ROYAL COLLEGE OF PSYCHIATRISTS

FACULTY OF LIAISON PSYCHIATRY NEWSLETTER

Contents

Editors:

Dr Sridevi Sira Mahalingappa

Dr Nora Turjanski

Dear Colleagues

Welcome to the summer edition of the Faculty of Liaison Psychiatry Newsletter.

It has been a very successful beginning to 2017. Our membership and general interest in liaison psychiatry continues to expand. We are very pleased to announce that we had a successful Liaison Faculty Conference in London in May. Our Faculty has made tremendous growth under the leadership of Dr Peter Aitken and Dr Al Santhouse and we are very grateful for their contribution over the last four years.

In June, taking over office at the International Congress in Edinburgh were Dr Jim Bolton and Dr Annabel Price who were elected as Chair and Vice Chair, respectively, of the Faculty. We would also like to take this opportunity to welcome Professor Wendy Burn as College President and thank her for her contribution to our newsletter.

In this summer edition, Dr Aitken writes a few words as parting chair of the Faculty. We are very grateful to everyone who has contributed to this newsletter. In this edition, articles give update about PLAN, give an overview of the specialist inpatient psychological medicine service in Leeds, reflect on psychiatry of cancer and cancer treatment and a personal account of challenge of moving job from old age psychiatry to liaison psychiatry.

As you know, this is not a peer-reviewed journal or a scientific publication but a platform to share good practice, ideas and a sensible dose of optimism! In the future, we intend to release this newsletter three times a year and we rely on your contributions to support this.

Please note that we will not publish any case reports in the newsletter but we will welcome submissions on matters relevant to liaison psychiatry including reports on service development, education, training, audits, conferences and events. Articles should be 1-2 pages long. Please include primary author name, title, place of work, picture and contact details. If you would like to contribute to our next editions please e-mail ***Stella.Galea@rcpsych.ac.uk*** using "Liaison Faculty Newsletter" as the subject title.

We would especially like to thank Stella Galea and Dr Peter Aitken for their support.

We hope you enjoy the Summer edition of the newsletter.

Chair's report - Dr Peter Aitken

Dr Peter Aitken MRCGP FRCPsych
Consultant in Psychological Medicine Director of Research & Development Devon Partnership NHS Trust. Chair, Faculty of Liaison Psychiatry.

Thank you. Thank you for a very enjoyable four years as your chair. Thank you for all the things we've done together in that time. It has been great fun. I now look forward to passing on the baton to Jim Bolton, new Faculty chair and Annabel Price, vice chair who will lead us into the next phase of development toward truly integrated psychological medicine. Congratulations to them both.

That we've achieved a commitment from governments to make liaison psychiatry part of general hospital life each hour of every day is truly remarkable. In England this is explicit in policy and being implemented in practice. In Wales the money is in policy and implementation in plan. In Scotland we hope to see commitment in their forthcoming mental health strategy and meetings in Northern Ireland offer hope that there too liaison psychiatry will continue to grow.

Since our last newsletter another key piece in the jigsaw that is the Faculty work program came into the public domain with the publication of the National Confidential Inquiry into Perioperative Deaths report "Treat As One." Congratulations to Sean Cross and many other members of the Faculty for their work and advice in relation to this. The report is all the more powerful sitting as it does outside psychiatry looking in from the perspective of others. Nine key cases set out in the most powerful terms the harms arising for medical and surgical patients with mental illness in general hospital care when mental health is overlooked, records incomplete or not shared, medication disregarded and inaccurate or incomplete diagnosis and risk planning. Most of the key recommendations point to the essential place of liaison psychiatry, liaison mental health services and closer integrated psychological medicine working in a common integrated health record within a common system.

In England the implementation of Core24 Liaison Psychiatry is happening alongside a welcome expansion in the provision of Improved Access to Psychological Therapies. The expansion in IAPT is to enable people with depression and anxiety presenting with symptoms such as aches, pains, fatigue and otherwise unexplained physical symptoms to enjoy the same access to NICE based treatment as people presenting with the more obvious symptoms of low mood, worry, pessimism and guilt. My thanks to Michael Sharpe, Amrit Sachar and Sarah Eales from the Faculty for working hard in the NHS England expert reference groups and work-streams developing guidance to help commissioners understand how these models of care can work together and support each other's effectiveness.

It is now increasingly clear to NHS Leadership that developing 'silo' mental health services like Core 24 and IAPT working alongside general hospital pathways is only a step, albeit a significant one, on a journey toward truly integrated psychological medicine. We began in an era where community based and on-call psychiatrists might be called into hospitals to help with the most obviously behaviourally disturbed people. At best the model allowed for a 'consult' and walk away approach with the hospital team still left with the management of

the problem. We've moved now to a time when dedicated liaison mental health teams can operate a 'consultation-liaison model' responding when called, co-creating a plan and walking alongside the hospital team to make sure it is delivered.

Where we need to go is toward the truly integrated psychological medicine team. All the multidisciplinary hospital medical & surgical teams and primary care teams we have historically regarded as 'general health' need to become integrated psychological medicine teams. To achieve this will mean injecting psychiatry and other mental health expertise into these teams in a way that allows them to share their expertise whilst at the same time retaining it. We as a Faculty need to describe how we organise psychiatry to do this.

In England, Core24 and 'Integrated IAPT' are part of the Five Year Forward View Program with budget planned to support delivery. In addition, 'New Models of Care' delivery is being tested in the Vanguard Program. However there is no explicit budget in this program for liaison psychiatry services already working in an integrated way. It is now recognised by the NHS England team that around the country there are already good examples of integration, both mental & physical and health & social. Many liaison psychology service models already represent close integrated working with medical and surgical teams working with conditions as diverse as tinnitus and cystic fibrosis. The principle is now agreed that these are examples of the kinds of services anticipated by Five Year Forward View and we ought to understand them, get to know them and avoid disrupting them.

To this end step forward Will Lee and his team, this time working with the British Psychological Society, to help them survey the psychological services already at work in our hospital medical and surgical pathways. Together with examples of truly integrated psychological medicine from liaison psychiatry these services are likely to become the exemplars for us all beyond 2020 and we should do everything we can to know them and support them.

No surprise then that the Faculty photo of the month goes to Sarah Burlinson and her exemplar integrated psychological medicine service in Oldham, visited by the health secretary!

Finally, thank you to the support of the many of you that supported my candidacy for College President. It was an enjoyable experience during which I learned much about the wider work of the College especially in the devolved nations and the international divisions. Democracy was well served by a 33% turnout and decided in favour of Wendy Burn who is now our President elect. Many congratulations Wendy, we look forward as a Faculty to supporting your leadership over these next critical three years. So I leave the Faculty leadership in good hands and stay with the executive in the role of immediately past chair and will work to support our new leaders as energetically I can.

Message from Professor Wendy Burn-President of Royal College Of Psychiatrists

Prof Wendy Burn
BM, MMedSc, FRCPsych
Consultant Old Age Psychiatrist, Leeds and York Partnership NHS Foundation Trust
President Royal College of Psychiatrists (From July 2017)

In January I was elected as the next College President and I took up this role in June at the International Congress.

This is a huge honour and privilege. I was College Dean for five years before handing over to the highly capable Kate Lovett last summer. In this position I worked closely with two Presidents, Sue Bailey and Simon Wessely, so I know what the job entails. I also know that as with any College work it is only possible as a result of the willingness of College members to help with the work that needs to be done. The College runs entirely on good will, everyone including the Officers is there as a volunteer.

I am going to need particular help from your Faculty to deliver my priorities. A major focus for me will be on promoting integrated care. We need to move beyond Parity of Esteem so that mental health care is not only as good as physical health care but is delivered as part of an integrated approach to health and social care. You are the people who are already doing this and who understand how we bring together psychiatric and physical healthcare services. I will need help in spreading this message and advice on how services will need to adapt.

Another priority of mine is recruitment. The recruitment strategy already in place is achieving something as our numbers rose slightly during my time as Dean against a background of a national fall but as the Red Queen in Alice in Wonderland said “It takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"

Illustration by John Tenniel in Through the Looking-Glass by Lewis Carroll

Your Faulty can and does assist with recruitment. You are the face of Psychiatry for many Foundation Doctors and we know that Liaison placements are amongst the most popular for Foundation trainees in Psychiatry. We need to work on this and on how we showcase our specialty for the increasing number of trainees passing through it in Foundation training.

As a College, we also need to take a long hard look at training and at what has happened to reduce the morale of trainees so drastically over the last few years. My belief is that increasing centralisation, rigidity and development of a “tick box culture” of assessment are the underlying issues. We have to do something about this, a system where only half of Foundation trainees move into specialty training is not sustainable.

Some of you will already be aware of the Gatsby Wellcome Neuroscience Project which I have been co-chairing over the last year. This involves a complete revision of the core curriculum with an emphasis on neuroscience so that our trainees will be prepared for the scientific advances that will come over the course of their careers. We are also going to look at the physical medicine contained within it, with the likelihood

that there will be an increased emphasis on maintaining skills in this area. I will continue this work and we plan to have a draft new curriculum by the end of this year.

I live in Yorkshire and know that the College can be considered London-centric. During my time as President I plan to travel widely in the UK (if there is a local Premier Inn I'll come) and hope to meet many of you and hear first-hand what you feel the College should be doing. So please invite me to your events and meetings. You can contact me via Wendy.Burn@rcpsych.ac.uk

I would like to finish by paying tribute to Peter Aitken who demits as your Faculty Chair. I worked collaboratively with him as Dean and we were able to achieve an enormous amount in Liaison training due to his energy and commitment including the Liaison endorsement for Old Age trainees and the Liaison credentialing work. I am sure that he will remain involved in College work and will continue to contribute on a national basis.

Stranger in a Strange Land?

Dr Simon Thacker
Old Age Psychiatrist, unendorsed Liaison Psychiatrist and Clinical Director Derby.

After 17 years working in community and inpatient Old Age Psychiatry (with spells in management thrown in), I secured a posting in the newly formed Derby RAID team allied to a Dementia Research post. The combination has proved personally stimulating and organisationally fruitful. Late career changes are potentially a leap in the dark but Liaison Psychiatry is especially suitable for old workhorses in need of enlivenment.

As a Senior Registrar (remember those?) working in Derby in the 1990s, I had the pleasure of working within the indecorously named Deliberate Self-Harm Team at the local acute hospital. Liaison Psychiatry was then a fledgling specialty despite the passage of 30 years from Enoch Powell's famous Water Tower speech advocating the establishment of Departments of Psychological Medicine within a district general hospitals. In those days, Old Age trainees had to do one year of general adult psychiatry and the job was combined with general adult inpatient duties. I was attracted to Liaison but my natural aversion to personality disorders (not uncommon in Old Age trainees!) and the fact that Old Age Liaison at that time comprised only a visitation from a (usually disconsolate) sector Old Age Psychiatrist, rather closed my eyes to the opportunities that Liaison might afford an enthusiast for old age work.

Scroll on nearly two decades of much tempering in the furnace of Old Age Psychiatry and my 6th decade thoughts turned existential – "Is that it?". I had nurtured numerous trainees and seen many enter upon enviable careers. I had seen Old Age Psychiatry miss out on nationally prescribed innovation – Crisis Teams, Functional splits, Early Interventions etc–and valued the way our "fuddyduddyness" as a discipline allowed that continuity of care that generates a comprehensive understanding of the painful journeys our patients travel. The pressures of performance management had got to me and I instinctively bristled at the diversion from patient contact generated by PBR, HONOS, risk assessment forms etc. I was finding that patients were increasingly portrayed as some sort of risk matrix rather than a human being with biography, hopes, aspirations and fears. Would a career change moderate my dissatisfaction or augment it?

The omens were good in that much provider and commissioning effort had gone into setting up the

RAID team in Derby. Psychiatry was not alien to the Royal Derby Hospital– Self-harm assessment team, Confusion nurses and an Alcohol Liaison team were already operating. The lead clinician for the self-harm assessment team had produced a compelling business case for an integration of the existing teams allied to dedicated medical input to produce a 24/7 RAID style liaison service meeting what would now be called Core 24.

The RAID development was seen as a flagship service for our Trust and something we must "make work" to demonstrate an accessible and cost-effective approach to urgent assessment.I was appointed as a half-time Old Age Consultant (alongside my research brief) working with 2 WTE consultants with Liaison Endorsements (I would have been sunk without their skill and support!).. Sub-teams covered the disciplines of Old Age, General Adult and Drug/Alcohol work with nurse leads in each. We decided that the merger of the 3 pre-existing teams provided specific skills but that basic psychiatric assessment is generic and we must all embrace each other's work.We did plenty of Forming and Storming before any sort of Norming occurred. Learning skills from each other was hard won and although we gave each other teaching sessions, it was via learning by shadowing each other, modelling and feeding back that we generated confidence in working across speciality (and age) boundaries. Daily team meetings and the recognition that nurses and medics must "live in each other's pockets" to nurture the learning environment necessary to create the breadth of skill needed to meet the patterns of referral.

Nearly 4 years on and I am still enjoying my new lease of life in Liaison. Learning from my new colleagues has been a privilege and a joy abetted by the comraderie that we have viewed as crucial to our survival as a team. The freedom from clinics (and the demeaning performance management that they involve) and the emphasis on acuity has been stimulating. Continuity of care may be lacking compared to my old post but I feel that the discipline of quick decision-making evidenced by parsimonious documentation has added vim to my clinical practice. The bell-weather position of the Liaison Team within the psychiatric service has provided insights into bed shortages, delays in time to treatment and the physical vulnerability of psychiatric patients that add potency to my testimonies within managerial spheres.

What have I learnt?

1) Initial chaos is unnerving but can release enthusiasm and creativity.

2) The breadth of Liaison Psychiatry is astounding. I now feel out of my rut.

3) Liaison Psychiatry is always in the news in some form. Bed crises, waits in ED, services for frail elderly, the plague of cheap alcohol, the plague of Novel Psychoactive substances. I have taken on the Public Engagement Officer role for the Trent Division and do interviews for local radio and TV.

4) I have always relished the strange and protean world of Delirium but the sheer extent of delirium within the general hospital allied to the potential to miss or miss-code it has alarmed and energised me. As part of my research and development brief, my Trust supported me in taking on a Strategic Clinical Advisor role for Delirium with the East Midlands Patient Safety Collaborative. Mental state as an indicator of the deteriorating patient is vitally important in our high-tech world of scans and data. Interestingly I have found common cause in promoting Delirium awareness and the development of a Delirium Pathway not just with the geriatricians but with anaesthetic colleagues and nationally within the Age Anaesthesia Association.

5) Somatoform presentations are alarming : surgeons and physicians obviously feel hidebound by the test results rather than

guided by the bigger picture. The low vital capacity in a patient who can effectively tap away at her IPAD may not be Guillame-Barre but something more subtle. Young women with high residual urine volumes and who end up self-catheterising for no clear organic reason who may need a more nuanced approach to their care. This is all old hat to a proper Liaison Psychiatrist but was revelatory to me.

6) Finally, personality disorder. Emotionally Unstable Personality Disorder is an often used diagnosis and now that I am older and wiser I no longer recoil but feel much sympathy for a vilified group who strike fear into the hearts of many practitioners probably because the medical, risk-aversive model has so little to offer them. In many ways, I think EUPD is a syndrome borne of our modern culture which has such propensity to generate distress and few means to discharge it. The loneliness and anxiety of the young person on the end of that smartphone is a new world to me and I am still trying to reconcile our obsession with suicide risk against our need to deliver appropriate care. I certainly was not anticipating this conundrum to be exercising me in the latter part of my career when I started out.

In conclusion, I would strongly recommend the leap into Liaison Psychiatry for colleagues who find themselves in a similar position in late career. You do have the skills to enter into this new world, the intense social whirl of the hospital and the diverse colleagues you will encounter provide a wonderful liberation.

National Inpatient Centre for Psychological Medicine (NICPM)

Dr Peter Trigwell
Consultant in Psychological Medicine and Clinical Lead
National Inpatient Centre for Psychological Medicine (NICPM)
Leeds General Infirmary

This article provides a brief update about the specialist inpatient psychological medicine / liaison psychiatry service in Leeds, which has a national function and is available for referrals of patients from anywhere in the UK. Until recently it has been known as the Yorkshire Centre for Psychological Medicine (YCPM). But following several visits and at the suggestion of NHS England and the Department of Health the name has been changed to better reflect its established national function. The new name is the National Inpatient Centre for Psychological Medicine (NICPM).

The NICPM is a general hospital-based specialist inpatient unit (ward) which delivers multidisciplinary care particularly for people with severe and complex medically unexplained symptoms (MUS). It has a history over many years of delivering services within Leeds and West Yorkshire, but since 2009 has been able to offer access to patients from across the UK. During that period these have come from numerous different centres, including in Berkshire, Buckinghamshire, Cambridgeshire, Cheshire, Cleveland, Cornwall, Cumbria, Derbyshire, Devon, Greater Manchester, Hampshire, Lancashire, Leicestershire, Lincolnshire, London, Nottinghamshire, Northumberland, Oxfordshire, Shropshire, Somerset, Staffordshire, Surrey, and Yorkshire, plus central and highland Scotland. All of this has helped to demonstrate the otherwise unmet need and demand for this service, and I would like to thank colleagues for the multiple referrals which we have received from across the UK over the past 7 years or so.

The NICPM is unique for several reasons, including because we take people with symptoms and illness involving any bodily system. The clinical approach is necessarily very individualised, but generally involves biopsychosocial formulation informing the delivery of physical and occupational rehabilitation alongside psychotherapeutic and psychotropic interventions, whilst addressing iatrogenic and treating co-morbid medical conditions. The clinical team is expert and experienced at dealing with these complex and interactive issues, and the service delivers significant improvements in health, quality of life, and recovery, for people who have previously been very difficult to help.

The NICPM team specialises in helping people with the following types of problems:

1. Severe and complex medically unexplained symptoms and illness
2. Severe CFS/ME
3. Psychological difficulties affecting the management of long-term physical health conditions

Patients admitted to this unit have often been seen in multiple general hospital services, for a broad range of investigations which have possibly all proved negative, or at least not provided results to explain the extent of the presentation. They may be housebound and/or bedbound, or may continue to present within the general hospital setting for further investigations and attempts at treatment. Due to the psychosocial aspects, or the interaction between the physical and psychological difficulties they are experiencing, attempts to make progress with them will often have been unsuccessful. All patients are, of course, unique, but of our most severe cases a “typical” patient may have been bedbound for years, fully dependent, perhaps tube-fed and/or catheterised, and taking numerous medications, but without organic pathology to explain their illness.

Given the nature of these cases, there may also be a need to manage significant co-existing physical health disorders, sometimes with acute elements, in order to keep these patients safe from a physical health perspective whilst addressing underlying psychological issues. This necessitates an effective approach to the involvement of relevant medical and surgical teams, sometimes to the level of shared-care. Acute medical cover, a critical care inreach nursing service, and coverage by the hospital resuscitation (crash) team are all in place and essential, as is access to the full range of acute general hospital diagnostic tests and investigations.

The NICPM team has the following elements:

- Liaison psychiatry / psychological medicine doctors
- Nursing (mainly registered mental nurses, but with additional training for managing physical conditions)
- Occupational therapy
- Physiotherapy
- Psychological therapies
- Dietetics
- Pharmacy
- Administration

As outlined above, we also have direct and easy access to medical and surgical teams within the general hospital system, across the full range of specialities.

Plans have been created and substantial capital funding has been secured to re-provide this service, in due course, in a new, expanded and improved facility. Work to establish the most appropriate general hospital site for this is ongoing.

Annual Reviews show consistently good clinical outcomes, eg:

- Overall improvement: major 59%, moderate 36%
- Proportions of patients improving: Self-care 100%, Mobility 87.5%, Activity 94.1%, Well-being 88.2%
- Patient feedback: Good/Excellent rating in 100%
- No complaints in over 7 years (since current model established in 2009)

The clinical and quality of life impact which is delivered is, in large part, made possible by the nature of the NICPM unit and its function within

the general hospital setting, but also due to the experience and expertise within the team.

Further details, including Annual Reviews, can be found on our Trust webpage: Centre for Psychological Medicine
www.leedsandyorkpft.nhs.uk/our-services/yorkshire-centre-for-psychological-medicine

The service has also been featured in a number of national documents. Most recently:

- Services for people with medically unexplained symptoms (Joint Commissioning Panel for Mental Health, Dec 2016)
- Severe CFS/ME: Shared Clinical Practice Document (BACME: British Association for CFS/ME, Jan 2017)

I hope colleagues will find this update useful, and again would like to thank those of you who have referred to us for your interest and support as we have developed this service.

PLAN - feel the love

Dr Jim Bolton,
Clinical Lead for PLAN
Consultant Liaison Psychiatrist
St Helier Hospital, Wrythe Lane, Carshalton, Surrey.

The success of the Psychiatric Liaison Accreditation Network (PLAN) has recently been shown by the growing number of PLAN members, the record attendance at the recent PLAN Annual Forum, and mention in a national report on mental healthcare in general hospitals.

Treat as One

The National Confidential Enquiry into Patient Outcome and Death recently published their report 'Treat as One – Bridging the gap between mental and physical healthcare in general hospitals. Many of you will have taken part in data collection for this project or will be supporting your hospitals in fulfilling the subsequent recommendations.

A heartening finding of the study was that, "The effect of having a liaison psychiatry team, especially one which was PLAN accredited, was positively associated with better quality of care". Of course association is not the same as cause, but it is a finding worth noting if you are seeking funding for PLAN membership or wish to demonstrate the value of your service to commissioners.

PLAN Annual Forum

The 2017 PLAN Annual Forum was held at the College's London headquarters in March 2017 and attracted a record attendance of over 170 delegates from PLAN teams across the UK. The plenary sessions reflected liaison psychiatry's high profile on the political and health service agenda, including a presentation on the recent NCEPOD document (above) from Dr Sean Cross (whom I suspect had a lot to do with ensuring that the findings reflected the value of PLAN – thanks, Sean).

Viral Kantaria from NHS England detailed the various strands of their work in which our specialty is involved and Dr Alys Cole-King gave an inspiring talk on suicide prevention. Alys highlighted the key role of compassion in our work, a theme that was also picked up by Mary Ryan, who held the audience rapt with her account of her experiences of being a patient of mental health services.

The poster presentations highlighted many areas of innovative practice being developed by services across the UK – I never cease to be amazed by the enthusiasm and dedication of colleagues. The posters were judged on the basis of content, practical application and presentation. The winners were Emily Glanville, Keith Shakespeare and Stuart Laverack for their poster describing 'The North Derbyshire Delirium pathway: Early Supported Diagnosis and Recovery Programme'.

Thanks go to the central PLAN team, especially Francesca Brightey-Gibbons, for organising such a successful day.

Growing PLAN membership

Francesca opened the PLAN Annual Forum with an update on the Network. There are now 76 teams who are PLAN members, with 43 having achieved accreditation and another 24 currently engaged in the process. As part of her presentation Francesca noted the consistent positive feedback that liaison psychiatry teams receive from hospital colleagues, patients and carers. One patient was particularly impressed by the help from the liaison psychiatry team from whom they received help, noting, 'I felt the love'.

The recent Forum was not only a valuable educational initiative, but also a chance to meet

Liaison Faculty Executive Committee

Officers

Dr Jim Bolton Faculty chair
Dr Annabel Price vice chair
Dr Laurine Hanna, financial officer

Elected members

Dr Philippa Bolton
Dr Sarah Brown
Dr Sarah Burlinson
Dr Mahnaz Hashmi
Dr Aaron McMeekin
Dr Marc Mandell
Dr Stella Morris
Dr Ross Overshott
Dr Muffazal Rawala
Dr Alex Thomson
Dr Luke Solomons
Dr Joanna Woodger

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Dr Peter Aitken
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Ms Katherine Chartres
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Dr Nora Turjanski
Dr Edwina Williams
Ms Nicola Wilson
Dr Peter Winterbottom
Dr Joanna Woodger
Dr Michael Yousif

Psychiatry of Cancer and Cancer Treatment – a short reflection on twenty years of clinical experience

Dr Andrew Hodgkiss MD FRCPsych
Consultant Liaison Psychiatrist, CNWL at The Royal Marsden NHSFT, London

I was introduced to the field of 'psychosocial oncology' as a senior registrar in liaison psychiatry at Guy's Hospital in the mid-1990s. The discipline was only in its second decade and the hospice movement in its third. The few UK psychiatrists prominent in the subject – Peter Maguire, Stephen Greer, Colin Murray Parkes and Amanda Ramirez – had special interests in communication skills, psychological intervention and bereavement. In her MD thesis Ramirez had tested whether adverse life events hastened the recurrence of breast cancer. As a senior registrar I was introduced to the application of CBT in the context of cancer care, what Greer and Moorey called 'adjuvant psychological treatment' in a nod to the language of oncology.

Over the course of a decade working as a sessional consultant liaison psychiatrist at Dimbleby Cancer Centre, the supportive care service founded by the Dimbleby family, Amanda Ramirez and Mike Richards at Guy's & St Thomas' Cancer Centre, I encountered people living with a wide range of cancers and consequences of treatment. And through weekly MDT meetings where clinical health psychologists, existential psychotherapists, a psychosexual therapist and cancer counsellors shared aspects of their work, I heard about many more. Initially my interest was in the narratives, illness perceptions and psychological aspects of this work and I was comfortable enough to be the team member who saw those with pre-existing mental health problems or those who might need psychotropic medication (predominantly antidepressants). I also took a lead on clinical governance, notably risk identification and management. But over time it slowly dawned on me that the role of doctors in the care of cancer patients suffering psychiatric symptoms could be much wider than this, distinctive, and mission-critical for high quality cancer care (in terms of patient experience, safety, and clinical outcomes).

A suitably trained doctor, be they an oncologist, palliative medicine physician or liaison psychiatrist, can foreground **psychopathology** and its prevention, early detection, assessment and management in all their work, and encourage clinical colleagues, such as cancer nurse specialists, to do so too. Their medical science background and postgraduate education equips them to analyse the likely aetiology of psychiatric symptoms arising from particular cancers and cancer treatments, then move on to arranging evidence-based medical, psychological and psychopharmacological intervention. If they choose to take the suffering and risks arising from psychopathology seriously, to give 'parity of attention' to the physical and mental health of the cancer patient, there is a great deal to think about that fully utilises their medical expertise. What follows cannot be left to non-medical supportive care colleagues. Six examples will suffice to illustrate this point:

1. Establishing screening for delirium for high-risk groups of cancer inpatients and investigating and managing such delirium expertly.

2. Understanding and assessing the psychiatric consequences of sex hormone manipulation (such as androgen deprivation therapy and oophorectomy).

3. Awareness of the psychiatric adverse effects of the many molecularly-targeted agents (MTAs) introduced since 2002, both monoclonal antibodies and 'small-molecule' MTAs. These include endocrinopathies, posterior reversible encephalopathy syndrome and

progressive multifocal leucoencephalopathy.

4. Excluding hypothyroidism, hypopituitarism and vitamin B12 deficiency as causes of psychopathology after radiotherapy to the head & neck, brain and pelvis respectively.

5. Understanding how conventional chemotherapies cause 'chemobrain' through various mechanisms.

6. Considering the emerging inflammatory theory of depression in relation to cancer patients with high levels of pro-inflammatory cytokines (eg. those with adenocarcinoma of the pancreas).

7. Working knowledge of paraneoplastic syndromes (both neurological and endocrine) as a cause of psychiatric symptoms associated with particular tumours.

So we, as liaison psychiatrists, should update ourselves in contemporary oncology, educate our oncology and palliative medicine colleagues to be more interested and expert in elucidating any medical causes of psychopathology, and tirelessly explain that **psychiatry of cancer** is a substantial field of knowledge and clinical practice that differs from **psychosocial oncology** as this is generally understood in the UK. Psycho-oncology services at cancer centres must include sessional input from a consultant liaison psychiatrist, and that a psychiatrist should be commissioned to teach oncologists the organic psychiatry of cancer and cancer treatment. Nursing and social work colleagues in community mental health teams, or psychologists and therapists working in Vanguard IAPT services, cannot be expected to deliver psychiatry of cancer and cancer treatment.

Careful role definition, and the ability to articulate our contribution to high-quality cancer care, does lead to service development. This year Macmillan are funding new consultant liaison psychiatry posts in SW London and in Cambridge, the first Macmillan psychiatrists ever I believe.

Finally, a word about research, which is not my field so I may be speaking out of turn. Cancer research grant-giving bodies should be challenged to look again at cross-disciplinary research at the potentially fertile interface between biological psychiatry and oncology. Those leading clinical trials of new cancer treatments should be assisted to pro-actively seek psychiatric symptoms, rather than awaiting spontaneous patient reports, and to name and grade these effects accurately. And academic psychiatrists interested in immunopsychiatry and affective disorders should consider taking a closer look at people living with cancer. To date they have possibly been deterred by the fact that there are no effective treatments for paraneoplastic neuropsychiatric syndromes due to onconeural antibodies directed at intra-cellular antigens (eg. anti-Hu encephalitis). However, patients undergoing cancer treatment are frequently exposed to very high dose corticosteroids, offering an opportunity to study the psychiatric effects of acute hypercortisolaemia. And high levels of pro-inflammatory cytokines (notably interleukin-6) seem to be the cause of the severe depression associated with adenocarcinoma of the pancreas, a depressive illness that often predates the cancer diagnosis.

References:

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2.Greer S et al (1992) Adjuvant psychological therapy for patients with cancer: a prospective randomised trial. BMJ 304: 675-80
3. Sharpe M et al (2014) Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2): a multicentre randomised controlled effectiveness trial. Lancet 384: 1099-1108
4. Hodgkiss A (2016) *Biological Psychiatry of Cancer and Cancer Treatment*. OUP: Oxford

Attention: Higher trainees currently working in liaison psychiatry

The Faculty of Liaison Psychiatry would like to determine whether individual training posts provide sufficient training to cover the new specialist curriculum 2016 for liaison psychiatry, introduced in August 2016.

The major changes are:

1) more clearly defined clinical presentations,

2) involvement in service development and improvement,

3) development of psychological therapy skills

We are asking for the help of trainees who are currently working in a liaison post, or who have worked in a liaison post since August 2016, to understand the current status of posts across the UK by answering a short survey: https://www.surveymonkey.co.uk/r/PJDWLD2

The results from the survey will be kept confidential. We will collate the results anonymously and feedback to the RCPsych Curriculum Committee and the GMC. We are looking for examples of good practice as to how posts have been, or could be, adapted to meet the needs of trainees.

The survey should only take 5 minutes to complete. For those trainees who provide an email address, a certificate can be provided for your portfolio to indicate your participation in the survey. Please get in touch at elenabaker-glenn@nhs.net if you have any questions.

The survey should be completed by 31 July 2017.

Many thanks for your help.

Dr Elena Baker-Glenn (Chair of the Trainees' and New Consultants' Committee, Liaison Faculty, RCPsych)

Dr Hannah Driver (PTC representative, Liaison Faculty, RCPsych)

Dr Thirza Pieters (Specialty Advisory Committee Chair and Executive member, Liaison Faculty, RCPsych)

Liaison Psychiatry Trainees, New Consultants, Nurses and Allied Health Professionals conference

Booking is now open for the Trainees, New Consultants, Nurses and Allied Health Professionals' (TNC-NAHP) 16th Annual Meeting in Cambridge

Date: 23 – 24 November 2017

Venue: Wellcome Genome Campus, Hinxton, Cambridge CB10 1RQ

There is a fantastic programme of speakers over the 2 days. Further information, the booking form and programme are available at:

http://www.rcpsych.ac.uk/pdf/TNNC_2016_booking_form.pdf

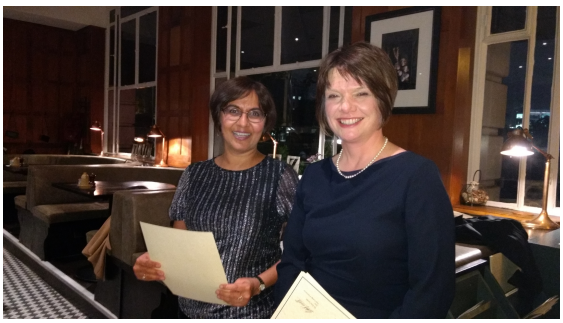
There will also be elections for the Trainees' and New Consultants' committee.

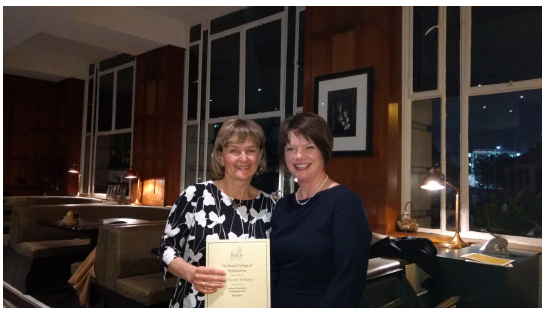
Please contact **elenabaker-glenn@nhs.net** for more information about the conference or the elections.

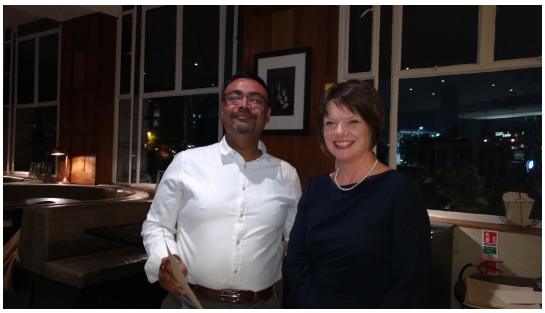
Please get in touch if you have any questions. Please pass this information on to your colleagues

Dr Elena Baker-Glenn, Chair of the Trainees' and New Consultants' Committee, Liaison Faculty.

Update from Liaison Psychiatry Credential Pilot







Dr Kate Lovett, Dean of the College joined the conference dinner to present the liaison psychiatry credential candidates with their completion certificate. It was a well-deserved moment in the spotlight as the candidates invested significant amount of time outside their normal work commitments

The liaison psychiatry credential pilot was a partnership project between HEE and the RCPsych to examine the feasibility of post CCT training to increase workforce flexibility. The project involved the creation of a credential curriculum, organisation of academic training, setting up of a mentorship programme, e-portfolio development and establishing an assessment and evaluation framework. The pilot finished at the end of April 2017 and involved 17 consultants from across the UK and is currently being evaluated.

Dr Thirza Pieters

Consultant Liaison Psychiatrist

Cambridge and Peterborough NHS Foundation Trust Papworth Hospital

Memories from Liaison Psychiatry Faculty Conference 2017

Winners of Poster and Research Prize at Liaison Psychiatry Faculty Conference 2017 .

Poster Prize Winner Dr Kostas Dimitrelis for the presentation entitled Systematic examination of all prn psychotropic drugs prescribed for and administered to inpatients in Derriford Hospital over a two-week period.

New Research Oral Prize Winner Dr Eleanor Gibbs for the presentation entitled Reducing Opiate Prescriptions for Pain in Cornwall – a Quality Improvement Project.

ROYAL COLLEGE OF PSYCHIATRISTS FACULTY OF LIAISON ANNUAL CONFERNCE 2018 WILL BE IN LIVERPOOL

More details about the conference will be published on the Faculty Website.

If you have any suggestions for the speakers or workshops for the next year's conference then please do email Stella Galea at ***Stella.Galea@rcpsych.ac.uk***