



Faculty of Liaison Psychiatry Newsletter

Winter Edition 2019

**Liaison Psychiatry Faculty
Newsletter**



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Psychiatry
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Editorial

Dear colleagues, it has been a universally busy and complex time for the Liaison Services since our last newsletter. We hope you will find the current edition informative and uplifting.

It contains an update by our Chair, Jim Bolton, with reflections on the stark reality of long waits for psychiatric beds and the difficulties with trainees' recruitment and retention into Psychiatry.

But we have plenty of good news! Our faculty is searching for innovative solutions to some of these problems, as demonstrated by the peer support workers' project run by the North Middlesex Hospital liaison service. We are also grateful to James Lee who provides a description of the Practitioner Trainee Programme in Wessex.

Training and retention are very relevant to liaison, as Will Lee and Sophie Whalley, currently running the fifth national Liaison Psychiatry Surveys of England (LPSE-5), tell us that demand for our services is still growing.

It is also good to look at our counterparts abroad. On behalf of the faculty we congratulate Professor Michael Sharpe who has been elected the 65th President and Chairman of the Board of the Academy of Consultation-Liaison Psychiatry (ACLP), our equivalent in USA!

Maria Xuereb describes how liaison services function in Malta.

We have also included a reminder about the bursary scheme that is available to support our members to attend the European Association of Liaison Psychiatry and the US Academy of Consultation-Liaison Psychiatry (CLP) conferences. Information on the bursary details are included in this newsletter. We would encourage all our faculty members to apply.

This year's bursary holders provided a good summary of the themes at this year CLP conference in California... and we are looking forward to our next Liaison conference **13 - 15 May 2020, St David's Hotel, Cardiff, save the dates!**

Once again, we rely on your support to continue publishing this newsletter. Articles should be no more than one to two pages long. Please include your name, title, place of work and contact details. Please note that this is neither a peer review process nor a scientific publication, but it gives a good platform to share good practice and ideas. Please e-mail Stephanie.Whitehead@rcpsych.ac.uk using "Liaison Faculty Newsletter" as the subject title.

We would like to thank Stephanie Whitehead for her support in preparing this Newsletter. Thanks to you all for your continuous support. We hope you enjoy the newsletter.

We wish you all a Merry Christmas and a happy and successful 2020!

Editorial Team Liaison Faculty Newsletter
Dr Nora Turjanski and Dr Sridevi Sira Mahalingappa

1 | Chair's report



Dr Jim Bolton
Liaison Psychiatry Faculty Chair
Consultant Liaison Psychiatrist
St Helier Hospital, Wrythe Lane, Carshalton, Surrey

Thank you

Our 2019 conference in London now seems a long way off, but if you were there, I hope that you found it as interesting and enjoyable as I did. For Nora Turjanski and Sridevi Sira Mahalingappa, our conference organisers (and Newsletter editors) this was their swansong. They did us proud by organising a high-quality meeting with a wide variety of topics. I am grateful for all their hard work on behalf of our Faculty in delivering a series of excellent meetings over the past few years.

I also want to express my thanks to the many of you who responded to my recent survey. Your responses were valuable in informing discussion of two current topics under consideration by the Faculty, the College and NHS England – lack of mental health beds and recruitment into Psychiatry.

Mental health beds

Firstly, as was raised with the President when she spoke at our conference, there is increasing disquiet in the profession about the lack of psychiatric inpatient beds. This has a direct impact on Liaison Psychiatry services who may have to manage patients who remain for several days in Emergency Departments until a bed is found. Your responses to the survey showed that the problem is almost universal. The College has commissioned an independent survey as a follow up to the 2016 Crisp Report on inpatient beds, which was published in the autumn. Our experiences are helping to shape the report's conclusions and recommendations.

Recruitment

One of the President's and the College's main areas of work is that of recruitment and retention into psychiatry. The Choose Psychiatry campaign is already bearing fruit in terms of recruitment into training. However, it will be clear to most of us that there are significant problems with recruitment into consultant and nursing posts, including in Liaison Psychiatry. The College has been keen to gather members' experiences of the employment of physician associates and peer support workers in the mental health workforce. In the recent Faculty survey, a number of you described your experiences of working with these two professional groups. As was discussed at our 2019 conference, I think that we will see more such staff working in Liaison Psychiatry in the future.

Discussions

As you can see, the summer has not been quiet. I and Faculty Executive Committee members have been involved in discussions about measuring the

quality of mental healthcare in acute hospitals, use of mental health legislation in the general hospital, integrated physical and mental health care, and whether a core 24 model of service is necessary for all hospitals. You will almost certainly hear more about these issues in the coming months – especially if you attend the Faculty annual conference in Cardiff next year (dates for the diary – 13-15 May 2020). The programme looks excellent and I hope to see many of you there.

Wishing you a Merry Christmas and a Happy New Year!

Jim Bolton
Chair of the Faculty of Liaison Psychiatry

2 | Peer support in the Emergency Department

“When people are never asked to give anything back, and when the assets they represent are ignored or deliberately side-lined, they atrophy. The fact that social needs continue to rise is due to a failure to ask people for their help and to use the skills they have.” (Boyle et al 2009)

Peer support workers (PSWs) exist across the NHS and social care system in many different roles. We might be very familiar and comfortable with the model in drug services for example, or in the context of psychological support groups for chronic illnesses from cancer to rheumatoid arthritis. The front line of ED mental health liaison services is less common territory to find the peer support model at work.

The Mental Health Taskforce *5 Year Forward View for Mental Health* (2016) and the more recent *NHS Long Term Plan* (2019) both highlight the importance of peer support and champion its on-going expansion and development within workforce planning in the years to come. The Long Term Plan acknowledges the lead that mental health services are already taking in this initiative.

In 2018, the Barnet Enfield and Haringey Mental Health Trust secured *Sustainability and Transformation Plan* (STP) funding for development of the liaison service incorporating funding for peer support workers. This project has now been live for over 12 months and preliminary evaluations of the model have now been released.

Seven PSWs were initially appointed in the Spring of 2018 to the North Middlesex Hospital Liaison team (employed by Barnet Enfield & Haringey Mental Health Trust). They were employed at band 3 and received eight days initial training via the Institute of Mental Health (University of Nottingham). One dropped out at an early stage, six PSWs were retained in post as of April 2019

(four full time, two part time) working shifts covering 07:00 to 21:30, 7 days a week.

The key area we needed to work on after winning the funding was precisely defining the role responsibilities and expectations. This was important for patients, PSWs themselves, and for the wider team. The impact on team dynamics of new roles shouldn't be under-estimated, even in well-established and well-functioning teams. Particular focus, perhaps unsurprisingly, was around risk and responsibility.

A description of a clinical encounter from one of our PSW's helps to illustrate the opportunity these new roles represent:

“A person came to ED frustrated with MH services. There was difficulty in communication of their needs to the staff in ED. They had been rude to staff, and had even been banned from their GP. The staff in ED had labelled the patient as particularly difficult.

When we saw the patient, I told them that my colleague and I were not the typical staff they'd normally see in ED, and that we'd had MH lived experience and are still living our recovered lives. They got really excited, asked what my diagnosis was, and requested to speak confidentially, so I invited them into the interview room together with my colleague.

In the interview room, they asked us about our coping skills, feelings of despair, and unhelpful behaviours. Once we'd shared our stories with them, we found so many similarities in the difficulties we also encountered as patients in seeking the right help. They said our interaction made them feel acknowledged, listened to, and like they were being treated like a human being. They felt able to be open and express their frustration.”

Clinicians in the team have reported multiple possible unanticipated benefits of the PSW role:

“Having the PSWs with me in consultation or in team handovers and meetings is like having a physical reminder of the recovery potential and capital within all patients, whatever stage of their journey they are at when I see them.”

“I feel that the key difference they make is making the patient interaction recovery focussed and not process focussed, as it so often can be in an ED setting”

Recent independent evaluation by Middlesex University has demonstrated that the project has been universally well supported and received by the team, the wider hospital, and by patients. It also highlights the areas of development required being clear role definition and risk responsibility. There are as yet no quantitative outcome reports.

We hope we have demonstrated that employing peer support workers in an ED setting is feasible and holds significant potential benefits for patients, workers, and clinicians.

The positive impact in our experience has been wide reaching; not only on improved quality of patient care, but also having positive impacts on liaison team members including embedding a recovery model and reducing stigma across the wider hospital system.

To end with, here are a couple of quotes from patients, that are typical of the feedback we have received.

"It helped so much that you understood what I was going through"

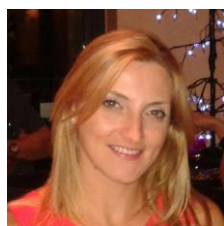
"You have inspired me so much. I can now see a way forward, maybe getting a job. You give me hope for the future"

***Sharif Mussa, Lindsey Phillips, & Sue Somers
Peer Support Workers at North Middlesex Liaison team***

***Justin Shute
Consultant Liaison Psychiatrist
Clinical Lead at North Middlesex Liaison team
PSW project lead***

***James Dove
Currently ST6 General Adult Trainee at Camden & Islington Foundation Trust
Previously higher trainee within the North Middlesex Liaison team and played supportive role on PSW project implementation***

3 | Liaison Psychiatry Services in Malta



**Dr Maria Bezzina Xuereb MD MRCPsych
Consultant Psychiatrist
General Adult and Liaison Psychiatric unit, Level 1 Brown block, Mater Dei Hospital, Msida, Malta MSD 2090**

I am honoured to have been asked by Dr Nora Turjanski to write a piece for the Faculty of Liaison Psychiatry newsletter. Dr Turjanski, at the Royal Free Hospital, and Dr Justin Shute, at the North Middlesex Hospital, shaped my passion for this area of psychiatry through their own dedication and vast experience in the field. I was a very fortunate trainee to have worked within their respective teams.

Fast forward a few years (I've been asked to not be too specific here!) and last April I was appointed consultant in Liaison Psychiatry at Mater Dei Hospital (MDH) in Malta. MDH is an NHS equivalent public hospital with over 1000 in-patient beds at its busiest months. It serves a population of over 0.5 million, a figure which has ballooned in recent years due to rapid economic growth and influx of both EU and non-EU employees mainly attracted to the health, gaming, hospitality, and construction industries. This has brought new challenges in terms of patient numbers coming through the doors of the main hospital in Malta, and the changing social fabric of the country.

At present, the liaison psychiatry team consists of my post on a FTE basis, and another consultant who provides three days of service, the equivalent of a core trainee and a higher trainee, together with a foundation year doctor. The service receives referrals from the A&E department, all MDH wards, and occasionally outpatient clinics. Referrals are received across all ages. MDH houses a 14-bed psychiatric unit with roughly half of the patients under the direct care of either myself or my consultant colleague. The other patients are under the care of other psychiatry consultants in the service who are largely based in the main psychiatric hospital on the island, some four miles away. The main scope of this 14-bedded unit is to provide direct admissions from the other MDH wards to patients requiring a longer hospital stay once they are medically discharged.

The availability of these beds allows us to provide the initial stages of psychotropic treatment, and psychological and occupational therapy prior to discharge to community clinics. If a patient requires a period of stay beyond the 4-week maximum at this unit, a transfer to the main psychiatric hospital is arranged. This generally occurs within the context of advanced cognitive impairment for patients awaiting admittance to an elderly nursing home. MDH is not a licensed facility to have patients who are being treated under the auspices of the Mental Health Act – therefore patients who require an admission under the Mental Health Act will also require transfer to the main psychiatric hospital.

The liaison team also provides a twice-weekly ECT service at the psychiatric unit. The ECT service provides treatment to patients within the acute hospital, the psychiatric hospital, or those attending treatment from home. We currently have the backup of a senior nurse manager and a higher trainee for this service, and are in the process of further staff training.

Referrals to the liaison team reflect the social challenges faced by the country. Since April, we have had over 1,500 patient contacts at MDH. This figure excludes reviews at the psychiatric unit. Roughly three-quarters of the patients we see in A&E, the short-stay observation wards, and the paediatric wards, are secondary to episodes of harm to self, illicit drug use, or excessive alcohol consumption. Referrals from ITU, orthopaedic, or neurosurgical wards tend to be in the context of serious suicidal attempts. Over the years, there has been a noticeable and sad change in the reality of diminished social support. Most adults are in employment with less time to offer to the care of elderly relatives, and a busier and technology-rich lifestyle directly influencing the core family unit... "Progression is regression" couldn't be any truer.

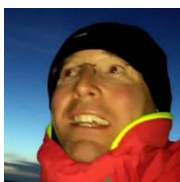
On the other hand, we are living at a time where central government and opposition have recognised the need to address the mental health needs of the population. 'A Mental Health Strategy for Malta 2020-2030' was launched in July 2019 after a period of public consultation. There are multiple needs that require addressing. We are promised a government strategy covering the development of the entire mental health provision.

In the liaison context, the most pressing need is to develop a fully-fledged service within the A&E department which doesn't solely consist of medical professionals. We are desperate to have a team consisting of nurses, social workers, and psychologists, who can provide a service in the context of the acute adult A&E presentations. A nurse-led service covering acute child and adolescent mental health referrals has been in operation for a few years – unfortunately the service is not covered consistently due to the few number of professionals within the team itself. Out of hours, the service is being provided by a senior trainee in psychiatry and an off-site consultant psychiatrist from the wider psychiatry service.

Our service depends on having excellent working relations with clinical and managerial staff and structures both at MDH and psychiatric services, whether these are in-patient or community. Relations with colleagues are on a developmental continuum, and the re-launch of the liaison service in April has so far been met with positive feedback from clinicians on the ground. We now depend on those who hold the purse-strings to deliver what is being promised towards tackling the mental health needs of an increasingly diverse, ageing, and growing population.

We need to be considered at par with other medical and surgical specialties. Whilst we wait with bated breath, we will continue to plough on to the sound of the liaison pager ringing with enthusiasm and the excitement of never knowing what to expect!

4 | Liaison Psychiatry Surveys of England – Update Late 2019



William Lee
Consultant Liaison Psychiatrist and lead, LPSE-5.
Sophie Whalley
Researcher, LPSE-5.

We are sure you all know something about the LPSEs: The Liaison Psychiatry Surveys of England. These are the regular surveys of all Liaison Psychiatry Services in England. These have been going since 2013 and collect and collate information to check, among other things, the progress in the development of the speciality against government targets. The surveys have also been in the

news, the most high profile being providing some of the numbers for David Cameron's mental health speech in late 2015.

We opened the fifth national survey of liaison psychiatry (LPSE-5) in June of this year. As usual, we are planning for a response from each of the 173 acute hospitals in England. It is important to get the full picture of liaison psychiatry services across the country and not to generalise about those who are difficult for us to access from those who are easier. There are likely differences between these services that cause them to be more or less easy to access.

The Surveys exist to measure progress towards government targets of Core 24 provision: In 2013 LPSE-1 found nine such services; subsequent surveys found sixteen, twenty two, and last year, fifty eight. Not all the responses are in for LPSE-5 yet. You can check if we have had a response from your service on this link: <https://urlzs.com/HEZfx>. If we have not, please get in touch with us at lpse@exeter.ac.uk and we'll do the rest.

We designed the Surveys to be as simple and accessible as possible for the wide variety of services we seek to measure. Year on year there are fewer responses to the initial emails, so we need to do more contacts by telephone, and it takes us more attempts by telephone to secure a complete response too. Our view is this reflects the increasing clinical demands on services and staff, because there is widespread and continuing support for the Surveys, for which we are grateful.

The Surveys are able to capture the heterogeneity of liaison psychiatry services through the open ended question design which allows for respondents to explain in detail how their particular service operates and increasing the validity of the data collected. This is part of what makes the Surveys unique and such a valuable resource for our community and for government.

We now hold a highly detailed description of the growth of Liaison in England. This can be very useful because matters of policy are so often settled by excellent data. Please get in touch if you would like a bespoke analysis. These have a number of uses, but usually it is protecting local services from threatened cuts, or shoring up bids for additional investment by showing how the proposals compare nationally.

Liaison in England is still growing apace. This is exceptional both for ourselves, and for our patients.

5 | Bursaries to attend the European Association of Psychosomatic Medicine or the US Academy of Consultation-Liaison Psychiatry Conferences 2020

Background

The European Association of Psychosomatic Medicine (EAPM) aims to promote an integrated psychosomatic/biopsychosocial approach to health and disease. The EAPM conference will be held in Vienna in June. For more information, please see: www.eapm2020.com

The US Academy of Consultation-Liaison Psychiatry (ACLPL) promotes a global agenda of excellence in clinical care for patients with comorbid psychiatric and general medical conditions. The ACLPL conference will be held in Phoenix, Arizona in November. For more information, please see: www.clpsychiatry.org/events/acplp-2020-annual-meeting/

Every year, the two organisations hold their own conferences, bringing together experts in liaison psychiatry and psychosomatic medicine to share knowledge and to network, and thus advance the field.

The Faculty of Liaison Psychiatry of the Royal College of Psychiatrists is offering bursaries to support the attendance of five future leaders in liaison psychiatry at either the 2020 EAPM conference or ACLPL conference. Of note, the ACLPL conference will be the first for the organisation's new President, Professor Michael Sharpe from Oxford.

Why?

Liaison Psychiatry services in the UK are expanding. We need to develop our workforce to meet this need. This includes developing talented leaders for the future. We are working with relevant organisations in the United States and Europe to strengthen our professional base, learn about innovative practice in other countries and attract talent to the United Kingdom.

We want to find the Liaison Psychiatry leaders for the future: The great thinkers, great communicators, and great clinicians. Those who are able to commit and inspire. Those who effortlessly go the extra mile. Those that others will look to.

Prize

Successful applicants will be offered up to £1000 to cover registration, standard class travel, subsistence and associated costs of attending one of the above meetings and contributing to the programme. The bursary winners can choose whether they attend the EAPM or ACLPL conference.

Eligibility

Applications from psychiatrists

Applicants must:

- Be registered with the General Medical Council.

- Hold one of the categories of membership of the Royal College of Psychiatrists.
- Must either:
 - Be actively engaged in providing a Liaison Psychiatry service in the UK, or
 - Be on an approved UK higher training scheme which includes sub-specialty training in Liaison Psychiatry, and must have completed the Liaison component by the date of the conference.

Applications from nurses

Applicants must:

- Be registered nurses on the Nursing & Midwifery Council register.
- Be actively engaged in providing a Liaison Psychiatry service in the UK.

Applications from psychologists

Applicants must:

- Hold a Professional/Practitioners doctorate and be registered with the Health & Care Professions Council.
- Be actively engaged in providing a Liaison Psychiatry service in the UK.

Submission Instructions

The following should be received by the closing date:

- A personal statement of not more than 600 words outlining professional achievements, reasons for wanting to attend the meeting, the ways in which attendance would specifically benefit training, development, or practice, and how learning might be disseminated to others.
- A full Curriculum Vitae.
- Two professional references/letters of support. These can be from a supervisor, educational supervisor, RCPsych Liaison Psychiatry Faculty member, or recognised leader in the specialty;
- Relevant written confirmations of registration and employment status;
- The applicant should indicate which conference they wish to attend (EAPM or ACLP).

Regulations

- Applicants must work in the UK.
- The winners will be selected by a panel nominated by the Faculty of Liaison Psychiatry.
- The panel will be looking for those with an active commitment to the specialty. Applicants should provide evidence of involvement in the progression of the specialty locally or nationally, including in research, leadership and service development.
- Winners will be expected to make a submission to the EAPM or ACLP call for presentations or posters.
- The Faculty reserves the right not to award a bursary if no suitable application is received.
- The bursary is for the 2020 EAPM or ACLP conference and cannot be deferred.

- The bursary must be claimed after the event by submission of an expense claim form supported by receipts and copies of tickets. Standard class travel and hotel accommodation of up to £100 per night will be funded.

Closing date

31 January 2020

Submissions and College contact:

Stephanie Whitehead, Committee Manager
stephanie.whitehead@rcpsych.ac.uk

6 | Developing a tool to help collect collateral cognitive histories



James Lee
Consultant Practitioner Trainee, Older Persons and Frailty
Health Education England, Wessex
Released from Salisbury Hospital NHS Foundation Trust
Current Placement: Salisbury Medical Practice Integrated Older
Persons Team
Twitter: @lee68_james

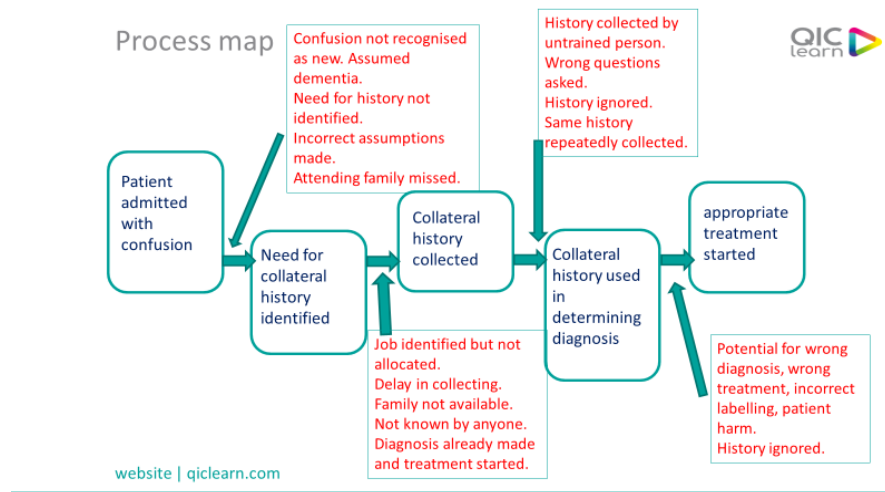
About me

I am employed by Salisbury Hospital NHS Foundation Trust, formerly an Advanced Nurse Practitioner in Older People, Frailty, and Movement Disorders. Salisbury have released me for three years onto the Health Education England (HEE) (Wessex) Funded Consultant Practitioner Trainee Programme in Older People and Frailty. The programme includes relevant clinical training placements across Wessex, negotiated with other providers and under Honorary contracts, normally for periods of six months. Trainees can choose their placements in negotiation with the programme leads and in order to fulfil learning needs and programme competencies up to consultant level. There are also Academic and Quality Improvement elements to the programme. I am currently finishing a Master's degree, and due to start Doctoral studies in March 2020. All salaries and on-costs, academic fees, travel costs and QI training are covered by HEE for the duration of the programme. The idea of the programme is to train Nurses and AHP's up to the level where they can work as Consultant Practitioners in their chosen field.

Background

The QI project subject was negotiated with the liaison team and I was able to use and pass on some of my expertise in quality improvement methodology. The aim of the project was to improve the collection of collateral cognitive history in the confused patient. Diagnostics were performed using a retrospective notes audit (n=12) and staff survey (n=21), producing a 'fish-

bone' process map, and PDSA (plan, do, study, act) cycles were used to trial and review interventions. A new training package and acronym HAD PIMMS was developed and has been administered to approximately 15 staff to date on the Acute Medical Unit.



The Tool

An acronym was used to assist staff in remembering key points of the collateral history (**HAD PIMMS**):

- **H**istory of confusion: Onset, Course and Features (this episode and any previous episodes, acute and chronic).
- **A**DL's (Change in: Mobility, toileting/bathing, managing finances, independence).
- **D**epression and other mood or personality changes.
- **P**hysical signs and symptoms suggestive of underlying cause (e.g. infection, falls, incontinence, constipation, pain).
- **I**ntellectual function – education and employment history.
- **M**edication history including non-prescribed drugs and alcohol.
- **M**emory and Dementia (investigations or diagnosis).
- **S**ensory deficits – hearing, sight, speech.

Future Plans

The plan is to administer more training, gather feedback on the training and review the collection of collateral histories through a further audit.

Acknowledgements

I would like to acknowledge the support of Dr Janet Butler and Helen Sarvar RMN.

7 | CLP 2019 – San Diego Conference Report

Amy Green, James Dove, Ayman Guirguis, Rory Conn, and Luke Solomons

The American Consultation Liaison Psychiatry conference is an annual fixture in the second week of November in a southern state – it definitely seems like a good way of soaking up some learning and sun as winter is approaching!

The scale of the conference is much bigger (as everything seems to be, across the pond!) than the Liaison Faculty conference with 1200 delegates and over 200 speakers offering a plethora of attractive sessions that made choosing challenging – we were torn between attending updates on areas we work in and seeking out new and exciting ideas such as use of ketamine and psychedelics. We describe a few standout sessions.

The sessions were divided up into broad themes that included:

Delirium & Agitation	Pulmonology, Infectious Disease
Education & Training	Palliative Care & Oncology
Future of C-L Psychiatry	Psychotherapy & Liaison Skills
Leadership & Career Development	Women's Mental Health
Medical Specialties	Addiction, Pain, Transplant
Neuropsychiatry	Collaborative Care, Community C-L
Cardiology, Endocrine, Renal	

San Diego is a friendly laid-back city with long association with the American Navy which are very apparent – the conference hotel was on the marina and we had warships on one side and planes landing in the airport on the other side. In addition to all our learning about CL psychiatry, we now know that Top Gun was shot in San Diego!

Since California is known for its fresh food and fine wine, it would have been rude not to sample some of this. The conference catering was of a high standard, impressing the foodies of the group, some of whom made room for second helpings.

Day 0 – 13/11/2019

Updates on CL psychiatry – The pre-conference updates programme/skills course appears to be a mainstay of teaching for liaison psychiatrists in the US, with large numbers of delegates catching up on their CPD from leaders in the fields. Topics ranged from delirium, perinatal, transplant and cardiac psychiatry to end-of-life care and ketamine.

The afternoon concurrent skills course included hands-on workshops offering a range of topics including collaborative care, launching proactive CL services, speaking skills. These sessions need to be paid for separately, but seem to be established as a way for busy clinicians to top up on training and skills before

the start of the conference. We wonder if the faculty might consider trialling them prior to the UK conference?

Day 1 – 14/11/2019

The conference kicked off in the Grand Ball room with conference director Madeleine Becker welcoming guests and introducing Rebecca Brendell, President of the ACLP.

Dr Brendell discussed the 'State of the Academy' and highlighted the close links of the academy with the European Association of Psychosomatic Medicine and the Royal College of Psychiatrists. The Academy of Consultation Liaison Psychiatry, (members voted to change their name from the Academy of Psychosomatic Medicine in 2017) does seem to be in good health, with CLP 2019 being the best attended conference with over 1200 registrations. Dr Brendell was followed by the Dean of Harvard Medical School, Dr Ed Hundert discussing the rapid changes in medical education, the science of successful learning and how to 'make it stick'. The entertaining talk debated if millennials learnt differently, and the use of simulation, movie clubs, social media, and handheld devices. We came away ruminating about his challenge of how to teach 'values' when not face to face with learners.

Invited Presidential Symposium: Delirium: The Most Important Condition for Our Subspecialty – which featured a comprehensive overview of delirium from Jose Maldonado, Professor of Psychiatry and Behavioural Sciences at Stanford University. And what this man doesn't know about delirium isn't known! Dr Maldonado presented the 'Systems Integration Failure' hypothesis for delirium – an interplay between neuronal aging, neuro-inflammation, oxidative stress, neuroendocrine changes, and circadian dysregulation. We took away the following simple messages that will help in clinical practice – 'sedation is not sleep', whether the patient presents with hypo or hyperactive delirium is determined by which neurotransmitter systems are overstimulated or suppressed (for example, increased glutamate and dopamine are probably related to hyperactive patients). Tom McCoy from Mass General Hospital discussed the epidemiology of delirium, differentiating state from trait, and the fluctuating course. Yelizaveta Sher from Stanford reviewed the evidence in managing delirium. Ted Stern, the Editor-in-chief of Psychosomatics wrapped up a comprehensive symposium with 'How to Teach' – an inspiring talk about interdisciplinary education.

We were fascinated by the pathophysiology of delirium and now have a much better understanding of complexity, causative factors, and management. This could help make a strong case to Acute Trust colleagues that although the investigations are apparently 'normal', the most likely cause for the patient's symptoms is still a delirium moves away from the 'medically fit for discharge' conundrum.

'Beyond Capacity: It's all about cooperation' – an excellent session on decision making capacity (DMC) was chaired by Donald Rosentein, Professor of psycho-oncology at University of North Carolina (UNC) had the rather small breakout room full to bursting. Bill Scheidler, also from UNC, kicked off the discussion to help the group discuss and navigate complex capacity assessments using a

framework that very usefully formed the skeleton of the session. Bill's use of Poll Everywhere – a real time online polling tool, made the session interactive and enjoyable. James Levenson, Editor of the Textbook of Psychosomatic Medicine discussed practical and ethical problems with making decisions 'in the best interests' of patients who lacked DMC. He illustrated the discussion with a case, the role of the ethics committee and supporting medical and surgical colleagues in dealing with these complex patients. Rebecca Brendell brought her legal and ethics expertise to pull together the threads of the discussion.

Pragmatic Effectiveness and Implementation Studies in Patients with Medical and Psychiatric Comorbidity: Bridging the Gap between Research and Practice chaired by Jurgen Unutzer from University of Washington, featured four very exciting reports of projects that dealt with real life clinical problems. Jesse Fan started the session by describing Pragmatic Clinical Trials, PRECIS-2 guidelines and reporting implementation research outcomes – directed the group to rethinkingclinicaltrials.org. He then described the BRITE study on follow up for patients with Traumatic Brain Injury. This was a very useful session and we came away with several ideas about studying practice in the real world.

"Acute management of functional neurological disorder symposium" covered the management of some of these conditions in acute hospital setting. Identifying that some of these conditions represent life-long pattern of maladaptive coping, there are patients for whom early intensive intervention can produce significant improvement in physical and psychological functioning. The traditional treatments include management of comorbid psychiatric conditions, referral to outpatient psychotherapy, and consistent outpatient medical follow-up. The session covered the phenomenology, aetiology, bedside assessment, acute management and limitation of treatment. It was delivered by psychiatry and neurology professors from Vanderbilt University Medical centre.

Another session in the afternoon was titled "What do you mean its functional?", which covered the history of the term and how its original meaning may be informative today. Neuroimaging data showing alterations in brain activity related to emotional processing that may be shared among functional syndromes, mechanistic hypothesis derived from differences in functional syndromes in childhood versus adulthood, and cutting edge research on the functional neurological disorders. Persistent postural-perceptual dizziness (PPPD) was used as an example of identifying unique alterations in psychological and physiological processes and associated brain activity underlying a specific functional disorder.

Day 2 – 15/11/2019

The Plenary began with Patrice Harris, a consultant psychiatrist who is the president of the American Medical Association – an impressive speaker who laid out the challenges facing healthcare in the USA including disparity in health outcomes, parity between physical and mental health, and the opioid crisis. She urged the audience to be politically aware and support the AMA and ACLP. She was followed by Darshan Mehta, a physician from the Osher Centre for Integrative Medicine who described Integrative Medicine – something we had not thought about very much about but now know would be what are called

'complementary therapies' in the UK. Dr Mehta described the size of the market for complementary therapies, and ways of checking efficacy and integrating therapies into everyday care for patients. Dr Rick Summers from the American Psychiatric Association discussed Physician Wellbeing and Burnout. He described the work the APA had carried out in identifying causes and addressing them. Electronic Medical Records seem to be a major source of stress, and he focussed on ways of bringing 'Joy back to practice'. He pointed the audience the psychiatry.org/wellbeing website for sources of information and support.



The RCPsych attendees at CLP 2019

Ayman's oral presentation was on 'Evidence of suboptimal management of antidepressants in patients receiving haemodialysis'. The presentation covered End stage renal disease (ESRD), depression in ESRD and the challenges in its diagnosis and management. The body of the presentation was about the study and future recommendation. More details on the study and ESRD will be covered in the newsletter.

"Changing faces: A clinical approach to personality changes due to another medical condition" was very interesting. It was about personality changes due to another medical condition, or medical personality changes driven from the codable diagnosis (F07.7), that can cause substantial functional impairment related to behavioural disruption, dysdecorum, and poor judgment. It covered changes in HD, TBI, Tumours, and neurodegenerative conditions, the importance of identifying and treating symptoms through systematic clinical approach, and the evidence base on managing the condition. Also covered were gaps in the literature regarding optimal assessment and clinical decision making.

Lipsitt Award Presentation: Current State and Future of Proactive C-L Model: How to Disseminate, Implement, and Expand Proactive C-L Service – Dr Hoachang Lee of the University of Rochester Medical Centre discussed how a proactive model of liaison psychiatry has been being developed by his team since 2009 when he was working in Yale. The model of true integration of psychiatric teams within medical teams has now been adopted in more than 12 centres across the states. Each of these teams have been able to demonstrate that their embedded presence can increase the 'impact' of the medical teams by

reducing length of stay in the acute setting. Time and again, the presenters returned to key messages that were learnt across the centres that formed the core of the success of the proactive liaison model – senior support and buy in to the intervention, proactive screening on the ground daily by a motivated senior clinician (not necessarily a psychiatrist), and co-location of team working.

The Poster session began from 5.30 pm, with an impressive array of posters on varying themes. There was a healthy footfall across all sections of the hall. Sadly, some of us lost our posters as we did not take them down at the end of the evening, and the hotel staff binned them!

Day 3 - 16/11/2019

The crowds were thinner on the last day of the conference, which began with a set of concurrent sessions.

Through the conference, there were a smorgasbord of psychotherapy sessions on offer including DBT, IPT, narrative therapy, MI, and psychodynamic. All sessions were delivered by experts – extremely thought provoking and engaging. We have already added new skills to our own therapeutic 'tool kit' and are using them to support people with FND and anxiety.

The final plenary had Jim Levenson and John Shuster, past presidents of the ACLP provide a history of the organisation as an entertaining double act introduced by Carol Bernstein, a professor of psychiatry and radio host. It seemed apt to look back at history when looking to the future.

The conference closed with Dr Brendell passing on the Gavel of the president of the ACLP to Dr Michael Sharpe, Professor of psychological medicine, University of Oxford, followed by a Mexican themed lunch under the bright blue Californian skies, an apt ending to an excellent conference.

We are grateful to the faculty of Liaison Psychiatry at the college and the Academy of CL Psychiatry for the opportunity to be at CLP 2019. A special thank you to ACLP executive director James Vrac.

Michael Sharpe becomes President of the ACLP

Professor Michael Sharpe, a Fellow of the Royal College and Oxford University Professor of Psychological Medicine, has been elected the 65th President and Chairman of the Board of the Academy of Consultation-Liaison Psychiatry (ACLP). ACLP is an international organisation, based in the USA, that aims to improve the psychiatric care of people with medical illnesses
www.clpsychiatry.org

Professor Sharpe received the ACLP gavel from the previous President, Rebecca Weintraub Brendel of Harvard University during the ACLP 2019 annual meeting in San Diego. He is the first person to hold the office from outside the USA.



Royal College of Psychiatrists Faculty of Liaison Annual Conference 2020

Date: 13-15 May 2020

Location: St David's Hotel, Cardiff, CF10 5SD

Register your interest:

Please email sarah.morrissey@rcpsych.ac.uk to register your interest in this conference.

We would like to extend our thanks to Ken Teh - Year 5 Medical Student, University of Nottingham who helped to prepare this newsletter.