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A new opportunity: three tales of training in liaison psychiatry of old age

Liaison psychiatry has emerged as a sub-speciality within general adult psychiatry, with specific experience and training being required to develop the skills and knowledge to address comorbid physical and psychiatric symptoms and illness (House & Creed, 1993; Lloyd, 2001). Older people often present with significant physical and psychiatric comorbidity (Ames *et al*, 1994; Holmes & House, 2000) and most old age psychiatry services receive one-quarter to one-third of referrals from general hospital wards (Anderson & Philpott, 1991). Despite this, there are no specific requirements for training in liaison psychiatry for old age psychiatrists at any level. The experience gained in assessing and treating general hospital referrals during basic and higher specialist training is felt to be adequate (Royal College of Psychiatrists, 1998).

The increased community focus of old age psychiatry means that trainees may not develop the best possible skills to manage psychiatric illness in the general hospital setting. To address this, Leeds Community and Mental Health Services Trust has developed a specialist old age psychiatry liaison service based at Leeds General Infirmary. This service was developed from waiting-list money, with the aim of reducing time spent waiting for a psychiatric assessment. It is based entirely within the general hospital setting and provides a consultation and liaison psychiatry service for approximately 45 000 older people in the city. The service has assessed and treated over 800 older people since its inception in 1999. The team consists of a senior lecturer/honorary consultant, a specialist registrar (SpR) and a senior house officer (SHO). Here we describe the experience of training in liaison psychiatry of old age from the perspective of a basic trainee, higher trainee and trainer.

The basic trainee's tale

This post was my seventh on the training scheme; my other experience in old age psychiatry was in my first post, which covered two old age psychiatry wards (one functional, one organic) on a general hospital site. I occasionally assessed referrals to the sector from the general hospital wards. My experience of liaison psychiatry was otherwise limited to that gained while on-call, together with parasuicide assessments. I entered the psychiatric training scheme directly from house jobs, so apart from a house officer's exposure to general medicine and surgery, I have had no other training in these areas.

One immediate and obvious advantage of working in the liaison service was that I was no longer the chief provider for the medical needs of older patients who were comorbidly ill. It is a common frustration among trainees in old age psychiatry to be painfully aware of their lack of training and resources for the management of older people who are physically ill. The general hospital setting of this training allowed me to concentrate on the psychiatric needs of such patients. This has been of benefit as I have been able to spend more time on psychiatric assessment and management. It has also benefited my self-esteem and job satisfaction, as I have spent the majority of my time carrying out tasks for which I am receiving training and supervision, rather than attempting to recall basic medical skills.

Far from lessening my exposure to general medicine, the detachment from the medical care of patients has actually benefited my knowledge of medicine. I now have the opportunity to observe, and if necessary revisit, cases that previously I would have had to transfer and so lose contact with. I have gained not only a longitudinal picture of how physical and psychiatric conditions interrelate, but I have also been able to witness the medical management at close hand. Indeed, as I have become well known on the wards, my medical colleagues have been only too pleased to answer any questions I might have. In this way, I have gained an insight into the changes in medical management and (especially) pharmacology since I last wore a white coat in 1997.

Where, previously, a complicated case would confound or frustrate me, I now have the time and resources to sit down and work through it thoroughly and often gain a sense of completion. I have also developed my communication skills among a range of medical and non-medical colleagues, rather than solely with harassed SHOs on-call. I have become aware that different medical specialities need different advice, often couched in different terms. For example, an acute cardiology team is less familiar with the concepts of

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psychosocial assessment and management than a care-of-the-elderly team, and advice needs tailoring appropriately. This is harder than I thought but am sure that the constant communication involved in the post has helped.

The issue of seniority for a psychiatric SHO is a potential drawback, but has not been a frequent problem. Referrers may expect a more senior opinion but most are satisfied that I receive full supervision, and I can recall only one or two occasions when my consultant has been asked to provide a further opinion. Continuity of care is another issue. Once the patients are discharged from the general hospital there is little further contact with them, and this may present a problem, as there is a lack of feedback on our management plans.

A person's views on working in a general hospital depend to a degree on individual preference. I enjoy working in hospitals and I am pleased that the opportunity arose at this stage in my training. The structure of the service means that this post has allowed me to spend more time on the psychiatric assessment and care of older people. I have been able to incorporate the presence of comorbid physical illness into my assessments, rather than being pressed to address it, and it alone, as a matter of urgency. I have been able to hone my communication skills with medical colleagues and better understand the needs of different medical and surgical sub-specialities. I believe most colleagues would derive benefit from a similar post at a later stage of basic training.

The higher trainee's tale

After a year as a SpR in a sector-based old age psychiatry post, I became the first SpR in this unique post at Leeds. Having previously experienced 'traditional' methods of managing liaison referrals, I was able to compare the training opportunities provided by sector psychiatry to those offered by the new, dedicated, liaison psychiatry service for older people.

Within sector old age psychiatry, the input offered to patients in general hospitals is limited owing to other demands upon the service. Consequently, there is limited time to complete an assessment and it may be difficult to return and review patients or to participate in discharge planning. A dedicated liaison psychiatry post increases the time available for clinical contact by reducing time spent travelling, and so offers the opportunity to learn in more depth about the particular complexities of this area in the treatment of the elderly. Clinically, assessments can be more thorough, with time to review patients, liaise with families and participate in care planning.

Working within the general hospital environment allows greater understanding of the practical problems faced by staff and patients and increases awareness of the need for compromise and flexibility in management strategies. Being on site also means it is possible to offer intensive psychiatric input to physically ill patients who have marked psychiatric problems. Previously, many of these patients would have been transferred to psychiatric wards, even if their overall needs were best met in the general hospital environment.

Education of general hospital staff is a key area within liaison psychiatry, at present the post enables teaching at an informal level, but there are plans to introduce a more formal teaching role. The post also offers the opportunity to revise medical knowledge and develop a better understanding of the interplay between medical and psychiatric illness. Because this is an evolving service, it has also been possible to gain further understanding of the complexities of new service development and to play an active role within this.

There are some limitations, however. First, the experience gained is restricted to patients within the general hospital setting compared to the variety of settings encountered in the community. Despite this caveat, provided community experience is acquired elsewhere, the post offers a valuable chance to develop skills further in an important area. Lack of continuity of care may also be an area of potential frustration. At present, patients discharged from hospital who need ongoing psychiatric involvement are referred to the sector team, at which point our involvement usually ceases. This situation should improve with further service development. For example, an out-patient follow-up clinic is being established, which is intended for discharged patients requiring brief psychiatric follow-up. Finally, the department is currently staffed only by psychiatrists, which limits the management options to some degree. However, the long-term goal is to establish a multidisciplinary team, which will broaden the scope of the department and further enhance training opportunities.

So, is a year spent in liaison psychiatry of old age worthwhile at SpR level? In my view, definitely yes. While the post may appeal particularly to old age psychiatry trainees with a special interest in liaison psychiatry, I would argue that any higher trainee in old age psychiatry could benefit and would acquire useful knowledge and skills to take back to a sector service.

The trainer's tale

Our old age liaison psychiatry service was initially developed to improve service delivery for older people with psychiatric illness, in general hospital settings. The knowledge and skills I gained during a year of higher specialist training in liaison psychiatry for working age adults were particularly helpful in planning and delivering our liaison psychiatry service. Similar experience specific to old age psychiatry training was not available. As our service evolved, it became apparent that the training opportunities it presented had the potential to offer much to trainees in psychiatry. We therefore developed two training posts in old age liaison psychiatry; one at basic trainee level and the other at higher trainee level, in order to give trainees experience in working at the interface of physical and psychiatric care.

What specific educational opportunities could such training posts offer? Looking back on proposals for both the basic and higher training posts, themes common to

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both were: an improvement in the understanding of the complexities presented by psychiatric illnesses in general hospital settings; development of the skills necessary to address this complexity; and enhancement of communication skills with patients, relatives and other health service and social service staff. These opportunities have been realised by the two trainees who have been in the posts to date. On reflection, and considering issues commonly raised during supervision of both trainees, other opportunities include an improved understanding of issues of capacity and consent in relation to treatment, placement and safety in the presence of cognitive impairment due to delirium, dementia or both. There is also the opportunity for trainees to see a new service evolve and obtain an understanding of issues influencing service development.

Discussion

Overall, the training received in these new posts has been well received. One useful feature is the compact geography of the service, meaning that trainees have more time to assess and manage complex cases. Both trainees commented on the benefits of really getting to the bottom of a difficult case because they had the time to obtain a fuller picture, with subsequent benefits to patients and trainees alike. This is assisted by the ability to revisit frequently, thanks to the on-site nature of the service, and it means that the psychiatric assessment is often the fullest of any of the components of the general hospital assessment.

Concerns have been raised over continuity of care and communication with community services. Similar concerns are often raised when any specialist service is established where a generalist service existed previously. Our experience suggests that, although loss of long-term community contact can mean less is known about outcomes, this can be addressed through good two-way communication with community services.

So, should such posts be developed elsewhere? We believe that they should be considered, although they are not an option for every setting. The development of liaison psychiatry services for older people, and therefore training in such services, depends on several factors including size of population, geography of services and local interest. Standard 4 of the *National Service Framework for Older People* (Department of Health, 2001) calls for a skills mix in the general hospital setting that is more geared towards the needs of patients. The high prevalence of psychiatric illness in this setting suggests that old age psychiatry services should aim for a higher profile, both in training other disciplines and in producing old age psychiatrists with the skills to match the complex care needs of older people with physical and psychiatric comorbidity.

Declaration of interest

J.H. has received expenses and fees for workshops and lectures on liaison psychiatry services for older people from Wyeth and Janssen pharmaceutical companies.

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