Faculty of Liaison Psychiatry Newsletter

Spring Edition 2021

Faculty of Liaison Psychiatry Newsletter

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Editorial

Dear colleagues,

Since our last newsletter in Summer 2020, the world and healthcare continue to adapt to the impact of the Covid-19 pandemic.

With restricted real-life opportunities to share our experiences, the newsletter is one of the myriad ways to learn from each other about the changes that are ongoing.

In his column, Dr Bolton comments on some of the service and presentation changes that have been seen in the last year. The College's strategic plan of 2021 aims to improve standards of psychiatric care, and in this edition, Dr Guirguis shares his findings of anti-depressant prescribing in haemodialysis patients.

In liaison psychiatry, the pandemic has shown us the importance of our own well-being when trying to help others. In their article, Dr Kaser and colleagues describe their efforts in setting up a staff mental health service.

The experience and development of trainees is not to be forgotten in these ever-evolving times, as Dr Annabel Price, Chair-elect of the Faculty, reminds us. The reflections of a trainee, Dr Mao Fong Lim, on the benefits of a placement in liaison psychiatry are informative to read about.

This is the last edition for Dr Nora Turjanski editor of the newsletter for some time! On behalf of the Faculty, we thank you. Personally, for your help in handing over to us as the new team, we are very grateful!

A reminder that we rely on your support to continue publishing this newsletter. Articles should be between one to two pages long. Please include your name, title, place of work and contact details. The newsletter provides the ideal platform to share good practice and ideas.

Please email your contributions to Stephanie Whitehead at Stephanie.Whitehead@rcpsych.ac.uk using "Liaison Faculty Newsletter" as the subject line.

Editorial Team Liaison Faculty Newsletter
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Newsletter Designed by Ratnu Vaidya, Medical Student, Newcastle University

Looking back, looking forwards: reflections from the Faculty Chairs

Dr Jim Bolton
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In my final column for the Newsletter as Faculty Chair, I am delighted to be joined by our Vice Chair, Annabel Price, who will take over as Chair in June 2021. Together we will look back at the recent work of the Faculty and forwards to the future for our speciality.

For all of us, the past year has been dominated by the pandemic, both professionally and personally. I will look back at some of the key implications for Liaison Psychiatry and forwards to potential learning and changes for future practice. In her column, Annabel will consider the wider achievements of the Faculty over recent years and her goals as Chair.

Looking back

Guidelines
We can be proud that ours was the first College Faculty to disseminate guidance for colleagues on adapting services in preparation for the pandemic. This guidance was compiled using the expertise of Faculty Executive members and has been regularly updated in the light of experience. Annabel also led on compiling information for patients on the potential psychological and emotional effects of being admitted to hospital with COVID infection.

Communication
We have had to adapt to greater online communication. This has been valuable in sharing expertise and good practice, and for providing social contact and support. I am grateful to Alex Thompson our Vice Chair elect; Shammi Shetty, a Foundation Trainee; and Em McAllister our Faculty

Patient Representative, who delivered a programme of webinars to help keep us informed and in touch throughout last year.

Thanks too to Emma Phillips, former Chair of the Trainees, New Consultants, Nurses and Allied Health Professionals (TNCNAHP) in Liaison Psychiatry Committee, and Kit Akass, the current Chair, for organising the first virtual TNCNAHP Conference in November 2020. This was a successful meeting that laid the groundwork for our online 2021 Faculty Conference on 19-21 May.

Alternatives to the Emergency Department
From the outset of the pandemic, there has been discussion about the provision of alternative assessment facilities to the Emergency Department for mental health assessments. I am grateful to all of you who took part on our survey of new care pathways last spring, the results of which informed a report by NHS England that I circulated last year. In summary, NHS England concluded that the evidence did not support a national roll out of such facilities, but it recognised that, in some areas, they may have been a useful temporary measure during the pandemic.

Psychopathology
Online communication was helpful in discussing our experiences of clinical presentations in the context of COVID-19. We shared anecdotal reports of florid cases of delirium, often in relatively young patients with prominent psychotic symptoms. These observations were later supported by research findings, particularly those of the CoroNerve surveillance study of psychiatric and neuropsychiatric complications of COVID-19.

By last summer, it was also recognised that many patients had long term sequalae of infection – so called 'long COVID'. This brings me to some thoughts about the future implications of the pandemic for Liaison Psychiatry.

Looking forward

Post COVID-19 syndrome
COVID infection may be followed by long-term fluctuating multi-system symptoms, including neurocognitive symptoms, chronic fatigue and mood disorder. In 2021, the College set up an advisory group to inform national work on this problem. Chris Schofield, a Faculty Executive member, has represented psychiatry on both the NHS Long COVID Taskforce and the NICE/SIGN/RCGP committee that has developed guidelines on managing the long-term effects of COVID-19. I commend

Chris for his work on our behalf, and for being instrumental in ensuring that the potential role of liaison psychiatry in the management of post COVID-19 syndrome is included in national guidelines.

There is much that it is not known about post COVID-19 syndrome. How common is it? What are the key epidemiological factors? What is the optimal care? I hope that the evolving local care pathways for this condition will embrace the philosophy of integrated physical and mental health care and recognise the need for Liaison Psychiatry involvement. The 2019 college Position Statement on this topic provides a model of care that includes Liaison Psychiatry expertise for the most complex cases.

Staff well-being

The potential impact on health professionals of working during the pandemic is well recognised. Unsurprisingly the key recommendations for supporting staff have primarily been about enhancing personal and team resilience, and providing appropriate working conditions – leadership, PPE, food, rotas etc. Individual psychological support should also be available for those that need it.

Many Liaison Psychiatry services have participated in the provision of psychological support for their hospital colleagues, often in collaboration with colleagues from other services and disciplines. I hope that we can build on this experience of multidisciplinary working in the future, to break down barriers between services and professions in order to enhance patient care.

From personal experience, many hospital colleagues have carried on working under extreme pressure, having little time to consider what they are going through. What will be the impact on individuals and teams when they do have time to reflect? I hope that the lessons about looking after staff well-being are not forgotten. These lessons are not peculiar to emergency situations and should be part of NHS 'business as usual'.

Mental health crisis care

Although the universal provision of alternatives to the emergency department for mental health assessments has not been endorsed, I think that the experience of the pandemic may inform the evolution of mental health crisis care. Might there still be merit in the provision of assessment facilities for patients in crisis who are already under the care of mental health services and for whom attendance at an emergency department could be avoided?

Where such facilities are introduced, we need to be wary of resources being transferred from Liaison Psychiatry Services to fund or staff such facilities. This would be to the detriment of the service for the general hospital and our patients.

Online working
I expect that most of us have considered how much of our work and contact will continue online following the pandemic. I have certainly saved time by attending virtual meetings.

When it comes to conferences, greater accessibility has meant that more delegates can attend online. Attendance at College events has more than doubled over the past year. However, live meetings and conferences often allow for a degree of social interaction and networking that is not possible online. I know that there is an appetite in the College to return to conferences where we can meet face-to-face. The future may be one of 'hybrid' online and live meetings. Perhaps our 2022 conference will allow the Faculty to test out this model.

Mind and body
One positive aspect of a grim year has been the widespread recognition that COVID-19 has had profound psychological and social implications, not only for those who have been infected, but the whole population. The mental health impact of the pandemic has been repeatedly discussed in the media. I hope that this biopsychosocial thinking will translate into further destigmatisation of mental illness, greater integration of mental and physical healthcare, and recognition of the value of Liaison Psychiatry.

Conclusion

It has been a challenging year for us all, both professionally and personally. Most of us will have worked under extreme pressure in challenging circumstances. Many of us will have been ill ourselves or have lost colleagues, friends and family members. However, we can be proud of the contribution of Liaison Psychiatry to patient care. You have demonstrated the energy, enthusiasm and innovation that attracted me to the specialty as a trainee, and which encouraged me to stand for election as Chair of the Faculty. I hope that our work during the pandemic will ultimately strengthen our profession.

In late 2020, I was invited to a meeting of senior NHS leaders to discuss the mental health implications of COVID-19. I was heartened by the recognition of the role that Liaison Psychiatry has played. As NHS England's National Mental Health Director, Claire Murdoch, said during our discussion, 'We need Liaison Psychiatry more than ever'. Amen to that.

Jim Bolton
Chair of the Faculty of Liaison Psychiatry

April 2021

Dr Annabel Price
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Last autumn, when I took a deep breath and pressed 'submit' on my application for Chair of the Faculty, I did not expect an email to pop into my inbox only a few days later congratulating me on being elected unopposed! I had a curious mix of feelings after the shock wore off -relief for not going through the wait to find out the ballot result, but also a sense of wondering if the outcome would have been the same in an opposed election, mostly though I am honoured to be leading the Faculty for the next four years.

I'm delighted to be joined by Alex Thomson as Vice Chair - he is a dedicated and passionate advocate for the development of services for our patients, and as 'educator of the year' in the latest RCPsych awards, we are truly lucky to have him in the role.

We have an active and thriving Faculty with a hugely energetic and capable executive. As I step into the Chair role, we will be joined by six new committee members (a warm welcome to all!). However, they will be replacing incredibly able and dedicated committee members who I hope will remain involved with Faculty work. This seems a good moment to say a very grateful farewell to Nora Turjanski, whose work, particularly on the Faculty conferences and newsletters, has been incredible. Nora and all of the outgoing executive members will be much missed.

For the past eight years, I have been on the Liaison Faculty executive, Vice Chair for the past four. In that time, it has been an honour and an education to work with excellent leaders in chairs, Peter Aitken and Jim Bolton and previous Vice-Chair Al Santhouse (to whom congratulations are in order on the recent publication of a book on the mind-body interface!).

During their time in role, we have seen a steady growth in liaison services, collaboration across our four nations, and strengthening of international links. Being part of a team that brings together doctors, nurses, psychologists, and experts by experience makes for an inclusive approach grounded in the real-life of services. We have seen a greater focus on the needs of children and a close relationship with our colleagues in the Paediatric Liaison Network. When I started as a liaison psychiatrist, I was one of few to specialise in the care of older people. I have been very pleased to see that this is now a growing area of practice though I hope to see liaison services for older people develop further. One of my ambitions as Chair is (in partnership with the Old Age Faculty) to establish an Old Age liaison network.

The past year or so has been hard for us all, but the adaptability and creativity shown by our speciality has been astonishing, and I've never been more proud to call myself a liaison psychiatrist. As I write this, the sun is shining, the spring flowers and blossoms are out, many of us have been vaccinated, and the number of patients very unwell with Covid has come down enough to allow ourselves some optimism, or at least a chance to pause and breathe for a bit. Liaison psychiatry services have found themselves in as much demand as ever, and the expertise of the speciality has been integral to the covid response. Not only have liaison psychiatry clinicians provided care to patients suffering the mental health impact of both Covid infection and pandemic response, but they have also set up new services and service models, provided psychological services to healthcare staff and contributed to the development of guidelines and policy.

The coming months will be key in establishing where liaison psychiatry is placed in the ongoing system response to Covid and its longer-term health consequences. While this continues, other active streams of work will impact the ways we practice in the future, including contributions to mental health and capacity law reform, response to patients presenting to the ED in crisis, outcome measurement, and sustainability.

There is much to look forward to over the next few months – the upcoming Liaison Faculty conference in May, the PLAN annual forum in June and the TNCNAHP conference in November will be real highlights.

Returning to my 'campaign' statement, as I prepared to write this article, I reflect on my three goals. They are works in progress and will continue beyond my tenure, but they will keep me focused on the job of meeting

the needs of the people we serve, continually examining the quality of the work that we do and looking after those who do the work:

1) Anyone accessing physical health care, for whatever reason, will receive excellent, compassionate and well-integrated mental health care

2) The widespread availability of high quality, evidence-based treatment

3) Developing a well-resourced and supported speciality that continues to attract and develop excellent clinicians, teachers and researchers.

No chair could ask for a better team than this talented, wise and diversely experienced liaison psychiatry executive and wider Faculty, supported so ably by Committee Manager Stephanie Whitehead.

I hope to see lots of you soon at the Faculty conference, but for now, I'd like to end with a huge thank you to Jim on behalf of us all for so skilfully steering us through the past four years.

Anti-depressant Usage in Haemodialysis Patients: Evidence of Sub-optimal Practise Patterns

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Background

End-stage renal disease is the complete or almost complete failure of the kidneys to function. Patients either require dialysis or transplantation. 64,887 adult patients were receiving renal replacement therapy (RRT) in the UK on 31/12/2017, an increase of 12.7% from 2013. RRT prevalence was 983 per million population, pmp, compared to 523 pmp in 2000. The most common identifiable primary renal disease (PRD) was glomerulonephritis (19.7%), followed by diabetes (17.8%) (UK Renal Registry 21st annual report 2017).

Depression is common in patients on haemodialysis (HD). Estimates of prevalence vary between 23 - 39% depending on methods used (Palmer et al. 2013). Diagnosis is challenging due to symptom overlap between depression and advanced chronic kidney disease (CKD), particularly fatigue (Chilcot et al. 2010). Depression is associated with reduced quality of life and increased mortality and may lead to reduced treatment adherence and self-care behaviour and greater healthcare resource use (Weisbord et al. 2014).

Management of depression in patients receiving HD is also difficult. A recent systematic review carried out under the auspices of the European Renal Best Practice Group identified only one small and inconclusive RCT and recommended well-designed RCTs in this setting (Nagler et al 2012). Since then, there have been three RCTs. The ASSertID study was a

feasibility RCT of sertraline versus placebo in patients on HD. There was no benefit of sertraline over placebo on depression severity over a six-month period, though more withdrawals were related to adverse effects in the sertraline group (Friedli et al 2017). A larger placebo-controlled study of sertraline in CKD patients not on dialysis also found no benefit of sertraline over placebo on mood, though there were more adverse effects in the sertraline group (Hedayati et al 2017). In a third study, there was a marginal, statistically, but not clinically significant benefit on mood of sertraline over cognitive behavioural therapy (CBT), though there was no control group (Mehrotra et al 2019). On the other hand, benefits of group (Duarte et al 2009) and chair-side (during centre-based HD) CBT have been reported (Cukor et al 2014). Hence though there is some evidence for the benefits of CBT in this setting, there is no firm evidence for the use of anti-depressants and some evidence for an increased prevalence of adverse effects.

Indeed, CKD may increase the risk of adverse events associated with anti-depressants. Some drugs or their active metabolites may be excreted renally and therefore retained in patients with CKD. The condition leads to a disturbed internal milieu which may substantially change the pharmacokinetic and pharmacodynamic properties of the drug (Gabardi et al 2005). We aimed to study anti-depressant management practices in this setting and adherence to relevant national guidelines.

Methods

The study combined prospective and retrospective observations of a cohort of ESRD patients who were initially screened for the (ASSertID study. It was carried out at 4 UK renal dialysis centres.

Patients taking anti-depressant medication at baseline screening of ASSertID study were followed up at a mean of 14 months later with repeat depression symptom scores and diagnostic psychiatric assessment. Changes in demographics, clinical and life circumstances and anti-depressive medication were also recorded. Assessments were made of adherence to NICE guideline (CG91) for the recognition and management of depression in adults with a chronic physical health problem.

The study was sponsored by East and North Herts NHS Trust, REC reference number 14/EE/0143.

Results

Seventy-six patients out of the 709 screened (11%) were taking anti-depressants at the time of screening. Of the original 62 patients, 41 (66%) were available for restudy (12 had died, 6 had been transplanted, one transferred, 2 did not consent). Ten different anti-depressant agents

were being taken, the most common being Citalopram (39%). The primary prescribers of anti-depressants were General practitioners (68%) followed by nephrologists (22%), and psychiatrists (10%). At baseline, 30 patients had a BDI-II score ≥16 indicating high depressive symptoms. Of these, 22 remained with high depressive symptoms at follow-up whilst 8 improved (BDI-II <16 at follow up). Of the 11 with BDI-II < 16 at baseline, 5 had increased score to ≥16 at follow up. Although 27 of 41 patients (66%) either deteriorated or failed to improve during follow-up, a change in medications took place in only 11 patients (27%). Diagnostic evaluation took place using the Mini-International Neuropsychiatric Interview, MINI, a short diagnostic fully structured interview to allow administration by non-specialised interviewers. It was developed jointly by psychiatrists and clinicians in the US and Europe, for DSM-IV and ICD-10 psychiatric disorder. It was designed to meet the need for a short but accurate structured psychiatric interview for multicentre clinical and epidemiology studies. At follow up MINI showed that 15 patients (37%) were suffering current or recurrent major depressive episode (MDE), 20 (48%) had evidence of past MDE, and 6 (15%) displayed no evidence of past or present MDE. All 15 patients with current or recurrent MDE at follow-up were among the 27 whose BDI-II score deteriorated or did not improve (56%). A change of prescription during follow up occurred in only 4 patients (27%) with current or recurrent MDE.

Discussion

In summary, a significant proportion of the HD population takes anti-depressant medication. Our findings suggest multiple problems with their use in this setting. Most initiation and management of anti-depressant medication was carried out in General Practice mandating effective communication with nephrology services. Multiple types of anti-depressants were being used, a number of which may be potentially problematic in this setting. There was evidence of over-prescription – in 15% of patients, there was no firm evidence of current or past depression. There was inadequate follow-up reflecting sub-optimal adherence to NICE guidelines. In addition, recent randomised studies have failed to confirm the efficacy of these agents in the CKD population whilst demonstrating significant issues with adverse effects. Furthermore, there is some evidence of increased mortality risk with some of these agents. Recent RCTs have failed to confirm the efficacy of these agents in the CKD population whilst demonstrating significant issues with adverse effects/some evidence of increased mortality risk with some of these agents. This suggests the need for a major reappraisal of the use of these agents in this setting.

A bespoke mental health service for NHS staff – Experiences from Cambridgeshire & Peterborough Staff Mental Health Service

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NHS healthcare workers have been in the spotlight as never before as a result of the Covid-19 pandemic. While lauded as heroes for their response to the unprecedented demands placed on the health service, this has come at a high cost to their own mental health. Clinicians working through the pandemic have been exposed to persistently high levels of traumatic stress and have faced hugely challenging clinical situations for which they have been ill-prepared. Some have experienced this as 'moral injury', increasing their risk of mental health problems[1]. While early reports suggest high rates of depression, anxiety and traumatic stress symptoms in NHS staff[2,3], the full extent of the mental health impacts of the Covid-19 pandemic have yet to be seen. The potential implications for NHS employers, particularly in retaining their highly skilled workforce, are a significant concern.

Even before the pandemic, it was well established that healthcare workers experience more mental health problems than the general population[4]. An NHS staff survey in 2019 showed that mental ill-health accounted for

25% of all sickness absences[5]. High-stress levels, lack of appropriate support in the workplace and risk of burnout contribute to this high prevalence. Presenteeism, staff attending work when unwell, is most strongly associated with doctors and can compromise clinical care and patient safety[6]. Stigma, concerns about confidentiality, fears of scrutiny from professional regulatory bodies and adverse consequences for career progression can delay or prevent NHS staff from seeking help[7]. High access thresholds and long waiting lists for secondary care mental health services are further confounders. Taken together, these factors are often cited as compelling reasons for bespoke staff mental health services.

The need to safeguard the well-being of staff during the pandemic has led to a wide range of offerings. Many focus on enhancing well-being and building resilience within teams and individuals. Local and national helplines, digital tools, support groups and access to brief psychological intervention via in-house psychologists or IAPT are among the diverse offerings. While these interventions meet the needs of the majority of staff, there remains a much smaller group of staff who develop more serious and persistent mental health problems. A gap in access to timely treatment for this group was identified early in the pandemic by the Cambridgeshire and Peterborough (C&P) Sustainability and Transformation Partnership. The Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) was commissioned to set up the C&P Staff Mental Health Service (SMHS).

The SMHS launched in September 2020 and, for governance purposes, sits under the umbrella of Psychological Medicine. The service is accessible to approximately 25,000 staff (from all job roles) based in 5 NHS trusts. From the start, our aim has been to provide a rapid access, inclusive and confidential service. Our multidisciplinary team consists of consultant psychiatrists, clinical psychologists and specialist nurses, including an occupational health nurse. While we offer secondary care input, the access threshold is very flexible, recognising that presentations to a staff service need to be considered not only in terms of objective severity but with the impact on occupational functioning in mind. We accept referrals from occupational health, GPs and other specialist services within the CPFT. An SMHS clinician contacts new patients within 72 hours to identify any immediate needs, and we offer an initial assessment within two weeks (90% seen within this timeframe). Staff can be seen during working hours, but we also offer evenings and weekend appointments. Confidentiality is key and supported by an enhanced protocol which includes procedures to cover the not infrequent occurrence

of SMHS clinicians having a personal or professional relationship with a referred staff member.

All patients have an initial psychiatric assessment, the outcome of which might include: advice and sign-posting to appropriate resources; further psychiatric input; a brief psychological intervention; formal psychotherapy (up to 20 sessions); specialist occupational health support. Where indicated, care may be 'brokered' to other services e.g. a specialist eating disorder service. We do not provide an emergency/crisis response but work closely with the CPFT First Response and Crisis teams. Psychological interventions with SMHS clinical psychologists include CBT, IPT, CFT, ACT and EMDR. Our specialist nurses can provide brief psychological interventions, including DBT and mindfulness-based approaches for a selected group of patients. A particularly innovative aspect of this service is embedded Occupational Health support. This has been a major benefit in liaising with Trust OH services (supporting timely and appropriate referrals), negotiating reasonable adjustments and supporting staff to remain in work or to return to work. It has also been enriching to gain a greater appreciation and understanding of OH and have that alternative perspective within the team.

The most common clinical presentations are depression and/or anxiety (not infrequently complicated by a past history of complex trauma). PTSD and personality difficulties leading to maladaptive coping are also common. While there have been presentations of substance abuse, these have been less frequent than expected, raising questions about access and covert problems. Screening questionnaires indicated average depressive symptoms in the moderately severe range (PHQ-9=16.22 ± 5.94) and anxiety symptoms in the moderate range (GAD-7=13.45 ± 4.70). 84% of patients scored above the clinical cut-off on a brief measure of PTSD (PCL-C >14), suggesting difficulties with posttraumatic stress. Interestingly, a notable group of patients have described prolonged mental health difficulties but have never accessed formal mental health support in the past.

The process of developing this service has been exciting and successful outcomes have been rewarding. Patient feedback has been very positive particularly in relation to the rapid access, bespoke nature and flexible approach of the service. Unsurprisingly, there have also been challenges. These include a higher than anticipated demand (approximately double), trying to recruit to a service in the context of temporary funding and setting up a new service that operates almost exclusively remotely.

Given the paucity of evidence to support the planning of services for healthcare staff, we have also embedded a full-time research assistant in the team and established collaborative links with our academic department. Research plans include a cross-sectional descriptive study as well as a full economic analysis of the service model. Early data will be presented at the next Royal College of Psychiatrists annual conference. Moving forward, we hope to secure extended funding for the service. We would be delighted to hear from others who might have set up or plan to set up staff services.

https://www.cpft.nhs.uk/smhs/

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Liaison Psychiatry Reflections

Dr Mao Fong Lim

Foundation Year 2 Doctor

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As an aspiring psychiatrist, I chose my foundation rotations with psychiatry as an anchor. 2 years ago, I wouldn't have anticipated my experience so far: 8 months of medicine for the elderly (with a pandemic), 4 months of stroke medicine and (almost) 4 months of liaison psychiatry for older people, sandwiched with intensive care at the start and obstetrics and gynaecology at the end. It has given me a good grounding in general medicine, especially for the elderly, as well as a fondness for palliative care.

My liaison psychiatry post has been, by far, my best experience as a doctor. In this time, I have matured as a clinician, and a person. I have felt truly nurtured and mentored towards some of the best work I have done as a doctor.

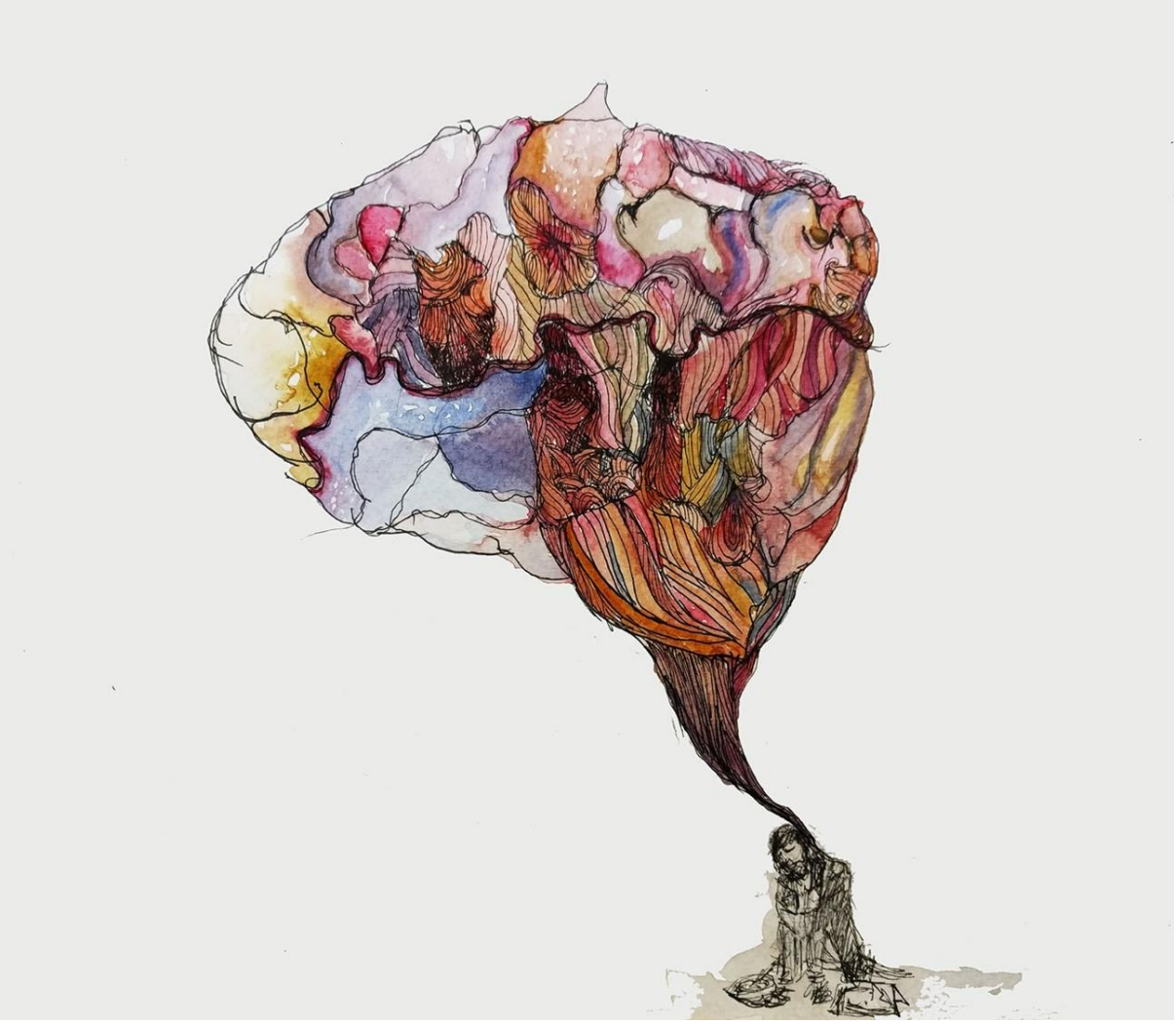
My most memorable patient had intractable breathlessness, pain and nausea, exacerbated by anxiety. On reflection, this case turned out to be more challenging than I had expected and brought with it several learning opportunities.

I was able to apply some brief psychotherapeutic interventions (such as Solution Focused Brief Therapy), continuing some of the psychological work that had been done in the community. It was slow work, requiring a high degree of patience, flexibility and creativity. At times, it was satisfying to feel that there were breakthroughs in the patient's level of engagement, and that there was a therapeutic relationship emerging. The psychological therapy frameworks gave me some structure to fall back upon, as well as to provide concrete suggestions for the ward team.

Being a creative person, I have long been an advocate for the positive benefits of arts in healthcare. I was able to tap on the resources available

within the trust for the benefit of this patient – including art posters and dance therapy.

Despite this, the patient's anxiety and physical symptoms continued to worsen. At the same time, the joint care between palliative care, medicine for the elderly and our team seemed to be moving in different directions. I suggested a joint professionals meeting - which was warmly received. We all recognised that the patient was deteriorating and endeavoured to work towards best interests.



Emotional Cartography

In working closely with palliative care, I was able to appreciate the crossovers. One of my key learning points was in discussion with the palliative care consultant, where we discussed the CBT model and how it applied to our patient's anxiety around breathlessness. In addition, it was interesting to note the dual-purposing of psychiatric medication in palliative care, such as olanzapine being used as an antiemetic.

This case illustrated the close relationship between physical and mental health, reaffirming my interest in liaison psychiatry. It also highlighted the strengths of an MDT, as well as the importance of tapping on the expertise of multiple specialties – which is an aspect of liaison psychiatry I particularly enjoy. Sadly the patient passed away but I feel privileged to have been able to contribute to their care in the last days of life.

Having moved on to obstetrics and gynaecology, the change in pace is strongly felt. Even though days are busy and hectic, psychiatry still remains an anchor for me. The transferable skills in communication and navigating emotionally charged situations are still extremely relevant. In fact, my colleagues have been very interested to hear about my experiences on liaison psychiatry, and are keen to learn more about brief psychotherapeutic techniques. I am grateful that I am part of a team that recognises the importance of this, and is more than happy to devote some precious time to be compassionate and caring, allowing me to be an everyday psychiatrist in the midst of our busy days.