

## JISC update Oct - Nov 2017

### Proving one's worth

**From Bristol** – 'do any other liaison nurse teams have to measure their worth... we're being asked to demonstrate are reduction in bed days and patient cost savings'.

**1. A response from NW London** - with a 'note of caution around cost savings and bed day reductions: I'd recommend becoming familiar with the approach used in the RAID evaluation, specifically:

- It was carried out by the London School of Economics and you need appropriate expertise and time to really demonstrate cost savings
- The cost savings accrued across the entire hospital population with mental health needs, not just the people seen by the RAID team (dubbed "the RAID effect").

Therefore if you only evaluate outcomes in the people who you're seeing, you'll miss the wider systemic benefits of the work done to improve pathways, educate clinical staff etc.

Furthermore, it's all very well demonstrating cost savings in a newly introduced service compared to what went before, but what are you supposed to use as your comparison group once a service has been established for a couple of years?'

This clinician would recommend introducing the full framework of the FROM-LP and ensuring that it's used regularly and the information fed back to management, patients, referrers and clinical staff – as a start.

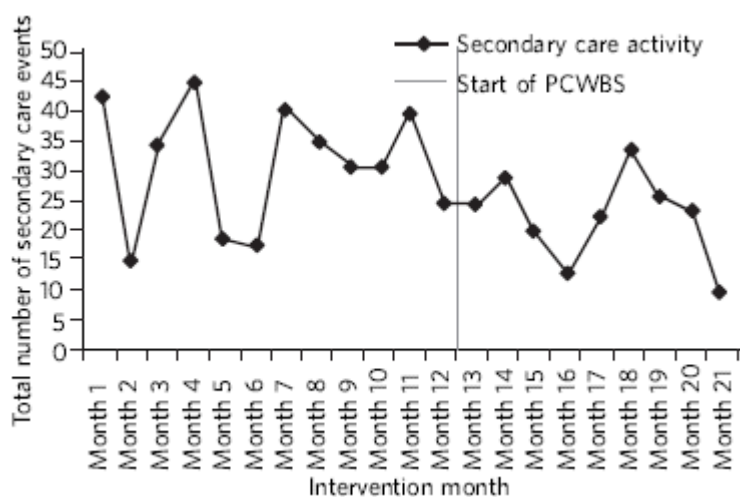
**2. Another comprehensive response:** for service level cost effectiveness 'you need to show three things:

1. A comparison period – otherwise you can't look for "Savings created by our service compared with costs when there wasn't a service, or there wasn't one staffed in the way it is now"
2. A sophisticated design and analysis e.g. bio stats at this service has helped by building a negative binomial regression model for length of stay, as the basis for an interrupted time series analysis.
3. Confidence in mental health coding in your hospital, if you are going to try and test the RAID claim that their service is paid for by savings in the patients they don't see.

At an Individual level 2 possible options are:

Give them an indication of case mix. Most managers and commissioners have no idea of the volume and complexity of cases seen in a typical liaison service

'Run up a small case series of your most complex cases [a] Outcomes = when seen/when discharged using some or all of FROM-LP. Shows people benefit clinically [b] Look at non-liaison general hospital contacts without any stats. Here's a figure from a short report coming out soon in Psychiatric Bulletin which shows a pattern before and after setting up a primary care-based liaison service. It's based on <30 people. The vertical line here could actually represent the point at which the service is set up or (if there isn't a new service) the point at which each individual is seen so the figure shows a pattern of contacts in the months before and the months after being seen. You could add them all together so xx contacts in 12 months before contact yy contacts in 12 months afterwards, but the picture tells a story: the clinical benefit is matched by service benefit. Don't worry about the case series being highly selected. You are illustrating a principle. If you're really stuck a case series of one can be powerful.'



## Managing trauma

**From North London** – ‘Where is the pendulum at with debriefing after trauma? I’m thinking of two different angles. One is the public / patients attending ED after a major incident. My understanding here is that the original negative research still applies to some extent.’ But is there a case for triage, signposting?

‘I would be interested in thoughts on current knowledge and the implications for major incident policy.’

**Response from South London** – ‘remember the two trials of simply giving a psychological education leaflet that showed a negative effect. The best immediate interventions - first hours/ days remain practical. A landline or phone charger would be top of the list’.

The second is staff groups and our role in supporting them. Here there seems to be evidence for CISM (Critical Incident Stress Management). This is more of an occupational health than a victim support approach; and potentially something for liaison teams to be lead on; in tandem with management. General supportive plus tactical debrief.

## Liaison v psychological medicine v...

**From Glasgow** – ‘I’ve been interested for a while in what might be a good name for a liaison psychiatry service. Is psychiatry off putting to patients? Is psychological medicine confusing for referrers?’

Our mental health services managers have decreed that our service name will change from ‘Glasgow Liaison Psychiatry Service’ to ‘Glasgow Liaison Mental Health Service’.

What do others think?

What is your service called?

What have been the pros and cons?’

**Respondent one – South London:** How about Medicine, Psychiatry and Psychology?

**Respondent two** - ‘I think that Liaison Mental Health better reflects the multi-disciplinary nature of liaison services. Our service is called the Mental Health Liaison Team. I think that it clearly describes what's in the tin and referrers appear to have a clear understanding of what the remit of the team is’

**Respondent three** – is currently doing a fellowship in another country and we are referred to as Medical Psychiatry department or Consultation-Liaison psychiatry.

In the UK my department was Psychological Medicine which I think reflects the medical model our patients like to fit into and also the multidisciplinary yet very biological and psychological model of the specialty and the skills required to do a good job at it.

**Respondent four from Australasia** – asks us to keep in mind is that “the name “Liaison” has a noble and important heritage that emphasizes that we do not flee after giving an opinion, but rather stand beside those who asked for our services as they struggle to implement our recommendations. Psychiatry in the UK was able to avoid using the awkward term “Consultation-Liaison Psychiatry”, presumably because it was not caught up in the bitter conflict that raged in the USA in the 1970’s over the model that should prevail, resolved by adopting the hybrid term. In Australia and New Zealand we took up the North American term out of loyalty rather than need, an action which I now regret having fostered. The term “Liaison” conveys a sense of identity. Perhaps ours is changing in the era of Precision Psychiatry.’

**Respondent five** – also from Oz - thinks there is no good answer to this question, but his unit is called “Consultation-Liaison Psychiatry”. ‘I always introduced myself to patients as “a consultation-liaison psychiatrist” and then give a 30 second spiel on what that means. The Australian and New Zealand Faculty of Consultation-Liaison Psychiatry just met to consider whether we should change our name (we do this about every five years). We decided to stick with Consultation-Liaison Psychiatry as we always have in the past.

**Respondent six** – ‘You might be interested to know that the APM in the USA is changing its name to ACLP in the spring - That is back to C-L psychiatry. Having said that our Oxford integrated service is very comfortable with the name psychological medicine!’

**Respondent seven from West Yorkshire** – ‘I’m not sure it’s too important. In Leeds I am professor of liaison psychiatry and EG is professor of psychological medicine. The main clinical service is liaison psychiatry and PT runs the national inpatient centre for psychological medicine.

On the other hand...

Liaison psychiatry is very broad (emergency psychiatry, dementia, psychological treatment for MUS and so on) but at times departments want to signal that they do other stuff. The two main strands are [a] work with mental health professionals who aren't psychiatrists. Generally nurses have shared the psychiatric label both in and out of liaison, so it's more often clinical psychologists who (perhaps not unreasonably) want a different name [b] teaching; especially as our MBChB curriculum broadens, we teach all doctors about psychological and social aspects of medicine.' He thinks that perhaps 'Psychological Medicine' captures all this a bit better.

**Another (8th) view** – 'The positive of the consultation-liaison Psychiatry name is that people understand that you are not coming to "take the patient away" or at least will not always do that. I actually started using this label in the UK when medical and nursing colleagues could not understand why I wasn't going to take the patient away from their wards and will co-manage within the hospital. I feel sometimes we ourselves create a gap between our service and rest of the medical world - contributing to stigma, and then we run campaigns to fight with that stigma. Shying away from 'Psychiatry' label is just one of the several such examples ('patient' changed to 'service user/clients' - is another such example). We want to be seen as different and then fight against it. Re. the multidisciplinary nature of our service: Lots of other medical services are also multidisciplinary, but they don't debate on the label. Cardiology have cardiac rehab nurses; Rheumatology/neurology/Orthopaedics have physiotherapists etc. etc. I have never understood how 'mental health' is better than 'psychiatry'.'

**From Oldham – 9th respondent:** 'I don't think my patients are bothered about whether they are seeing a Liaison psychiatrist or a consultant in psych medicine.'

**Respondent 10** – 'And any of these names are better than being persistently referred to as 'RAID' when your service has never called itself that....'

**And finally – from NW London...** My own dept is variously:

- Dept of Psychological Medicine
- Dept of Liaison Psychiatry
- Liaison Psychiatry Team
- Psychiatric Liaison Team

So we can't even decide whether we're a department or a team. Having arisen from a crisis-only "A&E Liaison Team" there are still traces of "A&E Liaison" in business systems and reporting. In Milton Keynes the liaison psychiatry department is called the Hospital Liaison Team and is quite strongly attached to that name.

I see branding is important though currently inclined to focus more on communicating why, how and what we do.'

Dr Jackie Gordon  
Worthing Mental Health Liaison Team