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Overview

Efficaciousness of Consultation Liaison Services in Psychiatry: A Brief Overview

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ABSTRACT

Consultation Liaison psychiatry (CLP) can be considered a landmark developmental milestone that has remarkably changed the face of psychiatry practice. With an increasing number of general hospital psychiatric units, mental health issues have been brought much closer to general health care and community. The purpose of the study has to explore about CLP Services in Psychiatry. The literature for this has been searched through electronic databases like Pubmed and Google Scholar as well as through manual searches. CLP has contributed significantly to the growth of the psychiatry and has brought psychiatry very close to the advances in the medicine. Medical students who do a rotation in consultation-liaison psychiatry can learn about different psychiatric manifestations of medical illness and their treatments and about care for medically ill patients who have psychiatric disorders.

Keywords: *Psychiatry, Liaison, Treatment, Medical Illness, Training, Community*

Liaison psychiatry is the specialty of psychiatry that deals with this relationship, and the link between people's physical and mental health. CLP as a subspecialty of psychiatry that involves providing clinical service, teaching and carrying out research at the borderland of psychiatry and medicine (Lipowski,1983). CLP is a subspecialty of psychiatry that provides assessment and treatment for general hospital patients with mental health comorbidities Physical illnesses of any kind are often associated with significant emotional and social consequences for both patients and the caregivers (Whiteford et al 2010). People with comorbidity of any mental health and physical illness were significantly more likely to be hospitalized than people with only a mental health condition, or only a physical illness (Australian Institute of Health and Welfare, 2012). Medical psychiatric comorbidity is linked to increased length of hospital stay, higher medical costs and often hospitalization (Jansen et al, 2018). It also provides teaching and research activities on mental health comorbidity to medical staff of non-psychiatric departments of general hospitals (Lipowski, 1971). It has brought psychiatry out of the mental asylums to the general hospitals and has also contributed significantly to the reduction of stigma that follows mental illness not only among members of the public but within the medical professionals and establishments also (Grover, 2011).

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Historical Background of CLP:
The clinical aspect of psychosomatic medicine, that is, CLP made a beginning in the early part of the 20th century, with the opening of the first viable general hospital psychiatric unit (GHPU) at the Albany Hospital in 1902 by JM Mosher. The basic aim of opening of the GHPU was to bring mental health professionals into close proximity with other specialists in medicine for the purposes of training and providing psychiatric care (Lipsitt,2001). The term "liaison psychiatry" was probably first used by Billings in 1930 (Parkar SR, Dawani,2001). From Indian perspective, Prior to 1930, mental health services in this country were confined to the mental hospitals. The C-L Psychiatry as a subspecialty started in 1930s with the establishment of general hospital psychiatric units (GHPUs). Dr. Girindra Shekhar at R.G. Kar Medical College and Hospital, Calcutta started the first GHPU in 1933 ((Parkar SR, Dawani,2001)). Till 1960 there were few GHPUs that were initially established in collaboration with Department of Neurology and were often called as neuropsychiatric clinics. However, 1960s saw a major rise in number of GHPUs and by late 60s-early 70s there were 90 GHPUs (Menon,2005). All India Institute of Medical Sciences was the first GHPU unit. When one compares this growth of C-L Psychiatry in India with worldwide development, the 2 rapid growth of C-L Psychiatry services in India coincided with that of development of the subspecialty in other parts of the world ((Menon,2005).

Needs of CLP Services:
Recognition of a psychiatric illness in general wards by the physician and surgeons remain difficult for various reasons which includes patients may not provide any cue, the cues are not picked up by the treating team, patients lack privacy to discuss, treating team doesn’t look beyond organic cause and at times, they may remain reluctant for psychiatric referral despite doubting for presence of a psychiatric disorder (Goldberg,1985). When inpatients of other departments are screened for mental disorders, psychiatric morbidity is found in 31-34.5% of the patients and 18.42%–53.7% of patients seen in various outpatients settings have one or other psychiatric disorder (Sachdeva et al 1986, Goyal et al 2001. However when the psychiatry referral rates for inpatients were evaluated, these have been found to be dismal (0.06%–3.6%) in studies from India (Srinivasan,1987). The reasons of their low psychiatric referral might be unawareness about the need and importance of psychiatric intervention, misconceptions about psychiatric disorders as incurable and psychotropic as addictive, fear of patient’s reaction on advice of such referral and their poor working relationship with psychiatrist (White,1990). Poor knowledge of mental illness and lack of training for the same during the undergraduate level is the major barrier for their poor attention and involvement in the management of mental disorders in patients (Cowan et al 2012).

Models of CLP in India:
There are various models of consultation liaison psychiatry across different centers and institutions (Huyse et al 2001). In India, in most of the centers, the CL psychiatry services follow the consultation model, wherein psychiatrists evaluate and manage the patients who are referred from a physician/surgeon (Grover,2011). Based on the studies available from India, broadly the C-L Psychiatry services at various centers focus on inpatient and outpatients. Studies which have been published in relation to the inpatient Consultation-Liaison Psychiatry services, most of these have been silent on the functional aspect of the services. In India, the C-L services are mostly in the line with the consultation model, in which on receiving a referral from the physician/surgeon, a psychiatrist evaluates the patient and psychiatric inputs are provided (Grover, 2019).

Importance of CLP:
Individuals with mental disorders are more frequently affected by physical conditions whereas a large proportion of patients suffering from medical conditions also experience mental health problems (De Hert etal 2011, Moussavi et al 2007, Stein,2020). CLP is a subspecialty of psychiatry that provides assessment and treatment for general hospital patients with mental health comorbidities. CLP have a positive impact on mental health problems and are cost effective (Wood &Wand,2014, Sartorius,2010). Joint projects between medical and psychiatric professionals seem to ensure the best way to reduce the existing gap between medical specialties and psychiatry.

CLP in an Indian Scenario
Instead of all these positive aspects compared to other subspecialties of psychiatry such as child and addiction psychiatry, consultation liaison psychiatry has received less importance in India (Grover,2011). There is an extensive literature in Western world with respect to CLP but from Indian perspective there is paucity of published data pertaining to consultation psychiatric services (CLP). Most of the studies on CLP have mainly explored CL services clinical aspects and socio demographic profiles. Beliefs, satisfaction, reaction to referral haven not explored much. Grover S et al conducted a study in 2015 to compare ―consultation‖ and ―hybrid‖ models of consultation liaison (CL) services provided to patients visiting the medical emergency outpatient services. Over the period of 18 months, two different models of consultation psychiatry services (July 2012 to March 2013 consultation model, April 2013 to December 2013 hybrid model) were compared. In the consultation model, the psychiatry resident was available on call to the internists. Whereas, for the hybrid model psychiatry resident was stationed in the medical emergency and was available to assess the patients directly requiring psychiatric evaluation. During the first 9 months, 22,000 patients were evaluated in various emergency medical outpatient services, of which 383 (1.74%) were referred to the on-call psychiatry CL team. However, when the hybrid model was followed, the number of patients evaluated by the psychiatry resident increased to 594 out of 24,737 patients (2.4%) who reported to the emergency during the next 9 months period. There was a substantial increase in the proportion of cases with medical illnesses for which psychiatric consultation was sought, and a change in psychiatric diagnostic profile was observed too. When compared to the consultation model, the hybrid model was associated with greater use of medications, investigations, referrals and psychological measures in the emergency setting itself (Grover et al 2015).

Research on CLP:
Psychiatric morbidity is associated with a high rate of request of medical services. Half of those who often require medical attention also have a psychiatric condition: recurrent depression or dysthymia (40%), anxiety disorders (22%), somatoform disorders (20%), panic disorder (12%), alcohol or other substances-related problems (5%) (Ewald et al,1999.). Vincze et al conducted a study in 2004 in which estimated percent of 21-46% of the patients hospitalized in non-psychiatric settings have a psychiatric disorder. Mental disorders' prevalence is about 25-50% with chronic medical conditions and less than 18% in those with medical conditions. Study shows that the use of antidepressants has a low frequency, as anxiolytics are commonly used (without proper indication) in depression (Vincze, et al.,2014). Alhamad et al conducted a study (2006) to assess the attitude and knowledge of physicians and patients towards psychiatry. Knowledge was poor and attitudes towards psychiatry was negative in both groups. This negatively influenced the referral rates and reflected the lack of integration of psychiatry and medicine at the training level. This is an indication that psychiatrists need to work in collaboration with hospital doctors to

integrate psychiatry into medicine at all levels and emphasizes the priority of education of hospital staff, patients and the community in consultation–liaison psychiatry. A study conducted (2006) to evaluate the usefulness of Casemix as a data collection system for consultation–liaison psychiatry services. Health information staff were requested to code psychiatric assessments and diagnosis prospectively for admissions to the Alfred Hospital, Melbourne, between July 2002 and June 2004 using Casemix. Psychiatric assessments were requested on 2.5% of all hospital admissions (n=2575). Casemix provided extensive demographic and hospital unit data for referred patients, is easy to set up, and is cost-free for the psychiatry service (Ellen, Lacey et al,2016). Another study conducted have evaluated of attitudes and practice of Mazandaran University of Medical Sciences physicians of teaching hospitals regarding CL psychiatry. In this descriptive study, all of the general practitioners, specialist and subspecialist physicians and assistants working in teaching hospitals of Mazandaran University of Medical Sciences were requested to fill in a questionnaire which was designed based on previous studies and observations to assess their attitudes and practice. One hundred and forty-nine (62.6%) physicians had very positive attitudes and 89 cases (37.4%) had positive attitudes; 234 physicians (98.3%) had acceptable practice, and 4 cases (1.7%) had unacceptable practice. There were no significant differences between physicians with positive and very positive attitudes and between physicians with acceptable and unacceptable practice regarding gender, age, education, specialty and place of work (hospital). The most common reasons of physicians for not requesting psychiatric consultation were lack of time, forgetfulness, lack of access to psychiatrist, and lack of belief in the need for psychiatric consultation respectively (Zarghami et al 2014). De Giorgio et al conducted a study in 2015 to investigate significant association between various clinical and extra-clinical factors brought out the activities of Consultation-Liaison Service. CLP activity was performed by the Psychiatry, Clinical Psychology and Psychiatric Rehabilitation Unit, University of Perugia at Perugia General Hospital, Italy. The hospital has 740 beds for inpatients and Day Hospital/Surgery Services and treats about 43,500 patients per year.: 1098 consultations were performed. The consultations carried out by the Emergency Unit were excluded from the study. The type and the reasons for the referrals were discussed such as the ICD-10 diagnosis and the liaison interventions too. Significant associations emerged between gender and: social status and occupation ($p < 0.05$ and $p < 0.01$ respectively). Clinical sector was related with reason for referral ($p < 0.01$), type of consultation ($p < 0.01$), liaison investigations ($p < 0.01$) and long-term treatment plan after hospital discharge ($p < 0.01$). The ICD-10 psychiatric diagnosis (Schizophrenia, Affective Syndrome and Neurotic-Stress Somatoform Syndrome) was associated with social status ($p < 0.01$), social condition ($p < 0.01$), consultation type ($p < 0.01$), advice ($p < 0.01$) and reason for consultation ($p < 0.01$) (De Giorgio el al 2015). Chen K, Evans R and Larkins S, conducted a study in 2016 aimed at to understanding the barriers to CLP inpatient referral. Systemic factors that improve referrals include a dedicated CLP service, active CLP consultant and collaborative screening of patients. Referrer factors that increase referrals include doctors of internal medicine specialty and those comfortable with CLP. Patients more likely to be referred were tend to be young, has psychiatric history, live in an urban setting or has functional psychosis (Chen et al 2016). A study was conducted (2017) to evaluate the psychiatric morbidity pattern, reasons for referral and diagnostic concordance between physicians/surgeons and the CL psychiatry team. In 57% of cases, a specific psychiatric diagnosis was mentioned by the physician/surgeon. The most common specific psychiatric diagnoses considered by the physician/surgeon included depression, substance abuse, and delirium. Most common psychiatric diagnosis made by the CL psychiatric services was delirium followed by depressive disorders. Diagnostic concordance between physician/surgeon and psychiatrist was low ($\kappa < 0.3$) for depressive disorders and delirium

and better for the diagnosis of substance dependence (κ = 0.678) and suicidality (κ = 0.655 (Grover et al 2017). Grover & Avasthi conducted a study in 2018 to evaluate the consultation-liaison psychiatry (CLP) training and services in India. An online survey was conducted involving at least one faculty member from the department of psychiatry working in various institutes providing postgraduate training in psychiatry. A total of 90 faculty members from different postgraduate institutes across the country participated in the online survey. In three-fourth of the institutes, the CLP services were provided in the form of on-call services with a three-tier system (i.e., CLP team comprising of faculty member, a senior resident, and a junior resident) existing in only about one third of 7 the institutes. In majority (60%) of the institutes, junior resident was the first line person responding to the call of other specialists. On an average, CLP teams receive 7.33 calls per day from various clinical departments with a range of 0–20. Among the three most common psychiatric syndromes seen in CLP setting, delirium figured as one of the three most common diagnoses among 79 (87.8%) institutes, and this was followed by substance use disorders (70%), self-harm (60%), and depression (38.9%). Specific CLP posting for junior and senior residents exists only in 28.9% and 12.2% of the institutes, respectively. Joint academic activities with other departments are conducted in 42.2% of the institutes. Regarding research, very few research projects are carried out in the area of CLP. Majority of the participants felt that CLP should be given equal importance or more importance than other subspecialties such as child psychiatry, addiction psychiatry, and geriatric psychiatry in postgraduate training programs.

Almost all the participants felt that having good knowledge of CLP helps in managing psychiatric patients in better way. All the participants reported that improving focus on CLP psychiatry will help in reducing stigma attached to mental illnesses and improve the training of postgraduates and the undergraduates (Grover & Avasthi, 2018). Over the last few decades, CLP as a subspecialty has made major strides across the globe, including India. However, although when one considers the beginning of development of CLP services and training, India was not far behind the developed countries like the United States in starting GHPUs. However, over the years, the CLP services and training in India have lagged behind the developed countries. Research in the area of CLP has never been the focus in India, except for one or two centers. Considering the increasing emphasis on providing person-centered care, there is a need to broaden the frontiers of training from identifying and managing only psychiatric disorders at the interphase of psychiatry and other disciplines (Grover,2019). A retrospective chart review conducted in a tertiary care 600 bedded teaching hospital in South Delhi. The study population consisted of inpatients who were referred for psychiatric consultation from other departments over a period of 20 months, from July 2015 to February 2017. A total of 605 patients were referred, which comprised 0.86% of total indoor admissions. Maximum number of consultations was sought from internal medicine. ―Unexplained physical symptoms‖ was the most common reason for referral (35%). Consequently, neurotic, stress related, and somatoform disorder (25.5%) was the most common psychiatric diagnosis followed by mood disorder (19.8%) (Gupta et al 2019). Dua & Grover conducted a review study in 2020 to evaluate all the published studies from India conducted in the consultation-liaison (CL) psychiatry setting to identify the diagnostic patterns and referral rates. A thorough literature search was done in August 2020 using different search engines (PubMed, Medknow, and Google Scholar). This was followed by an individual search of various Indian Psychiatry journals and a hand search of references in the available articles. Only those studies that described patients referred to psychiatry services from various specialties were included. A total of 33 studies were selected for the review. More than half of them were published in the last 5 years. Studies have primarily reported psychiatric profile medically ill inpatients referred to CL psychiatry services, with

the majority of the studies reporting the number of patients seen for the duration of at least 1 year. The referral rates for inpatients across different institutes have varied from 0.01% to 3.6%. The referral rates from emergency set-ups have varied from 1.42% to 5.4%, and in outpatients, from 0.06% to 7.17%. The most commonly diagnosed psychiatric disorders across different studies include depression; organic disorders, including delirium; substance use; intentional self-harm; and anxiety disorders (Dua & Grover,2020). Zoltan et al conducted a study in 2021 for quality assessment of a consultation-liaison psychiatry service through online survey in medical staff regarding their experience with different aspects of inpatient and outpatient CLP services. Physicians´ evaluations were statistically more positive than nurses´. As a group, respondents already employed before the CLP unit was established and those who used the CLP services more were statistically significantly more satisfied then respondents employed after the establishment of the CLP unit and those who used the CLP service less (Kovacs et, 2021).

Regarding author mental health professionals CLP uses a generic, multidisciplinary, crisis intervention approach to mental health consultation to facilitate humane and comprehensive yet cost-effective care for the medically indigent. Psychiatric Social work functions on the team include diagnosis, short-term individual and group treatment, referral, follow-up, staff development, in-service training, program planning, and interdisciplinary clinical instruction (Stine 1976). Current literature lacks data related to the role of psychologists on consultation-liaison (CL) services; previous data indicates only 4% of CL services are run by psychologists, while 32% of liaison mental health services include a psychologist. As CL psychologists' roles within hospitals grow, it is critical to identify clinical strategies and organizational structures of CL services across hospital systems (LaGrotte et al 2024). It has also found that CLP workload has increased considerably in the past 20 years with changes in patient demographic and clinical characteristics. A trend toward increase in medication-based patient management was observed. These findings suggest that the psychiatric needs of patients admitted to the general hospital are more frequently addressed by referring physician. (Zerbinati et al 2022)

CONCLUSION

CLP also known as psychosomatic medicine is an exciting subspecialty of psychiatry that focuses on the care of patients with comorbid psychiatric and general medical conditions. Consultation-liaison psychiatry deals with the understanding and advancement of medical science, education, and the provision of healthcare for medically ill patients. Medical students who do a rotation in consultation-liaison psychiatry can learn about different psychiatric manifestations of medical illness and their treatments and about care for medically ill patients who have psychiatric disorders. The Council on Consultation-Liaison Psychiatry focuses on policies and resources for the psychiatric care of persons who are medically ill and thus stands at the interface of psychiatry with other medical specialties.

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Conflict of Interest

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