

# Draft guideline for consultation psychiatry

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15

## COLOPHON

DRAFT GUIDELINE FOR CONSULTATION PSYCHIATRY

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30 The purpose of the Dutch Institute for Healthcare Improvement CBO, domiciled in Utrecht, is to provide support to individual professionals, their professional societies, and healthcare institutions in the improvement of patient care. Via its programmes and projects, the CBO provides support and guidance for the systematic, structured assessment, improvement and guarantee of the quality of patient care.

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### **Declaration of intent**

This guideline is not intended as a standard that can be considered applicable under all circumstances. Standards are compulsory and should, in principle, not be deviated from. Guidelines can be ignored in individual cases, given due consideration. They are meant to support rational clinical actions.

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The Guideline for Consultation Psychiatry is a code of behaviour for appropriate medico-psychiatric activity that has been agreed upon within the psychiatric profession, is based on the scientific literature and expert

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opinion, and is adhered to by the members of the Netherlands Psychiatric Association.

5 The guideline specifies how psychiatric consultations should be carried out in non-psychiatric settings, such as general practice, the somatic departments of general and university hospitals, nursing homes, and categorical institutions. The guideline discusses the context, models and efficacy of psychiatric consultations in these settings, as well as the way in which a consultation should be carried out in accordance with the rules of the profession. With reference to this last aspect, this guideline is  
10 a specific refinement of the 'Guideline for the psychiatric examination of adults' (Richtlijncommissie psychiatrisch onderzoek bij volwassenen, 2004), which appeared in 2004. Just as in this guideline, it is also true of consultation psychiatry that the order and extent of the information that should be collected during the consultation is determined by the situation  
15 in which the examination takes place and the condition of the patient. The skill of the psychiatrist in the area of history taking and examination also plays a role here. Moreover, the guideline devotes attention to context-specific aspects such as the role of the psychiatrist in a multidisciplinary field of work and the specific organisational, administrative, ethical and  
20 legal aspects.

All of the psychiatrists in the working group are clinically active and have practical experience with psychiatric consultations in general practice, general and university hospitals, nursing homes, and categorical institutions. All of the members of the working group collaborated in the  
25 creation of the guideline, without any conflicts of interest.

### **Responsibility**

In 2006, the Board of Directors of the Netherlands Psychiatric Association (NVvP) commissioned the creation of the *Guideline for Consultation  
30 Psychiatry* and appointed the chairman and members of the guideline committee on the recommendation of the Dutch Quality Care Committee (CKZ). Demands for such a guideline had been received from the field and from society. The guideline was developed in accordance with the 'evidence-based guideline development' (EBRO) system and financed by  
35 the Dutch Ministry of Public Health, Welfare and Sport (VWS) on the recommendation of the Guidelines Advisory Committee of the Order of Medical Specialists (OMS). The NVvP is responsible for the content of the guideline and the Dutch Institute for Healthcare Improvement CBO is responsible for the way in which the guideline was developed.

40 The guideline committee then established the *state of the art* and drew up a draft guideline on the basis of scientific know-how and practical experience. This draft guideline was assessed by the CKZ using the 'appraisal of guidelines and evaluation' (AGREE) instrument. Following a positive recommendation from the CKZ, the guideline was adopted by the  
45 Board of Directors of the NVvP on 13 February 2008 and published in March 2008. The guideline will remain valid for a maximum of five years, unless an earlier revision is felt to be necessary on the basis of

comments, scientific developments or other opinions within the profession.

*The Board of Directors of the Netherlands Psychiatric Association*

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## COMPOSITION OF THE WORKING GROUP

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- Mrs. J.J. van Croonenborg, senior advisor, Dutch Institute for Healthcare Improvement CBO, Utrecht (secretary until September 2006)
- 10 - Dr J.J.E. van Everdingen, secretary of the Medical Scientific Council of the CBO, Utrecht (secretary of the working group since September 2006)
- Dr C.M. van der Feltz-Cornelis, psychiatrist, Trimbos Institute, Utrecht and VUMC, Amsterdam
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- Dr H. van Marwijk, general practitioner, Almere
- Dr T.W.D.P. van Os, psychiatrist, GGZ (mental health service) Friesland
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- Dr R.J.M. Strack van Schijndel, internist/intensive care specialist, VUMC, Amsterdam

## CHAPTER 1. SUMMARY

### 1.1. Introduction

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Sections 1.2 through 1.4 of this chapter provide a summary of the questions posed, conclusions, other considerations, and recommendations for those topics that were studied by means of a systematic search of the literature. In view of the nature of the question, no summary has been made pertaining to the question of how a psychiatric consultation should be carried out in accordance with the rules of the profession; instead, the reader is referred to section 5.1. Section 1.5 provides a summary of the conclusions and recommendations for those topics that were not studied by means of a systematic search of the literature.

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### 1.2. Is psychiatric consultation in general practice effective?

#### 1.2.1. Conclusions

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Level 1	Psychiatric consultation as part of collaborative care in general practice is effective in patients with depressive and somatoform disorders. <i>A1: Bower et al. 2006; Gilbody et al. 2006 A2: Unützer et al. 2006; Katon et al. 1992; Van der Feltz-Cornelis et al. 2006 B: Smith et al. 1986, Smith et al. 1995</i>
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Level 1	Psychiatric consultation in general practice is more effective when consultation is given regularly at fixed times and by professionals with good psychiatric expertise. <i>A1: Gilbody et al. 2006</i>
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Level 2	Psychiatric consultation in general practice is probably more effective when a so-called 'consultation letter' is used. <i>A2: Van der Feltz-Cornelis et al. 2006 B: Smith et al. 1986; Smith et al. 1995</i>
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Level 3	Psychiatric consultation in general practice probably improves the diagnosis and treatment of depression in patients that are consuming high levels of medical care. <i>B: Katon 1992</i>
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#### 1.2.3. Other considerations

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Research into the efficacy of psychiatric consultation in general practice has been done mainly in the setting of 'collaborative care'. In the models used in the studies discussed here, the psychiatrist had always actually seen and spoken to the patient. The concept of collaborative care as a complex intervention in primary care, with psychiatric consultation

embedded in it, makes it difficult to measure the specific contribution of the psychiatric consultation in the complex intervention. It can be concluded, however, that collaborative care is effective, while there is hardly any evidence for the efficacy of psychiatric consultation alone in this setting. Only in the study by Katon et al. (1992) was a psychiatric consultation the only intervention. In some studies, a 'consultation letter' was used, so there were again other factors playing a role besides the advice of the psychiatrist (Smith et al. 1986, Smith et al. 1995).

An attempt to identify the effective ingredients of collaborative care in depressive disorders was made in a 'meta-regression'-analysis of 34 studies in primary care. The analysis showed that the degree of adherence to the recommendations of the consulting psychiatrist was a significant predictor of an effect from the intervention. When studies from the USA were analysed separately from those carried out elsewhere, then for the studies carried out outside of the USA, a positive outcome was found to be associated with a systematic screening of patients for depression, the use of case-managers with a psychiatric background, and the provision of regular consultation and supervision to the case-managers by psychiatrists (Unützer et al. 2006).

All of the research in primary care has been limited to patients with depression and somatoform disorders, so that the findings cannot be generalised to psychiatric consultation for general practitioners in the case of other mental symptoms or disorders. However, this is also in accordance with the purpose of such consultation, the goal being that general practitioners will continue to treat patients with depressive and somatoform disorders themselves, but will require support by means of consultation. For other disorders, referral is often a more obvious solution so that no consultation is required. Moreover, in studies on patients with somatoform disorders, the outcome parameter chosen is often the decrease in consumption of medical care and the related costs, even though this is not necessarily an indication of an improvement in the symptoms or the quality of life of the patient.

#### 1.2.4. Recommendations

The working group recommends that:

- Psychiatric consultation in general practice be embedded as much as possible in a broader system of collaborative care.
- An attempt be made to increase the basic expertise of consultees in the field of psychiatric diagnosis and treatment by means of liaison contacts.
- If psychiatric consultation is offered in general practice, it should be incorporated into daily practice in a structural manner and be carried out at fixed times by fixed consultants.
- In case of consultation in general practice, use be made of a so-called 'consultation letter', a written recommendation from the consultant containing a treatment plan that is given not only to the general practitioner but also to the patient, and is discussed

with the latter.

### 1.3. Are psychiatric consultations in hospitals or categorical institutions effective?

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#### 1.3.1. Conclusions

Level 1	<p>Psychiatric consultation in the hospital and nursing home setting is probably effective; there is no evidence for the efficacy of single evaluations based on the results of screening. However, the efficacy is often measured in terms of a decrease in the duration of hospitalisation and/or cost savings, and not or not only in terms of decreased symptoms or an improved prognosis.</p> <p><i>A1 Herzog, Stein, et al. 2003; C Saravay 1996</i></p>
Level 2	<p>In <i>selected populations</i>, screening according to protocol followed by consultation and liaison activities is probably more effective than providing consultation only on request.</p> <p><i>A2 Saravay 1996; B Levitan and Kornfeld 1981; Strain, Lyons, et al. 1991</i></p>
Level 3	<p>There are indications that consultation for the benefit of an emergency ward from the hospital's own consultation-psychiatric service is more effective than consultation by an external body or non-psychiatric specialists.</p> <p><i>B Brown 2005</i></p>
Level 3	<p>There are indications that carrying out liaison activities has a positive effect on consultees and leads to more and better referrals, a greater compliance with advice as to medication, and more satisfaction on the part of the consultee.</p> <p><i>C Schubert, Billowitz, et al. 1989; Scott, Fairbairn, et al. 1988; De Leo, Baiocchi, et al. 1989; Swansinck, Lee, et al. 1994</i></p>

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#### 1.3.2. Other considerations

The purpose of this literature search was to find articles on the efficacy of psychiatric consultations in general, from a point of view broader than a specific syndrome. A search into the efficacy of specific psychiatric interventions in specific syndromes, such as in delirium, for example, was not felt to fall under the tasks of the guideline working group. As a result, no conclusions can be reached regarding the efficacy of specific

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interventions in particular syndromes or patient populations. For such information, the reader is referred to guidelines pertaining specifically to the syndrome in question.

5 It is striking that research into the efficacy of consultation  
psychiatry has concentrated especially on a reduction in the duration of  
hospitalisation and/or cost savings, and to a lesser extent on clinical  
outcome measures such as symptom reduction and prognosis  
improvement. This is to some extent understandable, but critical  
10 comments could also be made. The combination of the fact that a great  
deal of psychopathology is not recognised in a somatic setting, together  
with the fact that somatic patients with psychiatric comorbidity cost more  
and receive general healthcare for longer periods of time, leads to the  
hypothesis that psychiatric consultation might contribute to shortening  
15 the duration of hospitalisation and reducing costs. However, economic  
considerations must not be the only factor to be considered. An improved  
prognosis and care of better quality should also be weighed against the  
costs of care. If psychiatric care is expected to pay for itself, regardless of  
the benefits to the patient, while the same is not said of somatic care, this  
20 can lead to discrimination between syndromes and groups of the  
population (Sturm 2001). Also, the fact that there is a robust association  
between psychiatric disorders and an increased consumption of medical  
care does not automatically mean that better psychiatric care will, or  
should, result in cost savings (Sturm 2001).

### 25 **1.3.3. Recommendations**

In order to increase the efficacy of psychiatric consultations, the working group recommends:

- setting up screening activities in selected patient populations, directed at the detection of the most frequently occurring psychiatric problems and the early identification of 'complex' patients
- maintaining follow-up contacts when a recommendation for further diagnostics or treatment is given after an initial consultation
- investing in the development of liaison activities in the departments that request consultations
- organising the consultation psychiatry and liaison activities within the general or university hospital itself, if possible, and not from an external organisation

## **1.4. What factors are associated with an improved follow-up of recommendations?**

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### **1.4.1. Conclusions**

Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with when the advice is given
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	earlier during the hospital stay or during the period of co-treatment.  <i>C Popkin et al. 1981; Huijse et al. 1992; Huijse et al. 1993</i>
Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with when a single consultation is followed by follow-up contacts.  <i>C Popkin et al. 1981</i>
Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with if the consultations are supplemented by liaison activities.  <i>C De Leo et al. 1989</i>
Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with if the consultant himself gives the medication orders to the nursing staff of the department that requested the consultation.  <i>C Wise et al. 1987</i>
Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with when the professional level of the consultant is higher.  <i>C Lanting et al. 1984</i>

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#### 1.4.2. Other considerations

All of the studies except two were carried out in university hospitals where consultation psychiatry was given special attention. Only one study in a general practice was retrieved, and only one study in a nursing home. For many of the associations listed, there is only limited evidence from a single study. Moreover, many of the studies were purely descriptive and the comparison of the degree of compliance with recommendations was not subjected to statistical analysis.

When the consultant writes the medication orders himself in the hospital department that requested the consultation, he bears the responsibility not only for the prescription of the medication, and the possible interactions or complications, but also for good communication on this point with the attending physician who must always retain an overview of the overall treatment of the patient.

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#### 1.4.3. Recommendations

In case of consultations in a general or university hospital, the working

group recommends:

- that an attempt be made, by means of liaison activities, to stimulate those requesting a consultation for patients for whom a psychiatric consultation is felt to be desirable to do this as early as possible during the hospital stay.
- that follow-up contacts be arranged whenever possible after an initial assessment in order to verify whether the diagnostic and therapeutic recommendations have been complied with and, if necessary, to insist upon it or to see to it one's self.
- that agreement be reached, whenever possible, regarding the possibility that that the consultant himself will give the medication orders to the nursing staff of the department that requested the consultation.
- that the care, in institutions where the consultations are given mainly by registrars in psychiatry, be organised in such a way that the supervising psychiatrist is as directly involved as possible with the consultative patient care and in the ideal situation sees every patient himself.

## 1.5. Other conclusions and recommendations

### 5 1.5.1. The role of the psychiatrist in a multidisciplinary team.

#### Conclusion

Level 4	The consultation psychiatrist is often part of a multidisciplinary team in which the borderline between the tasks and responsibilities of other disciplines is not always clear.
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#### Recommendation

In case of multidisciplinary collaboration in connection with psychiatric consultation, the working group recommends that the division of responsibilities between the disciplines be laid down in a document, in which the specific expertise of the various disciplines must be taken into consideration, and which must guarantee the assignment of specific medical tasks and responsibilities to the physician or psychiatrist.

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### 1.5.2. The role of the psychiatrist in complex problems of medical ethics

#### 15 Conclusion

Level 4	There are various opinions regarding the role of the psychiatrist in complex problems of medical ethics.
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#### Recommendation

The working group is of the opinion that, in certain cases, the psychiatrist

can make a useful contribution to decision taking around complex problems of medical ethics. The extent to which the individual psychiatrist wishes to fulfil this role depends on his interpretation of his tasks in general, and in general practice or the hospital.

### 1.5.3. The distinction between advising and co-treatment

#### 5 Conclusion

Level 4	The mode of operation and responsibilities of the consultation psychiatrist in cases of consultation and co-treatment are not always clear.
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#### Recommendation

As long as no legal consensus has been reached on the subject, the working group recommends that the mode of operation and responsibilities of the consultation psychiatrist in case of 'consultation' and 'co-treatment' be laid down in writing for the institution in question.

### 10 1.5.4. Bedside supervision versus supervision by telephone

#### Conclusion

Level 4	In the case of multidisciplinary collaboration, the professional standards specify that the psychiatrist can only assume responsibility for the treatment of patients that he seen himself. In the case of physicians in training for psychiatrist, the nature and intensity of the supervision are determined by the degree of experience.
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#### Recommendation

The working group recommends that the consultation psychiatrist should personally see all patients for whom he assumes therapeutic responsibility, with the exception of patients seen by physicians in training for psychiatrist that have been demonstrated to be sufficiently competent to evaluate patients in the consultation setting independently.

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### 1.5.5. The Medical Treatment Contracts Act (WGBO) versus the Psychiatric Hospitals Compulsory Admissions Act (BOPZ)

#### 20 Conclusion

Level 4	The rules and jurisprudence in the area of compulsory somatic treatment for mentally competent and mentally incompetent patients with a psychiatric disorder are not unambiguous.
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#### Recommendation

The working group recommends that, in case of lack of clarity regarding the legal framework around a patient in whom compulsory somatic treatment is being considered, legal advice be obtained from the jurist of the institution, provided that the delay in treatment that accompanies such a request for legal advice does not constitute an added risk to the patient's health.

### 1.5.6. The incorporation of consultation psychiatry into the organisational structure

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#### Conclusion

Level 3	Psychiatric consultation is more effective when the consultation psychiatrist is employed by the hospital where he gives consultations.
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#### Recommendation

The working group recommends that consultation psychiatrists be employed in a way that guarantees as good as possible an 'embedding' in the setting in which he gives his consultations.

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### 1.5.7. Spatial facilities on the emergency ward

#### Conclusion

Level 4	The safety on the Emergency Ward can be increased by positioning the room where psychiatric assessments are to take place in such a way that it can be observed from a central room, the inclusion of a second door as an escape route, and the installation of an alarm system.
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#### Recommendation

The working group recommends that the safety of the consultation psychiatrist also be taken into consideration in the planning of the spatial facilities, especially in the emergency setting.

## CHAPTER 2. GENERAL INTRODUCTION

### 2.1 Statement of the problem and motivation

5 The quality and efficacy of consultation psychiatry has been a topic of discussion in recent years in both general practice and general or university hospitals.

10 In general practice, forms of support for the recognition, treatment and guidance of patients with mental problems and psychiatric disorders have existed for a long time. In the previous century, this subject was addressed by Querido, Van Ravenszwaay and Gersons (Querido 1955; Van Ravenszwaay 1972; Gersons 1977). The psychiatrist visited the offices of the general practitioner and discussed his patients with him. General practitioners also discussed their problems in Balint groups. At 15 the end of the 1980s, these forms of consultation were no longer supported and died a quiet death. Their place was taken by training programmes for general practitioners, which were indeed cheaper, but which did not provide a satisfactory answer to the increasing number of referrals by general practitioners to mental healthcare facilities. In 1999, therefore, the Ministry of Public Health, Welfare and Sport (VWS) again drew up a 'consultation regulation'. The purpose of this regulation was to advise and support general practitioners by means of consultations in 20 first-line medical care, in the hope that they would start treating patients with mental problems and psychiatric disorders themselves, together with social workers and first-line psychologists, and so prevent the 'silting up' of the mental healthcare facilities (Verhaak, Groenendijk, et al. 2006). Under this regulation, many forms of support for the general practitioner, all of which were called 'consultation', were compensated. An evaluation of the consultation regulation took place as part of the project 'Tussen de 25 lijnen' [Between the lines] (Meijer, Zantinge, et al. 2003). This revealed that the intended effect was not achieved by forms of consultation in which the psychiatrist himself did not see the patient, such as consultations held by non-psychiatrists, e.g. social psychiatric nurses, or during group interviews and discussions of cases. These forms of 35 consultation even led to a 40% increase in the number of referrals to the mental health service (Meijer, Zantinge, et al. 2004). Patient-related consultations by the psychiatrist did have the desired effect, but despite this finding, it seems that many mental health services failed to use psychiatrists for consultations with the general practitioner. Moreover, the 40 Netherlands Psychiatric Association (NVvP) felt the great variation in the form and efficacy of consultations in first-line medical care to be undesirable (Nederlandse Vereniging voor Psychiatrie (NVvP) 2003). Both of these factors ultimately led to termination of the consultation regulation in 2005.

45 In 2004, in the field of hospital psychiatry, the Dutch Healthcare Inspectorate (IGZ) took inventory of aspects of quality in both general and university hospitals; this inventory also covered consultation

psychiatry. The purpose of this inventory was to provide a basis for the development of performance indicators for hospital psychiatry. Such an inventory was felt to be necessary because hospital psychiatry had not been systematically evaluated during the previous ten years, even though  
 5 major organisational changes had taken place during this time. One of these developments was the forming of Regional Mental Health Centres (RGCs) into which, in connection with the 'socialisation' of psychiatry, all psychiatric functions, including hospital- and consultation psychiatry, had to be incorporated. In 2004, the Minister of Public Health, Welfare and  
 10 Sport (VWS) concluded that the creation of RGCs had unintentionally led to a worsening of the position of hospital psychiatry, which was also reflected in the quality of hospital psychiatric patient care (Hoogervorst 2004; Robben and Tietema 2005). The most important finding in the preliminary inventory of the Inspectorate was that there was great  
 15 variation in the quality and organisation of hospital psychiatry, as well as major differences in the relationship with other facilities of the mental health service. The same conclusion was reached with regard to consultation psychiatry. This variation made it difficult to judge the quality of hospital psychiatry in general and to devise unambiguous performance  
 20 indicators. Moreover, the variation itself was also looked upon as a risk factor: due on the one hand to the clear differences in quality between the various institutions and settings, and on the other hand because the available care was not transparent to the referring doctors and patients (Robben and Tietema 2005).

25 In these developments, the Board of Directors of the Netherlands Psychiatric Association (NVvP) saw a reason to set up a working group with the task of drawing up a guideline for psychiatric consultation that would lead to greater uniformity and transparency. The working group was set up halfway through 2005 and actually began its work halfway  
 30 through 2006.

## 2.2. Concept determination and definitions

Over the years, a number of closely related terms, which are sometimes used interchangeably, have been devised to describe consultative  
 35 activities within psychiatry. In order to prevent confusion, the most commonly used terms are explained below.

'Consultation psychiatry' is the term most commonly used in the Netherlands to describe the activities of psychiatrists that provide consultations on the somatic wards of general or university hospitals, in  
 40 categorical institutions at the request of the specialists working there, or at the request of a general practitioner in first-line medical care. These psychiatrists provide interdisciplinary psychiatric consultations in non-psychiatric settings. The present guideline pertains to consultation psychiatry.

45 'Psychiatric consultation' is a concept that is intimately connected with the philosophy of the mental health services in the 1960s when Caplan introduced his models for 'mental health consultation' (Caplan

1963). 'Consultation' in this sense involves mainly the coaching of others in how to deal with complex behaviour. In this sense, consultation should be looked upon as a part of liaison psychiatry (see below), in which, in a general sense, advice with regard to patients can be given without having actually seen them. For this reason, in this guideline, the term 'consultation psychiatry' is preferred over 'psychiatric consultation'. In Flemish Belgium, the word 'consultation' has still another meaning and is synonymous with outpatient clinic contacts. 'Liaison psychiatry' is the term for the procedures developed by consultation psychiatrists to supplement the consultation model. In liaison psychiatry, the focus is on the system that provides patient care rather than on the patient. The didactic role is at the forefront here (Strain 2002). Although, in the opinion of the working group, consultation psychiatry should be combined with liaison psychiatry, and liaison psychiatry can increase the efficacy of consultation psychiatry, this guideline does not pertain primarily to liaison psychiatry. Within consultation psychiatry, the term 'consultation' is used to refer to the giving of advice. An explanatory list of terms can be found in Appendix 1.

### 2.3. Delineation of the subject

Within consultation psychiatry, there is a continuing search for new forms of care organisation that will meet the needs of patients with somatic and psychiatric comorbidity. In hospitals, the classical consultation for clinical patients is being replaced more and more by more structural forms of collaboration within multidisciplinary teams and chains of care. Activities are also being shifted in the direction of the outpatient clinic, and transmural care models are being developed. All of these developments make it difficult to delineate the coverage of this guideline. The working group has decided to limit itself to the *consultation setting*, i.e. the provision of interdisciplinary consultation in a setting that is not primarily psychiatric, such as a general practice, the somatic wards of a hospital, nursing homes and categorical institutions. The working group has specifically chosen not to include outpatient psychiatric evaluations at the request of a somatic medical specialist in the subject matter of this guideline, because such activities cannot be clearly distinguished from regular outpatient evaluation and treatment. Moreover, this guideline is limited to adult and geriatric psychiatry. Due to the specific context and implementation of consultations in paediatric psychiatry, this guideline does not pertain primarily to interdisciplinary consultation in paediatric psychiatry. Moreover, due to the lack of clarity regarding the legal context, this guideline does not pertain to consultation at the request of persons that are not physicians, such as psychologists and psychotherapists, even though the way in which a consultation is carried out will not be very different. Finally, in view of the goal of the guideline (see 2.5), the working group has not chosen to involve other disciplines that play a role within consultation psychiatry, such as consultative or

social-psychiatric nurses, nurse practitioners or physician assistants, in its development.

#### 2.4. Questions posed

- 5 This guideline is meant to provide an answer to the following initial questions:
1. How effective is psychiatric consultation in general practice? (see 3.3. Efficacy of consultation in general practice)
  - 10 2. How effective is psychiatric consultation in institutions? (see 4.3. Efficacy of psychiatric consultation in institutions)
  - 15 3. How should a psychiatric consultation be carried out in accordance with the rules of the profession? (see 5.1. The consultation procedure)
  - 20 4. What factors are associated with improved compliance with the recommendations of the consultation psychiatrist? (see 5.2. The compliance with recommendations from the consultation psychiatrist)

20 In addition to answering these initial questions, the guideline explains the context and models of consultation and discusses the following legal and organisational subjects: the role of the consultation psychiatrist in a multidisciplinary field of work, the role of the consultation psychiatrist in questions of medical ethics, legal aspects of advising versus co-treatment, legal aspects of supervision by telephone versus bedside supervision, and  
25 the distinction between the WGBO (Medical Treatment Contracts Act) and the BOPZ (Psychiatric Hospitals Compulsory Admissions Act). The organisational aspects that are discussed pertain to the incorporation of the consultation psychiatrist into the hospital organisation, staffing, and spatial facilities.

30

#### 2.5. Goal

This guideline is meant to serve as an aid to the systematic implementation of interdisciplinary psychiatric consultation. The expectation is that systematisation will lead to better diagnosis and  
35 treatment, as well as to more transparency and greater assessability of the actions undertaken. In addition, the guideline can be used to indicate what a psychiatric consultation entails and what demands may be made of it ('product typing'). Finally, it can be used as an educational tool in the instruction of psychiatrists.

40

In contrast to the case of syndrome-bound guidelines, this guideline does not propose specific forms of patient-related management, but is meant to establish a standard for a specific procedure (carrying out a consultation). In its description of how a psychiatric consultation should be carried out, this guideline constitutes a refinement of the 'Guideline for the psychiatric examination of adults' that appeared in 2004 (NVvP 2004).  
45

As already set down in the declaration of intent, the guideline is not intended to be a coercive protocol that prescribes how a consultation

must be carried out. Rather, the guideline helps to specify the information that should be collected during a consultation and the advice that should be given. The way in which the information should be collected and weighed is not prescribed. This depends on the one hand on the  
5 knowledge and experience of the psychiatrist, while on the other hand the condition of the patient often imposes limits.

## **2.6. Users of the guideline**

The target group of this guideline is in the first place psychiatrists and  
10 trainee psychiatrists. In addition, the guideline is meant to provide clarity, particularly to physicians that request psychiatric consultations, regarding the demands that may be made of a psychiatric consultation. Moreover, the guideline can be used by other professions as a model for the  
15 guidelines that they may wish to develop. Finally, the guideline can be used to assess whether a psychiatric consultation has been carried out in accordance with the rules of the profession.

## **2.7. Composition of the working group**

A broad base of support is of decisive importance for a really useable  
20 guideline. Because this guideline pertains to the work of psychiatrists, a monodisciplinary composition of the working group was initially chosen. An attempt was made, however, to achieve a diversity of primary frames of reference, work settings and geographic distribution. With regard to  
25 the primary frames of reference, the various members of the working group have specific knowledge and experience in the implementation of interdisciplinary consultation with both general practitioners and medical specialists in hospitals, nursing homes and/or other categorical  
30 institutions. With regard to the work settings, members of the working group are active in general and university hospitals and in mental health services. Because permanent feedback from the most important  
35 requestors of consultations (consultees) was considered to be essential, a general practitioner and an internist, both of whom have experience in working together with consultation psychiatrists, were added to the working group as full members early in the process, so that the group became multidisciplinary. Methodological and secretarial support was obtained from the Dutch Institute for Healthcare Improvement CBO.

## **2.8. Mode of operation of the working group**

During the course of one year (7 meetings), the working group devoted  
40 its efforts to the preparation of a draft guideline. The first step was to establish the component parts of the guideline. Next, literature searches were done wherever there were specific questions that could be answered on the basis of the scientific literature. The articles that were retrieved  
45 were evaluated with the aid of the standard assessment forms of the CBO. In those areas where no scientific research had been done, the group consulted consensus documents and 'expert opinions'. These were not only the opinions of members of the working group, but also the

opinions of international experts as published in journal articles and handbooks. The draft text of each separate part of the guideline was written by two or three members of the working group. During the meetings, the drafts were explained and discussed. In the case of  
5 divergent opinions, consensus was achieved within the working group by means of discussion.

The draft guideline was then submitted to two external referees by the NVvP for their comments. In addition, the draft guideline was made available to all members of the NVvP for three months via its website, and  
10 comments on the draft guideline could be made via the website. The draft guideline was then modified in several places on the basis of the reactions obtained. Next, the revised draft was submitted for comment to the most important representatives of the consultees: the Dutch College of General Practitioners (NHG), the Dutch Society of Internists (NIV), the Dutch  
15 Neurological Society (NVN), the Dutch Surgical Society (NVC), and the Dutch Federation for Hospital Psychiatry (NFZP). The NIV and NFZP agreed to the guideline. Of the other professional societies, only one commented on the content, which did not lead to any further changes in the guideline. Ultimately, the guideline was assessed by the Quality Care  
20 Committee (CKZ) of the NVvP and approved by the board of directors of the NVvP.

## 2.9. Scientific foundation

During the development of the guideline, use was made of the results of  
25 scientific research whenever possible. Several specific questions were answered with the aid of a systematic search of the literature. Wherever possible, the extensive guideline 'Konsiliar- und Liaisonpsychosomatik und -psychiatrie' of a number of German professional societies under the auspices of the Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen  
30 Fachgesellschaften (AWMF), which appeared in 2003, was used as a point of departure (Herzog, Stein, et al. 2003). Many points in this guideline are based on a systematic search of the literature over the period up to and including 1999. Whenever the questions to be answered were the same, the working group limited itself to supplementing this guideline with a  
35 literature search starting in 2000.

However, the scientific evidence was limited to a limited number of questions. For most of its recommendations, the working group had to rely on expert-opinion. As far as the implementation of a psychiatric  
40 consultation is concerned, these expert-opinions were found in a limited number of articles in scientific journals, and in the relevant chapters of textbooks and handbooks in the field of consultation psychiatry. Only when no scientific evidence or published expert opinion was available did the working group arrive at a consensus on the basis of personal  
45 experience and the opinions of its members.

The reliability, validity and efficacy of the collection of parts of this guideline should be subjected to further empirical study. The initiation of a scientific study is highly recommended by the working group.

### 2.10. Implementation and evaluation

During the various stages of development of the draft guideline, as much consideration as possible was given to the implementation of the guideline and the actual feasibility of the recommendations.

The guideline will be distributed to all relevant professional groups and hospitals. A summary of the guideline has also been submitted for publication in the Nederlands Tijdschrift voor Geneeskunde and the Tijdschrift voor Psychiatrie, and attention will be paid to the guideline in a variety of specific professional journals.

In order to stimulate the implementation and evaluation of the guideline, a number of indicators have been defined on the basis of which the implementation can be measured. In general, indicators make it possible for caregivers to evaluate whether they are providing the desired care. In this way, they can also identify aspects of the care that should be improved.

### 2.11. Legal significance of guidelines

Guidelines are not legal prescriptions but insights and recommendations that are based on the 'best available' scientific evidence, as much as possible, and that provide physicians and other caregivers with a basis for giving high-quality care. Since these recommendations are based mainly on the 'average patient', psychiatrists may deviate from the guideline in individual cases. In fact, deviating from the guideline is necessary if the situation of the patient requires it. However, when one deviates from the guideline, one should be prepared to give the reasons and to document one's actions.

### 2.12. Authorisation

The guideline has been authorised by the Netherlands Psychiatric Association (NVvP) and has been commented on by the Dutch Society of Internists (NIV) and the Dutch College of General Practitioners (NHG).

### 2.13. Revision

In 2012 at the latest, after consulting with or on the basis of advice from other societies that participate in the guideline, the Netherlands Psychiatric Association (NVvP) will decide whether the guideline is still up to date. If necessary, a new working group will then be set up in order to revise the guideline. The guideline will lose its validity earlier if new developments have been an incentive to start the process of revision sooner.

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## CHAPTER 3. PSYCHIATRIC CONSULTATION IN GENERAL PRACTICE

### 3.1. The context of the consultation

5 Psychiatric assessments in general practice differ from those in a primary psychiatric setting in a number of ways. Probably the most important difference is the fact that the general practitioner is the gatekeeper of mental healthcare. For patients that present with mental symptoms in general practice, the general practitioner is the first person to decide on a  
10 diagnosis and to propose treatment or referral. Whether a patient is actually referred depends on the degree to which the general practitioner recognises the mental symptoms, and on his readiness to treat these symptoms himself. In the filter model of Goldberg and Huxley (1980), the general practitioner thus serves as the first referral filter. This is an  
15 important difference from patients that are seen by the medical specialist: after all, they have already agreed to a referral and hence have indicated implicitly that they are receptive to further diagnosis and treatment. Whenever psychiatric consultation takes place in general practice, it is important to realise that the consultant is at that moment operating  
20 before the referral filter. More attention must then be given to explanation and to motivating the patient to accept treatment or referral.

Another difference is that when the general practitioner requests a consultation, in contrast to when the medical specialist requests one, he remains responsible for the integral care of the patient, has a long-term  
25 therapeutic contract with the patient, and is usually also the attending physician for the patient's partner and children, so that he has a clear view of the system surrounding the patient. All of this leads to different considerations when offering or insisting upon further diagnostics and therapy. The general practitioner must not put so much pressure on the  
30 patient that he withdraws from his care; moreover, there may also be conflicting loyalties towards other persons in the immediate surroundings, as well as conflicts of conscience. The consultant must keep these factors, which may be playing a role in the decisions of the general practitioner, in mind.

35 Finally, it is desirable to realise that the contextual organisation of general practices may differ sharply from one another. More and more general practitioners no longer work alone but form group practices and play a role in health centres where paramedical personnel is also available to provide care. Sometimes there is a collaborative relationship with  
40 psychologists or social workers, who often are already involved with the patient for whom a consultation is being requested.

### 3.2. Models of consultation

45 The models of consultation in general practice are generally described in the terms that Caplan formulated in the 1960s. From the perspective of 'community mental health', Caplan distinguished between four different types of consultation (Caplan 1963). The first form is the 'patient-centred

case consultation', in which the psychiatrist himself speaks with the patient. The second form is the 'consultee-centred case consultation', which has more of the nature of an interview in which the psychiatrist advises the consultee as to how to deal with a patient that the psychiatrist himself has not evaluated. The third form is the 'programme-centred administrative consultation', in which the main focus is on the organisation of treatment. Finally, the fourth form is the 'consultee-centred administrative consultation', in which attention is paid primarily to the role of the consultee in the organisation of the treatment.

This guideline pertains to patient-centred consultation. Within this form, there are also various possibilities. The psychiatric consultation in the strict sense of the term can take place at the location of the psychiatric practice: the 'diagnostic advisory centre' (DAC) model, or at the location of the general practice: the 'gatekeeper consultation' (POCO) model (Buis 1990; Van der Feltz-Cornelis 2002). In the latter variant, the general practitioner is present during the consultation, which facilitates the joint formulation of a treatment plan.

In practice, psychiatric consultation is often embedded in a larger collaborative relationship in which other disciplines, especially psychiatric nursing, also play a role. In practice, such collaborative models can take a variety of forms, depending on the psychiatric facilities and the target group (Starfield 1973; Pincus 1987). One model that is becoming more and more popular is the so-called 'collaborative care'. The most common form of 'collaborative care' is the one in which a case-manager, usually a social-psychiatric nurse, regularly speaks with the patient in the offices of the general practitioner and follows the course of the psychiatric disorder. The treatment is given in accordance with a treatment plan that was drawn up previously in consultation with the psychiatrist, and which is evaluated at regular intervals and adjusted if necessary. Beck (2004) distinguishes between four goals of 'collaborative care': improving the accessibility of the mental health service, improving the quality of the psychiatric treatment and its results, and improving the communication between the general practitioner and the specialist. Bower, Gilbody and Katon have suggested the following, most widely accepted, definition of collaborative care: collaboration between at least two of the following three professionals: a general practitioner, a nurse-care manager, and a consultation psychiatrist, in the treatment of psychiatric disorders in first-line medical care.

### 3.3. Efficacy of consultation in general practice

#### 3.3.1. Literature examined

In order to answer the question how effective psychiatric consultation in general practice is, a systematic review of the literature was carried out.

*Search terms:* 'consult', 'consultation', 'CL psychiatry', 'CL letter', 'primary care', 'general practice', 'collaborative care', 'psychiatry', and 'mental health', all in combination with 'treatment'.

*Limits:* The search was limited to the languages Dutch, English, German or French.

*Results:* The search yielded 11 hits, including 1 feasibility study, 7 randomised controlled trials (RCTs), 1 study protocol, 2 meta-analyses, and 1 systematic review on collaborative care.

*Other literature:* The Cochrane library was checked for meta-analyses in progress. This yielded a study protocol with the title 'CL letters' for patients with somatoform disorders in a primary care setting (Hoedeman et al. 2007). Moreover, studies in the area of consultation were looked for in the Trimbos Library. This yielded the evaluation of 'Tussen de lijnen' [Between the lines], the thesis by W. Buis, and a study by Bensing into the quality of communication during consultation in primary care. Three RCTs with which the working group was familiar but that were not retrieved by the search were also evaluated (Unützer et al. 2006; Smit et al. 2006; Conradi et al. 2007).

*Selection of the literature:* Only the meta-analyses and the randomised studies are evaluated in this guideline. The studies that were already included in the meta-analyses are not described for the second time separately.

### 3.3.2. Summary of the literature

Because of the great variety in the possible terminology, approaches and forms of organisation, it cannot readily be estimated how complete the results of the literature search were. Only a limited amount of research has been done into the efficacy of psychiatric consultation in general practice. Moreover, most of this research involved patients with a depressive or somatoform disorder, so that the conclusions are valid only for this group of patients and cannot be generalised to all types of psychiatric consultation for the general practitioner.

The meta-analyses that were included are shown in Table 3.1, while the included RCTs are summarised in Table 3.2. The meta-analysis of Gilbody et al. (2006) included 37 studies with a total of 12,355 patients, which investigated the effect of 'collaborative care' on the treatment and prognosis of depression. The 'collaborative care' involved a 'care manager', a consultant psychiatrist, and a 'tracking system'. After six months, the patients in the 'collaborative care' group clearly had fewer depressive symptoms than those in the 'care as usual' group. Even after five years there was still a difference in favour of 'collaborative care'. The authors found an association between this improved outcome and better treatment compliance. In addition, the manner of consultation to the case-managers was associated with a better outcome if the supervision was given at regular intervals, at fixed times, and by professionals with good psychiatric expertise.

The question posed in the second meta-analysis was the identification of active ingredients of 'collaborative care' in patients with depression; however, the meta-analysis also reached a conclusion as to the effect of 'collaborative care' (Bower et al. 2006). This meta-analysis

included 34 studies with a total of 11,606 patients. The patients in the 'collaborative care' group used more antidepressants (OR 1.92) and had a better outcome with regard to their depressive symptoms (standardised mean difference (SMD): 0.24). The largest trial included in this meta-analysis also reported that after 12 months, the patients in the 'collaborative care' group were more satisfied, had fewer functional limitations, and had a better quality of life (Unützer et al. 2006).

Most of the RCTs that were not included in a meta-analysis pertain to somatising patients. Katon et al. (1992) studied the effect of psychiatric consultation for 18 primary care physicians in two primary care clinics during the treatment of 'distressed high users'. Following psychiatric consultation, general practitioners prescribed antidepressants 38% more often and the treatment compliance of the patients was higher. In two studies, Smith et al. investigated the effect of a psychiatric consultation that also involved a so-called 'consultation letter', a written recommendation to both the general practitioner and the patient containing a treatment plan, in the case of somatising patients. The first study had a cross-over design and a follow-up of 18 months. In both groups, the intervention led to a decrease in medical costs, by 53% and 49%, respectively. This cost reduction was largely the result of decreased hospitalisation (Smith 1986). The second study had a follow-up of 24 months and revealed a 33% decrease in the costs of medical care compared to 'care as usual' (Smith 1995). Van der Feltz Cornelis et al. compared the effect of 'collaborative care' training and consultation with that of training of general practitioners without psychiatric consultation in the treatment of somatising patients in general practice. In the intervention group, the severity of the unexplained somatic symptoms decreased by 58%, while the social functioning was better than in the control group and the costs of medical care were less.

In two recently published RCTs, the effect of a depression prevention programme consisting of structured psycho-education, alone or with the addition of psychiatric consultation or cognitive behaviour therapy, was compared with 'care as usual' after six months and three years, respectively. Psychiatric consultation had no added effect after either duration of follow-up. There was a good response in all groups. Moreover, the randomisation procedure used led to unequal group sizes, the group that received psychiatric consultation being significantly smaller than the other groups (Smit et al. 2006; Conradi et al. 2007).

In an open, uncontrolled study, Buis investigated the effect of a diagnostic advisory centre (DAC) on referrals to the mental health service. The possibility of a psychiatric consultation in a DAC led to more referrals to the mental health service for diagnosis and advice, and to fewer referrals for treatment (Buis 1990).

### 3.3.3. Conclusions

Level 1	Psychiatric consultation as part of collaborative care in general practice is effective in patients with depressive and somatoform
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	disorders. <i>A1: Bower et al. 2006; Gilbody et al. 2006 A2: Unützer et al. 2006; Katon et al. 1992; Van der Feltz-Cornelis et al. 2006 B: Smith et al. 1986, Smith et al. 1995</i>
Level 1	Psychiatric consultation in general practice is more effective when consultation is given regularly at fixed times and by professionals with good psychiatric expertise. <i>A1: Gilbody et al. 2006</i>
Level 2	Psychiatric consultation in general practice is probably more effective when a so-called 'consultation letter' is used. <i>A2: Van der Feltz-Cornelis et al. 2006 B: Smith et al. 1986; Smith et al. 1995</i>
Level 3	Psychiatric consultation in general practice probably improves the diagnosis and treatment of depression in patients that are consuming high levels of medical care. <i>B: Katon 1992</i>

#### 5 3.3.4. Other considerations

Research into the efficacy of psychiatric consultation in general practice has been done mainly in the setting of 'collaborative care'. In the models used in the studies discussed here, the psychiatrist had always actually seen and spoken to the patient. The concept of collaborative care as a complex intervention in primary care, with psychiatric consultation embedded in it, makes it difficult to measure the specific contribution of the psychiatric consultation in the complex intervention. It can be concluded, however, that collaborative care is effective, while there is hardly any evidence for the efficacy of psychiatric consultation alone in this setting. Only in the study by Katon et al. (1992) was a psychiatric consultation the only intervention. In some studies, a 'consultation letter' was used, so there were again other factors playing a role besides the advice of the psychiatrist (Smith et al. 1986, Smith et al. 1995).

An attempt to identify the effective ingredients of collaborative care in depressive disorders was made in a 'meta-regression'-analysis of 34 studies in primary care. The analysis showed that the degree of adherence to the recommendations of the consulting psychiatrist was a significant predictor of an effect from the intervention. When studies from the USA were analysed separately from those carried out elsewhere, then for the studies carried out outside of the USA, a positive outcome was found to be associated with a systematic screening of patients for depression, the use of case-managers with a psychiatric background, and the provision of regular consultation and supervision to the case-managers by psychiatrists (Unützer et al. 2006).

All of the research in primary care has been limited to patients with depression and somatoform disorders, so that the findings cannot be

5 generalised to psychiatric consultation for general practitioners in the case  
of other mental symptoms or disorders. However, this is also in  
accordance with the purpose of such consultation, the goal being that  
general practitioners will continue to treat patients with depressive and  
10 somatoform disorders themselves, but will be given support by means of  
consultation. For other disorders, referral is often a more obvious solution  
so that no consultation is required. Moreover, in studies on patients with  
somatoform disorders, the outcome parameter chosen is often the  
decrease in consumption of medical care and the related costs, even  
10 though this is not necessarily an indication of an improvement in the  
symptoms or the quality of life of the patient.

### 3.3.5. Recommendations

The working group recommends that:

- Psychiatric consultation in general practice be embedded as much as possible in a broader system of collaborative care.
- An attempt be made to increase the basic expertise of consultees in the field of psychiatric diagnosis and treatment by means of liaison contacts.
- If psychiatric consultation is offered in general practice, it should be incorporated into daily practice in a structural manner and be carried out at fixed times by fixed consultants.
- In case of consultation in general practice, use be made of a so-called 'consultation letter', a written recommendation from the consultant containing a treatment plan that is given not only to the general practitioner but also to the patient, and is discussed with the latter.

Table 3.1 Summary of the evidence from meta-analyses for the efficacy of psychiatric consultation

Study	Type	Setting	Intervention	Outcome measure	Findings	Level of proof
Bower 2006	meta-analysis	depressive patients in general practice	collaborative care	1. severity of the depressive symptoms 2. treatment compliance with antidepressants	collaborative care was associated with: 1. fewer depressive symptoms following treatment 2. better treatment compliance with antidepressants	A1
Gilbody 2006	meta-analysis	depressive patients in general practice	collaborative care	1. severity of the depressive symptoms 2. treatment compliance with antidepressants	collaborative care was associated with: 1. fewer depressive symptoms following treatment 2. better treatment compliance with antidepressants	A1

Table 3.2 Summary of studies into the efficacy of psychiatric consultation in general hospitals, nursing homes, and categorical institutions. (RCT = randomised controlled trial).

Study	Type	Population	Intervention	Control group	N	Psychiatric diagnosis	Outcome	Level of proof	Remarks
Katon 1992	RCT	General practice	Single psychiatric consultation aimed at the prescription of antidepressants	'care as usual'	18 general practices	depression	Following intervention: - consumption of antidepressants increased - improved treatment compliance	A2	
Smith 1986	RCT Cross-over	General practice	Single psychiatric consultation with a CL letter	'care as usual'	38	somatoform disorder	Following intervention: - reduction in the costs of medical care by 53%	B	

Smith 1995	RCT	General practice	Single psychiatric consultation with a CL letter	'care as usual'	56	somatoform disorder	Following intervention: - reduction in the costs of medical care by 33% - improved physical function	B	
Van der Feltz Cornelis 1996	RCT	General practice	Collaborative care	'care as usual'	81	somatoform disorder	Following intervention: - improved social function - decrease in severity of the physical symptom - reduction in the costs of medical care	A2	
Unützer 2006	RCT	Patients 60 years of age or older in a general practice	Collaborative care	'care as usual'	1801	depressive disorder	Following intervention: - antidepressants used more often - improved treatment compliance - fewer depressive symptoms - improved quality of life	A2	
Smit 2006	RCT	General practice	Depression prevention programme, alone or combined with cognitive behaviour therapy or a psychiatric consultation	'care as usual'	267	depressive disorder	No difference between the interventions	A2	- high response in the 'care as usual' group - unequal group sizes
Conradi 2007	RCT	General practice	Depression prevention	'care as usual'	265	depressive disorder	No difference between the	A2	- high response in the 'care as

			programme, alone or combined with cognitive behaviour therapy or a psychiatric consultation				interventions		usual' group - unequal group sizes
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## CHAPTER 4. PSYCHIATRIC CONSULTATION IN GENERAL AND UNIVERSITY HOSPITALS, NURSING HOMES, AND CATEGORICAL INSTITUTIONS

### 5 4.1. The context of the consultation

Psychiatric consultation in a general or university hospital, nursing home or categorical institution differs in a number of ways from psychiatric assessment in a primary psychiatric setting. Referrals usually take place at the request of the somatic specialist or nursing home physician, rather than at the request of the patient. The patient also suffers from a somatic disease at the time of the assessment. These factors may complicate the diagnosis. Moreover, the psychiatrist is not the attending physician, he only gives advice. The extent to which this advice is adhered to by the attending physician can vary, so that the patient may not be treated optimally. In addition, the psychiatrist is unable to use a therapeutic climate during the treatment of the patient, something that is available in psychiatric wards. This means that a relatively large amount of time must be devoted to discussing the psychiatric findings and recommendations with the treatment and nursing team. Finally, consultation psychiatry in a hospital requires a high degree of flexibility: in principle, every request for a consultation must be honoured, regardless of the number, and it must be possible to carry out emergency consultations immediately.

Epidemiological studies have shown that there is psychiatric comorbidity in 30-60% of all patients admitted to hospital (Narrow and Rae 2002). On the basis of an average consultation rate of 1% in European hospitals, this means that psychiatric disorders are evidently being under-diagnosed, and hence probably also under-treated (Huijse, Herzog, et al. 2001). This not only has prognostic consequences for the patient, but also economic consequences: psychiatric comorbidity is accompanied by an increased consumption of care, including a longer duration of hospitalisation and more frequent readmission (Fink 1990; Saravay and Lavin 1995; Saravay, Pollack, et al. 1996). Although a cause and effect relationship has not been proven, it does seem likely.

### 35 4.2. Models of consultation

In general hospitals, the traditional model of consultation is generally followed. A medical specialist colleague requests a psychiatric consultation, after which the psychiatrist evaluates the patient and reports his findings and recommendations to the consultee. In this model, the psychiatrist enters the picture only after being asked. This classical model has two serious disadvantages. First of all, many psychiatric symptoms and disorders are not recognised by the attending physician; secondly, the advice of the psychiatrist is often not complied with. The liaison model makes an attempt to overcome these deficiencies. In this model, the psychiatrist pays attention not only to the patient, but also to the treatment team. The team learns how to identify vulnerable patients

and how to deal with frequently occurring psychiatric problems and disorders. A role for a consulting psychiatric nurse often constitutes a part of this liaison model.

5 In order to detect psychiatric disorders in a more structured manner, screening instruments have been developed that, in a research context, can be coupled to a psychiatric consultation, a liaison contact, or structured interventions (Saravay 1996; Bower and Gask 2002). In addition, based on the finding that the key problem in medical treatment is not so much psychiatric disorders in the strict sense of the term but  
10 'complexity', methods were developed to detect complexity in an early stage and to start with suitable interventions (Huijse, De Jonge, et al. 2001; Huijse, Lyons, et al. 2001). The most commonly used and best validated screening instrument is the 'complexity prediction instrument' (COMPRI) (Huijse et al. 2001). Once a patient has been identified as  
15 'complex', the nature of the complexity can be established by means of a more systematic inventory of the somatic, psychic and social factors, for example with the INTERMED method ([www.intermedfoundation.nl](http://www.intermedfoundation.nl)).

20 Consultation psychiatry makes use of many different therapeutic techniques. A single therapeutic recommendation often comprises several different points at the somatic, psychic and social level. Furthermore, recommendations are regularly given regarding the approach to and organisation of the care surrounding a patient. During the scientific study of the effect of such therapeutic recommendations, their great diversity constitutes a problem. The degree to which recommendations are  
25 complied with is often unclear. Recently therefore, the interventions have been standardised and described in protocols so as to make better research possible. For the time being, this pertains mainly to research into the consultation psychiatry that takes place in a transmural setting or a general practice (Bower and Gask 2002).

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### **4.3. Efficacy of psychiatric consultation in general and university hospitals, nursing homes, and categorical institutions.**

#### **4.3.1. Literature examined**

35 The point of departure in the literature search was the guideline "Konsiliar- und Liaisonpsychosomatik und -psychiatrie" (Herzog, Stein, et al. 2003) that appeared in Germany in 2003. At that time, a systematic literature search was done into the efficacy of psychiatric consultation given in hospitals over the period up to 1999.

40 *Search terms:* The hospital population (i.e. the subject of the guideline) was defined by the terms 'consultation liaison', 'psychiatric consultation', 'psychiatric diagnosis', 'psychiatric liaison', 'psychiatric service', 'liaison service' or 'psychosomatic consultation', '- liaison' or '- service' in the title or abstract. Subsequently, the term 'explode "Psychiatry" / all  
45 subheadings' was added. Next, this set was combined with 'psychiatric consultation' or 'diagnosis of mental disorders', both via controlled index terms and in free text, together with a list of all relevant hospital

departments, also via controlled index terms. Then, the outcome was defined by 'treatment-outcome' in the controlled index terms, 'outcome' in the title or abstract, or by 'length of stay' or 'mental disorders/rehabilitation'. Finally, this was again combined with 'Referral-and-Consultation' via controlled index terms or with 'referral' in the title or abstract, and with the study types 'clinical trials' or 'evaluation studies'.

The search strategy for nursing homes was somewhat broader: the definition of the population was the same, combined with 'psychiatric consultation' or 'diagnosis of mental disorders', both via controlled index terms and in free text. This set was then combined with 'nursing-homes' via the controlled index terms.

The same search strategy was repeated in Psychinfo. Finally, the Medline search was repeated with the index terms 'satisfaction' or 'consumer-satisfaction' in order to retrieve studies into the satisfaction of the consultees.

*Limits:* The search was limited to articles published since 1996 in one of the following languages: Dutch, German, French and English.

*Yield:* This search strategy ultimately yielded 113 articles for the hospital setting and 46 for the nursing home setting. The supplementary search in Psychinfo yielded 33 additional articles for both settings together. The search for articles on the 'satisfaction' of the consultees yielded 35 articles.

*Other literature:* The German guideline was looked upon as a systematic review of the literature up to 1999 (Herzog, Stein, et al. 2003). However, we also examined 3 articles that had not been identified as clinical trials in the German guideline (Levitan and Kornfeld 1981; Strain, Lyons, et al. 1991; Levenson, Hamer, et al. 1992), a study by Hengeveld et al. that was already published in 1988 but had not been included in the German guideline, and 4 articles that studied the added effect of liaison activities on consultation practice, with which the working group was familiar but which were not retrieved by the literature search (Scott, Fairbairn, et al. 1988; De Leo, Baiocchi, et al. 1989; Baheerathan and Shah, 1999; Swansinck, Lee, et al. 1994).

*Selection of the literature:* A total of 227 abstracts were evaluated; of these, the full text was ordered for 29 articles. The remaining 198 were rejected for a variety of reasons: the setting was not a general hospital or nursing home but, for example, general practice, mental health services, prisons, or paediatric and adolescent wards; the study described only the results of screening or the validation of screening lists or observation scales; no intervention was described or the intervention consisted of the involvement of a C-L nurse; the question posed was the concordance between the reason for requesting a consultation and the psychiatric diagnosis; or the population investigated consisted of self-referrals or referrals by the general practitioner. Finally, there were a number of duplicates between the different searches.

Of the 29 articles that were read, 18 were excluded after all for the following reasons: the question posed concerned the timing of requests

for consultation (3), the study was a comparison of an intervention carried out in different subgroups (3), the study concerned the validation of a screening instrument (2), or other reasons (10 times, each reason occurred only once). The remaining 11 articles were included.

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#### 4.3.2. Summary of the literature

Table 4.1 provides a summary of the reviews on the efficacy of psychiatric consultation, while Table 4.2 shows a list of the studies that were identified.

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The literature on the efficacy of consultation-psychiatric interventions is limited and diverse. Due to the broadness of the subject matter, it is difficult to estimate whether the literature search was complete. One remarkable finding is that in all the controlled studies retrieved, the giving of psychiatric consultation was not the intervention but the control condition, i.e. the 'care as usual'. In these studies, the intervention usually consisted of a form of screening, followed by a described activity if the outcome of the screening was positive. The activity can vary from a single consultation up to liaison activities and/or standardised interventions according to a protocol, in some cases transmural. The key question in these studies was therefore not the absolute effect of a psychiatric consultation but the possibilities of increasing the efficacy of a consultation.

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In the German guideline from 2003 and in an article by Saravay in 1996, the literature on the outcome and efficacy of psychiatric consultation and psychiatric interventions for somatically ill patients is summarised (Table 3.1). The authors of the German guideline concluded that psychiatric consultation is effective in three areas. First of all, there are positive effects on the clinical outcome measures. Moreover, there are effects on the consultees: these turn out to be more satisfied with the psychiatric care if the consultations are combined with liaison activities. Finally, they found that psychiatric consultation led to a shorter duration of hospitalisation. However, there was too little insight into the total costs of care to demonstrate a possible economic effect (Herzog, Stein, et al. 2003). In his review, Saravay suggests that a direct study into the effects of psychiatric consultation may not have been for ethical reasons: it is ethically unjustified not to carry out a consultation that has been requested. Research has been done, however, into the effect of psychiatric consultation done as a result of screening, as well as into the effect of combinations of screening and liaison activities. In his review, Saravay concludes that there are no indications that psychiatric screening done as a result of screening is effective. Interventions that were supported by liaison activities or that took place within a specialised team were effective (Saravay 1996).

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There are a few studies in which the effect of a consultation-psychiatric intervention was demonstrated. Levitan et al. and Strain et al. report positive effects from a consultation-psychiatric intervention following screening on both health and economic parameters in older

patients with a hip fracture (Levitan and Kornfeld 1981; Strain, Lyons, et al. 1991). Hengeveld et al. screened patients in an internal medicine ward for depression with the aid of the Beck Depression Inventory, followed by a psychiatric consultation when the patient scored higher than the cut-off point. They describe a positive effect from this intervention on existing depressive symptoms, but no cost savings (Hengeveld, Ancion, et al. 1988). De Jonge reports a reduction in the duration of hospitalisation, especially in patients over the age of 65, when a screening for complexity (by means of the Complexity Prediction Instrument, COMPRI) is carried out on admission to an internal medicine ward, followed by an integral screening with the INTERMED, and then followed by a psychiatric and/or multidisciplinary intervention (De Jonge, Latour, et al. 2003). Kominski et al. investigated an intervention that took place after discharge from the hospital on the basis of screening during the hospital stay. There was no difference in the clinical outcome measures between the intervention and control groups, but there were cost savings (Kominski, Andersen, et al. 2001). An uncontrolled study of patients with substance abuse that had been admitted for other reasons showed that a psychiatric consultation while in hospital led to decreased substance abuse after discharge (Alaja and Seppa 2003).

Two controlled studies in which screening was followed by a single psychiatric consultation revealed no effect from the consultation (Levenson, Hamer, et al. 1992; Gater, Goldberg, et al. 1998).

The study by Brown occupies a unique place. In this study, the differences in the efficacy of psychiatric consultation in the emergency ward between hospitals with their own consultation-psychiatric service and hospitals that must consult a psychiatrist from another organisation or that allow the psychiatric care to be provided by the staff of the emergency ward were examined from an organisational point of view. Hospitals with their own consultation-psychiatric service reported fewer recurrent presentations to the same emergency ward (Brown 2005).

The one randomised controlled trial (RCT) in a nursing home revealed no differences between the efficacy of a consultation-psychiatric approach to mental and psychiatric problems, 'collaborative care', or 'care as usual'. The patients in all three intervention groups improved to the same degree (Brodaty, Draper, et al. 2003). A second RCT, in which newly admitted patients were screened and referred to the regional (and hence external) mental health service, also revealed no differences in various measures of health after 12 months (Kotynia-English, McGowan, et al. 2005).

With regard to the satisfaction of consultees, Meesters found that nursing home physicians are generally satisfied with their psychiatric consultants, but that this may to some extent be based on limited expectations (Meesters 2002). In another uncontrolled study, Phillips describes the high level of satisfaction of referring physicians following the introduction of a consultation-psychiatric service in a hospital for obstetrics and gynaecology (Phillips, Dennerstein, et al. 1996). The only

controlled study in the area of the satisfaction of consultees with the psychiatric consultation shows that the consultee is more satisfied if the consultation was accompanied by liaison activities in the direction of the department concerned, and that this also leads to high percentage of consultations (Schubert, Billowitz, et al. 1989). It is interesting that this study was 'blinded': as demonstrated by questioning after the study, the registrars in the departments involved had no idea that they had been included in the 'liaison' group of a study. In a case of consultation psychiatry in geriatric patients, it appeared that the performance of liaison activities led to a higher referral rate, improved statement of the question by consultees, and better compliance with prescribed psychotropic medication (Scott, Fairbairn, et al. 1988; De Leo; Baiocchi, et al. 1989; Swansinck, Lee, et al. 1994).

#### 4.3.3. Conclusions

Level 1	<p>Psychiatric consultation in the hospital and nursing home setting is probably effective; there is no evidence for the efficacy of single evaluations based on the results of screening. However, the efficacy is often measured in terms of a decrease in the duration of hospitalisation and/or cost savings, and not or not only in terms of decreased symptoms or an improved prognosis.</p> <p><i>A1 Herzog, Stein, et al. 2003; C Saravay 1996</i></p>
Level 2	<p>In <i>selected populations</i>, screening according to protocol followed by consultation and liaison activities is probably more effective than providing consultation only on request.</p> <p><i>A2 Saravay 1996; B Levitan and Kornfeld 1981; Strain, Lyons, et al. 1991</i></p>
Level 3	<p>There are indications that consultation for the benefit of an emergency ward from the hospital's own consultation-psychiatric service is more effective than consultation by an external body or non-psychiatric specialists.</p> <p><i>B Brown 2005</i></p>
Level 3	<p>There are indications that carrying out liaison activities has a positive effect on consultees and leads to more and better referrals, a greater compliance with advice as to medication, and more satisfaction on the part of the consultee.</p> <p><i>C Schubert, Billowitz, et al. 1989; Scott,, Fairbairn, et al. 1988; De Leo, Baiocchi, et al. 1989; Swansinck, Lee, et al. 1994</i></p>

#### 4.3.4. Other considerations

The purpose of this literature search was to find articles on the efficacy of psychiatric consultations in general, from a point of view broader than a specific syndrome. A search into the efficacy of specific psychiatric interventions in specific syndromes, such as in delirium, for example, was not felt to fall under the tasks of the guideline working group. As a result, no conclusions can be reached regarding the efficacy of specific interventions in particular syndromes or patient populations. For such information, the reader is referred to guidelines pertaining specifically to the syndrome in question.

It is striking that research into the efficacy of consultation psychiatry has concentrated especially on a reduction in the duration of hospitalisation and/or cost savings, and to a lesser extent on clinical outcome measures such as symptom reduction and prognosis improvement. This is to some extent understandable, but critical comments could also be made. The combination of the fact that a great deal of psychopathology is not recognised in a somatic setting, together with the fact that somatic patients with psychiatric comorbidity cost more and receive general healthcare for longer periods of time, leads to the hypothesis that psychiatric consultation might contribute to shortening the duration of hospitalisation and reducing costs. However, economic considerations must not be the only factor to be considered. An improved prognosis and care of better quality should also be weighed against the costs of care. If psychiatric care is expected to pay for itself, regardless of the benefits to the patient, while the same is not said of somatic care, this can lead to discrimination between syndromes and groups of the population (Sturm 2001). Also, the fact that there is a robust association between psychiatric disorders and an increased consumption of medical care does not automatically mean that better psychiatric care will, or should, result in cost savings (Sturm 2001).

#### 4.3.5. Recommendations

In order to increase the efficacy of psychiatric consultations, the working group recommends:

- setting up screening activities in selected patient populations, directed at the detection of the most frequently occurring psychiatric problems and the early identification of 'complex' patients
- maintaining follow-up contacts when a recommendation for further diagnostics or treatment is given after an initial consultation
- investing in the development of liaison activities in the departments that request consultations
- organising the consultation psychiatry and liaison activities within the general or university hospital itself, if possible, and not from an external organisation



**Table 4.1. Summary of the evidence, from existing guidelines and reviews, for the efficacy of psychiatric consultation.**

Study	Type	Setting	Interventions	Outcome measure	Findings
Saravay 1996	scholarly review	General hospital and general practice	1. consultation at request 2. consultation based on the results of screening 3. integrated consultation and liaison model 4. collaboration within specialist multidisciplinary teams	Only clinical outcome parameters	1. no research has been done into consultation on request 2. consultation based on the results of screening is no more effective than consultation without screening 3. consultation embedded in an integrated consultation and liaison model or a multidisciplinary team is effective on clinical parameters.
Herzog 2003	Systematic review as part of an evidence-based guideline	General hospital	all psychosomatic and consultation-psychiatric and liaison activities	1. clinical outcome measures 2. effects on the referring physician 3. economic parameters	1. there are indications for positive effects on clinical outcome measures 2. the satisfaction of consultees is increased when consultation is accompanied by liaison activities 3. shortening of the duration of hospitalisation has been demonstrated, but there is too little insight into the total costs

**Table 4.2. Summary of studies into the efficacy of psychiatric consultation in general hospitals, nursing homes, and categorical institutions.**

Study	Int Type	Population	Intervention	Control condition	N	Psychiatric diagnosis	Outcome	Level of proof	Remarks
Levitan 1981	prospective, historical control group	Women over the age of 65 with a femur fracture	A single psychiatric consultation as a means of screening	'care as usual'	I: 24 C: 26	All	With intervention: - shorter hospital stay - cost savings - more often discharge home	B	

Hengeveld 1988	RCT	Patients admitted to an internal medicine ward	Screening with the BDI, and psychiatric consultation in case of positive screening	'care as usual'	I: 33 C: 35	Depression	- In the intervention group, less depressive and lower consumption of analgesics and psychotropic drugs on discharge - no differences in length of hospital stay or costs.	B	Randomisation via alternating assignment
Scott 1988	retrospecti ve, comparati ve	Geriatric admissions	Consultation in a liaison setting	Consultation on request	217	All	Liaison activities lead to: - 100% more referrals - better formulation of the question - better recognition of depression	B	
De Leo 1989	retrospecti ve, comparati ve	Geriatric admissions	Consultation from an integrated CL service	Consultation on request	607	All	An integrated consultation service leads to: - more referrals - better compliance with recommendations (possibly due to better follow-up) - shift in medication: less benzodiazepines more antidepressants	B	
Schubert 1989	RCT	Registrars in a department of internal medicine	Psychiatric consultation accompanied by liaison activities	Consultation on request	I: 16 C: 13		In the intervention group: - higher consultation rate - consultees more satisfied	B	

Strain 1991	prospective, historical control group	Women over the age of 65 with a femur fracture	A single psychiatric consultation as a means of screening	'care as usual'	452	All	With screening according to protocol: - more rapid discharge, cost savings - better clinical outcome parameters	B	
Levenson 1992	RCT	Patients admitted to an internal medicine ward	A single psychiatric consultation as a means of screening	'care as usual'	I: 256 C: 232 baseline C: 253 contemp- - oraneous	Depression, anxiety, confusion and pain	- no difference in costs	A2	the control group was limited to a single contact
Swanwick 1994	retrospecti- ve, comparati- ve	Hospitalised patients	Consultation and liaison activities	Only consultation	149	All	- no difference in the number of requests for consultation - better formulation of the question in the liaison model	B	
Philips 1996	prospective, non- comparati- ve	Consultees in the department of obstetrics and gynaecology	Introduction of a consultation service		45 physician s		- high level of satisfaction in the consultees - the consultation rate is no higher than before the introduction of a consultation service	C	
Gater 1998	RCT	Clinical patients on an internal medicine ward	Screening with the GHQ 28 and randomisation over three groups: 1. psychiatric consultation 2. screening result	3. the result of screening is not made known	I 1: 68 I 2: 70 C: 71	Mainly depression and anxiety	After half a year, no difference in the clinical outcome or costs	B	- the randomisation procedure is unclear - only a single consultation in the I 1 group

			reported to the attending physician						
Baheerath an 1999	prospective, naturalistic	Patients admitted to the geriatric ward	Addition of liaison activities to consultation alone	Only consultation	155	All	Fewer requests for a consultation	B	Simultaneous change in the admissions policy
Kominski 2001	randomised trial	Patients admitted to the internal medicine and surgery wards of more than 60 VA hospitals	A single psychiatric consultation as a means of screening. After discharge, in case of positive screening, the UPBEAT intervention (extensive psychogeriatric diagnostics with multidisciplinary treatment and coordination of care)	'care as usual'	1687	Mood disorders, anxiety disorders and alcoholism	- no difference in the clinical outcome or quality of life (both improved) - shift in the use of clinical and ambulatory psychiatric facilities - net cost savings in the intervention group	B	
Meesters 2002	prospective, non-comparative	Nursing home physicians	'care as usual' on a consultation basis		14 physicians from 14 nursing homes		- the consultees are satisfied with the psychiatric consultant	C	The satisfaction seems to be based partly on limited expectations
De Jonge 2003	prospective, historical control group	Patients admitted to an internal medicine ward	Screening with COMPRI and INTERMED; psychiatric or multidisciplinary intervention in case of positive screening	'care as usual'	231	All	Shorter hospital stay, especially in patients over the age of 65	B	
Brodaty	RCT	Patients from	A single psychiatric	3. 'care as	102	Dementia	Severity of the	B	

2003		11 nursing homes	consultation as a means of screening, followed by: 1. psychogeriatric case-management 2. written therapeutic advice with the possibility of a psychiatric consultation	usual'		with depression and/or psychosis	depressive or psychotic symptoms		
Alaja 2003	prospective, non-comparative	Clinical patients	A single psychiatric consultation as a means of screening, with an offer of after-care		218	Substance abuse	Less substance abuse after discharge	C	Follow-up in only 113 patients
Brown 2005	comparative, retrospective	Emergency ward	Psychiatric consultation by: 1. the hospital's own consultation service	Psychiatric consultation by: 2. an external psychiatric service 3. non-psychiatric emergency ward personnel	71 hospitals and 4686 patients	All	With an internal consultation service: fewer re-evaluations on the same emergency ward No difference in costs	B	Control groups 2 and 3 were combined for the analysis
Kotynia-English 2005	RCT	Newly admitted nursing home patients older than 65 years	Screening with HoNOS, MMSE, GDS, NPI and GDS. When GDS >5 referral to a regional mental health service	'care as usual'	I: 53 C: 53		- after 12 months, no difference in the clinical outcome measures	B	No internal consultation service, but consultation by an external body

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## CHAPTER 5. THE PSYCHIATRIC CONSULTATION

### 5.1 The consultation procedure

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#### 5.1.1 Introduction

In principle, the same points of departure and requirements pertain to a psychiatric assessment in general practice and on a somatic ward of a hospital as to every 'regular' psychiatric assessment. These are laid down in the 'Guideline for the psychiatric examination of adults' of the NVvP (Guideline committee on psychiatric examination of adults, NVvP 2004). Still, there are a number of aspects that make the assessment of patients in a general practice or on a hospital ward different from an assessment in a psychiatric outpatient clinic or a department of clinical psychiatry. In general practice, this is related to the fact that the psychiatrist is working ahead of the referral filter (see section 2.1), so that the presentation of the symptoms is often less clear and the patient is less motivated. In the hospital setting, the assessment is complicated mainly by the existing somatic comorbidity. In addition, in this setting, it is usually not the patient himself that has requested an assessment, but his attending physician. In both settings, the psychiatrist, as a consultant, usually does not treat the patient but has only an advisory function vis-à-vis the general practitioner or specialist. The policy with regard to patients that are seen in consultation must be agreed upon in a setting where both the physicians and the nurses often have little psychiatric expertise and experience, and where unfortunately there is sometimes also little affinity with psychiatric disorders. Finally, the location and circumstances in which the consultation must be carried out, especially in hospital, are sometimes far from ideal. These setting-specific aspects were discussed in chapters 3 and 4.

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#### 5.1.2 Literature examined

This chapter is based mainly on 'expert opinions' and consensus statements. With regard to the expert opinions, we have based ourselves as much as possible on published opinions. These were found in the chapters on psychiatric consultation in the available Dutch and foreign textbooks in the field of consultation psychiatry and psychosomatic medicine. For a summary of the literature consulted, please see Table 5.1. Whenever a finding or opinion is supported by research or additional literature, this has been included as a reference. The opinions of the members of the working group were adopted only in those cases where no relevant information was available. Section 5.2 was, however, written on the basis of a systematic search of the literature.

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#### 5.1.3 The psychiatric consultation

This section discusses the different stages of a psychiatric consultation, step by step, and provides an explanation of the special characteristics of

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psychiatric assessments in general practice and on the somatic wards of general or university hospitals, all in chronological order. Clarity regarding the collaborative agreements between consultee and consultant is important. With regard to the consultation itself, the following stages can be distinguished: the request for a consultation, the questions that are to be answered, the collection of the prior knowledge, the contact with the patient, including the assessment itself, possible supervision of the registrar (see chapter 8), the report to the attending physician, the treatment stage, the termination of the consultation, and the final report, if any, and concluding administrative procedures.

#### 5.1.3.1 *Collaborative agreements*

In both general practice and the hospital setting, it is important that the agreements regarding what is to be done are clear to both parties. In the hospital, these agreements are often implicit and based on tradition. These agreements in the case of a psychiatric consultation are not very different from those when other medical specialists are consulted. The situation in general practice is different, and some of the agreements must be made explicit. While a hospital psychiatrist is, in principle, responsible for all of the psychiatry in the hospital 24 hours a day, and must therefore see every patient, the psychiatrist can make agreements with the general practitioner regarding which categories of patients and how many patients he will see. For example, should the consultation psychiatrist see the general practitioner's acutely suicidal or psychotic patients, or should these be referred to the emergency mental health service? It should also be made clear that the consultant will not take over the treatment, and the possibilities of referral to the institution where the psychiatrist is employed should be clarified. It is also important to reach agreement regarding the question of whether or not the general practitioner should be present during the consultation, especially when the educational aspect of the consultation is relatively more important.

#### 5.1.3.2 *Requesting a consultation*

Depending on the organisation of the consultation service, requests for a consultation will either go to the consultant directly or be received at a central point, such as a secretariat. A central point for receiving requests is especially important when a number of consultants are employed within the institution, or when the consultant on duty often changes or is difficult to reach. A central telephone number for consultations lowers the threshold for referral by the consultee. During the very first contact by telephone, it is important to obtain not only the personal data and location of the patient but also a brief explanation of the question that is to be answered, so that an initial triage can be carried out. The goal here is to make possible an estimate of the degree of urgency. In the case of general practice, clear agreements should be made regarding the possibilities for an emergency evaluation of patients. In the hospital, all consultations on the emergency ward must be considered urgent, but

consultations on somatic wards where there is a serious behaviour disorder accompanied by hinder or danger, or a desire for immediate discharge on the part of a patient that may be mentally incompetent, must also be considered urgent. In the hospital, consultations concerning  
5 restless, confused, psychotic or possible delirious patients should be carried out on the day of the request, in view of the unpredictable course of these symptoms. This is also true of consultations concerning suicidal patients. Consultations requested for other reasons, such as an analysis  
10 of cognitive symptoms, depressive symptoms without a suicidal tendency, incomprehensible somatic symptoms, and difficulties in dealing with problems, can be carried out according to a regular schedule.

#### 5.1.3.3 *The questions that are to be answered in the consultation*

Before there is any contact with the patient, there must be clarity  
15 regarding the questions that are to be answered. The limited psychiatric expertise of the consultee means that the question posed will sometimes be unclear or incorrect, and the consultee may also have implicit and clearly unrealistic expectations regarding the consultation. Making the request for help more explicit also clarifies these mutual expectations. In  
20 this way, a well-aimed history can be taken so that the questions posed can be answered and a relevant report submitted to the attending physician. Adjusting the consultation to the questions posed by the attending physician leads to more satisfaction on the part of the attending physician and a higher consultation rate (Schubert, Billowitz, et al. 1989).  
25 Adequate adjustment of the consultation will also ultimately lead to more appropriate and better formulated questions and a decrease in the number of emergency consultations (Vaz and Salcedo 1996). In general, the consultee expects the psychiatrist to make a diagnosis and give advice as to treatment, so that part of the responsibility for the patient is  
30 assumed by the psychiatrist. The therapeutic advice may involve the prescription of medication, a recommendation for referral, or a recommendation regarding the approach to the patient (Shakin Kunkel and Thompson 1996). In addition, the consultee expects that possible referrals for psychiatric follow-up treatment following the assessment or  
35 after discharge will be arranged by the consultant (Cohen-Cole and Friedman 1982).

The timing of the request for a consultation can also yield valuable information, particularly regarding the inappropriate use of consultation. In the hospital setting, a psychiatric consultation is sometimes only  
40 requested when a particular symptom or problem threatens to escalate. Such a request for a consultation is then often accompanied by a request for transfer to the psychiatric ward, since the internal medical or surgical treatment has been 'completed'. Such transfer requests are usually unjustified and can often be prevented by requesting a consultation at an  
45 earlier stage (Schwab and Brown 1968). Other situations in which one should suspect 'inappropriate' requests are, for example, when patients cause hinder or when a so-called 'wrong bed' situation has arisen. In

these cases as well, the psychiatric consultation is often misused to accomplish or accelerate a transfer to the psychiatric ward or to a nursing home. The suspicion that there are communication problems with the patient or 'staff problems' can sometimes be aroused purely by the question that is posed. An emotional wording of the question, an unclear question, a request for a consultation at an abnormal time, an unjustified indication of urgency, and a hidden agenda are often indications of these kinds of problems (Hengeveld, Rooymans, et al. 1987). An inappropriate question or a double agenda are seen in an estimated 13% of all psychiatric consultations (Bustamente and Ford, 1981). When such referrals occur more than incidentally, there is a need for refresher training or other liaison activities directed at the consultee or department concerned.

#### 15 5.1.3.4 *Collecting the prior knowledge*

The argument that the patient should be approached with an open mind, without being influenced too much by prior knowledge, does not hold for consultation psychiatry. Before seeing the patient, the psychiatrist must inform himself thoroughly with regard to the context of the request for a consultation and hence the somatic diagnosis, the results of laboratory tests and any other supplemental diagnostics, the nature and stage of the treatment, and the prognosis. This contextual orientation is essential in order to gain the patient's confidence and to make it possible to assess the value of the information that is obtained during the consultation, as well as the patients' emotional reaction, if any (Yager 1989). Prior knowledge can be obtained via a personal conversation with the consultee or nursing staff, but this is not always necessary. When the question posed is clear, then a study of the patient's medical file will often suffice. Such an examination of the medical file must of course never be a reason for avoiding contact with the general practitioner or specialist. The general practitioner (in case the patient has been admitted to hospital) or previous attending physicians can also be consulted if necessary.

#### 5.1.3.5 *Contact with the patient*

##### 35 5.1.3.5.1 Time and place

In general practice, consultations will generally take place by appointment. In the hospital, a number of factors must be taken into consideration when the time of a consultation is planned. For the assessment of patients that are hospitalised, it can be useful to arrange a time at which the patient can be seen with the nursing staff of the department concerned, so as to avoid a situation in which the patient has just left or must leave for a diagnostic examination. When there is a need for a hetero-anamnesis, a visit by the key figures can be requested and an appointment can be planned, during or outside of visiting hours. Times at which the patient is supposed to rest should be respected if at all possible.

The conversation with the patient should preferably take place in a separate room that guarantees sufficient privacy so that symptoms that are embarrassing to the patient, or intimate details, can also be discussed. A possible alternative is to request the other patients in the ward to leave the room during the conversation. A feeling of privacy can be created by drawing the curtains around the bed and by focussing on the patient sufficiently. A fundamentally empathic attitude in which the psychiatrist displays sympathy for the circumstances in which the patient finds himself contributes to confidence and treatment compliance (Royal College of Physicians & Royal College of Psychiatrists 2003).

#### 5.1.3.5.2. Communication with the patient

In the setting of a psychiatric consultation, even more than during 'ordinary' assessments in the outpatient clinic, good communication is of great importance. Both in general practice and in a hospital setting, a low threshold and a motivating attitude are important because the patient must still agree to a possible referral or treatment. Greater demands are made on the empathic ability of the consultant. Patients that are hospitalised have been torn away from their normal environment and suffer from a somatic disease. This is accompanied not only by somatic symptoms but also by emotional symptoms, uncertainty, and sometimes by existential questions, certainly if there is danger of death. Sufficient attention will have to be given to these aspects during the consultation (Royal College of Physicians and Royal College of Psychiatrists 2003). Moreover, greater demands are made on the medical knowledge of the psychiatrist. He should be well informed regarding the somatic diagnosis, treatment and prognosis of the patient so that he can judge the patient's situation better and give more adequate answers to the patient's questions (naturally only to the extent that they pertain to the psychiatrist's own expertise).

The interview technique must also be adjusted to the patient. Most of these patients have had no experience with psychiatry. Psychoanalytic techniques that leave a great deal of room for free association and periods of quiet are seldom suitable in a psychiatric consultation (Shakin Kunkel and Thompson 1996). Psychodynamic interpretations of observed cognitions and behaviour can of course play a useful role (Viederman and Perry 1980). In general, a less open interview over a relatively short time should yield the information that is necessary to answer the questions posed. However, attention must of course also be given to the impact of the disease on the patient. Questions as to how the patient experienced his hospitalisation and whether or not he has confidence in the treatment can yield important information and provide clear evidence of possible conflicts with the attending physician in an early stage. It is also important to provide the patient with feedback, during the consultation, regarding the information that has been obtained. This can prevent misunderstanding and shows the patient implicitly that he is being listened to. Support, admiration and sympathy are important here. At the

end of the consultation, the patient must also be told the conclusions and advice.

5 Good communication with the patient is important because this can have a positive effect on the prognosis in a number of different ways. In the cognitive area, the transfer of information to the patient can lead to greater understanding of and insight into his own situation; in the emotional area, good communication can contribute to reducing distress and increasing patient satisfaction; at the behavioural level, good communication leads to better treatment compliance (Royal College of Physicians and Royal College of Psychiatrists 2003).

#### 5.1.3.5.3 First acquaintance

15 In general practice, a psychiatric consultation is generally requested and agreed to after consultation with the patient. It would be well to take the fact into consideration that in the hospital setting, in most cases by far, a psychiatric consultation is not requested at the patient's initiative and that the patient is in some cases not even informed of the fact that a psychiatrist will pay him a visit. It is advisable, therefore, to take this into consideration during the first contact by describing the framework within which the consultation will take place and by asking the patient whether he had been informed about the consultation (Yager 1989). If it turns out that the patient was not informed, this should of course be discussed with the attending physician.

25 Even if the patient was informed, it is possible that, as a result of prejudice or insufficient knowledge, he is not at all pleased with the idea of a psychiatric consultation. Such resistance must be recognised and openly discussed before one can proceed with history taking and examination. A more structured analysis of the symptoms can only begin after acquaintance has been made in a satisfactory manner, there is sufficient confidence, and the patient is clear about the framework in which the assessment will be made.

#### 5.1.3.5.4 Psychiatric evaluation

35 The system to be applied here is the same as with any psychiatric examination: a specific kind of history must be taken, insight must be obtained into the prior medical history and family history, and a mental status examination must be carried out, sometimes supplemented by one or more relevant psychometric scales, all in a relatively short time. In principle, the guidelines described in the Guideline for the Psychiatric Examination of Adults also apply here.

45 In connection with possible recommendations regarding the approach to the patient, it is useful not to limit the history and the psychiatric examination too strictly to the immediate question posed, but also to determine in a general sense how the patient feels about his disease and the treatment (Royal College of Physicians & the Royal College of Psychiatrists 2003). There are other factors that should not be discussed in too much detail. A single assessment, and certainly one

during a stay in hospital, is not a suitable context for an extensive exploration of emotionally laden subjects. A detailed exploration of recalled sexual abuse, for example, can lead to too much unease during a hospital stay and hence actually impede recovery. The collection of  
5 general information should be the point of departure here, not the building up of a therapeutic relationship. In such a case, it is better to give the patient a signal that his problem has been understood and to create the perspective of treatment following recovery or discharge.

#### 10 5.1.3.6 *Reporting and advice*

After the consultation has been completed, a report and advice must be given to the consultee. The latter usually has little knowledge or experience with psychiatry. This should be taken into consideration in the report so that essential information is correctly transmitted. Both form  
15 and content of the assessment and advice must be understandable for the consultee. The style of the report should be dictated by pragmatic considerations, for the purpose of giving therapeutic advice that is as specific as possible, in the hope that this will increase the compliance with the advice.

20 In the case of consultation in general practice, there are indications that a written therapeutic contract ('contracting') has a positive effect on treatment compliance. In 'contracting', the written report of the consultation (consultation letter) from the consultant is discussed with the patient and the patient commits himself explicitly to follow the treatment  
25 (for a summary of the studies that support this conclusion, please see section 3.3.2). There is no experience with such a model in the hospital.

In general, the report should be written in the form that is in general use in the medical model. This has a logical structure that fits in with the practice of general practitioners and somatic specialists: the  
30 reason for the consultation, anamnesis, psychiatric examination, physical or neurological examination if any, conclusions, and management. In the case of consultations in general practice, the consultant usually reports his recommendations to the consultee in a letter. In the hospital, interdisciplinary consulting forms are usually used. In principle, the report  
35 must then fit into the space provided by this form. If more documentation regarding the anamnesis is wanted, for the benefit of follow-up contacts, then a separate file can be set up for this purpose. In general, the institution's form for interdisciplinary consultations is used for an initial assessment and any follow-up contacts are merely recorded in the  
40 patient's medical file. Finally, it goes without saying that the report must also be readable. Naming or numbering the recommendations systematically imparts clarity and structure to the report.

45 The content should be businesslike and understandable, and should fit in with the background and experience of the consultee. This means that psychiatric jargon, which can be assumed not to be understood by every physician, must be avoided. This also means that the information must be based primarily on observed symptoms and complaints from the

patient. Both the conclusion and the therapeutic recommendations must be clear.

#### 5.1.3.7 *Treatment and follow-up contacts*

5 If an initial assessment leads to recommendations for further diagnostics or treatment, then the psychiatrist's role in this must be clear to the  
consultee. When a consultant limits himself to giving advice, then the  
principal therapist is responsible for its implementation; if there is to be  
10 co-treatment, then the psychiatrist is responsible for his part of the  
treatment. The consequences of advising or co-treatment are discussed  
further in section 8.1. Diagnosis and treatment should be carried out as  
much as possible according to the evidence-based guidelines that have  
been adopted by the professional society. In the case of psychiatric  
15 follow-up of hospitalised patients, the working group is of the opinion that  
the psychiatrist himself must bear the responsibility.

#### 5.1.3.8 *Terminating the consultation*

It must be clear to the attending physician when the involvement of the  
psychiatrist with his patient has ended. This should be indicated clearly in  
20 the correspondence or the patient's file. There should also be clarity  
regarding the gradual discontinuation or continued administration of the  
medication prescribed by the psychiatrist, and regarding any psychiatric  
follow-up care. Although it is in principle the task of the attending  
physician to see to it that any referral in fact takes place, it is often easier  
25 to make the appointments for follow-up care one's self.

Depending on the institution, it may or may not be the custom to  
write a letter regarding every consultation. In case of consultation in  
general practice, this is to be recommended. In the hospital this is, in  
principle, unnecessary since the attending physician is supposed to  
30 include any relevant therapeutic information in his discharge letter. Older  
research reveals, however, that this happens in only 50% of the cases  
(Callies et al. 1980), so that many consultation services have decided to  
report their findings in a letter anyway. For complex patients, and  
especially when they are referred to a different institution for follow-up,  
35 the indication and the proposed treatment can often be put into words  
better by the consultant, so that in these cases, in order to prevent  
misunderstanding, it is recommended that a letter be written to both the  
somatic therapist and the future psychiatric therapist.

#### 40 5.1.3.9. *Registration of the activities and procedures*

Registration of the activities and procedures is necessary in order to  
obtain management information. On the basis of this information, the  
capacity of the staff can be estimated and an improvement in quality can  
to a certain extent be directed. Sometimes, the registration of activities  
45 can serve other purposes as well, such as scientific research. Registration  
of activities and procedures is therefore necessary. For most institutions,  
the compulsory registration within the framework of 'DBC Zorg'

[Diagnosis Treatment Combination Care] and 'DBC GGZ' [Diagnosis Treatment Combination Mental health service] will suffice to achieve these goals. The DBC regulations are subject to frequent change. Current information regarding 'DBC Zorg' and 'DBC GGZ' can be found on their respective websites: [www.dbczorg.nl](http://www.dbczorg.nl) and [www.dbcggz.nl](http://www.dbcggz.nl).

#### **5.1.4. The use of measuring instruments.**

Measuring instruments are used more and more often in clinical practice in order to standardise the assessments. Depending on the purpose of the measuring instrument, the goal may be screening, diagnosis or the determination of severity. Screening may be either global, to determine the prevalence of not further specified psychiatric symptoms, or specific to determine the prevalence of a specified psychiatric disorder. Also with regard to diagnosis, the purpose may be the broad diagnosis of not further specified disorders, or the diagnosis of a specified psychiatric disorder. Other measuring instruments have been developed to determine the severity of a single symptom or syndrome.

Whether or not a measuring instrument is used depends, among other things, on the circumstances, the time available, and the experience of the assessor. The choice of a particular instrument depends, in addition to practical considerations, on the goal for which it will be used and its psychometric properties. It is important to know whether the instrument has been validated for screening, diagnosis or the determination of severity. For screening instruments, high sensitivity and a negative predictive value are important, while diagnostic scales should have a high specificity and a positive predictive value. In addition, it is important that the instrument be validated in the same setting and population in which it will be used. The multiplicity of measuring instruments available for a large number of disorders means that a systematic review of measuring instruments for use in consultation psychiatry falls beyond the scope and capabilities of the working group.

Screening will usually be done in high-risk populations and be aimed at a specified syndrome, for example a depressive or cognitive disorder. It was already pointed out in section 4.3.3. that there is no evidence for the efficacy of a single consultation on the basis of a screening result. Screening must be followed by adequate diagnostics and treatment.

### **5.2. The compliance with recommendations from the consultation psychiatrist**

#### **5.2.1. Introduction**

Interdisciplinary consultation can only be effective if the recommendations given by the consultant are actually followed up. It is therefore important to know which factors are associated with improved adherence to given advice. Especially those factors are of interest that can be influenced by the consultant himself, because they can contribute to a more effective consultation.

### 5.2.2. Literature selection criteria

*Search terms:* The search was done using the PICO technique. We started with a broad initial collection from which selections were made by adding specific terms for each question. The initial collection was created by searching for original research publications containing terms such as 'psychiatric consultation' or 'psychiatric service' in free text, plus controlled index terms such as 'explode psychiatry/all' for Medline and 'Consultation-Liaison-Psychiatry' for Psychinfo. This initial set was then combined with the additional terms 'concordance', 'adherence' and 'compliance'.

*Limits:* No time limit was specified. Only articles in English, Dutch, German or French were selected.

*Yield:* The search strategy yielded 67 hits in Medline. In Psychinfo there were 19 hits, 13 of which had already been identified in the Medline search.

*Other literature:* Four articles from the reference lists of retrieved articles and three articles with which the working group was familiar but which had not been retrieved by the search strategy were also included.

*Selection of the literature:* Of the articles found in Medline, 20 were included and 47 excluded on the basis of the abstracts. Articles were excluded for the following reasons: they dealt with concordance in the sense of a correlation between two measuring instruments (25), the setting was not one of consultation (14), they dealt with concordance in the sense of inter-assessor reliability (4), or other reasons (4). All 6 of the articles retrieved only by Psychinfo were excluded: 3 because they dealt with a correlation between two measuring instruments, two because they dealt with inter-assessor reliability, and 1 for another reason. The 27 remaining articles were read, after which 7 articles were excluded after all for various reasons, so that a total of 20 evaluated articles remained.

### 5.2.3. Summary of the literature

Due to the broadness of the subject and the multiplicity of terms, settings and syndromes, it is difficult to estimate the extent to which this search strategy resulted in complete retrieval of the available literature.

Eighteen of the 20 articles studied dealt with retrospective cohort studies carried out in order to provide a naturalistic description of clinical practice (type C studies according to the classification of the CBO [Dutch Institute for Health Care Improvement]). All had been carried out in the period 1979-1998 and were situated in university hospitals where consultation psychiatry was an area of special interest. Fourteen studies are purely descriptive and four are comparative. Only one of these studies took place in general practice, and even that did not pertain to consultation in general practice; the study dealt with the degree of compliance by the general practitioner, following discharge, with advice that was given during the period in hospital. One prospective cohort study took place in a nursing home and investigated whether the involvement of a consultation psychiatrist as part of the regular care organisation could

reduce the prevalence of depression in the nursing home. For this purpose, an intervention department where the interventions were implemented by the psychiatrist or social worker himself, in a single assessment whenever possible, was compared with two departments in which only advice was given. Of the 81 recommendations given in the intervention department, only 27 (33%) had been implemented after three months. In 35% of the cases this was due to the fact that the physicians, nurses or others had not changed their management in response to the advice, in 22% of the cases the patient had refused to consent to the intervention, and in 33% there was some other reason. The degree to which recommendations were complied with in the control departments is not described. The article did, however, report that there was no difference between the departments in the outcome measure, the prevalence of depression. One randomised study took place in patients with unexplained somatic symptoms in general practice. The purpose of this study was to investigate the efficacy of a form of collaboration between the consultation psychiatrist and the general practitioner. In this experimental setting, a compliance of 91.2% was reported.

In 15 of these 20 articles, the degree to which the advice of the consultation psychiatrist was complied with was related to one or more variables. The overwhelming majority of the comparative studies reported that advice as to medication was better complied with than advice regarding diagnosis. Only two studies reported that the nature of the advice made no difference. Medication advice was followed up in 68-98% (median 79%) of the cases, while diagnostic advice was followed up in 29-75% (median 56%) of the cases. One study reported a compliance rate of 99% with diagnostic recommendations, but 55% of these recommendations were implemented by the consultant himself. One study compared the degree of compliance with medication and diagnostic advice from the consultation psychiatrist with that with advice from the consultation cardiologist. The advice from the cardiologist was better complied with than that from the psychiatrist, in both the diagnostic and the therapeutic area. Recommendations pertaining to referral after discharge were complied with in 85-95% (median 91%) of the cases.

The degree to which recommendations were followed up turned out to be independent of the patient's gender, the nature of the somatic illness, the nature of the psychiatric diagnosis, and, in case of medication advice, the category of the recommended medication. Contradictory results were reported for the requesting specialty, the patient's age, and the nature of the medication advice (withdrawal, unchanged continuation, dose adjustment, or initiation). The compliance was generally better the earlier during hospitalisation or during the period of co-treatment the advice was given. The compliance was also better if there were follow-up contacts between the patient and the consultant (in contrast to single assessments), and when the consultant prescribed the medication himself instead of leaving it to the consultee (the compliance was 100% when the consultant prescribed the medication himself). There were also

contradictory results for the relationship between compliance and the professional level of the consultant. Two studies of a total of 721 consultations reported better compliance when advice was given by a more serious consultant and when the consultation was requested earlier during admission, while one study of 90 consultations found no relationship with these two variables. One study in a geriatric hospital reported better compliance with medication advice when the consultations were supplemented by liaison activities towards the department. A summary of the studies that were evaluated is given in Table 5.2, while a summary of the associations found is given in Table 5.3.

#### 5.2.4. Conclusions

Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with when the advice is given earlier during the hospital stay or during the period of co-treatment.
	<i>C Popkin et al. 1981; Huijse et al. 1992; Huijse et al. 1993</i>

Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with when a single consultation is followed by follow-up contacts.
	<i>C Popkin et al. 1981</i>

Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with if the consultations are supplemented by liaison activities.
	<i>C De Leo et al. 1989</i>

Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with if the consultant himself gives the medication orders to the nursing staff of the department that requested the consultation.
	<i>C Wise et al. 1987</i>

5

Level 3	There are indications that the advice given by the consultation psychiatrist is better complied with when the professional level of the consultant is higher.
	<i>C Lanting et al. 1984</i>

#### 5.2.5. Other considerations

All of the studies except two were carried out in university hospitals where consultation psychiatry was given special attention. Only one study in a general practice was retrieved, and only one study in a nursing home. For many of the associations listed, there is only limited evidence from a single study. Moreover, many of the studies were purely descriptive and the comparison of the degree of compliance with recommendations was not subjected to statistical analysis.

When the consultant writes the medication orders himself in the hospital department that requested the consultation, he bears the responsibility not only for the prescription of the medication, and the possible interactions or complications, but also for good communication on this point with the attending physician who must always retain an overview of the overall treatment of the patient.

20

### 5.2.6. Recommendations

In case of consultations in a general or university hospital, the working group recommends:

- that an attempt be made, by means of liaison activities, to stimulate those requesting a consultation for patients for whom a psychiatric consultation is felt to be desirable to do this as early as possible during the hospital stay.
- that follow-up contacts be arranged whenever possible after an initial assessment in order to verify whether the diagnostic and therapeutic recommendations have been complied with and, if necessary, to insist upon it or to see to it one's self.
- that agreement be reached, whenever possible, regarding the possibility that the consultant himself will give the medication orders to the nursing staff of the department that requested the consultation.
- that the care, in institutions where the consultations are given mainly by registrars in psychiatry, be organised in such a way that the supervising psychiatrist is as directly involved as possible with the consultative patient care and in the ideal situation sees every patient himself.

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**Table 5.2. Summary of studies into the factors determining the compliance with recommendations made during a psychiatric consultation.**

Study	Study Type	Population	Intervention	Control condition	N	Psychiatric diagnosis	Outcome	Level of proof	Remarks
Billowitz 1978/79	Retrospective, descriptive	Clinical admissions		Not applicable	273	All	- surgeons are less compliant than internists and gynaecologists - follow-up advice from a psychologist is complied with less than that from a psychiatrist	C	
Popkin 1979	Retrospective, descriptive	Clinical admissions			200	All	- advice to start with a medication is complied with better than other medication advice	C	
Van Dyke 1980	Retrospective, descriptive	Clinical admissions			55	All	- compliance is not related to the nature of the advice	C	
Popkin 1981	Retrospective, descriptive	Clinical admissions			394	All	compliance is better if: - the patient's age is > 60 - the patient already uses medication - the advice is given during the first half of the co-treatment period - surgeons are more compliant than internists	C	

							<ul style="list-style-type: none"> <li>- the nature of the somatic disease</li> <li>- the nature of the medication advice</li> <li>- there are follow-up contacts</li> </ul>		
MacKenzie 1981	Retrospective, descriptive	Clinical admissions			394	All	- medication advice is followed up better than diagnostic advice	C	
Popkin 1983	Retrospective, descriptive	Clinical admissions			394	All	<p>compliance is independent of:</p> <ul style="list-style-type: none"> <li>- the nature of the advice</li> <li>- the type of medication advised</li> <li>- the nature of the psychiatric diagnosis</li> <li>- the nature of the requesting specialty (with the exception of the poorer compliance by surgeons)</li> </ul>	C	
Popkin 1984	Retrospective, descriptive	Clinical admissions			1072	All	<ul style="list-style-type: none"> <li>- medication advice is followed up better than diagnostic advice</li> <li>- compliance is independent of the age of the patient</li> </ul>	C	
Lanting 1984	Retrospective, descriptive	Clinical admissions			90	All	<p>compliance is independent of:</p> <ul style="list-style-type: none"> <li>- the patient's age</li> <li>- the patient's gender</li> <li>- the referring</li> </ul>	C	

							discipline - the current use of medication - the professional level of the consultant - the time at which the consultation is requested		
Wise 1987	Retrospective, descriptive	Clinical admissions			200	All	compliance is better if the consultant orders the medication himself	C	
De Leo 1989	Retrospective, descriptive	Geriatric admissions	Consultation from an integrated CL service	Consultation on request	607	All	compliance is better if there is an integrated CL service and intensive follow-up		
Ames 1990	Prospective comparative cohort study	Nursing home patients	Consultation	Care as usual	90; 44 in the intervention group, 56 in the control group	Depression	medication advice is followed up better than diagnostic advice	B	
Seward 1991	Retrospective, descriptive	Clinical admissions			405	All	compliance is better if the patient was seen by the specialist himself	C	
Huijse 1992	Retrospective, descriptive	Clinical admissions			316	All	compliance is independent of: - the patient's age and gender - the somatic disease - the psychiatric diagnosis	C	

							<p>compliance is better if:</p> <ul style="list-style-type: none"> <li>- advice is given earlier during the hospital stay</li> <li>- the consultant has a higher level</li> <li>- there are multiple recommendations</li> </ul>		
Huijse 1993	Retrospective, descriptive	Clinical admissions			317	All	<ul style="list-style-type: none"> <li>- compliance with discharge recommendations is better if they are given early during the consultation</li> <li>- compliance with a recommendation for psychosocial diagnostics is better if given later during the consultation</li> </ul>	C	

**Table 5.3. Summary of variables and their association with the degree to which the advice of the consultation psychiatrist is followed up.**

<b>Variable</b>	<b>Better compliance</b>	<b>No relation to compliance</b>
Higher age of the patient	Popkin et al. 1981	Popkin et al. 1984 Lanting et al. 1984 Huijse et al. 1992
Gender of the patient		Lanting et al. 1984 Huijse et al. 1992
Nature of the somatic diagnosis		Huijse et al. 1992
Nature of the psychiatric diagnosis		Popkin et al. 1983 Huijse et al. 1992
Nature of the advice: medication advice is followed up better than diagnostic advice or a recommended psychosocial intervention.	Billowitz et al. 1978/79 Popkin et al. 1981 Mackenzie et al. 1981 Popkin et al. 1984 Ames 1990 Huijse et al. 1993 Von Gunthen et al. 1998	Van Dyke et al. 1980 Popkin et al. 1983
Current use of medication	Popkin et al. 1981	Lanting et al. 1984
Nature of the medication advice	Popkin et al. 1979 (starting medication is complied with less often than a change in or discontinuation of medication)	Seward et al. 1991
Type of medication		Popkin et al. 1983 Lanting et al. 1984
Prescription of the medication by the consultation psychiatrist	Wise et al. 1987	
Consultation earlier during the hospital stay	Popkin et al. 1981 Huijse et al. 1992 Huijse et al. 1993 (regarding discharge advice, but diagnostic advice is followed up better if given later during the hospital stay)	
Nature of the discipline	Billowitz et al. 1978/79	Lanting et al. 1984

requesting the consultation	(surgeons are less compliant) Popkin et al. 1981 (surgeons are more compliant) Popkin et al. 1984 (surgeons are less compliant only with diagnostic advice)	
Follow-up contacts	Popkin et al. 1981	
Liaison activities	De Leo et al. 1989	
The level of professional development	Lanting et al. 1981	Seward et al. 1991 Huijse et al. 1992

## CHAPTER 6. THE ROLE OF THE CONSULTATION PSYCHIATRIST IN A MULTIDISCIPLINARY FIELD OF WORK

### 5 **6.1. Collaboration with other disciplines**

Both in general practice and in the hospital, the consultation psychiatrist is often part of a multidisciplinary team. The team may also include psychologists, social or consultation-psychiatric nurses, and social workers, among others. Such collaboration has clear advantages. The  
10 borderline between psychiatric, psychological and psychosocial symptoms and problems is often unclear and multidisciplinary collaboration generally lowers the threshold for consultation and leads to shorter referral lines between the disciplines. This can lead to a more suitable and better  
15 coordinated treatment. Within such a multidisciplinary collaboration, justice must be done to the specific knowledge, experience, competencies and responsibilities of the various disciplines. If that takes place, then optimal use can be made of the differential expertise of the various disciplines, which has advantages for the patient. One danger of  
20 multidisciplinary collaboration, however, is that a shift of work and responsibility may take place on grounds other than the quality of the care, for example for personal or economic reasons. A number of studies that have taken inventory of these problems, both in general practice and in the hospital setting, reveal that this is indeed the case (Dutch Institute for Healthcare Improvement CBO 2002; Robben and Tietema 2005).

25 The working group is of the opinion that the psychiatrist must be able to fulfil his role as a physician within the team, and that he must also see to it that specific medical tasks and responsibilities are assigned to a physician and not to another discipline. The organisation in which the psychiatrist works must subscribe to such a point of departure and  
30 facilitate its realisation. Since arriving at a psychiatric diagnosis and prescribing medication are actions that are reserved for the medical profession, they must be carried out by a physician, and in this case the psychiatrist. Moreover, the 'revised psychiatric profile', supported in this by jurisprudence, states that a psychiatrist can only propose diagnostic or  
35 therapeutic measures for patients that he has seen himself (Netherlands Psychiatric Association (NVvP), 2005). This implies that the psychiatrist cannot accept the responsibility for the diagnosis and management of patients that have only been seen by other disciplines and not by himself. Adequate supervision must also be guaranteed when the psychiatric  
40 consultation is carried out by registrars, whether or not still in training.

### **6.2. Indications for psychiatric consultation**

According to the working group, and based on the specific expertise of the various disciplines, initial diagnosis by the psychiatrist is indicated in the  
45 following cases:

- (suspicion of) serious psychiatric disorders, including depressive disorders, anxiety disorders, cognitive disorders, delirium, and psychosis
- the assessment of patients who have attempted suicide
- 5 - the assessment of patients with relevant somatic comorbidity, especially patients in which a somatic, toxic, or drug-related aetiology of the mental symptoms must be taken into consideration
- the assessment of unexplained somatic symptoms
- 10 - all other pathology in which pharmacotherapy must be considered
- substance abuse

The fact that the psychiatrist bears the primary responsibility for the diagnosis in these cases does not mean that supplementary diagnostics and treatment may not be done by, or in collaboration with, other disciplines.

15

### 6.3. Conclusion

Level 4	The consultation psychiatrist is often part of a multidisciplinary team in which the borderline between the tasks and responsibilities of other disciplines is not always clear.
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### 6.4. Recommendation

In case of multidisciplinary collaboration in connection with psychiatric consultation, the working group recommends that the division of responsibilities between the disciplines be laid down in a document, in which the specific expertise of the various disciplines must be taken into consideration, and which must guarantee the assignment of specific medical tasks and responsibilities to the physician or psychiatrist.
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## CHAPTER 7. THE ROLE OF THE PSYCHIATRIST IN QUESTIONS OF MEDICAL ETHICS

### 5 7.1. Introduction

In certain patient populations, there are complex problems of medical ethics. Not only somatic and medicotechnical factors play a role here, also psychological or psychiatric and ethical factors. In general practice, such problems often concern the last stages of life and euthanasia. In the  
10 hospital setting, the problems usually concern medicotechnical developments and new therapeutic possibilities, such as transplantation, deep brain stimulation, in vitro fertilisation (IVF), the ability to determine certain genetic risks before birth, and again in this connection, decisions concerning the termination of life. In general practice, the decision can be  
15 taken to submit the problem to the SCEN Foundation (foundation that provides support and consultation in cases of euthanasia in the Netherlands). In the hospital it has become common practice to take such decisions in consultation with the different disciplines involved. The question can then be examined from various points of view and the  
20 responsibility for the decision can be shared. Depending on his position in the hospital, the consultation psychiatrist may, to a greater or lesser degree, be looked upon by his specialist colleagues as the person who understands such complex medical problems. The involvement of the psychiatrist in these decisions can take the form of a patient-related  
25 interdisciplinary consultation, or his involvement may be more liaison-like, where the psychiatrist has contact only with the multidisciplinary team and not with the patient concerned.

The consultation psychiatrist is a specialist in the biopsychosocial field and can advise his more medicotechnically oriented colleagues  
30 regarding the possible importance and influence of psychosocial and psychiatric factors. Not all consultation psychiatrists feel that they have a role to play in taking decisions on complex medical questions. Some psychiatrists prefer to use their expertise only for psychiatric problems in the narrow sense of the term and are of the opinion that a psychiatrist has no specific expertise and can provide no added value in the more  
35 emotionally charged, complicated and ethical questions that play a role in many complex medical problems. Other psychiatrists feel that their liaison activities make them an obvious participant in multidisciplinary consultations on complex medical problems, even when there is initially  
40 no question of a psychiatric problem. Value judgements and their unravelling play more of a role here than specific psychiatric knowledge. The consultation psychiatrist can shed new light on possibly rigid positions within a multidisciplinary team, has an understanding of interactions, such as those within a team or in relation to a patient, and can help to  
45 integrate the biopsychosocial points of view into the final consideration. Especially the latter may fit in with the way that the consultation

psychiatrist interprets his task, namely to provide the patient with integral care (Bannink et al. 2004)

## 7.2. Conclusion

Level 4	There are various opinions regarding the role of the psychiatrist in complex problems of medical ethics.
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## 7.3. Recommendation

The working group is of the opinion that, in certain cases, the psychiatrist can make a useful contribution to decision taking around complex problems of medical ethics. The extent to which the individual psychiatrist wishes to fulfil this role depends on his interpretation of his tasks in general, and in general practice or the hospital.

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## CHAPTER 8. LEGAL ASPECTS

### 8.1. Advising versus co-treatment

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#### 8.1.1. Introduction

A distinction is generally made, in consultation psychiatric practice, between 'advising' and 'co-treatment' in order to describe the responsibility for the treatment and the relation to the patient. In case of 'consultative' involvement, the consultant plays only an advisory role, while in the case of 'co-treatment' he bears the responsibility for this own part of the treatment. This classification is independent of the number of follow-up contacts. In the DBC [Diagnosis Treatment Combination] system, however, a different definition is used that fits in better with the clinical practice in mental health services, but less well with consultation psychiatric practice. Within DBC Care, only a single consultation can be submitted for payment as a 'consultation', while repeated contacts must always be reported as 'regular care' in the DBC mental healthcare system. Although the nature of the involvement is left unspecified, the term 'regular care' implies that the consultant is the principal therapist to the extent that the diagnosis and treatment are within his area of competence.

The law is unclear with regard to the legal assignment of responsibility. The jurisprudence in this area is scarce. The Dutch Healthcare Inspectorate and the Royal Dutch Society for the Advancement of Medicine (KNMG) also fail to provide guidelines. Previous jurisprudence indicates that the principal therapist is responsible for the overall management, even if he makes use of a variety of specialist consultations and recommendations (e.g., the decision of the Regional Disciplinary Tribunal for Healthcare in The Hague, 6 July 2004). The fact that the consultants involved bear their own responsibility for their advice does not diminish the responsibility of the principal therapist. Such an interpretation will lead to problems when there is a multidisciplinary treatment team in which the role of principal therapist is sometimes not clearly defined. The most important rule, however, is that every therapist is responsible for his own actions.

The division of responsibility remains equally unclear in the case of 'co-treatment'. In that case, the responsibility for the content of the advice is borne by the consultant, but the responsibility for the implementation of this advice is generally with the attending physician. This means that the attending physician must institute the recommended management. The consultant retains the responsibility with regard to follow-up, but both the consultant and the attending physician are responsible for making the follow-up possible. When the consultant writes prescriptions or medication orders himself in the department where he has been called in for consultation, he automatically becomes a 'co-therapist' and is also responsible for that part of the treatment.

### 8.1.2. Conclusion

Level 4	The mode of operation and responsibilities of the consultation psychiatrist in cases of consultation and co-treatment are not always clear.
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### 8.1.3. Recommendation

As long as no legal consensus has been reached on the subject, the working group recommends that the mode of operation and responsibilities of the consultation psychiatrist in case of 'consultation' and 'co-treatment' be laid down in writing for the institution in question.
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## 8.2. Supervision by telephone versus a personal evaluation

### 8.2.1. Introduction

10 In clinical practice, many consultations are given by non-psychiatrists under the supervision of a psychiatrist, including physicians in training for a medical specialty or consultative or social psychiatric nurses.

15 In the case of multidisciplinary collaboration, the revised Psychiatric Profile indicates that the psychiatrist may prescribe diagnostics and treatment only for patients that he has seen himself. This means that in case of an 'extended hand construction', adequate possibilities for supervision must have been created so that every patient for whom a psychiatric diagnosis is reached, additional diagnostics are indicated, or treatment is recommended can also actually be seen.

20 The situation is a bit different for the supervision of physicians in training for a medical specialty. In all medical specialist training courses, hence also in the training for psychiatry, final goals are laid down as part of the requirements for completing the course. These specify what the physician in training for a medical specialty must minimally have done, independently and/or under supervision, by the end of the course. The  
25 emphasis here is on independent work, so that at the beginning of the training programme most of the work is done under supervision, while at the end of the course the trainee must be able to work without or with marginal supervision. For physicians that are not in training for a medical specialty, the necessity for supervision must be estimated on the basis of  
30 their competence.

### 8.2.2. Conclusion

Level 4	In the case of multidisciplinary collaboration, the professional standards specify that the psychiatrist can only assume responsibility for the treatment of patients that he seen himself. In the case of physicians in training for psychiatry, the nature and intensity of the supervision are determined by the degree of experience.
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### 8.2.3. Recommendation

The working group recommends that the consultation psychiatrist should personally see all patients for whom he assumes therapeutic responsibility, with the exception of patients seen by physicians in training for psychiatry that have been demonstrated to be sufficiently competent to evaluate patients in the consultation setting independently.

### **8.3. The Medical Treatment Contracts Act (WGBO) versus the Psychiatric Hospitals Compulsory Admissions Act (BOPZ)**

#### **5 8.3.1. Introduction**

The Medical Treatment Contracts Act (WGBO) lays down the basic principles of the doctor-patient relationship and applies to all forms of medical treatment, also in the psychiatric setting and in consultation psychiatry. The Psychiatric Hospitals Compulsory Admissions Act (BOPZ) is applicable only in the case of compulsory admissions in connection with a psychiatric disorder that entails an imminent danger to the patient himself, third parties, or civil order. The only reason for compulsory treatment under the terms of the BOPZ is to eliminate the acute danger resulting from the psychiatric disorder. Although the scope of both laws in the strictly somatic or strictly psychiatric setting is generally clear, the borderline between the two laws in patients with psychiatric and somatic comorbidity often constitutes a point of discussion.

The problem that probably occurs most commonly in clinical practice in this connection is the patient who refuses a somatic treatment that is necessary to prevent serious damage to health (Koers 1999; Kramers et al. 2006). This leads to doubts regarding the patient's mental competence, as a result of which the somatic therapist requests an assessment from the consultation psychiatrist with a view towards compulsory admission. In such a situation, therapists tend to misuse the BOPZ in order to legitimise compulsory somatic treatment. This is understandable, in view of the reluctance to impose compulsory treatment in the absence of a clear legal justification. Considered formally, however, this is improper: compulsory admission does not legitimise compulsory treatment for a somatic disorder; even in psychiatric patients that have been admitted involuntarily, such treatment must take place within the framework of the WGBO (Klijn and Van den Berg 2004). Nevertheless, misunderstandings on this point often lead to unnecessary delay and serious complications. In the case of a mentally incompetent patient that refuses necessary somatic treatment, the treatment can be made compulsory under the terms of the WGBO. However, if hospitalisation is necessary for this purpose and the patient also refuses such hospitalisation, then a problem arises. Involuntary hospitalisation under the terms of the WGBO is not possible, because this would be done without an assessment by the court. Involuntary hospitalisation without an assessment by the court is in conflict with Article 15, paragraph 2 of the Dutch constitution and Article 5, paragraph 4 of the European Treaty on Human Rights. These articles guarantee the

individual's right to physical freedom. In such a case, an ethical dilemma arises: should one act in the interests of the patient's health or should one respect the patient's constitutional rights? In such a case, a 'flight' in the direction of the BOPZ sometimes provides a way to create a legal framework for hospitalisation, after which the compulsory somatic treatment can be given within the framework of the WGBO. In the case of an acute danger to the patient's health, an alternative is to hospitalise him against his will and treat him within the framework of 'good medical assistance' as described in Article 466, paragraph 1 of the WGBO. When the danger is not acute and the patient is mentally competent, then compulsory treatment is not possible. A decision tree with regard to the refusal of somatic treatment and the decision in favour of compulsory treatment is given by Klijn and Van den Berg (2004).

### 8.3.2. Conclusion

Level 4	The rules and jurisprudence in the area of compulsory somatic treatment for mentally competent and mentally incompetent patients with a psychiatric disorder are not unambiguous.
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### 8.3.3. Recommendation

The working group recommends that, in case of lack of clarity regarding the legal framework around a patient in whom compulsory somatic treatment is being considered, legal advice be obtained from the jurist of the institution, provided that the delay in treatment that accompanies such a request for legal advice does not constitute an added risk to the patient's health.

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## CHAPTER 9. ORGANISATIONAL ASPECTS

### 5 9.1. Incorporation of the consultation psychiatrist into the hospital organisation

#### 9.1.1. Introduction

10 One of the conclusions of the study of the role of hospital psychiatry by the Dutch Healthcare Inspectorate (GHI) was that there is a high degree of diversity in the relation between hospital psychiatry, including consultation psychiatry, and the other mental healthcare facilities in the region, a diversity that may also explain the qualitative differences (Robben and Tietema 2005). However, the effect of organisational incorporation on the quality of care has hardly been studied. One large  
15 retrospective study revealed indications that psychiatric consultation is more effective when the consultation psychiatrist is employed by the hospital where he gives consultations (Brown 2005). When a psychiatrist is employed by a general or university hospital, he is better 'embedded' into the organisation than colleagues who come to give consultations in  
20 the hospital from an external institution. Such 'embedding' involves not only familiarity with the person and a low threshold for possible consultation with specialists who request consultation, but also access to the consultative bodies of specialist colleagues, such as the staff meeting, and access to the Board of Directors of the hospital in which the  
25 consultations are given. In that way, there are more possibilities for exerting influence on the working conditions and terms of employment.

#### 9.1.2. Conclusion

Level 3	Psychiatric consultation is more effective when the consultation psychiatrist is employed by the hospital where he gives consultations.
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#### 30 9.1.3. Recommendation

The working group recommends that consultation psychiatrists be employed in a way that guarantees as good as possible an 'embedding' in the setting in which he gives his consultations.
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## 9.2. Staffing

#### 35 9.2.1. Introduction

Drawing up a staffing norm for the provision of adequate consultation psychiatric care in a hospital is difficult. In general, the consultation psychiatrist will not only perform consultation work but also carry out liaison activities and take part in multidisciplinary teams. In general  
40 practice, this aspect is less important because agreements can be reached there regarding the numbers of patients that can be assessed. In

addition, the consultation psychiatrist often also has non-consultative tasks and usually also tasks that do not involve patients. For the hospital setting, a number of recommendations have been issued over the years. The Hospital Psychiatry Commission that was set up by the Dutch Ministry of Public Health, Welfare and Sport recommended 1 FTE psychiatrist per 300 new consultations per year as a norm (Commissie Ziekenhuispsychiatrie 1995). Two years later, this norm was adopted by the Dutch Federation for Hospital Psychiatry (NFZP) (Nederlandse Federatie voor Ziekenhuispsychiatrie 1997). Based on his own experience, Rooymans (1984) recommended 1 FTE psychiatrist or registrar in psychiatry for carrying out 200 consultations per year.

The foundation for such a staffing norm could be built up as follows: for each new consultation, 1 hour is set aside for an initial assessment. This is in line with the guideline for a psychiatric examination as laid down in the 'Guideline for the Psychiatric Examination of Adults' (Richtlijncommissie psychiatrisch onderzoek bij volwassenen 2004). With an average of 3 follow-up contacts and an average duration of 30 minutes per contact, this comes to 2½ hours per new consultation. To this, one should add 30 minutes for internal case discussions, multidisciplinary consultation, administration and reporting, which yields a total of 3 hours of patient-related time per consultation. Assuming an employment contract for 1600 hours per year, and assuming that 10% of the time is devoted to liaison activities and 10% to educational or management tasks, this leaves 1280 hours for patient-related activities. Since there is marked variation in the daily number of consultation requests, the efficiency will not be 100% but an estimated 80%. This brings the number of patient-related hours per year to 1024, which is equivalent to 340 new consultations. No consideration is given, in this calculation, to the performance of accessibility services.

Independent of the number of full-time-equivalent psychiatrists that give the psychiatric consultations during office hours, 24-hour availability must also be guaranteed for emergency assessments. In addition to psychiatric staffing, the consultation psychiatrist must also be given adequate secretarial support.

### 9.2.2. Conclusion

Level 4	For qualitatively good consultations, 1 full-time-equivalent psychiatrist is probably necessary for every 340 consultations.
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### 9.2.3. Recommendation

The working group recommends that a norm of 1 FTE psychiatrist per 340 new consultations per year be used as the basis for calculating the required number of full-time-equivalent psychiatrists in hospitals.

## 9.3. Spatial facilities

### 9.3.1. Introduction

Adequate spatial facilities are important to guarantee the privacy of the patient during the assessment and to put him at ease. In general practice, the surgery will generally provide sufficient privacy. In hospital, each patient will ideally be seen in a specially designed room on the ward to which the patient has been admitted. Often, however, such a room does not exist and one has to use the conversation room or another room that was not designed for the purpose of patient assessments. This can be a problem, particularly if more than one patient is assigned to a room. If the psychiatrist has space in the outpatient clinic, it can be an option to assess the patient there, provided that the patient is able to walk or can be transported. If this is not possible, then the creation of as good a confidential relationship with the patient as possible will depend on the approach of the consultation psychiatrist.

On the Emergency Ward, however, additional demands must be made on the room where the patient is assessed. In view of the nature of the assessments that are made here, with a larger proportion of substance abuse, behaviour disorders and chronic psychosis, the safety of the consultation psychiatrist should also be considered in the design of the spatial facilities. His safety can be increased by positioning the room where psychiatric assessments are to take place in such a way that it can be observed from a central room or from the reception, the inclusion of a second door as an escape route, and the installation of an alarm system.

### 9.3.2. Conclusion

Level 4	The safety on the Emergency Ward can be increased by positioning the room where psychiatric assessments are to take place in such a way that it can be observed from a central room, the inclusion of a second door as an escape route, and the installation of an alarm system.
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### 9.3.3. Recommendation

The working group recommends that the safety of the consultation psychiatrist also be taken into consideration in the planning of the spatial facilities, especially in the emergency setting.
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- 15

## CHAPTER 10. POLICY AND IMPLEMENTATION

### 10.1 What is the best way to further the implementation of this guideline?

5 The success of the distribution and implementation of medical specialist  
guidelines has not been investigated intensively in the Netherlands.  
Studies into the implementation of standards for general practitioners are  
somewhat more readily available. A recent report described the factors  
10 that obstruct and further the implementation of standards and guidelines  
on the basis of published research (Hulscher 2000). In this and earlier  
reports, comments are made on review articles pertaining to various  
implementation strategies (Bero 1998). Guidelines that are made and  
distributed by recognised specialists in the field, that do justice to current  
15 practice, and that are distributed interactively are relatively successful.  
The form and content of a guideline of course also have a significant  
effect on the acceptance of the guideline, and after acceptance, on its  
implementation (Hulscher 2000; Bero 1998; Grol 2003). Ideal guidelines  
are valid, reliable, reproducible, multidisciplinary, applicable and flexible,  
20 clear, unambiguous, and well documented. The quality of a guideline is  
also increased if a trial trajectory is followed for implementation, its  
execution can be evaluated, and if, wherever relevant in the guideline,  
attention is also given to the points of view of the patient and society  
(e.g., costs and the organisation of care) and not only the point of view of  
25 the care giver. An expert valid instrument for the control of these items is  
available (AGREE instrument, [www.agreecollaboration.org](http://www.agreecollaboration.org)).

The Guideline for Consultation Psychiatry has been drawn up as  
much as possible in accordance with these AGREE-criteria. The  
argumentation of the guideline is transparent with regard to the balance  
30 between scientific considerations and other considerations, such as the  
organisation of the practice, legal aspects, patients' wishes and  
preferences, and the interests of society.

### 10.2. Conclusions

Level 3	A guideline is considered to be an important instrument for improving the quality of care, but its effect, measured at the level of implementation (application), is presently not yet optimal.  C: Hulscher, Bero, Grol
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Level 3	Supporting the implementation of a guideline can best be accomplished by applying a combination of strategies.  C: Hulscher, Bero, Grol
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### 10.3. Other considerations

The working group does not feel it to be its task to indicate how this guideline should be implemented, but is happy to do some suggestions. A number of activities follow directly from the work already started by the working group:

- 5 - The guideline will be distributed as widely as possible among the members of the Netherlands Psychiatric Association (NVvP).
- Information about the guideline will be distributed by submitting articles to the Dutch Journal of Medicine (Nederlands Tijdschrift voor Geneeskunde) and the Dutch Journal of Psychiatry (Tijdschrift voor
- 10 Psychiatrie).
- The Netherlands Psychiatric Association will evaluate the content of the guideline annually and decide whether total or partial revision is necessary.
- The guideline will be published in its entirety on the websites of the
- 15 Netherlands Psychiatric Association, the KNMG (artsennet), and the CBO (www.cbo.nl).

#### 10.4. Recommendations

The working group recommends that the following activities be developed in order to further the implementation of the guideline:

- presentation of the recommendations in the guideline at the scientific meetings of the NVvP;
- translation of parts of the guideline into protocols, wherever relevant, taking local circumstances into consideration;
- regular evaluation, at the institutional level, of the progress of implementation and the degree to which the guideline is being adhered to;
- development of the draft performance indicators formulated in chapter 11 into useable indicators, and the creation of a framework that will make possible their implementation in institutions;
- making the implementation of this guideline a component of visits to institutions;
- formulation of the remaining research topics and questions that are necessary to create a better foundation for the guideline, and passing them on to the various sources of subsidies and makers of policy.

#### 20 References

1. Bero LA, Grilli R, Grimshaw JM, Harvey E, et al. Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. The Cochrane Effective Practice and Organization of Care Review Group. Br Med J. 1998; 317: 465-8.
- 25 2. Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. Lancet 2003; 362: 1225-30.
3. Hulscher M, Wensing M, Grol R. Effectieve implementatie: Theorieën en strategieën. Nijmegen: Werkgroep Onderzoek Kwaliteit, 2000.
- 30

## CHAPTER 11. POSSIBLE PERFORMANCE INDICATORS FOR INTERNAL USE

### 11.1. Introduction

5 Within a system for healthcare quality control, an indicator is ‘a  
measurable element of care that provides an indication as to the quality  
of the care’. Guidelines also constitute a component of the healthcare  
quality control system. By translating the recommendations in a guideline  
10 actions in quantitative terms (Kwaliteitsinstituut voor de Gezondheidszorg  
[Dutch Institute for Healthcare Improvement] CBO 2002). For this reason,  
the Dutch Institute for Healthcare Improvement CBO has begun to include  
quality indicators in guidelines. Indicators that are based on  
15 recommendations for action are called structural indicators and process  
indicators. Outcome indicators, such as the mortality rate or complication  
rate, provide a more general picture of healthcare quality. Outcome  
indicators usually pertain to specific diseases or interventions.

The present guideline is also meant to give an impulse to the  
20 creation of indicators that will make an evaluation of elements of the  
guideline possible. All of the draft indicators that are named in this  
chapter are provisional indicators that must be investigated further as to  
their feasibility and relevance. Like the guideline itself, the indicators  
pertain to aspects of consultation psychiatry that are broader than a  
25 specific syndrome. For syndrome-related indicators in consultation  
psychiatry, such as for the diagnosis and treatment of delirium or the  
assessment of patients that have attempted suicide, the reader is referred  
to initiatives around these diseases or presentations. In the following,  
only those structural and process indicators are presented that make it  
30 possible to gain more insight into the availability and quality of  
consultation. In this section, the draft indicators will be explained briefly;  
more detailed support for them can be found elsewhere in this guideline.

### 11.2 Structural indicators

Indicator I	The number of FTE consultation psychiatrists available in the hospital per 100 (somatic) beds and per 1000 (somatic) admissions.
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#### *Explanation*

The provision of adequate care requires the sufficient availability of a  
consultation psychiatrist. The care provided can be expected to be better,  
both qualitatively and quantitatively, when the availability of consultation  
40 psychiatrists is improved. This indicator pertains only to the hospital  
setting; in general practice, it is easier to reach agreements as to the  
maximum number of patients to be assessed. For additional; explanation,  
please see section 9.2.

Indicator II	The availability of a consultation psychiatrist 24 hours a day for emergency consultation.
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*Explanation*

5 This indicator pertains only to hospitals. In case of acute restlessness, a suicidal tendency or other situations that constitute a danger to the patient, the therapist or civil order, an emergency assessment must be possible within an acceptable time limit.

Indicator III	The consultation psychiatrist is employed by the hospital in which he gives consultations.
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10 *Explanation*

This indicator pertains to the hospital setting. There are indications that a better 'embedding' in the institution in which consultations are given leads to qualitatively better care (Brown 2005).

15 **10.3. Process indicators**

Indicator I	The percentage of consultations in which follow-up, either within one's own organisation or externally, is arranged.
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*Explanation*

20 This indicator pertains to the hospital setting. In general practice, the aim of consultation is often to advise the general practitioner, who then treats or refers the patient himself. Consultations in hospital have been found to be more effective when follow-up contacts are arranged after the initial contact. To the extent that these are follow-up consultations during the period of hospitalisation or in the outpatient clinic of a general or  
25 university hospital, the data can be retrieved from the records of the DBC GGZ (Diagnosis Treatment Combination Mental health services). Since not all patients for whom a consultation is requested also require follow-up, the score for this indicator will never reach 100%.

Indicator II	The percentage of psychiatric consultations carried out by registrars in psychiatry under the 'bedside' supervision of the psychiatrist.
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30 *Explanation*

The direct involvement with the patient of someone at a higher professional level, in this case the specialist, leads to a more effective consultation (see section 5.2). Moreover, 'bedside' supervision is an  
35 important tool for furthering the expertise of the registrar.

**References**

1. Brown JF. Emergency Department psychiatric consultation arrangements. Health Care Management Rev. 2005; 30; 151-61.
2. Kwaliteitsinstituut voor de Gezondheidszorg CBO. Ontwikkeling van indicatoren op basis van evidence-based richtlijnen. Alphen aan den Rijn: Van Zuiden, 2002.

## CHAPTER 12. RECOMMENDATIONS FOR FURTHER RESEARCH

5 The purpose of this guideline was to establish a standard for how interdisciplinary psychiatric consultations should be carried out in a non-psychiatric setting. It was not the intention to discuss the psychiatric diagnosis and treatment of patients with specific psychiatric and somatic comorbidity. The recommendations for further research therefore also pertain mainly to the procedures and efficacy of psychiatric consultation.  
10 For general recommendations for research in the area of comorbidity, the reader is referred to the report of Trimbos Institute 'Zorg voor heel de mens' [Care for the whole person] (Van der Feltz-Cornelis et al. 2007).

15 This guideline first examined the efficacy of psychiatric consultation in general practice and in institutions. In the studies carried out in this area, the psychiatric consultation is generally not the intervention but the control condition, i.e. 'care as usual'. Attention was therefore given to forms of psychiatric consultation that are embedded in a broader multidisciplinary collaboration. The contribution of various disciplines, including psychiatry, in such models is unknown. Moreover, efficacy  
20 studies, especially in hospitals, are often directed at cost-effectiveness and only at the short-term reduction of symptoms, if at all. Whether there is a health benefit or improved quality of life in the longer term is unknown.

25 In the second place, an attempt was made to set a standard for how a psychiatric consultation should be carried out. In this connection, we often had to resort to expert opinion. Except for a few minor points, hardly any research has been done on the consultation procedure, even though this must be possible in specific areas.

30 Finally, we studied the factors that were associated with increased compliance with the advice that was given. The research on this point is mostly retrospective and outdated. Hardly any prospective studies have been done.

35 With regard to the procedures and efficacy of psychiatric consultations, the following aspects could well be subjects for further investigation:

- The efficacy of models of multidisciplinary care, especially with regard to the diagnosis, treatment and prognostic effects on health and quality of life, in both the intermediate and longer term, in patients with psychiatric and somatic comorbidity. This  
40 recommendation is in agreement with that of the Trimbos Institute.
- Validation studies to develop efficient and effective screening instruments for the most important forms of comorbidity that are applicable to a broad range of diseases. This recommendation is also in agreement with that of the Trimbos Institute.
- 45 - Making explicit the efficacy of the specific contribution of the psychiatrist within such multidisciplinary treatment models.

- The general effect of psychiatric consultation on health and the quality of life, not only in the short term but also in the intermediate and long term.
- Studies into the contribution of specific components of a psychiatric examination to the diagnosis, the compliance with advice and treatment, and the prognosis, as well as ways in which these aspects could be improved.

### Reference

- 10 1. Van der Feltz-Cornelis CM, Nuyen J, Verdurmen JEE, Pot AM. Zorg voor heel de mens. Psychiatrische en somatische comorbiditeit. Programmeringsstudie. Utrecht: Trimbos Institute, 2007.

## APPENDIX 1. EXPLANATORY LIST OF TERMS

### **adherence**

- 5 1. the degree to which recommendations from a guideline or protocol are complied with.  
2. the degree to which an attending physician complies with the recommendations given during an interdisciplinary consultation.

### **compliance**

- 10 1. the degree to which a patient complies with the recommendations given by the attending physician (treatment compliance).  
2. the degree to which an attending physician actually follows the recommendations given during an interdisciplinary consultation.

### **concordance**

- 15 1. the degree of agreement between two assessors, two assessments, or two assessment instruments.  
2. the degree to which an attending physician actually follows the recommendations given during an interdisciplinary consultation.

20

### **consultant**

a physician that provides an interdisciplinary consultation at the request of another physician.

### **consultation**

#### ***see also interdisciplinary consultation***

25 a procedure during which attending physicians are given advice as to the way in which they can best deal with psychiatric symptoms or complex patient behaviour, without the patient having been seen by the  
30 psychiatrist.

### **consultation psychiatry**

35 the subfield within psychiatry that specialises in giving interdisciplinary consultations. This term is often interpreted more broadly so that it also covers 'liaison psychiatry' (q.v.).

### **consultee**

40 a physician that requests an interdisciplinary consultation from another physician.

### **co-therapist**

45 a physician that is responsible for his own professional activity with reference to that part of the care of a patient for which he is not the principal therapist that has been assigned to him.

### **first-line psychiatry**

1. the subfield within psychiatry that specialises in the recognition,

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diagnosis and treatment of psychiatric morbidity in primary care, and in providing the general practitioner with adequate support.

2. all psychiatric procedures that take place in the setting of first-line medical care.

5

### **hospital psychiatry**

1. a subfield within psychiatry that specialises in psychiatric and somatic comorbidity.

10 2. all psychiatric activities that take place within the setting of a general or university hospital.

### **interdisciplinary consultation**

15 the provision, by a physician (the consultant), of assessment and advice regarding the diagnosis and treatment of a patient at the request of the attending physician (the consultee). The consultation begins with the first assessment of the patient and ends with the last follow-up contact and reporting.

### **liaison psychiatry**

20 a procedure within psychiatry that specialises in a more structural collaboration with general practitioners or other medical specialists in order to optimise the recognition and treatment of frequently occurring comorbid psychiatric disorders.

### **principal therapist**

25 the general practitioner or medical specialist that bears the final responsibility for the treatment and guidance of a patient placed under his care. In addition to making his own contribution to patient care, he is also responsible for coordinating the care and sees to it that other physicians  
30 that are involved can be confident that they can guarantee and bear the responsibility for that part of the care that has been assigned to them. The institution in which the care is given is responsible for providing adequate support, in an organisational sense, for this division of  
35 responsibility.