

Consultation–liaison in an old age psychiatry service

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This retrospective study looks at the outcome of 71 consecutive liaison referrals. Placement was noted at three-month follow-up and further use of medical, psychiatric and social services, compliance with clinical management and recommendations was also measured. Nearly half the patients had dementia and about half had a functional disorder. In 90% of referrals the recommendations were followed. At three-month follow-up 17% had died, 26% had further medical hospital admission, 39% had moved into a continuing care facility (residential/nursing home), and over half had further contact with the old age psychiatry services.

Previous studies of referrals to old age psychiatry consultation–liaison services have concentrated on descriptive analyses rather than the outcome of these referrals (Rabins *et al.* 1983; Folks and Ford, 1985; Ford & Folks, 1985; Wrigley & Loane, 1991; Mainprize and Rodin, 1987). Mayou *et al.* (1988) found that during the year following admission both those with affective disorder and organic disorder made considerable use of general hospital, psychiatric and social services. Popkin *et al.* (1983) devised a consultation–liaison outcome evaluation system to assess the effectiveness of consultative activities. This system assessed concordance of consultees' responses to consultants' diagnoses and recommendations. Cole *et al.* (1991) measured the effectiveness of a consultation–liaison service to elderly people admitted to a general hospital. They concluded that, while not highly effective overall, it may be useful to target those likely to benefit, and commented that greater effectiveness might be achieved if there was improved compliance with the recommendations by the referring physicians.

This study was carried out in order to examine an old age psychiatry consultation–liaison service in terms of further use of medical, mental health and social services, and also to assess compliance with recommendations.

The study

The study was conducted in the old age psychiatry service in Northwick Park Hospital, an urban district general hospital whose catchment area is the outer-London borough of

Harrow. There are approximately 30 000 people over the age of 65 years in the area and the old age psychiatry service is led by two senior psychiatrists with a multi-disciplinary team. Assessment and management of patients in the community forms the basic premise of the service, and a consultation–liaison service is provided to the general hospital.

The study was carried out by retrospective examination of medical case notes, nursing records and drug prescription charts of all general hospital in-patients referred to the service over a six-month period. Data collected included basic sociodemographic data, medical problems and reason for referral. Other data included psychiatric diagnoses and recommendations. A review of the notes conducted three months after the consultation identified current placement, further medical hospitalisation and use of mental health and community social services. Data were analysed using χ^2 tests where appropriate.

Findings

Socio-demographic data and community care services (Tables 1 and 2)

The study was carried out on a total of 71 patients. Just over two-thirds were women and

Table 1. Sociodemographic data

	<i>n=71 (%)</i>
Gender	
Male	23 (32)
Female	48 (68)
Marital status	
Married	18 (25)
Separated/divorced	4 (5)
Widowed	43 (61)
Single	6 (9)
Living circumstances	
Living alone	38 (54)
With family	27 (38)
With other	3 (4)
Sheltered	8 (11)
Residential	3 (4)

Table 2. Community care services before and at three-month follow-up

	Before, n=71 (%)	Three-month follow-up, n=31 (%)	
None	33 (49)	10 (32)	NS
Meals on wheels	17 (25)	13 (42)	NS
Home care	17 (25)	19 (61)	NS
Day care	7 (10)	9 (29)	NS
Respite care	0 (0)	1 (3)	NS
District nurse	3 (4)	6 (19)	NS

the mean age was 80.8 years (range 60–97). A quarter (25%) were married, and just under two-thirds widowed. More than half (54%) lived alone, while only three (4%) were in residential or nursing home care prior to admission. Almost half (49%) were not receiving domiciliary or health service support prior to admission and for those who were, the most frequent inputs were home care (27%) and meals on wheels (24%). Approximately one-ninth (13%) were in contact with structured day care, 9% with a district nurse and 6% with a community psychiatric nurse.

Psychiatric/medical data and reason for referral (Table 3)

Just over one-third (35%) had contact with the old age psychiatry service in the preceding 12 months but only two had a psychiatric admission. A diagnosis of dementia was made in 45%, a further 13% had an acute organic psychosis and 38% a functional disorder.

Many patients had multiple medical problems. The most frequent was cardiovascular (54%), with locomotor (45%) and central nervous system (39%) problems also occurring commonly.

In just over half (51%) the reason given for referral was a specific psychological symptom, 23% were referred for forgetfulness and 14% for a behavioural problem. Only 11% of referrals mentioned future placement as a reason.

Table 3. Psychiatric diagnosis

	n=71 (%)
Organic (chronic)	32 (45)
Organic (acute)	9 (13)
Functional disorder	27 (38)
Alcohol misuse	1 (1)
None	2 (3)

Recommendations (Table 4)

The single most frequent recommendation made was for social services care assessment and management (62%). For almost a quarter of these a specific medical recommendation was made for placement in a residential/nursing home, while 7% (five cases) were referred for psychiatric National Health Service (NHS) continuing care. Advice on psychotropic medication was given in almost half the cases (42%) and transfer to an acute psychiatric bed was advised in four (6%) cases. Nearly two-thirds (59%) were classed as needing follow-up by the Old Age Psychiatry service. Advice on behavioural or psychological management was the main contribution alone for 30% of cases. In 90% of cases the recommendations given were followed.

Three-month outcome (Tables 2 and 5)

At three-month follow-up almost a fifth (17%) had died, of the remainder half (44%) were still living in the community but a third (34%) were in residential or nursing home care and 4% were in psychiatric NHS continuing care. Community care services had increased overall. Prior to hospital admission half (47%) had no services, and at three months less than a third (32%) of community residents were receiving no

Table 4. Recommendations¹

	n=71 (%)
Psychiatric	
Advice only	21 (30)
Diagnostic investigations	4 (6)
Drug prescribing	30 (42)
Psychiatric admission	4 (6)
Other community follow up (e.g. CPN, day hospital)	42 (59)
Psychiatric continuing care	5 (7)
Social	
Social services	42 (62)
Residential home	8 (11)
Nursing home	2 (3)

1. Percentage may exceed 100 because all possible recommendations included.

Table 5. Outcome at three-month follow-up

	n=71 (%)	
Death	12 (17)	
Community	31 (44)	P<0.001
Residential/nursing home	24 (34)	P<0.001
Geriatric continuing care	1 (1)	NS
Psychiatric continuing care	3 (4)	NS

service. Overall the package of care had increased with a higher proportion receiving meals on wheels, home care and day care. Nineteen per cent were in contact with the district nursing service compared with only 4% prior to admission.

A quarter (24%) had a further general hospital medical admission, with a mean length of stay of 5.2 days. Further psychiatric contact was made in 54%, and 14% had a psychiatric admission.

Comment

As might be expected, there was a majority of much older women as reflected in the overall pattern of general hospital admissions. Despite this being a sample having multiple clinical problems almost half at the time of admission had no community services while just over half lived alone. At three-month follow-up there was an apparent increase in the use of community services, although due to the small numbers involved the differences did not reach significance. Increased use of community services is obviously a consequence of a systematic assessment of their care needs during the acute hospital admission (to which the liaison consultation may contribute). Some of this sample are likely to have substantial clinical and/or social morbidity or disability (e.g. related to dementia) prior to admission which has not been recognised, but for others the mental/physical deterioration leading to the acute admission means that new care needs are identified.

The distribution of psychiatric diagnoses is similar to that shown in other studies (Bergmann & Eastham, 1974; Ford & Folks, 1985; Mainprize & Rodin, 1987; Wrigley & Loane, 1991). There is a very low rate of 'no psychiatric diagnosis', indicating that the referral agencies recognised psychiatric illness in those they referred. The majority of referrals came from the care of the elderly service, and in this hospital there are close links between the two specialities with regular clinical and educational meetings. This undoubtedly increases awareness of the old age psychiatric service and ensures the appropriateness of referrals. In only 11% of cases was placement specified as the primary reason for referral. This reflects the situation which pertains in this borough where there is usually no major delay in procuring continuing care beds. Recommendations were followed in the majority of cases, unlike that found in other studies (Popkin *et al*, 1983; Cole *et al*, 1991). These recommendations were similar to those in other studies with only four being transferred to an acute psychiatric bed (Mainprize & Rodin, 1987; Wrigley & Loane,

1991). In two-thirds a referral for social services care management was recommended, emphasising the importance of the link between old age psychiatry and other agencies.

The prevalence of serious physical morbidity in the group is evidenced by the high mortality and frequent medical readmission at follow-up. It is not a psychologically homogeneous group as it involves patients with toxic confusional states, depression and dementia, all with primary physical illness. This increases vulnerability and emphasises the need for careful assessment, management and follow-up. Almost half were in some form of continuing care facility. It may be that admission to hospital is the final event prior to residential placement in a group with multiple problems.

Further psychiatric intervention occurred in over half of the group, and this result is in keeping with that of Mayou *et al* (1988), with 14% requiring admission and 24% further ward consultation. The consultation-liaison service is an essential part of an old age psychiatry service and one which requires regular clinical input and follow-up. Education and liaison with other departments are equally important activities.

This study re-emphasises the need for careful initial evaluation, management and follow-up of such patients. They need a multi-agency approach and good communication and coordination between medical, psychiatric and social services is essential. It also illustrates the significant psychiatric morbidity in consultation-liaison referrals and the value of an old age psychiatry consultation-liaison service. Further studies could include assessment of appropriateness of community care services and placement.

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