



UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES

APPROVED
LJUBLJANA, SLOVENIA, 17 October 2009

Due for revision: October 2013

CONSULTATION-LIAISON PSYCHIATRY IN EUROPE

INTRODUCTION

This position paper is prepared by the UEMS European Board of Psychiatry, after consultation with national authorities in member countries, with the European Federation of Psychiatric Trainees and with the Permanent Working Group of Junior Doctors.

This paper is intended to outline the position of the UEMS Board of Psychiatry regarding the current state and the future development of Consultation-Liaison (C-L) psychiatry within the European countries. It also aims to clarify some contentious and terminological issues.

C-L PSYCHIATRY IN FORMER DOCUMENTS OF THE UEMS SECTION AND BOARD OF PSYCHIATRY

In 1997, the UEMS European Board of Psychiatry approved the report *Consultation-Liaison Psychiatry and Psychosomatic Medicine in the European Union* [8]. The report focused on the organisation of C-L-services at the national level, the offer of postgraduate and advanced training in the subspecialty and the status and recognition of C-L psychiatry as a specialized area of psychiatry. The report provided limited information and contained no recommendations.

In 2000, the UEMS Section and Board of Psychiatry approved the *Requirements for the Speciality of Psychiatry* (Chapter 6 of the *Charter on Training of Medical Specialists in the EU*) [9]. It includes the concept of the *Common Trunk*, which refers to the fundamental knowledge and skills required of all candidates (the mandatory part of training). C-L psychiatry is mentioned as part of the *Common Trunk* and recommended as a rotation in the national training programmes.

The UEMS Section of Psychiatry had been asked, through the UEMS Council, to contribute as a stakeholder to the open consultation process on the Green Paper *Improving the Mental Health of the Population. Towards a Strategy on Mental Health for the EU* launched by the European Commission. In its response (April 2006) the Section pointed out that when allocating resources, the importance of liaison activities in general hospitals and nursing homes has to be considered.

DEVELOPMENTS IN RECENT YEARS

Up to now, the recommendation included in the UEMS Charter of Training has been implemented only in a few national training programmes. Rotation to a C-L service is mandatory in five countries (Denmark, Poland, Portugal, the Netherlands, and Spain), and recommended in three (Norway, Switzerland, and the UK). A no less unsatisfactory situation is to be found in national guidelines for training (Finland, Germany, the Netherlands, Spain, Switzerland, and the UK). In many European countries there is no formal training at all in C-L psychiatry.

National C-L psychiatry associations or sections and working groups within national psychiatric societies now exist in Austria, Belgium, Croatia, Denmark, Finland, Germany, Greece, Hungary, Ireland, Italy, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, and the UK. These organisations are primarily devoted to arranging training courses and information exchange. So far C-L psychiatry has been officially recognized as a psychiatric subspecialty or

special competence only in the UK (*liaison psychiatry*), in Finland (*general hospital psychiatry*), in Germany (*psychiatry, psychotherapy and psychosomatics in the consultation-liaison service*) and in Switzerland (*consultation-liaison psychiatry*). In Greece efforts are currently being made to promote C-L psychiatry as supplementary certification through the national authorities.

The World Psychiatric Association gave fresh impetus to the efforts in order to establish the field by including C-L psychiatry into the *Core Training Curriculum for Psychiatry*. C-L psychiatry was designed to be a core element both of the *Didactic Curriculum* and of the *Didactic/Clinical Rotations* [10].

EUROPEAN ASSOCIATIONS

Currently, there are two European organisations devoted to C-L psychiatry: The *European Association of Consultation-Liaison Psychiatry and Psychosomatics (EACLPP)* and the *Section on C-L Psychiatry* within the *European Psychiatric Association (EPA)*.

The *EACLPP* was formed in 1997 to promote and develop the field of C-L psychiatry and psychosomatics in Europe. The *EACLPP* developed out of the *European Consultation Liaison Workgroup (ECLW)*, founded in 1987. It consists of individual members, who do not officially represent the European national authorities. It functions as a Europe-wide forum for leading European C-L experts. The published guidelines for training in C-L psychiatry and psychosomatics have been one of the main projects of the *EACLPP* [7].

The *Section on C-L Psychiatry of the EPA* was formed in 2007. The *EPA* is the largest international association of individuals active in European psychiatry, consisting of 17 sections. Its mission is to improve the quality of mental health care throughout Europe by a wide range of activities.

DEFINITION OF C-L PSYCHIATRY

The concept of *Consultation-Liaison (C-L) Psychiatry* is made up of two terms: consultation psychiatry and liaison psychiatry.

By *Consultation Psychiatry* in a narrow sense one understands the diagnostic and therapeutic consultation, on behalf of other medical specialties, for patients in a medical setting (particularly in the general hospital but also rehabilitation or nursing care facilities), who present both somatic and psychiatric problems. This kind of activity represents the consultation side of the medical practice of any physician in any specialty, and as such is not specific to psychiatry. The consultation psychiatric duties are carried out today in most European general hospitals – depending on the size of the institution – by psychiatrists in private practice or by physicians from psychiatric institutions or departments.

The concept *Liaison Psychiatry* originates in the French word *liaison*, whose Latin root means 'connection'. *Liaison psychiatry* means the constant (regular), integrated, unrequested co-operation of the psychiatrist in the somatic field – usually as part of a multidisciplinary team – which includes, besides consultation aspects, other activities, such as regular participation in visits and discussions of ward cases, the education of somatic physicians and nurses, the implementation of therapies, as well as the constant support and, if needed, supervision of the medical team. The interactions are thus not restricted to patients but engage all those involved in the care of the patient. Such *liaison* models which are, unlike the consultation psychiatry, rather specific for the discipline of psychiatry, are sometimes found in pain clinics, intensive care and transplantation surgery, paediatrics, oncology and dialysis clinics. The differences between consultation psychiatry and *liaison psychiatry* have led to controversies regarding the pros and cons of these two approaches. However, this separation is artificial in nature for in practice one hardly ever finds the two strictly separated as many services offer a variably balanced mixture of both.

In Chapter 6 of the UEMS Charter on Training, *Liaison and Consultation Psychiatry* is defined as: "A model or component of the psychiatrist's work that involves attending general hospital wards or outpatients, or alternatively primary care settings to see and/or discuss patients, so

as to provide advice on the diagnosis and management of psychiatric disorder in such settings." [9].

In some European countries, such as the UK, France or Spain, the synonymous term in use to designate C-L psychiatry as a whole is *liaison psychiatry*; sometimes the term *Consultation Psychiatry* is used alone (e.g. in Italy).

Various descriptions emphasising different aspects have been used as a synonym for C-L psychiatry, including *General Hospital Psychiatry*, *Behavioural Medicine*, *Psychological Medicine*, *Medical Psychiatry*, *Medical-Surgical Psychiatry*, *Psychiatry in the Medically Ill*, *Psychiatry of Primary Care*, and *Psychiatric Care of the Complex Medically Ill*.

In the USA the psychiatric subspecialty *Psychosomatic Medicine (PM)* - a controversial name - has been officially in use since 2004. PM psychiatrists treat and study four groups of patients, referred to as the 'complex medically ill': those with co-morbid psychiatric and medical illnesses complicating each other's management; those with psychiatric disorders that are the direct consequence of a primary medical condition; those with somatoform disorders; and, patients with acute psychopathology admitted to medical-surgical units [6].

The denomination *Psychosomatic Psychiatry* is the newest European proposal to designate the discipline, in an attempt to minimise the ambiguities and controversies surrounding the terms [5].

The term *Consultation-Liaison Psychosomatics* is mainly used in Germany and in documents of the EACLPP. It designates the C-L activity which is not performed by a psychiatrist or a psychiatric service but by a psychosomaticist or a psychosomatic service. In 1992 *Psychosomatic Medicine and Psychotherapy* was recognised in Germany as a certified medical specialty alongside the established field of psychiatry. In particular in German and some Swiss-German university hospitals there are both psychiatric and psychosomatic C-L services with large overlap between both specialities, making it hard to understand both for patients and physicians indications for referrals [2].

CONCLUSIONS AND FUTURE CONSIDERATIONS

So far, the development of psychiatric services in Europe has been guided by the strong emphasis on services for people with psychiatric disorders such as schizophrenia and bipolar disorder. For other patient groups often there are less developed psychiatric services. Many patients choose not to attend specialised psychiatric treatment facilities, but present to other medical facilities (e.g. general hospital, primary care). If a C-L service is absent psychiatric disorders may not be detected or treated appropriately [1]. The importance of C-L psychiatry to psychiatric care lies also in the fact that psychiatric treatments are delivered at the site at which the patient presents [1]. Underdevelopment of C-L services is one of the reasons why only a minority presenting with psychiatric disorders receive specific mental health treatment. In many European countries C-L psychiatry still occupies a marginal position and is insufficiently represented in the decision making bodies and seldom considered in training. The postgraduate training requirements in the UEMS Training Charter were implemented in only a few national training programmes. Many C-L services are still poorly funded. Söllner and Creed have reported that there are large variations in the density, staffing and quality of specialised services, as well as in the standards of training across European countries [7].

The importance of C-L psychiatry has been increasingly recognised since the publication of the 1997 Report of the UEMS European Board of Psychiatry. This is evidenced by its quantitative growth, scientific development, increased attention in textbooks and the creation of Europe-wide organisations in the last decade. C-L psychiatry is playing an increasingly influential role in the training of health and mental health professionals. General hospitals are usually the principal training sites for medical students and trainees.

In view of the reform plans of the European Commission concerning mental health services it can be assumed that C-L psychiatry will continue to expand rapidly in parallel to the reduction of beds in psychiatric hospitals and the increasing demand for psychiatry to care for mental

disorders. The development of C-L services should also be encouraged by the growing importance of health economics and cost-effectiveness studies [1]. These trends ultimately underline the position of psychiatry as an integral part of the practice of medicine.

About 30% of all psychiatric consultations are carried out in the geriatric population. The size of this population is increasing in Europe. Due to the demographic changes and improved life expectancy old people's homes increasingly resemble geriatric wards requiring skilled nursing practices. Geriatric C-L psychiatry is increasingly confronted with 'complex medically ill' patients [6] especially those with co-morbid psychiatric and general medical illnesses which complicate management. Therefore, thorough training in geriatric psychiatry is indispensable to the C-L psychiatrist [3]. In recent years, in the USA and UK in particular, the emphasis in C-L psychiatry has moved away from a setting based specialty to the broader concept of expertise in the diagnosis and treatment of patients with physical and psychiatric problems.

The UEMS European Board of Psychiatry does not regard as desirable the creation of a distinct certified physician specialty dealing with a limited range of mental disorders. Splitting psychiatric care delivery may cause unnecessary and unhelpful competition in health care delivery and financing, and could adversely affect the efforts to diminish stigma of all psychiatric disorders.

Whereas the introduction of a distinct specialty of C-L psychiatry/psychosomatics outside psychiatry is not justified, one could consider enhancing certain fields within the discipline by defining subspecialties and strengthen them by special curricula. This has been the case in the past with several psychiatric subspecialties which have been officially recognised by national authorities. So far this status has been acknowledged to C-L psychiatry mainly in non-European countries such as USA, Australia and New Zealand.

C-L psychiatry is "psychiatry's ambassador" to the wider medical world. It has developed in Europe especially in the last decade. Its proximity to the general hospital and other medical settings will enhance the research interests and access to psychiatry within medicine: "Advances in clinical services and increased disease recognition and care by non psychiatric physicians have transformed an isolated specialty into one closely linked to all medical services." [4].

RECOMMENDATIONS ON C-L PSYCHIATRY

- C-L psychiatry is a significant part of the psychiatric field which should be promoted appropriately.
- The recommendations of the UEMS European Board of Psychiatry with respect to training in C-L psychiatry should be implemented at national level.
- The cooperation of the European organisations which are engaged in promoting C-L psychiatry should be encouraged. Standards of care, guidelines for training and continuous medical education, and in accreditation of courses should be defined.
- The recognition of C-L psychiatry as a subspecialty or special competence within psychiatry with its own training programmes and certification should be promoted.
- Due to the increased number of old aged patients with mental disorder in medical settings the training programme of C-L psychiatry should also contain old age psychiatry.
- The creation of a separate medical specialty outside psychiatry devoted to mental health aspects of medicine should not be encouraged.
- In order to clarify terminological ambiguity, the UEMS Board of Psychiatry recommends using the term *Consultation-Liaison Psychiatry*.

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