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GERALDINE SWIFT AND ELSE GUTHRIE

Liaison psychiatry continues to expand: developing services in the British Isles

AIMS AND METHOD
A postal survey of consultants in liaison psychiatry was carried out in the spring of 2002 to document the current state of liaison psychiatry in the UK and the Republic of Ireland. Information was collected on post specifications, clinical organisation and plans for further local development.

RESULTS
Ninety-three liaison consultants were identified. Seventy-seven posts were full-time or half-time, compared with 43 such posts in 1996. During the same time period, specialist registrar training posts have doubled from 30 to 61. A third of respondents anticipated further consultant posts in their region.

CLINICAL IMPLICATIONS
Despite the increase in the number of liaison consultants since 1996, the numbers still fall below that recommended by the Royal College of Psychiatrists. Liaison consultants need to improve links with primary care and continue to develop specialised services to demonstrate the qualitative and financial benefits that liaison psychiatry has to offer to a wide range of patients.

Psychiatric illnesses have been managed within general hospital settings for centuries (Mayou, 1989), but the development of specific services dedicated to the psychological assessment and treatment of medical and surgical patients is a much more recent phenomenon. Liaison psychiatry services were virtually unknown in the UK and the Republic of Ireland in the 1970s and by 1985, a survey documented only nine full-time consultant posts (Lloyd, 2001). Over the next 15 years, there was a rapid expansion of consultant-led liaison services in the UK to the extent that Guthrie identified 86 consultant posts by the mid-1990s (Guthrie, 1998). Forty-three consultants held either full-time equivalent (FTE) or half-time equivalent (HTE) posts and 16 of these had acquired their position in the preceding 2 years. The distribution of posts across the UK was patchy, with 23/86 based in London, and this uneven distribution persisted in a more recent survey (Burlinson & Guthrie, 2001). Meanwhile in the Republic of Ireland, the first liaison consultant was appointed in 1995 and the number of posts has crept up since to no more than a handful. Guthrie & Burlinson noted that the lack of a database of liaison psychiatrists made it difficult to monitor progress towards the College's recommended guidelines of 0.4 FTE consultants in liaison psychiatry per 100 000 population.

The aim of this study was to establish the current state of liaison psychiatry in the UK and the Republic of Ireland, and to set up a working database of consultant liaison posts.

Method

A list of liaison consultants was available from the earlier survey in 2000 (Burlinson & Guthrie, 2001). Names and addresses of additional consultants were sought from regional representatives of liaison psychiatry. Postal questionnaires were sent to consultants thus identified, who in turn were asked about liaison colleagues not on the list provided. In addition, delegates at the Royal College annual residential liaison meeting were also surveyed. Information was gathered between December 2001 and June 2002.

Information was sought on specifications of each post: whether it was full-time, part-time or sessional; sources of funding; and characteristics of the hospital in which it was based. From a clinical perspective, we enquired whether respondents worked in multidisciplinary teams; whether they offered specialised services such as psycho-oncology; and, given the recent transfer of resources to primary care teams, whether respondents accepted referrals directly from general practitioners (GPs). In terms of the expansion of liaison psychiatry, we asked how long each respondent had been in post and whether this post was new when they started; whether they were an approved specialist registrar (SpR) trainer; and whether there were plans to increase the number of SpR or consultant liaison posts in the region. Finally, respondents were asked whether the service they offered was sufficient for the size and complexity of the hospital. Questions were in the form of multiple choice and respondents were invited to comment on their replies. Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 10.0.

Results

107 questionnaires were completed. Of these, five respondents were working as liaison consultants in child and adolescent health services. Three consultants were working in adult liaison psychiatry, but posts were not funded. Seven respondents were either working as locums or had moved from a liaison post into other work. Therefore, 92 consultants were identified who returned information on funded adult liaison psychiatry posts. Seventy-six respondents (and one identified consultant who did not return a questionnaire) held either full-time or half-time equivalent (FTE/HTE) posts: of these, 20

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Table 1. Regional distribution of full-time/part-time consultant liaison posts in 2001 and 1996

Region	Number of consultant posts (2001)	Number of consultant posts (1996)
East Anglia	4	1
London	17	15
North East	2	0
North West	13	5
South East	3	3
South West	2	0
Trent	2	4
Yorkshire	4	4
West Midlands	6	1
Scotland	17	7
Wales	3	3
Northern Ireland and Republic of Ireland	4	Not surveyed
Total	**77**	**43**

were in academic posts. The geographical distribution of FTE/HTE posts is shown in Table 1.

Hospital settings

Sixty-five respondents (71%) work in teaching hospitals with 21 in District General Hospitals and three covering both. Hospitals are generally large, with a median of 800 beds (interquartile range=550). Mental health trusts are the sole fund holders for 48 posts (52%), 16 acute trusts (17%) and 11 universities (12%). The remainder are funded by some combination of the above, apart from one post funded by a primary care trust and one by endowment.

Clinical service

Fifty-seven of respondents (62%) accept referrals directly from GPs, although many commented that this was not common and/or that they screen letters for specific liaison problems such as somatisation. Fifty-one (55%) offer specialised services most commonly to neurology, obstetrics and oncology. Seventy-two (78%) work in a multidisciplinary team and colleagues most often include senior nursing staff, psychologists and cognitive therapists.

Service development

Respondents had been in their post a median of 5 years (interquartile range=6.5). Of those in full-time or part-time posts, 30/78 (38%) had acquired their position within the past 2 years. Sixty-one posts (66%) had been new at the time of appointment. In terms of future development, 61 (66%) respondents are SpR trainers in liaison psychiatry and 28 (30%) said there were plans to increase the number of SpR liaison posts in their region. Likewise, 32 (35%) believed that there were plans to increase the number of liaison consultants in the region. Only 22 respondents (26%) felt that the services they currently offer are sufficient for the size and complexity of the hospital.

Discussion

In this survey, we have documented 93 funded consultant adult liaison posts in the UK and the Republic of Ireland. It is possible that we have underestimated the current number of liaison posts by failing to identify them. One of the difficulties we encountered was that both the Royal College and the regional representatives for liaison psychiatry were unclear as to the geographical boundaries of the area they are representing. There was also considerable inconsistency regarding the definition of a liaison psychiatrist: in particular, not all neuropsychiatrists defined themselves as working in liaison posts. Finally, in recent years, several hospitals have developed nurse-led liaison teams that did not fall under the umbrella of this survey, but that would be useful to document in further surveys. However, given that we have used several methods of identifying liaison posts, we hope that we have captured most of them: moreover, by setting up a database that the liaison section will keep updated, this problem should diminish over time.

Clearly there have been a number of positive and exciting developments in liaison psychiatry over the past 5 years. Although the total number of consultant liaison posts has not changed substantially since 1996 (93 compared with 86), the number of full-time or half-time posts has increased from 43 in 1996 to 77 in 2002. In addition, there has been an increase in SpR training posts from 30 to 61, suggesting that there will be enough trained individuals to satisfy manpower requirements in the future. The increase in service provision has been most notable in Scotland and the North-West.

Despite this improvement in service availability, the current state of liaison psychiatry is still not ideal. Should liaison psychiatry fulfil the College recommendations of 0.4 full-time consultant posts per 100 000 population, there would be 184.8 posts in England, 20 posts in Scotland, 11.2 in Wales, 6.4 in Northern Ireland and 15.6 in the Republic of Ireland. Liaison psychiatry services continue to fall below that recommended by the College, with particularly poor service provision in Wales and Ireland. The finding that 38% of consultants are new in their post in the past 2 years, a finding identical to that in 1996, suggests that there is a high turnover within posts.

Moreover, it is of concern that approximately half of all services do not offer liaison services to particular departments. Sensky *et al* (1985) suggest that more patients receive appropriate psychological care where liaison teams are attached to specific units. Patients with a psychological reaction to physical illness and with somatic presentations of psychological disorders are particularly likely to benefit from this form of service organisation. In contrast, general liaison services tend to be reactive rather than proactive. Feldman (1987) has suggested that less than 1% of patients are referred to psychiatrists, even when psychological problems are recognised, and that the most common reasons for

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referral are disturbed behaviour and non-compliance (Maguire *et al*, 1974).

Historically, liaison psychiatry has been based in the general hospital: hence official agreements between the Royal Colleges of Psychiatrists, Physicians and Surgeons of England that funding for liaison psychiatry should come from acute trust budgets (Royal College of Physicians and Royal College of Psychiatrists, 1995; Royal College of Surgeons of England and Royal College of Psychiatrists, 1997). Our findings that such funding arrangements remain the exception rather than the rule reflect the inevitable difficulties that liaison psychiatry has in competing for funding with other priorities in secondary care. Respondents' descriptions in this survey of their links with primary care may imply that the expansion of liaison psychiatry towards primary care has not been as rapid as predicted (Guthrie, 1998). Moreover, the lack of mention of liaison psychiatry in the recent National Service Framework guidelines for mental health (Department of Health, 1999) might have implications for the funding of liaison psychiatry by mental health trusts. The constant risk for liaison psychiatry is of being restricted to the confines of a deliberate self-harm service. Consultant liaison psychiatrists have a wide range of skills to offer, from deliberate self-harm management to care of patients with somatoform disorders and patients with psychiatric presentations of physical illnesses. In order that the next 5 years in liaison psychiatry continue to be as dynamic as the past 5, it is important that liaison consultants are proactive in developing specialised services that demonstrate the qualitative and financial benefits of providing psychological care to all these groups.

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