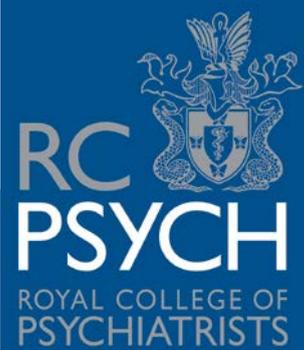


CR183



# Liaison psychiatry for every acute hospital

Integrated mental and physical healthcare

December 2013



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Integrated mental and physical healthcare

College Report CR183  
December 2013

Royal College of Psychiatrists  
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# Endorsements

College of Emergency Medicine

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# Working group

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# Executive summary: key messages

Liaison psychiatry is a critical service that should be integral to all acute hospitals (Joint Commissioning Panel for Mental Health, 2012; NHS Confederation, 2012). Services comprise multidisciplinary teams skilled to integrate mental and physical healthcare in people whose mental health problems arise in, or have an impact on management of, physical illness and symptoms. Some prefer the term psychological medicine; however, this report uses the current convention for national reports of liaison psychiatry.

The report starts with chapters that summarise existing evidence of need for liaison psychiatry services in all acute hospitals and then provides evidence for the range of problems addressed, and range of interventions required, to meet core mental health demands in acute hospitals. This is followed by a chapter showing case examples that demonstrate the benefit of services. The next chapter provides detailed considerations for service design, including principle organisational standards, access and response standards, hours of operation, remit and staffing. A chapter on governance follows to describe a range of clinical and organisational risks and how these can be reduced by liaison psychiatry services. The final chapter provides key considerations required to set local standards for common mental health-related problems that occur in acute hospitals. Each chapter ends with a summary of the key messages from the chapter. These key messages are listed below.

## BACKGROUND

### *MENTAL HEALTH NEEDS IN ACUTE HOSPITALS*

- Liaison psychiatry services in acute hospitals address the mental health needs of people being treated primarily for physical health problems and symptoms.
- Such services improve quality of care, dignity and quality of life for patients, improve mental health skills in non-mental health professionals and reduce adverse events and other risks to the acute hospital.
- Financial benefits come from reduced avoidable costs and ineffective or inappropriately located management of mental health problems by reduced length of stay, readmissions and investigations, and improved care of medically unexplained symptoms, dementia and long-term conditions.

## *WHAT THIS REPORT ADDS*

- Summarises and builds on earlier recommendations relating to the need for multidisciplinary liaison psychiatry services dedicated to each acute hospital to achieve integration and parity for mental health and physical aspects of care.
- Targeted report for senior clinicians and managers to support discussions with funding bodies, such as commissioners.
- Recommendations for adults of all ages across the UK, regardless of intellectual disability or other equality considerations.
- Justified detailed recommendations for service design, staffing, core functions and clinical governance to deliver integrated and equitable physical and mental healthcare in acute hospitals.
- Evidence to support planning of educational interventions.
- Core clinical considerations covering common referrals and other mental health considerations in an acute hospital.

## *WHAT IS NOT COVERED IN THIS REPORT*

- Enhancements to the core service required for developing specific care pathways, such as for long-term conditions or medically unexplained symptoms, alcohol-related disorders, intellectual disability or perinatal mental health problems extending into the community or for patients with milder mental health problems not affecting their care in the acute hospital.
- Enhancements to the core service to address increased or disease-specific needs within specialist services (e.g. bariatric surgery) and regional services (e.g. cancer, transplant or neurosciences units).
- Enhancements to the core service to deliver more than basic levels of education for acute hospital staff.
- Description of child liaison psychiatry services which, although not detailed in this report, should be an essential component of any acute hospital providing paediatric care and will share many principles and core standards of services for adults.

## **SCALE AND NATURE OF PROBLEMS NEEDING SPECIALIST SERVICES**

### *SCALE OF NEED*

- Mental health problems are common, increasing and more prevalent in acute hospitals than in the community (NHS Confederation, 2009).
- Mental health problems occur in 30–60% of in-patients and out-patients (Academy of Medical Royal Colleges, 2010) and are the presenting feature in 5% of all emergency department attendances

(Royal College of Psychiatrists & British Association for Accident and Emergency Medicine, 2004).

- The most common mental health problems in acute hospital in-patients are self-harm, depression, delirium, dementia, adjustment reactions and alcohol-related disorders (Royal College of Physicians, 2001; Academy of Medical Royal Colleges, 2010; Blunt *et al*, 2010).
- Dementia in older adults and mental health problems associated with long-term physical conditions and medically unexplained symptoms in working-age adults account for disproportionate costs related to mental health needs in acute hospitals (Parsonage *et al*, 2012).
- The extra cost of physical healthcare in acute hospitals associated with comorbid mental health problems, including medically unexplained symptoms, is £6 billion a year, equivalent to 15% of total expenditure in these hospitals (Parsonage *et al*, 2012).
- The prevalence and costs associated with mental health disorders are likely to rise with increasing medical acuity and complexity in acute hospitals as milder conditions are managed in community settings.
- Acute hospital staff lack training, knowledge and skills related to the recognition and management of common mental health problems affecting acute hospital care (Academy of Medical Royal Colleges, 2010; Parsonage *et al*, 2012).

### *EXPECTED BENEFITS OF LIAISON PSYCHIATRY*

- Reduced secondary healthcare costs, increased efficiency, reduced risks and improved quality of care related to mental health problems (Academy of Medical Royal Colleges, 2010; Joint Commissioning Panel for Mental Health, 2012; Parsonage *et al*, 2012).
- Improved compliance with mental health- and mental capacity-related legislation (Joint Commissioning Panel for Mental Health, 2012).
- Reduced risk of adverse events linked to mental health needs (Academy of Medical Royal Colleges, 2010) following clinical input and education of acute hospital staff in relation to legal frameworks, psychopharmacology and disturbed behaviour related to personality difficulties, substance misuse, complex adjustment disorders, delirium, dementia and psychosis.
- Improved quality of care (Joint Commissioning Panel for Mental Health, 2012), and contribution to reduced lengths of stay following education of acute hospital staff regarding communication, mental capacity and other areas of ward management related to behavioural and emotional reactions to physical illness and how these are influenced by personality, social and cognitive factors, as well as mental illness.
- Quality improvements related to improved attitudes, and reduced staff stress related to increased confidence, in acute hospital staff following liaison psychiatry involvement with, and education about, mental health problems that are common or difficult to manage in the hospital (Joint Commissioning Panel for Mental Health, 2012).

## SERVICE DESIGN

### *SERVICE DEVELOPMENT*

- A multidisciplinary liaison psychiatry service dedicated to the hospital is critical to every acute hospital to integrate mental and physical healthcare (NHS Confederation 2012; Joint Commissioning Panel for Mental Health, 2012).
- Services should be provided on an equitable basis regardless of age, intellectual disability, area of residence or location within the hospital (Parsonage *et al*, 2012).
- Staffing levels and skill mix need to be tailored to local factors including the size and complexity of the hospital, case mix and other local mental health services (Parsonage *et al*, 2012).
- Liaison psychiatry services should be subject to the same quality standards as other medical specialties in the hospital (Academy of Medical Royal Colleges, 2008).
- Mental healthcare needs to be funded in conjunction with physical healthcare (Academy of Medical Royal Colleges, 2010; Joint Commissioning Panel for Mental Health, 2012; Royal College of Psychiatrists, 2013) so that liaison psychiatry services to address mental health needs are included in specifications for emergency, unscheduled and elective physical healthcare. This principle should also apply to complex or regional services, such as those that are commissioned through national service commissioning.
- Funding mechanisms for liaison psychiatry, such as commissioning, need to be applied so that services are cohesive and can provide core functions outlined in this report.

### *SERVICE ORGANISATION*

- Services require dedicated accommodation on the acute hospital site and assessment facilities in the hospital to ensure safety, privacy and dignity (Soni *et al*, 2011; Parsonage *et al*, 2012).
- Staff in the liaison psychiatry service require skills to integrate physical and mental health knowledge relating to diagnosis, formulation and management.
- Essential members of a liaison psychiatry team will include dedicated administrative staff and specialist consultant liaison psychiatry and mental health nursing staff with expertise in working-age and older adults. Psychologists should also be regarded as core members. Each acute hospital should have a lead pharmacist for mental health and substance misuse and this is likely to require a dedicated post in large hospitals, with tertiary services where prescribing issues are likely to be complex.
- Working-age and older adults generally have a different nature and prevalence of problems that require a different skill mix and, in larger hospitals, may justify separate teams (Parsonage *et al*, 2012).

- Patients in acute hospitals should have equitable access to a consultant psychiatrist for mental health problems just as they do to a consultant for their physical health problems (Academy of Medical Royal Colleges, 2008; Joint Commissioning Panel for Mental Health, 2012; Parsonage *et al*, 2012).
- All service functions should be provided 5 days a week and all emergency or urgent clinical problems should be covered 7 days a week.
- Services should aim for a maximum response time of 1h for emergency referrals and 1 day (usually within 5 working hours) for urgent referrals.
- Completion of assessment under mental health legislation should generally occur within 4h where there are imminent risks as a result of the mental health condition.
- Although clinical needs and risk should always take priority, organisational issues, such as impact on further investigation or discharge, should also be considered when services need to prioritise referrals.
- Emergency departments and acute medical and surgical units will benefit from a minimum of a 7-day, 12-hour-a-day on-site service.
- Referrals from emergency departments or acute medical and surgical units will benefit from a response time of 1h where mental health assessment is needed for decisions about discharge or transfer from the unit.

## SERVICE FUNCTIONS

- Referrals should be accepted for any mental health problem that is moderate to severe and/or impairing physical healthcare.
- Liaison psychiatry staff need to support acute hospital management, including advocating for physical treatment, of people with severe and enduring mental health problems such as schizophrenia.
- Liaison psychiatry services should provide ongoing monitoring and advice on management of mental health problems and medication affecting physical healthcare while the patient remains in the acute hospital.
- Educational programmes and involvement in clinical governance within the acute hospital are core non-clinical functions of liaison psychiatry services (Academy of Medical Royal Colleges, 2008; Joint Commissioning Panel for Mental Health, 2012).

## SERVICE INTERFACES

- Liaison psychiatry services for associated mental health needs should be funded and planned in conjunction with physical health services (Academy of Medical Royal Colleges, 2010; Royal College of Psychiatrists, 2013) for emergency, unscheduled, routine and specialist care in the acute hospital.

- Liaison psychiatry in acute hospitals should be part of mental health service pathways, especially for self-harm, alcohol and substance misuse, eating disorders, dementia and psychological therapy in long-term conditions and medically unexplained symptoms.

## INTEGRATED GOVERNANCE OF LIAISON PSYCHIATRY

### *INTEGRATED GOVERNANCE*

- Liaison psychiatry services should participate in an integrated governance group (Joint Commissioning Panel for Mental Health, 2012) that meets at least quarterly, involving senior liaison psychiatry and acute hospital clinicians and managers, and individuals from both the acute hospital and the organisation providing liaison psychiatry (Soni *et al*, 2011).
- The integrated governance committee will benefit from including acute hospital leads for patient safety and quality, and linking to related groups such as planning and safeguarding.
- All services should demonstrate regular audits and implementation of findings covering a range of clinical and organisational parameters (Soni *et al*, 2011).
- Funding bodies should consider using standards set by the Psychiatric Liaison Accreditation Network (PLAN) (Soni *et al*, 2011) as performance indicators for services.

### *RISK MANAGEMENT*

- Acute hospitals need to be able to meet legal requirements of mental health legislation for patients subject to its provisions while in the acute hospital (Care Quality Commission, 2010). This is likely to require formal arrangements with the organisation providing mental healthcare.
- Emergency departments should include at least one designated room for mental health assessments with adequate provision for dignity, privacy and safety (Soni *et al*, 2011; College of Emergency Medicine, 2013).
- Serious untoward incidents or near misses in the acute hospital relating to mental health factors, including psychotropic medication, should be reviewed by the integrated governance committee.
- All acute hospitals should have a lead pharmacist for prescribing related to mental health and substance use disorders, who takes a lead in developing and auditing policies regarding psychotropic prescribing. They should work closely with the liaison psychiatry service and acute hospital ward pharmacists.
- Acute hospitals would benefit from liaison psychiatry services working with the acute hospital to develop an observation policy related to mental health needs that is tailored to the hospital.

- Security staff in acute hospitals would benefit from training and support in legal frameworks and how to manage patients with disturbed behaviour, especially when associated with mental health problems or lack of mental capacity.
- Liaison psychiatry clinicians will add value to work in acute hospital risk and complaints departments to improve understanding and management of complaints related to complex somatoform, factitious or personality disorders.

### *INFORMATION MANAGEMENT AND OUTCOME DATA*

- Liaison psychiatry staff need access to electronic and paper records used within the acute hospital and local mental health services (Soni *et al*, 2011), and should document assessments and advice in one set of integrated notes for mental and physical healthcare using the acute hospital record (Joint Commissioning Panel for Mental Health, 2012).
- Liaison psychiatry services should consider collecting outcome data using a balanced scorecard approach, including clinical outcome measures, process measures and patient and referrer feedback.

### CLINICAL TOPICS

Liaison psychiatry services should agree local standards for clinical care. These would benefit from including standards related to:

- self-harm
- depression and adjustment disorder
- delirium and dementia
- alcohol, opiates and other substance misuse
- medically unexplained symptoms
- psychosis
- eating disorders
- neuropsychiatric disorders
- specific considerations for older adults with mental health problems
- specific considerations for people with intellectual disability and mental health problems
- special observation of patients with mental health needs
- psychotropic prescribing.

The considerations provided in this report should be evaluated in line with local policies as well as local and national guidance such as from the Department of Health, National Institute of for Health and Care Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN) and professional organisations. As with other areas of practice, standards will need to be renewed in line with future recommendations.

# Background

Liaison psychiatry services in acute hospitals address the mental health needs of people being treated primarily for physical health problems and symptoms. Many prefer the term psychological medicine but this report uses the current convention for national reports of liaison psychiatry. Such services are multidisciplinary specialist mental health teams skilled to address a range of mental health problems that arise in all clinical areas of acute hospitals, many of which are outside the expertise of other mental health services. There is a call for liaison psychiatry services to expand into primary care (Parsonage *et al*, 2012). This report agrees with that proposal but is focused on service needs within an acute hospital since that is where the concentration of need, and evidence of benefit, is greatest.

## NATIONAL DRIVERS

Although details of drivers vary across the UK and for specific populations of people, such as the elderly or individuals with intellectual disability, there are broad, widely relevant recommendations supporting development of liaison psychiatry services relating to quality and economic factors:

- the need to reduce physical and mental health comorbidity (Academy of Medical Royal Colleges, 2009; Department of Health, 2011)
- the need to improve the management of long-term conditions and medically unexplained symptoms (Department of Health, 2011; Parsonage *et al*, 2012)
- services must be responsive and located where the need arises (Department of Health, 2000)
- physical and mental healthcare should be integrated (Department of Health, 2008)
- access to treatment needs to occur without organisational barriers (Department of Health, 2011; Joint Commissioning Panel for Mental Health, 2012).

The National Health Service (NHS) Confederation Mental Health Network produced a briefing paper (NHS Confederation, 2009) indicating how liaison psychiatry services could transform quality and productivity in acute hospitals. It later commissioned a report, *Liaison Psychiatry in the Modern NHS* (Parsonage *et al*, 2012), to review research, obtain clinical expert consensus and review five liaison psychiatry services across England to identify evidence of cost-effectiveness and clinical outcomes.

These papers describe several potentially cost-saving drivers for liaison psychiatry in acute hospitals:

- reduced admissions and readmissions
- reduced length of stay
- reduced healthcare costs for medically unexplained symptoms.

The papers also describe many drivers related to quality improvements, for example:

- parity for management of mental health and physical health problems
- improved access to mental health, substance misuse and learning disability services
- improved quality of care and legal compliance related to mental capacity and mental health legislation
- reduced physical and psychological morbidity, especially for people with dementia, acute or long-term physical conditions, serious mental illness, alcohol misuse problems and stresses leading to self-harm
- decreased rates of self-harm
- reduced emergency department waiting times
- reduced risk of adverse events
- increased knowledge and skills of the acute hospital workforce.

## PREVIOUS REPORTS

There are several reports recommending core principles of services (Academy of Medical Royal Colleges, 2008; Joint Commissioning Panel for Mental Health, 2012; Parsonage *et al*, 2012; Royal College of Psychiatrists, 2013). Common themes include:

- an on-site multidisciplinary liaison psychiatry service covering all wards and the emergency department is an essential service for every acute hospital
- services need to be securely and adequately funded and staffed to appropriate levels, and contain the necessary skill mix
- patients with mental health problems in acute hospitals should have the same level of access to a consultant psychiatrist as to a consultant for their physical health problems
- there should be equity of access for all people admitted to the hospital regardless of age, intellectual disability, diagnosis, location of home residence or any other factor influencing equality considerations
- organisational needs of the acute hospital, such as impact on discharge and further investigation, should influence response time to referrals in addition to clinical need and risk
- psychiatry and psychology provision should be fully integrated and co-provided with physical healthcare
- training and supervision of acute hospital staff in recognition and

management of mental health problems in physical illness is a core function of liaison psychiatry services

- out-patient work will produce enhanced benefits to a service restricted to ward and emergency department referrals
- liaison psychiatry is an essential component of dementia care, long-term condition and medically unexplained symptom care pathways but requires enhancements to the core service to extend into the community.

The recent guidance for commissioners in England (Joint Commissioning Panel for Mental Health, 2012) and the review of service design and outcomes (Parsonage *et al*, 2012) provide the most detailed recommendations related to liaison psychiatry services. The latter review clarifies:

- services should be tailored to specific local demands, with the scale and nature of a service varying according to local needs, such as the size and complexity of the hospital and provision of related services;
- different patient populations, as defined by age or diagnosis, have different needs that may justify separate subteams or focused developments in larger hospitals;
- liaison psychiatry services should work with older adults as a priority, both for clinical reasons and because savings are most likely to be achieved from reduced length of stay;
- liaison psychiatry services for younger adults are more likely to produce clinical benefits in patients with mental health problems contributing to increased clinical risks as well as producing cost savings through in-patient and out-patient work with complex and costly cases, particularly patients with medically unexplained symptoms and other intractable symptoms, who might otherwise be kept in hospital for lengthy periods;
- once a rapid-response generic service has become established, the next stage of development is likely to be in the provision of out-patient clinics for the treatment of mental health problems that cannot be resolved during the limited time that most patients spend in hospital. Out-patient treatment clinics should focus particularly on conditions that are not generally well managed in the community, for example medically unexplained symptoms and self-harm.

In addition to generic reports about liaison psychiatry services there are several relating to the provision of acute hospital mental healthcare for older adults (Royal College of Psychiatrists, 2005; Parliamentary and Health Service Ombudsman, 2011) or for people with intellectual disability (Guidelines and Audit Implementation Network, 2010; Heslop *et al*, 2013), where serious care failings have been highlighted. The need to improve poor management of delirium, which occurs in all ages but is more prevalent in older adults and in people with intellectual disability, is highlighted. This is important given the strong association of delirium and subsequent death (Witlox *et al*, 2010).

Volume 1 of the Francis Report (Francis, 2013) describes many failings in an acute hospital, especially regarding the care of frail elderly and other vulnerable patients, including those with dementia. Liaison psychiatry

services would be expected to contribute to remedying such failings through direct intervention and improving the knowledge and skills of acute hospital staff in managing patients with dementia and other mental health conditions.

## AIM OF THE CURRENT REPORT

The current report aims to make recommendations for services applicable across the UK, while recognising that differences in service funding and organisation or legal frameworks may mean some aspects do not apply or require modification for individual jurisdictions.

The report focuses on adults, acknowledging that details of services for working-age and older adults need to be tailored to the specific needs of different ages. Many principles and recommendations also apply to children and, although not considered in detail in this report, child liaison psychiatry services should be an essential component of any acute hospital providing paediatric care.

The ultimate aim of the report is to guide development of services to improve mental healthcare for those with physical health problems, leading to:

- improved quality of care and quality of life for patients
- improved mental health skills in non-mental health professionals
- reduction in adverse events
- reduction in avoidable costs or ineffective or inappropriately located management of mental health problems.

## NEW INFORMATION

In addition to providing an up-to-date summary of the scale of need and principles of service design outlined by others, this report will supplement earlier reports with operational details by:

- focusing on advice for senior clinicians and managers in physical and mental healthcare organisations to support discussions with funding bodies, such as commissioners
- specifically including all adults, including the elderly, individuals with intellectual disability and those with substance misuse
- providing justification for, and details of, core service and clinical considerations to address needs of all in-patients with mental health issues that are severe, risky or affecting the clinical care pathway through the hospital
- emphasising the role of liaison psychiatry services in improving the physical care of people with severe and enduring mental illness
- detailing core educational considerations for a liaison psychiatry service
- updating staffing needs to meet all service functions 5 days a week and to meet the needs of all emergency or urgent problems 7 days a week.

## LIMITS OF THE REPORT

Liaison psychiatry services that meet all the needs of specialist services, especially for dedicated out-patient work (such as bariatric surgery, regional neurosciences, oncology or transplant services), are not detailed in this report and will require enhanced service provision. However, such needs should be included in funding and planning for specialist, regional or national services, including those funded through specialist commissioning.

Integrated physical and mental healthcare in acute hospitals is critical since that is where patients who are most ill are found (Parsonage *et al*, 2012). Therefore this report focuses on the needs in acute hospitals, although supports recommendations for wider developments.

Enhancements to the core liaison psychiatry service for care pathways (such as for long-term conditions or medically unexplained symptoms, alcohol-related disorders or perinatal mental health problems) extending into the community or for patients who are not high or complex users of in-patient or out-patient settings in the acute hospital are also not detailed in this report. These will require enhanced service provision and will be influenced by other local services in the pathway.

## KEY MESSAGES

### *MENTAL HEALTH NEEDS IN ACUTE HOSPITALS*

- Liaison psychiatry services in acute hospitals address the mental health needs of people being treated primarily for physical health problems and symptoms.
- Such services improve quality of care, dignity and quality of life for patients, improve mental health skills in non-mental health professionals and reduce adverse events and other risks to the acute hospital.
- Financial benefits come from reduced avoidable costs and ineffective or inappropriately located management of mental health problems by reduced length of stay, readmissions and investigations, and improved care of medically unexplained symptoms, dementia and long-term conditions.

### *WHAT THIS REPORT ADDS*

- Summarises and builds on earlier recommendations relating to the need for multidisciplinary liaison psychiatry services dedicated to each acute hospital to achieve integration and parity for mental health and physical aspects of care.
- Targeted report for senior clinicians and managers to support discussions with funding bodies, such as commissioners.
- Recommendations for adults of all ages across the UK, regardless of intellectual disability or other equality considerations.

- Justified detailed recommendations for service design, staffing, core functions and clinical governance to deliver integrated and equitable physical and mental healthcare in acute hospitals.
- Core clinical considerations covering common referrals and other mental health considerations in an acute hospital.

### *WHAT IS NOT COVERED IN THIS REPORT*

- Enhancements to the core service to address specific care pathways – such as for long-term conditions or medically unexplained symptoms, alcohol-related disorders, intellectual disability or perinatal mental health problems – extending into the community or for patients with milder mental health problems not affecting their care in the acute hospital.
- Enhancements to the core service to address increased or disease-specific needs within specialist services such as bariatric surgery and regional services such as cancer, transplant or neurosciences units.
- Enhancements to the core service to deliver more than basic levels of education for acute hospital staff.
- Description of child liaison psychiatry services which, although not detailed in this report, should be an essential component of any acute hospital providing paediatric care and will share many principles and core standards of services for adults.

# Scale and nature of problems needing specialist services

Table 1 (p. 41) and Box 1 (p. 42) outline the problems a liaison psychiatry service should address. This chapter summarises evidence regarding the scale of such problems.

Acute hospitals have a higher prevalence of mental health and substance misuse problems and intellectual disability than the general population (NHS Confederation, 2009). This is due to a number of factors, including:

- high comorbidity of mental and physical health problems, especially with increased complexity of physical illness
- severe or chronic physical illness being a risk factor for many mental health disorders
- people with severe and enduring mental illness, such as schizophrenia and bipolar disorder, have increased risk of long-term physical conditions and risks related to serious physical complications of psychotropic medications
- increased physical health problems in people with intellectual disability
- physical complications of alcohol and drug misuse
- frailty, disability and risk of prolonged hospitalisation associated with dementia and delirium
- physical symptoms being a presenting feature of some mental disorders (e.g. depression and somatoform, panic or eating disorders)
- challenges for patients adapting to complex or long-term physical health treatment programmes, leading to problems such as poor self-care or poor adherence, resulting in increased admissions
- public accessibility of emergency departments
- increasing self-harm presentations, with a national increase of 11% in the past 3 years (NHS Networks, 2013).

## CLINICAL DEMANDS

- Of general hospital in-patients, 30% have a psychiatric disorder, most commonly dementia, delirium, depression and adjustment disorders; the figure for older people is 45% (Academy of Medical Royal Colleges, 2010).

- Of general hospital out-patients, especially in neurology, gastroenterology, cardiology and gynaecology clinics, 30–60% have predominantly medically unexplained symptoms, many of whom will have an underlying mental health diagnosis (Academy of Medical Royal Colleges, 2010).
- Of people presenting to emergency departments, 5% have a primary mental health problem (Royal College of Psychiatrists & British Association for Accident and Emergency Medicine, 2004), and people who attend more frequently are more likely to have a primary mental health problem. The percentage of patients with mental health issues as a comorbidity or as a contributory factor to their presenting problem is far higher.
- Alcohol misuse is the main reason for 10% of emergency department attendances, and is even more common in patients who present frequently, present following trauma or present with gastrointestinal complaints (Royal College of Physicians, 2001).
- Self-harm is one of the most common causes of acute hospital medical admissions (Blunt *et al*, 2010).
- Alcohol misuse is a common cause of physical problems leading to acute hospital admission and accounts for 12% of hospital expenditure (Royal College of Physicians, 2001).
- Lack of mental capacity occurs in 40% of unscheduled medical admissions (Raymont *et al*, 2004) and is more prevalent in acute hospitals compared with mental health hospitals (Owen *et al*, 2008).

## CLINICAL OUTCOMES

Mental health problems in acute hospitals are linked to poor clinical outcomes.

- About 1% of adults who have presented to hospital with self-harm will die by suicide in the following year (Hawton & Fagg, 1988) and people who leave an emergency department after a self-harm episode without a mental health assessment are more likely to repeat self-harm (Hickey *et al*, 2001).
- Delirium increases the risk of death and subsequent institutionalisation in older adults (Witlox *et al*, 2010).
- Depression in in-patients impairs quality of life (Creed *et al*, 2002) and rehabilitation (Turner-Stokes & Hassan, 2002), and has been linked to increased mortality.
- People with severe anorexia nervosa are dying in acute hospitals because of avoidable physical or mental health complications related to lack of understanding of the combined physical and mental health needs (Royal College of Psychiatrists & Royal College of Physicians, 2010).
- Psychiatric problems that may be seen as 'subthreshold' for diagnosis and intervention in the absence of physical health problems lead to significantly increased morbidity, such as with disordered eating and diabetes (Peveler *et al*, 2005).

## HEALTHCARE COSTS

Mental health needs in acute hospitals increase costs and resource use.

- Mental health needs increase emergency department waits (NHS London Health Programmes, 2013).
- Comorbid physical and mental health problems increase length of stay, delay discharges and contribute to increased readmission rates (Academy of Medical Royal Colleges, 2010).
- Medically unexplained symptoms are associated with markedly increased healthcare costs. For example, costs were five times higher in a study of neurology referrals (Hansen *et al*, 2005).
- Disturbed behaviour in an acute hospital consumes a disproportionate amount of resources (Academy of Medical Royal Colleges, 2010).

A recent review of liaison psychiatry services and research estimates that the extra cost of physical healthcare in acute hospitals associated with comorbid mental health problems – including medically unexplained symptoms – is about £6 billion a year, equivalent to 15% of total expenditure in these hospitals. For a typical general hospital of 500 beds, this corresponds to a cost of about £25 million a year (Parsonage *et al*, 2012).

## RISK MANAGEMENT

### CLINICAL RISKS

Adequately staffed and resourced liaison psychiatry services should help acute hospitals manage a range of clinical and organisational risks. Clinical risks that can be reduced by liaison psychiatry services include:

- impaired medical management due to lack of understanding of mental health problems, intellectual disability and cognitive impairment
- medical errors related to psychotropic prescribing
- antipsychotic prescribing for behaviour disturbance, especially in people with dementia
- incidents of violence or restraint related to behaviour disturbance resulting from mental health disorders, intellectual disability or cognitive impairment
- in-patient or subsequent suicide
- iatrogenic harm in factitious and somatoform disorders and in people with other complex medically unexplained symptoms.

### ORGANISATIONAL RISKS

Liaison psychiatry services can bring improvements to organisational risks on many levels:

- reduced risk of financial penalties from funding organisations by decreasing lengths of stay and readmissions

- improved compliance with statutory requirements around mental health and mental capacity legislation that have been highlighted as a cause for concern and risk financial and legal penalties (Care Quality Commission, 2010)
- reduced risk of complaints and serious untoward incidents by improving quality of care
- reduced risk of adverse outcomes and failing inspection processes by improving communication and understanding of the holistic needs of vulnerable people
- better complaints management, especially in people with personality disorder and other complex mental health problems.

## EDUCATION AND STAFF TRAINING

Despite mental health problems being common in acute hospitals, there is a lot of evidence that such conditions are poorly recognised or treated (Academy of Medical Royal Colleges, 2010; Parsonage *et al*, 2012). This is not surprising given the relative lack of mental health training and knowledge in acute hospital staff compared with other areas of medicine. Particular areas where educational needs have been shown include:

- attitudes towards people with mental health problems
- delirium and dementia care
- application of mental health and mental capacity legislation
- depression and adjustment disorders
- self-harm
- personality disorders
- medically unexplained symptoms, especially when associated with physical pathology.

### STAFF ATTITUDES

Over 75% of liaison psychiatry staff report witnessing apparent stigmatising attitudes from acute hospital staff to patients with mental health diagnoses at least monthly, and over 30% report that this has adversely affected the physical healthcare of patients (Bolton, 2012). Others have found that non-mental-health staff believe in a stronger association of mental disorders with risk and unpredictability than do mental health staff (Gateshill *et al*, 2011). Although the reasons behind this are complex, they should be addressed by formal and informal education from liaison psychiatry teams.

### DELIRIUM AND DEMENTIA

Delirium and dementia are common in acute hospital patients, especially among older adults, and can present challenges, especially for ward nursing staff and bed management teams in a busy acute hospital environment. Agitation, often occurring in delirium or dementia, is commonly associated

with inappropriate prescribing of antipsychotic medication (Barba *et al*, 2002; Young *et al*, 2011). The National Audit of Dementia in acute hospitals in England and Wales found only a third of staff felt they had received adequate training or guidance in dementia care (Young *et al*, 2011). The Francis Report (Francis, 2013) has been the most recent in a disturbing series of case reports and reviews showing neglect of basic care of patients, particularly those with delirium, dementia and intellectual disability.

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- Education by liaison psychiatry staff should increase staff confidence and their ability to manage the specific needs of people with intellectual disability, dementia or delirium on acute hospital wards and thus lead to improved basic care as well as direct management of mental health problems.
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## MENTAL CAPACITY

Acute hospital staff often fail to recognise lack of mental capacity (Raymont *et al*, 2004) or fail to appropriately apply relevant legislation (Heslop *et al*, 2013). Staff therefore risk failing to deliver appropriate care to patients who resist investigations, medication or basic nursing care yet do not have sufficient mental capacity to refuse, and where, if assessed, the intervention would be in their best interests.

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- Although not a focus of reviews of basic care failings (except for intellectual disability; Heslop *et al*, 2013), there are strong reasons to believe that improved training regarding clinical application and the relationship between legislation related to mental capacity, mental health and negligence is one route to improving basic care in patients with dementia, delirium and other mental health problems affecting care in acute hospitals.
  - Involvement of a consultant liaison psychiatrist should improve assessment of capacity and best interests in complex cases occurring in an acute hospital (Academy of Medical Royal Colleges, 2010).
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## DEPRESSION

Despite being common, depression is poorly recognised and treated by acute hospital staff, for many reasons. These include lack of knowledge and skills, misattribution of symptoms to the underlying physical illness, belief in lack of treatment efficacy, stigma, and belief that addressing mental health factors would be too time consuming or may unnecessarily upset the patient.

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- Even if treatment for depression is started, medication doses are often too low for benefit (Cadieux, 1998) and other factors affecting mood, such as adjustment reactions, are often not addressed and thus impair expected clinical gains.
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## SELF-HARM

Self-harm is a common reason for presentation to emergency departments (Academy of Medical Royal Colleges, 2010) so education of staff is crucial (College of Emergency Medicine, 2013). However, since self-harm is one of the most common reasons for unscheduled adult medical admissions (Royal College of Psychiatrists, 2006) and the association of chronic physical illness

and completed suicide is increasing (Bazalgette *et al*, 2011), there are strong reasons to extend such training to wider areas of the hospital. There is some evidence that staff education (Mann *et al*, 2005) and specialist psychosocial assessment by liaison psychiatry staff (NHS Confederation, 2009) can reduce repetition of self-harm and suicide attempts.

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- Recent developments in training hospital staff about self-harm extend the previous focus on risk assessment to suicide mitigation (Cole-King *et al*, 2013) and emphasise the importance of staff attitudes in what has been termed compassionate care (Cole-King & Gilbert, 2011).
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### *MEDICALLY UNEXPLAINED SYMPTOMS*

A range of mental health disorders can cause persistent, difficult-to-diagnose physical symptoms out of proportion to any underlying physical pathology that are widely referred to as medically unexplained symptoms. Somatoform, factitious, dissociative and personality disorders underlie some of the most complex cases and are associated with high treatment costs, largely due to repeated and extensive investigations, surgical procedures and admissions (Parsonage *et al*, 2012).

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- Education from, and collaborative care with, liaison psychiatry staff is recommended to help recognition and management, and reduce medico-legal concerns when treating patients with medically unexplained symptoms in the acute hospital.
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### *EDUCATIONAL INTERVENTIONS*

There are strong reasons to expect that training of acute hospital staff regarding the detection and management of mental health disorders will improve outcomes. However, educational interventions should be monitored using clinical outcomes, since education alone is not always sufficient to improve diagnosis, management and clinical outcomes (Lin *et al*, 2001; Gask *et al*, 2004), even when the programme is intensive (Learman *et al*, 2003). However, improving detection does not always lead to better outcomes (Allaby, 2010).

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- Even if education does not improve direct clinical outcomes for patients, it may still be beneficial for quality improvements related to staff attitudes and reduced staff stress related to increased confidence.
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## **LIAISON PSYCHIATRY STAFFING MATCHED TO ACUTE HOSPITAL NEEDS**

Studies have shown that referral rates to liaison psychiatry are higher in urban and teaching hospitals and from medical compared with surgical specialties, with the highest rates per bed from neurology and the most complex referrals coming from tertiary units (Holmes *et al*, 2011).

A detailed study of liaison psychiatry services across cities in Australia (Holmes *et al*, 2011) examined staffing, referral rates, referred diagnoses and average time involved in assessing and managing different types of referrals, and looked at minimum staffing for safe service delivery. The authors indicated that a minimum of 1.0 whole time equivalent doctor per 100 beds was required to safely manage just emergency and urgent mental health needs of admitted patients in a Monday–Friday 9am–5pm service. The study confirmed that more medical and multidisciplinary staff were needed in specialist areas to provide education and manage the more complex referrals that comprised a major focus of liaison psychiatry expertise, as well as to deliver comprehensive care.

Existing guidance in the UK (Soni *et al*, 2011) recommends staffing based on detailed monitoring of activity undertaken in several liaison psychiatry services in acute hospitals of about 650 beds without tertiary services. It states that a consultant, specialist and core psychiatric trainees, a Band 8 psychologist, a Band 8 team leader and four Band 7 nurses are required for a Monday–Friday 9am–5pm service for a hospital with 750 new patients who have self-harmed per year.

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- The comparison of five liaison psychiatry services across England (Parsonage *et al*, 2012) showed a wide variation of staffing matched to different service models and different local needs in the acute hospital and community. The report confirms that local factors in the community and acute hospital will affect the details of staffing requirements.
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## KEY MESSAGES

### SCALE OF NEED

- Mental health problems are common, increasing and more prevalent in acute hospitals than in the community.
- Mental health problems occur in 30–60% of in-patients and out-patients and are the presenting feature in 5% of all emergency department attendances.
- The most common mental health problems in acute hospital in-patients are depression, delirium, dementia, adjustment reactions and alcohol-related disorders.
- Dementia in older adults and mental health problems associated with long-term physical conditions and medically unexplained symptoms in working-age adults account for disproportionate costs related to mental health needs in acute hospitals.
- The extra cost of physical healthcare in acute hospitals associated with comorbid mental health problems, including medically unexplained symptoms, is about £6 billion a year – equivalent to 15% of total expenditure in these hospitals.
- The prevalence and costs associated with mental health disorders are likely to rise with increasing medical acuity and complexity in acute hospitals as milder conditions are managed in community settings.

- Acute hospital staff lack training, knowledge and skills related to the recognition and management of common mental health problems affecting acute hospital care.

### *BENEFITS OF LIAISON PSYCHIATRY*

- Reduced secondary healthcare costs, increased efficiency, reduced clinical and organisational risks and improved quality of care related to mental health problems.
- Improved compliance with mental health legislation and mental capacity legislation.
- Reduced risk of adverse events linked to mental health needs following education of acute hospital staff in relation to legal frameworks, psychopharmacology and disturbed behaviour as a result of personality difficulties, substance misuse, complex adjustment disorders, delirium, dementia and psychosis.
- Improved quality of care and contribution to reduced lengths of stay following education of acute hospital staff regarding communication, mental capacity and other areas of ward management related to behaviour and emotional reactions to physical illness and how these are influenced by personality, social and cognitive factors, as well as mental illness.
- Quality improvements related to improved attitudes, and reduced staff stress related to increased confidence following education about mental health problems that are common or difficult to manage in the hospital.

# Case examples illustrating gains to be made from investment in a liaison psychiatry service within every acute hospital

## REDUCED LENGTH OF STAY

- Mr A was admitted with a rapid physical deterioration during a mental health in-patient unit admission for a relapse of schizophrenia. A consultant liaison psychiatrist recognised signs of neuroleptic malignant syndrome and explained necessary investigation and management to medical staff. Mr A was appropriately treated for his life-threatening illness and his physical symptoms did not continue to be misattributed to chronic schizophrenia.
- Ms B was admitted with life-threatening malnutrition due to anorexia nervosa. She resisted re-feeding so acute hospital staff planned to discharge her as soon as her biochemistry normalised. Liaison psychiatry staff educated acute hospital medical staff about the risk of death in severe anorexia and worked with nursing staff to arrange 1:1 observation and a detailed care plan to support Ms B's distress while administering life-saving nutrition and other treatment.
- Mr C was assessed because of behaviour disturbance on the high-dependency unit. Identification of unrecognised delirium and treatment advice enabled him to be rapidly transferred to a general ward instead of remaining on the high-dependency unit.
- Mr D was referred to liaison psychiatry because of psychosis and poor engagement with rehabilitation 5 weeks after a routine repair of a hip fracture. Severe depression was diagnosed and treated successfully with medication, enabling a patient who had been perceived as a 'social problem' delaying discharge to be safely discharged home within 10 days.
- When on the intensive care unit, Mr E was seen by a mental health pharmacist, who ensured rapid reinstatement of his usual clozapine treatment on the day following admission. This avoided a delay in transfer to a surgical ward and risk of mental state deterioration resulting from a need to slowly titrate the dose of clozapine after omission for more than 48h.

- Ms F was admitted with alcohol-related seizures. Assessment and discussion with the community alcohol services started on the day of admission. This enabled immediate, appropriate treatment, so she did not develop Wernicke's encephalopathy. It also enabled early planning of community follow-up, with direct discharge to the abstinence-based day programme in her area as soon as medical treatment was completed.
- Ms G was admitted following a fractured neck of femur. Assessment enabled a prompt diagnosis of pre-existing dementia to be made, which not only allowed rehabilitation to be tailored to her level of cognitive function, but also facilitated discharge planning with an appropriately supportive care package set up.

## AVOIDANCE OF UNNECESSARY SURGERY

- Ms H had an extensive history of ongoing medical and surgical intervention, investigation and admissions to the acute hospital over the past 10 years and current ongoing care from five different specialties. Out-patient review by a consultant liaison psychiatrist enabled diagnosis of severe somatoform disorder and discussion with the orthopaedic team that avoided a redoing surgical procedure due to lack of effectiveness of the initial surgical procedure.
- Ms I had recurrent admissions with poor wound healing and infection. She was referred to liaison psychiatry with suspected factitious disorder. Assessment enabled Ms I to disclose intentional self-harm and identified underlying severe depressive disorder. This facilitated engagement with mental health services to address the mental health needs, thus avoiding recurrent admission with wounds and cellulitis.

## REDUCED HEALTHCARE UTILISATION

- Ms J had refused mental health referral in the community but assessment during admission uncovered that her admissions were related to escaping her husband's alcohol misuse. This finding enabled her general practitioner to provide her with support. Despite six admissions for abdominal pain in the preceding 8 months, she had no admissions in the 8 months following assessment.
- Mr K recently had five acute hospital admissions due to chest pain and breathlessness. Referral to the liaison psychiatry clinic led to a diagnosis of panic disorder. He was seen twice in clinic for advice on self-management. He had no acute hospital attendance in the following year.
- Ms L had had six acute hospital in-patient admissions and two further emergency department attendances for non-epileptic seizures in the 2 years prior to referral to the liaison psychiatry clinic. She had no admissions or emergency department attendances during the 10 months she was seen or in the 4 months since she was seen in clinic.

## AVOIDANCE OF LITIGATION

- Mr M was referred to the liaison psychiatry clinic from the ethics committee for psychiatric assessment because of concerns by cardiology about capacity for surgery and the patient planning litigation. A single review allowed formulation of the difficulties, provided advice regarding the complex capacity assessment and enabled a care plan that led to successful surgery.
- Ms N was referred to liaison psychiatry after being detained using mental health legislation. The liaison psychiatry team identified that the form completed for the detention had simply been filed in the clinical notes and not formally received by hospital managers. Correction of this ensured legal requirements of the legislation were met and avoided a charge of unlawful detention against the acute hospital.

## REDUCED MEDICATION RISKS

- Ms O, who had bipolar disorder, was admitted with acute renal failure. Acute hospital staff contacted liaison psychiatry for advice regarding lithium prescribed for the bipolar disorder. The liaison psychiatry consultant spoke with the lead mental health pharmacist and reviewed past mental health records. Advice given by the consultant enabled acute hospital staff to safely manage Ms O without her developing potentially fatal lithium toxicity or experiencing a major relapse of her mental illness.
- Mr P had a diagnosis of schizophrenia and attended the emergency department with dysuria. He was prescribed trimethoprim for a urinary tract infection. The unit pharmacist looked at the advice provided by the lead mental health pharmacist. This enabled conversion to an alternative antibiotic, thus avoiding the risk of life-threatening neutropenia due to combined effects of trimethoprim and the clozapine used to treat Mr P's schizophrenia.
- Mr Q became delirious after cardiac surgery. He was prescribed a depot antipsychotic to control his schizophrenia. Prescribing advice for delirium written by the lead pharmacist for mental health services ensured acute hospital staff used lower than normal doses of quetiapine and increased diazepam to manage the delirium. This avoided the increased risk of cardiac arrhythmias from excessive doses of antipsychotics.
- Ms R had a long-term diagnosis of dementia and was admitted with a chest infection. She was referred to liaison psychiatry as a result of behaviour disturbance from delirium. Liaison psychiatry nurses advised ward staff on management strategies to reduce the need for sedative medication. The liaison psychiatry consultant reviewed Ms R's medical records with the elderly care consultant, which enabled reduction in the number of prescribed medications and removed the antipsychotics being used for behaviour control. These changes reduced the incidents of aggression to ward staff, improved Ms R's alertness and reversed the urinary retention and constipation due to drug side-effects and interactions that were exacerbating Ms R's physical illness.

# Service design

## GUIDING PRINCIPLES

Current liaison psychiatry services vary in the detail of their remit and size according to the acute hospital they serve. However, they should all have overall service aims of:

- improving clinical care by direct intervention in mental health and substance misuse problems, advocacy for physical management in severe mental illness and referring to community-based services as needed
- facilitating acute hospital staff management of mental health and substance misuse problems by direct intervention, advice to staff and education
- reducing inappropriate burdens of mental health problems in acute hospitals by reducing length of stay, admissions and out-patient attendances, readmissions, and clinical and organisational risks
- avoiding inappropriate referrals into other secondary mental health services from the acute hospital.

Although services are likely to develop and expand incrementally according to local priorities, needs and finances, all acute hospitals need to ensure they meet core principles, many of which have been emphasised in earlier reports.

## FUNDING

In planning services for their local populations, organisations have to ensure that there are appropriately scaled hospital departments for physical problems such as heart disease or emergency attendances. Yet currently there is no such requirement to provide a corresponding service for liaison psychiatry (Parsonage *et al*, 2012), and this needs to change.

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- Services need to be funded so that physical and mental healthcare have parity (Royal College of Psychiatrists, 2013) and are integrated within the acute hospital (Parsonage *et al*, 2012).
  - Physical health services for unscheduled, elective and specialist care, including regional or national services, need to be planned and funded to include the necessary liaison psychiatry component to address mental health needs as an integral part of service provision.
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Once the hospital service has been established, liaison psychiatry services should consider expansion into integrated pathways across primary and secondary care (Parsonage *et al*, 2012).

- Planning service developments or changes should always include an impact assessment for the acute hospital, other mental health, substance misuse and learning disability services and primary care.
  - Funding mechanisms for mental health services in acute hospitals must be applied to ensure cohesive liaison psychiatry services able to provide the core functions outlined in this report.
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Funding mechanisms such as commissioning are currently challenging for liaison psychiatry and work regarding this is evolving.

Cohesive liaison psychiatry services will help ensure equitable, safe and effective clinical improvements through integrated mental and physical healthcare, resulting in improved quality and reduced risks related to the range of mental health problems occurring in and affecting acute physical healthcare.

Funders also need to factor in less tangible benefits of liaison psychiatry, such as improved well-being of the acute sector workforce who are less stressed after education and support related to problems they did not understand or feel able to manage (Parsonage *et al*, 2012).

## SERVICE DESIGN

Details of the service, as a result of differences in expected number and type of referrals, will be affected by local factors, especially related local services and the number of beds and provision of specialist services in the acute hospital (Royal College of Psychiatrists, 2005; Parsonage *et al*, 2012). However, all services should conform to core principles of service design.

- A multidisciplinary liaison psychiatry service dedicated to the hospital, covering all wards and the emergency department, is a core service for every acute hospital (Academy of Medical Royal Colleges, 2010; Joint Commissioning Panel for Mental Health, 2012; NHS Confederation, 2012; Parsonage *et al*, 2012).
- Equity of access to mental healthcare for all people admitted to the hospital is needed regardless of age, intellectual disability, diagnosis, location of home residence or any other factor that could affect equity of access.
- Liaison psychiatry services should be subject to the same quality standards in terms of response and skills expected as other medical specialties in the hospital (Academy of Medical Royal Colleges, 2008).
- Secure and adequate funding is needed, with staffing at appropriate levels and skill mix (Parsonage *et al*, 2012), to safely deliver the core service functions, matched to the size and complexity of hospital services and patient demographics.
- Staff in the liaison psychiatry service require skills to integrate physical and mental health knowledge relating to diagnosis, formulation and management.
- Patients with mental health problems in acute hospitals should have the same level of access to a consultant psychiatrist for their mental health needs as to a consultant for their physical health problems (Academy of Medical Royal Colleges, 2008; Joint Commissioning Panel for Mental Health, 2012; Parsonage *et al*, 2012; Royal College of Psychiatrists, 2013).

- Specialist expertise in the assessment and management of differing types and presentations of mental health problems in working-age and older adults is required in all acute hospital services (Royal College of Psychiatrists, 2005; Joint Commissioning Panel for Mental Health, 2012; Parsonage *et al*, 2102).
- Other patient populations may also justify separate subteams or focused developments, especially in larger hospitals.
- Funding mechanisms such as commissioning should be based on patient need, not just financial savings, to ensure mental health disorders do not prejudice care.

## ORGANISATIONAL PRINCIPLES

- Adequate dedicated accommodation on the acute hospital site (Soni *et al*, 2011).
- Suitable facilities for patient assessment in the emergency department and on all wards of the acute hospital to enable patient privacy and dignity and safety of staff and patients (Soni *et al*, 2011).
- Ready access to the paper or electronic notes and IT systems of the mental health services and the acute hospital (Soni *et al*, 2011).
- Clinical governance systems integrated into pathways within the acute hospital (Soni *et al*, 2011).
- Formal arrangements for the service and between acute hospitals and mental health services for specialist mental health pharmacy, mental health legislation (Care Quality Commission, 2010), risk and complaints management (Soni *et al*, 2011) and transfer of patients between different settings or organisations (Soni *et al*, 2011).

## SERVICE STANDARDS

- Timely and adequate assessment of all referrals unless the referrer is satisfied with telephone advice (Academy of Medical Royal Colleges, 2008; Joint Commissioning Panel for Mental Health, 2012).
- Organisational needs of the acute hospital such as delays to discharge should influence response time to referrals in addition to clinical need and risk.
- All information relating to risk assessment and diagnosis, investigations and pharmacological and non-pharmacological management should be documented in acute hospital notes.
- Education and advice are core service functions (Royal College of Psychiatrists, 2005; Joint Commissioning Panel for Mental Health, 2012; NHS Confederation, 2012; Parsonage *et al*, 2012), in addition to direct patient contact, to improve acute hospital staff detection and management of mental health problems as well as improve communication skills and reduce stigma related to treatment of people with mental health problems.
- Patient-centred and recovery-focused approach.

## ACCESS OF THE SERVICE

### AREAS OF THE HOSPITAL

All areas of an acute hospital are recognised to have a higher prevalence of mental health and substance misuse problems than the general population and require access to a liaison psychiatry service.

The needs of emergency departments and acute medical units differ from those of other hospital wards in terms of the most common types of mental health problems, processes and time pressures.

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- In large hospitals with very busy emergency departments (e.g. with 100 000 attendances or more each year), separate subteams for the emergency department/acute medical unit and hospital wards may be necessary.
  - Local factors (e.g. hospital layout, patient demographics, workload) should determine the precise organisation of the liaison psychiatry service and cover arrangements (Parsonage *et al*, 2012).
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The prevalence and complexity of mental health problems on acute hospital wards related to complex deteriorations in long-term conditions (e.g. dementia, diabetes, chronic obstructive pulmonary disease) and other severe physical illnesses are likely to increase because of a number of factors: development of services such as acute medical units able to rapidly assess, treat and discharge patients who do not have the severity of need to require longer admission; an aging population with increased medical comorbidities and dementia; and pressure on community services leading to delays in discharge.

Mental health problems are known to be more complex and more common in people with long-term conditions and severe physical illness, so the need for mental health expertise throughout acute hospitals and in regional services is likely to increase.

### AGES COVERED

Although services must be equitable for all ages and not discriminate on age, there need to be appropriate skills and service design to meet the specialist requirements of differing ages. Compared with working-age adults, older adults have mental health problems of a different nature and prevalence, which requires a different skill mix (Parsonage *et al*, 2012).

- The greater level of need in larger hospitals may therefore justify specialist subteams for different ages, with flexibility to ensure patient needs are matched to appropriately skilled staff (Parsonage *et al*, 2012).
- The specific needs of children mean they are always likely to require a specialist team. This is not considered in this report, but should not be omitted from liaison psychiatry services (Parsonage *et al*, 2012).

Benefits of separating younger and older adult subteams in large hospitals include:

- sufficient referral numbers to justify specialist subteams matching skills to most patients' needs

- staff who have close working relationships with relevant community mental health teams needed for timely community follow-up and discharge plans
- closer working links with acute hospital staff matching liaison psychiatry staff expertise to common problems addressed by acute hospital staff
- greater expertise in issues affecting older adults and links with social care for staff working with older adults
- greater expertise in managing personality disorders and complex medically unexplained symptoms in staff working with working-age adults
- greater expertise in issues affecting adjustment reactions and pharmacology in different ages
- staff confidence and skill in managing the common problems of self-harm and personality disorders or dementia that predominantly affect younger or older adults respectively.

It would be expected that even with age-specialist subteams there would be flexibility to ensure patients are seen by the subteam with skills most appropriate to their individual needs. Benefits of combining younger and older adult subteams include:

- easier to organise cross-cover during staff absences
- age not being a factor that influences referral
- development of generic assessment, diagnosis and basic management skills in all staff.

## HOURS OF THE SERVICE

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All services would benefit from:

- a 7-day service to the whole hospital, including nursing and medical expertise (Future Hospital Commission, 2013)
  - minimum of 12 hours-a-day on-site provision for emergency departments and the acute medical unit (College of Emergency Medicine, 2013; Future Hospital Commission, 2013)
  - clear arrangements for accessing assessment or advice from mental health teams covering out of hours if this is not provided by the liaison psychiatry service (Soni *et al*, 2011).
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Although core services for urgent and emergency work should be provided across 7 days, the exact hours for the hospital-wide core team and specialist subteams need to be considered in light of local factors including local need, alternative mental health provision and a cost-benefit analysis for all or part of the liaison psychiatry service and other services in and outside the hospital affected by the different hours worked (Parsonage *et al*, 2012). A service focused on office hours will:

- maximise supervision for consistency, expertise and multidisciplinary working of a core team to manage a range of mental health problems
- maximise skills and partnership for proactive care planning involving

all primary and secondary care professionals to avoid future crises or admissions

- enable extended nursing roles through closer senior medical supervision for referrals with complex physical and mental health needs, diagnostic or medication needs, or application of mental health legislation
- enable consistency to develop close working relationships with senior acute hospital staff to facilitate informal education and clinical governance.

A service providing cover into the evening or nights will:

- enable quicker response to unpredicted crises and urgent new referrals
- avoid the need to seek urgent advice from non-specialist mental health teams
- be particularly suited to the needs of the emergency department where demand is more constant than on hospital wards.

## RESPONSE TIME

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All services should aim to respond to referrals within:

- 60 min for emergency referrals (Soni *et al*, 2011)
  - the same day (usually within 5 working hours) for urgent referrals
  - 2 days (usually within 10 working hours) for other referrals.
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To achieve a rapid, same-day response, referrals need to occur in a timely manner and should be sent and accepted as early as possible following admission.

All services should arrange follow-up discussion with acute staff or visits to the patient when clinically required at least:

- daily when there is an unstable or clinically risky mental health problem
- once to twice a week for other mental health problems at risk of impairing physical health management or increasing in severity.

## CLINICAL FACTORS

Clinical urgency and potential risks should always be the primary determinants of response time.

The definition of all clinical scenarios meeting criteria for emergency, urgent or other referrals is beyond the scope of this report and will always need to be defined locally, taking into account factors such as ward staffing levels and expertise. However, examples of clinical situations likely to match the definitions of urgency are given here.

## EMERGENCY REFERRAL

An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the health or safety of the patient or others (Soni *et al*, 2011). For example:

- a patient with delirium or psychosis who is pulling out intravenous lines
- a patient thought to be at risk of suicide who is trying to leave hospital.

#### URGENT REFERRAL

A disturbance of mental state and/or behaviour which poses a significant but non-imminent risk to the health or safety of the patient or others (Soni *et al*, 2011). For example:

- a patient with delirium or psychosis who is distressed but staying in bed or being safely managed by ward staff
- a patient expressing strong suicidal ideas but who is in an observable bed and has made no attempt to leave or harm themselves
- a patient with depression or psychosis whose nutritional or fluid intake is minimal.

#### OTHER REFERRALS

All other referrals, including patients who require mental health assessment, where the patient's health will not be significantly impaired by waiting 1–2 days for assessment and where the problem is being safely managed by acute hospital staff. For example:

- a patient with low mood affecting rehabilitation but not basic self-care or associated with suicidal ideas
- a patient requiring diagnosis or assessment of psychological reasons for physical symptoms
- a patient with dementia who is not progressing with recovery as quickly as expected.

### *PATIENT FLOW AND CARE PATHWAY FACTORS IN THE ACUTE HOSPITAL*

Although clinical and risk factors must take priority, liaison psychiatry services will be most beneficial if they also take into account bed and other organisational pressures where the mental health assessment will affect the clinical care pathway through the acute hospital.

Ensuring timely discharge is particularly important in the emergency department and acute medical and surgical units where patient flow pressures can lead to delays in assessment or treatment of other patients. In addition to early referral and rapid assessment, avoidable delays in discharge should be reduced by ensuring mental health discharge plans are arranged in a timely manner.

- 
- The emergency department (College of Emergency Medicine, 2013) and acute medical or surgical units will benefit from a response time of 1h for referrals where mental health assessment is needed for decisions about discharge or transfer from the unit.
  - Priority should also be given to other patients throughout the hospital where mental health assessment is needed to guide clinical management decisions such as further investigation or treatment or where a patient is considered medically fit for discharge.
  - Plans for mental healthcare outside the hospital should be made in parallel with plans for medical discharge.
  - Mental health and acute hospitals should have a policy detailing the process for transfer of care when a patient requires admission to a mental health unit.
-

## *RESPONSE TIMES FOR ASSESSMENTS UNDER MENTAL HEALTH LEGISLATION*

Full assessment, after use of holding powers if applicable, for detention under mental health legislation for assessment or treatment of a mental disorder should occur within:

- 1 h in the emergency department (College of Emergency Medicine, 2013)
- 4 h where the mental health problem is putting the patient's physical health, other patients or staff at immediate risk
- 1 working day for patients who are not posing an immediate risk to themselves or others.

In rural settings where services are stretched over much larger geographical areas, the response times may need to be longer but should always be defined and locally agreed.

Acute hospital wards and emergency departments are not staffed or designed to safely manage patients with highly disturbed behaviour as a result of severe mental health problems such as schizophrenia, bipolar disorder or organic psychosis. It is therefore essential that services are able to respond particularly rapidly in situations requiring use of mental health legislation to manage both the mental disorder and the associated risks the patient may pose to themselves, to other patients or to staff. The service should also facilitate urgent patient transfer to a specialist mental health setting as soon as physical illness no longer requires the expertise of an acute hospital.

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- Assessment under mental health legislation should not be delayed until the patient becomes medically fit for discharge.
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## *CORE FUNCTIONS OF A LIAISON PSYCHIATRY SERVICE*

Liaison psychiatry services address many clinical and non-clinical needs in relation to improving the management of mental health problems that occur in physical illness (Table 1 and Box 1). The recommendations given here should be seen as a bare minimum in an acute hospital and many services would benefit from being expanded to meet other needs.

### *OVERARCHING FUNCTIONS*

- Informal education and advice for acute hospital staff.
- Advice and assessments in relation to detention under mental health legislation and complex mental capacity assessments.
- Advice on psychopharmacology.
- Advice on mental health diagnosis and biopsychosocial formulation.
- Participation in review of critical incidents and policies related to mental health problems.

**Table 1 Common referrals to a liaison psychiatry service and staff skills needed to address these**

	Physical illness in severe mental illness	Non-acute mental health problem	Acute mental health problem	Admission following self-harm	Primary mental health presentation to emergency department
Type of clinical problem referred	<p>Incidental severe mental illness</p> <p>Neuroleptic malignant syndrome</p> <p>Serotonin syndrome</p> <p>Lithium toxicity</p>	<p>Poor engagement and adherence</p> <p>Frequent attendance</p> <p>Medically unexplained (functional) symptoms</p> <p>Treatment refusal</p> <p>Excess opiate use</p> <p>Dementia</p> <p>Poorly controlled diabetes or other long-term condition</p> <p>Mental health/psychological problem impairing discharge</p>	<p>Suicidal thoughts</p> <p>Severe low mood/anxiety</p> <p>Psychosis (organic and functional)</p> <p>Behaviour disturbance</p> <p>Life-threatening anorexia</p> <p>Unclear if psychiatric diagnosis</p> <p>Treatment refusal and low mood</p> <p>Complicated alcohol withdrawal</p> <p>Acute cognitive impairment</p> <p>Mental health/psychological problem impairing treatment</p>	<p>Self-harm</p> <p>Associated mental illness, personality disorder, substance misuse or intellectual disability</p>	<p>Psychosis</p> <p>Suicidal thoughts</p> <p>Self-harm</p>
Skills in the liaison psychiatry service needed to address the problems	<p>Physical and psychiatric diagnosis</p> <p>Advocacy for physical and nursing management</p> <p>Pharmacology</p>	<p>Physical and psychiatric diagnosis</p> <p>Biopsychosocial formulation and management</p> <p>Pharmacology</p> <p>Advice and influence acute hospital doctors</p> <p>Coordinating management</p> <p>Physical and mental health risk management</p> <p>Rehabilitation advice</p>	<p>Physical and psychiatric diagnosis</p> <p>Biopsychosocial formulation and management</p> <p>Pharmacology</p> <p>Risk management (suicide, dehydration, malnutrition, absconding, violence)</p> <p>Advocacy for physical and nursing management</p>	<p>Diagnosis</p> <p>Pharmacology</p> <p>Risk management (suicide, dehydration, malnutrition, absconding, violence)</p>	<p>Mental health assessment</p> <p>Follow-up plan</p>

**Box 1** OVERARCHING FUNCTIONS OF A LIAISON PSYCHIATRY SERVICE NEEDED TO ADDRESS COMMON REFERRALS

- Formal and informal education of acute staff (diagnosis, management, staff interactions, legal issues, reduce stigma, attitudes, etc.)
- Legal advice (mental capacity, mental health legislation, factitious disorder)
- Develop care plans (biopsychosocial) to reduce acute hospital admissions or length of stay
- Psychopharmacology advice in medical illness
- Clinical governance input (pharmacology, risk and other policies/incident reviews) to acute trust

- Facilitating onward referral to other mental health and substance misuse services when appropriate.

*CLINICAL FUNCTIONS ENSURING PATIENT SAFETY*

- Assessment and follow-up plans for acute mental health presentations in the emergency department.
- Assessment and ongoing management of acute mental health problems, including self-harm, on wards.
- Advocacy for physical and mental health management for people admitted to hospital who have known enduring severe mental illness.

*CLINICAL FUNCTIONS MINIMISING INAPPROPRIATE LOCATION OF CARE AS WELL AS REDUCING IATROGENIC HARM*

- Assessment and advice on ward management of non-acute mental health problems which are affecting physical health in-patient management.
- Attendance at joint case conferences with the treating medical teams to advise on the management of patients with complex problems.
- Cross-directorate collaborative care management plans and staff education for patients with complex needs who have unexplained medical symptoms, a primarily non-organic illness and/or a large psychosocial component to their symptoms or repeated presentations to hospital to aid discharge, care planning, admission avoidance and community treatment.
- Clinic-based assessment and intervention for patients and the hospital system for complex medically unexplained symptoms or complex adjustment disorders, or affective illness in people with long-term physical conditions who are high users of hospital services.

## EDUCATIONAL FUNCTIONS

Informal education of acute hospital staff focused around advice regarding a patient currently under their care is often the most well received and should also translate into immediate, direct benefits for patient care. This is a core component of all liaison psychiatry interventions.

However, formal educational sessions should also form part of the contracted role for liaison psychiatry services (NHS Confederation, 2012). Such programmes are crucial to stepped care models of recognition and management by staff for the commonly occurring, milder mental health problems, and involvement of liaison psychiatry for more severe or complex disorders.

- 
- The content and depth of educational sessions should be tailored to the relative needs of staff, patients and carers in different areas of the acute hospital.
  - A tiered approach may be useful where the detail and frequency of training is matched to the likelihood of the staff caring for patients, with and making management decisions about, the topic in question.
  - Acute hospitals must provide staff with adequate study leave, and have sufficiently staffed services to enable nursing and medical staff to attend educational sessions.
- 

Examples of tailored education include greater emphasis on:

- self-harm and alcohol use disorders for staff in the emergency department and acute medical unit
- dementia for staff in elderly medicine, the acute medical unit, trauma services and admission services
- organic mental disorders and medically unexplained symptoms for staff in neurosciences services.

Examples of tailoring the depth and content of training about depression and mental capacity to the profession and expertise of different staff groups includes emphasis on their relationship to:

- nutrition, self-care, activity and medication refusal for ward-based staff
- diagnosis, medication, treatment refusal and the role of mental health legislation for senior medical staff
- specific communication skills and simple techniques to improve mood and behavioural activation for staff, which help improve mood and behaviour of confused patients.

Ensuring educational sessions include discussion about attitudes, communication skills, diagnostic issues, treatment efficacy with mental health and physical comorbidity, and other potential reasons behind lack of appropriate treatment delivery should improve clinical outcomes.

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- Any training programme should audit resulting improvements in clinical practice, since educational interventions alone, although improving confidence, often fail to change behaviour.
  - Involvement of patients is recommended to deepen understanding of patient perspectives and to change negative attitudes.
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The following level of formal educational sessions should be regarded as minimum for all services. Some services may achieve the educational objectives through online modules supplemented by face-to-face training.

- Two sessions per year per hospital on communication and other psychological skills to discuss and manage common emotional and behaviour reactions to physical illness in an acute hospital, including adjustment reactions.
- Three sessions per year per hospital regarding depression, self-harm, dementia, medically unexplained symptoms and challenging behaviour, including the influence of personality disorder, psychosis, alcohol withdrawal and delirium on acute hospital care.
- One session per year per hospital on the application of legislation related to mental and physical healthcare tailored to an acute hospital setting, including treatment refusal and detention for the patient's health or safety (in England this relates to the Mental Health Act 1983 and its interface with the Mental Capacity Act 2005).

Further details of the content of educational sessions are outlined in the chapter 'Clinical topics for mental healthcare in acute hospitals' (pp. 60–63).

## STAFFING

### *SKILL MIX*

Essential members of a liaison psychiatry team will include dedicated administrative staff, consultant liaison psychiatry staff and mental health nursing staff with specialist expertise in mental health problems in working-age and older adults. Psychologists for all ages should also be core members. Each team should, at a minimum, be able to link with a hospital-based lead pharmacist for mental health and lead social worker for mental health, and teams may benefit from having these professionals incorporated into their service. Other members of a multidisciplinary team will be valuable and should be tailored to the needs of the individual service and local priorities.

### *PSYCHIATRISTS*

Psychiatrists are uniquely placed team members with training in physical and psychological illness, managing uncertainty, application of legal frameworks in different settings, decision-making in atypical situations or outside protocols and are responsible for biopsychosocial formulation, complex decision-making and risk management (Royal College of Psychiatrists, 2010a). Their breadth of physical and mental health training also gives psychiatrists skills to work in a physical health or mental health framework according to the needs and wishes of the patient and knowledge and skills of the treating acute hospital clinician. Many consultant liaison psychiatrists have significant training in psychological therapy as well as medical treatment, which makes them well placed to work with complex patients, including those with medically unexplained symptoms or poor adherence, who are not ready to engage in formal psychological therapy.

The levels of physical morbidity in all patients in an acute hospital and resulting complex diagnostic, pharmacological and legal issues make the role of a consultant psychiatrist in liaison psychiatry services especially important for delivery of core functions. This is consistent with other areas of activity in general hospitals where consultant-delivered services produce greater efficiency (Royal College of Surgeons in England, 2009; College of Emergency Medicine, 2010; Royal College of Physicians, 2010).

## *MENTAL HEALTH NURSES*

Mental health nurses have invaluable skills to develop acute hospital nurses' and junior doctors' ward management of mental health and substance misuse problems. They can assess many referrals across the hospital with appropriate medical supervision and may be the key professional group in certain subteams, such as those focusing on self-harm or alcohol/substance use disorder. They have high levels of medical acuity and particular understanding of the challenges for acute hospital nurses in managing a busy ward environment and patients with disturbed behaviour as a result of delirium, dementia, personality disorder or other mental health problems. Mental health nurses can provide 1:1 modelling and coaching for ward nurses about the challenges of administering medication or nutrition for people with severe mental illness or cognitive impairment, and thus contribute to reduction in some of the basic care failings noted in reports such as the Francis Report (Francis, 2013).

Senior nurses, along with consultant liaison psychiatrists, will provide a significant leadership role within the team and within the acute hospital.

## *MENTAL HEALTH PHARMACIST*

A lead pharmacist for psychopharmacology will provide essential advice and support for other ward pharmacists in the acute hospital regarding complex prescribing and administration issues. They will also lead policy development, incident reviews and other clinical governance issues related to psychopharmacology across the hospital. These are important areas for the liaison psychiatry service to address given the many risks related to psychotropic prescribing in people with significant medical illness.

## *PSYCHOLOGISTS AND NURSE PSYCHOLOGICAL THERAPISTS*

Psychologists and nurse psychological therapists can help train and supervise other staff to deliver brief psychological interventions such as motivational interviewing or problem-solving therapy and use of cognitive-behavioural, interpersonal, attachment and cognitive-analytic therapy techniques. They will be valuable in providing direct therapy for patients with the most complex long-term physical conditions needing intensive secondary care input, who are ready to engage with therapy for related mental health disorders.

## *SOCIAL WORKERS*

Social workers will be particularly important for services related to older adults, individuals with intellectual disability or severe substance misuse,

and homeless people, where family, social and accommodation issues are crucial to discharge planning and are frequent factors influencing general hospital admission. Regardless of whether services have dedicated social workers, all liaison psychiatry services need to work closely with hospital-based social workers for discharge planning, housing and other social needs and child protection.

## OTHERS

Other professionals including physiotherapists, occupational therapists, specialist psychological therapists, speech and language therapists, substance misuse workers and clinicians required to assess for detention under mental health legislation would all add value to a service and help develop pathways crossing primary and secondary care settings.

## STAFFING NUMBERS

Development of liaison psychiatry services needs to match the number and skills of staff to the number and type of referrals, the latter being significantly affected by the age of patients and the number of beds and complexity of services in the acute hospital.

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- Due to the level of need and complexity of physical and mental health interactions, hospitals with tertiary care centres and services for younger adults tend to require more input at the consultant psychiatrist level (Parsonage *et al*, 2012).
- 

Table 1 and Box 1 show the common referrals and overarching functions and related skills and knowledge required to address the mental health needs in an acute hospital. Referrals of people with intellectual disability and substance misuse will occur across all referral groups.

Tables 2 and 3 indicate staffing requirements for a core service to a 650-bedded general hospital and to a 1000-bedded general hospital with tertiary centres, operating 7 days a week with only emergency and urgent referrals being seen at weekends and on bank holidays.

Although services must not discriminate on age, there need to be appropriate skills and service design to meet the specialist requirements of different ages. Therefore staffing numbers in Tables 2 and 3 are given according to current mental health training with expertise in managing adults 18–65 years and ≥65 years of age.

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- It would be expected that even with age-specialist subteams, there would be flexibility to ensure patients are seen by the subteam with skills most appropriate to their individual needs.
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The overall staffing number would still be expected to meet those outlined in Tables 2 and 3 even if some team functions were provided across the age range, thereby affecting the distribution of staffing in the subteams. For example, extended out-of-hours cover for the emergency department and acute medical unit may be solely provided by staff from the younger adults subteam and a dementia service solely from the older adults subteam.

**Table 2 Minimum staffing requirements (whole time equivalent) for a liaison psychiatry service providing to the emergency department and wards of a 650-bedded general hospital**

Profession	Ages 18–65 years	Aged ≥65 years
Medical	1.5 consultant liaison psychiatrist 1.0 staff grade or specialist trainee 1.0 junior trainee	1.0 consultant liaison psychiatrist 0.5 staff grade or specialist trainee 0.5 junior trainee
Nursing	1.0 Band 7/8 lead nurse <sup>1</sup> 2.0 Band 7 nurse <sup>2</sup> 4.0 Band 6 nurse <sup>2</sup>	0.5 Band 7/8 lead nurse <sup>1</sup> 1.0 Band 7 nurse <sup>2</sup> 4.0 Band 6 nurse <sup>2</sup> 1.0 Band 6 lead nurse for learning disabilities <sup>4</sup>
Other health professionals	0.5 Band 7 clinical or health psychologist 0.4 Band 7 mental health pharmacist <sup>3,4</sup>	0.5 Band 6 social worker 0.5 Band 5 occupational therapist 0.2 Band 7 clinical or health psychologist
Administrative	1.5 Band 3/4 administrator	1.0 Band 3/4 administrator

1. A lead nurse is expected to undertake clinical duties as well as nursing line-management duties in the team and would be expected to be Band 7 or 8 depending on their role in wider management/development of the service.
2. If nurses work as independent practitioners, then they will usually require being graded at Band 7.
3. A dedicated mental health pharmacist does not replace usual ward pharmacist responsibilities and may be part of the hospital pharmacy service rather than the liaison psychiatry service.
4. Dedicated mental health pharmacists and lead nurse for learning disabilities will work across all adult ages.

**Table 3 Minimum staffing requirements (whole time equivalent) for a liaison psychiatry service providing to the emergency department and wards of a 1000-bedded general hospital**

Profession	Ages 18–65 years	Aged ≥65 years
Medical	3.0 consultant liaison psychiatrist (including expertise in substance misuse) 1.0 staff grade 1.0 specialist trainee 1.0 junior trainee	1.5 consultant liaison psychiatrist 0.5 staff grade 1.0 specialist trainee 1.0 junior trainee
Nursing	1.0 Band 7/8 lead nurse <sup>1</sup> 3.0 Band 7 nurse <sup>2</sup> 4.0 Band 6 nurse <sup>2</sup>	0.5 Band 7/8 lead nurse <sup>1</sup> 2.0 Band 7 nurse <sup>2</sup> 4.0 Band 6 nurse <sup>2</sup> 1.5 Band 6 lead nurse for learning disabilities <sup>4</sup>
Other health professionals	1.0 Band 7 clinical or health psychologist 1.0 Band 7 mental health pharmacist <sup>3,4</sup>	1.0 Band 6 social worker 0.5 Band 5 occupational therapist 0.5 Band 7 clinical or health psychologist
Administrative	2.5 Band 3/4 administrator	2.0 Band 3/4 administrator

1. A lead nurse is expected to undertake clinical duties as well as nursing line-management duties in the team and would be expected to be Band 7 or 8 depending on their role in wider management/development of the service.
2. If nurses work as independent practitioners, then they will usually require being graded at Band 7.
3. A dedicated mental health pharmacist does not replace usual ward pharmacist responsibilities and may be part of the hospital pharmacy service rather than the liaison psychiatry service.
4. Dedicated mental health pharmacists and lead nurse for learning disabilities will work across all adult ages.

If fewer staff are provided than shown in Tables 2 and 3, the service will not be able to meet all the core clinical, educational and clinical governance requirements.

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- Not all functions of the liaison psychiatry service need to be provided across all hours of service functioning. More routine core functions of the service – such as service development, clinical governance, case conferences, education and routine assessments and follow-up – may be provided on a more restricted basis than rapid response to emergency and urgent referrals.
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The level of staffing and skill mix of staff may justifiably vary at different hours of operation of the service. The details of variation in staffing should be influenced by functions of the service and other local resources.

## PARTNERSHIP WORKING AND SERVICE INTERFACES

Liaison psychiatry services interface with many other services in primary and secondary physical and mental healthcare and within the third sector. Funding streams and organisational boundaries – such as between physical and mental health, mental health and substance misuse services or primary and secondary care – are recognised to impede holistic care and smooth transitions between clinical teams.

Detailed recommendations about these interfaces that are applicable to all jurisdictions of the UK are beyond the scope of this report. However, they should all be considered when planning services for mental or physical health in primary or secondary care.

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- Services for associated mental health needs should be funded and planned in conjunction with physical health services (Academy of Medical Royal Colleges, 2010; Royal College of Psychiatrists, 2013) for emergency, unscheduled, routine and specialist care.
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The challenges involved in working across interfaces will vary according to local and national service design, but common interfaces posing a challenge to liaison psychiatry include:

- funding streams for comorbid mental and physical health needs
- service boundaries for age transitions, mental and physical health, intellectual disability and social care
- pathways across primary and secondary care for people with alcohol and substance misuse problems alone or in combination with another mental disorder
- pathways with mental health services including for people with eating disorders or personality disorders
- pathways with psychological therapy, well-being services and the third sector
- primary and secondary care

- out-of-hours services for mental and physical health crises.

Disorders less commonly seen in other mental health settings, such as somatoform disorders, factitious disorder and complex adjustment reactions impairing adherence to physical health management regimes, require liaison psychiatry to be integrated with community-based services for psychological therapy, well-being and primary and secondary physical care.

## DEVELOPMENTS TO THE CORE SERVICE

After establishing a hospital-wide service to meet core demands across all ages, further developments should be tailored to specific local demands and priorities.

Specific services could benefit from subteams or enhancements to the core service, often expanding out-patient and staff educational functions, tailored to local needs. Such developments may focus on:

- diseases treated (e.g. asthma, cancer, heart failure, alcohol/substance use disorders)
- type of mental health-related problems (e.g. frequent attendance)
- specialist services (e.g. transplantation, bariatric surgery, regional neurosciences or oncology units).

Specific recommended early expansions to the core service, with appropriate staff increase, include the following:

- Extended service to ensure that a complete management plan for all referrals is made by sufficiently skilled staff within 1 day for emergency and urgent cases and within 2 days for others.
- Enhanced services for dementia and delirium care in older adults.
- Out-patient treatment clinics for conditions which are not generally well managed in the community, for example medically unexplained symptoms and self-harm (Parsonage *et al*, 2012).
- Involvement in care pathways engaging liaison psychiatry across both secondary and primary care (Parsonage *et al*, 2012) for functional disorders, complex adjustment reactions, neuropsychiatric disorders, self-harm and alcohol problems, with liaison psychiatry services having direct involvement in more complex disorders and an education and supervisory role for staff working with lesser degrees of complexity (Royal College of Psychiatrists, 2012).
- Dedicated out-patient and in-patient services linked with community services to areas of particularly high need (e.g. gastroenterology, neurology, respiratory medicine, cardiology or elderly care; Parsonage *et al*, 2012).
- Developments to meet specific needs of regional or other specialist services.
- Increased educational activity for staff linked to audits of incidents, movement through the care pathway or clinical outcomes.

## KEY MESSAGES

### *SERVICE DEVELOPMENT*

- A multidisciplinary liaison psychiatry service dedicated to the hospital is critical to every acute hospital to integrate mental and physical healthcare.
- Services should be provided on an equitable basis regardless of age, intellectual disability, area of residence or location within the hospital.
- Staffing levels and skill mix need to be tailored to local factors including the size and complexity of the hospital and other local mental health services.
- Funding mechanisms for liaison psychiatry, such as commissioning, need to be applied so that services provide core functions to improve quality and reduce risks related to the range of mental health problems occurring in and affecting acute physical healthcare.

### *SERVICE ORGANISATION*

- Services require dedicated accommodation on the acute hospital site and assessment facilities in the hospital to ensure safety, privacy and dignity.
- Staff in the liaison psychiatry service require skills to integrate physical and mental health knowledge relating to diagnosis, formulation and management.
- Patients in acute hospitals should have equitable access to a consultant psychiatrist for mental health problems just as they do to a consultant for their physical health problems.
- All service functions should be provided 5 days a week and all emergency or urgent clinical problems should be covered 7 days a week.
- Emergency departments and acute medical and surgical units will benefit from a minimum of a 7-day, 12-hour-a-day on-site service.
- The maximum response time should generally be 1 h for emergency referrals and 1 day (usually within 5 working hours) for urgent referrals.
- Completion of assessment under mental health legislation should generally occur within 1 h in the emergency department and 4 h on wards where there are imminent risks as a result of the mental health condition.
- Organisational issues, such as impact on further investigation or discharge, should be considered in addition to clinical needs when services need to prioritise referrals.
- Referrals from emergency departments or acute medical and surgical units will benefit from a response time of 1 h where mental health assessment is needed for decisions about discharge or transfer from the unit.

## *SERVICE FUNCTIONS*

- Referrals should be accepted for any mental health problem that is moderate to severe and/or impairing physical healthcare.
- Liaison psychiatry staff need to support acute hospital management, including advocating for physical treatment for people with severe and enduring mental health problems such as schizophrenia.
- Liaison psychiatry services should provide ongoing monitoring and advice on management of mental health problems and medication affecting physical healthcare while the patient remains in hospital.
- Educational programmes and involvement in clinical governance within the acute hospital are core non-clinical functions of liaison psychiatry services.
- Educational sessions should include factors such as communication and impact of physical illness on diagnosis and treatment to increase translation into improved clinical outcomes.

## *SERVICE INTERFACES*

- Liaison psychiatry services for associated mental health needs should be funded and planned in conjunction with physical health services for emergency, unscheduled, routine and specialist care in the acute hospital.
- Liaison psychiatry services in acute hospitals should be part of mental health service pathways, especially for self-harm, alcohol and substance misuse, eating disorders, dementia and psychological therapy in long-term conditions and medically unexplained symptoms.

# Integrated governance of liaison psychiatry

Clinical governance is the system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards (Scully & Donaldson, 1998). Integrated governance describes integration of corporate, financial and clinical governance (Department of Health, 2006). This is particularly appropriate when applied to mental health services in acute hospitals as they usually work closely with a variety of providers and services, including those managed by the hospital, mental health organisations, substance misuse agencies as well as social care and third-sector organisations.

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- This multiplicity of management lines needs integration to ensure robust, high-quality delivery of care and coordinated service planning for optimisation of mental health in acute hospitals.
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Integrated governance encompasses a range of interrelated domains that include openness and communication, clinical effectiveness and audit, risk management, information management, resource utilisation, education and training, and research and development.

NHS services must also adhere to a range of national and locally set performance frameworks. In England especially, these are rarely aligned between acute and mental health providers which can impede liaison psychiatry service functioning and development without effective integrated governance.

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- Psychiatric Liaison Accreditation Network (PLAN), part of the Royal College of Psychiatrists, provides a framework through which the quality of services can be assessed and accredited (Soni *et al*, 2011). Expert peer support is provided by PLAN to help liaison psychiatry services improve in terms of quality, efficiency and safety.
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## INTEGRATED GOVERNANCE COMMITTEE

Clear and appropriate communication between referrers, service providers and external agencies is a core aspect of safe patient pathways. Open communication is required not only for clinical pathways and service standards, but also for risk management and service development despite being challenging to achieve due to increasing business principles and competition, especially in England.

- There should be, at least quarterly, an integrated governance meeting involving senior liaison psychiatry clinicians, managers and clinical and managerial leads for patient safety and quality in the acute hospital as well as for organisations providing liaison psychiatry and physical care (Soni *et al*, 2011; Joint Commissioning Panel for Mental Health, 2012; College of Emergency Medicine, 2013). Where this occurs within the same organisation, the same outcomes are likely to be achieved through existing management lines.
  - The group should have clear reporting lines to hospital boards and effective links to related groups addressing, for example, planning, risk, safeguarding and patient experience.
  - As well as governance roles, the group should take an overview of service provision in the acute hospital and be the lead group planning service developments or changes.
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In large hospitals, smaller groups may be required for specific areas and then report into the overarching group.

In addition, clear communication with patients will ensure that quality of patient experience remains a focus of services. Regular patient experience surveys should be routinely undertaken and 'real-time survey' methods should be considered.

## CLINICAL EFFECTIVENESS AND AUDIT

Considerations for common areas of clinical care are listed in the next chapter. Services also need to ensure compliance with up-to-date local and national best clinical practice derived from published research and guidelines.

- All services should show evidence of regular participation in such audits and implementation of findings as a mechanism for service improvement.
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There are a range of clinical audit subjects that are relevant to mental health services in acute hospitals, including:

- response and communication times (Soni *et al*, 2011)
- serious untoward incidents and complaints (Joint Commissioning Panel for Mental Health, 2012)
- compliance with mental health and mental capacity legislation (Joint Commissioning Panel for Mental Health, 2012)
- patient and acute hospital staff satisfaction (Soni *et al*, 2011; Joint Commissioning Panel for Mental Health, 2012)
- psychotropic prescribing
- improvements to clinical care following educational interventions (Soni *et al*, 2011)
- audits related to mandatory guidance.

## RISK MANAGEMENT

Although organisations should already have robust risk management processes in place, there are particular risks arising from mental health problems in acute hospital settings that justify special consideration. These

are likely to be best managed through an integrated governance group as outlined earlier to ensure appropriate learning across different organisations and different areas within large organisations.

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- The integrated governance group should oversee review of risk-related issues and ensure joint review (Soni *et al*, 2011; College of Emergency Medicine, 2013) and dissemination of learning across all involved organisations.
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Risks that should be considered include:

- serious untoward incidents and near misses, including those related to psychotropic medication
- complaints
- compliance with and application of mental health and mental capacity legislation and other legal frameworks for clinical care
- estates (e.g. ligature points, rooms for assessment of high-risk patients)
- policies and training related to observation of patients at high risk of harming themselves or neglecting their self-care
- planning for high-risk but relatively infrequent clinical scenarios such as marked behaviour disturbance as a result of delirium or psychosis, severe anorexia nervosa, active suicidal intent, neuroleptic malignant syndrome, complex factitious disorder, and relation to factors such as nursing observation, medical review and security policies
- employment status of clinicians working in the service.

## *SERIOUS UNTOWARD INCIDENTS*

Definition of whether an incident is serious should ensure that both physical and mental health issues and their interface are assessed. For example, staff mainly concerned with assessing physical risk may not appreciate the need for investigation of factors and decision-making leading to discharge of a patient who then dies by suicide at home. Conversely, staff used to reviewing mental health risks may not appreciate the need to investigate delay in medical care for example, where symptoms of neuroleptic malignant syndrome were thought to be signs of underlying psychosis.

## *MEDICATION ERRORS*

Medication errors are a significant cause of morbidity in hospitals. Psychotropic prescribing errors and out-of-date prescribing patterns should be included in clinical incident reviews.

Hospitals are likely to benefit from the development of guidelines on clinical topics tailored to the acute hospital (as described in the following chapter). The hospital medicines reconciliation procedure should ensure that pre-admission drugs taken by the patient are checked so that easily missed psychotropic drugs – such as long-acting antipsychotic medicines – are prescribed in hospital, even if they are not recorded by the admitting clinician.

Formal arrangements need to be in place for the acute hospital trust to be able to share medicines policies from the mental health trust to ensure consistent prescribing practice.

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- The size of the problems and risks associated with medication justifies all acute hospitals having a named pharmacist with a lead mental health pharmacist.
  - Large hospitals with specialist services where complex interactions with psychotropic medication are more common, such as neuroscience, hepatology, transplantation or cardiothoracic units, are likely to benefit from a specialist mental health pharmacist post to implement and monitor psychopharmacology prescribing across the age range.
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## COMPLAINTS

Reduction of complaints has been proposed as an outcome of an effective liaison psychiatry service. Specific complaints to consider include those related to poor communication with patients, personality disorders and functional symptoms, problems with physical care due to misunderstandings about mental illness, and impact of disturbed patients on others.

Complaints from patients with severe functional disorders or complex personality disorders are especially likely to be difficult for acute hospital departments to manage because of a relative lack of expertise in disturbed interpersonal dynamics that often mark such cases.

## MENTAL HEALTH AND MENTAL CAPACITY LEGISLATION

Mental health legislation is not always easy to apply in physical health settings, especially where legislation regarding mental health and mental capacity appears to conflict.

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- Acute hospitals need to be aware of, and meet, requirements for qualifications and expertise of staff to take legal responsibility for patients detained under mental health legislation in their hospital (Care Quality Commission, 2010); these are unlikely to be met by acute hospital clinicians.
  - Acute hospitals will generally need a formal agreement with mental health services regarding clinical responsibilities (Care Quality Commission, 2010) and administration processes for patients requiring assessment and treatment under mental health legislation.
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Usually the liaison psychiatry consultant would be expected to take responsibility for mental health advice to detained patients, but other members of staff will need to be specified for out-of-hours and leave cover.

## ESTATES

Buildings designed for physical healthcare may not be the most suitable for patients with significant mental health needs. Consideration needs to be taken regarding safety features common in mental health units such as collapsible bed rails and avoidance of ligature points, emergency alarm systems for staff under desks in all out-patient rooms or plastic cutlery for patients judged to be at high suicide or self-harm risk. There will also need to be consideration where different patient needs have to be balanced, for example use of highly

observed beds for high-risk or unstable physical v. mental illness. Some features of estates should be core for any hospital, including:

- minimum of one designated room for the assessment of patients in the emergency department, with attention to requirements for privacy, dignity and safety (Soni *et al*, 2011; College of Emergency Medicine, 2013)
- a room for assessing high-risk patients that meets the standards outlined by PLAN and is located within the major areas of the emergency department or acute medical unit (Soni *et al*, 2011)
- agreed areas that can be used for private discussions with patients or relatives on all wards.

Rooms designated for the assessment of high-risk patients or assessments of an unknown patient should meet the health and safety standards required for all mental health unit assessment rooms.

## *SPECIAL OBSERVATION*

Acute hospitals tend to refer to observations in relation to cardiovascular parameters whereas in mental health settings observations tend to focus on preventing harm to self or others.

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- All acute hospitals should work with senior liaison psychiatry professionals to develop an observation policy and provide related staff education regarding patients at risk of harm to themselves or neglect of their self-care that takes account of local ward design, funding and identification of 1:1 staff and response of security staff.
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An observation policy should include clinical management and de-escalation advice related to circumstances requiring increased observation in acute hospitals. For example:

- delirium and other causes of agitation
- suicidal intent and risk of self-harm
- risk of violence to others
- re-feeding in anorexia nervosa
- psychosis and neuropsychiatric disorders
- severe intellectual disability
- absconding or wandering
- self-neglect, including neglect of nutrition and hydration
- responsibility of different staff, including security staff, if a patient tries to leave the ward.

## *SECURITY STAFF*

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- Security staff in acute hospitals should have training and support in legal frameworks and how to manage patients with disturbed behaviour, especially when associated with mental health problems and when trying to leave despite lacking mental capacity to make this decision.
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## INFORMATION MANAGEMENT

It is possible that mental health service providers in physical care settings will be using different information systems and it may be that those systems are incompatible with those in mental health settings. Therefore, consideration will need to be given to methods of documentation and information sharing.

- It is important that the primary care record, usually the acute hospital record, is contemporaneous and complete. Liaison psychiatry staff should therefore use the paper or electronic notes of the acute hospital to improve integrated physical and mental healthcare.

Liaison psychiatry services will also need to ensure relevant information is shared with community-based mental health teams as required in addition to discharge communication with all health professionals involved. There may be different procedures used according to how long the patient is remaining in the acute hospital and whether they are already known to a community-based mental health team.

Information used for performance management and service development is crucial. This is likely to require information derived from acute hospital systems, such as length of stay and physical diagnostic codes, as well as data from the liaison psychiatry team itself.

## OUTCOME DATA

Outcome data are a particular challenge for liaison psychiatry. Services deal with a wide range of clinical problems with referrals usually being made in terms of presenting problems and difficulties with medical management rather than by confirmed diagnosis. Indirect work such as case discussion and telephone advice are as important as direct contact with patients. Process measures such as response time as well as clinical outcomes are highly important. There is no agreed outcome measure for liaison psychiatry and it is likely that a mixture of measures will be needed in any one service due to the range of functions a service may have, from in-patient to out-patient work, clinical contacts to staff education and provision to unscheduled, elective and regional admissions or services.

Current consensus favours use of a balanced scorecard approach to service evaluation, including:

- clinical outcome measures (e.g. Health of the Nation Outcome Scales (Wing *et al*, 1999), Clinical Global Impression rating scales (Guy, 1976), disease-specific measures)
- process measures (e.g. response time, length of stay)
- patient and referrer feedback.

Data that can be useful for performance management and service design in liaison psychiatry include:

- number of different types of referral problems (e.g. people admitted after self-harm)

- number of referrals from different areas of the acute hospital (e.g. emergency department, acute medical wards, specialist services)
- response time to emergency, urgent and routine referrals
- satisfaction of patients and referring staff
- time of day of referrals from different areas
- delay in referral to liaison psychiatry from when the mental health problem first presented
- matching liaison psychiatry referrals to length of stay and readmission data
- benchmarking audits using relevant external recommendations such as NICE or SIGN guidelines
- proportion of individuals admitted to the acute hospital with alcohol problems who are seen, or referred for, brief interventions for alcohol misuse
- areas of the hospital using rapid tranquillisation
- use of mental health and mental capacity legislation in the acute hospital.

## KEY MESSAGES

### *INTEGRATED GOVERNANCE*

- Liaison psychiatry services should participate in an integrated governance group that meets at least quarterly, involving senior liaison psychiatry clinicians and managers and individuals from both the acute hospital and the organisation providing liaison psychiatry.
- The integrated governance committee will benefit from including acute hospital leads for patient safety and quality and link to related groups such as planning and safeguarding.
- All services should demonstrate regular audits and implementation of findings covering a range of clinical and organisational parameters.
- Funding bodies should consider using PLAN accreditation as a performance indicator for services.

### *RISK MANAGEMENT*

- Acute hospitals need to be able to meet legal requirements of mental health legislation for patients subject to its provisions while in the acute hospital. This is likely to require formal arrangements with the organisation providing mental healthcare.
- Emergency departments should include at least one designated room for mental health assessments with adequate provision for dignity, privacy and safety.
- Serious untoward incidents or near misses in the acute hospital relating

to mental health factors, including psychotropic medication, should be reviewed by the integrated governance committee.

- All acute hospitals should have a lead pharmacist for prescribing related to mental health and substance use disorders, who takes a lead in developing and auditing policies regarding psychotropic prescribing. They should work closely with the liaison psychiatry service and acute hospital ward pharmacists.
- Liaison psychiatry services should work with acute hospitals to develop an observation policy related to mental health needs tailored to the acute hospital.
- Security staff in acute hospitals would benefit from training and support in legal frameworks and ways of managing patients with disturbed behaviour, especially when associated with mental health problems or lack of mental capacity.
- Liaison psychiatry clinicians will add value to work in acute hospital risk and complaints departments to improve understanding and management of complaints related to complex somatoform, factitious or personality disorders.

### *INFORMATION MANAGEMENT AND OUTCOME DATA*

- Liaison psychiatry staff need access to electronic and paper records used within the acute hospital and local mental health services, and should document assessments and advice in one set of integrated notes for mental and physical healthcare using the acute hospital record (Joint Commissioning Panel for Mental Health, 2012).
- Liaison psychiatry services should consider collecting outcome data using a balanced scorecard approach, including clinical outcome measures, process measures and patient and referrer feedback.

# Clinical topics for mental healthcare in acute hospitals

Liaison psychiatry services should agree local standards for clinical care. The following considerations should be evaluated in line with local policies as well as local and national guidance from the Department of Health, NICE, SIGN and other professional organisations. As with other areas of practice, standards will need to be renewed in line with future recommendations.

## SELF-HARM

- Mental health assessment and management should proceed in parallel with physical care after self-harm (National Institute for Clinical Excellence, 2004) and be based on the principles of suicide mitigation.
- All people presenting to an acute hospital with suicidal ideas or after self-harm should receive a psychosocial assessment (National Institute for Clinical Excellence, 2004; Royal College of Psychiatrists, 2010*b*; College of Emergency Medicine, 2013) that informs a short-term management plan to address their needs and risks in hospital and at discharge. The initial assessment by acute hospital staff should include willingness to stay for further assessment, mental capacity to refuse treatment or further assessment as well as clinical details relating to risk, mental disorder and physical needs (National Institute for Clinical Excellence, 2004).
- Older adults at higher risk of future suicide and comorbid mental illness would benefit from being seen by professionals with expertise in later-life mental health and self-harm (Royal College of Psychiatrists, 2010*b*).
- Consideration should be given to patients judged to be at moderate or high risk of completed suicide, all patients aged 50 years or older and those who re-present within 6 months being seen by a specialist mental health professional before leaving the acute hospital.
- Where acute hospital staff discharge people presenting with self-harm without specialist mental health advice, there should be a regular forum with acute hospital and liaison psychiatry staff for review of discharge assessments.
- Incidents of self-harm or suicide attempts occurring in the acute hospital or within 1 month of discharge by acute staff without

consultation with mental health services should be jointly reviewed by acute hospital and liaison psychiatry staff, and learning points disseminated through the acute hospital and community mental health services.

- Acute hospitals and mental health services need agreed timescales (College of Emergency Medicine, 2013) for mental health teams to respond to a referral, and agreement about where patients who are intoxicated with alcohol or other substances should wait until they can be seen by the mental health team.
- Acute hospitals should have regular staff training that includes patient involvement related to managing patients presenting with self-harm (National Institute for Clinical Excellence, 2004; Royal College of Psychiatrists, 2010b; College of Emergency Medicine, 2013) for at least those staff who work in the emergency department or on the acute medical unit, intensive care unit and trauma wards.
- Management of people who present frequently to the acute hospital with self-harm or suicidal ideas would benefit from a care plan (Joint Commissioning Panel for Mental Health, 2012; College of Emergency Medicine, 2013) developed jointly between community staff involved with the patient, liaison psychiatry staff, emergency department and acute medical unit staff to guide management of future presentations, taking into account the needs of the patient and a recovery approach.

## DEPRESSION AND ADJUSTMENT DISORDER

- Education for acute hospital staff about depression/anxiety should include:
  - skills for diagnosis of depression/anxiety in physical illness
  - differentiation from adjustment disorder
  - information about pharmacological treatment safety and efficacy
  - psychological, behaviour and communication skills to discuss symptoms and treatment with patients
  - advice on how to ask about and respond to suicidal thoughts
  - advice on pharmacological and non-pharmacological treatments and management for milder disorders not requiring specialist mental health advice in the acute hospital.
- If introduced, screening for depression should be based on principles employed by the UK National Screening Committee such that screening takes account of the natural history of identified levels of depression, is accepted by patients and staff, is feasible to implement, has acceptable false positive and false negative levels, leads to treatment that improves outcomes and is only implemented after treatment is optimised (Allaby, 2010).
- Acute hospital prescribing guidelines would benefit from advice on anti-depressant medication in physical illness and for different ages.
- Acute hospital guidance for managing depression would benefit from including non-pharmacological treatments and advice regarding

management of subclinical low mood or low mood related to adjustment disorder.

- Liaison psychiatry services are most likely to be required at increased levels of need (Parsonage *et al*, 2012) for people with physical illness and depression (Royal College of Psychiatrists, 2012). Patients with depression should generally only be referred to liaison psychiatry if their mood disorder is moderate to severe or interfering with treatment or recovery from their physical illness. In other cases, depression should generally be managed by acute hospital staff and continued in primary care.

## DELIRIUM AND DEMENTIA

- Hospitals should have strategies to identify dementia and patients at high risk of delirium (Royal College of Psychiatrists, 2005; Young *et al*, 2011). Consideration should be given to routine assessment and documentation of cognitive function in all patients aged 75 years and over, and in all patients of any age group presenting with confusion or where dementia is suspected.
- An interview with an appropriate informant (e.g. close friend, relative) should be sought in all cases where cognitive impairment is apparent or suspected.
- Acute hospitals should have relevant information for carers regarding delirium and dementia as well as for patients who have had an episode of delirium.
- All acute hospitals should have a delirium and dementia policy (Young *et al*, 2011) that considers screening – with a checklist of investigations for potential underlying causes – which should be carried out in addition to a full medical examination in people where cognitive impairment is suspected. The priority or choice of items put on the checklist may differ in some areas of the hospital, for example in a regional neurosciences centre, and for different ages. The use of the checklist should be locally agreed for patients where cognitive decline has occurred in those already diagnosed with dementia or other pre-existing cognitive impairment.
- Acute hospital clinical teams should have access to expert second opinion from liaison psychiatry services in the case of more complex assessments in people with delirium and dementia.
- A senior liaison psychiatry clinician should work with senior clinicians in the acute trust to form a dementia group, advising on policies, care pathways and standards of care.
- All acute hospitals would benefit from a policy on minimising the risk and impact of delirium and dementia through modifying the ward environment.
- All acute hospitals should have a policy on pharmacological and non-pharmacological management of behaviour disturbance, including in the context of delirium and dementia.

- Acute hospital staff should have a policy on prescribing in patients with dementia, especially regarding the use of antipsychotic medications.
- Acute hospitals should provide nursing and medical staff with training in the awareness, basic assessment and management of delirium and dementia (Young *et al*, 2011), having involved liaison psychiatry services in planning the content and delivery. Content of training should be tiered according to level of contact.

## ALCOHOL, OPIATES AND OTHER SUBSTANCE MISUSE

- Acute hospitals' management of people with alcohol and substance misuse problems should be supported by input from liaison and substance misuse psychiatrists (Moriarty *et al*, 2010).
- Screening for alcohol misuse should be considered using the Alcohol Use Disorders Identification Test (AUDIT) (Babor *et al*, 1989) and the Fast Alcohol Screening Test (FAST) (Health Development Agency, 2002) in areas with high levels of alcohol disorder or particular risks from such a disorder, for example the emergency department, gastroenterology and antenatal services.
- Clear pathways with community alcohol services need to be developed so that people with alcohol problems can continue their treatment seamlessly, reducing the risk of relapse and readmission.
- All acute hospitals need clear and easily accessible protocols for alcohol detoxification based on relevant national guidance.
- Training programmes for acute hospital clinical staff should include recognising alcohol withdrawal symptoms, delirium tremens, Wernicke–Korsakoff syndrome, and how to manage alcohol withdrawal.
- Alcohol hospital liaison teams should be developed to provide brief interventions for those who have screened positive for alcohol misuse (Moriarty *et al*, 2010).
- All acute hospitals should have guidelines on opiate prescribing, taking into account their addictive potential, prevalence of overdose and risk of dose escalation in patients with functional or somatoform pain syndromes.
- Information about the addictive potential of hypnotics and opiate-based analgesics should be incorporated into training programmes about delirium, depression and medically unexplained symptoms.

## MEDICALLY UNEXPLAINED SYMPTOMS

- Liaison psychiatry services are essential in delivering a comprehensive care pathway for medically unexplained symptoms (Royal College of Psychiatrists, 2012). Such pathways need to include assessment of comorbid physical pathology and identification of the mental health diagnosis and formulation underlying the presentation.

- When somatoform, dissociative or factitious disorders are identified, the patient's care will benefit from collaborative working and care planning involving the relevant physical health teams, liaison psychiatry and primary care to manage professionals' decision-making and behaviour as well as providing direct intervention for the patient.
- Liaison psychiatrists have specific training to manage the complexity and uncertainty of medically unexplained symptoms, especially where physical and psychological factors overlap. They will add specific value and should thus be considered key professionals in work with people with medically unexplained symptoms or long-term conditions, especially where there are multiple symptoms, frequent presentations or complex medical or mental health comorbidity (Royal College of Psychiatrists, 2012). Liaison psychiatry services can help formulate reasons for the symptoms or high levels of healthcare use and initiate management plans for both further physical and mental healthcare.
- Once organic factors have been excluded in all people over the age of 40 years presenting with medically unexplained symptoms, due to increased prevalence, the underlying diagnoses of depression (World Health Organization, 2010) – including agitated depression – or anxiety should be considered.
- Somatoform or dissociative disorders rarely start in older adulthood and thus medically unexplained symptoms in people presenting over the age of 50 years would benefit from assessment by a specialist in liaison or older person's psychiatry.
- Large acute hospitals with specialist services would be particularly likely to benefit from a group to develop guidance related to diagnosis and management of complex medically unexplained symptoms in the acute hospital wards and out-patient clinics. The group should consider including a consultant liaison psychiatrist for working-age adults, a lead liaison psychiatry nurse, lead psychologist for the acute hospital, and representative consultants and senior nurses for gastroenterology, neurology, cardiology and gynaecology as well as heads of patient safety, complaints and legal services.
- Training programmes about medically unexplained symptoms would benefit from including advice on detection and management of medically unexplained symptoms attributable to underlying mental health problems such as panic, depression, adjustment, alcohol, somatoform, dissociative and factitious disorders, especially in the context of comorbid physical illness.
- Training programmes for acute hospital staff would benefit from inclusion of communication strategies about physical healthcare and explanation of the role of psychological factors for people with medically unexplained symptoms.
- Training programmes in areas with higher levels of medically unexplained symptoms, for example in acute medicine, neurology and gastroenterology, should include advice on personality and interpersonal problems affecting relationships with healthcare professionals as well as health-related behaviour.

## PSYCHOSIS

- Liaison psychiatry staff should help acute hospital staff assess and manage psychosis in the hospital setting.
- Training programmes for acute hospital staff would benefit from including information on diagnosing the cause of psychotic symptoms including delirium, personality disorder, organic psychosis and functional psychosis.
- Educational programmes should address factors related to poorer treatment of physical conditions in patients with severe mental illnesses such as schizophrenia.
- Educational programmes would benefit from reminding staff of the signs and symptoms of significant psychotropic side-effects such as neuroleptic malignant syndrome and serotonin syndrome and how these can be differentiated from the symptoms of the underlying mental illness.
- Liaison psychiatry staff should help community-based mental health teams work with patients with chronic psychotic disorders at risk of admission to hospital with physical illness, to write a short list of guidance for acute hospital staff tailored to the mental illness triggers, symptoms and relieving factors for distress of the patient as well as advice on communication and their support network.

## EATING DISORDERS

- Acute hospitals should have a group involved in re-feeding for anorexia nervosa, as recommended in the MARSIPAN guidance (Management of Really Sick Patients with Anorexia Nervosa; Royal College of Psychiatrists & Royal College of Physicians, 2010), including a named consultant physician and consultant psychiatrist with expertise in eating disorders, and involving other mental health and physical health clinicians.
- Acute hospitals should follow MARSIPAN recommendations and have written guidance for staff related to nursing management, physical management and mental health service involvement (Royal College of Psychiatrists, 2010b).
- If the patient is detained under mental health legislation for re-feeding, the responsible clinician will usually need to be the consultant psychiatrist who therefore needs to be involved in significant treatment decisions on an ongoing basis.
- All patients admitted to an acute hospital for re-feeding for anorexia nervosa should receive 1:1 observation by mental health-trained staff unless agreed not necessary by both the consultant physician and psychiatrist responsible for their care. Patients should also be assessed by a specialist in eating disorders to see whether/when re-feeding can be managed on a specialist eating disorders unit rather than in the acute hospital (Royal College of Psychiatrists, 2010b).

- There should be agreed care pathways for transfer and discharge of patients from the acute hospital (Royal College of Psychiatrists, 2010b) to mental health facilities agreed between all organisations funding or providing such care.
- Acute hospitals should have guidance for staff relating to safe discharge of patients with medical complications of eating disorders, such as hypokalaemia or dehydration. Guidance should emphasise that it is vital to take an holistic view of the patient's physical and mental health, for example including advice in addition to blood test results when assessing medical risk (Royal College of Psychiatrists, 2010b).
- Management of patients with severe eating disorders in acute hospitals would benefit from the involvement of liaison psychiatry or eating disorder specialists to facilitate staff meetings to ensure a consistent approach and minimise the risk of splitting (Royal College of Psychiatrists, 2010b).

## NEUROPSYCHIATRIC DISORDERS

- Education for acute hospital staff, particularly those in neuroscience centres, would benefit from including information about neuropsychiatric conditions such as mental health complications of stroke, epilepsy, head injury, multiple sclerosis, Parkinson's disease and other relevant neurological conditions.
- Patients with clinically significant neuropsychiatric complications of neurological disease would benefit from timely assessment by suitably trained clinicians; ideally a liaison psychiatrist or neuropsychiatrist.
- Clinicians treating mental health complications of neurological disorders should bear in mind specific drug interactions, neurotoxicity and problems with adherence.
- Local protocols and care related to mental health treatment in neurological conditions need particular attention to issues of communication difficulties, cognitive impairment or complex care needs.
- Regional neuroscience centres should have a dedicated liaison or neuropsychiatry service.

## PERINATAL MENTAL HEALTH PROBLEMS

- Liaison psychiatry services should ensure core provision to obstetric services unless there is a separate specialist perinatal mental health service.
- Perinatal teams should work with liaison psychiatry services to ensure that patients at risk of postpartum relapse of severe mental disorder or other mental health risks related to pregnancy and delivery have a comprehensive care plan available to acute hospital staff 24h a day.
- Liaison psychiatry services providing input to obstetric services should receive tailored training for consultant psychiatrist and nursing staff to

ensure sufficient expertise in recognising and managing acute mental health problems related to pregnancy and the postnatal period.

- Liaison psychiatry and acute hospital pharmacy services should have access to appropriate expert advice on prescribing medication to pregnant and breastfeeding women.
- All those involved in the mental healthcare of pregnant women and women with children should consider the potential impact of the mother's mental health problems on her children, even if the children are not present at the time of consultation.
- All those involved in the care of mothers with mental illness should be aware of the possible adverse effects on young children and be trained in child protection procedures.
- Staff should work closely with children's Social Services to ensure safe multi-agency working, and all staff must be familiar with local safeguarding children arrangements.
- Liaison psychiatry services should have protocols for identifying mother and baby unit placements for suitable patients 24h a day, and protocols for seeking funding where service agreements are not in place.

## SPECIFIC CONSIDERATIONS FOR OLDER ADULTS WITH MENTAL HEALTH PROBLEMS

- All acute hospitals should have access to liaison service provision by specialists in the mental healthcare of older adults (Young *et al*, 2011). It would be expected that all in-patients aged 75 years and over would receive such specialist input and that this would also be available for younger patients where indicated.
- Such specialist input should be provided by a team that has close working relationships with community older people's mental health services, as many patients will either already be receiving active management from these services or will require coordinated aftercare following discharge.
- All acute hospitals should ensure that their clinical teams receive training in relevant legislation relating to mental capacity and vulnerable adult safeguarding.
- It is essential that older adults are fully involved in consultations, but staff should also recognise the potential value of carers, not just for emotional support but also as informants and in facilitating communication, especially where there is cognitive impairment.
- Acute hospital policies on the management of behaviour disturbance, restraint or rapid tranquillisation should make special reference to modifications needed in frail elderly people as well as in those of any age with relevant medical comorbidities, and include non-pharmacological interventions as well as medication.

## SPECIFIC CONSIDERATIONS FOR PEOPLE WITH INTELLECTUAL DISABILITY AND MENTAL HEALTH PROBLEMS

- People must not be automatically excluded from any acute physical or mental health service purely as a result of having an intellectual disability (Guidelines and Audit Implementation Network, 2010; Royal College of Psychiatrists, 2013).
- Acute hospitals would benefit from strategies to identify and care for any patient with intellectual disability. This will involve making 'reasonable adjustments' to their services (Guidelines and Audit Implementation Network, 2010) to enable equal opportunities for healthcare in accordance with the Equality Act 2010 (Heslop *et al*, 2013).
- Essential components of any strategy will include:
  - the assessment of understanding and communication and strategies to address any identified deficits (Guidelines and Audit Implementation Network, 2010)
  - identification of essential carers and informants (Michael, 2008)
  - assessments of unknown areas of risk, including self-care, swallow and pain recognition (Guidelines and Audit Implementation Network, 2010; Royal College of General Practitioners & Royal College of Psychiatrists, 2012)
  - sensory deficits and other special environmental considerations (Academy of Royal Medical Colleges, 2009)
  - clear channels of communication and information-sharing protocols with specialist learning disability services.
- If patients display challenging behaviour it is essential that they are assessed for physical, psychological and social/environmental triggers and that liaison takes place with specialist mental health or learning disability professionals (Academy of Medical Royal Colleges, 2009; Royal College of Psychiatrists, 2009).
- Any prescription of psychotropic medication must be preceded by a biopsychosocial evaluation of potential predisposing, precipitating and perpetuating factors and with due regard to potential comorbidities, especially epilepsy. The use of medication should be accompanied by careful evaluation of capacity and either consent or best interest processes which include arrangements for regular review of necessity (Royal College of Psychiatrists, 2009).
- All staff must be familiar with legislation related to mental capacity (Guidelines and Audit Implementation Network, 2010; National Development Team, 2012) and decisions both to treat or not to treat must be accompanied by evidence of either capacity or documented best interest processes. Staff should also be aware of other related statutory obligations such as deprivation of liberty safeguards and advocacy (Guidelines and Audit Implementation Network, 2010).
- There should be local strategies to identify how acute hospitals obtain advice and help on the care of patients with intellectual disability

exhibiting mental disorders (National Development Team, 2012). In the first instance, this may be the liaison psychiatry service but, depending on individual patient need and local service considerations, there is likely to be a need for either advice, consultation or direct input from specialist learning disability services.

- Liaison psychiatry staff undertaking work with people with intellectual disability must be aware of the increased risk of mental health problems and the ways in which the person's intellectual and social functioning and communication can modify the presentation of symptoms. Liaison psychiatry staff should also be able to advise acute hospital staff of suitable modifications in consultation techniques and environmental adjustments. This can be particularly important when assessing and treating individuals with comorbidities such as autism spectrum disorder (Michael, 2008).
- It is essential that the patient with intellectual disability is fully involved in consultations, but staff should also recognise the potential value of carers, not just for emotional support but also as informants and in facilitating communication (Michael, 2008; Guidelines and Audit Implementation Network, 2010).

## SPECIAL OBSERVATION OF PATIENTS WITH MENTAL HEALTH NEEDS

- All acute hospitals should have a policy agreed with local mental health services regarding the identification and funding of staff to provide 1:1 observation for patients and principles to guide the level of expertise of such staff according to the problem triggering the need for individual observation.
- Staff providing 1:1 observation should be able to assess the mental state of the patient and intervene therapeutically to support them.
- Staff providing 1:1 observation should document mental health symptoms and signs, behaviour observations and problems with physical health management in the acute hospital ward nursing records at the end of each shift.
- Staff providing 1:1 observation should have clear arrangements for cover by other ward nurses for breaks.
- When a patient is transferred from a mental health unit and requires 1:1 observation, handover and documentation in the mental health service notes is needed at the end of each shift as well as in the acute hospital notes. The 1:1 observation should only be discontinued with the agreement of senior nurses from both the acute hospital and mental health unit.
- Acute hospital observation policies should be written in conjunction with liaison psychiatry staff to provide detailed guidance on required documentation, handover and specific consideration for observation related to risk of self-neglect of nutrition and hydration, self-harm, wandering or absconding.

## PSYCHOTROPIC PRESCRIBING IN ACUTE HOSPITALS

- Acute hospitals should have a designated pharmacist with responsibility for psychotropic prescribing, monitoring and guidance. Large hospitals with regional services where there are special challenges, such as in neuroscience units, are likely to benefit from a specific mental health pharmacist post.
- All acute hospital guidelines regarding psychotropic medication should include its relation to communication and non-pharmacological strategies.
- Acute hospitals should have guidelines developed with liaison psychiatry staff and a lead mental health pharmacist for:
  - rapid tranquillisation and preceding de-escalation strategies, including information about modification of the general guidelines for different ages or for patients with specific medical comorbidities, such as acute cardiac disorders, neurological diseases or intellectual disability
  - appropriate use of antipsychotics for agitation, including delirium, and in patients with dementia
  - detection and treatment of serious psychotropic side-effects requiring acute hospital admission (e.g. neuroleptic malignant syndrome, serotonin syndrome, lithium toxicity, clozapine-induced neutropenia and long QT syndrome), including management of physical health problems and resuming treatment of the underlying mental health disorder
  - pharmacological treatment of depression, psychosis, alcohol and opiate withdrawal, delirium and dementia, taking into account age and physical health comorbidities, with extra information for services where prescribing is especially complicated such as in regional neuroscience, transplant or cardiothoracic units
  - use of analgesia, including advice on prescribing analgesia in chronic pain and somatoform pain disorders such as explaining and communicating with the patient regarding the physical and psychological adverse effects of long-term or escalating doses of opiate analgesia
  - psychotropic medication and surgery, psychotropic medication and pregnancy.
- Acute hospitals need oral as well as intramuscular or intravenous medications for sedation or rapid tranquillisation in all areas of the hospital.
- Use of rapid tranquillisation or antipsychotics for behaviour control should lead to an incident report and regular review of such incidents aiming to reduce their occurrence and ensure appropriate prescribing.
- Acute hospital and liaison psychiatry staff should, as a minimum, regularly audit adherence to guidelines related to rapid tranquillisation, antipsychotic prescribing and opiate use as well as assessment of mental capacity and best interests if medication is recorded as not given due to patient refusal.

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