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POSTER ABSTRACT

Alcoholmisuse/dependence carepathway in and outside the general hospital. Detecting, motivating and treating the whole person.

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Problematic alcoholuse is a common problem, frequently missed , as somatic medicine and mental health services are seperated/siloed. Patients admitted to a general hospital have an increased probability of a comorbid alcoholproblem (and other mental health problems like depression and anxiety) which is not adressed due to the separation of mind and body, which leads to greater costs for society , poor patient experience and discomfort with the somatic team.

Comorbidity within the general hospital is largest for the patient with gastrointestinal (GI) problems, which is why we opted to roll out our approach here, gradually expanding to other patient groups in a later stage.

To tackle this problem, the mental health department of the hospital contacted the GI-team (i.e. nurses, doctors, social services), the psychological services, management, general practitioners and service users (AA).

After consultation of the existing literature, we chose a collaborative care approach mixed with population based screening and a proactive approach. In the past, a care pathway for alcohol was developed with first line actors (general practitioners, social services, psychologists, AA and mental health services), which was used to determine the level of care in the hospital and after discharge. The team comprises a fulltime psychiatric nurse and 0.3 full time employee (FTE) psychiatrist (trainee) embedded in the somatic GI team.

Patients are screened for alcohol and psychiatric issues within 48 hours. If necessary, the appropriate detoxification scheme is started and followed up by the somatic team, aided by the mental health team. The patient is assessed and encouraged to stop drinking, depending on the stage they are in. Motivational interviewing techniques are used, along with psycho-education and other (pharmacological) interventions. A care plan is developed together with the patient and is then communicated with the primary care provider.

After discharge, psychiatric follow-up is scheduled with the primary care provider, mobile crisis team or psychiatric nurse when pt comes for follow-up visits to the ambulatory GI service if needed.

Teammembers are trained in mental health issues so they become able to recognice and handle mental health issues, making them much more comfortable with comorbid psychiatric problems and optimizing workflows.

We have since expanded to the AE department and planned surgery.

Since the program started there were fewer cases of delirium tremens. Due to a merger with an other hospital while the pathway started we have no exact data. Over a period of 1 year 235 patients were included in the project and 143 were followed-up after testing positive on intake for planned surgery.

We want to further expand to the entire hospital and develop a digital care support plan which follows the patient after discharge, with all the information about the patient for future care-givers, with their care plan , controlled by the patient.

Due to COVID, involvement of partners outside the hospital was delayed. This is now top of the agenda.

As a proof of concept this integrated pathway was well received and initiated a new pathway , integrating mental health into perinatal care.