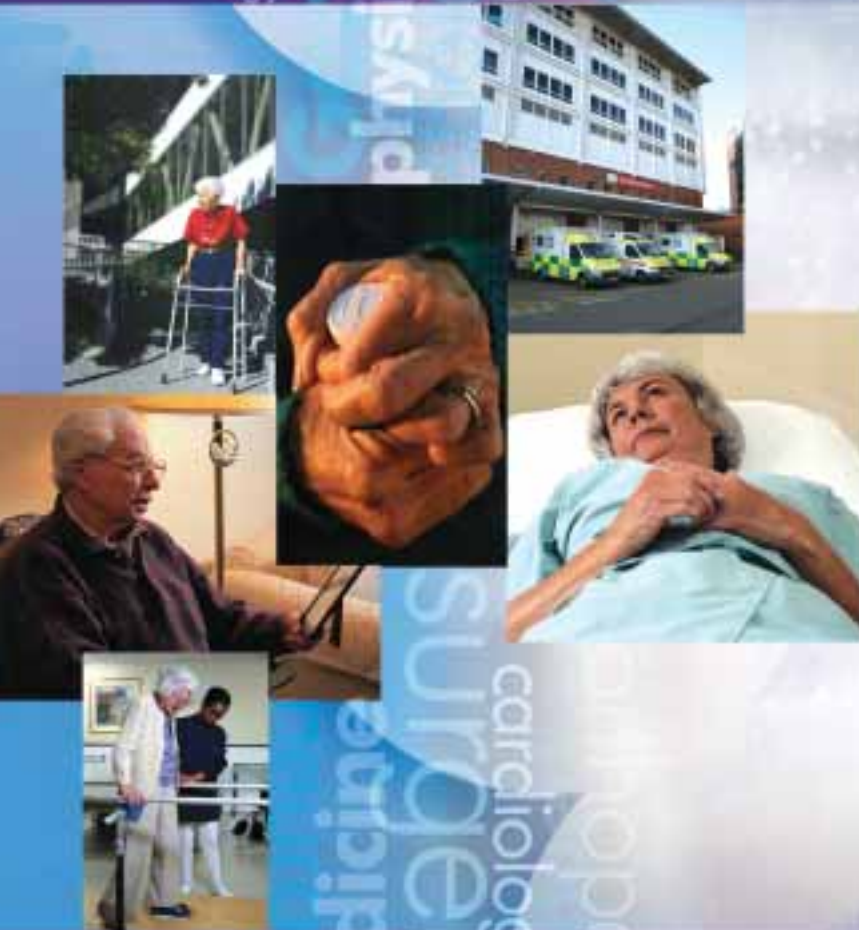


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2005



whocareswins

Improving the outcome for older people admitted to the general hospital:
Guidelines for the development of Liaison Mental Health Services for older people.

Report of a Working Group for the Faculty of Old Age Psychiatry, Royal College of Psychiatrists.

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Who Cares Wins

**Improving the outcome for older people admitted to the general hospital:
Guidelines for the development of liaison mental health services for older people.**

This report draws attention to the neglected clinical problem of mental disorder affecting older people admitted to general hospitals and calls for the development of specialist liaison mental health services for older people. It takes account of the best level of evidence where it applies to older people.

Older people occupy two-thirds of NHS beds and 60% of older people admitted to general hospital will have or develop a mental disorder. This mental disorder will predict a poor outcome for the older person and the service.

The present delivery of mental health services for older people in general hospitals is by the process of consultation. The superior method of multidisciplinary liaison is established for working age adults as a developed speciality. This approach should be established for older people and a failure to do so represents an ageist policy.

Better management of these disorders improves outcome and this has major implications for the care of older people, the efficiency of acute hospitals and the utilisation of health and social care resources. We believe that any strategy to improve the performance of acute hospitals is seriously deficient if it ignores the mental health needs of older people.

We urge acute hospital trusts, older peoples' mental health services and commissioners of health and social care to regard carefully the care of mentally disordered older people in general hospitals and work together to improve their outcome.

Who Cares Wins

Working Group for Liaison Mental Health Services for Older People,
Faculty of Old Age Psychiatry, Royal College of Psychiatrists.



Executive Summary

Introduction

1. This report is intended to draw attention to the neglected clinical problem of mental disorder affecting older people admitted to general hospitals, and calls for the development of specialist liaison mental health services for older people. It is based on the best available evidence.
2. Liaison psychiatry for working age adults is a developed speciality with at least 93 funded consultant liaison psychiatrists in the British Isles. These services have an established multidisciplinary model of service delivery with recommended staffing levels and training programmes. None of these standards exist for older people. Failure to deliver this quality of service for older people represents an ageist policy.
3. This inequality of service is both short sighted, as the population ages, and discriminates against older people.
4. The care of older people must be person centred respecting their unique individual characteristics, with attention to both their physical and psychological needs.

Section I – The Case of Need

5. Two-thirds of NHS beds are occupied by people aged 65 years or older. Up to 60% of general hospital admissions in this age group will have or will develop a mental disorder during their admission.
6. A typical district general hospital with 500 beds will admit 5000 older people each year and 3000 will suffer a mental disorder. On average, older people will occupy 330 of these beds at any time and 220 of these will have a mental disorder. This means that the acute hospital will have at least four times as many older people with mental disorder on its wards as the older people's mental health service has on theirs. Three disorders; depression, dementia and delirium, will account for 80% of this mental disorder co-morbidity, such that, 96 patients will have depression, 102 dementia and 66 delirium.
7. Mental disorder in this population is an independent predictor of poor outcome. These poor outcomes include increased mortality, greater length of stay, loss of independent function and higher rates of institutionalisation.
8. The cost of these disorders to sufferers and carers is substantial and the cost to services considerable. For example, in 2001, in the United States estimates indicated that delirium complicated hospital admissions for 2.3 million older people each year, involving more than 17.5 million hospital days and accounting for more than \$4 billion dollars of Medicare expenditure.

Section II – Can interventions improve outcome?

9. Mental disorder affecting older people admitted to general hospitals is poorly detected and managed. Controlled clinical studies have demonstrated the potential to prevent and treat these mental disorders and improve outcome.
10. For example, preventative interventions can reduce the incidence of delirium by 30-40% in at risk patients. This disorder carries a particularly poor prognosis. Specialist multidisciplinary care can reduce length of stay following hip fracture for those with mild or moderate dementia and increase the numbers returning to independent living. Depression responds to antidepressants and psychological treatment.
11. Liaison mental health services have the potential to reduce length of stay.
12. Improved outcomes have important implications for older people, carers and the utilisation of health and social care resources.

Section III – Service Models

13. The report describes several models that can be adapted to provide liaison mental health services for older people. They have advantages and disadvantages that need to be considered when planning a local service.
14. No single model will meet all needs and a range of local factors will influence the choice of model for a local service.
15. For a district general hospital the most appropriate model is the multidisciplinary liaison mental health team and all services should plan this development. It is best placed to meet the needs of older people and to deliver the core functions of a liaison mental health service particularly in association with a shared care ward.
16. Whichever model is adopted it should fulfil the minimum requirements of a liaison service. These include raising awareness of the importance of mental health, facilitating the acquisition of the basic skills of mental health assessment and treatment by general hospital staff through education and training, assisting with the management of serious and complicated cases of mental disorder and championing the cause of older people with mental disorder in the general hospital.
17. The usual delivery of mental health assessment and advice for older people admitted to a general hospital is the process of consultation, that is, case by case referral to the mental health department. Consultation has several limitations including slow response, no capacity to develop better standards of mental health practice in general hospitals and being essentially reactive.
18. In contrast, liaison mental health for working age adults is a developed speciality with at least 93 funded consultants in liaison psychiatry within the British Isles. These services have an established multidisciplinary model of service delivery with recommended staffing levels and training programmes.
19. The liaison approach is proactive, working collaboratively with general hospital departments and providing a major focus on education and training to improve the mental health skills of general hospital staff.
20. Liaison mental health services have been shown to offer several benefits in comparison with consultation. Services offering only consultation should develop a liaison style of working.
21. Liaison services should be based in the general hospital and become integrated with general hospital services in order that attention to the mental health aspects of clinical management become part of routine general hospital care.

Section IV – Characteristics of a Liaison Mental Health Team

22. Liaison mental health is a specialised area of work and staff need proper induction, training and clinical supervision. They must have dedicated time to fulfil their duties, adequate secretarial and administration support and be managed as a specialist service.
23. Liaison services need adequate office space based in the general hospital and the necessary resources to support their activity.

- 
- 24. Liaison services should have a clinical lead involved with service planning with dedicated time to perform these duties
 - 25. Liaison services should have an identified consultant psychiatrist with dedicated time in their job plan to fulfil these duties
 - 26. Consultation- liaison mental health should not be devolved to junior staff or practitioners working in isolation.
 - 27. Services offering consultation should plan to move to a liaison model of working.

Section V - Education and Training in General Hospitals

- 28. Education is a core business for liaison mental health services, and will need to be sufficiently resourced to allow time for this essential function.
- 29. Education can be provided by several methods and delivered in many forums. The subject matter and staff group will influence the approach.

Section VI - Strategic Planning

- 30. There are a number of national policies that would indicate that liaison mental health services for older people have an important part to play in the health care agenda.
- 31. All health and social care services must be aware of the standards and targets set for health care commissioners and providers of acute hospital care and understand how liaison mental health can contribute positively to achieving these goals.
- 32. Planning a liaison service will require a business case which will need to consider national and local issues, an option appraisal of service models with project management and evaluation.
- 33. Service development will need the support of all stakeholders.

Recommendations:

All:

1. Must work to eliminate any age discrimination that exists in the provision of mental health services to older people admitted to general hospitals.
2. Must ensure that older people admitted to general hospitals are not disadvantaged but have timely access to quality specialist mental health assessment and treatment.
3. Must fully understand how common are mental disorders among older people admitted to general hospitals, the significance of this for clinical care, and the adverse impact this has on outcome.
4. Must be fully aware of the evidence that mental disorder affecting older people in general hospitals can be prevented and treated and that this improves outcome.
5. Must work collaboratively to identify patient, carer and service needs that form the basis of coherent service development.
6. Must identify an appropriate mechanism whereby the acute hospital services, older people's mental health services and commissioners are able to review service performance and development.
7. Must develop a common agenda which recognises that the mental health care of older people in general hospitals is a shared responsibility.
8. Must recognise the pressing need for a research and development agenda that will support better care for older people with mental disorder in general hospitals.

Commissioners:

9. Need to ensure that all acute hospital trusts have clear plans to meet the mental health needs of older people. This will require the provision of specialist liaison mental health services, attention to skill mix and improved training of general hospital staff.
10. Need to ensure that the necessary mental health services for older people in general hospitals are clearly identified and properly commissioned with dedicated funding.
11. Need to consider opportunities to support liaison mental health services with access to intermediate care and domiciliary support services ensuring that liaison mental health services are considered as part of a whole systems approach to reducing unnecessary admissions, tackling delayed transfers of care and facilitating appropriate and timely discharge.

Acute Hospital Trusts:

12. Need to facilitate the incorporation of liaison mental health services for older people into the general hospital.
13. Need to work with mental health services to improve understanding and the routine assessment of mental health needs for older people admitted to general hospitals.
14. Must collaborate with mental health services to provide suitable accommodation and facilities that allow liaison services for older people to operate from the general hospital base.

- 
15. Need to collaborate with mental health services to provide patient information systems to support activity monitoring and audit.
 16. Should consider including an older peoples mental health liaison lead in the appropriate management forum, in order to encourage a coordinated response to identified needs, targets and priorities.

Mental Health Services:

17. Need to ensure that the development of liaison mental health services for older people in acute hospitals is clearly identified as a priority in business planning.
18. Should identify a consultant psychiatrist with responsibility for liaison mental health services for older people with dedicated time to fulfil these duties written into their job plan.
19. Should identify a lead clinician for older peoples mental health liaison services with committed time necessary to fulfil this responsibility included in the job plan.
20. Should ensure that the lead clinician takes a key active role in developing a strategy for the provision of liaison mental health services for older people.
21. Need to move from consultation to liaison adopting one of the models described that best meet the needs of the local population and services.
22. Must retain the principle that good mental health for older people is based in multidisciplinary team working, which should be the aim for liaison mental health services for older people.
23. Must recognise that general hospital mental health is a specialised field and this should be reflected in management structures.
24. Must ensure that all mental health professionals with liaison responsibilities receive proper induction, clinical supervision and opportunities for personal development with access to relevant training.
25. Must ensure that time for education and training of general hospital staff is built into the description of service and job plans.
26. Must collaborate with acute hospital trusts to provide patient information systems that support activity monitoring and audit.
27. Need to work with acute hospitals to maximise the contribution that mental health interventions make to achieving access and capacity targets.

1: The Case of Need

- 1.1 Many countries are experiencing ageing of their populations. In the United Kingdom, the number of older people, those aged 65 years or older, will rise by 59%, from 2000 to 2031, with an even greater increase of 79% in the “older old”, those aged 80 years and over (1).
- 1.2 Since many illnesses become more common with increasing age this demographic change has considerable implications for health care. An ageing population brings with it a disproportionate increase in common conditions such as degenerative disorders, stroke, cancer and dementia.
- 1.3 Older people currently consume approximately 40% of health care resources in England and Wales (2) and the position is similar in other parts of the British Isles. Older people occupy two-thirds of general hospital beds (2) so that, in a typical general hospital of 500 beds, at any time some 330 beds will be occupied by older people, and approximately 5000 older people will be admitted to this hospital each year.
 - **Two-thirds of NHS beds are occupied by older people.**
- 1.4 Older people frequently present complex problems for diagnosis and management. They have greater sensitivity to the adverse effects of drug treatments which are often limited by interactions and contraindications. Rehabilitation may be more difficult due to multiple disabilities and increased frailty. Health care services have responded to these demands by developing specialised departments, wards and multidisciplinary teams for older people in most general hospitals.
- 1.5 These wards and teams are essential for providing models of good practice and setting standards of care throughout the general hospital. Where general hospitals lack these specialist services older people will be admitted to wards where their complex care needs may not be adequately met.
- 1.6 The frequency and impact of mental disorder for the care of older people is such that providing specialised physical care without attention to mental health will similarly fail to meet the needs of patients. It is worrying that, in some parts of our health service, reorganisation has created an increasing separation of physical and mental health care.
- 1.7 What kind of mental health problems do older people have? Table 1.1 contains the most common conditions found in the community and their characteristic features. This is not exhaustive, but gives some idea of the disability and handicap that mental disorder can bring to this population and how these might complicate physical health care. The added stigma of mental disorder may mean these are not disclosed by the older person or are dismissed by attendant clinicians.

Table 1.1.

The common mental health problems that older people have and their community prevalence (3-7)

Condition	Features	Community Prevalence
Depression	Low mood, reduced energy and motivation, slowed or agitated movement, disturbed sleep and appetite, weight loss, lack of interest and enjoyment, reduced concentration and attention, low self esteem, ideas of guilt and worthlessness, ideas or acts of self harm or suicide	12%

Dementia	Global impairment of intellectual functioning with insidious onset and progressive course over months or years, bringing disturbed memory, disorientation in time, place and person, language deficits, reduced judgement, altered emotional control, social behaviour and motivation, interference with personal activities of daily living such as washing, dressing, eating, personal hygiene. The exact manifestation depends on the social and cultural setting in which the person lives. Commonly due to Alzheimer's disease or cerebrovascular disease	5%
Delirium	An acute disturbance of intellectual functioning, with altered consciousness and attention, perceptual distortions and hallucinations, altered thinking, memory, motor behaviour, emotion and sleep. Usually transient and fluctuating, with most cases recovering within four weeks, and caused by a concurrent physical illness. Having dementia increases the risk of developing delirium 5 fold.	1-2%
Anxiety disorders	Episodes of apprehension, motor tension, autonomic overactivity (hyperventilation and rapid heart rate), sometimes severe and associated with a feeling of impending doom. May be associated with particular situations.	3%
Alcohol misuse	Excessive alcohol intake can lead to dependence, with primacy of drinking over other activities, craving for alcohol, increased tolerance and withdrawal symptoms (tremor, nausea, sweating, insomnia and anxiety symptoms) on cessation. Persistent withdrawal may lead to delirium tremens, with fits and irreversible brain damage if not adequately treated.	2%
Drug misuse	The commonest group of drugs misused by older people are prescribed benzodiazepines, originally prescribed for the control of anxiety or insomnia. Cessation leads to rebound anxiety and insomnia, and some people experience unpleasant tactile hallucinations, delirium or epileptic fits on withdrawal.	11%
Schizophrenia	A debilitating condition with changes in thinking and perception, blunted or inappropriate affect and a reduced level of social functioning. Hallucinations and abnormal beliefs (often persecutory) are common. Onset is usually in the third decade of life; onset in old age is unusual but many people with schizophrenia exhibit some manifestations throughout their lives.	0.5%

How common is mental disorder in general hospitals?

- 1.8 To confidently examine the nature of mental disorder affecting older people in general hospitals a systematic review of the literature was performed. This identified 576 studies of potential interest, of which 97 met predefined quality criteria and were examined in detail (8-104).
- 1.9 The findings of this systematic review are summarised in Table 1.2. Some studies report the prevalence of cognitive impairment without differentiating between dementia and delirium. These studies have been carried out in different populations, different hospital specialities and using different methods of assessment. This, probably, contributes to the wide range of prevalence for some conditions.

Table 1.2.

The prevalence of mental disorder in older people in general hospitals.

Diagnosis	No. of studies	Total no. of participants	Mean sample size	Prevalence range	Mean prevalence
Depression	47	14632	311	5-58%	29%
Delirium	31	9601	309	7-61%	20%
Dementia	17	3845	226	5-45%	31%
Cognitive impairment	33	13882	421	7-88%	22%
Anxiety	3	1346	449	1-34%	8%
Schizophrenia	4	1878	376	1-8%	0.4%
Alcoholism	4	1314	329	1-5%	3%

- 1.10 To aid interpretation, Table 1.2 contains the mean prevalence for each condition obtained by adding the total number of cases detected by all studies and dividing this by the total sample in all studies. This mean prevalence is likely to represent the true prevalence of mental disorder of older people in general hospital wards. It should be noted that depression, dementia and delirium are much more common in general hospitals than in the community (see Table 1.1).

- **depression, dementia and delirium are much more common in general hospitals than in the community.**

- 1.11 To put these findings into context we return to our typical general hospital. We already know that of its 500 beds, 330 are occupied by older people at any one time. Two hundred and twenty of these older people will have a mental disorder. 96 will have depression, 102 dementia, 66 delirium, 10 alcohol misuse and two schizophrenia (Box I). Such a general hospital will have at least four times as many older people with mental disorder on its wards than the local mental health services have on theirs.

Box 1

A typical district general hospital with 500 beds:

- Will admit 5000 older people each year.
- 3000 of these will have or develop a mental disorder

In an average day:

- 330 beds will be occupied by older people.
- 220 will have a mental disorder
- 96 will have depression
- 66 will have delirium
- 102 will have dementia
- 23 will have other major mental health problems.

Does mental disorder affect outcome?

1.12 But, does mental disorder affect the outcome of a hospital admission? If it does then the high prevalence should make this problem a great concern to health services, older people and carers. To address this question a second systematic review has been performed to consider the prognosis of older people admitted to general hospitals who also have or develop a mental disorder. This identified 27 studies that met predefined quality criteria and these were examined in detail.

1.13 The findings of this systematic review are summarised in Table 1.3, with the reported effects on outcome. There are concerns over the quality of some studies, in particular, imprecise findings due to small sample sizes. However, the larger, more robust studies all report adverse effects on a range of important outcome measures, including mortality, length of hospital stay and institutionalisation. Some examples of this effect are shown graphically in Figures 1.1 and 1.2. Several of these outcomes are relevant to performance indicators used to measure the quality of care in general hospitals.

Figure 1.1

The effect of mental disorder on length of hospital stay after hip fracture (106)

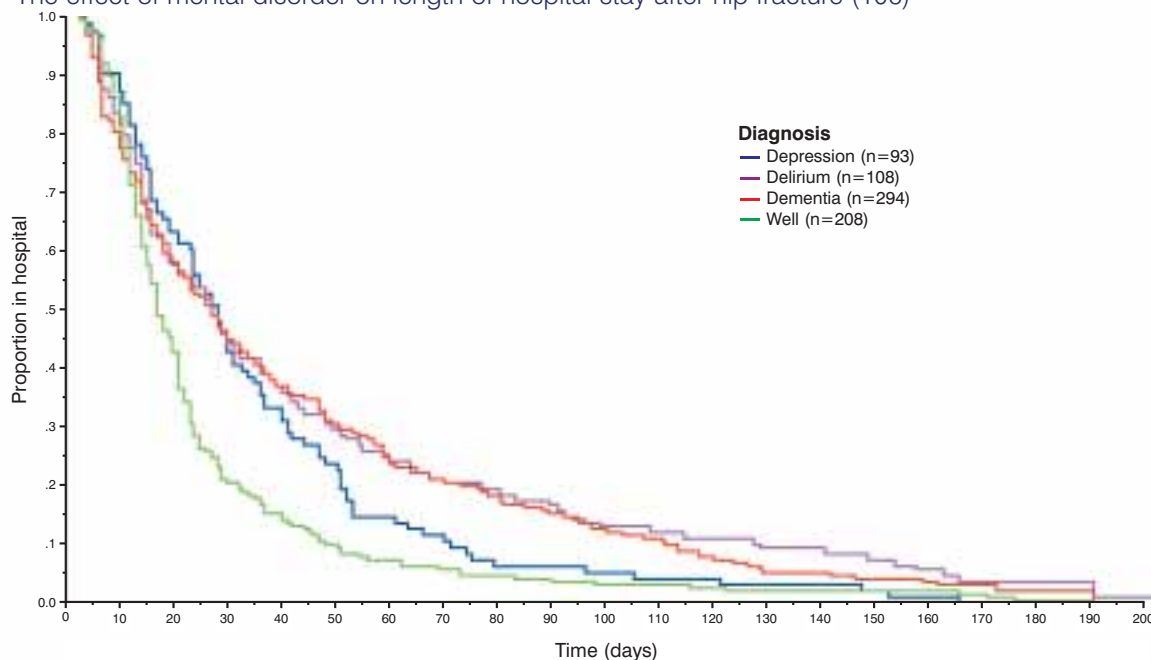
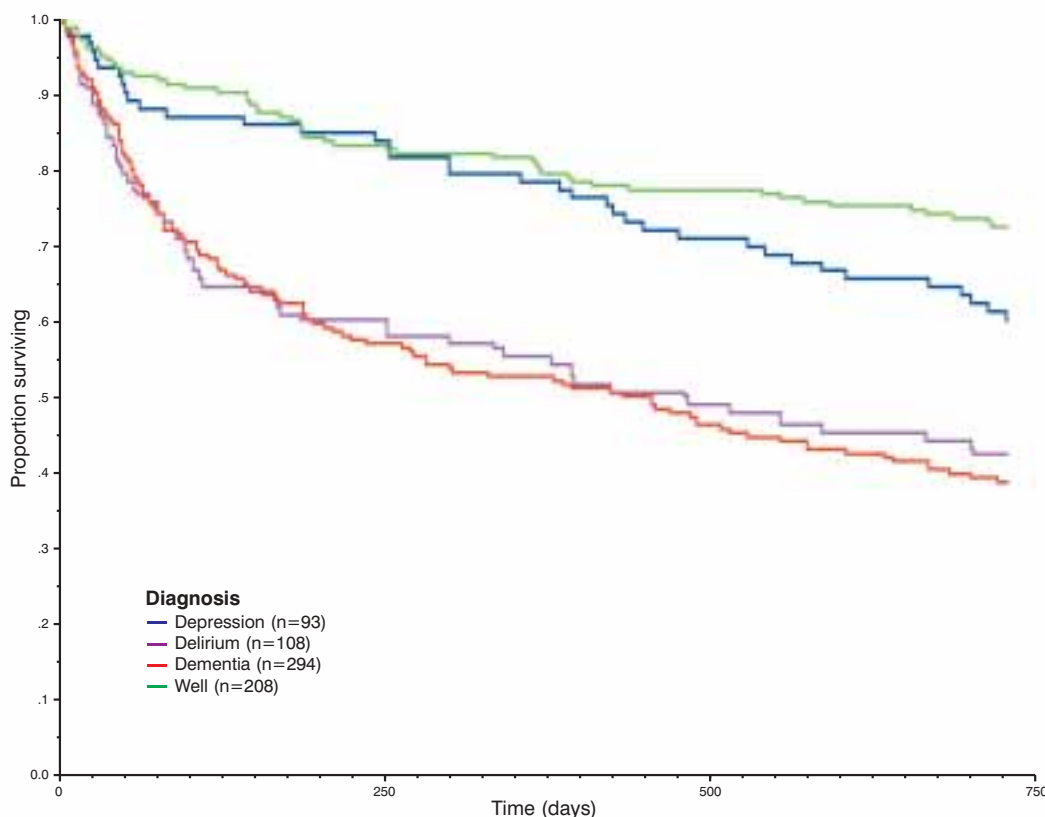


Figure 1.2

The effect of mental disorder on survival after hip fracture (107)



1.14 Why are outcomes so poor in this group? There are several possible explanations. One is that the presence of a mental disorder, like delirium, simply represent serious underlying physical pathology which is the real cause of the poor outcome. When studies control for this factor and other variables that might determine outcome, such as increased age and severity of physical illness, the majority find that mental disorder is an independent predictor of poor outcome. That is, the presence of the mental disorder itself has an adverse effect.

- **The presence of a mental disorder is an independent predictor of poor outcome.**

1.15 The cost of these disorders to older people and their carers is substantial and the cost to services considerable. For example, in 2001, in the United States, delirium was estimated to complicate the hospital admission of more than 2.3 million older people each year involving over 17.5 million hospital days and accounting for more than \$4 billion of Medicare expenditure. (110).

Conclusion

1.16 Mental disorder is frequently present in older people admitted to a general hospital and will have serious consequences for the prognosis of that older person. Furthermore, mental disorder will have an adverse effect on the performance of the general hospital responsible for that older persons care.

Table 1.3.

The effect on outcomes of mental disorder in older people in general hospitals.

Reference	Setting	Sample size	Findings
Depression			
105	USA General medicine or surgery	100	30 month mortality increased RR 2.3 (1.001-4.1)
44	Switzerland General medicine	190	Increased inappropriate bed days AOR 2.9 (1.0–8.1)
81	Italy All hospital departments	3168	Increased adverse drug reactions AOR 1.5 (1.1-2.2)
19	Switzerland General medicine	401	Significant increase in readmissions over 6 months HR 1.50 (1.03-2.17) Institutionalisation at 6 months not significant HR 1.73 (0.82-3.64) Significant increase in mortality at 6 months by 1.5 times
10	USA Rehabilitation	455	Increased mortality with moderate or severe depression OR 2.5 (1.2-5.2).
46	USA General medicine	525	Increased mortality at 2 years RR 1.7 (1.1-2.8)
67	USA Orthopaedics (hip fracture)	536	1 year physical dependence significantly increased
24,25	USA General medicine	572	Worse health status on discharge and at 3 year follow up Increased mortality at 3 years HR 1.34 (1.03-1.73)
106,107	UK Orthopaedics (hip fracture)	731	Increased 2 year mortality RR 1.5 (1.0-.2.4) Reduced risk of discharge RR 0.61 (0.47-0.79) Increased institutionalisation at 6 months by 3.3 times
Delirium			
85	Canada General medicine	203	increased mortality HR 1.71 (1.02-2.87) Increased risk of developing dementia, AOR 5.97 (1.83-19.54)
77	Ireland Geriatric medicine	225	Accounted for 6.7% of variance in LOS Increased institutionalisation at 6 months, AOR 2.8 (1.3-6.1)
34,108	USA General medicine	229	Increased LOS by 5 days Mortality at 6 months: no significant effect Activities of Daily Living at 6 months: no significant effect Increased mortality at 2 years RR 1.8 (1.04-3.2) Increased institutionalisation at 2 years AOR 2.6 (1.1-5.9)
64	USA General medicine	325	Length of stay: increased significantly (effect size not stated) 6 month mortality: no significant effect OR 1.3 (0.6-2.8) 6 month institutional placement increased OR 7.3 (2.6-20.5)
73	Canada General medicine	361	Increased mortality over 1 year, HR 2.11 (1.2-3.8).

106	UK Orthopaedics (hip fracture)	731	Increased 6 month mortality RR 2.9 (1.8-4.7) Reduced risk of discharge RR 0.53 (0.41-0.68) Increased institutionalisation at 6 months by 14 times
Dementia			
87	USA Rehabilitation	150	Poorer cognitive function predicts increased dependency and poorer continence at discharge
77	Ireland Geriatric medicine	225	Increased institutionalisation at 6 months, AOR 3.9 (1.5-10.4)
75	USA General medicine (stroke)	272	Increased rates of non-treatment with aspirin or warfarin, OR 2.57 (1.04 to 6.30). Increased adverse outcomes OR 3.59 (1.82 to 7.06).
66	USA Geriatric rehabilitation	372	Increased likelihood of requiring supervision on discharge
106	UK Orthopaedics (hip fracture)	731	Increased 6 month mortality RR 2.6 (1.7-4.0) Reduced risk of discharge RR 0.47 (0.38-0.58) Increased institutionalisation at 6 months by 18 times
Cognitive impairment			
32	USA General medicine	116	In-patient mortality: no significant effect
11	Israel Orthopaedics (hip fracture)	152	Increased complications with poorer cognitive function: 48.1%, 39%, 18.3% (severe, moderate, normal) Increased mortality with abnormal cognitive function (p=0.008) No effect on LOS
44	Switzerland	190	No significant increase in inappropriate bed days OR 0.7 (0.3-1.7)
61	Italy Geriatric rehabilitation	244	Probability of functional recovery decreased, OR=0.36 (0.14-0.92)
10	USA Rehabilitation	455	Increased mortality with severe cognitive impairment OR 2.1 (1.1-4.0).
36	USA General medicine or surgery	467	Increased LOS by 1.22
104	UK Orthopaedics (hip fracture)	492	Poor activities of daily living at 3 months OR 5.51 (3.16-9.60) Increased mortality at 1 year OR 2.33 (1.32-4.00)
46	USA General medicine	525	Increased mortality at 2 years if MMSE < 20, RR 2.0 (1.3-3.1)
67	USA Orthopaedics (hip fracture)	536	1 year walking ability significantly decreased 1 year physical dependence significantly increased 1 year instrumental dependence significantly increased
109	UK Orthopaedics (hip fracture)	643	1 year mortality increased 1 year institutionalisation increased
82	UK Orthopaedics (hip fracture)	882	Positive predictive value 0.54 for 1 year mortality

AOR = Adjusted Odds Ratio; HR = Hazard Ratio; LOS = Length of Stay; MMSE = Mini Mental State Examination; OR = Odds Ratio; RR = Relative Risk

2: Can Interventions Improve Outcome?

- 2.1 The majority of mental disorder co-morbidity affecting older people in general hospitals is due to three disorders; dementia, depression and delirium (see Section 1) and these have been the focus of research. Older people with medical illnesses and hip fracture have particularly high levels of co-morbidity and form the populations for the majority of these studies. Recent years have seen the publication of important controlled trials involving older people demonstrating effective prevention and treatment. There is little information on the management of other mental disorders affecting older people.
- 2.2 Also important are reports on the effect of providing different styles of consultation-liaison mental health services to general hospitals.
- 2.3 A pre-requisite to instituting treatment or referral for a mental health assessment is the ability to identify the problem. Reported detection rates for mental disorder in older people in general hospitals indicate difficulties at this stage. Missed diagnosis rates for delirium of 32-67% (111) and for cognitive impairment of 55% (112,113) are typical examples. A meta-analysis of the prognosis of depression in older medical patients reported the detection rate for depression as "rare to 26%", with a median of 10% (114).
- 2.4 Furthermore, there is an indication that general departments attempts to treat mental disorder are inconsistent. For example, depressed older medical patients may be as likely to receive benzodiazepines as antidepressants (115), as few as 25% of depressed older people with hip fracture receive antidepressants (106) and there seems to be an over reliance on psychotropic medication for the management of delirium (116). The use of psychological treatments is rare. There may be several explanations for these observations but poor knowledge, attitudes and skills combined with low confidence are likely to be significant factors.

Delirium

- 2.5 It is valuable to recognise the distinction between prevalent and incident delirium. Some older people arrive at the hospital with delirium (prevalent) while others develop delirium during their admission (incident). Studies aimed at prevention involve incident delirium and these have identified the most important characteristics that predict the risk of developing delirium (117).
- 2.6 It is possible to identify those baseline characteristics which place individuals at high risk for developing delirium (predisposing factors) and those factors causing high risk of precipitating delirium (precipitating factors). A simple combination of 4 predisposing and 5 precipitating factors has been used to produce a model that predicts the development of delirium for older people admitted to medical wards (118)(Box 2).
- 2.7 However, it is important to recognise that these prediction rules will differ between different populations of patients. For example, a slightly different set of risk factors has been found to predict risk of delirium among older people admitted for surgery (69).

Box 2

Predisposing factors

- Vision impairment
- Severe illness
- Cognitive impairment
- Raised blood urea nitrogen/creatinine

Precipitating factors

- Use of physical restraints
- Malnutrition
- More than 3 medications added
- Use of bladder catheter
- Any iatrogenic event (harmful consequence of a procedure or intervention)

- 2.8 Older people admitted with medical illness with 3 or 4 predisposing factors may be nine times more likely to develop delirium than patients with none (45). Patients at high risk could be identified at admission and strategies to prevent delirium incorporated into their care plan.

- **Routine assessment of all admissions could identify those at high risk of developing delirium.**

- 2.9 Predisposing and precipitating factors are highly interrelated and contribute to delirium in independent and cumulative ways. Generally, the greater the risk the less intense the precipitant needed to produce delirium. Consequently, patients at high risk may develop delirium easily and often while those with no risk factors develop delirium infrequently and usually only in response to a major medical insult. Recognition of this association allows intervention to be targeted at high risk patients.
- 2.10 A controlled trial of intermediate and high risk older medical admissions employing a preventative care programme concentrating on six domains of care (cognitive impairment, sleep deprivation, immobility, visual impairment, hearing impairment and dehydration) achieved a 33% reduction of incident delirium (119).
- 2.11 A randomised trial of older people with hip fracture receiving daily proactive geriatric consultation reduced episodes of delirium by one third and severe delirium by 40% (70).
- 2.12 Quasi controlled trials of perioperative care (120) and interpersonal and environmental nursing interventions (102) in hip fracture have been associated with a reduction of delirium and length of stay. A randomised trial of postoperative patient controlled analgesia was associated with significantly less postoperative confusion (121).

- **Strategies to prevent delirium should be incorporated into the care plan of an older person at risk.**

- 2.13 Once delirium develops the outcome is mostly determined by the seriousness of the underlying disorder and prompt, optimal medical treatment. This is complicated in older people with medical illness where multifactorial causation is common.
- 2.14 A randomised trial of systematic detection and specialist multidisciplinary care of delirium in older people with medical illness did not prove to be any more effective than usual care on a range of outcome measures (23). An earlier systematic review concluded that early identification and management of potential aetiological factors can have a large beneficial effect on cognitive and functional recovery especially with older people admitted for surgery (122).
- 2.15 Management may also include a range of environmental and pharmacological interventions and these have been described in consensus guidelines (123). There is little reliable evidence to indicate confidently the role of psychotropic drugs in the management of delirium as there are no controlled trials in older people. However, psychotropic drugs have been shown to benefit symptom control (122) but need to be used with caution.
- 2.16 A Cochrane review of multidisciplinary team interventions for delirium in people with chronic cognitive impairment found insufficient data on which to develop evidence-based guidelines for the diagnosis and management of this group of older people. Management remains empirical and based on the treatment of precipitating factors. The authors comment that it seems logical to think that closer monitoring of high risk categories would lead to better management, and prevention may reduce the problems caused by delirium (124).

Case Study

Mr. A, a 74 year old man, was admitted having collapsed at home. He was conscious on admission and no abnormalities were found on examination or investigations including a brain scan.

His mental state began to deteriorate from the fourth day and he began expressing the idea that he was a rapist and a murderer. He was frightened to leave hospital and became agitated especially at night. He voiced suicidal ideas. The medical team thought he was depressed and started antidepressants.

He continued to deteriorate and was referred for an urgent opinion from the on site liaison mental health team.

The liaison team saw him the same day. He was sweating, perplexed, agitated and unsteady. He was fearful and inattentive. His responses were inappropriate, he was disorientated in time, place and person and was unable to give any personal information. His conversation was limited and repetitive.

The liaison team made a diagnosis of delirium and checked if he had ever been known to the mental health services. They found that he had a history of depression and alcohol dependence. During one earlier mental health admission he had developed a similar condition shortly after admission. It was considered that his delirium was either due to alcohol withdrawal or Wernickes encephalopathy and they recommended a benzodiazepine withdrawal regime and high potency intravenous vitamins and fluids. Antidepressants were withdrawn. He was reviewed on a daily basis.

After five days he was completely recovered. His mental state was normal but he had no recollection of the days of delirium.

A study of older people referred to a liaison mental health service for assessment of depression found that 40% were diagnosed as delirium by the psychiatrist and that depressive symptoms were as common in the delirious as those diagnosed with depression. 44% of the delirious expressed a wish to die, 24% having suicidal thoughts and the majority thoughts of worthlessness and guilt (125).

This case illustrates the importance of accurate early diagnosis to prevent deterioration and possibly death. If the history of alcohol abuse had been established on admission this episode of delirium may have been prevented. Also, note that symptoms characteristic of depression are common.

Dementia

2.17 Older people with dementia are particularly vulnerable in general hospitals. They are highly susceptible to environmental change, suffer loss of independent function quickly and the presence of dementia is a major risk factor for delirium. Indeed, the presence of dementia is the strongest single risk factor for delirium, increasing the risk 5 fold (117). Consequently, there are multiple reasons why it is important to identify this diagnosis at the time of admission and for general care staff to recognise the impact that the presence of cognitive impairment will have for the older person's management and discharge.

2.18 A randomised controlled trial of intensive specialist multidisciplinary rehabilitation of older people with hip fracture achieved a reduced length of stay for patients with mild or moderate dementia and those with mild dementia were as successful returning to independent living as patients without dementia (126). Furthermore, patients with mild and moderate dementia from the intervention group were more likely to be living independently three months after fracture than the usual care control group.

- **Dementia should be identified on admission and care plans need to take account of the impact this will have for the older person's management and discharge.**
- **Dementia is the strongest risk factor for delirium.**

2.19 With the advent of pharmacological treatments for dementia and access to specialist services, it has become increasingly important to make the diagnosis early. Admission to a general hospital may be the first opportunity to identify dementia and these specialist services need to inform and advise the patient and carers accordingly.

- **Early diagnosis with advice to patients and carers is essential.**

Case Study

Mrs B. is an 80 year old lady who lives with her husband. She was admitted after fracturing her hip. After the operation she became confused and talked as if she was in a hotel not a hospital. She was unable to find the toilet and urinated in inappropriate places. She wandered, looking for her husband, ignored medication and food left for her and lost weight. She was referred for a mental health opinion.

The liaison nurse arranged to meet her husband, who said that she had become forgetful over the previous 2 years and less able to do the housework. The liaison nurse made a diagnosis of Alzheimer's disease noting that all her investigations were normal. She informed the orthopaedic team and arranged a home assessment. She was suitable for treatment with cholinesterase inhibitor drugs and the liaison nurse referred her to the older peoples community mental health team for review after discharge.

If the diagnosis of dementia had been noted at admission, and her husband involved at that stage the care plan could have more specifically addressed her need for more assistance and supervision.

This case illustrates the importance of identifying dementia on admission and care planning that may prevent anticipated management problems, and the value of involving carers early in admission.

Mrs. C is a 71 year old lady assessed in the medical assessment unit for recent confusion and personality change. She is referred for a mental health consultation but discharged before the assessment can be completed. One week later she is admitted.

On this occasion she is seen promptly by a liaison mental health nurse. Mrs. C. recognises the change in herself. She lacks motivation and needs assistance with personal care. She is irritable and anxious expressing feelings of guilt that she is a burden on her family, feelings of worthlessness since retirement and has nothing to live for. She has mild cognitive impairment.

The medical team insist there is no physical problem, that she has agitated depression and should be transferred to the mental health unit. Her condition is deteriorating quickly and the liaison nurse thinks she is losing her vision. The liaison nurse is concerned that the description from her family is not that of depression and asks the team psychiatrist to see her. The psychiatrist thinks she has neurological signs and suggests a detailed neurological examination, EEG and brain scan.

48 hours later she has a seizure. Her EEG is grossly abnormal and a neurologist is consulted. The diagnosis of Creutzfeldt-Jacob disease (CJD) is subsequently confirmed. Mrs. C dies two weeks later.

The general nursing staff request education about CJD from the mental health liaison team and this is provided over several sessions.

Although a rare condition this case illustrates common problems of differential diagnosis that can result in an incorrect line of management and also that it is essential for a mental health liaison nurse to have prompt medical support.

Depression

2.20 In the only randomised controlled trial of antidepressants in this population active treatment was superior to placebo for the treatment of seriously medically ill older people with depression and side effects were reported no more often with active treatment than placebo (127).

2.21 There is no strong evidence for the superiority of any particular antidepressant but side effect profile and safety are particularly important considerations for older people in this situation.

2.22 A single randomised controlled comparison of interpersonal counselling versus usual care for medical inpatients with minor depression showed benefits for those receiving psychotherapy (128).

- **An appropriate antidepressant and/or psychological treatment should be considered for all depressed older people in general hospitals.**

2.23 While the evidence demonstrates the benefit of actively treating depression there remains a need for much more research in this important area.

Case Study

Mrs. D is an 85 year old lady admitted with chest pain. The medical team refer her for a mental health assessment with a diagnosis of acute confusion with psychosis.

She was crying. She believed that she owed the Department of Social Security £50,000 and was waiting for the police to arrest her for fraud. She was convinced that she would go to Crown Court and receive a life sentence. She believed she was infested with lice because she felt her skin crawl and could hear other patients commenting on it. She believed that her story was being broadcast on the television. Her cognitive function was excellent.

The psychiatrist made a diagnosis of a severe depressive episode with psychotic symptoms. She was prescribed antidepressant and antipsychotic medication. Due to unstable heart failure it was preferable to treat her on the medical ward. Subsequently, the family reported that she had been taking an antidepressant at home and this was stopped on admission 2 weeks before referral.

She made a full recovery and returned home where she was reviewed by the local older people's mental health team.

This case illustrates the importance of accurate diagnosis and how those unfamiliar with psychotic states can be misled. It also demonstrates how treatable severe depressive states are and how it is unwise to discontinue psychotropic medication without knowing the indication for its use.

Mr E. is a 70 year old man who is referred urgently for hospital admission by his general practitioner who thinks he is acutely confused. He had attended the surgery that day saying that he owed the Inland Revenue unpaid tax and had no money to pay his bills.

The medical doctor found no evidence of ill health and referred Mr. E. to the hospital social worker because he has social and financial problems. The social worker also thought he was confused and the medical team agree to admit him.

10 days later investigations were complete and normal. However, Mr. E. had become constantly agitated, pacing the ward day and night, expressing guilt about his debts and saying he had no money and should be in prison. He was inconsolable. He hardly ate, lost weight and slept very little.

A mental health opinion is requested urgently and a diagnosis of classical severe depressive episode with psychotic symptoms made. He is immediately transferred to the older people's mental health inpatient unit where he eventually makes a full recovery.

This case illustrates how early diagnosis could have avoided unnecessary medical admission and the patient admitted directly to the mental health unit.

Consultation-Liaison Services

- 2.24 A systematic review of older peoples mental health services concluded that the liaison approach in general hospitals has advantages over consultation (129) (see Section 3). In particular, it is associated with more specialist assessments, more referrals with depression, better diagnostic accuracy by referring doctors, more mental health reviews and increased adherence to recommendations for managing the mental disorder.
- 2.25 A randomised trial found that older medical patients with various mental disorders were twice as likely to return to independent living if they received specialist mental health multidisciplinary liaison than those receiving usual care (130).
- 2.26 In a controlled trial, routine mental health liaison for older people with hip fracture was associated with a reduced length of stay (99). The intervention group had a mean length of stay two days less than the usual care group. The cost of the service was offset by the shorter duration of admission.

Conclusion

- 2.27 There is evidence that co-morbid mental disorder affecting older people in general hospitals is amenable to prevention and treatment. In certain circumstances this has brought benefits in terms of reduced incidence, reduced length of stay, better recovery, more successful rehabilitation and less transfer to institutional care.
- 2.28 The liaison style of mental health service appears to benefit patients and services more than standard consultation. Particular benefits have been shown for older people with hip fracture.
- 2.29 If these improved outcomes can be achieved in routine clinical practice the benefits would be considerable for older people, carers and health and social care providers.

3: Models and Styles of Service

- 3.1 There are several potential service models that would improve the delivery of mental health services for older people in general hospitals. Several factors may influence which particular model is chosen, as discussed later in this section. It is also possible to have more than one model operating simultaneously. Whatever model is chosen for a particular setting, it must be able to deliver the core functions of a liaison mental health service.
- 3.2 That is, a consultation-liaison service, whatever model is chosen, must be in a position to raise awareness of the importance of mental health in the general hospital and facilitate the acquisition of basic skills of assessment and treatment of mental disorder by general hospital staff. The service will need to champion the cause of older people with mental disorder who find themselves under general hospital care.
- 3.3 The ultimate aim is to see mental health care assimilated into the routine care of older people admitted to general hospitals.
- 3.4 The mental disorder co-morbidity is so great (see Section I) that mental health services cannot and need not evaluate all cases if general staff are sufficiently skilled. The majority of older people with simple and mild mental disorder should receive a competent response from the general hospital care team.
- 3.5 Some disorders are of such a degree or complexity that they require the mental health service. Consultation-liaison services need to develop an approach that will ensure that older people needing specialist mental health care are referred and seen promptly while those with simple mental health needs receive an appropriate response to their problems from the general care team. This will require clear policy, process, education and training.

- **Liaison services must promote the importance of mental health and facilitate competent assessment and treatment skills of general staff.**

Consultation or liaison?

- 3.6 Most older peoples mental health services offer consultation to general hospitals (131) This approach responds to referrals on a case-by-case basis offering diagnosis and advice on management with limited review. It is essentially reactive.
- 3.7 This is in stark contrast to services for working age adults where liaison mental health is a developed speciality with at least 93 funded consultants in liaison psychiatry in the British Isles (132). These services have an established multidisciplinary model of service delivery with recommended staffing levels and training programmes.
- 3.8 The liaison approach is proactive and not limited to direct patient contact. It aims to integrate the assessment and treatment of mental disorder into routine general hospital practice. This requires a physical presence in the general hospital, close collaboration with general departments, shared care and the development of education and training programmes. Reported benefits of the liaison approach are described in Section 2.
- 3.9 The assessment of mental health should be part of general hospital care (2). Mental health will only become part of general hospital practice if mental health is part of the general hospital. As long as mental disorder is referred to a geographically and organisationally distant mental health service on a consultation basis it will remain the responsibility of the mental health service and not the general hospital.

- **Consultation-liaison services should be based in the general hospital where the assessment of mental health should become part of routine practice.**

3.10 Other limitations of the consultation approach include slow response, low priority, little experience of the general hospital environment, little potential for training and development and poor adherence to recommendations. The problem of adherence is demonstrated in a single blind trial of mental health consultation for depressed older people admitted to medical wards where recommendations were implemented in less than 50% of cases (96). Consultation was no more effective than usual care. Characteristics of consultation and liaison are contrasted in Table 3.1.

- **Services providing only consultation should move to a liaison approach with practitioners having dedicated time to perform these duties.**

Service models

3.11 Each service model has strengths and weaknesses (Table 3.2). Several models of mental health care for older people in general hospitals are described below. They all need good community mental health services to operate to best effect.

3.12 Most services currently operate the standard sector consultation model provided by a community mental health team (Figure 3.1). The majority of old age psychiatrists feel that community-focused services do not adequately address the care needs of older people with mental disorder in general hospital wards (131).

3.1: Differences between consultation and liaison

Consultation

Reactive
Limited resources

Isolated input
Low priority
Limited impact

Slow response
Limited review

Mental health separate
from general services

Liaison

Proactive
Labour intensive

Collaborative
High priority
Developmental

Rapid response
Frequent review

Improve referrals
Improve adherence
Change practice

Mental health integrated
with general services

Standard sector model

3.13 This is the generalist service model, providing all mental health services for a defined population of older people who either reside within a particular geographical area or are registered with a particular group of general practices. It is a specialist service only in that it specialises in the mental health care of older people but not older people's mental health in the general hospital.

3.14 The standard sector model operates on a consultation basis usually provided by medical staff. Referral may not be straightforward. Referrers need to know which sector service to refer to and how to make contact. Travelling to the hospital may create inefficient use of time but this model



has the advantage of easy communication within the community team and continuity of care. Response can be slow and referrals of people in the community may be prioritised, being perceived as more at risk (131).

- 3.15 Where there are several sector teams all providing input to the same general hospital, the individual providing advice will differ depending on the sector of residence and the grade of that individual. For example, if a general hospital covers three mental health sectors and each sector community team has a consultant, specialist registrar and senior house officer, then nine different individuals may be offering advice for patients. This inconsistency may not be helpful.

Case Study

Mr. F has Parkinsons disease and was admitted to a rehabilitation ward. The staff felt that he may be depressed and this was impeding his rehabilitation. A referral is made to the old age psychiatrist. She works with a sector based community mental health team several miles away and receives frequent requests from the general hospital.

She had 6 hospital referrals outstanding but considers community referrals her priority and she has no designated time to perform general hospital consultations. She was able to see Mr. F, three weeks later at the end of her working day. She completed a brief assessment, recommended an antidepressant and another referral if there were further concerns. She was dissatisfied with the brevity of this consultation and recognised that her community patients received a much better quality of service. The antidepressant for Mr. F was not prescribed and he was referred again 2 weeks later.

This case illustrates how general hospital referrals are given low priority with consultation models, assessments are frequently brief and unsatisfactory and adherence to recommendations often poor. This consultation was completely ineffective and an inefficient use of time.

The enhanced sector model

- 3.16 In this model, a community mental health team receives extra staff time (usually nursing) to provide input to the general hospital. Community staff provide in-reach to general hospital wards. This creates opportunities for non-medical assessments and continuity of care. However, limitations of the standard sector model apply. Both standard and enhanced sector models operate primarily consultation and the opportunities for education and training are limited.

Case Study

St. Elsewhere is a district general hospital on the outskirts of a small town with three community hospitals spread over forty miles. Each hospital needs mental health advice from time to time but it would be inefficient to have a liaison mental health service at each site or to travel from St. Elsewhere's to the satellite hospitals.

Each community hospital is close to the base of an older peoples community mental health team. It is decided that the liaison service based in the busy St. Elsewhere's will take referrals from the general hospital while referrals from the community hospitals will be seen by the local community mental health team.

This case illustrates how more than one model may be necessary to provide a satisfactory service.

Outreach from mental health wards.

3.17 Here, staff from mental health wards visit general hospital wards to perform assessments. This is usually on a consultation basis, although there is potential for training and education. This model is only practical when wards are on the same site, and depends on ward staff being available when needed. This means that the response may be slow when an urgent assessment is necessary. With this model mental health staff have limited expertise working in the general hospital environment.

Case Study

Mr. G was a patient with dementia admitted to a medical ward after a fall and fractured femur. He was referred for a mental health opinion of his disturbed behaviour. A staff nurse from the older peoples mental health ward went to assess Mr. G at the end of her shift because her ward was short of staff and took priority.

Mr. G was restless, urinating in the corner of the ward and not eating food left out for him. The general care team assumed this to be part of his dementia and suggested he be transferred to the mental health hospital.

The mental health nurse met Mr. G's wife who reported that he was much more confused than normal and was usually continent and self caring. The nurse suspected a medical cause and the effect of environmental change to be the underlying problems. She told the primary nurse that Mr. G may have a delirium needing further investigation. She recommended regular toileting and assistance at meal times. She does not have time to routinely review patients.

Unfortunately, the information was not conveyed at the ward round and none of the recommendations were implemented. Mr. G was referred again 2 weeks later.

This case illustrates that even though the mental health nurse recognised the problem her lack of experience working in general hospitals and limited contact with the medical wards resulted in good advice being ineffective due to poor adherence.

The liaison mental health nurse

3.18 With this model, a mental health nurse is based in the general hospital with dedicated time to provide a liaison mental health service to general hospital wards. A liaison mental health nurse will respond quickly to referrals. Some referrals seen by the nurse may need medical input (10-20% depending on the maturity of the service).

3.19 This model has greater potential for the introduction of teaching and training, genuine shared care and the development of treatment protocols.

3.20 These services may be oriented towards high-referring wards, especially medicine for older people, but can provide input throughout the general hospital, limited only by the time available. A single liaison nurse working in isolation can rapidly become overwhelmed by increasing workload and expectation. This allows no time for training. Liaison nurses must have support from a designated consultant psychiatrist who has dedicated time for liaison.

3.21 There is the potential for a lack of continuity of care when community follow-up is required but good channels of communication can address this problem.

Case Study

The full time nurse for older people's mental health liaison works closely with all the wards and is based in the general hospital. She is able to see referrals the same day if necessary.

Mr. F (as Standard Sector Model) was seen the day after referral. The liaison nurse suggested updating some blood tests but agreed that Mr. F was depressed and recommended an antidepressant. She arranged to meet Mr. F's wife who confirmed that he had been depressed for several weeks before admission. The liaison nurse reviewed Mr. F throughout the week to ensure that treatment was prescribed and that there were no adverse effects. Despite his problems Mr. F and his wife wanted him to be at home.

The liaison nurse discussed Mr. F with the psychiatrist at their weekly review meeting. They agree that his depression would not prevent him being treated at home and she communicated this to the medical team. Mr. F was able to go home quickly to continue treatment under the care of the community mental health team. The liaison nurse contacted the community mental health team with details of Mr. F's admission, diagnosis and treatment and they reviewed him at home.

This case illustrates how on site liaison can respond promptly, allows a complete assessment involving carers, checks adherence and facilitates early discharge. A very different process and outcome than standard sector consultation managing the same case.

The liaison psychiatrist

3.22 Here, an old age psychiatrist has dedicated time for general hospital work. Activity is analogous to the liaison mental health nurse, with a similar rapid response for advice and assessment, education and training. The greater understanding of complex medical problems brought by the psychiatrist's medical training is helpful, but may be countered by, for example, less expertise of the non-pharmacological management of behavioural disturbance. Again, good communication with community services is necessary and low staffing levels can lead to burnout as workload increases.

The shared care ward

3.23 In this model, mental health and general nurses, psychiatrists, physicians and therapy staff work together delivering care in a ward where patients have complex physical and mental health needs that cannot be met elsewhere. This ward should be on the general hospital site to facilitate access to specialist medical treatment and investigations. This model can cope with complex care needs such as challenging behaviour in a patient with serious physical illness. There is also the opportunity to care, for example, for people with severe depression and substantial physical illness.

3.24 The high staffing levels and skill mix on a shared care ward reflect the complex care needs of the patients. This model builds up the clinical skills of all staff working on the shared care ward. Such a ward can act as a beacon of good practice and a valuable training resource for junior staff of all disciplines. There is also the potential for outreach to other general hospital wards.

Case Study

Mr. H was admitted for investigation of severe weight loss. He was seriously malnourished and had uncontrolled cardiac failure and diabetes needing specialist monitoring. Mr. H was extremely depressed and reluctant to eat or drink. He repeatedly removed a nasogastric feeding tube stating that he did not want treatment and wanted to be left to die.

Mr. H was detained under the Mental Health Act for treatment of depression. He required intensive medical and mental health care. He was treated on a joint ward on the general hospital site where the staff were skilled and qualified to meet both his medical and mental health needs.

This case illustrates the ability to manage serious co-morbidity when a person may be too physically ill for transfer to an isolated mental health ward yet seriously mentally disordered needing specialist mental health care.

The hospital mental health team

- 3.25 Here, a multidisciplinary team including psychiatrists, mental health nurses, occupational therapists, social workers and other disciplines work together to deliver mental health care in the general hospital. The general hospital can be thought of as the hospital mental health team's sector.
- 3.26 The team operates a single point of access. Each team practitioner is able to build relationships with general hospital disciplines and provide teaching, training and support, but can call on the specialist skills of other team members when needed. It is well suited to a single assessment process.
- 3.27 This model operates on a consultation and liaison basis. Referrals are received but also sought proactively through the comprehensive induction of staff with ongoing training and supervision, in order to improve the detection and management of mental disorder co-morbidity. hospital mental health teams can also provide support to staff members working in stressful areas.
- 3.28 The hospital mental health team relies on excellent channels of communication. Rapid electronic, written and telephone contact ensures that community teams and services are kept informed where community follow up is needed. It enables community mental health teams to easily request assessments for older people on their caseload who are admitted to the general hospital.

Case Study

Mr. I has dementia and was admitted after a fall. He lived alone. He is at risk of further falls and there is uncertainty about risk arising from his cognitive impairment. The general care team strongly recommended residential care and do not consider him safe to return to independent living. Mr. I wanted to go home but the occupational therapist was reluctant to perform a home assessment because she felt that Mr. I would not return to the ward.

A referral was made to the older people's multidisciplinary liaison team for an assessment of capacity, and Mr. I was seen by the liaison nurse. She talked with the team occupational therapist who then saw Mr. I. She was confident dealing with these situations and completed the home assessment accompanied by the liaison nurse and the general occupational therapist who could learn from the experience.

There were risks associated with Mr. I returning home but a risk minimisation strategy was formulated. Due to the level of concern the occupational therapist discussed the case with the liaison team social worker and psychiatrist at the review meeting to explore all alternatives. Mr. I agreed with the proposed plan. He returned home with a comprehensive care package and was reviewed by the community mental health team.

This case illustrates the benefits of a multi-skilled specialist team with good communication and the confidence to deal with issues of risk while trying to preserve the older persons autonomy and independence.

Other teams and disciplines

3.29 In some places, multi-professional teams exist to provide specialist input for specific conditions like dementia in older people. These teams may be organised in a similar way to a hospital mental health team but do not provide a comprehensive service.

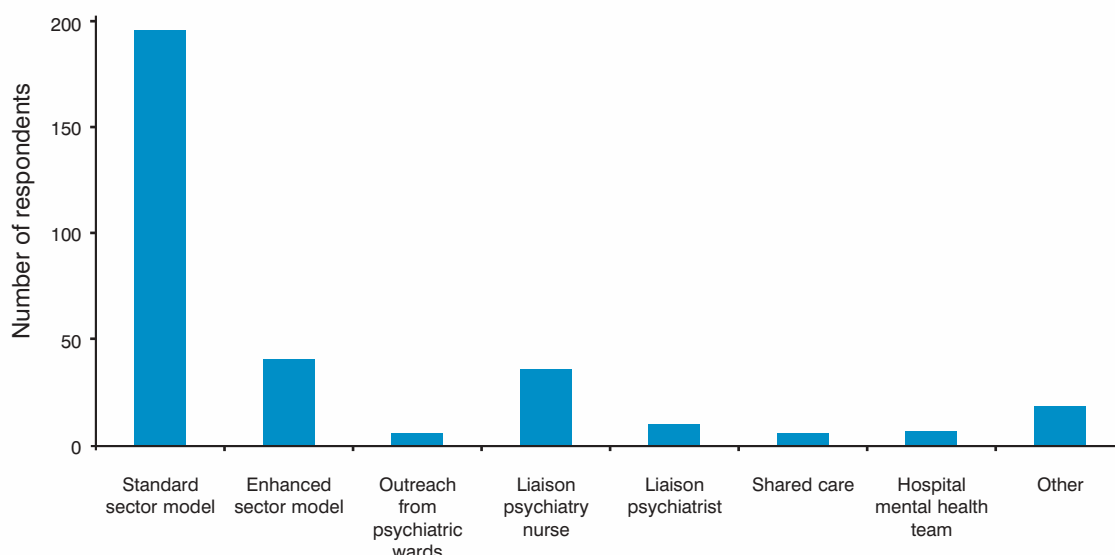
3.30 Other mental health professionals also practice in general hospitals, for example, many clinical psychologists provide input to pain clinics or stroke units, but this is not usually coordinated with other mental health professionals.

The older persons liaison mental health out-patient clinic

3.31 Specialist liaison mental health clinics for adults of working age exist in many parts of the British Isles treating patients with complex co-morbid conditions and somatic presentations of mental disorder. Older people also present with these conditions (133,134) and a similar clinic for older people would allow the specialist assessment of complex somatic presentations and short-term follow-up of self-limiting conditions such as delirium and adjustment disorders.

Figure 3.1

The range of general hospital service models operating for older people with mental disorder in the UK in 2002 (131).



Factors influencing the choice of service model

3.32 The choice of service model will be influenced by various factors. For several reasons one size does not fit all and it is important to carefully consider local factors and objectives. There are no studies that compare the effectiveness of different models. All have strengths and weaknesses (Table 3.2)

3.2: Strengths and weaknesses of different service models

Service Model	Advantages	Disadvantages
Standard Sector	Low cost Continuity of care	Low priority Slow response Consultation No specialist expertise Travelling Not multidisciplinary Multiple opinions (usually medical)
Enhanced sector	As Standard Sector	As Standard Sector Additional staff cost
Outreach	Low cost	Competing priorities Restricted response time Limited expertise Usually consultation No continuity with community
Liaison nurse	Specialist expertise Dedicated time Liaison approach Nursing expertise On site Rapid response Easy access	Cost Need medical support Isolation Increase demand Discontinuity with community
Liaison Psychiatrist	As liaison nurse Medical expertise	As liaison nurse
Shared Care	Expertise Joint working Staff training	Competing demands Considerable cost Risk of becoming convenient transfer for "stuck patients"
Liaison Mental Health Team	Multi professional expertise Parity of service with younger adults and community Strong mental health presence Strong peer support Training of multiple disciplines Coordinated management On site	Cost Discontinuity with community

Important factors influencing the choice of model include:

Hospital size and type

- 3.33 The size of an acute hospital will be important. For example, the typical 500 bed general hospital (described in Section 1) may require a shared care ward and hospital mental health team, while, a smaller general hospital may need a less extensive service and a 12 bed community hospital only sessions from a mental health nurse.
- 3.34 Teaching hospitals, tertiary providers and specialist units will pose different problems to district general hospitals or rehabilitation units.

History

- 3.35 The presence of established liaison mental health services for older people might influence further service development. Where liaison mental health services for older people do exist, clinicians in general hospitals are usually supportive of service developments, having seen the benefits these services bring for patients, carers and staff.
- 3.36 The presence of a well-established liaison mental health service for adults of working age will highlight the presence of age discrimination within mental health services and may drive the development of specialist services for older people.

Geography

- 3.37 Mental health and acute service providers may share a hospital site though this has become less common. In some places, particularly rural areas, large distances may separate mental health and general hospital services.

Champions and resources

- 3.38 Where liaison mental health services for older people have developed, it is usually the result of a local champion with a particular interest and not the result of strategic planning.
- 3.39 Local resources are never limitless and are likely to influence the model that can be provided. Services will start from different points. While a business case argues for additional resources it may be possible to adapt local services to provide a more effective model seeking to develop as services reorganise.

Central policy and competing priorities

This is discussed further in Section 6.



Conclusion

- 3.40 The service model most suitable for a particular area will require careful consideration of local factors, opportunities and the aims of the service. Services may need to evolve through different stages of sophistication. For a general hospital the multidisciplinary mental health liaison team provides the most complete service to patients and is most likely to deliver the core functions of a liaison mental health service for older people, particularly in association with a shared care ward.
- 3.41 It is essential to discuss service developments with the acute provider before introducing change. The acceptability and effectiveness of a liaison service requires partnership with the acute provider and an alliance will be an advantage when making a case for the commissioning of services.

4: Characteristics of a Liaison Mental Health Team

Consultation-liaison Teams.

4.1 While there is a lack of evidence to support a particular service model (see Section 3), the multidimensional nature of mental disorder in older people would suggest that the multidisciplinary team approach that forms the basis of community older people's mental health services is best suited to optimal patient care. Core members of this team would include psychiatrists, mental health nurses, occupational therapists, social workers and psychologists.

4.2 Consultation-liaison teams can also provide a valuable training experience for trainees as the general hospital creates the best experience of the physical and psychological interface. A clear arrangement for appropriate clinical supervision for all team members is essential.

- **Clear arrangements for clinical supervision are essential.**

4.3 The composition of the liaison team will be influenced by the model of service, size of hospital, services provided by the hospital, catchment area and the configuration of local older people's mental health and local authority services.

4.4 Every older people's mental health service should have a designated consultant psychiatrist for consultation-liaison with sufficient protected time to fulfil this function. The number of sessions will be dependent upon local factors and the service model in operation. These sessions should be written into the consultant's job plan. The consultant would be expected to take a lead on service development.

- **Every older peoples mental health service should have a designated consultant psychiatrist for consultation-liaison with dedicated time in their job plan.**

4.5 It is essential that this work is not devolved to inexperienced or junior members of staff whether consultation or liaison is in operation. Before taking on these responsibilities practitioners need adequate training and induction to this area of work. They will need time for personal development and access to continued training in this specialist field.

- **Consultation-liaison is a specialised area of work and staff need proper induction, training and time for personal development.**

4.6 Consultation-liaison must not be left to single practitioners working in isolation. Experience indicates that clinically unsupported practitioners are highly susceptible to overload and burn-out. Whether the approach is consultation or liaison all staff should have dedicated time to perform their duties that do not compete with any other duties that they fulfil.

- **All practitioners need protected time to perform consultation-liaison duties and should not work in isolation.**

4.7 The precise model and functions performed by the service will be linked to the resources available. Table 4.1 suggests minimum and developed functions of consultation-liaison teams.

4.1: Functions of older people's mental health liaison teams

Minimum functions:

- Improve detection of common conditions
- Assessment, diagnosis and treatment of referred cases.
- Risk assessment and minimisation
- Assessment of all cases of self harm
- Ensure that the outcome of assessments are incorporated into care plans
- Facilitate the development of care plans that reflect mental health needs
- Be able to review patients as appropriate and check adherence of recommendations
- Be available to offer advice on patient care as it pertains to mental health
- Facilitate access to mental health care where indicated
- Respond quickly where necessary
- Be able to work collaboratively with general departments
- Monitor those under the care of older peoples mental health services
- Promote the rights of older people with mental disorder
- Raise awareness of the importance of mental health
- Reduce stigma
- Engage with carers
- Have a clear referral protocol
- Have an operational policy
- Be able to record clinical data to allow audit
- Be the link between the general hospital and mental health services

Developed functions:

- Training and education programmes in mental health to improve detection and treatment.
- Treatment protocols
- Care pathways
- Use of assessment tools
- Research
- Develop training posts for all disciplines
- Promote the routine assessment of mental health

4.8 In addition to contact with new referrals, the liaison team is invaluable for reviewing patients of the mental health services admitted to general hospitals. The team can communicate mental health information to the general care team, monitor treatment, facilitate successful discharge and pass information back to mental health teams about the nature and progress of the admission. Many patients referred to liaison services are already known to mental health services.

4.9 Liaison teams will require a range of skills and characteristics to work effectively in general hospitals. These are shown in Tables 4.2 and 4.3.

4.2: Skills of liaison clinicians

- Clinical skills to support principal aims
- Leadership
- Diplomacy
- Communication
- Negotiation
- Collaboration
- Teaching

4.3: Liaison service characteristics

- Accessible
- Approachable
- Responsive
- Helpful
- Proactive
- Physically present

- 4.10 The liaison team will operate in a number of different clinical and training forums (Table 4.4). The clinical areas covered by a consultation-liaison team will be linked to the local organisation of services and the composition of the team. It is likely that all consultation-liaison teams will cover the inpatient wards of a general hospital. Ideally, they should cover Accident and Emergency and Medical Assessment Units where patients are assessed before admission. The advantage of working with these assessment units is the opportunity to influence admissions to hospital when some older people with mental disorder might be better managed by diversion to an alternative service. The impact on avoiding admission may, however, be limited by the paucity of services providing alternatives to admission for older people with mental health problems.

4.4: Forums for liaison activity

Clinical:

- Wards
- Case conferences
- Pre-discharge meetings
- Multidisciplinary team meetings
- Medical assessment units
- Discharge coordinators

Teaching:

- Clinical areas
- Grand Rounds
- Local postgraduate education programmes.
- Staff induction programmes eg. PRHO, SHO, nursing staff, PAMS
- Rolling programmes single or multidiscipline

- 4.11 Some hospitals will have specialist units that could benefit from a closer liaison with mental health services, for example, oncology, neurology and orthopaedics. Some working age adult liaison mental health services have developed out patient clinics either as an extension of the inpatient service or for patients with particular disorders, notably, medically unexplained symptoms (see Section 3). These are developments that would require extra resources.
- 4.12 The majority of consultation-liaison services for older people will operate during normal working hours. There will need to be a clear arrangement to provide mental health consultation out of hours and to bring patients to the attention of the consultation-liaison team for continued assessment and to monitor activity.
- 4.13 Consultation-liaison teams would expect to deal with the full range of mental and behavioural disorders. A particular note should be made of self harm. While older people only account for 5-15% of all cases of self harm admitted to general hospitals they represent a group at high risk of completed suicide. The majority have a mental disorder and all cases of self harm involving an older person should receive a specialist mental health assessment (135).

Administering liaison services

Management:

- 4.14 If liaison teams are to function effectively and develop they need clear lines of management. Line managers should have an understanding of the nature of liaison work and the special aspects of providing mental health services in the general hospital environment. The clinical problems and their resolution are not the same as community mental health and the priorities and demands for liaison teams are not those of community mental health teams. Managers must appreciate these differences.
- 4.15 It is advisable for teams to have a clinical lead with some managerial responsibility to be sure that management decisions are properly informed and relevant to the operation and development of

liaison mental health services. The clinical lead would have a natural connection with other management structures.

- **Consultation-liaison services need informed management and should have a clinical lead.**

Documentation:

- 4.16 This will need to be clearly laid out in an operational policy. It would be expected that details of assessments and recommended management be entered into the patients general care notes. If separate mental health records are kept a similar entry will be needed here.
- 4.17 It is advisable to send typed letters to the referrer with copies to the older person's general practitioner and the mental health notes. This may be at the point of assessment or at the completion of an episode if the team has prolonged involvement with a case. This provides a clear record and keeps the primary care team informed of the liaison team's involvement. To be of value, communication and correspondence must be prompt. Mental health diagnosis and management is commonly omitted from general hospital discharge summaries (9).

Policies:

4.18 All consultation-liaison services should have the following:

- Strategic development plan
- Operational policy
- Referral protocol
- Electronic patient database to support audit

And should promote the following:

- Protocols for common situations (for example, dementia, depression, delirium, use of psychotropic drugs)
- Care pathways for the assessment and management of common conditions
- Assessment and screening instruments

Facilities:

4.19 Liaison teams should be based within the general hospital and will require the following resources:

- Sufficient secretarial and administration support
- Sufficient office space
- Access to clinical databases, email and the Internet
- Telephones, fax machine, photocopier
- Pagers

Case Study (Failed Liaison)

John is the ward manager of a dementia assessment ward. He is told by his manager that the department are receiving complaints from the general hospital that mental health referrals are not being seen for weeks and he has heard that some services are employing mental health nurses for liaison mental health. John is seconded to be the liaison nurse from the following week.

John starts the week with a backlog of 10 referred cases and sets off to the general hospital. He explains to the wards that this is a new service. They don't really understand his role and doctors are very unhappy about referring cases to a nurse. There is no operational policy or referral process.

On the second day John needs advice from a psychiatrist about a complicated case of multiple physical illness, psychotic symptoms and behaviour disturbance. The medical team want the patient removed to the mental health unit. John contacts all the psychiatrists who tell him they have no responsibility for liaison mental health. The older person lives outside the department's catchment area and none of the sector teams think it appropriate for them to be involved.

Under great pressure from the medical consultant John transfers the patient to the mental health hospital. Within 48 hours the patient's physical condition deteriorates and he is transferred back to the general hospital. The mental health team are annoyed that the patient was accepted because he was suffering from delirium due to physical illness.

After 6 weeks John feels overwhelmed by the number of referrals, lack of confidence and lack of clinical supervision. He gives notice to leave the department. Nurse liaison is deemed to have failed.

This case demonstrates what happens when staff work unsupervised, unsupported and unprepared. Work in the general hospital is a specialised area and changes to service models should be planned and discussed with the general hospital before being implemented.

Case Study (Multidisciplinary liaison team)

Miss. J is a 72 year old single lady admitted with acute confusion and chest infection. The nurses think she has auditory and visual hallucinations and paranoid ideas at times.

She has hypertension, asthma, temporal lobe epilepsy and is registered blind due to macular degeneration. She is reported to be living in squalid conditions with several cats.

The liaison team review the mental health patient information database and find that she was seen by a psychiatrist 6 years earlier because of self neglect. At that time the opinion was that she did not suffer from mental disorder. The problem was considered to be secondary to blindness and she was referred to social services. It transpired that social services had not become involved.

The liaison team made a diagnosis of delirium due to chest infection and these resolved with treatment. But she described similar episodes occurring intermittently at home when she became disorientated and her surroundings took on a strange appearance. This was associated with visual distortions and she knew afterwards that she had thoughts that she did not usually hold.

She was eager to return home. The liaison team discussed the case together. The team occupational therapist completed a satisfactory home assessment and social worker arranged transfer to intermediate care while a care package was organised. The team psychiatrist suspected that the



intermittent abnormalities of her mental state might be explained by temporal lobe epilepsy and recommended referral to the epilepsy clinic.

She returned home successfully with review from the social worker and the neurologist agreed that her epilepsy was not optimally controlled.

This case illustrates the complexity of co-morbidity, the ability of multidisciplinary liaison teams to facilitate discharge in risk situations and to form a link between medical and mental health services.

Mr. K is a 74 year old man admitted after collapsing in the street. Investigations are all normal. He is discharged but readmitted 3 days later after a further collapse, unkempt and covered in faeces.

He has no family or confidantes. The medical team think he has cognitive impairment and recommend he goes to residential care. He refuses and insists on returning home. He is referred for a mental health opinion to establish his capacity to make this decision.

The liaison team confirm that he has poor memory and confabulates but it is difficult to be confident how well he appreciates his circumstances and there are no informants to corroborate his story. He has no general practitioner. There are concerns that if assessed at home he would not return to hospital. The liaison team confirm that he is not known to social services.

The liaison social worker arranges for a place to be reserved in a residential home and organises immediate support from the older people's mental health home treatment team. Mr. K then goes on a home assessment with the liaison team occupational therapist and a member of the home treatment team who would provide care if he refused to return to hospital. They find that Mr K. is living in squalor with no functioning amenities. Mr K. decides himself that he no longer wants to live in his flat and misses the comfort of the hospital. He decides to accept residential care and the home treatment nurse takes him to the home where he settles in well.

This case illustrates how the liaison team are more confident dealing with uncertainty and risk and are able to recruit the assistance of the mental health services. In this case the teams involvement allowed Mr. H to make his own decision about leaving home and may have avoided the need to direct him under compulsory powers.

Mrs. L is a 76 year old lady admitted for elective orthopaedic surgery. During two similar previous admissions she developed an acute schizophrenic disorder post operatively that responded completely to atypical antipsychotic medication. During these episodes she became mute, fearful, would not eat and resisted care because she was overwhelmed by auditory hallucinations and persecutory delusions.

On both occasions she was managed by the mental health liaison team who were responsible for referring her to the community mental health team after the first episode. At home she remained completely symptom free on a lower dose of antipsychotic medication but on this low dose she relapsed in the second post operative period. This was discussed between the liaison and community teams and agreed that the dose would be increased in advance of subsequent admissions.

Consequently, before the present admission the community psychiatrist increased the dose of medication for several weeks and the liaison team were informed of the admission. The liaison team saw her with her husband before surgery and throughout the post operative period explaining to the orthopaedic team the approach being adopted. For the first time her recovery from surgery was not complicated by psychosis and she returned home to her family and the care of the community team where the dose of medication could be reduced again.



This case illustrates the benefit of a liaison mental health team monitoring the admission of a patient who is under the care of community mental health services. The liaison team initially involved the community services and were then able to act as the link between the hospital and community and inform the treatment plan for subsequent admissions. Liaison teams become familiar with those older people developing mental disorder who may need regular admissions to hospital.

5: Education and Training in General Hospitals

- 5.1 Irrespective of the precise service model of liaison adopted there will be significant need for the mental health liaison service to provide education and training to ward-based staff. In one audit of a nurse-led liaison service 7.5% of time was spent directly on formal educational activity and 33% giving guidance, advice and making recommendations to the ward staff (136). It is essential, therefore, to build the delivery of education into a business plan for older people's mental health liaison services.
- 5.2 It is well known that clinician's attitudes, communication skills and the patient's age, gender and severity of symptoms all influence the detection of mental disorder (137). Lack of knowledge is another factor (137,138) and education can help rectify this. In one study, a one-day workshop for emergency care nurses led to significant improvements in screening for depression (139).
- 5.3 However, evidence from primary care suggests that offers of education to staff in isolation are often not taken up (140). Furthermore, it is not only the professional staff who may resist education about mental health. Compared to younger people the older person themselves is less likely to acknowledge mental health problems such as depression (141). They may benefit from education directed at self-awareness. The Royal College of Psychiatrists has useful information for older adults on its website. For educational initiatives to work time has to be set aside to gain the trust and confidence of the ward-based teams and this can take several months (142).
- **For educational initiatives to work time has to be set aside to gain the confidence of ward based staff.**
- 5.4 Education may be delivered to the patient (for example information about antidepressants), to individual professionals or groups (on or off the ward), to organisations such as Trusts or Workforce Confederations or even nationally. Junior medical staff have protected educational time. For them attendance in a group off the wards may be possible but for nurses shift systems and staff shortages may make this extremely difficult (142). Activities could be targeted at specific groups, as in the emergency nurse initiative cited above, or to a team. It is important not to overlook night-staff (142). There may be advantages to targeting particular wards. Lastly, liaison services may take a lead in stimulating research (143).
- 5.5 Principles of adult learning which may usefully be incorporated into educational programmes include timely and relevant information based on participant identification of learning needs and integration of new information into existing knowledge base(s) with time for consolidation and appropriate non-judgmental feedback to the individual (144).
- **Participants in training need to be involved with setting the training agenda.**
- 5.6 Increasingly, problem-based learning (PBL) is the preferred learning paradigm and lends itself to small group teaching using vignettes in the here and now. Actual cases managed by the ward staff create real meaning.
- 5.7 There is still a place for factual teaching, for example, the causes and management of delirium, how to manage behavioural problems in dementia, the diagnosis of depressive disorder in frail older adults, consent and capacity and a framework for risk assessment. Rapp et al (145), describe a successful programme designed to increase knowledge and confidence in managing confusion. They highlight the positive effects of top-up training if competencies and skills are to be consolidated.
- 5.8 Personal learning can encompass the Internet. For example, the International Psychogeriatric Association (IPA) offers free, high quality downloadable modules on Behavioural And Psychological Symptoms in Dementia.

- 5.9 Under the auspices of the English National Board (ENB), the University of Sheffield is commissioned to undertake a three year longitudinal study of the effectiveness of educational preparation to meet the needs of older people and their carers. This Website is designed to inform readers about the research and offer a forum for people to ask questions and contribute to the research by making comments and suggestions. The aim of the study is to explore the knowledge, skills and attitudes necessary to care for older people and the educational preparation of nurses in relation to older people and their carers.
- 5.10 Although it is questionable whether learning to administer instruments to screen for depression, delirium or dementia improves care, Shah (146) suggests that the screening procedure itself may increase awareness of relevant symptoms and hence may lead indirectly to improved management. There are well validated instruments available to screen for delirium (the Confusion Assessment Method)(147), depression (the Geriatric Depression Scale (148) – with a website containing the long versions and a number of translations); and dementia (The Mini-Mental State Examination)(149). For busy ward-based staff, there are shorter versions available which may also fit the requirements for a Single Assessment Process (SAP) introduced in the National Service Framework for Older People (2). An example is the Easycare schedule, a comprehensive geriatric evaluation schedule which includes two brief screens, one for depression (the 4-item GDS) and a 6-item one for confusion.
- 5.11 Lastly, a short risk assessment questionnaire can be useful for ward-based staff. Each locality has its own risk assessment tools which can be adapted.
- 5.12 Education directed at less publicised disorders such as anxiety, alcohol misuse and psychotic disorders in older people should not be overlooked. For example, the UPBEAT intervention programme in the United States targeted depression, anxiety and alcohol misuse (150). Co-ordination of educational outreach between services for older people and working aged adults needs to be thought through locally and plans should involve the recipients.
- 5.13 Protocols and integrated care pathways can be taught to staff. Ribby and Cox (151) outline the introduction of a confusion protocol with useful guidance. Although aimed at nurses other professional groups, including doctors, could benefit.
- 5.14 Finally, consider involving users and carers. Their credibility as those who actually experience the difficulties and their ability to graphically describe these experiences in the here and now can be a powerful tool for learning and change.
- 5.15 In summary, a strategy to introduce educational initiatives within an older peoples mental health liaison service includes attention to the following elements:
- The setting:
 - o Care of the elderly wards
 - o General medical wards
 - o Orthopaedic and other surgical wards
 - o Accident and Emergency
 - o Other

- The target condition:
 - o Dementia
 - o Delirium
 - o Confusion
 - o Depression
 - o Other disorders (for example, anxiety, alcohol misuse, schizophrenia)
- The audience:
 - o Individual professionals
 - o Professional groups
 - o A Trust
 - o National policy advisors
 - o Research funders
- The format:
 - o Individual tuition (usually ward-based)
 - o Problem-based learning – small groups (usually 8 –11)
 - o Lectures
 - o User and carer involvement
- The resources:
 - o Written educational material
 - o Printed screening instruments
 - o Educational material for patients
 - o Internet resources

Case Study

Mr. M is 86 and was admitted to hospital with acute confusion. He became wandersome, especially at night, disturbing other patients and was often found on other wards. He was prescribed a sedative when required. He received the first dose without obvious effect and was given a second 4 hours later. After a third dose he became sedated, fell, fractured his femur and lost his mobility.

Mr. M's relatives wrote a formal complaint. This was investigated and recognised that the difficulties presented by Mr. M were not unusual. The ward staff confirmed that acute confusion was common and they found it very difficult to manage. The liaison mental health team met with the ward staff. They agreed that it was not practical or appropriate to refer all such cases to the mental health team but the team could help with staff education.

Jointly they developed guidelines for the management of delirium and a pilot project to involve one ward with multidisciplinary workshops.

After staff training Mr. M was admitted to the same ward with acute confusion. He was found to have a chest infection. He was nursed in a side cubicle near the nursing station and some familiar things put in his room. The nurses made sure his hearing aid was working and that he wore his glasses. Each time they were in contact they reminded him where he was and why he was in hospital. They could see when he left his room and guided him back. No sedation was used and his confusion resolved over the week.



The liaison team agreed to run workshops for other wards in the hospital and to update these on a regular basis. A staff survey identified a range of topics including management of dementia, capacity and consent, use of psychotropic drugs and depression to be included in a training programme.

This case illustrates how an opportunity for training can arise from a single case and the constant presence of a liaison team facilitates confidence that allows ward staff to suggest a training need.

A multidisciplinary old age liaison team is well established and highly regarded in a district general hospital. The consultants in geriatric medicine are concerned that the liaison team may be receiving inappropriate referrals and that this is delaying them from seeing more important cases.

In collaboration they decide to audit referrals against jointly agreed criteria. They find that 78% of referrals are considered appropriate and 86% are seen within the time set by the operational policy.

It is agreed that the criteria for referral are reviewed and linked with care pathways for the management of common mental disorders. Furthermore, that the new criteria identify priority problems that need rapid response.

Within 4 weeks the necessary developments are in place and the care pathways are used in tutorials with general ward staff as part of a rolling training programme. It is the intention to re-audit after 6 months.

This case illustrates how collaborative audit can be developed to form the basis of training through non-judgemental feedback. The physical presence of a liaison team working in and with the general hospital facilitates the trust needed to produce a training agenda.

6: Strategic Planning

Liaison mental health and national health policy

- 6.1 This section attempts to pick up policy themes that are current and common to most if not all of the countries of the British Isles and likely to be important to service development in the next few years.
- 6.2 At the time of writing, Northern Ireland's Regional Strategy for Health and Well-being is awaiting publication following public consultation, though its content is likely to include elements already in the public domain from ministerial speeches and earlier strategy documents (152-154). England has the most detailed published national health strategy, targets and priorities (2, 155-157), though Ireland, Scotland and Wales all have published national health strategies that have common themes (158-161).

Common themes

- 6.3 Across the British Isles there is a commitment to increase financial resources for healthcare, with the expectation that this will reform services to deliver increased capacity, increased activity, and new ways of working to produce higher quality patient-centred services. Major drivers for change are the ageing population, medical advances, inflation in health care costs and increased public expectation. Governments are being more explicit about priorities, managing performance through target setting and monitoring, detailing national standards for service delivery with some form of independent inspection and are aiming to be more responsive to the needs of service users.
- 6.4 In all countries, services for older people and mental health are recognised as priorities requiring national attention and development. However, there is a greater focus on the acute general hospital, particularly with regard to emergency care and waiting lists to see specialists and for operations. This is the area where there are the most specific high-level "must do" national targets, to increase access and capacity. There is a common drive to reduce burden on general hospitals by avoiding unnecessary admission, reducing length of stay and facilitating early discharge recognising that this will require an expansion of primary care and community services. The phenomenon of "bed-blockers", people unable to be discharged due to inadequate services elsewhere in the system, is noted widely. Whole system thinking is needed to meet these demands.
- 6.5 Mental health care and general hospital services are usually considered separately in policy terms, though in Scotland's "Our National Health" (159) explicit mention is made of the evidence for the significant role of liaison mental health and the intention to promote development in this area. In England a short-listed prioritisation of targets has been published (157). This includes the development of protocols for the care and management of older people with mental disorder and supporting guidance specifically refers to liaison mental health (162).
- 6.6 In Northern Ireland the functions of health and social care are integrated. In the other countries there is a determination to ensure that organisational barriers do not detract from coordinated care for users, encouragement for joint working and for partnerships between statutory and voluntary bodies. Local planning is seen as essential to deliver responsive services. All countries have local bodies for planning services in line with national priorities and targets. The importance of engaging clinicians in the management process is endorsed.
- 6.7 Ageism in health and social care is highlighted as a potential problem and services should be based on need and not age. However, there does appear to have been a policy focus and



investment in mental health services for working age adults rather than older people. Age discrimination is likely to become more of an issue with the developing influence of the European parliament.

- 6.8 Better management of mental disorder in older people in the general hospital would make an important contribution to achieving all of the major policy priorities set out in this national context.

- **Better management of mental disorder in older people in the general hospital would help achieve many national health priorities.**

Influencing purchasing decisions

- 6.9 With many demands on a limited budget the ability of individual clinicians or managers within mental health services to influence purchasing decisions may seem limited. However, with a good case (and liaison mental health has a good case), close working between clinicians and managers and good interagency relationships the chances are considerably enhanced.

- 6.10 It is explicit policy in health departments to involve clinicians in management. Clinicians are experts who deal with uncertainty in their field that others cannot. Clinicians are the frontline staff who deliver the business of healthcare by dealing directly with patients and carers, and no service will succeed without their involvement. Managers have expertise in ensuring that organisational objectives are achieved, especially when that objective requires a range of activities performed through the efforts of a group and within budget. Clinicians and managers should use their respective strengths collaboratively.

- 6.11 However, good working relationships between a mental health clinician and manager alone will not be sufficient. There are a range of stakeholders within mental health services and other local partners that will need to be influenced and the number and strength of links within and across organisations will add strength to the cause. It is essential to understand how a proposed liaison mental health service will help others achieve their objectives and then help them to see the relevance of the plans.

- **Understanding how a liaison mental health service for older people will help others achieve their objectives is essential.**

- 6.12 From the previous policy themes, aspects to do with the access and capacity agenda, joint working with the community, anti-ageism and person-centred care are likely to be important to others.

- **Managers and clinicians should work collaboratively to build a case that will help achieve the objectives of all parties.**

- 6.13 One difficulty arguing for older persons mental health services within the general hospital is the cultural differences between the organisations. The culture of an organisation is an important determinant of acceptance or resistance to new ideas. There are blind spots, not necessarily through ill-will, but through ingrained beliefs and assumptions that mean some things are taken for granted without question. One such assumption is that the means to improve efficiency in the “acute” sector has nothing to do with mental health services for older people.

- **Time and effort are required to overcome cultural barriers.**

- 6.14 No opportunity for dialogue should be missed to educate or listen in order to understand others' agendas. Time spent listening to senior managers and clinicians from other organisations and involving them in developing a common idea for implementation is time well spent. The ability to be considered as "one of us" is important, and it is extremely helpful to be working together rather than in competition to meet common objectives.
- 6.15 Joint bids for financing with elderly care medicine, working age adult mental health services or social services are quite possible. However, positive relationships with trust may not come quickly. Commissioners, social services and the acute sector may require considerable dialogue to understand the potential of liaison mental health services for their own agendas.

Key Points

Clinicians and managers should:

- Use their respective strengths collaboratively.
- Build relationships with key stakeholders in relevant organisations.
- Understand the pressures and key objectives of potential partners.
- Make the most of opportunities for dialogue and education of others about liaison mental health services and how they may help to meet their service objectives cost effectively.
- Consider joint bids for funding with social services, elderly care medicine or working age adult mental health services.
- Be patient and persistent.

Writing the business case

- 6.16 Arguments for new funding need to be presented in a systematic way to allow commissioners of services or budget holders to consider why a project should be prioritised above others. In most cases an outline business case will be required.
- 6.17 A full business case would include more detailed financial information and predicted activity and would usually be expected prior to formal agreement to fund. Bids that have been developed collaboratively across agencies, are more likely to be successful, and the earlier commissioners are involved the better. The following is a guide to what should be included in an outline business case. Ask commissioners what format they prefer for bids and the optimum time for submitting.

Executive summary

- 6.18 The executive summary is a summary not only of the proposed service, but should also include key information in arguing the case for the service, covering the policy context, local need, options considered and overall cost. This is the section that is most likely to be read most fully. It must be clear and concise.

Strategic context

- 6.19 This might refer to national government policies and initiatives, as well as key reports by inspection bodies and professional organisations. It should include an understanding of local partners' service objectives and future plans. It is worth highlighting current good performance within the organisation and any other likely developments that may impact on the proposed

service. A comment should be made on the specific service developments that are required to meet the identified need. The implications (including cost) of investing or not investing in the scheme should be recorded.

Project management and evaluation

- 6.20 Summarise what the service objectives are and what benefits these objectives will bring. Objectives should be SMART (Specific, Measurable, Attainable, Relevant, Time-linked). Ideally, they should be outcome rather than process oriented and should be listed in order of priority for the commissioner receiving the bid. A description of the management of the project should be included with milestones and evaluation described according to the specified objectives.

Option appraisal

- 6.21 This section should consider a number (no more than 5) of different models of service delivery (see Section 3). One of the options considered should be the “do nothing” option.

- 6.22 A description of each option should include details of:

- Staffing (medical, nursing, management, secretarial etc)
- Activity (direct patient working, supervision, liaising with community, teaching and training).
- Particular benefits of that model
- Costs (start-up, capital and revenue including staff, accommodation, travel, administration, overheads etc)

- 6.23 The finance department should be involved as early as possible, as all costs must be included, and this section will be closely scrutinised. There may be potential savings to other parts of the health economy (health or social care). The “do nothing” option should also be costed as a baseline by which others will be compared. A forecast of how costs and savings might change over the first 3 years is recommended.

Risk

- 6.24 It is recognised that in all project plans timelines for achieving milestones and figures on expected activity and cost are estimates. The inclination when applying for funding is to underestimate costs and overestimate success. Potential threats to achieving the intended objectives should be considered, particularly the more likely or critical ones. This will demonstrate that the proposal has been thoroughly thought through and that the project management will be looking out for these factors in achieving a successful outcome for the service. Consideration of risk may influence which option is preferred. There may also be risks associated with the service being more successful than intended such as waiting lists, staff burnout etc.

Identify the preferred option

6.25 This is the concluding section, and should summarise the costs and benefits of the options (including the “do-nothing” option), and why the preferred option was chosen.

Key Points

Ask commissioners what format they require and the optimum time for submission

- Executive summary: key information, clear and concise.
- Strategic context: national and local priorities, service required for identified need, implications (including cost) of investing or not investing in new service.
- Project management and evaluation: timelines for achieving key objectives, monitoring and evaluation of the project against its key objectives.
- Option appraisal: consider different models of service including “do nothing” option. Include staffing, activity, benefits and costs of each.
- Risk: identify key risks and possible management of these for each option
- Identify the preferred option: summarise costs, benefits and reasons for preferred option.

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Appendix I

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Appendix II

Core Skills and Competencies for a Liaison Mental Health Nurse for Older People.

Knowledge

Normal ageing
Psychological adjustment to illness
Therapeutic interventions
Somatisation and illness behaviour
Medical conditions commonly producing psychological disturbance
Common medical conditions found in a general hospital
Physiology and nursing care
Mental disorders, prevention, assessment and management
Risk assessment and risk minimisation
Assessment and management of behaviour disorder
Legal and ethical issues, including mental health law, common law and capacity
Psychotropic medication and basic psychopharmacology
Health and social care policies and developments
Systems and consultation theory

Mental health nursing skills

Assessment
Risk management and risk minimisation
Person centred approach in collaboration with patients and carers
Psychosocial interventions
Specific psychotherapeutic interventions

Liaison skills

Change management skills
Interagency working
Education and training of general hospital staff
Clinical governance
Administrative skills
Supervision and support
Personal qualities (self directed, motivated, multidisciplinary team player, leadership)

Appendix III

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Dr. Greg Swanwick

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Appendix IV

Additional Sources of Information:

Liaison Psychiatry for Older People - <http://www.leeds.ac.uk/lpop/>

Royal College of Psychiatrists - <http://www.rcpsych.ac.uk>

British Geriatrics Society - <http://www.bgs.org.uk/>

Alzheimer's Society - <http://www.alzheimers.org.uk/>

Age Concern - www.ageconcern.org.uk

National Institute for Clinical Excellence - www.nice.org.uk

Faculty of the Psychiatry of Old Age, Royal College of Psychiatrists -
<http://www.rcpsych.ac.uk/college/faculty/oap/public/index.htm>

