



## education & training

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### Higher training in liaison psychiatry for older adults: experiences of two specialist training posts

Over the past decade, old age liaison psychiatry services have been developing across the UK. The driving force behind this has been the recognition of the inequity in service provision for people over the age of 65 with mental health problems in a general hospital setting. A postal survey of consultants in old age psychiatry in April 2002 showed that most respondents (71%) considered that the service they provided to older people in general hospitals was poor and needed to be improved (Holmes *et al*, 2002). Much work has been done to highlight this issue, and liaison psychiatry for older adults is gaining prominence. The national conference on liaison psychiatry for older people, which has been held in Leeds for the past 4 years, attracts large numbers of enthusiastic participants. The Department of Health (2006) document *A New Ambition for Old Age* specifically mentions the current poor standard of care that older people with mental health problems receive in a general hospital setting. The Royal College of Psychiatrists (2005) has produced guidelines for the development of liaison mental health services for older people.

The authors therefore believe it is timely to consider higher specialist training issues in liaison psychiatry for older adults. The principal obstacle to obtaining higher specialist training in this specialty is the lack of full-time designated training posts. A joint communiqué from the faculties of old age psychiatry and liaison psychiatry in November 2004 advised that although experience in liaison psychiatry for older adults could be gained by a variety of routes, a full-time training post in this specialty with an accredited trainer should be recognised as providing special experience.

A second obstacle to training is the lack of a competency-based framework. Currently each faculty within the Royal College of Psychiatrists submits a list of competencies that each trainee should reach before becoming accredited by the Postgraduate Medical Education and Training Board. No such competencies exist for liaison psychiatry for older adults but they could resemble the psychiatric competencies for higher specialist trainees in geriatric medicine. An example is shown in Box 1.

#### Box 1. Example of psychiatric competencies for higher specialist trainees in liaison psychiatry for older adults

Experience in assessment and management of the following:

- capacity and consent, including testamentary and financial capacity issues
- fitness to drive
- mental health law and the use of the Mental Health Act 1983 in a general hospital setting, including use of lasting power of attorney and knowledge of Court of Protection (in England and Wales knowledge of Mental Capacity Act 2005)
- depression in the setting of a physical illness
- delirium
- severe behavioural disturbance secondary to dementia, delirium, or both
- prescribing safely and recognising common drug interactions
- safe and effective use of electroconvulsive therapy for the treatment of severe depressive illness
- application of psychological treatments
- end of life issues.

Additional skills:

- enhanced communication skills
- effective teaching skills
- champion of rights of the older person in a general hospital setting
- ability to liaise across different specialties and organisations, including non-statutory organisations.

The authors describe their experiences of a year's training in two posts attached to specialist services.

#### Structure of the training posts

M.Y. was attached in 2005–2006 to the mental health for older adults psychiatric liaison service provided by the South London and Maudsley NHS Trust to Mayday University Hospital, Croydon. The service staffing consisted of a full-time clinical nurse specialist, a full-time staff grade psychiatrist, five consultant sessions per week and administrative input. Mayday University Hospital has approximately 500 beds excluding maternity and



paediatric services. Approximately 500 referrals to the service were received per year at the time of the attachment. S.M. was attached in 2004–2005 to the Leeds General Infirmary liaison psychiatry of old age service. At the time of the attachment in 2004, this service had five consultant sessions per week, a full-time senior house officer, a full-time specialist registrar and full-time administrative input; the team has since expanded to include other multiprofessional disciplines. The team were receiving on average 50 referrals per month, approximately 600 per year. These were mainly from Leeds General Infirmary, but a small number also came from St James University Hospital and the Seacroft Hospital. The Leeds service was established in 1999 and the Croydon service in 2002. Both services operated according to a consultation–liaison model and provided liaison reviews to all wards within the hospital with follow-up visits if required. Neither provided dedicated accident and emergency department cover or out-of-hours working. The Leeds service was based within the general hospital, the Croydon service in a community mental health team base within a 5-min walk of the general hospital site.

The six clinical sessions for both trainees involved participating in the core service activity of responding to referrals, carrying out initial assessments and further follow-up assessments when required. One session in M.Y.'s post consisted of an attachment to an elderly care multidisciplinary ward round, providing a full liaison model of service input. A second session involved attendance at the weekly liaison service multidisciplinary team meeting where all referrals and current case-loads were discussed.

## Authors' evaluation of training received

### General skills

During the period of the attachments, the authors believe that they improved their ability to obtain relevant information from a variety of sources, formulate a diagnosis, devise a management plan, and engage patients and their carers, all within a restricted time period. At the end of the year of training they felt that they had become much more effective in championing the rights of the older person with mental health needs. The use of psychiatric and medical expertise proved time-efficient and was believed to have helped to provide a more favourable outcome for patients and their carers. In particular, the authors gained valuable experience in diagnosing and managing delirium, experience that might not have been available in a generic post in old age psychiatry. Much experience was also gained in the assessment of capacity. In a review of referrals to an old age liaison service, it was found that 20% encompassed some aspects of capacity and that the balance of risks and benefits could be difficult, with hospital staff sometimes failing to differentiate between a person's capacity and capability (Brindle & Holmes, 2005).

### Experience of different models of service delivery

S.M. had the advantage of being based on a general hospital site. This allowed her service to respond to urgent referrals. Being on site also facilitated intensive psychiatric care to physically ill patients with co-existing severe psychiatric problems who might otherwise have been inappropriately transferred to a psychiatric unit.

M.Y. attended an elderly care multidisciplinary ward round for one session per week. The full liaison model of service provided here was similar to that described for the old age liaison service provided for King's College Hospital, London (Mujic *et al*, 2004). M.Y. felt that this model helped in establishing close working relationships with medical and nursing staff. The profile of psychiatry on the care of the elderly ward was increased, helping to breakdown mind–body dualism. The disadvantages were that it was time-consuming, considering the number of referrals generated, and that providing an enhanced service to only one ward could be considered inequitable.

S.M. subsequently worked in an old age sector team that provided a consultation service to a district general hospital. Having previously worked in a consultation–liaison service she was in a position to compare the two models of service delivery. She found the consultation model to be essentially reactive rather than proactive. Owing to the time taken in travelling to and from the hospital, response times could be slow, assessments time-consuming and revisiting patients difficult. Less priority was given to referrals from the general hospital site compared with those from the community, because patients in a general hospital were perceived as being in a place of safety. Advice given was often not acted upon or management plans implemented. It is her belief that the consultation model provides a lower quality of care than the consultation–liaison model.

### Mental capacity assessments

The assessment of mental capacity has become a growing issue for medical services and is an area where the input of an old age liaison service is frequently valued (Stewart *et al*, 2005). The authors gained extensive experience in assessing capacity, predominately around discharge arrangements but also in testamentary capacity and the ability to appoint a lasting power of attorney. Although these skills are generic to all trainees in old age psychiatry, exposure to more complex cases on a regular basis allowed for the development of a greater level of competence and confidence than might otherwise have been achieved.

### Educational input

Education was a large component of both jobs and occurred mostly on an informal basis. Patients were educated on the management of their psychiatric illnesses, carers were given information on diagnosis and treatment, and general hospital staff updated on the management of older patients with mental health needs.



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Informal education occurred by having a high profile on wards and by using case examples. The authors believe that this helped to change prescribing practice. S.M. had the opportunity to present cases at grand rounds which, she felt, was important in raising the profile of the service and increasing awareness among medical staff of the mental health needs of their patients.

### Other experience

The exposure on a daily basis to clinical medicine provided both authors with the opportunity to revise symptoms and signs of common medical conditions. It also allowed them to keep up to date with the latest clinical developments. M.Y.'s attendance on a geriatric ward with a multidisciplinary team gave her exposure to the management of the common conditions in geriatric medicine, and she was able to discuss with a consultant the rationale for prescribing choices that had been made. Managerial skills were developed as both posts offered the opportunity of observing the development of relatively new services. A greater understanding was gained of the issues that influence service development.

### Conclusions

Both M.Y. and S.M. found their year of training in liaison psychiatry for older adults to be very beneficial. The question could be asked if the skills gained in a specialist training post differ from those that would have been gained from an attachment in general old age psychiatry, or liaison psychiatry? From the authors' clinical experience and from discussions with colleagues it is believed that there is specific and important experience to be gained from training in this specialty. The authors believe that the necessary skills and competencies needed to safely and competently manage the mental health needs of those over 65 in a general hospital setting can only be developed by supervised exposure to patients with complex needs, and that this is best provided by a full-time specialist training post.

Finally, there is the need for recognition of higher specialist training in old age liaison psychiatry. The liaison psychiatry faculty recognises a year of higher specialist training in an approved training post by issuing an 'endorsement' of a general adult psychiatry Certificate of Completion of Training (CCT) at the time of completion of training. If age discrimination and inequality of service provision is to be truly addressed then training in liaison psychiatry for older adults should be given equal recognition to that of training in liaison psychiatry for adults of working age. One step towards this might arise from the proposal by the Royal College of Psychiatrists to reduce

the number of CCTs from six to one (Royal College of Psychiatrists, 2006). This might create a more level playing field in allowing developing specialties to become recognised. However the need for actual training opportunities will remain. In the era of Modernising Medical Careers there is likely to be an increasing emphasis on general training with less opportunity for experience in specialist areas. Specialist skills may have to be developed after CCT is gained but the structure for achieving this has yet to be clarified.

As two trainees who have had the experience of working in full-time training posts in liaison psychiatry for older adults, the authors strongly support the view that more designated higher specialist posts should be developed and that training in this specialty should become more formalised. We look forward to the day that higher specialist training in liaison psychiatry for older adults is recognised by the Royal College of Psychiatrists.

### Declaration of interest

None.

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