Faculty of Liaison Psychiatry Newsletter

Summer Edition 2019

Liaison Psychiatry Faculty Newsletter

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In this issue

Featured

Editorial

Welcome to the Summer Edition of the Newsletter 2019!

It is encouraging to see the diversity in the submissions for this newsletter. Many thanks to all who contributed articles for this edition.

Dr Jim Bolton our Faculty Chair provides a summary of changes to the faculty positions and outlines the exciting opportunities for liaison psychiatry in the NHS Long term Plan.

Dr Annabel Price updates on future changes to the Mental Health and mental capacity legislation and suggests interested readers sign up to the 39 Essex Chambers newsletter which provides regular updates on these topics.

Clea Martin Vargas has kindly shared links to her video which will help people having Dissociative Seizures to understand this condition and how to improve their quality of life.

Prof Tayyeb Tahir shares his research findings, arguing for better monitoring of sub-clinical depressive symptoms in high risk groups. In a separate piece, two of his students from Canada reflect on their experience of an integrated liaison psychiatry service.

Prof Khalida Ismail and Dr Luke Solomon give updates on recent developments in diabetes and psychiatry.

The positive impact of Liaison Psychiatry services is increasingly accepted by the wider community of clinicians. However, further developments in the field are a matter of some discussion. Dr Peter Aitken and Professors Else Guthrie, Allan House and Michael Sharpe debate potential priorities for Liaison Psychiatry.

The Faculty conference held in Liverpool in May 2018 was a huge success and we take this opportunity to say a massive thank you to all the speakers at the event. Their contributions were enormously appreciated.

Our next faculty conference is quite soon, and we hope to see you all on 15-17 May 2019 at the Royal College of Psychiatrists, 21 Prescot Street, London.

The newsletter is not a scientific publication and does not use a peer review process. It is a way to keep in touch and provides a good platform to share good practice and other innovative ideas.

We are always looking for submissions that are relevant to liaison psychiatry including reports on service development, education, training, audits, conferences and events. Articles should be no more than 1-2 pages long. Please include your name, title, place of work and contact details.

We would like to thank Stephanie Whitehead for all her support for our faculty work and newsletter.

We hope you enjoy this summer edition of the newsletter. We hope to see you at the Faculty conference!

Editorial Team
Liaison Faculty Newsletter

Dr Nora Turjanksi

Dr Sridevi Sira Mahalingpappa

Chairs report

London here we come!

Dr Jim Bolton

Liaison Psychiatry Faculty Chair, Consultant Liaison Psychiatrist, St Helier Hospital, Carshalton

By the time you read this we will be approaching the date of our annual Faculty Conference – you may even be reading this at the meeting in London. I see from the programme that Sri and Nora, our conference organisers, have once again arranged a fascinating and varied programme with something for everyone.

After several years convening our annual meetings, Nora and Sri will be standing down from this role. I want to give them my personal thanks for all their hard work and dedication in arranging a series of fantastic conferences across the UK. I am pleased to say that they will continue to be our Newsletter editors.

Next year, Alex Thompson, Abhi Shetty, Tanya Bugelli and Em McAllister will be arranging our 2020 conference at the St David's Hotel in Cardiff. The dates for the diary are 13-15 May 2020.

One piece of good news that we will hear more about in London is the plan for further growth in Liaison Psychiatry in England. Since our last Newsletter, colleagues in England will know that the NHS has published its Long Term Plan, which sets out the ambition for further growth in Core 24 liaison psychiatry services. The value of liaison psychiatry is recognised in the long term plan and we anticipate that the latest Liaison Psychiatry Survey for England will show growth in Core 24 services following the release of transformation funding from NHS England.

Another piece of good news from the Long Term Plan is the strong support for the expansion of emergency mental health services, including liaison psychiatry for children and young people. Our Position Statement on the Provision of Liaison Psychiatry Across the Lifespan is now published on the College website.

The Long Term Plan also sets out plans for developing integrated care in the NHS. I know this will be another topic for discussion at our conference. A working group of the Faculty Executive is currently compiling a College Position Statement on the Role of Liaison Psychiatry in Integrated Care.

Of course, the recommendations in both the above documents will apply across the UK. I look forward to seeing as many of you as possible from England, Scotland, Wales and Northern Ireland, and also further afield, at the Conference in May.

Policy update

Mental Health Act, Mental Capacity Act and liberty protection safeguards

Dr Annabel Price

Liaison Psychiatry Faculty Vice Chair, Consultant in Liaison Psychiatry for Older Adults, Addenbrooke's Hospital, Mental Health Specialty Co-Lead NIHR CRN:Eastern | Associate Specialist Director for Palliative Care, Cambridge Institute of Public Health

This is an exciting time for development and application of mental health and capacity legislation around the UK, with the ongoing review of the Adults with Incapacity (Scotland) Act 2000, an update of the (England and Wales) Mental Capacity Act 2005 code of practice in the pipeline, passage through Parliament of the (England and Wales) Mental Capacity Amendment Bill and parallel code of practice development; review of the (England) Mental Health Act 1983 and the recent announcement in March 2019 of a review of the Mental Health (Care and Treatment) (Scotland) Act 1983.

In October 2017, the Department of Health and Social Care and the Ministry of Justice jointly commissioned a review of the Mental Health Act 1983 (MHA), seeking to address concerns about how the Act currently operates. The government called for 'an Act in step with a modern mental health system, giving special attention to rising rates of detention and the disproportionate number of people from black and minority ethnic backgrounds being detained under the Act'. The Review, led by Professor Sir Simon Wessely, reported in December 2018: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

The review made 154 wide ranging recommendations under four overarching key principles (choice and autonomy, least restriction, therapeutic benefit and the person as an individual). Several of these recommendations addressed the resources that would be required to provide care to a sufficient standard.

The MHA review group comprised several topic groups addressing areas such as detention criteria, tribunals and aftercare. I was privileged to be involved in the detention criteria topic group which met for four sessions over the summer of 2018. The group was chaired by Colin McKay, the chief executive of the Scottish Welfare Commission (who undaunted by his experience will now lead the Scottish review). The constituency was diverse and (as with all areas of the review) had service user representation. In the case of the detention criteria group the service user rep reflected on her experience in a BMJ blog.

Whilst I was not officially representing the Faculty or College

on the topic group, I was able to feedback on areas where key decisions were being debated in order to gather and share the views of the College and liaison faculty exec. I would like to thank once more those (in particular our Faculty service user rep) who took time to consider the questions I asked (often with very short notice) and provided me with such detailed and thoughtful responses.

On publication of the report the Government committed to the introduction of a new Mental Health Bill and accepted two of the recommendations at once:

- Those detained under the Act will be allowed to nominate a person of their choice to be involved in decisions about their care.

- People will be able to express their preferences for care and treatment and have these listed in statutory 'advance choice' documents.

Now in 2019, an advisory group is being put together 'in order to bring together a range of stakeholders with an interest in the Mental Health Act and its application'. The group will meet regularly over the next several months and again I am fortunate to contribute and will continue to work alongside my colleagues in the exec and wider College.

At the upcoming Liaison Faculty meeting Professor Sir Simon Wessely will be presenting a session on the Mental Health Act so we will be able to hear first hand his perspective on leading such a huge piece of work. I'll be chairing so please come bursting with questions!

If you would like to contact me about the MHA review or the development of the MCA Liberty Protection Safeguards (LPS) code of practice development I'd be very happy to hear from you via Stephanie Whitehead, Liaison Faculty Committee Manager stephanie.whitehead@rcpsych.ac.uk

If you don't yet subscribe I can thoroughly recommend signing up to the 39 Essex Chambers newsletter for an easily digestible summary of events as they unfold and recent cases relevant to our practice

If that was bearable (and hopefully at least vaguely useful) then I'll come back in a future newsletter with updates!

'dis-sociated'

A documentary about Dissociative Seizures

Clea Martin Vargas

Documentary Film Maker

Over the last two decades there has been an impressive rise in research interest in Dissociative Seizures, and our understanding of this common condition has increased considerably. Nevertheless, patients often end up in limbo. Neurologists tell them that their problem is not "neurological",

but psychiatrists may feel uncertain how to help them - and patients may not want to see them anyway, because they can't believe their problem could be "psychological".

'dis-sociated' is the first full-length (51 minute) documentary about Dissociative Seizures and is now available - free to view or show - on YouTube:

https://www.youtube.com/channel/UC0h5tSMk6wq2ZiEi8FM-7xg

The film was produced as a declaration of friendship. Clea Martin Vargas, who made this film, was inspired to dedicate herself to this project when her friend developed Dissociative Seizures, which doctors took years to diagnose. After her friend finally received a diagnosis, Clea was dismayed at the lack of information on the condition. It was virtually unheard of beyond a very small circle of specialists. Clea took it upon herself to make a documentary that would help fill this void, and followed the stories of five men and women living with the condition, including her friend. Dis-sociated also provides up-to-date expert explanations of Dissociative Seizures by internationally recognised experts such as Lorna Myers from the US and Markus Reuber from the UK, whilst also seeking to offer balance between what is understood and what remains mysterious about the condition.

This film was intended to raise awareness and understanding of Dissociative Seizures among the general public, but it is an excellent therapeutic tool to show people affected by Dissociative Seizures how life can go on and how they can get better. Patients may find it easier to learn lessons about living with Dissociative Seizures from other individuals with the condition than from their doctors.

Identifying depression in hospital settings to improve patient outcomes

Prof Tayyeb Tahir

Department of Liaison Psychiatry, University Hospital of Wales, Cardiff

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The diagnosis of depression and its management with co-morbid physical health has proven to be challenging. It is well known that those with long-term physical health conditions have an increased risk of co-morbid depressive disorder in particular emotional distress in general.

To improve patient outcomes, screening for depression in general hospitals is one of the aims for 1000 Lives+ Intelligent Targets

So far, we have worked collaboratively with colleagues in cardiology, immunology, rheumatology, pain, neurology, HIV, renal, audio-vestibular and dermatology clinics.

Consecutive patients in these clinics were initially screened using the Two-item Patient Health Questionnaire (PHQ-2) to establish the need for further screening. Further assessments were done with PHQ-9, Hospital Anxiety and Depression Scale (HADS) and the Emotional Thermometers (ETs). High rates of depression were reported in those undergoing dialysis (55.8%), attending neurology (43.7%), HIV (30.1%), cardiology (25.5%), renal transplant (22.4%) and dermatology (17.27%) clinics. Suicidal thoughts were high in those undergoing dialysis (47%) and attending cardiology clinic (38.7%). Importantly ETs were able to identify high distress in those attending neurology clinics (69%) with high daily impairment in some domains of lives of those attending rheumatology (95%) and neurology (85%) clinics.

There will be little disagreement that depression can be easily missed in a busy hospital clinic. Depressive symptoms, even at the sub-clinical level, should be monitored. To assist all health professionals a symptom-based approach can be customised for routine algorithmic and targeted screening in high risk groups. Further research is needed to determine the usefulness of ETs in identifying depression in busy clinics.

Over the last few years students from the University of South Wales have been instrumental in rolling out this target. These students bring a set of skills which are invaluable. This is an example of working collaboratively with students with a drive to work in clinical setting.

Three students from the 2018 cohort, including two students from Canada, worked in dermatology and renal clinics.

Canada to Cardiff

Psychology students' experience in Liaison Psychiatry

Jasman Dhaliwal & Darbey Carlson

In any situation, stepping out of a comfort zone can be daunting. For us, this began with moving across the world from Canada to Cardiff for a Masters in Clinical and Abnormal Psychology at the University of South Wales.

When you're exploring and searching for your ideal career path it's never a bad idea to find the right balance between both academic learning and practical experience. While completing our Masters, we were fortunate to complete a placement in a real-life service setting. After a competitive selection process we were fortunate to build transferable skills and confidence within the Department of Liaison Psychiatry at the University Hospital of Wales, under the guidance of Professor Tayyeb Tahir and his small, but very effective team.

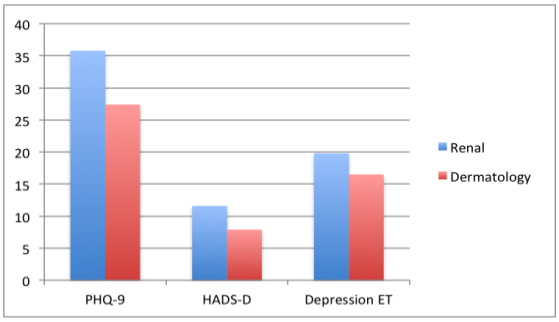
Whilst on placement, the Liaison Psychiatry team exposed us to many factors within the fascinating field of mental health. We often shadowed during clinical ward rounds as well as clinical sessions, and were questioned and challenged intellectually through teachable moments. As a team, after clinical ward rounds, we would brainstorm the important factors to take into

consideration when tailoring the session to the needs of each individual.

The overwhelming, but exciting and a simple question, "What did you think?" repeatedly gave us the opportunity to explore and apply our knowledge in ways we had not previously been exposed to. Our insights were always acknowledged, and if we had trouble conceptualizing a situation, we would be steered towards the right answer or course of action. This practice of making connections allowed us to build confidence and intrinsically motivated us to become more involved. A key takeaway, on specific occasions, was that it's necessary to be confident in your initial judgment. Other times, however, it was illustrated additionally that some patients may need you to dig a little deeper, be a little more curious and be aware that every situation that presents itself will be unique in its own way.

It was extremely enlightening to witness the effect of a valuable resource like Liaison Psychiatry, and the positive impact it makes on the daily lives of patients affected by mental illness associated with physical health problems. By creating a positive, open atmosphere while applying their strong expertise through a respectful manner, Professor Tahir, and his team demonstrated their essential role in the positive progress of general hospital patients.

Another invaluable aspect of this experience was that through our placement, we were able to complete our dissertations. The objective of our dissertations was to screen for depression in renal and dermatology clinics at the University Hospital of Wales, Cardiff. As part of the intelligent target for screening for depression in general hospital (1000 Lives Plus) we used the Emotional Thermometers - ET (Mitchell, 2013), Hospital Anxiety and Depression Scale - HADS (Zigmond and Snaith, 1983) and Patient Health Questionnaire - PHQ-9 (Spritzer, Kroenke, & Williams, 1999). According to the data collected, there is a significant prevalence of depressive symptoms amongst patients within both settings. The average prevalence rate of depression across the HADS, PHQ-9, and ET in the renal transplant clinic was 22.4% and 17.27% in the dermatology clinic (figure 1). In evaluating the performance of the emotional thermometers, the Distress ET, Anxiety ET, Depression ET, and Pain ET showed promise in predicting case status, however future research is necessary before implementation in clinical settings. Thus, our research highlights the importance and clinical value of the 1000 Lives Plus Initiative of screening for mental illness in all clinical settings.



When conducting these studies, we witnessed a resistance towards mental health screening in primary care from both patients as well as practitioners/staff. Some patients felt they did not understand the terms in the questionnaires, and felt it was not culturally applicable to them.

Others simply refused, stating that "this does not have anything to do with what I'm coming in for today." Physicians also stated that the questionnaires took too much time in their already demanding schedules, and also cited not understanding the relevance within their practice. While not from everyone, there appeared to be a prominent stigma still attached to mental health.

As students, not only did we get to strengthen our abilities of building rapport and gaining knowledge surrounding psychological practice, we were privileged to see clients in a new light – as empowered individuals trying to fight the villains of stigma, complex life situations and interpersonal challenges. We would like to thank these people for giving us the opportunity to learn from, not only their personal struggles, but also the positive progressions made whilst on placement. Medical conditions have a significant impact on the psychological well-being of an individual. In the absence of such teams, many patients can go mistreated and undiagnosed. This can prolong the effects and adherence to treatment. Acknowledging the importance of Liaison Psychiatry would be beneficial for both patients and service providers.

The experience we gained was truly invaluable and gave us great insight into the field of mental health and psychiatry.

Liaison Psychiatry where next?

Consultation-Liaison Model or Psychological Medicine?

Dr Peter Aitken MRCGP, FRCPsych
Clinical Director for Individual Patient Placement, Director of Research & Development and Medical Education, Devon Partnership NHS Trust

Now that liaison psychiatry is a term that can be both spelt and understood by the wider NHS community our attention is turning to what it really means. In the United States the American Academy of Psychosomatic Medicine has changed its name to the American Academy of Consultation-Liaison Psychiatry perhaps reflecting a move away from being about the conditions we treat in favour of the uniqueness of our model of care.

In essence consultation-liaison psychiatry's uniqueness lies in that we seek to bring our knowledge and skill in relation to the assessment and management of psychiatric disorder to the benefit of people in

the main being primarily cared for by another health or care professional. We work to make the experience of the physician and surgeon an effective one to the benefit of the person they're treating. The strongest practitioners of consultation-liaison psychiatry are familiar with working from the place the primary clinician and their patient starts, engaging to help differentiate distress and adaptive health behaviour from illness and maladaptive illness behaviour.

There are now examples of consultation-liaison psychiatry being used with great success to support general practice care and the care of other professional disciplines in pain and many other clinics in a primary and community care setting.

With a proposed new Community Framework for Mental Health and the emergence of Primary Care Networks in General Practice in England some are talking of the consultation-liaison model being the successor of clinical-case management for the majority of interventions by community psychiatrists. These developments predict a greater use of technology to assist consultation by a limited and potentially reducing number of experts across larger and more remote geographies. This is in part a response to a man power problem with insufficient psychiatrists and a lack of the right incentives to encourage those that there are to relocate and work in hard pressed areas.

Where may this lead consultation-liaison psychiatry? With a growing recognition that the shortage of psychiatrists and specialist mental health nurses will take a generation to solve there is instead a pressing need to bring specialist mental health skills and knowledge in supervision and support of a growing body of untrained care workers, peer supporters and volunteers. The development of Psychologically Informed Environments in residential rehabilitation care settings again sees the limited expertise of a few brought to the advantage of the many actually delivering the care.

The consultation-liaison psychiatry model seems to have a much wider application than the general hospital and general health clinic environment previously understood by us as the boundary of the work. In addition to physicians and surgeons, general practitioners and other professional roles the model can support unqualified carers, their managers, volunteers and peer support workers.

We therefore should be cautious that our speciality is only understood for our skills in communication, consultation and liaison. Perhaps the time is right to return to emphasising those aspects of our practice that make us truly specialist in Psychological Medicine.

As a balance to the clarity we've achieved with the name and the model of care we might now need to concentrate on reminding our audiences of our expertise with psychosomatic conditions, maladaptive illness behaviour and symptoms as part of the complexity of disease interaction in our, often multi-morbid, patients.

Whilst we must take care not to damage the useful awareness and appreciation of consultation-liaison psychiatry as a model grown over recent years, my sense is that now is

the time to grow new momentum toward promoting and developing our specialism as Psychological Medicine drawing not only from trainees in psychiatry but also general medicine and general practitioners who can work within a biopsychosocial framework and be equipped to make pharmacological, psychotherapeutic and social interventions.

Commentary on Peter Aitken's article

Professor Else Guthrie
Professor of Psychological Medicine University of Leeds.

I have always disliked the term Consultation-Liaison Psychiatry because it implies a very light touch form of intervention and indicates very little about the actual work we do. Most other specialties and sub-specialties in Medicine are defined by either the relevant bodily system (e.g. Respiratory Medicine) or the patient group (e.g. Paediatrics). Mental health is broadly similar with the exception of the Psychotherapy Faculty, which refers to a type of intervention.

I do not think that Forensic Psychiatrists would like to be called 'Consultation- Report-Writing Psychiatrists', because the term would imply that they provide interventions devoid of any discernible treatment, even if a medico-legal report is valuable and essential to the workings of the legal system, and helpful for patients. Report writing, of course, is not the only thing that Forensic Psychiatrists do, in terms of helping those who are referred to their services. The term Consultation-Liaison Psychiatry is equally misleading because it only captures a small component of what we do on a day to day basis, and implies we stroll round the hospital, chatting with colleagues, without actually providing any treatment or care.

I remember when the Faculty of Liaison Psychiatry (then a Section) debated changing its name to Psychological Medicine. Geoff Lloyd was the chair at the time (some years ago!). To cut a very long and meandering story short, the Liaison Section decided against changing its name, as we were likely to encounter opposition from The British Psychological Society, and our own College. The main impetus for changing the name of the Section at that time was because nobody knew what liaison psychiatry was. As Peter alluded to in his opinion piece, times have changed, and the words 'liaison psychiatry' have even passed the lips of the Prime Minister in the House of Commons. People have now heard of liaison psychiatry but I doubt they really know what it involves.

Although I dislike the term CL Psychiatry, and have always referred to myself since becoming a consultant as a Consultant in Psychological Medicine, I don't think a name change for the Faculty would be a wise move, at present, particularly as the term Liaison Psychiatry or Liaison Mental Health has gained a certain degree of traction with politicos and the public at large.

Of course the main argument behind Peter's piece was much deeper than that of a name change or a change of terminology. There has been a focus on and expansion of liaison services, via the CORE-24 initiative, which despite certain difficulties, has resulted in positive improvements in many services, some of which have been completely transformed. This focus, however, has been predominantly on high volume, low intensity work.

I was originally attracted to liaison psychiatry because of the variety and complexity of the kinds of patient problems I encountered on general hospital wards; not things that could be solved easily by a quick 'liaison' with a medical or surgical colleague. Some cases literally fascinated and astounded me. The paradox is that as CL Psychiatry has expanded, the 'psyche-somatic' core of the work, has been overshadowed and in some cases eclipsed by sheer volume and demand.

Just as with any specialty in medicine, complex work is important, as it enables trainees and consultants to develop and hone their skills. Supervision of junior staff and other professional colleagues becomes easier if the supervisor has experience of managing really difficult situations, challenging scenarios and complex patient problems. The new frontiers of work, to which Peter alludes in his opinion piece, will require psychiatrists who have a familiarity with psyche and soma, born from a deep understanding of the interplay between physical and mental health.

The 'complexity' aspect of our work, both in the hospital setting and primary care, is not given due emphasis and it is really important that we try to address the current imbalance between high flow/low intensity work and low flow/high intensity work. Both are important. Not only is complex work selfishly interesting for ourselves as clinicians, but it is desperately needed by the patients who we see, because nobody else is willing or able to provide treatment for them. IAPT services will not and are incapable of undertaking this kind of work, neither will General Psychiatry teams.

Professor Allan House
Professor of Liaison Psychiatry
University of Leeds

Delivery of a liaison psychiatry service has always been a balancing act – involving decisions about where it is practised, what clinical problems are tackled, the related question of where and how service contacts originate, and what staff are involved in service delivery. Influences on services development and resulting configuration have been varied and even in the NHS local factors have seemed the more important. The result has been considerable national variability against a background of some commonalities: services are mainly hospital-based and primary care provision - although glimpsed in our peripheral vision - has rarely got beyond transient experiments; the acute end of case-mix has taken

precedence, with over half of services providing no specialist outpatient care; most liaison services are multidisciplinary with liaison psychiatry nursing the most substantial component.

The past is constantly changing and three changes in the more recent past are exerting an influence on decisions about service configuration, decisions that can be regarded as an inter-related series of trade-offs. The first change is demographic – rising numbers of older people with multi-morbidity which includes dementia and a predisposition to delirium when physically ill. Second is the deficit in general mental provision brought about mainly by underfunding, leading to more unscheduled and acute psychiatry presentations. The third change is organisational: the embrace by NHS England of a model of liaison psychiatry as essentially acute hospital-based psychiatry delivering 24/7 rapid responses, offering short-order assessment and the minimum of treatment compatible with quick discharge. This last change has been associated with snappy labelling (CORE-24) but to my mind the most telling terminology change has been emergence of the phrase "ward in-reach" with its implication that we are really busy doing something else, somewhere else, and dropping in to somewhere we don't actually work.

So, the balance has shifted towards acute, hospital-based, short-order psychiatry at the expense of specialist services for complex, severe and chronic cases. The proposal before us is to rebalance by embracing something that sounds like a variant of case-management, coupled with a name change. We ought to be apprehensive about either suggestion.

It is far from clear that case management is an effective model for UK practice, even in its more circumscribed (better defined) form. Why then should we imagine it's a good use of a scarce resource to spend time in "supervision and support of a growing body of untrained…[healthcare workers]" in unspecified community settings? The core of my scepticism here is a belief that one of the defining features of liaison psychiatry is the contribution it can make to the management of complex severe cases – and that can't be delivered by hands-off supervision and support of those with low-level or no training. We give up direct involvement in the treatment of such cases at our peril.

And what about the name change? There's a touch of sophistry in the argument here. Pretty much nobody in the UK calls what we do consultation-liaison psychiatry. The word liaison describes well our role in bringing together mental and physical healthcare; the addition of "consultation" is tautological since all specialties offer consultation: it is designed (here) to imply that liaison psychiatry is now irreversibly identified with single-contact non-therapeutic work. It doesn't describe well the urgent medical parts of what we do and I suspect a preference for "Psychological Medicine" resides in part from a desire to avoid using the word "psychiatry" with its connotation of mad doctoring, which runs the risk of colluding with stigmatising attitudes. Liaison psychiatry has name recognition; by adding "nursing" or any other discipline it acknowledges multi-disciplinarity (psychological medicine

nursing anybody?); it never was identified solely with acute minimal-contact psychiatry and we should not accept it being so now.

Here are my alternative proposals for what should come next - in the order with which they could be delivered with the right commitment:

- Commissioning and planning to ensure that all relevant components of the mental health services are properly co-ordinated: that means especially liaison psychiatry, clinical health psychology, IAPT LTC. They don't all have to be managed in and delivered from the same organisation any more than all GPs have to be employed by hospitals to ensure good co-ordination of primary and secondary care. But they do have to be delivered so that patient flows are rational, coverage is comprehensive, and data collection and outcome monitoring supports equitable funding.

- A comprehensive training programme to ensure liaison psychiatry staff have the requisite skills to manage complex and chronic cases. I am thinking especially of skills in therapies informed by psychodynamic, interpersonal or systemic thinking. It should not take a generation to deliver – the basics can be taught quickly to anybody with a reasonable amount of clinical experience and interpersonal skills.

- Strategic development of an educational and training programme for all those who will go into healthcare work, starting in the undergraduate years and continuing throughout professional life.

Professor Michael Sharpe
Professor of Psychological Medicine, University of Oxford.
And Trust Lead for Psychological Medicine, Oxford University Hospitals

Peter Aitken raises important questions about not only the name we use for our speciality but also about its very definition and future: do we choose to define ourselves by the way we work, by our training, or by the illnesses we treat and does it matter?

Looking at how at how other medical specialities address this issue; it seems they do all three: surgery and radiology define themselves by what they do, nurses and doctors by their training and 'respiratory medicine' and 'cardiology by the illness they treat. So are we doctors who do liaison psychiatry, clinicians trained as psychiatrists, or clinicians who treat the psychological aspects of medical illness?

What we do
Liaison has become more widely accepted as a term. But it simply means communication with anyone, police, courts, army etc. (and adding consultation clearly does not help in defining a specific area so work). Defining the liaison as being with the general hospital is more specific, but as Peter Aitken point out may then

exclude us from the growing out of hospital care.

Our training
Our training is important and we should be proud to be psychiatrists. However, the scale of need we have to address greatly exceeds the number of psychiatrists. Liaison 'mental health' is more inclusive of nurses and others but vague (although its vagueness might sometimes be useful) and sounds separate from the rest of 'physical' medicine.

The illnesses we treat
There is perhaps controversy here. Do we treat only 'serious mental illnesses or do we have something to say about one aspect of a much broader range of illness? If, as I suggest we must, we seek to address the wider task of complex multi-morbidity, this will never be addressed by psychiatry alone. It will require not only psychiatrists, psychologists various 'mental health' practitioners but also non-psychiatric physicians and general nurses.

Having grappled with this issue in Oxford our solution is to define:

- The overall area of work of improving patient care as psychological medicine that can occur in any setting, not just hospital. We see this as an important component of the wider mission of achieving comprehensive 'whole patient care'

- The training of the people who do the work as including those trained in psychiatry and psychology as well as physicians, general practitioners, general nurses and others. We need to engage a wide range of disciplines.

- The way we do the work to include consultation and liaison, but also other activities such as education of staff and the shaping of policy. Ultimately we will only have an impact on care if we go beyond responding to referrals and increase the confidence and skills of all the other staff.

In summary, whilst we may rightly regard obsessing over names to be merely a distraction, how we think about what we do, and communicate that to others, will be crucial to our future part in improving the care of patients.

Diabetes and Psychiatry

Professor Khalida Ismail
Professor of Psychiatry and Medicine, Institute of Psychiatry, Psychology and Neuroscience, King's College London

Dr Luke Solomons
Consultant in Psychological Medicine/Psychooncology
Oxford University Hospitals NHS Foundation Trust

This special interest is growing from strength to strength as local and national commissioners of mental health and diabetes care are beginning to understand how common the comorbidity of psychiatric disorder and diabetes is, and when present, leads to worse outcomes in every and any dimension.

Some highlights:

1. Luke Solomons is leading the Liaison Faculty working group. If you are interested in getting involved, we need your help, so please get in touch with him.
2. We have set up a larger pan College diabetes psychiatry working group with representatives from each Faculty and we are drafting a mission and brief strategy.
3. Pan College Faculty reps met with Diabetes UK's policy lead, Bridget Riley, and NHSE's Associate National Clinical Director for Diabetes, Partha Kar (@parthaskar) on 7th March 2019 in Liverpool. He is leading the diabetes and mental health programme for NHSE. We set out the College's emerging views and we are pleased to share with you that we are now 'at the table'.
4. Recent publication outlining how integrated care identifies the sickest patients, the most expensive but can improve outcomes +++. Ismail et al Diabet Med. 2019 Feb 1. doi: 10.1111/dme.13918. [Epub ahead of print]. Use this for your business cases.
5. NHSE have commissioned two national pilots for type 1 diabetes and eating disorders, one at Bournemouth (mainly a diabetes and ED model) and one at King's Health Partners, (mainly a diabetes and liaison psychiatry model). The findings from the pilot will be very important for our faculty as there is a prospect of more NHSE funding for the more complex 'tip of the pyramid' cases such as recurrent diabetic ketoacidosis, which are increasingly considered as self harm. More information can be found in the BBC3 documentary.

https://www.diabetes.org.uk/guide-to-diabetes/life-with-diabetes/diabulimia

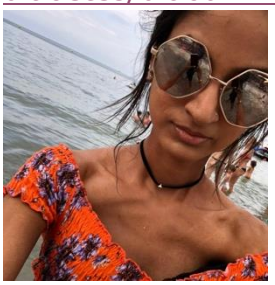


Figure 1: a patient at King's College Hospital with 'diabulimia'

www.bbc.co.uk/news/newsbeat-47358903

Next steps:
We need more liaison psychiatrists coming forward to lobby NHSE, NHS Scotland and NHS Wales. One of the recurrent comments from NHSE Diabetes Directorate is they have IAPT, the diabetes psychologists, the health psychologists lobbying but where are all the psychiatrists?

These are exciting times for liaison psychiatry: diabetes and other chronic conditions lets us get back to our roots in medicine plus our skills in psychiatry to make real clinical differences to patients. Folks, we psychiatrists can bring HbA1cs down, improve mental states, reduce unscheduled care in diabetes! This is a great time to make that difference and we, patients and diabetes HCPS need your expertise. Get in touch.

Royal College of Psychiatrists Faculty of Liaison Annual Conference 2019

Date: 15-17 May 2019

Location: Royal College of Psychiatrists, 21 Prescot Street, London E1 8BB.

CPD: Up to six CPD hours per day, subject to peer group approval

The conference dinner will take place at Cinnamon Kitchen, on the evening of 16 May.

The conference dinner is now fully booked - we are operating a waiting list. Please email sarah.morrissey@rcpsych.ac.uk to be added to the list.

Liaison Fun Run

Dust off your running shoes and take part in the Liaison Fun Run on Thursday the 16 May - no need to sign up, just show up!

Starting: 7:15am, Thurs 16 May, Reception of RCPsych, 21 Prescot Street

Pace: social

Cloakroom, shower and breakfast facilities available at the College.

Further details are available on the conference webpage.

Save the date!

The 2020 Liaison Psychiatry Faculty Conference is at the St David's Hotel in Cardiff on 13-15 May 2020. Put the date in your diary now and watch the website for details.