

LIAISON PSYCHIATRY

Simona Claudia Tamasan¹, Gabriela Zarie²

REZUMAT

Articolul prezintă o perspectivă locală asupra unor aspecte actuale în psihiatria de legătură: medicale, economice și sociale. Perspectiva medicală prezintă patologia psihiatrică cea mai frecvent întâlnită în secțiile medico-chirurgicale și serviciile de urgență - depresia, anxietatea și somatizarea. Perspectiva economică aduce în discuție raportul cost-eficiență favorabil al intervenției psihiatrice în spitalul general. Perspectiva educațională subliniază importanța recunoașterii de către orice medic a rolului factorilor psihosociali în determinismul bolilor somatice. Sunt discutate în final direcțiile de dezvoltare ale acestui domeniu de interdisciplinaritate.

Cuvinte cheie: psihiatrie de legătură, spital, tulburare psihică, legătura minte-corp, echipă multidisciplinară.

ABSTRACT

The present review presents a local perspective over different aspects of liaison psychiatry today: medical, economical and educational. The medical perspective will present the most frequent pathology found in medical-surgical departments and emergency services - depression, anxiety and somatization. The economic perspective will emphasize the positive cost-efficiency balance of the psychiatric intervention in a general hospital. The educational perspective will underline the importance of recognizing the role of psychosocial factors in disorder's determinism. Finally, we discuss the future directions for this interdisciplinary domain.

Key Words: liaison psychiatry, general hospital, mental disorder, mind-body connection, multidisciplinary team.

Liaison psychiatry, or liaison consultation, or psychosomatic consultation-liaison creates the bridge between psychiatric services and the other medical branches and family medicine. Liaison psychiatrists work in general hospitals or medical – surgical departments, outside psychiatric hospitals or specialized departments. They provide psychiatric evaluations for patients with somatic complaints referred by the physicians and establish the proper therapeutic conduct: psycho-pharmaceutical, psychotherapeutic, or a combined one.

Based on direct observation in this new field in Romanian hospitals, the present article aims at presenting a local perspective of liaison psychiatry from

three different points of view: medical, economical and educational. We will highlight the importance of the inpatient multidisciplinary approach, and also some particular aspects of the field.

In the general hospital, a significant number of medical – surgical patients having a neuropsychiatric pathology, even a serious one, get along undiagnosed properly and as a consequence, they are not treated. Furthermore, a frequently ignored issue is the psychological distress determined by the somatic disorder or surgical intervention, by the change that has occurred in the doctor – patient relation and the high technology's impact on a suffering person. These gaps are remedied or at least alleviated by the presence of a liaison psychiatry service.¹ The non directive and non paternalist approach of the consulting psychiatrist, and also the promotion of a true and empathic communication, transform the patient in an informed partner involved in his/her own healing process.

Individualized interventions, the need for permanent communication with colleagues from other specialties or with general practitioners, the specificity of the field require some important skills from the part of the consulting psychiatrist. The most representative

¹ Timisoara Clinical Emergency Hospital, ² Timisoara Municipal Hospital

Correspondence to:
Simona Tamasan, Clinical Emergency Hospital, 156 I. Bulbuca St.,
Timisoara, Tel. +40256463001.
Email: simona_tamasan@yahoo.com

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are considered to be the following:^{2,3}

- Understanding psychopathology, knowledge about differential diagnosis and formulating of an axis diagnosis;

- The way in which psychiatric co-morbidity varies;

- Ability to evaluate hospitalization stressors;

- Understanding factors' interaction from the social support network and interpersonal conflicts;

- Solid pharmaceutical knowledge, crisis intervention and conflicts resolution;

- The ability to look into perspective regarding the therapeutic plan;

- Promoting the application of ethic standards in the therapeutic management;

- Identifying and signaling the cases with forensic potential;

- Administrative co-ordination of problems that could be raised by the system;

- Knowledge about the economic realities of medical services.

The degree of development of the psychiatry liaison specialty and its mode of operation differ from country to country, depending on the organization of health services and the varying attitudes towards the disorders. There is a wide range of liaison psychiatric services models. The best description is done in terms of size, staff's experience and multi-disciplinarity.⁴ The mono-disciplinary services are based on a standard medical model where the psychiatrist has the role of consultant, while multidisciplinary teams work more and more in a manner comparable to the community model of mental health. The first model offers a relatively narrow range of interventions, most of the times tributary to the psychiatrist's favorite pharmacological or psychotherapeutic orientation.

The second model includes the latest specific psychosocial acquisitions, increasing the range of services provided to people in pain. The continuous change of these models is aimed at clarifying and increasing the role of liaison psychiatric services.

In Romania, the liaison psychiatry started at the University Hospital from Bucharest in August 1995, benefiting since the beginning from electronic data recording which permitted a permanent analysis of service functioning.⁵ The arguments provided by the service from Bucharest, the release of the legislative support in the Mental Health Law and the support received from the decision factors on the local level made it possible to start this healthcare domain also in the Banat region. The Clinical Emergency Hospital and the Municipal Hospital from Timisoara benefit

from a consultant psychiatrist's services since 2002, based for the moment on a standard medical model.

After 30 months of "real world" liaison psychiatry practice, and taking into account the international experience in this field, we will discuss three working perspectives. The medical perspective will present the most frequent pathology found in medical-surgical departments and emergency services; the economic perspective will debate the cost-efficiency balance of the psychiatric approach, and the educational perspective will underline the importance of recognizing the role of psychosocial factors in disorder's determinism.

1. THE MEDICAL PERSPECTIVE

The incidence and prevalence data of general morbidity demonstrate that within the community, a common form of suffering is represented by the somatic-psychiatric co-morbidity. In a general hospital, at least 30% of the patients have a diagnosable psychiatric disorder. Delirium is detected in 10% of the somatic patients and in over 30% individuals from the risk groups. Two thirds of the patients who are high users of medical services (in terms of multiple consultations and investigations performed) have psychiatric pathology: 23% depressive disorders, 22% anxious disorders and 20% have somatization disorders.³ Any type of superimposed psychiatric pathology proves to be a strong indicator for prolonging the duration of hospitalization or an increasing rate of re-admission. The percent of inpatients that benefit of a psychiatric assessment vary from case to case from 1% to 10 %.⁴

The liaison psychiatry's intervention domain is well represented in a wide variety of medical-surgical disciplines, and the consultation liaison population tends to change over time in term of levels of psychosocial and somatic functioning.⁶ The best documented until present, and the ones where the importance of liaison psychiatry services is expected to grow, according to the tendency of integrative approach of each patient in particular are the following:

- The entire internal and psychosomatic medicine;
- Neurology, neurosurgery and intensive care;
- Dialysis;
- Dermatology;
- Endocrinology;
- Psycho-oncology;
- Gerontology and palliative care;
- Orthopedics, trauma surgery, plastic and reparatory surgery;
- Obstetrics-gynecology;

- Interventions concerning organ transplant;
- Pediatric field.

Prevention, treatment and rehabilitation of a somatic disease include considerations related to the co-morbid or secondary conditions, psychiatric treatment, and interventions on abnormal behaviors related to the disease. The psychiatric evaluation facilitates case identification, which needs specialized intervention on abnormal behaviors or early interventions, thus lowering the global costs, and the transfer rate into a psychiatric unit.⁷ Ideally, in a general hospital the psychiatric service should be available around the clock and the initial consultation should be followed by at least one control consultation before referring the patient to the specialized psychiatric settings, or to the primary care. In the case of a chronic somatic condition (for example, a diabetic patient with over-added anxiety, or a coronary patient with depression) it is considered optimal to provide the follow-up psychiatric treatment in the same medical location for both disorders.

In current liaison psychiatrist's activity, the most frequent requests are for the following clinical conditions:

- Depression and/or anxiety;
- Psychomotor agitation state;
- Delirium, intoxication or withdrawal state after alcohol and other psychoactive substances;
- Hallucinatory states and organic psychosis;
- Suicide and deliberate self-harming;
- Insomnia;
- Somatization;
- Neurasthenia and chronic fatigue syndrome;
- Behavioral syndromes determined by a medical condition or by the presence of a painful syndrome insufficiently controlled;
- Non-compliance or refuse to consent to treatment or medical-surgical procedures;
- Cases with a forensic component.

Acute interventions are addressed to delirium, withdrawal states and intoxications in case of addictive patients, attempted suicide cases or deliberate self-harming, but also panic attacks or noisy somatic complains from the somatic diseases. Other similar situations are the psychotic symptoms determined by cerebral organic pathology or due to a medical condition, and some psychiatric disturbing disorders accompanied by physical symptoms.

Undoubtedly, the most frequent diagnosis found in liaison psychiatry is depression – often combined with anxiety, sometime as a common distress syndrome in medically ill patients.⁸ Very often somatization, or

so called medically unexplained symptoms, is also encountered. These pathology types are known to be great consumers of resources and medical services, both in primary care and also in medical-surgical wards. Most of the times, these individuals, with various degrees of psychopathology, get assistance only for the medical-surgical condition or for the somatic symptoms that requested hospital admission. Psychiatric and psychological problems are frequently not recognized; even if recognized, they are often not treated.⁹

Masked psychiatric pathology or the superposed one is identified by the consultant psychiatrist when a liaison psychiatry service with a proper referral route is present in a general hospital. Often enough, even if the main reason for requesting a psychiatric assessment was represented by another problem, the psychiatrist identifies a co-morbid psychiatric condition, not recognized, more severe (a patient with a slight agitation could be delirious, a withdrawn patient could have suicidal thoughts, and a non-cooperative patient can be demented). A significant group of mental health users appear in this manner for the psychiatric wards, outpatient psychiatric services or other mental health system's facilities, benefiting of a appropriate therapy, specific and targeted, efficient from the global costs point of view. From this perspective, work in liaison psychiatry has also specific preventive valences. In this way, selective prevention approaches – addressed to high risks individuals concerning psychiatric illness, and targeted prevention, dedicated to individuals with a minimum symptomatic level, are promoted. In order to meet such targets, a team approach, including psychologists for counseling and psychotherapy, specialized nurses for screening, monitoring and specific intervention, and also social workers seem to be indispensable.

Liaison services offer also specific interventions for the chronic psychotic patients in medical-surgical departments of the general hospital who are sometimes predisposed to some unwanted stigmatization.¹⁰ This type of patients, although they have an increased morbidity compared to the general population, are accessing with more difficulty the hospital's wards and the history of the psychiatric disorder is most of the times inaccessible to the liaison psychiatrist. Actual efforts are directed towards identifying specific needs of medical care of this particular category of patients.¹¹

During the ordinary hospital activity, liaison psychiatry services attend emergency care units. In these services, the psychiatrist can offer a systematic

selection that will reduce waiting or transit times and also ensuring an efficient integration and an adequate management of the psychiatric patients in these conditions.¹² The particularly stressful environment of this compartment, and also the limited time of the examination, the particularities of the decisional process, patient's and relatives' expectancies represent important challenges. Polymorphic complains, uncharacteristic or atypical for a certain medical-surgical condition and also agitated patients, severely disturbed or difficult ones require the psychiatrist's presence. Likewise, patients' complains that don't match with a medical or surgical condition recognized by the doctors from other specialties as being treatable are referred eventually to the consultant psychiatrist. In these cases, the consultant is essentially the physician and just secondary the psychiatrist, who approaches the differential diagnosis issue between a primary psychiatric pathology, or one secondary to some medical-surgical condition one.

2. THE ECONOMIC PERSPECTIVE

In the last decades, tributary to almost diametrically opposed tendencies regarding the increase of the medical services on one hand and the limitation of the financial resources on the other hand, each health services provider faces an increasing pressure in justifying costs. From the strategic perspective of the cost-efficiency balance in health care, the evaluation and systematic re-evaluation of the provided medical services' efficiency was created as a priority of the system managers.

The problem does not avoid liaison psychiatry programs which have to prove that the specific approach of the somatic patient, psycho-pharmacologically and/or psychotherapeutically is viable regarding resources' distribution.⁹ Besides directly quantifiable proofs of the treatment of co-morbid psychiatric disorders, indirect arguments are represented by the significant well-documented impact that psycho-social problems have on medical outcome and overall costs. Many times these issues, which are cared for by the psychiatric services from general hospitals, complicate the evolution and results of long term treatment of the chronic illnesses. The experience of a liaison psychiatry service can provide valuable data concerning the bio-psycho-social approach of such patients.

Rather implicating the indirect and hidden costs of the disease, the efficiency of the psychiatric intervention in general hospital is difficult to estimate. Although it is less representative, the easiest parameter

to follow is represented by reduced hospitalization days. Moreover, the impact of liaison psychiatric approach could be better quantified in terms of middle and long-term compliance, and benefits brought to the general health, social functioning and quality of life.

The psychiatrists from the general hospital are at the same time valuable partners of the managerial teams, responsible for the resource management and personnel administration. For the quality and effectiveness of the medical act, the active role of the psychiatry services in the general hospital cannot be neglected in providing acute intervention for burn-out syndromes of the medical personnel, a role which is well documented.¹³

3. THE EDUCATIONAL PERSPECTIVE

Improvement of the psychiatric screening in the general hospital and effective interventions, and also the optimization of the preventive valences of the psychiatric liaison require a very good cooperation with well-trained physicians from other specialties. Among contemporary educational priorities in medical education is the polyvalent approach: biological, psychological and social of the patient. The promoted liaison psychiatric services' experience provides valuable data in this direction.¹⁴ It seems to be indispensable for doctors to acquire a wide range of skills in psychological care, and to move on from a clear cut mind-body distinction approach.¹⁵

For these reasons, beginning with the training period, the psychiatry stage in a general hospital appears to be very helpful. Here favorable conditions exist for developing decisional capacities, abilities to face professional challenges and promptness, regardless of further medical practice field. The future doctors are getting familiar with the psychological perspective of the somatic disease. In the same time, they have to be familiar with the specific psychiatric pathology found in the medical or surgical wards. This perspective cannot miss from the continuous medical educational programs of physicians and surgeons who have to become receptive to the psychological needs of their patients and to be aware of the indications for an interdisciplinary psychiatric consultation.

FUTURE DIRECTIONS

The pressure to which doctors are exposed in a general hospital is about to modify the tendency regarding their therapeutic option – from the paternalist system towards the patient's transformation into an

informed partner, ready to actively participate to his/her own recovery. This change of paradigm in medical care can be done easier when a liaison psychiatric or psychosomatic service is involved in the process. Furthermore, the increasing importance presently given to the psychological and social factors involved in the determinism and evolution of somatic pathology reinvests the psychiatrist with key attributions in the therapeutic team of a general hospital. An essential factor in optimizing the interdisciplinary co-operation is overcoming the resistance to change, also regarding the physician and psychiatrist themselves.¹⁶⁻¹⁸

Finally, an ideal liaison psychiatric service should adopt, at the beginning of the 21st century, a community intervention model. Such approach would assume the existence of a well articulated multidisciplinary team, formed of psychiatrists, psychotherapists and psychologists, social workers and specialized nurses. This service should have a tight relation with doctors from the hospital, with other mental health services available at the local or regional level, and with primary care practitioners. Efficient cooperation would lead to active involvement of the service, not only in the treatment and rehabilitation of the inpatients, but also in every prevention phases. And perhaps, most significant, it would actively intervene in prevention of the communication gaps between the practitioners from different levels of the health care system.

REFERENCES

1. Creed F. Developments in liaison psychiatry. *Current Opinion in Psychiatry* 1996;9:433-8.
2. Tudose F. Liaison psychiatry in general hospital – contemporary direction in psychiatric reform. *Romanian Journal of Mental Health* 1998;10:37-46.
3. Bronheim HE, Fulop G, Kunkel EJ, et al. Practice guidelines for psychiatric consultation in the general medical setting. *Psychosomatics* 1998;39:8-30.
4. Huysse FJ, Herzog T, Lobo A, et al. European consultation-liaison psychiatric services: The ECLW collaborative study. *Acta Psychiatrica Scandinavica* 2000;101:360-6.
5. Tudose F. Body in psychiatry – Doctoral thesis 1998, University of Medicine and Pharmacy “Carol Davila” București.
6. Diefenbacher A, Strain JJ. Consultation liaison psychiatry: stability and change over a 10-year-period. *General Hospital Psychiatry* 2002;24:249-56.
7. Lederberg MS. Making a situational diagnosis: Psychiatrists at the interface of psychiatry and ethics in the consultation-liaison setting. *Psychosomatics* 1997;38:327-38.
8. Clarke DM, Smith GC, Dowe DL, et al. An empirically derived taxonomy of common distress syndromes in the medically ill. *Journal of Psychosomatic Research* 2003;54:323-30.
9. Lloyd GG, Mayou RA. Liaison psychiatry or psychological medicine? *British Journal of Psychiatry* 2003;183:5-7.
10. Byrne P. Psychiatric stigma. *British Journal of Psychiatry* 2001;178:281-4.
11. Lamdan, RM, Ramchandani D, Schindler BA. The chronically mentally ill on a general hospital consultation-liaison service: Their needs and management. *Psychosomatics* 1997;38:472-7.
12. Anderson WH. The emergency room, in Hackett, T.P. & Cassem, N.H. (eds.), *Massachusetts General Hospital Handbook of General Hospital Psychiatry*, 2nd ed., PSG Publishing Company, Littleton, Massachusetts, p 419-437, 1987.
13. Cox J. Psychiatric training and professional conduct. *Current Opinion in Psychiatry* 1996;9:372-6.
14. Strain JJ, Mustafa S, Flores LR, et al. Consultation-Liaison Psychiatry Literature Database (2003 update). Part I: Consultation - Liaison Literature Database: 2003 update and national lists. *General Hospital Psychiatry* 2003;25:378-85.
15. Kendell RE. The distinction between mental and physical illness. *British Journal of Psychiatry* 2001;178:490-3.
16. Mayou RA. Liaison psychiatry. *British Journal of Psychiatry* 2001;179:273-5.
17. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders fourth edition*, American Psychiatric Press, Inc., Washington D.C., 1994.
18. World Health Organization. *The ICD-10 Classification of mental and Behavioral Disorders. Clinical Descriptions and Diagnostic Guidelines*. Geneva. WHO, 1992.