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Short communication

The revised guideline on consultation-liaison psychiatry of the Netherlands Psychiatric Association

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1. Introduction

In December 2017, the revised guideline on consultation-liaison (CL) psychiatry of the Dutch Psychiatric Association was authorized and published in the online medical guideline database (https://richtlijnen database.nl/richtlijn/consultatieve_psychiatrie). The first guideline on CL psychiatry was initiated as a result of a nationwide study of the Dutch Health Inspectorate into the state of general hospital psychiatry, which revealed large differences in the organisation and quality of psychiatric care in general hospitals. Therefore, the aim of the first guideline on CL psychiatry was to create more transparency and uniformity of CL psychiatric consultation in general and academic hospitals. The guideline was published in 2008 and was the first procedural guideline on CL psychiatry that included specific clinical recommendations e.g. on how to conduct a psychiatric consultation and how to increase adherence to advice given in psychiatric consultation [1]. After its publication it received positive comments from various sources [2–4]. A revision of this guideline was necessary to bring its content in line with the changes in CL psychiatry that took place over the past 10 years in the Netherlands. These include the implementation of a new reimbursement system, the introduction of nurse practitioners and nurse specialists in the field of CL psychiatry, and the development of several professional standards in the field of general hospital psychiatry that also affect CL psychiatry. In addition to these reasons, there was also a formal reason for revision, since the validity of the guideline was set at 5 years when it was authorized.

1.1. Guideline development group

The guideline development group (GDG) consisted of 8 members

(the authors to this paper) and included four psychiatrists, one child-psychiatrist, a consultant in internal medicine and care of the elderly, a nurse specialist, and a methodologist.

1.2. Aim

The revised guideline on CL psychiatry aims at improving the quality and effectiveness of psychiatric consultations in general and academic hospital, as well to set standards for training in CL psychiatry. Contrary to the first edition of the guideline, the revised guideline did not exclusively focus on CL psychiatry in adult and geriatric patients, but also CL psychiatry in children and adolescents when evidence was available.

2. Methods

The development of this guideline followed the Medical Specialist Guidelines 2.0 report of the Advisory Committee on Guidelines of the Medical Quality Council. This report is based on the Appraisal of Guidelines for Research & Evaluation II (AGREE II) instrument (<https://www.agreetrust.org/agree-ii/>). This new approach to guideline development requires that guidelines focus on specific and relevant clinical problems and challenges. In order to identify these challenges, focus groups with patients as well as an invitational conference for professionals must be held.

2.1. Identifying clinically relevant challenges

A focus group with patients was organised, but had to be cancelled due to lack of interest. This lack of interest may have been due to the

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fact that no patient association exists for this area of psychiatry, and that patients that have been seen by a CL psychiatrist in hospital may not consider themselves psychiatric patients and may not feel enough affinity with the field of general hospital psychiatry or psychiatry in general.

An invitational conference with representatives from different disciplines and professional organisations in the field was held to identify clinical challenges. This conference yielded a large number of potential topics and research questions that were grouped into main themes and was the basis for discussion in the first meeting of the GDG.

2.2. Clinical questions

Based on the results of the invitational conference the GDG formulated seven clinically relevant research questions: 1) how should a CL-service best be organised? 2) how should a psychiatric consultation be performed? 3) which competencies are required to perform psychiatric consultations? 4) how can adherence to advice given during consultation be improved? 5) what can be the role of a CL nurse or nurse specialist in a service? 6) what is the effect of liaison activities? 7) what is the role of the CL psychiatrist in competency assessment?

2.3. Methods

A systematic review was performed for all of these questions. The quality of included studies was systematically assessed using validated risk of bias instruments, as advised by the Cochrane Collaboration: AMSTAR (Assessing the Methodology for Systematic Reviews) for systematic reviews (https://amstar.ca/About_Amstar.php), Cochrane Risk of Bias tool (RoB 2.0) for randomized controlled studies (<http://www.riskofbias.info>), and ACROBAT-NRSI (A Cochrane Risk Of Bias Assessment Tool: for Non-Randomized Studies of Interventions) for observational research (<http://methods.cochrane.org/bias/risk-bias-non-randomized-studies-interventions>). For those topics that showed a lack of scientific evidence, alternative sources of information were used, including textbooks, position papers, and consensus documents. When evidence was lacking published expert opinions and opinions of members of the guideline development group were considered.

3. Results

1) how should a CL-service best be organised?

The routine of performing psychiatric consultations only after request of the treating physician has been criticised because this “reactive” model of consultation would lead to under-recognition and under-treatment of psychiatric disorders in medical patients. Although appealing from a conceptual point of view, our systematic review could not identify evidence that would support hospital wide implementation of proactive models of psychiatric consultation in clinical practice, except for (very) low-level evidence that the “Rapid Assessment, Interface and Discharge” (RAID) model leads to a slightly shorter hospital stay and less re-admissions [5]. However, models as well as study designs vary widely, and outcomes have largely been focused on economic outcomes, such as duration of hospital stay, frequency of readmission and cost. Targeted proactive interventions in more selected hospital populations may show different results.

2) how should a psychiatric consultation be performed?

This section discusses the different stages of a psychiatric consultation: the consultation request, the question that needs to be answered, collecting information, assessing the patient, supervision, reporting to the attending physician, further diagnostics or treatment, termination of the consultation, the consultation report, and concluding administrative procedures. In answering this question, the GDG used

published consensus statements and “expert opinions”, and the scarce scientific evidence where available. Expert opinions were not only the opinions of the GDG, but were also found in the chapters on psychiatric consultation in Dutch and foreign textbooks in the field of consultation psychiatry and psychosomatic medicine.

3) which competencies are required to perform psychiatric consultations?

In the second revision of the Dutch medical specialist training guidelines for psychiatry (“Herziening Opleiding en Onderwijs Psychiatrie 2.0”, HOOP 2.0), training in consultation-liaison psychiatry has become compulsory [6]. However, the general competencies formulated in this overall training psychiatric guideline do not specifically address the CL setting. The GDG formulated competencies for CL psychiatry according to the CanMEDS framework in the format provided by HOOP 2.0 (<http://canmeds.royalcollege.ca/en/framework>). These were based on published training guidelines and expert opinion (such as [7]).

4) how can adherence to advice given during consultation be improved?

This clinical question was also part of the first guideline and published as a systematic review in 2010 [8]. The same search was performed again and yielded only 1 additional paper [9]. Investing in liaison activities, following up on patients, considering prescribing your own medication on wards that request consultation (rather than merely advising the treating physician to do so), and more direct involvement of senior staff members in consultations increase the adherence to advice given during consultation.

5) what is the role of a CL nurse or nurse specialist in a CL psychiatric service?

The introduction of psychiatric nurse specialists with extended permissions, such as autonomous treatment of patients including prescribing a limited number of medications has started a discussion in many hospitals about the role of CL nurses and nurse specialists especially within the CL setting. It was agreed that CL psychiatry by definition implies very diverse and highly complex somatic and psychiatric care in patients of all ages, ranging from paediatric to geriatric patients. Diagnosis and treatment of patients in a CL setting therefore requires broad differential diagnostic reasoning and knowledge of somatic diseases, (aberrant) metabolic disorders, laboratory test, side effects and interactions of both somatic and psychiatric medications. There was consensus that all initial psychiatric assessments in a CL setting should therefore be done under direct supervision of a psychiatrist. The subsequent treatment can be (partly) done by a CL nurse or nurse specialist, whereby the nurse specialist has a greater autonomy than the CL nurse.

6) what is the effect of liaison activities?

A systematic review into the effect of liaison activities showed low level evidence that these activities did not reduce the duration of hospital stay, nor the chance of re-admission after discharge. However, the primary aims of liaison activities are not focused at these economic outcomes. They are focused at early recognition of psychiatric problems and reducing stigma of psychiatric patients by educating medical personnel on somatic wards, with the ultimate aim of increasing the quality of care. The GDG is of the opinion that liaison activities remain important irrespective of their impact on patient outcome variables, since they contribute to the integration of psychiatry in the hospital setting and increase the psychiatric knowledge of somatic health professionals, which may reduce stigma and improve the quality of care.

7) what is the role of the CL psychiatrist in competency assessment?

In the Netherlands, psychiatrists are often consulted for routine competency assessments. However, according to Dutch medical training guidelines, every physician should be able to competency assessments. Within the GDG there was consensus that only in case of psychiatric disorders (e.g. cognitive decline, mood disorders or psychotic disorders), personality disorders or interactional problems between the patient and medical or nursing staff, assessment by a psychiatrist has added value.

4. Conclusion

The new approach to guidelines development makes the guideline for CL psychiatry clinically more relevant than the previous version. Findings and recommendations can easily be implemented in both clinical practice as well as training programmes. For many clinically relevant aspects of CL practice, little evidence is available. Among these are aspects related to the most effective organisation of CL care, improving adherence to advice given during consultation, and evaluating the effects of interventions done by CL nurses and nurse specialists. These should be topics of future research.

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