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# Comparison of consultation–liaison psychiatry services for inner-city, district or regional general hospitals using a common tool: Does one size fit all?

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ABSTRACT

*Objective:* Consultation–liaison psychiatry (CLP) services vary in terms of structure, function and responsiveness. It is not known whether evaluation measurements can be meaningfully compared across different CLP services to assess value and efficiency. The aim was to develop and test a common tool for measuring process and outcome measures in CLP.
*Methods:* A data collection tool was developed using the literature and consultation with CLP clinicians. The tool was used to prospectively gather referral data, response times, health utilisation data and functional outcomes for individuals referred over seven months to three different CLP teams, servicing inner city, district and regional areas.
*Results:* The structure, staffing, liaison attachments and scope of practice varied between the services. The regional CLP service attended seven hospitals and had the highest referral rate and largest inpatient population pool. The three services received referrals for similar reasons and made similar diagnoses. Multimodal management was the norm, and CLP facilitated follow-up arrangements upon discharge. Only the district CLP service saw all emergency referrals within an hour. Age and need for an interpreter did not affect response times.
*Conclusion:* Despite local differences in geography, CLP roles, hospital and community mental health service pathways and patient populations, the CLP data collection tool was applicable across sites. Staff resourcing and referral demand are key determinants of CLP response times.

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## 1. Introduction

There has been increasing interest in evaluating clinical services in Australia particularly with the advent of activity based funding. The subspecialty of Consultation–liaison psychiatry (CLP) connects general medical and psychiatric services. This dual focus creates complexity in determining what should be the appropriate goals and outcome measures in CLP [1]. Additionally, CLP services vary considerably in their size, local population needs, geographical location and scope of their activities, many of which do not fit neatly within the typical functions of either mental health or physical health services [2,3].

Recent discourse has highlighted the need to accurately capture activities of CLP services and achieve more cohesion and rigor in measurement of outcomes [3,4,5]. Objective measures of CLP should include structure, process and outcome [5]. Descriptions of the structure of CLP services should include staff number and discipline, and specialist time with reference to the hospital size and expected CLP roles (e.g. education, liaison attachments). Process measures in CLP such as the number and rate of referrals, response times, and health utilisation data (e.g. discharge destination and readmission rates) have been evaluated [1]. Developing universal outcomes has been challenging given the wide variation in CLP services, however it is beginning to be successfully achieved, as shown recently with a multisite consultee satisfaction survey [6] and cost-effectiveness and readmission rates [7].

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The primary aim of this study was to determine whether the same evaluation measures collected with one data collection tool could be used meaningfully across different CLP service types in three tiers and geographical locations of general hospital CLP services. Secondary aims were to compare the performance of the three CLP services on process and outcome measures.

## 2. Methods

### 2.1. Study setting

Three CLP services in New South Wales, Australia were selected and categorized by their location and service delivery.

1. One inner-city hospital CLP service was included, which was a tertiary referral centre and University teaching hospital, covering a local population of 378,680 [8]. This service was staffed by 1.7 fulltime equivalent (FTE) consultant psychiatrists, 2 FTE psychiatry registrars and one FTE senior clinical psychologist. Two FTE CLP clinical nurse consultants were employed separately by the general hospital in predominantly non-clinical roles, including supporting general nursing staff managing challenging patients, education, policy development and research. This CLP service had a liaison attachment to the Pain Clinic, with enhanced (but not a full liaison) attachments to Gastroenterology/Hepatitis C and Renal Transplant Medicine.
2. One district hospital CLP service was included. The hospital was located in a suburban area of Sydney with a catchment population of 220,000 [9]. This service consisted of 0.8FTE consultant psychiatrist, one FTE psychiatry registrar and 0.9FTE Clinical Nurse consultant/Nurse Practitioner, with liaison attachments to antenatal services and geriatric medicine.
3. One regional hospital CLP service was also included which was based at one of the acute hospitals in the area, but provided a service to another six hospitals. The base hospital was a University teaching hospital providing acute care, and the other six were a smaller acute regional and five step-down rehabilitation or district hospitals. These hospitals had a total catchment population of 368,822 [10]. This service was staffed by 1.4FTE consultant psychiatrists and one FTE psychiatry registrar with involvement in two medical outpatient clinics; neuropsychiatry and brain injury as well as a liaison attachment to one of the local rehabilitation hospitals.

The liaison psychiatry attachments at the three sites developed in a variety of ways, including medical team initiated and funded (e.g. pain clinic); special interest of the CLP psychiatrist (e.g. geriatrics); and necessity, where psychiatric assessments are mandated (e.g. suitability for interferon for Hepatitis C and kidney donation).

None of the CLP services provided primary psychiatric cover to their hospital Emergency Department (ED), as that role was performed by a separate acute mental health service. However, CLP provided second tier cover and support for the primary ED mental health team if that service was unavailable or requested assistance, and when medical teams referred patients prior to transfer from the ED to a ward. Only inpatient referrals to medical staff in each CLP service were considered in the analysis. Although data on inpatient referrals to CLP were collected for all seven regional hospitals, lag times were only calculated for the base acute hospital, due to distances traveled and because five of the satellite hospitals functioned differently to the acute hospital services (they provided slow-stream care or had patients awaiting placement).

The number of inpatient beds was 480, 158, and 520 for the inner-city, district, and the two acute regional hospitals, respectively. The five smaller subacute regional hospitals had a total capacity of 257 beds. Ethical approval was granted from the Human Research Ethics Committees at each of the study hospitals.

A two-page data collection tool was subsequently developed to capture key information on CLP referrals based on review of studies on CLP outcome measurement [4,5] and discussion between the lead researchers and their clinical colleagues at the three sites (see Appendix A). The following information was collected: patient demographics (age, English-speaking status, setting, Global Assessment of Functioning [11] and Karnofsky Scale score [12] at the time of consultation), referral details (referring team, time referral made, time seen, reason for referral, degree of urgency, whether a consultant reviewed the patient) and referral outcomes (CL diagnosis, GAF and Karnofsky Scale score on discharge, CL recommendations, follow-up service on discharge, team co-ordinating psychiatric follow-up care). Team registrars completed a unique data collection tool for each inpatient referred to CLP. A universal database was established to record the data electronically. It was determined that data would be collected prospectively for a seven-month period from July 2014–January 2015 to coincide with one registrar rotation (in order to capture data over a period of stable staffing).

Descriptive statistics are expressed as simple means, frequencies and standard deviations. Differences between the referral characteristics and CLP team interventions and recommendations across the three CLP service were evaluated using one-way analysis of variance (ANOVA) for continuous variables and Chi square analysis for categorical variables. SPSS version 18 was used for data analysis and results were considered statistically significant if the p value was $<0.05$.

## 3. Results

In total, 754 inpatient referrals to CLP were received during the study period (Table 1). The regional CLP service received more inpatient referrals overall, compared with the other two sites (Table 1). On average, rates of inpatient referrals were 25, 20 and 62/month for the inner city, district and regional CLP services, respectively. The district hospital saw more Emergency Department referrals (37, 30%) compared with the other two sites (2.5% and 1.7%).

The demographic and clinical characteristics of patients referred to the three CLP services indicate slightly younger patients were admitted to the district hospital ($F(2, 750) = 8.05$, $p < 0.001$) with a corresponding higher proportion of patients over the age of 65 referred to CLP services in regional hospitals (219/438, 52.6%, $X^2$ ($DF = 2$) $= 11.76$, $P = 0.003$; Table 1). The district hospital had the highest percentage of referrals needing an interpreter ($X^2$ ($DF = 2$) $= 26.73$, $P < 0.001$).

### 3.1. Process measures

Medical teams were the most common referring team at all services followed by surgical services, acute teams, maternal health and others (Table 1). The most common reasons for referral across all sites were depression, self harm/suicidal ideation or attempt and medication review (Table 2), past psychiatric history was significantly more commonly referred at the district hospital. The proportion of other reasons for referral was similar across sites.

The most frequent primary CLP diagnoses were delirium, which was more common at the inner-city hospital, or depression, which was equally prevalent across the three services, followed by adjustment disorder (Table 2). Other frequently made diagnoses were anxiety disorder (overall frequency across sites 9%), personality disorder 8.4%, no diagnosis (e.g. interpersonal conflict, capacity assessment) 8%, psychosis 7.2% and a substance abuse problem 6.8%.

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