Paul Aveyard 26.7 Psychiatry, liaison psychiatry,

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ESSENTIALS Psychiatry first developed as a separate medical specialty about 150 years ago when physicians were recruited to staff the new lunatic asylums. It later embraced psychotherapy and more recently has adopted com- munity rather than hospital-based working. The fact that psychiatry re- mains largely separate from other areas of medicine, together with the increasing focus on technical procedures in medicine, has led to some- times inadequate psychiatric care for medical patients. Measures to ad- dress this shortcoming began 50 years ago with the ad hoc development of liaison psychiatry teams, providing in-reach psychiatric services from mental hospitals to general hospitals. A more recent innovation is to re- integrate psychiatrists into medical teams as specialists in psychological medicine to provide joined up medical and psychiatric care. What is psychiatry? Psychiatry is the branch of medicine that specializes in the diagnosis and treatment of those illnesses traditionally considered to be ‘mental’ in nature. While there has been a long history of medical interest in mental illnesses, psychiatry as a defined medical specialty had its ori- gins only about 150 years ago. Modern psychiatry is a combination of two main historical strands. The first was a consequence of the setting up of lunatic asylums from

the early 1800s onwards; physicians were recruited to work in these new institutions built to serve the severely mentally ill and came to be regarded as specialists in what was called ‘alienism’. This institution-based care of the seriously mentally ill was revolutionized in the 20th century by the discovery of effective drugs for psychosis and depression; innovations that allowed increased community care and changed how psychiatrists worked. The second strand arose from the development of psychotherapy or talking treat- ments. Physicians have long used talking to their patients as a form of treatment. However, in the early 20th century Freud, a neurologist, and others developed more intensive forms of talking therapy called psychoanalysis. Psychoanalysis become influential in the United States in the first half of the 20th century, but less so in the United Kingdom. Psychiatrists and psychologists have since developed many new forms of talking therapy such as cognitive behaviour therapy, which have proven to be effective for several conditions such as depression and have become a major form of treatment in psychiatry. The establishment of psychiatry as a separate medical specialty was formalized in the United Kingdom in 1971 by the creation of the Royal College of Psychiatrists. Modern psychiatrists typically work in multidisciplinary teams and usually in community settings. The other professional groups making up the multidisciplinary team include: • Psychologists—nonmedically trained psychology graduates who have received clinical training (often as a ‘taught doctorate’). • Psychiatric nurses (often working as community psychiatric nurses, ‘CPNs’) who have training in mental illness, but often have little or no training in general nursing. • Members of other disciplines such as occupational therapists, social workers, and generic ‘mental health workers’ who have vari- able amounts of training. Psychiatry and the medically ill Before the rise of modern technological medicine, most physicians had to rely on listening and talking with the ill person, observing their behaviour, and using the doctor–patient relationship as a therapeutic tool. In the early 20th century, a small number of phys- icians in teaching hospitals actively specialized in the psychological aspects of their patients’ medical illnesses. This area of work called ‘psychological medicine’ did not survive in the United Kingdom as a specialty for physicians. In Germany, driven in part by a much stronger emphasis on psychoanalysis, a subspecialty of medicine called psychosomatic medicine, which is separate from psychiatry, has survived and prospered to this day. The formal development of a subspecialty of psychiatry that fo- cuses specifically on the medically ill is relatively recent. It had its beginning in the United States in the 1950s and has gradually devel- oped in the United Kingdom from the 1970s onwards. It originally went by the name of liaison psychiatry, but is increasingly adopting the old term of ‘psychological medicine’. What is liaison psychiatry? Psychiatric and medical services have remained organisationally separate in the United Kingdom since the setting up of the asy- lums. This division was maintained with the establishment of sep- arate mental health trusts in the UK in the 1990s. Consequently, 26.7 Psychiatry, liaison psychiatry, and psychological medicine Michael Sharpe

26.7 Psychiatry and psychological medicine 6537 psychiatric services to the medically ill were conceived of as an out- reach from mental health services into general hospitals, hence the term ‘liaison’ which refers to the linking of distinct services. What do liaison psychiatrists do? Medicine, despite the huge success in identifying and treating dis- ease processes, often finds itself ill equipped to deal with patients’ other needs. For example: • Patients who have self-harmed form a significant proportion of those presenting to general hospital emergency departments • A quarter of patients seen by specialist medical services have anxiety or depression • As many as half of acute medical inpatients suffer from delirium or dementia • A third of medical outpatients suffer from somatic symptoms inadequately explained by disease (medically unexplained symptoms) To

complicate matters further, these conditions—which are typic- ally deemed psychiatric rather than medical—are often inextricably interwoven with medical conditions. This phenomenon is called multimorbidity and necessitates that the patient receives joined up medical and psychiatric care. Common presentations referred to liaison psychiatry teams, the diagnoses they commonly make, and the interventions they use, are shown in Table 26.7.1.1. How do standard liaison psychiatry services work? Most liaison psychiatry services work by responding to referrals from physicians, although some screen medical patients to pro- actively identify psychiatric problems such as depression or al- cohol misuse. Liaison psychiatry teams are usually employed by a mental health provider, but have their accommodation in or near the general hospital. The composition of the liaison psychiatry team varies, but usually includes one or more consultants in liaison psychiatry, trainee psychiatrists, and mental health specialist nurses. Psychologists also commonly work in general hospitals, often as clinical or health psychologists, and they often work separately from the liaison psychiatry services. How to refer a patient to a liaison psychiatrist The ease of access to skilled help from a psychiatrist varies consider- ably between hospitals, and seeking it can sometimes be frustrating. Hospitals that have a dedicated liaison psychiatry service should ideally provide easy 24-hour access. Elsewhere a referral may need to be made to a general psychiatrist working in the community or in a psychiatric hospital. The initial response to a routine referral may be from a nurse or psychiatric trainee; if a consultant opinion is re- quired, this should be specifically requested. Before making a referral, it is useful for the physician to consider the following questions: • What exactly is the problem you need help with? • What is the differential psychiatric diagnosis? • What type of help are you requesting, and how quickly do you need it? It is important to be aware that, just as many physicians are not con- fident in psychiatric care, many general psychiatrists are not confi- dent in managing medical conditions and may need clear guidance on this aspect of the patient’s care. In addition, it is also important to remember that specialist psychiatric beds are commonly in very short supply and largely occupied by patients with severe psychotic illnesses. Consequently, an apparent lack of willingness to ‘take the patient away’ is more likely to be a reflection of this limitation in resource than of unhelpfulness by the psychiatrist. Psychological medicine There is a recent trend toward increasing the integration of psychi- atrists into medical services. This is happening for several reasons: • It is becoming clear that people using medical services very often have a mental illness that merits treatment in its own right and which complicates their medical care. This is especially the case with the increasing number of elderly patients and is an important aspect of the challenge of multimorbidity. • Patients and policymakers are increasingly demanding more effi- cient and more integrated care, with ‘parity of esteem’ for mental and physical illness driving policies that require more attention is paid to mental illness, including in the medically ill. • Research in neuroscience is increasingly raising questions about the fundamental rationale for distinguishing some illnesses as ‘mental’ and some as ‘physical’, when mental illness has functional and sometimes structural correlates in the brain. A recent innovation is to fully reintegrate psychiatry into the general hospital by employing psychiatrists (and psychologists) as members of medical teams. The advantages of this way of working are that psychiat- rists are more accessible to staff and to patients, have a much greater op- portunity to support and educate their medical and nursing colleagues in the management of psychiatric disorder, and use the same protocols and medical records. The result is that the patients experience seamless care. This model currently operates successfully at the John Radcliffe Hospital in Oxford. As it is not a liaison service (which means a link between two services), but is fully integrated into medicine, it is called an integrated psychological medicine service. The trend towards hope- fully integrating mental and physical care is likely to gather pace and will bring

psychiatry and medicine back together, to the benefit of both. Table 26.7.1.1 What do liaison psychiatrists do? Assess and manage presentations such as Make psychiatric diagnoses such as Provide interventions that may include Anxiety Confusion Delusions and hallucinations Disturbed behaviour Low mood Medically unexplained symptoms Nonadherence to medical treatment Self-harm and suicide risk Adjustment disorder Anxiety disorders Bipolar disorder Delirium Dementia Depressive disorder Personality disorder Schizophrenia Somatic symptom (somatization) disorder Collaborate with and support medical and nursing staff Provide education Do complex capacity and Mental Health Act assessments Facilitate discharge from hospital Link with community mental health services Give psychological treatments Recommend psychotropic drugs

SECTION 26 Psychiatric and drug-related disorders 6538 FURTHER READING Aitken P, et al. (2016). A history of liaison psychiatry in the UK. BJPsych Bull, 40, 199–203. Fossey M, Tutty C (2012). Liaison psychiatry in the modern NHS Michael Parsonage. Centre for Mental Health, London. Naylor C, et al. (2016). Bringing together physical and mental health. King’s Fund, London. Sharpe M (2014). Psychological medicine and the future of psychiatry (2014). Br J Psychiatry, 204, 91–2.

SECTION 27 Forensic medicine Section editor: John D. Firth 27.1 Forensic and legal medicine 6541 Jason Payne-James, Paul Marks, Ralph Bouhaidar,
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