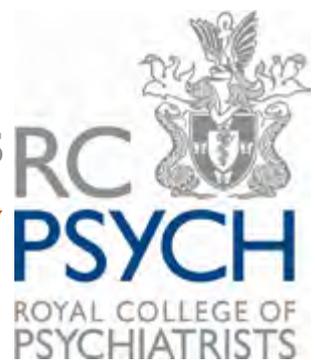




Vol 15:01
March 2015

ROYAL COLLEGE OF PSYCHIATRISTS
FACULTY OF **LIAISON PSYCHIATRY**
NEWSLETTER



EDITORIAL

Welcome to the first Newsletter of 2015. In this edition we are publishing our first examples of Audit from Liaison Psychiatry Services in the UK. This is not a peer reviewed journal but an forum for us as Liaison Psychiatrists to share practice and standards across services. We hope that this will open the doors for many other services to share examples of their Audits. There is obviously an appetite for this as we already have audit submissions for our next newsletter, but we are always looking for more particularly those that have developed standards so this work can be replicated in other services. We should highlight the excellent guidance on the Royal College website on how to perform audit, develop and set standards which may be of assistance, in particular to trainees. Please note that it is the authors responsibility to take account of the ethical and confidentiality aspects of their submissions. Audits can be submitted as full reports or summaries.

We also present to you an update on developments from the Chair of the Liaison Faculty, Dr Peter Aitken. We are also fortunate to have a message from the President of the College, Professor Sir Simon Wessley, who has practised Liaison Psychiatry and contributed considerably to the body of research in the subject and in addition has brought through the fold many Professors of Liaison Psychiatry and other eminent Liaison Psychiatrists.

The CCQI arm of the Royal College of Psychiatrists has lead many quality improvement exercises and a few years ago launched PLAN. The Psychiatric Liaison Accreditation Network. Services who participate have to demonstrate a number of different standards and provide feedback from patients, carers and referrers to the service. Accreditation has been taken up by many services across the country. The process is rigorous and driving up standards countrywide and we are lucky to have the Liaison Psychiatrist CCQI Lead Dr Jim Bolton's report on the PLAN process.

Conference

You will already have been alerted to the next Faculty Conference which is to be held at the College in May. This is an chance for Faculty Members to visit the new College building, with its extended space and facilities, if they have not been. Anne Price, Director of Development for the College, whose article appears in the newsletter, has kindly agreed to attend the Liaison Faculty AGM, where drinks will be served, talk about her role and show delegates around the building. The con-

CONTENTS

	2
Editorial	
	4
Chair's Report	
	6
Message from the College Chair	
	7
Clinical Pharmacy Interventions Pilot	
	8
Audit of Care Plans for Frequent Attenders to the Emergency Department	
	12
PLAN Conference Report	
	13
Message from Ann Paul	
	15
Obituary	

Liaison Faculty Newsletter

Dr Edwina Williams
Dr James Stallard
Dr Oliver Gale-Grant

Submissions warmly recieved - please e-mail SGalea@rcpsych.ac.uk using "Liaison Faculty Newsletter" as the subject.

Liaison Faculty Executive Committee

Dr Peter Aitken, Dr Adrian Flynn, Dr Hosakere Aditya, Dr James Bolton, Dr Dallas Brodie, Dr Janet Butler, Dr Charlotte Feinmann, Dr Anna Fryer, Dr Panthathan Grewal, Prof. Eispeth Guthrie, Dr Marcus Hughes, Dr Khalida Ismail, Dr James Kustow, Dr William Lee, Ms Nicola Long, Mrs Jackie Macklin, Dr Joanne Minay, Dr Colm Owens, Dr Thirza Pieters, Dr Annabel Price, Dr Gopinath Ranjith, Dr Amrit Sachar, Dr Alastair Santhouse, Dr Ankush Singhal, Dr James Stallard, Dr Geraldine Swift, Dr Catherine Taggart, Dr Tayyeb Tahir, Dr Peter Trigwell, Dr Edwina Williams, Dr Gemma Williams

ference is being held in collaboration with the Royal College of Physicians, Royal College of General Practice and the College of Emergency Medicine. We have input from Presidents, Chairs and Academic Vice Presidents and Mental Health Leads of these colleges, who will be presenting. We are fortunate to have many eminent speakers from Liaison Psychiatry and also from other colleges. Aside from the obvious academic aims of the conference this represents an excellent opportunity to hear the opinions; meet members of other colleges and to develop closer working partnerships.

As always we must thank staff at the College in particular Stella Galea for all her work on behalf of the Faculty Executive and Newsletter; to Emma George and Rosanne Brake for their support in organising the Conference in May 2015 and to my editorial colleagues. We are always happy to expand the ranks so anyone who considers that they might like to write or edit articles please contact us via Stella.

Cover Story

The photograph on the cover was taken at a recent visit to the Royal College of Physicians. It is from the Hoffbrand collection and shows an English Delft Ware wet drug jar from the 1600's. There were also dry jars of different shape to store other ingredients. These were designed to hold syrups and oils, with a narrow base to allow easy lifting and pouring from the spout which had a rim to allow a cover to be tied over it to protect the contents. Some substances used at that time are no longer prescribed. Jars contained Lohoch of Fox Lungs, sucked from the end of liquorice sticks to strengthen the lungs; oil of earthworm to cure arthritis and Oxymel of Squills, vinegar of squills (sea onions) boiled with honey which John Quincy reported produced a mighty good puke for children. Many others do remain in use such as Papaver. The jar illustrated contained Hypericum. Hypericum, or St John's Wort, has been used since ancient times for its antidepressant properties and continues to be used today in over the counter preparations often as teas. It was know to help people with depression, anxiety and was prescribed by Monks in Medieval Britain for Nuns who were fasting to excess. Problematic because of its enzyme induction it is as everyone knows closely related to SSRI's. The Psychological aspects of Medicine and antidepressant prescribing have an ancient history.

Dr Edwina Williams
Consultant Liaison Psychiatry
CNWL Foundation Trust

FACULTY OF LIAISON PSYCHIATRY ANNUAL CONFERENCE 2015



ROYAL COLLEGE OF PSYCHIATRISTS IN LONDON ON
13-15 MAY 2015

50% of tickets currently sold

CHAIR'S REPORT - DR PETER AITKEN



Can I extend my sincere thanks, on behalf of the faculty executive and the college, to all our members, fellows and friends who have contributed to our work in the last year.

Liaison Psychiatry and Psychological Medicine are no longer terms strange to politicians, commissioners or our public. The models of service we offer are becoming easy to explain to people who have never thought about mental health practice in hospital wards or accident and emergency departments or general practice surgeries. Even within psychiatry, liaison psychiatry has been perceived to move from the margins to the mainstream.

This is no accident. It is the culmination of many years of effort researching and writing reports, meeting and influencing people with the power to make things happen, and finding a way to explain things simply and in language that makes our work accessible rather than frightening or stigmatising. People with an experience of using our services, who have felt the benefit of liaison psychiatry services, have found a channel for their voice through the college, the faculty and the NHS, and speak up for us and for having more of us. The more liaison psychiatry we have, the more people of influence encounter it when they or their relatives are in hospital. Several senior civil servants using London hospitals and encountering liaison psychiatry have fed back to me how that experience has brought to light what we've been advocating for and in turn influenced their advocacy on our behalf.

Sadly, a great experience of our models of care isn't sufficient for the business case when it comes down to brass tacks. Building on Prof George Tadros RAID

from Birmingham and work led by Dr Steven Reid in North West London our real success has been having the models of care written down in language that commissioners can understand. This work was enabled by Dr Adrian James and Dr Geraldine Strathdee and delivered by the Strategic Clinical Network in the Southwest. We would not have been able to do this at pace were it not for the Joint Commissioning Guide led by Dr Paul Gill and Council Report 183 chaired by Dr Janet Butler.

Models in themselves are not enough, so we must again thank Matt Fossey and colleagues in the Centre for Mental Health for continuing their work from RAID and Liaison Psychiatry in the Modern NHS to give us an Outcome Framework. This has catalysed huge effort led by Dr Peter Trigwell and colleagues to define generic and condition specific outcome measures for liaison psychiatry. As care moves increasingly to be funded on the basis of NICE approval, Dr Al Santhouse now has the support of Dr Owen Bowden-Jones and the college policy office to help liaison psychiatry offer comment on all NICE guidance development in a systematic way. All of this has underpinned a political will to see the expansion of liaison psychiatry services to make sure that there is an adequate service in every hospital in England with an accident and emergency department. Without Dr Will Lee surveying around 180 English hospitals over a three month period at the beginning of 2014 we would have had no basis on which NHS England could then offer to put right the inadequacy he found in 60%. They are now able to provide funds to put the survey and supporting audits on an annualised basis. My thanks to Professor Tim Kendall and the National Collaborating Centre for Mental Health for agreeing to help and project manage this work in 2015.

So the last year has been unashamedly about the emergency and unplanned work arriving mainly with us through accident and emergency department and acute medical units. The policy framework has been the Crisis Care Concordat and that has helped us find our boundaries with Crisis Response and Home Treatment services, thank you Dr Mary-Jane Tacchi. It has also highlighted the inequity of age based service models and brought us into dialogue with Dr Peter Hindley and the faculty of child

and adolescent mental health around how to help with young people in transition to adulthood. At the other end of life the boundaries are helpfully blurring with liaison psychiatry for older people and my thanks to Dr Thirza Pieters and our Dean Dr Wendy Burn for pursuing the issue of credentialing and accreditation vigorously with Health Education England and the GMC. Thank you too to our co-opted nurse Consultants Nicola Wilson and Kate Chartres and Sarah Eales for the competency framework for liaison mental health nurses.

Finally to 2015 and beyond. We will have a general election. There will be a new government. Political alliances fostered over the last five years will need to be repaired and rebuilt but policy should not change. Professor Dame Sally Davies in her Chief Medical Officer's annual report keeps the focus on Public Mental Health. Professor Dame Sue Bailey and Professor Sir Simon Wessely have established cross party support for the importance of 'Parity of Esteem' and the need to pursue 'No Health without Mental Health'. A BMA report into the Physical Care of People with Mental Illness and Learning Disability by Professor Sheila, the Baroness Hollins articulates the problem of over 33 000 preventable deaths annually for the want of adequate physical care. There remains political will and policy imperative to tackle these issues and the related issue of £10billion pounds spent annually on the costs of untreated depression associated with long term conditions and £4billion spent on the wrong kind of care for people with 'medically unexplained symptoms'

The next year needs to be about these, the meat of liaison psychiatry and psychological medicine. We need to be as clear and organised in our description of our models of care for people with long term conditions and medically unexplained symptoms as we are for the emergency and unplanned care pathway. Dr Susan Mizen and Dr Simon Heyland from the Faculty of Medical Psychotherapy are leading the production of Joint Commissioning Guidance, ably supported by Dr Mahnaz Hashmi and Dr Amrit Sachar from our faculty and colleagues from the RCGP and BPS. We look forward to increasing our work with colleagues from the RCGP where Dr Elizabeth England is the mental health lead and colleagues from the Royal College of Physicians where Professor Rowan Harwood and Dr Ganesh Subramanian are already working with us on building a Diploma of Psychological Medicine. In addition we will be working with the British Psychological Society to bring their

expertise to help us understand the whole model of care from 'Hospital to Home' and Dr Nicky Scheiner, Clinical Psychologist, has been co-opted to the faculty executive.

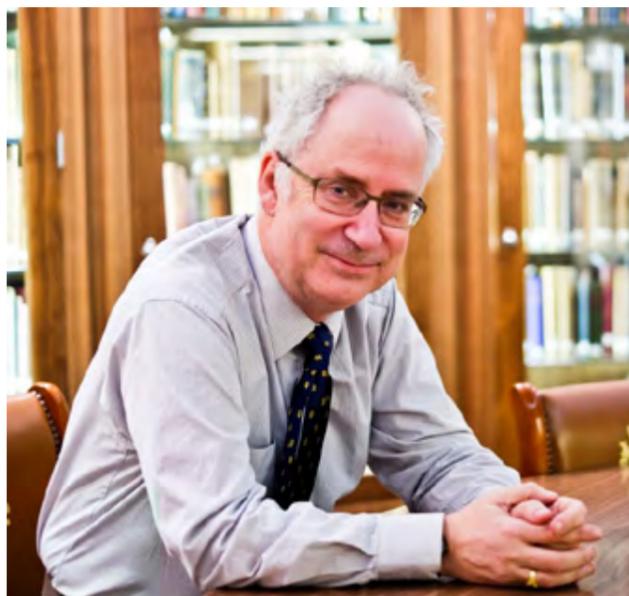
'Hospital to Home' is the theme of this year's annual residential meeting which will be held at the Royal College of Psychiatrists between 13 – 15 May 2015. We plan to involve as many colleagues as we can from emergency medicine, general practice, general medicine and psychology and celebrate all of our progress with both the emergency and unplanned work and now the work around on long term conditions and medically unexplained symptoms. This year sees the start of LP-Maestro, the NIHR program of research led by Professor Allan House from Leeds which aims to examine our existing and emerging models of care and the professionals, professional practice and the outcomes they achieve.

The financial situation seems a little bleak. The spending round gave more to general practice and general hospitals than to mental health. On the face of it a problem, but when we think about it perhaps an opportunity. We need all health care to have a little bit built in for mental health and all of our mental health care needs a bit of physical care built in. So I see that as our immediate challenge. I want to see all commissioned health care pathways with mental health standards and associated mental health outcomes. I want to see all the payment and pricing systems set to reward excellent mental health care. In other word, to achieve parity of esteem, to really make it No Health without Mental Health and if we are to make it No Mental Health without Health, we need to take our fair share of the resource coming to general practice and our general hospital systems by being a fully integrated part of the future systems of care.

Enjoy the festive season and the thought that liaison psychiatry is the most exciting and intellectually challenging specialty in medicine and probably in health care. And we get to do it!

Peter Aitken
Director of Research & Development,
Devon Partnership NHS Trust,
Hon Associate Professor,
University of Exeter Medical School, PenCLAHRC
@PeterPenCLAHRC

MESSAGE FROM THE COLLEGE PRESIDENT



Greetings to the faculty of liaison psychiatry and my sincere thanks on behalf of the college for the work you are doing raising the profile of psychiatry and the college with general hospital and general practice colleagues. In England we might feel a little disappointed not to have been more richly rewarded in the recent government spending round and we might like to notice how much better general practice and general hospitals did in that respect. But for once, the devolved nations haven't fared much better either (except of course their constant good fortune in having being spared the ghastly Health and Social Care Act).

The fact is that whilst we are all explaining 'parity of esteem' and how there can be 'No Health without Mental Health' to an increasingly appreciative political and public audience we are not seeing much more money obviously spent in mental health services. Of course, parity is not just about money, and some have argued that the real importance of parity is not financial, but in equal respect, rights, dignity and so on. Having said that, money is also a pretty good proxy for esteem as well.

So where ought we to look for the resource we will need if we are to extend the dialogue to 'No Mental Health without Health'? The physical care of people with severe mental illness and learning disability remains a national disgrace with over 33 000 preventable deaths a year and lives 20 years shorter than expected. General practice and general hospitals are where we must look. We need to become integral to their commissioning and outcomes. I have already argued at NHS England that must become unacceptable to commission a care pathway without mental health in its design – or at least to give a sound reason and case for why it is not there. I know of several incidents in which regional trauma centres, or centres of excellence for liver disease, were commissioned with every service (pathology, anaesthetics, radiology, intensive care etc etc) but mental health was simply forgotten. This is simply inexcusable, and we are working with NHS-England to ensure that it doesn't ever happen again.

It needs to be normal to spend a bit on mental health in every care service. All outcomes must have a mental health component. Commissioners of general practice and general hospitals hold the key to our future in liaison psychiatry in general and the psychological medicine of long term health conditions and medically unexplained symptoms in particular. Send your GP, Physician and Surgical friends a bigger card than usual this year. One that is all singing and dancing when they open it. That's the kind of mental health support they need from us. We must never be out of sight, otherwise they will be out of mind.

Professor Sir Simon Wessely
MA BM BCh MSc MD FRCP FRCPsych FMedSci FRC
President, Royal College of Psychiatrists

CLINICAL PHARMACY INTERVENTIONS PILOT AND REFERRALS TO A LIAISON PSYCHIATRY TEAM

Patients who are prescribed antipsychotic medications have an increased risk of falls, delirium, cerebrovascular events and death. It is therefore recommended that patients who are prescribed these agents are regularly reviewed by specialists to both optimise therapy and prevent harm. A baseline study found that only 1/3 of patients prescribed antipsychotics at City Hospital were referred to a specialist psychiatric team during their admission by their treating physicians (1). It was therefore felt that pharmacy could improve patients' access to psychiatric specialists by using real-time dispensing information to identify and subsequently review inpatients prescribed these agents. Guidance on patients who would require psychiatric referral (Figure 1) was developed and information on clinical pharmacy input to these patients collected (Figure 2).

Reasons for pharmacist referrals to RAID Liaison Psychiatry;

1. Unknown indication for antipsychotic medication
2. Reason for admission was potentially related to an adverse effect e.g. fall, confusion or stroke
3. Patient was experiencing an adverse drug reaction e.g. dystonia
4. The patient had a diagnosis of dementia and was prescribed antipsychotics without evidence of a recent (<12 weeks) specialist mental health review
5. Inadequately detailed treatment plan or review

Figure 1. Reasons for pharmacist referrals to RAID Liaison Psychiatry

During the first year (September 2012-October 2013) 385 patients were identified by the pharmacist following the prescription of an antipsychotic, mood stabiliser or dementia drug. Improved patient access to psychiatric services was seen with 47% patients now receiving inpatient RAID review. An additional 23% patients had their management plan informally discussed with liaison psychiatry (Figure 2) and as such 70% of patients were seen by psychiatry - if the pharmacist is considered part of the multidisciplinary psychiatric team. The pharmacist has access to RiO, the mental health electronic clinical records system and attends the weekly team meetings.

Improved patient access to the service is leading to better patient outcomes, less inappropriate prescribing and cost improvements. Research funding (Pharmacy Research UK) has been received to allow an alternative pharmacist with little prior psychiatric knowledge to test the new system. This will establish whether the process works on a larger, general scale.

References

- 1) Increase referrals intelligently and boost access to specialist advice. Brooks J et al. Clin Pharm 2013; 5: 176-8

Julie Brooks, Kate Holland, Pharmacy Department, City Hospital, Birmingham
Mahnaz Hashmi
RAID Liaison Psychiatry, Birmingham

DATE	CLINICAL NOTES (each entry must be signed)	DATE	CLINICAL NOTES (each entry must be signed)
Date/Time	<p>Pharmacy</p> <p>Re: Risperidone and confusion surrounding his dose (BD or QD)</p> <p>History confirmed with RAID and also information from ... care home. John has Lewy body dementia and lives in a specialist care home for dementia patients with challenging behaviour. He is known to be physically aggressive, have suicidal ideation and also persistent paranoia.</p> <p>Risperidone dose confirmed with RAID and care home as 500mcg nocte. He is currently prescribed this BD, although I note that he has not received any medication for 2/7 and is awaiting SALT assessment. If an NG tube is passed I recommend Risperidone Liquid 500mcg NOCTE.</p> <p>John is open to the CHMT (Consultant ...) and was last seen by his CPN (Jane ... Tel: xxx xxx) 2/52 ago who advised Risperidone to continue. This had previously been stopped but John's wife reported an increase in paranoia symptoms on discontinuation.</p> <p>Recommend Risperidone 500mcg NOCTE as per CHMT. Refer to RAID if there are any problems associated with challenging behaviour following this being started. Previous RAID full MH assessment filed in the notes for your reference.</p> <p>Julie Brooks Pharmacist (Sleep)</p>	Date/Time	<p>Pharmacy</p> <p>History confirmed with RAID (see recent letter filed in the notes). James is known to BSMHT with a diagnosis of dementia with challenging behaviour. He is known to Dr xxx at xxx CHMT and was last seen on 3rd May when he was started on both citalopram and risperidone for symptomatic behavioural management. James is known to be verbally aggressive but not usually physically aggressive.</p> <p>Risperidone is associated with increased cardiovascular risk and I note that he was admitted with chest pain although his troponin was negative. Dr XXX plans to review Ronald in November following 6 months of treatment but he is happy to see James earlier if it is clinically indicated. Recommend that if chest pain re-occurs that an earlier MH review of risperidone in case this has exacerbated the symptoms. Please can this be documented on James's TTO as I note that he planned for discharge later today.</p> <p>If James stays in hospital or you have any concerns please review to RAID for an inpatient review.</p> <p>Julie Brooks Pharmacist (Sleep)</p>

Figure 2. Examples of pharmacist liaison with psychiatry and documentation in medical notes

AUDIT OF CARE PLANS FOR FREQUENT ATTENDERS WITH SELF-HARM TO THE EMERGENCY DEPARTMENT

Introduction / Background

Self-harm or self-injury is when somebody damages or injures their body on purpose. This can take the form of cutting, burning, scratching, hitting or overdosing. Self-harm can be a way of expressing deep emotional feelings or problems that build up inside.

Although there is a connection between self-harm and suicide, a lot of patients who self-harm do not want to end their lives. For many people who self-harm, their actions are an attempt to cope with the stress and difficulties they face. However, there is a risk that those who self-harm may end their lives either deliberately or accidentally as the result of their actions. Self-harm increases the likelihood that the person will eventually die by suicide by between 50- and 100-fold above the rest of the population in a 12-month period.

Specialist self-harm interventions aim to reduce recurrent self-harming as well as the associated complications. Self-harm interventions help individuals in finding other ways to express their feelings, emotions and tensions.

The UHBristol Liaison Psychiatry Team sees a large proportion of patients who present to A&E or are admitted to the wards with self-harm. In addition to this, they have also been working closely with the secondary mental health teams and A&E staff to develop interventions and care plans for those patients who attend this hospital with self-harm on a frequent basis (i.e. 3 or more attendances in 6 months).

We aimed to review whether these frequent attender patients are being treated according to the NICE guidelines on longer-term management of self-harm (2011) and whether this is having an impact on reducing their frequency of attendances with self-harm.

Self-harm and suicide are associated with socioeconomic status. We acknowledged that it may be unrealistic to expect self-harm to have totally reduced, stopped or not increased in this entire patient group, due to the probability of future crisis events, changes in their life circumstances, etc.

Implementation of a local self-harm register incorporating data for self-harm attendances to the A&E departments at both the BRI and Frenchay Hospital enabled us to compare retrospective data to compare attendances before and after the introduction of these care plans.

Aims

- 1) Are care plans completed in accordance with NICE guidelines on the longer-term management of self-harm (2011)?
- 2) Are these care plans having an impact on the patients' longer term self-harm?
- 3) Are these care plans having an impact on the number, frequency and duration of the patients' A&E attendances?

Objectives

- 1) To assess completion of care plans in line with NICE guidance
- 2) To determine whether care plans are reviewed regularly
- 3) To see if the Liaison Psychiatry Team are regularly updating risk management plans for people who continue to be at risk of further self-harm, monitor changes in risk and evaluate the impact of treatment strategies.
- 4) To see if the Liaison Psychiatry Team's interventions are helping to prevent an escalation of self-harm, are reducing harm arising from self-harm or are reducing or stopping self-harm in this frequent attender patient group.
5. To see if the Liaison Psychiatry Team's interventions are helping to reduce the repetition of self-harm in the longer term.

Methods

All patients who attend A&E three or more times in a six month period with an episode of self-harm should have a frequent attenders care plan. Attendance data was collected from the self-harm register. All of these care plans (n=23) were divided into three piles and randomly distributed amongst the

CRITERIA	TARGET (%)	EXCEPTIONS
a) All care plans should include the aims of longer term treatment. These aims are to: b) Reduce harm arising from self-harm or reduce or stop self-harm c) Reduce or stop other risk-related behaviour d) Improve social or occupational functioning e) Improve quality of life f) Improve any associated mental health conditions	100	None
All care plans should be reviewed with the person, including the aims of treatment, and revised at agreed intervals of not more than 1 year	100	None
All care plans should be multidisciplinary and be developed collaboratively with: a) the person who self-harms b) their family c) their carers d) significant other	100	The person does not want their family, carers or significant others involved in their treatment. Or, the person does not have any family, carers or significant others
All care plans should a) Identify realistic and optimistic long-term goals including education, employment and occupation b) Identify short-term goals and steps to achieve them c) Identify the roles and responsibilities of team members and the patient d) Include a jointly prepared risk management plan e) Be shared with the person's GP	100	None
Risk management plans should:- a) Address each long-term risk identified b) Address the more immediate risks identified c) Address specific factors: i. psychological ii. pharmacological iii. social iv. relational d) Include a crisis plan, including: i. self-management strategies ii. how to access services e) Be consistent with the long-term treatment plan f) Updated regularly	100	None

Fig 1. Standards to audit against (from NICE Clinical Guideline CG 133)

Introduction / Background

Self-harm or self-injury is when somebody damages or injures their body on purpose. This can take the form of cutting, burning, scratching, hitting or overdosing. Self-harm can be a way of expressing deep emotional feelings or problems that build up inside.

Although there is a connection between self-harm and suicide, a lot of patients who self-harm do not want to end their lives. For many people who self-harm, their actions are an attempt to cope with the stress and difficulties they face. However, there is a risk that those who self-harm may end their lives ei-

CRITERIA	TARGET (%)	RESULTS
a) All care plans should include the aims of longer term treatment. These aims are to: b) Reduce harm arising from self-harm or reduce or stop self-harm c) Reduce or stop other risk-related behaviour d) Improve social or occupational functioning e) Improve quality of life f) Improve any associated mental health conditions	100	a) 34.8% Yes (8/23) b) 56.5% Yes (13/23) c) 43.5% Yes (10/23) d) 4.3% Yes (1/23) e) 8.7% Yes (2/23) f) 39.1% Yes (9/23)
All care plans should be reviewed with the person, including the aims of treatment, and revised at agreed intervals of not more than 1 year	100	26.1% Yes (6/23)
All care plans should be multidisciplinary and be developed collaboratively with: a) the person who self-harms b) their family c) their carers d) significant other	100	a) 34.8% Yes (8/23) b) 0% Yes (0/23) c) 8.7% Yes (2/23) d) 13% Yes (3/23)
All care plans should a) Identify realistic and optimistic long-term goals including education, employment and occupation b) Identify short-term goals and steps to achieve them c) Identify the roles and responsibilities of team members and the patient d) Include a jointly prepared risk management plan e) Be shared with the person's GP	100	a) 0% Yes (0/23) b) 52.2% Yes (12/23) c) 82.6% Yes (19/23) d) 39.1% Yes (9/23) e) 13% Yes (3/23)
Risk management plans should:- a) Address each long-term risk identified b) Address the more immediate risks identified c) Address specific factors: i. psychological ii. pharmacological iii. social iv. relational d) Include a crisis plan, including: i. self-management strategies ii. how to access services e) Be consistent with the long-term treatment plan f) Updated regularly	100	a) 1.7% Yes (5/23) b) 96% Yes (22/23) c) i. 65.2% Yes (15/23) ii. 39.1% Yes (9/23) iii. 39.1% Yes (9/23) iv. 30.4% Yes (7/23) d) 60% Yes (18/23) i. 26.1% Yes (6/23) ii. 47.8% Yes (11/23) e) 26.1% Yes (6/23) f) 13% Yes (3/23)

Fig 2. Results of audit (from NICE Clinical Guideline CG 133)

Conclusions & Discussion

The main limitation of this audit was that as it was being carried out, it became apparent that these care plans are not in fact designed to meet the guidelines for the long-term management of self-harm. They are more for use by Emergency Department staff

and psychiatric colleagues to help manage the patients' distress during their hospital stay.

We therefore acknowledge that long-term interventions such as those identified in standards 1 d) and e) cannot be carried out by the Liaison Psychiatry team nor can they be implemented in an Emergency

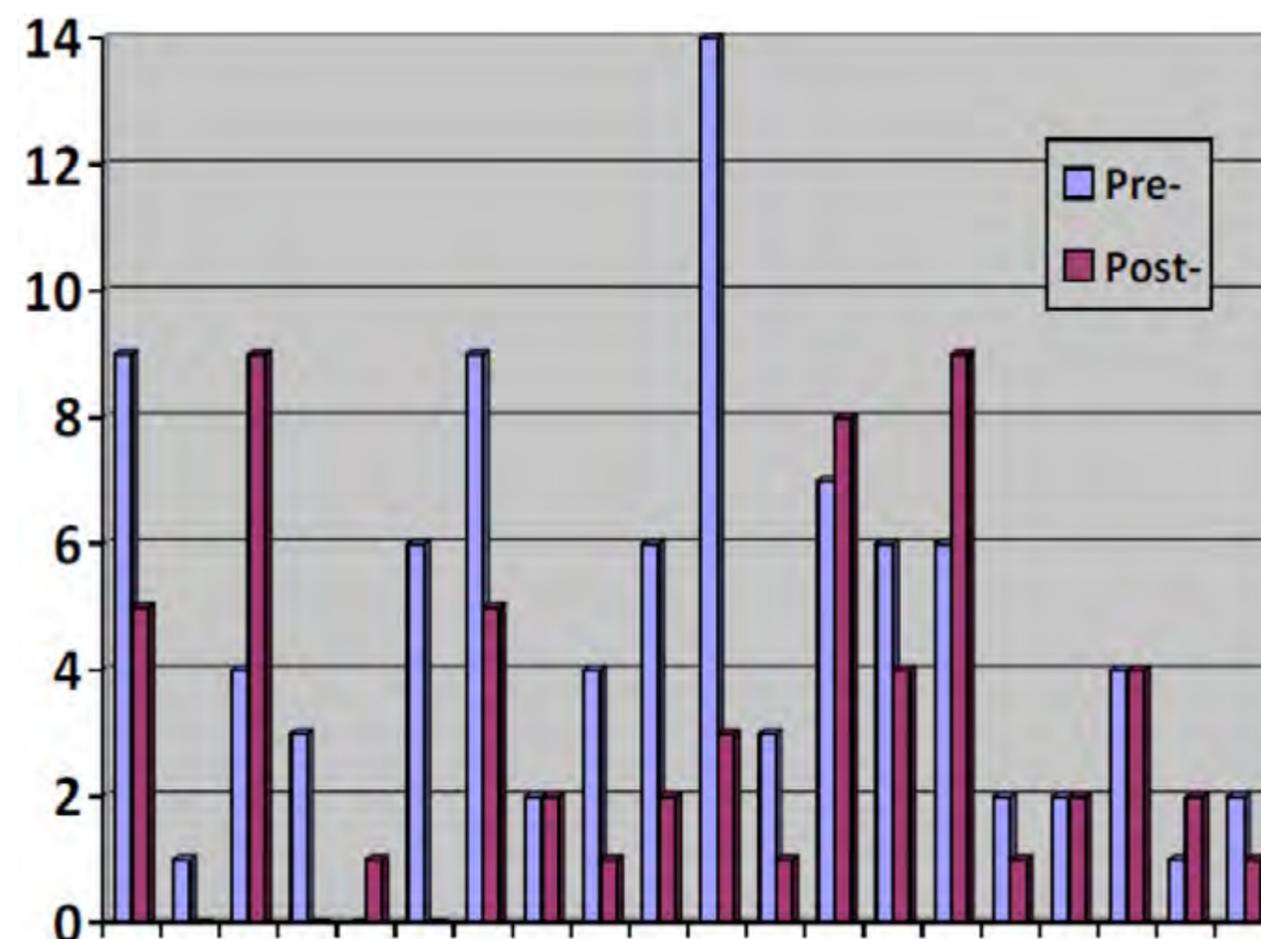


Figure 1 - Frequency of attendance pre and post care plan initiation - overall reduction of 34.1%

partment setting. As a result of this finding, we need to acknowledge that these care plans will probably not impact upon the number, frequency and duration of attendances. However, this additional data will be presented at the end of this report.

We also found that the design of the care plans does not clearly demonstrate some of the standards we were trying to measure. For example, we know that the care plans are reviewed with the person at yearly intervals (standard 2), but this is not documented. We can assume that all of the care plans were developed collaboratively with the patient and relevant others (standard 3). However, again this was not demonstrated in the document. Nor was it shown if the patient did not want relevant others involved.

Similarly, there was no evidence that the care plans had been shared with the patient's GP for standard 4 e), whereas in most cases they would have been.

As it is neither practical nor realistic for this team to be addressing long-term goals, there is a poor result for standard 4 a). Standards 4 b) and c) fare much

better, whereas 4 d) again scores poorly due to the lack of proper documentation around this.

Similarly with regard to longer term goals, standard 5 a) scores poorly, whilst 5 b) (more immediate risks) scores much better. The scores on 5 c) and d) are variable, highlighting the need to identify and manage the specific risk factors and management strategies more clearly. Standard 5 e) highlights the fact that these are not long-term treatment plans whilst 5 f) is similar to standard 2, i.e. lack of documented evidence that they are regularly updated.

Overall, the findings are variable. Some of the care plans did identify and work with longer term goals but these were inconsistent due to the reasons already mentioned. There is clearly some scope to review the consistency of these care plans and to amend them in order to demonstrate clearer collaboration with relevant parties as well as to show review dates.

Furthermore, in order to try to comply more closely with the NICE guidelines on the longer-term man-

agement of self-harm (2011), consideration could be given to the possibility of offering those patients not under secondary mental health services some short-term counselling for their self-harm. This type of service has already been shown to demonstrate positive outcomes in Manchester, where the Liaison Team there have shown the effectiveness of brief psychotherapy for people who self-harm by offering up to six sessions of therapy. However, this would have a huge resource impact on this team and considerable funding would need to be made available in order for this extended service to be provided.

Number of Attendances

A comparison of the data from the self-harm register which compared A&E attendances for the six month period pre- and post-implementation of the care plans showed promising results.

From the 23 patients with care plans, one was not a frequent self-harmer so no data was available from the self-harm database; one care plan was written well before the implementation of the self-harm database; and one had no attendances within the six month period either side of their care plan. As can be seen in the chart below, out of the remaining 20 patients, 12 showed a reduction in the number of attendances (60%), 5 showed an increase (25%) and 3 showed no change (15%). This amounted to an overall reduction in number of attendances of 34.1%.

Length of Stay

Regarding length of stay pre- and post-care plan, the self-harm database does not routinely collect a discharge time. Therefore this data was not as robust. However we did manage to collect data from 15 patients, shown in the chart below. Length of stay is shown in days.

Again, there is a significant reduction in 11 cases (73.3%), whilst 2 show an increase (13.3%) and 2 show no change (13.3%). This amounted to an overall reduction in length of stay of 43.4%.

It would be worth noting that these changes in number of attendances and length of stay could be due to a number of variables, of which the implementation of the care plan is one aspect. It would be unwise to suggest that these reductions are solely due to the care plans.

Also, due to the small numbers involved, it would be important to re-audit this on an annual basis in order to build up more robust figures over the next few years.

**Tom Hulme, Salena Williams,
Debbie Ottley, Temi Metseagharun,
Blanka Robertson and Katharine Bramley
University of Bristol Foundation Trust**



ing. Not only is it an opportunity to learn something new and to exchange ideas and good practice with colleagues, but I also find it useful therapy. Staff from different liaison psychiatry services often face similar challenges and the conference provides an opportunity to share these difficulties and perhaps to come up with some solutions.

I began the day by outlining to delegates some of the recent PLAN initiatives. These included the recent revision of PLAN standards to take account of new national policy and the experience of PLAN members in applying standards. One of the most common stumbling blocks to achieving PLAN accreditation is the provision of a sufficiently safe and private interview room in the emergency department.

Recently PLAN have carried out a survey of liaison psychiatry services across the UK to determine the

proportion of emergency departments that have an assessment room that meets the required standards. Responses to the survey were received from 60 liaison psychiatry services working in hospitals with emergency departments. Of these, 85% of the departments had assessment rooms, but overall only 23% had rooms that fulfilled the national standards for safety and privacy. The results of the survey have been submitted for publication and will be shared with the Care Quality Commission.

The first presentation of the day was by Dr Peter Aitken, Chair of the Executive Committee of the Faculty of Liaison Psychiatry. Peter Aitken gave an erudite and entertaining outline of the progress of liaison psychiatry at a political level. He discussed the discussions that had taken place about a possible tariff system of payments for the specialty (formerly "payment by results"), likening the high proportion of one-off assessments conducted to "one night stands". I suspect that this is a term which will stick!

**Dr Jim Bolton
Consultant Liaison Psychiatrist
St Helier Hospital, Surrey
Chair - PLAN Accreditation Committee**

RECORD TURNOUT FOR PLAN CONFERENCE



Over 200 delegates attended the 2014 Psychiatric Liaison Accreditation Network (PLAN) Annual Conference: "Improving Mental Health Care in General Hospitals". This is an indication of the success of PLAN, with an increasing number of teams undergoing accreditation. The attendance also reflects of the high quality of these annual meetings.

The meeting was organised by the PLAN team from the College's Centre for Quality Improvement, Lucy Palmer, Ro Cawdron and Ella Pollock. I was pleased to be invited to chair the meeting. This caused me to reflect on what I enjoy about the PLAN annual meet-

MESSAGE FROM ANN PAUL, DIRECTOR OF DEVELOPMENT, RCPsych



The Development office was set up to find voluntary funding for those strategic projects which we could not ordinarily afford.

Some recent successes include the Pathfinder Fellowship initiative, now in its third year and attracting some of the very best students into the world of mental health; the RCPsych Sustainability Fellow (Dan Maughan) as well as attracting a grant which allowed us to install much of the additional audio-visual equipment in the College headquarters.

Furthermore, we are delighted to have been awarded a very generous donation so that we can recruit a research fellow in Mental Health in the Workplace

next year. This is part of our growing and ambitious RCPsych Research Fund which we hope to grow alongside the new RCPsych Post Graduate Education Fund.

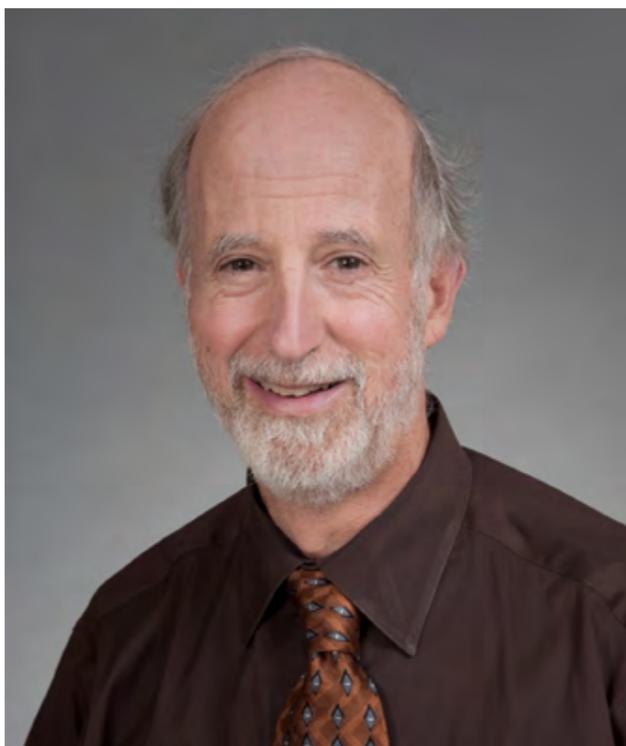
Development in the College spans all of our work and all of our Divisions and Faculties and will, hopefully, become embedded in the life and activities of all our members. The Royal College of Psychiatrists is your College – indeed, it is your Alma Mater although I have found that so few of our members think like this. It is my fervent hope that over the coming years, we will encourage all of our members to think of RCPsych as ‘their College’ and to make full use of all that College has to offer.

Clearly, as Director of Development, I also hope that members will consider supporting the College projects so that together, we can create a significant impact and a last legacy for the profession.

If you have any comments or suggestions, I would be delighted to hear from you or to meet you to discuss this further. As I am the only full time member of the Development team, I cannot hope to achieve this alone so would be really happy to hear from you.

Anne Paul
Director of Development, RCPsych
apaul@rcpsych.ac.uk
020 3701 2526 or 07718 191485

OBITUARY - DR. WAYNE KATON



Dr Wayne Katon MD

A leading academic consultation liaison psychiatrist and research pioneer whose work changed clinical practice.

Professor Wayne Katon, one of the most influential consultation-liaison psychiatrists of his generation and pioneer in collaborative and integrated care died from lymphoma on March 1st 2015 at his home in Seattle. He was 64.

Wayne published over 500 papers. This huge productivity was apparent when I first visited him in Seattle in the early 1990s and asked him for a copy one of his research papers. He opened a filing cabinet drawer bulging with manuscripts. I naively congratulated him on such a large number of publications; he looked at me quizzically and said, ‘these are the papers currently under review.’ He was not only prolific but also truly innovative. Wayne’s research was inspired by his clinical work. He made major contributions in three areas of liaison psychiatry:

Beginning in the 1980s and developing from his mentorship by Arthur Kleinman, Wayne’s research focused on the role of depression, anxiety and especially panic in somatic symptom production. In a series of studies of conditions including irritable bowel syndrome, pelvic pain, chronic fatigue syndrome, chest pain and tinnitus he found a strong association with depression and anxiety [1]. This work highlighted the critical role of psychiatry and psychology in managing these common syndromes.

From the 1990s onward Wayne worked to find out how outcomes could be improved for medical patients with depression. His answer, developed iteratively over a number of years was ‘collaborative care’, the key element of which is collaboration of a liaison psychiatrist with non-psychiatry physicians based on treatment guidelines and proactive care. [2]. Wayne subsequently worked with colleagues to deliver more trials of collaborative care including the large IMPACT trial for late life depression [3].

Collaborative care is now established as an effective approach to improving patient care internationally.

Wayne’s last ten years of research focussed in how best to integrate active management of both depression and chronic medical conditions. The demonstration of the value of this development of his collaborative care approach was the TEAM care trial published in 2010 [4]. This trial found that the integrated and active management of both medical (diabetes and heart disease) and psychiatric (major depression) disorders achieved not only better medical outcomes, but also a greater effect on depression than in his previous collaborative trials, showing the synergistic effect of integration.

He was not only an innovator but also an effective advocate for integrating mental and physical health-care as part of health care reform in the USA [5].

Wayne was a key figure in, and much loved member of, the American Academy of Psychosomatic Medicine the leading organization of psychiatrists working in medical settings (consultation-liaison psychiatry) in the USA. The esteem he was held in by his colleagues in the Academy was indicated by his election as president (2012 – 2013), his receipt of the Eleanor and Thomas P. Hackett Award, the Research Award and, on two occasions, the Dlin/Fischer Clinical Award.

Wayne’s unique and creative blend of apparent disparate qualities; Brooklyn boy and West Coast trail-walker; astute clinician and academic data hound; high-productivity scientist and generous, unassuming human being made him a very special person indeed to all who knew him. His personal, intellectual, and clinical legacy will continue to have an enormous impact.

A stellar academic who made a major contribution to medical practice and greatly enhanced the role of liaison psychiatry he was also a genuinely great guy and an inspiration to many.

References

- [1] Katon W. Somatization in primary care. *J Fam Pract.* 1985;21:257-8.
- [2] Katon W, Von Korff M, Lin EH, Walker E, Simon GE, Bush T, et al. Collaborative management to achieve treatment guidelines. Impact on depression in primary care. *J Am Med Assoc.* 1995;273:1026-31.
- [3] Unutzer J, Katon W, Callahan CM, Williams JW, Jr., Hunkeler E, Harpole L, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *J Am Med Assoc.* 2002;288(22):2836-45.
- [4] Katon WJ, Lin EH, Von Korff M, Ciechanowski P, Ludman EJ, Young B, et al. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med.* 2010;363(27):2611-20.
- [5] Katon WJ, Unutzer J. Health reform and the Affordable Care Act: the importance of mental health treatment to achieving the triple aim. *J Psychosom Res.* 2013;74(6):533-7.

Michael Sharpe
Professor of Psychological Medicine
University of Oxford
Psychological Medicine Research
Oxford University Department of Psychiatry
Warneford Hospital Oxford OX3 7JX, UK

Michael.Sharpe@psych.ox.ac.uk