CONSULTATION-LIAISON PSYCHIATRIC SERVICES

REVIEW OF PATIENT NEEDS, SERVICE DELIVERY MODEL AND FUNDING MECHANISM

Submission of the Victorian Branch of the Section of Consultation-Liaison Psychiatry of the Royal Australian and New Zealand College of Psychiatrists

SUMMARY OF RECOMMENDATIONS

1. All general hospitals should have a dedicated, consultant psychiatrist led multidisciplinary Consultation-Liaison (C-L) Psychiatry service in which all staff should have added qualifications or equivalent experience in this specialty. CAT and MSTS teams are unlikely to possess the required skills.

2. The liaison model is considered to be the mandatory method of delivery for major users of C-L psychiatry services and all services accredited for training by the Royal Australian and New Zealand College of Psychiatrists.

3. The minimum staffing level recommended by the Consultation-Liaison Workgroup of the Royal Australian and New Zealand College of Psychiatrists for a consultation-liaison psychiatry service with a 5% referral rate in a general hospital accredited for training in this rotation is 2 EFT dedicated clinicians per 100 beds, made up of 0.5 consultant psychiatrists, 0.7 psychiatry trainees, and 0.8 psychologists per 100 beds. In addition there should be 0.5 EFT dedicated nurses and 0.5 EFT socialworker/occupational therapists per 100 beds, and 1 EFT dedicated secretarial/administrative officer per service.

4. A minimum of 5% of inpatients should be referred. Where referral rates do not meet these standards, an audit assessing prevalence of caseness and detection, and standard of psychiatric care within referring units should be performed in order to determine the appropriate level of referral for those units.

5. Recommendations about threshold for referral are cast in terms of problems and level of expertise in referring units; a wider range of phenomena than is implied by the current use of the term "serious mental illness" is related to poor outcome in physical/psychiatric co-morbidity.

6. If C-L psychiatry is to be funded from within a block funding of psychiatry services in general, which is our preferred option, there needs to be explicit guidelines about the allocation to C-L psychiatry from within those funds. The minimum standards of staffing outlined above should be mandatory and funding for them be protected.

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1. DEFINITIONS

Consultation-Liaison (C-L) Psychiatry is that field of psychiatry which specialises in the diagnosis, treatment, study and prevention of morbidity among physically ill patients and those with physical symptoms (somatisers), and the provision of psychiatric consultations, liaison and teaching for non-psychiatric health workers in all types of health care settings, but especially in the general hospital.

Consultation-Liaison Psychiatrists are those psychiatrists who have had additional training or experience in the field, at a level indicated by the recommendations of the Liaison Psychiatry Group of the Royal College of Psychiatrists, and the Fellowship training program of the Academy of Psychosomatic Medicine.

Consultation-Liaison Psychiatry Allied Health and Nursing Staff are those staff who have had additional training or experience in the field, at a level indicated by their professional organizations.

Liaison refers to the model of service provision in which dedicated C-L teams are attached to medical, surgical or specialty units in such a way that they form a functional component of those units.

2. C-L PSYCHIATRY AS A MAJOR SUB-SPECIALTY

2.1 **C-L psychiatry is a major sub-specialty of psychiatry.** It is one of the 6 Sections of the Royal Australian and New Zealand College of Psychiatrists. Psychiatrists in training must spend 6 months in an accredited general hospital C-L service. C-L psychiatrists are expected to have had advanced training or experience as defined above. The Section of Consultation-Liaison Psychiatry of the RANZCP is developing guidelines for training and additional qualification in the field.

2.2 **Physical/psychiatric co-morbidity and somatisation are the commonest forms of psychiatric presentation in the community (1-3).** In respect to General Hospital inpatients, the target population of this review, between 1% and 6% of patients are referred to C-L psychiatry because of such problems. A further 30-50% have diagnosable psychiatric disorders during their admission (4). We estimate that a referral rate of 10% would represent an appropriate level of detection and referral (5-7). At this rate the number of inpatients needing to be seen by C-L psychiatry services in major Victorian general teaching hospitals would rise from 12,000 to 36,000 cases per year. Such patients are likely to have psychiatric disorders covering the whole range of categories (8).

3. SIGNIFICANCE OF PHYSICAL/PSYCHIATRIC CO-MORBIDITY AND SOMATISATION: need for revision of definition of "serious mental illness"

Controlled, prospective studies have shown that the presence of psychiatric disorder in patients with physical illness is associated with a significant increase in severity, length of stay, disability, re-admission rate and mortality (9,10). Delirium, impaired cognition, depression, anxiety and somatisation are the significant factors in this outcome. It is important to note that even sub-threshold levels of these phenomena can contribute to poorer outcome and greater utilisation of health care resources, as the studies cited and the Medical Outcomes Studies of the Rand Corporation have shown (1,2,11). Difficulties in coping or adjusting to physical illness by either the patient or the family are another source of poor outcome.

Thus the co-morbid presence of physical illness or physical symptoms qualifies all psychiatric disorders, including Adjustment Disorder, to be designated as "serious". At least 30% of general hospital inpatients have psychopathology of this type. These data also show that any consideration of the cost efficacy of inpatient C-L psychiatry services must take into consideration the long term effects of psychiatric comorbidity.

Psychosocial issues are operating at every phase of illness admission episodes; as factors that precipitate the illness episode, influence the decision to admit, modulate the course of illness, and help determine the discharge process and placement. The most telling economic argument for supporting C-L psychiatry services would be that based on evidence that psychosocial interventions at any of those stages has cost-offset benefits. A number of published studies suggest that this is so (12). It is generally agreed that more refined studies are needed if this argument is to be put beyond doubt, and these are in progress (13).

However the argument for support is also sustained by the high prevalence of psychiatric disorder in general hospital patients, its lack of recognition, the poor quality of treatment when it is recognised, and the a priori indication for assessing and treating psychiatric disorder when it exists (4,14). This is the point of view put by the Joint Working Party of the Royal Colleges of Physicians and Psychiatrists (15), the Section of Consultation-Liaison Psychiatry of the Royal Australian and New Zealand College of Psychiatrists, and corresponding groups

in North America (14), The Netherlands and across Europe. Measurement of efficacy of C-L psychiatry in this paradigm involves study of improvement in recognition and in implementation by non-psychiatrist doctors of practice guidelines (15). It also emphasises measurement of quality of life (16).

4. THRESHOLD FOR REFERRAL

In setting guidelines for threshold of referral for mental state dysfunction and behavioural disturbance, it must be realised that there are a number of factors involved; recognition of such phenomena by referring staff, judgement about their significance, judgement about the likely benefit of intervention, judgement about the need for referral to achieve adequate assessment and intervention, and patients' attitudes and wishes. We can define those disturbances which are likely to impair a patient's wellbeing, course of illness and care and for which assessment and intervention are likely to be beneficial. But we also need to define standards of recognition and standards of care that need to be in place in particular units. Only the can we provide a comprehensive set of guidelines about threshold for referral.

The benchmark minimum referral rate for inpatients in general teaching hospitals in Australia and New Zealand is 5% (5). Analysis of the Monash C-L psychiatry database shows that this rate will vary appropriately from unit to unit. Minimum referral rates for the major referring units are: General Medicine, 4%; Obstetrics, 2%; Gynaecology, 3%; Neurosurgery, 9%; Oncology, 12%; Renal Medicine, 17%; Neurology, 17%.

Where referral rates do not meet these standards, an audit is required. This should include an audit of prevalence of psychiatric disorder, using screening instruments for caseness (General Health Questionnaire), alcohol and drug use disorders and cognitive impairment (4). The audit will also require an assessment of the level of detection of such morbidity, and of the standard of management of those cases detected but not referred. It also requires an assessment of concordance with recommendations by the C-L psychiatry team.

Minimum benchmark referral rates for individual ICD-9 physical disorders could also be set.

For the reasons stated in Section 3 above, it is not appropriate to cite diagnostic categories in guidelines for threshold of referral of physical/psychiatric co-morbidity. It is phenomena such as confusion, anxiety, depressed mood and somatisation which are correlated with poor outcome and difficulties in care, Furthermore, those who refer the patients, the physicians and surgeons, do not use categorical psychiatric diagnoses, but rather use a problem orientated approach (8).

For these reasons, the recommendations about threshold for referral are case in terms of minimum referral rates, problems and standard of psychiatric care within referring units.

5. C-L PSYCHIATRISTS AS MENTORS FOR PATIENTS WITH COMPLEX PHYSICAL ILLNESS AND ITS CARE

Analyses of the extensive clinical databases now extant for C-L psychiatry have shown that the small proportion of patients with physical/psychiatric comorbidity who are actually referred to C-L psychiatry (1% to 5%) not only have a significantly greater length of stay, but are also more complex in their condition and their care, as measured by the parameters of number of diagnoses, number of units involved, number of investigations and number of complications (17,18).

The C-L psychiatrist comes to function as a mentor and broker for the patient with complex care, as he or she grapples with the fact of being ill, its consequences, and the demands which investigation and treatment place. This resembles the construct of the case manager for patients with psychiatric disorders that impair their judgement chronically. The physically ill do not usually have chronically impaired judgement. They may be impaired so at times, when they are delirious because of their medical condition or its treatment. But they are often overwhelmed by information, procedures, multiple doctors and conflicting opinions, and have to deal with these in a state of separation from their usual support system, propulsion into dependency, and the stress of physical illness and pain. Anxiety and depression are common, and a feeling of stress ubiquitous. The mentor/broker evaluates, educates and treats the patient, family and treating team, with significant reduction in length of stay, complications and re-admissions, and improvement in compliance with medication (10,19,20). This is the main reason why C-L services throughout the world have a predominance of medical staff and are led by a consultant psychiatrist specially trained in these skills.

6. KNOWLEDGE BASE FOR C-L PSYCHIATRY

We now have a much clearer idea of what is likely to be effective in C-L psychiatry work (20,21). The consultation model of service delivery is now regarded as an inefficient way of delivering such a service, because it cannot address adequately the systemic issues of the patient's situation within a particular medical culture comprising the unit in which they are located and the particular way it relates to other units and hospital services. Diagnosis is likely to be erroneous, treatment recommendations inappropriate, and concordance with recommendations low (22). For these reasons, the liaison model is considered to be mandatory for units which are major users of C-L services, and for all services accredited for training by the Royal Australian and New Zealand College of Psychiatrists.

Effective ways of educating non-psychiatrist doctors, nurses and allied health personnel about detection of psychopathology and management of common psychiatric conditions have been established, as have ways of enhancing patients' understanding of the interaction of psychosocial and biological factors. This enhances compliance (20).

7. FUNDING ISSUES

The amount of funding devoted to C-L psychiatry services in any one hospital varies greatly, and is dependent on the attitude of the budget providers rather than on the patients' needs (5). Historically, C-L psychiatry has been disadvantaged by its dependence for funding on either a segregated mental health system which does not concern itself with physical/psychiatric co-morbidity (see, for instance, the report of the Mental Health Workforce Consultancy), or on general hospital management which has difficulty in comprehending the issues of mental illness. A further disadvantage comes from the fact that C-L psychiatrists are consulting on other doctors' patients and liaising with medical, paramedical and nursing staff rather than working in the simpler mode of direct patient care. The introduction of case-mix funding exposes the funding problem and offers the opportunity for its resolution. **It is important that standards of best practice rather than current staffing levels be used as a basis for establishing recommendations.** In this respect, several Victorian hospitals are regarded internationally as providing such models, but this does not include all Victorian hospitals. Very few other Australian hospitals achieve this standard (5).

8. PROPOSALS FOR MINIMUM STANDARDS OF CONSULTATION-LIAISON PSYCHIATRY SERVICES

The proposals listed below are based on those of the Joint Working Party report of the Royal Colleges of Physicians and Psychiatrists (15). These are endorsed by the Victorian Branch of the Section of Consultation-Liaison Psychiatry of The Royal Australian and New Zealand College of Psychiatrists.

A. **All general hospitals should have a consultant psychiatrist led consultation-liaison psychiatry service. The exact model of such a service will vary according to local circumstances, but it must be consultant psychiatrist led, be multidisciplinary, and staffed at least to the minimum levels established by the Consultation-Liaison Workgroup of the Royal Australian and New Zealand College of Psychiatrists (5). It must include the range of skills required for such work, and staff should have the defined advanced training or experience.**

The level of skills required would not usually be found in Crisis Assessment and Treatment (CAT) and Mobile Support and Treatment Service Teams (MSTS). Furthermore, such teams would be unlikely to be able to provide the intense liaison required. Co-ordination with the CAT and MSTS teams is, however, essential.

B. All inpatient facilities must include private, quiet and safe facilities so that routine interviews can include a discussion of psychological problems.

C. **The service must include a component for self-poisoning and self-harm patients that meets the minimum standards for such a service laid down by the Royal College of Psychiatrists. It is not sufficient for this to be the only component of the service offered.** This situation tends to arise where staffing of C-L services is at too low a level (5). Such a situation does not meet the requirements of the Royal Australian and New Zealand College of Psychiatrists for training, and jeopardises accreditation. This in turn has implications for the quality of the service provided, and does not meet the general standards laid down.

The initial assessment and management of self-harm and self-poisoning patients should be performed by the C-L psychiatry team. Patients with these diagnoses who are admitted will have considerable physical morbidity, at least initially; the C-L team's skills are required at this stage. Liaison with CAT and MSTS teams should begin early in the C-L team's involvement.

D. **The service must include a component for patients with drug and alcohol problems that meets the standards laid down by the Section of Drugs and Alcohol of the Royal Australian and New Zealand College of Psychiatrists.** This may be offered in association with specific drug and alcohol services.

E. **The service must include a component that provides a service to all inpatient units for patients identified by them as in need of assessment and/or treatment, particularly those with unexplained physical symptoms and those whose mental state is adversely affecting their well-being, course of illness or management.**

F. **The liaison model of service delivery is considered to be mandatory for units which are major users of C-L services, and for all services accredited for training by the Royal Australian and New Zealand College of Psychiatrists.**

G. **The liaison model requires appointment of a dedicated C-L psychiatry team to a particular unit. The same team may service more than 1 referring unit.** From a position established by the fostering of close relationships with members of the unit, participation in its various activities, and identification with the mission of that unit, **the liaison psychiatry team will educate the staff about how to assess psychosocial aspects of the patient's presentation, how to manage the more common disorders, how to refer appropriately, and how to implement recommendations.** They will base this activity on the effective methods described in the considerable literature on education of non-psychiatrist health care personnel and on shared care of patients. **The outcome of this activity should be that all inpatients with mental state conditions affecting their well-being will be identified, assessed and managed to the standards established in the C-L literature.**

H. **The C-L service should maintain a record keeping system that allows regular** audit of the system. Auditing of C-L services should include assessment of the efficacy of liaison intervention as measured by such factors as referral lagtime, referral rate, range of problems referred, recording of psychosocial data and mental state, and concordance with recommendations. In addition, there should be outcome measures for patients. This will involve use of instruments appropriate to the type of psychiatric morbidity seen in C-L psychiatry work. In

some centres, such as Monash Medical Centre and the Austin Hospital in Victoria, C-L psychiatry services that approach internationally optimal standards of staffing and have reliable clinical databases in place have been established (8). These are regarded as models of best practice in Australia, and could be used as a benchmark for these data items. Use of screening procedures based on identification of psychosocial risk factors for complexity of care will help identify which patients require referral (7).

I. Threshold for referral to C-L psychiatry.

A minimum of 5% of inpatients should be referred. Minimum referral rates for the major referring units are: General Medicine, 4%; Obstetrics, 2%; Gynaecology, 3%; Neurosurgery, 9%; Oncology, 12%; Renal Medicine, 17%; Neurology, 17%.

Where referral rates do not meet these standards, an audit assessing prevalence of caseness and detection, and standard of psychiatric care within referring units should be performed in order to determine the appropriate level of referral for those units.

Routine recording of past psychiatric history, current psychiatric phenomena, current psychotropic medication and current and progressive mental status should be mandatory for all inpatients. Formulation and treatment plan should be stated where psychopathology is detected.

Referral is expected for:

(I) **Those at risk of poor outcome or management difficulties;** patients with a history of delirium or psychosis during previous admissions, those currently on major doses of psychotropic medication, and those whose care is complex - involving multiple units and long length of stay, and those where either the patient or family have coping problems.

(ii) **Those patients who appear to be the focus of staff problems.**

(iii) **Patients who have made a self-poisoning or self-harm attack or are considered at risk of such.**

(iv) **Patients whose behaviour is disruptive in the unit, particularly if violent.**

(v) **Patients who have psychotic phenomena, that is, display perceptual,** thought or behavioural disturbances that indicate that they have lost touch with reality.

(vi) **Patients for whom there are problems of judgement or testamentary** capacity.

(vii) **Patients with any of the following problems which are distressing to them, or affecting the course of their illness or the ability of staff to treat them, and for which the necessary skills are not available within the unit:**

Confusion
Anxiety
Depression
Somatisation
Pain
Drug or alcohol abuse or dependence
Cognitive impairment

9. PROPOSALS FOR FUNDING CONSULTATION-LIAISON PSYCHIATRY SERVICES

A. **The minimum staffing level recommended by the Consultation-Liaison Workgroup of the Royal Australian and New Zealand College of Psychiatrists for a consultation-liaison psychiatry service with a 5% referral rate in a general hospital accredited for training in this rotation is 2 EFT dedicated clinicians per 100 beds, made up of 0.5 consultant psychiatrists, 0.7 psychiatry trainees, and 0.8 psychologists per 100 beds. In addition there should be 0.5 EFT dedicated nurses and 0.5 EFT social worker/occupational therapists per 100 beds, and 1 EFT dedicated secretarial/administrative officer per service.** This is in keeping with the recommendations of similar groups in Europe and the United States.

B. **Casemix funding based on Diagnostic Related Groups is arguably an inappropriate basis for funding of psychiatric services (23). In their present form they are particularly inappropriate for C-L psychiatry because:**

(i) There is the general problem of their poor predictability of costs.

(ii) The restricted number of diagnoses permitted as co-morbidities does not incorporate the more recent data about the breadth of psychiatric diagnoses that can contribute significantly to disability and costs.

(iii) The restrictions on the number of diagnoses permitted as co-morbidity also limits severely the capacity of the DRG system to capture the extent of C-L work.

(iv) The patients referred to C-L psychiatry are so complex (their length of stay is 2-3 times greater than the mean) that any DRG weighting accruing from their psychiatric co-morbidity is likely to be lost amongst the other co-morbidities.

(v) Even those small amounts of funding which would be derived from a psychiatric co-morbidity would be returned to the unit which had primary responsibility for the patient; they would have to be extracted from their budget. Based on historical experience, this is likely to be difficult to achieve.

C. **If C-L psychiatry is to be funded from within a block funding of psychiatry services in general, which is our preferred option, there needs to be explicit guidelines about the allocation to C-L psychiatry from within those funds. The minimum standards of staffing outlined above should be mandatory and funding for them be protected.** Although psychiatry is returning to the general hospital, it has not necessarily embraced physical/psychiatric comorbidity and somatisation, that is, C-L psychiatry's target population, as falling within its ambit. The narrow and faulty concept of serious mental disorder still held by some psychiatrists and administrators threatens to deprive the general hospital patient of the psychiatric services to which he or she is entitled. It is fallacious to argue that it is the responsibility of physicians and surgeons to provide such care themselves. They do not have the skills or the resources to do so.

D. **There must be adequate funding for Training and Research.** At present there is no specific budget for this in psychiatry funding in Victoria. The stage of development of C-L psychiatry is such that training and research need to parallel service delivery if standards are to be developed and sufficient workforce numbers produced, in all disciplines. C-L nursing is in particular need of development.

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