**Feature Article**

The mental health nurse: A valuable addition to the consultation-liaison team

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**ABSTRACT:** Nurses, particularly those working in non-psychiatric settings, report that they do not feel adequately prepared to meet the mental health needs of patients. The psychiatric consultation-liaison nursing role has arisen in part, as a response to these difficulties and aims to facilitate access to mental health nursing expertise for general hospital patients and staff. The impact of the introduction of a nursing position into an established consultation-liaison psychiatry service was evaluated using an activity audit, a staff attitude survey, and staff focus groups. The findings demonstrated that the addition of the nursing role to the consultation-liaison psychiatry service improved access of general hospital patients to specialist mental health care. It also provided valued expert assistance to staff in the provision of care to this patient group, particularly those with complex problems and significant psychiatric comorbidity. The study found that the nursing consultation was particularly helpful because of its focus on practical and care-orientated interventions. The model of practice that evolved out of this project is described and the findings support the use of both direct and indirect patient interventions as important psychiatric consultation-liaison nurse activities.

**KEY WORDS:** consultation, general hospital, liaison, psychiatric comorbidity, psychiatric nursing.

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**INTRODUCTION**

Nurses frequently report that they are inadequately prepared to meet the mental health needs of patients (Bailey 1994; 1998; Brinn 2000; Gillette et al. 1996; Happell & Sharrock 2002; Muirhead & Tilley 1995; Nurse Recruitment and Retention Committee 2001; Roberts 1998; Sharrock 2000; Wynaden et al. 2000). In particular, nurses working in non-psychiatric settings of general hospitals report a lack of knowledge, skills, and confidence in the assessment and management of mental health problems in their patients (Bailey 1994; 1998; Brinn 2000; Fleming & Szmukler 1992; Gillette et al. 1996; Roberts 1998; Sharrock & Happell 2002; Wand & Happell 2001). Themes of fear, inadequacy and lack of understanding of patients who self-harm have been reported by critical care nurses (Bailey 1998). Reduced work satisfaction has been acknowledged by nurses caring for patients with eating disorders, schizophrenia, and those who self-harm (Bailey 1994; Fleming & Szmukler 1992). Emergency nurses have been found to question their role in caring for patients with mental health problems, giving priority to physical needs and task completion (Gillette et al. 1996). Issues such as lack of resources, expert assistance, and workplace policy in relation to people with mental health problems have
been identified as compounding the difficulties faced by nurses (Bailey 1998; Gillette et al. 1996; Wand & Happell 2001). There is some evidence that nurses are particularly challenged if patient behaviour is perceived as difficult, threatening, or disruptive (Happell & Sharrock 2002; Heslop et al. 2000; Pollard & Hazelton 1999). The attitude of nursing staff is an important factor when considering the quality of mental health nursing care delivered to patients. Both negative (Bailey 1998; Brinn 2000; Fleming & Szmukler 1992; Gillette et al. 1996; Mavundla & Uys 1997) and positive (Anderson 1997; McLaughlin 1994; Rogers & Kashima 1998; Sidley & Renton 1996) attitudes have been identified within nursing groups.

These findings are of concern because it has been estimated that between 30% and 65% of general hospital patients have psychiatric comorbidity (Clarke et al. 1991; Gomez 1987). Physical illness is known to increase the risk of psychiatric disorder (Clarke et al. 1991; Feldman et al. 1987; Mayou & Hawton 1986). In addition, people who have a psychiatric disorder are more likely to have physical problems and since mainstreaming, are now more likely to access general hospitals to meet their health needs (Koranyi & Potoczny 1992; Lawrence et al. 2001).

The psychiatric consultation-liaison nurse (PCLN) role has developed in response to these difficulties. Although models may differ, essentially the PCLN role is that of a specialist mental health nurse who consults to nurses and other health-care professionals within a non-psychiatric general hospital, department, or unit (Sharrock & Happell 2001). The role ensures that mental health nursing expertise is available to the patient, his or her relatives and the staff (Roberts 1998). Staff are provided with assistance, guidance, support, and education in relation to the mental health care of patients. A consultation can include working directly with the patient and with his or her relatives. It also includes working indirectly by providing assistance to the primary treating team in the development of a plan of care for the patient. In addition, the PCLN is a resource for mental health education and policy development purposes, and acts as a link between general and psychiatric services (Sharrock & Happell 2001).

Caplan’s (1970) model of mental health consultation has been applied to PCLN practice (American Nurses Association 1990; Gillette et al. 1996; Hicks 1989; Lewis & Levy 1982; Roberts 2002; Sharrock & Happell 2002; Tunmore 1997), and has been adapted by Roberts (2002) for the contemporary British context. This adapted model formed the basis for PCLN practice implemented in the present study. The paper describes an evaluation of a PCLN role following the introduction of a new position into an acute hospital and the model of practice that emerged from the evaluation.

**SETTING**

The present study was conducted at an Australian metropolitan teaching hospital that provides adult medical, surgical and mental health services as well as a range of community and outreach services. It includes a 26-bed hospice and 22-bed Geriatric Evaluation and Management Unit. There are approximately 46 000 admissions per year with an average length of stay (excluding single day admissions) of 7 days.

In April 2000 a PCLN position was introduced into the psychiatric consultation-liaison (CL) team. Prior to this, the CL programme consisted of psychiatric registrars and psychiatrists. The introduction of the nursing role into the team was, in part, attributed to the recognition that the medically focused psychiatric consultation did not adequately address the needs of the nurses when caring for general hospital patients with mental health problems.

As part of the introduction of the position, funding was provided by the Victorian Department of Human Services to evaluate the position. The evaluation aimed to explore the impact of the introduction of the PCLN into an existing consultation-liaison team by:

- Documenting the activities of the PCLN
- Exploring the impact of the PCLN on general nurses attitudes to caring for people with a mental illness
- Exploring the opinions of general nurses, allied health, and the CL team on the effectiveness of the PCLN position

**METHOD**

Audit of activities

An audit of the PCLN activities was conducted over a 12-month period from June 2000 to June 2001. The PCLN kept a detailed record of activities including: unit and ward from which the request was made, the nature of the request, the psychiatric and medical diagnoses of patients, behavioural problems of patients, and actions taken. Data were entered into an Access database and SPSS (SPSS, Chicago, IL, USA) was used for the analysis.
Survey of attitudes

A before- and after-survey design was used to measure the impact of the PCLN position on the attitudes of general nurses to patients experiencing mental health problems. The Health Professionals Survey (Small & Associates 1998) was adapted to measure general nurses’ attitudes to mental illness. The survey was piloted with 20 nurses working in the palliative care unit and the emergency department, and minor changes were made to the instrument based on feedback from the pilot. These two groups of nurses were chosen as they were not part of the areas serviced by the PCLN. Results from the pilot were excluded from the analysis. The survey was distributed via the nurse unit managers, to all nurses employed within the general wards in October 2000 and July 2001.

Focus groups

The aim of the focus groups was to explore the opinions of general nurses, allied health, and the CL team on the effectiveness of the PCLN position. Three focus groups with a total of 25 participants (13 nurses, 7 allied health staff and 5 members of the CL team) were conducted in September/October 2001. Focus groups were audiotaped and transcribed. The transcriptions were independently analysed using grounded theory by three researchers (two who conducted the focus groups and one independent researcher). Researchers then met and identified common themes.

RESULTS

Audit of activities

A total of 179 requests for clinical consultation with the PCLN were received. In total, 87.2% (156) were new referrals and 12.9% (23) were for patients known previously to the PCLN either from the current or previous admissions. Of those patients 53.6% (96) were men and 46.4% (83) were women. The age range of the patients was 18–91 years (median 47 years).

Nurses initiated 45.0% (80) of the consultations, medical staff 30.8% (55), and allied health 5.7% (10). In total, 14.5% (26) of consultations were initiated through liaison activity, that is, case identification via liaison contact or the CL ward round.

The clinical presentation of referred patients tended to be one of physical and psychological comorbidity. The psychiatric diagnoses were grouped according to DSM IV (American Psychiatric Association 1994) categories and are summarized in Table 1.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n</th>
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<tbody>
<tr>
<td>Mood disorders</td>
<td>69</td>
</tr>
<tr>
<td>Psychotic disorders</td>
<td>50</td>
</tr>
<tr>
<td>Substance-related disorders</td>
<td>50</td>
</tr>
<tr>
<td>Cognitive disorders</td>
<td>40</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>25</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>8</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>7</td>
</tr>
<tr>
<td>Somatoform disorders</td>
<td>1</td>
</tr>
<tr>
<td>No DSM IV diagnosis</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>262</td>
</tr>
</tbody>
</table>

Of patients 40.8% (73) had more than one diagnosis. Substance-related disorder concurrent with one or more diagnosis occurred in 22% (41) of patients and personality disorder in 10% (18) of patients. A total of 12 patients did not have a psychiatric diagnosis. Significant behavioural disturbance or behaviour that interfered with patient’s treatment was a frequent precipitant to a request for PCLN consultation. The types of behavioural disturbance identified are provided in Table 2.

<table>
<thead>
<tr>
<th>Behavioural disturbance</th>
<th>n</th>
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<tbody>
<tr>
<td>Compliance</td>
<td>78</td>
</tr>
<tr>
<td>Agitation</td>
<td>52</td>
</tr>
<tr>
<td>Aggression</td>
<td>50</td>
</tr>
<tr>
<td>Demanding</td>
<td>47</td>
</tr>
<tr>
<td>Suspicious</td>
<td>39</td>
</tr>
<tr>
<td>Abandoning</td>
<td>37</td>
</tr>
<tr>
<td>Eating disruption</td>
<td>23</td>
</tr>
<tr>
<td>Suicidal</td>
<td>23</td>
</tr>
<tr>
<td>Self-harm</td>
<td>21</td>
</tr>
<tr>
<td>Threatening</td>
<td>20</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>20</td>
</tr>
<tr>
<td>Dependent</td>
<td>17</td>
</tr>
<tr>
<td>Vocally disruptive</td>
<td>14</td>
</tr>
<tr>
<td>Abnormal illness</td>
<td>13</td>
</tr>
<tr>
<td>Manipulation</td>
<td>13</td>
</tr>
<tr>
<td>Disorganized</td>
<td>12</td>
</tr>
<tr>
<td>Attention seeking</td>
<td>9</td>
</tr>
<tr>
<td>Disinhibited</td>
<td>8</td>
</tr>
<tr>
<td>Drug seeking</td>
<td>6</td>
</tr>
<tr>
<td>Wandering</td>
<td>6</td>
</tr>
<tr>
<td>Retardation (psychomotor)</td>
<td>5</td>
</tr>
<tr>
<td>Sexually inappropriate</td>
<td>4</td>
</tr>
<tr>
<td>Intrusive</td>
<td>4</td>
</tr>
<tr>
<td>Complaining</td>
<td>3</td>
</tr>
<tr>
<td>Hypercritical</td>
<td>2</td>
</tr>
<tr>
<td>Unpredictable</td>
<td>2</td>
</tr>
<tr>
<td>Malingering</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>529</td>
</tr>
</tbody>
</table>

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Regular contact was made by the PCLN with the staff during the consultation process. This contact was important in order to gather assessment data, monitor progress of the patient and the effectiveness of the management plan, answer questions, respond to concerns, and provide guidance to the staff. Informal education was central to this communication process and it also provided opportunities to build trust and develop the relationship with the primary treating team.

Advice, guidance, and recommendations regarding care of the patient were provided to staff in verbal and written form. Detailed individualized care plans were developed for complex or longer-stay patients. A plan included a clear formulation of the patient’s problems, the aims of care, and intervention strategies for patient care. It also served as a medium for education of staff in the care of patients with mental health problems.

Written educational material was provided to staff in relation to 68 patients. The majority of information sheets were developed by the PCLN specifically aimed at non-psychiatric nurses. Journal articles and commercially produced material were also used. A total of 17 formal education sessions were provided to staff in relation to 19 patients. In addition, 531 staff attended a general education programme developed by the PCLN.

The PCLN participated in a range of organizational activities including attendance at key meetings, and participation in policy development such as aggression management, specialising (the 1:1 nursing care of a patient), application of mental health legislation to the general hospital, and discharge coordination.

There were 102 requests for brief informal consultations. In total, 36 nursing, 15 medical, 18 allied health, 10 management, 6 mental health and 1 non-health professional staff members made these requests. One request was made from a health professional external to the hospital. There were 15 requests where the details of the requesting staff member were not specified. An important component of this type of contact is that the PCLN enabled the staff to clarify their concerns about mental health issues, and to be directed to the appropriate resources. Statements such as ‘Can I run something by you?’ or ‘Could I pick your brains about something?’ often prefaced brief consultations. The majority of requests were in relation to a patient (88) or relative (4) whereas the remainder were general inquiries around mental health issues or in relation to a personal query by the staff member. Behavioural disturbance or recognition of mental illness in a patient was frequently the issue of concern. The PCLN provided information, advice and guidance, or linked the staff member to the relevant resources.

Survey of attitudes
For the first survey (October 2000), 347 questionnaires were distributed and 150 were returned (52%). In the second survey (June 2001), 380 surveys were distributed and 142 returned (37%). As expected, respondents were overwhelmingly women, with the majority aged between 20 and 29 years. Most were employed full time at grade 2 level. The only significant difference between the two samples was that proportionally more nurses from the cardiothoracic and intensive care unit areas responded to the first survey ($P < 0.05$).

There were no significant differences between any of the responses in the two surveys. That is, there was no difference in nurses’ attitudes before the arrival of the PCLN compared with attitudes 10 months later. Although the survey did not demonstrate any change in the attitudes of general nurses to people with a mental illness, it does suggest that some of the attitudes of general nurses are negative and warrants further exploration in future studies.

Focus groups
Participants in the focus groups discussed the processes that led to seeking assistance from the PCLN and resolution of the issue. They frequently described a perceived stress or pressure that led to seeking of assistance, although they did not always identify it as a mental health issue:

‘...sometimes you don’t [know if it’s a psychiatric issue] ... the patient’s behaviour doesn’t seem quite normal and you don’t know, and you have suspicions but you can’t really articulate that. Then you’re not sure possibly the best avenue of referral.’

Participants reported that the PCLN improved the accessibility of mental health service to patients in the general hospital through facilitating the pathway to a formal psychiatric assessment. Medical staff in the CL team described the PCLN as a vehicle for translating and interpreting their patient assessments into language and strategies that were accessible to the general nurses. The PCLN was also seen to provide practical assistance with managing the patient’s treatment and in assisting nurses to deal with their response to caring for the person.

The PCLN was described as a ‘sounding board’, a person who could be approached even if staff were unsure of whether the person had a mental illness. The ability of the staff to discuss issues outside of a formal referral system appeared critical to the effectiveness of the PCLN role.
it is nice to be able to have someone to talk through different sorts of treatments that you would be considering.

Participants described a range of strategies used by the PCLN to assist them both with the management of the particular patient and with the development of skills that could be applied in future situations. These strategies were patient-focused in that they generally related to the care of a particular patient. The use of education sessions at the ward level, as well as the development of care plans, was cited as examples of strategies used to assist the development of nurses. One nurse described the impact of repeated contacts with the PCLN and her growing ability to provide mental health care:

She certainly does that. That’s probably why I find her, or why I enjoy working with her because she does challenge what I think about. She does get you thinking about it a bit more, and I learn a little bit more each time I see her. I find that really positive because I’ve come from a background where I was working by myself, and it can be very difficult to actually try to learn something in my particular area. So I find that stimulating and actually very good.

Although the general nurses described the role of the PCLN in overwhelmingly positive language, a couple of allied health staff were more ambivalent about the role and expressed concerns that there was a lack of role clarity and role boundaries.

DEVELOPMENT OF A MODEL OF PRACTICE

Robert’s (2002) model of mental health liaison is a process model for PCLN practice. It identifies both clinical and organizational consultation as integral activities undertaken by the PCLN. Included in this model are interventions that the PCLN assumes directly with referred patients, and activities undertaken with the staff of general hospitals to enhance mental health care of patients. This model formed the basis for PCLN practice implemented in the present study but was refined as the project progressed. The activity and focus group data not only highlighted the value that staff placed on being able to refer identified patients for timely psychiatric assessment and treatment but also valued the interventions undertaken by the PCLN aimed at assisting staff to care for patients with mental health problems more broadly across the hospital. It also highlighted the dynamic nature of the relationship between direct and indirect patient interventions, and between clinical and organizational consultation. The model of consultation-liaison is represented in Figure 1 and reflects this dynamism.

In Figure 1, the solid arrows represent clinical consultation and include the triad of the PCLN, the patient, and the staff caring for the patient. The broken arrows represent organizational consultation and include the dyad of the PCLN and the organization. Direct interventions refer to those undertaken in face-to-face contact with patients and are represented by the grey arrow, and indirect interventions refer to those undertaken with staff in relation to patients and are represented by black arrows. The liaison relationship between the PCLN and the staff and the PCLN and the organization underpins the model.

Clinical consultation

When a request for clinical consultation by the PCLN is received, information is gathered by the PCLN from the staff member making the referral, other staff, and the clinical file. It is important for the PCLN to determine whether the concerns raised by the requesting staff member have, firstly, been discussed with the patient and secondly, discussed within the context of the multidisciplinary team. This assists the PCLN to ascertain if the focus of intervention should be directed towards an individual staff member, the treating team and/or the patient. If it is determined that direct intervention with the patient is required, then a referral for the patient is made to the CL team.

The patient is then assessed through interview, and collateral information is gathered from a range of sources. The assessment may be undertaken by the PCLN or jointly, for example, with a psychiatric registrar. The
mental health issues of concern are identified, diagnoses are made where applicable, and recommendations for treatment and care are provided. Recommendations may relate to treatment, further diagnostic investigations, increased levels of nursing observation and surveillance, referral to other services for consultation or transfer for ongoing care to a psychiatric facility.

Throughout the assessment and review processes, the PCLN pays particular attention to the impact of the presenting problems on nursing staff and the delivery of care. The nursing staff are more likely to require intensive assistance in cases where the mental health needs of the patient are beyond the expertise of the staff, or the symptoms (particularly behavioural) interfere with treatment, have implications for nursing care, present risks to patient, staff and others, are disturbing or perplexing for staff or impact significantly on ward system. The nursing focus of the PCLN role results in attention to practical care issues in terms of patient care-oriented tasks and planning of care to ensure the delivery of skilled nursing care.

Each interaction the PCLN has with the patient is an opportunity for role modelling effective communication strategies for staff. In addition, each contact the PCLN has with staff is an opportunity for informal education. The PCLN is mindful of the goal of improving the care of the patient, as well as the goal of improving the mental health expertise of the staff. Formal education can also be provided through education sessions with staff on mental health topics that will assist in the care of the identified patient. The education topics are selected based on the identified patient’s presenting issues and the requests of the staff. Written resources are made available to staff to support the education sessions and for staff who are unable to attend the education sessions. Formal education of staff can also be provided through clinical reflection sessions. These are patient-focused structured group discussions facilitated by the PCLN that provide an opportunity for staff to reflect on clinical nursing issues in relation to the mental health needs of a patient in their care. They are supportive sessions that utilize a reflective learning model and this allows the staff to process their contribution to the care of and relationship with the patient (Sharrock & Happell 2000).

When a request for consultation with the PCLN is made in relation to a patient who is not aware or does not share the concerns of the staff, is declining the offer of psychiatric assistance, or is unable to communicate (e.g. is semiconscious or unconscious), the PCLN utilizes indirect interventions to assist the staff in the care of the patient. The PCLN then relies on collateral information and draws on a broad range of clinical, theoretical, communication, interpersonal and problem-solving expertise in order to assess the situation and proceed appropriately.

Organizational consultation
The focus of organizational consultation is on an organization such as a general hospital or a ward or department of a hospital. The organization requests the expertise of the PCLN relating to addressing mental health issues in relation to patients, staff or the organization as a whole. The focus and content of organizational consultations will vary according to the needs of the organization at the time. Activity that the PCLN may undertake can include participation in the development of guidelines or policies aimed at improving the mental health care of patients. Policies and guidelines may also be focused on addressing an aspect of the mental health of staff, for example, in relation to critical incident stress debriefing. Systemic interventions aimed at improving the function of the organization may also be provided. Collaboration between the PCLN and the general hospital staff in research, quality improvement projects and education programmes can also be the focus of this type of consultation activity. Issues identified within the clinical consultation can precipitate activity undertaken within an organizational consultation. For example in this project, the PCLN utilized information from clinical consultations involving patients receiving 1:1 nursing care in the development of a policy for this nursing intervention. Conversely, the work of policy development in 1:1 nursing informed clinical consultations where 1:1 nursing was utilized.

Liaison
The term liaison is used to represent a number of aspects of PCLN practice. It represents the linking of the knowledge base of psychiatric/mental health nursing and the care of patients with actual and potential physical health problems (American Nurses Association 1990). It also refers to the regular interaction and relationship between the PCLN and staff of the non-psychiatric service. Regular contact is made through various formal and informal channels such as meetings, clinical reviews, informal discussions, and formal or informal educational activities (Roberts 2002). The focus of this contact is to provide assistance to staff in the recognition, management, and prevention of psychosocial and psychiatric problems in general hospital patients (Tunmore & Thomas 1992). How effectively this is achieved is dependent on the quality of the relationship between the PCLN and the staff.
Lewis and Levy (1982) suggest that the PCLN works hard to develop a professional alliance so that the effectiveness of the interventions initiated is maximized. This alliance or liaison relationship is central to the clinical practice of a PCLN just as the therapeutic relationship is to psychiatric nursing practice. Regular and frequent contact between the PCLN and the general hospital team means that the PCLN gathers an understanding of the way in which an individual team operates, its communication channels, and its idiosyncratic needs and stresses. As effective and meaningful communication occurs between the PCLN and the team, trust develops. The work that is carried out within the alliance becomes increasingly effective and sophisticated. When a complex and demanding referral is received by the PCLN, much of the groundwork necessary for understanding the request for consultation has begun. In addition, the PCLN's credibility has been established within the eyes of the staff. The staff trust the PCLN's expertise and judgement, which leads to the effective implementation of recommendations (Sharrock & Happell 2000). Barbiasz et al. (1982) stress that it is particularly important to plan and attend to the process of initiating and maintaining liaison relationships when a PCLN position is newly introduced, as their development can affect the success of the position.

The liaison relationship between the PCLN and the staff, units and the organization as a whole underpins both the clinical and organizational consultation processes.

**DISCUSSION**

The complexity and breadth of the role of the PCLN was illustrated in the present study. The PCLN is required to balance multiple aspects of the role and use a broad range of interventions. The patient characteristics are usually complex in terms of identified issues, the presence of significant comorbidity, and the wide age range of patients. Almost all the patients had a DSM IV diagnosis (American Psychiatric Association 1994), with mood disorders being the most frequent. Almost half had comorbid psychiatric diagnoses, with substance abuse and personality being the most common comorbid diagnoses. This suggests that the PCLN responded to serious and complex mental disorders and that general nurses were able to identify and appropriately identify patients requiring further assessment.

Thematic analysis of the focus group interview data provided some preliminary evidence indicating that the nursing consultation was particularly helpful because it was focused on nursing care. The PCLN activity was care-orientated, practical and goal-directed, and led to resolution of the issues that precipitated the request. There was also evidence that the provision of education in the context of a particular nursing problem was useful, and that clinical consultation led to demystification of mental illness and a sense of empowerment for general hospital staff in the delivery of care to patients in the medical-surgical setting experiencing mental health problems. The likely result is increased recognition by nurses of mental health problems in the future. This preliminary evidence supports the notion that the PCLN role should maintain a nursing focus through attention to practical care issues and both direct and indirect patient interventions are important PCLN activities.

Role overlap with other health professionals, particularly social work, was identified in the focus groups. Lewis and Levy (1982; p. 66) identified the potential for role overlap and confusion between the PCLN and social workers. Although general nurses are the primary target audience of the PCLN, it is important that the role compliments and supports all the members of the patient’s treating team. It is also important that the PCLN role within the CL team is clearly articulated to general hospital staff.

The present study illustrated the importance of the PCLN working as part of a broader CL team and having the ability to facilitate referral to the CL service. The identification and treatment of people with a mental disorder in the general hospital is the primary role of the CL team, and this was complimented and enhanced by the PCLN through the provision of practical assistance, support and education for nurses who provide the care.

**LIMITATIONS**

Although it was anticipated that the research would evaluate the introduction of a new PCLN role, in fact the PCLN commenced 3 months before the evaluation began. Although any impact the PCLN had in these early phases is likely to have been limited, it would have been more desirable to commence the evaluation before the arrival of the PCLN.

The design of the attitude survey did not allow for the identification of any changes to nurses attitudes. Although some difficulties may have been caused by the lack of sensitivity of the instrument, the inability to determine which nurses had completed the survey the first time and who had completed it the second time limits that usefulness of the data. In addition, the response rate in the second survey was low.
CONCLUSION

The CL nursing position made a valuable contribution to the CL Psychiatry Service and contributed to increased staff (particularly nurses) satisfaction with the quality of the service provided by the CL team. The results demonstrated the breadth of activity of the PCLN across multiple ward areas with patients exhibiting complex symptomatology. The majority of patient consultations related to mental health issues, with many patients having more than one psychiatric diagnosis. Although the attitude survey did not demonstrate any significant differences over a 9-month period, focus group results demonstrated the important contribution of the PCLN to the level of confidence of nurses caring for patients with mental disorders. The PCLN role provided a valuable addition to the CL team and made a positive contribution to the care of patients with a mental health problem in the general ward areas. Preliminary evidence suggests that it is important to general hospital nursing staff to maintain the nursing focus of the PCLN role.

Data from the 12-month evaluation of the role were utilized to refine a model of mental health consultation that can be applied to the general hospital setting. Clinical and organizational consultations form the basis of the consultation model and the liaison relationship between the PCLN and the staff underpin the consultation process. However, it is important to emphasize that the evidence is preliminary and that further research into the application of this model to the clinical setting is warranted. Areas of potential research include exploration of the impact of PCLN interventions on patient outcomes, on staff expertise and attitudes, and on organizational culture towards mental health.

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