What makes CL services for older people effective?

A/Prof. Brian Draper
Academic Dept. for Old Age Psychiatry,
Prince of Wales Hospital, Randwick
&
University of NSW, Sydney, Australia

"Futile suffering and wasted resources can be minimised only by service delivery research which determines the most effective and most efficient mix of Psychogeriatric Services for particular groups of elderly psychiatric patients."

Cole, 1988

Consultation liaison psychiatry is ‘that part of psychiatry involved with non-psychiatric health workers in a variety of teaching and consultative roles’.

Lipowski (1983)

Unmet Needs Concerning Mental Disorders in Old Age

- The combined demands for a resolution of health problems by patients, their families, and their communities **to which the health system has an effective response** (WHO)
- Effective interventions are those that have a predictable and significant positive effect and are acceptable

Some attributes of quality in health care (Donabedian, 1992)

- ***effectiveness*** - the ability to attain the greatest improvements in health now achievable in best care

- ***efficiency***
- ***optimality***
- ***acceptability***
- ***legitimacy***
- ***equity***

Designation of Levels of Evidence

Level I	Evidence obtained from a systematic review of all relevant randomised controlled trials.
Level II	Evidence obtained from at least one properly designed randomised controlled trial
Level III	Evidence obtained from non-randomised controlled trials
Level IV	Evidence obtained from case series

How effective are CL services for older people?

- **Level II** evidence that CL services reduce LOS and costs, but mental health outcomes are not significantly better,
- **Level II** evidence that integrated hospital and community care is effective
- **Level IV** evidence that combined medical/ old age psychiatry wards are effective (Draper & Low, 2004)

How effective are interventions in geriatric mental health?

Depression

- Antidepressants – Level I evidence even when comorbid with chronic physical illness (though not with acute physical illness)
- Cognitive Behaviour Therapy – Level I evidence
- Physical Exercise – Level II evidence
- ECT - Level III evidence

How effective are interventions in geriatric mental health?

Dementia

- Cognitive decline – Level 1 evidence of modest effect of cholinesterase inhibitors
- BPSD – Level 1 evidence of modest effect of antipsychotic drugs and some psychosocial interventions
- Carer Stress – Level 1 evidence of effectiveness of carer support/education programs to reduce stress and delay placement

How effective are interventions in geriatric mental health?

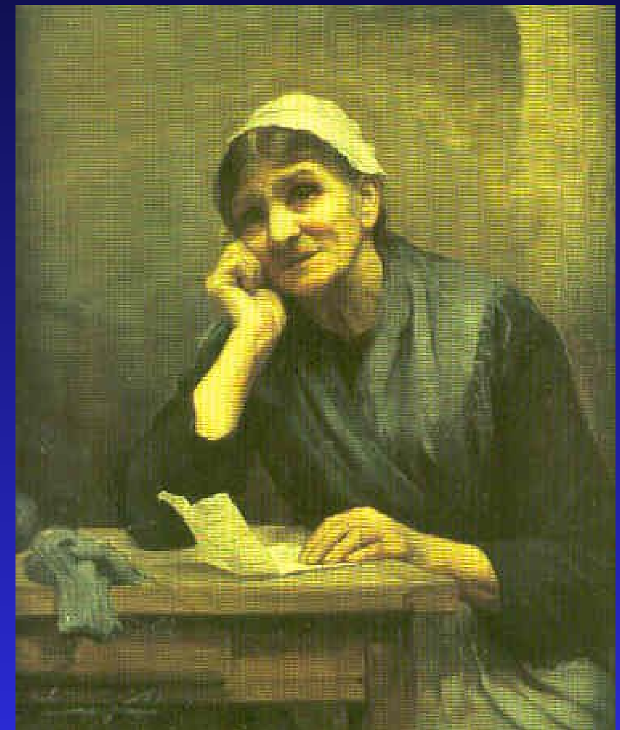
Delirium Prevention

- Level 1 evidence that systematic interventions to prevent delirium in elderly medical patients are effective
- Level 1 evidence that delirium prevention programs are NOT effective when there is comorbid dementia .

Translating effective interventions into practice -1

Training and Education

- Ensure adequate training of Old Age CL staff
- Train hospital staff (nurses, social workers, emergency ward staff, house doctors etc) in recognition of symptomatic and at risk older people (possible role of screening tools) and in provision of first line management



Skills & Knowledge required for Treating the Elderly

- Medical gerontology
- Biological determinants of mental disorders Stress of hospitalisation on elderly
- Diagnosis in patients with co-morbidities
- Ability to modify assessment techniques
- Non-ageist attitudes
- Understanding relevant laws e.g. guardianship, elder abuse, mental health
- Awareness of community aged care resources

Tier 7
Extreme disorders

Tier 6
Severe mental disorders

Tier 5
Moderate but complex mental disorders

Tier 4
Moderate mental disorders

Tier 3
Mild Mental Disorders

Tier 2
Risk Factors for Mental Disorders- Selective prevention

Tier 1
No Mental disorder – Universal prevention

Intervention Use Cumulative

Tier 2: Selective Prevention

Older people at high-risk of mental disorders

- Dementia but no BPSD
- Medical disorders such as stroke, Parkinson’s disease, macular degeneration
- Past history of recurrent mood disorder
- Acute physical illness & risk factors for delirium

Tier 2 Interventions

- Delirium prevention programs - modestly effective for intermediate risk patients without comorbid dementia (e.g. Inouye et al, 1999).
- Treatment of all post-stroke patients with antidepressants, e.g. sertraline reduced depression rates at 12 months (Rasmussen et al, 2003)
- Caregiver training programs may prevent or delay emergence of BPSD (Brodaty & Gresham, 1989)
- Depression relapse prevention enhanced by combined antidepressant/psychotherapy (Reynolds et al, 1992)

Translating effective interventions into practice - 2

Best practice protocols

- Unproven effectiveness in terms of treatment outcomes though evidence of increased recognition and treatment of depression and medication guidelines for BPSD lead to more appropriate use
- Provide guidance for hospital staff that are used to having such protocols in other fields
- Staff training can lead into the adoption of protocols

Translating effective interventions into practice (3) – Liaison Style of Service

CONSULTATION

- See patients upon request
- Advise on diagnostic and management issues
- Direct service provision mainly by primary care provider, some by consultant

LIAISON

- Greater focus on education and support of primary care
- More emphasis upon supervision of primary care management
- See patients upon request
- More resources needed

Meta-analysis of Consultation and Liaison Service Styles

Draper & Green

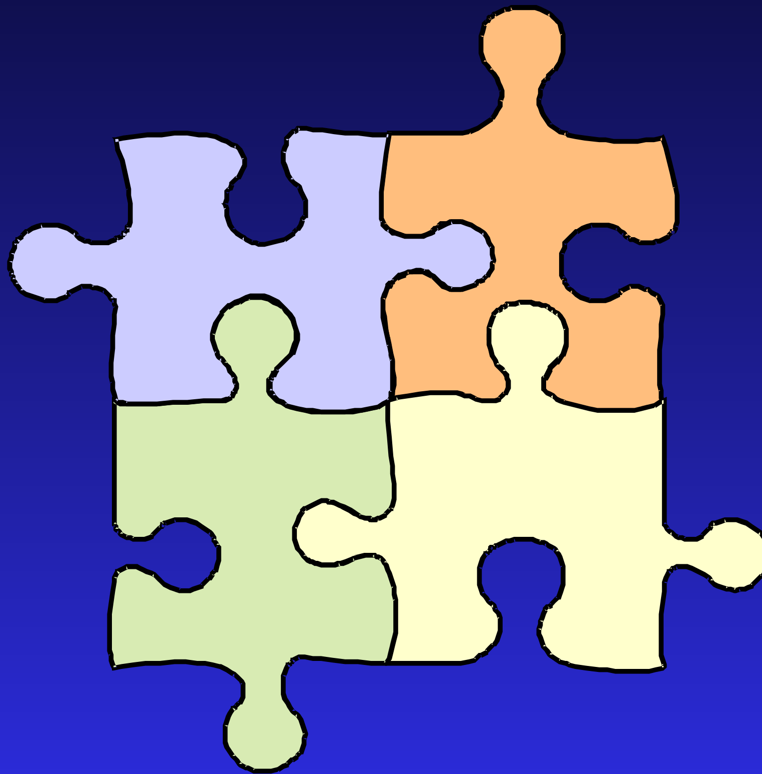
- Consultation style studies were found to be **ineffective** with a effect size of -0.06
- Liaison style studies were **effective** with an effect size of 0.60
  - Positive effect on costs, LOS (for acute care settings), anti-psychotic use
  - Mixed effect on function, behavioural disorders

Unresolved Questions

- How can you best deliver a liaison style service with limited resources?
- What is the ‘minimum effective dose’ to achieve an effective liaison style service?
- Is the liaison style service delivery cost effective?

What can you do if you do not have the resources to offer a full liaison style service?

1. Develop Good Relationships with Key Hospital Staff



- Essential in all service delivery but likely to compensate for resource deficiencies that prevent full liaison service
- Shared care style – work with the referring team

2. Provide a Selective Liaison Service (1)

Focus on specific departments e.g.

- Geriatric medicine
- General medicine
- Neurology
- Orthopedics
- Emergency Room

3. Provide a Selective Liaison Service (2)

- Delirium or BPSD ‘Flying Squad’ ± combined medical/OAP beds

Translating effective interventions into practice - 4

- **Service organisation**
  - Single entry point
  - Triage
  - Documentation
  - Regular case reviews
  - Routine Clinical Outcome Measurement
  - Integrated hospital & community care

Triage - Risk Assessment Screen (Draper & Melding, 2001)

A. Harm Assessment

levels of risk of harm to self or others – 4 levels low to severe

B. Medical context assessment

The nature of the patient's medical and psychiatric condition will also have an impact upon the urgency of the assessment. 3 levels – low to high

C. Ward environment assessment

The capacity of a ward to manage behaviours often depends on the suitability of its design and the purpose of the ward. Four levels – poor to excellent

This risk assessment allows for a more accurate triage of referrals.

Three categories of referral can be identified:

- 1. Emergency - requires an immediate response
- 2. Urgent - requires a same-day response
- 3. Non-urgent - the assessment should be undertaken as soon as practicable, usually within 72 hours of referral.

Reviews & Routine Clinical Outcome Measurement

- Ensure that there are regular case reviews within the service that include the community old age mental health team ± other care providers
- Collect outcome data e.g. HoNOS-65
- Research!

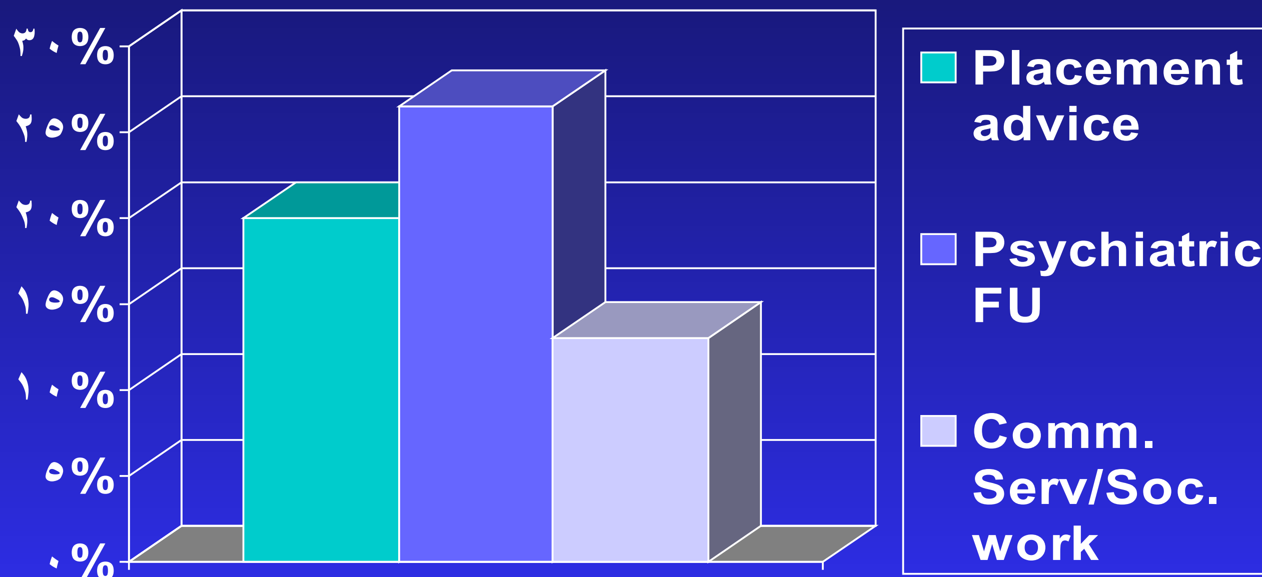
Outcomes Of Depression In Elderly Medical Patients

Cole & Bellavance (1997)

- meta-analysis of 8 studies

	≤ 3 months	≥ 12 months
Well	18%	19%
Depressed	43%	29%
Dead	22%	53%

Management Recommendations - Old Age Psychiatry Services (Draper, 2001)



Conclusion

- Effective services use evidence-based approaches to patient care including
  - ‘Best Practice’ interventions
  - service delivery style adopted
  - focus on prevention

Thank You!

- Brian Draper

B.Draper@unsw.edu.au

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