# Psychosomatics, self-harm and staff support – how psychotherapy interfaces with liaison services

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# Yin and yang?

**Liaison psychiatry services**

**Specialist psychotherapies services**

# Yin and yang?

**Liaison psychiatry services**

- Rapid throughput
- Single contacts
- Unplanned/emergency
- Daily team meetings
- Co-working with acute medicine
- DSH/psychosis/delirium/PD crisis/etc etc etc….

**Specialist psychotherapies services**

- Slow throughput
- Multiple contacts
- Highly planned non-emergency
- Weekly team meetings
- Usually work in isolation
- PD/treatment-resistant depression (but often co-morbid DSH & MUS)

# What is our common ground?

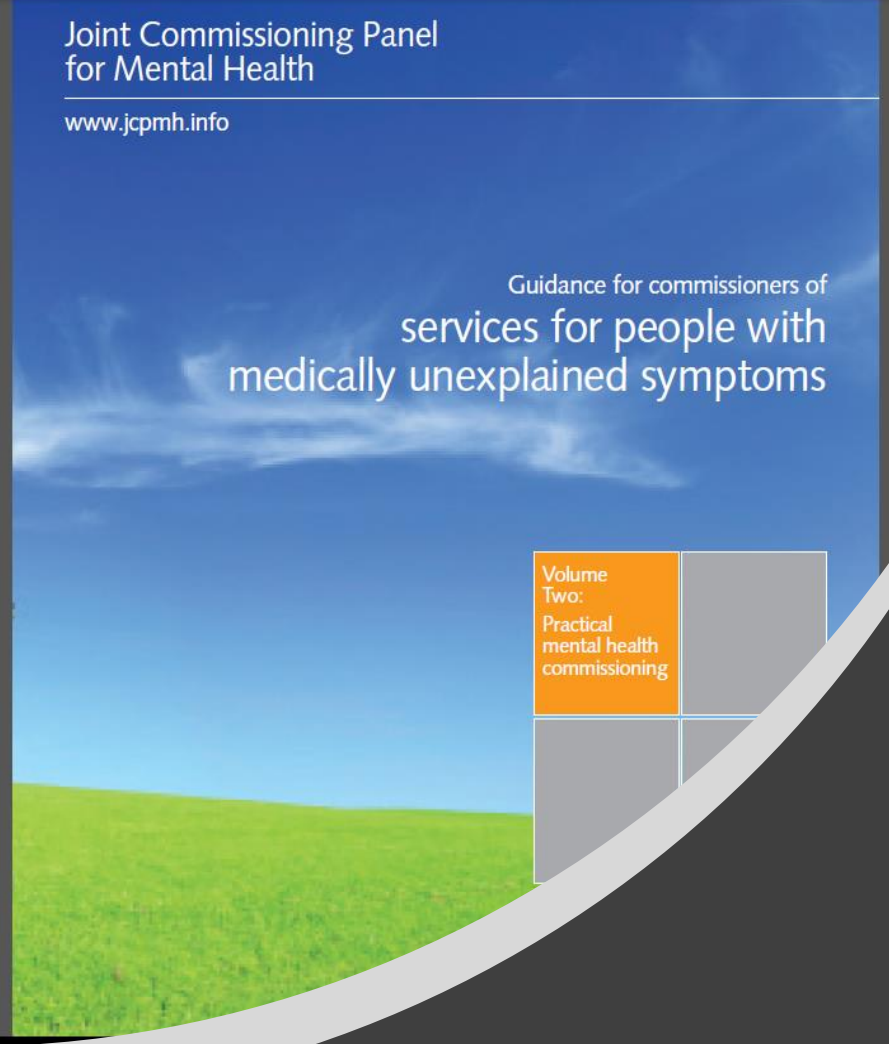
- Psychological medicine ⟺ medical psychotherapy
- Psychological aspects of psychiatry
- Get regularly called on to consult to colleagues about complex cases
- Appreciation of the impact of healthcare systems on patients and on staff
- ?idealised and denigrated more than other psychiatric specialties

# What kinds of interfaces are we talking about?

- Psychotherapy services
  - Primary/secondary/tertiary care
- Psychotherapies
  - CBT/psychodynamic/systemic/group/CAT/EMDR/DBT/MBT/CFT
- Psychotherapists
  - Medical/non-medical
  - Introductory/intermediate/advanced training

# 3 areas of interface

- Psychosomatics (the MUS bit anyway)
- Self harm
- Staff support




# Medically unexplained symptoms

- JCPMH 2017
- Chaired by RCGP & RCPsych
- Expert Reference Group
  - 5 x GPs
  - 4 x Liaison psychiatrists
  - 2 x Medical psychotherapists
  - 1 x psychologist
  - 1 x MIND
  - 1 x service user

# What should we be doing about MUS?

1. Improve clinicians' and healthcare commissioners' awareness of treatability

2. Make services less dualistic
   - Collaborative professional relationships
   - Joined-up care pathways
   - Multi-disciplinary team
   - Psychological therapies in acute settings

3. Train clinical staff
   - GPs
   - Hospital specialists
   - Mental Health Professionals

- Creed, Henningsen and Byng (2011) Achieving optimal treatment organisation in different countries: suggestions for service development applicable across different healthcare systems. In Creed et al (2011) **Medically Unexplained Symptoms, Somatisation and Bodily Distress: Developing Better Clinical Services**

# Evidence and availability of services

* Effective evidence-based management strategies for MUS exist[13,14] in both primary and secondary care, but availability is limited due to:
  * Lack of specific training in such interventions for doctors
  * System problems with healthcare design which separate physical and mental healthcare
  * Patient engagement can be difficult - many patients with MUS do not present to mental health services and do not accept psychological explanations for bodily distress, or accept psychological interventions

# Psychosomatics

- **Upskill liaison teams and develop new service models**
  - Train staff in evidence-based therapies?
    - CBT and brief psychodynamic (eg PIT)
  - New types of primary care-facing services?
    - London, Oxford, Bristol, Stockport, Oldham, Leeds
  - Medical psychotherapists in liaison teams?
    - Warwick, Cambridge, London

# Knock-on benefits for liaison staff

- Variety is the spice of life
  - See broader range of patients
  - Get some respite from emergency work
- Gain advanced therapeutic skills to use in everyday clinical work

# Staged approach in PIT for MUS

- Advise referrer how to lay the foundations, to prepare the patient for your involvement
- Address ambivalence about seeing you
- Emphasize the reality of the symptoms (and the patient's suffering)
- Use the biopsychosocial model to engage the patient, assess motivation for psychological treatment
- Listen to the story of the symptoms. Exploration of physical symptoms can be a guide to the underlying psychological problems
- Aim to develop a shared language of the symptoms first
- Later on you can link physical and psychological issues

# Knock-on benefits for liaison staff

- Variety is the spice of life
  - See broader range of patients
  - Get some respite from emergency work
- Gain advanced therapeutic skills to use in everyday clinical work
- Job satisfaction
- Potential for career progression within the team
- Recruitment & retention

# Self harm

- Extremely common presentation to A&E
- Bread-and-butter for liaison teams
- What's the treatment plan?
  - IAPT?
  - CMHT psychology?
  - Specialist psychotherapies service?
- Risk management/accessibility are major barriers

# Self harm

Wouldn’t it be better to have:

- Brief evidence-based psychotherapies available quickly,
- delivered in acute care settings,
- by therapists comfortable with high risk?

# Self harm: what to offer?

- Is CBT the only fruit?
  - Behaviours and thoughts - coping skills; cognitive restructuring etc
- What about feelings and relationships?
  - The majority (~ 80%) who self harm cite an interpersonal difficulty as the main precipitant for the self-harm episode
  - Rationale for non-CBT therapies which target these areas
    - Brief psychodynamic psychotherapy
      - Evidence base for PIT (Guthrie 2001)
        - 2 x multi-centre RCTs underway (SafePIT and FReSH START trials)
        - Therapists – liaison nurses and doctors. Don't bat an eyelid about risk
        - Supervisors – medical psychotherapists trained in PIT

# Staff support

- Pandemic burnout is rife in the NHS
- GMC requirement for all doctors to become reflective practitioners
- Complex stressful work conditions impair team functioning and communication with avoidance of hot topics
- Team reflective practice group = sharing difficulties and learning how to expand the range and type of issues we can communicate about openly with each other
- Team functioning, morale, and wellbeing can all be enhanced by RP group
- Top-down - RCPsych working group on reflective practice; RCPsych and RCGP joint work has begun
- Bottom-up – have any teams in your trust got a RP group?

# How to create interfaces

- Top-down
  - Wait for national directives/pump-priming funding projects
  - Respond to the call from senior managers in your trust
- Bottom-up
  - Discuss service development ideas with liaison colleagues
  - Find out who your local medical psychotherapist is and have a chat

# Reflections

- Does the expansion of LP create a risk of it becoming like IAPT – universal but only giving a little bit of a few things to a limited group of patients?
- Does liaison psychiatry want to become a purely urgent/emergency care specialty?
- Or should it offer brief evidence-based therapies to selected patient groups who are best seen in acute settings?
- Would liaison teams benefit from having their own reflective practice groups?
- Is it worth developing your interface with psychotherapy?