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The role of liaison psychiatry in integrated physical and mental healthcare

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POSITION STATEMENT

Executive summary

The illnesses from which we all suffer have physical, psychological and social aspects. Some patients have complex illnesses with a combination of physical, psychological and social needs each of which may require help from services and professionals with the appropriate skills.

Liaison psychiatry is one such profession. Clinicians trained in liaison psychiatry provide mental healthcare in physical healthcare settings. They have expertise in the assessment and treatment of mental illness when it occurs in someone with physical illness, particularly in the most complex cases.

People with multiple needs often find it difficult to get effective help. This is because we have separate mental, physical and social care professionals working in separate services. The result is that care may be uncoordinated and inefficient and patients fall into the gaps between services. Integrated care aims to remove these gaps.

Providing good integrated care requires the relevant professionals to work together in unified pathways of care, both in and out of hospital. This document focuses on the integration of mental and physical healthcare, emphasising the essential role of liaison psychiatry in the provision of a comprehensive care pathway.

Integrated physical and mental healthcare should be provided in a way that enables patients to access the right care in the right place and at the right time. In the design and delivery of services, equal value should be given to patients' mental and physical healthcare needs.

Integrated physical and mental healthcare requires integrated commissioning. Meeting the needs of patients with problems of different complexity requires expertise from a range of health professionals and services. Existing liaison psychiatry, clinical and health psychology and psychological therapy services that already work with people with physical illness provide a basis to develop new models of care.

We propose a stepped care approach organised according to the complexity of patients' problems. Liaison psychiatrists are best placed to manage the most complex cases. Their expertise in supervision and training also contributes to the care of patients with less complex needs.

We describe examples of innovative services that demonstrate the value of liaison psychiatry expertise in integrating physical and mental healthcare.

Purpose of this Position Statement

In this document we describe the essential role of liaison psychiatry in meeting the mental health needs of the most complex and high-risk patients within a comprehensive integrated healthcare pathway.

We explain what integrated care is and why it is particularly important for patients with severe, complex and multiple illnesses. Such patients include those with long-term physical health conditions, those with medically unexplained symptoms and cases where physical and mental illness need to be managed together as part of patients' immediate healthcare.

We summarise the current plans for the development of integrated health and social care across the UK and suggest key principles that should inform service development. We describe a stepped care framework for the provision of integrated physical and mental healthcare, whereby different professions focus on patients with problems of different degrees of severity and complexity. Within this framework, the core role of liaison psychiatrists is working with the most complex cases.

Finally, we give several examples of innovative services that illustrate the value and essential role of liaison psychiatry in the delivery of integrated physical and mental healthcare

What is integrated healthcare?

'Integrated' means *unified* **or** *made whole.* Integrated healthcare describes a form of care where all the parts are brought together to work seamlessly for patients.

We particularly need integrated healthcare if we have more than one problem – for example if we have several physical illnesses at the same time or if we need both physical and mental healthcare. In healthcare, integration is especially important to ensure that patients with severe, multiple and long-term illnesses get the help they need. Such patients are likely to have a complex combination of physical, psychological and social problems that require help from professionals with different skills working together.

Just as the health service is made up of different parts that work together, so is a human being. Our minds and bodies work together and affect each other. The way we think and feel affects us physically and vice versa. There is no such thing as a completely 'physical' or 'mental' illness.

Nor do we exist separately from the world around us. Our social situation – such as our home, family, job and stresses we find ourselves under – affects both our mind and body and we, in turn, affect the world around us. Overall, the illnesses from which we suffer have physical (or biological), psychological and social aspects, often referred to as the 'biopsychosocial' nature of illness. Integrated healthcare is a way of describing services that offer good biopsychosocial care.

This document focuses on the integration of mental and physical healthcare, emphasising the essential role of liaison psychiatry in the provision of comprehensive care. Liaison psychiatry specialises in the assessment and treatment of patients with both physical and mental illness, particularly those with the most complex problems.

The challenge: health and social care are complicated

One of the main reasons why people can find it difficult to get the help they need is because services for mental, physical and social care are separate:

- The overall health service is made up of separate parts such as hospitals, general practices and community services.
- Within each of these parts there are smaller components that have specific functions, such as different out-patient clinics for particular illnesses.
- Staff in the health service also have specific roles, such as doctors, nurses, occupational therapists and managers.
- Different staff will usually specialise in a particular area of work. For example, some staff work in cancer care, while others work in services for older people with dementia.

All of these different components are supposed to work together for a common purpose – but it's a complicated system. If the different parts of the health and social care services do not fit together as they should, there's a danger that patients fall through the gaps.

Integration ensures that professionals that specialise in different areas of care work together (Kodner & Spreeuwenberg, 2002). Good integrated health and social care should be tailored to an individual patient and bring together all of the different elements of care that they need (WHO, 1996; The Mental Health Taskforce, 2016). The goal is to enhance the quality of care, quality of life and system efficiency for patients with complex or long-term problems.

Who needs integrated mental and physical healthcare?

Some patients have complex problems that cannot improve without addressing both their physical and mental health needs. There are three main groups of such problems:

- One large group of people who require integrated physical and mental healthcare is those with long-term physical illnesses, so-called 'long-term conditions'. Many people with long-term conditions also have mental health problems that are associated with poor outcomes for their physical illness and greatly reduce their quality of life (King's Fund, 2012).

- Another group requiring integrated healthcare is those whose physical symptoms cannot adequately be explained by physical disease but require consideration of how the mind and body interact to cause the symptoms. Such problems are often called 'medically unexplained symptoms'. They are some of the commonest symptoms in healthcare (Bermingham et al, 2010).

- The third group of problems is experienced by people in a situation where both their physical and mental health problems need to be managed as part of their immediate healthcare. For example, some physical illnesses or their treatments affect the brain in ways that cause mental disorders. Also, some mental illnesses or their treatment can cause physical health problems, such as the physical health consequences of eating disorders or the side effects of antipsychotic medications.

Long-term conditions

Mental illness is much more common in those with physical illness. (NHS Confederation, 2009; Department of Health, 2012) Compared to the general population, people with illnesses such as diabetes, high blood pressure or heart disease are twice as likely to have a mental illness. The rate is even higher in some long-term conditions, such as long-term lung disease and stroke, and in patients with more than one physical illness (Department of Health, 2012).

Depression occurs in about one in five people with a long-term illness and the two conditions interact. The pain and impact of a physical illness on someone's life can cause depression or make it worse. In turn, depression can worsen the pain, distress and disability associated with physical illness. (NICE CG91) Someone with both a long-term condition and depression is less likely to stick to their treatment and follow advice for healthy living. Having both a physical and mental illness delays recovery from both and reduces life expectancy (Naylor & Bell/King's Fund, 2010; HM Government, 2012; NICE, CG 91).

When someone with a long-term condition has a mental illness, the cost of their physical healthcare increases. (King's Fund, 2012) For example, patients with depression and long-term lung disease have longer hospital stays. Also, the cost of treating diabetes is over four times higher for those who are depressed compared with those who are not (King's Fund, 2010).

Medically unexplained symptoms

Many people experience physical symptoms that do not have an identifiable cause in physical disease or are out of proportion to an underlying physical illness. The symptoms are nonetheless real and cause disability and distress (Bolton & Attard, 2015). Such problems are often called 'medically unexplained symptoms'. However, they ***can*** be explained if we think about how the mind and body interact.

Medically unexplained symptoms are common. One in five GP consultations and over one in four out-patient appointments are due to medically unexplained symptoms (Bermingham et al, 2010). Patients with such symptoms often undergo potentially unnecessary, costly and sometimes damaging investigations and treatment (NHS Commissioning Support, 2011).

Medically unexplained symptoms cause a lot of disability and reduce patients' quality of life (Bermingham et al, 2010). There is also a strong association between medically unexplained symptoms and other mental illnesses; over four in ten patients have anxiety or depression (Academy of Medical Royal Colleges, 2009).

In 2008–9, the cost to the NHS of medically unexplained symptoms in England was estimated at £3bn per year (Bermingham et al, 2010). In addition, the associated cost of sickness absence and decreased quality of life amounted to over £14bn.

Urgent healthcare problems

Examples of when both immediate physical and mental healthcare are required include people who become delirious and disturbed during an episode of physical illness or following surgery. Up to one third of patients admitted to an acute hospital will experience delirium (Siddiqi et al, 2006).

Older patients are particularly vulnerable to delirium, especially those who already have dementia. In an acute hospital more than a quarter of all elderly in-patients are likely to have dementia, with up to a third of them having significant emotional or behavioural problems during admission. Patients with severe mental illness, such as schizophrenia, have higher rates of physical illness than the general population. In a general hospital, both their mental and physical health needs have to be managed simultaneously.

One of the commonest problems seen in emergency care is self-harm. In England and Wales there are more than 200,000 hospital attendances a year due to self-harm (Hawton et al, 2007). Following self-harm, patients require care for both the physical effects of what they have done and for any underlying mental health problem.

Implications for mental healthcare

Care for patients with long-term conditions or medically unexplained symptoms should be provided in a way that enables patients to access the right care, in the right place and at the right time (The Royal Colleges of Psychiatrists, General Practitioners and Physicians, and the British Psychological Society, 2015). A key factor in good care is

ensuring that the appropriate mental healthcare is available in physical healthcare settings (NHS England, NHS Improvement, National Collaborating Centre for Mental Health, National Institute for Health and Care Excellence, 2018). Bearing in mind the variable severity and complexity of different patients' mental health needs, effective integrated care requires expertise from a range of mental health professionals and services. In particular, liaison psychiatrists have expertise in managing complex problems in those who are physically ill.

Liaison psychiatry and integrated healthcare

What is liaison psychiatry?

A liaison psychiatrist is a medically qualified doctor with expertise in the assessment and management of:

- mental disorder in those with physical illness
- mental illness and other psychological factors that interfere with recovery from physical illness
- medically unexplained symptoms
- the use of drug treatments for mental illness and psychological therapies in the context of physical illness
- complex cases, including the use of both pharmacological and non-pharmacological treatments.

Liaison psychiatry services, sometimes called psychological medicine services, consist of multidisciplinary teams including: liaison psychiatrists; liaison psychiatry nursing staff; clinical and health psychologists; healthcare support workers; occupational therapists; social workers; and pharmacists. Most services are based in general hospitals but, increasingly, they work with patients both in the community and primary care who have both mental and physical illness.

Liaison psychiatry expertise

The expertise of liaison psychiatry is essential in delivering comprehensive integrated healthcare for patients with long-term conditions and medically unexplained symptoms. Specifically, liaison psychiatry professionals have expertise in the following:

1. Assessment formulation and management of complex cases

Their medical training equips liaison psychiatrists to manage complexity and uncertainty in patient care, particularly where physical and psychological factors interact. Factors that contribute to the complexity of cases are listed in Figure 1.

2. Working across the healthcare system

Liaison psychiatry professionals have a detailed knowledge of local health and social care services, both within hospitals and throughout their local community. This enables them to liaise effectively with different services to ensure that patients get the care they need. They can support integrated healthcare governance, including the application of mental health and capacity law in a general hospital setting.

3. Management of patients where combined medical and psychiatric expertise is required

Liaison psychiatrists' medical training equips them to assess the relative contribution of physical and psychological factors in a patient's presentation and management, including:

- Potential interactions and side-effects when prescribing medication for mental illnesses, such as antidepressants, for a patient with physical illness – especially those already prescribed several other drugs
- Interpreting medical investigations
- Discussing patients' concerns about physical symptoms and diagnoses
- Managing persistent pain, including withdrawal of potentially addictive pain-killing medication.

4. Teaching and supervising colleagues

Education and training are integral to the role of the liaison psychiatry professional. Training may be ad hoc, delivered to colleagues, such as hospital staff, in the course of day-to-day clinical work. It may also be formal, delivered as teaching sessions or through the supervision of colleagues. It can take the form of:

- Training colleagues in the management of patients with medically unexplained symptoms and long-term conditions
- Contributing to the development of multidisciplinary care plans for such patients
- Supervising colleagues who are undertaking psychological therapy with patients, including those mental health professionals who are unfamiliar with work involving physical illness.

Liaison psychiatry's contribution to integrated mental and physical healthcare

Liaison psychiatry services already work in a collaborative way within health services and settings. However, the provision of comprehensive integrated mental and physical healthcare for patients with long-term conditions and medically unexplained symptoms requires a greater degree of integration between mental health professionals, between physical and mental healthcare, and between hospital and social and community care. Within such a system, the skills and expertise of liaison psychiatrists mean that they are uniquely able to manage patients with severe and complex long-term conditions and medically unexplained symptoms. In addition, they contribute to the care of other patients through the training and supervision of other staff and by developing education and self-help materials.

Examples of complex clinical situations that benefit from liaison psychiatry expertise are given in Box 1 on the following page.

Box 1: Examples of complex clinical situations that benefit from liaison psychiatry expertise

Diagnostic complexity – physical health

- Multiple, persistent and severe medically unexplained symptoms that don't fit standard diagnostic categories or which encompass multiple categories
- Use of multiple drug treatments, including opioid or equivalent analgesia
- Multiple physical diagnoses, including where long-term conditions and medically unexplained symptoms coexist
- Uncertainty about the relative contributions of physical and psychological factors to a patient's symptoms
- Understanding physical health problems and treatments and how these might affect a patient's psychological state
  Disability out of proportion to the severity of physical illness
- Significant poor adherence to, or misuse of, therapeutic regimes
- Factitious disorders which are characterised by intentionally feigning symptoms or injury in oneself or another person, motivated by internal incentives.

Diagnostic complexity – mental health

- Hypochondriasis which is characterised by persistent preoccupation with, or fear about, the possibility of having one or more serious, progressive or life-threatening illnesses
- Complex and enduring mental health problems in addition to physical illness or medically unexplained symptoms
- Suicidal thinking and self-harm in patients with medically unexplained symptoms and long-term conditions.

Organisational complexity – healthcare

- Frequent unscheduled attendances, e.g. in primary care or at emergency departments
- Recurrent unscheduled acute hospital admissions
- Recurrent unnecessary physical investigations, especially in the context of medically unexplained symptoms
- An individual patient receiving healthcare from multiple providers
- Failure to respond to first-line treatment or where treatment is discontinued due to adverse effects
- Decisions about management of risk and the use of compulsory powers, including mental health and mental capacity legislation.

Organisational complexity – social care

- Receipt of benefits dependent upon ongoing disability or illness
- Various forms of assisted living for disabilities associated with medically unexplained symptoms.

Social complexity

- Wider social dysfunction – e.g. tension or conflict with others or an impoverished illness-centred social network having an impact on health or healthcare that acts as a barrier to effective brief psychological therapies
- Children or others as enmeshed carers
- Involvement in long-running and contested litigation or complaints related to health or healthcare.

Developing integrated mental and physical healthcare services

A foundation for service development

In England, the Five Year Forward View for Mental Health described how health services will need to dissolve their traditional boundaries to deliver care for patients with long-term conditions (NHS England, 2015). Similarly, the Joint Commissioning Panel for Mental Health, in its guidance for commissioners of services for people with medically unexplained symptoms, emphasised that a "new kind of multidisciplinary approach is required bringing together professionals with skills in general practice, medicine, nursing, psychology/psychotherapy, psychiatry, occupational therapy and physiotherapy" (Joint Commissioning Panel for Mental Health, 2017).

Integrated care is a key component of NHS England's Long-Term Plan, whereby patients get "properly joined up care at the right time in the optimal care setting" (NHS England, 2016). The Plan describes a 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. The NHS and partners, including local authorities, will create Integrated Care Systems, bringing together local organisations in a pragmatic and practical way to deliver this triple integration.

In Wales, work is underway to deliver the commitments set out in *A Healthier Wales: Our Plan for Health and Social Care* (Welsh Government, 2018). This sets out a long-term vision of a 'whole system' approach, such that a patient's health and social care are seamless.

Similarly, the Scottish Government is seeking to ensure that health and social care services are integrated around the needs of individual patients. To help achieve this, NHS Boards and local authorities are being brought together as single integrated authorities (Scottish Government, 2014).

Since 2008, English psychological therapy services have been developed under the Improving Access to Psychological Therapies (IAPT) programme. In line with the Five Year Forward View for Mental Health, NHS England and local commissioners have supported the expansion of IAPT services for patients with long-term conditions and medically unexplained symptoms (NHS England, 2016). However, it is emphasised in national guidance for commissioners that IAPT services are not able to meet the needs of patients with more severe and complex problems (NHS England, NHS Improvement, National Collaborating Centre for Mental Health, National Institute for Health and Care Excellence, 2018). IAPT services for patients with long-term conditions and medically unexplained symptoms should be developed alongside liaison psychiatry, and clinical and health psychology services, with clear arrangements for joint working.

Clinical and health psychologists have expertise in understanding patients' psychological states and delivering psychological therapies to those with physical illnesses. Psychologists may work within liaison psychiatry or IAPT services or they may be employed by individual hospital departments to support patients with specific illnesses.

Overall, providing integrated mental and physical healthcare requires integration of mental and physical healthcare services and staff into single care pathways for patients with similar problems.

Potential challenges

In 2018, a survey of liaison psychiatry staff found that liaison psychiatry and IAPT services are rarely integrated with each other. The current situation nationally, where such services are not integrated, is inefficient and leads to gaps and uncoordinated provision of care.

Some of the potential pitfalls in developing integrated physical and mental healthcare include:

- Different services are often commissioned by different people and have different funding systems. In particular there is often a separation between commissioning for physical and mental health services. Integrated physical and mental healthcare requires integrated commissioning.

- Different services often have different information and patient record systems, making communication and sharing of information about patients difficult. Integrated care requires integrated governance and information technology systems.

- A recent focus on the provision of IAPT services may lead to the misunderstanding that this is all that is required to provide integrated mental and physical healthcare. IAPT services provide time-limited psychological therapies for a large number of patients of relatively low complexity and non-response and relapse rates are high (NHS Digital, 2018). Alternative expertise and treatments are required for patients with severe and complex problems who require more than this or who are not able to engage with treatment provided by psychological therapy services.

Principles of service development

The patient is the centre of care

- Throughout the planning and provision of services, the patient perspective should be the organising principle of service delivery (Shaw S, Rosen R, Rumbold B, 2011). It may be helpful to consider what health and social care services would be like for patients if they were truly integrated. How different would it be to receive support from, or to work in, such a service?

- Consistent with recognising that we are not separate minds and bodies, there should be consideration of meeting the needs of the whole person, which will require the participation and expertise of physical, mental and social care services.

- New care models should be developed in partnership with patients and their carers to ensure that they address and measure outcomes that are important to them. For example, a major determinant of a patient's health-related quality of life is their mental health.

- Mental and physical health should be valued equally. This principle is often referred to as 'parity of esteem' between mental and physical illness (Naylor, Taggart & Charles, 2017).

Planning and commissioning

- There are many potential models and levels of integration that may be suitable for different groups of patients and in different settings. In the development phase, the level of integration will depend on:

  - the available infrastructure, such as the location of staff and services
  - the resources and capacity of the service
  - the roles and competence of staff
  - the funding and governance of the service, such as the level of information sharing and joint working.

  An initial care pathway that encourages joint working between existing services may be a first step towards establishing a fully integrated service.

- Mental healthcare should be considered from the initial design stage of a new model of care for patients with physical illness; it is harder to integrate mental healthcare if it is added at a later stage.

- An existing liaison psychiatry service can provide a basis for the establishment of an integrated care pathway for patients with long-term conditions and medically unexplained symptoms.

- New models of care should include not just healthcare services but all organisations that may impact on people's health and well-being, including social care, other statutory agencies (e.g. police and ambulance services) and voluntary sector organisations.

- There should be a single commissioning model whereby the mental and physical healthcare for a defined population is commissioned as part of the integrated healthcare pathway.

Establishing the care pathway

- A pathway of care should be developed around a defined population of people with similar illnesses or problems.

- Care should be informed by the best evidence and delivered according to agreed protocols.

- There should be common referral protocols that ensure clarity about how patients can access services, avoiding unnecessary waits or repeated assessments. Clearly defined processes should be in place to enable a person to progress within or between services and professionals collaborating in the provision of care.

- Care should be timely. No one should be disadvantaged when they move between services or pathways. In such instances, providers and commissioners should use their judgement to guide an appropriate response time.

- There should be a collaborative approach to care planning. This should include providing the person with a named contact responsible for the coordination of their care and developing an agreed care plan that is shared with all agencies involved in the person's care.

- Patients, and their families and carers, should be provided with clear information about their illness, care plan and the services involved in their care.

Governance

- There should be common management structures to ensure that care is coordinated and that there are effective working relationships amongst health professionals and services.

- Organisations within the care pathway should have shared governance structures, including protocols for the delivery of care, audit and measurement of outcomes.

- There should be investment in building relationships and networks between mental and physical healthcare professionals.

- Joint training and staff development programmes are required to promote integration across all areas of the pathway.

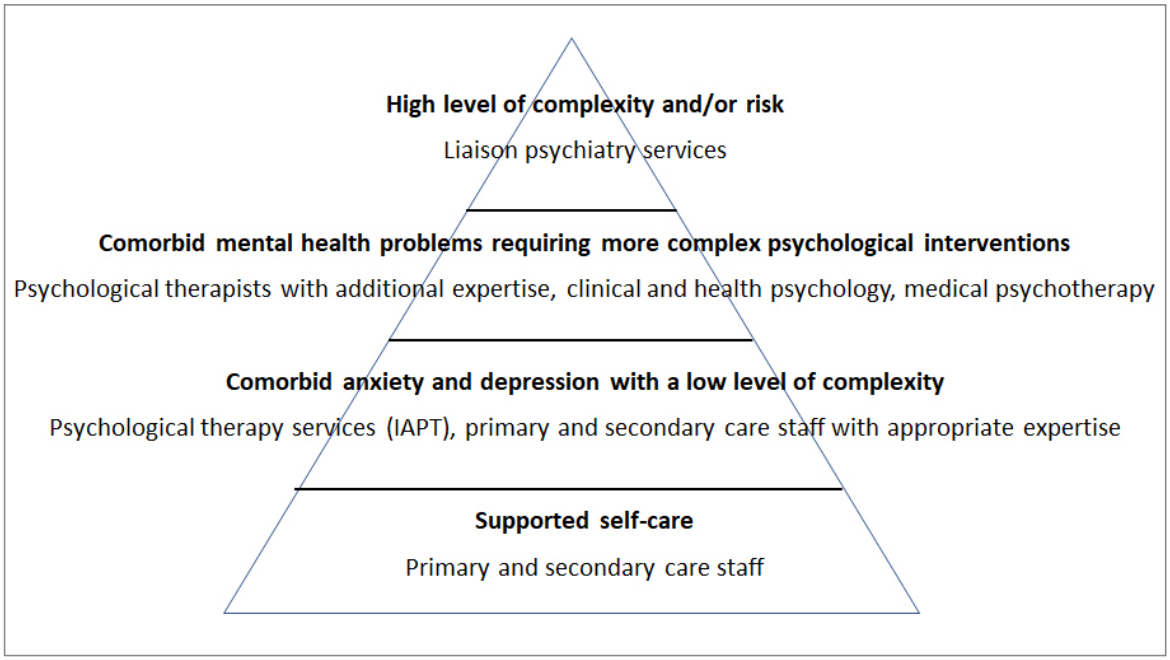
- Both mental and physical health factors should be considered in the investigation of, and learning from, serious incidents. This encourages an integrative approach to patients from the outset of their care, such that meeting mental and physical health needs are perceived as routine in clinical practice.

A framework for integrated mental and physical healthcare

One way to think about how mental health services might work together within a wider integrated healthcare service is to consider a stepped care framework, whereby different services focus on patients with problems at different levels of severity and complexity. Figure 1 describes a pyramid with the majority of patients whose care needs are most straightforward being in the lower levels and those with the most complex care needs at the apex. The framework suggests which mental health services have the necessary expertise to manage cases of increasing complexity.

Within an integrated service, the expertise of different healthcare professionals can be shared in the multidisciplinary discussion of cases, facilitating the movement of patients up and down the different levels as their needs change. Within this stepped care framework, the core role of liaison psychiatry is working with the most complex cases. However, the expertise of liaison psychiatry staff in supervision and training can also contribute to the care of patients in the levels below.

Figure 1: A stepped care framework for delivering comprehensive mental healthcare within an integrated healthcare system



Specialist in-patient services

For the most severe and complex cases of medically unexplained physical symptoms, it may prove impossible to provide effective treatment in out-patient or community-based services. In such cases, biopsychosocial treatment within a specialist in-patient programme may be required.

Cases of this level of severity will usually have been investigated by several general hospital services without identifying a primary physical cause for their symptoms and multiple local services will have been unable to arrest their deterioration or to deliver effective treatment. Such patients suffer from severe and generally longstanding symptoms, causing significant disability and often high levels of dependency. The point may have been reached at which every moment of the patient's daily life, and the lives of their family or carers, is impacted on by their illness.

In the UK, there is currently very limited service provision for patients with the most severe and complex medically unexplained symptoms. A small number of specialist in-patient neuropsychiatry services provide in-patient treatment for some severe cases if the medically unexplained symptoms are of a 'neurological' type. But there is currently only one unit delivering integrated mental and physical in-patient treatment for patients with severe and complex medically unexplained physical symptoms in any bodily system. The National Inpatient Centre for Psychological Medicine (NICPM) is described in examples of integrated mental and physical healthcare services below.

Estimating the national level of need for in-patient service provision is challenging. However, clinicians in primary and secondary healthcare do recognise and refer patients who require and can benefit from specialist in-patient treatment and this, alongside a decade of experience within the NICPM service, indicates a significant level of unmet need in the UK population.

Examples of liaison psychiatry as a component of integrated healthcare

There are a number of examples of integrated mental and physical healthcare where liaison psychiatry expertise has been incorporated into care pathways to treat patients with severe and complex long-term conditions (The Kings Fund, 2016). In 2018, we requested examples of such services and received over 30 innovative examples from liaison psychiatry services across the UK. The following demonstrate different degrees and models of integration, work with different problems and patient groups, and provide evidence of both clinical and cost benefits. Overall the services describe the value that liaison psychiatry expertise brings to integrated physical and mental healthcare in the assessment and treatment of the most complex problems.

Fully integrated physical and mental healthcare: Oxford Integrated Psychological Medicine

Oxford Integrated Psychological Medicine (OIPM) is a radically new model for providing medical care. Psychiatrists and psychologists are not part of an in-reach or liaison psychiatry service from another organisation but are employed and managed within Oxford University Hospitals Foundation Trust.

OIPM was started in 2013. It currently has 16 psychiatrists and 40 psychologists who work as fully integrated members of specific medical teams. They participate in team multi-disciplinary discussions, advise on patient care and consult on individual patients. In this way, the physical and mental aspects of a patient's care are unified within a single team, a single medical record and a single management plan, thereby delivering fully integrated patient-centred care.

- For patients, it enables the medical team to give them better patient-centred care. It provides parity in the delivery of care for each patient's mental and physical needs and removes the potential stigma of referral to a separate mental health service.

- For services, it improves the efficiency of care – reducing length of stay and providing better discharge planning. It helps services to manage the risk to patients and staff from challenging behaviour. It also provides education and support for staff and reduces the stress associated with caring for behaviourally disturbed patients.

- For the Trust, it gives it the capability to provide integrated mental healthcare to the high proportion of patients with coexisting medical and physical illnesses, making it a capable provider of complex care.

The OIPM model has been endorsed by NHS England in 2015 as achieving a culture change in the acute hospital and by the Royal College of Psychiatrists who awarded it 'Team of the Year 2018'.

Integrating liaison psychiatry into primary care: The Primary Care Psychological Medicine, Rushcliffe, Nottinghamshire

The Primary Care Psychological Medicine (PCPM) service integrates a secondary care liaison psychiatry service into primary care to support the management of patients with medically unexplained symptoms and those with mental health needs who are frequent users of primary care services.

The service was originally established as part of NHS England's multispecialty community provider vanguard programme (NHS England, 2016). Liaison psychiatry staff and expertise are provided by the Department of Psychological Medicine, based within Nottinghamshire Healthcare NHS Foundation Trust but working within local general practices. In addition to directly assessing and managing patients, liaison psychiatry staff support and train GP colleagues.

Measures of the clinical effectiveness of the service have shown statistically significant improvement after six months for nearly all patients who have received care. Feedback from patients and GPs has also been positive.

The service has also led to significant cost savings in secondary care, e.g. fewer presentations by patients at emergency departments and fewer hospital admissions and out-patient appointments.

A GP comments on the service:

> "A wonderful service is being provided to the practice and to the patients. PCPM have offered a very prompt response time and the feedback from patients has been fantastic".

Integrated mental healthcare for patients with long-term respiratory illness: The Sunderland Liaison Psychiatry Service Integrated Chronic Obstructive Pulmonary Disease Pathway

The Sunderland Royal Hospital Liaison Psychiatry Service works with colleagues in the general hospital and community, including in-patient staff and specialist nurses, to deliver integrated care for patients with chronic obstructive pulmonary disease (COPD).

Patients undergo an assessment of their mental health needs and, where appropriate, receive medication for a coexisting mental illness and psychological therapy delivered by liaison psychiatry nursing staff and support workers. Assessment and care take place either within hospital or at patients' homes.

Evaluation of the services has demonstrated clinically significant improvement in patients' mental health and reduced use of healthcare services. Patients have fewer emergency department attendances and in-patient admissions. When patients are admitted, their hospital stays are shorter.

Feedback from a patient: "You have changed my life".

Liaison psychiatry as an integrated component of rehabilitation: The London Spinal Cord Injury Centre

Spinal cord injury is a devastating and life-changing event with the potential to cause significant mental health problems, including depression, post-traumatic stress disorder and substance misuse, which complicate patients' recovery and rehabilitation. In addition, people with a pre-existing mental illness are at greater risk of sustaining a spinal cord injury due to accidents or self-harm, such as jumping from a height. The London Spinal Cord Injury Centre (LSCIC) is based within the Royal National Orthopaedic Hospital. Liaison psychiatry is embedded within the LSCIC rehabilitation programme for patients.

Liaison psychiatry staff are key members of the multidisciplinary team. Every patient is offered a 'psychosocial clinician' – either a psychiatrist or psychologist – to support them during their rehabilitation. The liaison psychiatry staff assess and manage patients' mental health problems and use both medication and psychological therapy. The staff also work with patients' families and support other members of the multidisciplinary team to meet patients' emotional needs.

The liaison psychiatry component of the service is valued by both patients and other staff. It has been demonstrated that the integrated liaison psychiatry care provided enables patients with pre-existing mental health problems to benefit as much from rehabilitation as those without (Warner, Ikkos & Gall, 2017).

Following recognition of the benefits of liaison psychiatry, the remit of the service has been extended within the hospital to support patients with persistent pain and complications of complex injury or disease.

Examples of patient feedback:

> "The psychological care I have received has been life changing and wonderful."

> "Very useful service and really good that family members can access this service too."

> "They made me feel positive and good about myself."

Using information technology to enhance integrated physical and mental healthcare: IMPARTS, King's Health Partners

IMPARTS is a project, run by King's Health Partners' Mind & Body Programme, that provides a package of screening, pathway support and training to clinicians working in physical health clinics, supporting better integrated mental and physical care for out-patients at Guy's and St Thomas's NHS Foundation Trust and King's College Hospital NHS Foundation Trust.

Working within dozens of physical health clinics, IMPARTS uses an informatics platform to facilitate the collection of patient-reported outcomes as part of routine clinical care. These outcome measures are both general, such as screening for symptoms of anxiety and depression, and ones that are tailored to particular patient groups. Information is

collected about how well a patient is coping emotionally and also how they are managing their physical condition. The information is instantly uploaded into the patient's electronic health records so that their clinician can review it and discuss it with their patient at their appointment.

This information is supplemented with guidance about how the patient can be referred on, if necessary, for specific mental healthcare. The different options and mental healthcare pathways are based on the existing resources, including primary care, clinical psychology and liaison psychiatry.

IMPARTS also includes a suite of self-help materials and resources on a range of issues related to physical and psychological health and functioning. Staff who use IMPARTS are offered training to ensure that they feel confident and competent to address their patients' mental health needs.

So far, the IMPARTS informatics platform has been used to screen over 37,000 patients in a total of over 50,000 contacts across 56 clinics. IMPARTS data has been used to demonstrate the mental health needs of patients with physical illness. This has supported the expansion of liaison psychiatry and clinical psychology within the hospitals, as well as the publication of research.

An example of the benefit of the IMPARTS programme:

A lady fell down a flight of stairs, fracturing several bones. Over the next three years, she received treatment at her local hospital for her injuries but not her mental health. However, when she attended a limb reconstruction clinic at King's College Hospital, she completed the IMPARTS screening tool. This identified her significant mental health needs and recommended that she receive psychological therapy.

She later said that:

> "I became [myself] again, with a life-changing injury and a team who cared for the whole person. The IMPARTS assessment showed the impact of the accident on my life and gave me and the team the opportunity to benefit from psychiatric review and from cognitive behavioural therapy as part of my recovery."

Integrating liaison psychiatry into cancer care: The Macmillan Cancer Psychological Support Team, St George's University Hospitals NHS Foundation Trust

The Macmillan Cancer Psychological Support (CaPS) Team is integrated into the cancer services of St George's Hospital and offers mental healthcare for any adult patients affected by cancer and their families and carers.

The CaPS Team includes liaison psychiatrists and clinical psychologists who use a range of interventions, including medication and psychological therapy. The service has a single point of access for both in-patients and out-patients and works closely with colleagues in the general hospital and wider community.

The CaPS team also delivers innovative training to nurses and doctors within the acute trust, including an inter-professional simulation training programme which addresses work at the interface of cancer, mental health and end of life care.

Outcome measures for the service have shown high levels of patient satisfaction, with a statistically significant reduction in the severity of patients' symptoms and improvement in their day-to-day functioning. In 2017, the CaPS Team were nominated for a Macmillan Excellence Award on the basis of their innovative care and training.

Case example

A 78-year-old lady referred to the CaPS Team had become depressed, paranoid and suicidal after being diagnosed with lung cancer. She was assessed urgently by a liaison psychiatrist who established that her mental illness was a relapse of a previous severe depressive illness and not caused by the cancer or its treatment. The CaPS Team worked closely with community mental health services to ensure that the patient could be safely treated at home. The CaPS liaison psychiatrist was able to suggest appropriate drug treatment for her mental illness that would be safe in the context of treatment for her cancer. The CaPS Team also provided psychological support for both the patient and her family and she made a good recovery.

Another patient treated by the CaPS Team commented, "I would be costing the system so much more money if I hadn't had the help. I wouldn't have a job, my daughter probably wouldn't be living with me and I would probably have got ill again. I would likely have ended up in hospital because I would have attempted suicide".

Integrating liaison psychiatry into pain management: The Cornwall Opioid Reduction Quality Improvement Project

This project was initiated after it was recognised that high doses of opioid analgesia were being prescribed for hospital in-patients with persistent and often unexplained abdominal pain. Furthermore, it was known that Cornish clinicians were high prescribers of opioids in the wider community.

The project was a collaboration between liaison psychiatry, gastroenterology, the pain team and primary care. A multidisciplinary team met fortnightly to develop strategies to reduce opioid prescribing. These strategies included an opioid prescribing programme for the hospital, which included the need for consultant review of any patient's prescribed high-dose medication for more than two days. Information about opioid treatment was developed for patients and an education programme was launched for clinicians in both primary and secondary care.

Since the project was established, there has been a dramatic reduction in opioid prescribing on the gastroenterology wards – over 40% for general prescribing and 70% for intravenous opioids. In addition, there has been a gradual reduction in opioid prescribing in Cornwall at a time when the rate has remained static across England.

Case example

A lady in her 20s had frequent in-patient admissions with unexplained abdominal pain. Her admissions often lasted for several weeks and she was often readmitted after only a few days at home. Liaison psychiatry and the wider multidisciplinary team engaged with the patient and her family, provided information about opioids and developed a strategy for reducing and stopping the patient's medication over three months. One year later she had remained off opioid medication, had had no further hospital admissions and had resumed her work and social life.

Integrated physical and mental healthcare for young people: The Persistent, Problematic, unexplained Physical symptoms (P3) multidisciplinary service, Exeter, Devon

The Persistent, Problematic, unexplained Physical symptoms (P3) service was established to work with children and young people whose symptoms were affecting their school attendance and everyday life. The multidisciplinary team includes staff from liaison psychiatry, child and adolescent psychiatry, paediatrics, psychology and education services.

Joint assessment by paediatric and liaison psychiatry colleagues helps to facilitate a change in thinking in young people, and their families and carers, about how the mind and body interact to cause symptoms. Assessment allows those patients with an underlying mental illness to be identified and to receive appropriate treatment. Others benefit from psychological therapy to help them understand and manage their symptoms.

Following intervention by the service, many young people who were previously receiving alternative educational provision have been able to return to mainstream schooling. Additional cost savings have come from a reduction in the need for physical investigations and fewer onward referrals to specialist pain and chronic fatigue services. In addition, the recognition of, and clinical approach to, concerns about possible fabricated or induced illnesses have been more robust.

Case example

A 15-year-old boy was referred to the P3 service with persistent unexplained abdominal pain and daily vomiting. Investigations had not identified any underlying physical cause for his symptoms. By the time of the referral he was receiving home tuition and spending much of his time in bed.

The multidisciplinary team identified that the boy had significant underlying anxiety. The link between his anxiety and his physical symptoms was explained to him, his family and his school, and he received specific treatment for his anxiety. Following this he was able to return to school and complete his GCSEs.

Feedback from the parent of a young person treated by the P3 service:

> "The change came when we met [the mental health professional] and were able to explore the hidden depths of [our child's] mind to work out why this was happening. We are extremely grateful."

An integrated in-patient service for severe and complex medically unexplained physical symptoms: the National Inpatient Centre for Psychological Medicine

The National Inpatient Centre for Psychological Medicine (NICPM) is provided by the Leeds and York Partnership NHS Foundation Trust and is based within Leeds General Infirmary which is part of the Leeds Teaching Hospitals NHS Trust. The NICPM delivers specialist, multidisciplinary, biopsychosocial in-patient care and treatment for people with the most severe and complex medically unexplained physical symptoms.

The NICPM takes referrals from commissioners across the UK. Currently this is funded on a cost-per-case basis. Patients are admitted regardless of the bodily systems involved and usually have severe levels of disability.

In the most severe cases patients may be:

- bedbound and highly dependent upon others for feeding, toileting and/or personal hygiene
- tube fed and/or catheterised
- taking numerous medications (many without a clear biological rationale) and be dependent upon opiate and other analgesic medications
- living in such a manner that every moment of their daily life is influenced by their illness.

Among the professionals in the multidisciplinary team are liaison psychiatrists, nursing staff, occupational therapists, physiotherapists, psychological therapists, pharmacists and dieticians. The service also draws upon expertise from the medical and surgical teams within the general hospital.

A recovery-focused programme of care and treatment is delivered by an expert team in an appropriate general hospital in-patient setting, allowing progress to be made which had not been possible before. Care and treatment are necessarily individualised but, generally, patients receive comprehensive biopsychosocial assessment, physical and occupational rehabilitation, psychotherapeutic interventions and biological treatments for both physical and psychological comorbidities.

Clinical outcomes, even in a range of very chronic and complex cases, are often very good and patient feedback is overwhelmingly positive (in 2018/19, 100% of patients and carers rated the service as either ‘excellent’ or ‘good’).

The College position

Integrated healthcare should meet patients' physical and mental health needs and should be provided in a way that enables patients to access the right care, in the right place and at the right time. As patients have a variable severity and complexity of mental health needs, effective integrated care requires expertise from a range of mental health professionals and services.

The College believes that liaison psychiatry is essential in the provision of comprehensive integrated mental and physical healthcare. This is because of its unique expertise in the assessment and management of patients with the most complex and high-risk problems.

Recommendations for action

- Throughout the planning and provision of services, the patient perspective should be the organising principle of service delivery. Integrated physical and mental healthcare should be provided in a way that enables patients to access the right care in the right place and at the right time.

- Mental healthcare should be considered from the initial design stage of a new model of integrated care for patients with physical illness, with equal value being given to the mental and physical components of care.

- Integrated physical and mental healthcare requires integrated commissioning. There should be a single commissioning process whereby the mental and physical healthcare for a defined population is commissioned as part of the integrated healthcare pathway.

- Effective integrated healthcare must be able to meet the needs of patients with problems of different complexity. A stepped care approach, including liaison psychiatry, clinical and health psychology and psychological therapy services, provides a basis to develop a new model of care.

- Comprehensive and effective integrated mental and physical healthcare must include liaison psychiatry expertise in the management of patients with the most severe and complex problems.

- Specialist multidisciplinary in-patient services should be commissioned on a national basis to treat patients with the most severe, complex and disabling medically unexplained physical symptoms.

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Compilation of this Position Statement

This Position Statement was compiled following discussion by the Executive Committee of the College's Faculty of Liaison Psychiatry by a working group of the Faculty of Liaison Psychiatry.

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