Consultation–liaison: from dream to reality

A systematic approach to developing C–L mental health service delivery

Frits J. Huyse and Graeme C. Smith

A series of developments in recent years have revealed the plight of consultation–liaison (C–L) psychiatrists in the health care arena. Though C–L psychiatrists stem from psychiatry, they operate in a dark area between medicine and psychiatry which forms a no-man's land in most national health care schemes. The decision to become a psychiatrist is probably the most radical choice a doctor can make. It defies the division between mental and general health care. One challenge to C–L psychiatrists is to secure a more formalised position for mental health service delivery within the general health care sector, in both organisation and funding. This would enhance both the quality and quantity of health services to medically ill people with psychiatric comorbidity. The purpose of this article is to increase the awareness of such problems, and to set out strategies to consolidate the professional development and positioning of C–L psychiatrists in the health care field.

Problems

The psychiatric–medical divide

Despite variations in the ways patients are distributed over health service delivery systems in Western societies, there is more or less a split between the general and the mental health care systems. This is tied to a series of problems psychiatrists face when they try to work in the general hospital system.

First, there is the problem that non-psychiatric doctors have with the identity of the psychiatrist. Their knowledge of psychiatry is generally limited. Medical training focuses mainly on psychoses and personality disorders, conditions difficult to understand, deal with and treat. In reality, mental illness in the medical sector is far more widespread. Common ailments include anxiety, depression, substance misuse and somatisation disorder, in both their full-blown and their sub-threshold forms.

A second problem is that negative attitudes of medical specialists and nurses are reinforced by the inappropriate mental health facilities available in the medical setting, and the parallel inadequacies of mental health settings. This complicates the transfer of comorbid patients between the general and mental health care, which ultimately can often depend on the perservance of the C–L psychiatrist involved.

The return to the field of medicine

Psychiatrists who return to medicine vary considerably in their degree of preparation for the C–L role, depending on the sophistication of the C–L service in their training programme. Three major factors can be blamed for their deficiencies.

First, there is too little data on the effects of psychiatric interventions in the medically ill during general hospital stays. Since a call in the beginning of the 1980s to improve C–L research a series of studies funded by the US National Institute of Mental Health have revealed the formidable difficulties of experimental research on physical/psychiatric comorbidity (Saravay & Strain, 1994). In addition to randomised clinical trials, various groups are working on audit systems which are eventually to set standards for C–L service delivery (Huyse *et al*, 1992). The European Consultation–Liaison Workgroup (ECLW) has conducted a collaborative study followed by a quality management study (Huyse, 1996*a*,*b*). Similar initiatives on a more modest scale have been taken in the US and Australia (Strain *et al*, 1996).

A second difficulty is to get across to the medical and health care policy community what specific role C–L psychiatrists fulfil in the general hospital and what structural basis is required for their activities. Studies assessing interaction within the medical system, such as those on staff conflicts that interfere with appropriate care and on the degree of staff compliance with C–L

psychiatric recommendations, have appeared only in C–L literature.

The third problem is that a return to the medical system entails a change in psychiatrists' strategies towards patients. Becoming a psychiatrist involves a sort of estrangement from the medical system – an internalisation of psychotherapeutic principles with their tendency to observation and passivity. Psychiatrists may now find it hard to become active again in the presence of their medical colleagues. More so than patients seen by generalist psychiatrists, those suffering physical/psychiatric comorbidity often find themselves in a personal existential crisis which demands a more active approach. A similar change in activity levels is required for the psychiatrists' relationship to the medical staff. The question arises whether they should explicitly put forward how they see their role on a ward or should they adopt a more psychotherapeutic attitude, seeking openings to introduce their views. Just as in giving psychotherapy, a psychiatrist here must be careful to avoid verbalising problems that are impossible to solve.

Two recent randomised clinical trials, one US study on hip fracture in the elderly (Strain *et al*, 1991) and another Dutch study on physical/psychiatric comorbidity in the medical population 75 and older, suggest that management needs to take a more proactive, preventive approach to physical/psychiatric comorbidity. In the latter study, Slaets *et al* (1994, 1997) have demonstrated significant clinical and cost effects of admission screening and of treatment by both a psychogeriatrician and liaison nurses. This was evident by a better functional status at discharge and by shorter lengths of stay, including readmission days in a six month follow-up period. Obviously such an active role in managing ward personnel requires specific training and skills not likely to be gained in most of today's training programmes.

Strategies

Several different strategies are needed to develop a more formalised basis for the mental health care of patients in general medical settings. These are intended to provide a more secure basis for psychiatrists wishing to establish themselves at this interface. We discuss these strategies here in random order.

Organisations

One requirement for developing the field of C–L psychiatry is a higher level of professional organisation (Huyse, 1991). If this is not achieved then C–L psychiatry will forever be a domain for pioneers trying to find their niche in a hostile environment. The need for better organisation has already been recognised in the creation of groups such as the Academy for Psychosomatic Medicine, the Liaison Psychiatry Group of the Royal College of Psychiatrists, the Section of Consultation Psychiatry of the Royal Australian and New Zealand College of Psychiatrists, and sections or interest groups within several other European psychiatric associations. Several such groups are moving more or less explicitly towards sub-specialisation status through a focus on curricula, fellowship training programmes, funding and research strategies (Ford *et al*, 1994).

Another approach is the establishment of international organisations like the European Association for Consultation–Liaison Psychiatry and Psychosomatics (EACLPP). Its main focus is on international networking, trying to set up an international forum and a more active exchange between participants. Recently, Mayou & Creed have urged more active participation of representatives of national organisations in the C–L field (personal communication). This would effectively generate needed information to reinforce national initiatives. A meeting of the EACLPP will be organised as a satellite of the next European Conference for Psychosomatic Research (ECPR) in Manchester September 1998.

Curricula and training requirements

Ford *et al* (1994) has reviewed 49 fellowship training programmes and formulated the Academy of Psychosomatic Medicine's goals and standards for C–L training. These refer to a knowledge base for diagnosis and treatment, which is to include a full range of consultation and liaison techniques. However, they devote insufficient attention to a number of issues: finding a proper balance between passivity and activity; applying complementary psychotherapeutic strategies; protocollised strategies for patients with common psychiatric comorbidities; treatment of more complex, longer-lasting or fluctuating psychiatric disorders. Furthermore there is the question of the different roles C–L psychiatrists can fulfil in medical teams. There is the role of the 'gatekeeper' who facilitates transfers from the mental to the general health care sector and vice versa, and that of the mentor who furnishes both patients and health professionals the information and strategies needed to cope with complex illnesses and ensure continuity of care. There are also different roles as care provider, from psychotherapist to case manager. In addition, on the general hospital wards the C–L psychiatrist must collaborate closely with liaison nurses and guide them in observing and containing patients' behaviour. Together C–L psychiatrists and C–L nurses could develop ward programmes to provide more

https://doi.org/10.1192/pb.21.9.529 Published online by Cambridge University Press

integrated care to specific populations, such as elderly, trauma, oncological, intensive care unit or neurological patients. Residency/registrar training programmes should also be considered, such as the US Rochester dual training model, as well as models of general practitioner training in psychiatry. The question arises as to whether C–L psychiatrists would enhance their credibility and position by helping develop curricula for internal medicine, neurology and general practice.

Organisation and funding

Since the field of physical/psychiatric comorbidity lies between medicine and psychiatry, who will take it in and give it asylum? The failures of C–L psychiatry are best reflected in case-mix funding based on diagnostic related groupings, where both primary psychiatric diagnoses and comorbidities are limited to substance misuse, psychotic and organic mental disorders, and where only a limited number of physical diagnoses are permitted with psychiatric comorbidity. Consultant–liaison organisations and health delivery organisations in many countries are now seeking solutions to this problem (Smith *et al*, 1994). Two important paradigmatic developments in this respect, which should have an impact at the international level, are the document entitled *The Psychological Care of Mental Patients: Recognition of Need and Service Provision* (Royal College of Physicians & Royal College of Psychiatrists, 1995) and the book *Liaison Psychiatry. Defining Needs and Planning Services* (Benjamin *et al*, 1994).

An overt strategy towards the general health care system

All such issues need to be drawn together as an integrated policy, and a structure needs to be developed to implement it. But is it the responsibility of psychiatry alone to achieve this? The Royal College of Physicians and the Liaison Psychiatry Group of the Royal College of Psychiatrists (1995) have formulated a key answer: the joint working party. This is a model of how things should proceed from here. Other medical specialities should be drawn into the planning process to help them see their responsibility for the integrated care of their patients, and to assure them of the sound knowledge base and skilled psychiatric support needed to achieve this.

Novel C–L quality management and audit approaches systems need to be integrated into existing hospital systems. This can aid the collection of more reliable and extensive data to evaluate whether interdisciplinary standards have been met. At present in the framework of the Biomed1 programme, a practical admission risk screening instrument (Compri) to predict the complexity of hospital care, and a multidimensional method to assess health service needs (Intermed) are being tested to assess the integrated health care needs of the patients requiring complex hospital care (Huyse, 1997). There purpose is the early detection of psychiatric comorbidity in high-utilisers and the subsequent provision of appropriate care and referral.

References

BENJAMIN, S., HOUSE, A. & JENKINS, P. (1994) *Liaison Psychiatry. Defining Needs and Planning Services*. London: Gaskell.

FORD, C. V., FAWZY, I. F., FRANKEL, B. L., *et al* (1994) Fellowship training in C–L psychiatry: education goals and standards. *Psychosomatics*, **35**, 118–124.

HUYSE, F. J. (1991) Consultation–liaison psychiatry: does it help to get organized? *General Hospital Psychiatry*, **13**, 183–187.

—, LYONS, J. S., ZWAAN, W. A., *et al* (1992) Audit in C–L psychiatry. *International Journal for Review in Psychiatry*, **4**, 5–14.

—, HERZOG, T., MALT, U. M., *et al* (1996*a*) The European Consultation–Liaison Workgroup (ECLW). Collaborative Study: I. General outline. *General Hospital Psychiatry*, **18**, 44–55.

— (1996*b*) C–L Psychiatry in International Perspective. In *Textbook for C–L Psychiatry* (eds J. R. Rundell & M. Wise), pp. 228–255. Washington, DC: American Psychiatric Press.

— (1997) From consultation to complexity of care prediction and health service needs assessment. *Journal of Psychosomatic Research*, in press.

ROYAL COLLEGE OF PHYSICIANS AND ROYAL COLLEGE OF PSYCHIATRISTS (1995) *The Psychological Care of Medical Patients. Recognition of Need and Service Provision*. (Council Report CR35). London: Royal College of Physicians and Royal College of Psychiatrists.

SARAVAY, M. S. & STRAIN, J. J. (1994) APM task force on funding implications of consultation–liaison outcome studies special series introduction: a review of outcome studies. *Psychosomatics*, **35**, 227–232.

SLAETS, J. P. J. (1994) *Geriatric Intervention: A Clinical–Empirical Study* (PhD thesis). Rotterdam: Eramus University.

—, KAUFFMANN, R. H., DUIVENVOORDEN, H. J., *et al* (1997) A randomized trial of geriatric liaison intervention in elderly medical in-patients. *Psychosomatic Medicine*, in press.

SMITH, G. C., ELLIS, P. E., CARR, V. J., *et al* (1994) Staffing and funding of consultation–liaison psychiatry services in Australia and New Zealand. *Australia and New Zealand Journal of Psychiatry*, **28**, 398–404.

STRAIN, J. J., LYONS, J. S., HAMMER, J. S., *et al* (1991) Cost offset from a psychiatric consultation–liaison intervention with elderly hip fracture patients. *American Journal of Psychiatry*, **148**, 1044–1049.

—, HAMMER, J. S., HIMELEIN, C. (1996) Consultation–liaison psychiatry database: part III topic, contributors and database. *General Hospital Psychiatry*, **18**, 314–376.

*Frits J. Huyse, *Associate Professor of Psychiatry, Free University Hospital, Amsterdam, The Netherlands and* Graeme C. Smith, *Professor of Psychological Medicine, Monash University, Melbourne, Australia*

*Correspondence