Understanding the scope of consultation-liaison psychiatry referrals in a general hospital setting in New Zealand

- RANZCP Faculty of CLP inaugural meeting, Hobart
- 21st September 2019

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Outline

- Background
- Objectives
- Methods
- Key Findings
- Discussion
- Summary
- Q & A session
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Background

- People with physical illnesses have \textsuperscript{↑}ed likelihood of developing mental illnesses and vice versa (Doherty & Gaughran, 2014)

- CLP works at the interface between mental and physical health needs and aims to reduce this comorbidity
- Wide variation → service configuration, funding and staffing
- Hours of operation, acute vs non-acute
- ED
- Age-inclusive
- Addictions
- MDT
- Clinical/Health Psychology
- Specialisation
- Outpatients
- MH vs Medical vs Mixed funding
- Consultation vs Liaison
CLP services

- Save money
- Reduce length of stay
- See lots of (complex) patients
Problems

- Difficult to capture activities of CLP services
- What interventions do CLP services provide
Assessment of CLP services

- Italy (Giorgio et al, 2015)
- Australia (Devasagayam & Clarke, 2016)
- USA (Kishi et al, 2004)
- Ireland (Lyne et al, 2009)
- UK (Guthrie et al, 2016)
No prior studies in New Zealand
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To characterise:

- source/acuity of referrals
- reason for referral
- were referrals accepted
- the main interventions offered by the CLP service
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Study setting

- Waitemata DHB, Auckland → catchment area of ≈650,000
- Largest district health board in the country
- Fastest growing DHB
- 2nd “greyest” DHB
- Electronic health record systems for MH/Medical services
• 2 Emergency Departments (ED) – split coverage

• Variety of medical, surgical, obstetric and other disciplines on-site

• Wards, 1 intensive care unit and outpatient clinics

• Total inpatient bed-capacity → 953 beds
- CLP services offered at the two teaching hospital campuses (North Shore and Waitakere)

- The CLP service at Waitemata ➔ multidisciplinary and consists of consultants, clinical psychologists, registrars and nurses

- 24/7 age-inclusive service

- Acute and non-acute assessments
CLP

- largely consultation
- liaison with diabetic, renal, gastro services
- education e.g. Medical Grand Rounds, teaching for trainees
Shorter stay targets in ED

- NZ – 6hr admitted, transferred, discharged
- Australia – NEAT, 4hrs
Study design

- Retrospective observational study
- Analysis of all referrals (n=1,100) made to the CLP service at Waitemata DHB
- 6-month timeframe (from November 1st 2017)
- Only working adults and older age adults were included (<18yo were excluded)
Descriptive statistics summarised, de-identified variables from patient records:

- Socio-demographic data (e.g. Age, Sex, Ethnicity, Employment)
- Features of referral (e.g. Referral source, Acuity of referral, Which DHB)
- Features of assessment (e.g. Diagnosis by CLP)
- Features of intervention (i.e. Main interventions offered)
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Demographics

- $\approx 80\% \rightarrow$ aged 18-65yo
- $\approx 20\% \rightarrow >65yo$
- $\approx 80\% \rightarrow$ individuals had prior hx of mental illness
- $\approx 35\%$ unemployed
- $\approx 1\%$ homeless
Acuity & source of referrals

- 97% referrals accepted
- \(\approx 45\%\) of referrals were regarded as urgent
- Average duration with CLP team: btw 1-3 days
- ED largest user of the service (\(\approx 66\%\))
- 30% inpatient & 5% outpatients
- 10% patients \(\rightarrow\) from outside catchment area
Main reasons for referral

- Self-harm/suicidal ideation (40%)
- Alerts (13%)
- Mood disorder (8%)
- Adjustment (6%)
- Staff support (6%)
Referral to consultation-liaison psychiatry services, frequency by Referral Diagnosis

- Self-Harm
- Mood Disorder
- No mental health concerns
- Adjustment/Grief Reaction/Acute Stress
- Psychosis/Paranoia
- Suicidal Ideation
- Anxiety
- Delirium
- Dementia
- Somatoform Disorder
- Eating Disorder
- Renal
- Personality Disorder
- Neuropsychiatry
- PTSD

Diagnosis by CLP
Most common interventions offered by the CLP service

- Risk assessments
- Decision-making capacity assessments
- Advice e.g. medication, legal
- Disturbed behaviour management
- Psychotherapy
- Psychoeducation for patients/staff
- Sign-posting or recruitment of other services (e.g. social worker, addiction services)
Outcomes

- Discharge to CMHT (≈50%)
- Inpatient MH unit (≈13%)
- Respite unit (≈3%)
- GP follow-up (5%)
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Large proportion of those seen:
- Self-harm/suicidality/depression
- Acute adjustment reaction
- Mental illness
  - better training to distinguish pervasive mood disorders vs acute adjustment reactions
Majority of those referred had pre-existing mental health problems

- New Zealand’s high rate of mental and substance use disorders?
- configuration of the CLP service?
- WDHB → CLP services provide assessments in the ED
- ↑ turnover whereas in other DHBs, ED may be covered by CMHTs exclusively
There were more ED referrals compared to inpatient referrals:

- Lower ward referral rates e.g. poor recognition of mental illnesses by physicians, poor engagement between the referring team and patients, lack of hospital policies to guide referrals and patient stigma around mental health
- Government targets (waiting times in the ED) → ED referrals prioritised
Limitations

- Retrospective
- Single DHB
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- Large demand for acute assessment at the ED
- Diversity of CLP input
- Mostly adults of working age were seen
- Significant minority were elderly
- Small proportion were from outside the catchment area or homeless
- Pre-existing mental illness
- Self-harm/suicidality/depression
- No mental illness/adjustment disorder
- Implications ➔ optimal service funding and delivery

- Study consists of a rich dataset ➔ possibility of applicability of study methods and findings elsewhere
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Q & A session
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