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▶ Consultation-liaison psychiatry in general hospitals: improvement in physicians' detection rates of alcohol use disorders.

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Diehl A., Nakovics H., Croissant B. et al.
Psychosomatics: 2009, 50(6), p. 599–604.

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When an addiction psychiatrist modelled good alcohol assessment practice while accompanying doctors once a week during their ward rounds, the result was steeply increased rates of correct diagnosis of drink problems and of referral to treatment, offering an alternative to possibly unwelcome training or direction of clinical staff.

SUMMARY In general hospitals alcohol abuse and dependence commonly remain undetected and untreated. Though recommended, specialty training and routine screening are rarely implemented. This study from Germany investigated an alternative approach which involved neither direct training nor recommending doctors change their practice. Instead it investigated whether correct identification and referral to treatment of inpatients on a general medical ward would be improved by a consultation–liaison psychiatry initiative which involved ward physicians being accompanied on their rounds by an addiction psychiatrist.

Despite a major focus on substance use disorders, in Germany psychiatric specialists see only a minority of patients, especially if they only come when asked to by ward physicians. In contrast, consultation–liaison services influence patient care through direct clinical contact with patients (consultation) but more importantly, by encouraging changes in the behaviour of other physicians through an educational relationship (liaison) which affects how they diagnose and treat patients, even when the psychiatrist is not there.

The consultation–liaison model tested by the study involved a consultant psychiatrist with expertise in addiction medicine joining hospital physicians in their ward rounds once a week. They demonstrated a diagnostic procedure which first screened for alcohol use disorders using the three questions which constitute the AUDIT-C screening questionnaire. Screening also included laboratory data, chart review for alcohol use disorders, and physicians' or patients' statements about any alcohol use problems. If at least one of these methods indicated problem drinking, a 'gold standard' procedure (the International Diagnostic Checklists) for making psychiatric diagnoses under the World Health Organization's classification system was completed to confirm alcohol abuse or dependence. Depending on these results, the psychiatrist then offered therapeutic recommendations. Physicians were neither told that this approach was an educational intervention directed toward them nor instructed to change their own diagnostic or therapeutic routines. The aim was to motivate them indirectly and enable them to use standardised diagnostic exploration and therapeutic procedures without evoking defensive reactions by explicit instruction or recommending specific modifications in their practice.

Key points
From summary and commentary

This study from Germany involved a psychiatrist experienced in addiction accompanying general medical ward physicians once a week on their ward rounds, demonstrating by example diagnostic and therapeutic procedures for alcohol use problems.

Compared to a ward which continued with usual practice, rates of correct diagnosis of alcohol abuse and dependence and of referral to treatment increased steeply after implementation of the service.

Such a service provides a resource-light alternative to direct training and instruction of ward staff and avoids possibly resistance-provoking instruction or direction of clinical staff.

The study at a single hospital involved a pair of very similar general medical wards which saw many patients suffering from alcohol-related illnesses. Patients were assessed every four weeks (when a new set of patients would normally have been admitted) to determine whether the ward physicians' alcohol disorder diagnoses tallied with those indicated by the International Diagnostic Checklists. During the first eight weeks the psychiatrist saw patients only when requested. Over the next eight weeks, a randomly selected one of the pair of wards implemented the consultation–liaison service described above while the other (the control ward) continued with usual practice. The key issue was whether compared to the usual-procedure first phase, over the second phase rates of correct diagnosis and referral of patients to specialist alcohol treatment would increase in the consultation–liaison ward but not (or not as much) in the control ward. If they did, it would indicate that the initiative had improved alcohol diagnosis and referral practice.

Main findings

Compared to the first phase, after implementing the consultation–liaison service there was on that ward a significant increase in rates of correct diagnosis of alcohol abuse (from 44% to 91%) and dependence (from 20% to 73%) and in referrals to alcoholism treatment (from 25% to 84%) ▶ chart. By contrast, these rates did not change significantly on the control ward. The result was that though at first correct diagnosis and referral rates did not significantly differ between the two wards, after the consultation-liaison service started significant differences emerged favouring the consultation-liaison ward.

The consultation–liaison service required up to three additional working hours per week for the

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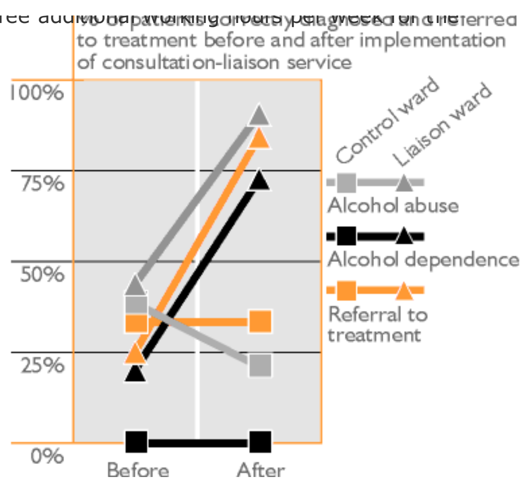
The consultation-liaison service required up to three additional working hours per week for the psychiatrist and up to one hour for hospital physicians. None of the patients refused the conjoint treatment, and all the physicians wanted the service to continue.



The authors' conclusions

These tentative results from a pilot study provide support for the feasibility and effectiveness of a conjoint consultation–liaison model to improve physicians' rates of detection and intervention in alcohol use disorders. Benchmarked against a standard diagnostic system, hospital physicians' detection and referral rates improved significantly and increased more than twofold during implementation of the service. The service was well accepted by patients and physicians, and the additional workload was manageable. Implemented at regular intervals, such a service may represent an important step toward improving health care beyond the case-focused approach typical of interactions between psychiatrists and non-psychiatric physicians. However, the service was trialled on just one ward and results may not generalise to other settings.

FINDINGS COMMENTARY The model tested in the study seems to provide an alternative to directly training general medical physicians in screening, diagnosis and referral, and directly instructing them through management and supervision to implement those procedures. Instead of imposing what may be seen as unwelcome extra work which erodes the clinician's discretion to determine clinical priorities, the model entailed physicians 'absorbing' good practice from more experienced/expert practitioners during normal ward routines. The result was very high rates of correct diagnosis and referral to treatment.

The alternative of encouraging ward staff to screen all new admissions and asking them to refer as appropriate to the hospital's alcohol liaison nurse has been trialled in the UK but just 37%, 18%, and 29% of patients were screened on the three wards. Barriers included time constraints, paperwork and lack of staff motivation. Disappointing results were found too in Australia after ward nurses had been trained and required to document whether patients had been asked about their substance use. A review of research on such barriers found that though patients appear to expect more discussion of drinking, real or perceived lack of knowledge and fear of upsetting patients prevents staff meeting this expectation.

These kind of restraining influences on screening and intervention seem amenable to an approach which involves demonstrating good practice during routine ward rounds rather in a separate training session which may not be attended and/or may be seen as an unwelcome diversion from clinical work. On-site mentoring and example allows ward doctors to see how patients actually react, and seems likely to maximise relevance to their concerns and needs by modelling good practice in the same setting and with the same patients the doctors work in and with.

However, the authors' caution that this study showed how the service worked on one ward and that it may not work as well elsewhere is important. Numbers of physicians and patients involved were small, and it is not clear whether ward physicians knew a study was underway to test their reactions to the consultation–liaison service. If they did know, it could have influenced their diagnosis and referral of patients in ways which would not have happened without the presence of research monitors. Also it is unclear from the featured report who made the diagnoses against which the ward doctors' diagnoses were benchmarked, and whether they knew that one of the wards was trialling what was intended to be a way of improving diagnoses.

Thanks for their comments on this entry in draft to Jonathan Chick of Castle Craig Hospital in Scotland. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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