

Consultation liaison psychiatry in Africa – essential service or unaffordable luxury?

Consultation liaison psychiatry (CLP) - also known as psychosomatic medicine - is the psychiatric subspecialty that focuses on the diagnosis and treatment of psychiatric disorders/difficulties in complex medically ill patients. "Complex medically ill"¹ are patients with active medical, neurological, obstetrical or surgical condition(s) or symptoms, who also meet one of the following criteria:

- Patients with an acute or chronic medical, neurological, or surgical illness in which psychiatric morbidity is actively affecting their medical care and/or quality of life. Examples include acute or chronic psychiatric patients with HIV infection, organ transplantation, brittle diabetes, heart disease, renal failure, a terminal illness, cancer, stroke, traumatic brain injury, COPD, high-risk pregnancy, among others.
- Patients with a somatoform disorder or with psychological factors affecting a physical condition ("psychosomatic condition")
- Patients with a psychiatric disorder that is the direct consequence of a primary medical condition

Consultation liaison psychiatry (CLP) has always existed as a service, though it is only in the last decade or two that it has been formally recognised as a subspecialty in a number of countries.¹ In South Africa CLP has been recognised by the College of Psychiatrists as a formal subspecialty and the University of Cape Town offers the MPhil in CLP.

CLP is often seen as hospital based specialty, with a focus particularly on patients in tertiary care facilities. It has been argued that in Africa, where resources are limited, services should focus on primary care and that CLP is not an appropriate subspecialty.

We, however, submit that it is precisely in low resource settings that CLP is needed. Psychiatric disorders, particularly anxiety and depression are as common in African medically ill patients as their counterparts in the developed world.^{2,3} Co-morbid psychiatric and medical illness is associated with a greater likelihood of poorer adherence with medical treatments; a poorer prognosis of the medical illness; a greater likelihood of hospitalization or institutionalization; a greater likelihood of healthcare service use of all types; and a greater impairment in quality of life.⁴ This has significant economic consequences for the patient (longer hospital stays, delayed return to work or disability), as well as health care services (increased utilization of services). In resource poor settings, health care delivery must be cost effective.

In Africa, many health professionals view mental illness as synonymous with psychosis, and are often poorly equipped to diagnose and manage depression and anxiety. Consequently, patients with co-morbid medical and psychiatric illnesses are often under-diagnosed, or incorrectly managed, with important consequences for both physical and mental health. The first purpose of the recognition of the subspecialty of CLP is to

improve the psychiatric care of patients with complex medical, surgical, obstetrical and neurological conditions. This will draw greater attention to the complex psychiatric needs of the medically ill leading to improved care through better diagnosis and treatment. It will also improve the training of psychiatrists who care for medically ill psychiatric patients.

Furthermore, subspecialty recognition will also lead to the expansion of successful medical-psychiatric care environments. In Africa, CL psychiatrists would work to design and implement integrated screening and basic treatment programs for the medically ill at primary care level. At both primary and secondary care level, the focus of the CL psychiatrist would be on training all levels of health care professional and to recognise and provide appropriate care for patients with complex medical illness, as well as ongoing education and oversight of these services. At tertiary level CL psychiatrists would develop conjoint services with other specialities to address complex psychiatric and medical problems and provide integrated care.

Finally, and perhaps most importantly, recognition of consultation liaison psychiatry as a subspecialty would increase awareness among health care providers of both the prevalence and impact of mental illness, in particular the multiple interactions between mental and physical health. By demonstrating how treating mental illness can improve physical health, the idea that psychiatry is something separate from medicine as a whole can gradually be dispelled.

The World Health Organisation has stated that "there is no health without mental health".⁵ Who better than consultation liaison psychiatrists, working at the interface between physical and mental illness, to spread that message.

Bavi Vythilingum¹, Bonga Chiliza²

¹Department of Psychiatry, University of Cape Town, Cape Town, South Africa

²Department of Psychiatry, University of Stellenbosch, Stellenbosch, South Africa

email: bavanisha.vythilingum@uct.ac.za

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