Liaison psychiatry – the way ahead

This Briefing sets out the findings of a report that details a study of liaison psychiatry services. It was commissioned by the NHS Confederation on behalf of the SHA mental health leads, and written by the Centre for Mental Health.

The study set out to identify how liaison psychiatry can most effectively contribute to the Government’s quality, innovation, productivity and prevention (QIPP) challenge of improving health outcomes while also reducing healthcare costs.

It is based on case studies of five established liaison psychiatry services around the country, a review of published research and discussions with academic and other experts.

Key points

• Failing to deal with mental and physical health issues at the same time leads to poorer health outcomes and costs the NHS more money.
• Liaison psychiatry offers an ideal way of contributing to the NHS’s QIPP agenda of better health at a lower cost.
• Every general and acute hospital should have a dedicated in-house liaison psychiatry service – the scale and nature of which should vary according to local needs.
• Long-term development of liaison psychiatry is likely to lie primarily in the expanded provision of community-facing services.

Background

People with a physical health condition are two to three times more likely to also have a mental illness than the rest of the population. Prevalence is particularly high in the hospital setting – around half of all inpatients suffer from a mental health condition such as depression, dementia or delirium. Liaison psychiatry services tackle the mental needs of people who are being treated primarily for physical health problems or symptoms.

Currently, these services are mostly provided to patients attending general and acute hospitals, but there is also an under-developed role for liaison psychiatry in improving services in community settings for people with co-morbid physical and mental health problems. There are concerns that many co-morbid mental health problems are being undiagnosed and untreated and, if so, can lead to poorer health outcomes, including increased rates of mortality and morbidity.
Mental health co-morbidities also substantially increase the costs of physical healthcare – overall it is estimated that co-existing mental health problems including medically unexplained symptoms cost the NHS around £13.5 billion a year in extra spending on physical health services.\textsuperscript{1,2} Half of this cost is borne by hospitals. For a typical 500-bed general hospital, this equates to extra costs of around £25 million a year.

The authors believe that it is possible for a liaison psychiatry service in such a hospital to generate savings of as much as £5 million a year, particularly by reducing lengths of stay among older inpatients.

**Study design**

The study was commissioned as a follow up to a short report published last year in which the authors set out an economic evaluation of the RAID (Rapid Assessment Interface and Discharge) liaison psychiatry service in Birmingham City Hospital,\textsuperscript{3} also detailed in a NHS Confederation briefing.\textsuperscript{4}

The previous report found there was a strong business case for the RAID model, which could reduce acute inpatient bed use by shortening lengths of stay and reducing rates of re-admission, particularly among older patients. A number of new liaison psychiatry services based on the RAID model are now under development around the country.

In the new report, the authors wanted to identify the key components and characteristics of a good psychiatric liaison service, drawing on a wider range of evidence than covered in the previous report. They worked closely with five established liaison psychiatry services around the country considered to be examples of good practice, based in Carshalton, Exeter, Hull, Leeds and the Wirral.

Different models of service provision were studied and during visits to the five sites, the authors carried out detailed discussions with those responsible for managing and providing liaison psychiatry services, as well as with a range of acute hospital clinical staff and with local commissioners.

All site visits were completed over a five-week period, with each visit lasting two days. Information and advice was also gathered from a number of other providers of liaison psychiatry services around the country, including:

- providers based in Cambridge, Edinburgh and Southampton
- members of the Royal College of Psychiatrists' Liaison Psychiatry Network
- academic experts in the field of liaison psychiatry, particularly Professor Michael Sharpe of the University of Oxford.

In addition, the authors reviewed the published research literature on liaison psychiatry, focusing on evidence on the effectiveness and cost-effectiveness of different service models.

**Key recommendations from the report**

- Services should focus on complex and costly cases, like those who are likely to stay in hospital for longer periods of time.

- All services should be provided on an all-ages basis, which in many cases is likely to imply more work with older people and with children and young people.

- Services should approach establishing a service in two stages: a rapid-response generic service, and then an outpatient clinic for the treatment of mental health problems, which should consider enhancing the community-based provision of such liaison services.

- All liaison psychiatry services should provide mental health training and supervision to acute hospital staff as a core function.
Liaison psychiatry in hospitals

Most liaison psychiatric services are currently provided in general and acute hospital settings. Some hospitals appear to have little or no provision of organised mental health support, while others have large in-house specialist teams. In addition, provision of liaison psychiatry varies greatly according to the coverage and organisation of services.

Health services are not always organised in a way that supports integrated care, particularly for people with multiple health problems. Service models are largely oriented around single diseases, with a particularly sharp divide between physical and mental illness. Liaison psychiatry seeks to bridge this divide in the hospital setting and promotes more integrated care for those patients who have physical and mental health co-morbidities.

From their visits to the sites and the other evidence gathered and analysed, the authors concluded that liaison psychiatry was seen in some quarters as an optional extra in the NHS. In the context of the Government’s QIPP challenge, liaison psychiatry should instead be considered as essential to the provision of high-quality and efficient healthcare.

The number of staff in the different services visited reflected the range and type of work undertaken, the size of the population covered and the working practices of the different teams. Staff numbers varied from seven whole-time equivalent clinical staff at Carshalton to 75 in Leeds.

Several of the sites visited during this study were able to point to local evaluations showing evidence of cost savings and also to identify other possible reductions in resource use, such as introducing a liaison psychiatry service leading to a 50 per cent reduction in admissions of older people to psychiatric hospitals.

The report recommends that every general and acute hospital should have a dedicated liaison psychiatry service, located in the hospital, in order to capitalise on the advantages of onsite provision, compared with the main alternative of support provided on a case-by-case outreach basis by community-based crisis teams or other mainstream secondary mental health services.

The scale and nature of operations of a hospital-based liaison psychiatry service should vary according to local needs and should be set up on a sustainable basis, requiring secure funding, a minimum size of service and a minimum level of expertise. There is also a good case for incorporating related services such as clinical psychology and substance misuse services within a hospital-based liaison psychiatry service.

Future liaison psychiatry services should aim to integrate psychiatry and psychology fully into medical care, which will mean close day-to-day working with medical teams, a strong focus on the education, training and supervision of acute hospital staff and a change in the culture of the hospital so that psychological factors are more widely recognised and embedded in the routine care of patients.

Hospitals in which liaison psychiatry support is currently limited or non-existent should focus on setting up a rapid-response generic service dealing with assessment, day-to-day management of patients during their time in hospital and onward referral to community services. Such a generic service should aim to provide liaison psychiatry support on an all-ages, all-conditions basis, but in many cases this would imply more work with older patients and with children and young people.

More support for older inpatients is particularly important, because they account for about 80 per cent of all hospital bed-days occupied by people with co-morbid physical and mental health problems. Because of the scale of mental health co-morbidities, it is likely that only a small proportion of all patients who could benefit would be directly seen and managed by a liaison psychiatry service. The service should focus on complex and costly cases, particularly those with intractable symptoms.
who might otherwise be kept in hospital for lengthy periods.

Once a rapid-response generic service is established, the next stage of development for a hospital-based liaison psychiatry service is likely to be in the provision of outpatient clinics for the treatment of mental health problems that cannot be resolved during the limited time that most patients spend in hospital.

**Training of staff**

The liaison psychiatry services in all the sites visited during the study provided education and training for hospital staff, although the scale of this varied and in some cases they reported difficulties in engaging clinical staff.

Nationally, the picture on training was less satisfactory. On the issue of dementia, for example, deficiencies in staff training were widely identified as a source of concern in relation to quality of care provided in hospitals. The training and supervision of acute hospital staff should be a core function of all liaison psychiatry services. This is likely to be the most cost-effective way of increasing the overall capacity of the hospital to improve the management of patients with co-morbid mental health conditions.

The report, however, warns that the provision of education and training is a relatively time-intensive activity. But over time the scale of these activities is likely to decline, as knowledge and understanding of mental health problems and the associated ability of staff to manage patients with these problems become more firmly embedded throughout the hospital workforce.

**Liaison psychiatry outside the hospital**

Most liaison psychiatry services are based in general hospitals with good reason – the high prevalence of mental health problems in this setting – but liaison psychiatry should reflect wider trends in healthcare, namely the growing importance of chronic rather than acute physical illness and a shift in the balance of care from hospital to the community.

The report proposes that liaison psychiatry services should extend their remit through an enhanced community focus, not necessarily as a replacement for existing hospital work but rather as an appropriate response to changing patterns of health need and service delivery. One means of achieving this is to open up all outpatient treatment clinics run by hospital-based liaison psychiatry services to referrals from GPs and other community-based providers.

Some of the sites visited during the study had already taken steps down this road, such as the outpatient clinics run by the liaison psychiatry service in Leeds, where around half of all referrals came from GPs and other community-based providers. Also, the work undertaken by the service for older people in St Helier Hospital, Carshalton, included follow-up home visits to patients who had been discharged from hospital to check that problems such as delirium identified during an inpatient stay had continued to improve.

There was a broad measure of support for the general principle that liaison psychiatry should provide more services that span the primary/secondary care boundary, but with a major reservation – the potential scale of demand for such work was so large that services ran the risk of being swamped by it.

In addition, other possible areas in which to expand were medically unexplained symptoms in patients and perinatal mental health, particularly during the antenatal period. Although in some areas CAMHS (child and adolescent mental health services) provide specialist perinatal teams, there is limited availability around the country. Liaison psychiatry services could provide an alternative model.

The authors argued that the biggest area for developing community-based liaison psychiatry was in contributing to the management and treatment of mental health problems among people with long-term physical conditions such as diabetes or chronic cardiac problems.

Given that there are an estimated 4.5 million people in this country with a long-term physical condition and co-morbid mental
Local decisions should continue to determine the exact way in which services are provided – but no longer in a national policy and management context which regards liaison psychiatry as something that is merely nice to have.

health problem such as depression or anxiety, the potential scale of such activity is large. However, that also reflects the huge potential for benefit in terms of improved health outcomes and reduced costs of care. To be able to expand in this area, liaison psychiatry would most likely need to be involved in integrated stepped-care models of provision, working in collaboration with other providers including GPs, community nurses and IAPT (improving access to psychological therapies) services.

The role of liaison psychiatry would be to focus on treating severe and complex cases, alongside training and supervising other staff responsible for more straightforward cases. There are some limited examples of community-based liaison psychiatry services operating along these lines emerging in different parts of the country.

The report concludes that given the prevalence and cost attached to mental health co-morbidities among people with long-term conditions, developing community-based collaborative care services with an integrated liaison psychiatry component should be a high priority for all clinical commissioning groups as they work with local providers.

Measuring outcomes
Well-designed liaison psychiatry services can generate both health improvements and cost savings, but there remains a need to demonstrate this through the use of a robust measurement framework. Identifying and quantifying the outcomes attributable to liaison psychiatry interventions is far from straightforward and there is at present no consensus on the best measures to use. We favour a balanced scorecard approach, bringing together a range of measures on different areas of potential improvement, including clinical outcomes, service use and patient experience.

Next steps for liaison psychiatry
Liaison psychiatry provides a vital service that helps bridge the gap between the physical and mental health needs of patients.

In drawing their conclusions from the study, the authors look ahead to how such services can be developed and strengthened further and underline their large potential to improve healthcare and save the NHS money.

Better management of co-existing physical and mental health conditions offers more scope for contributing to the QIPP agenda of better health at lower cost than any other activity in the NHS. Although the QIPP challenge is daunting, it offers a major opportunity for liaison psychiatry, given its key role in the provision of care at the interface between physical and mental health.

The report recommends that every general and acute hospital has a dedicated in-house liaison psychiatry service. The scale and nature of operations of a hospital-based liaison psychiatry service should vary according to local needs – the requirements of a large inner city teaching hospital providing a broad range of tertiary services differ considerably from those in a small suburban or rural district general hospital.

Every service should also be established on a sustainable basis, meaning secure funding, a critical minimum size of service and a minimum level of professional expertise. It also makes sense to incorporate related services such as clinical psychology and substance misuse services within a hospital-based liaison psychiatry service.

Liaison psychiatry services should aim to integrate psychiatry and psychology fully into medical care, which is a multi-factorial effort including:

- having an onsite mental health team in the hospital
- close day-to-day working with medical teams
- a strong focus on the education, training and supervision of acute hospital staff
• a leadership role in changing the culture of the hospital so the central importance of psychological factors is more widely recognised and embedded in the routine care of patients.

In those hospitals where liaison psychiatry support is currently limited or non-existent, the initial priority should be to set up a rapid-response generic service, which focuses on assessment, the day-to-day management of patients during their time in hospital and onward referral to community services as appropriate.

After such a service is established, the focus can move to developing other forms of provision such as outpatient clinics.

Although a generic service should provide liaison psychiatry support on an all-ages, all-conditions basis, different groups of patients have different levels of need so it is likely that there will be more work with older patients and with children and young people. The case for more support for older inpatients is particularly strong and this area of work should be a top priority for all liaison psychiatry services.

Training and supervision of acute hospital staff should be a core function of all liaison psychiatry services, because this is likely to be the most cost-effective way of increasing the overall capacity of the hospital to improve the management of patients with co-morbid mental health conditions.

After establishing the rapid-response generic service, the next stage of development for a hospital-based liaison psychiatry service is likely to be providing outpatient clinics for the treatment of mental health problems that cannot be resolved during the limited time that most patients spend in hospital. Mostly, these patients could be referred to primary care or to mainstream community-based mental health services, but for some conditions the expertise of these services is limited and a continuing role for support from a liaison psychiatry service could therefore be necessary.

The way ahead for the long-term development of liaison psychiatry is likely to be in the expanded provision of community-facing services such as:

• opening up outpatient treatment clinics to referrals from GPs and other community-based providers
• a role in perinatal mental health
• contributing to management and treatment of mental health problems among people with long-term physical conditions.

In planning services for their local populations, all commissioners have to ensure that there are appropriately scaled hospital departments for cardiology, oncology, gastroenterology and so on, but there is no such requirement to provide a corresponding service for liaison psychiatry.

The development of a comprehensive network of liaison psychiatry services should be a strategic priority for the NHS to be promoted and driven forward at national level by the National Commissioning Board.

Mental Health Network viewpoint

One year on from the Centre for Mental Health’s review of the RAID service in Birmingham, the Liaison psychiatry in the modern NHS report and this Briefing build on the key points from the earlier economic review by analysing five psychiatric liaison services from across England.

The NHS has been tasked with reducing costs to generate £20 billion savings by 2014/15 through the QIPP agenda, while maintaining high-quality care for people who access NHS-funded services. One of the major themes of the report therefore is that, particularly in the QIPP context, the status of liaison psychiatry has to change. The evidence and case studies in the report show the benefits, both economically and in health outcomes, that psychiatric liaison services offer.
Liaison psychiatry can contribute financially to the required cost savings through physical and mental health services working in an integrated manner to treat co-morbid physical and mental health problems in hospitals.

Although low in number at present, and acknowledging that a considered approach is needed to establish the foundations of a new service, liaison psychiatry is a valuable component of NHS-funded healthcare. It provides targeted services predominantly in acute hospitals and also in community settings that meet the needs of the local population, as well as increasing the capacity of existing services through staff training, education and supervision.

The report says there is still much variation around the country in terms of the level of liaison psychiatry provision and models of service delivery. This is because liaison psychiatry is considered by some as an optional extra in the NHS, whereas the development of a comprehensive network of liaison psychiatry services should in fact be a strategic priority.

For more information on the issues covered in this Briefing, please contact Dawn Fleming at dawn.fleming@nhsconfed.org

References

Further information
The Mental Health Network

The NHS Confederation’s Mental Health Network (MHN) is the voice for mental health and learning disability service providers to the NHS in England. It represents providers from across the statutory, for-profit and voluntary sectors.

The MHN works with Government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of its members and to influence policy on their behalf.

For further details about the work of the MHN, visit [www.nhsconfed.org/mhn](http://www.nhsconfed.org/mhn) or email mentalhealthnetwork@nhsconfed.org

Centre for Mental Health

Centre for Mental Health is an independent national mental health charity. It aims to inspire hope, opportunity and a fair chance in life for people of all ages with or at risk of mental ill health.

The Centre acts as a bridge between the worlds of research, policy and service provision and believes strongly in the importance of high-quality evidence and analysis. It encourages innovation and advocates for change in policy and practice through focused research, development and training.