we intend to release this newsletter three times a year. We need your contributions to support this.

Submissions should be on matters relevant to liaison psychiatry including reports on service development, 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. If you would like to contribute to our next editions please e-mail ***Stella.Galea@rcpsych.ac.uk*** using "Liaison Faculty Newsletter" as the subject title.

We would especially like to thank Stella Galea and Peter Aitken for their support.

We hope you enjoy the Winter edition of the newsletter and wish you the best for the festive season. Wish you Merry Christmas and Happy New Year.

Editorial Team - Liaison Psychiatry Faculty Newsletter



## Message from Chair - Dr Peter Aitken

*Dr Peter Aitken MRCGP FRCPsych*

*Consultant in Psychological Medicine Director of Research & Development  
Devon Partnership NHS Trust. Chair, Faculty Of Liaison Psychiatry.*

It is with some pride (and no little relief) that I can now looking back over the last three and half years of my term as chair and can see genuine progress in all the work we set out to do. We have a great executive and a hugely engaged and supportive faculty. The work-stream leads have built the momentum and kept us focused on the things we said we'd do. Our meetings and conferences have been very well attended and faculty funds have never been healthier. For me, the ambition now is to keep momentum and hand on the role of chair in July 2017 without losing our energy and focus.

The role of chair is a privilege. It is an elected role and as such implies a certain level of appreciation by ones peers. That creates an equivalent sense of responsibility. I've seen the role more like being the conductor of an orchestra than director or dictator. In its way it is like a Saturday morning voluntary orchestra. No one needs to be there. We are there because we have a passion for liaison psychiatry. So its got to be fun. Nevertheless its a serious business and folk want to play great music. So for me chairing the faculty has been about setting the conditions for fun, creating strong intellectual conversation, helping engagement & participation, listening and influencing the agenda to the focus we all agreed. I've been keen that the executive meetings are inclusive and I've very much enjoyed the contribution from people with lived experience, nursing & psychology who have helped change the dynamic. It is a great group of people to work with and I encourage members of the faculty to think about becoming chair. Some have asked me about the time commitment and the external work. With a great executive team the chair is free to represent the interests of the faculty in other college meetings and outside. The key relationships are with the department of health and NHS England in England, and the chairs or

leads in the devolved nations. For liaison psychiatry there is also work with other Royal Colleges and groups representing people who use our services and other professional bodies representing nursing and psychology. The role could be all consuming so it helps to be well organised and good at prioritisation.

Government doesn't wait, they set the agenda, so being able to respond quickly and attend key meetings requires an understanding trust CEO and perhaps an understanding family. The chair may make use of delegates and alternates from the faculty to attend the various groups and meetings that emerge. On average I have spent around one day a week focused on college business. In reality that can mean busier weeks with overnight stays in London, and other weeks with a handful of phone calls to make by the Friday afternoon. One of the greatest pleasures of being chair is the people you meet and the opportunity to present them with a positive image of psychiatry.

We had our strategy day where we started to re-set the work for the incoming chair. We will review the work on models of care, payment & pricing and measurement and outcome. We need to understand the place of PLAN and CQC in assuring the quality as our surveys, LP-Maestro and the NCEPOD audit tells us ever more about developing services and their impact. Our connection with politics and policies in England, Scotland, Northern Ireland and Wales is growing and along with it an opportunity to share and compare development. The international bursaries start this year with faculty executive members attending the American Academy for Psychosomatic Medicine in Austin Texas, November and the first people to win awards attending next year in California.

My sense is that our Education and Training and Communications work-streams are emerging as key to tackling the morale and recruitment challenges we face attracting people into medicine and psychiatry. For that reason Kim Catcheside, the new Director of Communications for the RCPSYCH will join our strategy day and work with us to help sharpen what we need to say, and who we need to be saying it to, in our effort to broaden wider public appreciation of psychiatry and encourage medical undergraduates into the specialty. With growing evidence that taster sessions and foundation experience in psychiatry, and especially in liaison psychiatry, changes minds in favour of a career in psychiatry, the faculty is well placed to lead. We are finalising our conference plans for May 2017 and it would be good to see posters and oral presentations from school leavers who have had work experience in

psychiatry, undergraduates with great experience in curriculum or on elective, and more from foundation doctors and academic fellows. Equally we might engage trainees in other areas of medicine and invite them to share their experiences of working with the growing number of liaison psychiatry services around the country.

For me, I look forward to continuing to lead the faculty for the remaining nine months of my time and supporting my successor in the following year as immediate past chair.

For the faculty, my sincere thanks and appreciation. I am confident we'll continue to make progress under pressure and get to truly integrated psychological medicine services.

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## Report from Vice Chair

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*Dr Alastair Santhouse, MA, FRCP, FRCPsych  
Consultant Psychiatrist in Psychological Medicine  
South London and Maudsley NHS Foundation Trust & King's Health  
Partners.  
Dept of Psychological Medicine, Guy's Hospital, 20 Newcomen St, London.*

When I was appointed vice-chair of the liaison faculty some three years back, an old joke passed through my mind. It was a joke attributed to President Woodrow Wilson's former vice president. It goes along the lines of, a poor American woman has two sons. As they grow up, one decided to become a sailor and went off to sail the seven seas. The other went into politics and eventually became Vice President of the United States. And after that neither boy was ever heard of again.

Whilst the role of vice chair in the faculty carries responsibilities within the executive and wider faculty, it is not as clearly delineated as the role of chair, or indeed some of the other positions on the executive. But the

benefit of this arrangement is that it allows the freedom to develop interests as they arise and to take on those jobs that don't neatly fit anywhere else.

One of the main roles that has developed over the last couple of years is that of coordinating response to NICE guidance, which Janet and Nora have also taken an active role in. This has been a significant project. NICE produces a great many pieces of guidance, technology appraisals, reviews of guidance for update, and in all specialties. Indeed, it is hard to find a specialty that does not relate to liaison psychiatry, or where guidance would not be improved by an understanding of the contribution that psychiatry may be able to make in management of often complex patient groups. A coherent response to the regular requests for our involvement has been made possible by a concerted effort of the entire faculty. Many members, in response to our requests, have offered to contribute in either the

review of guidance or to join the guideline development groups, in the different subspecialties within liaison psychiatry. This has allowed us to develop a database of willing experts for future current and reference, and thereby develop the infrastructure for ongoing projects. In the last few months alone, we have contributed to NICE guidelines in acute chest pain, dual diagnosis, care of dying adults and rheumatoid arthritis, as well as considering the need for update to other guidelines, for example self-harm guidance. This month also saw the publication of the national acute kidney injury (AKI) guidelines, with psychiatry playing a central role in guideline development and dissemination. In taking the time to contribute in this way, liaison psychiatry puts itself at the forefront of acute medical care, and the faculty is able to deliver on one of the key aims of promoting liaison psychiatry within the general medical setting, for the overall benefit of patient care.

Another work stream has started to become embedded in the culture of liaison psychiatry is that of outcome measures. This has been an ongoing project led by Peter Trigwell, and in which I have been involved amongst several other of the faculty members. It has been a

challenge to consider how to provide outcome measures that adequately reflects the range of work that we do. The outcome measures though have taken shape. They are flexible enough to apply to all commonly encountered clinical situations and with an ease of use and validity that has encouraged their take-up by the liaison community. Work is ongoing within the faculty, in the further development of outcome measures in liaison psychiatry.

As Peter says, sometimes it's good to stop and admire the view, but from where we are standing the view ahead looks even better.

Over the months ahead, we will be developing our links with the American Academy of Psychosomatic Medicine, and there will surely be potential for collaboration with other countries in the future both within and outside Europe. Another project that I have been considering is the interface with the public, so that liaison psychiatry becomes more mainstream in the public consciousness, just as it is increasingly becoming so in the minds of ministers and decision makers. So the road ahead promises to hold significant opportunities for liaison psychiatry, and it will be up to us all to maximize these in the months and years ahead.

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## Report from Northern Ireland

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*Dr Jo Minay*

*Consultant Liaison Psychiatrist, Bluestone Unit, Craigavon Area Hospital, 68 Lurgan Road, Portadown.*

Northern Ireland has a population of 1.85 million. We have 5 different Health and Social Care Trusts to serve this population. Unfortunately the expansion of Liaison posts seen in Great Britain has not occurred with us. At present there are two permanent General Adult Liaison posts, 2 Old age liaison posts and a Pilot RAID like project. There is currently no commitment to invest further and two trusts out of five still have no dedicated Liaison sessions. On a positive note one of the POA Consultants is part of the credentialing pilot and we hope that will expand opportunities for trainees. We remain a very small faculty and over the next year aim to try and rekindle our relationship with the College of Psychiatrists with Ireland to expand our networks.

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# Brief Report - Measurement & Outcomes



*Dr Peter Trigwell*

*Consultant and Clinical Lead Yorkshire Centre for Psychological Medicine (On behalf of the FROM-LP Working Group, Liaison Psychiatry Faculty Executive, RCPsych.*

The Faculty of Liaison Psychiatry continues to make progress in relation to the need to optimise outcome measurement approaches to enable Liaison Psychiatry services in the UK to demonstrate clinical effectiveness and justify service developments. As a key part of this, the FROM-LP (Framework for Routine Outcome Measurement in Liaison Psychiatry) was produced by a Faculty Executive working party as a Faculty Report in May 2015.<sup>1</sup>

Multiple services and teams have started to use it, leading to generally very positive feedback, and the profile of the framework has been raised further by a recent BJPsych Bulletin paper by Peter Trigwell and James Kustow (July 2016).<sup>2</sup>

DH/RCPsych Expert Reference Group on OM has also positively received the FROM-LP and

are acting to require all RCPsych Faculties to work to produce their own FROM.

Regarding the next iteration of the framework, colleagues in Prof Else Guthrie's team are well on the way to producing an effective LP-specific clinical activity and outcome measure (clinician-rated but taking into account patient views), which it is hoped will enable improvement and simplification of the FROM-LP approach. Further testing of the new tool is planned and will soon be underway to explore this possibility.

1. Trigwell P, Kustow J, Santhouse A, Gopinath R, Aitken P, Reid S, et al. Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP). Faculty Report FR/LP/02. Royal College of Psychiatrists, 2015 (<http://www.rcpsych.ac.uk/pdf/FRLP02.pdf>).

2. A multidimensional Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP). Trigwell P, Kustow J. BJPsych Bulletin (2016), 40, 192-194.

The European Association of Psychosomatic Medicine (EAPM), the European umbrella organisation that includes liaison psychiatry held its annual meeting in Lulea, Sweden in June. Lulea is close to the Arctic Circle in North Sweden. In summer it is the land of the midnight sun. It is unspoilt and beautiful. It is also unfortunately quite hard to get to and was therefore rather vulnerable to the SAS pilot strike, which occurred at the beginning of the meeting. Some arrived later, some undertook heroic journeys, but in the end the meeting was thankfully a great success. <http://eapm2016.com/>

This is largely to the credit of the indefatigable effort of Dr Ursula Werneke, the local organiser. Over 400 individuals from 40 countries attended and indeed via the website you can have a glimpse of the meeting through the conference video. <http://eapm2016.com/2016/06/eapm-2016-signing-off/>

This is a rich meeting with diverse European perspectives on the problems we all work with. If the 2017 meeting is anywhere near as good as this one, I would recommend it. The meeting will be in Barcelona from 28th June to 1st July. <http://www.eapm.eu.com/>

American Academy of Psychosomatic Medicine meeting, took place in Austin, Texas in November, an even larger meeting (a thousand attendees) with obviously a more North American flavour. <http://www.apm.org/>

As Britain sits poised between the United States and Europe, it is clearly essential for you to try to attend if you can.....

*Professor Michael Sharpe (Vice President EAPM, Secretary APM)*



# Growing your own Liaison Nurses

*K Chartres, BSc Hons, Nurse Consultant, Sunderland Psychiatric Liaison Team.*

Over the last year to 18 months, Liaison Services within Northumberland Tyne and Wear Trust have embarked on a new venture in a bid to develop a sustainable workforce. As services develop in line with core 24, we have embarked on the exciting journey of 'knitting' a unique workforce, offering newly qualified staff to develop their skills and complete preceptorship within a liaison setting. Locally, we believed that from wherever we get our nurses they always require further bespoke training and even the most experienced nurses need around 3 months of support to develop competency within this unique service area and sometimes a lot longer to develop expertise. Furthermore, people often come to the service with ways of working that actively challenge the style needed in liaison psychiatry. For these reasons, despite there being a prevalence of Band 5 nurses occupying positions in other community services including Crisis, we had not considered following suit, convinced as we were of our inherent uniqueness. However, our interest in developing a recipe for a specialised workforce from raw ingredients was tweaked and we were able to test it out by taking in a number of Band 5 new starters across our services ranging from 1 in a team to 3 in our largest service.

## RECIPE

Have you ever considered what your perfect liaison nurse would look like? Perhaps he or she would comprise among other things, a liberal helping of competency, 6 ounces of knowledge about long term conditions, a pint and a half of unbridled passion for developing an intuitive understanding of the psychological impact of having a long term condition, a sprinkling of 'balls of steel' to challenge the status quo, half a pound of assessment and formulation skills, a healthy portion of autonomy and a sprig of willingness to question and to experiment with flavours and techniques.

## METHOD

Bake time is expected to be between 18 months and 2 years.

In an ideal world all the ingredients for a new preceptor should be prepared in advance and have been marinated in a sauce of knowledge and specialist formal induction before being placed in the oven.

The best case scenario is that our newly qualified preceptorship nurses start at the same time and in line with our trust wide induction. The induction includes a simulation day, CYPs, Delirium and Dementia, Challenging behaviour, Disability awareness, Legal Frameworks, Acute disturbance, Dual Diagnosis, Cultural Sensitivity, Veterans and Risk management and assessment.

The Trust wide induction is a week's course facilitated by our experts within Liaison Services and our wider trust colleagues for specific areas.

The induction week is enhanced by working half time across each part of the service where we have a separation of Emergency and Liaison.

Initial Assessments are completed jointly, initially observed, then as skill is developed, they might start to take the lead with support.

Brief psychological interventions are developed over time and with training available in-house and externally for Liaison Visits.

The induction experience could be further enhanced by opportunities to work with other specialities within the Acute Trust e.g. Specialist respiratory nurses.

## BAKE TIME

The Liaison Nurse Competency Framework is used in conjunction with other preceptorship documents with the view that establishing a level 3 in all areas is suggestive of an individual's readiness to start applying for a band 6 role. (Eales, S., Wilson, N. & Waghorn, J. (Eds) (2014) A Competency Framework for Liaison Mental Health Nursing. London, London Wide Liaison Nurses Special Interest Group).

## RESTAURANT CRITIQUE

We appear to have lost the respective bungee ED and Liaison bungee effect! Coined by Dr S Eales, this is where individuals are no longer dragged back to the ED or ward by an invisible force when work comes from the less preferred environment.

We have an opportunity to enhance medical knowledge through being effectively supernumerary and so create interesting learning opportunities.

We are developing ageless/specialist generic liaison nurses.

**Band 5 feedback:** “As a band 5 I tended to complete assessments with a Band 6, take a lead role in assessments at times, document and liaise with carers/professionals if required. Coming from working within an acute inpatient setting for the previous 11 years as a support worker and staff nurse I felt I had a lot of transferable skills to offer. However, my

assessment skills were limited as we do not tend to do this type of assessment on inpatient wards. I felt being a band 5 gave me the opportunity to work with different people in the team and gain experience of different styles of assessment and I felt able to utilise this in adapting my own way of assessing. It helped me build my confidence in the knowledge that someone was there to guide and advise”. Clare Ord, Acting Band 6 Liaison Nurse.

**Clinician feedback:** “It has been great having two staff that have shown commitment, dedication and a passion for learning. Both have thrived and taken any opportunity that has come their way. It has been enjoyable to offer them a journey of development, and being able to help nurture their careers. The limitations are that when or if a band 6 opportunity was to arise in our team, Band 5s would still have to go through central recruitment to apply for a band 6 job and also that if we are “growing our own,” then there has to be a point where we could, once targets are met, upgrade their banding. Joanne Sharp, Clinical Team Leader.

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## Liaison Faculty Executive Committee

### Officers

Dr Peter Aitken, Faculty chair

Dr Alastair Santhouse, vice chair

Dr Laurine Hanna, financial officer

### Elected members

Dr Sarah Burlinson

Dr Janet Butler

Dr Jackie Gordon

Dr Panthraton Grewal

Dr William Lee

Dr Marc Mandell

Dr Aaron McMeekin

Dr Annabel Price

Dr Luke Solomons

Dr Geraldine Swift

Dr Peter Trigwell

### Co-opted members and regional representatives

Dr Hosakere Aditya

Mr David Ainsworth

Dr Alice Ashby

Dr Elena Baker-Glenn

Dr Jim Bolton

Dr Sarah Brown

Dr William Bruce-Jones

Ms Katherine Chartres

Dr Sarah Eales

Dr Charlotte Feinmann

Dr Adrian Flynn

Prof Elspeth Guthrie

Dr Mahnaz Hashmi

Dr Christopher Hilton

Prof Allan House

Prof Khalida Ismail

Prof Eileen Joyce

Dr Geoff Lawrence-Smith

Dr Kirsten Lawson

Dr Katherine Martin

Dr Joanne Minay

Dr Ana Miorelli

Dr Sri Perecherla

Dr Joanna Woodger

Dr Thirza Pieters

Dr Stephen Potts

Dr Steve Reid

Dr Amrit Sachar

Dr Nikki Scheiner

Dr Chris Schofield

Dr Ankush Singhal

Dr Sridevi Sira Mahalingappa

Dr Sentil Soubramanian

Dr Catherine Taggart

Dr Tayyeb Tahir

Dr Nora Turjanski

Mrs Rebecca Walters

Dr Edwina Williams

Ms Nicola Wilson

# The Prevalence of Anxiety and Depressive Symptoms Post-Myocardial Infarction.



*Dr Ana Miorelli, Consultant Liaison Psychiatrist, Princess Anne Hospital, Southampton.*

*Michael Louis and William Ward, 4th year medical students at Southampton University.*

*Dr Simon Corbett, University Hospital Southampton NHS Foundation Trust.*

*Prof Richard IG, Professor in Diabetes & Endocrinology University of Southampton.*

## Background

Diabetes, depression and anxiety are important risk factors for cardiovascular disease. Evidence shows the presence of one or more of these risk factors increase the risk of developing a myocardial infarction (MI) or its recurrence. The prevalence of depression and anxiety in the immediate post-infarct period are under researched. Furthermore, it is unknown whether mental health interventions at this time would be as effective in improving cardiac outcomes.

## Aims & Method

The aim of our study was to assess the prevalence of post-MI depressive and anxiety symptoms. We also assessed whether there were differences in these symptoms between patients with and without diabetes and in those with an ST elevation MI (STEMI) and a non-ST elevation MI (NSTEMI). We undertook a cross-sectional pilot study of people admitted to cardiology wards at Southampton General Hospital between January and April 2016. We approached individuals after their first biochemically proven MI, if they were aged over 18 years and could speak English fluently.

Each of the participants completed a structured quantitative interview which gave details about basic demographic details including sex, age, marital status, employment status, socio-economic status and ethnicity. We also recorded their self-reported past psychiatric history including depression, anxiety, other mental illness and pharmacological or psychological treatments. For those with diabetes, the type, duration and current treatment were noted. Other cardiovascular risk factors (hypertension, dyslipidaemia, smoking, etc.) and clinical measurements (weight, height, and blood cholesterol and glucose levels) were

collected from the clinical notes or the Myocardial Infarction National Audit Project (MINAP) database. Depression and anxiety symptoms were measured using 3 self-reported questionnaires: Hamilton Depression Rating Scale (HAM-D), Hamilton Anxiety Rating Scale (HAM-A) and Patient Health Questionnaire-9 (PHQ-9).

## Results

46 participants took part in the study: their mean age was 63.1 years; BMI of 27.0 Kg/m<sup>2</sup> (overweight); 28.3% were female; 15.2% had type 2 diabetes (T2DM); NSTEMI to STEMI ratio of 27:18. Our sample had varied employment, marital and socioeconomic statuses. 30.4% of participants reported previous depression and 14.6% of participants reported previous anxiety. Based on the classifications of mild or greater symptoms:

- 32.4% reported depression symptoms on the HAM-D questionnaire
- 45.7% reported anxiety symptoms on the HAM-A questionnaire
- 50.0% reported anxiety symptoms on the PHQ-9 questionnaire

There were significant associations between women and higher scores on HAM-D (Mann-Whitney U test:  $P=0.027$ ) and PHQ-9 ( $P=0.003$ ). There were significant associations between NSTEMI and higher scores on HAM-A (Mann-Whitney U test:  $P=0.015$ ).

There appeared to be no correlation between age, BMI or specific cardiac risk factors with questionnaire scores. Additionally, there was no relationship between the "length of stay until questionnaires were completed" or "total length of stay in hospital" with questionnaire scores. This shows that the timing of the interview post-MI did not affect the severity of depression and anxiety symptoms reported.



## Conclusions

There is a high prevalence of mild depression and anxiety symptoms in patients post-MI. The existing literature suggests a clinically significant increased risk of mortality for this population.

No association between cardiovascular risk factors and questionnaire score was found. A small sample size limits the results. Further research is needed, specifically examining those with diabetes and 30-day mortality rate.

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## From hearing aids to hearing voices: an audiovestibular medicine trainee's experience in Liaison Psychiatry

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*Rosa Crunkhorn ST3 Audiovestibular Medicine, University Hospital of Wales.*

Audiovestibular medicine is the medical specialty concerned with hearing and balance disorders in adults and children. Training includes placements in other specialities such as Paediatrics, Genetics, Neurology, and Psychiatry to gain breadth of knowledge and at least some experience in these related fields. And hence one Monday afternoon I found myself approaching the liaison psychiatry department.

The first difference I noticed was that in audiovestibular medicine, by and large, patients will walk in, sit down and explain the problem. In Liaison Psychiatry I found this wasn't necessarily the case. And consultations which looked relatively straightforward on paper frequently took a completely unexpected turn once underway.

But the ward rounds were altogether different. Saying the patients were varied is a cliché but true. The round moved seamlessly from patient to patient: one a highly charged and fractious substance misuser; the next a silent, cachectic patient obviously too ill, tired and fed up to even open their eyes. The problem of people being difficult to engage looked exhausting yet no one seemed perturbed.

The next difference was the need to gain background information regarding each referral. This process often involved putting together snippets of information gleaned from passing comments in the corridor, overheard telephone conversations, volumes of notes, and of course the reports from fellow staff. There were lots of fantastic staff, but also lots of flicking of handover sheets on the wards, and many missing pieces to the story. Information was slowly sifted out but rarely readily available. I realised that I've often been that ward doctor –

completely task orientated and completely unaware of the story behind each patient.

Moving on to seeing the patient, history taking was an art form – an effortless subtle mixture of being interested, inquisitive, cajoling, persuasive, sometimes firm and always polite and professional. Stories told were unbelievably sad. This was the norm and I began to feel incredibly lucky. Everything was dealt with in a calm and measured way. People ready for a battle were disarmed. Patients who adamantly did not want to engage did, despite the inevitable probing questions and demanding cognitive tests, and progress was made.

I was all too often flabbergasted at the complexity of consultations. But perhaps even more surprising were the patients who weren't complex – just occasionally there were completely absurd consultations. Could this patient really be so blatantly compensation seeking? Why didn't they at least try to hide it?

And there are of course the misconceptions of psychiatry to deal with. I have been that annoying medical SHO on the phone begging for help with an aggressive 84-year-old inconveniently requiring the presence of six burly security guards. How annoying that the psychiatry SHO was, at least in my mind, sat drinking coffee somewhere rather than racing to my assistance. And at 4.30pm trying to find the appropriate team for your particular patient's needs can seem like an impossible task. The worlds of acute medicine and psychiatry often seem poles apart – with liaison psychiatry as the link between.

So what have I learnt. Firstly, the realisation of the massive elephant in the room throughout medicine of “medically unexplained symptoms”.

In audiovestibular medicine we know many patients with tinnitus, hyperacusis, and dizziness for whom emotional and psychological factors are obviously worsening symptoms, preventing recovery and prolonging rehabilitation. I wonder what the longer term strategy will be in all areas of medicine to cope with this growing issue.

Secondly I used to think I was generally pretty good at communication. This is now laughable – my jaw has dropped as I have wondered how on earth I would have survived had I been in the driving seat. Dealing with the range of emotions thrown around the consultation room – in

particular the all too frequent hostility, I know I would have been tempted to scuttle away. I wonder how the ability to manage these difficult situations and turn the consultation around can be bottled and shared out elsewhere in medicine.

Lastly my curriculum objectives – to obtain an adequate psychiatric profile of a patient and to recognise common conditions, referring appropriately. More reading to be done, but the route so far has been incredibly interesting.

*With many thanks to Prof Tabir and his team at the University Hospital of Wales for arranging and supervising my placement.*

## The Paediatric Liaison Psychiatry Network

*Dr Elaine Lockhart*

*Consultant in paediatric liaison psychiatry, Co-chair of the Paediatric Liaison Psychiatry network. Royal Hospital for Children, Glasgow.*



Paediatric Liaison (PL) psychiatry is a sub-specialty of Child and Adolescent psychiatry which brings together mental health clinicians who can think holistically with paediatric colleagues, safeguarding and mental health teams about the child, their family and their community. This allows for physical and psychiatric complexity to be understood, so that children who present with emotional distress through physical symptoms and those who experience psychiatric disorder associated with chronic paediatric conditions can have all of their health needs met.

This may include;

- responding to children presenting with psychiatric crises in acute medical settings
- management of unexplained symptoms
- treating anxiety and mood disorders which are co-morbid with chronic paediatric and life-limiting conditions
- diagnosing and managing children with complex neuropsychiatric disorders.

At any one time about 10% of children will have a psychiatric disorder which is having a significant impact on their daily life. This is significantly increased in children with chronic paediatric conditions particularly neurological

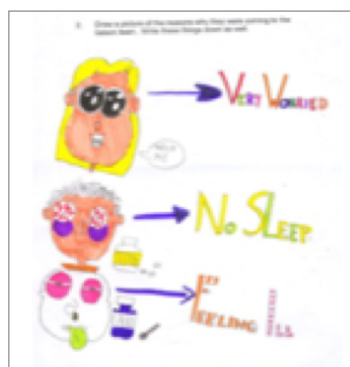
e.g. more than 35% of children with epilepsy will have an associated psychiatric disorder. Families appreciate that their children benefit from having all of these difficulties understood and treated in the one setting. Understanding the developmental issues with children is key and there is a network of colleagues within child health and other agencies to connect with.

A PL service is not simply a CAMHS service located within a paediatric setting and works best as multi-disciplinary teams with much of the work focusing on supporting paediatric

practice through clinical discussions, joint work, teaching and research activities.

The Paediatric Liaison (PL) network was

set up in 2002 by about 20 enthusiastic clinicians, most of whom had limited if any sessions attached to this work. Since then it has grown to involve over 200 psychiatrists, mostly



based in the UK but also linking in with international colleagues. There has been an expansion of dedicated PL consultant posts around the UK but services continue to be patchy with limited expertise available outside some of the main paediatric centres. The network has supported colleagues through the use of clinical and commissioning advice via the mail base, free bi-annual meetings and the establishment of an executive and research interest group. A recent meeting in January was attended by over 50 psychiatrists.

Despite a commitment nationally to parity of esteem between physical and mental health, there continues to be a lack of dedicated mental health services within paediatric settings, even

less than adult Liaison Psychiatry provision. Changes to how services are commissioned have created a further challenge with PL work often being omitted in bidding processes by both psychiatry and paediatric services and this work cannot be safely undertaken by an all ages Liaison Psychiatry service.

We have applied for Special Interest Group (SIG) status within the Royal College of Psychiatrists to support further the development of this sub-specialty and would welcome the support of the Faculty of Liaison Psychiatry.

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## **BMJ Award for team who are incorporating mental health service into dermatology clinic**

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King's Health Partners' pioneering IMPARTS project (Integrating Mental & Physical healthcare: Research, Training & Services) has been highly commended in the 'Integrating Physical and Mental Healthcare' category, sponsored by NHS England, at the Positive Practice in Mental Health Awards.

The annual Positive Practice in Mental Health Awards is designed to showcase the very best in mental health services across the country. This year they were held on Thursday 13 October.

IMPARTS is designed to integrate mental and physical healthcare by supporting clinical teams to provide timely, tailored and evidence-based care to patients. It is currently running in 32 services across both Guy's and St Thomas' and King's College Hospital sites. In physical healthcare settings, it involves asking patients to complete a screening questionnaire while waiting for their appointment. The questionnaire is designed to reveal any psychological issues so that appropriate support and treatment can be arranged.

The initiative is also being extended into services at South London and Maudsley, to help improve the physical healthcare of people with severe mental illness.

The team's work to provide holistic care for people with skin disease at the St John's Institute of Dermatology at Guy's and St Thomas' recently received the BMJ Award for Dermatology Team of the Year 2016.

The team has also been shortlisted for a Health Service Journal award in the Innovation in Mental Health category. Winners to be announced 23rd November 2016. "We look forward to continuing our work and seeing the long-term impacts of this project, both with the Guy's dermatology team, and the wide range of other services across King's Health Partners using the IMPARTS model to improve mind and body care for patients."

The award judges said that they found the project "inspirational", commenting that: "This team are leading the way, and have created a path and model that others could follow."

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## Liaison Psychiatry in England: an update on the 'what', 'when', 'where' and with 'who' and plans to explore the 'why'.



*Professor Allan House, Professor of Liaison Psychiatry  
Dr Andrew A Walker Senior Research Fellow/LP-MAESTRO Project Co-ordinator  
Leeds Institute of Health Sciences, School of Medicine, University of Leeds'.*

Readers may be aware of two collaborative funding initiatives mapping Liaison Psychiatry: A national survey of liaison psychiatry (LP) services in acute hospitals completed on behalf of the Royal College of Psychiatrists and the National Collaborating Centre for Mental Health commissioned by NHS England (Liaison Psychiatry Survey of England 2015: LPSE 2015); and a research study funded by the UK's National Institute for Health Research Health Services and Delivery Research (HS&DR) programme to evaluate the effectiveness and cost-effectiveness of LP services (LP-MAESTRO).

An electronic survey of all 179 acute hospitals with an Emergency Department in England discovered 168 had a LP service and collected information on, amongst other things, staffing levels, hours of service, response times and whether the service extends beyond the acute care pathway. Additionally, 61 telephone interviews covering 57 hospitals provided additional information on what the LP services were providing, where, when, and to who. The results of these two initiatives have been submitted for peer-reviewed publication.

On behalf of all those involved in LPSE 2015 and LP-MAESTRO, THANK YOU to everyone who participated in this important and timely work.

Four clusters (LP services more similar in some sense or another to each other than to those LP services in the other three groups) emerged from statistical analysis of the LPSE returns. The three most obvious features distinguishing between LP services were (1) the acuity of the acute Emergency Department and ward service (hours of cover, response time standards), (2) the likelihood of providing non-acute care in outpatients, and (3) the decision to have separate teams for older and working age adults. This may suggest that when LP services scale up from the basic provision found in smaller hospitals they do

so in one of these three directions; (1) increasing intensity of acute work, (2) developing outpatient and non-acute work, or (3) developing specialist old age teams. All of the LP-MAESTRO interviewees will be contacted by email when the results of the interviews (and LPSE 2015) are published and we hope to present a summary of findings in a later edition of this Liaison Faculty newsletter.

The next phase of LP-MAESTRO is to find out what contextual and individual factors influence why LP services are set-up in the ways they are. To this end, the LP-MAESTRO team plan to interview representatives (both clinical and non-clinical) from LP services within the four clusters. LP services will be purposively selected (that is selected based on inclusion in a cluster and other features) for inclusion in the next phase and, if selected, both the LP team and the Research & Development department for the team will be contacted directly by the LP-MAESTRO team.

Alongside the interviews we will ask LP services to carry out a simple activity survey, which can also be made available to services who are not approached for interview or who are approached but cannot accommodate the interviews yet would like to contribute in some way.

We hope you agree that LPSE 2015 and LP-MAESTRO are important initiatives and should meaningfully contribute to discussions about Liaison Service configuration and commissioning in the future.

For any enquiries about LP-MAESTRO or to express interest in using the activity survey please contact Dr Andrew Walker, Senior Research Fellow for LP-MAESTRO, at [hssawa@leeds.ac.uk](mailto:hssawa@leeds.ac.uk)

LPSE 2015 was completed on behalf of the Royal College of Psychiatrists and the National Collaborating Centre for Mental Health and funded by NHS England.

The LP MAESTRO project is funded by the National Institute for Health Research HS&DR (project number 13/58/08).

Department of Health Disclaimer: The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR, NIHR, NHS or the Department of Health.

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## ROYAL COLLEGE OF PSYCHIATRISTS FACULTY OF LIAISON ANNUAL CONFERENCE

### ‘INTEGRATED PSYCHOLOGICAL MEDICINE’

**10-12 MAY 2017 LONDON**

We are delighted to announce that the **Liaison Psychiatry Faculty Annual Conference this year will be held on Wednesday 10 May to Friday 12 May 2017, at the College headquarters in London.**

#### CALL FOR POSTERS

The Faculty of Liaison Psychiatry invites all professionals to participate by sending abstracts.

**More details about the conference can be found on the Faculty Website.**

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Liaison Psychiatry Faculty is delighted to announce that **Dr Peter Aitken, Chair of our faculty has been awarded the honour of RCPSYCH Psychiatrist of the Year, 2016.**

This is the second time in three years the award has gone to a liaison psychiatrist with Professor Michael Sharpe being the recipient in 2014.



**The judges said:** “Dr Peter Aitken has demonstrated exceptional leadership at national, regional and local levels. He has promoted the Liaison speciality and its models of care, through the Crisis Care Concordat and into the NHS Mandate and Five Year Forward View. Peter developed the commissioning guidance for the Core24 liaison psychiatry services in the SW that are being implemented now and which will be in 50% of English Hospitals by 2020. Peter is an excellent communicator and appears regularly in the media promoting psychiatry in medicine and the wider society.”

#### Message from Dr Peter Aitken

“ I am very proud to be RCPSYCH Psychiatrist of the Year, personally and collectively on behalf of the Faculty of Liaison Psychiatry. I have been proud to be our chair. We are also electing new officers and members, so please look out for the election ballot in the coming month.

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## **Opportunity for Liaison Psychiatry Clinical Fellowship at Central and North West London NHS Foundation Trust**

This may be of interest to an ST registrar who wishes to pursue a career as a liaison psychiatrist but has not been able to secure a liaison psychiatry post within their training rotation, or to a CT3+ registrar who needs additional time to pass MRCPsych or secure an ST4 number.

Our dept is advertising a 12 month clinical fellowship in liaison psychiatry, starting in August 2017, with 20% protected time for a specific teaching or quality improvement project. For ST registrars we have previously secured RCPsych approval for the fellowship to count as OOPT leading to endorsement in liaison psychiatry for both general adult and old age CCTs, so this offers a potential alternative route to liaison psychiatry CCT endorsement (subject to TPD approval and competitive application).

Although these posts are hard work – they are on a 24/7 full shift rota – they are fun, rewarding, handsomely paid (band 1A – 50% supplement) with a strong sense of camaraderie and adequate ‘playtime’ away from the shopfloor. To give you an idea of the experience on offer, current clinical fellows are:

- Introducing a clinical outcomes framework for liaison psychiatry
- Improving pathways for medical assessment & transfer to psychiatry inpatient wards
- Organising, delivering and evaluating our dept’s teaching programme
- Improving care for people who attend the emergency dept with mental health needs
- Delivering training in structured suicide/self-harm interventions for liaison psychiatry staff

Upcoming opportunities include improving the quality of 1:1 nursing care on the older adult wards, reviewing and improving our use of healthcare IT, and improving alcohol care in the acute trust. All our junior doctors from FY1 to SpR will be submitting posters to the 2017 RCPsych Faculty of Liaison Psychiatry national conference, with a view to writing them up for publication thereafter.

The link to the advertisement is here:

Anyone who is interested is welcome to get in touch with the consultants (Justin Kington and me) and team manager (Fungayi Useya). We can also put people in touch with the current fellows to hear about their experience. The closing date is currently 16.01.2016 with a view to interviewing on 27.01.2016 – though we may close the advertisement early if we receive a large number of applications.

Best Regards,

Dr A Thomson

Consultant Liaison Psychiatrist, Clinical Network Lead for Psychological Medicine. Dept of Psychological Medicine, Northwick Park Hospital, Watford Road, Harrow HA1 3UJ.