In the light of these findings we intend to provide more information and training for junior doctors about the role of Home Options, to emphasise that all potential referrals should be discussed first with a senior doctor and to bid for additional funding to increase the range of services available for patients presenting in crisis out of hours, who would not usually warrant in-patient care or admission to Home Options.

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GEOFFREY G. LLOYD

Origins of a Section: liaison psychiatry in the College

Why has liaison psychiatry been slow to develop in the UK? The asylum mentality and the current flight into the community have focused psychiatric resources on chronic psychotic illnesses, neglecting the psychological problems of general hospital patients. Nevertheless, there is abundant evidence that medical and surgical patients have a high prevalence of psychiatric disorder that can be effectively treated with psychological or pharmacological methods.

Until the 1970s specific liaison psychiatry services were virtually unknown in Britain. The separation of psychiatric services from university and district general hospitals made it difficult to provide an effective service. Patients referred from other medical specialities were seen as ward consultations by general psychiatrists, or allocated to general psychiatry out-patient clinics. A small number of specialised consultant posts were established but there was no officially recognised body to represent liaison psychiatry.

Inception and early development

Informal discussions between interested clinicians took place in the early 1980s and a consensus emerged that liaison psychiatry would be served best by establishing a group within the College. A letter to the *Bulletin* drew a response that indicated there was considerable enthusiasm for establishing a national group to provide a forum for clinical, research and teaching interests in the field of consultation and liaison psychiatry (Mayou *et al*, 1982). A preliminary meeting was held during the College quarterly meeting in Oxford in 1983, followed by a further meeting during the Annual General Meeting in Edinburgh in 1984. The College was then persuaded to recognise liaison psychiatry as a special interest group, although there was opposition from some senior Fellows who did not regard liaison psychiatry as a distinct clinical activity. A survey of members of the group (Mayou & Lloyd, 1985) indicated that there was substantial clinical and academic activity but respondents complained there was insufficient time to carry out all aspects of the work satisfactorily. Services appeared to have developed haphazardly and few districts had given priority to developing liaison psychiatry. Most of the services were provided by general psychiatrists, some of whom had a special interest in liaison psychiatry. Only nine full-time liaison posts were identified in adult psychiatry and one in child psychiatry. Little had changed by the time a second survey was undertaken 5 years later (Mayou *et al*, 1990).

Richard Mayou, who had been the prime mover in establishing the group, was elected chairman and served in this capacity until 1989. Subsequently the chair has been taken by Francis Creed (1989–1993), Christopher Bass (1993–1997), Allan House (1997–2000) and Geoffrey Lloyd (2000–). Rachel Rosser, Geoffrey Lloyd, Charlotte Feinmann, Trevor Friedman, Allan House, Robert Peveler and Elspeth Guthrie have held the post of secretary. The first residential meeting was held in Oxford in September 1987. Its success was vital to the development of the group and the annual residential meeting has now become an established event in the College's calendar.

The increased recognition and status of liaison psychiatry have led to the creation of a growing number

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of consultant posts and a handful of university chairs. By 1996 there were 86 consultants in England, Scotland and Wales who carried out specific liaison work, 43 of whom had either full-time or half-time posts in liaison psychiatry (Guthrie, 1998). Sixteen new posts had been created during the previous 2 years but staffing levels still fell below the College's recommended guidelines of 0.4 full-time equivalent posts per 100 000 population. Many large general hospitals now have a distinct liaison psychiatry service and these developments have enabled more trainees to acquire relevant experience, although training opportunities are not evenly distributed (Burlinson & Guthrie, 2001). The College has recognised this by elevating the group to the status of a Section in 1997.

Training and education

Members of the Section have advised the College on the desirable content of training posts at senior house officer and specialist (senior) registrar level, emphasising the need for regular supervision by a consultant with a special commitment to liaison psychiatry (House & Creed, 1993). College representatives on advisory committees for consultant appointments should ensure that candidates have fulfilled the training requirements before an appointment is made. Recommendations have also been made to improve undergraduate education and the psychological and psychiatric aspects of general patient care (Sharpe *et al*, 1996).

The section has been keen to hold joint meetings with other organisations, thereby involving other medical specialists and non-medical professionals who treat similar patients. Several meetings have been held with the British Diabetic Association and biennial meetings with the Society for Psychosomatic Research. Joint meetings have also been held with liaison psychiatrists from Holland, Portugal and the Nordic countries. Building on the success of these international meetings, members of the Section have been active in the recent establishment of the European Association for Consultation–Liaison Psychiatry and Psychosomatics.

Of crucial importance has been the development of links with other Royal Colleges. Two joint conferences with the Royal College of Physicians of London were held on medically unexplained symptoms (Creed *et al*, 1992), and psychiatric aspects of physical disease (House *et al*, 1995). These facilitated the establishment of a joint working party on the psychological care of medical patients, whose report made recommendations on the provision of a liaison service in each general hospital and on the training of medical and other staff in recognising and managing psychological problems in medical patients (Royal College of Physicians & Royal College of Psychiatrists, 1995). The report further recommended that purchasers of health care should expect providers to meet the psychosocial needs of patients attending general hospitals; acute services that failed to make such provision should not be purchased (Royal College of Psychiatrists & Royal College of Physicians, 1995). A joint working party with the Royal College of Surgeons published a similar report on the psychological care of surgical patients (Royal College of Surgeons & Royal College of Psychiatrists, 1997). This underlined the importance of training clinicians to recognise psychological problems in surgical practice. Surgical teams working in areas of high psychiatric morbidity, for example, breast care, pain control, cancer and cosmetic surgery, should identify staff members who would be trained in the delivery of effective psychological care. For help with the management of problem cases every surgical team should have rapid access to a consultant-led liaison psychiatry team. A joint working party with the British Association for Accident and Emergency (A&E) Medicine (Royal College of Psychiatrists, 1996) made recommendations on the provision of safe and secure assessment facilities in all A&E departments and on the availability of appropriate educational facilities for relevant staff. Like the other documents, this report stressed that a high quality psychiatric service depends on an adequately staffed multi-disciplinary liaison psychiatry team. A further report is being prepared with the Royal College of Obstetricians and Gynaecologists.

Members of the section have made major contributions to Council Reports on the management of chronic fatigue (Royal College of Physicians *et al*, 1996) and deliberate self-harm (Royal College of Psychiatrists, 1994) and to the College seminars series (Guthrie & Creed, 1996). There have also been publications on the planning, organisation and management of services (Benjamin *et al*, 1994), including specialist settings (Peveler *et al*, 2000).

The future

With a current membership in excess of 1500, the liaison psychiatry section has obviously met a need of College Members. It has helped develop criteria for training and encouraged the establishment of liaison services with specific consultant appointments. It is the only national body to represent liaison psychiatry in the UK. Its future will be intimately linked with the development of liaison psychiatry as a specific area of psychiatric practice and research and it is uniquely placed to shape this development. The regrettable separation of psychiatry from the rest of medicine, embodied in the establishment of separate community mental health trusts, will increase the need for a psychiatric service dedicated to the psychological needs of medical and surgical patients in general hospitals. The funding and management arrangements for such a service needs to be clarified and agreed nationally. With mental health trusts moving their resources into community facilities it would be appropriate for liaison psychiatrists to look to general hospital trusts for financial support. The further development of liaison psychiatry will largely depend on the ability of its exponents to convince purchasers that this element of medical care is an essential component of a high quality health service.

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IN CONVERSATION WITH PETER TYRER

Treading the skies: David Goldberg

David Goldberg

David Goldberg was educated at William Ellis School and Hertford College, Oxford. He took a degree in psychology and went on to do his clinical work at St Thomas' Hospital. After house jobs at the National Hospital, Queen Square and the Brompton Hospital he studied psychiatry under Sir Aubrey Lewis at the Maudsley. He developed the General Health Questionnaire as a DPM project, and developed it further for his DM degree. After leaving the Institute he spent a year in Philadelphia before returning to Manchester as a senior lecturer. In 1972 he was appointed Professor and Head of Department at Manchester and spent the next 20 years building up the Department. He is an exponent of a bio-social model for common mental disorders, and has written books dealing with both epidemiological aspects of psychiatry and straightforward textbooks. He returned to the Maudsley in 1993 as Professor of Psychiatry and Director of Research and Development, and was knighted in 1997. He became a Professor Emeritus of King's College London in 2000.

This interview was carried out in a restaurant in the South of Naples with the backdrop of Mount Vesuvius and Pompeii to the South and the Bay of Naples to the West. I think that this was an appropriate setting to set in context the contribution of probably the most important influence on social psychiatry in the past 30 years. It is an influence that extends far beyond the shores of these islands and will be recognised immediately by all those who go to international conferences and hear his work mentioned with reverence. David, if present, will always do his best to be suitably irreverent in his own contributions, but no one can doubt his immense achievements in

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