Acute medicine and its interface with Liaison psychiatry

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A Liaison Psychiatry service should be…

‘a primary partner in the effective management of the emotional and adjustment/behavioural needs of all patients presenting to acute services’

and ‘an integral part of the services provided by acute hospital trusts. Trusts that have incorporated a liaison service have demonstrated much better cost-effectiveness’

The Joint Commissioning Panel for Mental Health (Royal College of General Practitioners and the Royal College of Psychiatrists) 2012
General comments

- Communication: The importance of establishing an effective open relationship with each other *can only be good for the patient*
- Mental health problems: Our quest to eradicate *mental health stigma* in the hospital
- Thinking about what we want from the medical team; and what you want from us – and what is desirable versus *what is realistic*
- Interface can be challenging – often when significant needs *medically and psychiatrically*
General comments

- The liaison service in *your* hospital – they *vary hugely in size and capacity* e.g. Brighton has 24/7 service. Many services have less e.g. Worthing 0.8 consultant, 2.0 nurses – a 9-5 7 day/week presence

- Consider our priorities and response times – e.g. emergency (1 hour) for A&E – we may be elsewhere when you call us

- Liaison psychiatrists are an enthusiastic bunch – use this resource e.g. we love to teach

- Be aware of limitations of psychiatric inpatient unit re. medical care – cannot give ivs, may not be doctor on ward
Some specifics

• We find medical histories are generally done very well – *but what may be forgotten is*:

• An alcohol and substance misuse history – despite AUDIT-C on the form

• Some sort of cognitive assessment e.g. AMTS (very useful if cognitive problems later e.g. Wernickes)

• Some record of your thinking about patient capacity and risk
Alcohol and substance misuse

- *High prevalence* on medical units (our AMU audit showed 1 in 6 admissions had alcohol problems)
- Identifying leads to appropriate early referral to right service – also if link made with substance and medical problem *at the time* then this becomes strong motivator for patient change
- Identifying also opportunity for *brief intervention*?
Risk Management

• Best predictor of future behaviour is past behaviour
• Demographics highlight groups at higher risk but are limited
• Our human instincts are often right e.g. feeling threatened, worrying a person may take their life
• Keep calm, consider the facts, seek our advice – we may have information on that patient
Risk Management

• Behavioural disturbance on medical ward can be trying: nurse specials, security, police, rapid tranquilisation, Mental Health Act v Mental Capacity Act; sometimes sedate and HDU; sometimes transfer to psychiatric unit if medically stable

• Educational agreement between acute and mental health trusts; seizing informal teaching opportunities

• Crucial relationships between all relevant parties e.g. hospital security, psychiatric unit, anaesthetists and ITU etc etc
Teaching opportunities

• Informal teaching and discussions can be very powerful

• e.g. recent patient with medically unexplained seizures – opportunity to explain to doctor why patient may be having them, what is the treatment and how patient should be managed in the general hospital

• Formal: invite your liaison team to your teaching sessions (medical and nursing staff) on a regular basis!
Thank you!