

Liaison psychiatry and the management of long-term conditions and medically unexplained symptoms

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Key points

- 1 Government strategy highlights the importance of integrating the management of comorbid physical and mental disorders.
- 2 Liaison psychiatrists have specific expertise in the management of psychiatric illness in medically ill patients.
- 3 Interventions delivered by liaison psychiatry services can improve patients' physical and psychological health outcomes and reduce healthcare costs in the management of long-term conditions and medically unexplained symptoms.

Liaison psychiatry: introduction

A liaison psychiatrist is a medically qualified doctor who has expertise in the diagnosis and management of:

- psychiatric illness in the medically ill
- psychiatric illness and other psychological factors that interfere with recovery from medical illness
- bodily symptoms that are not adequately explained by underlying physical illness
- use of psychiatric drug treatments and psychological therapies in the context of physical illness.

Liaison psychiatry services are often based in general hospitals, but increasingly work with primary care in the management of comorbid medical and psychiatric illnesses.

Liaison psychiatry in long-term conditions and medically unexplained symptoms

LONG-TERM CONDITIONS

Long-term medical conditions such as diabetes, heart disease and chronic obstructive pulmonary disease have significant adverse effects on an individual's quality of life. Patients with medical illness are three to four times more likely to develop a psychiatric disorder than a member of the average population (NHS Confederation, 2009). Having both a psychiatric and medical illness delays recovery from both (HM Government, 2011). The presence of comorbid psychiatric disorders can lead to decreased adherence to treatment, increased health service costs and poorer outcomes (Naylor & Bell, 2010).

MEDICALLY UNEXPLAINED SYMPTOMS

Some people are affected by persistent physical symptoms that do not have a readily identifiable medical cause, or are out of proportion to any underlying medical illness. The symptoms are nonetheless real and cause disability and distress (HM Government, 2011). There is also a strong association between medically unexplained symptoms and psychiatric disorder; over 40% of patients with medically unexplained symptoms have anxiety and depression (Royal College of Psychiatrists & Academy of Medical Royal Colleges, 2009).

Medically unexplained symptoms account for 20% of new presentations in primary care and 20–40% of medical out-patient referrals (Royal College of Psychiatrists & Academy of Medical Royal Colleges, 2009). Patients with medically unexplained symptoms often undergo potentially unnecessary, costly and sometimes damaging investigations and treatment (NHS Commissioning Support for London, 2011).

COST OF LONG-TERM CONDITIONS

- The total health expenditure on patients with diabetes and depression is 4.5 times higher than for those patients with diabetes who do not have depression (Naylor & Bell, 2010).

- Patients with both chronic heart disease and depression are more likely to experience complications and undergo invasive procedures (Royal College of Psychiatrists & Academy of Medical Royal Colleges, 2009).
- Patients with chronic obstructive pulmonary disease and depression have longer hospital stays (Royal College of Psychiatrists & Academy of Medical Royal Colleges, 2009).

COST OF MEDICALLY UNEXPLAINED SYMPTOMS

- Medically unexplained symptoms cost the National Health Service in England £3 billion every year (HM Government, 2011).
- Patients with medically unexplained symptoms are often subject to high levels of diagnostic investigation and unnecessary and costly referrals to secondary care (Naylor & Bell, 2010).
- A minority of patients with medically unexplained symptoms have a disproportionate cost. These tend to be more complex cases, which are more likely to be referred to secondary care, undergo potentially unnecessary investigations and to have repeated presentations to both primary care and emergency departments (NHS Commissioning Support for London, 2011).

ROLE OF LIAISON PSYCHIATRY IN THE MANAGEMENT OF LONG-TERM CONDITIONS AND MEDICALLY UNEXPLAINED SYMPTOMS

The expertise of liaison psychiatry is essential in delivering a comprehensive care pathway for long-term conditions and medically unexplained symptoms, in which it has the following specific roles.

1. WORKING ACROSS THE HEALTHCARE SYSTEM

Liaison psychiatrists can liaise effectively with medical colleagues in both primary and secondary care about individual patients' presentations and appropriate management.

2 ASSESSMENT AND MANAGEMENT OF COMPLEX CASES

Medical training equips liaison psychiatrists to manage complexity and uncertainty in patient care, particularly where physical and psychological factors interact. There are several key areas where this can take place.

- Patients with multiple symptoms and/or repeated presentations and referrals to secondary care. In such cases there is more likely to be uncertainty about the relative physical and psychological contributions to a patient's presentation.
- Complex psychiatric comorbidity, for example dissociative disorder, hypochondriacal disorder, body dysmorphic disorder, personality disorder or substance misuse.

- Complex physical comorbidity.
- Patients who have not responded to first-line management.

3 *MANAGEMENT OF PATIENTS WHERE COMBINED MEDICAL AND PSYCHIATRIC EXPERTISE IS REQUIRED*

Liaison psychiatrists' medical training equips them to assess the relative contribution of physical and psychological factors in a patient's presentation and management, including:

- potential drug interactions and side-effects when prescribing psychotropic medication, such as antidepressants
- interpreting medical investigations
- discussing patients' concerns about physical symptoms and diagnoses
- managing medically unexplained chronic pain, including withdrawal of potentially addictive analgesic medication.

4 *EDUCATION AND SUPERVISION OF COLLEAGUES*

- Training of colleagues in both primary and secondary care in the management of medically unexplained symptoms and long-term conditions.
- Supervising case managers and therapists engaged in psychological therapy with patients.

BENEFITS OF LIAISON PSYCHIATRY IN THE EFFECTIVE MANAGEMENT OF LONG-TERM CONDITIONS AND MEDICALLY UNEXPLAINED SYMPTOMS

There is evidence that liaison psychiatry can improve outcomes and reduce costs of medical care (NHS Confederation, 2009).

1 *INCREASED PRODUCTIVITY AND REDUCED COST*

One of the most promising opportunities to improve productivity in the NHS is by strengthening the interface between mental and physical healthcare (Naylor & Bell, 2010). This is a key role of liaison psychiatry and one that offers a reduction in healthcare costs (NHS Confederation, 2009).

2 *FEWER REFERRALS, HOSPITAL ADMISSIONS AND UNNECESSARY INVESTIGATIONS*

Addressing comorbid psychiatric illness can achieve sustained reductions in admissions to hospital for people with a range of long-term conditions, with the associated savings being in excess of the cost of intervention (Naylor & Bell, 2010).

Effective intervention for medically unexplained symptoms can prevent patients undergoing unnecessary and costly investigations and treatment (NHS Commissioning Support for London, 2011).

3 IMPROVED HEALTHCARE OUTCOMES

A key area for action in the Government's mental health outcomes strategy is that fewer people with medical conditions, including those with long-term conditions and medically unexplained symptoms, should have psychiatric disorders (HM Government, 2011).

CASE EXAMPLES

The cases described have been adapted to ensure patient anonymity.

MEDICALLY UNEXPLAINED ABDOMINAL PAIN

A 50-year-old woman underwent multiple investigations for abdominal pain in three separate out-patient clinics – surgery, gastroenterology and gynaecology. When her symptoms remained medically unexplained, she was referred to liaison psychiatry. Following a detailed assessment, the patient was helped to recognise the link between her pain, childhood abuse, and current marital and occupational problems. With both pharmacological and psychological treatment, her pain gradually improved and she was weaned off strong painkillers. The psychiatrist liaised with the patient's general practitioner (GP) and consultants in secondary care to minimise any further investigations and to reduce the frequency of consultations. The patient was eventually discharged back to her GP, free of pain.

DIABETES AND DEPRESSION

A 25-year-old man with insulin-dependent diabetes was struggling to manage his illness and was frequently admitted to an intensive care unit as a result. Hospital staff noted that the patient appeared to be low in mood and he was referred to a liaison psychiatrist for assessment. The psychiatrist discussed with the patient his difficulties in managing his diabetes and also problems with family relationships and finding work. These were major contributors to his depression. The psychiatrist identified that his emotional distress was being expressed as neglect of his physical health, with poor self-care of his diabetes. Meetings were arranged with the liaison psychiatrist, the patient and family members. The patient's mood and diabetic control quickly improved, and his emergency admissions ceased. This intervention by liaison psychiatry led to a reduction in the predicted healthcare costs of £70 000 for this patient over the next year.

CARE PATHWAYS

In care pathways that follow National Institute for Health and Clinical Excellence (NICE) guidelines for the management of depression in physical illness, liaison psychiatry expertise is essential to the provision of collaborative care and is most likely to be required within Steps 3 and 4 (National Institute for Health and Clinical Excellence, 2009).

The Kaiser chronic care model (Fig. 1) focuses on integrating services and removing distinctions between primary and secondary care (NHS

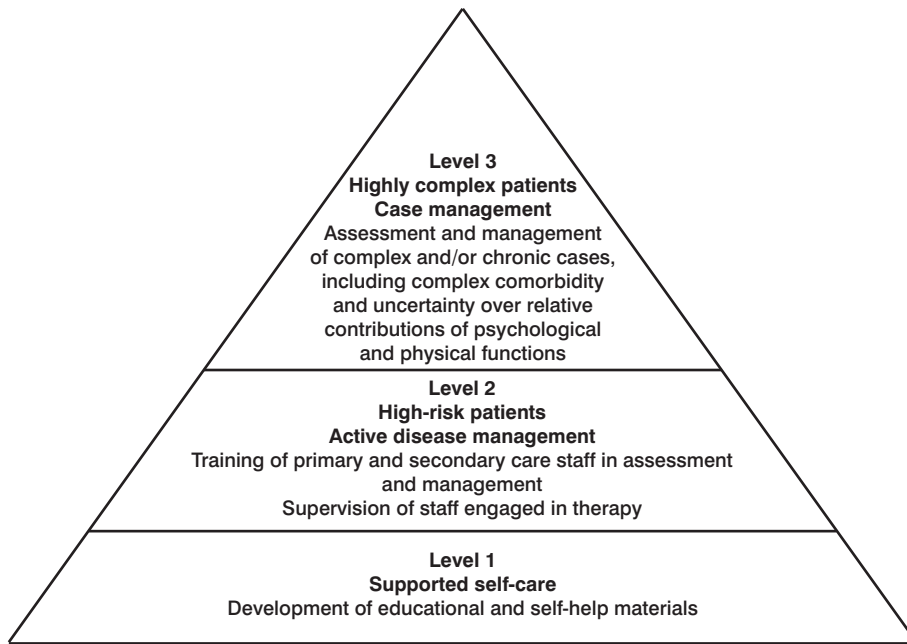


Fig. 1 The role of liaison psychiatry in the levels of care of long-term conditions and medically unexplained symptoms (adapted from NHS Institute for Innovation and Improvement, 2006).

Institute for Innovation and Improvement, 2006). Liaison psychiatry's core role is working with complex cases in Level 3, but its expertise in supervision and education can also contribute to management in Levels 1 and 2.

CONCLUSION

Adding liaison psychiatry to medical management offers a cost-effective and evidence-based approach to delivering integrated care for people with comorbid physical and mental disorders, particularly those with long-term conditions and medically unexplained symptoms.

Appendix A. Examples of services

PENNINE MUSCULOSKELETAL PARTNERSHIP INTEGRATED CLINICAL ASSESSMENT AND TREATMENT SERVICE, OLDHAM

The service manages patients with a range of rheumatological and orthopaedic conditions. It is delivered in a community setting by a multidisciplinary team with both physical and psychiatric expertise. Patients with comorbid psychiatric and musculoskeletal disorders receive a specialist liaison psychiatry assessment and a detailed management plan, and can access a range of psychological and physical interventions. Two-thirds of patients who received an intervention from the service reported a significant improvement in their condition.

For further information, contact Dr Sarah Burlinson (sarah.burlinson@nhs.net).

KING'S COLLEGE HOSPITAL DIABETES SERVICE, LONDON

The King's College Hospital Diabetes Service includes two dedicated mental health professionals, a liaison psychiatrist and a clinical health psychologist, who are integrated into the multidisciplinary diabetes team. The liaison psychiatry clinic offers assessment of psychiatric disorders and psychological problems in patients referred from both primary and secondary care. The clinic also provides psychological therapy and drug treatment, and case management of patients with complex presentations. The liaison psychiatrist provides a consultation service and training for colleagues in the recognition and basic management of comorbid psychiatric disorders and diabetes.

For further information, contact Dr Khalida Ismail (khalida.2.ismail@kcl.ac.uk.)

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