ELECTIVE (SSC5a) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

What are the common presentations in liaison psychiatry in East London? How might this differ with the rest of the UK?

As I have understood it in the last three weeks, although Liaison Psychiatry at the Royal London (RLH) is one team, there are three key areas that they provide psychiatric and psychological expertise for: A&E, general medical and surgical wards, and for more specific (generally long-term) conditions (e.g. renal-specific or liver-specific psychological medicine). You could also think about the type of work as being frontline (A&E, the wards) and other (e.g. outpatient clinics).

In A&E the patients I saw presented primarily with psychiatric symptoms. In contrast, patients on the wards typically had psychiatric symptoms or a long-term psychiatric condition unrelated, or secondary to, a medical/surgical condition. The range of conditions that patients present with is as wide as what exists in psychiatry i.e. anything and everything! In A&E, common presentations included substance abuse disorders, low mood and suicide attempts, and agitation and behaviour changes e.g. acute psychosis or mania. There are some frequent attenders – commonly it seems, those with personality disorders – but also many patients who have previously been unknown to the trust. I suspect this is standard for emergency departments across the UK, although as RLH is a major trauma centre – and the only London hospital to have a HEMS service – liaison psychiatry here see a greater number of traumatic suicide attempts and violence-related incidents (although I did not personally see any).

On the general medical and surgical wards patients common referrals include for low mood and ?delirium. I've seen several patients who have been in the hospital for quite some time and (unsurprisingly) are low in mood. I spent a morning with Older Adults and saw a couple of patients with memory problems also.

As RLH is a specialist tertiary centre liaison psychiatry here also includes specific care and clinics for long-term conditions like end-stage renal disease and diabetes. Dual speciality outpatient clinics are not uncommon, e.g. a consultant psychiatrist and gastroenterologist may see patients with functional gastro disorders together.

How is mental health provision organised in East London? How does liaison psychiatry fit into this?

The Liaison Psychiatry team here are called the 'Tower Hamlets department of psychological medicine' and are directly employed by the East London NHS Foundation Trust (ELFT). They cover RLH, Barts hospital and Moorfields. This is separate to Barts Trust which runs the hospital itself. ELFT provides mental health community and inpatient services to children, young people, adults of working age, older adults and forensic services to the City of London, Hackney, Newham and Tower Hamlets. Mile End is the mental health hospital associated with RLH and this Liaison team, although within ELFT there are also inpatient wards in Homerton and Newham.

The team is multi-disciplinary and is made up of psychiatrists, psychologists, nurses, occupational therapists and admin staff. They sit across multiple buildings in the vicinity of RLH (I'm unclear as to why they are not located within the hospital itself). The team meets remotely at 9:15am every day to check in and allocate roles for the day (e.g. referrals, a&e coverage).

The nature of liaison psychiatry is indicated in the name, i.e. they deliver care via liaising between medical and surgical staff in the hospital who are currently caring directly for the patients and whatever specialist or community psychiatry input they may need. This involves working with, and referring to, many other teams. Some examples of this include: discharging home with care from the Home Treatment Team, admitting voluntarily or under section to an inpatient bed, referral to secondary psychotherapy, and referral to the alcohol treatment team. They also commonly engage with non-NHS organisations such as homelessness organisations and charities. Patients may remain under care from liaison psychiatry during their entire stay before being discharged from the service although from what I have seen this is not common. Some patients may need regular (2-3 times/week) input whereas others may remain on the patient list but don't necessarily need to be seen frequently.

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How might the cultural backgrounds of the patients influence their presentations to liaison psychiatry in RLH? How do clinicians decide who to refer?

It's a given that RLH sees people from a wide range of cultural backgrounds. However, I think this objective is rather clumsily worded by me and I don't really feel like I'm in a position to comment on it without stereotyping or making sweeping statements. I also don't think it is something that is often front of mind for clinicians, although where needed it will be taken into consideration. A small but significant proportion of patients will not speak English well which makes medical communication more difficult but this is even more pronounced in psychiatry. You can get so much information about someone through the way that they speak and their phrasing that can be lost in translation. Doing a suicide risk assessment is difficult and grey enough as it is without not being able to directly understand what the patient is saying.

A significant amount of the frontline liaison psychiatry work, particularly in A&E, seems to be about assessing risk. This is incredibly difficult and I have frequently come away from seeing a patient with a clinician and felt very unsure about what I would do. This seems to be one of the key themes of psychiatry and what differentiates it from other specialities. Frameworks do exist, yes, but a lot of the decision-making is based on clinical judgement, which in turn is based more on consultation skills. There are very few tests to order! I think the brain-teasing nature of this is one of the features that I am drawn to in psychiatry, although I am sure it is exhausting.

To explore an area of psychiatry that I have minimal understanding of and see if this is something that I would like to pursue in the future.

Prior to this placement I didn't have any real understanding of what Liaison psychiatry was. I now know that it is psychiatry within the physical health realm of a general hospital. I've really enjoyed the nature of it being about bridging the gap between physical and psychological healthcare, and I can see how it would be a great option to still maintain involvement with general medicine whilst being specialised in psychiatry. I've also enjoyed the problem-solving aspect of A&E and having to figure out what is wrong with the patient at the time, sometimes with little previous knowledge of them. I thought perhaps I would miss being able to follow-up with patients over a longer period of time, but have since realised that this too is possible in the outpatient clinic setting. It seems an area of psychiatry that is very varied and can be shaped to your interests which is also appealing.

Overall, it's been a really interesting placement and has left me really looking forward to my FY2 Psychiatry rotation!

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