Consultation-Liaison Psychiatry in Aotearoa New Zealand – past, present and a blueprint for the future

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This paper has been developed to provide an overview of current Consultation-Liaison Psychiatry (CLP) services in Aotearoa New Zealand, highlight the importance of CLP and propose a blueprint for policy, service and workforce development, to guide the future direction of this psychiatric sub-specialty. The paper has been authored by John Hopkins, Fred Sundram and Wayne de Beer on behalf of the Committee of the Aotearoa New Zealand Faculty of Consultation-Liaison Psychiatry (FCLP), with its full consultation and support.

What is Consultation-Liaison Psychiatry (CLP)?

Consultation-Liaison Psychiatry (CLP) is the psychiatric specialty that focusses on the care of people presenting with both mental and physical health needs regardless of presumed cause; employs the bio-psychosocial model; and operates mainly in general hospital emergency departments (EDs) and wards, and medical and surgical outpatient settings.[1] CLP services generally have a degree of multidisciplinary staffing, and provide a mix of consultation, liaison, specialised psychological interventions, training and research, though individual services vary widely depending on local needs and circumstances.[2] Mental disorder accounts for approximately 5% of ED attendances, while approximately . 30% of hospital in-patients have comorbid mental disorder.[3] A comprehensive CLP service will respond to patients - presenting to ED with mental health needs, those with comorbid mental and physical disorders, those patients being treated for the physical complications of alcohol and substance misuse, those where physical illness and its treatment are causing mental health problems, and those with medically unexplained physical symptoms. CLP services have a role in the training of general medical staff in the recognition and basic management of common mental health problems.[4] The key benefits of a comprehensive CLP service for a general hospital include - improved psychiatric and medical patient outcomes, enhanced patient experience of medical care, increased patient safety, and greater cost-effectiveness of medical services.[5]

Just over 10 years ago, a CLP service[6] was developed in Birmingham, U.K (RAID) that provided one point of mental health contact for the general hospital, 24-hour coverage including the ED, and an emphasis on the needs of older people (who occupy approximately 65% of the beds). Evaluations of this service[6, 7] showed significant reductions in length of stay and re-admission rates, and a four-fold return in investment to the hospital as a result of these impacts. This led to policy imperatives[8], commissioning initiatives[3], service standards[9], and a surge of CLP service expansion in the 170 hospitals with EDs in England over the past 10 years.[2]

The local environment CLP operates in

CLP is recognised by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) as a subspecialty area of psychiatry (having gained section status in 1995 and faculty status in 2016), requiring skills at the interface of physical and mental health. CLP in Aotearoa New Zealand has generally developed haphazardly from its beginning in the 1980's, as in-reach from adult community mental health services (MHS) in response to a combination of local interests, perceived need and opportunism. There is no national blueprint for CLP, or widespread agreement on service models, priorities and pathways for further development. The resulting heterogeneity limits the generalisability of comparisons between services in terms of models, resourcing and outcomes.[10] Of the 60 public hospitals in this country, 36 have EDs operating 24 hours a day, seven days a week (24/7). Of these 36 hospitals:

- 15 (with ≥ 200 beds) have specialised CLP services.
- 21 (with <200 beds) are covered by in-reach from the adult community mental health service (AMHS).
- 4 children's hospitals have specialised Paediatric Consult Liaison Teams (PCLT).
- 19 hospitals with children's wards are covered by in-reach from the community Child and Adolescent Mental Health service (CAMHS).
- Coverage of older people is more variable and includes - generic cover by CLP services, specialist old age liaison services, in-reach by Mental Health Services for Older People (MHSOP), and splitting the hospital between general (CLP) and rehab wards (MHSOP).

What data do we have?

The first national survey of CLP services in Aotearoa New Zealand (CLPSNZ-1) was conducted in 2018 using a multiple-choice online survey, covered 12 specialist CLP services and was published in Australasian Psychiatry in 2020.[11] CLPSNZ-1 established that:

- Most hospitals of ≥ 200 beds had designated CLP services; and these were generally funded and managed solely by the mental health division, operated within office hours, and had psychologists and other allied health staff completely external and separate to their service.
- There was significant heterogeneity amongst these services in terms of structure and function and in particular, the coverage of EDs and young/older patient groups.
- These services were not adequately resourced, only two operated 24/7, no service had a full multi-disciplinary team within it, integrated clinical governance and funding (between mental health and the general hospital) was rare, and specialised and/or integrated coverage of special patient groups (young people, older people, addictions etc.) was uncommon.
- Liaison with other hospital specialties was under-developed with most services operating a consultation-based approach.
- General and and/or specialist CLP outpatient clinics were provided by only half of the services.

The **second national survey of CLP services in Aotearoa New Zealand (CLPSNZ-2)** closed in late 2021, utilised an emailed questionnaire containing 44 questions, and covered both CLP and community mental health services that provide "liaison" to the 36 hospitals that operate EDs 24 hours a day, 7 days a week. Preliminary unpublished results for CLPSNZ-2 (Hopkins J, Skudder E, Vroegop P, and Sundram F, personal communication 2022) have established that:

- There are now 15 designated CLP services and 4 specialist PCLTs (Paediatric Consult-Liaison Psychiatry Teams) that cover the 4 specialist children's hospitals.
- The designated CLP services remain largely funded and managed by the mental health division alone, almost all operate in office hours Monday to Friday, none is the single point of contact in their hospital for mental health referrals or advice, and none has a full multi-disciplinary team.
- The heterogeneity amongst these services found in CLPSNZ-1 in terms of structure and function (esp. the coverage of EDs and young/older patient groups) has been replicated in CLPSNZ-2.
- Liaison with other hospital specialties remains under-developed.
- The workforce for the 15 CLP services (see Appendix 1) consists of a total of 79.9 FTEs, of which 5.4 FTE are unfilled, and 1.8 FTE are occupied by locums. There are 18.8 FTE Psychiatrist positions, 15.5 Psychiatric Registrar positions, 38.8 FTE Nursing positions (with 19.3 of these being senior nursing positions), and 6.8 Psychology positions. 80% of the clinicians in these positions are of European ethnicity, while 14% are Asian. The CLP psychiatric workforce is generally mature, stable and highly experienced.
- Inadequate resourcing remains a serious issue - 11 respondents considered their services were "inadequately" or "poorly" funded, and indicated that a funding injection (of between 10 & 110%, with an average of 50%) was required for their service. Nine of the 15 services have < 1.0 FTE Psychiatrists.
- It is clear (see Appendix 1) that the designated CLP services have two separately resourced functions - one covering ward referrals and liaison with hospital departments with/without outpatient services, and a second one providing acute mental health coverage to the ED. What is also clear is that both of these functions are inadequately resourced.

What are the main issues?

- There is **no agreement over what a CLP service in Aotearoa New Zealand should look like or do**. There is no blueprint for developing or evaluating our CLP services.
- There are **no agreed benchmarks** upon which to develop "liaison" services for large hospitals (>500 beds), medium sized hospitals (>200 beds) and small hospitals (<100 beds) in our national context. The benchmarking data that exists (see Appendix 2 & references) is either from overseas or informal and based on individual local services, and therefore can't be generalised. [12, 13, 14]
- There is **no agreement over whether the Emergency Department (ED) should be covered by CLP services**, or by acute community mental health services.

- The **needs of special populations** including young people, older people, people with addictions, and people with medically unexplained symptoms or chronic pain issues are ill-served by the degree of heterogeneity that exists with these services. The reliance on inreach services, the limited access to joint outpatient clinics, and the arbitrary division between CLP and psychology are illustrations of this issue.
- **CLP is caught between mental health and the general hospital**, with neither extracting optimal value from its contribution. A **lack of parity of esteem** between physical and mental health and poor integration of physical and mental health services add more challenges for CLP to overcome.
- CLP operates in the interface between the siloes of physical and mental health and is **increasingly dealing with complexity and multi-morbidity.** The two recent reviews (He Ara Oranga, Report of the Government Inquiry into Mental Health and Addiction, 2018 [15] and the Health and Disability System Review, 2020 [16)] failed to address this – neither review adequately addressed multimorbidity, while He Ara Oranga emphasised primary care options despite no NGO being able to address the complexity CLP does.
- The **rising demand for consultations** (and especially complex consultations) has disrupted and diverted from the provision of the other core functions of CLP, being liaison, OP, training, teaching, and service evaluation & development.
- **Multiple points of contact** for mental health referrals from the general hospital (with multiple mental services responding to different departments, age groups and types of presentations on the same hospital site) lead to fragmentation, confusion, duplication and gaps.
- The **funding model is problematic** because at present CLP is funded locally and inconsistently by mental health at the DHB level, which in turn is funded using a capped population-based formula. This is inadequate for the level of mental health need in the general hospital (approx. 5% of presenters to ED and 30% of inpatients), and disincentivises the beneficiary of CLP activity (the general hospital) from investing in its sustainability and expansion, as they are effectively getting CLP for free. CLP services are at risk of **losing their fitness for purpose or perishing altogether** due to chronic under-investment.
- Health psychologists (psychologists working in physical health settings) have been recruited into specific specialist hospital services, completely separately to CLP, and utilising different models of care. This has **introduced an unnecessarily competitive dimension** and only added to an already dis-integrated system.

What are potential solutions for CLP in Aotearoa New Zealand?

The RANZCP proposes that the issues outlined above would be most appropriately and effectively addressed by the development of a **blueprint** containing the following elements:

- Full **recognition that CLP is the sub-speciality**, that having evolved in the interface between physical and mental health, has unique and valuable contributions to make in the general hospital

and its outpatient departments, to other specialist mental health and addiction services, and to primary care.

- **Valid benchmarks for CLP services** (informed by CLPSNZ-2) with core numbers and mix of FTEs, and additional loadings for increases in scope, activity & specialisation, for the full range of public hospitals in NZ (large i.e. >500 beds, medium i.e. 200 - 500 beds and small i.e. <200 beds) that have EDs available 24 hours 7 days a week.
- Agreement that hospitals of ≥200 beds should have a **specialist CLP service**, and for those services the Emergency Department (ED) belongs in CLP, there should be one point of mental health contact in that hospital, and specialisms for young people, older people and addictions should all be accommodated within the umbrella of a broader CLP service.
- For hospitals of <200 beds, referrals are managed by community crisis teams, MHSOP and CAMHS (i.e. the status quo), but these services should be bolstered by realistic levels of funding and clarity about priorities and response times.
- A **sustainable model for funding and governance** that adequately addresses the mental health need in the general hospital, enables appropriate levels of consultation, liaison, outpatient work, teaching, supervision and research, recognises both the contribution of mental health and the benefits accrued by the general hospital, and reflects the contribution of CLP at the "whole of hospital" level.
- A sustainable model for **funding and governance for psychology in physical health settings** that complements CLP rather than competing with it and encourages integration with CLP services.
- **Practical guidance** for commissioning CLP services (analogous to that in the UK[3]).
- A clear set of **quality standards** for CLP services (similar to that of the RCPsych PLAN[9]) allied to agreed, consistent outcome measurement, regular audit cycles, and appropriate quality improvement initiatives.
- A plan for **CLP workforce development**, that ensures – a workforce fully reflective of the ethnically diverse CLP patient population and well-equipped to provide culturally safe and equitable services, true multi-disciplinary working, adequate levels of advanced training and career advancement, and continuous renewal and prudent succession planning. Careful planning and innovative recruitment strategies will be required to transform the CLP workforce to reflect the cultural diversity of the population of Aotearoa New Zealand. It is also vitally important that there is a secure and predictable advanced training "pipeline" producing new consultants to attract local trainees and avoid them heading off-shore because there are no jobs here.
- Confirmation of the **key academic role** CLP plays in the education of doctors by providing an experience of the interface between mental and physical health, and the discipline of integrating complex physical and mental health presentations. This is true for both 4th and 5th year medical students, and post-graduate years 1 & 2 house officers. Whilst rotations for undergraduate students in CLP are well-established, there is a strong argument for expanding house officer exposure to CLP to ensure skills in assessing and managing behavioural disturbance, insomnia and substance

withdrawal, safely prescribing psychotropic medication, and assessing decisional capacity, are integrated in general medical practice.

- Confirmation that the 6 month **psychiatry registrar rotation in CLP** remains a core requirement for specialist RANZCP Psychiatry training in Aotearoa New Zealand with expectations that this training experience is a high-quality and career-informing one.
- Recognition, consistent application and expansion of the **role CLP services play in teaching** undergraduate nursing and allied health students, post-graduate nurses and allied health staff and junior and senior doctors in the general hospital setting.
- Recognition and promotion of the **role CLP services play in the de-stigmatisation** of mental disorder and psychological distress in the general hospital setting.
- The **establishment of national evaluation and research centres** to – pilot and evaluate novel therapies and service approaches; validate, implement and audit standardised outcome measures; and support and sustain ongoing surveys of CLP services in Aotearoa New Zealand.

Conclusion

CLP services play a unique and vital role in re-integrating mind and body, and re-aligning physical and mental health care. CLP services improve patient outcomes, enhance patient experience and safety, and produce significant cost-efficiencies for the general hospital. Yet in Aotearoa New Zealand in 2022, CLP services are struggling to deliver these benefits due to chronic under-investment and under-development. This paper has provided an overview of CLP services, highlighted the importance of CLP and presented a series of policy, service and workforce initiatives which will form the foundations of a blueprint to guide the future direction and development of this psychiatric sub-specialty.

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Appendix 1: Preliminary unpublished benchmarking data from CLPSNZ-2

Hospital	Pop[n]	Relevant Beds	Level of Activity	SMO FTE	SMO FTE /100 beds	Total FTE	Total FTE /100 beds
North Shore[1]	440k	570	High ED / High Ward / Low OP	2.2	0.39	12.1	2.12
Auckland[1]	545k	735	High ED / High Ward / Low OP	4.0	0.54	14.7	2.0
Tauranga	240k	265	Mod ED / Mod Ward / Low OP	0.5	0.30	4.1	1.55

New Plymouth	120k	125	Mod ED / Mod Ward / Nil OP	0.8	0.64	2.1	1.68
Palmerston North	180k	270	Mod ED / Low Ward	2.0	0.74	6.0	2.22
Rotorua	110k	185	Mod ED/Low Ward/ Nil OP	0.5	0.27	1.6	0.86
Whangarei	180k	170	Low ED / High Ward / Mod OP	0.8	0.47	1.8	1.06
Waikato	420k	470	Nil ED / High Ward / Low OP	0.9	0.19	4.9	1.04
Middlemore[1, 2]	560k	630	Nil ED / High Ward / Nil OP	2.6	0.41	7.6	1.21
Waitakere[1]	190k	170	Nil ED / Mod Ward / Low OP	0.6	0.35	5.0	2.94
Christchurch[3]	570k	790	Nil ED / Mod Ward / Mod OP	1.5	0.19	5.2	0.66
Wellington	320k	400	Nil ED / Mod Ward / Mod OP	1.1	0.28	6.9	1.73
Hutt	150k	250	Nil ED / Mod Ward / Low OP	0.5	0.20	4.1	1.64
Hawkes Bay	165k	320	Nil ED / Mod Ward / Nil OP	0.3	0.09	1.3	0.41
Dunedin	330k	290	Nil ED / Mod Ward / High OP	0.5	0.17	2.5	0.86
Totals	**4,520k**	**5,640**		**18.8**	**0.33**	**79.9**	**1.42**

Pop[n] = DHB catchment population	Relevant beds = those beds specifically covered by CLP	ED = Emergency Dep[t.] referrals
Ward = Ward referrals	OP = Outpatient referrals	SMO = Consultant Psychiatrist
CNS = Clinical Nurse Specialist	RN = Registered Nurse	Reg = Psychiatric Registrar
Psych = Psychologist	[1] = see denominator comment below	[2] = see Middlemore comment below
[3] = see Christchurch comment below		

The FTE/100 beds figures in Table 2 can be compared to those in Table 1 provided the following is noted. The denominator is lower in Table 2 because beds not covered by the CLP have been subtracted from the total bed numbers in that hospital. The Auckland metro FTE/100 bed figures in Table 2 are lower than in Table 1 for this reason. In table 1, the Middlemore figures included the Mental Health Intake and Assessment Team that covers the ED; while in Table 2 the Middlemore figures include only the CLP team that covers the wards. In table 1, the Christchurch figures included both the adult CLP team and the older person's CLP team; while in Table 2 the Christchurch figures include only the adult CLP team. This explains why the Table 2 FTE/100 beds figures for Middlemore and Christchurch are lower.

The hospitals have been ordered according to a broad measure of activity (nil/low/moderate/high across ED referrals/ward referrals/outpatients) from highest to lowest.

Note that 9 of the 15 CLP services have less than 1.0 FTE Psychiatrists.

Appendix 2: Previously available benchmarking data

Hospital/Model	Comments	Staffing (FTE's)	Current FTE /100 beds	Proposed FTE/100 beds
Aitken Core 24	24/7 coverage[1*]	0.8 M + 2.6 N + 0.4 A	-	3.8
Melbourne 2011	2-3% of admissions[2]	0.26 SMO + 0.58 Reg	0.84	1.0

Victoria 2016	1% of admissions [3]	0.4 SMO + 0.7 R + 0.2 P + 0.5 N	-	1.8
	2% of admissions[3]	0.7 SMO + 1.0 R + 0.5 P + 0.5 N	-	2.7
North Shore	2018 data[4]*	3.2 M + 5.8 N + 0.4 P	1.5	3.4
Waitakere	2018 data[4]*	2.0 M + 7.0 N + 0.5 A	3.8	2.1
Auckland City	2018 data*	4.5 M + 8.3 N + 0.7 P	1.6	3.0
Middlemore	2020 data[5]*	5.1 M + 11.0 N	2.3	3.3
Waikato	2020 data[6]	3.1 M + 1.9 N	0.9	-
Wellington	2016 data[7]	3.1 M + 1.8 N + 1.0 P	1.1	-
Christchurch	2016 data[7]	4.0 M + 2.0 N + 1.5 P (PCS + PSE)	0.9	-
Dunedin	2014 data[8]	1.5 M + 1.0 N	0.7	-

M = medical staff undifferentiated	S = SMO	R = Registrars
N = nursing	P = psychology (within CLP)	A = other allied health staff
[1] = the Aitken model 2014	[2] = Holmes et al 2011	[3] = Service Model for CLP in Victoria 2016
[4] = NRA Regional review of CLP 2018/9	[5] = MMH data 2020 (ED + Ward teams)	[6] = JH personal communication
[7] = JH 2014 site visit updated 2016	[8] = JH 2014 site visit	* = services with extended hours or 24/7 coverage

The **Core 24 figures** come from the Aitken model, first published in 2014, based on existing CLP services in England with increasing levels of coverage and resourcing, and premised on CLP services covering the whole general hospital (including ED), with a strong emphasis on providing 24/7 cover. Hence the staffing mix is dominated by nursing and has a strong medical presence. The core unit is a 500 bed hospital. The Aitken model has proved very influential in England, is the core of CLP commissioning there, and is the basis of the government targets that are being monitored by a series of annual surveys (LPSE 1 – 5).[2]

The **Australian figures** use FTEs per 100 beds as the core unit; the staffing mix is heavily medical, focussed on specialised ward referrals, with an attempt to relate FTEs to numbers of hospital admissions.

The **New Zealand figures** are based on site visits, surveys and personal communications conducted by JH. The figures are expressed as FTE per 100 beds to be consistent with the Australian data. There remains some uncertainty over both numerator (actual FTE's as these are informal & somewhat historical) and denominator (these are based on DHB published bed numbers without specifying bed types).