EDITORIAL

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Liaison psychiatry

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What is it?

"What is Liaison Psychiatry?" is the question asked most frequently by non-psychiatrists when introduced to the concept of liaison psychiatry. Essentially, it is the provision of psychiatric services to people attending or admitted to general hospitals under the care of physicians and surgeons.

Beginning originally in the US in the 1920s and developing in the UK in the 1950s, liaison psychiatry is now regarded as a subspecialty of psychiatry. However, consultant posts are still few and there are only 12 full-time higher training posts in liaison psychiatry in the UK.[1]

Epidemiological considerations

Liaison psychiatry is concerned with conditions where physical and psychological disorders overlap such as the psychological reactions to physical disease and where a psychological disorder presents with physical symptoms.

Studies indicate that the prevalence of anxiety and depressive disorders among medical patients is 12%-15% but can reach 25%-35% among selected subgroups. Failure to recognise and treat these disorders may delay recovery, increase mortality and increase the risk of suicide as well as impairing quality of life.

Patients admitted to hospital or attending accident and emergency following deliberate self-harm are at particular risk. Statistics show that 10% will go on to complete suicide.[2] Careful evaluation and management is required in order to try and reduce the risk of suicide. The work of the liaison psychiatrist goes hand in hand with the Government Task Force on Suicide Prevention.

Alcohol and drug abuse are prevalent among people admitted to hospital. Up to 27% of male admissions have been identified as problem drinkers. Alcohol problems are also commonly encountered in the accident and emergency department.

Among new medical outpatients, between 25% and 50% have no demonstrable organic disease to account for their symptoms.[3] Half of such patients have either an anxiety or depressive disorder. A small number have chronic somatisation and incur significant costs in terms of both multiple investigations and admissions. They are also at risk of iatrogenic problems.

Delirium occurs in 10% of acute admissions and may be associated with marked behavioural disturbance requiring psychiatric intervention. Death rates of acute admissions associated with delirium are raised.

Benefits of liaison psychiatry

An effective liaison psychiatry service meets the psychological needs of the patients in the general hospital system and leads to improved training of general hospital staff, increasing their awareness of the psychosocial aspects of illness. Psychological problems are detected earlier resulting in health gains, with improved quality of life and less dependence on the general hospital system.

People presenting with deliberate self-harm are managed appropriately and suicide risk reduced. Anxiety and depressive disorders are detected more frequently. Studies indicate that the number of unwarranted medical outpatient attendances are reduced, inappropriate hospital admissions can be avoided, length of stay is reduced and unnecessary medical investigation can be limited.[4]

Components of a liaison psychiatry service

The *Joint Report of the Royal College of Physicians and the Royal College of Psychiatrists* recommends the creation of a generic liaison psychiatric team consisting of a full-time consultant psychiatrist, one or more psychiatrists in training, two clinical nurse specialists, a social worker and a psychologist.[5] The minimum consultant input to the liaison team should be five sessions.

In certain situations, depending on the specific services offered by a hospital, it may be appropriate for joint clinics to be held or for the psychiatrist to be present in a medical clinic. Patients with intractable, non-malignant pain or chronic fatigue can benefit from the involvement of a psychiatrist in their care using a biopsychosocial model of illness and implementing cognitive-behavioural practices.

Provision of services

At present, liaison services are patchy, offering a variable standard of care. In my opinion, it would be appropriate if each large teaching hospital had a full-time consultant liaison psychiatrist and multi-disciplinary team. Many consultant psychiatrists currently offer liaison services but also have busy sectors to attend to. The sector commitment can take precedence over the liaison one leading to a relative deficiency in liaison service provision. Many consultants express a desire to do more liaison work but time constraints prohibit it. In smaller hospitals, perhaps one consultant could take responsibility for liaison services so that posts can be accredited and trainees supervised by a designated liaison consultant. Local factors, however, usually play an important part and consultant numbers are critical in determining service provision.

Services should be provided within the general hospital setting as many presentations are acute, requiring an urgent response. Also, it is sensible to have on the same site, the mental health services for those patients with chronic physical illnesses who have to attend the general hospital on

a long-term basis. Furthermore, patients with chronic somatisation are reluctant to attend psychiatric services and can be better engaged in a general hospital setting.

An effective service will also have close links with psychiatrists working outside the general hospital and general practitioners. Many patients admitted to general hospitals are currently attending local psychiatric services and general practitioners are experienced in dealing with people with chronic somatisation.

Consideration has also to be given to the needs of children and the elderly. Liaison services can be tailored to meet their needs.

Education and research

As a developing subspecialty, liaison psychiatry offers tremendous opportunities for research. Many collaborative projects can be conducted.

Education is of vital importance as the bulk of psychological care, delivered in the general hospital setting, does not involve psychiatrists but rather, the medical and surgical staff.

Conclusion

Liaison psychiatry brings an extra dimension to the general hospital services, improving the quality of care of patients admitted or attending as outpatients who have either psychological disorders complicating physical disease or psychological disorders presenting with physical symptoms. The management of patients presenting with deliberate self-harm is enhanced with a consequent reduction in suicide. Service provision is, however, patchy and service development required on a national scale.

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