

Liaison psychiatry and older adults

Lloyd & Mayou (2003) argue cogently for the development of liaison psychiatry, or 'psychological medicine in general hospitals' as they prefer it. Their arguments would carry more weight with commissioners if they included the mental health needs of older people. Two-thirds of general hospital beds are occupied by people aged over 65 and it is obvious to anyone visiting a general medical ward that the majority of 'bed-blocking' is caused by older people with dementia, depression and prolonged delirium. The epidemiology, together with demonstrably poor coordination of services, is highlighted in a recent report, partly commissioned by the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists (Holmes *et al*, 2002).

The time is now ripe for old age psychiatrists to take their multi-disciplinary skills and experience of community support into general hospitals to enable earlier discharge of so-called bed blockers. Liaison psychiatrists could develop their services (and sub-speciality status) more quickly and comprehensively if they worked more closely with old age psychiatry colleagues clinically, and within the Royal College of Psychiatrists.

Holmes, J., Bentley, K. & Cameron, I. (2002)

Between Two Stools: Psychiatric Services for Older People in General Hospitals. Leeds: University of Leeds Academic Unit of Psychiatry and Behavioural Sciences.

Lloyd, G. G. & Mayou, R. A. (2003) Liaison psychiatry or psychological medicine? *British Journal of Psychiatry*, **183**, 5–7.

J. Seymour Older Adults Mental Health Care Group, Michael Carlisle Centre, Nether Edge Hospital, 75 Osbourne Road, Sheffield S11 9BF, UK

Liaison psychiatry and general hospital management

In their excellent editorial Lloyd & Mayou (2003) lament the lack of substantial progress in the development of liaison psychiatry. They refer to Scotland's greater cognisance of liaison psychiatry (Scottish Executive Health Department, 2000), before reaching practical conclusions, foremost among which is for liaison psychiatry services to be managed by the acute hospitals they serve. They also refer to Kendell's analysis of the physical-mental divide (Kendell, 2001). I wish to pick up these points.

As a mentor after I took up post in Edinburgh, Bob Kendell impressed on me his view that liaison psychiatrists were 'ambassadors of psychiatry' in the general hospital. He pointed out that, for most hospital specialists, liaison psychiatrists would be the only psychiatrists they were likely to encounter – so we had to be available, approachable, helpful, practical, considerate and sensible; we had to be good clinical psychiatrists and we had to resolve problems rather than cause them.

That does not mean liaison psychiatrists cannot bring special skills to the workplace, but it does imply that such skills have to be welded to basic clinical nous and rapport with colleagues. The significance of this is increased in a world in which we tend to be more valued by physicians than fellow psychiatrists – perhaps increasingly so as psychiatry becomes focused on severe and enduring mental illness, and other forms of disability, suffering and resource demand are marginalised.

Next, I made the leap from mental health to general hospital management when trusts were first mooted (without understanding the implications – it just felt right), and this turned out to be a fortuitous decision. Liaison psychiatry at the Infirmary rapidly expanded as I planned with medical colleagues solutions to the clinical problems we faced: some funds came through the Trust Improvement Programme and some from individual directorates seeking to purchase consultant sessions. I do not believe this initiative would, or could, have happened had I remained with the mental health unit. Now the rest of Scotland has progressed as the Executive's intentions have been made good – notably, with the appointment of four consultant liaison psychiatrists and 10.5 liaison nurses in Glasgow.

The consequences of going with the acute trust have been far-reaching. Psychiatry is not regarded as an alien speciality – we are seen as assets. We understand the environment and the pressures and we respond to the needs that arise rather than pursue a purist agenda. Crucially, we appreciate that what the acute hospital requires primarily from its psychiatric service lies in the areas of rapid assessment, immediate management and optimal resource usage rather than the proven areas of effectiveness that are highlighted as the rationale for spending on liaison psychiatry.

As a tangible illustration of our significance and role, the department of

psychological medicine in Edinburgh's new Royal Infirmary has not been located up some back alley or on the top floor. We are sited on the ground floor near the hospital's front door because we are recognised as a key constituent in the modernisation agenda that has swept through acute medical care in the hospital. Without 'going native' I doubt that much of this progress would have occurred – so seek to make this management leap rather than sticking with tried and trusted strategies that have been found wanting.

Kendell, R. E. (2001) The distinction between mental and physical illness. *British Journal of Psychiatry*, **178**, 490–493.

Lloyd, G. G. & Mayou, R. A. (2003) Liaison psychiatry or psychological medicine? *British Journal of Psychiatry*, **183**, 5–7.

Scottish Executive Health Department (2000) *Our National Health*. Edinburgh: Stationery Office.

G. Masterton Department of Psychological Medicine, Royal Infirmary of Edinburgh, 51 Little France Crescent, Edinburgh EH16 4SA, UK

Adverse events following neurosurgery

Matthews & Eljamel (2003) gave an excellent overview of the controversial field of neurosurgery for mental disorders (NMD). I agree with them that 'the accumulated literature on neurosurgery for mental disorder remains highly unsatisfactory' but would like to point to some recent evidence.

Matthews & Eljamel state that 'there is surprisingly little evidence' to support the occurrence of adverse personality change. In my opinion, some of the literature suggests otherwise. Herner (1961) noted that in a group of 116 capsulotomy cases, frontal lobe deficit syndrome was obvious at follow-up in 30%. In the anxiety group, 40% and 13%, respectively, had adverse events of mild and of modest severity. In another study (Kullberg, 1977), capsulotomy caused 'some personality changes in the majority of the patients'. Adverse events in those studies included fatigue, emotional blunting, emotional incontinence, indifference, low initiative, disinhibition and impaired sense of judgement.

In a very recent study (Rück *et al*, 2003), 26 anxiety patients who had undergone bilateral thermocapsulotomy were followed up after a mean of 13 years. Psychiatric methods included symptom rating scales and neuropsychological testing. To

avoid bias, ratings were done by psychiatrists not involved in patient selection and postoperative treatment. Seventeen of 23 patients alive at long-term follow-up were seen in person and relatives were interviewed. The reduction in anxiety ratings was significant both as 1-year and long-term follow-up. Seven patients were, however, rated as experiencing significant adverse events, the most prominent symptoms being apathy and dysexecutive behaviour; also neuropsychological performance was significantly worse in these patients. I therefore agree with Matthews & Eljamel that we must continue to evaluate the efficacy and safety of NMD.

Declaration of interest

C.R. has participated in numerous educational events sponsored by pharmaceutical companies and has been a consultant for Pfizer.

Herner, T. (1961) Treatment of mental disorders with frontal stereotaxic thermo-lesions: a follow-up study of 116 cases. *Acta Psychiatrica Scandinavica Supplementum*, **37**, 45–60.

Kullberg, G. (1977) Differences in effect of capsulotomy and cingulotomy. In *Neurosurgical Treatment in Psychiatry, Pain, and Epilepsy* (eds W. H. Sweet, S. Obrador & J. Martín-Rodríguez), pp. 301–308. Baltimore, MD: University Park Press.

Matthews, K. & Eljamel M. S. (2003) Status of neurosurgery for mental disorder in Scotland. Selective literature review and overview of current clinical activity. *British Journal of Psychiatry*, **182**, 404–411.

Rück, C., Andréewitch, S., Flyckt, K., et al (2003) Capsulotomy for refractory anxiety disorders: long-term follow-up of 26 patients. *American Journal of Psychiatry*, **160**, 513–521.

C. Rück Psychiatry Section, Department of Clinical Neuroscience, Karolinska Institutet, Karolinska Hospital, SE-171 76 Stockholm, Sweden

Authors' reply: Rück makes reference to a series of studies reporting personality change following anterior capsulotomy, including his recent review of 26 patients undergoing thermal capsulotomy for anxiety (Rück *et al*, 2003). He raises interesting questions about the prevalence of personality change following certain (if not all) neurosurgical procedures for mental disorder, and such questions remain, we believe, essentially unaddressed by previous research. Rück's rate of apparent personality change following anterior capsulotomy is comparatively high at approximately 30% of patients. This rate is higher than those rates reported in earlier literature, which suggest

rates of up to 10% for stereotactic subcaudate tractotomy (Ström-Olsen & Carlisle, 1971; Goktepe *et al*, 1975) and 2% for stereotactic cingulotomy (Dougherty *et al*, 2002). However, 24% of patients undergoing limbic leucotomy had transient apathy which resolved fully (Montoya *et al*, 2002).

In addition to the lack of uniformity of measurement across studies, another key difference may lie in the fact that many of the larger studies included patients with a variety of diagnoses, including depressive disorder, obsessive-compulsive disorder (OCD) and anxiety disorder. In fact, non-OCD anxiety disorders made up a small percentage of most of the studies cited above, whereas Rück's study sample comprised entirely patients diagnosed with non-OCD anxiety disorder.

The lesions of anterior capsulotomy disrupt the continuity of the fronto-striatal-pallidal-thalamic circuits which are believed to be dysfunctional in OCD (Modell *et al*, 1989). Important connections between the orbitofrontal cortex, anterior cingulate regions and the thalamus also lie in the anterior part of the internal capsule and are thought to play an important role in the pathogenesis of major depressive disorder (Tekin & Cummings, 2002).

Most psychiatrists, neurologists and neurosurgeons would probably predict high rates of serious psychopathology – including personality changes – if such lesions were made within 'healthy brains'. If the existing literature can be considered reliable, including the report of Rück and colleagues, it is quite remarkable that the reported rates of significant frontal psychopathology are so infrequent. Hence, three possibilities (at least) must be considered:

- that neuropsychological and personality screening for frontal impairment has been grossly inadequate in almost all studies;
- that the deleterious effects of frontal surgery on patients with chronic intractable affective disorders may be minimised because the target brain structures are already dysfunctional, perhaps with important frontal functions being undertaken by non-frontal structures (such plasticity of mammalian brain function is plausible, see e.g. Kolb & Gibb, 1993);
- different forms of psychiatric disorder may be associated with different risks of adverse consequences following

NMD; for example, thermal capsulotomy for non-OCD anxiety disorders may present a higher risk of frontal psychopathology than capsulotomy for OCD or depression.

In reality, the true picture may represent a combination of influences from these three factors. What is clear is that all NMD must be accompanied by detailed prospective audit with comprehensive evaluation of 'frontal' neuropsychology and personality functioning.

Declaration of interest

K.M. has received payment for lectures on the management of depression from various pharmaceutical companies.

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Modell, J. G., Mountz, J. M., Curtis, G. C., et al (1989) Neurophysiologic dysfunction in basal ganglia/limbic striatal and thalamocortical circuits as a pathogenetic mechanism of obsessive-compulsive disorder. *Journal of Neuropsychiatry and Clinical Neuroscience*, **1**, 27–36.

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Tekin, S. & Cummings, J. L. (2002) Frontal-subcortical neuronal circuits and clinical neuropsychiatry: an update. *Journal of Psychosomatic Research*, **53**, 647–654.

D. Christmas, M. S. Eljamel, K.

Matthews Ninewells Hospital and Medical School, Dundee DDI 9SY, UK

Neuroscience and psychodynamics

I was taken by surprise to read a positive article concerning psychoanalysis. In response I would like to make some comments on facts and their interpretation, the individual and his or her context and the impossible relationship between mind and brain.