Mental Health Policy
Implementation Guide

Liaison Psychiatry and Psychological Medicine in the General Hospital

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November 2007

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1. Introduction

When the Mental Health Implementation Guide was launched in March 2001, policy focused on the needs of those with long term conditions associated with the greatest vulnerability to risk. In the last five years, policy has refocused with the greater ambition of achieving mental well-being for our whole community. Services directed toward the psychological well-being of users of acute trust services require redesign to fit with the National Service Framework teams.

Sections of the Guide issued at that time included model service specifications for these newer service elements - early intervention, crisis resolution/home treatment and assertive outreach teams. Many colleagues involved in implementing service change in mental health have asked for similar guidance on liaison psychiatry and psychological medicine services to general hospitals as they evolve within a whole system which includes functional specialised teams. This document responds to these requests.

We know that the level of development of liaison psychiatry and psychological medicine services varies markedly around the country, as does the level of development of the newer functional teams.

The emphasis in this document is on identifying the functions which a liaison psychiatry and psychological medicine service will perform in such a whole system, rather than on specifying the precise structure: local flexibility and close working relationships between all key stakeholders will enable the best arrangements to be developed in each locality.
2. Who is the service for?

Adults of working age with the full range of mental health problems presenting in the general hospital: age limits to be determined in line with locally agreed protocols for transitions from adolescent to adult and adult to older adult services.

The liaison psychiatry and psychological medicine team (LPT) performs functions for four groups of people:

1. People with impaired mental well-being – providing advice, signposting and hand holding for people who are not mentally disordered but who have impaired mental-well-being or emotional distress, coincident with physical health disorder, and are cause for concern to their general hospital team.

2. People with time limited mental disorders amenable to brief intervention. These include:
   i. adjustment disorders
   ii. anxiety disorders,
   iii. depression,
   iv. acute confusional states (delirium).

The LPT can provide brief interventions for people with time limited disorders who will only require GP level care when their condition has improved after a period of weeks or months and an average of 5 contacts. Timely intervention is important as it can improve health outcomes and reduce length of stay.

3. People with physical disorders caused by alcohol or substance misuse who are not linked into appropriate services for these conditions. Brief interventions in the general hospital setting have been proven to result in decreased consumption.

4. People with longer term conditions associated with risk – providing the transition to specialist mental health services for integrated care within the Care Programme Approach, including home treatment or mental health admission and recovery services. These include:
   i. Severe and persistent mental disorders associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder.
   ii. Longer term disorders of lesser mental severity but which are characterised by abnormal illness behaviour including unexplained medical symptoms and high utilisation of general medical services.
   iii. Severe disorders of personality where these can be shown to benefit by continued contact and support.
   iv. Any mental disorder where there is significant risk of self-harm or harm to others or where the level of support required exceeds that which a primary care team could offer (e.g. eating disorders and addictive behaviours).
v. Disorders requiring skilled or intensive treatments (e.g. cognitive behavioural therapy, vocational rehabilitation, medication maintenance requiring blood tests) not available in primary care.

vi. Complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act (1983), Mental Capacity Act (2005).
3. What is the service aiming to achieve?

The general hospital represents another cluster of population in our community, with special features where mental well-being may be impaired. Mental well-being may be impaired by virtue of mental disorder, or by psychological reaction to being physically unwell. The mental disorder may pre-exist the physical disorder, may be inter-current with physical disorder, or may arise as a result of physical disorder or its treatment.

Liaison psychiatry and psychological medicine services (LPT) aim to increase the detection, recognition and early treatment of impaired mental well-being and mental disorder to:

i. Reduce excess morbidity and mortality associated with co-morbid mental and physical disorder.
ii. Reduce excess length of stay associated with co-morbid mental and physical disorder.
iii. Reduce risk of harm to the person or others in the general hospital by adequate risk assessment and management.
iv. Reduce overall costs of care by reducing time spent in the emergency department and general hospital beds and minimising medical investigation and use of medical and surgical outpatient facilities.

Four distinct functions are required of a liaison psychiatry and psychological medicine service.

i. Giving advice, training and coaching on the management of mental health problems by other professionals in the general hospital.
ii. Providing bio-psycho-social assessment, formulation and diagnosis for people identified by general hospital staff as experiencing impaired mental well-being or whose physical symptoms are unexplained.
iii. Providing brief interventions or advice, signposting and hand holding to care provision from a range of other agencies.
iv. Conducting Mental Health Act and Mental Capacity Act assessments and risk assessments for harm to self and others. Providing expert advice regarding capacity to consent for medical treatment in complex cases involving both physical and mental health problems.

The liaison psychiatry and psychological medicine function can in addition:

i. Increase mental care capacity within the general hospital through collaboration.
ii. Enable the physical care of people with mental disorder.
iii. Reduce the stigma associated with mental health care.
iv. Ensure that care is delivered in the least restrictive and disruptive manner possible.
The liaison psychiatry and psychological medicine team should be able to:

i. Maximise access for general hospital patients to services for improving mental well-being and treating mental disorder.

ii. Provide mental health advice and support to general hospital staff, patients, their families and carers.

iii. Provide prompt and expert assessment of mental health problems.

iv. Provide effective, evidence based brief interventions and treatments to reduce and shorten distress and suffering.

v. Ensure that inappropriate or unnecessary medical investigations and treatments are avoided.

vi. Provide support and advice in relation to mental health to general hospital services corporately.

vii. Contribute to educational programs for general hospital staff.

viii. Ensure that there is shared clinical governance between the LPT and the general hospital.

ix. Ensure that regular clinical meetings occur between the LPT and the general hospital teams to discuss and share the management of patients.

x. Establish effective liaison with local primary care team members and other agencies to provide onward care pathways.

xi. Establish a detailed understanding of all local resources relevant to support of individuals with mental health problems and promote effective interagency working.

xii. Gain a detailed understanding of the local population, its mental health needs and priorities, and provide a service that is sensitive to this, and its religious and gender needs.

xiii. Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign Language.
4. What does the service do?

Liaison psychiatry and psychological medicine services have a number of key components. Each must be in place if the service is to operate effectively.

**Table 1: Key components of liaison psychiatry and psychological medicine services**

<table>
<thead>
<tr>
<th>Key Component</th>
<th>Key Elements</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WORKING WITH GENERAL HOSPITAL</strong></td>
<td>Corporate relationship with general hospital</td>
<td>The LPT should be hosted in a directorate of the general hospital. LPT members need honorary contracts with the host organisation</td>
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<td></td>
<td>Committee representation in general hospital</td>
<td>The LPT should have a representative place at the general hospital security forum and operation risk committees</td>
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<td></td>
<td>Pre-referral discussion with principle referring units in the general hospital</td>
<td>Prior good working relationships are essential for planning capacity and flow and managing disagreement</td>
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<td></td>
<td>Single point of referral</td>
<td>Obstacles to referral should be minimised, team administrator should collect faxed, emailed, voice mailed and written referrals and log for presentation in morning referral meeting</td>
</tr>
<tr>
<td></td>
<td>Serve the agreed hospital population of adults of working age</td>
<td>There should be no artificial boundaries to referral on the basis of general practice or local authority boundary; the service exists to meet the needs of the hospital population regardless of where the person lives</td>
</tr>
<tr>
<td><strong>ASSESSMENT</strong></td>
<td>Everyone referred should be assessed</td>
<td>General hospital mental health skills are insufficient to adequately triage mental health need</td>
</tr>
<tr>
<td></td>
<td>All referrals should be assessed for risk</td>
<td>Thought should be given to risks of harm to self and others, absconding, non-adherence to treatment and a safe environment planned for the assessment</td>
</tr>
<tr>
<td>Key Component</td>
<td>Key Elements</td>
<td>Comments</td>
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</tr>
<tr>
<td><strong>ASSESSMENT</strong></td>
<td>• Conduct joint assessments where possible</td>
<td>• Joint assessment reduces risk from allegation of inappropriate behaviour by emotionally vulnerable people, strengthens opinion and enables mental health trainees and general hospital staff to work alongside expert clinicians</td>
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<tr>
<td></td>
<td>• Use formal instruments</td>
<td>• The LPT should agree to use a set of formal assessment tools common to the care pathways in the general hospital. Examples include the Hospital Anxiety and Depression Scale, the Five Shots for alcohol assessment and the Mini Mental State Examination for cognitive impairment. General practice increasingly makes use of the PHQ-9</td>
</tr>
<tr>
<td></td>
<td>• Make diagnosis or bio-psycho-social formulation</td>
<td>• The assessment should finish with a diagnosis or formulation that informs a plan aimed at overcoming the risks and disorders identified</td>
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<td></td>
<td>• Communicate in real time</td>
<td>• Systems should allow real time communication with all people involved in the immediate assessment and a contemporary record of the process made. It is good practice to communicate with the general practice by phone on the day of discharge and for written reports to be available to the next point in the chain of care within 5 working days.</td>
</tr>
<tr>
<td><strong>ENGAGEMENT</strong></td>
<td>• Reliable safe place</td>
<td>• Assessments need dedicated planned space to be conducted in safety and privacy both in the Emergency Department and on the wards</td>
</tr>
<tr>
<td></td>
<td>• Relationship</td>
<td>• A prolonged interview facilitating the service user led agenda can improve engagement and is in some cases therapeutic</td>
</tr>
<tr>
<td>Key Component</td>
<td>Key Elements</td>
<td>Comments</td>
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</tr>
<tr>
<td>ENGAGEMENT</td>
<td>• Motivational techniques</td>
<td>• Motivational interviewing skills can promote engagement and are transferable to work with eating disorders and addictions</td>
</tr>
<tr>
<td></td>
<td>• Reliable communication</td>
<td>• Commitments made to service users should be honoured and alterations kept to a minimum</td>
</tr>
<tr>
<td>INTERVENTIONS</td>
<td>• Signposting</td>
<td>• The person needs direction to a specific set of mental health resources, but there is no duty to check that the direction has been taken</td>
</tr>
<tr>
<td></td>
<td>• Handholding</td>
<td>• The person needs to be taken to other mental health or social care services and has the capacity to agree to this. There is a duty to check that handover has been effective</td>
</tr>
<tr>
<td></td>
<td>• Compelling</td>
<td>• The person is vulnerable and subject to provision of the Mental Health Act or the Mental Capacity act and can be safely held and conveyed to alternative care settings. Care may also be given against their expressed wishes</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic interview</td>
<td>• The use of time is a key component of effective mental health care practice and should be adequate for the task with some flexibility built in. Note: the mean face to face assessment time is 90 minutes</td>
</tr>
<tr>
<td></td>
<td>• Brief psychotherapeutic interventions</td>
<td>• Brief five sessions interventions using problem solving or solution focused techniques can be available to all team members and delivered to an evidence base. Cognitive Behavioural and Interpersonal Therapeutic techniques are desirable. Longer psychotherapies are better planned with specialist psychotherapy services</td>
</tr>
<tr>
<td>Key Component</td>
<td>Key Elements</td>
<td>Comments</td>
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<tr>
<td>---------------</td>
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</tr>
<tr>
<td>INTERVENTIONS</td>
<td>• Pharmacotherapy</td>
<td>• There should be an agreed formulary in line with local medicines management for the teams’ use of antidepressants, antipsychotics, mood stabilizers, rapid tranquilization, anxiolytics, hypnotics, alcohol and opiate detoxification regimes and adjuncts to pain management</td>
</tr>
<tr>
<td></td>
<td>• Social toolkit</td>
<td>• The team should have access to practical solutions for every day problems such as replacing clothes and shoes, gaining access to accommodation, which otherwise would act as a barrier to avoiding use of hospital based care</td>
</tr>
<tr>
<td></td>
<td>• Safe holding and breakaway</td>
<td>• Control and restraint capability needs to be available to the LPT and LPT team members may be trained. All team members should be trained in breakaway and de-escalation techniques</td>
</tr>
<tr>
<td>LIAISON WITH OTHER PARTS OF THE HEALTH SYSTEM</td>
<td>• General practice</td>
<td>• The majority of the teams’ work (70%) relates to mental well-being and access to interventions at the primary care level. This includes the wider primary care team, walk-in centres and NHS Direct</td>
</tr>
<tr>
<td></td>
<td>• Crisis and inpatient Teams</td>
<td>• Of the proportion with mental disorder (30%) only a small number will need to be admitted, Joint assessments with crisis team members can help plan for alternatives to admission</td>
</tr>
<tr>
<td></td>
<td>• Specialist mental health teams</td>
<td>• A small number of people will require specialist services for eating disorders, offending behaviour, addictions and severe personality disorders</td>
</tr>
<tr>
<td>Key Component</td>
<td>Key Elements</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
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</tr>
<tr>
<td>LIAISON WITH OTHER PARTS OF THE HEALTH SYSTEM</td>
<td>• Social services</td>
<td>• Safeguarding adults and children and providing safe accommodation for people at risk are tasks shared with social services</td>
</tr>
<tr>
<td></td>
<td>• Police, ambulance, fire and rescue</td>
<td>• These agencies are partners on the care pathway for many emergency department and emergency medical and surgical presentations. Liaison with these agencies can help design common strategies for people who frequently use general hospital services (‘high utilisers’ or present high risk to themselves or others.</td>
</tr>
<tr>
<td></td>
<td>• Non-statutory agencies</td>
<td>• Organisations such as Samaritans and MIND offer a range of support for people and form key additional resource for advice or signposting.</td>
</tr>
</tbody>
</table>
5. Management of service and operational procedures

Model of service delivery
Liaison psychiatry and psychological medicines teams function best as discrete, specialised, fully integrated teams comprising multi-professional healthcare staff, under single leadership and management, which have:

i. Staff members whose sole (or main) responsibility is working within that team.
ii. An adequate skill mix within the team to provide all the interventions listed above.
iii. Strong links with other mental health services and good general knowledge of local resources.
iv. Clear and explicit responsibility for a local population and links to specified GPs.
v. One set of integrated multi-professional healthcare notes and clear overall clinical and managerial leadership.
vi. Fully integrated consultant medical staff.

Caseload
The population served by a district general hospital will be around 350,000. Access to services will be impacted on by age demographic, morbidity and travelling distances.

The following guidance for workload capacity and team constitution are calculated on a model of a district general hospital supporting 650 beds with 750 new self-harm presentations annually, serving a mixed urban and rural community.

However, these figures clearly require modification in the light of such factors as:

i. Complexity of need.
ii. Local demography.
iii. The stage of development of other functional teams, especially crisis teams and self-harm teams operating in emergency departments.

The teams will serve all people presenting to the emergency department and as inpatients in the general hospital. It is unhelpful to determine LPT services on the basis of general practice cluster or local authority areas. Normally outpatients will access community based services. Occasionally outpatients with complex integrated physical and mental health problems will be accepted for assessment.

People who use the service frequently (also known as ‘high utilisers’) 
People who attend the emergency department more than four times in the year, people using more than four separate outpatient clinics and repeated medical admissions with no single evident medical or surgical cause, represent groups with likely impaired mental well-being or disorder but who are presenting with medical problems. These people should be identified from hospital and general practice information systems and active management plans put in place to improve their access to and use of mental health and social care resources. These people are at higher risk of inadvertent harm from investigative intervention so it is reasonable to keep a register of their names and make sure there is an accessible written plan of care available to admitting physicians and surgeons and on-call psychiatrists.
**Staffing**
A LPT requires the skills of nursing, psychology and psychiatry. Different team structures agreed locally will require different staffing structures and there can be a degree of flexibility: for example, the proportions of nurses and psychologists may vary depending on staff availability. There is no evidence to justify being too prescriptive. However, the team should reflect the ethnic range of the local population, and service users should be involved in staff selection.

As a guide to the likely level of resource required, the table below gives details by way of an example, of levels and skill mix for a team serving a general hospital with 650 beds and 750 new self harm presentations annually.

Consultant level psychiatrically trained doctors need to be present and fully integrated in the team. The number will be determined by the skills in the team and local availability.

**Table 2: Core liaison psychiatry and psychological medicine team**

<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 per annum</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, information gathering and communication.</td>
</tr>
</tbody>
</table>
If providing service for older people to end of life:

<table>
<thead>
<tr>
<th>Role</th>
<th>Grade</th>
<th>Time</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Staff Grade</td>
<td>whole time</td>
<td>To support additional assessment of organic disorders and mental capacity</td>
</tr>
<tr>
<td>Nursing</td>
<td>Band 7</td>
<td>whole time</td>
<td>Skills in cognitive assessment</td>
</tr>
</tbody>
</table>

Services for people with learning disabilities:

<table>
<thead>
<tr>
<th>Role</th>
<th>Grade</th>
<th>Time</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Band 7</td>
<td>Whole time</td>
<td>Increased bed side work load, managing communication and hand holding in outpatients and during investigations.</td>
</tr>
</tbody>
</table>

Training

<table>
<thead>
<tr>
<th>Role</th>
<th>Grade</th>
<th>Time</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>ST 4 - 6</td>
<td>8PA</td>
<td>Trainees of all disciplines enrich the team but should be planned to be supernumerary to the core team.</td>
</tr>
<tr>
<td>Medical</td>
<td>F1 /2</td>
<td>1 - 2 whole time</td>
<td>Foundation trainees can provide basic medical skills and learn from the nurse practitioners.</td>
</tr>
<tr>
<td>Role</td>
<td>Grade</td>
<td>Time</td>
<td>Comment</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Nursing</td>
<td>Final year</td>
<td>Whole time</td>
<td>Self-harm</td>
</tr>
<tr>
<td>Medicine</td>
<td>Year 3</td>
<td>Weekly</td>
<td>Self-harm assessments</td>
</tr>
<tr>
<td>Medicine</td>
<td>Year 5</td>
<td>Whole time</td>
<td>Unexplained medical symptoms</td>
</tr>
<tr>
<td>Psychology</td>
<td>Undergraduate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mental health nurse practitioners capable of autonomous decision taking are the core of the team. Extended and enhanced skills in psychotherapies are essential for the delivery of brief psychological interventions.

A full time consultant in liaison psychiatry will provide leadership for the team, manage and supervise risk, provide expertise regarding the psychopharmacological treatment of inpatients with physical illness, provide expertise regarding medico-legal issues and supervise and train other medical staff affiliated to the LP team. Many liaison psychiatrists are also skilled in the provision and supervision of psychological treatments.

Psychologists make a significant contribution to the well-being of general hospital patients but are not always available in core LPTs. Sessions may have to be bought in. Where this happens, (or where there is only one member of a discipline in a team) adequate professional support and supervision must be provided. Skills training of other disciplines can be pursued to provide traditional psychology inputs.

In addition to engaging, assessing, managing and planning the onward care of their patients, all clinical members of the LPT must:

i. Have the ability to communicate clearly and effectively in the team and with other teams from medical and social cultures
ii. Have the ability to maintain clear, accurate and contemporary multidisciplinary notes
iii. Be willing and able to cross cover between disciplines and role-blur within the limits of their skills
iv. Have a broad understanding of the medical and mental health needs of the team’s patients, including their range of disorders and cultural backgrounds
Support staffing and infrastructure

i. Adequate administrative support is essential if a LPT is to deal with the high clinical turnover and its associated paper work: 1 – 1.5 WTE administrative assistant/secretary

ii. IT and audit support from central resources to comply with clinical governance

iii. Team base located in close proximity to (or in) the general hospital with space for modular team working and break out rooms for confidential management processes

iv. Access to out-patient rooms with reception

Hours of operation

Working hours are generally weekdays from 9 – 5 with flexible out of hours working for specific tasks (e.g. evening work for a relative support group). Some teams work with moderately extended hours e.g. 8am – 7pm, embracing GP surgery times, and this is to be strongly recommended for improved primary care liaison. Some services operate 7 days according to local need.

No crisis provision is made out of hours by the LPT and patients and carers would access the local emergency services (crisis resolution teams, help lines, A&E etc).

Referrals

LPTs aim to reduce barriers to general hospital patients accessing help for mental health problems. To make sure this happens referrals should be accepted by a range of explicit routes and no administrative or technological hurdle put in the way. Their receipt should be to a single point so that a record of the referral can be made and the process of information begun. Priority should be agreed - usually to emergency departments and emergency medical units - and specific timeframes negotiated.

Meetings

The team should meet twice daily, a 30 minute referral and allocation meeting should happen in the first hour of the day. All team members working on the day must attend. A 30 minute wrap up team supervision in the last hour of the day protects all team members from having to carry risk decisions ‘home alone’. Attendance at the evening meeting should also be compulsory and acts as a check that all the work of the day has been accomplished.

The team should meet weekly for 30 minutes to consider new evidence, law, guidance and policy, contribute to audit, review, record keeping and plan education and training. Research projects may be discussed. This meeting is key to receiving new learning from incidents, appreciation and complaints, service user and carer feedback and service evaluation. Immediate actions should be agreed and reviewed for completion in the subsequent meeting.

The team should also have in-depth case discussion of the most complex care plans for inpatients and once a month reflect on the care plans for people who use the service frequently (‘high utilisers’).
Clinical and professional supervision
Every member of the team should receive professional supervision from their own discipline, discussing clinical cases as well as contributing to appraisal, job planning and personal development plans. In addition, the team will, as a matter of routine, discuss cases in the meetings and in between as required. Joint assessment and working promotes critical conversation around each case. The prompt and accurate recording of the work on a secure server enables the consultant and team leader to review all documentation on-line.

Members of other mental health teams supporting work in the emergency department and emergency medical units out of hours should receive professional clinical supervision for this work, in particular self-harm assessments. It helps handover from out of hours’ staff to the LPT if this takes the form of a regular weekly supervision meeting for one hour. Monday is a good day for this meeting so that any issues from the weekend can be addressed early. Once a month this meeting can be given over to discussion of people who use the service frequently ('high utilisers').

Working rapidly with the acute presentation of emotional disorders is taxing and risks staff burn out. It is protective for the team to have monthly supervision from a group therapist to address issues of transference.

Risk assessment and policy on violence
LPTs should have a written policy outlining procedures for managing different levels of risk (e.g. joint assessments). The operational policy should explicitly address issues of staff safety including a statement of zero tolerance for racial or physical abuse. This should ensure adequate assessment to ensure that treatment is not withdrawn inappropriately e.g. when abusive behaviour is a manifestation of psychotic illness or delirium.

Staff training
LPTs must see that their training needs are given appropriate priority within the overall education and training plan for their host trust. Induction periods are needed for new staff and should include an emergency department and emergency medical unit placement. Users and carers should be involved in the delivery of training, which should include:

i. Skills in delivering the interventions listed above.
ii. Team building, team working and peer support.
iii. Principles of the service including gender and anti-racist training.
iv. Medication management – including local policies on administration, storage, legal issues, concordance training and assessment of side effects.
v. Use of the Mental Health Act and alternatives to hospitalisation.
vi. Use of the Mental Capacity Act
vii. Engaging and interacting with other services – both within the mental health trust (or PCT where it provides the service) and with other agencies such as primary care, or the police and probation services.
viii. Suicide awareness and prevention techniques and approaches.
**Information for people who use the services**

All patients and their families and carers should be provided with information on the services both in printed form and also as part of individualised engagement. This should include:

i. Description of the service, the range of interventions provided and what to expect.
ii. Name and contact number and details of the care co-ordinator and other relevant members of the team.
iii. Contact details for out of hours advice and help.
iv. A written plan of care.
v. Specific information about their disorder and any drug being used, including side-effects.
vi. Relapse plan and crisis plan.
vii. Contingency plans.
viii. Information on how to express their views on the service and make complaints.
ix. Information about patient/user forums and PALS.

**Continual service improvement**

Regular clinical audit of the service should be undertaken to ensure that gaps in service provision are identified and managed and that targets are met and incrementally improved. Clinical audit should be balanced by service evaluation using feedback from service users and carers.

**Measurement of outcomes**

Measurement of outcome should include both quantitative measures and qualitative measures to reflect both what is done and how it is done. Measures should include elements of patient experience as well as patient satisfaction.

Measures should be determined on the basis of agreed objectives within a performance framework at the level of:

i. The individual service user develops objectives and their measures in partnership with their clinician in the context of their care plan
ii. The team develops objectives owned by the team members and related performance measures that enable real time improvement
iii. The service has objectives and performance measures that meet the needs of the organisation
iv. The trust has objectives and measures meet the needs of the commissioners and the regulators

Outcomes information should be collected using instruments designed for collecting both quantitative and qualitative data.
6. Further reading

National Service Framework for mental health: modern standards and service model. Department of Health Published date: 30 September 1999

Layard: A New Deal for Depression and Anxiety Disorders
The Centre for Economic Performance’s Mental Health Policy Group
http://cep.lse.ac.uk/research/mentalhealth

Second edition 2003
http://www.rcpsych.ac.uk/files/pdfversion/cr108.pdf

Psychiatric services to accident and emergency departments
Royal College of Psychiatrists, British Association for Accident and Emergency Medicine
London Approved by Council: January 2003 Due for review: 2006
Council Report CR118 February 2004
http://www.rcpsych.ac.uk/files/pdfversion/cr118.pdf

Assessment following self-harm in adults Royal College of Psychiatrists
London Approved by Council: January 2004 Due for review: 2009
Council Report CR122 October 2004
http://www.rcpsych.ac.uk/files/pdfversion/cr122.pdf

Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE Clinical Guideline 16 July 2004 Developed by the National Collaborating Centre for Mental Health
http://www.rcpsych.ac.uk/files/pdfversion/cr122.pdf


The Interface Between Physical and Psychological Symptoms Kurt Kroenke, M.D
Primary Care Companion J Clin Psychiatry 2003;5 (suppl 7)

https://www.rcplondon.ac.uk/pubs/contents/ea90ff6a-fcd3-4112-b958-d98f0cc2246a.pdf
Appendix 1: Referral and Resource Use in a Model Liaison Psychiatry Service to 650 beds

The data overleaf were obtained from 1004 nurse liaison mental health assessments during 2200 referrals to the Exeter Liaison Psychiatry Service. The data were collected using the liaison psychiatry database developed in collaboration between 12 UK centres.
Referral by general hospital attributed problem and disease area:

Proportion of Referrers to Liaison by Medical Specialty

- Medicine: 50.00%
- A&E: 35.83%
- Obstetrics & Gynaecology: 1.10%
- Paediatrics: 0.10%
- Psychiatry: 0.40%
- Radiology: 0.10%
- Surgery: 6.79%
- Unknown: 5.19%
- Anaesthetics: 0.50%
Frequency
CVS 1%
Respiratory 1%
Trauma 8%
Unknown 18%
Poisoning 55%

Eye/ear
Neoplasms 0%
Genito-urinary 1%
Digestive 2%
Skin 2%
Endocrine 2%
Neurological 2%
Unexplained 4%

Breast 0%
Endocrinology 0%
Eye/ear 0%
Neoplasms 0%
Infectious disease 1%
Genito-urinary 1%
Pregnancy 1%
CVS 1%
Respiratory 1%
Musculoskeletal 1%
Digestive 2%
Skin 2%
Endocrine 2%
Neurological 2%
Unexplained 4%
Trauma 8%
Unknown 18%
Poisoning 55%
Referral by physical and mental health diagnosis:

Distribution of Physical Diagnoses of Referrals

- Poisoning
- Unknown
- Trauma
- Unexplained
- Neurological
- Endocrine
- Skin
- Digestive
- Musculoskeletal
- Respiratory
- CVS
- Pregnancy
- Genito-urinary
- Infectious disease
- Neoplasms
- Eye/ear
- Endocrinology
- Breast

Frequency
Distribution of Psychiatric Diagnoses

ICD 10 Diagnosis Code

F30 - 38 Mood affective dis. (Bipolar, mania, depr. etc)
F43 Reaction to severe stress, and adjustment disorders
F10/12/13/14/15/16/19/11 Addictions
F60/61 Personality Disorder
Unknown
F20 - 28 Psychosis
F40 -41 Anxiety Disorders
F04 - F09 Organic/physical brain disorders
F45 Somatoform disorders
F50 Eating disorders
F90 + Conduct and Emotional Disorders
F44 Dissociative [conversion] disorders
F70 - 72 Retardation
F84-F89 Developmental Disorders
F69 Unspecified disorder of adult personality and behaviour
F53 Disorder related to puerperium
F42 Obsessive - compulsive disorder
F66 Disorders associated with sexual development & orientation
F62 Personality changes, not attrib. to brain damage/disease
F59 Unspecified disorders related to physiological cause
F54 Disorder assoc with disorders/diseases classified elsewhere

Frequency

0 100 200 300 400 500 600

ICD 10 Diagnosis Code

Frequency
Referral by mental health diagnosis: 10 year probands:

- F30 - 38 Mood affective dis. (Bipolar, mania, depr. etc)
- F43 Reaction to severe stress, and adjustment disorders
- F10/12/13/14/15/16/19/1I Addictions
- F60/61 Personality Disorder
- F44 Dissociative (conversion) disorders
- F42 Obsessive - compulsive disorder
- F39 Unspecified disorders related to psychological cause
- F69 Unspecified disorder of adult personality and behaviour
- F84-F89 Developmental Disorders
- F70 - 72 Retardation
- F90 Conduct and Emotional Disorders
- F50 Eating disorders
- F45 Somatoform disorders
- F40-F41 Anxiety Disorders
- F20 - 28 Psychosis
- F90 + Conduct and Emotional Disorders
- F59 Unspecified disorders related to physiological cause
- F54 Disorder assoc with disorders/diseases classified elsewhere
- F59 Unspecified disorders related to physiological cause
- F56 Personality changes, not attrib. to brain damage/disease
- F62 Disorders associated with sexual development & orientation
- F66 Disordered sexual development & orientation
- F53 Disorder related to puerperium
- F47 Personality changes, not attrib. to brain damage/disease
- F69 Personlity changes, not attrib. to brain damage/disease

Gender Unknown Age <21
Gender Male Age <21
Gender Female Age <21
Gender Unknown Age 31-40
Gender Male Age 31-40
Gender Female Age 31-40
Time taken for face to face assessment:

Frequency Distribution of Assessment Times (Mean 82.4 minutes)
Mean Assessment Time in Minutes and Count of Referral Reason Checked Yes by Reason

IMPORTANT: Take care when interpreting these differences in the mean. Low counts can skew averages a lot. See Worksheet "Q5 Data2" for actual counts.
Time taken for face to face assessment by mental and physical diagnosis:

Mean Assessment Time by Psychiatric Diagnosis

IMPORTANT: Take care when interpreting these differences. Low counts can skew averages a lot. See Worksheet "Q4 & Q5 Data" for actual counts.
Mean Assessment Time by Physical Condition

IMPORTANT: Take care when interpreting these differences. Low counts can skew averages a lot. See Worksheet "Q4 & Q5 Data" for actual counts.
Time taken for face to face assessment by gender and age:

Mean Assessment Time by Age and Gender

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Time / Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total</td>
<td>84.00</td>
</tr>
<tr>
<td>Unknown</td>
<td>84.00</td>
</tr>
<tr>
<td>61+</td>
<td>104.00</td>
</tr>
<tr>
<td>51-60</td>
<td>92.00</td>
</tr>
<tr>
<td>41-50</td>
<td>88.00</td>
</tr>
<tr>
<td>31-40</td>
<td>92.00</td>
</tr>
<tr>
<td>21-30</td>
<td>84.00</td>
</tr>
<tr>
<td>&lt;21</td>
<td>80.00</td>
</tr>
</tbody>
</table>

IMPORTANT: Take care when interpreting these differences. Low counts can skew averages a lot. See Worksheet "Q4 & Q5 Data"
Commentary:

There are four main problem groups referred to a general hospital liaison psychiatry service:

1. Affective disorders
2. Adjustment reactions
3. Addictive behaviours
4. Personality disorders

Mean face to face assessment time is 90 minutes.

Assessments take longer with

1. Unfamiliar problems
2. Problems related to cancer
3. Older women
Proportion of users of liaison psychiatry and psychological medicine services subject to the care programme approach:

Percentage Referrals with CPA Level

- Enhanced: 28%
- None: 56%
- Standard: 10%
- Unknown: 6%
Proportions of CPA Level In Each Diagnostic Group

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Groups</td>
<td></td>
</tr>
<tr>
<td>F62  Personality changes, not attrib. to brain damage/disease</td>
<td></td>
</tr>
<tr>
<td>F66  Disorders associated with sexual development &amp; orientation</td>
<td></td>
</tr>
<tr>
<td>F54  Disorder assoc with disorders/diseases classified elsewhere</td>
<td></td>
</tr>
<tr>
<td>F59  Unspecified disorders related to physiological cause</td>
<td></td>
</tr>
<tr>
<td>F69  Unspecified disorder of adult personality and behaviour</td>
<td></td>
</tr>
<tr>
<td>F44-F89 Developmental Disorders</td>
<td></td>
</tr>
<tr>
<td>F53  Disorder related to puerperium</td>
<td></td>
</tr>
<tr>
<td>F42  Obsessive - compulsive disorder</td>
<td></td>
</tr>
<tr>
<td>F44  Dissociative [conversion] disorders</td>
<td></td>
</tr>
<tr>
<td>F70 - 72 Retardation</td>
<td></td>
</tr>
<tr>
<td>F90  + Conduct and Emotional Disorders</td>
<td></td>
</tr>
<tr>
<td>F60  Eating disorders</td>
<td></td>
</tr>
<tr>
<td>F45  Somatoform disorders</td>
<td></td>
</tr>
<tr>
<td>F04 - F09 Organic/physical brain disorders</td>
<td></td>
</tr>
<tr>
<td>F40  -41 Anxiety Disorders</td>
<td></td>
</tr>
<tr>
<td>F20  - 28 Psychosis</td>
<td></td>
</tr>
<tr>
<td>F69  Unspecified disorder of adult personality and behaviour</td>
<td></td>
</tr>
<tr>
<td>F66/61 Personality disorder</td>
<td></td>
</tr>
<tr>
<td>F10/12/13/14/15/16/18/19/11 Addictions</td>
<td></td>
</tr>
<tr>
<td>F43  Reaction to severe stress, and adjustment disorders</td>
<td></td>
</tr>
<tr>
<td>F30 - 38 Mood affective dis. (Bipolar, mania, depr. etc)</td>
<td></td>
</tr>
</tbody>
</table>

Enhanced  None  Standard  Unknown
Planned and recorded next step on care pathway:

Percentage Outcome Disposal

- Mental Health in-pt admission: 9.98%
- Ongoing liaison to Gen Hosp: 12.77%
- Other: 3.59%
- Out-patient liaison: 0.50%
- Referred back to GP: 37.13%
- Referred back to Acute Trust: 2.79%
- Referred to MH services: 26.75%
- Unknown: 6.39%
Commentary:

1. Over 40% of assessments have their subsequent care planned from primary care
2. Around a quarter of assessments are referred on to mental health teams
3. Around 12% of team time is taken up with ongoing liaison work in the district general hospital
4. Less than 10% of assessments result in mental health admission
5. Less than 1% is taken on for five session brief intervention
Patterns of solicited alcohol consumption by patient estimated units:

Percentage Referrals by Alcohol Consumption

- Zero Units: 21%
- <14 Units: 23%
- 14-20 Units: 6%
- 21-27 Units: 7%
- 28-49 Units: 12%
- 50-74 Units: 10%
- 75-100 Units: 4%
- 100+ Units: 6%
- Unknown: 11%
Alcohol Use in Top 5 Psychiatric Diagnoses

- F43 Reaction to severe stress, and adjustment disorders
- F10/12/13/14/15/19/1I Addictions
- F32/33 Depressive Disorders
- F60/61 Personality Disorder
- NI
- F20 - 28 Psychosis

- Unknown
- 100+ Units
- 75-100 Units
- 50-74 Units
- 28-49 Units
- 21-27 Units
- 14-20 Units
- <14 Units
- Zero Units
Alcohol Consumption by Age
Commentary:

1. Hazardous and dependent use of alcohol is a major management issue for general hospital teams looking after inpatients and people who attend emergency departments.

2. Almost half the people assessed volunteered that they are drinking at levels in excess of government recommendations for safe drinking.

3. Almost a quarter are drinking at levels commensurate with hazardous use and dependence.

4. Over 50 units the male to female ratio is 7:3

5. But from 21 – 49 units the ratio is reversed with women to male 6:4

6. People with psychosis report less hazardous levels of alcohol use compared to the other main problem groups

7. 50% of people aged 41 – 50 are drinking above recommended guidelines for safe drinking.

In summary:

These data provide a guide for service planners interested in understanding the range of common problems requiring the services of a liaison psychiatry and psychological medicine team.

They are based on a district general hospital with no major regional services.
Appendix 2

Liaison Psychiatry Service Annual Report Data April 2006 – March 2007

Total Number of New Referrals = 643
Total Referrals Made To Liaison Psychiatry
April 2006-March 2007

Total referrals:
- Apr-Jun 06: 152
- Jul-Sep 06: 154
- Oct-Dec 06: 155
- Jan-Mar 07: 182
Referral by Ward Source

- ED
- EMU
- Wards
- Other

- Apr-Jun 06
- Jul-Sep 06
- Oct-Dec 06
- Jan-Mar 07
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exeter</td>
<td>70</td>
<td>79</td>
<td>71</td>
<td>91</td>
</tr>
<tr>
<td>EDPCT</td>
<td>51</td>
<td>31</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>MDPCT</td>
<td>7</td>
<td>25</td>
<td>30</td>
<td>32</td>
</tr>
<tr>
<td>NDPCT</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Teignbridge</td>
<td>10</td>
<td>4</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>OOA</td>
<td>8</td>
<td>10</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Unreg</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

### Referral by PCT (April 2006-March 2007)

- **Exeter**: 47%
- **EDPCT**: 24%
- **MDPCT**: 15%
- **NDPCT**: 2%
- **Teignbridge**: 4%
- **OOA**: 2%
- **Unreg**: 2%
<table>
<thead>
<tr>
<th></th>
<th>Apr-Jun 06</th>
<th>Jul-Sept 06</th>
<th>Oct-Dec 06</th>
<th>Jan-Mar 07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>6</td>
<td>13</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>SpR</td>
<td>12</td>
<td>16</td>
<td>17</td>
<td>24</td>
</tr>
<tr>
<td>SHO</td>
<td>23</td>
<td>23</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>F2</td>
<td>-</td>
<td>16</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Nurses</td>
<td>87</td>
<td>74</td>
<td>77</td>
<td>83</td>
</tr>
<tr>
<td>Other (CRT, on-call)</td>
<td>18</td>
<td>9</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>Self-discharged</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>152</strong></td>
<td><strong>154</strong></td>
<td><strong>155</strong></td>
<td><strong>182</strong></td>
</tr>
</tbody>
</table>

**Assessment Done By:**

- **Medics**: 38%
- **Nurses**: 50%
- **Other**: 9%
- **Self-discharged**: 3%
Psychiatric ED 4 hour wait breach data April 06- March 07

Number of Breaches

<table>
<thead>
<tr>
<th>Month</th>
<th>Working Hours</th>
<th>Out of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-06</td>
<td>2</td>
<td>1</td>
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<tr>
<td>May-06</td>
<td>3</td>
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<td>Jun-06</td>
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<td>Jul-06</td>
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<tr>
<td>Aug-06</td>
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<tr>
<td>Sep-06</td>
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<td>Oct-06</td>
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</tr>
<tr>
<td>Nov-06</td>
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</tr>
<tr>
<td>Dec-06</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Jan-07</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Feb-07</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Mar-07</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>