The Academy of Psychosomatic Medicine Practice Guidelines for Psychiatric Consultation in the General Medical Setting

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This practice guideline seeks to provide guidance to psychiatrists who regularly evaluate and manage patients with medical illnesses. The guideline is intended to delineate the knowledge base, professional expertise, and integrated clinical approach necessary to effectively manage this complex and diverse patient population. This guideline was drafted by a work group consisting of psychiatrists with clinical and research expertise in the field, who undertook a comprehensive review of the literature. The guideline was reviewed by the executive council of the Academy of Psychosomatic Medicine and revised prior to final approval. Some of the topics discussed include qualifications of C-L consultants, patient assessment, psychiatric interventions (e.g., psychotherapy, pharmacotherapy), medicolegal issues, and child and adolescent consultations.

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The purpose in developing psychiatric consultation guidelines is to broadly instruct and guide practitioners who care for patients with psychiatric symptoms in a general medical setting. These guidelines will review the assessments and interventions that are necessary for management of patients with comorbid medical and psychiatric conditions. The development of guidelines for psychiatric consultation is important because significant numbers of patients with unrecognized, yet serious, neuropsychiatric disorders are inadequately assessed and managed, and psychological distress induced by the highly technological world of the general medical setting is often ignored.

These guidelines are not intended to delineate universal, professionally mandated regulations and actions. Instead, they are meant to serve as an outline for the training and knowl-

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edge that are generally necessary to guide the clinician's approach to the patient.[1]

In general, the aims of psychiatric consultation in the medical/surgical setting are 1) to ensure the safety and stability of the patient within the medical environment, 2) to collect sufficient history and medical data from appropriate sources to assess the patient and formulate the problem, 3) to conduct a mental status examination and neurological and physical examinations as necessary, 4) to establish a differential diagnosis, and 5) to initiate a treatment plan.

Consultation-liaison (C-L) psychiatry is the subspecialty of psychiatry concerned with medically and surgically ill patients.[2] The C-L consultant must have an extensive clinical understanding of physical/neurological disorders and their relation to abnormal illness behavior. The C-L consultant must be a skilled diagnostician, be able to tease apart and formulate the patient's multiaxial disorders, and able to develop an effective treatment plan. The C-L consultant must also have knowledge of psychotherapeutic and psychopharmacological interventions as well as knowledge of the wide array of medicolegal aspects of psychiatric and medical illness and hospitalization. The psychiatric physician, by virtue of his/her professional stature and knowledge, has the ability to supervise a multidisciplinary team.

These proposals for care supplement those developed for *Psychiatric Training in C-L Psychiatry* by the Academy of Psychosomatic Medicine (APM)[3,4] and the practice guidelines developed by the American Psychiatric Association (APA).[1,5–9] These current proposals are also related to the recommendations reported in *Psychological Care of Medical Patients*, drafted by the Joint Working Party of the Royal College of Physicians and Psychiatrists[10] and to the goals of *Fellowship Training in C-L Psychiatry* put forth by the Academy of Psychosomatic Medicine.[11] Although primarily based on consensus, they include, to the extent possible, the desirable attributes (e.g., validity, clinical applicability, clarity) delineated by the Institute of Medicine.[12]

MEDICAL NEED AND STAFFING

Population at Risk and Case Identification

In the general medical setting, as many as 30% of patients have a psychiatric disorder.[13–15] Delirium is detected in 10% of all medical inpatients[16] and is detected in over 30% in some high-risk groups. Two-thirds of patients who are high users of medical care have a psychiatric disturbance: 23% have depression, 22% have anxiety, and 20% have somatization.[17,18] Clearly, psychiatric comorbidity has an impact on health care economics.[19–23] The presence of a psychiatric disturbance has repeatedly been shown to be a robust predictor of increased hospital length of stay.[24–27] Nearly 90% of 26 studies have demonstrated either an increased length of stay or an increased medical readmission rate in patients with psychiatric comorbidity.[28] Only a small subset of the population at risk is currently being adequately identified. The percentage of patient admissions receiving psychiatric consultation varies from institution to institution,[29] ranging from 1% to 10%.[29–32]

Intervention studies have suggested that elderly patients with hip fractures benefit from psychiatric consultation; they have shorter length of hospital stays and are more often discharged home, rather than to a nursing home.[33–34] A liaison approach with increased case identification and earlier psychiatric intervention and treatment resulted in a marked decrease in the need for transfer to inpatient psychiatric facilities.[35]

The principal methods of case identification and psychiatric service delivery to the medically/surgically ill patient embrace the principles of C-L psychiatry.[36] In contrast to the standard medical-referral model, in which the consultation psychiatrist waits to be called, the liaison model is based on an early detection strategy to identify potential problems. As part of the multidisciplinary medical team, the liaison psychiatrist may participate in ward rounds and team meetings while addressing the behavioral issues of patients. Education of nonpsychiatric physi-

cians and allied health professionals about medical and psychiatric issues related to a patient's illness is a core component of the liaison model. Liaison services lead to heightened sensitivity by medical staff, which results in earlier detection and more cost-effective management of patients with psychiatric problems.

Guideline

Each institution is responsible for the continuing medical education of medical/surgical staff about the psychological consequences of illness and the indications for psychiatric consultation. Areas of focus should include the recognition of substance abuse, delirium, dementia, affective disorders, anxiety disorders, and suicidal ideation. These issues should also be incorporated as part of undergraduate and postgraduate residency and fellowship medical training.

QUALIFICATIONS OF CONSULTANTS

Training and Skills Assessment

Evaluation of the mental health of patients with serious medical illness, formulation of their problems and diagnosis, and organization and implementation of an effective treatment plan involve complex clinical skills that require specialized training (Table 1). In addition to the usual psychiatric examination, specialized knowledge about diagnosis, medicolegal issues, and psychotherapeutic and psychopharmacological interventions is necessary. The consulting psychiatrist must be familiar with the routines of the medical/surgical environment and knowledgeable about medical and surgical illnesses. The psychiatric consultant must also be aware of the effects that illnesses and drugs have on behavior, especially when they contribute to or confound the diagnosis or treatment. Furthermore, the psychiatric consultant must be supportive of the patient and remain sensitive to the effects of the patient on the staff.

Despite the fact that the psychiatric consultant possesses all the necessary skills to organize a treatment plan, teams composed of health professionals with complementary skills may also be used. The leader of such a multidisciplinary team should be the psychiatrist with specialized C-L training.

The *Recommended Guidelines for C-L Psychiatric Training in Psychiatry Residency Programs* specify that the faculty of a C-L service be certified by the American Board of Psychiatry and Neurology and have specific expertise in C-L psychiatry.[3] The ideal C-L service has faculty who are fellowship-trained in C-L psychiatry or who have extensive clinical experience.

Guideline

All providers of psychiatric consultation in the general medical setting must be licensed physicians. All students and trainees must be

TABLE 1. Required skills for the evaluation and treatment of patients with psychiatric disorders in the general medical setting

1. Ability to take a medical-psychiatric history
2. Ability to recognize and categorize symptoms
3. Ability to assess neurological dysfunction
4. Ability to assess the risk of suicide
5. Ability to assess medication effects and drug–drug interactions
6. Ability to know when to order and how to interpret psychological testing
7. Ability to assess interpersonal and family issues
8. Ability to recognize and manage hospital stressors
9. Ability to place the course of hospitalization and treatment in perspective
10. Ability to formulate multiaxial diagnoses
11. Ability to perform psychotherapy
12. Ability to prescribe and manage psychopharmacological agents
13. Ability to assess and manage agitation
14. Ability to assess and manage pain
15. Ability to administer drug detoxification protocols
16. Ability to make medicolegal determinations
17. Ability to apply ethical decisions
18. Ability to apply systems theory and resolve conflicts
19. Ability to initiate transfers to a psychiatry service
20. Ability to assist with disposition planning

closely supervised, with documentation of training cases appropriately recorded and maintained. All consultants must have appropriate credentials and privileges at the hospital or outpatient setting where their consultations are performed.

Indications for Consultation

Psychiatric consultation is indicated whenever another doctor asks for help with a patient. Consultation requests cover a wide range of topics (Table 2). Commonly, the overt reason for initiating a consultation may not be as serious as a comorbid, but unrecognized, problem.

TABLE 2. Problems that commonly lead to requests for psychiatric consultation in the medical/surgical setting

1. Acute stress reactions
2. Aggression or impulsivity
3. Agitation
4. AIDS or HIV infection
5. Alcohol and drug abuse (including withdrawal states)
6. Anxiety or panic
7. Assessment of psychiatric history
8. Burn sequelae
9. Change of mental status
10. Child abuse
11. Coping with illness
12. Death, dying, and bereavement
13. Delirium
14. Dementia
15. Depression
16. Determination of capacity and other forensic issues
17. Eating disorders
18. Electroconvulsive therapy
19. Ethical issues
20. Factitious disorders
21. Family problems
22. Geriatric abuse
23. Hypnosis
24. Malingering
25. Pain
26. Pediatric psychiatric illness
27. Personality disorders
28. Posttraumatic stress disorder
29. Pregnancy-related care
30. Psychiatric care in the intensive care unit
31. Psychiatric manifestations of medical and neurological illness
32. Psychological factors affecting medical illness
33. Psychological and neuropsychological testing
34. Psycho-oncology
35. Psychopharmacology of the medically ill
36. Psychosis
37. Restraints
38. Sexual abuse
39. Sleep disorders
40. Somatoform disorders
41. Suicide
42. Terminal illness
43. Transplantation issues

Note: AIDS = Acquired immunodeficiency syndrome; HIV = Human immunodeficiency virus.

THE CONSULTATION PROCESS

It can take a considerable amount of time before the consultant is accepted by and becomes familiar with the practices of a medical team.[32] Outside consultants, unknown to other physicians, unfamiliar with the particular hospital system and unable to provide immediate response when necessary, should not replace consultation services.[37]

Guideline

Institutions should follow the *Recommended Guidelines for Consultation-Liaison Psychiatric Training in Psychiatry Residency Programs* for staffing a C-L psychiatry service. In all medical settings, there must be adequate staffing to provide psychiatric consultation 24 hours/day, throughout the year. In settings where psychiatric residents perform consultations, faculty staffing must be adequate to provide supervision 24 hours/day.

Psychiatric consultations should be performed by psychiatrists with expertise in the medical setting and credentials and privileges at the institution where the consultation is performed. Treatment may be delegated to another mental health professional under the direct supervision of the consulting psychiatrist. Psychiatric consultation involves an initial consultation and follow-up examinations (two on average).

If inpatient psychiatric treatment is required for the medically compromised patient to ensure continuity of medical care, psychiatric treatment should, when possible, be provided at the same facility where the patient is receiving medical care. The ideal setting is in a location where medical and psychiatric capabilities are integrated.

Follow-up outpatient psychiatric care for patients with psychiatric problems related to a serious or persistent medical condition (e.g., acquired immunodeficiency syndrome [AIDS], cancer, organ failure requiring transplantation) should, when possible, be provided at the same treatment facility where the patient receives primary medical care.

Referral of patients with complex medical–surgical illness in the outpatient setting should be facilitated:

1. When requested by the primary care physician in the outpatient setting,
2. When requested by any physician in a specialty medical clinic,
3. In response to a patient's request for a reevaluation or second opinion, or
4. As a referral for follow-up by any C-L consultant who evaluated the patient while in the hospital.

ASSESSMENT

Reasons for Referral

Consultations are usually requested by physicians who are directly responsible for the care of the patient. In some settings, this is the attending physician, in others it is the house staff (under supervision by the attending physician). At some institutions, other health professionals, such as nurses and social workers, may initiate a consultation in emergency situations. In institutions with ongoing liaison activities with medical or surgical services, the psychiatrist as part of the team may accept a referral and evaluate any patient admitted to the service.

The so-called "routine consultation" may have life-and-death implications for a patient because the overt cause for referral may reflect a more serious problem. For example, the patient who appears withdrawn may be suicidal; an uncooperative patient with mild agitation may be delirious. Delay in the detection and diagnosis of these disorders may have dire consequences.

To provide appropriate and timely care for patients, each institution must ensure that the C-L service not be restricted from performing psychiatric consultations when medically indicated for any individual or group of patients within the institution.

Guideline

When the consultee asks for a psychiatric consultation, the consultant should establish the urgency of the consultation (i.e., emergency or routine—within 24 hours). Commonly, requests for psychiatric consultation fall into several general categories:

1. Evaluation of a patient with suspected psychiatric disorder, a psychiatric history, or use of psychotropic medications. The evaluation aims to properly assess the underlying psychiatric syndrome and to mitigate its effect on the medical/surgical condition.
2. Evaluation of a patient who is acutely agitated. The evaluation should carefully review the medical and psychiatric reasons for agitation (e.g., psychosis, intoxication, withdrawal, dementia, delirium) and should delineate possible etiologies (e.g., toxic metabolic disturbances, cardiopulmonary, endocrine, neurologic disorders).
3. Evaluation of a patient who expresses suicidal or homicidal ideation. Any patient who voices such ideation should be evaluated by a psychiatric consultant. In situations where the consultant is not immediately available, appropriate precautions should be recommended by the consultant (e.g., placing the patient under constant observation until the psychiatrist arrives at the bedside).
4. Evaluation of a patient who wishes to die, including one who requests hastened death, physician-assisted suicide, or euthanasia.

No presumption should be made that such requests are "rational" until a complete evaluation has been performed.

5. Evaluation of a patient who is at high risk for psychiatric problems by virtue of serious medical illness. In some circumstances (e.g., organ transplantation), a medical or surgical service or protocol may require psychiatric evaluation of all patients. Psychiatric consultation in specific settings has proven valuable and should be encouraged.
6. Evaluation of a patient who requests to see a psychiatrist. Any patient who requests to speak with a psychiatrist should be evaluated only after the physician responsible for the patient's care has been contacted about the case.
7. Evaluation of a patient in an emergency situation. In emergencies, a consultation may be requested by any health professional involved with the care of the patient (subject to the rules of procedure of the institution). The patient should be prevented from harming him- or herself or others (constant observation) until the consultant arrives.
8. Evaluation of a patient with a medicolegal situation (e.g., where there is a question of a patient's capacity to consent to or refuse medical or surgical treatment).
9. Evaluation of a patient with known or suspected substance abuse.

Emergency Consultations

The process for conducting emergency evaluation of adults has been outlined by the APA in its *Practice Guideline for Psychiatric Evaluation of Adults*.[1] In the general medical hospital setting, there are no established procedural definitions for which clinical situations are designated as emergencies; rather, the emergency designation is based on the requesting physician's perceived need for prompt service.[38]

Guideline

Coverage for emergencies should be available on a 24-hour basis by on-call psychiatric consultants, Emergency Room services, or the C-L service itself. Interventions and recommendations for emergency consultations may include the following: 1) use of physical restraints; 2) use of pharmacologic sedation; 3) constant observation (1:1); 4) recommendations for further medical evaluation and workup; 5) implementation of treatment over the patient's objections; 6) involuntary psychiatric commitment; and 7) other behavioral interventions.

Psychiatric History and the Consultation Note

1. Medical-Psychiatric History. Contrary to the usual medical or psychiatric examination, the medically ill patient seldom initiates or requests a psychiatric consultation and may even assume an adversarial attitude toward the C-L consultant. To obtain a psychiatric history that is more than superficial, the consultant must be skilled at rapidly establishing the context of the psychiatric disorder in the medical setting.

In the *Practice Guidelines for Psychiatric Evaluation of Adults,*[1] the outline of a comprehensive examination is discussed at length. The C-L consultant may determine that to address a specific consultation question, not all domains are necessary to complete or to record in the consultation note. However, an assessment adequate to formulate and organize DSM-IV multiaxial diagnoses must be made.

An assessment of the medically/surgically ill patient requires that the C-L consultant be prepared to take a history and to make inquiries that go beyond the usual domains of a standard psychiatric evaluation. These areas of special inquiry include the following.

a. Clarification of the Consultee-Stated vs. Consultant-Assessed Reasons for Referral.

The overt reason expressed for the need for consultation may be incomplete, or a request may be made for the assessment of one problem (e.g., depression) when another more serious problem (e.g., delirium) is unrecognized. Requests may be vague if made by someone other than the person who observed the behavior of concern. Therefore, direct contact with the individual who initiated the request is beneficial

for obtaining exact information about the patient's behavior, which may not appear in the record.

b. Assessment for the Extent the Patient's Psychiatric Disturbance is Caused by the Medical/Surgical Illness.

Many of the patients seen by C-L consultants have complex medical conditions. The medical chart must be reviewed for pertinent medical factors that could contribute to the patient's current state. Attention must be given to the description of the mental status and the behavior noted by the medical staff.

c. Assessment for the Adequacy of Pain Management.

Seemingly exaggerated complaints and/or abnormal behaviors are often associated with insufficiently treated pain.[39] The consultant should review with the patient the nature of the pain and the effectiveness and duration of effect of any analgesics. Fears of unremitting pain, as well as feelings of unattended suffering and helplessness, need to be addressed. The consultant should carefully review the record of analgesic administration (narcotics and others).

Clinicians should have familiarity with the following topics: the types of pain (acute, chronic, recurrent, and cancer-related); the distinction between pain, nociception, suffering, and pain behaviors; the multidimensional nature of pain (physiological, sensory, affective, cognitive, behavioral, and psychopathological, i.e., as a symptom of psychiatric illness); pain measurement and assessment; pain management (therapeutic goals, pharmacological and non-pharmacological strategies, multidisciplinary and multimodal management, monitoring of strategies and side effects); and the impact of pain and unrelieved pain (on recovery from illness or surgery, on the individual, on the family). Clinical skills include the following: evaluation and monitoring of psychopharmacological agents; ability to administer or appropriately refer a patient for psychological and behavioral interventions (e.g., cognitive–behavioral therapy, relaxation therapy, hypnosis, biofeedback, stress management, and education of patients and their families); and knowing when to recommend other modes of treatment (e.g., physical therapy, anesthetic interventions, or surgical evaluation).[40,41a]

General principles of pain assessment and management include the following elements: obtaining information about the pain complaint; having an awareness of how pain contributes to specific illnesses (e.g., cancer, sickle cell disease, arthritis); having an awareness of how psychiatric disorders and symptoms contribute to pain complaints and vice versa (e.g., anxiety in acute pain, depression in chronic pain); and making a detailed assessment of all analgesics and adjuvant medications. It is crucial to have an understanding of the factors that contribute to undertreatment of pain, the appropriate diagnostic workup for pain complaints, and the elements of integrated, multimodal assessment and management of patients in pain.[41b,42]

d. Assessment for the Extent the Psychiatric Disturbance Is Caused by Medications or Substance Abuse.

The patient's medication list and recent changes in medication are critically important to review. Psychiatric symptoms are frequently produced by medications (e.g., corticosteroids) prescribed for medical disorders. These symptoms can be produced at therapeutic levels, may emerge at times of withdrawal, or may arise as a result of drug-drug interactions. Analgesics, sedatives, anticonvulsants, anesthetics, psychotropics, and anticholinergics are groups of medications commonly associated with psychiatric disturbances.

The type, quantity, and frequency of prescription drug use as well as illicit drug and alcohol use should be assessed. Previous episodes of structured outpatient or inpatient treatment should be inquired about, as well as prior experiences associated with drug withdrawal. Urine and serum toxicological screening may be requested when there is suspicion of, or the need to document, substance abuse.

e. Assessment for Disturbances in Cognition.

Because so many psychiatric, behavioral, medical, and legal considerations depend on assessment of cognition, the search for even subtle

disturbances in cognition is crucial to every psychiatric evaluation of the medically ill patient. If a disturbance in cognition is identified, the C-L consultant should then determine if the change in mental status is chronic and due primarily to the consequences of an underlying disorder (e.g., Alzheimer's disease, multi-infarct dementia) or acute and arising secondary to the effects of illness, medication, or a combination of factors.

f. Assessment of Psychiatric Symptomology and Behavior.

"Is the patient's behavior a normal response to the stress of illness and/or hospitalization and, therefore, likely to resolve with improvement in physical health?" In this assessment, the patient's perspective of possible precipitating, exacerbating, or resolving factors is most pertinent. Review of prior response to illness or psychiatric treatment can facilitate proper diagnosis and treatment. The consultant should be able to assess how well the patient is coping and whether he/she will be able to endure the course of illness.

g. Evaluation of the Patient's Character Style.

As opposed to the usual "What does this patient have?" the C-L consultant must assess, "What kind of patient has the illness?" Information from several domains (e.g., developmental history, social history, occupational history) must be integrated to form a dynamic life narrative leading up to the current illness. Medical illness, surgery, and the many stresses of hospitalization are managed differently by individuals with different character styles or DSM-IV Axis II personality disorders. Understanding how character influences the experience of physical illness is critical for explaining abnormal patient behaviors, emotions, and demands.

h. Inquiry About Thoughts of Dying.

Many patients think about dying, especially when their illness is protracted, exhausting, or critical. Some patients express their wish to die to the medical staff; this may lead to a request for a psychiatric consultation. Thoughts of dying related to life-threatening physical illness and suicidal ideation related to depression need to be distinguished. Inquiry about the patient's understanding of the physical illness—its course and prognosis—allows the consultant a unique opportunity to correct cognitive distortions on the part of the patient. In some situations, it is necessary to assess the capacity of the patient to refuse treatment and to help the patient set reasonable limits on further treatment. To do so, the consultant must be familiar with the medical treatment and/or hospital course to ascertain the patient's understanding of his/her illness and its possible course, with or without treatment.[43]

2. Physical and Neurological Examination. The psychiatric consultant should review the results of the physical examination with special regard to the neurological examination. Additional physical or neurological examinations by the psychiatric consultant may be necessary, based on the results of the psychiatric interview and on the list of potential diagnoses created during the formulation of the case. Specific areas of physical examination that relate to psychiatric disorders may include an organ-specific evaluation for unexplained somatic complaints or potential medication side effects; observable signs of self-injury or intravenous drug abuse; or the presence of frontal release signs, tremor, and parkinsonian symptoms.

3. Mental Status Examination. In addition to an examination to elicit signs and symptoms of psychiatric disorder, the purpose of the mental status examination for the medically ill is to elicit the patient's capacity to understand and cope with the illness and to make decisions about care. The level of detail for assessment of cognitive function varies depending upon the patient's combined medical and psychiatric condition. The mental status examination can be tailored to the patient's clinical presentation, which may include judgment about the patient's capacity to participate in exams with formal rating scales.

4. The Consultation Note. Although the comprehensive consultation requires attention to all domains, the consultation note is best if brief and

focused on the referring physician's concerns. The consultant should avoid using acronyms, psychiatric jargon, or other wording that is likely to be unfamiliar or confusing to other medical/ surgical specialists. Medical records are legally available to patients, hospital review committees, and insurance and managed care companies, so the consultant must carefully select which confidential information to include. The consultation note should be written with these factors in mind.

A structured consultation note that provides a framework for providing information back to the referring physician is best.[44] An identifying statement that succinctly summarizes the patient's presenting condition and the referring physician's reason for consultation should be present. The note needs to be titled with mention of "Psychiatry" and "Consultation" or some equivalent terms. The names and position of the consultant or residents involved with the assessment need to be included, and the note must be signed. Documentation of the date and time of consultation is necessary; the consultant may elect to document the length of time involved in performing the consultation for billing purposes. The content of the consultation note should also meet the requirements of federal (Health Care Financing Administration [HCFA]) and state regulations that apply with regard to documentation.

Sources of information used for the consultation, if other than from the consultee, medical record, or interview of the patient, should be recorded. The history of present illness should include the relevant data from the history that may have significant bearing on the diagnosis and/or formulation or on the rationale for management and treatment. The consultant's objective findings on mental status examination and physical/ neurological examinations should be carefully documented. The formulation, diagnosis, and recommendations should be written concisely. Clear statements of follow-up and management (by whom and when) are desirable. The C-L consultant should make an effort to communicate verbally to the consultee and to identify the procedure for follow-up contacts or questions.

5. Diagnosis. Because it is important to synthesize affective, behavioral, cognitive, social, and medical factors that contribute to the crafting of an individualized treatment plan, the consultant should organize the diagnosis section according to the DSM-IV's multiaxial guideline.[45] Axis I or II diagnosis cannot always be made at the time of the initial consultation. If this occurs, a statement about the need for further evaluation or inclusion of a provisional or "rule-out" label can be added. Several possible diagnoses can also be listed. Only the one or two central medical diagnoses should be included on Axis III, preferably the ones of greatest clinical relevance to the disorders noted on Axis I or II. Significant medical and psychological stressors can be noted and documented on Axis IV, and the patient's overall functional level should be included as Axis V if it directly involves some aspect of the treatment plan. Axes IV and V may be omitted if the consultant feels they will not be useful or familiar to the consultee.

Guideline

The development of the medical-psychiatric history, as well as pertinent aspects of the physical and mental status examination, must be integrated by the psychiatric consultant to yield a carefully structured consultation note, i.e., one that synthesizes the data, provides a diagnosis, and recommends appropriate testing and treatment.

Diagnostic Testing and Consultation

In addition to the comprehensive clinical interview and mental status examination, the consulting psychiatrist may need to perform or request additional specific medical or neurological examinations, specialized laboratory tests, psychological and neuropsychological evaluations, or consultations concerning legal and ethical issues.

During the course of a clinical interview, the C-L consultant may use diagnostic assessment instruments, cognitive screens (e.g., the Mini-Mental State Exam [MMSE][46]) depression in-

ventories (e.g., the Geriatric Depression Scale[47] or Hamilton Depression Scale [Ham-D],[48] or instruments to screen for alcohol and drug abuse (e.g., the CAGE [a test for alcoholism][49] and the Michigan Alcohol Screening Test [MAST][50] Use of such psychometric inventories allows for ongoing follow-up via an empirical method that facilitates enhanced communication with consultees.

Guideline

The C-L consultant must be familiar with diagnostic testing regarding

1. The indications for anatomic brain imaging or neurophysiological screening by computed tomography (CT), magnetic resonance imaging, electroencephalogram, and positron emission tomography scans.[51]
2. The indications for the administration of neuropsychological testing (e.g., Minnesota Multiphasic Personality Inventory, Wechsler Adult Intelligence Scale, and Trail Making, parts A and B).[52]
3. The use of instruments to aid in diagnostic interviews and screening or measuring severity of comorbid mental disorders (e.g., MMSE, Ham-D).
4. The controlled administration of amytal or other hypnotics to interview for conversion disorder or a barbiturate challenge test for barbiturate dependence.
5. The initiation of a dementia workup, including thyroid function tests, VDRL (test for syphilis), B_{12}, folate, urinalysis, chest X ray, electrocardiogram, sequential multiple analysis 20, complete blood count, human immunodeficiency virus (HIV), and CT scan.[16]

The psychiatric consultant must be prepared to advocate for further surgical, medical, neurological, or other evaluations if there are indications of an underlying medical condition that may be contributing to the psychiatric disturbance.

Follow-Up

The scope, frequency, and necessity of follow-up visits depend on the nature of the initial diagnosis and recommendations. Follow-up visits reinforce the consultant's recommendations and allow the consultant to evaluate the results of recommendations, help prioritize the relative importance of particular interventions, and prevent breakdowns in communication between consultants and consultees.[53] Follow-up visits range in frequency from several times daily to none at all.[54] Follow-up care allows for the further development of a doctor–patient relationship, ongoing data collection, systems interventions, psychopharmacological monitoring, prevention of behavioral or psychiatric relapse, and increased compliance with treatment recommendations.[55] In identifiable patient groups with medical and psychiatric comorbidity, more frequent follow-up examinations by the C-L consultant improve psychosocial outcome, enhance adjustment to physical illness, and decrease length of stay.[56,57]

Guideline

The frequency of follow-up care by the C-L consultant depends on the parameters of the clinical situation; it varies from patient to patient. At least daily follow-up should be considered for several types of patients: those in restraints or on constant observation; those who are agitated, potentially violent, or suicidal; those with delirium; and those who are psychotic or psychiatrically unstable. Acutely ill patients started on psychoactive medications should be seen daily until they have been stabilized.

In some circumstances (e.g., for determination of capacity to consent or refuse treatment, for evaluation prior to organ transplantation, for facilitation of same-day transfer to an inpatient psychiatric setting, or for patients with a history of psychiatric disorder that is in remission), only an initial consultation may be necessary.

All recommendations for initiation of new procedures or interventions, consultation with other specialists, eventual transfer to other psy-

chiatric settings, and/or initiation or discontinuation of psychotropic medications should be accompanied by adequate monitoring until other health professionals can assume responsibility for the patient.

INTERVENTIONS

Psychotherapy

A C-L consultant must have the ability to apply a variety of psychotherapeutic techniques to the medically ill. In many cases, an understanding of how the patient's behavior and emotions fit known patterns affects the ability of the consultant to obtain a relevant history, arrive at a diagnosis, and develop an effective treatment plan.

An understanding of an individual's innate defensive, cognitive, and interpersonal styles (i.e., the core character and personality) enables the consultant to provide coping strategies for the patient. Additionally, individuals with personality disorders are prone to stereotypical maladaptive behaviors and emotions in response to medical illness and may stimulate negative or hostile reactions in health care providers.[58,59] Goal-directed cognitive–behavioral therapy crafted to the individual patient can often facilitate cooperation and compliance. In patients with terminal illness, complex medical conditions, chronic pain, or with patients undergoing repeated testing, open-ended supportive psychotherapy may be necessary.

Medical psychotherapy encompasses a body of clinical techniques (e.g., crisis interventions, short-term therapy, supportive therapy, interpersonal therapy, group therapy, cognitive–behavioral therapy, hypnosis) that may be applied singly, in combination, or alternately in different stages of an illness.[60–72] Extensive review of the literature[73] reveals the benefits of a wide range of psychotherapeutic modalities, especially when they are structured for the specific illness or condition (e.g., cancer or heart disease) and when the psychiatric consultant is familiar with the problems encountered in the specific medical/surgical setting (e.g., the cardiac care unit, cancer service, otolaryngology service, etc.).[74–78]

Guideline

The psychotherapeutic approach to the medically ill should be considered carefully, and the modality introduced should be primarily selected in response to the patient's needs. No single psychotherapeutic modality will be effective with all patients, at all times, in the medical setting.

The C-L consultant should have extensive knowledge and clinical experience dealing with the psychological stresses inherent in medical illness (e.g., separation anxiety, fear of pain, fear of loss of control, impending death, guilt about dependency, and grief). The C-L consultant should be experienced in the treatment of patients with complex personality disorders and comorbid medical/surgical illness, and the C-L consultant should be prepared to deal with the emotional reactions of health care providers to their patients.

Pharmacotherapy and Other Somatic Therapies

Psychopharmacological interventions are an essential part of the management of the medically ill. It is estimated that at least 35% of psychiatric consultations include recommendations for medications.[79] About 10%–15% of patients require reduction or discontinuation of psychotropic medications because they are contributing to the clinical presentation. Numerous physical conditions may cause, exacerbate, or first present themselves as psychiatric syndromes, and appropriate use of psychopharmacology necessitates a careful consideration of the underlying medical illness, drug interactions, and contraindications. In addition, many medications used in the treatment of medical/surgical illness are associated with psychiatric syndromes (e.g., hallucinations with L-dopa, anxiety with bronchodilators, psychosis with steroids). Therefore, the C-L consultant must be knowledgeable about the psychiatric effects of medications as well as the specific indications for psychopharmacol-

ogical interventions. Pharmacotherapy of the medically ill often involves modification in dosage (e.g., to account for older patients with an increased volume of distribution, a decreased rate of metabolism, and an increased physiologic reactivity).[80] Furthermore, modifications may be necessary because of liver, kidney, or cardiac disease, or because of potential for multiple drug–drug interactions.[81–84] Pregnancy presents another challenge, with concerns regarding potential teratogenicity.[85–88]

The decision to use pharmacological agents follows immediately upon the differential diagnosis, and appropriate agents should be prescribed when major psychiatric syndromes arise. C-L psychiatrists should be familiar with current reviews and databases in the literature for pharmacotherapy of the medically ill.[89–93]

The C-L psychiatrist must be knowledgeable about electroconvulsive therapy (ECT) and recognize when to introduce it in depressed, catatonic, or critically ill patients.

Guideline

The C-L psychiatrist must be a licensed physician with extensive clinical experience and knowledge about the use of pharmacological agents.

The psychiatric consultant should recommend and prescribe medications whenever a major psychiatric syndrome is diagnosed and when the benefits of treatment outweigh its risks.

As an essential skill, the C-L consultant must have additional pharmacological knowledge related to the following:

1. Variations in diagnoses and the natural progression of psychiatric disorders in the medically/surgically ill;
2. Indications for initiation, reduction, and discontinuation of therapy with specific psychopharmacological agents;
3. Appropriate adjustments of dosage depending on the patient's age, gender, and medical condition; physiologic abnormality (including liver, renal, and cardiac disease or pregnancy); and the potential for drug–drug interactions;
4. Recognition of drug-induced psychiatric syndromes (e.g., depression, psychosis, delirium);
5. The use of psychotropic agents for the treatment of substance-induced psychiatric disorders (e.g., withdrawal syndromes) and substitution algorithms for detoxification protocols. Because noncompliance and subtherapeutic use of psychotropics are common, the C-L consultant must make additional efforts to ensure appropriate and timely compliance with pharmacological recommendations arising from inexperience on the part of the consultee or resistance on the part of the patient. Obtaining medication blood levels should be considered when available; and
6. The appropriate indications for ECT.

Referral, Outpatient Follow-Up, and Signing Off

1. Referral and Requests for Services of Other Consultants. The C-L consultant should recommend that other professionals be brought into the case when additional expertise is required. Such expertise includes neurology, pain, substance abuse, geriatrics, and neuropsychology; it may be provided by practitioners from a variety of disciplines (e.g., psychology, social work, occupational therapy, physical therapy, pastoral care, and psychiatry as in behavioral medicine or ECT) or from patient representatives or especially knowledgeable nonmedical volunteers.

Guideline

Psychiatric consultants should recommend consultation with other physicians and nonphysician specialists, when appropriate. The request for additional consultation(s) should in general be arranged by the physician of record (i.e., the original consultee). When appropriate, the psychiatric consultant may end his/her involvement with the patient when another specialist is prepared to deliver the necessary care to the patient.

When the consultant recommends psychotropic medications, he/she should continue to follow the patient for the duration of the hospitalization, until psychotropics have been discontinued, or until the consultee no longer requires the consultant's services.

2. Outpatient Follow-Up and Disposition. It is the responsibility of the psychiatric consultant to recommend patients for outpatient psychiatric follow-up when necessary and to discuss the recommendations with both the patient and the consultee. The eventual disposition of a patient is determined by the nature of the psychiatric problem and the physical, psychological, economic, and social resources of the patient. The psychiatric consultant should work with the primary care physician, the social worker, and the patient's family to arrange the best disposition for the patient.[37]

Guideline

It is the responsibility of the consultant to suggest outpatient psychiatric treatment and to discuss these recommendations with both the patient and the consultee.

3. Signing Out and Signing Off. Psychiatric consultation for patients in the general medical setting must be available 24 hours/day, 7 days/week. A system of coverage should be arranged to provide this level of care. Problem patients who require close follow-up and patients who are under observation for suicidal and/or homicidal ideation should be formally "signed out," either in writing or verbally to the person who will be responsible for their care.

The decision to terminate involvement with a patient should be made in concert with the consultee and discussed with the patient.[94]

Guideline

When the decision to stop seeing a patient has been made, the consultant should discuss the planned termination with the consultee and with the patient. A sign-off note should be placed in the patient's medical record with information as to how the C-L consultant can be reached, should the need arise.

Constant Observation and Restraints

The decision to use constant observation and restraints is extremely serious. Because of the delicate balance between medical necessity and individual liberty, the implementation of these measures requires documentation of medical need, follow-up monitoring, and reporting of consequences. Constant observation and restraints should be implemented for the shortest possible time with the least restrictive, though effective, means available; these interventions must not be made solely for the convenience of medical staff. Assessment and treatment of underlying psychiatric conditions that contribute to the patient's need for these measures should be expeditiously undertaken.

1. Constant Observation. Constant observation is often necessary to ensure patient safety in the medical/surgical setting. It is typically provided by nursing staff and at times with the assistance of family members.[95] Patients who require constant observation typically fall into one of three categories: patients who have attempted suicide; patients with an altered mental status (e.g., secondary to dementia or delirium) who may inadvertently harm themselves or others; and patients with psychopathology (e.g., severe depression or psychosis) who are at risk for suicide or assaultive behaviors.[96,97] Other categories of patients who may require constant observation include those with mental retardation and those who are attempting to leave the hospital against medical advice. Because patients monitored with constant observation often require inpatient psychiatric hospitalization, it is reasonable to request psychiatric consultation on all patients who require this type of treatment.[98]

Guideline

Although the initial need for constant observation is generally instituted by the physician

of record, psychiatric consultation is recommended for these patients to facilitate diagnostic evaluation and to reduce harmful behaviors and litigious outcomes.

Policies regarding constant observation should be delineated, including the writing of orders to initiate and discontinue observation, the role of the staff providing constant observation, the requirements of record keeping, and the appropriate documentation regarding the discontinuation of observation.

2. Restraints. Restraints should be applied in accordance with written institutional policies that are developed in accordance with local and state laws and the standards of accrediting agencies (e.g., Consolidated Omnibus Reconciliation Act, HCFA, Joint Commission on Accreditation of Healthcare Organizations); restraints should be monitored as a special treatment procedure that requires specific justification. Restraints include soft or leather restraints, wrist or ankle cuffs, jackets, belts, sheets, gerichairs, and mittens.

The C-L consultant should be knowledgeable about the physical and emotional risks of restraints; the need to implement the least-restrictive alternatives in managing agitation; the most conservative level of assessment methodology; the highest guidelines of documentation (i.e., doctor's orders and progress notes); and the need to frequently reevaluate the patient, allowing for the earliest, safest release from restraints possible.[99–106]

Guideline

Psychiatric consultants must be knowledgeable of all applicable state, local, and institutional guidelines with regard to restraints. Restraints should not be used for discipline or as a convenience for the staff. The C-L service must provide 24-hour, 7-day/week coverage for all patients who they have evaluated and who require restraints.

Competency Evaluations

Although psychiatric consultants cannot legally declare a patient incompetent, they can clinically evaluate the medicolegal elements of the decision-making capacity of the patient within the context of the medical–psychiatric presentation.[107–111] The psychiatric consultant should perform a complete diagnostic examination with an extended cognitive evaluation. The consultant should evaluate the extent and accuracy of information given to the patient and subsequently retained by the patient;[112] the patient's understanding of the nature of the illness; the risks and benefits of the proposed treatment; treatment alternatives; and the consequences of treatment refusal. Because the incompetent patient often has underlying cognitive deficits, the consultant needs to be knowledgeable about the evaluation and treatment of the cognitively impaired patient and emergency evaluations.[113–115] The consultant must clarify that the patient's capacity or lack thereof is specific (e.g., a patient may be competent to accept treatment without being competent to execute a will).

Guideline

The C-L psychiatrist's role is to evaluate a patient's capacity for medical decision making with regard to a specific medical determination. A patient who clearly demonstrates diminished capacity may be treated over objection in an emergency (i.e., if as a result of refusal the patient is likely to suffer serious adverse medical consequences or to die). However, the clinical determination of capacity is often relative, and it requires a complex medical decision (of benefits and risks with regard to which intervention for what medical illness given possible outcomes). Impaired judgment in one area does not imply incompetence in all matters.

When the C-L consultatnt has determined that the patient has impaired decisional capacity, the C-L consultant should recommend that a court order be obtained to treat a patient over the patient's objection. Where no medical emergency exists, this may involve appointment of a guardian. Decision-making powers of the guardian differ from state to state.

Treatment of an incompetent patient who does not object is subject to ethical and legal

considerations appropriate to the patient, the occasion, and the community standard.

Psychiatric Commitment and Transfer to Psychiatry

As part of a complete psychiatric evaluation, the consultant should consider the appropriateness of inpatient psychiatric treatment. This determination requires familiarity with the voluntary and involuntary legal statutes of the state and local mental health acts; an evaluation of the suitability of the type of intended psychiatric unit (e.g., locked or open, dual diagnosis, rehabilitation/detoxification, medical–psychiatric, conventional psychiatric or geriatric units) and an evaluation of the capacity of the psychiatric unit to provide the necessary medical/surgical care required by the patient.

Guideline

The psychiatric consultant should be familiar with the clinical indications for, and potential benefits of, inpatient psychiatric admission for particular psychiatric conditions. The C-L consultant should be familiar with all appropriate legislation and institutional rules about admission and transfer to psychiatric units. The C-L psychiatrist is also responsible for determining whether the patient is medically stable before transfer and in a condition suitable enough to be able to receive appropriate inpatient psychiatric care, without imminent physical decompensation.

ADMINISTRATIVE ISSUES

Data Collection and Quality Control

It is no longer sufficient merely to do a consultation and write a note in the record. Records must be kept for administrative and clinical review purposes (e.g., as proof of supervisory services rendered). A review of cases should be conducted by each C-L service to ensure quality control. This may be a review of all cases seen over a specified period of time (e.g., a week or a month of a resident's rotation), or reviews may target an area of clinical interest. For example, a review of attempted suicides in hospitalized patients might reveal environmental risks (e.g., windows that can be opened by patients) that could be minimized.[116]

All untoward events should be reviewed thoroughly and problems dealt with by a quality assurance committee. Areas in need of remediation should be identified and addressed appropriately by staff education, by recommendations for alterations in protocols and policy, by recommendations for alterations in the physical plant, or by changes regarding staffing and supervision.

Guideline

C-L consultants should create a system for regular internal quality review of the service's clinical, research, and supervisory activities. Records must be properly maintained and safely stored, yet readily accessible for clinical and research purposes. Patient confidentiality must be considered and safeguarded.

Supervision of Trainees

The education of psychiatrists and other medical staff has always been an important mission of C-L psychiatry. Previously published guidelines recommended that the C-L experience is best suited for PGY-3 or PGY-4 psychiatric residents, rather than less experienced residents.[3] The education of psychiatric residents, nonpsychiatric residents, psychologists, social workers, and nurses is in part provided through supervision of clinical activities, with discussion of diagnostic and psychotherapeutic issues. Appropriate didactic material should be used in the training of residents and others.[117–121] These materials should be modified for individuals in different disciplines. The performance of trainees should be assessed periodically to maximize the development and refinement of their skills.[122,123]

Guideline

A sufficient number of faculty should be made available so that all new patients consulted by a resident can be seen by an attending psychiatrist, preferably within 24 hours. The attending supervisor may determine when a case requires his/her bedside examination, and case supervision may be made initially via telephone if an attending physician is not physically on site. The resident should make a notation in the chart that the case was discussed, with whom, and note any recommendations made by the attending physician. Trainees should receive didactic training in the topics outlined in the *Recommended Guidelines for Consultation-Liaison Psychiatric Training in Psychiatry Residency Programs*.

Ethical Guidelines

All physicians have a primary duty to conduct themselves ethically and to examine the ethical dilemmas that arise in the care of their patients. The ethical practice of medicine is outlined in the APA and American Medical Association guidelines.[124] In addition to knowledge of the ethical guidelines, the C-L consultant has a special role in alerting the staff and in exploring the ethical issues that arise in the care of the patient.

Despite overt statements of intent to the contrary, many requests on the part of the patient are made for reasons, sometimes hidden, that run counter to the true wishes of the patient. It is the responsibility of the C-L consultant to give ethical consideration to these issues with regard to right of treatment refusal, capacity to consent to treatment, civil commitment, or medical futility.[108,112,125,126]

C-L consultants are also entrusted with certain private information from and about patients. At its core, the relationship is based upon trust both in the physician and in the principles of medical ethics. An awareness that the medical record may be read by a variety of staff may lead the psychiatric consultant to limit what information is put in the patient's chart to protect the patient's confidentiality.[5]

The C-L consultant is exposed to a variety of conflicting issues that require careful consideration regarding ethical decision making.[127,128] When faced with pressures from consultees, hospital utilization review committees, managed care companies, or a patient's family, the consultant must skillfully negotiate numerous challenges to act in the best interests of the patient.[129–131]

Guideline

C-L consultants should follow the principles of medical ethics in all patient interactions. They should collaborate with the medical staff to resolve ethical dilemmas that may arise in the care of a patient. The psychiatric consultant must be prepared to act as an advocate for the patient and clarify the underlying intent and meaning of his/her overt statements. C-L consultants must also be knowledgeable of the medicolegal issues (e.g., capacity to consent to treatment, refusal of treatment, civil commitment, responsibility of a health care proxy, and conservatorship). It is the responsibility of the consultant to be knowledgeable about the laws and guidelines that are to be considered in ethical and medicolegal determinations in the hospital setting.

CHILD AND ADOLESCENT CONSULTS

Although the general guidelines for consultation regarding children and adolescents are similar to those for adults, there are specific considerations that are unique to the pediatric population. Consultation with children and adolescents requires specialized clinical experience and knowledge that goes beyond that of most C-L consultants. Not all consultants at the present time are required or assumed to have this additional capability.

Qualifications and Role of the Consultant

The role of the C-L consultant includes the evaluation and treatment of developmental, be-

havioral, and psychological problems as manifest in children, adolescents, and families in the medical setting.[132] Often this role includes an awareness of the special psychiatric needs of this population in a pediatric setting, particularly in children facing traumatic medical procedures and hospitalization. In addition to an ability to identify the social, environmental, and cultural factors relevant to any psychiatric consultation, the consultant should be able to appreciate developmental and family issues as they apply to diagnosis and intervention.[133] It is essential that the consultant have expertise in areas that include behavioral effects of medications, noncompliance with treatment, treatment of chronic pain, reaction to acute and chronic medical illness, disorders of attachment, parent–infant relationship difficulties, speech and language disorders, learning disabilities, and psychiatric disorders specific to childhood. The C-L consultant should have an in-depth understanding of medical illness, as well as a general knowledge of procedures, medications, hospital routines, and outcomes for children and adolescent patients.

C-L consultant qualifications for this role should include board eligibility or board certification in child and adolescent psychiatry and the ability to perform in a leadership role within a multidisciplinary team.

Clinical Procedure

Before starting the consultation, the consultant should ascertain that both the child and the parents or legal guardians have been informed about the purpose of the consultation. Given the importance of the family to the child, the frequent contribution of family dynamics to the child's symptoms, and the impact of the child's medical illness on the family system, it is essential that the consultant obtain information from family members. An alliance with the family is essential for successful intervention. When relevant, consultation should include contact with others (e.g., members of the school system, the primary pediatrician, the caseworker, the probation officer, or the therapist).[134] It is also crucial to consider the impact of developmental issues and regression observed in children hospitalized with serious medical illnesses.[135] By virtue of their complexity, pediatric consultations typically take longer than consultations with adults.

Legal and Ethical Issues

The consultant should have a thorough knowledge of the relevant local laws that apply to this population. These include the mandatory reporting of suspected cases of sexual or physical abuse or abandonment; the obligation to report suspected maternal use of drugs during the neonatal period; the child's right to treatment (particularly when this conflicts with the parents' desire to refuse or withhold treatment in the case of critically ill neonates or due to parental religious beliefs); the legal age for consent and the legal definition of an emancipated minor, which may vary according to state and according to the nature of the illness or problem (e.g., in the area of reproductive rights); and the involuntary medical or psychiatric treatment of minors.[136]

The limits to confidentiality implicit in a psychiatric consultation become even more complicated when the consultation involves minors, especially with regard to the issue of sexual behavior, teen pregnancy, criminal behavior, or substance abuse. These limitations should be clarified with both the family and the child at the time of the consultation.[134] It is important to safeguard the documentation of sensitive information in the medical record; this concern extends to disclosure of information to contacts made at schools and other outside agencies.

Interventions

Knowledge of treatment modalities should encompass cognitive and behavioral interventions (including hypnosis); psychotherapy (including individual, family, and group modalities); and expertise in the area of pediatric psychopharmacology.[137] In addition, the consultant should have familiarity with the local out-

patient referral resources, support groups for parents and children, and special educational resources.

Future Research and Review

Given the relative shortage of research in this field, consultants should promote and develop research in the areas of assessment, intervention, and prevention of illness in children and adolescents in a pediatric setting.[138] Finally, given the complexity of the issues relating to psychiatric consultation in children and adolescents, a large-scale survey of this field should be undertaken with the goal of developing more detailed practice guidelines for this patient population.

Guideline

The principles of psychiatric consultation with children and adolescents are similar to those of adult consultation. However, special knowledge and clinical experience related to the pediatric population are required.

BIBLIOGRAPHY

C-L consultants should be familiar with the extensive literature and resources that currently exist for support of practitioners in the field. Major works and commonly used resources in the field of C-L psychiatry are listed below.

Journals

Psychosomatics, *Psychosomatic Medicine*, *General Hospital Psychiatry*, *Psychiatric Services*, *International Journal of Psychiatry and Medicine*, *Journal of Pediatric Psychology*

Textbooks

Psychiatric Care of the Medical Patient, edited by Stoudemire A, Fogel BS. New York, Oxford University Press, 1993

Massachusetts General Hospital Handbook of General Hospital Psychiatry, 4th Edition, edited by Cassem NH, Stern TA, Rosenbaum JF, et al. St. Louis, MO, Mosby-Year Book, 1997

The American Psychiatric Press Textbook of Consultation-Liaison Psychiatry, edited by Rundell JR, Wise MG. Washington, DC, American Psychiatric Press, 1996

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Societies

The Academy of Psychosomatic Medicine
The American Psychosomatic Society
The American Academy of Child and Adolescent Psychiatry
Society of Pediatric Psychology
Association of Medicine and Psychiatry

GUIDELINES DEVELOPMENT

Next Steps

The development of guidelines on the nature of psychiatric consultation and intervention is a serious undertaking that must be carefully reviewed. No single report on guidelines can be complete in itself. The Task Force endorses the Institute of Medicine's principles in the process of developing guidelines. The practice guidelines presented here represent a step along that process. Further efforts should be directed at the following:

1. Establishing the validity, reliability, and reproducibility of the guidelines;
2. Refining the clinical applicability, flexibility, and clarity of the guidelines;
3. Documenting the development, participant assumptions, and rationale behind creation of the guidelines;

4. Identifying opportunities for collaborative endeavors;
5. Maintaining a viable standing committee for guidelines development; and
6. Inviting interested parties to offer review and comment through contact of the office of the Academy of Psychosomatic Medicine (1-703-556-9222).

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