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Liaison psychiatry services in Wales

AIMS AND METHOD

To determine the nature of current liaison psychiatry services in Wales, a structured telephone interview was conducted with representatives of all 11 National Health Service trusts.

RESULTS

Three trusts (27%) had no dedicated liaison psychiatry service and only

one of the eight (13%) with a service had a full-time consultant liaison psychiatrist. Only two services (25%) had a full-time junior doctor and three (37%) were not multidisciplinary, comprising nursing staff alone. No team had a clinical psychologist and only two (25%) provided a psychological treatment service.

CLINICAL IMPLICATIONS

Liaison psychiatry services across Wales are fragmented, under-resourced and unlikely to meet patients' needs. They fall well short of the recommendations of the Royal Colleges of Physicians and Psychiatrists.

Psychiatric disorder is common in the general hospital with estimated prevalence rates ranging from 30 to 60% (Bell *et al*, 1991; Marchesi *et al*, 2004). Presentations include self-harm, organic brain syndromes, comorbid psychiatric and chronic physical illness, and somatoform disorders. They are often accompanied by considerable disability and use of resources. There is a clear need to appropriately assess and manage this group of patients. The Royal Colleges of Physicians and Psychiatrists recommended liaison psychiatry services as the best way to address this need (Royal Colleges of Physicians & Psychiatrists, 2003).

Over the past two decades the provision of liaison psychiatry services across the UK has improved, although concern has been expressed that there is a lack of rational planning of liaison services and that they are not needs-based (Howe *et al*, 2003; Ruddy & House, 2003). A survey published 4 years ago showed that they continue to fall below the medical Royal College recommendations, with idiosyncratic provision and particularly poor service provision in Ireland and Wales (Swift & Guthrie, 2003).

The National Service Framework for Mental Health in Wales (Welsh Assembly Government, 2005) has recommended that each general hospital needs a truly multidisciplinary team including liaison psychiatry sessions to provide mental health services. There are concerns among service providers, however, that despite this recommendation the limited provision of liaison psychiatry services has not been addressed, with the exception of bolstering services to accident and emergency (A&E) departments in order for them to meet the 4-hour target. Indeed, concerns have been expressed that while the recent focus on A&E may provide an opportunity to increase liaison psychiatry services for one department there is a risk that other patient groups will be neglected (Kewley & Bolton, 2006).

We aimed to determine the level of provision of liaison psychiatry services across all of Wales in relation to the Royal College of Physicians & Psychiatrists' (2003) recommended staffing levels.

Method

We tried to identify consultant psychiatrists with a remit, interest or sessions in liaison psychiatry in all 11 acute National Health Service (NHS) trusts in Wales. Where this was not possible we contacted the clinical director or other professionals working in liaison psychiatry in that trust.

A telephone interview was conducted using a structured questionnaire to enquire about the level of service provision, team members and their sessional input, hours of working and plans for service development. Finally, individuals were asked to comment on their service and, if they were not satisfied with it, how the existing service could be improved. In order to verify the results they were shared with liaison psychiatry specialists across Wales and further enquiries made if possible inaccuracies were identified.

Results

Eleven NHS trusts were identified. Three trusts (27%) did not have a dedicated liaison psychiatry service but had a crisis resolution home treatment team or a sector team who also covered liaison psychiatry work. Of the eight trusts (73%) with a liaison psychiatry service, one had two separate services which were combined for the purpose of the results. The results were quantified and compared with the level of service provision recommended jointly by the Royal Colleges of Physicians & Psychiatrists (2003).

Service provision and staffing

Of the eight trusts with a liaison psychiatry service only one (13%) had a full-time consultant liaison psychiatrist but still failed to meet the Colleges' recommendation of at least two in a teaching hospital.

Three services (37%) were not multidisciplinary, comprising nursing staff alone. Only two teams (25%) had a full-time junior doctor. None of the teams had a



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clinical psychologist and only two teams (25%) provided a psychological treatment service.

The staffing levels of the eight liaison psychiatry services in Wales are shown in Table 1, alongside the Colleges' recommendations for Wales' total population of 2 903 085 people. Wales has only 22% of the recommended number of consultant psychiatrists, 31% of other medical staff, 34% of nursing staff and 21% of individuals capable of providing psychological interventions. However, in reality the situation is likely to be worse than this as the Colleges recommend a larger service for teaching hospitals.

Nature of the service

All eight services assessed ward referrals, including individuals who had self-harmed, but only six (75%) provided services to the A&E department. In the remaining two (25%) A&E referrals were covered either by a crisis resolution home treatment team or by a community mental health team. Only three teams (37%) offered an out-patient service or services to specific groups, and only one (13%) accepted older patients but referred them to the elderly team if required after six follow-up sessions.

Hours of service

None of the teams provided a 24-hour service, five (63%) worked extended hours including weekends and three (37%) provided a normal working hours (09.00 to 17.00 h) service.

Future development

Only three trusts (37%) had plans for future development of liaison psychiatry services, the rest had none with one trust's services having been significantly reduced over the past 2 years because of funding issues.

General comments

Broadly speaking, most of those who took part in the study wanted a multidisciplinary liaison psychiatry team to be developed in their area with increased input from consultant psychiatrists, psychologists and junior doctors. They also wanted to improve their capacity to cover the A&E department and to offer specialist services.

Selected comments included:

'It's very disappointing that such a nice service has been eroded'

'It is insufficient and it's like fighting fire!'

'It works remarkably well considering the limited resources.'

'As a DGH the emphasis is more on community work rather than a liaison service.'

Discussion

This is the first survey of its kind to provide a complete picture of liaison psychiatry service provision in Wales. There has been an increase in service provision compared with a previous estimate 17 years ago (Mayou *et al*, 1990). However, there are still three NHS trusts that do not have a service at all.

The Royal Colleges of Physicians & Psychiatrists (2003) recommended one full-time consultant psychiatrist, a senior house officer, five nursing staff and one to two psychologists for an average district general hospital serving a population of 250 000. Despite inclusion in the National Service Framework it is clear that liaison psychiatry provision in Wales falls way below the Colleges' recommendations, is less well-provided for than English services (Kewley & Bolton, 2006) and highlights a significant service gap. This is a major concern, likely to adversely affect patient care and to be associated with increased risk.

The current situation means that liaison psychiatry services in Wales are reactive rather than proactive with less than half providing services to specific units. This significantly reduces the ability to identify many patients who would benefit and to overcome barriers to referral such as stigmatisation (Morgan & Killoughery, 2003).

Table 1. Staffing of the eight liaison psychiatry services in Wales

NHS trust	Number of staff (full-time equivalent)			
	Consultant	Other medical	Nurses	Psychological therapists/counsellors/psychologists
A	1	0.5	2.5	0.4
B	0.2	1	1.2	0
C	0	0	2	0
D	0.4	1	4	0
E	0.2	0.6	3	0
F	0.8	0.5	2	2
G	0	0	1	0
H	0	0	4	0
Total	2.6	3.6	19.7	2.4
Colleges' recommendation	11.6	11.6	58	11.6



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There is an urgent need to address the shortfall in this area and develop adequately staffed and resourced services across Wales. Unfortunately, liaison psychiatry has not been prioritised for development by trusts or the Welsh Assembly Government in the past. This needs to change if the current situation is to improve. The National Service Framework for Mental Health in Wales requires all NHS trusts to deliver effective liaison services by March 2009. Given the current picture, meeting this requirement will be a major challenge requiring considerable work and investment.

Declaration of interest

None.

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Supplementary prescribing: a new way of working for psychiatrists and nurses

AIMS AND METHOD

To describe the implementation of supplementary prescribing and nurse-led care in an acute in-patient unit. The issues of delegation and distribution of responsibility were explicitly addressed. Structures were developed for training and

supervision, to ensure improved medicines management in the acute setting.

RESULTS

We present our five-step model of nurse-led in-patient care and our experience of using a clinical management plan for 33 patients.

CLINICAL IMPLICATIONS

Implementation of supplementary prescribing provides a model for new ways of working, requiring engagement of both doctors and nurses, clear delegation and distribution of responsibilities, and well-developed governance structures.

Most psychiatrists are currently involved in an active review of roles and responsibilities as part of the New Ways of Working (Department of Health, 2005) initiative. Key to this are changes within the multidisciplinary team to prioritise consultant workload and the distribution of responsibility and leadership across teams. The General Medical Council has issued guidance on the legal framework for this process of distribution (General Medical Council, 2005) recognising the independent responsibility of nurses, working within their skills and competencies, for patients, without the responsibilities being in any way delegated or supervised by a doctor. The guidance also emphasises the important role of employers in creating a managed, safe environment for this.

Prescribing is no longer a solely medical task, we now have patient group directives, supplementary prescribing and lately independent nurse prescribing

(Department of Health, 2006a). Supplementary prescribing is a delegated responsibility, where the overall responsibility for patient management remains with the delegating doctor (General Medical Council, 2006), although the persons delegated to are accountable for their own decisions and actions. The delegating doctor has responsibilities to ensure communication about the patient and the treatment needed, and must ensure that the person delegated to has the necessary qualifications, experience, knowledge and skills.

Supplementary prescribing has the potential to improve patient outcome (National Prescribing Centre, 2005). However, there are acknowledged difficulties in implementation. Organisational barriers and lack of knowledge and confidence have been identified as causes of non-adoption of supplementary prescribing by trained nurse prescribers (Brimblecombe *et al*, 2005) as has the