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Review of Mental Health Liaison Services in the South West of England

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Mental Health, Dementia, Neurological Conditions

Commissioning Liaison Psychiatry/Mental Health Liaison Services in the South-West of England: findings from a short review

Preface

This report presents the findings of a brief review of Mental Health Liaison Services in the South West of England. This review was commissioned by the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions (South West) in April 2013 in order to inform priorities for service improvement in the South West 2013-14.

This report has been submitted to the Urgent and Emergency Care Review commissioned by NHS England (2013) as a source of evidence about the provision of mental health liaison services in the region. It identifies service commissioning and delivery issues with a particular focus on variability in investment, access, and service design, and makes recommendations to progress the commissioning of mental health liaison services.

In response to this report the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions (South West) has commissioned the development of exemplar service specifications for mental health liaison services, and an associated outcomes framework. The service specifications will be published jointly with the Royal College of Psychiatry and National Institute for Health Research CLARC – South West Peninsula in September 2013. The outcomes framework for mental health liaison services will be published jointly with the Royal College of Psychiatry, National Institute for Health Research CLARC – South West Peninsula, and Centre for Mental Health in February 2014.

Commissioning Liaison Psychiatry/Mental Health Services in the South-West of England: Findings from a short review

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Introduction

Liaison psychiatry or mental health commonly refers to services aimed at addressing the mental health needs of people being treated in general hospitals for physical disorders. This includes:

- people presenting in A&E following an overdose or self-harm
- people with co-morbid conditions (ie. a mental health and a physical disorder, whose mental health needs are required to met whilst in the general hospital)
- people with medically-unexplained symptoms (MUS) and
- people with dementia or potential dementia.

Some services have greater aspirations that include, for example, improving health outcomes for people with a physical illness that impacts on their psychological wellbeing, and some also have preventive aims. Good liaison psychiatry services are implicated in all of the five domains of the NHS Outcomes Framework, which now has a stronger emphasis on mental health and dementia.

Liaison psychiatry services have developed rapidly in recent years and are available in many acute hospitals. They are often seen as providing an invaluable contribution to acute care, working with people with complex needs and training and supporting general staff colleagues. However, it has been argued that services and liaison psychiatry models have developed without rational planning and some have been described as 'idiosyncratic'.

Certainly the evidence suggests that there is wide variation in how services are planned, staffed and delivered, without a clear rationale for this variation. This leaves commissioners without the good, clear evidence and information they need to decide how to commission services in the future despite recommendations that liaison services should be explicitly commissioned.

The South West Clinical Network commissioned a brief review of liaison psychiatry services in the South-West of England. The aims of the project were:

- To profile the liaison psychiatry services in the South-West of England
- To describe in more detail the models, demand, and use in a small number of different and distinct hospital settings in the South-West
- To briefly review recent peer-reviewed and 'grey' literature
- To make recommendations for liaison psychiatry services that will be of practical use to commissioners
- To make recommendations for further work to support commissioners and providers in developing gold standard liaison psychiatry services

The methods used to deliver the findings in this report are briefly:

- Brief literature review
- A survey sent to all commissioning bodies in the South West
- An in-depth pathway audit on a sample of ten consecutive patients in four sites, augmented by discussion with clinicians

Further details of methodologies available from the author.

Mental health liaison services in the general hospital

There is a plethora of literature arguing for good mental health liaison services and a number of issues have been identifying as pertaining to best service development. Within the literature, criticisms exist at a number of levels:

- Lack of good evidence of effectiveness
- Many services not needs-based
- Staffing levels and staff mix not routinely complying with recommendations by the Academy of Royal Colleges
- Poor or no response out of hours in many services
- Poor emergency response in some services
- Poor linkages with community based services in some services[1]

Further, some key issues are worth further exploration.

1. The general hospital is a significant point of access for people with mental health problems

It is important to acknowledge that people may access mental health services through attending general acute hospitals, particularly through Accident & Emergency Departments (now more commonly known as Emergency Departments, or EDs). Although widely regarded as an inappropriate point of access to mental health services, EDs nonetheless continue to play an important role for some service users especially for those who have self-harmed. One study found 45% of out of hours mental health contacts in a London locality took place through EDs (Payne 2000[2]).

2. Linked to this, mental health is a major issue in general hospitals

The King's Fund recently noted that a small number of users of emergency services are 'frequent attenders' that often result in admission. Many of these frequent attenders are people with drug and alcohol addictions or mental illness, or have social problems such as homelessness or unemployment.[3]

The research evidence suggests that at least 30% of acute inpatient bed occupancy is by people with mental health problems, and that deliberate self-harm accounts for up to 170,000 ED attendances in England each year[4].

People with medically unexplained symptoms are an important group. Although small in number, they may account for up to 50% of acute hospital outpatient activity[5].

People with serious mental illness are likely to need more hospital care than the rest of the population as they have higher morbidity rates of long term diseases than the general population[6].

3. Nonetheless, the evidence base for liaison service design and interventions is not yet well developed

Much of the published literature around liaison psychiatry and mental health services can be useful, although it tends to be descriptive rather than evaluative. Some important evidence is available for management of deliberate self harm, and there is some research-based evidence for liaison mental health services more generally, though with few randomised controlled trials or other outcome-based studies undertaken.

Research evidence is further complicated by the different models, structures and activities of liaison psychiatry services under investigation, making it difficult to make comparisons and to know which models work best. Furthermore, methodologies used are often self-report (such as surveys), rarely include patient outcomes, focus on only limited aspects of a service (eg. deliberate self-harm) and rarely include costs. Hence, the evidence for deciding on one liaison service model rather than another is limited[7].

A meta-review of systematic reviews of interventions in liaison psychiatry found disappointing results, with large gaps in the evidence in both clinical areas (ie. disorder-based liaison work) and in common interventions such as assessment, advice and service-level interventions. Poor quality data was one of the biggest problems. The authors concluded that it is difficult to base service design and development on the current evidence base.[8]

4. However, we do know that psychosocial assessment and interventions are helpful for people who attend hospital after deliberate self-harm

Hospitals in England see around 220,000 attendances following deliberate self-harm each year[9]. Deliberate self-harm is the strongest risk factor or predictor for future suicide, with men at higher risk, and risk increasing with age; the risk in the first year after self-harm may be 66 times higher than the annual risk of suicide in England and Wales[10]. In many hospitals, more than half of people who attend ED following deliberate self harm are discharged from the emergency department without specialist assessment, yet those who receive a psychosocial assessment may be less likely to repeat self-harm.[11]

Follow up may also be valuable. For example, a randomised controlled trial of brief psychological interventions (four sessions) delivered by nurse therapists after deliberate self harm resulted in significant reduction in suicidal intent, more satisfaction with treatment and fewer further episodes of self harm.[12]

5. We also know that excellent services may be cost-effective

The best evidence for this is probably that provided by the Centre for Mental Health about the RAID (Rapid Assessment Interface and Discharge) project in Birmingham. This study found that the comprehensive RAID model, with a multi-disciplinary team operating round the clock seven days a week resulted in cost-savings due to shorter length of stays and reduced rates of readmission.[13]

6. Critically, useful guidelines for the commissioning and delivery of effective liaison mental health services exist

Along with NICE guidelines for effective services for people attending ED with mental health problems, there are also a number of products published by the Royal Colleges:

- Mental Health in Emergency Departments: A Toolkit for Improving Care was published earlier this year by the College of Emergency Medicine. It provides a list and definitions of key areas for quality.
- PLAN standards[14]. These are quality standards and criteria to guide best practice for psychiatric liaison services that, if met, allow services to become accredited through the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).
- Guidance for Commissioners of liaison mental health services to acute hospitals. Published by the Joint Commissioning Panel for Mental Health in 2012, this describes a clear rationale for liaison services, key components, example of team composition and staffing levels required, suggested standards and outcomes.

NICE has also recently issued a new quality standard for better initial and longer-term management of deliberate self-harm in general hospitals. The standard says that people who self-harm should be treated with compassion. After each episode, the person should have a comprehensive physical, suicide risk, mental health, social and psychological assessment. The standard suggests that this assessment might form the start of ongoing therapeutic work and discusses the potential for structured psychological therapies to avoid further self harm.[15]

Findings from this project

Commissioning services in the South West

All commissioning bodies in the South West were contacted and asked to complete a questionnaire; eight forms were returned.

Some commissioners could not complete the forms as they were not aware of the services being commissioned; they asked the providers themselves to complete the forms. It is also worth noting that only one of the four teams visited for this project was included in the returns, suggesting that much information is not available to commissioners about what services are available.

Important missing information from returned forms included costs, activity data and outcome measures.

Table 1 shows key basic aspects of the models identified through the commissioner questionnaires. Notwithstanding missing data, the returned forms demonstrated that there are very different models of provision across the South West, running with different team compositions, covering different hours and at different costs. One interesting point to note is that one Trust provides services to four of the eight CCGs; this Trust provides different services to each, but not necessarily based on local need. It is understood that this is under review.

All services are based within general hospitals, with some also having a 'presence' in other hospitals, including community hospitals and other community settings.

Team composition varies from a solely nurse-based service to multi disciplinary teams. The most common teams are composed of nurses and sessions from a consultant psychiatrist. Only one team has an OT and only two have a social worker. No team has a psychologist within the team though some mentioned access to health psychology services. All teams have admin support. Varying levels of sickness cover are provided.

Most teams are discrete, stand alone teams but one team (Area 1) was described as integrated within the Crisis Resolution/Home Treatment team. This is the only team providing 24-hour, 7 day a week full cover, although it was noted that there are varying levels of liaison expertise within the CRHT team. Most of the other teams work 9am – 5pm, either 7 days a week or 5 days a week. Out of hours cover is most often provided by other local teams, such as local intensive support or crisis resolution services. However, in some cases, the arrangements appear to be quite complicated with certain out-of-hours slots covered by community teams and others covered by junior on-call doctors.

Table 1: Basic components of liaison models in the South West (Commissioner Survey)

	Team composition	Hours	Eligibility	Costs
Area 1	Multi-disciplinary but no psychologist Includes 1.0 admin	24 hrs, 7 days a week cover (through integration with CRHT – so not all staff liaison team staff)	16+, excludes primary alcohol & substance misuse No upper age limit	Block contract; no information provided on specific costs
Area 2	Nurses & consultant psychiatrist Includes 1.0 admin	9-5, 7 days a week with a reduced service over Bank Holidays	Adults No upper age limit	£404,000
Area 3	Nurses & consultant psychiatrist Includes 1.0 admin	8am-10pm, 7 days a week including Bank Holidays	16+ if self harm; 18+ all others. Separate teams for alcohol & for older people. Exclusions incl people in custody, those with LDs or psychosocial problems without co-existing mental health problems	£641,000 to include older people's & community hospitals liaison team
Area 4	Nurses & consultant psychiatrist Plus 0.4 alcohol liaison nurse Includes 0.4 admin	9-5, 7 days a week	Adults (no lower age given) No upper age limit No explicit criteria but "responds to amber/red risk"	£286,400 adults; £90,542 older adults Total £376,942
Area 5	Nurses, consultant & staff grade psychiatrist Includes 0.8 admin	9-5, M-F	18+,no exclusions No upper age limit	No costs information provided
Area 6	Nurses, consultant & staff grade psychiatrist Includes 1.0 admin	9-5, M-F	18+, attendances at A&E or admitted with mh disorder, crisis or self harm No upper age limit	£444,000
Area 7	Nurses only Includes unspecified WTE admin	9-5, 7 days a week	16+ No upper age limit	Block contract; no information provided on specific costs
Area 8	Multi-disciplinary team without psychologist or OT Includes unspecified WTE admin	9-5, 7 days a week	18+ No upper age limit	£237,000

Eligibility for the service differs by age (starting at either 16 or 18, or a combination of both), alcohol, drug and psychosocial problems, and in one case whether an 'amber or red' risk exists. Some services have access to specialist services for alcohol or drug misuse. No service has an upper age limit but only one service mentioned having a separate older person's liaison service.

Costs information was incomplete. Of the five areas where costs were provided, these varied significantly but comparisons are difficult to make as costs related to different levels of service. The lowest cost service (Area 8), offering a multi-disciplinary service from 9-5, 7 days a week, costs £237,000. The highest cost service (Area 3), offering nurses and consultant psychiatrist from 8am-10pm, 7 days a week costs £641,000, covering an ED liaison team, a specialist older person's liaison team, a community based liaison team (working across community hospitals) and alcohol liaison team.

The Commissioner questionnaire included a list of activities that a liaison service might offer and commissioners were asked to indicate which services were included in the services they had commissioned, as shown in Table 2.

The activities identified in this list were sourced from the Guidance for Commissioners mentioned in the previous section. It is worth noting that only a few of these activities were stated as provided by liaison services in the South West. These primarily related to rapid response and assessment and advice and training to other professionals on the management of mental health problems in the general hospital. Areas that were less commonly stated as provided were care planning, brief interventions, Mental Health Act and Mental Capacity Act work, and – notably – work with medically unexplained symptoms or with people with drug and alcohol problems.

Table 2: Services stated as provided by the liaison team

Activity	Stated as provided by	Stated as __not__ provided by
Advice, training and coaching on the management of mental health problems to other professionals in the general hospital	All	
Bio-psycho-social assessment, formulation and diagnosis for people experiencing impaired mental wellbeing	All	
Bio-psycho-social assessment, formulation and diagnosis for people whose physical symptoms are unexplained	All	
Risk assessment for harm to self and others	All	
Rapid response to requests for assessment in A&E including assessment and management of people who have self-harmed	All	
Arrangement of appropriate follow up after discharge	All	
Brief interventions, advice and signposting for patients		Area 5 – not brief interventions Area 8 – not brief interventions
Participation in Mental Health Act & Mental Capacity Act assessments		Area 8
Expert advice on capacity to consent for medical treatment in complex cases involving both physical and mental health problems		Area 1
Acting as a Responsible Clinician under the Mental Health Act for people detained under the Act receiving care in the general hospital		Area 1 Area 6 Area 7 Area 8
Development of care plans		Area 4 (unsure) Area 8
Management of people with MUS in partnership with primary care, specialist medical teams and others		Area 1 (in discussions) Area 4 Area 6 Area 8
Contributing to the psycho-social care and management of people with long-term physical conditions (eg diabetes) in partnership with primary care, specialist medical teams and others		Area 1 (in discussions) Area 4 Area 6 (unless significant mental health problem) Area 8
Assessment, management and signposting of patients with alcohol and substance misuse disorders		Area 1 (separately commissioned via DAT) Area 8 – alcohol management provided separately by Alcohol Liaison Nurse

Detailed analysis of Four Teams

Four services were visited as part of this project. Staff were interviewed and invited to share their experiences of the service, what was working well and what could be improved. They were also asked to complete pathway audit forms on 10 patients consecutively discharged from the service six months earlier. It was important for

a) the patient audit to cover consecutive patients in order that no patients were selected out or in of the study, and

b) for the audit to look at patients six months earlier so that, potentially, the pathway after the index attendance could be tracked.

Teams were identified as Service A, B, C and D. A brief description of each service is provided in Tables 3A – 3D.

Table 3A – description of service A

Staffing	1 x WTE Social Worker (AMHP) (team leader)
	1 x WTE Band 6 nurse (job shared)
	Admin provided by social work team admin.
	On call consultant provides telephone support & dedicated time as required.
	Offers separate older people's liaison service
Operating hours & out of hours cover	Monday – Friday 9-5pm
	Out of hours: Crisis Response Team based in the hospital, provides cover 5-11pm, Monday to Friday, weekends & Bank Holidays. However this covers the whole community, not just the hospital
Operating criteria & service expectations	Adults 18+ with a separate service for older people. Sees mainly people referred from ED or Emergency Medical Unit (EMU).
	Aims to respond within 4 hours of referral.
Area & local issues	County hospital with 400 beds in county market town, serving around 210,000 residents. Population swells in summer through tourism.
	About 45,000 attendances at ED each year. Outposted community hospitals difficult to cover and rurality an issue.
Funding issues	Adult liaison service funded through mental health service. Social worker is employed by the council. Older person's liaison nurse works separately, funded through 'Reablement' monies. Difficult to identify financial streams as the mental health service is funded through block contract.
Added value	Shares office with Crisis Team on hospital site, allows good liaison between teams.

Table 3B – description of service B

Staffing	1.2 WTE Consultant Psychiatrist
	3 x Band 7 WTE nurses (1 is team leader)
	1 x Band 6 WTE nurse
	1 x Band 4 WTE admin
	1 x Band 3 PT admin
	In addition to core team medical & nursing students & junior doctors on placement
Operating hours & out of hours cover	Monday – Friday 9-5pm.
	Out of hours: Crisis service night nurse practitioners 7.30pm-8.30pm, junior doctors on call. Daytime weekends junior doctors; nighttimes: nurse practitioners
Operating criteria & service expectations	Adults 18+ with a separate service for older people. About a third of referrals from ED, a third from acute medical ward (AMU), and a third from other parts of the hospital including people with medically unexplained symptoms. Includes people with eating disorders.
	For ED, aim to respond within an hour.
	For AMU, aim to respond within the day.
Area & local issues	City hospital, with 800 beds, providing services to 400,000 residents
Funding issues	The Band 3 administrator is funded from medical student placement monies.
	Looking for monies to provide services over extended hours.
Added value	"Our one-off contact is a therapeutic intervention, not just an assessment."
	Links with Samaritans; can organise for Samaritans to ring patient (with consent)
	Specialist Eating Disorders service
	PLAN accredited
	Multiple supervision streams, including a Monday morning supervision to review weekend presentations

Table 3C – description of service C

Staffing	Four separate teams led by overall manager. ED liaison team has 5 x WTE Band 6 nurses and 0.5 WTE consultant psychiatrist. (Other teams are older people's liaison, alcohol liaison & community mental health liaison working across 8 community hospitals with a caseload of mainly older people).
Operating hours & out of hours cover	Seven days a week, 8am-10pm using shift working. Out of hours, access to crisis team and on call consultant.
Operating criteria & service expectations	Adults aged 18+ or 16+ if ED referral. Older people, alcohol liaison and community mental health liaison teams are separate. Receives referrals from anywhere in the hospital but majority from ED. Hospital risk matrix determines response times but majority seen within 2 hours. Holds Medically Unexplained Symptoms clinic
Area & local issues	County trust serving 612,000 residents, with 2 x DGHs. Team based in one of the DGHs, has "a presence" in the other.
Funding issues	Alcohol liaison service directly commissioned by CCG Joint Commissioning, LA funded.
Added value	Delayed discharges discussed in multi-disciplinary meeting to identify issues that may be preventing people from moving on "There's no such thing as an inappropriate referral" Carrying out work with community mental health colleagues around frequent attenders to improve care co-ordination and prevent crises; includes clinical alert on IT system & a one-page individual support plan

Table 3d – description of service D

Staffing	1.2 WTE Consultant Psychiatrist Staff grade psychiatrist 1.0 WTE Band 8a Clinical Service Manager 1.0 WTE 3 x Band 7 Nurses (2.5 WTE) Admin Band 3 1.0 WTE In addition to core team medical and nursing student placements and specialist registrar training placements
Operating hours & out of hours cover	Monday – Friday 9-5. Out of hours service provided by SHO 5-10pm (9am-10pm at weekends), and CRHT team 10pm-7pm but will only see people assessed as 'red' risk
Operating criteria & service expectations	Adults 18-64. Younger adults 16-17 can be referred to CAMHS. People aged 65 and older have separate liaison service for older people but this does not cover ED so the ED service responds to all over 18s. There are also specialist alcohol or specialist drug nurses not directly managed by the liaison service but closely linked into it.
Area & local issues	Busy inner-city hospital in large diverse community of approximately 433,100. ED sees about 60,000 patients a year.
Funding issues	Very complicated funding arrangements. Some funding from acute trust (ED funded nursing staff) and some from mental health trust
Added value	Self-harm surveillance register provides useful data to support service development and suicide prevention Hepatology clinic Self-harm clinic available for patients who choose not to wait in ED or who have been assessed as 'green' (low) risk. Counsellor attached to that clinic offers CBT.

Presentations

Patient profiles are shown in Figure 1. Note that ethnicity is not included in the table, but all patients in all four samples were identified as white British. The average age of patients was 42 years for Service A and D, 38 for Service B, and a much younger 29 for Service C. The Figure shows how the presentations are quite different at each of the four services. Some of the variation is due to service availability. For example, Service C has a separate alcohol liaison nurse and specifically excludes people with alcohol problems from the service. Also Service C is primarily an ED based service and therefore sees more people who have taken overdoses, while Service D is more likely to see hospital inpatients, meaning that only 5 of the 10 patients were people who had taken an overdose.

People presented with a variety of psycho-social problems and some moderate-severe mental health problems. Some presentations were of a highly serious nature, including the following examples:

> *A woman presented to the ED after having taken an overdose. She had been hearing voices telling her to join them in the underworld. Her mother and sister had recently died. She could not vouch for her own safety. She had previously overdosed. (Service A).*

> *A 32-year old man with a history of depression attempted to hang himself. His relationship had recently broken up and he was struggling financially. Three family members had committed suicide, including his father when he was 8 years old (Service B)*

> *A 32-year old woman was admitted following an overdose. She had a long history of depression following childhood sexual abuse, and had been addicted to heroin. She was feeling suicidal, experiencing paranoia, anxiety and social phobia. (Service D)*

Services A and B were notable for the number of people presenting with alcohol issues and some severe mental health issues. Service D also saw some people with very serious mental health issues including psychotic disorders and major depression. Service C presentations constituted a markedly younger group experiencing anxiety and depression, often presenting after an overdose due to relationship problems. The following presentation was more typical of Service C:

> *A 25-year old woman took an overdose of her brother's medication after an argument with her boyfriend. She regretted the overdose and there was no evidence of mental illness. (Service C).*
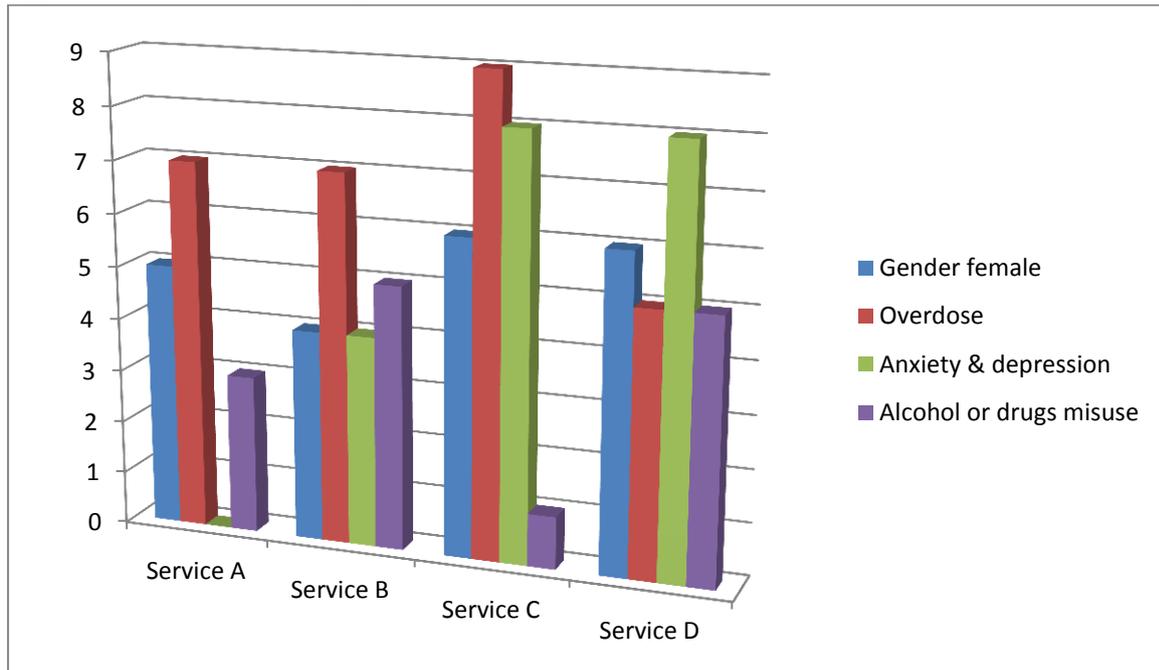
Service Response

Time of arrival

Data on time of arrival in the Emergency Department was missing or apparently unreliable in two of the four sets of records, and in another set of records only half of the referrals came from the ED, so it is difficult to make any comment. However, in the one service where data looked reliable, 6 of the 10 patients arrived at the ED between 22.00 and 07.59. In Service D only 5 people entered the service via the ED and all 5 arrived outside of the team's working hours. This team's surveillance register report on annual figures noted that two thirds of episodes of self-harm involved patients presenting out of the service's working hours.

Urgency of referral

Respondents were asked if referrals were marked as

- emergency (to be seen within 4 hours)
- urgent (to be seen within 24 hours)
- routine (response time not specified).

Results are shown in Figure 2 and show considerable variation in the expectations of referrers. All of Service C's referrals were expected to be seen within 24 hours, whilst 6 of the 10 referrals to Service D were expected to be seen within 4 hours.
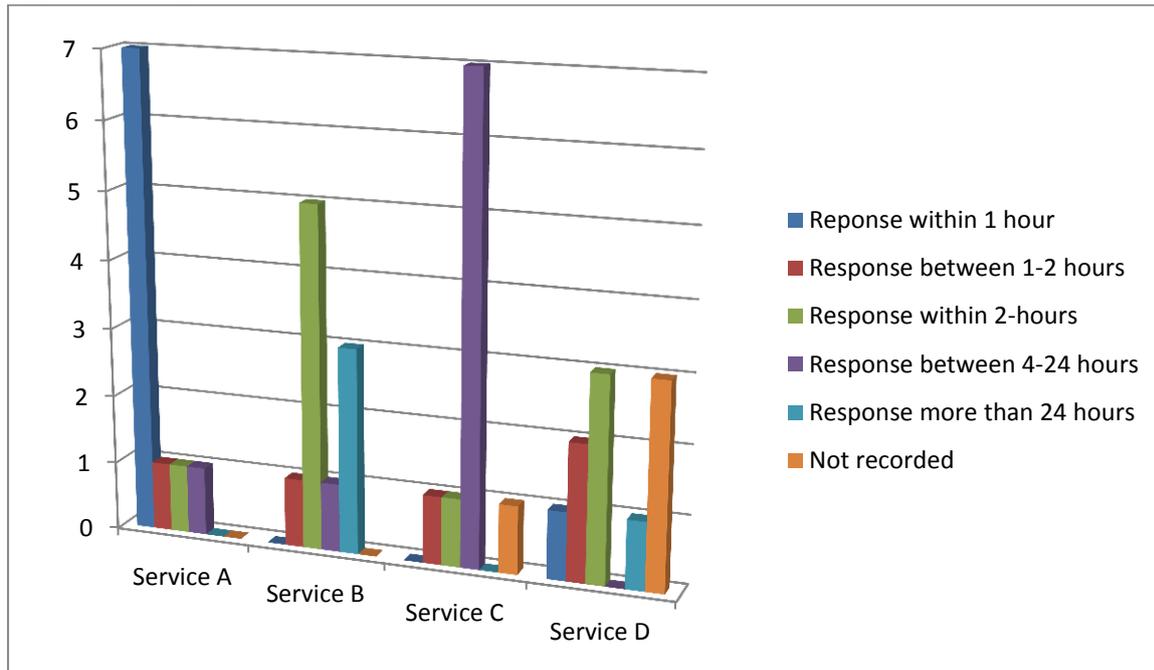
Figure 2: Urgency of referral
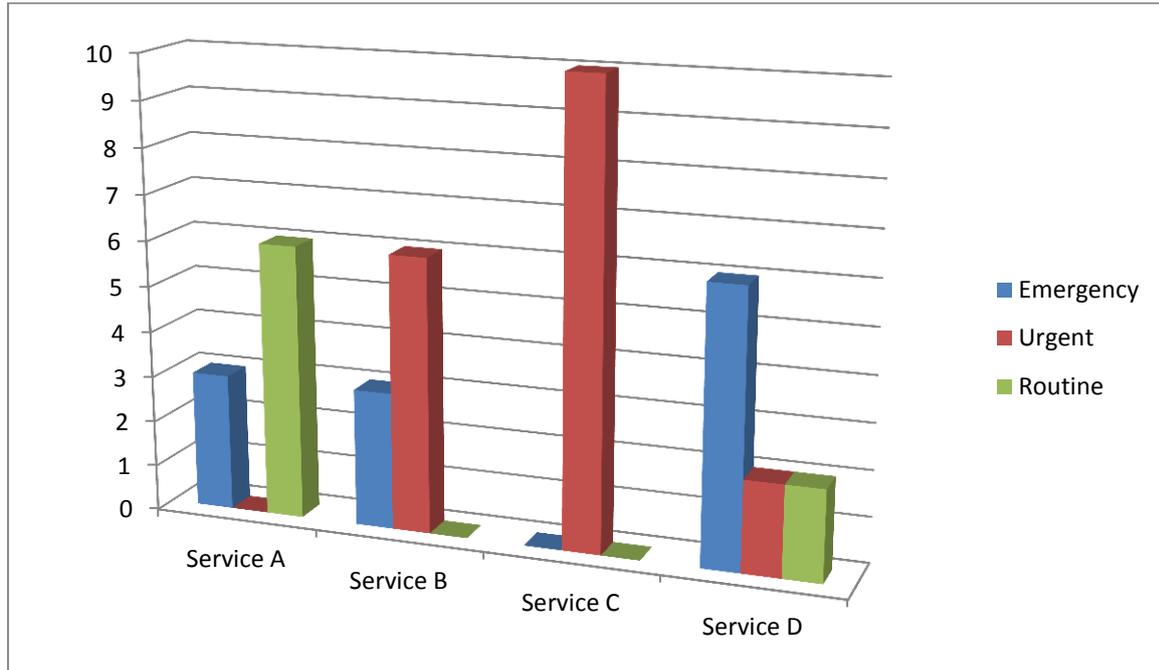
Response times and out of hours cover

Data was collected on the time lapse between referral and the team's response. Figure 3 shows that nearly all patients were seen within 24 hours, and interestingly, the least resourced service (Service A) saw most people within an hour. However, it is very important to note that the day of the week was not recorded and it could be that any longer response times could be due to referrals being made at weekends.

There is, however, no mention of any patient in this audit being seen by alternative services – such as Crisis Resolution/Home Treatment teams - providing out-of-hours cover. This may be an artefact of the limited pathways audit. However, it does highlight issues about whether or not in practice out of hours cover is actually in place for all services.

Figure 3: Response times

Legend:
- ■ Reponse within 1 hour
- ■ Response between 1-2 hours
- ■ Response within 2-hours
- ■ Response between 4-24 hours
- ■ Response more than 24 hours
- ■ Not recorded

X-axis: Service A, Service B, Service C, Service D

Assessments

Most assessments were completed (two were incomplete due to patient levels of consciousness), and undertaken by one or two practitioners in the teams. Risk assessments were carried out with all patients and included assessment of suicide risk, risk of harm to others, and risk of self-neglect. No Mental Health Act or Mental Capacity Act assessments took place.

Interventions

There were marked differences in care planning between the four services. No care plans were put in place by the liaison teams in Service A or C. Service B implemented care plans for 5 of the 10 patients. Service D implemented care plans for all 10 patients. Differences may be due to recording practices. Service B and D care plans included:

- advice to hospital colleagues
- management of alcohol withdrawal
- commencing or monitoring medication
- advice to patient about possible services
- anxiety management

Similarly, there were differences in interventions provided. Services B and D were much more likely to record that they had delivered interventions. Service A recorded very few interventions, whilst Service C recorded signposting only (see Table 4). Notably, although psychiatrists were available to all services, only those where psychiatrists were part of the team (B and D) included medication prescribing. These were also the only services where psychiatrists were recorded as having seen the patient.

Most patients were seen only once in every service although a few patients were seen more frequently especially in services B and D. Service C only saw patients once. No service provided any ongoing support, psychological therapies or interventions after the patient was discharged from hospital. There was little involvement of families or partners.

GP letters were recorded as having been sent by all services although not for every patient, except in Service D.

Table 4: Recorded interventions

	Service A	Service B	Service C	Service D
Therapeutic assessment	3	10	0	7 (+3 additional support)
Medication	0	4	0	3
Signposting	1	9	10	8
Active support or recommendations to ward staff*	0	3	0	3
Family involved	1	2	2	1
Referral to mental health (includes refer back to patient's existing team)	7	3	6	5
GP letter recorded	5	5	9	10
Other referral	3	5	1	5
No. of times each patient seen	1-2 (mode 1)	1-7 (mode 1)	1	1-7 (mode 1)

*Note: advice to "discharge when medically fit" not included here

Patient pathways

Pathway data was not always complete and respondents reported difficulty in accessing information about patient contacts before and after the index episode of care, and outcome data within six months following the index admission. Where available, the data showed some interesting differences.

Contact with services prior to index episode

In Service A, 8 of the 10 patients were in contact with mental health or drug and alcohol services before seeing the liaison service; 6 of these patients had seen mental health services within a week of arriving at the hospital. Four patients had had psychiatric admissions in the previous year.

In Services B and D only 3 patients were in contact with services prior to the index episode. Two from Service B had had psychiatric admissions in the previous year and one had a hospital admission avoided. In Service C, 5 of the 10 patients were in contact with services, although only 2 of these had been seen within the previous week. No patients had been admitted to a mental health ward in the previous year in either service C or D, but two in both services had a hospital admission avoided.

Service A therefore looks quite different from the others in this respect. These are very small samples and without further information it is not possible to draw substantive conclusions. But taken alongside the patient profile of Service A, which shows a group of people with serious mental

health issues, there is an implication that Service A may be viewed as another mental health service to the local population.

In each of the four services, two people had had prior contact with the liaison service in the previous year. In Service A and B a further one person had had contact with the liaison service more than a year earlier.

Length of hospital stay

When asked to comment on facilitating discharge, services gave varying types of response. Primarily a timely assessment was seen as the key to preventing lengthy admission. Sometimes, a referral on to a mental health team was also seen as helping facilitate discharge.

Length of stay varied between the four services. All patients in Service C were discharged within the day. Service A length of stay ranged from 0-15 days, with a mean length of stay of 2.3 days. Service B length of stay ranged from 0-33 days with a mean length of stay of 9.3 days and Service D ranged from 0-23 days with a mean length of stay of 6.7 days. A number of factors might affect length of stay, and in three cases (in each of Services A, B and D) patients with longer stays had serious physical health conditions.

Reattendances

Within the six months following the index admission, 37.5% of the total sample of patients reattended hospital. In each of Services A, B and D, four patients reattended; in Service C, three patients reattended. Data availability on reasons for reattendance was poor, so it is not possible to say with confidence whether attendances were for self-harm, mental health or other reasons.

Other outcomes

Four patients in this audit died within six months of the index admission– all as a result of physical health conditions that may have, at least partly, contributed to their need for liaison services. For example, one person was severely depressed in relation to a diagnosis of cancer.

Other outcome data was largely incomplete so it is not useful to summarise. Notably, it was difficult for services to say whether or not patients had had contact with mental health or primary care services after discharge, even if they had referred patients themselves.

Patient feedback

Anonymised feedback is routinely sought for services but no individual patient feedback was available to be recorded on the audit forms.

Issues raised by the teams

In discussion with the teams and hospital colleagues, a number of critical issues emerged that were considered to impact – both positively and negatively - on teams' ability to provide the services they felt were needed. Summarised in Table 5, these could be categorised as

- unmet need
- team capacity, composition and staffing
- hours of operation
- pathway information
- follow up provision

- recruitment and retention
- sustainability

Table 5: Issues raised in discussion with teams

Issue	Specific point raised by team or hospital colleagues
Unmet need	Under-resourced team means cannot offer liaison to hospital wards – they need support and advice. Problem for the hospital, results in 'specialling' inpatients beyond acute medical need. (Service A)
	People with learning disabilities may slip under the radar. (Service C)
	Surveillance register shows only see 50% of self harm patients coming into ED. The rest are leaving without an assessment. (Service D)
Team capacity, composition and staffing	Need psychological input; there is only one part-time psychologist in the regional renal service. CAMHS service also now based separately and less easy to access. (Service A)
	Would like a psychologist and a social worker in the team. (There is a separate health psychology team in the hospital). Need staff with skills, knowledge, experience and ability to build relationships. (Service B)
	Need more capacity to offer formal team based training and education to hospital colleagues. Would like social care integrated into team Need very experienced nurses in the team. (Service C)
Hours of operation	Would like to offer extended hours as audit shows people attending out of hours and not sure who is missed (Service B).
	Local audit shows 2/3 of patients attend out of hours (Service D)
Pathway information	Difficult to access all information needed to understand patient pathway. Mental health notes cannot be accessed via the acute system. (Service A)
	Cannot access all information on patient pathway. Don't know whether patient has seen GP prior to attendance, for example. (Service B)
	Difficult to capture outcomes for patients. (Service C)
	Cannot access follow up data on the system; don't know, for example, if patient acts on care plan objectives (Service D)
Follow up provision	Would like to be able to offer follow up clinics (Service B)
Recruitment and retention	Recruitment & retention problems. Currently only one P/T nurse in post. She is an experienced nurse but not experienced in liaison mental health & had been in post for only a few weeks at time of visit. (Service A)
	Satellite services difficult to recruit to; risk of underbanding posts. (Service B)
Sustainability	Important to ensure the service has everything in place and be clear about what can be delivered, otherwise not sustainable. (Service B) Monthly staff supervision meeting very important to maintain resilience of staff (Service B)
	Small service works well but concerns about sustainability. Complicated funding & management arrangements exacerbate concerns. (Service D)

Summary of Service Review

Service A is a very small service with limited resources, staffed by a social worker and two nurse (1 x WTE jobshare) although at the time of the study visit, only one part time nurse was working. The patient profile referred to this service showed a high level of mental health need and many patients were already in contact with mental health services. For this sample, Service A offered mainly a quick, timely assessment, including risk assessment, and referral on or back to mental health services.

Services B and D resemble each other in that they are both multi-disciplinary services actively working with people referred via the ED and the hospital wards. Their patients have mixed presentations and the service for these samples included timely, therapeutic assessment, advice to ward colleagues, medical intervention and signposting. Both Services B and D have developed services for complex needs within the hospital including eating disorders and hepatology.

Service C is a nurse-based service that appears to be focused primarily on people coming into the service via the ED following self-harm. The patients in this sample constituted a much younger group with less obvious mental health need. Service C offered this sample an efficient, timely assessment, signposting, and a GP letter. No patients in the sample needed to be admitted.

Discussion and conclusions

Liaison mental health services are widely regarded as essential to ensure best quality services to people with mental health problems attending general hospital. However, criticisms of services have been well publicised. Both the reported benefits and strengths and the commonly-held criticisms have relevance to the services commissioned and provided in the South West.

Clarity for commissioners

The commissioner survey revealed a wide variety of services commissioned, a lack of certainty amongst commissioners about what has been commissioned, and in most cases, lack of clarity of aims and objectives for the service. There were some large gaps in information notably on needs and demand, costs and expected outcomes. A few services commissioned were stated as providing all the components listed in the Commissioning Guidance. However, the more detailed audit suggests that there may be a gap between expectations of services and what they are in practice able to deliver; empirical data is needed. Therefore **one recommendation** from this project is **for a brief report from each commissioned service in the South West, to include patient pathway audit to provide empirical data to ascertain exactly which patients are seen by the service, what is delivered, what happens to patients out of hours in practice, and what the gaps in service provision are.**

Improving partnership working

The team visit and audit of four services was limited in a number of ways. In particular, the number of patients included was very small, there was no option to audit training, education and supervision activities of the teams and it was not possible to talk to patients about their experience of the service. Furthermore, it was not possible to obtain some significant pathway data. Nonetheless, the visits and audit revealed a number of useful findings.

- Services were provided by a dedicated, passionate and skilled set of practitioners keen to provide the best possible service but with varying demands, resources and capacity
- All services provided a timely response to people attending ED following an overdose or deliberate self-harm and this was clearly core business.
- Services could not access pathway information so did not always know whether people were already seeing mental health services or whether they kept appointments after the index episode. Thus only a very small part of the patient pathway is managed and is visible.
- They rarely knew if the patient had recently seen the GP, which is an area that could be very important in prevention and proactive management of distress leading to deliberate self-harm (including safer prescribing). According to the Academy of Royal Colleges, a close working relationship is required with primary care.[16]

Two further recommendations emerge from this. Firstly, **improved data sharing protocols need to be in place between acute and mental health services**. Secondly, **liaison services could be required to work more proactively with primary care services to develop preventative strategies and support people at risk of deliberate self harm, especially repeat attenders.**

Work together to agree best service models

There were some basic similarities between services. They all saw the ED as a prime source of referrals and people who self-harm as a significant client group. A psychosocial assessment, brief mental health assessment and risk assessment were core business for all services. An important similarity was that no service was able to offer ongoing therapeutic interventions with people after discharge from hospital, despite evidence and NICE recommendations promoting psychological therapies as a way of reducing future self-harm.

However, the pathways audit also highlighted a number of important differences in service provision including:

- Services had very different team composition and level of staffing, not apparently related to need. Some of the current staffing capacity seemed very poor and unsustainable (Service A).
- There was no psychologist on any team and only one team had a social worker; the Royal Colleges recommend a psychologist as essential and at least prompt and easy access to a social worker.
- The profiles of patients using the service varied considerably with some (in Service A) resembling patients whose needs might be the core business of secondary mental health services.
- There was varying capacity to work with people with mental health problems not referred via the ED or Emergency Admissions unit.
- Services varied in whether or not they worked with people with complex problems and medically unexplained symptoms admitted to the hospital. With a focus on ED (as in the example of Service C), patients could be seen quickly and efficiently and admission was apparently avoided; however this may mean that the service is less likely to be able to address the needs of patients with more complex problems and medically unexplained symptoms.
- The teams had different strengths and each had at least one feature that could be described as adding extra value, such as special expertise with working with people with eating disorders.

A critical finding is that out of hours provision varied. The one team with seven day a week provision appeared to avoid admissions (Service C). Out of hours provision did in theory exist for the other three services, but no one in the (admittedly small sample) was seen by an out of hours practitioner, despite the majority of people arriving out of hours. This throws up a number of issues:

- Some services rely on cover from other services (notably, Crisis Resolution/Home Treatment teams) to supplement their service out of hours, but are patients actually being seen by these teams?
- If they are not, what is the impact on the patients who attend out of hours – especially at weekends? For example, are these patients more likely to leave without a full assessment? Studies have shown that people attending ED after deliberate self-harm between 5pm and 9am are less likely to be assessed.[17]
- Again, at weekends, what is the impact on length of stay in the hospital?

- Is out of hours cover for liaison mental health services an appropriate of use of CRHT teams given that their remit should be to work with people with SMI at risk of mental health patient care, to help avoid or limit admission?

There are clearly wide variations in the way the teams are constituted, how they work, and with whom. This variation, coupled with the findings from the Commissioner survey, leads to a **fourth recommendation**. It is suggested that the South West Clinical Network commissions the development of a service specification for commissioning, and to share knowledge and experience that will support commissioners in the commissioning, design and continuing improvement and development of liaison services across the area. It would be important to allow for *planned* variation in services, such as the special expertise that some services have developed, along with an emphasis on local needs and outcomes. Factors to be considered include:

- description of the core business of liaison teams across the Network catchment area, including aims and objectives.
- minimum and optimum staffing levels and team composition, based on evidence of need
- hours of operation and best solutions for out of hours care
- core outcomes for patients
- how the work of liaison teams can integrate with primary care and mental health care, including sharing information
- how to work best with the 'added value' features that individual teams bring to the liaison psychiatry work
- working with particular groups, such as people who use the service frequently
- preventative work
- how to grow and share knowledge and expertise.

Involvement and expertise of service users
Finally, no feedback from service users was available for this project. All services invited anonymised feedback but there was no evidence available that service users influenced the development and operation of services. This may have been due to the limitations of this project. It is critical that the voices of service users are heard when further developing services and the fifth recommendation is that **service specifications should include a requirement that arrangements are made for service users to contribute to service development** and to give shared feedback on services. Service users could be invited to the Liaison Network day if that recommendation is accepted.

Summary of recommendations
1. **Require a brief report from each service - to include a patient pathway audit to ascertain exactly which patients are seen by the service, what is delivered, the service focus, and gaps in service provision.**
2. **Develop improved data sharing protocols between mental health and acute health services.**
3. **Require liaison services to work more closely and proactively with primary care.**
4. **Commission the development of a commissioning specification to include planned variations, for local adaptation.**

5. **Promote and continue to develop the specialist expertise in mental health liaison services in the region.**
6. **Ensure arrangements are in place for service users to contribute to service development.**

Dr Edana Minghella

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[1] For a range of critical commentary, see for example, Gordon G and Wolf J (2010) Liaison Psychiatry Services in the South of England. The Psychiatrist. (34) 270-273 and Ruddy R & House A (2003) A Study of Liaison services within 6 SHAS. Psychiatric Bulletin (27) 457-460

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[15] NICE (2013) The NICE Quality Standard for Self Harm

[16] Academy of Royal Colleges (2008) Managing urgent mental health needs in an acute trust.

[17] Hickey et al (2001) as above.