The Function of Consultation-Liaison Psychiatry

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2.1 Introduction: The Dual Roles of the Consultation-Liaison Psychiatrist

There are two sets of dual interrelated roles that a consultation-liaison psychiatrist plays—consultation and liaison, and consultant and psychiatrist.

2.1.1 Consultation and Liaison

The term, consultation-liaison psychiatry, consists of the two primary functions—that of a psychiatric specialist providing expert advice on the consultee's patient and that of a liaison or link. Historically, the *liaison* function indicated that the psychiatrist was stationed in, and worked as a member of the medical team. Currently, the term has been expanded to indicate the educational, and facilitative function of the consulting psychiatrist, i.e., the linkage the psychiatrist provides the consultee between medical and psychiatric knowledge and skills on the one hand, and the facilitation of communication and understanding that the psychiatrist provides between the patient and the health care personnel. Thus, the liaison function is inherent in the comprehensive approach utilized by the psychiatric consultant to the patient and the health care system. Furthermore, increasingly, the liaison function includes administrative/legal services required of the consultant such as determination of decision making capacity, conservatorship, and involuntary hospitalization.

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2.1.2 Consultant and Psychiatrist

The CL psychiatrist is both a consultant and a psychiatrist, i.e., he or she has two masters, the requesting physician (consultee) and the patient. The obligation to the requesting physician often extends to serving the interests of the health care facility, and of society at large. Sometimes this duality leads to an internal conflict, such as in situations when the perceived interest of the patient conflicts with the desires of the consultee, the needs of the hospital, or of society (See Sect. 2.4, below).

CL psychiatry developed mainly in teaching hospitals with psychiatric residency training programs. There is usually a psychiatric consultation-liaison service in major teaching hospitals consisting of one or more full or part-time faculty, one or more psychiatry residents rotating to it, and, perhaps other staff and trainees, e.g., resident rotating from another specialty (most commonly internal medicine or family practice), medical student, psychiatric nurse, social worker, psychologist. Such CL services generally serve several explicit and implicit functions, i.e., *clinical, educational, administrative, and research*. In medical settings without a formal CL service, one or more full or part-time psychiatrists may be hired or designated to be a consultant for defined times. Such CL psychiatrists' function may be limited to the clinical and administrative functions.

2.2 Clinical Function: Consultation vs. Referral

The consultant's primary clinical function in an acute general hospital is to facilitate the *medical* treatment of the patient since that is the primary reason why the patient is in the hospital. In this sense, *consultation* should be distinguished from *referral*, usually seen in outpatient settings and chronic care facilities. In referral, the psychiatrist is asked to take over the psychiatric care of the patient if indicated, while in consultation, the psychiatrist renders an opinion or advice to the requesting physician. In addition to such advice and opinion, the requesting physician usually, and implicitly, requests collaborative care of the patient if indicated, which forms the basis of the direct rendering of treatment by the CL psychiatrist. Except in emergencies and psychotherapy inherent in diagnostic interview and facilitation of communication through meetings and phone calls with members of family and staff, direct treatment of patients including ordering medications should be with the explicit acknowledgement and cooperation of the consultee so as to prevent a diffusion of responsibility for direct care.

2.3 Educational Function

The liaison part of consultation-liaison psychiatry largely denotes its educational function. Education is for patients, requesting physicians, nursing staff, patient's families and friends, and the health care system. Examples of liaison education include teaching the psychological needs of patients based on their personality styles (see Chap. 25), the immediate management of psychiatric conditions (Chap. 4), use of psychotropic drugs (Chap. 8), determination of capacity to consent to procedures (Chap. 10).

The CL Service in teaching hospitals has formal educational functions in addition to the liaison function. They include the teaching of various trainees including psychiatric residents, residents from other departments such as internal medicine and family medicine, medical students, nursing and social work students, psychology interns, etc. The consultation-liaison setting is particularly well suited to teach medical students and primary care residents the aspects of psychiatry that would be most relevant to any physician. Members of the CL team may also give lectures and seminars or participate in the grand rounds of other departments as a part of the formal teaching function. A survey of primary care training programs showed that about 60 % of psychiatry departments provide didactic courses, 36 % participate in case conferences, and 15 % participate in joint rounds with primary care training programs (Leigh et al. 2006).

In the outpatient setting, the integrative care model (see Chap. 9) establishes formal teaching and supervision of mental health workers as a main function of the CL psychiatrist.

2.4 Administrative Function

The administrative functions of the CL psychiatrist are often mandated by either the government or the institution and often involve coercive measures such as emergency hold and involuntary hospitalization. Institutional rules usually mandate that an acutely suicidal or homicidal patient has to be evaluated by a psychiatrist, who will decide whether the patient should be placed on an emergency involuntary hold and be transferred to a psychiatric facility when medically stable. The CL psychiatrist may be required to evaluate a patient with suspected dementia and apply for a conservatorship.

The Risk-Management Department of the health care institution relies on the CL psychiatrist to evaluate patients' capacity to sign out against medical advice, to refuse medical/surgical procedures, and for general behavioral problems that disrupt the facility's function.

At times, the mandated administrative function may interact or interfere with the clinical function of the consultant, such as an emergency hold disrupting rapport with the patient. These conflicts can usually be resolved with skillful communication, but the CL psychiatrist must recognize and be comfortable with the multiple roles inherent in the function.

2.5 Research Function

The CL setting provides unique opportunities for research in the interface between psychiatry and medicine. Much of psychosomatic research in the twentieth century was done by CL psychiatrists. The CL setting gave rise to such subspecialty fields as psychonephrology, psychooncology, psychoimmunology, psychoendocrinology, and psycho-obstetrics and gynecology.

The role of psychiatric intervention in medical utilization has also been a productive field of research, and has provided evidence that psychiatric intervention actually reduces the cost of health care (Katon et al. 2005; Wells et al. 2005). In primary care settings, a collaborative care model in which the primary care physician works closely with a care manager (mental health worker) supervised by a CL psychiatrist is shown to be more effective than care as usual (Huijbregts et al. 2013).

This type of collaborative care with stepped up specialized care when needed is expected to be increasingly utilized with the implementation of the Affordable Care Act (ACA). (Unutzer et al. 2013; Unutzer and Park 2013a, b)

Affordable Care Act, aka Obamacare, promotes new programs and tools, such as health homes, interdisciplinary care teams, co-location of physical health and behavioral services, and collaborative care. (Mechanic 2013; Sorrell 2013) This provides fertile new venues for exciting research for the CL psychiatrist.

As the gene–brain–environment interaction becomes better understood, the CL setting may provide unique opportunities to study the role of epigenetics interacting with development in the selection or sequence of organ dysfunction (e.g., the subgenual cingulate cortex and the intestines, See Chap. 7) (Leigh 2011).

References

Huijbregts, K. M., de Jong, F. J., van Marwijk, H. W., et al. (2013). A target-driven collaborative care model for major depressive disorder is effective in primary care in the Netherlands. A randomized clinical trial from the depression initiative. *Journal of Affective Disorders, 146*, 328–337.

Katon, W. J., Schoenbaum, M., Fan, M., Callahan, C. M., Williams, J., Jr., Hunkeler, E., et al. (2005). Cost-effectiveness of improving primary care treatment of late-life depression. *Archives of General Psychiatry, 62*, 1313–1320.

Leigh, H. (2011). *Genes, memes, culture, and mental illness: Toward an integrative model*. New York, NY: Springer.

Leigh, H., Stewart, D., & Mallios, R. (2006). Mental health and psychiatry training in primary care residency programs: Part I. Who teaches, where, when,

and how satisfied? *General Hospital Psychiatry, 28*(3), 189–94.

Mechanic, D. (2013). Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. *Health Affairs (Millwood), 31*, 376–382.

Sorrell, J. M. (2013). The patient protection and affordable care act: What does it mean for mental health services for older adults? *Journal of Psychosocial Nursing and Mental Health Services, 50*, 14–18.

Unutzer, J., Chan, Y. F., Hafer, E., et al. (2013). Quality improvement with pay-for-performance incentives in integrated behavioral health care. *American Journal of Public Health, 102*, e41–45.

Unutzer, J., & Park, M. (2013a). Older adults with severe, treatment-resistant depression. *JAMA, 308*, 909–918.

Unutzer, J., & Park, M. (2013b). Strategies to improve the management of depression in primary care. *Primary Care, 39*, 415–431.

Wells, K., Sherbourne, C., Duan, N., Unützer, J., Miranda, J., Schoenbaum, M., et al. (2005). Quality improvement for depression in primary care: Do patients with subthreshold depression benefit in the long run? *The American Journal of Psychiatry, 162*, 1149–1157.

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