

An overview of liaison psychiatry and its role in contemporary practice

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Introduction

This paper aims to give a brief overview of liaison psychiatry, a psychiatric (or medical) subspecialty that has evolved a lot in the past century and has brought significant changes in the way illness is being viewed and managed. A liaison psychiatry service is a multidisciplinary team based in general hospitals, dealing with psychiatric emergencies in the Accident & Emergency (A&E) department as well as with patients who have a comorbid physical and mental illness on the wards, irrespective of the cause. In some cases, liaison psychiatry teams also run outpatient clinics for patients with medically unexplained symptoms, functional illnesses or chronic pain. There are a few terms that are used interchangeably in literature to describe this speciality so a good starting point would be to define those and examine how they evolved, too.

Keywords: liaison psychiatry, integration, training, psychological medicine

Terminology

Christian Heinroth (1773-1843) was one of the first psychiatrists to think of illness as a continuum between body and mind and he is considered to be the individual who came up with the concept of “psychosomatic” illness for the first time.

George Engel was the first person to coin the term “biopsychosocial” (Engel, 1977) and one of the pioneers of consultation liaison psychiatry in the US. The term “psychological medicine” which currently describes the specialty in the US was coined by Felix Deutsch in 1922 (Lipsitt, 2001). Deutsch was Freud’s personal physician towards the end of his life and was also the first Professor of Psychosomatic Medicine at Washington University following his immigration to the US.

Dr Edward Billings, an American psychiatrist and pioneer in this field, coined the term “liaison psychiatry” for the first time and along with his colleague Dr Franklin Ebaugh they set up the first liaison psychiatry service at the University of Colorado in 1939 (Bloch et al, 2014). “Consultation liaison psychiatry”, “Liaison Psychiatry” and “Psychosomatic Medicine” are the three most used terms in current practice to describe this psychiatric subspecialty, with the latter being used the most in the US and Europe. If one was to try and define the concepts accurately, they should say that the first two terms describe the branch of psychiatry that lies between general medicine and psychiatry and its interface, whereas the psychosomatic medicine is a medical field which explores the interface between biological, social and psychological aspects of illness.

A very good definition of psychosomatic medicine, summarising nearly two centuries of opinions on this field, was given by Fava & Sonino in 2010 as “a comprehensive, interdisciplinary framework for:

- assessment of psychosocial factors affecting individual vulnerability and course and outcome of any type of disease;
- holistic consideration of patient care in clinical practice;
- integration of psychological therapies in the prevention, treatment and rehabilitation of medi-

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medical disease (psychological medicine)" (Fava & Sonino, 2010).

One could say that consultation- liaison (or liaison) psychiatry is the practice of psychosomatic medicine, which is essentially the theoretical framework and academic field of psychiatry.

In the UK, the term officially used by the Royal College of Psychiatrists is "Liaison Psychiatry", however some of the biggest departments across the country use the term "Psychological Medicine". A well-established department using this term is the one in Oxford and they define their role as "Our key characteristic is integration: first, integration with the medical services within which we work; second, integration of disciplines (psychiatry and psychology); and third, integration with the University" (<http://www.ouh.nhs.uk/psychologicalmedicine>, 2017).

Historical Aspects

Amongst the young psychiatrists that have recently finished their training in the UK, liaison psychiatry is considered to be a relatively young subspecialty, too. Most of us recall very well the incredibly positive results that came out of the economic evaluation done by Parsonage & Fossey in 2011 on the successful Birmingham RAID service but very few of us understand that the basis on which all liaison principles stand today, was formed long before that.

According to Geoffrey Lloyd (1980), liaison psychiatry is a "largely American phenomenon". Liaison psychiatry (a term formally agreed to describe the speciality at the interface between psychiatry and medicine in the UK) started flourishing in the US long before the 70's, which was the time when the very first steps were made in the UK. Formal training in consultation liaison psychiatry was on offer from the beginning of the 20th century in the US, with two most popular sites being the University of Rochester under the lead of George Engel and the Massachusetts General Hospital under Thomas Hackett's lead (Leigh, 2007). A lot of effort was put into promoting the importance of psychiatric aspects in physical illness and making psychiatry part of the medical community again. "Consultation-liaison psychiatry" was probably the most descriptive term to be used for this role as a psychiatrist who is working in the general hospital formally assesses patients from a psychiatric perspective but also has to liaise with several different disciplines and also increase awareness amongst his medical colleagues. So liaison psychiatry can be seen as having a therapeutic but also preventative role (Strain & Grossman, 1975).

It has been recorded in the literature that in the mid-

to-late 70's, the Psychiatry Education Branch of the National Institute of Mental Health in Washington increased the funding used towards training liaison psychiatrists by 270%, offering overall to liaison psychiatry 20% of its resources (Lloyd, 1980). This brought about a massive increase in the workforce of liaison psychiatry and led to the expansion of services across the country. In 1992 it was the first time when Consultation- Liaison psychiatry was proposed for the first time as a subspecialty. However, the American Board for Medical Specialties rejected the Academy of Psychosomatic Medicine's application (Camsari & Babalioglu, 2016). The psychiatric subspecialty was proposed again under the name of "Psychosomatic Medicine" in 2001 and eventually this was accepted officially in 2003.

In the United Kingdom, the initiative to incorporate psychiatry in the practices of a general hospital came later but didn't lack in enthusiasm and fruitfulness. The establishment of the Royal College of Psychiatrists brought different groups of psychiatrists together. The discussions were initiated by a small group of psychiatrists, led by Richard Mayou and Geoffrey Lloyd and in 1984 the first liaison psychiatry special interest group was created within the college. The former psychiatrist became the chairman of the group and remained in post until 1989. This group was instrumental in the way liaison psychiatry developed in the future years and its activities included: holding regular meetings, setting up surveys to monitor progress, doing research, promoting service development, facilitating teaching and training, drawing up guidelines and creating links with other medical organisations as well as (Aitkin et al, 2016). The special interest group developed into a section of the College in 1997 and a faculty in 2004 and it now counts more than 4000 members. The Liaison Faculty within the College consists of an Executive committee and 12 elected members and organises conferences and meetings on an annual basis. In the United Kingdom, Liaison psychiatry is a subspecialty of General Psychiatry, recognised by the General Medical Council and it has its own curriculum (http://www.gmc-uk.org/education/approved_curricula_systems.asp, 2017).

In Greece, as in many other countries, the development of Liaison Psychiatry has been linked to the development of psychiatric departments in the general hospital and the de-institutionalization movement. The movement of bringing psychiatric wards back to the premises of the general hospital and providing input towards the treatment of physically ill patients with a mental illness, started from the periphery rather than large urban (big) centers. The reasons for this order of changes are complex and relate mainly to political decisions but also to the resistance that led to the deinstitutionalization and the transition from the large psychia-

tric hospital to the general hospital by the professionals of the regions who had established psychiatric services for many years. This resistance was minimal in the region where psychiatric services were rare (Douzenis, Lykouras & Christodoulou, 2008). The first one to form was that of Alexandroupolis University Hospital in 1978 (Lykouras & Douzenis, 2012). A few years later, in 1983, another department was founded at the University Hospital of Ioannina and since then, using a framework for the establishment of services that would support the de-institutionalization, psychiatric departments were founded in all the newly established general hospitals by the Greek National Health System (EZY) and since 1986 in the existing general hospitals (Hyphantis, Mantas & Mavreas, 2008; Douzenis, Lykouras & Christodoulou, 2008). The most widespread model of Liaison Psychiatry in Greek State Hospitals is the traditional consultation model where a psychiatrist is called to evaluate a patient who raises concern among the physicians with his behavior or who has an established psychiatric diagnosis or upon admission and during hospitalization receives psychiatric medication (Madianos, Madianou & Stefanis, 1993). In Greece, it is considered that the "patient-centered" approach increases the autonomy of the psychiatrist. This approach has its benefits, but one of its disadvantages is that there is inadequate continuity of care. Patients are assessed from a mental health perspective, but little effort is made to maintain contact with psychiatric services after their discharge. Some departments try to overcome this difficulty by planning an outpatient appointment before the patient's discharge, but this is not always feasible. The "Doctor-centered approach" is rarely used as it implies that physicians accept the psychiatrist as a specialist who overlooks the patient's care and can direct the physicians towards the best possible approach and empower them to address some of the psychological needs of their patients (Madianos, Tsiantis & Zacharakis, 1999). This approach is used to some extent in university hospitals. Some hospitals have also developed specialized outpatient clinics, an example being the psycho-oncology and self-harm clinics in the liaison psychiatry department of the "SOTIRIA" Hospital and / or approaches such as the psychodynamic approach at the Ioannina University Hospital (Moussas et al. 2009; Moussas & Papadopoulou, 2012; Hyphantis, Mantas & Mavreas, 2008). Currently, there are 37 district general hospitals operating a liaison psychiatry service out of a total of about 100 across Greece. Liaison psychiatry is not currently recognized as a subspecialty of psychiatry in Greece, although the recommendation was approved in 2007 (alongside Old-Age Psychiatry and Forensic Psychiatry) by the Central Council of the Ministry of Health (Lykouras et al. 2007).

Scope of practice

In 2011, the European Association of C-L Psychiatry and Psychosomatic Medicine and the Academy of Psychosomatic Medicine published a consensus paper on the journal *Psychosomatics* (Leentjens et al, 2011) outlining the competencies and scope of work for liaison psychiatry. The aim of this was to establish a base for the international liaison psychiatrist and their service. The consensus was agreed amongst a taskforce that was formed a few years earlier for that purpose. According to the methodology outlined on the paper, the group used mainly expert opinions published in scientific journals and textbooks but also evidence based evidence where appropriate.

The authors of this paper identify six categories of patients who would benefit from liaison psychiatry input. These are: patients who have comorbid physical and mental illnesses, patients who are suffering from medically unexplained symptoms, patients whose mental illness is a direct consequence of a medical condition, patients whose management is only available in a general hospital setting, patients who have self harmed or have attempted suicide and patients whose personality traits or health behaviour may interfere with their treatment.

In terms of the competencies a liaison psychiatrist should have, according to the authors of this paper these are not limited to the medical expertise in the diagnosis and treatment of patients with comorbid physical and mental illness. Liaison psychiatrists should also have expertise in the roles of the "Communicator", "Collaborator", "Manager", "Supervisor", "Health Advocate", "Scholar" and "Professional".

Finally, the paper includes a number of the most common psychiatric syndromes a liaison psychiatrist will come across. These included delirium & dementia, mood anxiety and psychotic syndromes, personality disorders, self-harm and suicidal behaviour, psychological problems stemming from terminal illness, neuropsychiatric disorders, medically unexplained symptoms, sleep disorders, psychological issues related to bereavement and adjustment, behaviours interfering with medical or surgical treatment and chronic pain.

This consensus was developed with the view to be reviewed in 2015 but according to our knowledge it hasn't been replaced as yet.

Service models

80% of hospital occupancy is by patients who have a comorbid physical and mental illness (RCPsych, 2013). In long-term physical conditions, 25-33% of pa-

tients have a comorbid mental illness, which invariably impacts on their overall treatment and recovery (Naylor et al, 2012). Following the development of the RAID (Rapid Assessment Interface and Discharge) service in Birmingham in 2009 and the subsequent evaluation of the savings for every hospital employing that model, the development of liaison services across the United Kingdom took a very positive turn. In 2013, "The Psychiatrist" published a paper on the impact and cost savings of the RAID model (Tadros et al, 2013). According to the authors, the use of a RAID service in a hospital of 600 beds reduced the length of patient stay by 21-42 beds per day. They also showed reduction of readmissions of patients following direct RAID input to 4 readmissions for every 100 patients as opposed to 15 readmissions in the pre-RAID model. The results correlated with the estimation of an overall saving of £1:£4 by the London School of Economics (Parsonage & Fossey, 2011) which meant that for every £1 put in to the service, the RAID model would bring back to that hospital £4 in total savings.

In the United Kingdom, four models of liaison care have been proposed as suggestions for service specification, depending on the demands of the locality and the funds available (Aitken et al, 2014). The Core liaison service is the most basic model for the purpose that the subspecialty serves and is proposed to be used in those areas where mostly emergency psychiatric care is needed and a 24/7 model wouldn't be cost effective. The Core 24 model serves a locality with greater demands and likely a busy emergency department and it operates 24 hours a day, 7 days a week. The Enhanced 24 liaison psychiatry services go one step further by having some specialist input like drug & alcohol and also covering gaps in other mental health pathways or providing some outpatient services. Finally, the Comprehensive liaison psychiatry service covers both emergency and elective care, it includes specialist services as well as other disciplines like psychology and occupational therapy. They may support outpatient services and on some occasions have specialist liaison inpatient beds.

Training in the United Kingdom

The curriculum for training in Liaison Psychiatry is set out by the Royal College of Psychiatrists, an updated version of which was published in 2016 (RCPsych, 2016). This documents sets out the learning objectives trainees need to meet and the knowledge they have to acquire in order to be awarded with an endorsement in liaison psychiatry along with their Certificate of Completion of Training in General Adult Psychiatry. The document is read in conjunction with the

Core Curriculum in psychiatry, which refers to the whole of the specialty.

The pathway for achieving a CCT in liaison psychiatry in the UK starts with the Foundation Programme for a total of two years during which the trainee achieves basic competencies in medicine. The trainee enters this programme after medical school through national recruitment and it has its own curriculum. Once this is completed, the trainee who has chosen to follow psychiatry will go through national recruitment again in order to enter its Core training which typically lasts for three years during which the trainee will again have to show certain competencies, go through the process of appraisal every year and also pass their professional exams in order to obtain Membership with the Royal College of Psychiatrists (MRCPsych). When this has been achieved, the trainee will enter the final stage of the training through national recruitment, the higher or advanced training. During these final three years, the trainee has to choose whether they would like to practice in General Adult Psychiatry, Old-Age Psychiatry, Child & Adolescent Psychiatry, Psychiatry of Learning Disability, Forensic Psychiatry and Medical Psychotherapy.

Liaison Psychiatry is an approved sub-specialty of General Adult and most recently Old-Age Psychiatry. It is awarded through an "endorsement" in the subspecialty (others being Rehabilitation psychiatry and Substance misuse psychiatry). For the endorsement in liaison psychiatry to be recognised, the trainee has to complete 12 months practicing in an approved liaison psychiatry post during their higher specialty training and they have to achieve the competencies set out in the aforementioned curriculum. More detailed information can be found on the webpage of the Royal College of Psychiatrists (www.rcpsych.ac.uk).

Discussion

Liaison psychiatrists do not need to prove the importance of their presence in a general hospital. The number of patients in need of psychiatric input while being admitted with physical illness has been documented numerous times over the past decades and the medical community also supports the view that their presence is essential. More work is required in increasing awareness in the psychiatric community of the value of liaison psychiatry. The battle for psychiatry being recognised as an important speciality as any other isn't over yet. The value of the presence of psychiatrists in the general hospital is not limited to diagnosing and treating mental illness. There is greater importance in raising awareness amongst patients and staff and also raising the bar

of good quality care and parity of esteem for psychiatry that most psychiatric communities would agree has not been achieved yet. Liaison psychiatry is about fighting the stigma of mental illness from within, mixing with the “accepted side” of illness, embracing the critics of psychiatry and slowly but surely making small steps towards decreasing that gap on the scale of acceptance of mental vs physical illness.

Teaching and training in the general hospitals is a fundamental part of liaison psychiatric practice. This is not only because of the exchange of information amongst different disciplines and the raising of awareness but most importantly because of its significant potential to help the medical community normalise the concept of psychiatry and mental illness as part of life, like it has in other medical specialities.

The field of psychiatry has chronically suffered from criticism more than any other medical speciality. If we forget about the stigma for a moment, understanding the brain and its functions, defining what is a mind, trying to differentiate mental illness from one’s core sense of being, has been very difficult. The high volume of research that has taken place recently has helped a great deal towards putting a substance to abstract terms and hypotheses.

Being great believers of liaison psychiatry and with great respect to the whole of psychiatry and its contributions, we think that liaison psychiatry places our unique speciality in a great position to prove our value in clinical care, integrate not only mental health with physical health but also medicine with surgery, medicine with nursing and social care and all other aspects of clinical care. This is based on the observation that clinical care suffers from lack of communication and patience as well as integration that psychiatry has brought back to the front line and patients can truly benefit a great deal from this.

References

- Aitken P, Robens S, Emmens T. (2014). Developing models for liaison psychiatry services- Guidance, Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions, South West.
- Bloch S, Green SA, Holmes J. (2014). *Psychiatry: Past Present and Prospect*, Oxford University Press, ISBN: 9780199638963.
- Camsari U, Babalioglu M. (2016). Editorial: Brief History of Consultation-Liaison Psychiatry, its current status and training in Modern Psychiatry, Turkish journal of psychiatry.
- Douzenis A, Lykouras L, Christodoulou GN. (2008). Consultation liaison psychiatry in Greece. *J Psychosom Res*;64:457-8.
- Engel GL. (1977). The need for a new medical model: A challenge for biomedicine. *Science* 196:129-136. ISSN 0036-8075 (print) / ISSN 1095-9203.
- Fava GA, Sonino N. (2010). Psychosomatic Medicine DISCLOSURES, *International Journal of Clinical Practice*, 64(10):1155-1161.
- Holmes J, Bloch S, Green S. (2014). *Psychiatry: Past, Present and Prospect*, Oxford University Press, ISBN: 9780199638963.
http://www.gmc-uk.org/education/approved_curricula_systems.asp. (2017).
http://www.gmc-uk.org/education/approved_curricula_systems.asp. (2017).
<http://www.ouh.nhs.uk/psychologicalmedicine>. (2017).
- Hyphantis T, Mantas C, Mavreas V. (2009). The psychodynamically oriented Consultation-Liaison Psychiatry Unit, University of Ioannina, Greece. *Journal of Psychosomatic Research* 66, 95-97.
- Leentjens AF, Rundell J, Wolcott D, Guthrie E, Kathol R et al. (2011). *Journal of Psychosomatic Research*, 70 (5), 486-491.
- Leigh H, Streltzer J. Eds. (2007). *Handbook of Consultation Liaison Psychiatry*, XIV, 420p., 10 Illus., Hardcover, ISBN: 978-0-387-69253-1.
- Lipsitt DR. (2001). Consultation-liaison psychiatry and psychosomatic medicine: the company they keep. *Psychosomatic Medicine*, 63:896-909.
- Lloyd GG. (1980). Whence and whither 'liason' psychiatry?, *Psychological Medicine*, 10(1):11-4.
- Lykouras E, Gournellis R, Zervas I, Douzenis A, Politis A, et al. (2007). Interuniversity harmonization for the development of subspecialties of consultation-liaison: Psychiatry, old age psychiatry and forensic psychiatry. Consensus statement of the Hellenic College of Academic Psychiatry. *Arch Hellenic Med*;24:487-507.
- Lykouras L, Douzenis A. (2007). Consultation- Liaison Psychiatry in Greece, *Psychiatriki*, 18(2):110.
- Madianos MG, Madianou D, Stefanis CN. (1993). Help-seeking behavior for psychiatric disorder from physicians or psychiatrists in Greece. *Soc Psychiatry Psychiatr Epidemiol* 28:285-91.
- Madianos MG, Tsiantis G, Zacharakis C. (1999). Changing patterns of mental health in Greece (1994-1996). *Eur Psychiatry*, 14:462-7.
- Moussas G, Papadopoulou A. (2012). The Psychiatric Section of the General Hospital and patients with cancer. *Psychiatriki*, 23:199.
- Moussas G, Tournikioti K, Tselebis A, Rizos E, Bratis D et al. (2009). Suicide attempts in the General Hospital and warning signs. *Psychiatriki*, 20:153-161.
- Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M. et al. (2012). Long- term conditions and mental health: the cost of co-morbidities. London: The King's Fund and Centre for Mental Health.
- Parsonage M, Fossey M. (2011). Economic Evaluation of Liaison Psychiatry Service, Centre for Mental Health.
- Royal College of Psychiatrists. (2013). Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health. London: Royal College of Psychiatrists.
- Royal College of Psychiatrists. (2013). College Report 183; Liaison Psychiatry for Every Acute Hospital; Integrated Mental and Physical Health Care.
- Royal College of Psychiatrists. (2016). A specialty based curriculum for Specialist Training in Psychiatry.
- Schwab JJ. (1989). Consultation-Liaison Psychiatry: A Historical Overview, *Psychosomatics*, 30(3): 245-254.
- Strain JJ, Grossman S. (1975). *Psychological care of the medically ill: A primer in liaison psychiatry*, Appleton- Century-Crofts, New York.
- Tadros G, Salama R, Kingston P, Mustafa N, Johnson E et al. (2013). Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: The Birmingham RAID model. *The Psychiatrist*, 37:4-10.