

THE ROLE OF THE PSYCHIATRIC CONSULTATION-LIAISON NURSE IN THE GENERAL HOSPITAL

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ABSTRACT

The mainstreaming of psychiatric services has increased the amount of contact nurses have with clients experiencing mental health problems within the general hospital environment. A review of the literature suggests that general nurses find themselves lacking in the skills, confidence and knowledge to care adequately for these patients. The aim of this paper is to discuss the potential contribution of the psychiatric consultation-liaison nurse in addressing such problems in order to improve health outcomes for patients experiencing mental health problems. While a number of positions for Psychiatric Consultation-Liaison Nurses are being created throughout Australia, there is a paucity of literature relating to the development of this important role. This paper is intended to contribute to the advancement of a body of knowledge in this area.

INTRODUCTION

The launch of the National Mental Health Policy (Australian Health Ministers 1992) provided the stimulus for fundamental changes to psychiatric services delivery within the Australian health system. Central to these reforms is the concept of mainstreaming. Mainstreaming refers to the shift from traditional psychiatric institutions as the basis of care for people with mental health problems to the integration and co-location of these services into the mainstream general health system. It is envisaged that by reducing the isolation and stand-alone nature of psychiatric services, clients will have increased access to quality general health care services (Australian Health Ministers 1992). As a direct consequence of mainstreaming, a larger number of clients experiencing mental health problems are now being cared for within the general hospital environment. The Psychiatric Consultation-Liaison Nurse (PCLN) has a crucial role in providing knowledge, enhancing skills and being supportive of nurses providing care for these clients.

This paper will examine some of the problems incurred in the realisation of the goals of the National Mental Health Policy (Australian Health Ministers 1992), with particular focus upon nursing care issues. The discussion will include; the incidence of mental health problems among general hospital patients; the ability and confidence of nurses in general hospitals to provide for this client population; the concept of consultation-liaison (C-L) psychiatry; the role of the Psychiatric Consultation-Liaison Nurse (PCLN) and the importance of this role for improved health outcomes for patients.

MENTAL HEALTH PROBLEMS IN THE GENERAL HOSPITAL

An implication arising from mainstreaming is that general hospitals are having more contact with psychiatric services and their clients. This places a responsibility on general hospitals to ensure that their services are accessible and responsive to this group of patients and that staff are equipped with the knowledge and skills needed to provide quality care that meets their needs. The Australian health system also needs to ensure that people with mental health problems are not subjected to the stigma and other forms of discrimination associated with service delivery prior to mainstreaming.

While mainstreaming may have increased the frequency, contact with patients with mental health problems is not a new phenomenon for general hospitals. Indeed, physical and mental health problems can occur in general hospital patients (Mayou and Sharpe 1991) according to whether they:

1. occur simultaneously, either co-existing by chance or being precipitated by a common cause such as a major life event;
2. are a complication of a physical problem; or
3. are the cause of a physical problem.

Grouping mental health problems in this way is helpful but does not provide a clear definition of a mental health problem. The presence of a diagnosed psychiatric disorder can be considered a defining characteristic of a mental health problem. However, this definition is limiting as there are patients who present with psychological problems who are considered likely to benefit from some form of psychological intervention, but whose symptoms are not severe enough or cannot be classified neatly into current psychiatric diagnostic categories (Mayou and Sharpe 1991). Sub-clinical depression or severe anxiety in response to physical illness, behavioural disturbance such as aggression, and treatment difficulties such as poor compliance are a few clinical examples that demonstrate this issue. The absence of a definition of mental health problem means that accurately determining the incidence of mental health problems in general hospital patients has been difficult. Results vary depending on the definitions of mental health problem used and the population examined (Mayou and Sharpe 1991). Nevertheless, a number of studies demonstrate that a significant percentage of patients in general health care settings experience mental health problems.

In the general hospital setting, patients with physical illness have been found to have higher rates of psychiatric disorder than the general community (Gelder et al 1996). It has been reported that approximately 25% of the general population are likely to suffer from emotional or psychological disturbance and that approximately a further 15% suffer from a diagnosed psychiatric disorder

(Mental Health Consumer Outcomes Task Force 1991). Clarke et al (1991) examined a sample of medical and surgical admissions to a major metropolitan teaching hospital in Melbourne and estimated that 30% of their sample of patients had 'significant psychiatric morbidity that warranted attention' (primarily depression and anxiety). Gomez (in Tunmore 1997) suggests the prevalence of psychiatric morbidity is between 30% and 65% in medical inpatients.

The nature of psychiatric morbidity varies. Affective and adjustment disorders are common in the elderly and alcohol problems more common in young men admitted for medical care (Gelder et al 1996). Organic mental disorders are more frequent in geriatric units and alcohol problems more frequent in liver units (Mayou and Hawton 1986). Up to 45% of new referrals to outpatients clinics for physical treatment have no diagnosis ascribed that can explain the patients' physical symptoms. While a proportion of these patients eventually have a physical diagnosis made, the remainder are likely to have a psychological explanation made of their symptoms (Mayou and Hawton 1986). Presentations to general hospitals for treatment of deliberate self-poisoning account for approximately 10% of medical admissions in Australia (Henderson et al 1993). Patients who attempt suicide constitute 3-5% of all admissions to major intensive care units in Melbourne (Bailey 1998).

ARE NURSES IN GENERAL HOSPITALS EQUIPPED TO PROVIDE CARE FOR CLIENTS WITH MENTAL HEALTH PROBLEMS?

The role of nurses in the recognition of mental health problems and subsequent care of the patient is undoubtedly significant. As the largest professional health care group that provides the greatest amount of direct and indirect care to patients, their contribution to the provision of optimal care is enormous. However, local research evidence indicates that the problems and needs of people with mental health problems are poorly assessed and understood by nurses. Critical care nurses studied in Melbourne indicated that they believed they were poorly prepared to care for patients with mental health problems (Bailey 1998). General nurses indicated that they did not enjoy caring for people with eating disorders, schizophrenia or those who deliberately self-harmed as a result of a mental health problem (Fleming and Szmukler 1992).

Emergency nurses have also been found to question their role in caring for patients with mental health problems and it has been claimed that they do not see it as part of their 'real' work (Gillette et al 1996). A lack of resources and difficulty accessing psychiatric expertise has also been identified as compounding nurses' ability to meet the mental health needs of patients who present to the emergency department (Gillette et al 1996) and the intensive care unit (Bailey 1998). Feelings of fear and

powerlessness and an acknowledgment of the increased length of time required to care for people with mental health problems frequently resulted in these nurses avoiding patients with mental health problems (Gillette et al 1996).

The nature of the mental health problems themselves further perpetuates this situation. Patients with mental health problems admitted to a general hospital may engage in behaviour that is not in keeping with the 'sick role', consequently they are likely to be stereotyped and negatively labelled. Negative labelling results in adverse consequences for the patient including perpetuation of problem behaviours and the occasional application of extreme measures to control such behaviour (Trexler 1996).

It is important to clarify that the existing research studies have examined discrete areas of interest such as nurses' experiences with particular disorders or sets of symptoms (Bailey 1998, 1994; Fleming and Szumukler 1992) or specific settings (Bailey 1998; Gillette et al 1996; Bailey 1994). There are no studies that have examined the subjective experience of caring for people with mental health problems in the general health care setting, from the perspective of those nurses who provide the care. Although one might expect to find similarities, such research should be conducted as a matter of urgency.

The existence of negative attitudes towards patients with mental health problems among general hospital nursing staff is problematic for a profession which champions holism as a central tenet to guide and direct its philosophy and practice. Holistic care is the facilitation of health collaboratively with the patient, considering the physical, psychological, social, spiritual and cultural domains (Newbeck 1986; Blattner 1981). It acknowledges the interdependence of the mind, the body and the spirit. In contrast to this it is suggested that nurses working in general hospitals primarily focus on physical care and tasks and feel less skilled to attend to the psycho-social needs of their patients (Gillette and Bucknell 1996; Swan and MacVicar 1990; Whitehead and Mayou 1989; Wilson-Barnett 1978). Nurses working in a general hospital may therefore find it challenging and difficult when faced with patients who require input that is not physical in nature. While such negativity continues, the goals of the National Mental Health Policy (1992) will not be able to be fully realised.

The changes to nursing registration contained in the Victorian Nurses Act (1993) were substantially influenced by a commitment to the principles of holistic care. Comprehensive undergraduate nursing education, which had already been adopted in most other States of Australia, was long considered the vehicle through which graduates of nursing programs would emerge as skilled in psychosocial as well as physical care. The graduate of the comprehensive program was envisaged to be sufficiently

skilled to function at the level of beginning practice in all health care areas, including psychiatry (College of Nursing Australia et al 1989). It might therefore be expected that as more graduates emerge from these programs they will be sufficiently skilled and knowledgeable to provide such care in a competent and non-judgemental manner.

An examination of the changes made to the psychiatric nursing component of undergraduate nursing curricula throughout Victoria following the introduction of the Nurses Act (1993) would, however, shed significant doubt on such a view. A review of curricula throughout Victoria (Happell 1998) indicates that the majority of Victorian universities did not alter the psychiatric component of the programs at all following legislative change. It is clear that future comprehensive nurses would have substantial variation in the amount of exposure to the theory and practice of psychiatric nursing encountered during their undergraduate program. The review by Happell (1998) revealed the compulsory component of psychiatric nursing to be between 0 and 17.4% of total curriculum hours, with the large majority of programs being below the 10% mark. It is therefore not possible to be confident that these graduates will be sufficiently skilled, knowledgeable and confident to provide holistic nursing care to clients experiencing mental health problems across a broad range of health care settings.

CONSULTATION-LIAISON PSYCHIATRY DEFINED

The problem of knowledge deficit is, of course, not unique to nursing. The development of Consultation-Liaison (C-L) Psychiatry was a direct response to the acknowledgment of the deficits of general health care professionals in providing care to clients with mental health problems within the general health care system. C-L psychiatry was defined by the Department of Health and Community Services (now the department of Human Services as):

...a service provided to patients who are admitted to a general hospital for a non-psychiatric condition, but who may exhibit symptoms of a psychiatric condition and whose case may be enhanced by the expertise of health workers with mental health care training. This service is provided either through direct consultation with the patient, or indirectly, through support, education and advice to other health professional responsible for the care and treatment of the patient (Dept of Health and Community Service 1996, p9).

In keeping with Victorian Government policy directions (Dept of Health and Community Service 1996) the delivery of C-L services via multi-disciplinary teams and in particular the inclusion of nurses, is advocated (Dept of Health and Community Service 1996). This presents a stark contrast to a 1991/1992 survey of Australian and New Zealand teaching hospitals which

found that 77% of the C-L psychiatry staff were medical, with varying degrees of input from nurses, psychologists, social workers and occupational therapists (Smith et al 1994). C-L Psychiatry teams in Victoria have tended to remain medically dominated with psychiatric registrars forming the 'backbone' of the service (Dept of Health and Community Service 1996).

PSYCHIATRIC CONSULTATION-LIAISON NURSING

In relation to psychiatric nursing practice, the development of this sub-specialty originated in North America in the 1960s and was influenced by moves toward holistic and patient-centred nursing care (Robinson 1982). To varying degrees, nurses in Australia are establishing themselves as a key component of C-L Psychiatry teams (Smith et al 1994), albeit after their North American (Robinson 1991) and British colleagues (Tunmore 1997).

The inclusion of psychiatric nurses as part of the C-L team is crucial. The North American experience demonstrates that nurses contribute to the team in a way that is significantly different but complementary, to the medical staff (Robinson 1987). While the C-L psychiatrist is primarily called upon to give an opinion in cases of 'diagnosis uncertainty', C-L nurses are more likely to be asked to assist with patients suffering depression, anxiety or displaying a disturbance in behaviour. In keeping with the medical model, psychiatrists focus on assessment, diagnosis and treatment; they rarely suggest nursing care or provide other forms of support to nursing staff. On the other hand, nurses who are appropriately skilled, knowledgeable and experienced are able to provide such knowledge, advice and support from a specifically nursing perspective.

The PCLN assists the primary care nurses to develop a plan of care that may or may not include the PCLN working directly with the patient (Robinson 1987). The focus is on guiding and supporting the primary care team by providing information, assistance and education (Robinson 1982; Tunmore 1990a; 1990b). The PCLN endeavours to strengthen the teams' existing skills in mental health nursing as well as facilitate the development of new skills. However, the objective of the medical and nursing staff is mutual, that of improved patient care (Robinson 1987).

C-L psychiatry is based on an understanding of human beings from a biopsychosocial perspective and an understanding that diagnosis, treatment and prevention of illness incorporates these domains (Smith 1993). Utilising the consultation process, C-L psychiatry teams apply their specialist skills in psychiatry and mental health to assist general health care teams in the provision of mental health care to their patients. Commonly, C-L teams are based within general hospitals and provide consultations to general or specialist medical and surgical teams (Lipowski 1991).

The PCLN provides consultation primarily (but not exclusively) to nurses working in general health care settings. The PCLN may work directly with patients and their families in providing mental health nursing assessment and intervention (Robinson 1987). However, the PCLN works more often with nursing staff, assisting them to develop a care plan that incorporates mental health concepts in order to meet the needs of patients. The PCLN acts as a resource to the staff on mental health issues, provides supportive formal and informal education and acts as a link between general and mental health services. The PCLN also works with general health care nursing staff in the development of policies and processes in relation to mental health issues (Tunmore 1997). Because the PCLN works closely with the nursing staff, s/he is particularly interested in the reactions that nurses have to patients with mental health problems and how these reactions effect the relationship between the patient and nursing staff (Tunmore 1997).

IMPROVED OUTCOMES FOR PATIENTS WITH MENTAL HEALTH PROBLEMS

The key in determining the value or otherwise of PCLNs primarily concerns whether or not assistance with patient care provided to general hospital staff by the C-L team makes any difference to the quality of care delivered. In the terms of our current environment, improved quality of care means shorter length of stay, decreased readmission rates, decreased morbidity and mortality and improved patient satisfaction. While the literature indicates that this has been notoriously difficult to demonstrate, some inroads are being made (Fleming and Szmukler 1992; Strain et al 1991; Schubert et al 1989; Fulop et al 1987; Mumford and Schlesinger 1987; Pincus 1984; Levitan and Kornfield 1981). These studies primarily demonstrate a decrease in length of stay and the associated costs with C-L intervention.

However, as Mumford and Schlesinger caution:

Although cost benefits may be realized through the operation of a C-L psychiatry service, such quantifiable benefits represent only one yield of the service and should not eclipse the value of relieved suffering, expansion of skills and competencies in students and residents, or the acquisition of new knowledge. A financial orientation should not constitute the sole rationale for such a service. (1987, p.360)

Effectiveness of PCLN interventions and the impact of the role on quality of patient care have been largely anecdotal. One study estimated that cost savings of \$65,000 were achieved by a PCLN over an 8-month period through the provision of family therapy to 10 families in a 250-bed community hospital in Connecticut, USA (Ragaisis 1996). In a qualitative study, Roberts (1998) interviewed the nursing staff of a haematology

ward in Britain where PCLN services were provided on a regular basis. The nurses valued the PCLN's availability and accessibility and appreciated the specialised expertise and skills in counselling that the PCLN offered. Assessment of patients' reactions to illness, input into managing mental health problems of patients, facilitating skill development in the nursing staff and assisting nurses in development of the nurse-patient relationship were specifically identified as significant contributions made by the PCLN. Similar themes emerged from a consultee (primarily nursing staff) satisfaction survey conducted over a three-month period on 75 requests for consultation by a PCLN in a general hospital. Accessibility and responsiveness were again identified as highly valued aspects of the service and, in addition, the assistance provided by the PCLN in the development of patient care plans was appreciated. The staff gave particularly positive feedback for referrals where the PCLN was involved as a primary therapist in the care of the patient and his/her family (Newton and Wilson 1990).

Unfortunately there has been little attempt to evaluate the potential role of the PCLN in Australia. One exception to this has been a significant and recent research project undertaken by Victorian nurses, the 'Evaluation of Psychiatric Nurse Consultancy (PNCC) in Emergency Departments Project' (Gillette et al 1996). This project placed two skilled psychiatric nurses in the Emergency Departments of two public hospitals in Melbourne. The nurses undertook a consultancy role similar to the PCLN role. This report demonstrated a number of positive outcomes including decreased length of stay for mental health consumers in the Emergency Department. Most notable was an increased satisfaction with care on the part of clients, some evidence that aggression was managed more effectively and an increased confidence in the nursing staff when working with clients with mental health needs. It is important to note that a number of Emergency Departments in Victoria have psychiatric nurses providing consultancy services similar to the service developed in this project. The PNCC project is an example where the work of psychiatric nurses is shown to contribute in a positive way to the care of general hospital patients.

In order to evaluate the input psychiatric nurses as consultants can have on the care of patients with mental health problems in non-psychiatric settings, similar studies to the PNCC Project need to be undertaken. Documentation of Australian and New Zealand experiences of psychiatric nurse consultancy within the literature in this area is sparse even though it is known to the authors that there are a number of nurses working in this area across these countries. Although it makes sense that this type of consultancy can contribute in a positive way to health outcomes, evaluation studies from the perspective of patients, relatives and staff must be undertaken as a matter of urgency.

CONCLUSION

Psychiatric nurse consultancy is a developing area for psychiatric nursing. The role of the Psychiatric Consultation-Liaison Nurse is one that offers psychiatric nurses an opportunity within the general hospital setting to improve the quality of attention to the psychological and psychiatric needs of patients (Tunmore 1990b). The mainstreaming of psychiatric services within the general health care system has increased the need for nurses to be equipped with the skills and knowledge required to provide optimum care to clients experiencing mental health problems. Research findings, although limited, suggest that nurses do not consider themselves sufficiently prepared to provide care to this clientele. The role of the PCLN therefore has the potential to assist the staff in general hospital in contributing to care in a manner that is consistent with National Mental Health Policy (Australian Health Ministers 1992).

Consultation Liaison Psychiatry is, to some degree, an established sub-specialty of psychiatry. Nurses are beginning to join their medical colleagues but the development of the PCLN role, particularly in Australia, is in its infancy. The skills and knowledge that psychiatric nurses have to offer the C-L Psychiatry service differ from those of their medical colleagues but are complementary. Given that nurses form the greater percentage of general hospital staff, psychiatric nurses are well placed to assist their nursing colleagues in the care of patients with mental health problems. Preliminary evidence demonstrates that this input can have a significant influence on the quality of health outcomes for patients. Further local research and documentation within the literature needs to occur so that meaningful debate and role development can occur within Australia.

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