Why refer to a psychiatrist?

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The importance of psychological factors in medical practice is now firmly established. Numerous studies have demonstrated the high prevalence of psychiatric disorder among general hospital patients, which is up to twice that of the population at large. Furthermore, psychological problems that may not amount to a specific psychiatric disorder have an important bearing on the presentation and course of many medical conditions. These problems include non-adherence to treatment, abnormal eating habits, lack of capacity to consent to treatment, and denial or exaggeration of symptoms. Few physicians now doubt that much of their clinical time is spent dealing with the emotional problems which complicate their patients' illnesses and symptoms. They also have to manage the medical consequences of deliberate self-harm and substance misuse, provide preliminary psychological interventions and arrange for more specialised treatment where appropriate.

Many of these problems are successfully managed by physicians and their teams without the help of psychiatrists or any other mental health professionals. It is highly appropriate that this should continue. Nevertheless, we know that much psychiatric morbidity among medical patients goes unrecognised and therefore untreated. It is evident that physicians continue to experience difficulties in diagnosing their patients' psychological problems, initiating treatment and knowing when to refer for expert psychiatric or psychological assessment.

To help overcome these difficulties, the Royal College of Physicians and the Royal College of Psychiatrists convened a joint working party to prepare a practical guide for physicians and other healthcare professionals.[1] This report, which updates and complements a previous report on the same theme,[2] addresses the particular psychological problems likely to be experienced by patients attending general hospitals, either in secondary or tertiary care. It also makes the clearest possible case for ensuring that the psychological care of medical patients is given higher priority than hitherto within the service agreements between general hospital trusts and their commissioners. Its recommendations are shown in Table 1.

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Table 1. Recommendations from *Psychological care of medical patients: a practical guide*.[1]

1 Liaison psychiatry services should be established in all general hospitals that are commissioned to provide comprehensive medical care for a defined population. The service should be multidisciplinary and include nurses, clinical psychologists, social workers and trainee psychiatrists, led by a consultant psychiatrist with special training in liaison psychiatry. Clinicians in other specialties should have ready access to the expertise of a liaison team.

2 Teaching hospitals require increased staffing levels to cope with demands from tertiary medical services. Some hospitals have developed special liaison services to manage patients following deliberate self-harm and those with alcohol problems. These developments should be supported.

3 Communication skills are fundamental to good clinical care and facilitate detection of psychological problems. These skills should be taught during postgraduate medical training and actively maintained throughout a professional career. Physicians could also gain valuable and relevant experience by spending six months at senior house officer level in psychiatry.

4 Training should be provided to enable physicians to apply basic psychological treatments, to recognise the indications for prescribing psychotropic drugs, and to manage patients suffering from alcohol and drug misuse.

5 Simple protocols should be developed for the detection and management of common psychological problems by general hospital staff.

6 Referral of patients to a liaison psychiatry service should be uncomplicated, with clear guidelines as to who should be referred.

7 There should be good channels of communication within the general hospital and with community services with regard to psychiatric as well as physical health.

8 Liaison psychiatry departments require adequate space for clinical work together with space for secretarial staff and support facilities to provide computerised record-keeping, thus enabling audit and clinical research to be undertaken.

9 Clinicians should be familiar with the principles of common law and the Mental Health Act 1983 as they apply to general hospital practice. Hospital trusts should arrange appropriate training for doctors and non-medical staff, including security staff.

10 The separation of mental health services and acute hospital trusts creates difficulties for liaison psychiatry, and management arrangements will vary according to established local practice. To ensure optimum delivery, a liaison psychiatry service should be managed within an acute hospital trust, alongside other medical specialties.

11 Funding for liaison psychiatry should be provided by those specialties that use the service. Recognition of this funding should be incorporated into all service agreements between acute hospital trusts and their commissioners.

Benefits of treatment

One reason why psychiatric disorders in the medically ill are not adequately treated is that they are often regarded as an understandable and inevitable consequence of illness, particularly of severe or chronic illnesses such as cancer, stroke or heart disease. This view can no longer be sustained. Most people cope with becoming ill in an adaptive and constructive manner without developing a psychiatric disorder. For those who do become psychiatrically ill, treatments which successfully relieve symptoms are available. Several psychological treatments have been applied. The most thoroughly evaluated of these is cognitive behaviour therapy,[3] which has been shown to reduce depression and anxiety in patients with cancer,[4] and has proved effective in treating so-called functional syndromes, such as chronic fatigue, irritable bowel syndrome and unexplained chest pain.[5] Other forms of psychological treatment, including counselling and psychoanalytic psychotherapy, have not been so extensively evaluated in a general medical context.[6] Nevertheless, counselling services have been established in many general hospital departments, including oncology, clinical genetics and HIV medicine. Counselling is usually well received by patients and has been shown to have beneficial effects in several acute medical conditions,[6] but it needs further evaluation with the chronically ill if it is to be used more widely.

Psychological treatments are particularly popular with patients who have an antipathy to drug treatment because of a fear of side effects or dependence. Unfortunately, there is a severe shortage of psychologically trained therapists to administer psychological interventions. There is usually a long delay before patients can be assessed and treated, and for many physicians referring a patient for psychological treatment is not a practical option. Antidepressant drugs have therefore remained the mainstay of treatment for depression accompanying medical illness. A Cochrane Review[7] has concluded that they are effective in a wide range of medical conditions. They are also effective in treating patients with functional symptoms.[8] Selective serotonin re-uptake inhibitors have replaced the tricyclics as the drugs of first choice because they have fewer side effects and are safer in overdose. Adherence to antidepressant treatment can be improved if patients are given an explanation of the biochemical basis of depression, the mode of action of the drug, the likely side effects and the delayed onset of beneficial effects.

When to refer

A recent survey of physicians' practice of managing psychological problems found that nearly all considered psychological factors to be important in the course of physical illness and to be part of a hospital doctor's work.[9] Over one-third claimed to use cognitive or behavioural methods of treatment, and more than three-quarters thought that hospital doctors should be able to use psychotropic drugs. Physicians' attitudes towards the psychological aspects of medical care appear to be changing in a positive direction and many would like to be able to spend more time with their patients. This attitudinal change may be due in part to improved teaching of psychiatry and communication skills at undergraduate level. The central role of communication skills in diagnosing and managing psychological problems is given due emphasis in the report, particularly the need for these skills to be maintained throughout a doctor's career. During their training, physicians should be able to acquire expertise in basic psychological treatments such as cognitive behaviour therapy. This would be feasible if training programmes allowed more flexibility than currently prevails so that trainee physicians were able to spend six months in a psychiatric post with a reciprocal arrangement for trainee psychiatrists.

For a minority of patients with more serious mental health problems, it is necessary to seek expert advice from a mental health professional. The report provides guidance as to when referral to a psychiatrist or psychologist is appropriate. Diagnostic dilemmas, treatment resistance, acute behavioural disturbance, assessment of capacity and the application of the Mental Health Act 1983 are among the more common reasons why patients may need to be referred.

Some patients object to a psychiatric referral or even flatly refuse it. The stigma associated with psychiatric illness lives on, despite concerted efforts by several professional organisations to eliminate it. The suggestion that a colleague is being called in because of his or her greater expertise is more acceptable if the physician has conducted a preliminary psychological assessment and possibly started treatment. Patients may need to be reassured that they are not considered mad or hopeless and that their symptoms are not thought to be imaginary. The referral is also easier to explain if the physician and psychiatrist collaborate regularly.

Organisation of services

A psychiatric service in a general hospital is best delivered by a multidisciplinary team led by a consultant liaison psychiatrist. Liaison psychiatry nurses and clinical psychologists are essential members. The service needs to be located within the hospital it serves and to be able to respond quickly to urgent requests for assessment and treatment. A service needs to be provided for inpatient units, accident and emergency departments and outpatient clinics. Within a liaison service, there may also be special provision for patients admitted following deliberate self-harm and those with alcohol or psychosexual problems. Liaison nurses have taken on a leading role in the management of patients who have deliberately harmed themselves. This could be extended to other areas of the service.

The creation of single specialty mental health trusts has separated psychiatry from mainstream medicine, at least as far as funding and managerial arrangements are concerned. This administrative apartheid risks repeating the mistakes of the nineteenth century when the establishment of large, rural asylums resulted in psychiatry being practised at a distance from the main medical centres. Inevitably it became divorced from the rest of medicine intellectually as well as geographically. Kendell has argued that because the managers of these asylums were concerned only with insanity it was easy for them to regard

it as different from other illnesses, thus perpetuating the flawed separation of mental and physical illness.[10]

These administrative changes may cause problems for liaison psychiatry. Nearly all its patients are under the care of an acute general hospital trust and many live well outside the catchment area of the local mental health service. This is particularly so in teaching hospitals which have several tertiary services and contracts with distant commissioners. It may therefore be more logical for a liaison psychiatry service to be managed within an acute hospital trust and to be funded from that trust's budget. Whatever arrangements are made, it is important that effective links are established between acute trusts and mental health trusts so that services can be planned jointly. Primary care trusts and other commissioners need to be made aware of the importance of an effective liaison psychiatry service and that provision of such a service should be an essential part of the commissioning process.

Other changes have created new opportunities. The case for liaison psychiatry has been strengthened as a result of psychiatry's shift towards a community-based practice.[11] Community psychiatrists spend much of their time in mental health centres or visiting patients in their homes. They have little time for general hospital work. Liaison psychiatry is well placed to fill the vacuum created by this move into the community. There has been a steady but slow expansion of consultant posts in liaison psychiatry but many district general hospitals still have a rudimentary service, sometimes amounting to no more than an assessment service for patients following deliberate self-harm. Departments of liaison psychiatry should be established in all general hospitals which are commissioned to provide acute medical care and physicians should, as a matter of course, have the right to refer patients for psychiatric assessment and management to a team which is available and responsive. In the light of accumulating evidence of therapeutic effectiveness, this is an area of medical care where failure to provide an effective service can no longer be justified.

References

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