

Liaison Psychiatry Services For Older People Project

An NHS SDO funded programme –
April 2006– June 2008

Phase 1: Literature review

Phase 2: Service mapping

Phase 3: Service evaluation (in progress)

Background to project

Older people occupy almost two-thirds of general hospital beds. Psychiatric illness is common in older people in general hospitals, and this psychiatric co-morbidity brings adverse consequences across a range of outcomes, with increases in length of hospital stay, rates of institutionalisation and mortality, and reduced quality of life for patients and their carers. Increased levels of frailty and complexity will serve only to compound the problem of psychiatric co-morbidity. A high proportion of psychiatric illness in general hospital settings is managed by general hospital staff who have received little or no training to deal successfully with this co-morbidity. This results in psychiatric illness not being recognised, or when it is recognised, management of both the psychiatric and physical illness may be sub-optimal or inappropriate with adverse consequences for services, patients and carers. This will also impact on the general hospital's ability to meet national targets set out in the NHS Plan and National Service Framework for Older People.

The magnitude of the problem is often widely under-recognised, with estimations of prevalence from senior clinical staff frequently being as low as 5%. However, rates of 27% for depression, 27% for dementia and 29% for delirium are typical, with even higher prevalences in particular settings; for example, on orthopaedic wards delirium is found in 61% of older people with hip fracture and depression and dementia are also more common than in community settings.

The outcomes for patients and carers are less well understood, but we do know for example that mortality is increased in depression (relative risk 1.6), dementia (RR 2.6) and delirium (RR 2.9), and hospital stays are longer (by as much as 11 days) after hip fracture in association with these problems. Institutionalisation and costs are also greater in the presence of mental health problems. Delirium leads to long-term symptoms of mental health problems and predicts the development of dementia. Also, older people make up only 2% of the self harm population but account for 25% of suicides.

There are several possible reasons for these poor outcomes, but the knowledge, skills and attitudes of general hospital staff towards the management of older people with mental health problems seem particularly important. General hospital staff regard mental health problems in older people as a problem for mental health services rather than for themselves, despite the fact that these older people are under their care and not the care of mental health services. In turn, mental health services for older people have developed a strong community focus that does not serve the general hospital population well, despite receiving between 25% – 50% of their referrals from general hospital wards and with referrals from this source rising.

A high proportion of mental health services for older people operate a consultation service to general hospital wards. Unfortunately, the consultation model relies on general ward staff both to detect mental health problems and to refer appropriately and there are deficiencies at both these steps, as mentioned above. Even when a referral is made the response may be too slow to be of benefit; only 5% of mental health services for older people surveyed in 2002 felt that they could respond to a request for assessment the same day, and only 40% felt that they could respond within a week. The speed of response is particularly important in NHS general hospital departments where turnover is high (such as medical assessment units), and the possibility of a response to an older person with mental health problems in an Accident and Emergency Department is remote at best, leading to inappropriate admissions to avoid breaches of the four hour target. Even where a mental health assessment is carried out through the consultation model, the advice offered is often not acted upon and the assessment has little influence on practice or outcome.

In recognition of this problem, some organisations have developed liaison mental health services for older people. These provide greater input to general hospital settings than the conventional consultation model. Their development provides older people with similar liaison mental health services to those available for adults of working age and provides a solution to the ageist provision of liaison mental health care as required by Standard One of the National Service Framework for Older People.

Literature review

One reason that the liaison model has not been more widely adopted is because there is little high-level evidence of effectiveness to justify the development of liaison mental health services for older people. A systematic review of mental health services for older people suggests that the liaison approach is superior. One randomised controlled trial found that older people with mental health problems in a general hospital setting were more likely to return to independent living if they received specialist multidisciplinary mental health liaison, and a further controlled trial from the USA of a liaison mental health service suggested that it could reduce length of hospital stay after hip fracture by 2 days and provide an overall cost benefit. This evidence was not, however, the main driver of choice of model by our survey respondents; they were much more concerned about the quality of care that older people with mental health problems in general hospitals received. Nevertheless, the potential for liaison mental health services for older people to benefit the whole health and social care economy (and particularly the performance of acute general hospitals) is evident. This whole-systems view may be particularly important given the approach to examining the implementation of the National Service Framework for Older People adopted by the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission, where a whole health and social care community rather than individual organisations are examined.

Hierarchy of Evidence-Results

LEVEL OF EVIDENCE	DESCRIPTION	NUMBER OF STUDIES
N/A	Meta- analyses and systematic reviews	5
I	Well designed randomised controlled trials	0
II-1A	Well designed controlled trials with pseudo-randomisation	8
II-1B	Well designed controlled trials with no randomisation	1
II-2A	Well designed cohort (prospective) study with concurrent controls	3
II-2B	Well designed cohort (prospective) study with historical controls	4
II-2C	Well designed cohort (retrospective) study with concurrent controls	3
II-3	Well designed case control (retrospective) study	0
III	Large differences from comparisons between times and/or places with and without intervention	0
IV	Opinions of respected authorities based on clinical evidence, descriptive studies, reports of committees	84

Our literature review demonstrates a lack of evidence pertaining to liaison psychiatry services for older people, and a proper, well-designed randomised controlled trial with cluster randomisation is required to evaluate this further.

Results

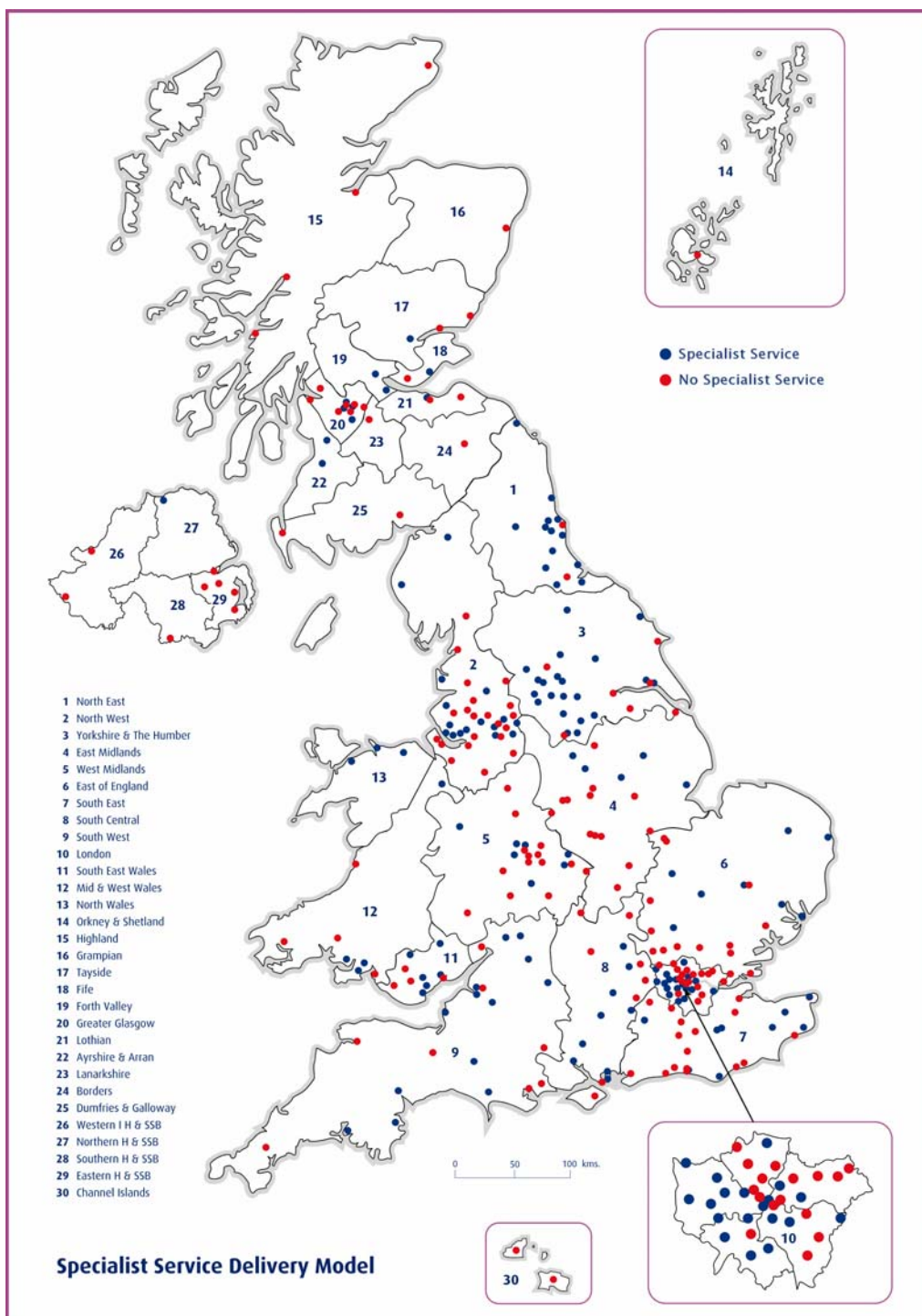
- Most studies were on liaison psychiatrist or sector model, with fewer on multidisciplinary teams.
- Results from randomised studies were mostly non-significant. However, these results should be approached with due caution as none had adopted the correct methodology of cluster randomisation for evaluating a complex intervention such as a liaison psychiatry service – these negative results could be misleading because of the inappropriate individual randomisation used, which could give rise to contamination between study groups.
- In terms of non-randomised studies, the Strain (1991) study is still the best evidence we have in support of liaison psychiatry for older people, indicating a reduction in length of stay and significant savings in hospital costs in patients who received the intervention.
- The results from other non-randomised evaluative studies have also been encouraging, hinting at the potential effectiveness of liaison psychiatry services for older people, although most of these studies are retrospective or use historic controls, and therefore, in terms of the evidence hierarchy, these studies are less reliable.

Conclusions

- We can make some deductions from the descriptive studies, although these studies do not formally evaluate outcomes, for example: improved compliance with the psychiatrist's recommendations, improved concurrence rate between reason for referral (as stated by referring physician) and the psychiatric diagnosis (as stated by the psychiatrist), higher rate of referral and shorter length of stay for referred patients and shorter response times. However, we cannot definitively state whether these improved outcomes are as a direct consequence of the liaison service, as other uncontrolled confounding factors may have contributed to these outcomes.
- A wide range of barriers and drivers to development have been recognised, with a central theme of clinicians' interest. Therefore services have developed in spite of, not in response to national policy and strategic planning.

Service Mapping 2006

374 (76%) of key clinicians involved in the delivery of mental health services to general hospital settings responded to our survey on service configuration. Data from other sources provides a comprehensive picture of the current service provision across the UK (100% of general hospitals in England).

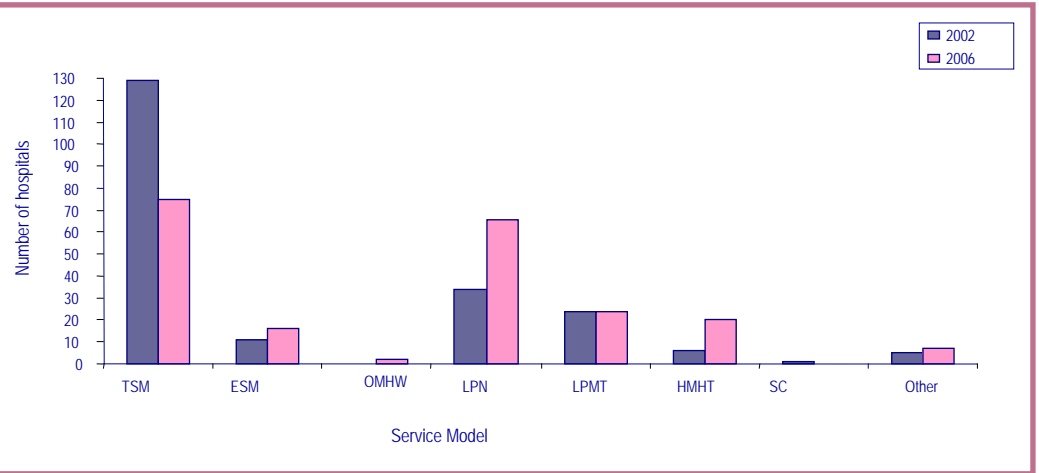


Specialist services comprise of several different models, some of which may operate with only an educational rather than clinical component. The exact choice of model is driven by a complex range of factors such as history, geography, personal interest of clinicians and managers, and resource allocation.

<i>Model</i>	<i>Description</i>
TSM	Traditional sector model
ESM	Enhanced sector model
OMHW	Outreach from mental health wards
LPN	Liaison psychiatry nurse
LPMT	Liaison psychiatry medical team
HMHT	Hospital mental health team
SC	Shared care
Other	Combined models

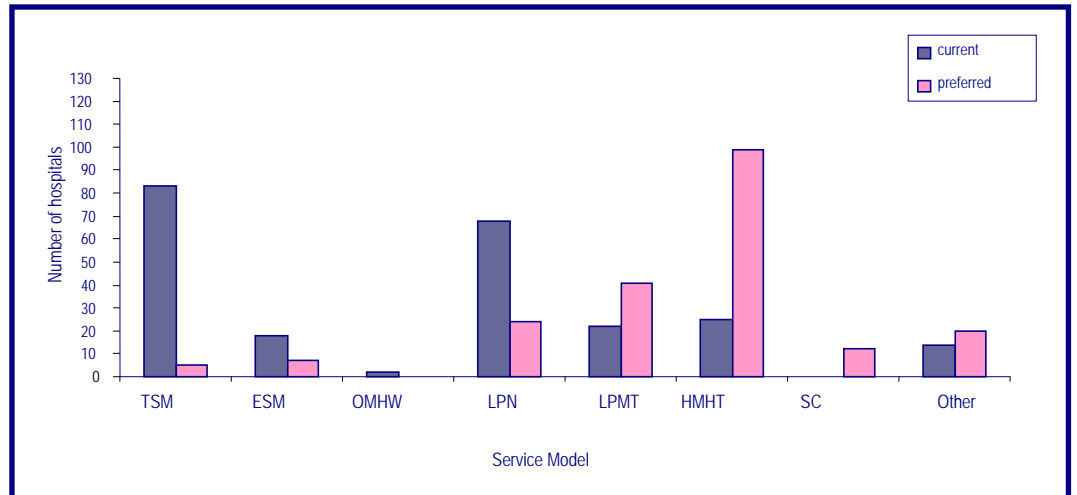
Changes to service configuration

Many clinicians report that the current model has changed from the initial service mapping in 2002. This has largely been towards more specialised services.



Preferred service models

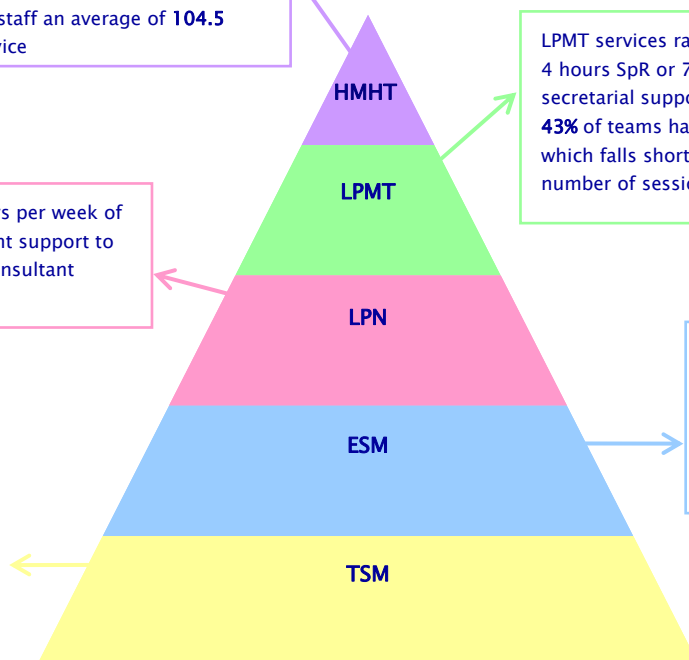
At the same time, many clinicians report that the current model in use is far from the ideal of that which is required to meet local needs, and that which has been recommended by the Royal College of Psychiatrists in the recent 'Raising Standards' report.



HMHT services range from 80 hours Consultant, 40 hours SpR and 112.5 hours Nursing time with f/t secretarial support or 15 hours Consultant, 4 hours SpR, 4 hours SHO, 187.5 Nursing hours, 30 hours OT, 70 SW hours and f/t secretarial support to 12 hours Assoc. Spec., f/t Nursing staff and part-time secretarial support. **87.5%** of teams have a Consultant and **87.5%** of teams have Nursing staff. A Consultant spends an average of **22 hours** and Nursing staff an average of **104.5 hours** per week providing the service

LPN services range from 225 hours per week of Nursing time with some Consultant support to 18 hours Nursing time with no Consultant support.

TSM services have no dedicated time from any profession to provide the service.

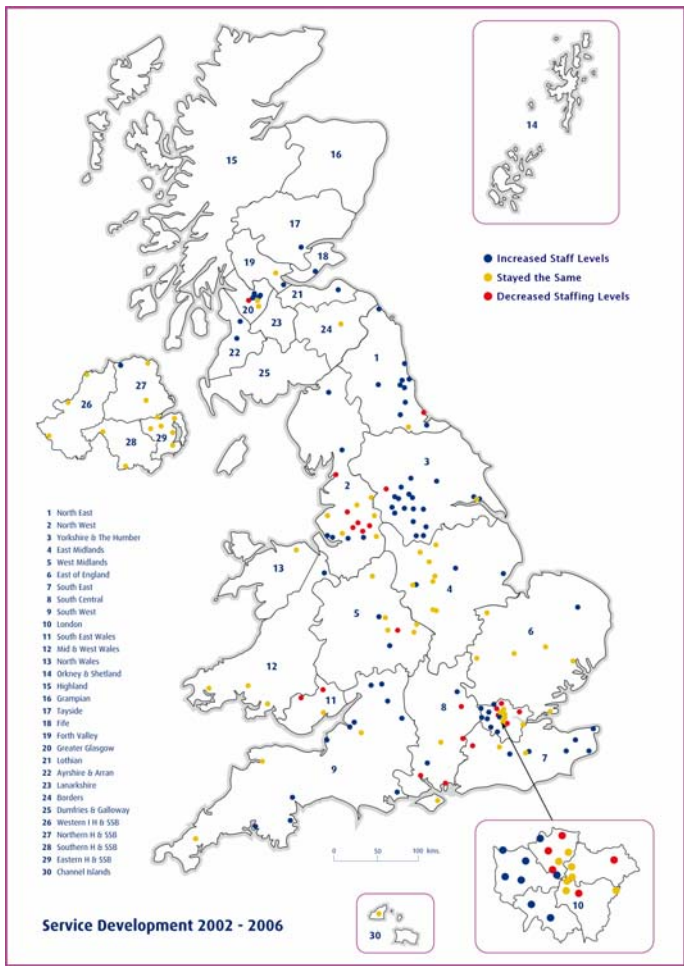


LPMT services range from 10 hours Consultant and 4 hours SpR or 75 hours Staff Grade and 5 hours secretarial support
43% of teams have some dedicated Consultant time which falls short of recommended minimum number of sessions for size of hospital.

ESM services typically comprise of 1 hour Consultant, 10 hours Staff Grade and 2 hours Nursing time. **20%** of these services have some dedicated Consultant time.

Service Staffing Analysis

There is evidence that **developments may not be in response to local needs** and are mainly driven by personal interests of clinicians concerned in the delivery of care. A 'postcode lottery' exists similar to that seen in the development of other specialities. Likewise, many liaison services continue to provide a reactive response to need, evidenced by the dedicated amount of clinical time in which to provide the service falling far short of that which has been recognised as basic minimum requirements. In fact, we were unable to establish a relationship between amount of clinical time and local population needs.



The majority of developments were attributed to key reports and service development guides (Between two stools, Everybody's Business, Who Cares Wins) designed to help prepare business cases for proposed funding (81%). Of those services that had a level of specialism, almost all had developed out of personal interest of clinicians concerned in the delivery of the service (87%). Only 28% of services reported development through pilot studies or audits of local needs. 18% of all respondents reported definite plans to change the model in the future. These planned changes were all concerned with securing funding to increase or maintain the current level of specialist liaison service. 30% of these proposed changes were driven by the results of local pilots and/or audits and almost all by service development guides (97%). The motivation for clinicians clearly lies within the context of attempting to meet general hospital demands:

'we need to respond to acute hospital demands and requests'

'we need to reduce bed blocking on medical wards'

Typical barriers to development clearly indicate a lack of priority being given at commissioning level:

'The challenge is getting the acute trust to own and develop the service.'

'No-one accepts responsibility for the services'

'No clear responsibility taken for service delivery'

'Our service is not managed by anyone'

'The service is commissioned by two different PCT's. Consequently we have a different service model for different patients within the same hospital'

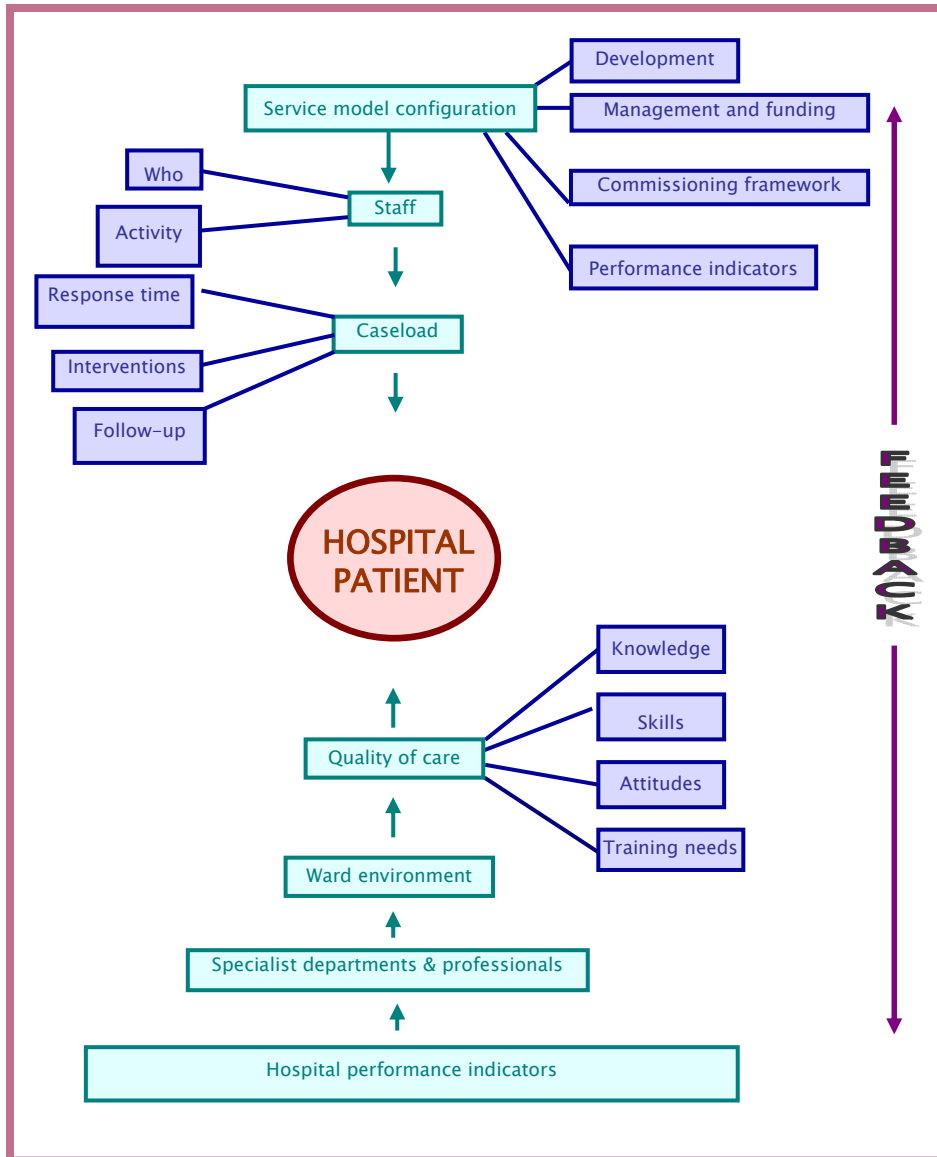
'Need resources. All resources are directed to the adult psychiatry and old age services are neglected'

'Financial restraints across the NHS. Psychiatry a low priority with fund holders; old age liaison even lower a priority'

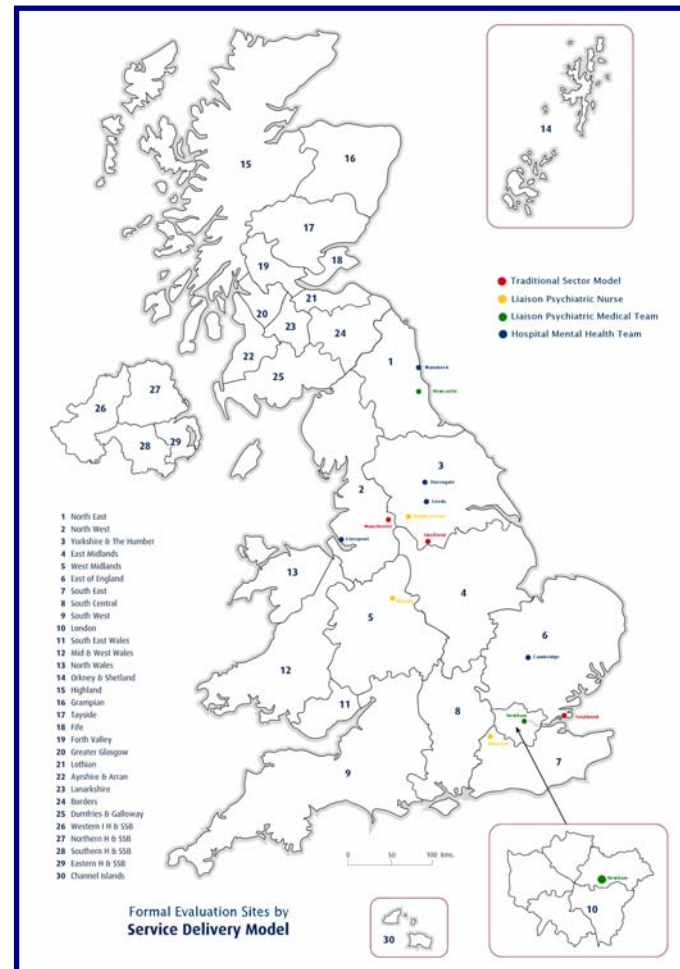
It is clear that lack of ownership persists, and without clearly defined priorities older people and their carers will continue to receive inappropriate, ad-hoc and in some instances no care tailored to meet their individual needs. General hospitals and mental health service providers need to understand the best evidence for successful service provision in order to meet these needs. The largest part of our study is designed to provide this information.

Service Evaluation

Our evaluation work to date has helped us to understand what outcomes can be measured that will help to demonstrate the effectiveness of different services. Broad areas of evaluation are shown below.



Initial piloting work, based locally, has provided insights into the complexities of organising trust wide research across different trust types and of the different methodologies that can be employed. These have been developed with the collaboration of service users and carers. A mixture of quantitative and qualitative data is being collected that will provide useful descriptions of services set within their local context. Multivariate analysis will highlight factors affecting the quality and quantity of care received. This work will also allow us to understand the extent of that which can be measured within a trial setting. All site evaluations will have been completed by the end of November 2007 with reporting due early in 2008.



Formal Site Selection

A selection of stratified sites operating different service models have been randomly selected to undergo an in-depth pragmatic evaluation of their services. Although this will not allow for direct comparisons to be drawn against different service models, it will provide us with valuable information on the scope of service provision and likely outcomes from typical configurations.

A service mapping exercise undertaken in 2006 reveals a significant increase in liaison– based work, which is related to a more responsive service with 83% of liaison–based services reporting that they can assess patients within one working day of request. All models report that they can respond to urgent referrals within 2 working days of receipt, which indicates that performance indicators have become a ‘must do’, regardless of method of service delivery . Nevertheless, traditional consultation models and understaffed specialist services continue to take almost one week to provide an adequate response. The persistence of inadequate provision despite a liaison service is common for sole clinicians who are often working in isolation from either community or general hospital based staff support, which in effect renders the service non existent during certain periods of absence. There is evidence that services have attempted to move towards a more effective method of delivery only to have funding denied and in some cases withdrawn, demonstrating a lack of priority given to this important area by funding bodies. Several reasons for this are exposed. There is a lack of time and facilities that are available to developed or emerging services in which they can effectively demonstrate their success. Conversely, even in those instances where services have been able to show effectiveness, their impact has been ignored by local commissioning bodies. Lack of agreement over responsibility for providing and managing the services lies at the core of this. The majority of services in our sample were funded entirely by mental health trusts, with acute trust funding being secured on an ad hoc basis for some condition–specific services or to facilitate speedy discharge. This lack of commitment is not surprising given that liaison mental health services for older people are not part of healthcare commissioning standards. This is likely a consequence of the current climate of emphasis on response times of services, and a focus on reducing length of stay rather than the actual quality of care the service is able to provide, or even the ability of the designated service to meet its basic aims and objectives. Better management of this group of patients would make a significant contribution to achieving all of the major policy priorities set out in a national context.



Contributors: David Anderson (Consultant Old Age Psychiatrist–Liverpool); Robert Baldwin (Honorary Professor of Psychiatry and Consultant Old Age Psychiatrist); Alistair Burns (Professor of Old Age Psychiatry–Manchester); David Challis (Professor of Community Care Research–Manchester); Marianne Dale (Project Secretary–Leeds); Amanda Farrin (Senior Medical Statistician–Leeds); Simon Gilbody (Senior Lecturer in Mental Health Services Research–York); Justin Keen (Professor of Health Politics and Information Management–Leeds); Jenny Hewison (Professor of the Psychology of Healthcare–Leeds); John Holmes (Senior Lecturer in Liaison Psychiatry of Old Age–Leeds); Allan House (Professor of Liaison Psychiatry–Leeds); James Mason (Professor of Health Economics–Durham); Carolyn Montaña (Project Manager–Leeds); Gwen Powell (Research Assistant–Leeds); Helen Pratt (Advanced Practitioner–Tameside); John Young (Consultant Geriatrician–Bradford)

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For further information about the project and if you would like a list of referenced material, please contact the Chief Investigator Dr John Holmes or the Project Manager Carolyn Montaña at the details given below:

Academic Unit of Psychiatry and Behavioural Sciences
School of Medicine
The University of Leeds
15 Hyde Terrace
Leeds
LS2 9LT
Tel: 0113 343 2469/1964
e.mail: j.d.holmes@leeds.ac.uk/c.montana@leeds.ac.uk