



ACADEMY OF
MEDICAL ROYAL
COLLEGES

NO HEALTH WITHOUT MENTAL HEALTH

THE ALERT SUMMARY REPORT

JULY 2009



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CONTENTS

NOTES ABOUT THE REPORT.....3

EXECUTIVE SUMMARY.....5

1. Introduction.....9

2. Recommendations.....11

3. Awareness.....12

4. Liaison Psychiatry Services.....20

5. Engaging Patients and Carers.....30

6. Re-organisation of Services, Commissioning and Quality Standards.....34

7. Training and Education.....38

8. Summary.....41

ACKNOWLEDGEMENTS.....42

REFERENCES AND FURTHER READING.....44



NOTES ABOUT THE REPORT

- The report refers primarily to legal frameworks and organisational structures in healthcare services in England. However, the statement of the importance of recognising the link between physical and mental health and the call for better services are likely to resonate across all countries of the United Kingdom
- Where relevant, guidance provided by the National Institute of Health and Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) is referred to. For a full report on the mental health content of NICE and SIGN guidelines, please see www.rcpsych.ac.uk/nohealth

EXECUTIVE SUMMARY

There is a clear link between mental and physical health and an urgent need to strengthen both the provision of mental health care to people with physical illness and the quality of physical health care provided to people with mental health problems in general hospitals and primary care. This report provides a framework with a focus on improvement within the general hospital, which can be brought about at relatively little additional cost by focusing on five priority areas:

Awareness of the link between physical and mental health

Liaison Mental Health Services

Engaging Patients and Carers

Re-organisation, Quality & Commissioning

Training and Education

Awareness

...of mental disorders in people with physical illness

Physical illness can have profound social and emotional consequences. As a result, many people with physical illness have mental health problems. This association is true for children and young people and for older people. Mental health problems can impede recovery from a physical illness and increase mortality rates. Mental disorders often go unrecognised in patients with physical illness. Some people have physical symptoms which cannot be fully explained. Mental health problems increase the cost of physical healthcare.

...of physical disorders in people with mental illness

People with mental illness are more likely to have reduced life expectancy, often due to poor physical health. The increased mortality is due to factors that often occur in combination. These include: social deprivation; lifestyle factors; adverse effects of medication and poor access to services.

...of physical disorders in people with learning disabilities

The causes of learning disabilities can predispose the person to certain physical illnesses. There are many barriers to meeting these physical health needs. These include: difficulties in communication; diagnostic overshadowing; challenging behaviour; attitudes among professionals and poorly developed links between specialist learning disability and general hospital services.

Liaison Mental Health Services

Admission to hospital can be a distressing experience. More than one quarter of general hospital patients have a mental disorder. Mental disorder manifests as a range of common presentations in the general hospital including: self-harm; alcohol problems; dementia; delirium and disturbed behaviour. Liaison services improve the care of patients with such problems.

Engaging Patients and carers

To be actively involved in their care, patients need better information. Well informed patients experience less anxiety and better outcomes. Engagement includes enquiring about mental distress. Patients can be supported to self-manage long term disease. There remains a stigma around mental illness that needs to be challenged. Involving patients in service development, research and audit can improve mental health care in the acute setting. There are many barriers to involving patients in improving services but the value of patient expertise should not be underestimated.

Re-organisation, Quality & Commissioning

General hospitals need flexible and responsive liaison psychiatry services. However, there is little incentive for the NHS to develop such services. There are different models of service, but a liaison psychiatry team requires adequate staffing with a range of multi-disciplinary skills. We need quality standards for mental healthcare in general hospitals, and the national Psychiatric Liaison Accreditation Network will help support their implementation.

Training and Education

Many healthcare professionals would welcome better mental health training. Front-line staff recognise this gap in their knowledge. Doctors need better training in the detection and treatment of mental health problems in patients who are physically ill. Competencies need to be checked and training in primary care needs to be improved. Training and national guidance should ensure that mental health issues receive adequate focus.

1. INTRODUCTION

In 2008, the Academy of Medical Royal Colleges commissioned the Royal College of Psychiatrists to write a report summarising the link between physical and mental health. The aim was to draw attention to the mental health problems that are associated with, or arise from, physical illness and the physical health needs of people with mental illness.

The Royal College of Psychiatrists' Centre for Quality Improvement worked with the College's Faculty of Liaison Psychiatry and other experts to collate the evidence and make recommendations. This is part of the Royal College of Psychiatrists' Fair Deal campaign: www.fairdeal4mentalhealth.co.uk.

Fair Deal is a three year campaign founded on the views of psychiatrists, service users and carers. One of Fair Deal's eight objectives is a fundamental shift in understanding and practice among all health professionals about the relationship between mental and physical health.

Fair Deal promotes equal rights and fairness for mental health service users, carers, and those working with them. It challenges us to address inequality, unfairness and discrimination across eight key areas:

- Funding
- Access to Services
- In-patient Services
- Recovery
- Discrimination and Stigma
- Engagement with service users/carers
- Availability of psychological therapies
- Linking mental and physical health.

Two documents have been produced; this 'ALERT summary report' and a more in-depth report 'No Health without Mental Health: the evidence'. The latter describes in more detail the interface between physical and mental health in a broad range of patient populations and different clinical services. It underpins the first part of the ALERT report which states the importance of awareness of the link between physical and mental health. To access the evidence report, please visit www.aomrc.ac.uk or www.rcpsych.ac.uk/nohealth.

2. RECOMMENDATIONS

Awareness

- All national guidelines about medical conditions – including those issued by NICE and SIGN – should include specific advice about the detection and treatment of mental health problems associated with medical conditions
- Screening for depression in specific long term conditions in primary care should be continued and extended under the Quality and Outcomes Framework (QOF)
- Screening for depression and other common mental health problems should be routinely introduced in the acute hospital setting
- People with learning disabilities and people with severe mental illness should receive relevant annual physical health checks.

Liaison Mental Health Services

- Each general hospital should have an adequately funded liaison mental health service to provide mental health care throughout the entire hospital to all who need it, including those with learning disabilities
- Liaison services should include specified and appropriate provision for older people, as well as children and young people
- Patients in general hospitals with mental health problems should have the same level of access to a consultant psychiatrist as they would from a consultant specialising in physical health problems.

Engagement with users and carers

- Information and education should be developed and provided in appropriate ways for service users, carers and the public to develop community awareness of the psychological aspects of physical conditions
- Service users and carers should be involved in designing and improving mental health services to general hospitals and primary care settings, through audit, research and training. Full support should be provided.

Re-organisation, commissioning and quality

- Liaison mental health services should be commissioned and reviewed against agreed specific service standards, to ensure they provide effective, evidence based interventions to treat mental health problems in the general hospital
- All care pathways for delivering physical healthcare should have a mental health component. There should be a counterpart pathway for commissioning practice to ensure the services are in place to deliver this.

Training

- All health practitioners should have training in mental health
- The curricula and assessment of all doctors in training and the continuing professional development of qualified doctors should reflect the relationship between mental and physical health, both in general and in specific conditions
- National guidance should ensure that mental health issues receive adequate focus.

3. AWARENESS

3.1 Awareness of psychological disorders in people with physical illness

Physical illness can have profound social and emotional consequences

People who have severe physical illness often lose the ability to perform a range of activities which previously maintained their 'sense of themselves' as human beings, whether as a parent, provider or worker.^{1,2} This is particularly true for those with a long term condition. One example of this is diabetes. Although people in the early stages of treated type 1 diabetes may feel physically well, they have to change their normal lifestyle. This might include limiting their diet and having to comply with a demanding treatment regime. Some find it difficult to accept these restrictions. Later, as complications develop, people with diabetes may experience a range of gradual or sudden deteriorations in health, including impaired vision, poor renal function, and cardiovascular vascular disease. The loss of physical function can result in unemployment, financial hardship, stress within the family, loss of sexual function, loss of social activities, and threat to life. Physical illness therefore can have a major adverse effect on a person's quality of life.^{3,4}

Many people with physical illness have mental health problems

Patients with any form of long term physical illness have an increased risk of depression,^{5,6} and the more threatening a patient perceives their physical illness to be, the more likely they are to become depressed.⁷ The biological factors associated with some physical illness also increase the risk of depression. These factors include hormonal, nutritional, electrolyte or endocrine abnormalities, the effects of medication and the physical consequences of systemic and/or intracerebral disease.

The association is also present for children and young people

As well as having a higher incidence of mental health problems than the general population, children and young people with physical illness are more likely to have learning and development and autistic spectrum disorders.⁸ Disabled children are more at risk of experiencing abuse and this abuse can leave a legacy of mental ill health.^{9,10}

...and for older people

The number of older people with mental health problems will increase by a third over the next 15 years to 4.3 million, which is one in every 15 older person.¹¹ In the general hospital setting the prevalence of mental health problems in older people is very high: sixty percent of people over the age of 65 who are admitted to a general hospital have or will develop a mental disorder during their admission, the most common being the 'three Ds' — dementia, delirium and depression.¹⁰ Particular attention should be paid to older people with a physical illness because poor physical health increases the risk of suicide.¹² The Care Services Improvement Partnership has developed a toolkit primarily aimed at healthcare staff caring for older people with mental health needs in acute hospitals (www.olderpeoplesmentalhealth.csip.org.uk/lets-respect.html).

Mental ill health impedes recovery from physical illness

Mental health problems can affect recovery from every kind of physical illness. In extreme cases, an individual with severe depression may simply give up on treatment because they believe they are a burden on their family or the healthcare system and would be better off dead. Even relatively mild mental health problems in patients with physical illness can have a major effect on their physical condition. For example, a mild eating disorder in a patient with diabetes will have potentially serious long term consequences, of a disproportionate nature to the severity of the eating disorder itself.

Factors which predispose a person to mental illness (childhood adversity, maladaptive behaviours and maladaptive patterns of attachment) increase the likelihood of poorer self-care and increased use of health services.¹³ Mental health problems can also affect a person's confidence in participating in complex care or rehabilitation programmes. Poor mental health also affects a person's ability to respond to pain control.¹⁴

For older people, the presence of mental illness is an independent predictor of poor physical health outcomes, such as increased mortality, greater length of stay, loss of independent function and higher rates of institutionalisation.¹⁵

Box 1: Mental disorders can increase mortality rates, for example:

- The risk of depressed patients with coronary heart disease dying in the two years after the initial assessment is twice as high as it is for non-depressed patients¹⁶
- People with Chronic Obstructive Pulmonary Disease (COPD) and depression have an increased rate of mortality¹⁷ and when faced with end-of-life decisions, they are more likely to opt for 'do not resuscitate'¹⁸
- Depression in stroke patients is associated with increased disability and mortality.¹⁹

Mental disorders often go unrecognised in patients with physical illness

Over half of all cases of depression in the general hospital setting go unrecognised by physicians and nursing staff²⁰ and there are similar problems with detection in primary care.^{21,22,23} This may be because healthcare professionals do not think to enquire about psychological symptoms, or because they feel uncomfortable doing so. Even if these symptoms are discussed, practitioners might, quite reasonably, regard depression and anxiety as an understandable reaction to being physically unwell. As such, the patient's symptoms are normalised²⁴ and practitioners may not realise that the mental illness could be treatable.

General Practitioners (GPs) have a key role in helping people cope

GPs are ideally placed to facilitate a natural psychological adjustment to physical illness in their patients. GPs also need to recognise when patients with physical illness are becoming depressed and treat them accordingly. In primary care, brief screening for depression in certain chronic disease groups (diabetes and coronary heart disease) is established under the Quality and Outcomes Framework (QOF).²⁵ The challenge in primary care is to extend such screening to all long term conditions and to provide or refer to appropriate interventions for people when depression is detected.

Brief mental health assessments should also be made routine for people admitted to acute hospital beds to identify those with mental disorders or those at high risk of developing them. Care plans could then include strategies for prevention and prompt management of these conditions.

Box 2: Long term conditions are associated with a high emotional burden.^{32,40,50}

For example in diabetes, depression is linked to:

- Poor self management
- Poor quality of life
- Poor control of blood glucose levels
- More diabetic complications
- Increased risk of dying
- Delay or avoidance of diabetes treatment
- Increased costs.

Some people have physical symptoms which cannot be fully explained

Medically unexplained symptoms (MUS) account for 20% of new presentations to primary care and for up to 30%-40% of newly referred medical outpatients.²⁶ Often the patients concerned experience a high degree of suffering. In most cases, no obvious physical reason is identified, but a small proportion of MUS are eventually found to have an underlying organic disorder. Psychological factors are closely associated with medically unexplained symptoms²⁷ and research suggests that the more bodily complaints reported, the greater their degree of psychological distress.²⁸ Also, the more complaints reported, the greater the degree of impairment and the more frequent use of health care services.²⁹ Over 40% of outpatients with MUS have an anxiety or depressive disorder.³⁰

Mental health problems increase the cost of physical healthcare

Patients with depressive disorder are twice as likely to use emergency department services as those without depression.³¹ In diabetes, total health expenditure is four and a half times higher for individuals with depression than for those without depression.³² In chronic heart disease, depressed patients have higher rates of complications and are more likely to undergo invasive procedures.^{33,34} People with chronic obstructive pulmonary disease (COPD) who are also depressed have longer hospital stays and increased symptom burden.³⁵ The presence of dementia and delirium increases the length of stay of older people in general hospitals by up to ten days.³⁶

3.2 Awareness of physical disorders in people with mental illness

People with mental illness have reduced life expectancy

On average, people with mental illness die five to ten years younger than the general population.³⁷ The box below shows the standardised mortality ratios for different types of mental disorder.³⁸

Box 3: Standardised Mortality Ratios relating to Common Mental Health Disorders

Mental disorder	SMR	Comments
All forms of mental disorder	1.5	
Schizophrenia	1.6	Unnatural causes: 9 x more common
Bipolar disorder	1.7	
Depression	1.4	
Panic disorder	1.7	
Eating disorders	5.4	Self-starvation caused 65% of deaths
Alcohol abuse/ dependence	1.9	
Substance misuse	4.9	
Personality disorders	1.8	Unnatural causes: in 52% of deaths

People with mental illness are more likely to have poor physical health

The physical health problems associated with mental illness include serious conditions such as respiratory and cardiovascular diseases, diabetes, cancer and epilepsy.

Box 4: Example of physical health problems associated with mental illness:

- People with bipolar disorder have higher levels of physical morbidity and mortality than the general population³⁹
- Major depression doubles the lifetime risk of developing type 2 diabetes⁴⁰
- Depression is a risk factor for developing heart disease⁴¹
- People with schizophrenia are three to four times more likely to develop bowel cancer⁴²
- People with schizophrenia have a 52% increased risk of developing breast cancer.⁴²

The increased morbidity is due to factors that often occur in combination...

Social deprivation

People with mental disorders are more likely to live in poverty, be unemployed, have poor housing, to be homeless or to live in an institution such as nursing home, penal establishment, or secure psychiatric facilities.^{43,44,45} They are more likely to depend on state benefits for income, and social isolation compounds their difficulties.⁴⁵

Lifestyle factors

Compared with the general population, people with a mental illness are more than twice as likely to smoke tobacco,⁴⁶ eat less fruit, are less likely to exercise regularly,⁴⁷ have higher rates of obesity (70%) and more often develop the metabolic syndrome.⁴⁸ Some also argue that people with mental health problems are more likely to become physically disabled as a result of accidents or attempted suicide.⁴⁹

Adverse effects of medication

In particular, the long term use of antipsychotic drugs increases the risk of developing metabolic syndrome which is characterised by weight gain, high blood lipid levels, high blood pressure and glucose intolerance which can lead to diabetes.⁵⁰ The risk of sudden death in schizophrenia increases incrementally with each additional psychotropic medication taken.⁵¹

Box 5: Patient viewpoint on taking medication for both physical and mental health problems:

'I take psychotropic medication for mental health as well as medication for physical health. This can be problematic because of the contraindications – in my experience, neither group of specialists cared about (or explained to me) the effects these medications can have on each other. I had to borrow a BNF [British National Formulary] and look it up myself.'

(Service user, London, 2008)

Poor access to services

People with mental health problems, compared to those without, receive poorer quality healthcare.³⁷ They are less likely to seek medical help and do not receive the same standard of physical health care in either primary or secondary health services as the general population. They may not register with a GP or dentist (or may lose their registration), and can experience difficulty making and keeping appointments. People with severe mental health problems are less likely to take part in health screening such as mammography and cervical cytology.³⁷ The presence of a mental disorder may 'overshadow' the recognition and treatment of physical health problems. This overshadowing can result in a reduction in the quality of physical health care provided by health professionals.

3.3 Awareness of physical disorders in people with learning disabilities

Box 6: Many of the causes of learning disabilities can predispose a person to physical health problems

Learning disabilities arise from a range of genetic conditions as well as adverse events in the pre-natal, peri-natal and post-natal periods and can predispose the person to a range of concurrent physical health problems. For example:

- People with Down's Syndrome have high rates of congenital heart disease, thyroid disorder, sensory impairments and dementia.^{52,53} As a result, they have a life expectancy which is shorter than that of the general population⁵²
- The food seeking behaviour of people with Prader-Willi Syndrome means that they are at a greater risk of obesity and type 2 Diabetes⁵⁴
- People with cerebral palsy experience a range of musculoskeletal deformities and high rates of dysphagia and associated respiratory problems⁵⁵
- The rate of epilepsy is 20% in the learning disability population, rising to 50% in those with more profound learning disabilities⁵⁹
- People with learning disabilities have lower bone density than the average population⁵⁶
- Respiratory disease is the most common cause of death (46%-52%) for people with learning disabilities⁵⁷
- Unmet physical disorders can contribute to challenging behaviours, especially in individuals with more severe learning disabilities⁵⁸
- People with learning disabilities are more likely than the general population to experience mental health problems and the associated risks.⁵⁹

A useful matrix of genetic disorders and the potential physical and psychological disorders linked to each disorder is available on www.rcpsych.ac.uk/nohealth

There are many barriers to meeting the health needs of people with learning disabilities

The Disability Rights Commission investigation of equal treatment³⁷ confirmed major deficits in the physical health care of people with a learning disability and the Mencap report '*Death by Indifference*'⁶⁰ highlighted the tragic issue of unnecessary and avoidable deaths resulting from unacceptable care.

Health checks for people with learning disability involving systematic questioning and structured physical examination have been shown to discover high levels of unmet need^{135,136} and that the benefits of such interventions are sustained.¹³⁷ The recent introduction of primary health care checks for people with a learning disability, as a directly enhanced service (DES) in the United Kingdom is, therefore, a welcome development. Specialist learning disability services can play an important role in facilitating this process, including the provision of relevant education, guidance and, where necessary, practical support.

Several factors can contribute to unequal access to healthcare, including:

Difficulties in communication

The delivery of healthcare in the UK largely depends on the patient seeking help. People with little or no means of verbal communication often cannot do this. Even those with more mild or hidden learning disabilities may struggle to negotiate a system which assumes competence in areas such as literacy. Information is rarely presented in a form that is tailored to individual needs, and individuals may be unable to provide information in the form that healthcare professionals require.

Some people with learning disabilities may also have sensory impairments such as deafness, and should not be denied access to good quality mental health care simply because the health service is ill equipped to communicate with them. When seeking or receiving healthcare in any setting, deaf people have the right to be assessed by a trained worker who has deaf/deafblind awareness and skills in working with people with the whole range of hearing related communication needs.⁶¹

Side effects of medication

People with learning disabilities are particularly susceptible to the physical and psychological side effects of medication. This can be further compounded by a tendency to acquiesce and a reduced capacity to recognise and communicate problems related to side effects.

Diagnostic overshadowing

Clinicians may dismiss behaviours that are manifestations of pain or delirium as being intrinsic to the person's learning disability. Similarly, hearing or vision problems may go undetected because healthcare professionals wrongly attribute low levels of functioning to the learning disability itself.⁶²

Carers may be unaware of the significance of health deficits or may view them as an intrinsic aspect of the individual's condition. They may also assume that the health problem is not amenable to treatment.

Challenging behaviour

This may result from the fact that many people with learning disabilities find clinical environments frightening and threatening. It is important to look beyond the presenting problem to identify potential physical, psychological and environmental causes. These difficulties can then be minimised through careful planning and preparation.^{63,64}

Attitudes among professionals

Professionals who are unfamiliar with the needs of people with learning disabilities can be unduly pessimistic, with inappropriate decisions being made based upon ill-founded opinions about their quality of life and values as citizens.⁶⁵

Poorly developed links

People with learning disability have equal rights to access generic healthcare services. This may require additional input from specialist learning disability services to facilitate this process. However, the links between these specialist services and general hospital services are often poorly developed. Some recently developed networks in the form of liaison learning disability services have shown promising results.⁶⁶

The importance of making reasonable adjustments

It is important to allow the time required to speak to the individual. An effective consultation depends on a number of factors including:

- Providing accessible information in a style that suits the individual (this may include the use of communication aids)
- Checking for understanding
- Offering appropriate support
- Seeking background information from someone who knows the patient well
- Assessing the person in an optimum environment
- Preparing the individual for any associated physical examination
- Establishing an effective therapeutic alliance.

For further advice, please see the 'Top Ten Tips on Effective Consultation', at http://www.intellectualdisability.info/values/top_ten_tips.htm. This checklist has been written primarily for GPs but can be usefully applied to a general hospital setting.⁶⁷

4. LIAISON PSYCHIATRY SERVICES

This section will explore the role that liaison psychiatry can play in bridging the gap between physical and mental health in the general hospital.

Admission to hospital can be a distressing experience

In addition to the distress arising directly from their physical illness, people admitted to hospital enter an unfamiliar, stressful environment. Many older people, who are orientated in their own home may become confused when placed in a new and strange environment. This is compounded if patients are moved from one clinical area to another. Patients often share toilet and bedroom facilities with strangers, give up their normal clothes and personal belongings, and dress in nightclothes. They have to interact with many different nurses, doctors and other health professionals. At the same time their access to relatives and loved ones is restricted. Those who smoke heavily or drink alcohol might find the restrictions imposed by hospital admission particularly difficult.

Hospital clinicians may find it difficult to deal with fear, worry and other strong emotions in a hospital setting

Nurses and doctors in hospitals are often wholly occupied by the physical illness and might not have time to enquire about emotional distress. They might also feel uncertain about how to manage distress if patients become upset.⁶⁸ Not all hospital wards have interview rooms where patients and their families can be seen in private and personal conversations often take place behind a curtain drawn around the patient's bed.

Box 7: More than one-quarter of general hospital patients have a mental disorder

- Twenty-eight percent of consecutive patients admitted to an acute medical setting were found to have a psychiatric disorder that met diagnostic criteria and a further 41% had sub-clinical symptoms of psychological distress.⁶⁹
- Depressive and anxiety disorders are twice as common in hospital patients as they are in the general population⁷⁰
- The figures are even higher for older people, who occupy two-thirds of NHS beds. Sixty percent of people over the age of 65 who are admitted to a general hospital have or will develop a mental disorder during their admission. Up to 40% have dementia, 53% depression and 60% have delirium.¹⁵

There are many different kinds of mental health problems in the general hospital setting

Self-harm

Self-harm is one of the most common reasons for admission to an acute medical bed and a quarter of people who self-harm and attend emergency departments report experiencing negative attitudes from staff.⁷¹ NICE recommends that people who self-harm should receive the same standard of care as other patients and that a detailed psychosocial risk assessment be undertaken.⁷² This is important because people who leave the emergency department or hospital without an adequate psychosocial assessment are less likely to be offered follow up⁷³ and may be more likely to repeat self-harm.⁷⁴ Despite this, not all patients are currently offered a

psychosocial assessment and even when they are, some patients report dissatisfaction with this.⁷¹ Many general hospital professionals report a lack of training, support and supervision regarding working with people who self-harm.¹²⁹

Alcohol

Alcohol is responsible for about 10% of unselected attendances at emergency departments, and a higher percentage of attendances with trauma.⁷⁵ Whilst many patients attend the emergency department as a direct and obvious result of alcohol (for example after a drinking binge, or in a state of withdrawal), approximately 20% of patients admitted to hospital for illnesses unrelated to alcohol are regularly consuming unsafe levels of alcohol, representing *'the future burden of alcohol misuse on hospital services'*.⁷⁵ Alcohol problems often go unrecognised,⁷⁶ although there is good evidence that for people who are drinking above safe limits, detection followed by a brief alcohol intervention results in significant reductions in alcohol consumption post discharge.⁷⁷

Disturbed behaviour

This is defined as behaviour that interferes with a person's care or safety, or the care and safety of others. About 4% of general hospital patients display disturbed behaviour, and it is more common in males than females.⁷⁸ In most cases aggressive behaviour is directed towards staff rather than other patients. Although an uncommon occurrence, disturbed behaviour on a general hospital ward can consume a disproportionate amount of resources, particularly staff time.⁷⁸ There are proven techniques in preventing, de-escalating and managing disturbed behaviour;⁷⁹ the use of sedative medication in physically unwell people is risky and requires expertise.

Dementia

Dementia affects approximately 30% of elderly people admitted to an acute general ward.¹⁵ Patients with dementia are particularly vulnerable in general hospitals. They are highly susceptible to environmental change and may find it difficult to communicate their needs, for example regarding toileting or pain relief. Better management of dementia in hospital can result in improved function and decreased length of stay.⁸⁰

Delirium

Delirium occurs in 15-20% of all general hospital admissions and rates are considerably higher in elderly patients (up to 60%) especially those with dementia.¹⁵ These disorders often go undetected in the general hospital; for example, acute staff may not recognise delirium in 50% of cases.⁸¹ Very little is known at present about how to identify patients at high risk of developing delirium, although those patients with three or more risk factors are nine times more likely to develop delirium during their hospital stay than patients without.¹⁵ Having dementia increases the risk of delirium five fold.¹⁵

Box 8: Risk factors associated with developing delirium during a hospital stay

Predisposing factors

- Vision impairment
- Severe illness
- Cognitive impairment
- Raised blood urea /creatinine

Precipitating factors

- Use of physical restraints
- Malnutrition / dehydration
- More than three medications added
- Use of bladder catheter
- Any iatrogenic event (harmful consequence of a procedure or intervention)

Liaison psychiatry services improve the care of patients with such problems

Table 1 summarises the ways in which liaison mental health services can help with some of the common problems associated with mental disorder among patients in the general hospital. Many liaison mental health teams include psychologists or nurses with expertise in cognitive therapy and other psychological therapies. As well as providing direct patient care, liaison staff train and support general hospital staff in the better detection and treatment of mental health problems. This can result in more positive attitudes towards mental ill health and greater confidence in addressing emotional distress expressed by patients or patients' relatives. Health psychology and clinical psychology also provide specific psychological treatment for people with depression and anxiety, but do not cover the whole range of mental health problems that present in a general hospital.

TABLE 1: COMMON PROBLEMS MANAGED BY LIAISON PSYCHIATRY SERVICES

CONDITION OR PROBLEM	DIFFICULTIES FACED IN THE HOSPITAL	WHAT CAN LIAISON PSYCHIATRY SERVICES DO?
Psychological reaction to physical illness	Some patients will develop major depression or anxiety as a consequence of their physical disorder.	The liaison service can treat depression, leading to reduced health care costs (e.g. in diabetes).
Delirium	Failure to detect and manage properly.	The liaison service can improve patient outcome and decrease length of stay.
Dementia	Failure to detect and manage properly.	The liaison service can improve patient outcome and decrease length of stay.
Disturbed behaviour	Places the patient and others at risk and is difficult to manage in the acute setting.	Liaison services have the expertise and skills to help hospital staff manage patients with very difficult and disturbed behaviour.
Self-harm	One of the most common reasons for admission to an acute medical bed. Those patients who are admitted are those who have made the most serious attempts to kill themselves. Some professionals in the general hospital find working with people who self-harm to be stressful.	Liaison services can effectively assess and treat self-harm, resulting in decreased psychological symptoms and decreased repetition of self-harm. They can also provide support and training to acute colleagues.
Medically Unexplained Symptoms	These patients require high usage of health resources.	Liaison psychiatry interventions can improve patient outcomes and reduce costs.

WHAT IS THE EVIDENCE BASE?

A systematic review concluded that, compared with consultation, the liaison approach for older people in general hospitals results in more specialist assessments, more referrals with depression, better diagnostic accuracy, more mental health reviews and increased adherence to recommendations for managing the mental disorder.⁸² Depression in the elderly physically ill can be treated with a liaison psychiatry intervention⁸³ and treatment of depression in older adults improves physical functioning.⁸⁴ A randomised trial found that medical patients with various mental disorders were twice as likely to return to independent living if they received specialist mental health multidisciplinary liaison than those receiving usual care.⁸⁵ Depression can be successfully treated in patients with diabetes using collaborative care.⁸⁶ In type 2 diabetes psychological treatments improve long term glycaemic control.⁸⁷ A systematic review has concluded that antidepressants are of benefit in the physically ill with depression.⁸⁸

A randomised trial of older people with hip fracture receiving daily proactive geriatric consultation found that this reduced episodes of delirium by one third and severe delirium by 40%.⁸⁹ Quasi controlled trials of perioperative care⁹⁰ and interpersonal and environmental nursing interventions⁹¹ in hip fracture have been associated with a reduction of delirium and length of stay. There is good evidence that both typical and atypical antidepressants are effective in treating delirium.⁹²

In a controlled trial, routine mental health liaison for older people with hip fracture was associated with a reduced length of stay. The intervention group had a mean length of stay of two days less than the usual care group. The cost of the service was offset by shorter duration of admission.⁹⁰ A randomised controlled trial of intensive specialist multidisciplinary rehabilitation of older people with hip fracture achieved a reduced length of stay for patients with mild or moderate dementia and those with mild dementia were as successful returning to independent living as patients without dementia. Furthermore, patients with mild and moderate dementia from the intervention group were more likely to be living independently three months after fracture than the usual care control group.⁹³

There are proven and recommended techniques for the de-escalation of violence and disturbed behaviour,⁷⁹ which mental health teams are trained to deliver.

Participants randomised to brief psychodynamic interpersonal therapy had a significantly greater reduction in suicidal ideation at six month follow up compared with those in the control group. They were more satisfied with their treatment and were less likely to report repeated attempts to harm themselves at follow up.⁹⁴ Psychosocial treatment following self-harm results in reduced depression, hopelessness and improvement in problems.⁹⁵ Specialist self-harm teams significantly improve the quality of psychosocial assessment.⁹⁶ Emergency department and ambulance staff who receive support and expertise from liaison mental health colleagues are less likely to report low morale when working with people who self-harm.⁹⁷

Liaison psychiatry interventions can improve patient outcomes and reduce the costs associated with medically unexplained symptoms.⁹⁸ Systematic reviews of the efficacy of antidepressants and psychological treatment for treating patients with medically unexplained symptoms, suggest both approaches are beneficial.⁹⁹

TABLE 1: COMMON PROBLEMS MANAGED BY LIAISON PSYCHIATRY SERVICES CONT.

CONDITION OR PROBLEM	DIFFICULTIES FACED IN THE HOSPITAL	WHAT CAN LIAISON PSYCHIATRY SERVICES DO?
Alcohol Abuse	There is poor management of alcohol withdrawal states resulting in increased length of stay or unnecessary admissions.	Brief liaison interventions can be effective in the reduction of alcohol use by patients identified as having alcohol problems in the general medical setting.
People who attend the ED regularly ('frequent attenders')	These patients are high users of health resources and more likely to experience poorer mental health.	Liaison psychiatry can help ED staff manage patients appropriately and ensure patients are offered appropriate community based services. Case reviews can also be undertaken where appropriate.
Lack of mental capacity	The Mental Capacity Act and the Adults with Incapacity (Scotland) Act highlight the need for rapid assessments of capacity to consent to medical treatment in the general hospital setting. Failure to implement these Acts appropriately may disadvantage the patient. It can also result in legal action.	An experienced Consultant Liaison Psychiatrist might be best equipped to make an informed judgement about capacity for patients with complex physical and mental health problems.
Severe mental illness	A small proportion of medical in-patients have severe mental illness (e.g. schizophrenia). These patients cause great anxiety in general hospital staff and there are often major risk issues which need to be managed.	Liaison Services can respond rapidly and provide a continuity of service between community and hospital whilst the patient's physical needs are being attended to.
All mental health problems	General lack of knowledge and skills amongst general hospital staff in the detection and management of any mental health problem.	Education and training delivered by liaison services improve knowledge, skills and attitudes amongst general hospital staff.

WHAT IS THE EVIDENCE BASE?

Heavy drinkers who receive a brief alcohol intervention are twice as likely to moderate their drinking six to 12 months after an intervention when compared with heavy drinkers who receive no intervention.¹⁰⁰ In the general hospital setting, heavy drinkers who are counselled about their drinking have a significantly better outcome than controls when followed-up 12 months later.⁷⁷

50% of patients who frequently attend the ED have mental health problems.⁹¹ Liaison mental health staff can help ED staff to understand the needs of this group and the reasons why they use services frequently.¹⁰² There are very few controlled studies of psychiatric intervention in this group of patients. A recent study suggests that multidisciplinary case management has a positive effect on psychosocial factors for frequent attendees but increases ED utilisation.¹⁰³

40% of acute medical patients do not have mental capacity to make informed decisions about medical treatment, and clinical teams rarely identify patients who do not have capacity.¹⁰⁴ Liaison psychiatrists receive mandatory training in the assessment of capacity in relation to the Mental Capacity Act in England and Wales. Some liaison psychiatrists will also be trained to provide assessments under the Deprivation of Liberty Safeguards (DOLS): the new legal framework to safeguard the rights of people who lack capacity and need to be detained in a safe environment.

NICE has published clinical guidelines on the treatment and management of schizophrenia¹⁰⁵ and bipolar disorder.¹⁰⁶

NICE has published guidance on the treatment and management of most mental health and behavioural conditions including in 2009 a guideline on depression in chronic health problems (www.nice.org.uk). Psychiatric treatment has shown to be effective in treating patients with complex physical and mental health problems.¹⁰⁷

Box 9: Providing mental health services to emergency departments (ED)

In many areas, mental health input to the ED is provided by Crisis Resolution and Home Treatment Teams (CRHTs), a system which has the advantage of providing 24 hour cover. However, these teams are expected to prioritise patients in the community, with a major focus on home treatment, meaning that they are not always able to respond promptly to patients in the ED. Liaison psychiatry offers an alternative way of providing mental health provision to EDs, either through liaison teams based entirely in the ED or preferably via teams set up to manage urgent mental health needs throughout the whole of the hospital. This would help ensure equal access to mental health care for all general hospital patients.

Liaison psychiatry services are not limited to a general hospital setting

Integrated clinical assessment and treatment services have been set up as a way of managing referrals into secondary care and providing patients with rapid access to assessment and treatment. Liaison psychiatry services can be embedded into these new services so that psychological problems and treatable mental illness can be accessed in parallel with physical health treatment. Liaison services can also link more closely with primary care to provide supervision for primary care practitioners for complex cases and provide greater continuity of care for patients with long term conditions.

Box 10: Links between liaison psychiatry and primary care

There are two key areas where liaison mental health services can directly support the work of primary care practitioners:

- The care of people who have psychological reactions to physical illness
- The care of people with medically unexplained symptoms.

Information about the detection and management of both these health problems is available in a recent joint report by the Royal College of General Practitioners and the Royal College of Psychiatrists entitled 'The Management of Physical and Psychological Problems in Primary Care: A practical guide'. The two colleges have also recently established a Forum for Mental Health in Primary Care. The aims of the forum are to guide and promote good practice in mental health care, act as an expert resource, and influence national policy and strategy. (www.rcpsych.ac.uk/college/mentalhealthinprimarycare.aspx)

Mental health services should establish effective liaison with local primary care team members and other agencies to provide onward care pathways.

Links with community learning disability services

In most areas, community learning disability services can offer access to a range of professionals who are skilled in working with people who have learning disabilities. These professionals can help patients access primary and secondary care. This can be a helpful resource for patients, general hospital staff and liaison mental health teams, as the learning disability professional will offer support regarding assessment and treatment, and where necessary, any concurrent challenging behaviour.

Box 11: Providing mental health liaison to maternity services

Psychiatric disorder is a leading cause of maternal morbidity and mortality, yet less than half of mental health trusts in the UK provide specialised perinatal psychiatric liaison as recommended by the maternal deaths enquiries.^{108, 109, 110}

Perinatal liaison services are ideally placed to:

- Provide expert advice and support to maternity professionals on the individual risk and benefits of psychiatric treatment during pregnancy and breastfeeding
- See individual patients in crisis and conduct assessments.

Mental health provision to maternity services should ideally occur within a network which includes access to specialised inpatient mother and baby units if necessary.^{108,109} This ensures that the most seriously ill women can quickly access the appropriate level of care without unnecessarily being separated from their babies.

5. ENGAGING PATIENTS AND CARERS

This section addresses two aspects of patient engagement; the importance of involving patients in their own care; and the broader issue of involving patients and carers in service design, delivery and improvement.

To be actively engaged in their care, patients need to be better informed

The National Institute for Health and Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) emphasise the importance of providing information that enables patients to exercise choice in their care and treatment. NICE has recently produced a guideline on Medicines Adherence¹¹¹ that is *'about enabling patients to make informed choices by involving and supporting them in decisions about prescribed medicines'*.

Many patients would like to be more involved and better informed

A survey of more than 50,000 inpatients in English general hospitals¹¹² demonstrated that although most were generally satisfied with the care they received from the NHS, many expressed concerns about lack of choice and information about treatment and care. Other patient and carer surveys reveal similar findings.¹¹³

Box 12: Survey of over 50,000 adult inpatients

- Three quarters of those whose admission to hospital were planned in advance was not given a choice of admission dates
- Half felt that they were involved in decisions about their discharge, 30% said that they were involved to some extent and 17% felt that they were not involved
- Half of the patients who took medicine home were not given information about the possible side effects
- During their hospital stay, only 6% were asked to give their views on the quality of their care
- A third said that staff did not give their family or carer all the information they needed to help care for them
- Half of patients did not receive copies of letters sent between hospital doctors and their family doctor.

Well informed patients experience less anxiety and better outcomes

Patients who are well informed about prognosis and treatment options are more likely to adhere to treatments and have better health outcomes.¹¹⁴ They are also less likely to experience anxiety in relation to health screening¹¹⁵ and operative procedures.¹¹⁶ Communication is also important. For example, when working with patients for whom English is not their first language, staff need to make sufficient time available for an individual to express and explain themselves fully. This also allows time to gain a better understanding of cultural norms and values.

Engagement includes taking account of mental distress

Some people with mental and physical health problems feel that general hospital staff do not take their emotional wellbeing into account. For example, many people who attend hospital following self-harm report that staff do not ask about their emotional distress and one third of emergency department staff reported that they showed less respect and offered less support to people who self-harm compared with other patients.¹¹⁷ The attitude of professionals can have a profound impact on patients and carers:

“The nurse made such a difference to me just by taking the time out to chat and being sensitive to how mixed I was feeling about the situation”

– Adult attending the emergency department following self-harm, 2007

Box 13: What do people with physical and mental health problems want from services?

A 2004 study¹¹³ found that two thirds of respondents had problems accessing mental health services because of their physical impairment. A similar proportion had difficulties using physical disability services because of their mental health needs. When asked what they wanted from services, key factors were:

- For general hospital staff to take account of patients’ mental health needs, without making negative judgements or behaving in a derogatory manner
- For staff to take seriously the patient’s own view of their health, and not to interpret physical impairments purely as a manifestation of mental illness. One person, for example, said that, when he was in hospital, *‘the fact that I said I had [asthma and arthritis] was seen as an aspect of mental illness’*
- For mental health staff to have a greater understanding of physical health needs, without having negative attitudes or low expectations of the patient
- For all healthcare professionals to have a greater understanding of the relationship between mental and physical health
- For staff to treat the patient as a whole person and not a disease
- For mental health professionals to take account of access needs relating to physical impairment, and vice versa
- Clear communication and positive attitudes from staff: *“He was actually helpful because he seemed normal and he didn’t use words that were not understandable”.*

Patients can be supported to self-manage long term disease

The Expert Patients Programme¹¹⁸ is a user-led self-management programme specifically for people living with long term conditions. The aim of the programme is to support people by increasing their confidence, improving their quality of life and enabling them to better manage their condition. Having been successfully piloted, the Expert Patients Programme currently offers around 12,000 course places a year. It is being made available through primary care trusts and partner organisations. Work is underway to adapt courses for people with mental health problems, and for carers. Feedback from around 1,000 patients who completed the course between 2003 and 2005 indicates that the programme is achieving improved health outcomes for patients and reducing the degree to which they use healthcare services.

Box 14: Engaging with carers

Consideration should be given to the support needs of people who care for someone with mental and physical health problems. Carers may find it difficult to access health professionals and the health of carers is also often overlooked.

There remains a stigma around mental illness

Many patients feel embarrassed to talk about their emotional problems for fear of a negative response from health service staff, and there remain deeply entrenched views amongst some clinicians that mental health problems are shameful or a sign of weakness. Liaison psychiatry services are well placed to challenge stigmatising views of mental illness, through education, training and high visibility in acute medical settings.¹¹⁹

Involving patients in service development, research and audit can improve mental health care in the acute setting

The NHS Plan¹²⁰ places patients at the centre of service design and delivery. Ideally this involvement should extend to the planning of local services, recruitment, training and education of staff, research, clinical audit and service evaluation. Box 15 illustrates how this can work in practice.

Box 15: Involving service users in the improvement of self-harm services

The Royal College of Psychiatrists' 'Better Services for People who Self-harm' project was established in 2005 (www.rcpsych.ac.uk/cru/auditselfharm.htm). People who self-harm were involved on many levels, including developing training materials and courses for clinicians, providing training, designing data collection tools and writing reports and recommendations. Users worked alongside ambulance, emergency department and mental health staff to plan service improvement through meetings, workshops and peer-review visits to other hospitals. NHS staff described their input as 'very helpful' in bringing about positive change as described:

"[They gave] an insight of what it is like to receive a service...a good relationship was established, allowing a freedom to share views, even those of a potentially controversial nature. It felt that service users were extremely active and equal partners and played a significant role in the project. For this we thank them."

Many of the service users involved gained from the experience:

"I have been able to develop training skills which has led to me being invited to join the planning team for student nursing training at a local university. I have gained sufficient confidence in my own abilities to be able to return to work, albeit part time and in a junior position, for the first time in six years."

"All my trouble with self-harm has finally been put to use and my experiences have been invaluable in helping improve things. I feel useful!"

Both NICE and SIGN involve patients and carers in the process of developing their clinical practice guidance. In England, Lord Darzi concluded in his 2008 report that ‘People want a greater degree of control and influence over their health and healthcare’.¹²² In keeping with this, the focus in the NHS is shifting from treatment outcomes that are defined by the clinician to those that are defined by the patient. This is reflected in the Department of Health’s work to develop Patient Reported Outcomes Measures (PROMS) for use in performance management of services.

There are many barriers to involving patients and carers in improving services

In reality however, the often very good intentions of involving patients ‘can sometimes fail to move beyond rhetoric into reality’¹²¹ and runs the risk of being tokenistic and superficial. Several factors can hinder meaningful involvement, including practical barriers relating to recruiting, supporting and paying users and carers. Some professionals also describe difficulties in finding people who are representative of the ‘typical patient’ but Lindow¹²³ warns that this should not be used as a reason to exclude patients:

“The most usual strategy to discredit user voices is to suggest that we are too articulate, and not representative...We ask how representative are others on the committee? We point out that as they are selected for their expertise and experience, so are we...We ask, would workers send their least articulate colleagues to present their views, or the least confident nurse to negotiate for a change in conditions?”

It is equally important that people should not be disenfranchised purely because of intellectual impairments. When given appropriate support and opportunity people with learning disabilities and their carers are capable of giving invaluable insights into potential barriers to effective health care.⁶³

The value of patient expertise should not be underestimated

‘By definition, no one else, no matter how well trained or qualified, can possibly have had the same experience of the onset of illness, the same contact with services or the same journey through the health system.’¹²¹

These experiences are an important resource that can help to improve individual packages of care as well as services generally. When involving patients or carers in any kind of service review or improvement, care must be taken to provide the appropriate emotional, financial and practical support.

6. RE-ORGANISATION OF SERVICES, COMMISSIONING AND QUALITY STANDARDS

General hospitals need flexible and responsive liaison mental health services

This is the view of the Royal College of Physicians, Royal College of Psychiatrists and the Academy of Medical Royal Colleges.^{70,81} A Royal College of Physicians taskforce recommends that acute mental health services, including those dedicated to the needs of older people, should be part of the acute spectrum of care, and that all future acute medical units should have a safe area for managing patients with acute mental health problems, a relatives/carers room and a room for private or confidential interviews.¹²⁴

However, there is little incentive for the NHS to develop such services

This is because local mental and physical healthcare services are commissioned separately and managed by different organisations. Liaison mental health teams are therefore not a *'must do'* for either mental health or acute services. As a result, there is patchy and inconsistent provision across the UK. Where a hospital does have a liaison mental health service, this is invariably provided and managed by the local mental health trust.

The Department of Health's drive for integrated care, especially for long term conditions, and the shift in commissioning to primary care and development of *'Practice Based Commissioning'*, present an opportunity for the development of services in a less dualistic fashion.¹²⁵

There are different models of service

However, liaison psychiatry services work most effectively when they are embedded into the work of the general hospital. This allows liaison staff to work closely with general staff to improve rapid detection and treatment of patients with mental problems in the general hospital setting. Most services include training and educational components to improve the overall quality of service provision in the general hospital. Liaison services will also help ensure appropriate guidelines (e.g. NICE and SIGN) are being followed and that clear pathways of care are developed for patients with particular mental health problems.

Liaison services should *'map'* onto the specific needs of an acute hospital. As acute hospitals vary in size and service delivery, the size and make up of each liaison service will also vary. For example, teaching hospitals require larger liaison services than district general hospitals, because they are usually larger and are often located in inner city areas with high rates of deprivation. Teaching hospitals also manage patients who are tertiary referrals (i.e. people with highly complex health problems).

A liaison mental health team requires adequate staffing

The table below gives an approximate guide to the minimum levels and skill mix for a basic team serving a general hospital, operating Monday to Friday, 9am - 5pm.¹²⁶

Box 16: Suggested minimum staffing for a team serving a general hospital¹²⁶

ROLE	GRADE	TIME	COMMENT
Medical	Consultant	Whole time	Consultant involvement is essential, including managing risk, providing supervision and training and offering expertise on psychopharmacological treatment, complex patients, capacity and the Mental Health Act.
Nursing	Band 8	Whole time	One of the nursing roles should be as team leader.
Nursing	Band 7	3 X Whole time	The nurses operate as autonomous practitioners, undertaking assessments, and brief treatment interventions, and liaising with mental health teams in primary care. Those working with older adults will become involved in detailed discharge planning.
Clinical Psychology	Band 8	1 X Whole time	May be provided from health psychology team, but should be an integral part of a liaison team to provide supervision, training and delivery of brief psychological treatments.
Team PA	Band 4	1.5 X Whole time	Core to referral management, information gathering and communication.

These staffing levels represent the absolute minimum, and additional cover would almost certainly be required, depending on the population served. To provide a comprehensive liaison service which specifically caters for the special needs of adults with complex needs and dementia, greater numbers of the staff listed above are required. In addition, the team would also require at least one full time occupational therapist, 1.5 WTE social worker, sessions from a support worker and additional administrative support. The staffing levels required to provide a liaison service to older-aged patients are available at <http://www.rcpsych.ac.uk/PDF/RaisingtheStandardOAPwebsite.pdf>.

If liaison professionals are to provide teaching, training and support to colleagues within their team and throughout the general hospital; the staffing ratios above would need to be increased to allow for this.

Finally, the table above does not include child and adolescent mental health services (CAMHS) to general hospitals. This ought to be provided by specialist multidisciplinary CAMHS liaison teams, but current provision is currently patchy and further investment is required.

Quality Standards

We need quality standards for mental healthcare in general hospitals. These would clarify the role of liaison services, and provide a means by which to measure and improve the quality of care they provide. In a 2008 report by the Academy of Medical Royal Colleges,¹²⁷ the Chair of the Academy emphasised the importance of setting such quality standards (Box 17).

Box 17: The importance of setting standards

"We witness mental distress and mental illness daily, in people of all ages and in many different circumstances. Yet in our society they command less priority than do physical problems...the same standard of assessment, diagnosis and intervention should be provided for mental health care as is expected for physical health care. This requires an extension of current standards to cover practice in these acute services, commissioning of services and assessment of performance."

- Professor Dame Carol Black, Chair, Academy of Medical Royal Colleges

The Psychiatric Liaison Accreditation Network will support implementation

The Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) has established a national accreditation programme for mental health services to general hospitals (www.rcpsych.ac.uk/PLAN).

Box 18: The Psychiatric Liaison Accreditation Network (PLAN) will:

- Provide assurance to service users, carers, commissioners, government departments, regulators and the public that accredited liaison services are of an acceptable quality and that safety and quality standards have been met
- Recognise local achievements measured against rigorous national standards
- Stimulate liaison services to constantly improve the quality of care they provide
- Give commissioners confidence to invest in accredited liaison services
- Develop a professional identity for accredited liaison services and raise awareness of the value of effective services.

Figure 1 describes the quality improvement cycle.

Figure 1: The quality improvement cycle adopted by PLAN



A process of self- and peer-review will culminate in a decision about whether a liaison service has met essential standards and can therefore be accredited by the Royal College of Psychiatrists. Although the main focus will be on the liaison team, participating teams can choose to nominate other departments in the hospital for an additional 'Mental Health Friendly Award'. For example, a department of the hospital would receive such an award if it met a number of core standards which demonstrate that the mental health needs of patients are well met in that department.

7. TRAINING AND EDUCATION

Many healthcare professionals would welcome better mental health training

The lack of integrated thinking about physical and mental health in the NHS means that there is a real need for healthcare professionals to acquire a greater understanding of the relationship between mental and physical health. However, recent recommendations and audit findings reflect the fact that many healthcare professionals have not been provided with adequate mental health education:

Box 19: Training needs of general hospital staff and GPs

- In 2003, the Royal Colleges of Physicians and Psychiatrists recommended that commissioners ensure improved training of general hospital staff in the mental health needs of older-aged adults⁸¹
- At the same time, the Children's National Service Framework stated that liaison arrangements should provide for the education and training of all children's health care staff in the mental health needs of children and their families¹¹⁰
- In 2008, the Academy of Medical Royal Colleges recommended better mental health training opportunities for staff in emergency departments, medical, paediatric and surgical wards¹²⁷
- The Health Promotion Agency for Northern Ireland surveyed over 500 primary care professionals in 2008 and found that eight out of 10 wanted more training in recognising mental health problems, suicide, self-harm and mental health promotion. Barriers to training were identified as a lack of time and a lack of access. A suggested solution to this problem was online training¹²⁸
- A recent audit found that more than half of 500 emergency department staff would have liked their initial training to include more emphasis on mental health¹²⁹
- Various NICE and SIGN guidelines stipulate the need for better mental health awareness amongst physical health professionals (www.nice.org.uk)
- Training in relation to the needs of people with learning disability is also generally inadequate leaving many health care professionals feeling uncomfortable and unprepared¹³⁰
- The learning disability component of the Royal College of Psychiatrists' curriculum for basic specialist training emphasises the importance of recognising the influence of physical factors on psychological presentation. It is essential that general hospital staff are trained about not just the high rates of and atypical patterns of health deficits in people with learning disability, but also the potential atypical presentation of physical symptoms.¹³¹

Doctors need better training in the detection and treatment of mental health problems in patients who are physically ill

Most UK medical students receive relatively little training in mental health, and most of that focuses on the management of severe and enduring mental health. Medical graduates initially become foundation doctors for two years, during which time they acquire the majority of their core mental health competencies in anticipation of becoming general practitioners or hospital specialists.¹³²

The foundation curriculum emphasises the importance of psychological, social and cultural factors in the assessment and management of physically ill patients. More specifically, foundation doctors must be able to manage patients following self-harm, with an acute confusional state and with psychosis. They are also required to develop positive attitudes, in which they must consider the impact of:¹³²

- Physical problems on psychological and social well-being
- Physical illness presenting with psychiatric symptoms
- Psychiatric illness presenting with physical symptoms
- Somatisation
- Family dynamics.

Box 20: All doctors working in a general hospital setting should be able to:

- Elicit patient's concerns about illness in a sensitive and competent manner
- Screen for depression and anxiety
- Assess cognitive function using the Mini Mental State Examination
- Carry out a basic risk assessment for suicide and self-harm
- Be able to assess basic capacity to give consent for medical treatment
- Detect dementia and delirium and treat these appropriately
- Detect symptoms of drug and alcohol withdrawal and treat these appropriately.

However, the dichotomy of care between mental health and acute trusts or NHS boards can make acquisition of these competencies very difficult. There are a number of ways in which mental health staff can facilitate the process:

- General hospitals have weekly grand rounds which should be attended by multidisciplinary members of the liaison psychiatry team, who should also take their turn in presenting and discussing cases and issues of shared interest
- Mental health professionals should participate in the regular teaching of acute trust staff – not only in the formal setting of continuing professional development – but also on the wards. Sharing knowledge and attitudes during routine care offers the opportunity of involving the patient's own perspective and expectations
- Mental health professionals should develop working relationships with acute care units where the prevalence of psychological morbidity is particularly high – such as rheumatology and gastroenterology. The day to day presence of mental health professionals on these units promotes learning and increased awareness of mental health issues
- Mental health professionals can train colleagues in the use of easily implemented mental health screening questionnaires, which improve staff awareness for psychological and psychiatric complications. The Hospital Anxiety and Depression Scale is a well validated self-rating scale for use in the general hospital.¹³³

Competencies need to be checked

'*Knowing Why*' and '*Knowing How*', usually tested by written and clinical exams, are not considered to be sufficient evidence of competence. The current gold standard is the Workplace Based Assessment, particularly as this includes feedback and reflective practice. Two of these, currently approved by the Postgraduate Medical Education and Training Board, lend themselves particularly well to the development of integrated physical and mental health skills:

- Case Based Discussion (CBD): In the CBD the healthcare professional discusses an individual patient. The trainer can focus the conversation on aspects of management that require attention to physical and psychological needs, and can help identify points of strength and areas that could be developed further
- Mini-Clinical Examination (mini-CEX): In the mini-CEX, which usually lasts 10-15 minutes, the healthcare professional interacts with a patient whilst being observed. The exercise could, for example, be to assess the patient's mood, the impact of their physical illness on their emotional health, or their understanding of their illness. Again, the trainer or supervisor can focus the subsequent feedback and discussion on areas relevant to integrated care.

Training in primary care needs to be improved

There are also opportunities for teaching and awareness raising in primary care. Recent developments such as primary care mental health teams, GPs with special interests in mental health, the Improving Access to Psychological Therapies (IAPT) Programme and the Gateway Workers Programme raise awareness of mental health issues and access to treatments in primary care. These teams need to train and support active case managers and patients with long term conditions to integrate physical and psychological care. Secondary care mental health specialists need to train, supervise and support primary care staff to acquire and maintain relevant mental health skills.

The Royal College of Psychiatrists and the Royal College of General Practitioners recently recommended that GPs in training would benefit from spending an attachment in Liaison Psychiatry.¹³⁴ The type of mental health problems seen by liaison psychiatry services are more diverse than those seen by teams who specialise in the treatment of severe mental illness, and the problems are more relevant to those most frequently encountered by GPs in their daily practice. The colleges also recommended that more psychiatric trainees should spend a six month attachment in primary care. The newly established Forum for Mental Health in Primary Care also provides useful updates about psychological aspects of physical health and acts as an expert resource (www.rcpsych.ac.uk/college/mentalhealthinprimarycare.aspx).

Many patients with chronic conditions such as pain are increasingly likely to be seen in intermediate care settings. New services need to include mental health specialists so that staff become familiar with managing the interface between physical and psychological care, and training needs should be prioritised.

Finally, the national guidelines developed by NICE and SIGN relating to physical conditions vary in terms of mental health content (see www.rcpsych.ac.uk/nohealth for a detailed description). It is vital that national guidance ensures that mental health issues receive adequate focus.

8. SUMMARY

It is hoped that the ALERT report will not only enhance understanding of the link between mental and physical health, but also provide a much needed impetus for the development of better services for this significant and largely neglected group of patients. More substantial mental health provision across the general hospital setting will benefit patients, carers and healthcare professionals from all backgrounds. It is envisaged that the Medical Royal Colleges and other organisations will work together to make the recommendations in this report a reality.

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