

The present state of consultation and liaison psychiatry

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Although referral by general hospital doctors is a major pathway to specialist psychiatric care, and there is known to be much clinically unrecognised psychiatric morbidity among general hospital patients, consultation and liaison services have received much less emphasis than community care. A 1984 survey found that consultation liaison services were haphazard (Mayou & Lloyd, 1985). Despite recent evidence of increasing clinical and academic interest, few local strategic plans refer to consultation and liaison services; even when mentioned they are given a lower priority than community developments (Kingdon, 1989).

This further survey is in two parts: a national survey of liaison psychiatrists; and comprehensive reports of all consultation and liaison within Scotland, Wales and three English regions.

National survey

Questionnaires were returned by psychiatrists in 52 districts of the United Kingdom (see Table I). The general picture remains as described by Mayou & Lloyd (1985): haphazard care largely provided by duty doctors or sector teams, with services varying greatly between areas with similar resources. Very few districts keep systematic records of general hospital referrals, and most were unable to provide more than guesses at the numbers of patients seen, usually in the range of 1-3 referrals per week.

Teaching hospitals reported the most elaborate services. Several respondents commented that sharing liaison responsibilities between a number of consultant teams made for difficulties in co-ordinating training, student teaching and the management of attempted suicide and other emergencies. A number of teaching hospitals separate Accident and Emergency Department care entirely from the consultation-liaison service.

Services provided by District General Hospital Psychiatric Units were generally the most satisfac-

TABLE I
Summary of replies by psychiatrists from 52 health districts within the United Kingdom

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|---|----|
| Formal consultation service | 27 |
| Designated consultant with overall responsibility | 18 |
| Service dependent on duty and/or sector teams | 32 |
| Facilities | |
| DGH unit | 24 |
| Rooms within general hospitals | 6 |
| Nil in general hospitals | 22 |
| Multidisciplinary team | 22 |
| Attempted suicide | |
| Specialist service | 19 |
| Some special arrangements | 17 |
| No special arrangements | 16 |
| Other services | |
| Liaison attachments | 23 |
| Specialist out-patients | 18 |
| Beds for psychiatrically and medically ill | 8 |
| Other specialised services | |
| Mother and baby service | 17 |
| Child psychiatry liaison | 39 |
| Substance abuse | 15 |
| Psychogeriatric liaison | 44 |

tory, with better organisation of emergency and consultation work. Even so, the majority of DGH Units were unable to specify particular staff as having consultation responsibility. Most districts have psychiatric out-patient clinics based in the general hospital, some receiving high proportions of referrals from the general hospital. Few of these offer any special expertise in the problems of medical patients or in functional somatic symptoms. Very few districts have any in-patient facilities for those with both medical and psychiatric illness.

General hospital consultation by psychiatric subspecialties was often unsatisfactory. Psychogeriatric liaison was often well developed; liaison by substance abuse services was usually unsatisfactory. Few

districts have any special liaison for obstetrics. Many general hospitals have no child psychiatry consultation for emergencies.

Only two respondents said they were "very satisfied" with the present situation, 21 were reasonably satisfied with services ranging from very elaborate to minimal and 29 were very dissatisfied. Reasons for dissatisfaction included:

- (a) lack of organisation and co-operation in emergency and consultation services to general hospitals
- (b) inadequate supervision of junior staff
- (c) the difficulties caused by sectorised services and service provision by emergency teams
- (d) poor professional staffing together with minimal administrative resources.

Reports of local plans provide modest encouragement. Several areas have either recently appointed consultants with designated liaison sessions or hope to do so in the future. There was evidence of recent or imminent improvements in 28 districts, but changes were thought unlikely in the foreseeable future in the other 24 districts

North East Thames (Charlotte Feinmann)

North East Thames differs from the other regions in having four teaching hospitals and a high proportion of urban districts with large general hospitals.

The four teaching districts have the greatest commitment of consultation-liaison. All have organised services for attempted suicide, day and night-time emergencies, and ward and out-patient consultation. The City and Hackney (St Bartholomew's) has consultant and junior staff sessions with secretarial support, but specialist liaison is for teaching purposes only. Bloomsbury (UCH and Middlesex) has a supervised consultation service and liaison by consultants with a number of specialised units including neurology, oral surgery, ear, nose and throat, gynaecology and oncology. Hampstead (Royal Free) provides specialist liaison to the ward for HIV patients and to the Liver Unit. Tower Hamlets (London Hospital) has a general consultation service with limited specialist liaison.

The City and Hackney and Bloomsbury districts have special in-patient facilities for management of patients with medical and psychiatric problems. The City and Hackney, Bloomsbury and Hampstead all have nurses working for liaison teams. A particular interest in Bloomsbury has been the development of a service for breast cancer, head and neck cancer and obstetric units in which nurse counsellors are supervised by psychiatrists.

Two non-teaching districts, Islington and West Essex and Hackney also have well established con-

sultation services. Islington has recently changed its service so that one registrar assesses all referrals to the Whittington Hospital under consultant supervision. West Essex has one registrar who deals with liaison referrals and another who deals with alcohol-related problems, both being supervised by consultants. The development in West Essex of an academic department of human development and aging can be expected to increase the extent of liaison.

The other 10 of the 16 districts in the region provide much less organised consultation, usually limited advice on ward referrals and emergencies being seen by duty or sector teams.

Psychogeriatric consultation in general hospitals is widely available. The region has no specialised in-patient facilities for mother and baby problems, substance abuse or psychiatric problems relating to HIV. There are out-patient facilities for these specialist problems in all areas. Bloomsbury provides a regional drug and alcohol service and is developing services for HIV and drug-related problems. Child psychiatrists are not generally available for emergency care but provide routine out-patient services.

Oxford Region (Richard Mayou)

The only organised consultation and liaison service is in Oxford which has a full-time NHS consultant and an honorary consultant with a special interest. One other district, West Berkshire, has a half-time post established in 1988. Two Buckinghamshire districts share an elaborate mother and baby unit which has well established liaison with obstetric units.

Most districts have simple systems for emergencies and ward referral. There are a small number of liaison attachments. A number of general consultants in the Region, especially those in the few general DGH units, report good working relationships with their medical and surgical colleagues. Services to smaller and to more specialised general hospitals are much less satisfactory than in the DGHs.

The service in Oxford city is probably the largest in Britain and the first to have a full-time liaison consultant. A multidisciplinary team manage attempted suicide and other Accident and Emergency Department patients. Ward consultations are seen by two supervised SHO/registrar and one general practice trainee. There are several liaison attachments and a specialist out-patient clinic.

The extent of liaison by consultants in the subspecialties varies throughout the region. Some psychogeriatricians work closely with medical colleagues, but in other areas psychogeriatric consultation is relatively disorganised and there is dissatisfaction both on the part of the general hospital and of the psychiatrists. The Regional Alcohol Unit is in Oxford and the consultant is expanding liaison links

with the departments in the Oxford general hospitals. There is no consultation for alcohol problems outside Oxford and no consultation for drug offenders in the Region.

Oxford is the only one of the five rotational training schemes in the Region to offer a consultation and liaison placement. The Regional Higher Training Scheme has a liaison placement in Oxford; there are also opportunities in several districts for senior registrars to undertake sessional liaison attachments to general hospital services. The University Department of Psychiatry has a major programme of research.

South West Region (Gail Hodgson)

It is remarkable how much consultation and liaison psychiatry is being carried out in the region, particularly as there are no consultants with a designated responsibility. All general psychiatrists in the South Western Region work, or are about to work, in a sectorised system and most have their bases some distance from colleagues in other specialties. All but two of the 11 districts have the majority of their general in-patient beds in large psychiatric hospitals, often in rural areas remote from the more centrally sited DGH.

All districts have consultation services, usually based on a rota system or a Sector team. Psychiatric trainees and clinical assistants are usually supervised on request only.

Deliberate self-harm (DSH) referrals and records are generally well organised. Most districts have a defined policy and some have assessment protocols. Ten districts require wards to refer the patients to a central point by a given time each day. In nine districts everyone over 16 is seen and in two districts most are seen, the rest being assessed by house or casualty staff. All school age children are seen by senior child psychiatrists and often followed up by the same individual. Eight districts have a rota for psychiatric assessment for between five and seven days a week. Three districts use sector back-up with the initial assessment done in two districts by medical social workers and in one by a specially employed full-time psychiatric social worker using specially designed assessment forms.

Referral systems are often rudimentary and records are usually limited to letters to GPs. Referrals are usually seen either by an on-call rota system or sent direct to the sector consultant team. In one district where mental health services are largely community based most referrals are made to one consultant. Two districts commented that they felt that DGH teams were not referring because of the obstacles to referrals caused by sectorisation.

Out-patient clinics are sited within the DGH in ten districts. There are no special facilities to care for

patients who have combined major medical and psychiatric disorders within any of the district general hospitals.

In one district there is a close and long-standing liaison between the neuroscientists, neurologists, neurosurgeons and neuropsychiatrists. Other liaison services are for radiotherapy/oncology (2 districts), terminal and palliative care (3), chronic pain (2), eating disorders (1), gastroenterology (1) and dermatology (1) clinics.

Liaison by psychiatric sub-specialties is most highly developed in child/adolescent psychiatry, where close contact with paediatricians is seen as an integral part of the routine clinical work. Psychogeriatric liaison with geriatricians is increasingly seen in the same light, despite a shortage of consultants. In one district, services are going to merge. Psychogeriatricians find that links with orthopaedic surgeons are less good. Ten out of 11 districts have or are about to have designated consultants with sessional commitment to alcohol and drug abuse. Eight districts have some service for those infected with HIV virus, two have designated consultants.

There are no facilities in any of the district obstetric units for caring for a newly delivered mentally ill mother, although four districts have mother and baby facilities on acute psychiatric wards and there is one specialist mother and baby unit within a large psychiatric hospital.

Clinical psychologists have shown an increasing interest in DGH patients. At least two districts have between a half and one whole-time equivalent Principal Clinical Psychologists attached to a local DGH.

Most psychiatrists contacted were dissatisfied, and some embarrassed, about their general hospital services. There was considerable concern that hospital consultation-liaison had suffered from the emphasis on community services: at the same time, most felt that their general psychiatric service would improve once they had moved to a DGH site. Greatest satisfaction was expressed by psychiatrists already working from a base in a small DGH where they had regular informal personal contact with their consultant colleagues. Five districts are seriously examining plans for improved liaisons, three would like a consultant with a designated responsibility for liaison, one has two liaison beds planned, three are considering training specialist nurse counsellors.

Formal teaching or specialised training is minimal. However, 11 hours of teaching time has recently been allocated to liaison psychiatry in the Regional MRCPsych Part II course.

Scotland (Helen Anderson)

A recent survey (Anderson, 1989) showed that liaison services have developed little compared with a

previous survey ten years ago (Brooks & Walton, 1981), and were similar to those described in a national survey by Mayou & Lloyd (1985).

The typical service is an emergency psychiatric service seeing mainly overdose cases. The number of patients seen is usually small. Teaching is of low priority and although a consultant psychiatrist is usually nominated as having a special interest in liaison work, the service remains largely undeveloped with no specific sessions laid aside. Most liaison and consultation work appears to take place outside psychiatrists' ordinary working hours. Despite the obstacles and lack of training opportunities, respondents to the Scottish survey were generally enthusiastic about this aspect of psychiatry. Psychiatrists working in district general hospitals were generally more satisfied than those with no general hospital base. However, they did not provide a wider range of services or more sessional commitments or more teaching.

As in other areas of the country, no record is kept of the number of patients seen by the service. Since referrals tend to be made by varied means and collected in several places, it is impossible for either psychiatrists or managers to assess the number of patients seen or the resources used. Links have been established with specialist units across the country but these have been haphazard and have been brought about by the enthusiasm of particular individuals.

There are particular difficulties in providing a specialist service for geographically large rural catchment areas with scattered populations. Inevitably, such services tend to be sectorised and all psychiatrists are equally involved in general hospital work.

Three of the four university teaching hospitals have liaison services which provide post-graduate teaching and training in liaison psychiatry. Edinburgh remains the most developed service in Scotland with the only full-time consultant in liaison work and the largest number of para-medical sessions. The unit provides training at registrar and senior registrar level. Specialist liaison links and increasing para-medical support are being actively developed.

In Glasgow, the psychiatric services are provided by several psychiatric hospitals around the Glasgow area, as distinct from Edinburgh's more centralised service. The Professorial Unit in Glasgow provided a valuable training post in liaison psychiatry. For some years the psychiatric registrar has attended a medical ward round on a regular basis. All psychiatric staff are involved in an international pain clinic with in-patient and out-patient facilities and staff in the unit also attend a regular clinic at the Glasgow Dental Hospital. In Dundee, the consultation-liaison service is provided by a separate senior rotation to the main general hospital. One consultant has developed a close liaison with the obstetric unit.

Because of dissatisfaction with current services, a variety of changes are planned across Scotland. Although only one hospital (Dumfries) initiated a liaison service within five years prior to this survey, several areas hope to appoint consultants with specific interest in consultation-liaison psychiatry over the next few years. There is encouraging evidence that services around the country are set to develop.

Wales (Peter Jenkins)

Arrangements for hospital consultations vary from area to area. Only one district, Gwent, has a specific consultant post with a special responsibility for the development of the liaison service. This post has recently been filled and the service has yet to be developed. In most areas, one or more consultants have some nominal responsibility for aspects of the consultation service, but few have specific sessions or administrative support. No area reported a centralised record of consultations.

The majority of work is concerned with the assessment and management of deliberate self-harm, and is normally undertaken by a junior doctor with consultant or senior registrar supervision available on request. The extent of such requests is unknown. Arrangements vary, but the only area with designated beds is Llandough Hospital Poisons Unit, Cardiff.

The majority of ward consultation requests are emergency requests and seen by junior doctors, except in one area, where all consultations are seen by a consultant. In a three-month survey in South Glamorgan, 51 requests were received, of those no follow-up was arranged in about 50% and no notes made in 34%. It is unlikely that the quality of service is significantly higher in other areas.

The University Teaching Hospital, Cardiff, has the most developed service in Wales. Apart from emergencies, between three and five non-emergency ward consultations per week are seen by well supervised junior staff based on the DGH acute psychiatric unit. There are a number of liaison services and a named psychiatrist is available to the Departments of Surgery, and Geriatric Medicine, the epilepsy and bone marrow transplant units, Dental School, adolescent renal unit, and the tinnitus clinic. There is an active research programme. It is hoped to start an out-patient clinic and eventually to appoint a designated consultant.

No area has a medical/psychiatric in-patient unit or specific liaison out-patient clinics. All areas have provision for mothers and babies in specific units. Child and adolescent services are relatively underdeveloped in terms of in-patient treatment as are alcohol and drug treatment units. There is close liaison between geriatric medicine and psychogeriatric services throughout Wales.

Comment

Detailed reviews of Wales, Scotland and several English Regions, and the replies of psychiatrists from more than 50 districts, suggests that the current practice of consultation in liaison psychiatry has changed little in the last few years. Few of those who replied were satisfied with services and their accounts suggest that they are able to do little more than cope with emergencies. It was widely felt that these problems have severely impaired the management of psychiatry among other hospital specialties. There are several particular reasons for concern:

- (a) The management of deliberate self-harm fails to meet College and Department of Health guidelines in many districts.
- (b) Services are unable to adequately assess and treat non-emergency psychiatric disorder. Relatively few ward consultations are seen and there is little liaison with medical units or expertise in the out-patient care of medical patients. There are very few beds for patients who are psychiatrically and medically unwell.
- (c) The lack of adequate records prevents audit of the quality of services, impairs planning and hinders research and teaching.
- (d) Existing services are largely haphazard and provided by sector or emergency teams. There is a need for designation of consultants with a responsibility (and sessions) to coordinate consultation-liaison and to ensure it is efficient, well supervised and properly documented.
- (e) Training in general hospital work is generally poor. The assessment of liaison work is inadequately supervised. Few areas have the skills and facilities to fulfil Royal College and JCHPT guidelines or to train psychiatrists for special interest consultant posts.
- (f) Psychogeriatrics is the only sub-specialty which has made substantial progress in the development of its general hospital service.

Many large general hospitals have no child psychiatry service for urgent referrals, obstetric liaison is uncommon and for substance abuse unsatisfactory.

Lack of resources is a very substantial obstacle to providing adequate care to distressed people in general hospitals. Greater medical in-put and improved para-medical support are necessary to make a major impact on this time-consuming, but largely undocumented, aspect of psychiatric care. However, it is also apparent that lack of awareness and poor organisation of what is already available are both important factors. Our survey showed that a number of districts are able to use modest resources to provide efficient and innovative consultation and emergency services.

It is essential for the welfare of patients and the reputation of psychiatry that all health districts audit their consultation and liaison services, improve their use of present resources and make detailed plans for better emergency, out-patient and in-patient care. There can be no single plan suitable for all areas. Teaching hospitals require skilled senior staff to provide a clinical service to train psychiatrists and to offer teaching to medical and other students. Specialists may be inappropriate in rural areas where general practitioners cover large catchment areas. The Liaison Group and the Royal College must set out guidelines for the organisation and staffing of consultation and liaison services.

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