



Farewell to C-L? Time for a change?☆

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“How do we operationalize liaison?” In 1984, Harold Allen Pincus formulated the most pertinent and still unanswered question posed to our field be it in the USA or elsewhere in the world [1]. A question in line with Thomas P. Hackett’s earlier question: “How do we move from ‘consult’ to ‘liaison’ or from ‘fire-brigade’ to ‘fire-prevention’?” It was the end of the pre-*DSM-III* era. According to Melvin Sabsin — at that time Director of the APA — the 80s were turbulent times for American psychiatry. The *DSM-III* became the almost medical-model antidote for the “bottomless pit” of deinstitutionalization and community psychiatry. It led to the predominance of the empirical model of research and the biological orientation of psychiatry. It provided our field a better understanding of the prevalence of psychiatric morbidity in the medically ill. It led us — among other things — to the current *DSM*-based paradigm for the treatment of depression in the medically ill with the Patient Health Questionnaire [2]. It shifted the focus from the more generic integrative psychosomatic approach “How does it fit together?” to specialization and related fragmentation “What are the psychiatric components?” Or as Edward Shorter — historian of psychiatry — recently stated: “According to the biopsychosocial model psychiatry should be bringing the care of the whole person together, rather than just carving of the mind into a watertight specialty of its own” [3]. The pertinence of the message of Engel’s publication on the “biopsychosocial model” in *Science* was its timeliness [4].

Engel’s model represented the state of the art of scientific thinking on integrated care at the end of the pre-*DSM-III* era. It was visually well reflected in Miller’s [5] operationalization of the general systems theory for the general hospital (Fig. 1). This integrated thinking is our core competency, the reason of our existence; it is psychosomatic thinking. As Robert Shorter said, with the *DSM* psychiatry decided to become a specialty between the other specialties and ignored the core of our thinking. The eminent report by the Institute of Medicine “Crossing the Quality Chasm; A New Health System for the 21st Century” recognizes the need of integration and therefore is a landmark publication for consultation-liaison (C-L) psychiatry and psychosomatics [6]. The report addresses the impact of fragmented care: “Physician groups, hospitals, and other health care organizations operate as silos, often providing care without the benefit of complete information about the patient’s condition, medical history, services provided in other settings, or medication prescribed by other physicians. Trying harder will not work. Changing systems of care will!” In addition to practical recommendations, the importance of approaches beyond the biomedical model is emphasized to improve our understanding of our patients and the quality of their care. It is further elaborated in a series of articles in the *British Medical Journal* in the past years. It opens with an article on complex adaptive systems: “While systems can be broken down into parts which are interesting in and of themselves, the real power lies in the way the parts come together and are interconnected to fulfil some purpose.” “As soon as interconnections can be identified and the powers of the underlying dynamics can be understood, a given situation can often be perceived as less chaotic or even meaningful and a controlled approach becomes possible” [7,8]. In his recent foreword to “The Loss of Sadness: How Psychiatry

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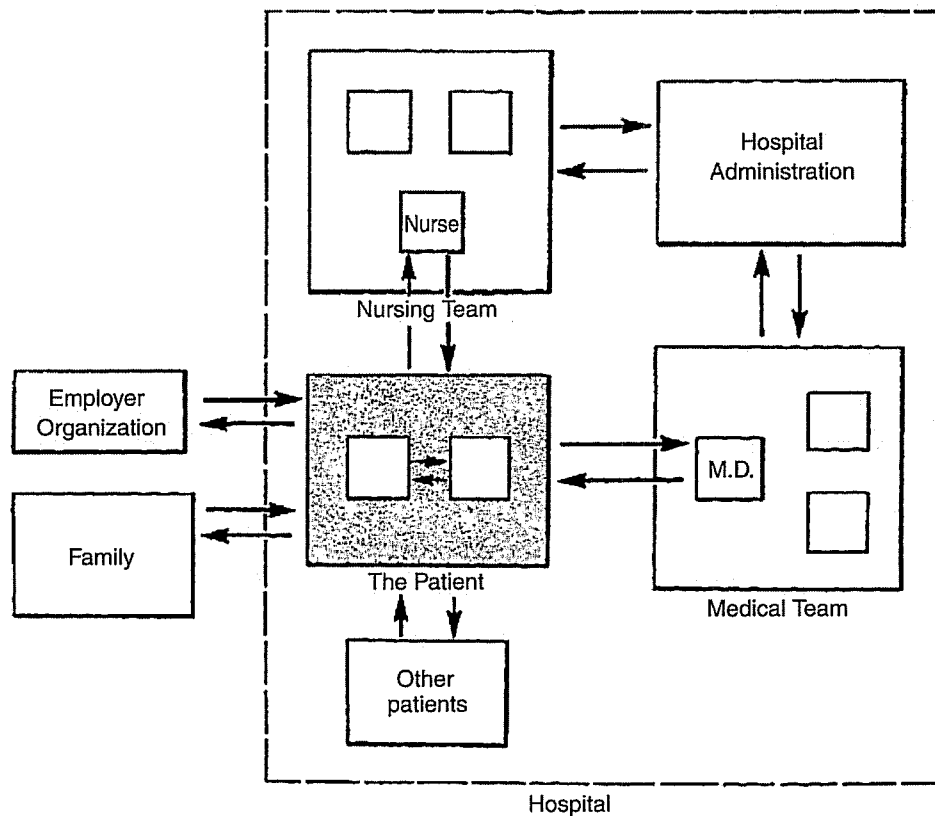


Fig. 1. The multiple systems and levels relevant to the hospitalized patient.

Transformed Normal Sorrow into Depressive Disorder” [9] by Horwitz and Wakefield, Robert L. Spitzer — the former head of the task force that created *DSM-III* — reflects on the definition of mental disorder introduced in *DSM-III* [10]: “Since then [1980, inserted by author], Dr. Wakefield has critiqued my efforts in ways that I have largely become convinced are valid.” “The diagnostic criteria formulated on the basis of *DSM-III* definition of mental disorder specified the symptoms that must be present to justify a given diagnosis but ignored any reference to the context in which they developed. In so doing, they allowed normal responses to stressors to be characterized as symptoms of disorder.” “Because their [Wakefield’s and Horwitz’s; inserted by author] analyses is anchored in psychiatry’s own assumptions, it will be hard for those now constructing the *DSM-V* (expected publication in 2011) to ignore.” “It has caused me to rethink my own position and to consider how the author’s concerns might best be handled.” Lack of recognition of the context might be one of the major reasons behind the almost negative findings in a recent review in *JAMA*’s “Depression Screening and Patient Outcomes in Cardiovascular Care; A Systematic Review”; a modest improvement of depressive symptoms but no improvement in cardiac outcomes [11]. Moreover, the effectiveness of psychopharmacological antidepressant treatment might be very modest or poor according to a recent review by Turner in the *New England Journal of Medicine*; by taking negative unpublished studies

into account, the overall effect is small [12]! Without ignoring the meaning of *DSM* for the introduction of empiricism in psychiatry, it became a business with vested interests colluded with the pharmaceutical industry. Both are currently probably the main determinants of who and what we are, what we mean for health care, and how the public sees us. Can this be justified in the perspective of the above mentioned? As research paradigms ultimately shape clinical practice through evidence-based guidelines, will the *DSM* diagnoses-driven research paradigm for depression become the main paradigm for liaison or integrated service delivery? Pertinent reasons have been given to rethink our position: “time for a change”? Luckily, our field’s awareness of the problem already existed before the introduction of *DSM-III*. It was not only summarized in George Engel’s statement in *Science* [3], a whole separate world based on these integrative principles existed and further developed in the German-speaking countries. Graeme Smith recently carefully described the conceptual problems related to the current empirical model and suggests alternative pathways — including qualitative — to improve our knowledge and skills in the direction of the population we serve; the complex medically ill [13]. The INTERMED (IM) group came with such an integrative answer to Pincus’ question: “How do you operationalize liaison?” We operationalized complexity in terms of interfering health risks and needs indicative for negative outcomes of health care and assessed

complexity in several populations [multiple sclerosis, diabetes, rheumatoid arthritis, neurology (outpatient), general internal medicine (inpatient), and C-L psychiatric consult service patients ($n=1050$)] [14]. In all population, the IM score predicted negative outcomes, for instance, a high HbA_{1c} in diabetes patients, a long length of stay in internal medicine inpatients, or death in dialysis patients. In a latent class analysis, the patients of these populations can be clustered in three main groups: noncomplex, borderline complex, and complex. The population of C-L patients had the largest proportion of complex patients (70%), patients with diabetes follow (50%), and dialyses patients had 30% complex patients. In some populations there are rather large proportions of patients with borderline complexity, such as in nephrology and rheumatology patients. Thinking from a general systems perspective, populations with many patients with borderline complexity are of interest as the assessment of their complexity might reduce their complexity and improve the capacity of health professionals to arrange appropriate treatment. It is evident that the complex group is in need of complex interventions, interventions beyond the classical research paradigm: homogenous groups with one diagnosis and one simple intervention, such as a drug. Fritz Stiefels' group from Lausanne Switzerland just published the results of such an RCT in diabetes and rheumatoid arthritis patients [15]. Patients who scored beyond a defined level of complexity (IM score >20) were included and randomized. In this group, more than 50% of the patients qualified for the formal psychiatric diagnosis of depression. An individualized multifaceted (complex) intervention was designed and carried into effect based on their risk profile. Among others, the intervention resulted in a significant reduction of depression to below 25% and a reduction of the readmission rate in the rheumatoid arthritis group [15].

The INTERMED method is now applied and trained in various settings. In comparison with the PHQ-driven collaborative stepped care model for depression, the complexity-driven model for integrated care focuses on the complex medically ill beyond a specific psychiatric diagnosis. It has as main focus to create order in the chaos of care of the complex medically ill leading to individualized integrated care on indication. It starts with an interview to evaluate patient's health risk and needs. The clinimetric method of scoring of the findings is designed to provide a link between level of risk and action level [16]. That allows the translation of the risk profile in a visualized integrated plan with goals and actions. The schematic organization of the plan is designed to reduce complexity and thereby to improve communication and collaboration between the different professionals and organizations involved. Therefore, it is supportive for case management of the complex medically ill. Such a system can be easily integrated in health care systems, utilizing indicators for complexity [17]. These can be derived from available administrative or clinical information, including risk variables of the IM method, or screening instruments, such as the PHQ. Keeping Spitzer's reflections in mind, one

could even say: never a significant score on the PHQ without its context; the INTERMED. The Case Management Society of America (CMSA) has decided in collaboration with Cartesian Solutions to adopt the complexity model and made it the core of their Integrated Case Management Training (www.cmsa.org, www.cartesiansolutions.com). Also in Europe, there are higher-trained nurses who have specific interest in the development of integrated care with the complexity model. The Hogeschool of Amsterdam (nursing school) in the Netherlands will make the method part of their core curriculum. Moreover, the INTERMED is part of a series of studies designed to develop geriatric services in the Netherlands. In Germany, it is part of a larger epidemiological study in the elderly. In addition, the first studies in the Netherlands, Switzerland, and Italy have started to develop a self-assessment version to facilitate the communication between the patient and health care professionals. In Canada, in the Children's Hospital of Eastern Ontario, a pediatric version is currently field-tested. Since spring 2008, the method is available as web service in different languages. Therefore, our group is convinced to have provided an answer to Pincus' question, "How do we operationalize C-L?" In a time when, in almost every Western country, health care systems get overstretched, it is needed that direction be given at the care for the most costly patients: the complex medically ill. Such patients do not require ad hoc consults but long-term integrated care. So, farewell to C-L! Time for a change! Change the consult service into an emergency psychiatric function for the complex medically ill and develop and negotiate indication driven models for integrated care. Is there a role for the PHQ? Once again, as Robert Spitzer said: "No symptom without context"; the INTERMED group concludes: "No PHQ without an INTERMED" (www.intermedfoundation.org).

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