BIO-PSYCHO-SOCIAL MANAGEMENT MODEL: ROLE OF LIAISON PSYCHIATRY

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Bio-psycho-social model of patient management is now an upcoming issue although psychosomatic disorders are being managed mostly in medical settings that cut across a continuum from primary-care to tertiary treatment facilities. This particular management approach is one of addressing the patient and the significant others in the sequential stages of illness: acute, convalescent, and rehabilitative. Therefore, the clinical problems containing a medical-psychiatric interface not only offer clinical challenges but also are areas for new knowledge and better interventions[1].

Meta-analysis of relevant studies suggests that up to 50% of patients seen in primary care may have independent or co-morbid mental health problems, the severity and duration of which often being similar to those found in the specialized health facilities[2]. Depression is the most common mental disease in patients hospitalized with physical illnesses. Depression and anxiety disorders in general hospitals are frequently underdiagnosed and inappropriately treated. In one of the studies in general hospital about 12.5% of patients had significant depression, 18.75% had significant anxiety, and 8.3% had significant mixed anxiety and depression. About 22.9% of patients warranted psychiatric referral for further assessment and management[3]. In both primary and tertiary settings, clinicians deal with the complex interrelationships between medical and psychiatric disorders. Several factors including delivery of interventions by primary care providers who have pre-existing clinical relationships influences the patient outcome to a great extent. Primary care physicians with basic training in collaborative care are found to have greater knowledge, skills, and comfort in managing psychiatric disorders, independent of demographics and interest in psychiatry[2].

It has been reported in western studies that in tertiary care setting the annual referral rate increased as did the mean age of referred patients. The referral pattern changed to anxiety and depression from evaluation of psychosis and suicide. However, referral lag time did not change significantly and a higher proportion of patients received a single consultation although many ultimately required psychiatric inpatient care. An increased awareness of the possibility of undiagnosed psychiatric disorders is therefore required, along with prompt and appropriate use of collaborative psychiatry services. The nature of referral changed towards older and sicker patients which, together with an increased referral rate, significantly increased the demand on available resources[3,4].

Liaison psychiatry, a subspecialty in psychiatry, is referred to as the guardian of the psychological and holistic approach to patients. It has been undergoing rapid changes especially in the developed countries but its practice is strongly affected by stigma and negative attitude by professional colleagues. It is therefore recommended that liaison psychiatry must not be restricted to conspicuous acute psychiatric disorders alone but must have impact across the whole of medical management. The concerned mental health professionals must not only concentrate on managing psychotic patients but must strive to maintain intellectual and clinical leadership for the psychological system in its entirety. There is yet more to be done in the area of research and campaign against stigmatization[5].

Liaison psychiatry did not emerge as a prominent psychiatric subspecialty until the remedicalization of the psychiatric profession in the 1970s. The future of liaison psychiatry depends on developments in four areas: psychosomatic research, behavioral medicine, holistic health care, and general hospital psychiatry. To ensure the purpose of the subspecialty, the discipline must meet fiscal, research, and political challenges, develop collaboration with other behavioral disciplines, extend close relationship with the nursing profession, enjoy the support of medical school departments of psychiatry, and transform the consultation model into a comprehensive consultation-liaison model[6].

The liaison psychiatry in the United States has had to reassess its priorities with the change in health care economics in the 1980s. Liaison programmes and educational programmes for primary care staff

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are jeopardized. The emphasis has shifted from liaison to reimbursable consultation activities. Hospital stays have been reduced with emphasis on outpatient and prepaid settings. Less expensive health care professionals are often asked to see patients previously evaluated by specialists. Therefore, reassessments of funding strategies for consultation-liaison programmes, models of staffing consultation-liaison services, continuity of care from inpatient to outpatient services, integration of consultation-liaison psychiatrists in prepaid health care settings, primary-care educational programmes, and psychosocial intervention programmes for high-risk primary-care patients have become demand of the hour[7].

As it is mentioned earlier, liaison psychiatry has an important role in the identification and management of psychological problems in patients with medical disorders in general hospitals. The diagnostic tools usually available may reveal to be limited because particular psychosomatic syndromes and subthreshold psychopathology may remain undetected by psychiatric diagnostic criteria. The Diagnostic Criteria for Psychosomatic Research (DCPR) were developed with the aim of providing clinicians with operational criteria for psychosomatic syndromes to overcome the limitations shown by the most often diagnosed disorders in medical settings as adjustment, somatoform, mood, and anxiety disorders. In a group of 66 consecutive liaison psychiatry inpatients, a consistent prevalence of 71% DCPR syndromes was found, particularly secondary functional somatic symptoms, persistent somatization, health anxiety, and demoralization. Their overlap rates with existing diagnostic criteria showed that the DCPR syndromes were able to identify psychological dimensions that are not detected by currently available diagnostic criteria. Furthermore, the DCPR syndromes identified patients with clinically significant functional impairment. These findings reinforce the need for further research to clarify their mediating role in the course and the outcome variance of medical and psychological problems of hospital inpatients referred for psychiatric consultation[8].

Liaison psychiatry is an outgrowth of consultation psychiatry which it extends by emphasizing its teaching function with the physicians, nurses, patients and their families. Liaison teaches methods of identification, assessment, diagnosis, and therapy based primarily on an open-ended interview technique. This approach serves in and of itself, as well as by extension, as a brief psychotherapeutic process. The liaison model utilizes a general systems approach in its study of the patient pursuing the latter's problem from the molecular through organ systems, intrapsychic processes and interactions with the social milieu. These are largely influenced by the environments and the processes occurring therein. The discipline might well be called comprehensive psychiatry inasmuch as it utilizes conceptual approaches of the social sciences, behavioral medicine, neuroscience, and psychopharmacology. In addition, the function of the liaison consultant seems to be increasing as an arbiter when there are conflicts between colleagues around decision-making processes[9]. These frequently involve ethical problems affecting the behaviour of staff and patients. Perceived medico-legal barriers to adjust to the situation can be addressed by adequate personal professional liability protection on the part of each practitioner, and ensuring that other health care professionals are similarly covered[2].

Now coming to the perspective of medical students it has been suggested that they wish to focus their learning in psychiatry on general skills that are applicable to all doctors. Two ways that medical students believe their teaching can be made more relevant to their future careers are: there is a need to focus on scenarios which students will commonly encounter in their initial years of employment; and psychiatry should be better integrated into the overall curriculum, with the opportunity for teaching in different settings. However, when developing curricula the need to listen to what students believe they should learn needs to be balanced against the necessity of teaching the fundamentals and principles of a speciality[10].

In conclusion, it may be said that successful liaison and collaboration requires preparation, time, and supportive structures, building on preexisting clinical relationships. Collaborative practice is likely to be most developed when clinicians are collocated and most effective, and the location is familiar and nonstigmatizing for patients. Degree of liaison and collaboration does not appear to predict clinical outcome. Enhanced collaboration paired with treatment guidelines or protocols offers important

benefits over either intervention alone. Systematic follow-up is a powerful predictor of positive outcome in collaborative care. A clear relationship between collaborative efforts to increase medication adherence and clinical outcomes was not found evident. Liaison and collaboration alone has not been shown to produce skill transfer in knowledge or behaviours in patient management. Service restructuring designed to support changes in practice patterns of all level health care providers is also required. Enhanced patient education was part of many studies with good outcomes. Education was generally provided by someone other than the healthy care personnel. Collaborative interventions that are part of a research protocol may be difficult to sustain for long without ongoing funding. Consumer choice about treatment modality may be important in treatment engagement in liaised and collaborative care[11].

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