Liaison old age psychiatry
Reasons of need for liaison in POA

- The prevalence of mental health problems in general hospital settings is higher than in community settings
- These mental health problems predict poor outcome
- The management of mental health problems in older people in this setting is often suboptimal
- Referrals from general hospitals comprise 25% of referrals received by old age psychiatry services
- Current older people’s mental health service model does not adequately meet the challenges of optimizing management and improving outcome
How common are mental health problems in older people in the general hospital?

- Depends on:
  - The hospital setting (orthopaedic wards have higher levels of delirium, population on general medical/surgical wards vary from day to day unlike areas that deal with single conditions)
  - Case-finding (difficulties to distinguish temporary symptoms of distress and adjustment from mental illness, comorbidities of dementia, delirium and depression)
  - Recruitment (difficulties of consent in some patients)
  - Sampling methods (condition versus general medical ward)
  - If the prevalence figures are to be believed, then 60% of older people in a typical general hospital have a mental health problem, either associated with a physical problem or as the sole reason for presentation. 6 times as many people with mental health problems than outpatient services.
The impact on outcomes

• Who for, carers, patients, managers?

• Outcome studies depend on: Timing of recruitment, confounding variables, sample size and analysis

• Adverse effects for depression, delirium, dementia, and unspecified cognitive impairment on mortality, length of hospital stay institutionalization, physical dependence, and general health status.

• This means that as well as being common, mental health problems in older people in general hospital are independent predictors of poor outcomes.
Why are outcomes so bad?

• Mental Health Problems are poorly detected.
• Physical care needs are prioritized over mental health needs.
• General hospital staff lack the knowledge and skills to manage mental health problems.
• Mental health services are seen as slow to respond.
• There are low referral rates from particular specialties.
Consultation or liaison

• Improving outcome: Part of the problem of mental health problems in general hospitals is likely to lie in the configuration and activity of old age psychiatry service rather than antidepressants or antipsychotics alone.

• Consultation: a model that relies on general hospital staff to detect mental health problems, refer on a case by case basis and follow the advice offered.

• Liaison: proactive service, working collaboratively with general hospital colleagues to train and educate them, so that they are confident in the basics of the management of the common mental health problems they come across, and so they know who, when and where to refer.
Models of Liaison

• The standard sector model: General hospital input is on a consultation basis and referrals are usually seen by medical staff, although other members of the community mental health team may visit people already on their caseload. (Parking, travelling, several medical staff give advice, limited opportunities for teaching and training)

• The enhanced sector model: Community mental health teams receive additional staffing to provide input to the general hospital.

• Outreach from mental health wards: Staff will review a patient who has been transferred from the psychiatric ward to the general hospital ward.

• The liaison mental health nurse: A specialist mental health nurse is based in the general hospital and provides a responsive liaison mental health service to general hospital wards. (Referrals are seen quickly, monitor that mental state, check that advice is followed, triage role).

• Liaison psychiatrist: Rapid response to referrals and an emphasis on teaching and training.

• The shared care ward: a ward in the general hospital site has psychiatric and general nurses, psychiatrists, physicians and therapy staff who work together delivering care to patients with both physical and mental health care needs that would otherwise fall between the services.
The hospital mental health team

• Model of true liaison, a multidisciplinary team with a similar professional mix to a community mental health team work with the general hospital population. Teaching and training of general hospital staff are core business for a hospital mental health team, resulting in ward staff taking ownership and responsibility for mental health problems on that ward and providing the basics of management, with specialist referral to the mental health team as required. There is a single point of access and referrals are responded to promptly. Possibility of introducing staff support in areas where stress is high.

• Older person’s liaison mental health outpatient clinic: brief follow up after hospital discharge.
The difference between consultation and liaison for the general hospital setting

<table>
<thead>
<tr>
<th>Consultation</th>
<th>Liaison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive</td>
<td>Proactive</td>
</tr>
<tr>
<td>Low cost</td>
<td>Higher cost</td>
</tr>
<tr>
<td>Professionally isolated</td>
<td>Collaborations with other professions</td>
</tr>
<tr>
<td>General hospital referrals a low priority</td>
<td>General hospital referrals a high priority</td>
</tr>
<tr>
<td>Slow response to referrals</td>
<td>Rapid response to referrals</td>
</tr>
<tr>
<td>Low review rates</td>
<td>Frequent review rates</td>
</tr>
<tr>
<td>Some poor quality referrals</td>
<td>Fewer poor referrals</td>
</tr>
<tr>
<td>Poor adherence to recommendations</td>
<td>Improved adherence to recommendations</td>
</tr>
<tr>
<td>No influence on practice of general hospital staff</td>
<td>Influence practice of general hospital staff</td>
</tr>
<tr>
<td>Mental health managerially separate from general services</td>
<td>Mental health managerially integrated with general services</td>
</tr>
</tbody>
</table>
# Reasons influencing choice of model for input into the general hospital

<table>
<thead>
<tr>
<th>Choosing the traditional sector model</th>
<th>Choosing a liaison model</th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s the service I inherited. I believe this traditional sector model is still most appropriate for community referrals, I cannot provide a full liaison service. Keeps the patients within our community mental health teams so not having to liaise with yet another set of professionals who are not well known to us. Continuity of care Why change? Liaison... although I see it as very important is still an unpaid hobby and development area A sense that the patients in hospital are being looked after, the patient living alone and unwell seems more unworthy If a patient is in a hospital bed they are already in a place of safety.</td>
<td>The educational part of liaison is missing Complexity of patient problems needs a multidisciplinary team approach and that needs to be based in the District General Hospital not visiting occasionally. Dedicated team can influence the atmosphere in medical wards and over time change practice and attitudes Patients get a bad deal We suffer from fairly concrete opposition from the general hospital trust and some of the geriatric physicians to setting up joint service- the general attitude is that anyone with a psychiatric label should be put in a corner and ignored – almost universal on surgical and orthopaedic wards</td>
</tr>
</tbody>
</table>
What evidence is there that introducing a liaison service can help?

The UK picture

- 73% use the traditional sector model
- 14% used a liaison nurse


- The majority of studies indicate that old age psychiatry services have positive acute treatment outcomes, particularly with depression. There is insufficient evidence to determine which processes of care are associated with better outcomes.
What an old age liaison psychiatry service should do

- Clinical activity
- Educational and promotional activity
- Operational activity
Clinical activity

• the prompt assessment, diagnosis, and management of referred older people, including all those who have self harmed
• risk assessment and risk moderation
• incorporation of advice and treatments into care plans
• regular review to monitor response to treatment and adherence to advice
• engaging with carers and relatives
• arranging suitable psychiatric aftercare
Educational and promotional activity

• Provide educational programmes to improve detection and management of common psychiatric disorders in the general hospital setting
• Develop treatment protocols and care pathways in conjunction with general hospital colleagues to improve ownership and uptake
• Develop training posts within the service for a range of disciplines
• Raise awareness of the importance of mental health and challenge and reduce stigma
• Advocacy for vulnerable groups
Operational activity

• Develop operational policies and clinical governance structures
• Establish clear lines of management for all professionals
• Use clear signposting for referrers, including a single point of access
• Work collaboratively with general hospital colleagues to develop shared objectives and outcome.
The liaison curriculum and teaching general hospital staff

• The general approach: Holistic, person centred approach that promotes dignity and respect, talking to people with mental health problem is a particular skill that with need to be taught.

• Specific conditions: Dementia, delirium, depression, anxiety, alcohol misuse, schizophrenia (staff should be aware of the basics of management)

• Problem behaviour: De-escalation techniques, motivational techniques

• Psychotropic medication

• Legal issues: issues of capacity and consent, mental health legislation
Steps towards establishing a liaison service

- Assess the need (how many people with mental health services in the general hospital and link that to poor outcome, what national policy)
- Scoping the project (issues of funding, capacity for change, reorganization of services)
- Mapping the process (What will the service look like? National standards for staffing of services, what can be built on, collaborate rather than reinventing)
- Service design: Design clinical pathways and systems
- Implementation: communication strategy and managerial involvement
- Evaluation: Number of referrals, satisfaction questionnaire, length of hospital stay, delayed transfer of care, referrals to community teams, teaching activities recorded, successful evaluation service.
- Sustainability and spread
A bit on memory clinics

• Early assessment and diagnosis of dementia, and the subsequent provision of appropriate treatment, care, information, and support to patients.

• Team: doctor, nurse and clerical support and possibly clinical psychologist, speech therapist and OT.
Assessment and diagnosis in a memory clinic

- History: an informant other than the patient is important, including functional abilities, and personal and social circumstances
- Mental State: important to look for depression and anxiety, often accompany the onset of dementia, assess for psychotic symptoms, behavioural symptoms
- Possible scales: Geriatric Depression Scale, Neuropsychiatric Inventory, MOCA, ACE-III, FAB
- Physical examination and laboratory investigations (B12 and Folate, Thyroid function, VDRL, HIV)
- Structural neuroimaging: CT or MRI
- Assessment of capacities and needs of support network
- Need for reassessment in 6-12 months
Management

• Disclosure of the diagnosis to the patient and the family.
• Patient and family need to be able to return and ask questions
• Provide contact with the local Alzheimer Society
• Driving assessment
• Healthy Heart advice (exercise and MIND diet)
• EPOA and updated Wills
• Medication: Donepezil and Rivastigmine (Cholinesterase inhibitors), Memantine (glutamatergic system by blocking NMDA receptors).