the population covered by this clinic, extrapolation determined where and how often other clinics were needed during the week. Eventually I started clinics in Hawes, Leyburn and Bedale as well as Thirsk. These are all run on a shifted out-patient model but at each I see the GPs and discuss their patients. The prospect of doing these clinics was welcomed with open arms by most GPs but in one corner of the district they strongly discouraged me. This made me feel that the need there was even greater and eventually the GPs agreed to a three monthly clinic in which I would see patients once, give an opinion but then the GPs would continue with the treatment. I, as a consultant, would just be consulted. This service has now developed into a treatment service and referrals have increased, not only in the clinic but also as emergencies. At another clinic the GPs have declined the offer of formal regular meetings but we do often meet to discuss the patients. The style of all these clinics has been determined largely by the needs of the local GPs with some purely wanting an opinion, others wanting treatment to be provided and a few wanting all the psychiatric care to be taken over. It has proved much easier to fulfil the wishes of the GPs as clarification of the reason for the referral has been possible through our regular clinics. In addition the GPs can receive advice over treatments of patients who are not referred onto the psychiatrist. This also improves the GPs' psychiatric knowledge. It has become clear that GPs whom I meet less often and who are irregular attenders at our meetings are those with the least psychiatric skills.

However many clinics are held there remain large distances for some patients to travel and therefore home visiting has become a major part of the out-patient service. Much of this is done in nursing homes and homes for the elderly. The staff of these homes need to be frequently told of the different roles of the GP and the specialist in the case of their residents.

The GPs could have felt threatened by the development of a new community mental health service impinging on their territory. This has been avoided by restating their role as primary health care doctors and then by close personal contact improving communications over patients, educating them in psychiatry and subsequently encouraging appropriate referrals. As a result of this approach more severely mentally ill people who had not been treated for years are benefiting from appropriate treatment.

There are many problems to providing a community service in a rural area in this way, such as enormous travelling times, being unavailable to deal with emergencies in the hospital and day hospital quickly due to distances, the consultant doing all the administrative work in the clinics and carrying all the notes around. In addition, some people find it unacceptable to sit in the local psychiatric clinic waiting room and prefer to be seen away from their own community. The advantages outweigh these; less distance for patients to travel, better liaison between specialist and GP, increased job satisfaction, less stigmatisation for patients and good training experience for junior doctors. In the end the patients are benefiting by a closer working relationship between the consultant and GP.

Attempts are presently underway to evaluate our changing service but since the White Paper one of the most important tests will be whether the local GPs decide to contract our service. I believe by basing our service so firmly on the importance of the GP we have increased our chances of this enormously.

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Liaison psychiatry in Scotland: the present service

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The term 'liaison psychiatry' is becoming increasingly popular. Indeed, the Royal College of Psychiatrists has set up a special interest group, the Liaison Psychiatry Group, which has a growing membership. There appear to be developments in training and in service provision but it is difficult to assess their clinical impact. Ongoing research is required to quantify the actual level of service provided to general hospitals.

This paper outlines the results of a survey of the psychiatric service to general hospitals in Scotland in 1987/88. A questionnaire (available on request from the author) was constructed and sent to every general psychiatric hospital in Scotland.

Results

Of 26 hospitals, 25 responded. Two hospitals did not provide any liaison service.

The typical service

Analysis of the results revealed the following Scottish liaison service. Typically a service is provided to one general hospital and covers emergencies at all times, ward consultations, overdoses and self harm cases, and patients over 65. There is a link to a specialised unit. Teaching is provided to psychiatric trainees only. There is a consultant with a special interest in liaison work but no specific sessions are allocated to this service. The number of patients seen per week is difficult to enumerate but is thought to be less than five, including overdoses and self-harm cases. No routine referral procedure exists, referrals being made by a variety of means and collected by the secretarial staff. The general hospital provides a consultation room but no other facilities or additional staff. The service as described has been operating for more than five years but, as a result of psychiatric dissatisfaction with the current service, changes are planned.

The Edinburgh service differs greatly from the above, providing over 60 sessions per week to two major general hospitals. The number of patients seen is greater, more facilities and staff are provided, and specialised clinics are being organised. Rural areas generally have a sectorised service and scattered population. There are often more hospitals and outpatient clinics to cover with fewer staff. The organisation of the liaison psychiatry service is therefore difficult but despite this, the service is being reviewed and changes are being made in these areas.

Referrals

All services see patients aged 16 to 64, except one service which refers overdose cases to the Regional Poisons Unit. The child and adolescent service assesses those under 16 and psychogeriatricians often review the elderly.

Most hospitals can only provide an approximate number of patients seen. Patients are generally assessed on the wards and numbers range from less than five per week in four services up to 50 per week. When figures for overdose cases are removed, no service sees more than ten general ward referrals per week.

Staffing

Staffing of the liaison service varies greatly across the country, each area adopting its own approach. Fourteen hospitals (56%) have a consultant with a special interest in liaison psychiatry but only 12 hospitals (48%) set aside time for the service. Two services have access to a social worker and one provides two half-time psychologists.

Teaching

Teaching is seen by 20 hospitals (80%) as being a function of their service, all providing teaching for psychiatric trainees, but few teaching medical students.

Age of service

Only one service has been in its present form for less than five years. In the 12 month period prior to the survey, no new service has been inaugurated.

Plans for change

These include:

(a) the provision of more medical, nursing and para-medical staff
(b) more contact with other specialties
(c) improved training at Senior Registrar level and below
(d) sectorisation of the service with more psychiatrists involved in general hospital work
(e) improvements in referral procedure.

In one case there are plans to move into the general hospital.

Shortfalls of the service

These include:

(a) lack of facilities
(b) psychiatric colleagues' lack of interest in the service
(c) difficulties with referrals, including poor initial assessment and inappropriate expectations of the service
(d) problems related to the organisation of the service.

The role of the service

Respondents were asked to describe the role of their service to the general hospital. This proved to be difficult. Replies ranged from "a disposal service" to the comment that the service "reminds colleagues of the importance of patients' attitudes, emotional state and coping resources". Other replies indicated respondents' concern about the status of the service, describing lack of facilities, time and interest from other specialties and even resistance to a psychiatric unit in a general hospital. One commented that there was insufficient ground work prior to psychiatric referral and that their rapid and efficient service was not reciprocated. One respondent commented "we do not normally talk of a medical ward in a hospital as providing a service to the psychiatric department there".

Definition of liaison psychiatry

When asked to define liaison psychiatry, only one reply did not focus exclusively on aspects of consultation work in general wards. Several comments were made about overdose assessment "liaison is mainly seeing overdoses". Only one respondent mentioned

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staff counselling and support. Research and education were mentioned by another and two respondants commented that the term meant "all things to all men". Six respondents felt that liaison psychiatry should be a specialist service (24%) while 16 (64%) felt it should not.

Comment

Many studies have shown evidence of considerable psychiatric morbidity in the general hospital with only a small number of cases referred for psychiatric advice (e.g. Maguire *et al*, 1974). Mayou & Lloyd (1985) showed that deliberate self harm takes up much of the time of the general hospital psychiatrist. This study confirms that deliberate self harm cases remain by far the largest category of patient seen in general hospitals in Scotland.

The present study shows that a considerable variety of services is offered, reflecting the findings of the national survey by Mayou & Lloyd (1985). Some areas, through individual efforts, have developed excellent links with specific general hospital units. Others provide no more than the most basic service to general hospitals. Similarities between services lie in the separation of child and adolescent work, in the lack of other professional staff involved and in the lack of time allocated to liaison work. Even those psychiatrists working in DGH units provide a similar level of service.

This study has produced similar results to those of Brooks & Walton (1981). They too found that it proved very difficult to obtain accurate figures for the caseload of the service, that there were wide variations in psychiatric staffing arrangements and referral methods, and that communication between psychiatrists and other specialists was open to criticism. In both studies the desire to expand the liaison service was hampered by manpower shortages and professional attitudes to general hospital work varied widely. Interestingly, DGH units were viewed positively in both studies.

There are, however, differences between the two studies. This study found teaching to be of more prominence and identified a desire for the involvement of other professional staff which was not apparent in the earlier work. These differences may reflect the higher profile of liaison psychiatry in 1987/88 than in 1979 when the first study was undertaken.

Conclusion and recommendations

Several respondents remarked that liaison work was performed at the end of the working day. The results reveal that time is rarely set aside for liaison work. This cannot produce an optimum service to other specialists. The allocation of specific time would enable discussion with other professional staff and relatives and thus achieve a more satisfactory case formulation. In addition, the haphazard collection of caseload figures masks the true extent of this work. It is therefore difficult for management to assess accurately the resource requirements.

Brown & Cooper (1987) have shown that reorganisation of the service results in increased numbers of general ward referrals. However, this consultation work is only one aspect of liaison psychiatry. Such provision as joint case conferences, joint ward rounds and staff liaison work were rarely mentioned by respondents to this survey. Likewise multidisciplinary liaison teams, although mentioned by many authors as being of value, e.g. Gomez (1987), exist only in one area of the country. It is clear that the service in Scotland still requires development and suggestions are as follows:

(a) One named consultant should be available in each hospital with responsibility for organising the service. This should include the provision of teaching and research opportunities.
(b) Other professional staff such as psychologists, social workers and nurses should participate in the service.
(c) A standard referral procedure should be instituted in each hospital, processing all referrals through one central point, e.g. medical records departments. Data collection would therefore be simplified.
(d) Sessions must be allocated to liaison work.
(e) As the service develops regular review and modifications will be required to take account of change in demands.

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