Consultation and liaison psychiatry

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Consultation-Liaison Psychiatric Service

Definition

- Consultation-Liaison Psychiatry is a sub-specialty of psychiatry that incorporates clinical service, teaching, and research at the borderland of psychiatry and medicine.

  (Lipowski, 1983)

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.

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 St. 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.

History of Consultation – Liaison Psychiatry

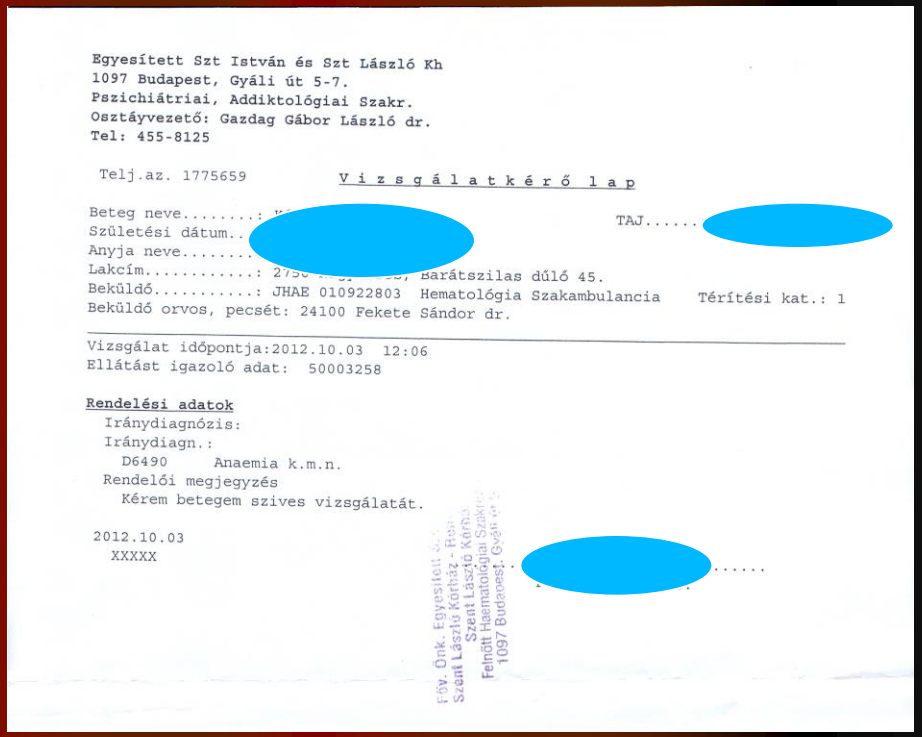
- Its early origins reflect the emergence of General Hospital Psychiatry.
- In the 1920s psychiatry became closer to medicine as hospitals started to establish psychiatric units .
- The concept of psychosomatic relationships and the role of emotions and psychological states in the genesis and maintenance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

Characteristics of psychosomatic medicine

- 1) Studies the correlations of psychological and social phenomena with physiological functions
- 2) Focuses on the interplay of biological and psychosocial factors in the development, course and outcome of all diseases.
- 3) Advocates the biopsychosocial approach to patient care.

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

1. Talks with the referring physician, nursing and other staff before and after consultation. Clarifying the reason for the consultation is the initial goal (not an easy job sometimes).
2. Establishes the level of urgency.



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Osztályvezető: Gazdag Gábor László dr.
Tel: 455-8125

Telj.az. 1775659 **Vizsgálatkérő lap**

Beteg neve.....: [redacted] TAJ..... [redacted]
Születési dátum..
Anyja neve.....
Lakcím.....: 2750 [redacted], Barátszilas dűlő 45.
Beküldő.....: JHAE 010922803 Hematológia Szakambulancia Térítési kat.: 1
Beküldő orvos, pecsét: 24100 Fekete Sándor dr.

Vizsgálat időpontja:2012.10.03 12:06
Ellátást igazoló adat: 50003258

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

2012.10.03
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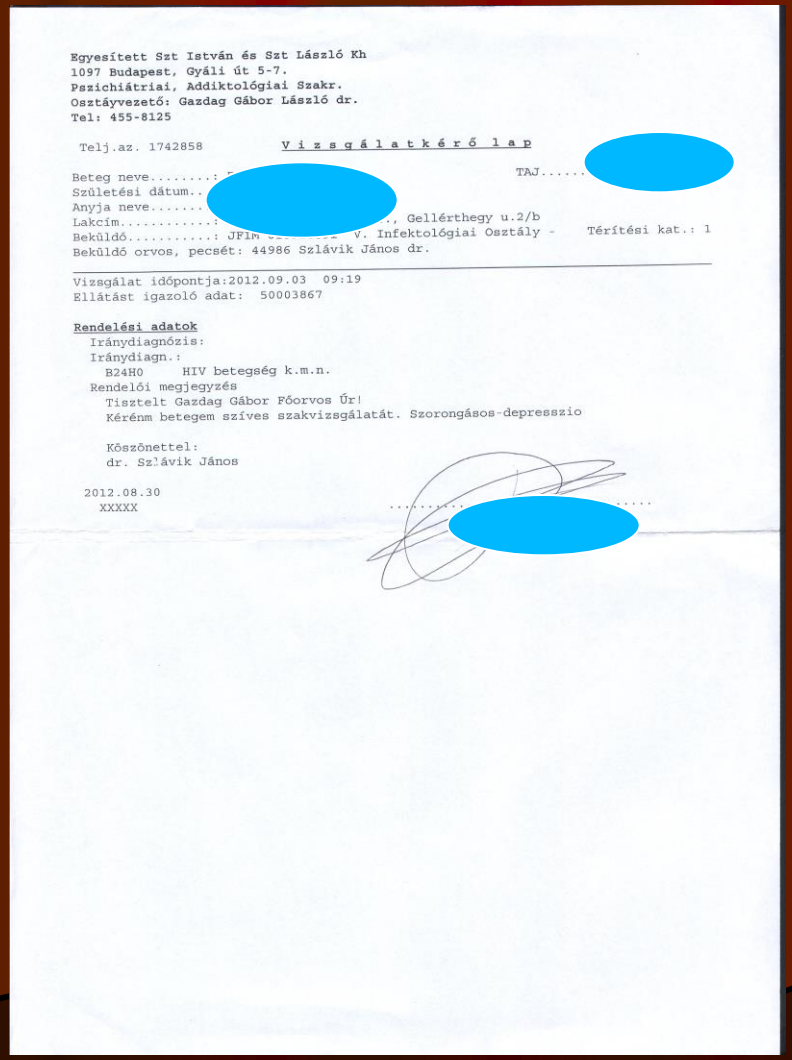
[redacted]

Főv. Önk. Egyesített Sz.
Szent László Kórház - Ren.
Szent László Kórház
Felnőtt Haematológiai Szakr.
1097 Budapest, Gyáli út 5-7.

Examples for referrals



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Osztályvezető: Gazdag Gábor László dr.
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Telj.az. 1742858 **V i z s g á l a t k é r ő l a p**

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Születési dátum..[redacted]
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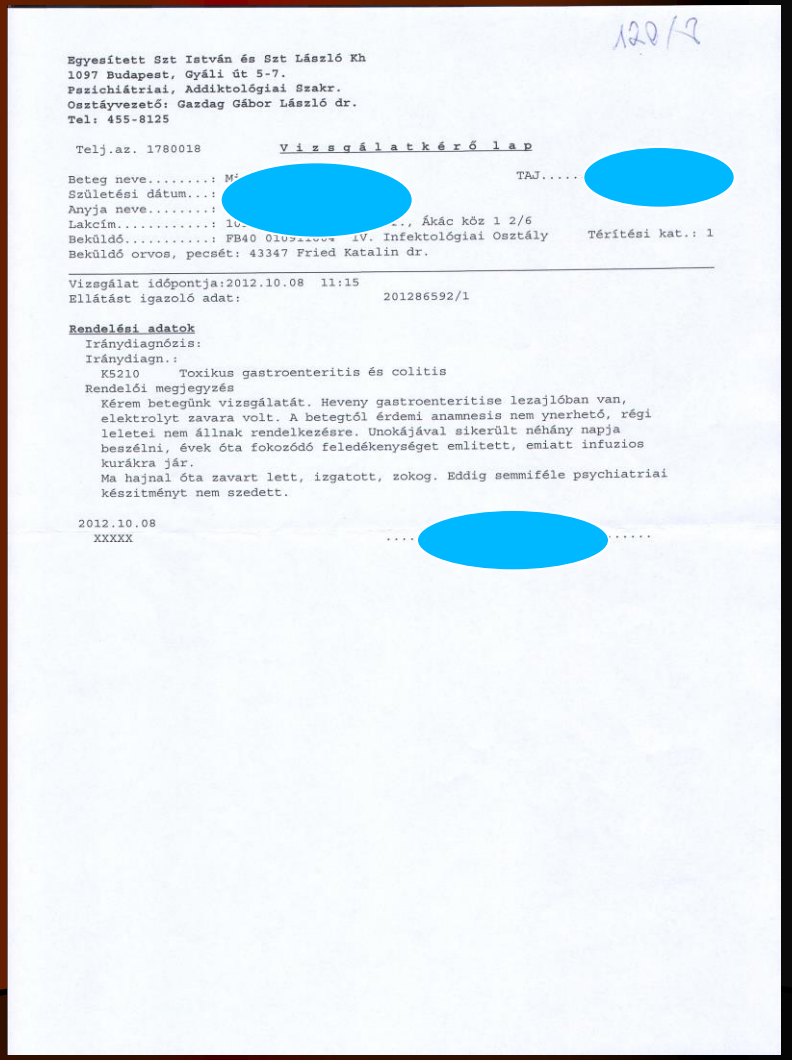
Lakcím.....[redacted], Gellérthegy u.2/b
Beküldő.....: JFIM [redacted] v. Infektológiai Osztály - Térítési kat.: 1
Beküldő orvos, pecsét: 44986 Szlávik János dr.

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

Rendelési adatok
Iránydiagnózis:
Iránydiagn.:
B24H0 HIV betegség k.m.n.
Rendelői megjegyzés
Tisztelt Gazdag Gábor Főorvos Úr!
Kérénm betegem szíves szakvizsgálatát. Szorongásos-depresszio

Köszönettel:
dr. Szlávik János

2012.08.30
XXXXX .....[redacted]



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Osztályvezető: Gazdag Gábor László dr.
Tel: 455-8125

Telj.az. 1780018 **V i z s g á l a t k é r ő l a p**

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Anyja neve.....:[redacted]
Lakcím.....: 10[redacted], Ákác köz 1 2/6
Beküldő.....: FB40 [redacted] 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:
Iránydiagn.:
K5210 Toxikus gastroenteritis és colitis
Rendelői megjegyzés
Kérem betegünk vizsgálatát. Heveny gastroenteritise lezajlóban van, elektrolyt zavara volt. A betegtől érdemi anamnesis nem ynerhető, régi leletei nem állnak rendelkezésre. Unokájával sikerült néhány napja beszélni, évek óta fokozódó feledékenységet emlitett, emiatt infuzios kurákra jár.
Ma hajnal óta zavart lett, izgatott, zokog. Eddig semmiféle psychiatriai készitményt nem szedett.

2012.10.08
XXXXX ....[redacted]

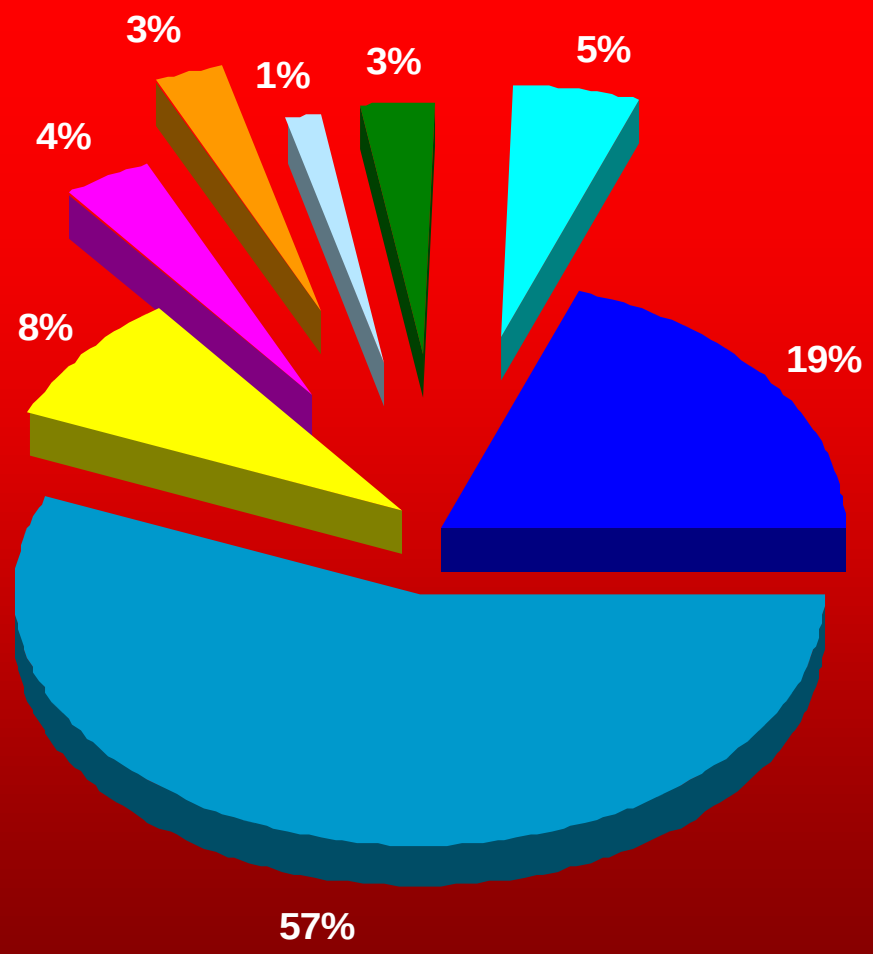
ASSESSMENT

- The consultant should establish the URGENCY of the consultation (i.e., emergency or routine—within 24 hours).
- Commonly, requests for psychiatric consultation fall into several general categories:
- 1. Evaluation of a patient with suspected psychiatric
- disorder, a psychiatric history, or use of psychotropic medications.
- 2. Evaluation of a patient who is acutely agitated.

Requests for psychiatric consultation

- **3. Evaluation of a patient who expresses suicidal or homicidal ideation.**
- **4. Evaluation of a patient who is at high risk for psychiatric problems by virtue of serious medical illness.**
- **5. Evaluation of a patient who requests to see a psychiatrist.**
- **6. Evaluation of a patient with a medicolegal situation (capacity to consent)**
- **7. Evaluation of a patient with known or suspected substance abuse.**

Reasons for referral (own data)



Common psychiatric symptoms as reasons for consultation

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

No organic basis for symptoms (8%)

- Conversion disorder: different neurologic symptoms(anesthesia, paresthesia, seizures, etc) with autonomic nervous system symptoms
- **Somatization disorder** (Briquet sy): multiple body complaints
- Factitious disorder: wish to be hospitalized (wish for attention)-provoking physical symptoms (e.g. fever, hypoglycaemia)
- Malingering: obvious secondary gain (compensation case)

Prevalence of somatization

- Medically unexplained symptoms
  - Common in community samples
    - General practice / New out-pt referrals
      - Up to 40% have symptoms for which no organic cause is identified
    - 'Much less common' in in-pt samples (8%)
  - Majority of patients can be reassured
    - Minority persist or develop other symptoms
      - Strong association between number of somatic symptoms reported and likelihood of underlying mental illness

Aetiological factors

- Childhood experience
  - Lack of parental care
    - Physical illness triggers care and attention which otherwise they would not receive
- Lack of social support
- Family re-inforcement
  - Over-solicitous care or ‘helpful advice’
- Iatrogenic causes

Iatrogenic causes

- Medicalisation of pt's symptoms
  - Over-investigation
  - Inappropriate treatment
    - Especially by junior doctors
  - Failure to provide clear explanation for symptoms
    - Increasing uncertainty and anxiety
  - Failure to recognise and treat emotional factors

Consequences of somatisation

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

Functional somatic syndromes

Gastroenterology	Irritable Bowel Syndrome
	Functional dyspepsia
Cardiology	Atypical chest pain
Neurology	Common Headache
	Chronic fatigue syndrome
Rheumatology	Fibromyalgia
	Complex regional pain syndromes (Reflex sympathetic dystrophy)
Gynaecology	Chronic pelvic pain
Orthopaedics	Chronic back pain

Approach to management

- Identify features of organic disease
  - 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'
- Determine the appropriate programme
  - Physical / psychological / both

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 as indicated.
- 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. Has the knowledge to prescribe psychotropic drugs and be aware of their interactions (with somatic therapies).
- 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. Respects patient's rights to know 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. Arranges out-patient care-if necessary.
- 14. Does not take over the aspects of the patient's medical care unless asked to do so.
- 15. Follows advances in the other medical fields and is not isolated from the rest of the medical community.

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

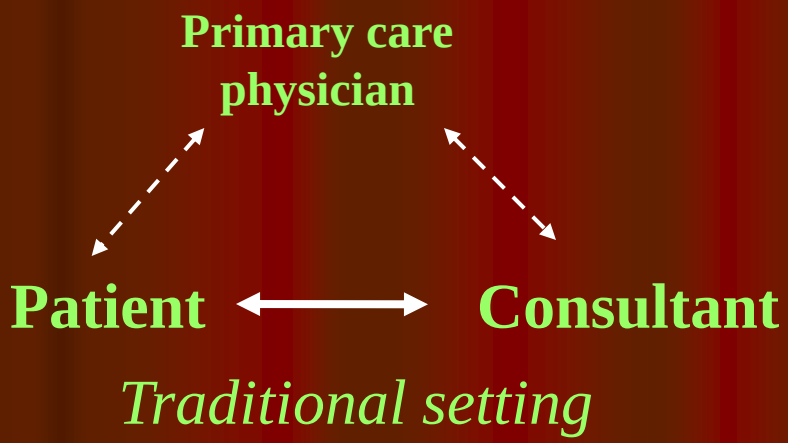
- **The "liberating troop"**

The Liaison psychiatrist

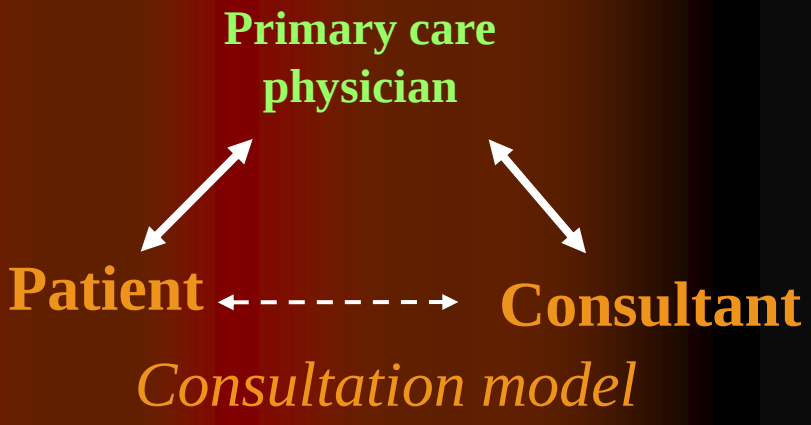
- Consultation
  - – patient centred
- Liaison
  - – team centred

- **Member of the team**

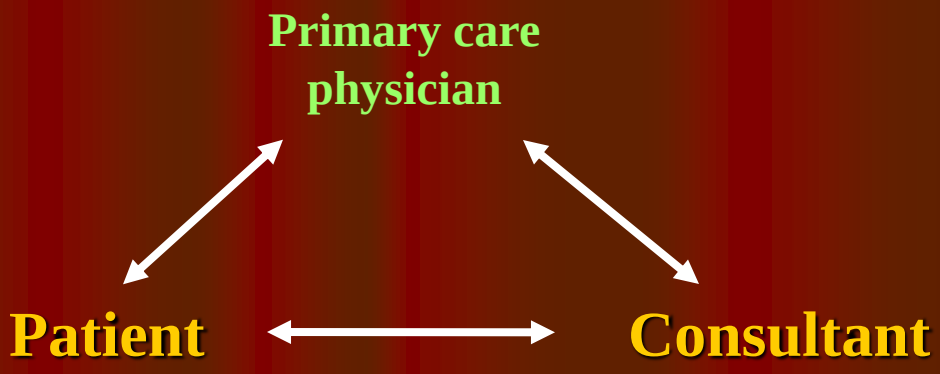
Patterns of liaisons



Traditional setting



Consultation model



Consultation-Liaison model

Psychiatric disorders in the medical setting

- As many as 30% of patients have a psychiatric disorder.
- 2/3 of patients who are high users of medical care have a psychiatric disturbance.
- Delirium is detected in 10% of all medical in-patients & in over 30% in some high risk groups (e.g. in ICU).
- The presence of a psychiatric disturbance is associated with increased hospital length of stay OR an increased medical readmission rate.

Psychiatric disorders in the medical setting

- **Only a small subset of patients is currently being identified.**
- **The percentage of patients receiving psychiatric consultation varies from 1% to 10%.**
- **There is a great disparity between the amount of psychiatric pathology that exists in the medical setting and that which is identified by medical staff.**

Psychiatric diff diagnoses in medical settings

- **Psychiatric presentations of medical conditions**
- **Psychiatric complications of medical conditions or treatments**
- **Psychological reactions to medical conditions or treatments**
- **Medical presentations of psychiatric conditions**
- **Medical complications of Psychiatric conditions or treatments**
- **Comobid Medical and Psychiatric conditions**

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 the **DSM-IV's multiaxial guideline (or ICD-10 in Hungary).**
- Axis I or II diagnosis **cannot always** be made at the time of the initial consultation.
- Only the one or two central medical diagnoses should be included on Axis III
- Significant medical and psychological stressors can be noted and documented on Axis IV.
- Axes IV and V may be omitted if the consultant feels they will not be useful or familiar to the consultee.

DSM-IV axes

- Axis I: Clinical disorders, including major mental disorders, and learning disorders
- Axis II: Personality disorders and mental retardation
- Axis III: Acute medical conditions and physical disorders
- Axis IV: Psychosocial and environmental factors contributing to the disorder
- Axis V: Global assessment of functioning

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)**

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
- Prioritize relative importance of particular interventions
- 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**
- **Agitated, potentially violent, or suicidal**
- **Delirium**
- **Psychotic or psychiatrically unstable.**
- **Acutely ill patients started on psychoactive medications should be seen daily until they have been stabilized.**

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.**

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 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.

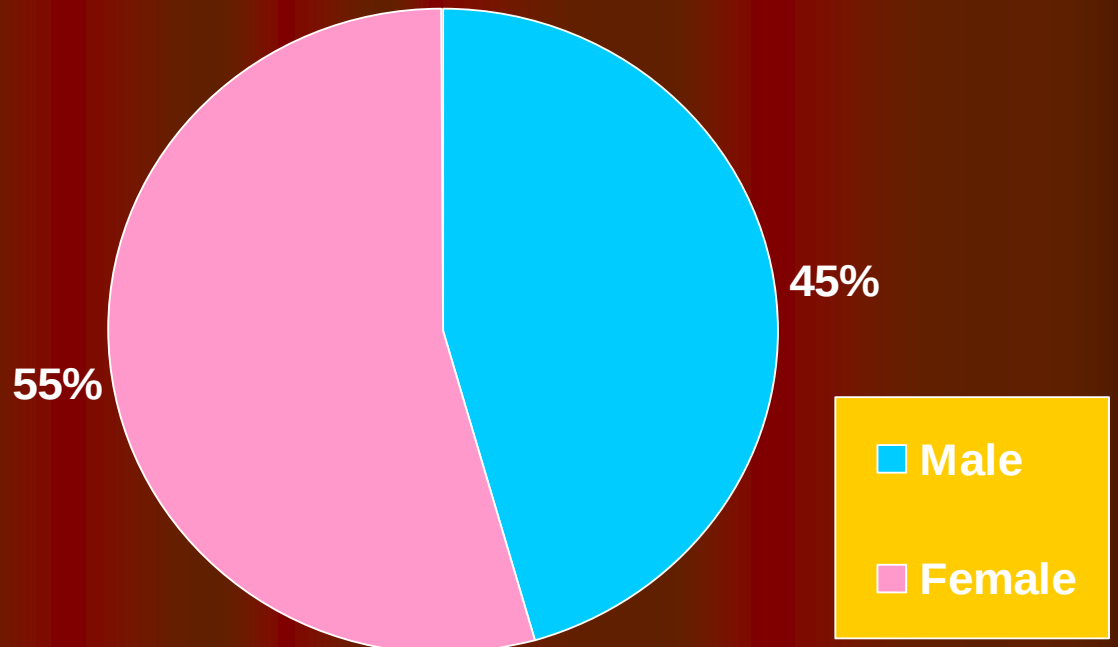
- The C-L psychiatrist must be knowledgeable about electroconvulsive therapy (ECT)

Important field of C-L activity 1: Noncompliance

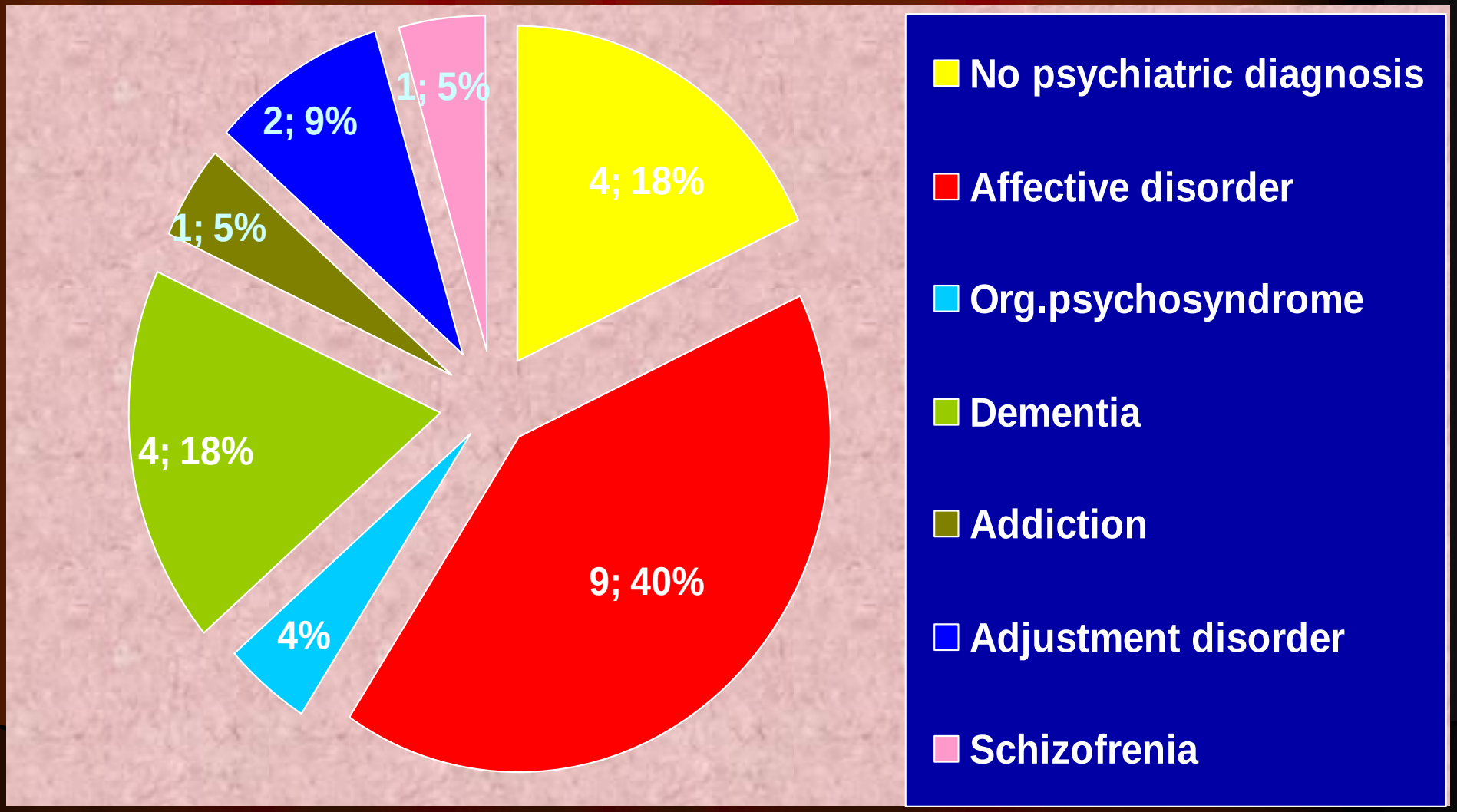
- Causes:
- Negative transference between patient and primary care doctor
- Fear of medication or procedure
- Impaired cognitive capacity

Noncompliance study
(retrospective chart review)

- 1020 consultations between 11/99 and 11/04.
- In 22 cases the reason of the consultation was: noncompliance (2.2%)



Psychiatric syndromes behind noncompliance



Conclusions

- In patients with chronic illness
  - Illness behavior frequently negative (ambivalence, psychosocial factors)
  - Noncompliance can result rapid somatic deterioration (DM) that can result hospital admission
  - Noncompliance can be a symptom of a hidden psychiatric disorder

Important field of C-L activity 2: delirium

- Delirium is COMMON
- Symptoms are alarming
- 10-15% of patients on surgical ward and 15-25% on general ward experience episode of delirium during hospital stay.
- 30-40% of hospitalized patients over age 65 have had an episode of delirium.
- 30%-90% patient in ICU experience delirium.

- Kaplan & Sadock's Synopsis of Psychiatry. 8th Ed. Philadelphia, PA, 1998.
- Liatker, D., Locala, J., Franco, K, Bronson, DL, Tannous, Z. Preoperative risk factors for postoperative delirium. Gen Hosp Psychiatry. 2001; 23:84-89.

Definition of Delirium

A. Disturbance of consciousness
B. Change in cognition
C. Develops over a short period of time (usually hours to days). Tends to fluctuate during the course of the day.
D. There is evidence from history, physical exam, or laboratory findings that the disturbance ***is caused by*** the direct physiological consequences of ***a general medical condition, Substance Intoxication or Withdrawal, use of a medication, or toxin exposure***, or a combination of these factors.

- DSM-IV-TR, 2000

Associated Features

- Psychomotor disturbance
- Agitation (related to disorientation or confusion)
- Apathy and Withdrawal
- Emotional disturbances and instability
- Sleep Impairment

- Merck Manual of Geriatrics

Course

- Symptoms usually develop over hours or days
- In some they begin abruptly (e.g. after head injury)
- More typically, prodromal syndromes such as restlessness, anxiety, irritability, disorientation, distractibility, sleep disturbance progress to full-blown delirium within a 1-3 day period.
- May resolved in few hours to days or may persist for weeks to months, part in elderly or people with pre-existing dementia.
- Duration largely controlled by course of underling condition Symptoms of delirium typically become most severe at night.

- DSM-IV-TR, 2000
- Casey et al. Delirium: Quick recognition, careful evaluation, and appropriate treatment. Postgraduate Medicine, 1996, 100(1).

Risk Factors

- Advanced age
- Young age (children)
- Underlying brain disease such as dementia, stroke or Parkinson's
- Multiple severe, acute or unstable medical problems
- Polypharmacy
- Infection
- Alcohol dependence
- Sensory impairment
- Malnutrition
- History of delirium
- Low levels of social interaction

Prognosis better if…

- Underlying etiological factor is promptly corrected.
- Patient has better pre-morbid cognitive and physical function.
- Patient has NOT had previous episode of delirium.

Elderly Patients

- Persistent cognitive deficits common in elderly suffering from delirium.
- These deficits can be due to a pre-existing dementia that was not fully appreciated.
- Delirium may be the only indication of acute illness in older patients suffering from dementia.

Diagnosis: Delirium

- WHAT IS CAUSING IT?

I WATCH DEATH (acronym)

- I Infection (pneumonias, UTI, sepsis, cellulitis, menigitis, encepalitis, syphilis)
- W ithdrawal (bezos, alcohol, sedative-hypnotics)
- A cute metabolic (electrolytes, acidosis, renal failure, abnormal glycemic control, pancreatitis,)
- T rauma (head injury, pain, fracture, burns)

I WATCH DEATH

- C NS pathology (tumor, AVM, encephalitis, abscess, normal pressure hydrocephalus, seizures, stroke)
- H ypoxia from COPD exacerbation, anemia,
- carbon monoxide poisoning, cardiac failure
- D eficiencies (B-12, folate, water)
- E ndocrine (thyroid, cortisol, cancer, hyper or hypoglycemia)
- A cute vascular (MI, stroke, intracerebral bleed)
- T oxins or drugs (medications, pesticides, solvents)
- H eavy metals (lead, mercury)

Important field of C-L activity 3: dementia

- Aim of our survey conducted in geriatric inpatient population:
- To asses comorbide psychiatric syndroms in geriatric patients who are admitted to internal medicine wards
- To asses the impact of the cognitive deterioration on the length of hospital stay

Results: dementia – length of hospital stay

Cognitive function (MMMS points)	Number of patients (n=83)	**Mean length of hospital stay (LOS)**
Cognitive deterioration is possible (MMMS; ≥ 85 pont)	34 (41%)	12,4 days
Detectable cognitive deterioration (75-84 point)	14 (17%)	14,7 days
Moderate cognitive deterioration (60-74 point)	21 (25%)	15,3 days
Severe deterioration (59 pont ≥)	14 (17%)	**19,8 days**

Other important fields of C-L activity

- Transplantation medicine (Bone marrow, heart and lung, liver, kidney, living donations)
- Oncology
- Legal issues (competency)
- HCV, HIV, AIDS
- Addictions

Cost-Effectiveness of CLP

- **Studies have repeatedly demonstrated that C-L service can significantly lower health care cost and at the same time improve the quality of medical care of medically ill patients with psychiatric symptoms.**

- **There is a significant association between psychiatric or psychological AND medical comorbidity and increased length of stay.**

- **Early detection and treatment may significantly decrease LOS and the expenditure of medical resources**

Thank you for your attention!