PROACTIVE PSYCHIATRIC CONSULTATIONS BENEFIT MICU PATIENTS

Preexisting mental illness and substance abuse disorders are common in patients being treated in intensive care units (ICUs), as is delirium. There is increasing appreciation for the impact of these conditions on overall health outcomes, length of hospital stay and mortality.

Proactive psychiatric consultation has demonstrated improved outcomes in the general hospital setting. Accordingly, Brigham and Women's Hospital has launched and studied an innovative proactive psychiatric consultation model in the intensive care setting. In this model, a psychiatrist is embedded with the medical ICU (MICU) team and participates in daily walk rounds, rather than the standard approach of having psychiatric consultations conducted only when called by the primary care team.

"These are patients who are critically ill and at their most vulnerable," said Nomi Levy-Carrick, MD, MPHIL, an associate psychiatrist in the Brigham's Department of Psychiatry. "The idea is that if you can identify any psychiatric conditions or delirium early in the course of their treatment, you are more likely to be able to bring an informed approach to managing those issues. In that way, you can help to support patients as they navigate this critical period."

A 2018 study published in *Psychosomatics* by Dr. Levy-Carrick and her colleagues at the Brigham found that including proactive psychiatric consultation for patients in the ICU led to shorter hospital stays, particularly for those who needed to be on ventilators as part of their

care. In the study, two MICUs at the Brigham were randomized to either proactive or conventional psychiatric consultation models.

Due to the study's positive results, this program remains active at the Brigham. It is managed in cooperation with the critical care medicine and nursing staffs in the ICU.

Beyond what was shown in the study, there are many other ways that patients can benefit from proactive psychiatric consultation. One situation is in the case of delirium, which is common in the ICU setting.

"We're able to help alleviate their agitation, including through the use of medication, to minimize distress," Dr. Levy-Carrick said. "Many people come to the ICU already taking a variety of psychotropic medications. We can help manage these medications in the context of the broader medical complexity. We make sure that these drugs are either continued or discontinued in ways that can improve the patient's overall outcome."

One built-in component of this model is that it takes into account the possible role of trauma in psychiatric health and recovery. "We've recognized that someone's prior exposure to trauma impacts their ability to tolerate hospitalizations," Dr. Levy-Carrick said. "At the same time, medical procedures themselves can be potentially traumatic. It's important that we find ways to mitigate that to prevent the progression of any kind of pathology related to their experience of hospitals."

Another important part of this program is that members of the psychiatry team continue to follow patients after they are moved to a regular medical floor, and even beyond.

"We follow these patients longitudinally from the point of critical illness through medical stabilization. We also have the opportunity to see them again after they've gone home through our Critical Illness Recovery Program," Dr. Levy-Carrick said. "It provides us with an increased opportunity to be able to help these patients, many of whom may have longer-term psychiatric and other medical needs."