Consultation-liaison psychiatry worldwide

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Don Lipsitt provides a historical view of psychiatry in the general hospital in USA and concludes on a cautionary note reflecting the severe funding difficulties faced by consultation-liaison (C-L) psychiatrists in USA over recent years. What is the relevance of this to the rest of the world?

The evidence regarding the prevalence of psychiatric disorders around the world is now clearer than ever. In Australia, UK and USA, for example, population-based studies indicate that 20-27% of adults have suffered from affective, anxiety or substance misuse disorder in the last year, whereas 0.4% had psychosis (1). A minority of these people receives specific mental health treatment, reflecting the fact that most present to general medical facilities, where psychiatric disorders may not be detected and treated (2). In developing countries there is a much higher prevalence of depressive and other disorders and only a tiny proportion receive treatment (3). In most countries the principal source of help is primary care, and the global World Health Organization study confirmed that depressive, anxiety, neurasthenic and alcohol misuse disorders are the most common disorders seen in this setting (2). These psychiatric disorders are closely associated with the presence of physical illness and have a profound effect on occupational functioning.

By contrast, the development of psychiatric services in many countries has not been guided by these epidemiological findings. There has been a strong emphasis on services for people with schizophrenia and other severe psychiatric disorders and the mental hospital dominated services during the last century. This emphasis on services for the seriously mentally ill continues in many Western countries, at the expense of C-L services in those countries where they were most developed, principally USA. In many other countries, where C-L services had not previously developed, they are struggling to do so against a tide of concern to provide intensive community services based in community mental health centres, rather than in the general hospital.

Set against this background, the future of C-L psychiatric services may appear bleak, but there is another body of evidence that is gradually having impact on the planners of general medical services. Reports of unmet need for psychiatric treatment among the patients of general hospitals are increasingly accompanied by evidence that effective treatments are available. A large European study indicated that C-L services are still developed according to the energy and persuasiveness of individual C-L psychiatrists rather than according to need (4). Reports are now emerging that call for better developed C-L services, which are funded by the acute medical services (5).

The development of C-L services should be encouraged by the increasing importance being placed on health economics and cost-effectiveness studies. Psychiatric disorders, most commonly depressive and anxiety disorders and neurasthenia, impair health-related quality of life and lead to greater healthcare costs (6,7). Cost-effectiveness studies demonstrating the advantages of developing psychiatric treatments in primary care (8,9) are now being performed in general hospital patients with equally beneficial effect (10). The importance of these studies to C-L psychiatry lies in the fact that these results can only be achieved if psychiatric treatments are delivered at the site to which the patients present, since such patients will not attend specialised psychiatric treatment facilities.

As our understanding of the biological and social basis of common psychiatric disorders increases, the evidence supporting the delivery of appropriate psychiatric care within general medical care becomes more compelling. As evidence-based medicine begins to influence health planning, we should see the growth of C-L psychiatric services, though these are likely to be linked more closely to primary care rather than be confined to general hospitals, as has been the case to date. C-L psychiatry, as Lipsitt concludes, is work in progress.

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