GUIDANCE ON THE DELIVERY OF LIAISON PSYCHIATRY (MENTAL HEALTH LIAISON) SERVICES IN WALES

Introduction

This document provides guidance on the functions of Liaison Psychiatry Services (LPS) in Wales. It has been developed in conjunction with key stakeholders throughout Wales and all professional groups have been represented. Service user and carers’ voices have been sought and are reflected in this document. The most up to date research and evidence has informed its content. It also sits firmly in the context of the Parliamentary Review of Health and Social Care in Wales\(^1\) and specifically the quadruple aim is to:

- Improve population health and wellbeing through a focus on prevention
- Improve the experience and quality of care for individuals and families
- Enrich the wellbeing, capability and engagement of the health and social care workforce and
- Increase the value achieved from funding of health and care through improvement, innovation, use of best practice and eliminating waste.

A Healthier Wales\(^2\) also states the following principles should be considered in developing transformative services:

**Prevention and early intervention** – acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing.

**Safety** – not only healthcare that does no harm, but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other kinds of harm.

**Independence** – supporting people to manage their own health and wellbeing, be resilient and independent for longer, in their own homes and localities, including speeding up recovery after treatment and care, and supporting self-management of long term conditions.

**Voice** – empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on ‘what matters’ to them, and to contribute to improving our whole system approach to health and care; simple clear timely communication and co-ordinated engagement appropriate to age and level of understanding.

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**Personalised** – health and care services which are tailored to individual needs and preferences including in the language of their choice; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes.

**Seamless** – services and information which are less complex and better co-ordinated for the individual; close professional integration, joint working, and information sharing between services and providers to avoid transitions between services which create uncertainty for the individual.

**Higher value** – achieving better outcomes and a better experience for people at reduced cost; care and treatment which is designed to achieve ‘what matters’ and which is delivered by the right person at the right time; less variation and no harm.

**Evidence driven** – using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working.

**Scalable** – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations.

**Transformative** – ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add an extra permanent service layer to what we do now.

**Standards**

The standards in this document were developed to support equitable access to and provision of LPS in Wales and reflect both The National Institute for Health and Care Excellence (NICE) and professional body standards. Collecting information in relation to the standards will assist health boards to develop a clear picture of service demand, uptake and delivery. It is expected that both qualitative and quantitative information will become available as services develop and mature. Auditing information about the LPS should enable health boards to make evidenced-based decisions about the future provision of that service.

Data collections tools and data dictionary definitions where needed to support the collection of auditable information about liaison psychiatry services will be provided in a separate document. It is proposed the LPS, scheduled and unscheduled care will work together to determine, quantitative and qualitative key performance indicators that they wish to utilise.
Purpose

Whilst this document provides a framework for the delivery of services, it does not supersede clinical judgement or any new and emerging evidence base; the needs of the person should determine the actions to be taken. The needs of families and wider care networks should also be considered.

It is recognised that at the time of publication, local areas will be at different stages in the implementation of this guidance, however it is expected that all health boards will be in a position to evidence full implementation of the guidance by 2021.

Equity and diversity

The Welsh Language Act (1993) and the Welsh Language (Wales) Measure (2011) set standards for public bodies regarding the provision of services in the Welsh language.

Wales has a diverse range of people and cultures. In the creation of services that are designed to meet the needs of the whole population, health board planners are required to adhere to the Equality Act 2010 which specifies the protected characteristics; age, race, gender reassignment, disability, marriage and civil partnership, pregnancy and maternity, religion and belief, sex and sexual orientation.

The Equality Act also places a duty on public bodies to make reasonable adjustments for people with impairment, including mental impairment that constitutes a disability under the Equality Act. The reasonable adjustments that a person may need should be considered as part of their assessment and intervention.

Evidence in support of LPS

LPS meet the mental health needs of those individuals who are being treated primarily for physical health problems. The incidence of mental health problems for those experiencing physical health problems is two to three times higher than the general population, with the prevalence particularly high in the hospital setting. Often these conditions are unrecognised and subsequently untreated with significant impact on the individual and consequent effect on their wellbeing and increased impact on the health care system.

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The evidence for the benefits of LPS is considerable and includes decreased length of stay, reduction in psychological distress, improved service user experience, improved dementia care and enhanced knowledge and skill of general hospital clinicians. While there is less formal evaluation of outcomes due to heterogeneity of services and complexity of both intervention and clinical results, there is a growing evidence base to support clear economic benefits.

'About half of all patients being treated for physical health problems in acute hospitals have a co-morbid mental health problem such as depression or dementia. Most of these cases of mental illness go undetected by medical staff, leading to poorer health outcomes and substantially increased costs of care, equivalent to around 15% of total expenditure in acute hospitals (£6 billion a year in total, or £25 million a year for a typical general hospital of 500 beds). There is growing evidence that a dedicated proactive liaison psychiatry service working with medical staff can substantially reduce this burden of extra costs, particularly among elderly inpatients, who should be a priority group for intervention.'

Liaison Psychiatry Standards

- Standard 1: “Integrated liaison services”
- Standard 2: “Ease of access”
- Standard 3: “Timely and appropriate response”
- Standard 5: “Consent and collaboration”
- Standard 6, 7: “Skilled interventions” “Training and support”
- Standard 8: “Improve patient flow”

Flowchart:
- ED Triage
- WARD Assessment
- LPS / SPOA
- LPS Assessment
- Formulation and Plan
- Intervention and Treatment
- Discharge and Follow Up
Standard 1 - Integrated liaison services

The LPS should be fully integrated into the general hospital setting in order to ensure timely recognition and response to potential mental health needs in all patients.

- The health board should ensure that LPS are planned, organised and managed with consideration of local population assessment and need and that delivery of liaison psychiatry will be considered an integral part of a health board response to comorbid mental health and physical health conditions. Consideration of these standards and current best practice will inform the commissioning and planning of LPS (Appendix 1).

- The health board should be cognisant of the fact that the non-patient benefit from effective LPS lies within hospital services and that the drive for parity of esteem to meet mental health needs necessitates joint planning and commissioning arrangements between hospitals and mental health services.

- Liaison psychiatry consultants and associated mental health staff should be actively integrated into all relevant governance structures within the hospitals; to include issues around audit, risk management, education and training, serious/adverse incident investigations and senior director level meetings.

Standard 2 - Ease of access

Practitioners delivering hospital services should have a clear understanding of how to contact the LPS should they have concerns about the mental health of their patients.

- The LPS should develop standard operational procedures and pathways to ensure evidence based referral pathways and clinical processes are known to all potential referrers.

- LPS should consider the introduction of a single point of contact to ensure ease of access to timely and consistent response.

- The LPS will work closely with crisis and home treatment services to ensure smooth transition to inpatient and community mental health services and may have a discrete function and identity.

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8 Integrated services will be services that have clear-shared governance structures and where there is agreement about roles and responsibilities and how appropriate assessment and interventions will be provided.


Standard 3 - Timely and appropriate response

The LPS should be accessible to users in a timely fashion and be able to provide a service in a setting that is appropriate to the individual user, considering confidentiality, dignity and safety of staff and others.

- The importance of providing a timely response has been well researched. Those planning and delivering services should be aware of the most up-to-date guidance. Generally, referrals to the LPS will be of an emergency or an urgent nature. Mature services may also respond to referrals on a routine basis via outpatient clinics and planned intervention post discharge.
- An emergency referral (usually requested from the emergency department (ED)) will be responded to by LPS within 1 hour; within 4 hours a biopsychosocial assessment will have been completed or a Mental Health Act (MHA) assessment will be underway and the patient will either:
  - have a care plan in place and be enroute to the next care location or
  - follow up will have been agreed and/or signposting completed and the patient has left the ED.
- An urgent referral (usually requested from an inpatient ward) will be responded to by LPS within 1 hour to determine urgency of required response and within 24 hours a biopsychosocial assessment completed and outcome determined as detailed above13
- There should be a defined 24/7 response for children and young people under 18 years
- The health board should provide assessment and interview space in ED and on the inpatient wards, consistent with current best practice standards that promote a safe environment to allow management of high-risk assessments and support patient confidentiality and dignity14.

Standard 4 - Resourced to meet the needs of all

The LPS should be resourced and staffed to ensure that the service can be delivered proportionately to the demands placed on it by the ED and wider general hospital population. The LPS should be able to meet the needs of individuals of all ages, with reasonable adjustments in place to provide services for those with protected characteristics as well as complex needs.

- The LPS should be designed to meet the mental health needs of the inpatient and ED population; be able to respond proportionately to the demands that arise from the range of services in the wider hospital, while in the case of mature services, the psychological need of outpatient and primary care patients may also be a focus15 (Appendix 2)
- All district general hospitals (DGH) that provide a type 1 ED (Consultant lead 24 hour)16 service, should provide a LPS that is capable of undertaking a comprehensive biopsychosocial assessment as in standard 3 across 24 hours
- The LPS will have a skill mix and professional balance to enable service to be provided

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for patients of all ages including children and young people\textsuperscript{17}
\begin{itemize}
  \item to assess and intervene in alcohol and substance misuse issues
  \item to support those who present in mental health need and also have a developmental disorder or learning difficulty.
\end{itemize}

The required skill mix will be reflective of the need presented within the inpatient and ED patient group (\textit{Appendix 3})

- LPS maybe delivered by discrete sub-teams or practitioners with specialist skills, but referral response/assessment and outcome should not be delayed nor service delivery disjointed as a result.

\textbf{Standard 5 - Consent and collaboration}

Assessment, care planning and intervention provided by the LPS should be governed by a full understanding of the consent given (or not given) by the individual, particularly when mental capacity is not present. The voice of the patient and their family/carers will be integral to the specific decision making by the LPS in alliance with the patient.

- Each patient should have a clear documented record of any concerns regarding their capacity to engage in the assessment and/or to agree to any decisions made as a result
- There is an expectation that all NHS staff will have a clear understanding of the Mental Capacity Act (MCA)\textsuperscript{18} and be able to undertake proportionate capacity assessments. The LPS will therefore not be sole arbiters of the individual’s mental capacity, but will support the hospital teams to make determinations if required
- Each patient requiring an ongoing intervention from the LPS should have a named LPS Practitioner and/or Consultant documented in clinical notes, with a clear mental health safety/care plan formulated with the person and family\textsuperscript{19}.

\textbf{Standard 6 - Skilled interventions}

LPS staff undertaking assessment and intervention should be suitably skilled/qualified and able to provide a range of evidence based interventions.

- The primary interventions of the LPS will be a specialist and comprehensive biopsychosocial assessment, including risk assessment and development of an appropriate care plan; signposting as appropriate and where necessary, the coordination of any mental health care provided. In order to undertake this function, the practitioners will hold a number of competencies both core and specialised (\textit{Appendix 4}). These will include:
  \begin{itemize}
    \item Up-to-date knowledge of relevant legal frameworks (for example, Mental Health Act and Mental Capacity Act)
  \end{itemize}

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\textsuperscript{17} Royal College of Psychiatrists (2019)\textsuperscript{\textcopyright} Position Statement on Liaison Psychiatry Across the Lifespan. \url{https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_19.pdf?sfvrsn=87ec0e23_2}

\textsuperscript{18} Mental Capacity Act (MCA)

• Ability to complete personalised risk assessments, including for self-harm and suicide prevention
• Up-to-date knowledge of the general hospital system
• Knowledge and skills around the care and treatment of older adults, people with drug or alcohol use problems, people with learning disabilities and people with physical health problems
• Skills in providing training and support to general hospital staff around mental health problems
• Knowledge of local services for people who use drugs or alcohol, including social care and voluntary sector services.

• Brief and very brief interventions, such as Making Every Contact Count (MECC)\textsuperscript{20} will be a core function
• LPS may, in addition, provide a range of evidenced-based psychological therapies and/or work alongside health psychology to do so.

**Standard 7 - Training and support**

A core function of the LPS is training, guiding and supporting hospital teams in relation to the patient’s mental health needs throughout the patient pathway. The LPS should develop a culture and environment where the psychological/psychiatric needs of the individual are addressed equitably with physical health need by all practitioners.

• The LPS should have the capacity to provide formal and informal training opportunities. This knowledge building and nurturing of a psychologically informed culture has been proven to have a bigger impact on length of inpatient stay than direct management by LPS\textsuperscript{21}.

**Standard 8- Improve patient flow**

The LPS will work with the inpatient clinical team to promote timely discharge through the provision of appropriate interventions in relation to the patient’s mental health need as required. To improve that transition, the LPS will signpost and refer patients to appropriate community support, provide proportionate follow up/support to the outpatient and when required, liaise with and hand on to specialist mental health services.

• The LPS can provide support for and coordination of mental health community service response for those patients who might require follow up on discharge
• Evaluation of effective LPS highlight the important role of signposting and referral of patients to support services in the community\textsuperscript{22}

\textsuperscript{20} http://www.wales.nhs.uk/sitesplus/888/page/65550
\textsuperscript{22} NHS Confederation (2011) With Money in Mind; The benefits of liaison psychiatry https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/With_money_in_mind_161111.pdf
The LPS should coproduce written safety and discharge plans to manage current and future mental health crises (EDPS, Oxford)\(^\text{23}\).

Appendix 1: What would a good liaison service look like\(^\text{24}\)?

**Model of service delivery**

A good liaison service functions best as a discrete, specialised, fully integrated team comprising multi-professional health care staff, under single leadership and management. A core service should be based on the following principles:

- Staff members’ sole (or main) responsibility is to the acute liaison team
- The team includes adequate skill mix
- The team has strong links with specialist mental health services and good general knowledge of local resources
- There is clear and explicit responsibility for all patients in the acute hospital setting
- There is one set of integrated multi-professional healthcare notes
- Consultant medical staff are fully integrated.

**Key components of the service**

A comprehensive liaison service will have the following features:

- Ability to work closely with the acute hospital through integrated governance, open (pre-referral) discussion with the hospital’s principal referring units, a single point of referral and the capacity to serve the agreed hospital population
- Provision of comprehensive assessment and formulation, including risk assessment and joint assessment where appropriate, using recognised formal instruments to provide diagnosis and formulation that leads to an agreed plan that is communicated in a timely manner
- Capacity to engage effectively with the patient in a safe place that allows a positive therapeutic relationship to be built
- Provision of a range of interventions including signposting, support, psychosocial interventions, therapeutic interview, brief psychotherapeutic interventions and pharmacotherapy
- Effective liaison with other parts of the health system, including general practice, crisis and in-patient teams, specialist mental health teams, social services, emergency services and non-statutory agencies
- Broad capacity building across the health and social care system so that mental health is much more readily recognised as a concomitant to physical health (liaison clinicians should be able to assess physical health as well as mental health, manage mental health issues, recognise the remit of their capabilities and refer to psychiatric services when appropriate)
- Provision of supervision, liaison and direct clinical activity outside the acute setting and into primary care when care pathways for patients with medically unexplained symptoms (MUS), long-term conditions (LTCs) or other issues require consistency of care in order to avoid deterioration or re-admission

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\(^{23}\) Good Practice example: Emergency Department Psychiatric Service (EDPS), John Radcliffe Hospital and Horton General Hospital, Oxford University Hospital NHS Foundation Trust

• All age inclusive services, including liaison services for children, older people and adults with dementia
• Holistic and culturally responsive services.

Appendix 2: Models and levels of LPS\textsuperscript{25}

Each model builds on the previous level, from the core minimum regarded to be effective in managing emergency department and admissions work sufficient to return the cost and quality benefit suggested in this guidance:

- Core LPS, working or extended hours only.
  - These services would have the minimum specification likely to offer the benefit suggested by the literature. Core will serve acute health care systems, with or without minor injury or emergency department environments, where there is variable demand across the week including periods of no demand where a 24 hour staffed response would be uneconomical. This model mainly serves emergency and unplanned care pathways.

- Core 24 LPS, twenty-four hours, seven days a week.
  - These services have the minimum specification likely to offer the benefit suggested by the literature where there is sufficient demand across the 24 hour period to merit a full service. Typically, these acute health care systems are hospital based in urban or suburban areas with a busy emergency department. This model mainly serves emergency and unplanned care pathways.

- Enhanced 24 LPS, twenty-four hours, seven days a week.
  - These services have enhancements to the minimum specification to fit in with gaps in existing pathways and services. Often they have additional expertise in addictions psychiatry and the psychiatry of intellectual disability. Demography and demand may suggest additional expertise with younger people, frail elderly people or offenders, crisis response or social care. This may extend to support for medical outpatients. This model mainly serves emergency and unplanned care pathways, but extends to support elective and planned care pathways where mental health problems co-exist.

- Comprehensive LPS, twenty-four hours, seven days a week, enhanced with inpatient and outpatient services to specialties at major centres.
  - Comprehensive services are required at large secondary care centres with regional and supra-regional services. These services include Core 24 level services, but will have additional specialist consultant liaison psychiatry, senior psychological therapists, specialist liaison mental health nursing, occupational and physiotherapists. They support inpatient and outpatient areas such as diabetes, neurology, gastroenterology, bariatric surgery, plastic and reconstructive surgery, pain management and cancer services. They may include other condition specific elements such as chronic fatigue and psychosexual medicine teams. Some may include specialist liaison psychiatry

inpatient beds. Comprehensive services run over office and extended hours supported by the core service running 24 hours, seven days a week. This model serves emergency and unplanned care pathways as well as planned and elective care where mental health problems co-exist.

These models, their staffing and set-up, are described in detail in document 3 “Developing Models for Liaison Psychiatry Services - Guidance for Commissioning Support”.

Appendix 3: Skill mix and staffing

## Table 1: High level summary of differences between models

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Appendix 4: LPS Practitioner role competences

Common to all roles
- Up-to-date knowledge of relevant legal frameworks (for example, Mental Health Act and Mental Capacity Act)
- Ability to complete personalised risk assessments, including for self-harm and suicide prevention
- Up-to-date knowledge of the general hospital system
- Knowledge and skills around the care and treatment of older adults, people with drug or alcohol use problems, people with learning disabilities and people with physical health problems
- Skills in providing training and support to general hospital staff around mental health problems
- Knowledge of local services for people who use drugs or alcohol, including social care and voluntary sector services.

Medical
- Expertise in pharmacological treatments
- High level of competence in biopsychosocial assessment
- High level of leadership
- Specialist training in working with older adults and people who use drugs or alcohol (in enhanced 24 or comprehensive services)
- Nursing
- High degree of clinical leadership, providing clinical expertise and supervision
- Specialist training in working with older adults and people who use drugs or alcohol
- Ability to work autonomously and complete biopsychosocial assessments - see the competence framework for liaison mental health nursing
- Drugs and alcohol
- Skills in addiction treatment, including comprehensive assessments, care planning, medically-assisted alcohol withdrawal, detoxification, psychological interventions and relapse prevention support
- Skills in brief intervention
- High level of competence in assessment of co-occurring drug or alcohol use and mental health problems
- Specialist training in drug or alcohol use in line with National Occupational Standards (NOS) Skills for Health
- Ability to train, advise and supervise others in co-occurring drug or alcohol use and mental health problems
- High level of skills in engaging, liaising and co-ordinating across organisational boundaries - see the Dual Diagnosis Competency Framework 24 or the Leeds Dual Diagnosis Capability Framework 25.

**Older adults**
- Specialist expertise in old age psychiatry
- Knowledge of particular presentations and treatments of mental health problems in relation to coexisting physical health problems
- Ability to identify social factors in the presentation of mental health problems in older adults
- Expertise in the assessment and management of those presenting with delirium
- Specialist expertise in dementia identification, assessment and diagnosis developmental and learning disabilities
- Expertise in developmental and learning disabilities
- Knowledge pertaining to complex needs and completing comprehensive assessments.