Liaison Psychiatry Services - Guidance
Contents

Preface 2

With thanks and appreciation 3

What people told us they wanted from the Guidance 4

Introduction 6

Connecting liaison psychiatry services with other pathways of care 6

Models of hospital based liaison psychiatry services for which there is evidence of cost and quality outcome benefits 8

Effective liaison psychiatry services 9

Where liaison psychiatry services can impact 11

Key references 12
Preface

This guidance provides advice on commissioning liaison psychiatry services, specifying minimum and optimum service specifications, costs and quality outcome measures. It was commissioned by the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West.

The guidance is provided as four related documents, each with increasing levels of detail:

- **Liaison Psychiatry Services - Guidance** - sets out the key considerations to be made when commissioning liaison psychiatry services.

- **An Evidence Base for Liaison Psychiatry - Guidance** - sets out the evidence gathered from lay people, professionals, commissioners and the literature about what is needed from liaison psychiatry services.

- **Developing Models for Liaison Psychiatry Services - Guidance** - provides the technical information needed for commissioning liaison psychiatry services.

- **Model Service Specifications for Liaison Psychiatry Services** - sets out exemplar service specifications for four models of liaison psychiatry.
With thanks and appreciation

We would like to recognise and appreciate the contribution of the following people for their work in putting together this guidance:

- people with an experience of our services, commissioners and commissioning supporters
- the Faculty of Liaison Psychiatry at the Royal College of Psychiatrists
- the Academy of Emergency Medicine
- the National Clinical Director for Mental Health
- the Centre for Mental Health
- the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West
- the research and development team at Devon Partnership NHS Trust, and
- Dr William Lee, Reader in Psychiatric Epidemiology, Plymouth Peninsula Schools of Medicine and Dentistry.

Dr Peter Aitken's time was funded by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care for the South West Peninsula (PenCLAHRC).

The views and opinions expressed in this paper are those of the authors and not necessarily those of NHS England, the NIHR or the Department of Health.
What people told us they wanted from the Guidance

People using services

People told us that they want to encounter liaison psychiatry services in their hospitals that help them and the doctors and nurses treating them, rather than serve age, disorder or post code. They want to be listened to, and be confident of communication between the liaison psychiatry team, community mental health services and other medical services. They want inclusive services that can recognise their problems and help them to overcome them. They want to get to the right help from professionals and services offering them a good experience of care and recovery.

Commissioners

Commissioners told us that they need to understand what liaison psychiatry is, which models work, and options for commissioning in the context of different size hospitals, community hospitals and existing arrangements for other pathways of care.

Commissioning support managers

Commissioning support managers told us that they want clear exemplar service specifications, with reference to policy and the evidence base, presented in a way that fits with national commissioning templates, and covering quality, safety, outcomes and finance.

Liaison psychiatry professionals

Liaison Psychiatrists, Liaison Mental Health Nurses and Clinical Psychologists told us that liaison psychiatry, also known as psychological medicine, is the medical specialty concerned with managing mental health aspects of health care in people who have presented to hospitals with medical, surgical and related problems. Practitioners are skilled in assessing medical, psychological and social aspects of the person’s needs and formulating plans to help manage symptoms and enable recovery. Professionals want to work in services that have excellent communication pathways with other teams and support from the hospital within which they are based.
This guidance is set out to help commissioners

This guidance sets out, as four documents with different levels of detail, recommendations for commissioners and their partners who are developing detailed local business cases for effective models of liaison psychiatry in their locality. The document is styled to enable the Clinical Commissioning Group (CCG) commissioner to understand the models of care and key considerations from reading this executive summary, and for their partners to be guided to the detail in the text and appendices that follow.

What is liaison psychiatry?

Liaison psychiatry is the sub-specialty of medicine concerned with the management of mental disorder in general medical settings. It deals with conditions where the problem is the co-existence of physical and psychological symptoms regardless of causation. Also called consultation-liaison psychiatry it is increasingly referred to as psychological medicine in the UK. It is a medical discipline not to be confused with psychological therapies or Improving Access to Psychological Therapies (IAPT).

Provenance

This work was commissioned by the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West in response to a survey of existing liaison psychiatry services in the region. This found a differing range of services serving its acute hospitals with significant variance in spend, skill mix, hours of operation and little evidence of outcomes. We spoke to people using services, commissioners, their supporters and professionals delivering the services to scope the style and content of this report, in order to inform commissioning.
Introduction

There is evidence that for every £1 invested in the liaison psychiatry service models recommended in this guidance up to £4 of value is returned to the local health economy.

This guidance makes recommendations for commissioners of liaison psychiatry services on the minimum and optimum service configurations likely to return this value, and how to create the business cases and service specifications and performance management that follows.

It is accepted and supported by the evidence that over 25% of people admitted to our acute hospitals have a co-morbid mental health problem. Many more are drinking alcohol in a harmful way. Over 95% of people with dementia who are admitted are admitted in an emergency with 60% passing through emergency departments accounting for over 10% of all admissions. Self-harm remains the commonest cause of female admission in younger adults with over 150 000 emergency department attendances in England each year.

Connecting liaison psychiatry services with other pathways of care

Liaison psychiatry services will be focused on the needs of people with dementia, frail elderly care, psychosis, alcohol and substance misuse, personality disorder, anxiety and depression, perinatal, criminal justice, social and domestic crisis support.

Liaison psychiatry services should be integrated with other hospital services and pathways, from the point of admission to contributing to planning discharge, working alongside pathways for long-term medical conditions and as part of integrated care teams.

Services should follow the patient’s journey from primary care, to planned and unplanned admission to hospital, and discharge.
Six key patient groups attending for emergency or unplanned care at our acute hospitals stand to benefit from effective liaison psychiatry services

1. People who self-harm and need medical or surgical treatment as a consequence.
2. People with the physical and psychological consequences of alcohol and drug misuse.
3. Frail elderly people where there is a possible diagnosis of delirium, depression and / or dementia and a perceived need for basic physiological support, supportive nursing and further investigation.
4. People with known severe mental illness particularly when in relapse.
5. People admitted with primarily physical symptoms which, on assessment, have mainly psychological or social causation.
6. Vulnerable groups including homeless people, people with personality disorder, people who may be subject to domestic violence and abuse, children and young people at risk.

For planned care pathways the benefit seems clear but the evidence base is weaker

We know that liaison psychiatry / psychological medicine practitioners can help manage long term conditions in outpatient clinics, general practice and integrated care settings to the benefit of those with overt anxiety, depression and other mental disorders complicating diabetes, acquired brain injury and other long term conditions. There is emerging and compelling evidence of outcome benefit to people with apparently unexplained medical symptoms. The economic benefits seem obvious but the evidence base remains in development and we suggest priority is given to securing effective services in the emergency and unplanned care pathway before moving to expand the model into outpatient and community settings.

Finding the model for my urban or rural locality

Much of the evidence in support of the quality and economic benefit from liaison psychiatry services has come from the RAID service in Birmingham. There are also indications from work in North West London and five national exemplar sites at St Helier, Exeter, Cheshire and Wirral, Humber and Leeds and their impact on emergency and unplanned care. We set out recommendations for adapting from these models of care for hospitals of various sizes, with and without emergency departments and with varying demand across the 24-hour period as a consequence of urban or rural location. We call these models: Core, Core24, Enhanced24, and Comprehensive.
Models of hospital based liaison psychiatry services for which there is evidence of cost and quality outcome benefits

Core

These services have the minimum specification likely to offer the benefit suggested by the literature. Core will serve acute health care systems with or without minor injury or emergency department environments where there is variable demand across the week including periods of no demand where a 24-hour staffed response would be uneconomical.

Core 24

These services have the minimum specification likely to offer the benefit suggested by the literature where there is sufficient demand across the 24-hours period to merit a full service. Typically these acute health care systems are hospital based in urban or suburban areas with a busy emergency department.

Enhanced 24

These services have enhancements to the minimum specification to fit in with gaps in existing pathways and services. Often they have additional expertise in addictions psychiatry and the psychiatry of intellectual disability. Demography and demand may suggest additional expertise with younger people, frail elderly people or offenders, crisis response or social care. This may extend to support for medical outpatients.

Comprehensive

Comprehensive services are required at large secondary care centres with regional and supra-regional services. These services include Core24 level services but will have additional specialist consultant liaison psychiatry, senior psychological therapists, specialist liaison mental health nursing, occupational and physiotherapists. They support inpatient and outpatient areas such as diabetes, neurology, gastroenterology, bariatric surgery, plastic and reconstructive surgery, pain management and cancer services. They may include other condition specific elements such as chronic fatigue and psychosexual medicine teams. Some may include specialist liaison psychiatry inpatient beds. Comprehensive services run over office and extended hours supported by the core service running twenty four hours, seven days a week.
Effective liaison psychiatry services

Effective liaison psychiatry services are multidisciplinary, medically led by a consultant liaison psychiatrist, supported by specialist liaison mental health nurses and psychological therapists. Liaison psychiatry teams are expert in psychopharmacology in the medical and surgical setting and equipped with psychotherapeutic skills appropriate to brief interventions. With approved mental health practitioners, they can safely operate the Mental Health Act and Mental Capacity Act in general hospital settings. The number of practitioners is dependent on the hours of operation of the service and its connection with outpatient and community based work.

Effective liaison psychiatrists

Liaison psychiatrists are doctors skilled in general and mental health diagnosis, psychological and social formulation and therefore able to see people early in triage where the cause of their presentation remains obscure and can be physical, psychological or social. Liaison psychiatrists have a key role in liaison psychiatry services, providing medical leadership, translation with medical and surgical culture, and the supervision of other team members in bio-psychosocial formulation, care planning and delivery of brief interventions.

Locating liaison psychiatry services

Liaison Psychiatry Services need to be based in close proximity to the acute care hospital environments they serve so that their practitioners can offer the rapid response fast paced emergency and unplanned care pathways require. Much of liaison psychiatry service is about connecting and moving peoples’ care onto the right pathway and enabling professionals in other agencies to do their job. Common location in an acute care ‘hub’ is ideal with access to information support in common with other health, social care and criminal justice agencies and enabling technologies that allow liaison psychiatry practitioners to offer telephone, video-conferencing, email and text support.

Outcomes from liaison psychiatry services

Liaison Psychiatry work must be measured in terms of the experience and outcome for the patient and the experience and outcome of the referring clinician with further evaluation of the impact of the service on the safety culture of the hospital and the benefit to the wider health system. A balanced score card is recommended. We describe the current framework under test.
Providing, managing and governing liaison psychiatry services

Liaison Psychiatry is a high-risk service model. The support of emergency and unplanned pathways means high volumes of work with relatively little time or information at the point of need from which to make a diagnosis, formulation and risk assessment. Practitioners have to deal with complexity and uncertainty that can make decision making about treatment and care difficult. As a result liaison psychiatry services must be clinically led, trained, supervised and managed by professionals expert in liaison psychiatry. Whilst provision may come from a range of providers, the work of the service should be managed and governed by the host organisation for the clinical work, usually the provider of acute hospital care.

What follows

The narratives in the other parts of this guidance expand on the summary points made in this executive summary, with a range of appendices aimed at supporting the work of commissioners and providers putting together local service specifications and business cases for their locality.
Where liaison psychiatry services can impact
Key references


Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of liaison mental health services to acute hospitals. Available at www.jcpmh.info


NHS Confederation (2009). Healthy mind, healthy body: how liaison psychiatry services can transform quality and productivity in acute settings. London: NHS Confederation
