Liaison Psychiatry

PAUL BARCZAK, Senior Registrar in Psychiatry, The General Hospital, Birmingham

'You ask me what it is I do. Well actually, you know,
I'm partly a liaison man and partly PRO.
Essentially I integrate the current export drive
And basically I'm viable from ten o'clock till five.'

Executive
John Betjeman

A liaison is a union or effective conjunction with another unit or force. A liaison officer is seen as one who forms links or integrates such units or forces. This is a simple definition obtained from a standard dictionary but a further attempt at defining what is meant by liaison psychiatry is not so easy. This problem of definition and the lack of uniformity in such services in different settings may partly result in the marked under-utilisation of psychiatric expertise in dealing with the large number of medical patients who have a psychiatric disorder regardless of the presence or absence of a physical illness.[1]

As will be shown later, the overlapping of a number of historical trends in medicine resulted in the evolution of liaison or consultation liaison psychiatry. Psychosomatic medicine was much influenced by the holistic movement and favoured an approach to the patient as a whole taking into account psychological, biological and social factors. Of significance also was the move from the practice of psychiatry in remote asylums to the general hospital. Liaison psychiatry therefore can be seen as the interface between psychiatric and non-psychiatric medicine as practised in a general hospital setting.

It is helpful to trace briefly the development of these trends in medicine. A lack of precision in using these terms makes an attempt at definition an important starting place. Psychosomatic medicine can be seen as one type of holistic medicine. The word holistic is derived from the Greek 'holos' meaning whole and was first used by Smuts.[2] Used initially in a metaphysical sense to mean that a whole is always more than the sum of its parts with personality seen as the highest evolved structure in the universe incorporating mind and body, it later came to be regarded as the study of the human organism as a whole. Lipowski[3] stated that holistic referred to 'an approach to the study of man in health and illness and to health-care that focuses on the person as a whole, that is to say a mind-body complex embedded in a social field. The holistic approach calls for an integrated use of data, concepts and techniques derived from biological, psychological and social modes of abstraction, to explain human behaviour and to study and treat all deviations from health in individuals'.

Adolph Meyer, a contemporary of Smuts, introduced the principles of a holistic approach to the training of undergraduate medical students at the Johns Hopkins Hospital. Meyer used the term 'psycho-biology' to mean the study of man as a person in health and disease. His multi-factorial approach refuting a mind-body dualism has had a lasting effect on the practice of psychiatry in Britain.

Lipowski acknowledges psychosomatic medicine's debt to the holistic movement and attempts a tripart definition: 'Psychosomatic medicine is a scientific discipline concerned with the study of the relationships of biological, psychological and social determinants of health and disease. It is a set of postulates and guidelines embodying a holistic approach to the practice of medicine and it encompasses consultation liaison psychiatry.'

The origins of psychosomatic medicine can be found in early Greek writings of the fifth century BC.[4] A major work by Tuke[5] brought together its basic principles. From the 1920s onwards two distinct developments were to occur, having both lasting beneficial and adverse effects. Alexander[6], a practicising psychoanalyst, proposed that certain illnesses such as asthma, ulcerative colitis, rheumatoid arthritis, essential hypertension, peptic ulcer, neurodermatitis and thyrotoxicosis, could be caused by unconscious conflict. Lack of a sound causal model and the failure to develop appropriate therapies cast a shadow on the whole field of psychosomatic medicine and no doubt contributed to one description of it as an improbable hybrid of clinical thinking, physiological speculation and psychoanalytical theory.[7]

A seemingly more promising development was a psychophysiological approach relying on the work of Cannon & Wolff and concerning itself with the physiological pathways through which conscious conflict and emotion could provoke or exacerbate many more physical illnesses. Although this was based on a more solid body of scientific research, the methodological problems and difficulties of making the jump from physiological to pathological changes are still unresolved.

Although the first psychiatric ward attached to a general hospital was at Guy's Hospital in 1728 for the treatment of

https://doi.org/10.1192/S0140078900027802 Published online by Cambridge University Press

'lunatics', the development of general hospital psychiatry has occurred in this country mainly in the last 20 years. Much of the literature therefore on liaison psychiatry comes from the United States where the first unit was opened in 1902 at the Albany Hospital.[8] Lipowski[9] describes the recent rapid increase in the number of such units throughout the United States. Henry[10] published a paper entitled 'Some Modern Aspects of Psychiatry in General Hospital Practice' which laid the foundation stones of liaison psychiatry by incorporating the developments in psychosomatic medicine with an holistic approach to illness in a general hospital setting. Flanders Dunbar in 1934 at Columbia University Medical Centre first used the term 'psychiatric liaison'. Despite growth in this area in America, Britain has lagged behind with little published work, and to date there are only six or seven consultants in full time liaison work in this country (Mayou, R. personal communications).

To return to the problem of definition referred to in the opening paragraph. What exactly is consultation/liaison psychiatry? Lipowski defines it as 'that area of clinic psychiatry that encompasses clinical teaching and research activities of psychiatrists and allied mental health professionals in the non-psychiatric division of a general hospital'. He further distinguishes between the several functions implicit in the term. Consultation is seen as the more limited role of providing an opinion and advice on the management of a patient at the request of a non-psychiatric specialist. A liaison to him meant a psychiatrist eliciting sources of conflict between the patient and the health team and, by interpreting what was happening, acting as a mediator between the two, thus allowing for better care. The liaison psychiatrist is also seen as mediating between psychiatrists and non-psychiatrists.

This definition fails to encompass the many activities of the psychiatrist in a general hospital. There is no doubt of the association between physical and psychiatric illness in general practice in both medical and psychiatric outpatients and in-patients. For example, Maguire[11] showed that 23% of medical admissions excluding those presenting with deliberate self harm could be regarded as having a significant psychiatric disorder. He also showed that 34% of psychiatric in-patients had current physical illness and that in half such cases it had not been previously diagnosed.[12] Shepherd[13] found an even higher figure in those attending medical out-patients with 38% having psychiatric disorder but no significant physical illness.

Although the number of psychiatric referrals has more than doubled over the last 20 years[14] this is accounted for by the increase in acts of deliberate self-harm and few patients admitted for other reasons are referred.

There are probably a variety of reasons to account for this, including resistance on the part of physicians to accept that psychological factors are important in illness, the decision to take responsibility themselves for this aspect of management and simple ignorance of what is being offered by psychiatrists.

We believe that some of this ignorance stems from the vagueness of the term 'liaison psychiatry' and the lack of clear guidelines to physician colleagues of what is on offer.

We propose that the main components of liaison psychiatry be listed separately to avoid this problem.

(1) *Ward consultation service*. At the request of the physician or surgeon a psychiatrist assesses the patient and either gives advice or takes over the management of the patient's psychiatric treatment. There are two parts to this service:
(a) deliberate self-harm (DSH) assessment; (b) non-DSH assessment.

(2) *Accident and emergency department consultation service*. As in (1) above, the psychiatrist assesses the patient and either gives advice or takes over complete management. This again can be divided into DSH and non-DSH assessment.

(3) *Psychiatric out-patient services*. Straightforward outpatient clinics situated in the general hospital.

(4) *Joint psychiatric/medical out-patient service*. Here psychiatrists would meet doctors of other disciplines and discuss patients or families joint interest.

(5) *Staff consultation service*. Dealing with staff groups or individual staff problems. This service may be centred on individual wards in functional groups of wards or in special units (such as renal dialysis, intensive care or coronary care).

(6) *Co-ordinating service*. An overall co-ordinating role in linking up various mental health care professionals for the better psychiatric, psychological and social management of patients in general hospitals.

(7) *Research service*. A research function assisted by a broad-based knowledge of both biological and behavioural sciences.

Conclusions

Having been criticised for lacking a coherent theoretical framework consisting of a mishmash of biological, behavioural concepts, the absence of clear functions and lack of organisation, liaison psychiatry as a movement could be said to lack direction. However, with more and more of the work of the general psychiatrist being handled by primary health care teams, social services and voluntary agencies, this field of medical practice could become increasingly important in the future and provide a valuable role for the psychiatrist left wondering what is left for him to do. A clear statement of the areas in which a psychiatrist could make a contribution as outlined above should assist in research developments and ensure that 'psychiatry in the general hospital is here to stay.'[15]

ACKNOWLEDGEMENT

The author is grateful to Professor J. E. Cooper for his help and advice in preparing this article.

REFERENCES

[1]NABARRO, J. (1984) Unrecognised psychiatric illnes in medical patients. *British Medical Journal*, **289**, 635–636.

https://doi.org/10.1192/S0140078900027802 Published online by Cambridge University Press

[2]SMUTS, J. C. (1926) *Holism and Evolution*. New York: Macmillan.
[3]LIPOWSKI, Z. J. (1981) Holistic-medical foundations of American psychiatry. *American Journal of Psychiatry*, **138**, 888–893.
[4]WITTKOWER, E. D. (1974) Historical perspective of contemporary psychomatic medicine. *International Journal of Psychiatric Medicine*, **5**, 309–319.
[5]TUKE, G. H. (1872) *Illustrations of the Influence of the Mind upon the Body in Health and Disease*. London: Churchill.
[6]ALEXANDER, F. (1950) *Psychosomatic Medicine*. New York: W. W. Norton.
[7]SHEPHERD, M. (1971) Book review of *Modern Trends in Psychosomatic Medicine*, 2, (ed. O. W. Hill) *Journal of Neurological/ Neurosurgical Psychiatry*, **34**, 207.
[8]SWEENEY, G. H. (1962) Pioneering general hospital psychiatry. *Psychiatric Quarterly*, (Suppl. part 2), **36**, 209–268.
[9]LIPOWSKI, Z. J. (1974) Consultation-liaison psychiatry—an overview. *American Journal of Psychiatry*, **131**, 623–630.
[10]HENRY, G. W. (1929) Some modern aspects of psychiatry in general hospital practice. *American Journal of Psychiatry*, **86**, 481–499.
[11]MAGUIRE, G. P. (1974) Psychiatric morbidity and referral in two general medical wards. *British Medical Journal*, **1**, 268–270.
[12]——(1968) Physical illness in psychiatric patients. *British Journal of Psychiatry*, **113**, 1365–1369.
[13]SHEPHERD, M. (1960) Psychiatric illness in the general hospital. *Acta Psychiatrica et Neurologica Scandinavica*, **35**, 518–525.
[14]ANSTEE, B. H. (1972) The pattern of psychiatric referrals in a general hospital. *British Journal of Psychiatry*, **120**, 631–634.
[15]LLOYD, G. G. (1980) Whence and whither 'liaison psychiatry'. *Psychological Medicine*, **10**, 11–14.

Development of Mental Health Services

IAN B. COOKSON, Consultant Psychiatrist, Sefton General Hospital, Liverpool and Chairman, Division of Psychiatry, Central/Southern Liverpool

In the Mersey Regional Health Authority it has been decided that closure of at least one large mental illness hospital will take place within some 10 years and may be complete by 1992. To facilitate this the region has provided funding for every long-stay patient who might be discharged to the care of voluntary organisations or Social Services Departments and joint assessments of patients have been undertaken by the Health Service and Social Services staff.

Plans for the future of mental health services are advanced with regard to mental handicap and many subspecialties within psychiatry but the Steering Group created by the Chairman of the Regional Health Authority to speed the move to the practice of community mental health has sought further detail of the requirements for general adult services.

Liverpool District Health Authority, formerly two districts, now serves a population of some 400,000 and the requirements of the region and its principal city have been examined, several categories of patients being identified by consultant psychiatrists in a questionnaire as unsuitable for long-term treatment in district general hospitals. They are those patients with chronic schizophrenic disorders resistant to drug treatments, those with chronic brain syndrome (below the age of 65) and those with brain damage, those chronic patients with borderline mental handicap and psychosis, those requiring physical nursing for disorders such as Huntington's Chorea, those requiring medium security and those with personality disorders requiring treatment in therapeutic communities. There is also a large group of patients in crisis who would be better dealt with in a residential and day centre for evaluation and treatment of morbid distress of psychosocial origin.

Assuming the new chronic schizophrenic patients would require some 65 beds, the chronic brain syndrome and brain-damaged patients some 25 beds, physical nursing some 15 beds, medium security some 10 beds, and personality disorder, under the age of 22 years, some 15 beds and over the age of 22 years some 15 beds, it seems that approximately 145 beds are required for Liverpool in wards or hostel wards in the community, under the care of psychiatrists in order that adequate psychiatric nursing may be provided for these patients; direction and coordination of medical, psychological and social input will continue as at present. These figures are derived from the Regional survey, 200,000 of the Liverpool population having been loaded 25% for the factor of deprivation which has been assumed to be responsible for the increased demand for mental health services in the central area of the city.

It is quite clear that adequate provision for the non-acute patients cannot be provided adequately in the average district health authority and the practice of general adult psychiatry must function at a supra-district level in the future, if it is not to be splintered further to the detriment of individual patients and of the profession by the development of yet more parallel services. Perhaps consultants in general adult psychiatry should all have a half-time special interest with responsibility for two district health authorities.

This problem is being addressed in the Mersey Region and it is hoped that Liverpool, with a population of approximately twice that of an average district health authority, may act as a model for such developments. A central site, perhaps a complex of single-storey units for no more than 10 or 15 patients might be a new plan for the grouping of hostel wards in the community for patients not well

https://doi.org/10.1192/S0140078900027802 Published online by Cambridge University Press