# Submission to the Royal Commission into Mental Health

## Physical Health Care in patients with mental illness

## Ensuring adequate Mental Health Care for patients in Victoria's General Hospitals.

**A Submission from Consultation-liaison Psychiatrists**

## Executive Summary

Consultation-Liaison Psychiatry (CLP) teams provide specialist mental health care for patients admitted to Victorian general hospitals. Adequate mental health services are required in order to provide quality care, ensure patient flow and maintain safety. National and international literature suggest that at least 1% of general hospital admissions require specialist mental health services, with more developed services required in hospitals with high turnover and in specialist setting such as Cancer services.

CLP funding through the Victorian Department of Health and Human Services' (DHHS) mental health branch has remained stagnant over the past 20 years despite major growth in acute health services.

The underdevelopment of CLP has occurred due to:

1. The failure to fund mental health services when opening new medical units, hospital and services.
2. The mental health branch and acute health each having an expectation of the other to fund CLP services, leading to stalemate.
3. The lack of 'visibility' of CLP within key data sets whereby the increased service demands, decreased responsiveness and capacity limits remain hidden.
4. The absence of a model for service development involving both acute and mental health that demonstrates activity and quality and can respond to changes and growth within the acute health system.

Recommendations

1. Mental health services at general hospitals are delivered by CLP teams
2. Mental health services are available to all Victorian public hospital patients proportional to the hospital size and activity.
3. Statewide data set for the provision of mental health services within general hospitals.

## 1. Statement of Purpose

Consultation-liaison psychiatry (CLP) teams provide mental health care for general hospital inpatients that require immediate expert care.

Unlike other services in the general hospital, which are funded through DHHS acute health, core CLP is funding is provided by DHHS mental health branch. This funding has remained stagnant over the past 20 years despite major growth in acute health services. The consequence is that currently CLP services in Victorian general hospitals are grossly inadequate, leading to poor quality care, increased length of stay, preventable behavior disturbance and unsafe discharge planning.

The authors acknowledge that CLP is one component of a large and complex mental health system. At the same time CLP has a central role in bridging acute and mental health services, transmitting knowledge and skills and facilitating patients flow.

## 2. Psychiatric Disorders in the General Hospital

The prevalence of mental disorder is higher in the general hospital than in the community. At any time, up to 20% of hospital inpatients have a diagnosable mental disorder. Of these, a minimum of 1% of patients require immediate specialist mental health care.

All types of mental disorders are present in the general hospital. Mood and anxiety disorders are most common, especially in patients with cancer, terminal illness, chronic physical illness and pain. Delirium and/or dementia occur in a third of patients over 65. Bipolar disorder, schizophrenia, anorexia nervosa, and personality disorder are overrepresented due to poorer health outcomes, and accidental and intentional injury.

Many patients with mental disorders in general hospitals are already receiving treatment or can be managed adequately by the primary admitting unit. The capacity of general units to manage management of mental disorders is enhanced by the activities of CLPs, especially in liaison activities.

The inadequate management of mental disorders in the general hospital is associated with a range of negative outcomes. These include:

- increased length of stay
- repeat admissions
- increased health care costs
- decreased physical health outcomes
- poor treatment adherence
- behavioural disturbance and serious incidents, including inpatient suicide.

## 3. Consultation-Liaison Psychiatry: What does it do?

### 3.1 Overview

CLP is the multi-disciplinary service which assesses and manages major psychological problems and psychiatric disorders in general hospital inpatients.

The most common reasons for referral to CLP services are for:

- following a suicide attempt
- depression and anxiety
- confusion
- behavioral disturbance
- psychosis
- advice about current psychotropic medications.

In adult hospitals, about half of the patients referred to CLP services in the general hospital are aged 65 years or over.

Within pediatric hospitals, CLP services are provided to those patients aged 0 to 18 years and their families. The most common reasons for referral to pediatric CLP are eating disorder symptomatology, psychosomatic symptoms, anxiety and lowered mood.

### 3.2 Scope of practice

***Consultation (Assessment and management)***

CLPs respond to referrals from medical/surgical wards. The patient is assessed at the bedside where a diagnosis is made and a management plan is formulated. Feedback is provided to the referring team. The patient is reviewed as required and post-hospital psychiatric follow-up is arranged. Organising psychiatric or psychological follow-up is often challenging, especially in rural settings, and can be a source of delay in discharge.

Some general hospital patients are subject to the Mental Health Act. The psychiatrist may also be required to give substitute consent for medical or surgical treatment.

The CLP provides psychological expertise and support to medical ward teams in the care of mentally disturbed patients. This includes a role in the support of staff that have been traumatized by distressed and mentally impaired medical patients, including verbal or physical abuse or assault.

***Liaison***

Liaison is the building of professional relationships between CLP services and individual general hospital units. In a liaison role, CLP staff attend unit meetings, clinical reviews, case discussions and educational activities. The CLP clinician in liaison role aims to facilitate early identification of referrals, improve mental health awareness and skills and provide support in the management of complex care of patients. CLP members also act as a resource to the hospital for mental health related projects, education and policy development aimed at improving patients' mental health care.

Liaison attachments are most useful in subspecialty areas with high degrees of comorbidity and complexity (for example: spinal, transplantation, neurology, cancer streams, HIV, gastroenterology, renal, pain).

Currently the liaison component of most CLP services is inadequate - far from the aim of about 50% of time being spent on education and up-skilling of non-mental-health staff in general hospitals. Liaison is usually the first component of a CLP service to go if under-resourced, despite it being a vital component to improve quality of care and to reduce stigma.

***Outpatient clinics***
There are no outpatient CLP services in most hospitals. There is a group of patients who currently fall in the 'gap' between public AMHSs and private psychiatry/psychology/primary care that would benefit from having a specialised outpatient CLP clinic. They often have complex medical and psychiatric conditions (for example, functional neurological disorders) that require specialised and multi-disciplinary care. In the absence of CLP services these patients often have increased general hospital service use without their underlying problems being addressed.

**Specialised psychological interventions**
CLPs provide brief psychological interventions for acute distress, especially in trauma, intensive care and oncology settings.

**Nursing**
CLP nursing has developed out of the recognition that the needs of nurses managing patients with mental health problems were not being met. Most major teaching hospitals now have mental health nurses, but the positions are not distributed equitably. The Australian Nursing and Midwifery Federation has lodged a claim for CL nurses in all Level One and Level Two hospitals across the state - the outcome of which will impact on the CL reform process.

**Training**
Team members provide training on general hospital staff and students on mental disorder, behavioral disturbance and use of the Mental Health Act.

**Research**
CLP is commonly involved with collaborative research within the general hospital.

### 3.3 Multidisciplinary Staffing

**Medical**
Consultant psychiatrists specializing in CLP and psychiatry trainees provide foundation expertise in CLP. Their medical background allows for assessment of both the physical and psychological elements of patient problems.

**Nursing**
Over the past 15 years, CLP nursing has developed a role in consultations in the care of patients that challenge the knowledge, skills and confidence of the staff, particularly the nursing staff. Significant cost savings, improved patient care and referrer satisfaction have been demonstrated.

The CL nurse can provide assistance in cases where:
- mental health care needs are intense or challenging for generalist nurses
- symptoms are difficult to manage in a general ward

- the patient has a significant systemic impact
- the patient is in hospital long term and requires supportive counselling and monitoring
- 1:1 nursing care for disturbed mental state ('specials') is required
- the patient has been transferred from mental health inpatient settings (including forensic services)
- a person is under the Mental Health Act
- the patient requires electroconvulsive therapy
- education is required.

The CL nurse can assist in the formulation of collaborative management plans for patients with complex and comorbid health problems. In addition, the CL nurse provides expert mental health nursing input into the organisation on mental health related education policy development, projects and research.

**Clinical Psychology**
The clinical psychologist in CLP assesses patients and provides specialised psychological interventions. This is particularly useful in patients in whom the psychological disturbances are affecting their physical health. These include patients with eating disorders, substance abuse, pain, or in relation to severe physical trauma, or chronic and disabling medical conditions. Their role may include the formulation of collaborative management plans for patients and the provision of support to family and carers. They may provide focused individual psychotherapy or group or couple therapies and may assist in developing behavioral management plans.

**Management**
The manager supports the employment of the clinicians and facilitates the relationship with other parts of the general and mental health care systems. The manager may have a particular role in facilitating the transfer of patients to mental health beds.

**Administration**
Administrative support is required for Mental Health Act processes, collection of data, facilitating communication, supporting quality assurance and program development.

## 4. Other Mental Health services in the General Hospital

In some general hospitals, clinical psychology is delivered as a component of allied health. These services are often available to a limited number of units at restricted times. In a few cases, clinical psychologists are embedded in particular units.

Neuropsychology may be available to neurology, geriatrics and head injury units. Clinical Neuropsychologists provide the assessment of cognitive disorders on the basis of standardised and validated tests. This enables:

- differential diagnosis of psychiatric/neurological disorders or subtypes of neurological disorders
- characterisation of a cognitive profile to assist with management planning, client-appropriate interventions and carer understanding
- assessment of cognitive competency in a medico legal setting

- achievement of precise baseline measures to assist with documenting change over time or with regard to treatment.

## 5. Consultation-Liaison Psychiatry in Victoria

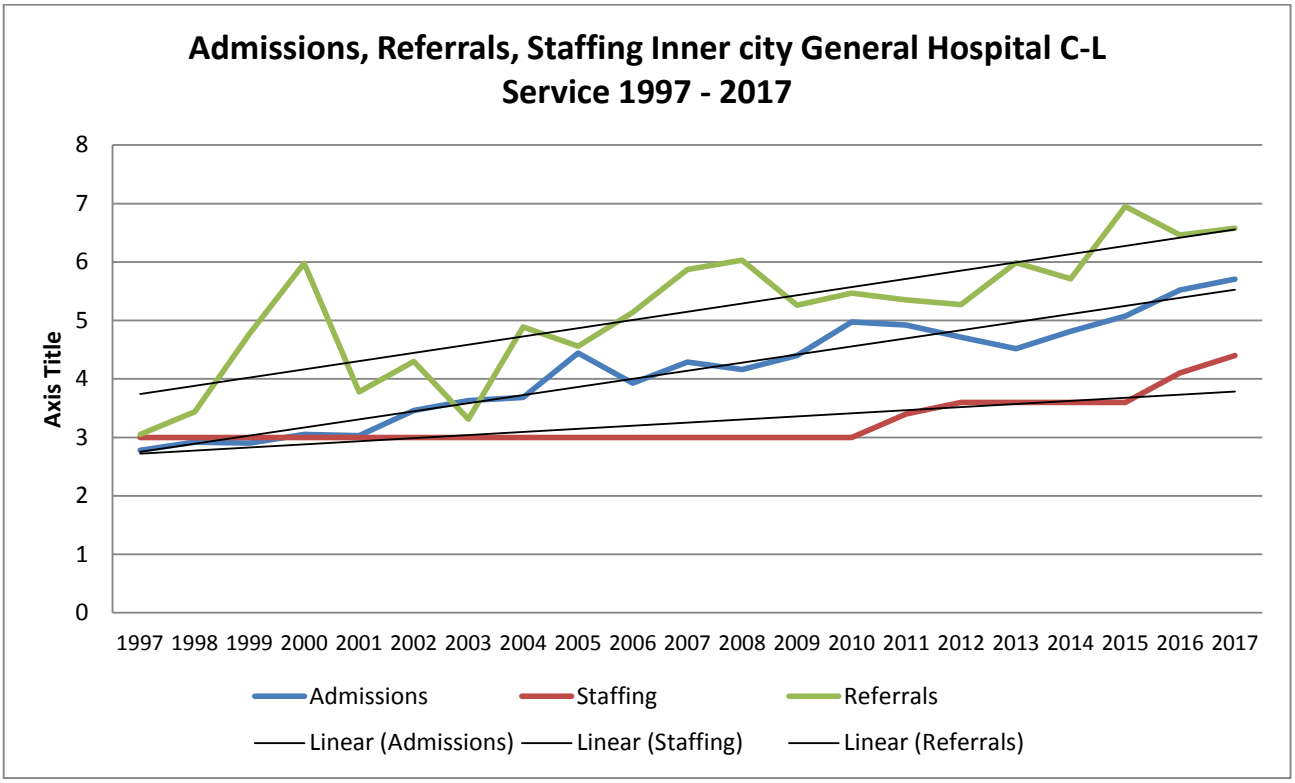
The funding of CLP has not matched increased service demand. CLP services in Victoria are primarily funded through the mental health branch of DHHS. This funding is historical, inadequate and not indexed. Admissions to general hospitals have increased by at least 30% over the past 10 years without corresponding expansion of CLP services (figure 1). In addition, CLP funding has not been included when new medical services are opened, for example obstetrics services at Sunshine and new intensive care beds at Melbourne Health. **There is no framework that establishes the aims, role or scope of practice of CLP. There is no method of matching CLP resources to the growth in acute health services.**

The block funding of CLP by the mental health branch of DHHS has discouraged funding from within DHSS acute health and from hospitals themselves. It is assumed by acute health that the psychiatric care of an inpatient will be funded by the mental health branch. Concurrently, the mental health branch has adopted a position of not expanding services, in part as a strategy to force the hand of the hospitals or acute health to fill in the gap. This stalemate has been ongoing since the 1990s is the core driver of the current and unsustainable situation and pays scant regard to the needs of patients admitted to hospitals in need of CLP services.

The over-stretching of CLP has led to the closing of CLP clinics. CLPs are unable to follow up the patients they have seen during their admission. In addition, patients with complex comorbid physical and psychiatric problems managed by the hospital, often using high levels of resources, cannot be seen. These patients are <u>not</u> seen at community clinics and substantially add to the health care costs in the acute hospital.

One positive development in CLP has been CL nursing. CL nursing has been effective in reducing 1:1 nursing costs, developing mental health related policies, processes and educational programs (for example aggression, 1:1 nursing, restraint and risk management) and improving the capacity of hospitals to deal with behavioral disturbances.

Figure 1:




## 6. Consequences of inadequate CLP

**Decreased Quality of Care**

The gap in assessment and management of psychiatric comorbidity in general hospital patients leads to:

- delayed recovery
- decreased physical health outcomes
- poor treatment adherence
- behavioral disturbance and serious incidents
- increased risk of self-harm and inpatient suicide
- perpetuation of stigma.

The adverse consequences also extend to the patient's family and carers.

**Increased Costs**

The gap in assessment and management of psychiatric comorbidity in general hospital patients leads to increased costs through:

- increased length of stay
- repeat admissions

- delayed discharge though slower recovery or delayed transfer to mental health services
- over servicing of patients with abnormal illness behavior
- lack of cohesive management in patients with co-occurring complex psychiatric and physical illness.

## 7. Evidence for the Benefits of Consultation-Liaison Psychiatry Services

There is extensive literature on the benefits of CLP. One example is a study of a CLP model tested in a 600-bed general hospital in the United Kingdom. The service led to:

- marked reductions in length of stay
- marked reductions in readmission rates
- substantial savings in terms of bed-days (estimated savings of ~14,000 bed-days over 12 months, or ~38 beds per day).

Most of the savings were observed in elderly patients, particularly in geriatric medicine wards.

Cost benefit analysis have identified many potential areas of savings related to CLP. An analysis using local data modeled the benefits through reducing length of stay and 1:1 nursing* (appendix 4).

## 8. Guidelines for baseline services in CLP

The Queensland Government was the first state to develop a model of care in CLP. They recommended:

- 3.5 FTE per 100,000 of population with 1.8 FTE per 100 beds
- higher CLP staffing rates in specialised settings.

The Victorian Branch of the RANZCP has made the same recommendation as the minimum level at which safe and competent CLP services can be maintained.

## 9. Recommendations

## Summary

1. Mental health services at general hospitals be delivered by CLP teams

2. Mental health services be available to all Victorian public hospital patients.
    - Existing health services (acute, specialist, and subacute) have adequate baseline staffing
    - New services should include mental health care as a core component of their service delivery

3. Statewide data set for the provision of mental health services within general hospitals.

### 9.1 Integrated delivery of mental health services through CLP

The historical division between allied health psychology and CLP through the area mental health service can lead to duplication, inefficiency and poor communication. In a complex hospital environment, CLP as a multidisciplinary service bridging the mental health and acute health systems is able to provide a responsive coordinated 'one stop shop' for mental health needs.

### 9.2 Adequate baseline staffing

Based on local and international literature, CLP services should have the capacity to assess and manage at least 1% of admissions

The clinical staffing required to provide this capacity is 1.8 EFT per 100 beds.

Different variations in the make-up of the multi-disciplinary team are appropriate in different settings.

In areas of increased need (Appendix 2), the numbers and complexity of cases are increased.

Enhanced CLP services should have the capacity to assess and manage at least 2% of admissions.

The clinical staffing required to provide this capacity is 2.7 EFT per 100 beds.

### 9.3 Uniform data set and Performance Measures for CLP

Adequate mental health services in general hospitals require the collection, analysis, reporting and review of a uniform data set. This data would comprise measures of activity and performance which can be reported at team, hospital and statewide levels.

## 10. Conclusion

CLP services are vital to efficient and effective management, reducing length of stay and limiting readmissions. The development of CLP alongside expanding acute health services has been inhibited by outdated divisions between mental and physical health and a lack of understanding of the complexity and role of CLP services. The consequence is that services are currently unable to adequately address the immediate need of hospital inpatients with direct impacts on efficiency and patient outcomes. The opportunity exists for a system redesign, which addresses current deficiencies and is responsive to future challenges.

**Case Study:**

Kali (a pseudonym) is a previously well unemployed woman in her 20's referred by family to the emergency department with poor oral intake, nausea, vomiting body tightness". She described numbness in the teeth, skin feeling like there is glad wrap on it, electric shocks on her face and head, and throat tightening.

Physical examination findings and extensive neurological investigations were normal.

Kali described recent stressors which included a relationship breakdown, living with extended family of 8 in overcrowded 3 bedroom flat with, "no privacy" and "mum always telling me to get married".

Kali was born in Africa. She lived in a refugee camp from an early age before migrating to Australia when primary school age. She said she found her first five years in Australia difficult due to home situation, language and cultural barrier. She described delayed speech development, bullying in primary school and learning difficulties throughout school. She left school during Year 10 and took several years to complete a childcare certificate.

In hospital Kali was a young slim African woman, hair covered with traditional scarf, lying in bed under sheets. She engaged with good eye contact. She described mood as "numb". Her thought was preoccupied with bodily complaints.

The Consultation-Liaison Psychiatry (CLP) assessment formed the opinion that Kali had developed psychosomatic symptoms in the context of relationship breakdown, housing stressors and unemployment on a background of childhood learning difficulties, complex migration history and disrupted attachment style. She was diagnosed with somatic symptom disorder (a condition whereby psychological distress manifests as physical symptoms).

Kali was followed up in the Community Clinic in collaboration with her GP. She continued to complain of multiple somatic complaints, but rather than undergo repeated medical investigations and hospital admissions she was given education and relaxation techniques. She continues to engage with the mental health service and has not represented to the acute hospital.

This case is an example of the value of complex CLP assessment and management in reducing unnecessary investigation and hospital admissions in people with somatic symptoms not due to physical illness.

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***The views expressed in this submission represent those of the individual authors, rather than the views of any organisations with which the authors are affiliated.***

## Appendix 2: Areas of need

Specialist units requiring higher levels of baseline staffing include

- Cancer services
- Transplant services
- Trauma services
- Spinal services
- Pain services
- Rehabilitation services
- Renal Services
- Geriatric services
- Neurology
- ICU
- Obstetrics
- Pediatrics
- Statewide services