A Survey of Liaison Psychiatry in the United Kingdom and Eire

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The recent formation of a Liaison Psychiatry Group within the College reflects the growing integration of psychiatry with other medical specialties in the general hospital. The Group was established to foster the development of psychiatry in relation to medical and surgical patients, including its clinical, teaching and research components. The title, Liaison Psychiatry, is not an ideal term but has become firmly established in other countries to denote that area of psychiatry where the psychiatrist has particular skills to contribute to the care of the physically ill, and to those in whom psychiatric disorder presents in somatic terms.[1]

The growth of liaison psychiatry has been particularly rapid in the United States where it is regarded as a sub-specialty: many psychiatrists, and indeed departments, devote their entire time to liaison work. By contrast, there are few specialized posts in the United Kingdom, even though general psychiatrists have, for many years, seen patients referred by their physician and surgeon colleagues.[2] This collaboration has grown with the establishment of psychiatric departments, especially in-patient units within general hospitals, and has been encouraged by several official publications. The Department of Health has recently issued amended guidelines on the management of patients who deliberately harm themselves.[3,4] These emphasize the need for a well-organized service and well-trained staff in every hospital treating such patients. In another paper on the management of drug and alcohol abuse, detailed suggestions were made concerning the provision of care by casualty, general medical and psychiatric staff.[5] These official views are supplemented by a College paper on the management of attempted suicide in young people under 16, advocating that child psychiatrists should be directly involved in their care.[6]

Relatively little is known of the practice of liaison psychiatry in Britain. Brooks and Walton[7] surveyed the 20 psychiatric administrative areas in Scotland. They found that few areas had psychiatrists with special interest or responsibility for liaison work. Referrals were usually made impersonally, and there was an overall impression of unsatisfactory communication between psychiatrists and other hospital doctors. In most areas there was a wish to improve and expand liaison services, but lack of resources was a major obstacle. In 1981, a working party of the Association of University Teachers of Psychiatry conducted a survey of teaching of consultation and liaison psychiatry.[8] Almost half the medical schools provided no practical experience for medical students apart from the assessment of self-poisoning. It appeared that most trainee psychiatrists had some experience of the assessment of deliberate self-harm, but that few had opportunities for experience in ward consultation or liaison. Only a minority of training schemes had specific posts in liaison psychiatry.

The survey

To determine the extent and range of collaboration, we conducted a survey of all those who had become members of the College Liaison Psychiatry Group. A specially constructed questionnaire was sent by post and 216 replies were received from members in the United Kingdom and Republic of Ireland. One hundred and fifty-nine were adult psychiatrists (including several psychogeriatricians and psychotherapists), while 57 were child psychiatrists (including two specialists in mental handicap). Replies were received from all the regions or equivalent administrative areas in the United Kingdom and Eire. Psychiatrists working in teaching hospitals and in district general hospitals were over-represented. The replies from trainees largely came from those training schemes with particularly good training in liaison and consultation.

Results

Adult psychiatry

Work in liaison psychiatry: These results are shown in Table I. Most respondents were involved in ward consultation, but well over half claimed to have liaison links with specific medical and surgical units. There was considerable involvement in teaching, particularly of psychiatric trainees, and nearly half the adult psychiatrists claimed to be undertaking research in liaison psychiatry.

Staff and type of unit: Most services were provided by general psychiatrists, and few regarded themselves as liaison psychiatrists (Table II). The number of sessions devoted to liaison psychiatry ranged from half to 11 per week. It is not possible to give an average figure because many indicated that they had no specific sessions set aside, and had to see their

TABLE I
Nature of work in liaison psychiatry—numbers responding (with percentages in brackets)

	Adult psychiatry		Child psychiatry	
	Consultants (n = 115)	Trainees (n = 44)	Consultants (n = 47)	Trainees (n = 10)
Emergencies	80 (70)	27 (61)	28 (60)	7 (70)
Ward consultation	104 (90)	40 (91)	44 (94)	7 (70)
Liaison with specific units	74 (65)	25 (57)	32 (68)	9 (90)
Teaching				
—medical students	49 (43)	20 (45)	18 (38)	6 (60)
—psychiatric trainees	92 (80)	22 (50)	35 (74)	5 (50)
—other medical staff	42 (37)	10 (23)	22 (47)	5 (50)
Research	49 (43)	22 (50)	11 (23)	3 (30)

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TABLE II
Staff and type of unit—numbers responding (with percentages in brackets)

	Adult psychiatry		Child psychiatry	
	Consultants	Trainees	Consultants	Trainees
Staff—general	64 (61)	23 (72)	25 (61)	6 (67)
—general with special interest	32 (30)	7 (22)	15 (37)	3 (33)
—liaison	9 (9)	2 (6)	1 (2)	0 (0)
Service—consultation	56 (53)	22 (69)	14 (31)	3 (33)
—consultation/ liaison	49 (47)	10 (31)	31 (69)	6 (67)

TABLE III
Satisfaction with service and working relationships—numbers responding (with percentages in brackets)

	Adult psychiatry		Child psychiatry	
	Consultants	Trainees	Consultants	Trainees
Service				
—very satisfactory	5 (5)	0 (0)	6 (14)	1 (11)
—satisfactory	69 (68)	24 (75)	20 (45)	8 (89)
—unsatisfactory	28 (27)	8 (25)	18 (41)	0 (0)
Relationships				
—very satisfactory	16 (16)	1 (3)	9 (20)	1 (11)
—satisfactory	65 (64)	21 (68)	22 (49)	6 (67)
—unsatisfactory	21 (21)	9 (29)	14 (31)	2 (22)

TABLE IV
Facilities grouped by area

	Adult psychiatry (n = 85)	Child psychiatry (n = 40)
Type of Unit:		
In-patient ward	49	9
Day unit—no ward	4	1
Out-patient department only	16	17
Liaison office in general hospital only	4	0
Service based outside general hospital only	12	13
Staff:		
General psychiatrist only	55	24
At least one general psychiatrist with special interest	23	15
Full-time (or part-time) specialist liaison psychiatrist	7	1

general hospital referrals after out-patient clinics, in the evenings or at weekends, time when the referring medical staff are often not available.

General hospital base: Fifty-eight per cent of the consultants and 73 per cent of the trainees in adult psychiatry were based in a teaching hospital. An in-patient psychiatric ward in a general hospital was available to 52 per cent of consultants and 41 per cent of trainees. In other cases, the in-patient facilities were separate and the service was conducted from an out-patient department, a liaison office in the general hospital or a psychiatric hospital.

TABLE V
Experience for trainees in adult psychiatry by area (n = 85)

	Often	Occasionally
Assessing patients after attempted suicide	66	5
Other emergencies	42	20
Ward consultations	31	28
Liaison with specific units	5	10
Out-patient clinics	44	4

TABLE VI
Experience for trainees in child psychiatry by area (n = 40)

	Often	Occasionally
Assessing patients after attempted suicide	13	10
Other emergencies	7	11
Ward consultations	10	6
Liaison with specific units	7	2
Out-patient clinics	17	4

Satisfaction: Most respondents claimed to be satisfied with the service they provided and with working relationships with other medical colleagues (Table III). However, several qualified their replies by indicating that the satisfactory state of affairs applied to some specialties only; elsewhere matters were far from satisfactory.

Adult facilities grouped by area

It is difficult to summarize replies from the different areas as the organization in many areas appeared to be haphazard and there were differences between services provided to general hospitals in the same area (Tables IV, V and VI). Only a minority of districts had clearly organized services; in the majority, current practice depended upon the individual interest of a few consultants, the presence of a DGH unit, the referral practice of physicians and surgeons and the complexities of duty rotas. A number of replies said that it was hoped to introduce a consultation service soon. Almost all the services were largely provided by general psychiatrists fitting in their liaison responsibilities at the end of the day.

In only a quarter of the areas were non-medical staff (nurses, psychiatric social workers, clinical psychologists) regularly involved in assessment and treatment, and there were very few multidisciplinary attachments to any part of the general hospital. District general hospital psychiatric units were more often able to use the whole range of therapeutic resources in the treatment of referrals.

(1) *Psychogeriatrics:* In a third of areas, psychogeriatricians

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had taken on responsibility for the care of all the elderly patients in general hospitals, and a number of other districts were intending to adopt this practice. In another third, responsibility was shared by general psychiatrists and psychogeriatricians. In hospitals with well-developed consultation services, these were usually responsible for the initial assessment of most referrals of elderly patients.

(2) *Ward consultations:* Just over half the services had a consultant with overall responsibility and slightly less than half had a special consultation service. Most were dealing with more than five referrals a week. The majority of respondents said that consultations were undertaken by consultants or senior registrars, but in a quarter, registrars were responsible for consultations with varying degrees of supervision. In a fifth of the districts, ward consultations were seen by one team with a single consultant and in a slightly smaller proportion, consultants took responsibility for particular wards or parts of general hospitals. In the remainder, there were complicated systems depending upon the physicians' and surgeons' preferences, the duty rota and sector responsibilities.

Only 20 per cent of services had access to in-patient beds within the general hospital, suitable for the care of patients who are both psychiatrically disturbed and medically unfit for a normal psychiatric ward. Fifty per cent of the services included some specific liaison, usually with no more than one or two specialist units. Liaison with renal and cancer units, pain clinics, geriatric medicine, obstetrics and venereology were the most common, extensive collaboration with the main general hospital units being very rare. In a quarter, there were regular joint meetings with other specialties.

(3) *Attempted suicide:* Most services saw more than five referrals a week, but only 60 per cent aimed to assess all attempted suicide attenders. Just under half had a special arrangement for the assessment of attempted suicide. This was usually a special duty rota of junior doctors, but 10 per cent had various forms of multidisciplinary teams. Supervision of junior staff varied from review of all referrals to none at all. It was usual for child psychiatrists to be responsible for the assessment of self-harm by children, and most areas also had a special procedure for adolescents. However, a quarter of districts had no special facilities for the assessment of young people.

(4) *Accident and emergency referrals:* Most services reported that they saw very few referrals from accident and emergency departments, usually less than five a week. Patients were usually seen by the trainee psychiatrist on duty, but there were a very few notable exceptions of well-organized multidisciplinary teams. Liaison meetings were uncommon. In a half of the districts there was access to specialist alcohol services for the management of patients with drinking problems, although only a third had any special detoxification facilities. Just over half had access to special services for the treatment of drug dependent patients.

Child psychiatry

Fifty-one per cent of the consultants and 67 per cent of the trainees were based in a teaching hospital. Child psychiatrists were less likely than their adult psychiatry colleagues to have an in-patient ward in the general hospital: this was available to 19 per cent of consultants and 30 per cent of trainees. In three-quarters of the areas, there was regular liaison with the paediatric departments, and three-quarters held regular joint meetings with paediatricians. Three held joint out-patient clinics. Child psychiatrists were less likely than general psychiatrists to have assistance from junior or non-medical staff. A number commented that working relationships were much less satisfactory with paediatric surgeons and other specialists than they were with paediatricians.

Discussion

We received replies from a minority of health districts in the United Kingdom and Eire, and our respondents cannot be taken as typical of all psychiatrists who work in general hospitals. However, we think they are representative of those who are currently most interested and active in liaison psychiatry, and therefore give an over-optimistic picture of current practice. The replies show that there is considerable clinical, teaching and research activity in this field, much of it being conducted outside the major academic centres.

A recurring theme in the comments which we invited was that there was insufficient time to undertake all aspects of the work satisfactorily. This was reflected by the fact that many could not state how much time they devoted to the work because no sessions were specifically allocated. They were general adult and child psychiatrists who had to see patients at inconvenient times or between out-patient clinics or ward rounds. An outstanding impression is that liaison services for ward consultation, attempted suicide and accident and emergency departments have grown up haphazardly and that they have depended upon the interest of a small proportion of consultants in any district. Very few districts have given any priority of resources to the development of liaision psychiatry. However, a number of the questionnaires reported impressive achievements in liaision psychiatry in the context of a hard-pressed general psychiatry service. Only a minority of areas are able to provide services required by DHSS and College guidelines. Many respondents said they would like to learn how other people used limited resources to provide an adequate service and to teach.

Even though the precise role of liaison psychiatry is uncertain,[1] there can be little doubt that in most British hospitals there are inadequate services for the management of psychiatric problems in in-patient, out-patient and emergency departments. Unless there is a large expansion in the consultant establishment it is unlikely that many full-time liaison psychiatry posts will be created, but we suggest that in each district there should be at least one consultant who has a special responsibility for co-ordinating administration, clinical work and teaching. Specific sessions should be allocated for liaison work in all general hospitals, with appropriate accommodation and secretarial services. Some in-patient beds should be available within the general hospital, even if the district services are based elsewhere, since many physically ill patients with an associated psychiatric disorder cannot be adequately managed in a medical ward but are too ill to be transferred to a distant psychiatric hospital. We believe

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more consultant posts should include a special interest in liaison psychiatry and we would urge the College's representatives to influence health authorities and boards in this direction when job descriptions are defined. In university hospitals, the teaching commitment should be recognized.

Liaison work is obviously seen as an important experience for psychiatrists in training, and this was available in most of the centres from which we received replies. The commonest experience involved assessing patients after attempted suicide, but this should not be the trainee's sole experience of liaison psychiatry. Ward consultation and liaison with specific units should be encouraged. It is important that this work is adequately supervised; time should be allocated for regular supervision of trainee's work by a consultant who should also be available for advice on a more informal basis when the need arises. The majority of trainees who replied were in senior registrar posts and this is probably the optimum stage in training at which to gain liaison experience. A broadly-based experience at registrar level, together with a higher professional qualification, will give the trainee greater clinical confidence and his opinion will carry more authority in the eyes of other specialists. The possibilities of specific liaison links and the development of research projects (the two are often linked) are also better at this level because a senior registrar is likely to stay in the post longer than a registrar in a rotating training scheme. However, if a liaison attachment is part of registrar training, we believe it should not be held until the trainee has received two years' experience of general psychiatry.

In summary, our survey has confirmed considerable activity in an area of psychiatry which hitherto has received little official recognition in Britain. Liaison psychiatry is being practised under difficult conditions with clinical time constantly eroded by other commitments. We believe the College can do much to consolidate its achievements and foster its further development.

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Quality Health Assurance: A Note from the King's Fund

The King's Fund has set up a national project to promote quality assurance in health services in Britain. A major hurdle appears to be the lack of available information and experience relevant to this country; thus the faint-hearted may give up, the persistent may re-invent the wheel.

The King's Fund Centre is therefore going to provide an information service in conjunction with the DHSS Library to put interested individuals or groups in touch with relevant documentary sources and with other people working in the same field. There is probably much more experience in Britain than is represented in published papers; so, in order to make the most of that experience, we would like to hear about local projects in psychiatry. Of particular interest would be examples of standards (such as criteria for a 'good' service, therapeutic policies), measurement (such as responding to the Pippard and Ellam study of ECT). For the present purpose, a brief outline would suffice—enough to tell an enquirer whether it is of sufficient interest to follow up.

Anyone wishing further details of the project or able to offer information is invited to contact: Dr Charles D. Shaw (Project Co-ordinator); Paula Harvey (Assistant); or Anne Holdich Stodulski (Library Projects Officer) at King's Fund Centre, 126 Albert Street, London NW1 7NF (telephone: 01-267 6111).

Burden Research Medal and Prize

Entry for the Burden Research Medal and Prize is open to all registered medical practitioners who are working in the field of mental handicap in the United Kingdom or Republic of Ireland.

The award for 1986, consisting of a gold medal and prize of £500, may be presented for outstanding research work which has been published, accepted for publication, or presented as a paper to a learned society during the three-year period ending 31 December 1985. Five copies of the paper or papers, with application form, should be submitted to the Secretary of the Burden Trust by 10 January 1986.

Further information and application forms are available from the Secretary, Burden Trust, 51 Princess Road, Richmond upon Thames, Surrey TW10 6DQ.

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