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ANDREW MOLODYSKI, JIM BOLTON AND LOUISE GUEST

Is liaison psychiatry a separate specialty? Comparison of referrals to a liaison psychiatry service and a community mental health team

AIMS AND METHOD

The aim of the study was to compare referrals to a liaison psychiatry service and a neighbouring community mental health team (CMHT). Demographic and clinical information were compared for 100 consecutive referrals to each service.

RESULTS

The liaison psychiatry service had a smaller ongoing case-load

and a higher referral rate than the CMHT. Larger proportions of patients referred to liaison psychiatry had comorbid physical illness (49 v. 10%) or had harmed themselves (41 v. 10%). More patients referred to the CMHT had a primary diagnosis of a mood disorder (49 v. 28%), but fewer had organic disorders.

CLINICAL IMPLICATIONS

The differences in service delivery and clinical problems referred imply that different expertise is required by those working in each service. This supports the view that community and liaison psychiatry are separate specialties, with implications for higher specialist training.

In the UK and Ireland, liaison psychiatry is a sub-specialty of general adult psychiatry, with some debate as to whether it should have full specialty status. Some argue that the work of a liaison psychiatry team can be done by an adequately staffed community psychiatry service, whereas others believe it requires separate and specific expertise and models of service delivery (Lloyd & Mayou, 2003). The argument for liaison psychiatry's specialty status depends on demonstrating clear differences between liaison and community psychiatry. However, there are few published data on the problems managed by such services. The aim of our study was to compare referrals to an established liaison psychiatry service and a CMHT within the catchment area of the same hospital.

Method

Liaison psychiatry service

The liaison psychiatry service studied here is based within a district general hospital in south London with approximately 600 in-patient beds and approximately 67 000 accident and emergency attendances per year. The team comprises one consultant, one specialist registrar, one senior house officer and two mental health nurses. It is of note that there is no input from psychology, social work or occupational therapy services.

The liaison service accepts referrals of patients over 17 years of age with no upper limit, including all older patients except those under the care of medicine for the elderly services. Referrals are accepted from general hospital staff, but not from primary care. Patients are seen on the hospital wards, in the accident and emergency department and in psychiatry out-patient clinics held in the hospital. The service aims to assess emergency referrals immediately, urgent referrals within the same working day and non-urgent referrals within 2 days.

Community mental health team

The community mental health team (CMHT) operates in a suburban area of south London, with a community base where out-patient clinics are held. In-patient beds are provided by the local psychiatric hospital. The CMHT accepts referrals of patients aged 18–74 years; the majority of referrals are from primary care. The team aims to see emergency referrals within 1 day, urgent referrals within 7 days and non-urgent referrals within 28 days. The team comprises one consultant, one specialist registrar, one senior house officer, 4.5 whole time equivalent (WTE) mental health nurses, two social workers, one occupational therapist and 0.5 WTE psychologist.

The majority of patients on the case-load of the CMHT have complex mental health and social care needs, and consequently are managed using the enhanced care programme approach.

Catchment areas

The catchment area of the CMHT has a population of approximately 47 000 people and lies within the catchment area of the general hospital, which comprises approximately 300 000 people. Generally, this is a suburban area, with districts of relative affluence interspersed with some more deprived areas. The indices of social deprivation (Office of the Deputy Prime Minister, 2004) for the CMHT catchment area (14.6) and general hospital catchment area (15.9) are similar.

Working hours

Both the CMHT and the liaison psychiatry service operate between 09.00 h and 17.00 h, Monday to Friday. Outside these times, urgent referrals are made to the out-of-hours psychiatry service.



The survey

We prospectively collected details of 100 consecutive referrals to each service, starting on the same date. Data were collected from the mental health records and were supplemented by information from staff members. In addition to demographic information, the following were recorded:

- source of referral;
- previous or current contact with secondary mental health services;
- presence of significant physical health problems, as defined by the presence of a problem severe or chronic enough to require follow-up by secondary care;
- whether self-harm was part of the index episode;
- urgency of referral;
- whether the patient was subsequently followed up by the service;
- psychiatric diagnosis made by assessor.

Diagnoses were clustered into broad categories, based on the chapter headings for the ICD-10 (World Health Organization, 1992). Data were compared using a *t*-test for mean ages and chi-squared tests for the differences between proportions.

Results

One hundred new referrals were made to the liaison psychiatry service over a period of 56 days (mean referral rate 13 referrals per week) and to the CMHT over 108 days (mean referral rate 6.5 referrals per week). At the outset of the study the ongoing case-loads of the liaison psychiatry service and the CMHT were 48 and 355, respectively. There was missing information in only 2.2% of the data-sets collected. Table 1 compares demographic and clinical information for patients referred to the two services and Table 2 compares the diagnostic groups ascribed. Two of the patients referred to the liaison

Table 1. Comparison of demographic and clinical information

	CMHT referrals (n=100)	Liaison service referrals (n=100)	Difference (95% CI)
Age, years			
Mean	38.8	49.9	
Range	18–74	18–95	11.1 (6.3 to 15.9)
Standard deviation	41.0	12.9	
Male gender, %	38	39	1 (–13 to 15)
In employment, %	61	34	27 (13 to 40)*
White ethnic origin, %	90	92	2 (–6 to 10)
Living alone, %	26	37	11 (–2 to 24)
Previous contact with psychiatric services, %	68	62	6 (–7 to 20)
Currently under the care of psychiatric services, %	6	27	21 (11 to 31)*
Significant physical health problems, %	10	49	39 (26 to 50)*
Self-harm as part of the index episode, %	10	41	31 (19 to 42)*
Urgent referrals, %	17	62	45 (33 to 57)*
Follow-up by service after initial assessment, %	65	15	50 (38 to 62)*

CMHT, community mental health team.
**P* < 0.05.

Table 2. Primary diagnoses

ICD-10 diagnostic group	CMHT (n=100) %	Liaison service (n=100) %	Difference (95% CI)
Organic mental disorder (F00–F09)	0	23	23 (15 to 31)*
Mental and behavioural disorders due to psychoactive substance use (F10–F19)	12	19	7 (–3 to 17)
Schizophrenia, schizotypal and delusional disorders (F20–F29)	6	7	1 (–7 to 7)
Mood disorders (F30–F39)	49	28	21 (8 to 34)*
Neurotic, stress-related and somatoform disorders (F40–F48)	15	6	9 (0 to 17)
Disorders of adult personality and behaviour (F60–F69)	6	7	1 (–6 to 8)
No psychiatric diagnosis	10	10	0

CMHT, community mental health team.
**P* < 0.05.



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psychiatry service and none of those referred to the CMHT were given a diagnosis of a somatoform disorder.

The CMHT received 75% of its referrals from local general practitioners, 12% from allied healthcare professionals, 9% from other psychiatric services (including the liaison psychiatry service) and 2% were self-referrals. The liaison psychiatry service, which does not accept referrals from primary care, received 68% of its referrals from the general in-patient wards, 22% from the accident and emergency department and 10% from out-patient clinics.

Discussion

This is the first comparison of an established liaison psychiatry service with a CMHT in the same geographical area. A previous comparison (Creed *et al*, 1993) surveyed referrals to a single member of a liaison team in a newly established service. There is evidence that there are significant changes in referral patterns as such a service develops (Vaz & Salcedo, 1996).

There is relatively little published research on the work of established liaison psychiatry services. The Royal College of Physicians & Royal College of Psychiatrists (1995) summarised data from three UK services. In comparison with our survey, they found a similar proportion of patients referred following self-harm, but a lower proportion with an organic psychiatric disorder. This latter finding probably reflects the role of the service we studied in assessing older adults.

Previous descriptions of the work of CMHTs in the UK have reported diagnoses based upon ongoing case-load (Greenwood *et al*, 2000; Hunter *et al*, 2002). Their findings of rates of psychotic disorder of around 40% reflect the primary focus of such services being the management of patients with 'severe mental illness', and are not directly comparable with our study, which describes new referrals rather than ongoing case-load.

Service delivery

The liaison psychiatry service had a much smaller ongoing case-load and a higher referral rate. This reflects the role of the service in referring patients to appropriate longer-term mental healthcare and facilitating their discharge from the general hospital. In contrast, the main role of the CMHT is the ongoing management of patients with severe and enduring mental illness in the community. This is reflected in the larger case-load, larger multidisciplinary team and the higher proportion of new referrals who are followed up. Patients who are likely to remain on the ongoing case-load of the liaison psychiatry service are those who are closely linked to the general hospital, especially those with chronic physical health problems (Bolton, 2003).

The liaison psychiatry service received a larger proportion of urgent referrals. Urgency may be due to the patient's clinical problem as well as the need not to prolong the person's hospital admission while a psychiatric assessment is awaited. The CMHT, located away from the general hospital and with other priorities, would be

unlikely to deliver as responsive a service for general hospital patients.

Expertise

The differences in the proportions of certain primary diagnoses in patients referred to the two services imply that different forms of expertise are required. Nearly a quarter of patients referred to the liaison psychiatry service had a primary organic disorder; these were largely older adults with delirium or dementia. Currently, higher specialist training in liaison psychiatry does not require the specific development of knowledge and skills in the psychiatry of older adults.

Patients with comorbid physical illness were more often referred to the liaison psychiatry service. The specialist expertise required by such a service includes the management of mental illness in the context of physical illness, including the appropriate use of psychotropic medication and psychological therapies.

The number of patients referred to liaison psychiatry following self-harm supports the need for both appropriate expertise and services for the acute assessment and management of this patient group within the general hospital.

Limitations

This comparison of referrals does not fully describe the work of the two services studied, such as the application of the care programme approach by the CMHT and the significant amounts of formal and informal education of general hospital staff by the liaison team. Broad diagnostic categories were used, which may hide important differences between the particular problems managed by the two services. In particular, somatoform disorders – which would be expected to be more prevalent among referrals to the liaison service – were subsumed in the wider category of neurotic, stress-related and somatoform disorders. Comorbid psychiatric diagnoses such as substance misuse and personality disorder are commonly made in patients referred to both services, but were not recorded in our study. The reliability of the primary diagnoses made by individual clinicians in the two services was not measured.

There may be difficulties in generalising the results of this survey to other liaison psychiatry services, which vary in terms of size, expertise and hours of work (Swift & Guthrie, 2003; Ruddy & House, 2004). However, we feel that the service studied is broadly representative of teams in many district general hospitals. It would be of interest to survey the changes in referral patterns to a newly established liaison service, and the impact it might have upon local community psychiatry referrals.

Implications of the study

Our findings indicate that there are distinct differences in service delivery and clinical problems referred to a liaison psychiatry service and a neighbouring CMHT. Such differences imply that the specialist expertise required by



those working in each service would also be different, supporting the view that community and liaison psychiatry are separate specialties, with implications for higher specialist training. The recognition of liaison psychiatry's specialty status is important in encouraging the development of services and the provision of effective mental healthcare for general hospital patients.

Declaration of interest

None.

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***Andrew Molodynski** Specialist Registrar, Tolworth Hospital, Red Lion Road, Tolworth, Surrey KT6 7QU, e-mail: andrew73@doctors.org.uk, **Jim Bolton** Consultant Liaison Psychiatrist, Department of Liaison Psychiatry, St Helier Hospital, Wrythe Lane, Carshalton, Surrey SM5 1AA, **Louise Guest** Consultant Psychiatrist, Carshalton Community Mental Health Team