

Scottish Needs Assessment Programme

LIAISON PSYCHIATRY AND PSYCHOLOGY

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EXECUTIVE SUMMARY

Patients with medical problems almost all have accompanying psychological needs. The evidence is accumulating that the size and importance of these needs has been underestimated and that they are going unrecognised and unmet in the 'non-mental-health' parts of our health services.

This neglect has a significant detrimental effect on patients and health services. For patients it causes prolongation of suffering, disability and dissatisfaction; for services it leads to inappropriate treatments and excessive use of resources including unnecessary investigation, unneeded hospital admission and longer lengths of stay.

This situation has arisen for a number of reasons including: a traditional pattern of thinking and service organisation which perpetuates the unhelpful, and unhealthy, split between 'mental' and 'physical' and between psychological/psychiatric and somatic/medical systems of care. This is compounded by the continuing stigma associated with 'mental' ill health.

Patients are now beginning to demand that these aspects of ill-health are better recognised and treated and many clinicians and service planners are now realising the potential benefits to the health services of redesigning care to take this unmet need and demand into account. This is not happening uniformly across Scotland and there were, until recently, and probably still are, areas where there is little, if any, provision.

This report addresses a number of specific areas in which there is scope to recognise and address these unmet needs including:

- the problem of somatic complaints presenting to doctors that are poorly understood or unexplained by disease;
- the psychological problems that frequently accompany acute medical illness;
- chronic pain and chronic fatigue, 'behavioural' problems such as deliberate self-harm, alcohol problems and substance misuse.

The report highlights the main aspects of these conditions, presents some of the evidence for benefit of addressing their psychological aspects, gives some indication of the scale of the problem and proposes ways of improving services.

RECOMMENDATIONS FOR NHS ORGANISATIONS

It would be easy to make a large number of recommendations for change but there are many competing priorities for health services. We have therefore confined our suggestions to a limited number of areas in which we feel each agency could address the identified unmet needs of patients.

The Scottish Executive should:

- through the reports of the Mental Health and Well Being Support Group and its contribution to the Performance Assessment Framework ensure that a basic Liaison Psychiatry and Psychology Service is provided in all NHS Board areas
- through the new Special Health Board for Education in NHSScotland ensure the required manpower with the appropriate skills are available to provide these services

NHS Boards should:

- assess and set out a clear statement of existing local provision of services for patients with Liaison Psychiatry and Psychology needs
- ensure, with the support of the Mental Health and Well Being support Group, that a basic Liaison Psychiatry and Psychology Service is available in primary and secondary care (this should be clearly set out and resourced in the local Joint NHS strategy)
- assess the extent of local need by reviewing data on the key groups described in this report e.g patients with psychological needs attending general hospitals; deliberate self-harm, alcohol related problems and medically unexplained symptoms
- agree on and prioritise the major gaps in services

Acute and Primary Care Trusts should:

- develop robust referral routes to Liaison Psychiatry and Psychology services to those who need them in primary and secondary care
- respond at an early stage to the recommendations in the Plan for action on alcohol problems
- in view of the morbidity and mortality associated with alcohol misuse review local Liaison Psychiatry and Psychology against the principles set out in the template published by the Mental Health and Well Being Support Group

The Medical Royal Colleges in Scotland should:

- consider ways in which demonstration projects could be developed focusing on e.g. better management of patients with medically unexplained symptoms and/or chronic fatigue
- develop referral guidelines to improve the appropriateness of referrals to liaison psychiatry and psychology services

ISD Scotland should:

- explore how data on the psychological needs of patients could best be collected
- review the collection of data on manpower relating to psychological and psychiatric services

The Special Health Board for Education in NHSScotland should:

- develop and ensure resourcing for workforce planning and training schemes to ensure the availability of staff with the necessary skills to provide the services described in this report.

RECOMMENDATIONS FOR RESEARCH

Research into the psychological aspects of medical conditions and their psychological management is a small but rapidly developing field. This is not surprising given that many large expensive evaluations of new pharmacological agents produce only small increments in health gain compared with existing therapies, whereas the paucity of psychological care in the NHS means that a psychological management programme can often produce very substantial health gains over 'usual' NHS care.

The Scottish Universities, the NHS and the Chief Scientist's Office, already support some research in this area. There is a programme of Psychological Medicine Research at Edinburgh University with relevant work also being done in the other Scottish Medical Schools. Because this is essentially clinical research that does not require massive investment in equipment but does benefit from well-organised and well-documented services. Scotland provides an ideal opportunity, not only to conduct research that will benefit the Scottish people, but also to make it a world leader in this area of research.

Important topics to address include:

- the role of psychological intervention in preventing suicide and alcohol misuse;
- the management of medically unexplained symptoms;
- the rehabilitation of those recovering from physical illness and those with 'symptom' problems such as pain and fatigue.

These would be ideal areas for an 'action research' approach led for instance by the Royal College of General Practitioners.

We would also like to see improvements in the availability of data to assess need and track the outcomes of care for patients with psychological care needs. This will obviously require some investment and realignment of information services.

Finally some work is required to develop referral guidelines particularly for primary care. SIGN are developing guidelines for the management of anxiety and this is welcome but there are a number of areas highlighted in this report where guidance on who to refer to whom and where are required.

1 INTRODUCTION

Behaviour is a key factor in the aetiology of Scotland's major health problems of mental illness, cardiovascular disease, cancer and stroke. Psychological factors are a major determinant of health services use and the psychological needs of patients with serious medical and surgical conditions may go unaddressed with a resulting worsening of outcome.

The benefits of addressing the psychological needs of patients potentially include:

- prevention of disease in those identified as being at risk;
- a reduction in the inappropriate use of medical services with benefits for waiting lists and costs;
- improved health and economic outcomes for patients, employers and the country.

Perhaps the major and most neglected opportunity for health gain is the failure to provide psychologically appropriate rehabilitation to patients who have had acute illness and injury such as myocardial infarction, stroke, and acquired brain injury. Many of these patients go on to be chronically disabled, dependent on benefits and economically inactive, where appropriate rehabilitation and appropriate self-management could return them to functional independence.

The aims and scope of this report

This report aims to set out some of the main areas of need for patients and provides a number of suggestions for ways of pursuing these objectives. It focuses on a number of areas of particular need. These are divided into three main groups:

- The first area includes the large problem of somatic complaints presenting to doctors that are poorly understood or unexplained by disease as well as the psychological problems that frequently accompany acute medical illness.
- The second area includes conditions that, although not well understood, benefit from psychological assessment and intervention. They include chronic pain and chronic fatigue.
- The third area is behaviour, which leads to medical and surgical admissions, disease and death and includes deliberate self-harm and alcohol and substance misuse.

The scope of the subject

There are difficulties of terminology in discussing this subject given that it cuts across many specialties and that services have developed in the traditional rather 'ad hoc' way. Thus the specialties of 'liaison' psychiatry (implying psychiatrists working closely with clinical colleagues from non-psychiatric specialties) and clinical psychology are involved but so are many others including therapists, social workers and others. This area of clinical work is sometimes referred to as 'psychological medicine'. Clinical psychologists bring to the team a psychological model which is different from the medical model of health care and patients' problems. Their core basic training is in human behaviour and thinking, both of which have a major impact on response to illness. They may, therefore, have a role with patients who do not have mental health problems as well as with those who do and this makes their contribution distinct from psychiatrists and CPNs.

The need for this kind of 'linking' across traditional treatment boundaries is becoming increasingly apparent. There is now a substantial body of research that highlights how important it is for health services to address these issues: e.g. deliberate self harm is one of the most common reasons for medical admission; approximately a quarter of medical patients suffer from significant anxiety and depression; and a quarter to a half of medical outpatients have symptoms that are 'medically unexplained'. Furthermore, there is evidence (at the level of systematic reviews) for the effectiveness of psychological and psychiatric interventions in these patients and that compliance with many accepted treatments, notably prescribed drug treatment, is poor.

The work of psychiatrists and specialists in psychological medicine should be not only to consult on specific cases, but also to develop the psychological skills of doctors, nurses and other staff working in all non-psychiatric medical services through education and liaison work with them. In this way psychological medicine would have an essential role not only in making medical care more effective and efficient, but also in ensuring that medical treatment, which is increasingly viewed by patients as narrowly 'disease-focused' is both evidence based and genuinely holistic.

The obstacles to change

If the case for improving psychological aspects of medical care is so strong why has it not already been done? We believe the answer lies in a combination of:

- lack of awareness of recent research;

- an inappropriate distinction between psychological and medical care in service planning and organization; and
- implicit provider and financial vested interests in biological procedures to the neglect of psychological and self-help interventions.

How can these unmet needs be addressed?

In the long-term better integration in thinking, planning and delivery between psychological and psychiatric services and general medical services is needed. An increasing amount of research indicates that many of the illnesses previously thought of as 'mental' have a neurological basis and that most illnesses previously thought to be purely 'physical' are strongly influenced by psychological factors. As treatment technologies develop we are increasingly able to take advantage of this research. Health services need to reorient themselves to take advantage of these.

Areas not included in the report

Important groups identified but not dealt with specifically in this report include older adults and those with learning disability. We expect that the Chief Medical Officer's *Report of the Expert Group in the Care of the Older Person* will have pertinent points to make about the former.

In addition, services for children and young people are not considered. These are, by and large, very different. In general it is well recognised that there is a psychological component to many if not most childhood somatic complaints. The complex educational and child protection issues that can arise in paediatrics mean that it is essential that this specialty should sustain a psychosocial approach.

Community child health services are similar to child and adolescent mental health services in their commitment to a bio-psycho-social model of practice, meshing with hospital paediatric and primary care teams. Child and adolescent psychiatrists are likely to see liaison with colleagues in paediatrics and community child health as a core activity. In order to address the needs of young people attending adult health services there is a need for close links between developing adolescent liaison services and services provided for adults. These services are being discussed in the context of the proposed Template for Child Health Services which should complement the *Framework*

for Mental Health Services in Scotland. Mental Health Services for children and young people are the subject of a SNAP report which is currently in preparation.

Obstetric and Perinatal Liaison services also contain significant issues that make them distinctive. The recent report of the Confidential Inquiry into Maternal Deaths 1996 – 1999 *Why Mothers Die*, points out that suicide is the commonest cause of maternal death in the first year after delivery of a baby and makes a number of recommendations which are highly relevant. Where sufficient population numbers allow, dedicated perinatal mental health services would, ideally, encompass the role of obstetric liaison in order to provide a ‘seamless’ service to women during pregnancy, labour, and post-natally. One large urban NHS Board is discussing the commissioning of a perinatal liaison psychiatry service and, while a similar model would not necessarily be appropriate for smaller centres of population, there are specific liaison issues here to be addressed in the future. We note that the Royal College of Psychiatrists is in the process of developing new guidelines for commissioners of healthcare with regard to perinatal psychiatry.

Finally we recognise the important role in mental health of social workers and others from the social services. The importance of psychosocial factors in all ill health, but in mental health matters in particular, is now beginning to get the recognition it deserves. Working partnerships between psychiatric and social work services have traditionally been strong but, undoubtedly, there remains much to be done in this regard. We apologise to our colleagues in the social services if this report appears to focus too much on the ‘medical’ aspects of care.

2 THE POLICY BACKGROUND

Mental Health in ‘Our National Health’

This National Plan for health services sets out national priorities for health and for NHSScotland. It states the intention of developing high quality services in the three clinical priorities: coronary heart disease, cancer and mental health; and of ensuring the needs of specific groups are met.

Our National Health promises to accelerate implementation of the *Framework for Mental Health Services* and acknowledges that severe and or enduring mental illness is only the ‘tip of the iceberg’. It also acknowledges the evidence to support the significant role that liaison psychiatry has to play and promises to support further development in this area.

The *Framework for Mental Health Services in Scotland*

(http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/circular.htm)

This was launched by the Minister for Health and the Arts on 19 September 1997. In an appendix, it describes services for people with eight types of particular needs, including “people who present to a general hospital with a physical illness who have mental health problems, including those who self-harm”. The *Framework* sets out a number of Core Service Elements (Section 2) of which one is “services offering Psychological Interventions”. This was revised recently. HDL(2001) 75 issued on October 2001 states:

“Psychological interventions can provide an important contribution to the treatment of mental health needs in the community. Interventions are based around “talking treatments” which can involve one to one, group or counselling approaches and encourage self help as part of the treatment and support options.”

The document expands on the existing guidance within the published Framework. It acknowledges the increasing evidence base for psychological therapies; draws attention to the emphasis in “Our National Health” on services in the community for people suffering from anxiety and depression and on “positive mental health” and highlights the expanding professional base of those providing psychological interventions.

Principles of service organisation are set out, notably: that commissioners of local joint mental health services “agree a resource envelope” for psychological interventions; that

social work departments and voluntary organisations have a role in specifying the overall service; and that, as part of commissioning, a projection of the staff numbers with the skills required to provide an accessible range of psychological interventions should be made.

This addition to the Framework sets out a 'tiered' framework for service provision at the level of community; self care; extended primary care; intermediate, secondary and tertiary care. It usefully highlights a number of particular needs and suggests ways in which services could respond e.g. through provision of attached Mental Health Workers with skills in liaison/secondary consultation.

Standards of clinical practice are set out to assist quality assurance.

In the light of slow progress being made in implementing the *Framework* the Mental Health and Well Being Support Group was established by the Minister for Health and Community Care in March 2000. The remit of the Group is to "support, influence and advance the further development of mental health services in Scotland; offer advice locally and to the Scottish Executive on solutions and best practice in implementation of the Framework's agenda for change and improvement in mental health services; and provide additional focused local activity assessments to the Scottish Executive and the agencies involved."

The Group undertakes a rolling programme of visits to each Health Board area to explore areas under development as part of the implementation of the *Framework*.

3 SOMATISATION DISORDERS AND PSYCHOLOGICAL COMORBIDITY

Medically Unexplained Physical Symptoms

Introduction

A major proportion of the work of the Scottish NHS is devoted to managing patients with physical symptoms that cannot be attributed to any identifiable 'disease'. These are referred to as functional, somatoform or Medically Unexplained Symptoms (MUS). The Scottish NHS is ill-equipped to help these patients. On the one hand inappropriate management by repeated investigation for disease entities which are not to be found wastes considerable NHS resources and adds to waiting lists. On the other hand patients fail to receive the evidence-based psychological and psychiatric management that would help them.

Extent and Nature of the Problem

Physical symptoms presented to doctors that are frequently unexplained by disease include chest pain, back pain, abdominal pain and chronic fatigue. Although different labels are applied by the different medical specialties these patients actually have much in common. Many are distressed, disabled and have a poor prognosis (Wessely 1999).

MUS constitute a large proportion of the work of primary care. In one study less than ten percent of symptoms presented to primary care doctors were found to be associated with disease (Kroenke and Mangelsdorff, 1989). MUS account for a quarter to a half of all new referrals to hospital medical clinics and for a significant proportion of hospital admissions. Fink (1992) found that a third of patients who had been admitted more than ten times in an eight year period had recurrent MUS and that the associated cost was substantial.

Current Patterns Of Care

Patients referred to hospital with MUS are typically subjected to expensive investigations and can also suffer medically induced (iatrogenic) illness and disability as a result. MUS are a high-cost phenomenon with poor outcome. Yet, whilst most doctors will accept this, it is barely recognized by the existing service. There are isolated examples (for example the Psychological Medicine service to neurology in Edinburgh) but almost no

systematic organisation of services to address what is one of the most prevalent and costly medical problems for NHSScotland.

There is a clear need to recognise the size and importance of the problem posed by MUS and the evidence that coordination of care and assistance of the general practitioner reduce health care costs. Antidepressant drugs have a role as demonstrated in a systematic review (O'Malley, 1999) and psychological treatment has been demonstrated to be effective in a recent systematic review (Kroenke and Swindle, 2000).

Implications For Services

Large numbers of patients in both primary and secondary care have unexplained physical symptoms and their needs are ill-met by services which currently exist. Hospital managers and NHS Boards need to begin addressing this problem and to think about the positive management of MUS when planning services.

Several practical measures are possible. Firstly, medical services could be planned to explicitly address this problem rather than ignoring it. For example many patients with chest pain attending rapid access chest pain clinics will have non-cardiac chest pain. Secondly, all general hospitals need psychological medicine services that can provide effective treatments to provide and coordinate the provision of services and education of staff (Mayou and Sharpe 1997). Thirdly, general practitioners could be supported in managing these patients by providing clear criteria for referring and managing patients with symptoms but negative investigations. Dedicated nurses supervised by hospital psychological medicine services could aid this. Finally we need to make appropriate psychological therapies available for selected patients with MUS and not just for patients with obviously psychological problems.

These patients will continue to present both in primary and secondary care. Although it may be argued that provision of such services will be expensive, the failure to provide them is likely to be even more expensive.

Psychological Problems Accompanying Physical Illness

'Physical' illness always has a psychological component. In many cases the psychological component is significant and may even be predominant. When the

psychological disturbance is sufficiently severe to qualify as a psychiatric illness it is regarded as psychiatry comorbidity. There is a great and largely unmet need for the psychological aspects of physical illness and its treatment to be more actively addressed (Mayou & Sharpe 1995).

Extent and nature of the problem

The most common psychiatric co-morbid condition is depression. Co-morbid depressive and anxiety disorders are found in as many as a quarter of patients with medical conditions (Feldman 1987). Co-morbid depression and anxiety magnify suffering and disability (Katon 1996), lead to greatly increased costs from increased use of general medical services (Henk 1996) and may even reduce survival (von Ammon 2001).

Delirium (confusional state) is another common co-morbid psychiatric disorder in elderly hospital inpatients and is associated with a greater length of hospital stay (Taylor 1993) .

Meeting patients' needs

Meeting the needs of patients with psychiatric co-morbidity could produce a very substantial health gain and reduce the burden on medical services for a modest cost. Whilst large sums of money are spent on new medical treatments that often offer only marginal benefit over existing management, the potential benefit of recognising and actively managing co-morbid psychiatric disorder goes largely ignored. Some medical specialities such as cancer services have limited provision of dedicated psychology and psychiatry whilst other services such as general surgery, where the need is arguably just as great, commonly have none.

The practical need is for the importance of co-morbid psychiatric disorder to be recognised in the planning of services and for the detection of co-morbid psychiatric illness to be part of routine assessment.

Once these conditions are recognized, existing medical and nursing staff need education and supervision in managing co-morbid psychiatric disorders. In primary care existing mental health teams could potentially do this, although they often feel that patients whose psychiatric difficulties are accompanied by significant medical problems are outside their expertise. In hospital it is best done by a multi-disciplinary psychological medicine service, which provides both a focus for the recognition of the problem and a means of delivering education and supervision and also a source of specialist advice

and treatment. As with medically unexplained symptoms there is a role for out-reach from hospital services to assist in the management of patients in primary care.

Chronic Pain, Chronic Fatigue, Self Management and Rehabilitation

In a number of conditions, such as Chronic Fatigue Syndrome or Chronic Pain, treatment based on an acute medical model appears to have limited efficacy and patients remain significantly disabled. In conditions such as chronic angina or spinal injury, where physical symptoms persist then the psychological aspects may begin to impede recovery or even aggravate the physical disability. This can result in unnecessary invalidism with a significant impact on the individual's quality of life and with considerable costs for the NHS. A bio-psycho-social model of care is more appropriate for these conditions with a focus on rehabilitation and self-management.

Chronic Fatigue Syndrome (CFS/ME).

Chronic Fatigue Syndrome, sometimes termed Myalgic Encephalomyelitis (ME), is a poorly understood condition associated with severe chronic disability. Its symptoms are various but fatigue is central. Although there has been considerable controversy about the nature of this illness and how patients should best be helped, there is increasing evidence that a psychologically informed rehabilitative approach is able to achieve substantial improvements of functioning in the majority of patients. This has been confirmed in the recently published Report of the CFS/ME Working Group, an independent working party commissioned by the CMO (England) to which service users, their carers, and representatives of voluntary organisations contributed. This report is being considered by a working group in Scotland to assess how it could be applied in Scotland.

Extent and nature of the problem

There is a wide range in estimates for the prevalence of the disorder, but in its severe form it is probably of the order of 0.5% of adult population. There is a predominance of young women, but men and women of all ages and children are affected (Wessely, 1998). There are few specific services for such patients in Scotland. Many patients are conservatively managed in primary care, some receive hospital medical assessments before being returned to primary care but arrangements are generally 'ad hoc'. Antidepressants are given to many patients, although their effectiveness is uncertain.

Many patients turn to alternative medicine. A substantial number develop chronic disability, which is expensive to the patient and to the state.

The only form of intervention for which there is substantial clinical evidence is psychologically informed practical rehabilitation. This includes cognitive behaviour therapy (CBT) and appropriately administered graded exercise therapy (Sharpe 1997).

Three systematic reviews of the evidence (Price 2000; Reid 2000; Whiting et al 2001) have concluded this form of the therapy had substantial efficacy.

There are two main problems in delivering this treatment to patients. First there is a lack of therapists with the necessary time and skills. The second is that many patients with a diagnosis of CFS/ME may reject the treatment as it is delivered in 'mental health' settings. These problems could be overcome by a modest service development of relevant psychology and liaison psychiatry services. An example of a dedicated service is that at Kings College Hospital in London.

In addition the education of practitioners and greater availability of evidence based self-help literature (Campling, 2000) could have substantial benefit for patients in terms of reduced disability and return to work. It also offers potential cost off-set by providing appropriate evidence based treatment for patients who would otherwise be treated less appropriately or simply neglected.

Chronic Pain

Chronic pain has been defined as pain with or without any identifiable pathological cause which exists beyond the time of expected resolution, usually for a period of at least three months (International Association for the Study of Pain, 1986). Unrelieved pain has a major impact on sufferers because of its personal, social and occupational consequences. Disability from chronic pain is recognised as a major health problem but the true prevalence of chronic pain in Scotland is unknown (Scottish Office Home and Health Department 1994). A UK population study found a chronic pain prevalence rate of 70 per 1000 (Bowsher 1991).

Pain is a complex experience and psychological processes play a major role in people's perception of pain and their response to it, especially if pain becomes chronic. Chronic pain is also a cause of emotional distress. A British study (Tyrer 1989) found that 21% of the pain-clinic population was clinically depressed. Early identification of associated psychological problems appears to be important to prevent unnecessary suffering in

patients. For a small number of patients presenting with chronic pain, psychological problems may be more clearly seen as the source of the pain. These patients may develop abnormal illness behaviour, unnecessary invalidism and dependency on others. It is important to identify this group because, not only do they use disproportionately large amounts of NHS resource, but, in common with patients with unexplained symptoms, they may undergo unnecessary surgical and medical procedures which may, in themselves, lead to long-term health problems.

Psychological research has contributed significantly to an understanding of pain mechanisms and led to improved assessment and treatment. Psychological therapeutic techniques such as Behaviour Therapy and Cognitive Behaviour Therapy have been used to manage or to alleviate the effects of pain particularly where medical and surgical techniques have failed to bring relief.

Reviews of chronic pain services in Scotland and the UK have recommended that, in order to provide a satisfactory service to people with chronic pain, services need to be multidisciplinary, both in primary and secondary care (Scottish Home and Health Department 1994; Pain Society 1995). They have recommended the development of a number of Pain Management Programme (PMP) Centres throughout Scotland. These centres, using a psychologically based rehabilitative approach, are designed for patients with chronic, benign pain who are thought to have considerable unnecessary loss of function due to the pain. Pain specialists in the UK have specified the necessary criteria for PMPs (Pain Society 1995). There is now considerable evidence for the effectiveness of such psychological approaches for chronic pain (Flor 1992). An example of a PMP is based in Astley Ainslie Hospital in Edinburgh. However, the majority of chronic pain patients in Scotland who would benefit from such a rehabilitative approach to pain management are unable to get access to it. There is, as a result, continued suffering and loss of function for the people involved and considerable cost to the NHS and benefits system.

Self Management and Rehabilitation

Most people who suffer an episode of illness or trauma resulting in physical symptoms will also experience psychological and social repercussions. While they may come to terms with, and adjust to, the circumstances, some may find that these psychosocial

factors impede recovery or even aggravate their physical disability. In some instances the psychological accompaniment to physical illness may amount to a specific psychiatric disorder, such as clinical depression but, in many cases, less well-defined symptoms persist which, nonetheless, have a significant effect on quality of life.

Rehabilitation is a process aimed at assisting people to make as full a recovery as possible after illness or injury in physical, psychological and social terms. Similarly, palliative care aims at helping people adjust to progressive disease in a holistic manner. Such specialist services need to operate on a bio-psycho-social model in contrast to the traditional medical model, which tends to focus on the abnormal 'physiology' that results from 'pathology'.

There are numerous theoretical models which attempt to explain how an individual's beliefs about health affect their well-being and their recovery from disease (Schwartzter 1994, Weinman 1990). These health beliefs and attributions influence response to treatment (e.g. in response to health promotion advice, participation in screening programmes and compliance with medication and professional advice when illness occurs). In addition, there is a growing body of evidence of a direct relationship between mental state and physiology in terms of effects on the immune and neuro-endocrine systems (Watkins1997, Dixon and Sweeney 2000). Such concepts might be summarised as people taking responsibility for their own health and the self-management of disease and disability.

The intelligent application of techniques of psychological medicine, liaison psychiatry and psychology has a key role in fostering self-management of health and rehabilitation in several ways, notably:

- Specific clinical input: e.g. cognitive behavioural therapy in pain management, palliative care, psychosexual problems etc;
- Education of other primary and secondary care professions in management of psychological aspects of physical disease and trauma;
- Health promotion initiatives in collaboration with other agencies;
- Secondary prevention: e.g. cognitive behavioural therapy in ischaemic heart disease.

Success in such roles relies on good inter-disciplinary communication and teamwork within and between primary and secondary care and the liaison psychiatrist or psychologist. At the heart of such an integrative approach lies the therapeutic relationship with the patient (Dixon 2000) without which all attempts to engender effective self-management are likely to fail. Key aspects of this relationship include trust, respect, honesty, and empathy (Silverman 1998) and the specific knowledge and expertise of the clinician.

Liaison psychiatrists and health psychologists thus have a potentially key role in training and supporting other health care professionals in the bio-psycho-social approach to the management of physical symptoms in rehabilitation practice. Cognitive behavioural therapy has a proven role in the rehabilitation of many conditions (e.g. pain, sexual difficulties after disease or trauma) and there is also a role for liaison psychiatry/health psychology in health promotion and secondary prevention of various conditions.

Alcohol and Substance Abuse, Deliberate Self-Harm and Suicide

Although there is considerable 'poly'-drug use in Scotland, especially among the young, by far the greatest problem facing the acute care sector in terms of substance abuse is the consequence of problematic use of alcohol, particularly acute intoxication, withdrawal symptoms, injuries and liver disease.

Alcohol and Substance Abuse

This challenge to the health service has been highlighted in detail by the recent report of the Royal College of Physicians (RCP) which recommends that "problems from alcohol misuse must be recognised as falling within the remit of all liaison psychiatry services".

Alcohol Related Problems: extent in Scotland

From 1983 to 1995 marked increases in problems related to alcohol were reported in Scotland. There was a 180% increase in male discharges for alcohol dependence whilst for females the increase was 360%. Death due to alcoholic liver disease in males rose by 117% and in females by 150% (ISD Scotland).

One in four adults in the UK are drinking hazardously. (Scottish Executive 2002) People in the youngest age group (16-24) are the most likely to exceed recommended limits (Scottish Health Survey 1998).

Scottish women are drinking more and alcohol-related death rates for women have doubled in the last decade.

Men in the most deprived areas (Deprivation Category 7) are seven times more likely to die an alcohol-related death or to be admitted to an acute hospital with an alcohol related diagnosis than those in least deprived areas.

There is evidence that binge drinking leads to many acute problems such as seizures, aspiration pneumonia or trauma, whereas regular daily over consumption is more likely to lead to severe liver disease in time.

Effectiveness of Treatment

The RCP report highlighted the use of three screening questionnaires, which have already been used widely in the UK to highlight vulnerable individuals, and to target “brief interventions” delivered by an alcohol specialist nurse employed by the acute trust and working in conjunction with local liaison services (MAST, AUDIT and PAT screening tests).

Estimates for the cost to the NHS hospital sector of alcohol problems range between £0.5 and £2.9 billion, from a total spend of £23.4 billion (RCP 2001). The annual cost to NHSScotland is estimated to be around £96 million (Scottish Executive 2002).

Potential Areas for Development of Alcohol Liaison Mental Health Services

Locations for establishing alcohol intervention services could include:

Primary Care: Practice nurses or health visitors following adequate training could provide services aimed at reducing alcohol use, within the primary care team, as happens in Lanarkshire.

Accident & Emergency Units: There is ample evidence for the increasing problem that alcohol causes in A&E departments. Forty per cent of attendees at Edinburgh Royal Infirmary have been drinking prior to their attendance, and 32% are over the legal driving limit.

Acute Receiving Specialties: Many patients who attend A&E are subsequently referred to acute receiving specialties (such as general medicine, general and facio-maxillary surgery, orthopaedics and gynaecology, and even paediatrics).

Elective Surgery: Alcohol withdrawal problems commonly occur in patients admitted for elective surgery. Early detection and treatment to prevent post

operative withdrawal problems may help to reduce the length of stay (see illustrative case histories: Appendix 2).

Other Hospital Specialties: Most trauma cases are now looked after in orthopaedic wards and head trauma is often managed in general surgical units. There is a high proportion of alcohol-related problems in these patients and their injuries may be aggravated by the presence of alcohol. In addition gastroenterology services report being stretched providing care for Alcoholic Liver Disease (Butler 2001)

A number of examples of good clinical practice in management of alcohol problems already exist e.g. screening and brief interventions in A&E Departments of Edinburgh Royal Infirmary; Alcohol Liaison Nursing at the Royal Liverpool University Hospital; and St. Mary's Hospital Paddington; agreed protocols for management of alcohol withdrawal between general wards and psychiatric units (e.g. CIWA Scale, Glasgow Royal Infirmary).

Substance Misuse

Extent of Illicit Drug Use in Scotland

It has been estimated that 30% of adults have used illicit drugs in the UK, and that misuse of prescribed drugs is even more common. 100,000 people use heroin, and an unknown but increasing number use ecstasy and amphetamines.

A further, but hidden, problem is the misuse of over-the-counter drugs. Increasingly powerful drugs are available without prescription; excessive use of cough medicines and analgesics, inter alia, is now recognised as a major health problem, especially among adolescents.

The health consequences of drug abuse are serious, particularly if the drugs are injected. Depending on the type of drug and on the route of administration, these can include peripheral emboli, deep vein thrombosis, constipation, hypertension, infections (especially HIV and hepatitis B and C), abscess formation, endocarditis, psychotic-like symptoms, depression, dependence, and withdrawal symptoms (e.g. convulsions).

The Effectiveness of Treatment Drug Related Problems

Some evidence of the effectiveness of treatment has been reported by the National Treatment Outcome Research Study (Gossop 1998), a large, longitudinal cohort study of

treatment outcomes which followed 1075 patients with severe, long-standing problems related to substance use in 54 different establishments. Four treatment modalities were examined: residential inpatient treatment, residential rehabilitation programmes, community methadone maintenance, and community methadone reduction programmes.

At a one-year follow up substantial clinical improvements in the use of heroin, cocaine and other drugs were reported; residential treatment led to greater reductions in drinking, although overall reductions in alcohol were modest; fewer physical health problems were reported; and that there was a marked reduction in criminal behaviour to the extent that this benefit alone more than covered the cost of the treatments (www.ntors.org.uk).

The decrease in general health care costs following treatment of alcohol related problems provides appears not to be seen when considering drug-related problems. Apart from the NTORS Project, little evidence for the cost-reducing effects of treating drug problems appears to exist.

Adequacy of Current Provision

In Scotland provision of service for drug and alcohol abuse is patchy. Staff in acute specialities feel that their priority is to manage those with severe illness, and experience frustration when mental health services are not located on-site. At the same time GPs demand greater availability of specialist alcohol and drug services in the community.

One difficulty is acknowledgement of 'ownership' of the problem. Within mental health services there is debate about whether alcohol and drug problems in acute trusts should be the responsibility of liaison psychiatry/psychology or of substance abuse services. There needs to be clear definition of responsibilities, particularly if liaison services cannot be provided on-site. Training specialist alcohol health workers or specialist nurses for work in acute trusts would be one way to improve the situation.

Key gaps in Services include:

- lack of on-site psychiatry liaison service in the majority of Scotland's Acute General Hospitals;
- lack of dedicated alcohol specialist nurses in general acute hospitals to identify problem patients, conduct brief intervention and to co-ordinate follow up with local psychiatric or alcohol rehab services
- lack of specialised primary care services for referral of alcohol and drug abusing patients for detoxification and rehabilitation services.

Ways in which these could be addressed include:

- On-site alcohol support services, either via liaison psychiatrist or alcohol specialist nursing giving 24 hour cover to the various areas outlined above
- Increased training in alcohol related problems for all NHS staff, but especially those in A&E, Acute Medical Receiving Units, ITU, and Gastroenterology.
- Co-ordinated liaison psychiatry and psychology services in the acute hospital setting for assessment, specialised treatment and long-term follow-up of drug-misusing patients.
- Education and training for all health professionals in prevention, early identification and successful interventions in patients with or at high risk of drug misuse.

Deliberate Self-Harm and Suicide

Attempted suicide, parasuicide and deliberate self-harm are all terms used to describe this type of behaviour. The term deliberate self-harm is used here to include those who fully intend suicide, those with no suicidal intent and those with complex or mixed motives.

The Scale of the Problem

In Scotland, the mean annual number of suicide deaths was 157 per annum for women and 456 for men in 1996-8 (Platt, 2000). About half of people who commit suicide have a history of deliberate self-harm. About one percent of those who deliberately self-harm go on to kill themselves within a year and, in the subsequent 10 years, up to 10% go on

to kill themselves. Up until the 1990s, deliberate self-harm was more common among women than men but recent data suggest that there is now little difference in rates between men and women (Williams, 1997).

Acts of deliberate self-harm account for around 15-20% of the workload of medical units and 10% of the workload of Accident & Emergency departments (Jones & Volans, 1999). It is not known how many individuals deliberately self-harm and do not contact medical services.

Causes and characteristics

Deliberate self-harm is associated with a variety of problems and there are recognised factors which increase the risk of suicide e.g. socio-demographic factors related to social isolation and deprivation; psychological factors relating to perceived loss; threat; and personal vulnerability and recent life changes.

Current Patterns of Care

Patterns of care for people who deliberately self-harm vary throughout the country. Some areas offer a psychosocial assessment to everyone who attends the A&E department following deliberate self-harm whilst other areas offer no dedicated service or a strictly limited service.

Effective Interventions

Although it has been recognised for many years that successful intervention to prevent episodes of deliberate self-harm would represent a major contribution to improving health, there has been little robust evidence that interventions might be of benefit.

There is now some evidence to suggest that relatively brief psychological interventions, particularly those which include problem solving and cognitive strategies, can be beneficial for this group of patients in reducing the rate of further episodes of self-harm (Hawton et al, 1998).

There is also evidence that the sub-group of patients with personality disorder can be managed best with more intensive and structured psychotherapies and also planned and co-ordinated service provision from mental health services offering longer-term support.

Arguably, all patients who are admitted to or attend a general hospital with deliberate self-harm should receive a detailed psychosocial and psychiatric assessment from an appropriately trained mental health professional to determine suicidal risk psychiatric

status and psychosocial need.

Following a review of the literature on the prevention of suicide through interventions in the Accident and Emergency Department, Repper (1999) suggested that “action to reduce suicide needs to be taken at all levels of the organisation” and that the role of the appropriately trained mental health professional “needs to include support, training and development as well as time-limited therapy with a highly targeted group of patients at specific risk”.

In adults, hospital admission may be required for reasons related to physical illness but admission may also be justified in order to ensure that vulnerable individuals receive an adequate psychosocial assessment.

The Royal College of Psychiatrists and the Royal College of Physicians (1998) have produced guidelines for managing deliberate self-harm in young people. These suggest that it is desirable that all of those up to age 16 who present with deliberate self-harm should have a brief admission for assessment that includes specialist child and adolescent mental health understanding.

An example of current good practice

The Liaison Psychiatry service in Dundee covers a population of around 200,000. There is a designated nursing service which provides a psychosocial assessment seven days a week for all those referred by the local A&E department following an episode of deliberate self harm. Follow up care, if required, can be arranged via the Liaison Service (both medical and nursing staff) to ensure continuity of care.

Ways in which the needs of these patients could be better met include:

- better education and training for all staff who come into contact with patients who deliberately self-harm;
- all patients who attend a general hospital with deliberate self-harm should, ideally, receive a psychosocial and psychiatric assessment from a mental health professional with appropriate expertise to determine suicidal risk, psychiatric status and psychosocial need;
- designated facilities for the emergency admission of psychosocially vulnerable or medically sick patients presenting with deliberate self-harm could be identified in each area.

4 DEMAND, RESOURCES AND RECENT SERVICE DEVELOPMENTS

Whilst we would ideally be able to quantify the current levels of provision of services for patients and the scale of need and demand, the ways in which information is currently collected on medical and non-medical manpower in NHSScotland and the lack of a common framework for service provision make this difficult. A number of sources of information do exist, however, and an attempt to summarise these is made here.

Mental Health and Well Being Support Group: Waiting Times Initiative and Psychological Therapies Census

In *The Framework for Mental Health Services in Scotland* (1997) psychological therapies were included as a core component of the 'Service Element'. In July 2000 psychological therapies were included in an announcement by the Deputy Minister about a Waiting Times Initiative.

Two approaches were taken forward: the first was a census of the availability of psychological therapies; the second was to pilot projects in 4 health board areas, using funding from the Mental Health and Well Being Development Fund, employing support from the Glasgow Institute of Psychosocial Interventions (GIPSI*) and the Scottish Development Centre for Mental Health Services to examine how services could best be organised.

The Scottish Executive asked the Support Group to co-ordinate a census of access to, and provision of, psychological therapies, in both primary and secondary care. The Mental Health and Well Being Support Group made this data available in an anonymised format to the SNAP group. Note: this is not 'psychological medicine' but it is some indication of the current access to psychological services. Even so the data are of inadequate quality.

The returns submitted from the census do not provide a coherent national or local picture and so are not reproduced here. There are significant gaps in the data rendering validated comparisons and conclusions difficult. Also there is variation in the way the questions were interpreted by those responding and insufficient information was provided in the returns from Local Health Care Co-operatives on which to base a national analysis.

Data was provided broken down by referral for different types of treatment e.g. for alcohol abuse, eating disorder, drug abuse etc but these data are even less complete.

The census returns do offer some insights, for example, in showing evidence of wide variations in the waiting time positions for each area. Waiting times e.g. for clinical psychology at Primary Care Trust level varied from 10 to 130 weeks whilst the ratio of clinical psychology staff per 10,000 patients (aged over 16) varied from 1.65 to 0.43.

The census data therefore highlight variations in service need but also the remarkable lack of useful comparative data in this area.

The MHWBSG followed up the census with visits to a number of locations (Grampian, Tayside and Lothian) to discuss with commissioners and service staff the organisation of local services, resources, inter-agency working and how overall provision reflects local needs. This is discussed later in this report.

Workforce

Information on the numbers and types/grades of staff working in Liaison Services in Scotland is available from routine health service data (ISDScotland). Data on medical and dental workforce is available from personnel departments whilst data on non-medical personnel is gathered from workforce planning censuses and from Trust/Health Board payroll systems.

The number of whole time equivalent clinical psychologists in Scotland was 133 in 1980 and rose to 385 in 1998 (ISD Scotland 1999). It is not known how many of these were working in 'liaison' roles. A workforce planning census carried out in 1996 revealed high vacancy rates in many areas particularly Glasgow Trusts, the State Hospital and Borders (source: Scottish Council for Postgraduate Dental and Medical Education). We understand (L Green, personal communication) that the situation changed in Glasgow after 1996 with the introduction of a new clinical psychology directorate structure so that, by 1998, when there was a review of Clinical Psychologists in Scotland (report is in the public domain - Scottish Council "Psychology Service in Scottish Health Care") the vacancy rate was 8%.

The number of consultant 'general' psychiatrists (Whole-Time Equivalents) rose over the same period from 171 in 1980 to 199 in 1998 (ISD Scotland 1999). Again it is not known how many were involved in liaison type work but it is likely to be a small minority.

Liaison Psychiatry has now been added to routine data collection as a psychiatric specialty code so this information should be more available in future.

An informal survey of Liaison Psychiatry was carried out in 1999 by Scottish Liaison Psychiatrists. The survey found a total of 317.5 sessions dedicated to liaison work in Scotland 1999. Table 1 gives a breakdown of the provision at national level.

Table 1 Liaison Psychiatry and Psychology Staffing, Scotland 1999

Grade	Sessions
Consultant full time	33
Consultant part time	55.5
Psychologist	15
SHO SpR Lecturer Associate specialist	113.5
Liaison nurse	133
Social worker	18.5
Total	368.5

The distribution of these sessions by Trust and by NHS Board is shown in Tables 1 - 3 (Appendix 1). The extent of variation is striking. Lothian and Grampian appear relatively well staffed but the total time in relation to the evidence of need remains small. Ayrshire

and Arran, Fife, Borders and the Islands appear to have had no service provided at the time these data were gathered.

Current Service developments

The Mental Health and Well Being Support Group in the course of visits to Health Boards has gathered information on service developments and on difficulties experienced by those planning services. Transcripts of these were made available to the SNAP group in anonymised form and these give some insight into current developments in Health Boards.

There appears to be a growing awareness of the need for this kind of service and of a steadily rising demand. There is widespread realisation that staff skills need improvement and training is being developed in many areas particularly in Cognitive Behaviour Therapy (CBT).

Perceived problems include: the inevitable difficulty in finding resources to expand services, the rising waiting lists once services are in place, the difficulties of 'quality assuring' some aspects of psychological services and the rising complexity of case loads.

Other Service Developments

Four pilot projects are being taken forward: in Forth Valley, Dumfries and Galloway, Ayrshire and Arran and Greater Glasgow to explore models of provision of psychological therapies. This is being done in co-operation with the Scottish Development Centre for Mental Health (SDCMH) and a grant from the Mental Health and Well Being Support Group.

The Glasgow Institute for Psycho-Social Interventions (GIPSI) is also involved in this work. GIPSI is a resource centre for staff of the Greater Glasgow Primary Care Trust. It aims to provide training and supervision to staff in short-term psychosocial interventions for the severely mentally ill or those with chronic psychosocial disorders, and secondly and to carry out research in psychosocial therapies.

Again this may not be 'Psychological Medicine' but it gives some indication of where we are nationally in improving the response to psychological health needs.

The 'User' View

The group spent some time discussing this and was fortunate to have as a lay member

someone who is in contact with users of services in Scotland. The main conclusions from this perspective were:

- Attitudes of staff - although staff attitudes are changing there are staff especially in A&E departments who find it very frustrating to deal with people with psychological problems - they can be 'less than tactful' in displaying this – at times staff attitudes can be 'barbaric' showing little regard for the vulnerability or confidentiality of patients with emotional problems or mental distress.
- This is not confined to A&E departments or to psychological medicine. It is part of a widespread need for improved training and monitoring of staff - User Group members had often talked about the need for some sort of A&E 'first-aid' approach to people with a mental illness discreet to other emergency services.
- Some people may leave hospital at night time without the opportunity for a proper assessment. In some situations there may be no satisfactory arrangements for follow up - either because the user rejects them or because no system exists.
- The business of a general hospital does not always 'fit in' with the needs of a person in considerable distress.

5 CONCLUSIONS

The evidence drawn together here suggests that there is a substantial need for the development of improved psychological medicine services (liaison psychiatry, psychology and associated disciplines) as well as improved training for doctors and nurses in the recognition and management of the psychological aspects of illness in a wide range of settings in the NHS in Scotland. Previous service development has tended to ignore this need – in part because it falls between ‘mental health’ and ‘general medical services’. Service provision is therefore patchy and fragmented and much of the need is currently unmet.

This is an area in which there is a major potential for health gain, especially in comparison with some of the new technologies which are being funded in the health services. The evidence base for this aspect of treatment is growing rapidly. The relative under-investment in exploring the potential for this kind of approach contrasts with the intense investment (largely by the pharmaceutical industry) in drug treatments.

Demand is increasing for these services both within and outside of the services themselves. This is clear from the work of the Mental Health and Well Being support Groups visits across Scotland. However, levels of provision are very variable across Scotland with services much more developed in some areas than in others. This is being tackled slowly but there still appear to be areas where patients have little or no access to services. There is thus a significant issue of equity requiring to be addressed.

Difficulties in assessing the scale of need arise because of the ways in which we gather data in NHSScotland. Although we collect information on inpatient psychiatric admissions (SMR04) we lack adequate data from general practice on hugely important issues such as e.g. patients with unexplained physical symptoms, alcohol problems or anxiety. ISD are currently reviewing the collection and utilisation of data on mental health in Scotland and we hope that they will take the findings set out in this report into account. It is impossible to plan or monitor services without good data.

Barriers to change in service provision thus include:

- attitudes to mental illness;
- poor information on the extent of need;
- lack of awareness of the effectiveness of interventions; and

- the inertia inherent in service structures which have grown up over time and which now perpetuate the divisions between the psychological and physical aspects of illness and largely give predominance to the latter.
- Another significant barrier must be the current lack of clear guidance for primary care on which patients to refer and to which agencies.

An examination of the evidence available suggests that improving services in this area could have a substantial impact on acute admissions, on levels of patient satisfaction and on patient empowerment and compliance with treatment. There appear to be significant opportunities to improve health outcomes and service efficiency.

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APPENDIX 1

TABLE 1 LIAISON PSYCHIATRIC REFERRALS/YEAR

Hospital	Beds (N)	Liaison sessions	DSH	Inpatients	Outpatients	A & E
Aberdeen Royal Infirmary	959	51	1500	381	208	50
Glasgow Royal Infirmary	678	29.5	332	230	100	0
Edinburgh Royal Infirmary	655	88	3103	674	229	85
Ninewells Hospital	587	38.5	820	262	96	364 (incl. DSH)
Western General Hospital	503	50	N/A	268	149	N/A
Monklands District General Hospital	444	13	400	80	25	400
Royal Alexandra Hospital	429	2	540	N/K	N/K	N/K
Victoria Infirmary, Glasgow	429	11.5	N/K	375	0	0
Stobhill Hospital	363	13	426	60	N/K	N/K
Inverclyde Royal Hospital	320	25.5	191	103	135	N/K
St. John's Hospital	301	13	402	212	112	N/K
Stirling Royal Hospital	301	7	280	N/K	N/K	N/K
Falkirk & District Royal Infirmary	251	22	265	115	50	N/K
Dr. Gray's Hospital	166	3	N/K	310 (inc. DSH)	N/K	37

Source: Scottish Liaison Psychiatrists 1999

TABLE 2 LIAISON PSYCHIATRIC SESSIONS / HOSPITAL

Hospital	Beds	Consultant sessions	Other medical sessions	All liaison session
Aberdeen Royal Infirmary	959	11	13	51
Western Infirmary & Gartnavel General Hospital, Glasgow	872	0	0	0
Glasgow Royal Infirmary	678	7	11.5	29.5
Edinburgh Royal Infirmary	655	25	29	88
Ninewells Hospital	587	5	11.5	38.5
Southern General Hospital	562	0	0	0
Western General Hospital, Edinburgh	503	18	21	50
Raigmore Hospital	484	0	0	11
Crosshouse Hospital	468	0	0	0
Monklands District General Hospital	444	2	0	13
Royal Alexandra Hospital	429	2	0	2
Victoria Infirmary	429	3	3	11.5
Law Hospital	408	0	0	0
Stobhill Hospital	363	2	0	13
Hairmyres Hospital	348	0	0	0
Victoria Hospital, Kirkcaldy	324	0	0	0
Inverclyde Royal Hospital	320	4	5.5	25.5
The Ayr Hospital	318	0	0	0
Dumfries & Galloway Royal Infirmary	303	0	0	0
St. John's Hospital	301	7	6	13
Stirling Royal Hospital	301	1.5	0	7
Falkirk & District Royal Infirmary	251	0	11	22
Queen Margaret Hospital	247	0	0	0
Perth Royal Infirmary	237	0	0	0
Borders General Hospital	237	0	0	0
Dr. Gray's Hospital	166	3	0	3
Stracathro Hospital	138	0	0	0

Vale of Leven District General Hospital	136	0	0	0
Stonehouse Hospital	121	0	0	0

Source: Scottish Liaison Psychiatrists 1999

TABLE 3 LIAISON PSYCHIATRIC SESSIONS / HEALTH BOARD

Health Board	Consultant Session	Liaison nurse sessions	Other medical sessions	All liaison session
Argyll & Clyde	6	16.5	5.5	28
Ayrshire & Arran	0	0	0	0
Borders	0	0	0	0
Dumfries & Galloway	0	0	0	0
Fife	0	0	0	0
Forth Valley	1.5	0	11	29
Grampian	14	22	13	54
Greater Glasgow	12	27.5	14.5	54
Highland	0	11	0	11
Lanarkshire	2	11	0	13
Lothian	50	33	58	153
Orkney	0	0	0	0
Shetland	0	0	0	0
Tayside	5	22	11.5	38.5
Western Isles	0	0	0	0

Source: Scottish Liaison Psychiatrists 1999

APPENDIX 2

PERSONAL EXPERIENCES OF UNMET NEED

Alcohol and drug use – lack of local services

PT, a 21-year-old unemployed man was living with his partner and 4 year old son. He came to his GP surgery requesting help to kick his £80 a day heroin habit. Looking back in the case-notes his GP discovered he had had an alcohol problem for several years. Despite going through several successful detoxification regimes in the primary care setting he always relapsed before receiving his appointment with alcohol services several months later and would subsequently default. He now claimed he had finally managed to stop drinking but had replaced this addiction with his current heroin addiction. He refused to enter a methadone programme and was keen for a rapid detoxification regime. However the GP was reluctant to prescribe this in the community, as there were no local psychological services to support the medical treatment and this was therefore unlikely to be successful.

Medically Unexplained Physical Symptoms

CS is a 48-year-old married, unemployed lady. She presented to her GP with abdominal pain and diarrhoea. The pain was intermittent and only slightly troublesome but she reported being significantly disabled by increased frequency of bowel motions and reported that on one occasion she had soiled herself when out shopping. After the symptoms had persisted for four months she was referred to a gastro-enterologist. Investigations were entirely normal and she was told she had irritable bowel syndrome. She herself spontaneously reported that her symptoms were worse when she was under stress and agreed to referral to a liaison psychiatrist saying, "I'll try anything if you think it will help". By this time she was rarely leaving home, as she feared further episodes of soiling and the embarrassment and humiliation which followed.

Drug overdose – need for staff training

Andrew was admitted to hospital after taking a large overdose – his story was very positive; the existence of a liaison psychiatric nurse was very much appreciated and treatment in A&E and the admissions ward very good - the fact that people with a mental illness may be very mobile and need distraction did not fit easily with the wards of a general hospital. His main point was that he struck up a relationship with someone with a drug problem - he

overheard a nurse asking another nurse "Who's the smackhead?" and a nurse in his presence gave that person his medication with the words "here's your methadone."

Grief and Alcohol-related problems

Jean has a psychiatric illness but recently witnessed the death of her newly married husband and a friend in a mountaineering accident. She became drunk and very distressed at Christmas to the extent that those around her became worried about her safety and called the police. She was taken to accident and emergency with no outdoor clothes no money and no means of getting home - whilst in hospital she 'reached out' to a nurse, as she recalls it, to get some comfort - the consequence of this was that the police were called and she was taken to the police cells for some considerable time before being charged with assault and then admitted to the psychiatric hospital. The charges were later dropped.

Somatisation – unneeded surgery.

RT is a 29-year-old divorced woman. Her GP referred her to a liaison psychiatrist with special interest in chronic somatisation. The patient herself had recently attended the GP angrily demanding re-referral to a consultant urologist and only extremely reluctantly agreed to see the psychiatrist as she perceived that the GP would block further physical investigation and management if she refused. Over the years this patient had presented with a wide array of physical symptoms and over the last 10 years she had seen a cardiologist, 2 gastro-enterologists, a gynaecologist, an ENT surgeon, a neurologist, 2 general surgeons and a urologist. None had found evidence of unequivocal organic disease yet on the basis of persisting frequent complaints of increasingly severe symptoms and literally hundreds of out of hours calls she had been admitted to hospital on 18 occasions (mostly as emergencies) and had had an appendicectomy, a cholecystectomy, a hysterectomy and a colectomy. None of these organs was diseased. She was now presenting with urinary symptoms and demanding surgical intervention for their relief.

Pain Management

DM is a 38-year-old staff nurse who had been on "long-term sick leave" for two years because of low back pain which she attributed to an injury while assisting an elderly obese patient some five years previously. Despite consultations with orthopaedic and neurosurgeons and multiple investigations, no operable problem was discovered. She

described constant pain, which “had ruined her life”, as she could not work, do her shopping or walk any distance without severe discomfort. Her GP had arranged physiotherapy but this “just made the pain worse”. She had seen an osteopath and an acupuncturist privately and on both occasions after a brief period of improvement her symptoms returned.

The local Pain Clinic had recommended various oral medications including antidepressants, tried the use of a TENS device and local injections to the painful area but all without success. She was referred to the Chronic Pain Management Service and assessed by the clinical psychologist and physiotherapist and was enrolled in a tailored programme based on cognitive behavioural principles. This was aimed at helping her adjust to and live with her pain rather than continue to seek a cure and to counter her misconceptions and fear which were leading to avoidance of activity. Contacts were made with the occupational health service and after the programme she returned to work part-time in the out-patient clinic and reported gradually increasing exercise tolerance

Cardiac Rehabilitation

A 45 year old, previously healthy garage proprietor suffered a heart attack from which he made a good physical recovery. Prior to the illness he was described as a driving ambitious “workaholic”. Three months later he began complaining of almost constant chest pain unrelated to exercise; fatigue and feelings of worthlessness and showed little interest in his business or his family. His GP prescribed antidepressants which he took reluctantly but with no benefit. He was referred for cardiac rehabilitation and, after medical screening, he was enrolled in a group programme of graded exercise and activity. As he was still struggling with his mood state, this was supplemented by individual sessions with the health psychologist who used a cognitive behavioural approach to help him manage his mood and marriage difficulties including advice on sexual issues. Six months later he was back at work but had promoted a mechanic to manager allowing him to spend more time with the family. He was no longer on medication and his wife reported that they had just returned from their first proper holiday in years which she described as like a second honeymoon.

Chronic fatigue

Ms M is a 30-year-old woman who had a successful job. However after several bouts of ‘flu’ she became increasingly fatigued and after struggling found herself unable to continue her work. She was told to rest at home which she did for 6 months. She was referred to general psychiatric services but did not see herself as psychiatrically ill and did not attend. She was

seen by a hospital physician and referred for Liaison Psychiatry assessment. At this assessment she complained of severe fatigue and dizziness and was also found to be severely depressed. She reported having never been told what was wrong with her and to be very worried about this. She was given a diagnosis of Chronic Fatigue Syndrome and depression that was fully explained. A self-help rehabilitation programme was agreed and an antidepressant agent prescribed, and a series of appointments made to review her progress and deal with problems. After 6 months she was able to return to work.

Bad experiences in A&E

My memories of my treatment in A&E are sometimes vague. However, those I have are, until recently (when things have improved), generally upsetting and have given me or my friends/relatives and even psychiatric nurses with me at the time cause to complain.

It is probably not an exaggeration to say that I have had hundreds of admissions to different A&E departments over many years. Most of them have been when I have been acutely mentally unwell, but I am also frequently physically ill or injured.

In one particular hospital in the past I have been left on a trolley on my own in corridors for hours in an extremely distressed state and with no comprehension of what is going on around me. Nursing and medical staff have made it clear that they consider me worse than a nuisance and have made no effort to find out or understand what was going on. I had no psychiatric input whilst on the ward, even after I had been a sectioned patient. They did not take my physical complaints seriously. I was medicated against my will (sometimes for the wrong condition), insulted, patronised, ignored and roughly treated. I was allowed to leave when clearly unfit and as a result suffered harm and sometimes required re-admission. The staff who knew me clearly had an unspoken agreement about the way I was to be handled and nothing was ever discussed with me. I am quite sure that their opinions of me followed me into other medical contexts unchallenged for years. As a result I moved away from the area.

More recently, the local A&E department has been much better informed about my circumstances and my mental and physical condition. This is because I have been sectioned for a long time and they have liaised with my consultant psychiatrist, who is generally supportive. Also because I am sectioned I frequently have a psychiatric nurse with me to speak for me when I am unable to. This has resulted in a more reasonable protocol for my treatment and discharge. However, I still have problems - mostly with staff's attitude towards me as a "mental patient" i.e. stigma. I think that this could best be dealt with if they

would provide me with an opportunity to discuss everything with a member of staff when I am well, though I do recognise that for a long time I was probably never sufficiently well to do this. However, now it would give them an opportunity to see that I am usually quite "normal" and that I have valid anxieties about my admissions. It would give me the reassurance that they accept this, which is very important and presently lacking. Given the frequency of my admissions I think that such an opportunity should be automatically offered and it should be accorded to all regular users.

Somatisation

SM is a 25-year-old woman, who was first seen by a junior psychiatrist at a District General Hospital at the age of 15, following an overdose. She was sent home from the Accident and Emergency Department with a statement that she was not suffering from psychiatric illness and no further psychiatric involvement was arranged. She subsequently presented to her GP on numerous occasions, with abdominal pain for which no explanation could be found. As symptoms persisted between the age of 17 and 23 years, the patient was seen by a number of Medical, Surgical and Gynecological Specialists and received numerous investigations, with no change in her symptoms. Her abdominal pain resolved when she became pregnant, but following the birth of her baby, she developed seizures, which were initially thought to be epilepsy.

Review of her physical health care was prompted following the involvement of a Clinical Psychologist because of infant feeding difficulties. During the course of the assessment of these, SM disclosed a history of sexual abuse, which had been the precipitant of her overdose at the age of 15. Reassessment by a Consultant Physician, lead to better understanding of the patient's medically unexplained symptom including both abdominal pain and seizures, which were found not to be to be epileptic. The Patient agreed that these were likely to have been triggered by abuse and appropriate counseling was then arranged by the General Practitioner.

Failure to detect alcohol dependency

The duty medical SHO is asked to see a 53-year-old male orthopaedic patient because of an acute confusional state. The patient sustained a fracture of his right elbow in a fall during a fight in a local pub 3 days previously. The fracture was pinned on the night of admission. The anaesthetist noticed abnormal blood tests suggesting high alcohol intake pre-operatively. The patient remained drowsy post-operatively but denied alcohol abuse.

The SHO was delayed by a cardiac arrest in CCU and 2 hours later saw the patient, who by this time was becoming not only confused but also extremely aggressive, experiencing frightening visual hallucinations. It was now 11pm, alcohol withdrawal was diagnosed and he was given sedation.

Unfortunately this did little to change his mental state and he was becoming increasingly difficult to manage, climbing out of his own bed and attempting to get into bed with other patients. When he was moved to a single room he became more alarmed and attacked the shaving mirror in his room with the drip stand to which he was connected.

By this time he was requiring all the ward staff to restrain him. The SHO was called again by which time all intravenous access had been lost. During the ensuing struggle he punched two nurses and attempted to cut the other with a shard of mirror, which had fallen on the floor. There were only 2 porters on duty in the hospital and they were busy transporting a road accident victim to theatre. By the time they were available the patient had cut himself with a piece of the glass and required to be sutured. Using considerable forcible restraint venous access was reinstated and intravenous sedation administered until the patient became drowsy. His wounds were sutured and the duty psychiatric SHO contacted to ask for an urgent review and possible transfer to a psychiatric ward for more expert supervision of his sedation.

The psychiatric SHO was based in the local psychiatric hospital 3 miles away and could not at first be contacted. He replied, when eventually found, that he was unable to come to the general hospital because his consultant would have to come in to cover the psychiatric hospital. He advised continuing the patient on different sedation as required and they would arrange an outpatient appointment at the Alcohol Problems Clinic in 10 days time.

The patient's sedation appeared to be wearing off and without much warning he sustained a grand mal seizure during which time he aspirated. A few hours later, a chest x-ray showed changes compatible with acute pneumonitis and the duty anaesthetist was called. They felt that the patient needed intravenous antibiotics and ventilation in ICU.

Four days later, and 7kg lighter, he was transferred this time to the Medical Unit where he was found to be jaundiced, with liver damage. He was started on drugs, given a blood transfusion (because of anaemia secondary to his infection), and tube feeding. Ten days later he left hospital, still not having received any formal alcohol counselling from the local psychiatric services although he did receive a visit from a representative of Alcoholics Anonymous.