CHAPTER 1

Basic skills and competencies in liaison psychiatry

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Liaison psychiatrists, like any other specialists in psychiatry or medicine, have a range of roles to fulfil, with overlapping but different skills, attitudes and competencies. Attempts to define those skills and competencies have been made by a variety of professional groups; there is, for example, a competency-based curriculum for specialist training in psychiatry that contains relevant material (Royal College of Psychiatrists, 2009). There is also the CanMEDS 2005 physician competency framework, created by the Royal College of Physicians and Surgeons of Canada (Frank, 2005) as a resource for all those interested in medical education, physician competence and quality care (Fig. 1.1). It is organised around seven roles, with that of medical expert being central. The CanMEDS framework has greatly influenced the development of the curriculum for liaison psychiatry, which is discussed in more detail in Chapter 2.

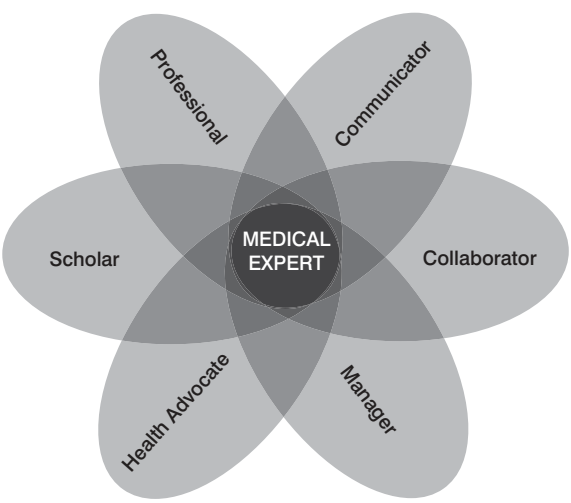

Fig. 1.1 The CanMEDS framework. Copyright © 2005 Royal College of Physicians and Surgeons of Canada. Reproduced with permission.

The central role: Medical Expert

The CanMEDS framework outlines six key competencies of medical experts, that they:

- function effectively as consultants, integrating all of the CanMEDS roles to provide optimal, ethical and patient-centred medical care
- establish and maintain clinical knowledge, skills and attitudes appropriate to their practice
- perform and complete an appropriate assessment of a patient
- use preventive and therapeutic interventions effectively
- demonstrate proficient and appropriate use of procedural skills, both diagnostic and therapeutic
- seek appropriate consultation from other health professionals, recognising the limits of their expertise.

This chapter will concentrate on those areas that are most relevant to liaison practice.

Assessments on general hospital wards

Liaison psychiatry services receive requests for assessments of patients on general medical wards for a variety of problems. The first step in responding to any request is an assessment of the problem (Box 1.1).

What is the problem? Understanding the question asked by the referrer

There are a number of reasons why a liaison assessment is requested. There may be questions about the patient's emotional and mood state, the causes of the patient's symptoms ('no physical cause found'), the patient's reaction to the diagnosis or treatment (denial, non-adherence to treatment, repeated need for reassurance) or the patient's help-seeking behaviours (repeated attendance or requests for investigation, insistence on an alternative diagnosis).

It is important that the liaison psychiatrist considers who is requesting the assessment and why, and what is the core problem, as this may not be entirely clear from the initial referral. The referral may have been driven by the patient's family, medical staff, nursing staff or social workers rather

Box 1.1 Assessments on general hospital wards

- What is the problem? Understanding the question posed in the referral
- Collecting the evidence: interview and supporting information
- Formulation: collating the information and coming up with a hypothesis; answers the question posed in the referral

than the patient, and in such circumstances the patient may not be clear why a psychiatrist has been asked to see them.

Collecting the evidence

Before seeing the patient, it is helpful to obtain information that may give some idea of what needs to be addressed in the actual assessment. This should include: careful and detailed review of the medical notes; review of any investigations which have been carried out and the results; the medication chart; and nursing notes (often neglected).

These sources may give the liaison psychiatrist the idea of the time course of the problem, circumstances in which the current problem evolved, and possible predisposing, precipitating or perpetuating factors. Questions to ask while collecting this evidence include:

- whether there have been any previous episodes of a similar nature, even in a different physical setting
- clues about past behaviours or beliefs regarding physical problems
- observations regarding family members
- information about personality, coping styles and the patient's reaction to past medical consultations.

As the patient may not have requested an assessment, it is important that the psychiatrist checks that ward staff have explained to the patient beforehand that an assessment has been requested and the reasons for this. It is preferable to find a quiet and private place to conduct the interview, although this may be difficult on a busy medical ward, especially if the patient is confined to bed. Even if the patient is aware of the reasons for assessment, it is important that the psychiatrist discusses the nature and purpose of the interview at the outset and tries to allay any anxieties or reservations the patient may have about being asked to see a psychiatrist. Common anxieties patients have are 'Do the doctors think I am making this up?', 'Do they not believe me?', 'Are they saying it is all in the mind?', 'Are they saying I am going mad?'. Patients are unlikely to volunteer such thoughts to a psychiatrist at the outset and it is helpful if the psychiatrist raises and addresses any key concerns. Addressing any ambivalence at the outset of the assessment can facilitate the establishment of a good rapport with the patient.

It is helpful to start the interview by discussing the patient's primary concerns, which are likely to be physical in nature. It is important that the interviewer listens to the patient's description of their problems, while picking up emotional cues and the patient's understanding of what is wrong and what they have been told. It is particularly important that the interviewer obtains a clear picture of the patient's beliefs about the illness, treatment and prognosis.

The rest of the interview may need to be conducted flexibly, rather than following a set pattern of questions. It should cover the usual areas of family, personal, medical, psychiatric and social histories as well as mental

state and cognitive testing. However, further areas relevant to a general hospital setting may need to be explored. For example:

- a family history of physical illness and the impact of this on the family may influence the patient's reaction to their own illness;
- the patient's previous experience of medical care, as it may point to problems such as post-traumatic stress or influence their reaction to medical consultations or treatment subsequently;
- occupational and financial issues arising from the illness and disability;
- family reaction to the patient's illness.

Depending on the patient's medical condition, a full detailed interview may not be practical, and one may need to prioritise the areas that are most important for exploration.

Regardless of the length of assessment, it is helpful to summarise the information gathered at the end of the interview in a formulation and feed this back to the patient in a friendly and collaborative way. This can provide the basis for establishing a strong working treatment alliance.

Collating the information obtained to come up with a hypothesis

Questions that are asked of liaison psychiatrists in the general medical setting can rarely be answered by a diagnostic label. It is important that the nature of the questions are understood and addressed in a way that helps the referrer and the patient. This will normally involve summarising the problems and developing a formulation that helps staff and the patient to understand the nature of the problems and how they can be best managed. Elements such as the patient's personality traits or coping styles, their reaction to the illness/illness beliefs, and relevant social and familial influences may also be highly relevant in making sense of the difficulties that have led to the request for an assessment.

For some patients, discussing their physical problems in a biopsychosocial context may be therapeutic as they may begin to understand the relevance of psychosocial factors in their overall physical health problems. Some patients find it helpful to draw up a life chart of their problems as a way of making these connections.

Communicating the outcome of the assessment

The conclusion of the assessment may lead to:

- a summary opinion in the medical notes
- a letter to the clinician who made the referral and copied to the general practitioner (GP), and preferably copied to the patient as well
- further follow-up while in hospital
- an offer of follow-up in the out-patient clinic for further assessment or management
- a multiprofessional team meeting to discuss the team's treatment of the patient if he or she has complex or challenging needs.

Assessment in the liaison psychiatry out-patient department

The process is similar to that on general hospital wards. However, collecting supporting information needs to take place outside the out-patient visit, prior to or between visits, especially information from other professionals. It is important to recognise that patients with a complex history may require additional time spent purusing (an often substantial) set of notes or further information requested from the GP.

Dealing with emergency referrals

Liaison psychiatrists may be called to wards or the accident and emergency (A&E) department on an urgent basis. Reasons for urgent referrals may include a behaviourally disturbed patient with delirium, psychosis or acute alcohol withdrawal, or a patient who is threatening self-harm or refusing urgent treatment which is considered life-saving. Such events generate a high level of anxiety on the part of the professionals as well as concern for the safety of other patients or staff.

The challenge when responding to such requests lies in collecting essential information and in making a rapid assessment of the problem, followed by the development of a plan to manage the situation safely and effectively (Box 1.2). The assessment will cover the following.

What is wrong with the patient?

- The time course and development of the disturbance
- Available medical/psychiatric background
- Abnormal investigation results and perusal of the drug chart
- Any information from relatives or carers

Who is there?

- People available to help in managing the incident or those affected or needing to be taken care of
- Medical and nursing staff
- Availability of security staff

Box 1.2 Emergency referrals

- Assess:
  - what is wrong with the patient
  - who is on site that may be at risk or who may be able to help
  - where is the incident – potential risk factors.
- Plans to address:
  - immediate – safety, de-escalation, capacity, observation
  - short term – diagnosis, treatment, triggers, supervision
  - longer term – responsibility for follow-up.

- Relatives or carers
- Other patients

Where is the incident?

Anything in the area that needs to be considered for risk assessment (e.g. a drip stand, window, oxygen, furniture, breakables).

How to manage the incident?

The management plan should include immediate responses.

- Is the patient in a safe and calm environment?
- Are they responding to any attempts to de-escalate, negotiate care, do they require medication (oral or parental)?
- What is the patient's decision-making capacity?
- What is the level of observation needed for the patient?
- Is there a need to call for more help (e.g. mental health nursing, security)?

Short-term responses may include:

- further information/investigations to clarify the underlying diagnosis
- medical treatment for the underlying cause if appropriate
- address possible precipitating and perpetuating factors for the incident, which may be physical, mental, emotional or interpersonal
- is there a need/place for the use of Mental Health Act 1983 or Mental Capacity Act 2005?
- what levels of ongoing observation/supervision are required?
- negotiation of the management plan with the patient, medical staff, security or ongoing mental health input
- deciding on the best setting to treat and nurse the patient (e.g. side ward, medical or psychiatric ward).

Longer-term responses may include:

- if the patient remains on the medical unit or is transferred from A&E to a medical ward, it is important that the staff are aware of plans for follow-up from liaison psychiatry.

In many hospitals, liaison psychiatrists and their team are also involved in training staff in handling commonly encountered problems such as treating patients with delirium or dealing with patients who are withdrawing from alcohol or in delirium tremens. As requests for detaining patients arise commonly in such situations, training in the area of the Mental Health Act and Mental Capacity Act are equally important.

Beyond assessment – planning and delivering care

Because of the nature of liaison psychiatry, very little practice is based on the simple expedient of making a diagnosis and applying a treatment

with vigorous empirical support for its cost-effectiveness. Instead, the psychiatrist is required to make a number of judgements based on clinical experience and expertise (Box 1.3).

- Matching the intervention, not just to diagnosis but to:
  - the social circumstances of the patient
  - the patient's preference or willingness to collaborate
  - the feasibility of treatment, especially if the patient is seriously physically unwell.
- Sequencing multiple interventions. For example, a patient may have multiple problems such as a long history of medically unexplained symptoms, together with a history of childhood abuse, or current family tensions and work issues, plus dependency on opiates. How does one balance the need for immediate practical help (e.g. work problems) against the need for longer-term therapy (e.g. withdrawal from opiates)?
- Selecting the appropriate therapy – surprisingly (to some) cognitive–behavioural therapy (CBT) does not cure everything and one may have to choose other approaches: couple or family therapy, interpersonal therapy or referral for psychodynamic therapy.

How are these judgements made? The first important point is to start with what is pressing rather than what seems most interesting. Thus the priority may be social or work problems or overwhelming depressive symptoms.

Second, try to match early approaches to what suits the patient's style. If what the patient wants is a structured problem-solving approach, then start there – the need for further intervention will become apparent if it fails.

Third, remember that the whole approach does not have to be sketched out at the beginning. The response to early intervention is part of the assessment, just as assessment is part of the initial intervention.

The aim should be to come up with:

- an initial plan for assessment and intervention
- an immediate focus on process – engaging the patient; identifying their preferences and willingness to participate
- an option appraisal, including the option of no action
- a timetable for reassessment.

Box 1.3 Planning and delivering care

- Match the intervention to the individual not the condition
- Prioritise and sequence interventions
- Consider the best approach for the patient

Offering expert opinions

There are three areas of practice where a liaison psychiatrist may commonly be asked for an expert opinion other than a standard clinical one:

- in clinical practice where the question relates typically to interpretation of the law: when is it acceptable to treat an unconsenting patient?
- in clinical practice where the question relates to potential fabrication of symptoms, particularly if there are risk issues involving children;
- in medico-legal practice where the question is typically about the attribution of severity of a particular mental state.

In such situations it is important to clarify whether the psychiatrist is being asked for an expert opinion or for a factual report.

> Dr A has been seeing Mrs X in his clinic for 3 months following referral from the cardiac surgery service. She had persistent scar pain following cardiac surgery and it emerged that she had traumatic memories of an episode during her early post-operative recovery when she required urgent intervention following a delayed haemorrhage. Mrs X's solicitor has written asking for a report on her diagnosis and treatment because she is concerned that the haemorrhage was a result of negligently conducted surgery. In this case, it is important for Dr A to clarify whether he is being asked for a factual report on Mrs X's hospital contact or an expert opinion about the nature and cause of her condition.

It is also important to determine who is making the request, and how will the information be used.

> Dr B was asked to give an opinion about a man with a previous diagnosis of schizophrenia. The patient was refusing surgery for an oesophageal stricture and was as a result becoming severely malnourished. At the time of the consultation the patient was being fed intravenously on a surgical ward and the question was what was the legal position given his refusal of surgery.
>
> Dr B was able without too much trouble to ascertain that the patient lacked mental capacity and he advised that since surgery would be life-saving they could proceed without his consent. He was, however, surprised on reviewing the medical records to discover that he was the third senior psychiatrist to offer this opinion on the case. Dr B discovered that the requests were being made on the instructions of the hospital's lead for risk management, who subsequently read each opinion over the telephone to the hospital's legal advisor. Since the previous opinions had been written as medical opinions from one doctor to another, the lawyer was advising that they were not adequately detailed as legal justifications for action. Dr B clarified exactly what the risk manager and legal advisor wished to see in a written opinion and the matter was (eventually) satisfactorily resolved.

It is important that the liaison psychiatrist ensures that they have the relevant expertise to give an opinion in certain cases.

> Dr C was asked to give an opinion about the capacity to consent to surgery of a 17-year-old boy with autism. She declined, suggesting that the team consult an adolescent psychiatrist because she had no experience of the condition at hand. However, what she was being asked was not to exercise any expert skills

in relation to adolescent autism; she was being asked for help in applying the test for mental capacity – the nature of which is independent of diagnosis.

Finally, there is the question of the format of the opinion offered. Here, the most important message is to match the opinion format to the area of expertise and not to the clinical details of the case. To draw an analogy: when applying for a new job it is important to point out how one's characteristics match those of the job and person specification, not simply to send a standard CV. In the same way, reviewing a case in standard clinical terms and then offering an opinion is less useful than structuring the assessment to the specifics of the case.

For example, in justifying a decision about mental incapacity, a standard account of the clinical picture (even with a cognitive assessment) is less helpful than a description of the questions put and answers received that demonstrated that the patient did not meet the criteria for mental capacity.

The liaison psychiatrist as Communicator

The CanMEDS framework defines competencies in this role as (Frank, 2005):

- develop rapport, trust and ethical therapeutic relationships with patients and families;
- accurately elicit and synthesise relevant information and perspectives of patients and families, colleagues and other professionals;
- accurately convey relevant information and explanations to patients and families, colleagues and other professionals;
- develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care;
- convey effective oral and written information about a medical encounter.

Good interpersonal skills are an essential clinical component for a liaison psychiatrist. It is also important to have a deep understanding and appreciation of people's differing and varied approaches to life, their bodies, illness, etc. It is not surprising that communication between doctors and patients sometimes falters and misunderstandings arise. It is not uncommon to encounter patients who have walked away from a consultation with a message that is far from that intended by the doctor. Liaison psychiatrists should try whenever possible to take account of people's differing reactions to illness or treatment, and try to repair and address any misunderstandings that arise.

Poor communication between patients and doctors can result in high anxiety levels (for patient or clinician), poor treatment adherence or cooperation, hostility from family members, and in extreme cases, breakdown of therapeutic relationships. Some of these situations lead to referrals to liaison psychiatry as the patient's reaction to their illness or proposed treatment may seem inexplicable to the treating team and the

patient comes to be seen as difficult or obstructive. Typical problems may arise from:

- a lack of a shared understanding about the clinical problem;
- a misunderstanding about terminology, often medical (e.g. a patient who was told he had hypertension and had taken that to mean too much stress (hyper-tension) in his life);
- a different model of illness between the patient and clinician (e.g. a biomedical model of diagnosis and treatment may not be appropriate in the management of medically unexplained symptoms or end-of-life care);
- the patient's natural coping style (e.g. some patients cope by requiring detailed information about their condition, and are dissatisfied with the usual level of information given).

A high-quality liaison psychiatry assessment as outlined earlier would fulfil much of what is defined in the CanMEDS framework for a good communicator. However, when there appears to be a significant communication gap between clinicians and patients, one may need to focus on areas where such gaps arise. This may mean:

- eliciting and understanding the patient's illness narrative or representation in depth. This may require time and ability to conduct an interview that may not be highly structured. It helps to have curiosity, empathy and the ability to ask questions in a non-judgemental way, and to explore patients' views of their illnesses and the meaning or impact of their symptoms on their lives;
- finding a shared vocabulary. It is important to check what patients understand by certain medical terms, and whether they have understood these terms correctly. This may involve looking out for emotional cues to identify 'medical words' that have caused difficulties. It is sometimes helpful to find ways of explaining medical concepts to people using paraphrases, pictures or allegorical examples.
- understanding the patient's coping style from a personal history or an informant's history;
- communicating with clinicians to help them understand patients' reaction to illness or treatment, so that the medical team can arrive at a shared understanding of the patient's problems and formulate an agreed treatment plan with the patient.

The liaison psychiatrist as Collaborator and Health Advocate

These two roles have been linked as there is a common theme in the area of mediation. The CanMEDS framework defines the roles as follows (Frank, 2005):

- Collaborator:
  - participate effectively and appropriately in an interprofessional healthcare team;
  - effectively work with other health professionals to prevent, negotiate, and resolve interprofessional conflict.
- Health Advocate:
  - respond to individual patient health needs and issues as part of patient care;
  - respond to the health needs of the communities that they serve;
  - identify the determinants of health of the populations that they serve;
  - promote the health of individual patients, communities and populations.

An assessment from a liaison psychiatrist may be requested in response to difficulties negotiating a patient's treatment or discharge plans. The immediate question may relate to the patient's decision-making capacity, but in such situations assessment for the presence or absence of mental illness or capacity alone may not lead to resolution of the difficulty. Although it does not mean that liaison psychiatrists would be expected to come up with the solutions, it is sometimes helpful to take a more systemic approach to problems, and helping to mediate between different groups of health professionals may improve patient care.

Mediation may be required between a number of parties: between medical teams and the patient or family; between the patient and their family; between the general hospital and mental health services and primary care. Typical examples include: the management of challenging behaviours in patients with head injury; the location of care for a patient with mental health problems who also requires significant physical healthcare; and frequent clinic attenders. Mediation between social and health care is commonly required in disputes about accommodation and care arrangements for people with intellectual disability or dementia. During such mediation, common issues that may need resolution are:

- placement and discharge planning, including consideration of guardianship or a need for care coordination
- exploration of anxieties and frustrations arising from boundaries of responsibility
- assessment and management of risk issues, including those of self-neglect, risks arising out of physical vulnerability
- management of anxiety on the part of the treating team or other caregivers
- managing expectations of the patient or treating team or other caregivers.

The liaison psychiatrist as Manager

A manager's role in the CanMEDS framework requires the practitioner to (Frank, 2005):

- participate in activities that contribute to the effectiveness of their healthcare organisations and systems
- manage their practice and career effectively
- allocate finite healthcare resources appropriately
- serve in administration and leadership roles, as appropriate.

The main management task facing all liaison psychiatrists involves delivering multidisciplinary care to patients. Sometimes all components of the care can be delivered from within the liaison team; sometimes parts have to be outsourced – in the latter case the challenges are in fact very similar, although the negotiating skills in meeting them may differ. The psychiatrist needs to:

- identify skills available in the team
- identify the needs of the patient under consideration
- match skills to needs
- coordinating the delivery of care so that as far as possible it is experienced as integrated and 'seamless' by the patient. Without this coordinating function, different disciplines work as a pseudo team – all staff are involved in the patient's care in some way, but not in reality working together towards a single goal.

These activities are much easier to deliver if the multidisciplinary team is functioning well in an atmosphere of mutual respect. To achieve this, the team needs to have the following characteristics:

- each member needs clarity about their own role
- all team members need to be able to balance autonomy with collaborative working
- there needs to be a mechanism for resolution of conflict and tension between team members
- the team (and not just its individual members) needs a training plan so that it can offer a reasonably comprehensive portfolio of interventions.

Generally speaking, the consultant in liaison psychiatry is by designation the multidisciplinary team leader. All this will therefore require the liaison psychiatrist to develop a number of skills:

- working in different worlds – with clinicians from different specialties and with staff from different disciplines, the latter often organised and managed within a discipline even when they are part of a multidisciplinary team defined by a specialty;
- formulating the group's emotional dynamic and its cognitive and skill-based strengths and weaknesses;

- being able to think systemically about problems of treatment and service delivery;
- adopting and maintaining a stable leadership style.

The liaison psychiatrist as Scholar

The liaison psychiatrist's role as Scholar includes (Frank 2005):

- maintain and enhance professional activities through ongoing learning;
- critically evaluate information and its sources, and apply this appropriately to practice decisions;
- facilitate the learning of patients, families, students, residents, other health professionals, the public and others, as appropriate;
- contribute to the creation, dissemination, application and translation of new medical knowledge and practices.

The liaison psychiatrist may be a teacher to many others – physicians and surgeons, nurses on medical wards, patient groups, even other psychiatrists. What might the liaison psychiatrist be called upon to teach?

- Facts – for example about drug use, mental health legislation, the meaning of symptoms.
- Ways of thinking – one of the main functions for which a good liaison psychiatrist is valued is not for their medical knowledge but for their ability to formulate a difficult case, for example helping staff to understand perplexing or challenging behaviour.
- What help is available – navigating services and explaining how different sources of help can be accessed.
- Dealing with feelings – including ways of coping with anger or frustration.

How does this teaching take place? Most commonly (and usefully) in the direct liaison or consultation setting, through discussion of cases or explanation of opinions. Set-piece seminars or lectures are less useful than the experiential learning that comes with participation. The liaison psychiatrist may be teaching as an outsider, on a visit as it were, or as an insider – demonstrating specific skills through their clinical practice to other members of the team.

The output of such teaching can be as various as the settings. Explicit knowledge is useful but probably overvalued compared with implicit knowledge (how to behave). Attitudes are hugely important – an intervention that changes the approach of one key staff member to, for example, self-harm in the A&E or somatoform disorder in medical patients is worth a dozen fact-oriented teaching sessions. Probably the most important skill – best taught by demonstration – is the ability to interview under difficult circumstances, when the patient is agitated, frightened or hostile, or when a difficult decision has to be made at short notice.

The liaison psychiatrist as Professional

Finally, CanMEDS confirms some well-established general statements about the need for doctors to (Frank, 2005):

- demonstrate a commitment to their patients, profession and society through ethical practice;
- demonstrate a commitment to their patients, profession and society through participation in profession-led regulation;
- demonstrate a commitment to physician health and sustainable practice.

Conclusions

Liaison psychiatrists fulfil a range of roles at the interface of psychiatry and other clinical specialties in primary and specialist care. As a result, liaison psychiatrists interact not only with patients and their carers but with a wide range of clinicians and professionals in a variety of medical settings. A systemic approach is often helpful in carrying out assessments in a medical in-patient setting, taking into account the roles carers and clinicians play in managing patients' illnesses. Liaison psychiatrists should try to answer questions posed by the referral in a way that makes sense to both the patient and the referrer. Liaison psychiatrists need to be familiar with how the Mental Health Act and Mental Capacity Act apply in medical settings. Liaison psychiatrists can play a valuable role in helping negotiate treatment for physical conditions where adherence or refusal is an issue. Finally, the educational role of the liaison psychiatrist can involve both formal and informal processes.

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