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# Profile and Assessment Outcome of Patients in the Emergency Department Managed by Consultation-liaison Psychiatry: A Cross-sectional Study

Nilamadhab Kar<sup>1,2,3</sup>, Haridha Pandian<sup>4</sup>

<sup>1</sup>Department of Psychiatry, Black Country Healthcare NHS Foundation Trust, <sup>2</sup>University of Wolverhampton, Wolverhampton, UK, <sup>3</sup>Department of Contemplative and Behavioural Sciences, Sri Sri University, Cuttack, Odisha, India, <sup>4</sup>King's College Hospital NHS Foundation Trust, London, UK

## Abstract

**Background:** Outcomes following consultation-liaison psychiatry (CLP) assessment provide key direction for mental health care regarding crisis intervention. **Aim:** We intended to find the clinical characteristics of all consecutive psychiatric patients referred to CLP in a month ( $n = 100$ ), specifically reasons for referral, diagnoses, stressors, the outcomes of the assessment, and subsequent care pathways. **Settings and Design:** Emergency department in a General Hospital. A cross-sectional study. **Methods and Material:** Data was extracted from electronic patient records in a pre-designed proforma. International Classification of Disease-10 and index of multiple deprivations were used. **Statistical Analysis:** Percentages, mean and standard deviation. **Results:** The sample (56 male and 44 female patients) mostly belonged to the deprived areas of the city. The majority (90%) of them presented with thoughts or behaviors related to self-harm or suicide. Most (73.0%) of them had psychiatric diagnoses; depression (36%) was the most common, followed by personality disorders (22%) and alcohol or substance use disorders (17%), and many of them had comorbidities. Almost half of the patients (48%) had self-harm history. A considerable proportion (40%) was under the influence of substances when they attended the emergency department. Common psychosocial stressors were relational problems (38%) with partner or family followed by pandemic-related concerns (19%). More than a third (37%) of the sample was seen in the previous 12 months, and the re-attendance rate in the 3 months following the study was 21%. While acute psychiatric care was provided to around 30% (inpatient admission: 13% and home treatment: 17%), 24% were discharged to general practitioners and 18% to community mental health teams. **Conclusions:** Most patients managed by CLP had multiple complex clinical needs along with suicidality. This suggested that a robust suicide risk management strategy and supportive resources are essential components of CLP care.

**Keywords:** Consultation-liaison, emergency department, outcome, psychiatry, self-harm, suicide

## INTRODUCTION

Consultation-liaison psychiatry (CLP) is an essential service, providing psychiatric treatment for patients in the outpatients, wards, and emergency department (ED) of general hospitals, being an interface of physical and mental illnesses. While it is well established in many parts of the world, it is in various stages of development in many places. A proportion of the patients managed by CLP are referred from ED, who are in mental health crisis needing acute psychiatric care.

Over the years, number of psychiatric patients attending ED of general hospitals has increased in the UK.<sup>[1]</sup> There has been a positive national focus on mental health crisis care,<sup>[2]</sup> and a

commitment was made to provide core 24-h CLP services in 70% of acute hospitals in England and Wales by 2023–2024.<sup>[3]</sup> The patients attending CLP through ED usually have mental health crises, including self-harm or suicidal ideas or attempts, and need acute psychiatric care. They are assessed and managed by the CLP team. This is a multidisciplinary work, and the supportive interventions require input from various teams in the community, social services, and healthcare.

**Address for correspondence:** Prof. Nilamadhab Kar, Black Country Healthcare NHS Foundation Trust, Steps To Health, Showell Circus, Wolverhampton, WV10 9TH, UK. E-mail: n.kar@nhs.net

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It is currently estimated that up to 4% of all ED attendances are due to mental or behavioral disorders, and a third of these are specifically due to self-harm or suicidal ideation.<sup>[4]</sup> Reasons behind self-harm and suicidal behavior are multifactorial, similarly their management, which may require collaboration of various services such as crisis resolution and home treatment (CRHT) team, inpatient psychiatric care, community mental health services, and social services in assessment and management besides the emergency physical intervention in ED or general hospital.

Patients referred from ED form a specific group as most of them are in crisis, needing acute psychiatric care, and crisis management, which requires multidisciplinary team input. To inform CLP service quality improvement, it is essential to understand the profile of patients attending CLP, their clinical needs, assessment outcomes, and the care pathways.

Based on the above, the specific aims of this study were to find out the clinical characteristics of psychiatric patients referred from ED for assessment and management by CLP, especially the reasons for referral, diagnoses, and features associated with repeat attendance. It was intended to study the assessment outcomes and care pathways. It was expected these observations would suggest methods of service quality improvement.

## MATERIALS AND METHODS

### Setting

The cross-sectional study was conducted in a large district general hospital ED. The hospital primarily caters to a city in the West Midlands, England, with a population of more than 250,000. The ED has a dedicated CLP team consisting of a clinical nurse specialist team with support from psychiatrists. The study was conducted during July 2020.

### Sample

The sample included all patients referred to the CLP from a tertiary care general hospital ED during a month. There were no exclusion criteria.

### Data

The data were extracted from the electronic patient information system. The variables collected included patient demographics, date and time of attendance to ED, reason for referral to CLP, known International Classification of Disease-10 (ICD-10) diagnoses,<sup>[5]</sup> previous self-harm history, alcohol or substance misuse at the time of presentation, recent psychosocial stressors, and outcome of the CLP assessment. The data were also collected on attendances to ED with mental or behavioral problems in the 12 months preceding and 3 months following this particular CLP assessment.

We checked the areas of residence by postcode of the patients assessed by CLP, for index of multiple deprivations (IMD).<sup>[6]</sup> It is presented by deciles 1–10, 1 being the most deprived and 10 least deprived.

### Ethics

The project was approved by the institution as a service evaluation. Ethical principles were followed; no individually

identifiable data were collected from the electronic records. There was no individual patient contact for data collection.

## Analysis

The data were checked for quality and were analyzed using SPSS version 28 (IBM Corp, Armonk, NY, USA). Missing data were not included in the calculations. Statistical tests employed to analyze the data were primarily proportions by percentages.

## RESULTS

During the month of the study, 101 patients were referred to the CLP from the ED. One patient was excluded due to a lack of data available on the electronic patient information system. The final study sample consisted of 100 patients, with 56 males and 44 females, with average age of  $34.6 \pm 11.6$  and  $34.0 \pm 12.3$  years (NS), respectively. There were 82% white, 8% Asian, 3% Black African or Caribbean, and 6% mixed, and it was not recorded in one patient.

Most of the patients came from deprived areas based on IMD; there were 27% in 1<sup>st</sup>, 29% in 2<sup>nd</sup>, 11% in 3<sup>rd</sup>, 12% in 4<sup>th</sup> decile, and 5% in 5<sup>th</sup> decile; all other 14% from 6<sup>th</sup> to 10<sup>th</sup> percentile; and 2% had no accommodation.

### Time and day of referral

Around one in five (21.0%) of patients presented to ED on Saturday and Sunday; suggesting that 79% presented during the weekdays. There were no significant differences between gender and the day or time of referral to the CLP. Number of patients referred at various time periods is given in Figure 1. Around one-third (30.0%) of patients attended CLP during normal working hours between 8:00 AM and 15:59 PM. The majority presented outside of these hours, with the greatest proportion being 24% ( $n = 24$ ) between 20:00 PM and 11:59 PM.

### Reason for referral to the consultation-liaison psychiatry from emergency department

The reason for referral to CLP from ED is given in Table 1. The most common reason for referral to the CLP was “thoughts or intent of self-harm or suicide” (50.0%). In total, 29.0% of patients were referred due to overdose. Patients used various methods to overdose including psychiatric

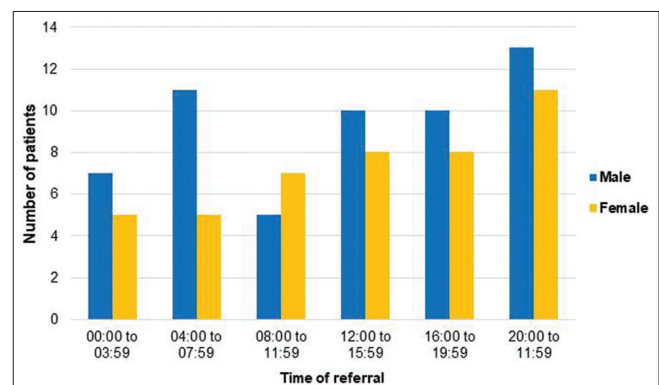


Figure 1: Time of referral to consultation-liaison psychiatry

medications (7.0%), physical health medications (11.0%), mixed medications (8.0%), illicit substances (1.0%); and 2.0% did not disclose the substances used to overdose.

A minority of patients (5.0%) were referred to the CLP due to psychotic symptoms, including auditory/visual hallucinations or delusional ideation. Reasons for referral for self-harm by laceration or scratching self were observed in 7.0% of patients. Less common reasons for referral included attempted suicide by hanging (1.0%), drowning (1.0%), suffocation (1.0%), or ingestion of toxic substances such as bleach (1.0%). Finally, the category “Other” (5%), consisted of patients presenting with miscellaneous complaints such as memory loss, confusion, or requesting a change in their psychiatric diagnosis.

The frequency of psychiatric diagnoses based on ICD-10 in patients presenting to ED and assessed by the CLP team is given in Table 2. Most (73.0%) patients had psychiatric diagnoses which were previously diagnosed based on ICD-10. Within this group, 22.0% had two psychiatric diagnoses, 5% had three diagnoses, and 1% had four separate diagnoses.

The most common diagnoses were depressive disorders and personality disorders, specifically emotionally unstable personality disorder (EUPD) (15%). Among male patients, common diagnoses were depressive disorders, personality disorders (including EUPD: 8.9%), alcohol and substance

use disorders, and anxiety disorders. Among female patients, common diagnoses were depressive disorders, personality disorders (including EUPD: 22.7%), and anxiety disorders. Any specific diagnoses were not associated with re-attendance rates to CLP.

**History of self-harm**

Overall, 48.0% of patients had a history of self-harm before their assessment by CLP; 42.9% (24/56) of males and 54.5% (24/44) of females had a history of previous self-harm (NS). However, there were no significant associations between a history of self-harm and the likelihood to re-attend CLP in the 3 months following this assessment.

**Substance use**

A considerable proportion (40.0%) of patients were under the influence of alcohol or an illicit substance upon presentation to ED; 5.0% of patients were under the influence of two such substances, whilst 1.0% admitted to having taken three. The most common substance used was alcohol, with 44.6% (25/56) of males and 18.2% (8/44) of females under its influence upon attendance to ED. Alcohol or illicit drug misuse was not significantly associated with the likelihood to re-attend CLP in 3 months following this assessment.

Recent psychosocial stressors cited by patients preceding their presentation to CLP are presented in Table 3. Patients named up to 6 recent psychosocial stressors that contributed to their presentation to ED. The most commonly named triggers included conflict with their partner and the COVID-19 pandemic. Other common triggers included conflict with family, financial difficulties, issues with accommodation, and recent bereavement. The “other” category (8.0%) consisted of triggers including social isolation and legal problems.

The outcome following the assessment and intervention from CLP is given in Table 4. The majority of patients were discharged to their general practitioner (24.0%) or to the community mental health team (18.0%). More than one in ten (13.0%) patients were admitted to a psychiatric hospital, with 10.0% being informal and 3.0% under the Mental Health Act. A proportion (17.0%) was referred to the CRHT, and 14.0% were referred for psychological therapy. A considerable number of patients left ED before the assessment by CLP, and 1.0% were admitted to the general hospital due to physical health injuries. No particular outcome had a significant association with re-attendance to CLP or another mental health team within 3 months of this assessment.

**Re-attendance to the consultation-liaison psychiatry**

Around one in five (21.0%) patients, re-attended to CLP within 3 months; 9.0% of patients re-attended once, whereas the remainder re-attended multiple times within 3 months of initial presentation. The highest number of re-attendances was 9. Of 37 patients that had previously been assessed by CLP in the preceding 12 months, 37.8% (n = 14) were reassessed within 3 months (P < 0.01). This demonstrated that there

**Table 1: Reason for referral to the consultation-liaison psychiatry from emergency department**

Reasons	Male, n (%)	Female, n (%)	Total, n (%)
Thoughts of suicide/self-harm	27 (48.2)	23 (52.3)	50 (50.0)
Overdose	15 (26.8)	14 (31.8)	29 (29.0)
Self-harm	5 (8.9)	2 (4.5)	7 (7.0)
Suicide attempt	3 (5.4)	1 (2.3)	4 (4.0)
Psychotic symptoms	4 (7.1)	1 (2.3)	5 (5.0)
Other	2 (3.6)	3 (6.8)	5 (5.0)

**Table 2: Psychiatric diagnoses**

Diagnosis	Male, n (%)	Female, n (%)	Total, n (%)
Depressive disorders	19 (33.9)	17 (38.6)	36 (36.0)
Personality disorder	10 (17.9)	12 (27.3)	22 (22.0)
Anxiety disorders	7 (12.5)	6 (13.6)	13 (13.0)
Alcohol use disorders	8 (14.3)	3 (6.8)	11 (11.0)
Substance use disorders	6 (10.7)	0	6 (6.0)
Posttraumatic stress disorder	2 (3.6)	2 (4.5)	4 (4.0)
Learning disability	1 (1.8)	3 (6.8)	4 (4.0)
Bipolar disorder	2 (3.6)	1 (2.3)	3 (3.0)
Schizophrenia	3 (5.4)	0	3 (3.0)
Psychotic disorder	0	2 (4.5)	2 (2.0)
Eating disorder	0	2 (4.5)	2 (2.0)
Gender identity disorders	2 (3.6)	0	2 (2.0)
Autism	1 (1.8)	1 (2.3)	2 (2.0)
Attention deficit hyperactivity disorder	1 (1.8)	0	1 (1.0)

**Table 3: Recent psychosocial stressors reported by patients seen by consultation-liaison psychiatry**

	Male, n (%)	Female, n (%)	Total, n (%)
Conflict with partner	14 (25.0)	12 (27.3)	26 (26.0)
Conflict with family	10 (17.9)	2 (4.5)	12 (12.0)
COVID-19 pandemic	13 (23.2)	6 (13.6)	19 (19.0)
Financial difficulties	6 (10.7)	3 (6.8)	9 (9.0)
Issues with accommodation	7 (12.5)	2 (4.5)	9 (9.0)
Recent bereavement	5 (8.9)	4 (9.1)	9 (9.0)
Physical/sexual assault or domestic violence	1 (1.9)	5 (11.4)	6 (6.0)
Work-related stress	5 (8.9)	1 (2.3)	6 (6.0)
Physical health problems	2 (3.6)	2 (4.5)	4 (4.0)
Illness in a family member	1 (1.9)	2 (4.5)	3 (3.0)
Other	7 (12.5)	1 (2.3)	8 (8.0)

**Table 4: The outcome following the assessment by the consultation-liaison psychiatry**

	Males, n (%)	Female, n (%)	Total, n (%)
Psychiatric admission (informal)	8 (14.3)	2 (4.5)	10 (10.0)
Psychiatric admission (under MHA)	3 (5.4)	0	3 (3.0)
Admission to CRHT	12 (21.4)	5 (11.4)	17 (17.0)
Discharge to CMHT	6 (10.7)	12 (27.3)	18 (18.0)
Discharge to GP	10 (17.9)	14 (31.8)	24 (24.0)
Discharge to LD	1 (1.8)	2 (4.5)	3 (3.0)
Discharge to psychological services	10 (17.9)	4 (9.1)	14 (14.0)
Admission to general hospital	1 (1.8)	0	1 (1.0)
Patient left ED before assessment by CLP	5 (8.9)	5 (11.4)	10 (10.0)

CMHT: Community mental health team, CLP: Consultation-liaison psychiatry, CRHT: Crisis resolution and home treatment team, ED: Emergency department, GP: General practitioner, LD: Learning disability service, MHA: Mental health act

is a significant rate of representation of patients to CLP. Re-attendance to CLP or another mental health team was not significantly associated with gender, ethnicity, IMD decile by postcode, self-harm history, or being under the influence of alcohol/illicit drugs on presentation.

## DISCUSSION

This study provides an insight into the nature of patients managed by CLP who were referred from ED within a large district general hospital in West Midlands, UK. The results highlighted that the majority of patients were from deprived areas and had previously diagnosed psychiatric illnesses; the most common reason for referral to CLP was self-harm or suicidality which was present in the majority of cases, and a considerable proportion reported stressful life events which were commonly relational problems.

The majority of patients were from relatively deprived areas according to IMD data. It is well known that deprivation and mental health problems have a stronger association,<sup>[7]</sup>

especially depression.<sup>[8]</sup> It is also important to look at access to health services both primary care and mental health services in these areas.

Patients generally self-presented to the department, with the majority being outside of normal working hours. It would be relevant to check the reasons patients did not access the usual care or if they had any difficulty. Most of the usual care in the community is based on appointments and limited scope for urgent assessment and care; however, there are facilities for patients to contact CRHT and other crisis support organizations in the voluntary sector. However, attendance in the ED assures interaction with professional clinicians for specific help.

A large proportion of patients presented to the ED under the influence of alcohol or illicit substances (40.0%). This is increasingly a major concern worldwide.<sup>[9]</sup> This is further increased during holidays, social occasions, and sporting events leading to challenges to services at ED.<sup>[10]</sup> Many of these patients have substance use-related psychiatric disorders and need mental health support. Out-of-hour joint working with ED, CLP, and deaddiction team is essential for managing the multiple needs of these patients.

A large majority (90%) of patients were referred because of suicidality which included cognitions or behaviors. This is a concern looking at the patient profile, such as that the mean age of attendees was in mid-thirties; most were from a socioeconomically deprived background; most of them had mental illnesses, with a considerable proportion with substance use disorder; almost half (48%) of them had a history of self-harm; and many presented with relational problems. Considering the psychiatric illnesses, depression and personality disorders have been the most common, and the comorbidity was high. All these are known risk factors for suicide.<sup>[11-16]</sup>

Drug abuse in younger adults has been linked to excess mortality,<sup>[17,18]</sup> and a considerable proportion had alcohol and substance use disorders. Linking with the drug addiction team, providing appropriate support during crisis and follow-up is essential.

A proportion of patients mentioned COVID-19 as their stress factor, and the stress of the pandemic has been reported.<sup>[19]</sup> It has been reported that self-harm thoughts and behaviors have significantly increased during the pandemic in the UK and elsewhere.<sup>[20,21]</sup>

All these suggest that most of the work in the CLP has been linked to suicide prevention in a vulnerable group with complex presentation. It highlights that multidisciplinary resources including psychological and socioeconomic provisions should be available for the CLP team to arrange satisfactory support of the patient.

In this study, patients who had been previously assessed by CLP were significantly more likely to re-attend to the

service. This highlights that probably their care needs are not appropriately met in the community using the usual resources. Future studies may explore specifically the reasons behind repeat attendance in ED and CLP.

Considering the outcome following the CLP assessment, almost one-third were managed in acute care either inpatient or CRHT, and interestingly, almost a quarter were discharged to GP. Considering the psychiatric diagnoses, stressors, suicidality, and substance use, the proportions referred for psychological services appear meager, although some of the patients in mental health teams may have access to psychological interventions. However, the results suggest that there is still scope to improve access to psychotherapy for these patients. This is specifically important as there is increasing evidence base for the effectiveness of psychosocial interventions for managing suicidality.<sup>[22-24]</sup> It has been reported that providing aftercare and psychological therapies as part of the CLP service is perceived as essential to improving not only patient safety but also the experience and well-being of the staff.<sup>[25]</sup>

Most work of CLP revolves around suicide prevention. In this regard, training,<sup>[26]</sup> preparedness, awareness of attitudinal issues among clinicians,<sup>[27-29]</sup> and availability of resources in the form of appropriate services in the community are important areas to consider to improve the care provided to the patients.

There are a few limitations of this study. This is a single-center study at a district hospital, and results may not be generalizable to all kinds of general hospital settings. The sample size was limited to the referrals received within a month, a larger sample involving a longer duration may be more appropriate to avoid any periodic or seasonal variation in ED attendance and referral.

## CONCLUSIONS

This evaluation highlighted that ED in a general hospital setting sees many patients with mental health crises who need urgent psychiatric assessment and care. The need for CLP services in general hospital settings especially within the ED cannot be overemphasized. Integrated CLP services are uniquely placed to provide comprehensive, specialist assessment, treatment, and referral of psychiatric patients to the appropriate additional services.

In this study, most people referred to CLP had suicidality, which suggests the importance of readiness and access to appropriate resources for suicide prevention work, which can be at least initiated in the acute care setup. Comorbidities of psychiatric disorders, personality disorder, substance use disorder, and a range of stressors, make the management task more complex and challenging in an acute care setting. It requires robust multidisciplinary support systems in the community to resources appropriate support for the patients. This might decrease high re-attendance rates and suicidality.

Further research is required on the specific clinical and demographic characteristics of the patient group that frequently

attends CLP, to better identify risk factors for repeat attendance and devise strategies to reduce this. It is also important to study the effectiveness of the interventions provided by the CLP while managing the mental health crisis. In the future, it may be useful to collate data on service users' experience of attending CLP and their perception of the service, to further inform service development.

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## Conflicts of interest

There are no conflicts of interest.

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