Psychiatry, medicine and consultation–liaison

RICHARD A. MAYOU

Consultation–liaison (liaison psychiatry in Britain) has evolved from the ashes of psychosomatic medicine, a long tradition of specialists in psychological medicine working alongside physicians in teaching hospitals, procedures for dealing with emergencies and, in the United States, from a federally funded initiative to improve medical education. It is now widely recognised as a special interest within psychiatry. It has two distinct features: it is *geographical* in its concern with what goes on in the general hospital, and it requires special *clinical expertise*. In Britain, the Royal College of Psychiatrists' Group for Liaison Psychiatry, founded in 1980, has had a considerable influence as the first of many national organisations. It sounds a success story, but the success is modest and the future uncertain. Should consultation–liaison continue to restrict itself to conspicuous acute psychiatric disorder, or is it potentially a sub-speciality which will have an impact across the whole of medical care? We need to answer four questions: First, is psychiatry meeting current expectations? Second, what more could be done? Third, how could more ambitious care be provided? And fourth, can we justify the use of greater resources?

IS PSYCHIATRY MEETING CURRENT EXPECTATIONS?

The general hospital is a major pathway to specialist psychiatric care (Gater & Goldberg, 1991) but most current consultation–liaison services in all countries offer no more than minimal emergency care for medical inpatients and emergency department attenders (Working Party of the Royal College of Physicians and Royal College of Psychiatrists, 1995; Rundell & Wise, 1996). Psychiatric consultation frequently depends upon rotas of general psychiatrists, often unsupervised juniors, and its quality falls far short of what is now expected from psychiatric services to communities. Such care is inefficient (Mayou *et al*, 1990). It should be little or no more expensive to provide a consultation–liaison service supervised by a senior psychiatrist who has an interest and experience in general hospital problems. Local planners and psychiatric services must implement what is already accepted as necessary and feasible by physicians and psychiatrists (Benjamin *et al*, 1994; Working Party of the Royal College of Physicians and Royal College of Psychiatrists, 1995).

WHAT MORE COULD BE DONE?

Most plans put forward by consultation–liaison psychiatrists (Benjamin *et al*, 1994) are modest and tentative. Proven interventions for out-patient attenders and liaison with medical units get little mention, as is conspicuously evident in the contents of a new, very large, American textbook on consultation–liaison (Rundell & Wise, 1996). Two types of evidence show the size and nature of psychological morbidity in medical settings and how more could be done.

Epidemiology

Many studies have shown the substantial size of the problems (Mayou & Sharpe, 1995; Working Party of the Royal College of Physicians and Royal College of Psychiatrists, 1995). First, around one-quarter of those with major physical disorders suffer psychiatric disorder or other psychologically determined but 'medically unnecessary' complications, which include adverse effects on quality of life, poor compliance with effective medical treatments and possibly some effects on long-term physical morbidity and on mortality. Second, 'medically unexplained' symptoms are extremely common in primary and hospital care (Mayou *et al*, 1995). Many result in persistent distress and disability, which are often difficult to treat and associated with a huge use of medical resources. Third, there are a wide range of behavioural problems including self-harm, substance misuse, sexual difficulties and eating disorders (Working Party of the Royal College of Physicians and Royal College of Psychiatrists, 1995; Rundell & Wise, 1996).

Treatment

There is consistent and compelling evidence that psychiatric, psychological, behavioural and educational interventions can all be highly effective in improving outcome of all three types of clinical problem (psychological, quality of life/mortality, use of medical care) and that, if properly organised, there are often savings in overall health costs (Working Party of the Royal College of Physicians and Royal College of Psychiatrists, 1995).

We already know enough to make changes in care which would have benefits for patients and their families and improve the satisfaction of those treating them. Many of these changes require shifts in attitude and organisation, rather than major new specialist resources.

HOW COULD MORE AMBITIOUS CARE BE PROVIDED?

Improved care requires a combination of simple and inexpensive changes in *routine care* by non-specialists, together with better access to psychological and psychiatric assessment and treatment services to provide *specialist assessment* and treatment. Such changes will depend upon improved training for all those involved in health care, psychiatrists and psychologists as much as non-specialists. There are several ways in which specialist expertise could be provided. A few psychiatric consultation–liaison services have established successful special links and areas of expertise in relation to particular physical disorders, such as cancer, or various types of medically unexplained symptoms, for example chronic fatigue, low back pain, irritable bowel. There are also many innovative programmes which provide behavioural medicine treatments for symptoms such as irritable bowel or chronic pain (Mayou *et al*, 1995). However, psychiatry is not the only discipline attempting to deliver new methods of care. Behavioural medicine, mainly staffed by clinical psychologists, is increasingly prominent in North America and in some other countries (Agras, 1992). This new

https://doi.org/10.1192/bjp.171.3.203 Published online by Cambridge University Press

expertise is welcome, although it is sometimes seen as an alternative to psychiatry rather than complementary to it. More worryingly, there has also been a considerable growth in unproven counselling and advice by specialist nurses and others, few of whom are adequately trained or supervised (Wessely, 1996). Outside orthodox medicine, complementary and alternative medicines are very widely publicised and used. We need a solution which makes the best use of the professional skills available to support primary and general medical care.

CAN WE JUSTIFY THE USE OF GREATER RESOURCES?

One reason that liaison psychiatry has received little support from fellow psychiatrists is a widespread assumption that consultation–liaison threatens scarce resources for major psychiatric disorder seen in more traditional psychiatric settings (Kessel, 1996). This is incorrect. Psychological and psychiatric services to medical patients are much more satisfactorily financed as an integral part of high-quality medical care (Working Party of the Royal College of Physicians and Royal College of Psychiatrists, 1995) and are no threat to over-stretched resources to community and other psychiatric services. Inadequate funding and administrative difficulties in community psychiatry should not distort discussion on the entirely separate issues concerning the role of consultation–liaison psychiatry.

The lack of support from psychiatric colleagues may reflect much wider conceptual arguments about the scope of psychiatry (Lieberman & Rush, 1996). Many psychiatrists are preoccupied with major traditional mental illness and with community services (Kessel, 1996) and reject the opportunities for new roles and responsibilities. As a result, a retreat from the care of those with non-psychotic disorders (wherever they present) has been accompanied by an abdication of interest in a very large proportion of psychological disorder, an abdication which could finally exclude psychiatry from medicine (Wessely, 1996).

CONCLUSION

Consultation–liaison has struggled to achieve recognition within psychiatry and medicine. We have not yet achieved the basic general hospital services which are the declared aim of psychiatrists, many medical specialities and, increasingly, of planners. Even so, I believe we must now move on to a different and more ambitious approach in which psychiatric and psychological expertise would be applied much more widely and effectively to the whole of medicine. Unless we do so, the bandwagons of guidelines, evidence-based medicine and systematic reviews will proceed apace across the whole of medicine and surgery, but their essential psychological and social dimensions will either be ignored or be taken on by other disciplines or by unevaluated counselling and alternative medicine. It is highly dangerous, at a time of reorganisation and turmoil in general and community psychiatry and of new methods of funding (Gonzales & Randel, 1996), to ignore an area in which our combination of medical and psychological expertise has much to offer for improving the care of very large numbers of people.

I believe that consultation–liaison should now move on from its restricted, even marginal, emergency role to become a major sub-speciality within psychiatry that works closely with the rest of medicine. The challenge is to achieve this in a manner that will not be divisive but will be seen as a valuable reformulation and extension of the role of clinical psychiatry (Lieberman & Rush, 1996). The implications are as great for underdeveloped countries as for developed ones (Sartorius, 1987).

RICHARD A. MAYOU, University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX

(First received 18 November 1996, revised 30 January 1997, accepted 7 February 1997)

REFERENCES

Agras, W. S. (1992) Some structural changes that might facilitate the development of behavioural medicine. *Journal of Consulting and Clinical Psychology*, **60**, 499–504.

Benjamin, S., House, A. & Jenkins, P. (1994) *Liaison Psychiatry: Defining Needs and Planning Services*. London: Royal College of Psychiatrists.

Gater, R. & Goldberg, D. (1991) Pathways to psychiatric care in South Manchester. *British Journal of Psychiatry*, **159**, 90–96.

Gonzales, J. J. & Randel, L. (1996) Consultation–liaison psychiatry in the managed care arena. *Psychiatric Clinics of North America*, **19**, 449–466.

Kessel, N. (1996) Editorial: Should we buy liaison psychiatry? *Journal of the Royal Society of Medicine*, **89**, 481–482.

Lieberman, J. A. & Rush, A. J. (1996) Redefining the role of psychiatry in medicine. *American Journal of Psychiatry*, **153**, 1388–1397.

Mayou, R. & Sharpe, M. C. (1995) Psychiatric illnesses associated with physical disease. *Baillière's Clinical Psychiatry*, **1**, 201–223.

—, Anderson, H., Feinmann, C., *et al* (1990) The present state of consultation–liaison psychiatry. *Psychiatric Bulletin*, **14**, 321–325.

—, Bass, C. & Sharpe, M. (1995) *Treatment of Functional Somatic Symptoms*. Oxford: Oxford University Press.

Rundell, J. R. & Wise, M. G. (1996) *Textbook of Consultation–Liaison Psychiatry*. Washington, D. C.: American Psychiatric Press.

Sartorius, N. (1987) Mental health policies and programs for the twenty-first century: a personal view. *Integrative Psychiatry*, **5**, 151–158.

Wessely, S. (1996) The rise of counselling and the return of alienism. *British Medical Journal*, **313**, 158–160.

Working Party of the 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.