Liaison Psychiatry Elective Write Up – 14/04/14 – 30/05/14 Bhavna Gilani

1. **Observe the patterns of mental health problems in East London and compare these to global trends**

East London, and specifically Tower Hamlets, is a diverse area with a range of different ethnic communities and socioeconomic groups. From what I observed on this placement, this is reflected in the variety of psychiatric disorders that patients present to liaison services with. During the course of this placement I have come into contact with patients with acute exacerbations of severe and enduring mental illness such as bipolar affective disorder and schizophrenia as well as delirium, depression, anxiety, personality disorders and patients suffering with medically unexplained symptoms and somatoform disorders. The patients were from different cultural groups and from what I observed, this often had an impact on their mental health problems. This was particularly true with somatisation disorders. For example, patients from cultures where mental health problems are taboo often experience somatic symptoms and use them to externalise psychological distress. East London also has a large asylum seeker and immigrant population. Often these patients have experienced traumatic events and post traumatic stress disorder (PTSD) can be seen in this patient group.

Post traumatic stress disorder is important in terms of global mental health. 'Disaster psychiatry' is an emerging field and psychiatrists from developing countries affected by conflict and natural disaster are increasingly coming into contact with patients with PTSD.

2. **Relate the models of liaison psychiatry in the UK to those in other developed countries e.g. the USA**

The model of liaison psychiatry I observed on my placement was the Rapid Assesment Interface Discharge (RAID) model. This was developed by Birmingham and Solihull Mental Health Foundation Trust. The focus of this model is to improve services for people with both physical and mental health problems as well as to be cost effective for the National Health Service (NHS). The RAID model is meant to reduce acute inpatient bed use by shortening patients' length of stay in hospital and reduce re-admission rates.

Funding difficulties and an emphasis on cost-effectiveness are also seen the USA. In the USA the focus of psychiatric care has shifted from acute hospitals into the community. There is also variation in the provision of mental health services throughout the country. This has meant that there is no national model of liaison psychiatry services. However, the principles of the services are the same as those in the UK – to provide psychiatric care for patients who have co-morbid physical health problems on the acute medical and surgical wards, in an emergency setting and in outpatient clinics.

3. **Improve skills in assessing mentally unwell patients through taking a psychiatric history and mental state exam.**

Before undertaking this placement I had not come across patients who were as acutely mentally unwell; during my 4th year psychiatry placement I clerked patients who had been inpatients on the ward for relatively long periods of time. However, over the past six weeks I have observed the assessment of patients with very acute presentations whilst shadowing the doctors with the psychiatric liaison service. I came into contact with many patients who were in hospital following suicide attempts or other acts of self-harm; through this experience I feel as though my skills at assessing suicide risk and taking a focused psychiatric history have improved immensely. I have also developed my mental state examination skills and feel more confident using them in the context of the patient's history to form a diagnosis and assess risk. Improving these skills was important to me because this kind of work is a significant part of the workload when 'on-call' as a junior doctor in psychiatry, as well as a junior in the Emergency Department or in General Practice. I was also able to observe and help use methods other than the history and mental state examination to assess patients. For example, the Bush-Francis Catatonia Rating Scale and the HIV Dementia Scale. I had not seen either of these used before so it was a new and interesting experience.

Through attending specialist liaison clinics I have also come into contact with patients who are presenting with chronic problems. This was something I had already had some experience of through my 4th year placement but it was useful to revisit it. I observed psychiatrists assess patients to establish their current symptoms, how these had progressed and what effect their treatment was having. This was useful to revisit as management of patients with chronic problems in an outpatient or community setting is an increasingly important part of the workload in most specialities, not just psychiatry.

4. **Appreciate the relationship between physical and mental health**

I have always been interested in the relationship between physical and mental health and this is the reason I wanted to undertake an elective in liaison psychiatry. Throughout the past six weeks, the patients I have seen have all had physical health problems as well as mental health problems.

The patients who I came into contact with who were in hospital as a result of suicide attempts or deliberate self-harm were often suffering with the physical consequences of their acts. This further complicated the relationship between their mind and body. Those patients whose attempts had led to permanent disability, in particular, suffered a deterioration in their mental health. Whilst reviewing inpatients on hospital wards I also came into contact with patients whose mental state had an adverse impact on serious physical health problems. For example, I observed the assessment of patients whose physical condition had deteriorated severely due to the self- neglect caused by their mental health problems. Physical conditions also played a part when formulating a psychiatric diagnosis as organic pathology was always excluded first.

The complex nature of the relationship between mind and body was also apparent in the specialist liaison clinics I attended. In the HIV liaison clinic, I observed the effect of stigma and society's perception of an illness on an individual and their mental health as well as on the management of their chronic disease. The importance of a patient's social circumstances was also impressed upon

me in this clinic. The importance of a good doctor-patient relationship and clear communication was highlighted during my time in the head and neck psychoncology clinic. Patients in this clinic and their families often had trouble coming to terms with their cancer diagnosis and it had a huge impact on all areas of their life; thus it was important for all the clinicians, not just the mental health professionals, to handle this sensitively and take time to understand the effect of the physical disease on the patient's daily life and their mental health. I also had the opportunity to observe the patients in a psychodermatology clinic. This was very interesting because not only did I see patients who had presented primarily with a skin problem which then had psychiatric sequelae and vice versa, I also saw patients whose problems were very much interlinked. This combination was often totally debilitating for them and many patients were trapped in a cycle of worsening psychiatric and dermatological conditions. This clinic was also interesting as I also came into contact with patients who were stabilised using relatively low doses of psychotropic medication or simple psychological interventions. Often these patients had a dramatic improvement in symptoms with treatment – contrary to the belief that psychiatric patients do not get better or that there is limited treatment available for them. I also came into contact with patients who were suffering with medically unexplained symptoms and somatoform disorders. Often these patients had to deal with difficult life events and social circumstances as well as their symptoms, which were often debilitating.

All my experiences in liaison psychiatry over the last six weeks have demonstrated that the relationship between physical and mental health is far from linear and that this is a fact that all doctors and healthcare professionals need to appreciate, not just psychiatrists. The complexity of the relationship between mind and body that has been demonstrated to me during this placement has also taught me the importance of using a biopsychosocial model to assess patients.

5. Improve knowledge of liaison psychiatry as a career

Prior to undertaking this placement, I had no first-hand experience of liaison psychiatry but wanted to see what the working life of a liaison psychiatrist would involve. Over the past six weeks, I have gained some insight into what a career in liaison psychiatry involves. One aspect I particularly liked was the variety of patients that a liaison psychiatrist is exposed to because the turnover of patients is quicker than that in a community mental health team. This meant that I observed psychiatrists using a whole range of skills when assessing these patients. From what I have observed, this does not happen as much in other psychiatric specialties.

On the other hand, because liaison psychiatrists are not in charge of a patient's care in the community, they do not often build up long term relationships with the patients they review on the wards. However, there is scope for managing a patient's care long term in specialist liaison clinics; often the psychiatrists knew these patients well and had built up a rapport with them over many appointments.

I also learnt more about psychiatric careers generally through talking to both senior psychiatrists and the junior doctors in psychiatry. Through my discussions with them I got the sense that training in

psychiatry is very well supported and that there is plenty of scope for personal and professional development.

I was also privileged enough to attend the weekly teaching for the juniors and also the monthly academic meetings. This highlighted the importance of keeping oneself up to date with developments in psychiatry and also demonstrated the wealth of research and other academic opportunities available in this field.

Overall, I feel as though I have increased my knowledge of liaison psychiatry as a career and am still interested in pursuing it as a specialty but feel I need to experience it as a junior doctor actually working in psychiatry and also gain a deeper insight into other psychiatric specialties. I will try to ensure that I choose a liaison psychiatry post when deciding on rotations for my core psychiatric training. I have also secured a foundation year one post in psychiatry and am certain that the improved history taking and examination skills I have gained will stand me in good stead.