An international perspective on consultation-liaison psychiatry and the general hospital

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Don Lipsitt's review and preview of the relationship between psychiatry and the general hospital in the USA raises issues that resonate with those in other countries, albeit modified by history and culture. Differences in the organization of health services and in attitudes towards patients with disorders occurring at the interface of the psyche and the soma colour the method and context of delivery of care to such patients (1). These differences permit a refreshing opportunity to re-examine the ways in which patients with physical/psychiatric comorbidity and somatization can be helped. The International Organization for Consultation-Liaison Psychiatry (2) was formed to facilitate this process. It is an umbrella organization for all psychiatrists and physicians who specialize in clinical work, teaching and research at the medical/psychiatry interface. It aims to facilitate development of the field in all parts of the world.

The challenges identified by Lipsitt are universal. How can these best be met? The interface between medicine and psychiatry is a no-man's land, somewhat alienated from both. It is a difficult position from which to argue, let alone expect protection. However, there are some examples of successful strategies. The Academy of Psychosomatic Medicine in the USA has lobbied successfully for the setting of standards for integrated care. In Australia, similar lobbying was successful in obtaining acknowledgement that the National Mental Health Plan had the unforeseen consequence that funding agencies had erroneously equated severity with diagnosis rather than level of need and disability (3).

The arguments that can be put in such lobbying concern the prevalence and seriousness of disorders at the psyche/soma interface, and the availability of effective treatments that can make a difference in patients' general health outcome (4). Physical/psychiatric comorbidity and somatization are the commonest forms of psychiatric presentation in the community, and are chronic. These disorders matter. Depression is a risk factor for the major physical disorders of coronary artery disease and stroke. It also increases the morbidity and mortality of those who already suffer from these disorders. Treatment helps. Psychological interventions are very effective for somatization, and for outcomes in coronary heart disease, cancer and diabetes. Antidepressants are relatively safe and effective in the physically ill.

Psychiatry, with its dependence on the biopsychosocial model, must be aware of the fact that other disciplines using other paradigms have a strong interest in work at the psyche/soma interface. The paradigms of complexity, patient-centredness, quality of life and demoralization are some of these (5,6). Psychiatry must learn to work with those who use them. The studies of Wells et al (7) and Simon et al (8) have shown quite clearly that new (to the USA) models of care involving a seamless web of pre-admission/admission/post-discharge functions delivered in a flexible structure and location, with integration with primary care and use of case management principles, are required in future. Risk factor screening for psychiatric caseness and complexity of care would be an important part of such a program. The European Consultation Liaison Workgroup has developed appropriate instruments (1,9). Psychiatry needs to be involved in policy making at all levels. In particular, it needs much greater involvement with consumers than has previously been the case. Finally, it must produce better evidence of its efficacy (10).

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