

The psychological care of medical patients

A practical guide

Report of a joint working party of the Royal College of
Physicians and the Royal College of Psychiatrists

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of Physicians



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1 | Introduction

SUMMARY

- ▶ The report addresses the particular psychological problems experienced by patients attending general hospitals. It aims to encourage clinicians to develop skills of good psychological care and to promote a psychological component in organisational development.
- ▶ This is a practical guide which outlines the common psychiatric syndromes and advises on their recognition and management.
- ▶ Communications skills are fundamentally important and are given special consideration in the report.
- ▶ Emphasis is also placed on the need for doctors to be familiar with the Mental Health Act 1983 and common law as they apply to general hospital practice.
- ▶ The case for developing liaison psychiatry services in all general hospitals has gained ground following the shift of mental health care towards a community-based service.

The psychological welfare of medical patients is attracting increasing attention. Becoming physically ill is a stressful experience. Whilst most people adjust well to the limitations imposed by their condition, a significant number develop some form of psychological disorder secondary to their physical disease. Other patients present with physical symptoms for which no adequate medical explanation can be established and in many the symptoms are found to be the result of a hitherto unrecognised psychological problem. Several government reports in England and Wales have emphasised the need for medical patients to have access to psychiatric and psychological services.^{1,2} The first joint report from the Royal Colleges of Physicians and Psychiatrists highlighted the nature of the problems and made recommendations for the provision of psychological care in general hospitals.³ The present report updates the earlier report in the light of recent developments in treatment, health service organisation and medical law.

1.1 Aims of the report

The aims of this report are similar to those of its predecessor in addressing the particular psychological problems likely to be experienced by patients attending general hospitals, either in secondary or tertiary services. It is specifically concerned with adult patients under the care of physicians in any of the recognised medical specialties, but its principles are relevant to other branches of medicine. It is also relevant to adults with learning difficulties although it does not address their needs specifically, for which the reader is referred to a separate report in England⁴ and similar reports in Scotland⁵ and Wales.⁶ This report does not cover the needs of children and adolescents.

We wish to encourage all hospital staff to develop skills of good psychological care and to be able to assess and manage their patients' psychological problems. We also wish to promote a psychological component in organisational development which includes staff education and support, and hospital design. The report will therefore be relevant not only to physicians but also to clinical psychologists, nurses, managers and other professionals who work with medical patients in general hospitals.

This is essentially a practical guide for clinicians. It outlines the common psychiatric syndromes encountered in day-to-day practice and advises on how these can be recognised. Special consideration is given to developing communication skills, which are crucially important in the provision of better treatment and general care, and in the detection of psychiatric disorders. Also, patients now expect more open communication with their doctors. They want more information about their health problems and expect to be involved in decisions concerning their treatment. For many patients the role of a carer is also important. Doctors need to be aware of these expectations and to be able to provide support and information according to patients' needs, which often change with time. We have also given special attention to the use of the Mental Health Act 1983 and common law in the general hospital. Recent case law has clarified the doctor's responsibility in assessing mental capacity and providing treatment for those who are unable to give informed consent. In future, liaison psychiatrists are likely to become involved more often in advising their colleagues when a patient's competence to refuse or consent to treatment is in doubt, or when a patient wishes to die by terminating life-support treatment.

Physicians successfully treat considerable psychiatric morbidity in their patients and do so without the assistance of psychiatrists or any other mental health professionals. It is highly appropriate that this should continue. The various treatment options available to the clinician are reviewed here with reference to recent publications establishing the effectiveness of psychological and

pharmacological treatments. It is clear that therapeutic nihilism is misplaced: treatments work.

By highlighting the prevalence of psychiatric disorder in general hospitals and the real benefits to patients if this is managed appropriately, we hope to see a sustained development of liaison services throughout the country. The report sets out the clearest possible case for ensuring that the psychological care of medical patients is given a much higher priority within the service agreements between acute hospital trusts and their commissioners.

1.2 Psychological and psychiatric problems in the general hospital

The more common psychological and psychiatric problems seen in general hospital practice are:

- ▶ physical and psychiatric comorbidity
- ▶ medically unexplained symptoms
- ▶ deliberate self-harm
- ▶ drug and alcohol misuse
- ▶ acute organic disorders
- ▶ behavioural problems (eg non-adherence to treatment, lack of capacity to consent).

Patients with these problems often have complex needs, requiring the co-ordinated help of a multidisciplinary medical team. Only a minority require referral to a mental health professional. The report provides guidance as to when referral to a psychiatrist or psychologist is appropriate, although this cannot be specified precisely because much depends on local facilities and the clinician's own interest and expertise. When specialist mental health management is required, it is best if this is delivered by a liaison psychiatry service which should include liaison nurses, clinical psychologists and social workers in addition to consultant and trainee psychiatrists. The original report made specific recommendations about the staffing of a liaison service and that advice has been followed in many hospitals. There has been a steady expansion of posts in liaison psychiatry, health psychology and liaison nursing, although developments have not been uniform throughout the country: some hospitals, particularly district general hospitals, continue to have rudimentary liaison services often amounting to no more than an assessment service for patients following episodes of deliberate self-harm. In view of the accumulating evidence for therapeutic effectiveness, this is an area of healthcare delivery where failure to provide an available and responsive service can no longer be justified.

1.3 Identifying patients and referral for treatment

Much has been written about the identification of patients who have developed a psychiatric disorder but who have been referred to a physician because of concurrent somatic symptoms, whether or not these symptoms are the manifestations of organic pathology. It is generally acknowledged that psychiatric disorders are much more difficult to detect when masked by somatic complaints and therefore such patients' psychological problems are less likely to be recognised and treated. A theoretical remedy to this problem is to use one or more screening instruments in the shape of questionnaires devised to detect depression, anxiety or other psychological symptoms. High scores will identify patients with psychiatric disorders for whom appropriate treatment can then be arranged. Unfortunately such an approach has not been vindicated by controlled trials,^{7,8} and the routine use of screening instruments cannot be recommended in general hospital practice. Identification of those with psychiatric disorders continues to be based on clinical assessment involving a carefully taken history and an evaluation of the patient's mental state, supplemented by other sources of information provided by the general practitioner, relatives and friends. The physician thus has a pivotal role in the diagnosis of psychiatric disorder.

It is important that the training of physicians and other clinical staff emphasises the development of communication and interviewing skills. Postgraduate medical education is encouraging doctors to specialise at an early stage in their careers and training schemes lack the flexibility to enable experience of other specialties to be acquired. We believe that many physicians would gain valuable and relevant experience if they were able to spend six months at senior house officer level in psychiatry. Conversely, trainee psychiatrists would benefit by spending an equivalent period in a medical post. The recent introduction of psychiatry posts at pre-registration house officer level is a welcome development which enables more doctors to obtain experience of psychiatry after qualifying.

Since the establishment of separate mental health trusts, the case for the development of liaison psychiatry services has gained ground.⁹ Psychiatry and psychology have moved their focus of operation from hospitals into the community and many general psychiatrists currently spend most of their time in community mental health centres or treating patients in their homes. They have little time for general hospital work, and nor do they have the required expertise. Acute trusts and mental health trusts will need to develop clear responses to this new organisational context. It will be essential to ensure that liaison psychiatry services are placed at the forefront of the relationship between acute and mental health trusts if medical patients are not to fall into an organisational vacuum.

References

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- 8 Gater RA, Goldberg DP, Evanson JM, Lawson K *et al*. Detection and treatment of psychiatric illness in a general medical ward: a modified cost-benefit analysis. *J Psychosom Res* 1998;45:437–8.
- 9 Lloyd GG, Mayou RA. Liaison psychiatry or psychological medicine? *Br J Psychiatry* (in press).

Further reading

- Guthrie E, Creed F (eds). *Seminars in liaison psychiatry*. London: Gaskell, 1996.
- Peveler R, Feldman E, Friedman T (eds). *Liaison psychiatry: planning services for specialist settings*. London: Gaskell, 2001.

Executive summary and recommendations

Doctors are increasingly aware of the importance of developing good communication skills and of attending to their patients' psychological symptoms. This second joint report of the Royal College of Physicians and Royal College of Psychiatrists aims to highlight the importance of addressing the psychological dimension of medical practice and to foster the development of services designed to improve the psychological care of medical patients. The latter target is best achieved by establishing a multidisciplinary liaison psychiatry service in every general hospital.

Although most people adjust well to the limitations imposed by their illness, a significant proportion find that their coping mechanisms are overwhelmed. The high prevalence of psychiatric disorders in general hospital patients is now well established. Depression, anxiety disorders, delirium and substance misuse are particularly common, and deliberate self-harm accounts for approximately 140,000 presentations to hospitals in England and Wales each year. Physicians need to be able to identify these problems, to arrange basic psychological care and to know when to refer patients to specialist psychiatric and psychological services. Depression and other psychiatric disorders have often been regarded as inevitable and understandable responses to illness and therefore not amenable to treatment. This opinion is no longer sustainable. Patients with significant and persistent psychological symptoms respond well to psychological or pharmacological treatments. Therapeutic interventions are also effective for managing patients with problems of alcohol misuse, those who present after episodes of self-harm and those who somatise their problems.

Recommendations

The Working Party makes the following recommendations to promote the psychological care of medical patients in general hospitals:

- 1 Liaison psychiatry services should be established in all general hospitals that are commissioned to provide comprehensive medical care for a defined population. The service should be multidisciplinary and include nurses, clinical psychologists, social workers and trainee psychiatrists, led by a consultant psychiatrist with special training in liaison psychiatry. Clinicians in other specialties should have ready access to the expertise of a liaison psychiatry team.

- 2 Teaching hospitals require increased staffing levels to cope with demands from tertiary medical services. Some hospitals have developed special liaison services to manage patients following deliberate self-harm and those with alcohol and drug problems. These developments should be supported.
- 3 Communication skills are fundamental to good clinical care and facilitate detection of psychological problems. These skills should be taught during postgraduate medical training and actively maintained throughout a professional career. Physicians could also gain valuable and relevant experience by spending six months at senior house officer level in psychiatry.
- 4 Training should be provided to enable physicians to apply basic psychological treatments, to recognise the indications for prescribing psychotropic drugs, and to manage patients suffering from alcohol and drug misuse.
- 5 Simple protocols should be developed for the detection and management of common psychological problems by general hospital staff.
- 6 Referral of patients to a liaison psychiatry service should be uncomplicated, with clear guidelines as to who should be referred.
- 7 There should be good channels of communication within the general hospital and with community services with regard to psychiatric as well as physical health.
- 8 Liaison psychiatry departments require adequate space for clinical work together with space for secretarial staff and support facilities to provide computerised record-keeping, thus enabling audit and clinical research to be undertaken.
- 9 Clinicians should be familiar with the principles of common law and the Mental Health Act 1983 as they apply to general hospital practice. Hospital trusts should arrange appropriate training for doctors and non-medical staff, including security staff.
- 10 The separation of mental health services and acute hospital trusts creates difficulties for liaison psychiatry, and management arrangements will vary according to established local practice. To ensure optimum delivery, a liaison psychiatry service should be managed within an acute hospital trust, alongside other medical specialties.
- 11 Funding for liaison psychiatry should be provided by those specialties that use the service. Recognition of this funding should be incorporated into all service agreements between acute hospital trusts and their commissioners.