Australian Mental Health Outcomes and Classification Network

'Sharing Information to Improve Outcomes'
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Allocation of Mental Health Phase of Care in Consultation Liaison Psychiatry

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Acknowledgements

We acknowledge Aboriginal and Torres Strait Islander peoples as the first inhabitants of this nation and the traditional custodians of the lands where we live, learn and work. We pay respect to all Aboriginal and Torres Strait Islander Elders, past and present from every nation.

We would like to recognise those with lived experience of mental health conditions in Australia. We acknowledge that we can only provide quality care through valuing, respecting and drawing upon the lived experience and expert knowledge of consumers, their families, carers and friends, staff and the local communities.

These vignettes were developed with extensive input from clinicians in health services in Victoria. Their expertise and knowledge was greatly appreciated.

GENERAL COMMENTS

Consultation-Liaison Psychiatry provide specialist mental health care for patients admitted to general hospitals. These teams comprise staff from various disciplines including medical practitioners (consultant psychiatrist, psychiatric registrars), nurses, psychologists.

These vignettes are not longitudinal descriptions of changes in the presentation of consumers but snapshots of the usual presentation of a patient in that particular phase. They aim to support clinicians' deliberations during their allocation of Mental Health Phase of Care in Consultation-Liaison Psychiatry.

CHILD AND ADOLESCENT

Case 1: Intensive care unit

13 year old female of Nepalese heritage was admitted to ICU with Glasgow Coma Score of 3, after a significant overdose of medications (Amitriptyline – 20g, Olanzapine – 17.5g and Paracetamol) obtained from home (Father's medications). A review post extubation revealed a coherent young female with joint Child Protection and Police involvement following the recent disclosure of childhood sexual assault by extended family member. She expressed ongoing suicidal ideation with plans and intent. She was transferred to the paediatric unit for ongoing monitoring and a further risk assessment by the child and adolescent mental health service the next day. Shortly after her transfer to the paediatric unit, she started to develop psychotic features. These were thought to be an indication of withdrawal from the medications that she had taken as part of the overdose.

MHPoC: Acute

Case 2: Paediatric ward

12 year old male with multiple admissions secondary to abdominal pain. This abdominal pain has undergone multiple investigations including gastroscopes, colonoscopy, appendectomy, all of which found no abnormalities. The child was referred by the paediatrician who is concerned that the mother is seeking an organic diagnosis and has been over-medicating the child's pain resulting in a functional gut disorder. On assessment the child appeared to be in pain for the majority of the interview but readily engaged towards the end of the assessment. There were no abnormalities of the child's thought form or content detected.

MHPoC: Assessment Only

Case 3: Paediatric ward

14 year old female of Sudanese descent admitted with a relapse of an eating disorder and ongoing suicidal ideation and overdose on iron tablets. She is currently case managed by child and adolescent mental health service and current case manager is on leave. The paediatrics team requested a review of the patient's mental state. She was difficult to engage but the consultation liaison team made repeat visits to support improvements in food intake.

MHPoC: Functional Gain

ADULT

Case 1: General hospital admission

A patient is admitted under General Medicine for several days following a polypharmacy overdose. The patient is assessed by mental health in the emergency department and then seen daily by the CL Psychiatry team during the general hospital stay. On discharge, referral occurs to the acute care team for follow-up.

MHPoC: Acute

Case 2: Surgical ward

A patient is admitted for surgery. Postoperatively, the patient becomes behaviourally disturbed as a result of delirium. The patient is referred to CL Psychiatry by the surgical team. A nurse from the consultation-liaison team sees the patient on the day of referral. The nurse makes some treatment recommendations and hands the patient's care back to the treating team.

MHPoC: Assessment Only

Case 3: Cardiology

A patient is admitted under Cardiology. The patient is experiencing moderate to severe depressive symptoms in the context of physical ill-health and severe medication side effects. The patient is referred to CL Psychiatry by the Cardiology team. A psychologist sees the patient from the consultation-liaison team, who reviews the patient every second day, including weekends, throughout their long admission.

MHPoC: Intensive Extended

Case 4: Oncology

A patient is admitted under Oncology. The patient is experiencing mild depressive symptoms in the context of a poor prognosis. The patient is struggling to cope with their current situation, which has a significant impact on their interactions with family and friends. This is distressing for the patient and their visitors. The patient is referred to CL Psychiatry by the oncology team. The patient is seen by a registrar from the consultation-liaison team, who advises the patient on practical coping skills given their current situation. A nurse from the consultation-liaison team undertakes a follow-up visit several days later to monitor progress and ensure that the patient is practising their coping skills.

MHPoC: Functional Gain

Case 5: Orthopaedics

A case managed client of Community Psychiatry attempts suicide, sustaining multiple serious traumatic injuries. Initially seen as Acute, the patient spends weeks in the hospital under the care of the Trauma team and is seen by the CL Psychiatry team who visit the patient throughout their admission to monitor and provide support. On each visit, the team finds the patient stable but continues their contact given the seriousness of the suicide attempt.

MHPoC: Consolidating Gain

Case 6: Orthopaedics

A case managed client of Community Psychiatry attempts suicide in response to command hallucinations. Initially seen as Acute, the patient spends weeks in the hospital under the care of the Trauma team and is seen by the CL Psychiatry team who visit several times per week throughout the patient's admission given the patient's fluctuating presentation and potential for relapse. The CL Psychiatry team works actively with medical and nursing staff to manage the patient's care. They liaise with the community mental health team and the patient's family.

MHPoC: Intensive Extended

Note: Although Case 5 and Case 6 describe a consumer who has self harmed and sustained traumatic injuries, they differ in that there is more activity associated with meeting the needs of Case 6 and hence the allocation of Intensive Extended.

Case 7: Gastroenterology

A patient is admitted under the Gastroenterology team with ischaemic colitis. The patient also has a long history of cardiac complications. The patient is referred to the CL Psychiatry team because of a deterioration in mental state, cognitive changes and lowered mood. During their lengthy admission, it is a diagnostic challenge to determine their physical health status. CL reviews the patient every second day during their admission, with the view to referral for ongoing mental health case management on discharge.

MHPoC: Intensive Extended

Case 8: Neurology

A patient is referred to the CL Psychiatry outpatient clinic by Neurology. The patient has established Multiple Sclerosis and presents with depressive symptoms of mild to moderate severity. They are seen by a Psychiatry registrar and respond well to therapy but continue to be monitored on a three monthly basis to ensure stability.

MHPoC: Consolidating Gain

Case 9: Surgery

A patient is admitted for a surgical procedure and nursing staff find them to be particularly anxious. They are in a shared room and this anxiety leads to conflict with other patients. A nurse from the CL Psychiatry team visits and determines that a brief course of mindfulness therapy would be appropriate to manage their anxiety and reduce this conflict. They visit over the next two days to support the patient's practice of this technique.

MHPoC: Functional Gain

Case 10: Intensive care unit

37 year old female admitted to intensive care unit after an overdose of Olanzapine (30g approx.) in the context of significant alcohol intake. She is currently being treated by the mental health continuing care team with a diagnosis of complex post traumatic stress disorder, borderline personality disorder and episodes of dissociation amnesia. Reviewed by consultation liaison team for referral to community mental health team following medical stabilisation.

MHPoC: Assessment Only

Case 11: Medical Ward

35 year old female with known eating disorder, Anorexia Restrictive type, of long standing. She was admitted to hospital with a letter from her general practitioner. She has altered biochemistry and vital signs. Her eating disorder is currently managed by the mental health continuing care team where she has input from a psychologist and a dietitian. She was referred to the consultation liaison team for monitoring of her mental state. She was difficult to engage but the consultation liaison team made repeat visits to support improvements in food intake.

MHPoC: Functional gain

OLDER PERSONS

Case 1: Intensive care unit

67 year old female originally presented to the emergency department following a fall. She was admitted to the intensive care unit for management of increasing confusion, nausea and vomiting. Multiple medical comorbidities including chronic kidney disease, lithium toxicity, bipolar disorder and recently diagnosed brain tumour. 7 days into the admission she was referred to the consultation liaison team. Diagnostic challenge to determine if the variability in her presentation was a delirium versus a relapse of the existing bipolar disorder. Required multiple visits over a long admission by consultation liaison team during medical stabilisation and prior to admission to the acute mental health unit.

MHPoC: Intensive Extended