

Consultation and liaison psychiatry

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Szent István and Szent László Hospital,
Consultation-Liaison Psychiatry Service

Content

- History of C-L
- Definition of consultation-liaison psychiatry
- Present position of C-L in medicine
- A typical example for C-L activity
- Characteristics of the effective consultant
- Reasons for referral
- Pattern of liaison
- Therapeutic alliance
- The consultation note
- Interventions and Follow-up

Where did the name (C-L) come from?

VOL. II.

JULY, 1922.

No. 1.

AMERICAN JOURNAL OF PSYCHIATRY

THE BROADENED INTERESTS OF PSYCHIATRY.*

By ALBERT M. BARRETT, ANN ARBOR, MICHIGAN.

Presidential honors bring responsibilities that cannot help but weigh heavily upon the recipient. While not wishing to avoid these, I hope one may be pardoned for confessing to a feeling of inadequacy that comes to him as he prepares the address that the custom of this association expects of its presiding officer.

This feeling of inadequacy comes from a keen personal appreciation of an inability to do the task as well as he might wish and especially because of a bewilderment as he tries to collect from out the mass of present day psychiatric interests something that might be concretely considered on an occasion such as this.

There was never a time in the world's history when there was such a widespread interest in the mind and its disorders in their relation to human life in its social and medical aspects. Interest in psychology and psychiatry is no longer confined to the teachings of class rooms and laboratory investigations carried on in schools and colleges, nor to the clinics and hospitals specially concerned with mental disorders. Its scope is apparent to all who keep informed regarding present progress.

Human character and behavior is being analyzed and measured in respect to standards of mental health. Individual successes and failures, and social problems are explained, excused or condemned in terms of mental qualities. Our periodicals carry in their pages stories woven around themes of mental strangeness, and essays and discussions on social and industrial problems in which the writer sees a psychiatric problem. We have the psychological novel and the psychological play. In art and music moods and desires for expression find outlets in symbolic forms that only

* Presidential Address at the seventy-eighth annual meeting of The American Psychiatric Association, Quebec, Canada, June 6, 7, 8, 9, 1922.

Beginning of the story

- In the 1920s psychiatry became closer to medicine as hospitals started to establish psychiatric units.
- The concept of psychosomatic relationships and the role of emotions and psychological states in the genesis and maintenance of organic diseases emerged at that time.
- Thus, Consultation – Liaison Psychiatry became an applied form of psychosomatic medicine.

Definition

- Consultation-Liaison Psychiatry is a subspecialty of psychiatry that incorporates clinical service, teaching, and research at the borderland of psychiatry and medicine.
(Lipowski, 1983)

What is consultation-liaison psychiatry?

- **Liaison psychiatry**, also known as **consultative psychiatry** or **consultation-liaison psychiatry** (also, **psychosomatic medicine**) is the branch of psychiatry that **specialises in the interface between other medical specialties and psychiatry**, usually taking place in a **hospital or medical setting**. "Consults" are called when the primary care team has questions about a patient's mental health, or how that **patient's mental health is affecting his or her care and treatment**. The psychiatric team works as a "liaison" between the medical team and the patient. **Issues that arise** include **capacity to consent** to treatment, **conflicts** with the primary care team, and the **intersection of problems** in both physical and mental health, as well as patients who may report physical symptoms as a result of a mental disorder[1]. (Wikipedia)

What is consultation-liaison psychiatry's present position?

- The American Board of Psychiatry and Neurology: recommended subspecialty for Consultation-Liaison Psychiatry renaming it Psychosomatic Medicine
- June 2001: American Psychiatric Association Board of Trustees supported application
- 2003: American Board of Medical Specialties approved the recommendation
- ***Psychosomatic Medicine became the 7th subspecialty in Psychiatry***

What is consultation-liaison psychiatry's present position in Europe?

- **Germany:** Consultation-liaison psychiatry services are provided in virtually all German general hospitals, mainly by the medical specialty of psychiatry and psychotherapy and to a lesser extent by the specialty of psychosomatics and psychotherapeutic medicine, exclusively so in 5%. The latter specialty includes non-psychiatric physicians. (Diefenbacher, 2005)
- **Hungary:** in the majority of the general hospitals formal consultations are provided, only a few special C-L services exist (one of them in the Szent. László Hospital). A workgroup is representing this field in the Hungarian Psychiatric Association and there is a C-L course organised by the workgroup biannually.

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A typical case for C-L intervention (What is C-L good for.)

- 21 years old male patient
- 2 months earlier lymphadenomegaly
- Acute lymphoid leukemia was diagnosed
- Chemotherapy initiated
- Used THC 10 days ago while in the hospital to treat fear of death
- Few days after the THC use, hallucinations and delusions developed
- Psychiatric consultation was requested

A typical case for C-L intervention

- Based on his grandiose delusions, agitation, flight of ideas, distractions, and elevated mood, manic state with psychotic features was diagnosed
- Treatment with intravenous haloperidol+clonazepam was introduced
- Transfer to a psychiatric department was considered and rejected, because bone marrow suppression posed a high risk of infection.

A typical case for C-L intervention

- Follow-up was performed with daily visits
- In the first week family members guarded him in his room. Unpredictable violence appeared frequently.
- Dose of the psychopharmacotherapy was titrated according to his actual condition.
- On the second week his psychiatric condition begun slowly improve.
- Psychiatric medication was changed to oral risperidone and lithium

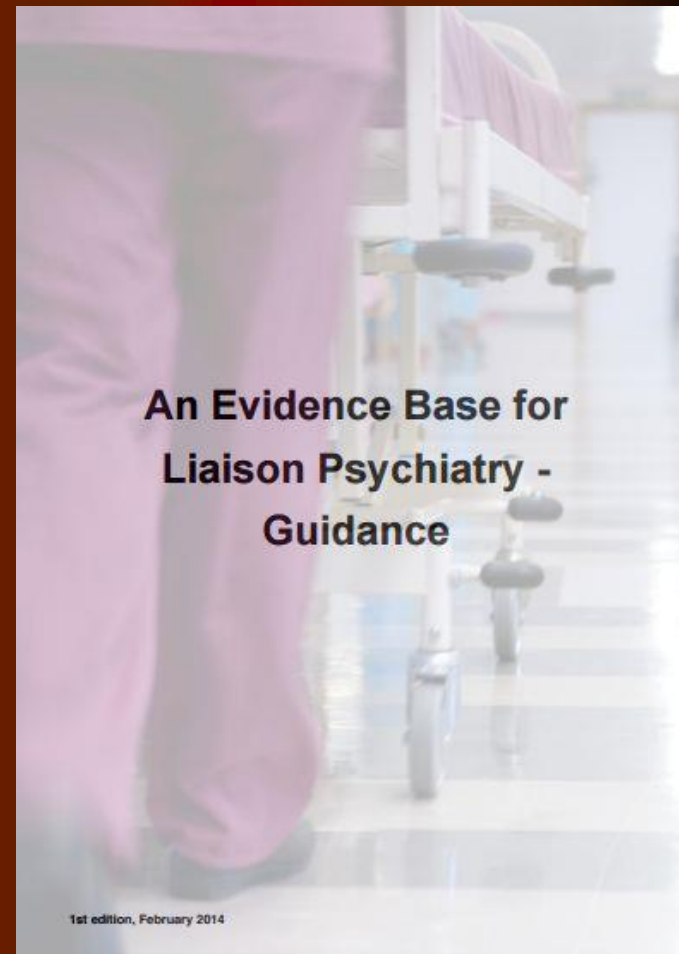
A typical case for C-L intervention

- Manic symptoms disappeared after four weeks
- He could leave the hospital 3 months later in a stable psychiatric condition on lithium maintenance therapy

The ideal C-L team

(UK guidance for C-L services, 2014)

- Led by a consultant liaison psychiatrist
- Specialist mental health nurses
- Clinical psychologist
- Occupational therapist
- Social workers



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What the psychiatric consultant must do to perform an effective consultation?

(Goldman, Lee, Rudd: Ten commandments for effective consultations. Arch Intern Med, 1983)

- 1. Determine the question:** the requesting physician and the consultant can have totally different impressions of the reasons for which the consultation was requested (15%).

Clarifying the reason for the consultation is not an easy job sometimes.

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Pszichiátriai, Addiktológiai Szakr.
Osztályvezető: Gazdag Gábor László dr.
Tel: 455-8125

Telj.az. 1775659 Vizsgálatkérő lap

Beteg neve.....
Születési dátum..... TAJ.....
Anyja neve.....
Lakcím.....
Beküldő.....
Beküldő orvos, pecs..... ulancia Térítési kat.: 1

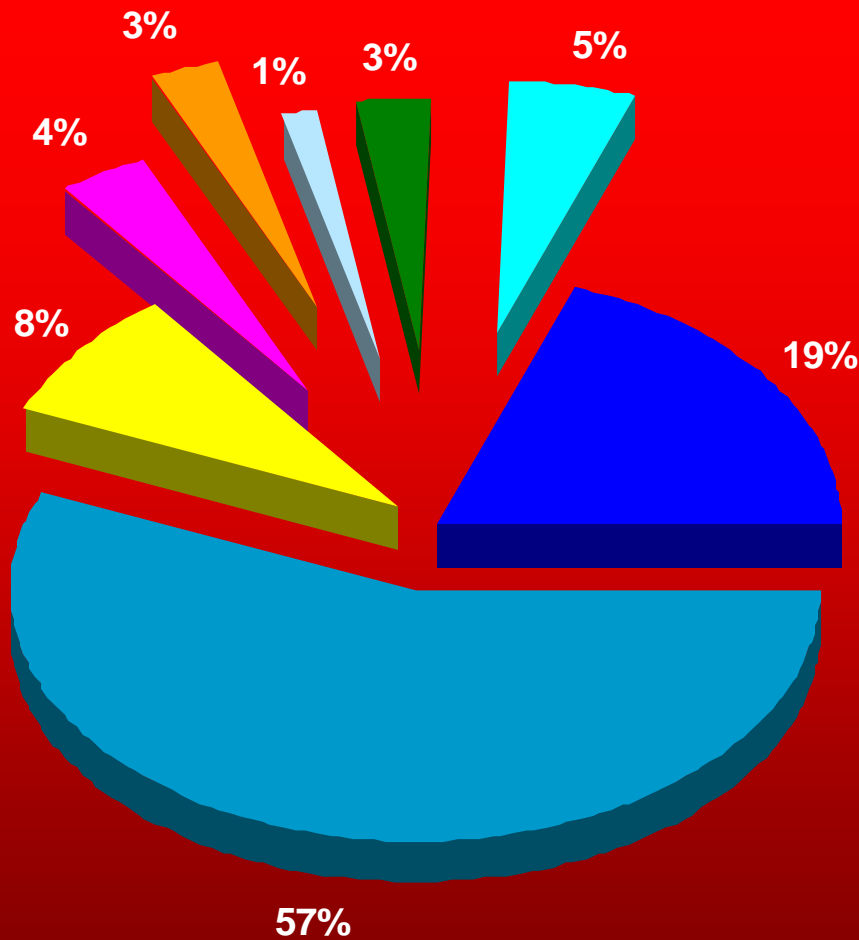
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Ellátást igazoló adat: 50003258

Rendelési adatok
Iránydiagnózis:
Iránydiagn.:
D6490 Anaemia k.m.n.
Rendelési megjegyzés
Kérem betegem szives vizsgálatát.

2012.10.03
XXXXX

Főv. Önk. Egyesített Szt. István és Szt. László Kórház - Rehabilitációs Osztály
Szent László Szent István Kórház
Felsőpszichiátriai Szakambulancia
1097 Budapest, Gyáli út 5-7.

Reasons for referral (1020 referrals)



- Not known
- Psychiatric symptoms
- No organic basis for the symptoms
- Noncompliance
- Positive psychiatric history, therapy revision request
- Legal reason
- follow up
- More contemporaneous reasons

Examples for referrals

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Telj.az. 1742858

Vizsgálatkérő lap

Beteg neve..... TAJ.....
Születési dátum.....
Anyja neve.....
Lakcím....., Gellérthegy u.2/b
Beküldő..... JFLM..... V. Infektológiai Osztály - Térítési kat.: 1
Beküldő orvos, pecsét: 44986 Szlávik János dr.

Vizsgálat időpontja:2012.09.03 09:19
Ellátást igazoló adat: 50003867

Rendelési adatok

Iránydiagnózis:
Iránydiag.: B24H0 HIV betegség k.m.n.
Rendelési megjegyzés
Tisztelt Gazdag Gábor Főorvos Úr!
Kérem betegem szíves szakvizsgálatát. Szorongásos-depresszió

Köszönettel:
dr. Szlávik János

2012.08.30
XXXXX

120/9
Egyesített Szt István és Szt László Kh
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Osztályvezető: Gazdag Gábor László dr.
Tel: 455-8125

Telj.az. 1780018

Vizsgálatkérő lap

Beteg neve..... M..... TAJ.....
Születési dátum.....
Anyja neve.....
Lakcím....., Ákác köz 1 2/6
Beküldő..... FB40 0102..... IV. Infektológiai Osztály Térítési kat.: 1
Beküldő orvos, pecsét: 43347 Fried Katalin dr.

Vizsgálat időpontja:2012.10.08 11:15
Ellátást igazoló adat: 201286592/1

Rendelési adatok

Iránydiagnózis:
Iránydiag.: K52.0 Toxikus gastroenteritis és colitis
Rendelési megjegyzés
Kérem betegünk vizsgálatát. Heveny gastroenteritise lezajlóban van,
elektrolyt zavara volt. A betegről érdemi anamnesis nem nyerhető, régi
leleteti nem állnak rendelkezésre. Unokájával sikerült néhány napja
beszélni, évek óta fokozódó feledékenységet említett, emiatt infuzios
kurákra jár.
Ma hajnal óta zavart lett, izgatott, zokog. Eddig semmiféle psychiatriai
készítményt nem szedett.

2012.10.08
XXXXX

- Data about the somatic illness
- Increasing forgetfulness in the past years
- became disturbed and agitated this morning
- no psychopharmacotherapy in the history

How can the consultant clarify the reason for consultation?

- Can ask for a written referral note (put a question to the consultant)
- Can talk with the referring physician, nursing and other staff before and after consultation.



Characteristics of the effective psychiatric consultant:

2. Establishes the level of urgency.

i.e., **emergency** (immediate, that should be completed within an hour time) or **routine** (that should be completed within 24 hours).

Typical **emergency** situations:

- 1. Evaluation of a patient who expresses **suicidal or homicidal ideation**.
- 2. Evaluation of a patient who is **acutely psychotic or agitated**.
- 3. Evaluation of a patient with severe **withdrawal syndrome** (delirium)

Level of urgency - routine

Typical **routine** situations:

- 1. Evaluation of a patient who is at **high risk for psychiatric problems** by virtue of serious medical illness.
- 2. Evaluation of a patient with a **medicolegal situation** (capacity to consent) (R, but can be urgent from medical point of view)
- 3. Evaluation of a patient with known or suspected **substance abuse**.
- 4. Evaluation of a patient who requests to see a psychiatrist. (R or ?)

Characteristics of effective psychiatric consultant (Goldman, Lee, Rudd, 1983):

- 3. Reviews the **chart** and the data thoroughly.
- 4. Performs a complete **mental status exam** and relevant portions of a history and physical exam.
- 5. Obtains medical history from family members or friends (if possible).
- 6. Makes **notes** as brief as appropriate.
- 7. Arrives at a tentative **diagnosis**.
- 8. Formulates a **differential diagnosis**.
- 9. Recommends **diagnostic tests**.

Characteristics of effective psychiatric consultant (Goldman, Lee, Rudd, 1983):

- 10. Recommends **therapy**. Has the knowledge to prescribe **psychotropic drugs** and is aware of their interactions (with somatic therapies). Experienced in the field of psychotherapy.
- 11. **Makes specific recommendations** that are brief, goal oriented and free of psychiatric jargon and **discusses findings** and recommendation with consultee – **In person** whenever possible.
- 12. Inform patients that the identified “customer” is the consulting physician. (maintaining absolute Doctor-Patient confidentiality is not possible for a psychiatric consultant)

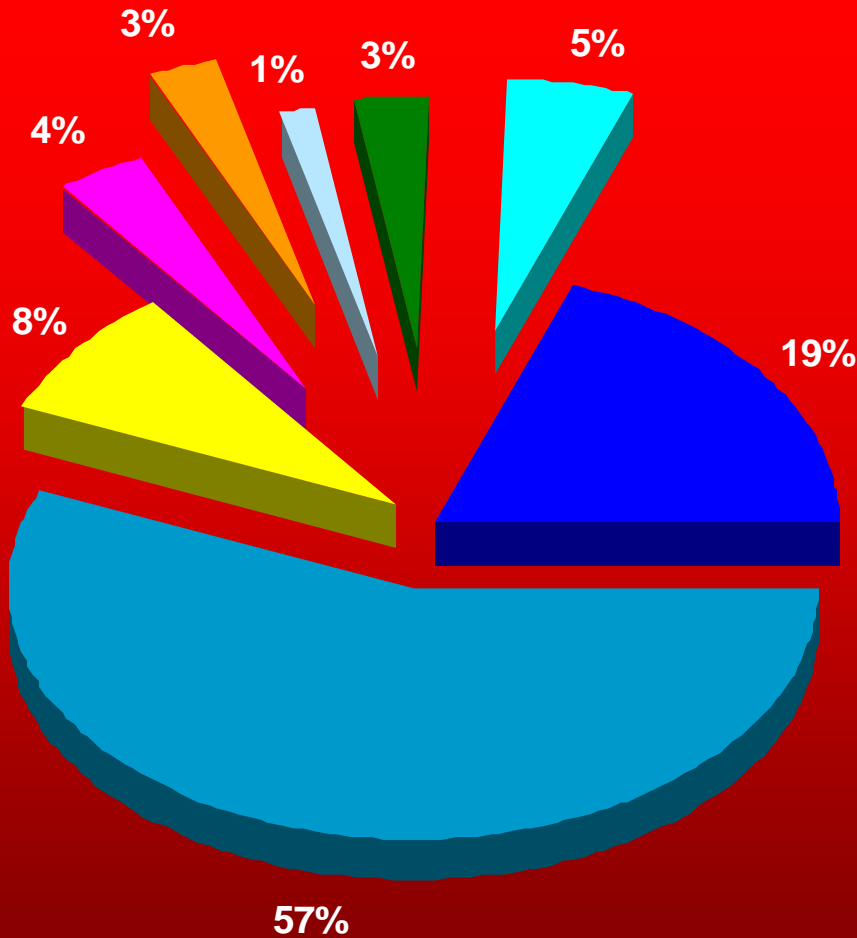
Characteristics of effective psychiatric consultant (Goldman, Lee, Rudd, 1983):

- 13. Follows-up patient until they are discharged from the hospital or clinic or until the goals of the consultation are achieved (if he/she is asked to do so). Arranges out-patient care-if necessary.
- 14. Does not take over the aspects of the patient's medical care unless asked to do so (competency?).
- 15. Follows advances in the other medical fields and is not isolated from the rest of the medical community.

Challenges of the C-L work

- The use of psychopharmacological agents in the presence of compromised physical status
- The possibility of an interaction between medications for physical and those of mental illness.
- The tendency of some non-psychiatric specialists to reject the mentally ill patient due to stigma
- Determining when to evoke the guardianship administration or the mental health act
- Determining when to transfer the mentally disruptive patient from the non-psychiatric unit to the psychiatric facility
- Working with two clients—the referring specialist, and the referred patient.

Reasons for referral (own survey)



- Not known
- Psychiatric symptoms
- No organic basis for the symptoms
- Noncompliance
- Positive psychiatric history, therapy revision request
- Legal reason
- follow up
- More contemporal reasons

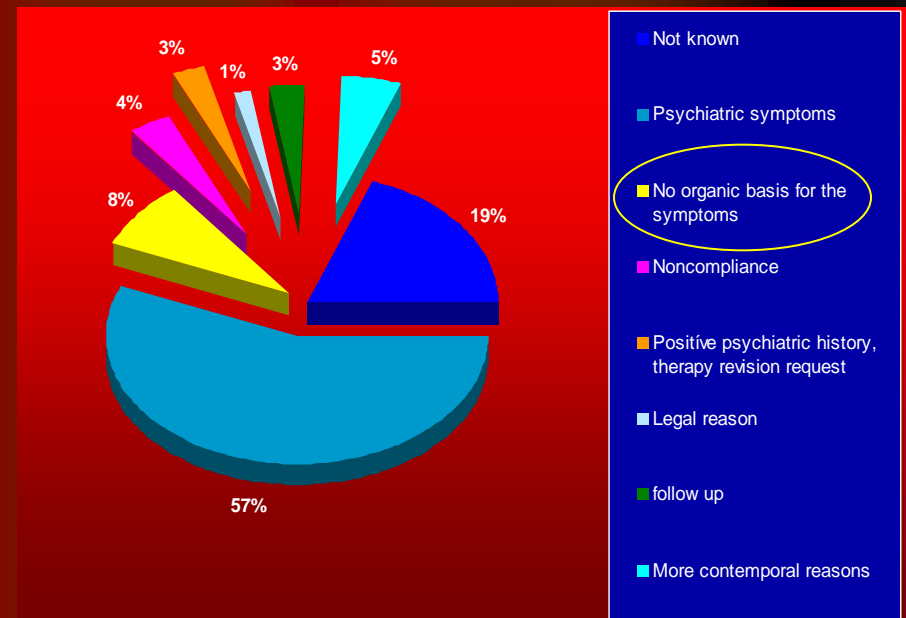
Common psychiatric symptoms as reasons for consultation

(in hierarchical order)

- Depressed mood
- Agitation
- Disorientation
- Hallucinations
- Anxiety
- Sleep disorder
- Suicide attempt or threat
- Behavioural disturbance

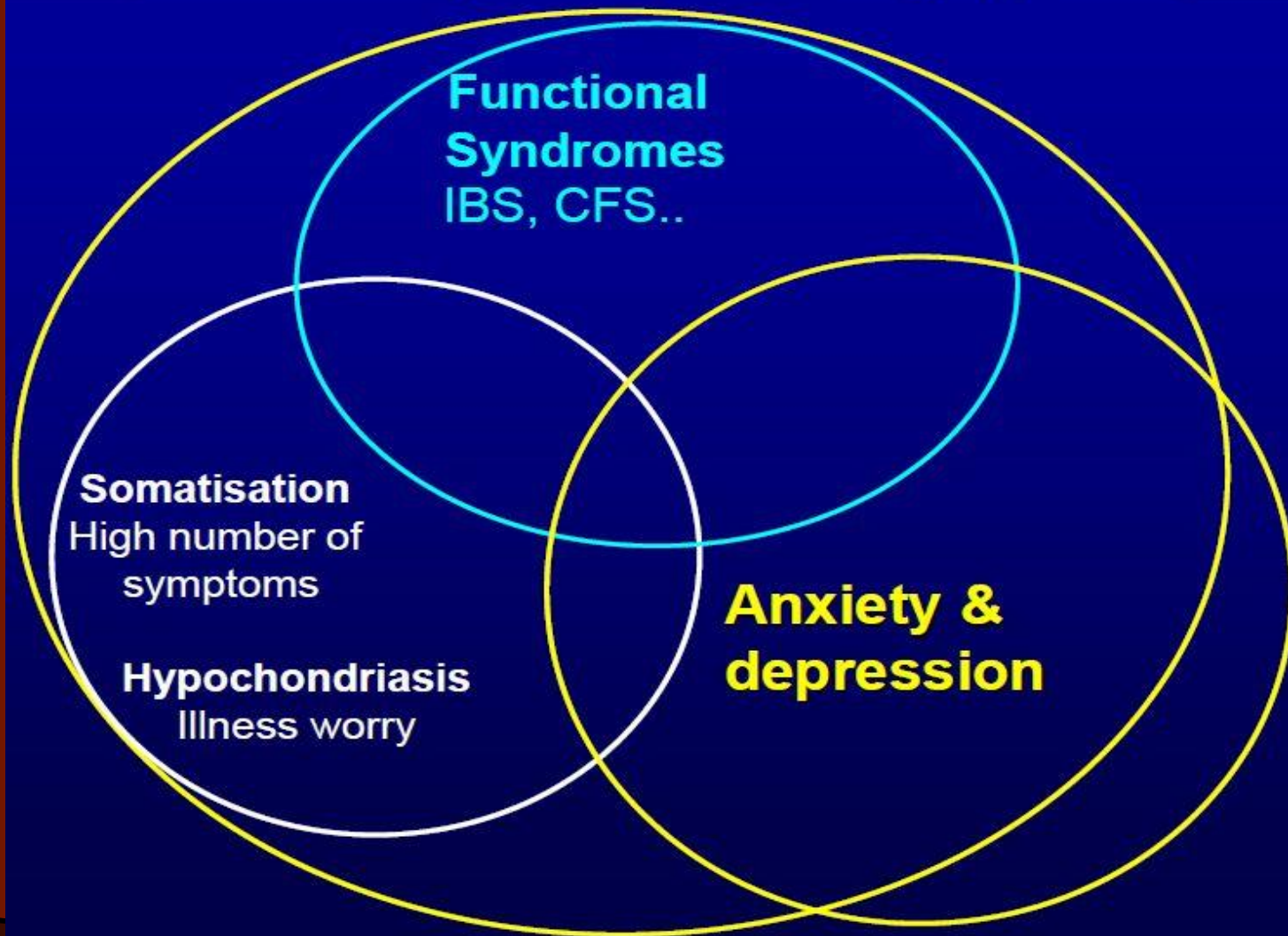
Prevalence of cases with no organic basis for the symptoms (also called MUS) (only 8% in our C-L sample)

- Medically Unexplained Symptoms are a common reason for attending a physician
- Prevalence of MUS is:
 - 15-25% in primary care
 - 39-52% in specialist clinics
 - > 60% in neurology(Van Hemert et al., 1993; Hamilton et al., 1996; Nimnuan et al., 2001; Reid et al., 2001; Kirmayer et al., 2004; Fiddler et al., 2004; Kooimanet al., 2004)



Underlying syndromes:

Medically Unexplained symptoms



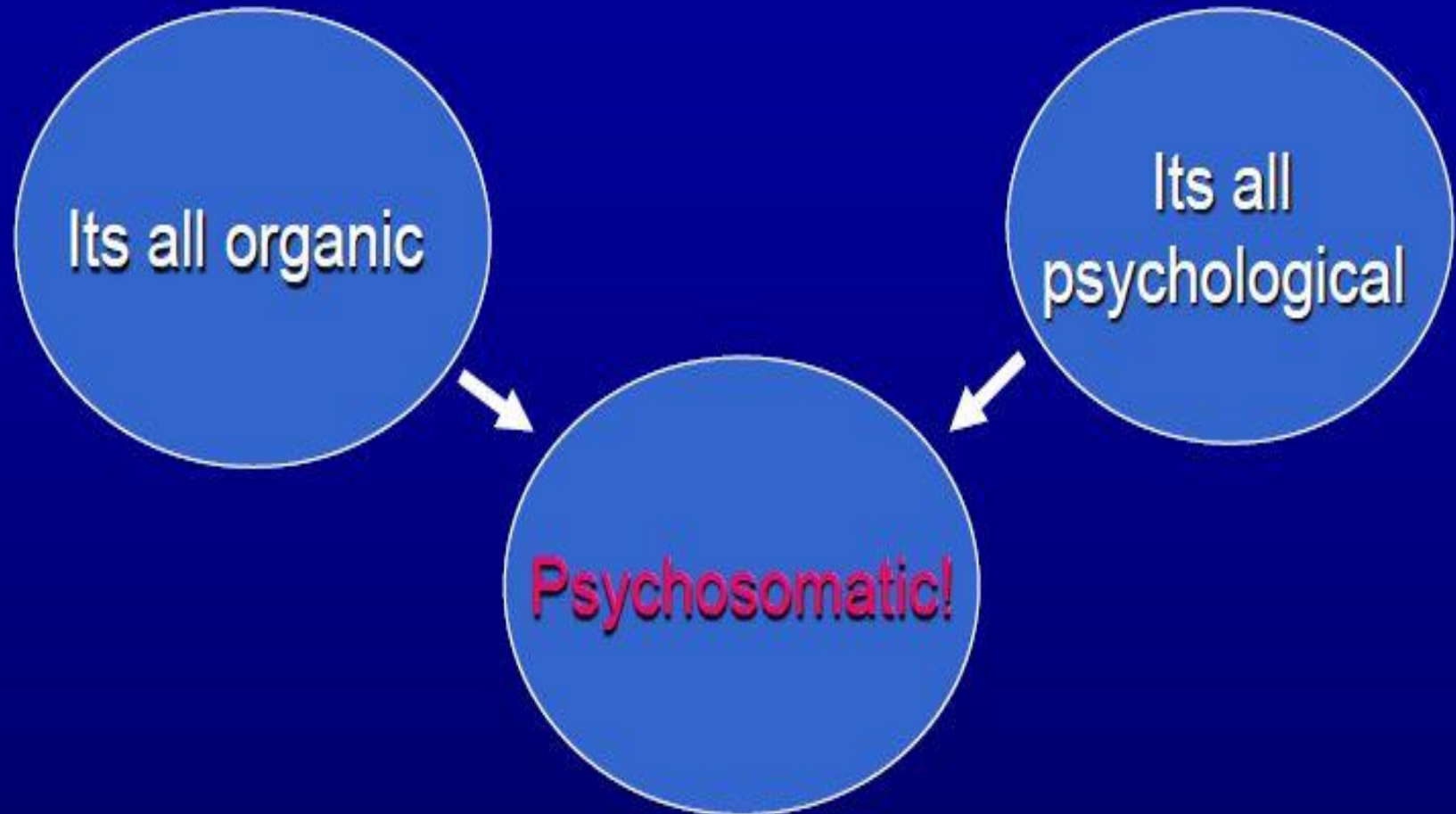
Critical comments

(Creed et al. and Voigt et al., Psychosom Res, 2010)

- Negative definition – defines group by what it is not.
- We should move away from the 'either/or' notion – that symptoms are either due to organic disease or psychological abnormalities.

Suggestion:

(Creed et al., Psychosom Res, 2010) :



DSM 5: Somatic Symptom Disorder

(formerly somatization disorder, hypochondriasis with somatic symptoms, pain & undifferentiated somatoform disorders)

A. Somatic Symptoms: One or more somatic symptoms that are distressing and/or result in significant disruption in daily life.

B. One or more of: Excessive **thoughts, feelings,** and/or **behaviors** related to these somatic symptoms or associated health concerns:

- 1) Disproportionate and persistent thoughts about the seriousness of one's symptoms
- 2) Persistently high level of anxiety about health or symptoms
- 3) Excessive time and energy devoted to these symptoms or health concern

C. Chronicity: Although any one symptom may not be continuously present, the state of being symptomatic is persistent and lasts > 6 months.

Testing diagnostic validity: Field Trial Results

Prevalence when 1 somatic symptom + 1 psychological symptom + 6 month duration was required:

- 7% of healthy individuals
- 15% of the medical illness group (cancer or coronary heart disease)
- 26% of the “Functional Somatic Syndrome” (IBS, FM) group were coded for SSD.

Somatic Symptom Disorder Concerns

Millions of people will now meet criteria for a mental health condition.

- Is this valid?
- If it is, do we have resources to offer them all treatment?
- Would it be better to have more stringent criteria so that only the most severely affected were identified?

Aetiological factors of MUS

- Childhood experience
 - Lack of parental care
 - Physical illness triggers care and attention, which otherwise he/she would not receive
- Lack of social support
- Family re-inforcement
 - Over-solicitous care
- Iatrogenic causes

Iatrogenic causes

- Medicalisation of pt's symptoms
 - Over-investigation
 - Important: the level of certainty physician wants to reach - influenced by the patient's anxiety
 - doctors task is to confirm diseases and not health (!)
 - Inappropriate treatment
 - Especially by junior doctors
 - Failure to provide clear explanation for symptoms
 - Increasing uncertainty and anxiety
 - Failure to recognise and treat emotional factors

(undesirable) Consequences of MUS

- Unnecessary use of healthcare
 - Over-investigation
 - Unnecessary admissions for treatment / operations
 - Often making matters worse
- Prescribed drug misuse and dependence (pain killers, anxiolytics)
- Disability and loss of earnings
 - Increasing social disability payments
- Poor quality of life
 - Impact on family / social network

Approach to management

- Rule out organic disease
 - Explore overlaying psychological elements
- Establish degree of insight
 - Extent to which the patient recognises psychological basis for the problems
 - Extent to which the patient 'wants out'
- Perform psychiatric evaluation
- Determine the appropriate programme
 - Physical / psychiatric / psychological / both (interdisciplinary approach)

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The "formal" consultant

- Works in a the traditional psychiatric setting, starts, and arrives back there

The liaison psychiatrist

Works on the "Terra incognita" field between somatic and psychiatric care.

The "formal" consultant

- Set up the diagnose
- Treat
- Act as a dispatcher

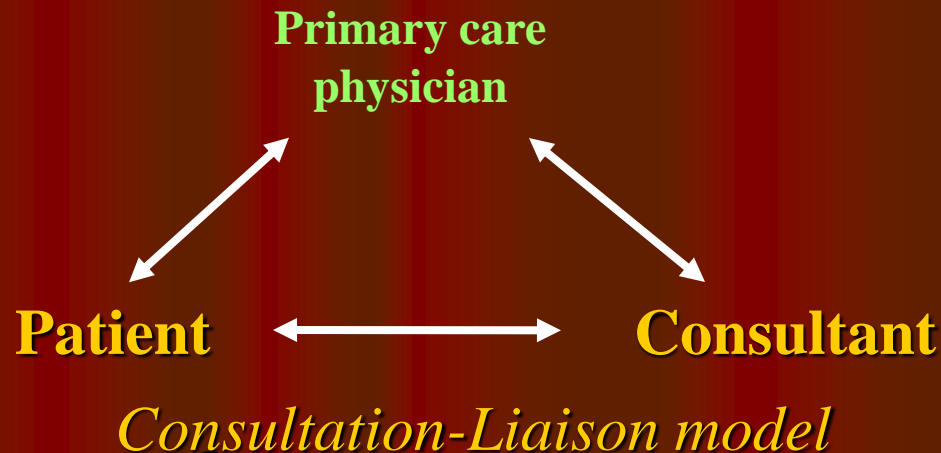
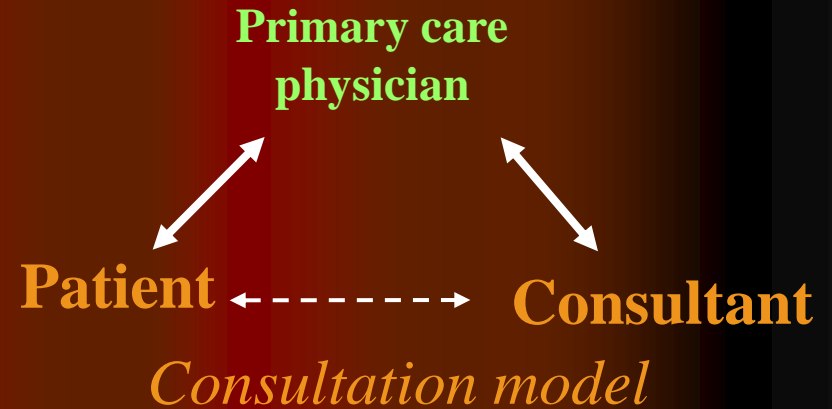
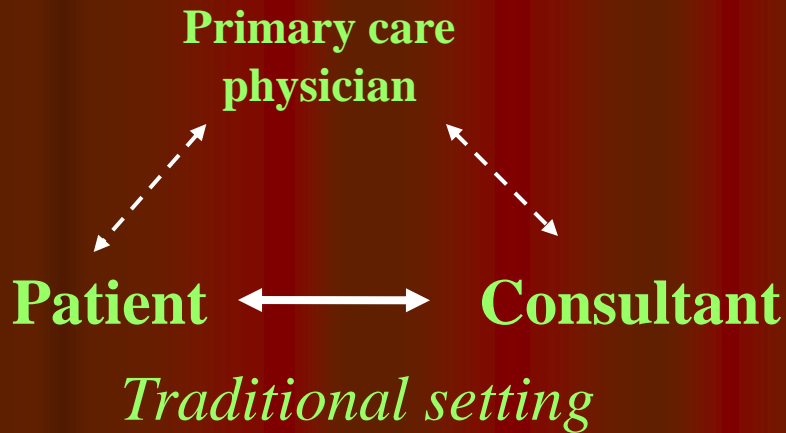
- **The "liberating troop"**

The Liaison psychiatrist

- **Consultation**
 - – physician centred
- **Liaison**
 - – team centred

- **Member of the team**

Patterns of liaisons



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What is Therapeutic Alliance?

- The readiness of a patient to work with energy with a willing psychotherapist.
- It has not commonly applied to the type of brief encounter experience by the consultation-liaison psychiatrist in hospital setting. Nonetheless, insofar as the consulting psychiatrist fosters hope and expectation in patients seen in that context, however brief the contact, the relationship (alliance) has the capacity to promote maturation and well-being in any patient.
- The psychiatric consultant makes use of all the principals of good psychotherapy although they are often modified to accommodate the realities of the hospital setting and the unusual way in which psychiatrist and patient are brought together.

Nine behaviors,
“do’s”, that enhance therapeutic
alliance (Yager J)

I. Sit Down.

- Sitting reduces the status difference between doctor and patient and the likelihood that the Pt will perceive the MD to be assuming a lordly demeanor and also conveys to the patient that the doctor has some time to spend with them.
- Introduce yourself.
- State the reason for the visit (the customer is the referring physician).

II. Do something tangible for the patient.

- Be helpful in small ways, do what a good nurse will do, ask the patient if he is comfortable.
- Increase the comfort of the patient.

III. Touch the Patient

- The physical intimacy of touch is helpful with a frightened, dependant, and/or very physically ill patient and conveys a human caring that can reduce the feeling of aloneness and alienation in dehumanizing medical environments.
- Handshake, hold patient's hand, touch patient's shoulder
- The least touched patients?

IV. Smile

- Reduces interpersonal distance
- Decreases sense of threat
- Has a disarming effect
- Must be culturally acceptable

V. Begin by telling the patient what you know about his/her situation.

- Ask the patient to correct you.
- The positive effects
 - * Patient does not have to go through the information again.
 - * Helps to get feed-back from Patient.
 - * Patient can assess the level of the consultants understanding and concern.

VI. Ask the patient what his/her most pressing concerns of the moment are.

- The patient's preoccupation with major fear or concern needs to be cleared to have the patient's full attention and cooperation.
- Clears the air so the necessary information can be used more effectively.

VII. Ask in detail about the patient's belief system regarding the nature, cause and prognosis of the illness or injury, and about the patient's specific concerns about pain, disability or death.

- Tune into the patient's perspective and expectations of what the patient is confronting.
- Correct misimpressions and provide education.
(facilitate cooperation with medical stuff)

VIII. Ask in detail about the patient's family major social roles such as occupation, and the impact of the current illness or injury on those relationships and roles.

- The patient is concerned about the negative consequences of the illness on loved ones and on the ability to maintain major social role functions in family, work and community.

IX. Acknowledge the situation in which the patient finds him/herself.

- The physician should tell the patient that faced with similar circumstances, the physician might well display similar psychological difficulties.

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The Consultation note

- Is best if **brief and focused** on the referring physician's concerns with attention to all domains.
- Avoid using **jargons or other wording** that is likely to be unfamiliar to other physicians.
- The note needs to be titled with mention **"Psychiatry" and "Consultation"** .
- The history of present illness should include the relevant data from the history that may have **significance**
- The consultant's objective findings on mental status
- The formulation, diagnosis, recommendations should be written **concisely**.

Diagnosis

- The consultant should organize the diagnosis section according to **ICD-10 (in Hungary)**.
- Differential diagnoses should be also listed.
- Relevant somatic illnesses should be mentioned.

Diagnostic Testing and Consultation

- The C-L consultant must be familiar with diagnostic testing regarding:
 - The indications for anatomic brain imaging or neurophysiological screening by **CT, MRI, EEG**, etc.
 - The indications for the administration of psychological testing (cognitive functions, personality traits)

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INTERVENTIONS

- **Psychotherapy** (a dream in Hungary):
 - The modality introduced should be primarily selected in response to the patient's needs.
 - No single psychotherapeutic modality will be effective with all patients, at all times, in the medical setting.

INTERVENTIONS

- **Pharmacotherapy and Other Somatic Therapies**

- **35%** of psychiatric consultations include recommendations for medications.
- About **10%–15%** of patients require reduction or discontinuation of psychotropic medications.
- Appropriate use of psychopharmacology necessitates a careful consideration of the underlying **medical illness, drug interactions, and contraindications.**

Pharmacotherapy and Other Somatic Therapies

- Pharmacotherapy of the medically ill often involves modification in dosage because of **liver, kidney, or cardiac disease**, or because of potential for **multiple drug–drug interactions**.
- Pregnancy presents another challenge, with concerns regarding potential **teratogenicity**.
- The C-L psychiatrist must be knowledgeable about electroconvulsive therapy (ECT)

Follow-Up

- The scope, frequency, and necessity of follow-up visits depend on the **nature of the initial diagnosis and recommendations**.
- Follow-up visits **reinforce** the consultant's recommendations and allow the consultant to **evaluate results of recommendations**
- **Prevent breakdowns in communication** between consultants and consultees.

Follow-Up

- At least daily follow-up should be considered for several types of patients:
- Those in:
 - restraints
 - potentially violent, or suicidal
 - delirious, agitated or psychotic
 - or psychiatrically unstable.
- Acutely ill patients started on psychoactive medications should be seen daily until they have been stabilized.

Thank you for your
attention!