Getting psychologists into your liaison psychiatry team: the benefits, pitfalls, hints and tips

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About Us
Overview

- Psychologists and RAID
- Clinical Psychology Training and qualification
- The value and roles of an integrated Liaison Psychologist
- Challenges/pitfalls
- Tips/next steps
Why are you here?

- Questions in mind for today’s workshop?
- What do you want to get out of the session?
Psychologists and RAID

- RAID = paradigm shift in LP – manifest through inclusion of senior psychologists as part of the MDT.

- New concept to both liaison services and Clinical Psychologists
Your views & experience

• What is the role of a clinical psychologist within a RAID/Psychiatric Liaison Service?

• Experiences of Psychologists within RAID or interaction with other psychology teams?
Profession of Clinical Psychology Core Function and Purpose

- ‘reducing psychological distress and enhancing and promoting psychological well-being through the systematic application of knowledge derived from psychological theory and evidence’ (BPS 2006)

However,

- ‘for NWoW to be effective, the added value from Applied Psychologists is as much to do with the resource which they bring to the rest of the team as with the quality of the work they undertake with service users with complex problems. Applied Psychologists bring a range of essential skills to their teams and services’… (BPS 2007).
Clinical Psychology Training

• DClinPsy – NHS funded and salaried (for now)

• 60:40 applied: academic

• Highly competitive (1:6-7 586 accepted for training, 3857 applicants (2012). 30 training centers.)

• Lifespan training - Child and Families; Adults; Learning Disabilities; Older Adults – specialist placements e.g. Health and Neuro / Forensic…

• 4 x core placements (usually 6 months each (3 days per week)
• 1 x specialist placement 9-12mths duration (3-5 days per week)
Core Skills – LP congruent

• Transferable skills – models and modes across ages and populations; think critically and reflectively…

• Assessment – including psychometrics and neuropsychological assessment

• Formulation – psychological theories individuals, groups, organisations – consideration of context.

• Intervention – direct and indirect

• Evaluation – of work, of services, small N…

• Research and audit – ‘scientist-practitioners’, complete doctoral level research

• Teaching/Training - including clinical supervision

(BPS 2006)
## Psychology/Psychiatry career pathway

<table>
<thead>
<tr>
<th>Psychiatry</th>
<th>Psychology (Clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Degree (5 years)</td>
<td>Psychology Degree (3-4 years) 2:1</td>
</tr>
<tr>
<td>Foundation trainees (2 years – including Ψ placement?)</td>
<td>Assistant / Research Assistant Psychologist (3 years) ± MSc/PhD – AfC 4-5</td>
</tr>
<tr>
<td>CT1</td>
<td>Trainee Clin Psych – Foundation AfC - 6</td>
</tr>
<tr>
<td>CT2</td>
<td>Trainee Year 2</td>
</tr>
<tr>
<td>CT 3</td>
<td>Trainee Year 3 – Doctorate completion</td>
</tr>
<tr>
<td>ST 4</td>
<td>AfC B7 – Newly Qualified – Clinically Responsible</td>
</tr>
<tr>
<td>ST 5</td>
<td>Afc 8a – Highly Specialist – Supervise trainees</td>
</tr>
<tr>
<td>ST 6</td>
<td>Afc 8b – Highly Specialist - Service</td>
</tr>
<tr>
<td>Consultant</td>
<td>Consultant - AfC 8c Tripartite Role</td>
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**Recommended Skill Mix for RAID**  
LPT 650 beds, 750 Self harm referrals

<table>
<thead>
<tr>
<th>role</th>
<th>grade</th>
<th>time</th>
<th>comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Consultant</td>
<td>10 PA</td>
<td>Accessible consultant leadership is essential to team functioning</td>
</tr>
<tr>
<td>Nursing</td>
<td>Band 8</td>
<td>Whole time</td>
<td>One of the nursing roles should be as team leader.</td>
</tr>
<tr>
<td>Nursing</td>
<td>Band 7</td>
<td>3 x whole time</td>
<td>The nurses operate as autonomous practitioners</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>Band 8</td>
<td>1</td>
<td>May be provided from health psychology team</td>
</tr>
<tr>
<td>Team PA</td>
<td>Band 4</td>
<td>1.5 x whole time</td>
<td>Core to referral, management, info gathering and communication</td>
</tr>
</tbody>
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*Mental Health Policy Implementation Guide, Liaison Psychiatry and Psychological Medicine in the General Hospital, 2008*
Direct Clinical:

- 6 month period 5% of new referrals in 24 hour service. Joint worked/active direct involvement with 26%.

- Outpatient clinic (1 session per week): Frequent attenders, self harm, MUS, timely psychological assessment responsive to need (no waiting lists)
- Clinical Audit Lead for RAID Programme in Birmingham
- Plan Lead
- Service Developments – RADAR, PDU

Indirect Clinical:

- Clinical Supervisor for 4 nursing staff, 1 Trainee clinical Psychologist, 1 Research/Assistant Psychologist
- Monthly reflective practice group for City Hospital RAID team
- Teaching and Training for RAID programme. Recently 3rd year workshop on MUS, post traumatic stress following ITU
Royal London Hospital

**Direct Clinical:**

Mainly Ward based aside from frequent attenders project.

30:70 split - front line assessment vs specialist role.

Clinical work includes post trauma/ serious self harm, complex cases involving multi-agency working, personality disorder, Brief ACT, anxiety and depression impacting on rehabilitation and length of stay, neuropsychology, MUS and LTHC, challenging behaviour.

Joint lead for frequent attenders/length of stay QI projects

Business cases for trauma, haematology and gastro.

**Indirect Clinical:**

Clinical Supervisor for 2 nursing staff, 1 Qualified Clinical Psychologist, 1 Trainee clinical Psychologist, 4 Research/Assistant Psychologists, 1-2 junior doctors.

Monthly reflective practice group for Admission Avoidance team and individual wards.

Teaching and Training for RAID programme.

Trustwide formulation training for PLN’s and complex case series for Acute staff.

Project lead for RAID Sickle Cell pilot

Developed and lead Schwartz Rounds.
Examples of good practice from around the UK

- RAID Psychology
- MUS Research and Innovation
- Psychologically informed ITU care
- Frequent attenders pathway
- Neuropsychology for brain injury
- Self harm clinic
- Persistent physical health clinic
Trainee CPs in RAID

- 2-4 placements provided yearly
- 2nd-3rd year only (CT2-3 equivalent).
- Older Adult and Adult competencies
- Specialist MUS placement
- Academic requirements per placement e.g service evaluation; SCED; Case Study…
- Provide high quality clinical input – assessment and formulation, provide talking therapies, carer support (NICE) continuity of interventions and evaluation of outcome
  Contribute to teaching/training in house
Adding Value

To the Team
• Expert psychological resource to and of the team - theory, practice and methods – ‘psychology direct’.
• Psychological assessment and evidence based interventions – in and op (e.g PIT for MUS, CBT for self harm, mindfulness for pain).
• Clinical leadership, management support.
• Team working – managing and working with complex cases independently and in partnership with psychiatry and nursing.
• Interface with other psychological services e.g IAPT, pain management etc.
Adding Value

- Building and supporting psychological capacity in team and hospital – teaching, training, supervision…
- Assistant Psychs support research and audit.
- Value for money – increased high quality workforce at no additional cost via trainees!!

To the hospital
- Staff support and reflective practice
- Teaching/training
- Joint working e.g. Schwartz rounds
- Reducing costs and length of stay….e.g MUS work / upstream interventions, Sickle Cell work, frequent attender projects, length of stay.
Case example 1: Working with teams

- 70 year old gentleman – complex history of non-engagement.
- **Service use:** 9 admissions, 14 A&E attendances, 96 days in hospital.
- **Psychological Assessment:** Integration of cognitive, psychological and background history to develop complex psychological formulation.
- **Psychological intervention:** Close work with OT/physio to understand ways to build confidence and reduce anxiety relating to rehab, capacity ax, co-ordination with community teams/care providers and training in person centred engagement ready for discharge.
- **Outcome:** No further hospital admissions to date, successfully engaged with community services at his home.
Case example 2: Health psychology

- 46 year old gentleman – idiopathic small bowel fibrosis & severe depression. Previously seen by primary care therapy.
- **Service use:** 2 admissions, 75 days in hospital.
- **Psychological intervention:** NICE compliant psychological intervention, CBT/Mindfulness.
- **Outcome:** No further hospital admissions.
- **Feedback:** More positive, hopeful & in control. Now a member of feedback panel.
Case example 3: MUS

- Young female, complex MUS and personality disorder
- **Service use:** 4 admissions in 6 months, 88 days in hospital
- **Joint psychological & psychiatric approach:** Multi-agency and MDT coordination based on psychological formulation.
- **Outcome:** 1 A&E attendance in last 3 months, no hospital admissions.
Case example 4: MUS

- 63 year old woman. Multiple presentations due to headaches, and difficulty swallowing.
- Lengthy admissions up over 100 days, no organic explanation for symptoms, inconsistent presentation.
- Under multiple specialities as an outpatient. All appear to suggest functional element but continue to offer follow-up.
- RADAR project: extensive review of medical notes.
- Symptoms emerge shortly after partner’s death.
- Inpatient engagement and outpatient treatment. PIT approach. Enabled linking of emotional distress.
- Detailed MDT communication to reduce unnecessary investigations and reinforce biopsychosocial approach.
Case example 5: Neuropsychological assessment

- 23 year old man with brittle diabetes, homeless, rent arrears, dependency on hospital admissions. Background of neglect and loss of secure attachment.
- Vulnerable adult but lack of clarity about skills deficits
- Multi agency approach required to secure placement
- RAID psychologist carried out in depth neuropsychological assessment. TOPF, RBANS, Hayling and Brixton. Significant deficits in verbal language and attention.
- Enabled appropriate placement
Challenges/Pitfalls

- Perceptions of psychology versus new ways of working. Risks associated with lack of integration
- Health psychology and Liaison psychology
- Initial hostility – ‘I’m looking for a real Dr’ professional isolation and bio-medical dominance and culture. Requires confidence (suitable for newly qualified)
- Reciprocity – learning and working together in partnership – not competition.
- Respecting similarity as well as difference.
Tips/Next steps

- Adaptation to local need
- Identifying and formalising need/gaps
- Recruitment & business case
- Links to Liaison Psychology network
- Development of role in your service?.......
Final thoughts

• ‘A LPT requires the skills of nursing, psychology and psychiatry.’ (Aitken, 2007)
• RAID model and its success has had a significant contribution from clinical psychology…
• There is no health without mental health and there is no psychiatry without psychology…..so
• ‘let wisdom guide’ and encourage recruitment of clinical psychologists within your liaison team!
Thank you!

- Any questions?
References


• Royal College of Psychiatrists 2011 *No Health Without Mental Health*

• *Mental Health Policy Implementation Guide, Liaison Psychiatry and Psychological Medicine in the General Hospital, 2008*