

# **A Three Phased Model to support the Design and Development of Core Competency Education for Liaison Mental Health Clinicians**

## **Abstract**

**Purpose:** This paper provides an insight into the design, development and delivery proposals for a first of its kind 'Liaison Mental Health Training Programme'. In the UK there has been a significant investment in Liaison Mental Health Services and an expansion of the workforce (NHS England, 2016). However, the complexity and varied presentations of patients who attend to acute physical health services now requires a dedicated strategy to address any skills deficit in the mental health liaison workforce and to support core competency development (DOH, 2016).

**Design / Methodology / Approach:** This paper provides an overview of preparations to develop a regional educational pilot programme using a 3 phased model. Phase 1 – Review of policy and best practice guidelines; Phase 2 – Stakeholder Data Collection; Phase 3 – Synthesis and Development.

**Findings:** An insight into the developmental processes undertaken to shape a core competency liaison mental health training programme is presented. Additionally, we provide insight into educational theory and an overview of the LMH Core Competency Curricula.

**Practical Implications:** This paper provides the reader with an insight into our findings and a focussed core competency training model for those working within LMH services. This programme development was reviewed throughout by both those using LMH services and the LMH practitioners working within them, ensuring the curriculum proposed was endorsed by key stakeholders. The 3 phased model has transferable benefits to other training development initiatives.

**Originality Value:** This training is the first of its kind in the UK and addresses the education of essential core competencies of a regional liaison mental health workforce. The collaboration of clinical and academic expertise and model of co-production makes this endeavour unique.

**Key Words** Liaison Mental Health, Parity of Esteem, Training and Education

**Paper Type** Case Study

**Introduction**

Mental health and physical health difficulties are often intertwined however often the mental health needs of people with co-morbid physical health needs are overlooked. Until recently this has been particularly seen within acute physical health services. In the UK the development of liaison mental health (LMH) services has started to address this service deficit (Joint Commissioning Panel for Mental Health, 2013). Liaison Mental Health (LMH) is the psychiatric specialism that focusses upon the mental health care of patients in acute hospital settings with co-existing physical health needs (Department of Health [DOH], 2016) and have been introduced into acute hospitals to enhance assessment and treatment provision of patients who present with mental health difficulties and those who have physical health conditions, but also who may go onto develop or have co-morbid mental health difficulties (Opmeer et al., 2017). Liaison mental health teams are central to the parity of esteem agenda, whereby mental and physical health needs are equitably prioritised through a true biopsychosocial framework and whole person approach to assessment, formulation and care planning (DOH, 2016). These teams are multi-disciplinary and based in acute hospitals where patients are in receipt of treatment for physical conditions can receive rapid LMH assessments. LMH ensure an essential link to clinicians in acute service by providing accessible mental health expertise hence enabling physical and mental health needs of patients to be addressed simultaneously.

The Five-Year Forward View for Mental Health (FYFV) (NHS England, 2016) outlined the requirement for effective LMH with the commitment to invest in services to achieve high quality LMH models of care referred to as CORE-24. CORE-24 provides a set of recommendations that guide the standards of providing MHL service provision, 24 hours a day, 7 days a week (NHS England, 2016) with a focus that *“By 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the ‘core 24’ service standard as a minimum”* (NHS England, 2016 page 34).

The key standards of the LMH service includes;

- The effective provision of 24/7 liaison in acute hospitals
- The recruitment of staff with varied occupational background and a key skill mix.
- A responsive service that will see emergency referrals within one hour and urgent referrals within 24 hours.

(National Institute for Health and Care Excellence [NICE], 2016).

Historically LMH services have been delivered in the absence of any clear framework, which has resulted in national variation and inconsistency in service provision. Until recently investment and staffing configuration has been somewhat neglected, and the lack of training and supervisory structures have been overlooked (Brightley-Gibbons et al, 2017; Palmer et al, 2014). Aitken et al (2014) found that 60% of LMH services were ineffective and only 14% met the criteria as a CORE 24. This ambition to expand services and

develop consistency is not without challenge as with this new investment and significant LMH workforce growth, many of the clinicians will be new to this complex field of LMH and the diversity of knowledge required.

A review of North West MHL services (Merseyside and Cheshire) was conducted (Verma et al., 2016) highlighting how all services fell short of the national guidance for minimum service specification for; staffing resource, deficits in terms of availability and provision of liaison specific line management, supervision and training (NHS England, 2016). Despite services reporting that they provided psychological interventions, at that point only one service had recruited a qualified psychologist within the multidisciplinary team. Interventions overall were therefore found to be delivered in the absence of robust governance structures appropriate supervision, training and leadership (Bullen-Foster et al, 2016).

The recent investments in MHL services (NHS England, 2016) is anticipated to address the variations in LMH service provision and increase the multi-disciplinary diversity amongst teams. However, financial investment and recruitment alone will not meet the needs of this expanding workforce in terms of their clinical development and sustainability. The CORE-24 model aims to standardise services and encompassing the growth of more diverse multi-disciplinary team input that will include professional groups who are unlikely to have gained exposure to acute services or this specialism during their core training (including Occupational Therapy and Psychology). Furthermore, the significant increase in nurse practitioners required to staff the 24-hour service model may lead to the recruitment of less clinically experienced personnel working within these specialist services (NICE, 2016). In response to the significant growth of MHL services, Bullen-Foster and Verma (2016) outlined a training matrix for skilling up this multidisciplinary CORE-24 workforce.

LMH practitioners require a wide range of skills and knowledge of mental health conditions and the complex relationship with acute physical illnesses, and evidence based brief psychological interventions (Eales et al, 2014; DOH, 2016). NHS England (2016) further highlighted that the clinical workforce across NHS acute services require training to enhance understanding of mental health problems and develop the skill to treat people with dignity and respect of which LMH practitioners will play a key role.

## **Aims**

This paper outlines a regional response to the educational challenges outlined and a 3 phased training development model. The aim of the paper is to;

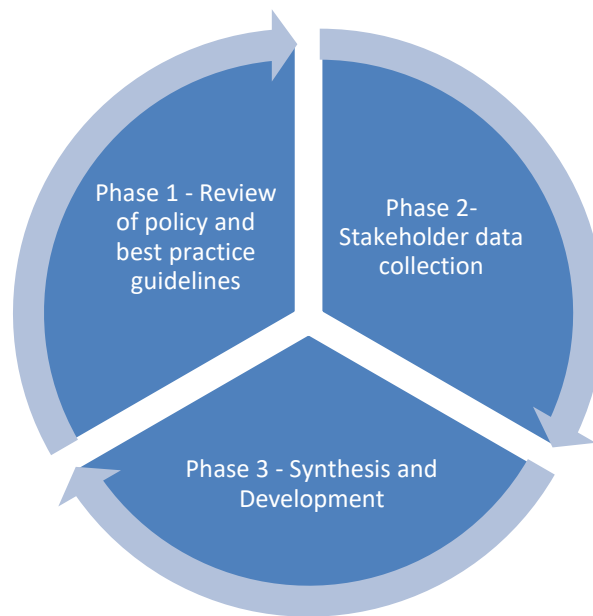
1. Provide a clear exploration of policy context that informs and provides the rationale for this educational programme.
2. Identify and engage with key stakeholders to gather primary data that will inform the development of the programme

3. Review and synthesis the data collectively to inform the development of LMH core competency training that addresses the needs of the workforce across the region.

## Methods

Our aims are outlined in the below a 3-phased model (Figure 1)

Figure 1 – A 3-phased model for developing core competency education for liaison mental health



Phase 1 – Aimed to explore current literature, policy and best practice guidance informing a draft ‘Competency Matrix’

Within this phase we identified and carried out a review of existing background policy and literature mapping this against a self-developed competency matrix (figure 2).

Phase 2 – Aimed to engage stakeholders, collect qualitative data and analyse this data

Within phase 2 we identified and engaged with a range of key stakeholders including LMH clinicians, LMH leaders and the wider workforce.

Phase 3 – Aimed to synthesis and develop a LMH core competency training programme

Within this phase we analysed all collected data from phases 1 and 2 and synthesised this data to inform the finalised development of LMH core competencies training programme.

The results from the 3 phased model have enabled the development of a core competency LMH training programme and an overview of the curriculum will be shared.

### **Phase 1 - Review of policy and best practice guidelines**

In preparation for developing this programme of education, a thorough exploration of key current policy and best practice guidance enabled the development of a draft core competency matrix framework. The following key documents were mapped against this matrix and included; the psychiatric liaison accreditation network (PLAN) standards (Palmer et al, 2014), The CORE 24 (Staff/Service Liaison Mental Health Service [LMHS]) implementation guidance (NICE, 2016), the liaison nurse competency framework (A Competency Framework [NCF]) (Eales et al, 2014) and the mental health core skills education and training framework (MHCSTF) (DOH 2016).

Fourteen core competency areas were identified from this review. Each competency is mapped and cross referenced against the literature. In the plan standards (Palmer et al., 2014) we map the competency area to the outlined standards using the specific standard numbers and in the MHCSTF we map them against the specific subject areas outlined by the DOH (2016) (Figure 2)

Figure 2. Competency Matrix

| Competency   | Mapping exercise against guidance |                 |                |     |                               |
|--|-----------------------------------|-----------------|----------------|-----|-------------------------------|
|  | CORE-24 Staff                     | CORE-24 Service | PLAN Standards | NCF | MHCSTF Subjects               |
| Competency 1<br>Bio-psychosocial Assessment & Care Planning                        | Yes                               | N/A             | 5, 6, 7, 8, 18 | Yes | 2, 4, 6, 7, 8, 11, 12, 15, 16 |
| Competency 2 - Liaison Outcome Assessment  | N/A                               | Yes             | 19             | Yes | N/A                           |
| Competency 3 - Legal Frameworks  | Yes                               | N/A             | 18             | Yes | 16                            |
| Competency 4 - Older Adults (including Dementia & Delirium)                        | Yes                               | Yes             | 18, 26         | Yes | 8                             |
| Competency 5 - Alcohol & Substance Misuse  | Yes                               | N/A             | 18             | Yes | N/A                           |
| Competency 6 - Learning Disabilities   | Yes                               | N/A             | 17, 18         | Yes | 8, 10                         |
| Competency 7 - Psychosis   | N/A                               | N/A             | 18             | N/A | N/A                           |
| Competency 8 - Self-harm & Acts of Suicidal Intent                                 | N/A                               | N/A             | 18             | Yes | 5                             |
| Competency 9 - Common Presentations  | N/A                               | N/A             | 17, 18         | N/A | 1                             |
| Competency 10 - Complex Physical and Psychological Presentations                   | N/A                               | N/A             | 18             | Yes | 1                             |
| Competency 11 - Liaison Interventions  | Yes                               | Yes             | 27             | Yes | 2, 3, 4, 5, 6, 7, 8           |
| Competency 12 - Working Within the Acute Setting                                   | Yes                               | N/A             | 17             | Yes | 3                             |
| Competency 13 - Collaboration, Training, Supervision & Support to Acute Colleagues | Yes                               | Yes             | 10, 28, 29, 30 | Yes | 1, 2, 3, 4, 5, 7, 16          |
| Competency 14 - Leadership, Supervision & Training                                 | Yes                               | N/A             | 14             | Yes | 18                            |

This process provided us with deductive information that enabled the development of a framework for training informed via key literature and guidance specific to the expansion and standards outlined for LMH services.

## **Phase 2 - Stakeholder data collection**

The completion of the competency matrix (Phase 1) provided direction and foundation from which to further develop this LMH regional training programme. However, further regional and frontline intelligence was required to capture the views of those working as frontline practitioners in the LMH services and those in receipt of them (patients using LMH services) via inductive data collection processes. The early involvement of frontline clinicians is essential to implementing change with those involved shaping the programme (NICE, 2007). Three listening events were set up. Key stakeholders were invited to take part in the events to inform the design and development of this training initiative. Our stakeholders included a range of mixed multi-disciplinary members who are currently working on the frontline of LMH services and patients and carers, who had recently used LMH services. Two of the listening events were hosted in person and 1 was hosted online (Table 1).

Table 1 – Events and Participants

| <b>Event Type</b>       | <b>Participants (n)</b> | <b>Backgrounds</b>   |
|-------------------------|-------------------------|--|
| Face to Face Workshop 1 | 7                       | 6 Qualified MH Nurses<br>1 Student MH Nurse  |
| Face to Face Workshop 2 | 7                       | 6 Qualified MH Nurses<br>1 Consultant Psychiatrist                                 |
| Online Listening Event  | 47                      | 47 participants with twitter handles engaged with a national reach of 1.6 million. |

### **Face to Face Events**

Participants were recruited using a purposive sample and this was achieved via emails to regional liaison mental health service teams and clinical / operational NHS trust leaders. Most of the attendees were LMH Nurses which was not fully representative of the wider mixed multi-disciplinary ambition for LMH services.

### Method

Two group face to face events were facilitated and included a variety of group activities including presentation of the supporting literature, brain storming activities, feedback and completion of questionnaires in order to gather inductive information to further shape our proposals (NICE, 2007). Data was collected via written field notes by GL/ CBF, participant narrative data on flipcharts and questionnaire responses.

Each group commenced with presentations to provide an overview of supporting policy and literature which included;

- Five year forward view for mental health (NHS England, 2016).
- Stepping forward MH workforce plan for England (Health Education England, 2017).
- CORE 24 services and standards to be reached for liaison mental health services were also discussed (NICE, 2016).

The findings from phase 1 were shared as was the provisional structure of the core competency matrix. This was reviewed by the group who were invited to feedback and share thoughts and ideas, highlighting areas requiring further attention or missing as an educational need of the LMH workforce. The workshop was structured with a range of activities to help refine the proposed programme. Additionally, proposals of delivery formats were explored with a blended learning approach being considered most appropriate and accessible due to the programme covering the large geographical area of Northern England. Training was delivered at the University of Salford where high-tech clinical simulation suites, that mimic real life clinical environment for skills-based learning were provided.

### Analysis and results

Data gathered was analysed by a small group of academics including both co-authors who used thematic analysis techniques (Braun and Clarke, 2006). Themes were summarised to enable further refinement of the training proposal. All participants included in the face to face group events were provided with the copies of the finalised report and invited to share further feedback regarding the analysis and interpretation of the data we collected.

### Online Listening Event

An online listening event was conducted using twitter with the support of @WeMHNurses, ensuring a national reach and participation of LMH professionals, patients and carers. Inclusion of patients and carers was of paramount importance as were the views and experiences of those who access LMH health services, who provided useful insights relating to the needs of the service from a user perspective. This guaranteed that this project was shaped by those whom were most likely benefit from it and embraced a model of lived experience co-production (Lamph et al, 2018). A series of questions were developed to guide discussion during the event.

All participants were recruited via twitter through advertisement. The event had a national reach of over 1.6 million and a total 345 tweets were registered.

### Analysis

Data from all 3 listening events was analysed and a method of thematic analysis used by the academic team and supported by facilitators from @WeMHNurses (Braun and Clarke, 2006).

## **Phase 3 – Synthesis and Development**

From our collective synthesis of results from data collected in phases 1 and 2, we were able to identify 3 main themes.

### Theme 1 – Bringing Theory to Practice

This theme outlines through our 3 phased model, the importance of shaping and reviewing educational developments by review of the evidence and policy guidelines alongside the gathering of clinical frontline intelligence from those working in practice and those in receipt of their services. If literature alone had been our only source of information used to shape the programme some fundamental details and areas of clinical need would have been overlooked.

### Theme 2 - Content focus

Secondly was a respective emphasis on the diverse and different types of mental health conditions/ symptoms that LMH staff required educationally in order to be able to work effectively within LMH services and the diversity of presentations they will encounter. Whilst phase 1 provided a clear framework linked to the evidence and literature, insights from clinical practice and patient feedback enabled us to fine tune and develop some important revisions and nuanced changes in the development of the curriculum.

Whilst psychosis was felt to be important, it was outlined that a focus should be upon the skills and development of knowledge relating specifically to early intervention in psychosis and working with / assessing 'at risk mental states' , as it was felt that many of those presenting with acute psychotic illness are likely to already to be involved with mental health services.. Participants also felt that acute psychosis was less likely to be seen in accident and emergency departments but that people presenting with early psychosis were more likely to attend and that they would often go undetected or present with somatic symptoms which could mask underlying mental health symptoms. Dual diagnosis (mental illness / substance misuse) was raised as requiring

inclusion into the programme as was personality disorder awareness and understanding.

The development of clinical skills alongside knowledge was highlighted, as was the need to develop confidence in educating and supporting acute service colleagues hence improving knowledge and attitudes towards mental health (NHS England, 2016). The need to challenge mental health stigma was raised, as was the need to address knowledge deficits of LMH practitioners relating to physical health difficulties and acute service organisational processes, including blood record reading, pharmacology terminology and delirium.

Service user involvement was another common theme to emerge. The enhancement of advanced interpersonal skills, formulation and brief psychological interventions were recommended. Interpersonal skills outlined included developing staff resilience, mindfulness, coaching skills and knowledge of clinical burnout. Trauma informed care was commonly discussed particularly during the twitter event, but this may have been skewed as the practitioners facilitating the event are well known in the field of personality disorder research.

Overall the listening events provided both confirmation and approval of the ideas whilst refining the development of the training programme to meet the needs of the LMH practitioners. Development of materials did not commence until consensus amongst the core development team was reached.

### **Educational theory informing the programme development**

Alongside the listening events and engagement activities, the academic team considered their knowledge of educational theory to inform the development of this programme. It was decided that face to face training sessions would be developed taking both a constructivism and behaviourism focus to ensure the learning was not delivered in the traditional 'chalk and talk' style (Fry, Ketteridge & Marshall, 2008). A blend of pedagogical approaches was taken to ensure students felt engaged by the variation of activities. The elements of constructivism covered in this programme was achieved via the active engagement of the students in their learning by ensuring small group work activities were embedded throughout. Additionally, each session was introduced using a standardised teacher focussed lecture to educate the students with theoretical and evidence-based knowledge hence each session also took a 'behaviourism' stance. Those delivering the sessions were actively involved in its development hence were well prepared and involved prior to the delivery phase of the face to face session. Good and thorough preparation for educational sessions is fundamental to the success of learning (Allen, 1996).

One of the key skills of effective teaching, is in the ability to remove barriers to student learning and development and hence makes learning possible (Ramsden, 2003). In order to achieve this the teacher is required to understand the barriers that get in the way of learning and enable students to overcome them. Mixed learning methods and more student involvement in the learning process was employed to enable people to learn most effectively (Biggs and Tang, 1999). A flipped classroom approach was adopted this approach is a pedagogical approach in which the activities are directed outside of the taught session to enhance students learning and experience. There is a growing body of evidence that engaging students in this way enhances learning and the student experience. This approach allowed the lecturers to facilitate learning and embrace the knowledge of the students as a learning opportunity for all (Blazquez et al, 2019). The LMH students bring a wealth of knowledge owing to their multidisciplinary backgrounds and hence this provides an opportunity to share their own unique service specific experiences and learn from each other. Within the blended learning approach we set out a range of pre-session activities, which were directed at reflections on practice, information gathering and self-directed research. This enabled the delivery team to make the most effective use of the face to face taught time, but also to develop group-based problem-solving activities in which student to student knowledge and expertise could also be nurtured.

### **The proposed training model**

After considering / reflecting on the policy directives, listening event feedback and exploring educational theory, the proposed training model was finalised. A blended learning approach was proposed that included both face to face and distance learning approaches. The rationale for providing a blended learning approach was adopted to support a flexible approach to learning which has benefits in its cost effectiveness via reduced travel, room costs, flexibility of learning, and lecturer time (Clarke and Mayer, 2016). Eleven full day sessions were delivered on a bi-weekly basis.

Figure 3 – Pilot Programme Syllabus

| <b>Session Title</b>               | <b>Content</b>  |
|------------------------------------|---|
| Introduction                       | Introduction to the programme, overview of aims, objectives and expectations and pre-reading  |
| Assessment                         | Bio-psychosocial assessment and care planning including risk assessment, crisis plans, formulation and liaison mental health outcome measures |
| Common mental health presentations | Identification, assessment and understanding within a liaison mental health context and acute setting   |

|   |   |
|---|---|
| Liaison specific interventions and formulation                        | An introduction to liaison mental health specific interventions and formulation   |
| Dementia & Delirium   | Detection, assessment and management of dementia and delirium within a physically ill population  |
| Self-harm & suicide   | An introduction to self-harm and suicide  |
| Psychosis / Personality Disorder                                      | An introduction to psychosis / Personality Disorder   |
| Self-harm & suicide   | Differences between self-harm and suicidal intent, impact of attitudes upon patient experience  |
| Psychosis / Personality Disorder                                      | Detection, assessment and management of psychosis within a physically ill population. Personality disorder assessment / interactions and challenging stigma and misunderstandings     |
| Legal Frameworks  | Legal frameworks relevant to liaison mental health including MHA, MCA and DoLs  |
| Complex physical and psychological presentations                      | The interface between complex physical and psychological conditions, working across the physical and mental health interface and using liaison specific interventions and formulation |
| Substance misuse  | Presentations within an acute setting, physical and psychological effects of substance misuse   |
| Learning disability   | Specific needs of learning-disabled patients, reasonable adjustments and challenging behaviour  |
| Leadership, supervision, training and education skills                | Clinical leadership skills for MDT and acute colleague support, skills to develop and facilitate training, presentation topic preparation   |
| Clinical Simulation Day – Presentation, Interventions and Reflections | Presentation delivery, reflections on collaboration and supporting acute colleagues, next steps   |

*Distance learning delivery (Dark Grey) Face to face delivery (Light Grey)*

All content was built in collaboration and with oversight of a 'Clinical Reference Group' made of senior multi-disciplinary LMH practitioner from across the region ensuring that content built was of benefit to a diverse range of multi-disciplinary LMH practitioners. Within this group we also recruited people with lived experience of mental health liaison involvement. The clinical reference group whilst supporting development also provided critical independent reviews of the developed materials and the applicability and acceptability to LMH practitioners needs.

## **Discussion**

This paper provides a unique insight into the development of new and novel educational programmes for LMH clinical workforce. It highlights important areas of focus whilst providing a template that could have transferable benefits to other LMH services outside of the northern England region. Equally it provides a systematic and novel approach to the development of training initiatives with its outlined 3 phase model, bringing together evidence and literature, and frontline intelligence from LMH practitioners and those using services, hence recognising from their experiences areas requiring attention in the needs of skilling up the workforce and improving service experience. This intelligence provides unique insights also into meeting the needs of a diverse and mixed multi-disciplinary group of LMH practitioners. The challenges of a rapidly expanding specialist clinical service should not lose sight of the need to educate the workforce. Whilst on the job learning will take place, the diverse multi-disciplinary practitioners will have developed discipline specific expertise but LMH provides a new challenge. In LMH services there is an expectation to work with a diversity of complex mental and physical difficulties that will require expanded knowledge for all practitioners, hence educational models should look to focus upon deficit areas of knowledge and skills. The template we developed focusses holistically on the needs of the multi-disciplinary workforce and on essential core competency training that all LMH practitioners will be required to possess in order to address deficits in knowledge and skill and develop more confident and competent LMH practitioners of the future. Investment in ongoing training is required and to overlook such investment and attention to workforce development is likely to have a negative impact on service effectiveness, staff retention, service user experiences.

Within this paper we provide some insights into the educational theory we applied to this programme, that enabled a range of learning approaches and styles, that combined knowledge development alongside clinical skills development.

## **Limitations**

Limitations to the approach outlined include staff costs and resource implications for releasing them from frontline duties for training. Due to the diversity of conditions likely to be encountered in LMH, the proposed training is not something we believe can be delivered as a short programme. Our programme was a 11 days training programme requiring one day a week release from practice for each practitioner. Hence in order for such initiatives to be successful this will require leadership and commissioning support if core competency training and development of LMH workforce is to be provided. Furthermore, research and evaluation of the impact of such training on practice from both the LMH practitioner perspectives and the service outcomes, and service satisfaction of patients and carers is required. Without

this data such training programmes often become a 'would like to do' rather than a 'must do' training.

## **Conclusion**

This paper provides an overview of the design and development of a first of its kind core competency training for multi-disciplinary LMH workers. It outlines a clear rationale for the need for this training and the decisions reached that have influenced the educational content and delivery formats included in the programme. The processes and thorough developmental procedures are described and use of a 3 phased model which have brought together policy, literature and been further enhanced by the systematic and innovative approach to including a range of views, experiences and feedback from both people with lived experience and practitioners working within LMH services via the listening events. The 3 phased model could hold potential utility for other clinical educational initiatives. The partnership of the NHS provider and Higher Education Institution and co-production involvement of people with lived experience is novel and a key strength of the outlined model.

The delivery of first of the three cohorts has now been completed and the evaluation of this training and its results will be disseminated via commissioner reports (Bluff et al., 2019) and future publications to ensure that others can learn from our experiences and it is hoped that this programme if proven effective, will in future years have a national impact and achieve wider dissemination. The thorough preparatory work outlined in this paper provides a clear rationale to support the proposed training programme and an overview of the content that should be included in providing liaison mental health clinicians with core competency training.

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