

# The Future for Consultation Liaison Services for Older People

Brian Draper MD  
University of NSW  
Sydney, Australia



# Summary of Presentation

- CL services for older people circa 2006 – what is happening and are they effective?
- Projections of population ageing & mental health
- Hospitals in health service delivery – past, present and future
- CL services for older people – the future
- Conclusion

# Mental Disorders in Old Age

<b>Disorder</b>	<b>Community</b>	<b>General Hospital</b>
Dementia	5% 65+ 20% 80+	22-61%
Delirium	< 1%	15-48%
Depression	8-13%	23-45%
Anxiety	5-15%	4-11%
Alcohol	2-3%	2-13%
Psychotic disorder	1%	2%

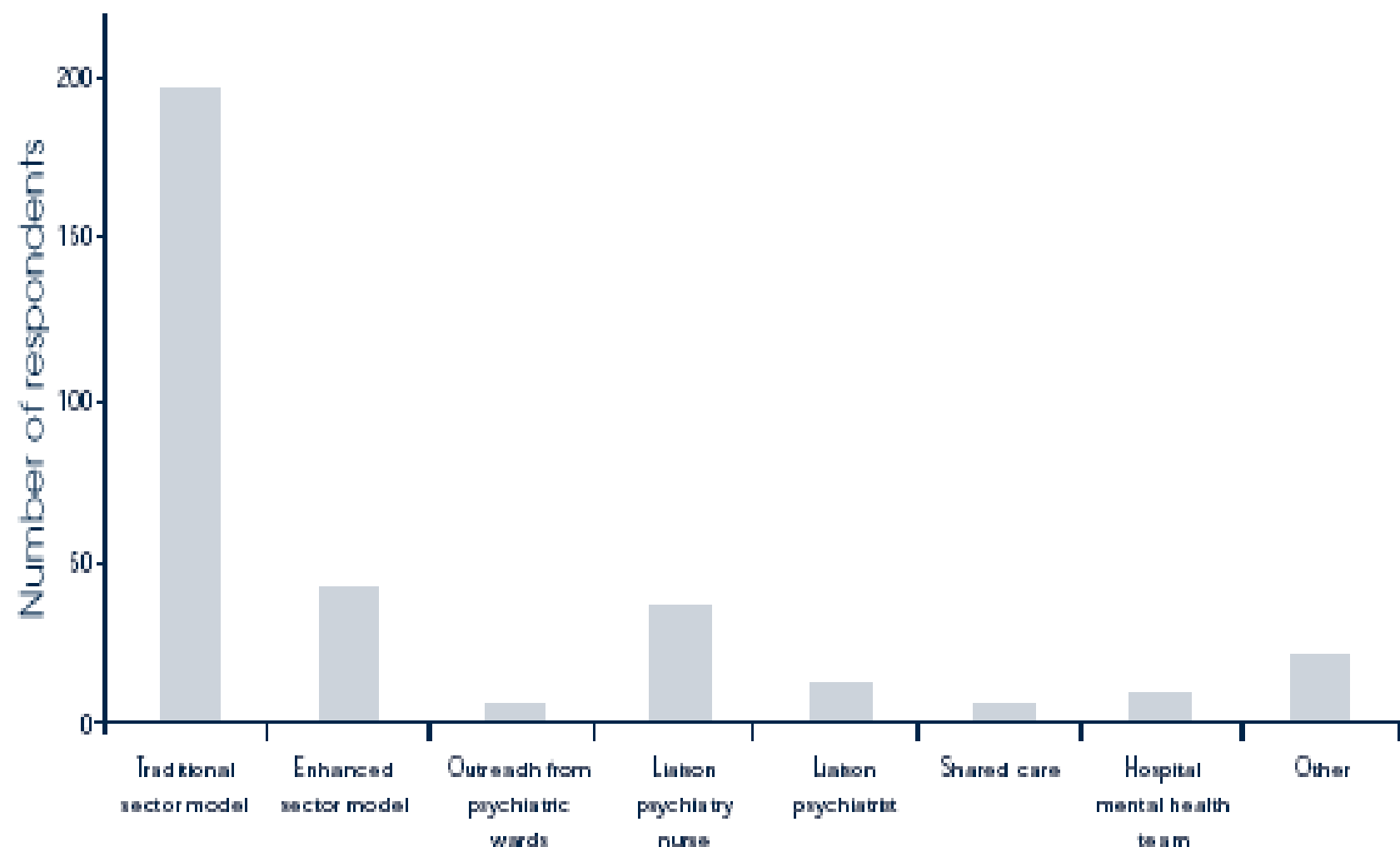
# Referral Patterns of Older Patients

USA - over last 15-20 years proportion of elderly CL referrals has ↑ from 20-30% to > 50% (Draper, 2001)

UK - 25% of referrals to old age psychiatry services from general hospitals (Holmes et al, 2002)

0.9 - 5.5% of older general hospital patients are referred for consultation – lower rates than younger patients (Draper, 2001)

Figure 6.1 The range and number of current psychiatric service models for older people in general hospitals



# Underutilisation of Psychiatric Consultation for the Elderly

- Less than 25% of patients who met a 'high risk' profile were referred

Swigar et al, 1992

Improved referral rates by:

- Liaison style service
- Use of screening instruments by ward staff
- Education

# 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
- Effective interventions are those that have a predictable and significant positive effect and are acceptable

How effective are consultation  
liaison services for older  
people?

# 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

# Audits of Effectiveness of CL Services for the Elderly (Draper, 2001)

- Reduced LOS
- Improved physical functioning
- Increased recognition of depression
- Increased service use post-discharge
- Fewer nursing home transfers
- **Level IV Evidence**

# Medical Psychogeriatric Wards

Draper & Low (WHO Health Evidence Network, 2004)

- Combined psychogeriatric and geriatric medical wards intentionally established to be jointly run by psychogeriatricians and geriatricians
- Apart from uncontrolled LOS, discharge and mortality data, there are no other reported outcomes.
- only Level IV evidence of effectiveness

# Consultation/Liaison to Medical wards

Draper & Low (WHO Health Evidence Network, 2004)

- Level II evidence that C/L services reduce LOS and costs, but mental health outcomes are not significantly better

# Integrated CL and Community Care

Kominski et al (2001) 'UPBEAT' study

RCT of 1687 older medical inpatients screened positive for depression, anxiety or alcohol

UPBEAT intervention involved in-depth psychogeriatric assessment and proactive mental health care coordination by a multi-disciplinary clinical team

12 month FU - mental health and general health improved in both groups

UPBEAT resulted in overall savings of \$1,856 per patient by reducing inpatient bed use

# Integrated CL and Community Care

Draper & Low (WHO Health Evidence  
Network, 2004)

- On the evidence hierarchy there is Level II evidence that integrated hospital and community geriatric mental health care is effective on non-mental health outcomes

# Current Trends

Move from Liaison to Consultation on high risk groups e.g. elderly hip fractures

Due to:

- Limited cost effectiveness data
- Reduced LOS
- Lack of reimbursement mechanisms
- Understaffing

# Consultation or Liaison Service Style?

## CONSULTATION

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

## LIAISON

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

# Comparisons of Liaison & Consultation Models

Liaison models have advantages:

- Most have higher referral rates
- More depression referrals
- Better diagnostic accuracy in referring doctors
- More reviews by consultant
- Better compliance with treatment

(Scott et al, 1988; De Leo et al, 1989; Swanwick et al, 1994; Baheerathan & Shah, 1999)

# Meta-analysis of Consultation and Liaison Service Styles

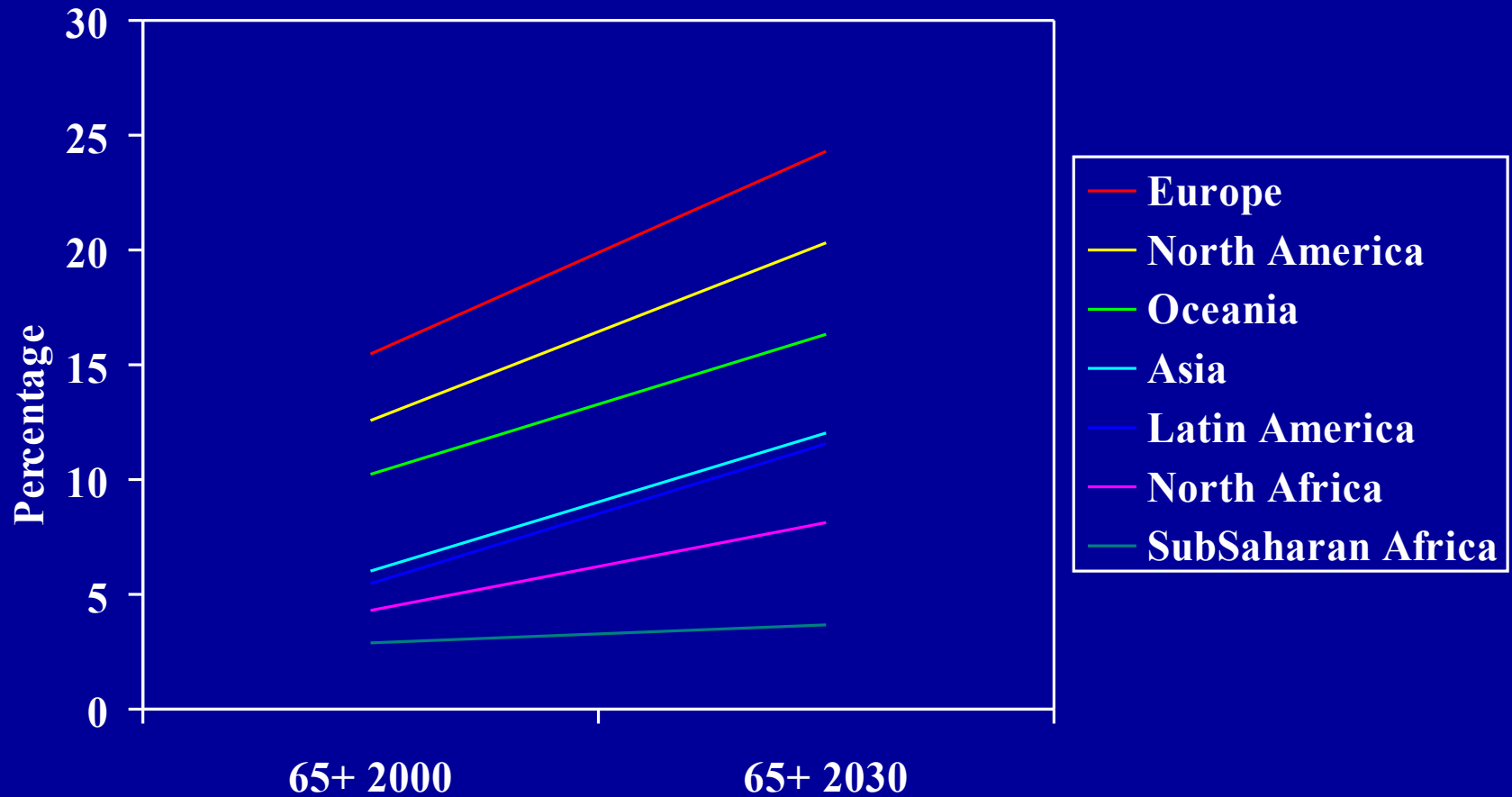
Draper & Green (unpublished)

- 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

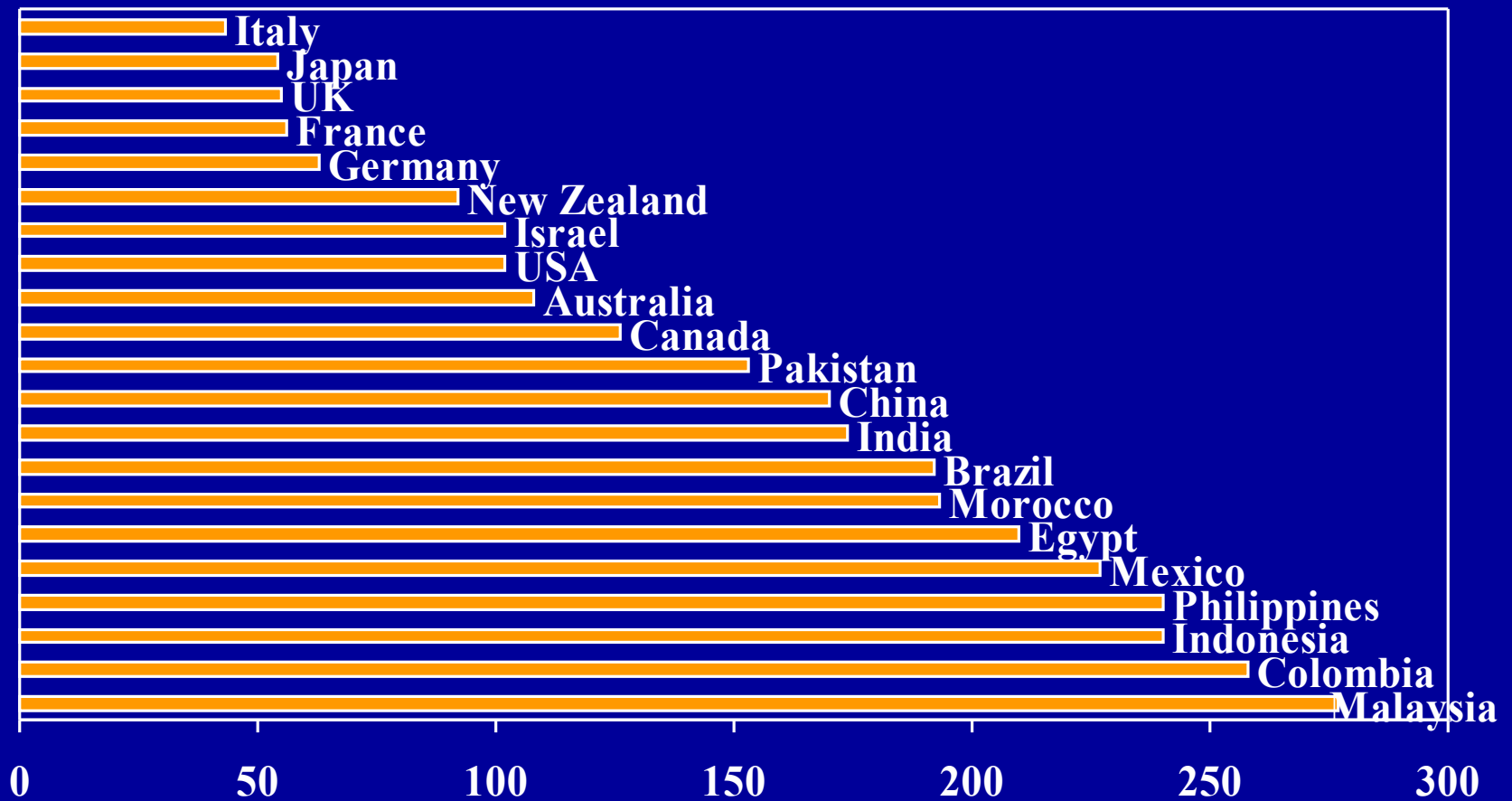
# The Ageing Population



# Impact of an Ageing World: Percent Elderly by Age - 2000 to 2030 (US Census Bureau, 2001)

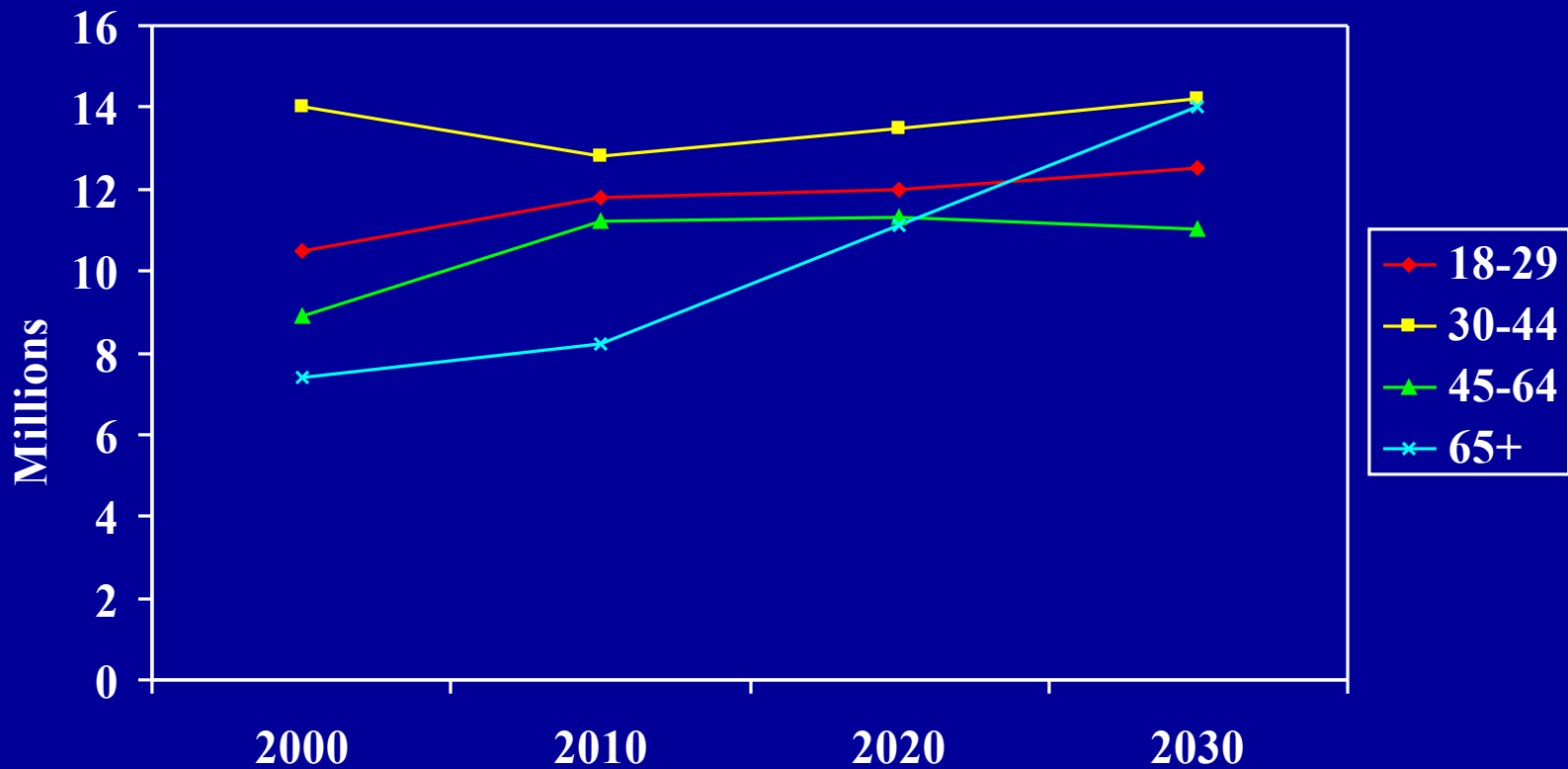


# Percent increase in elderly population in selected countries, 2000 – 2030 (US Census Bureau 2001)

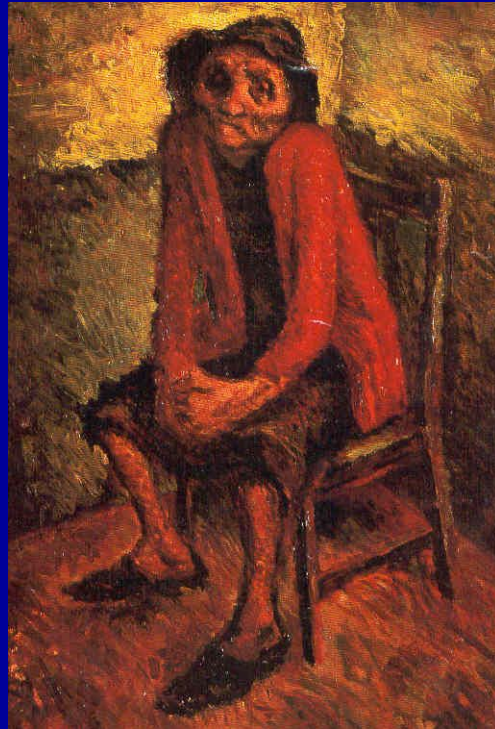


# Estimated Prevalence of Major Psychiatric Disorders by age-group

Bartels 2003



# Hospitals in health service delivery – past, present and future

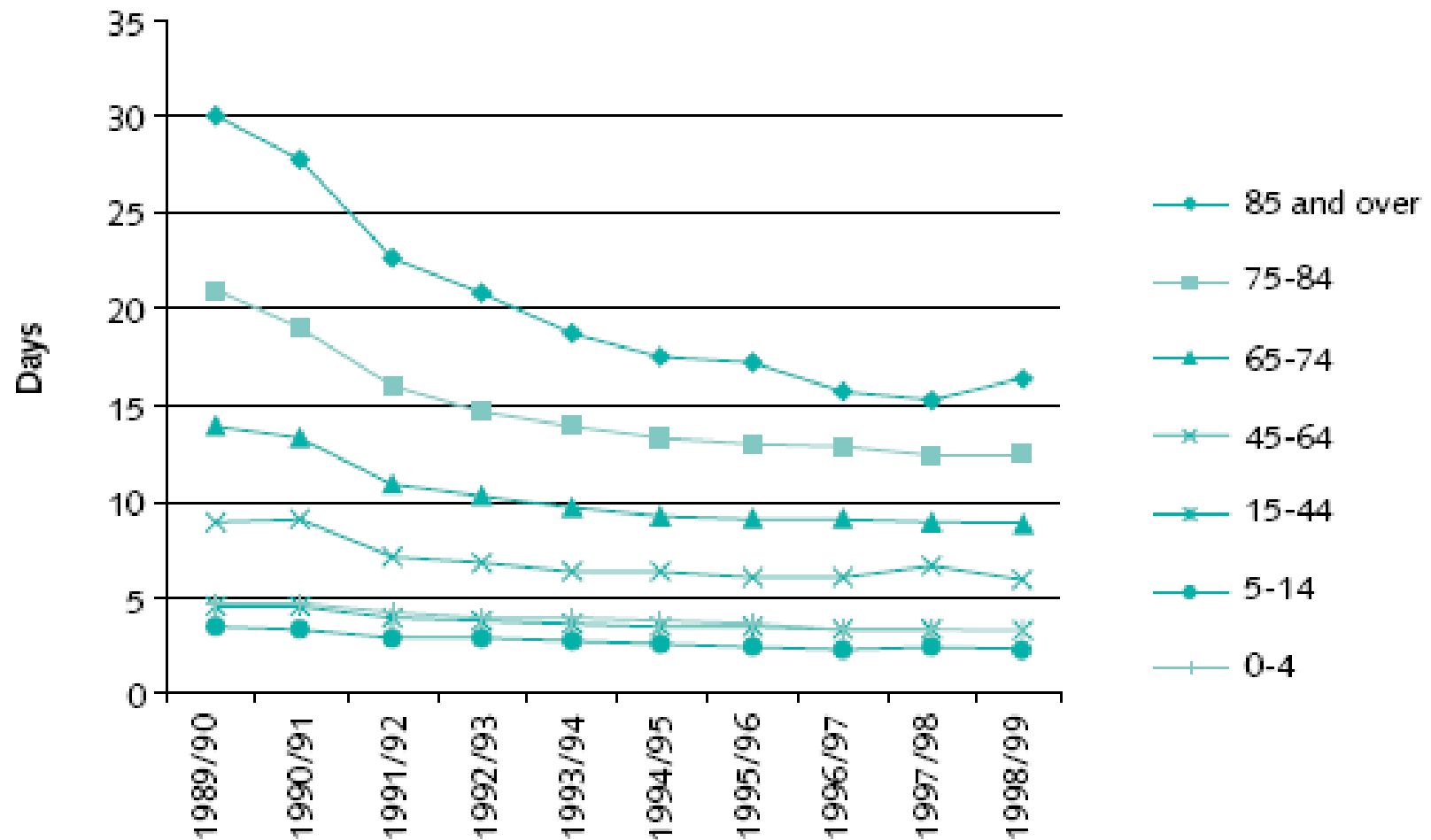


# Trends in UK hospitals

- Total bed numbers ↓ 39% (1970-98)
- Per capita bed numbers ↓ 42% (1970-98)
- Day beds ↑ 400% (1987/8-1998/9)
- 3.4% pa ↑ in admissions (1980-1998)

# Length of Stay UK Hospitals 1989-99

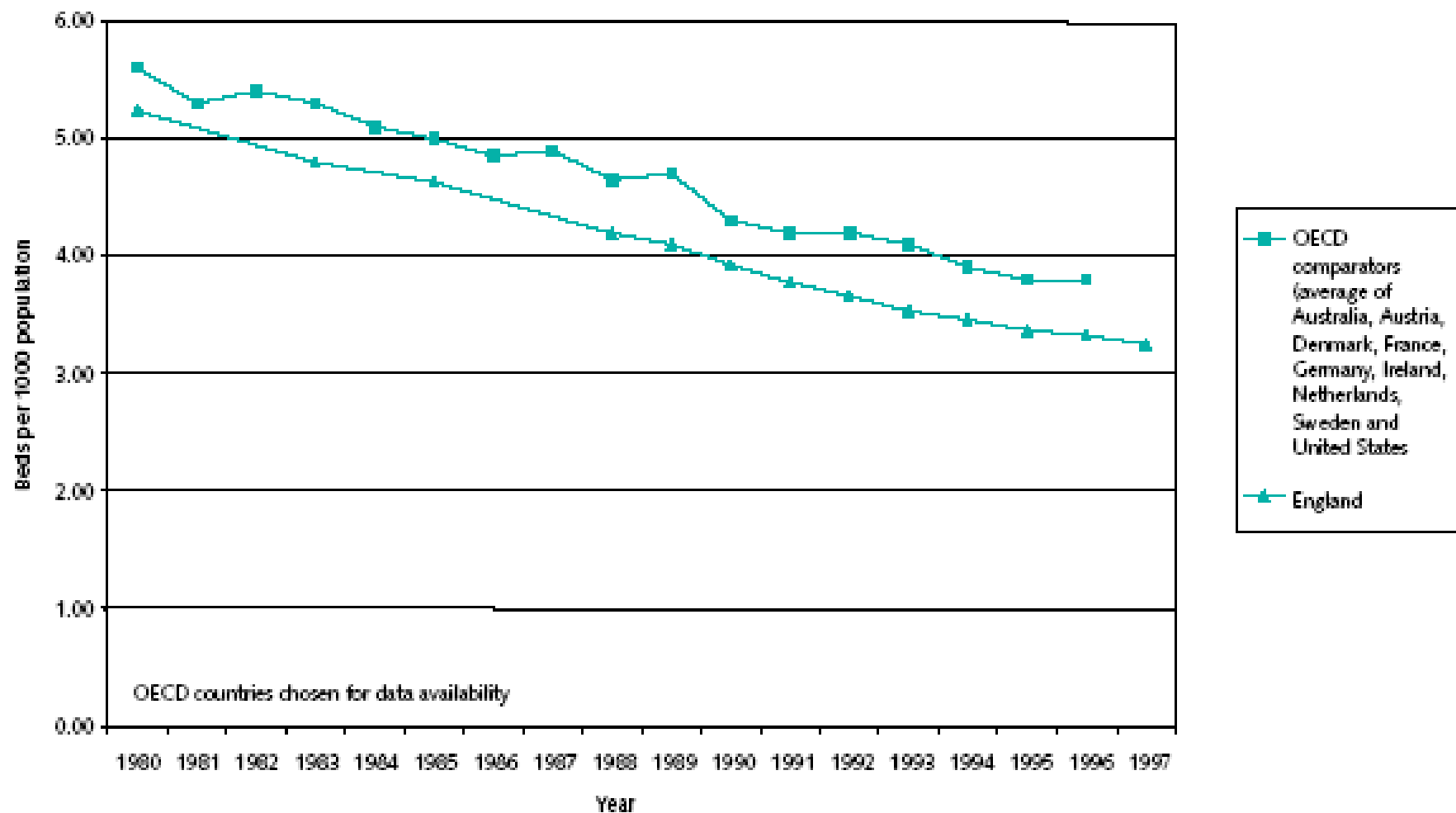
Chart 3.6 General and acute length of stay (by age group)



# Older People in UK hospitals 1998/99

- People aged 65 and over
  - 16% of population
  - 37% hospital admissions
  - 63% bed days

Chart 5.2 Trends in acute beds in England and in OECD countries 1980-1996/7



Source: OECD/Department of Health. England figures include general, acute and maternity beds plus private bed estimate.

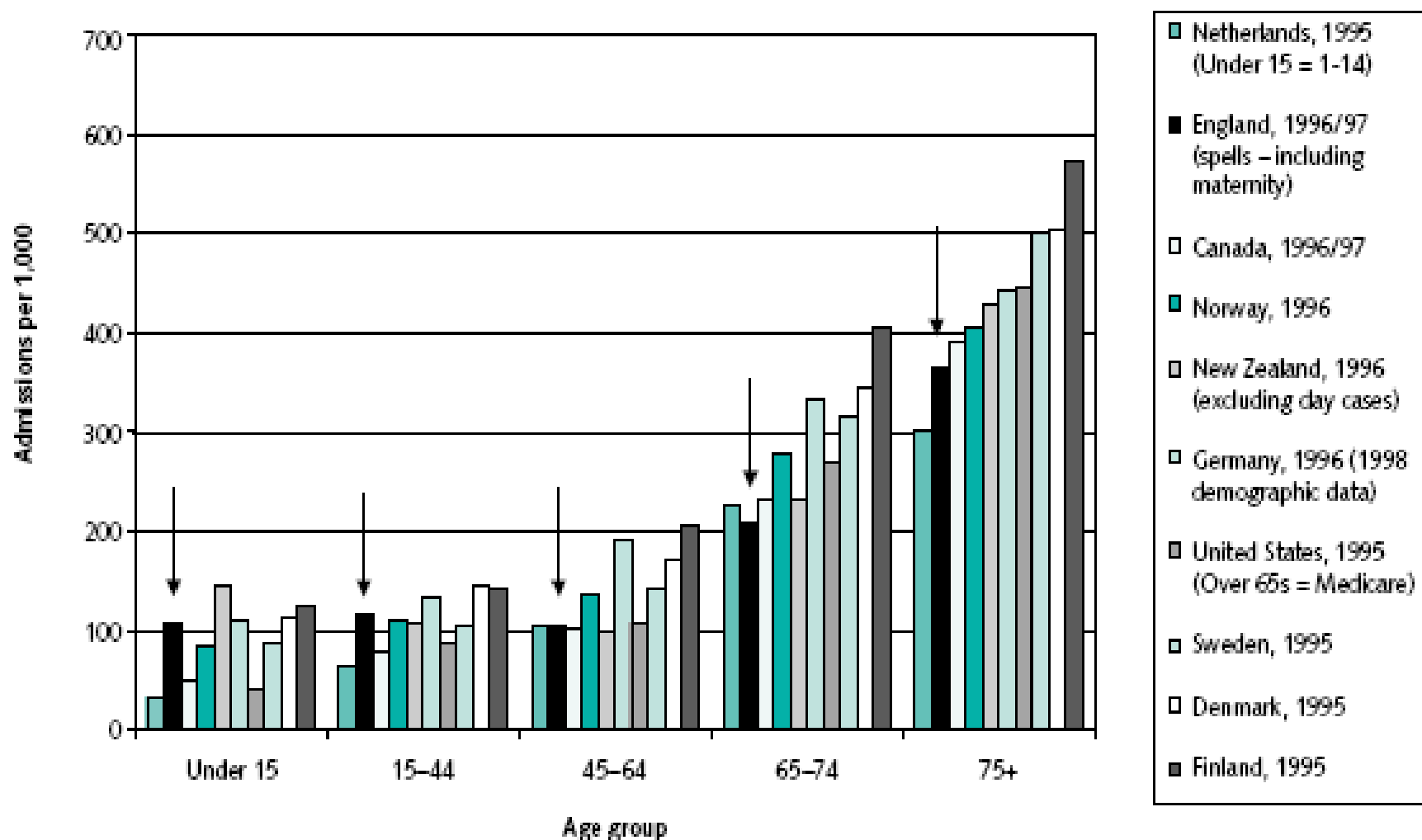
# Trends in Australian Hospital Utilisation Private vs Public 1997-2002

- Public Hospital beds, Separations and Patient days are all declining
- Private hospital beds, Separations and Patient days are all increasing

In both sectors

- Same day separations are increasing
- Average LOS is decreasing

**Chart 5.5 An international comparison of age-specific acute (overnight) hospital admissions for a number of developed countries**

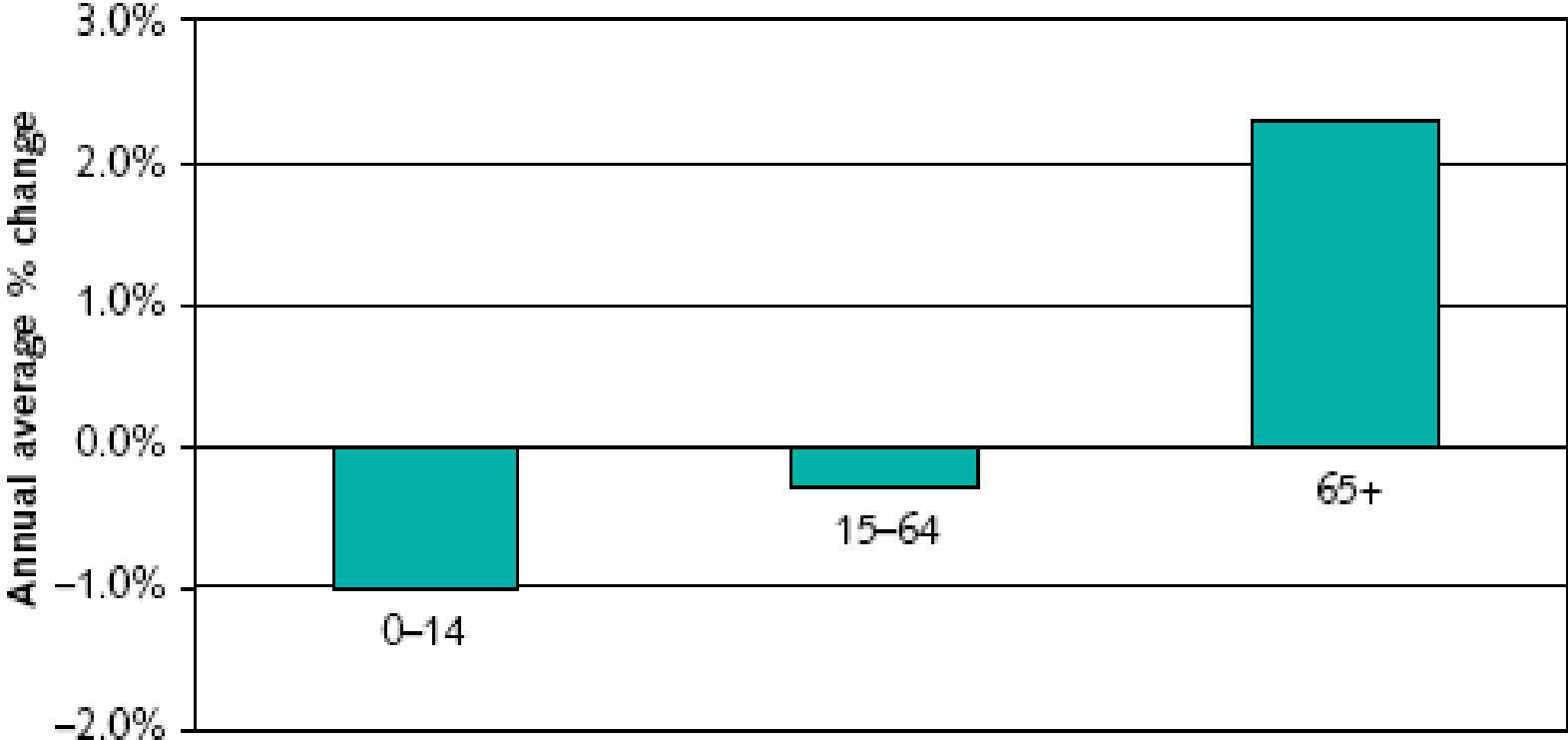


Source: OECD/Department of Health. England data excludes admissions to private hospitals.

# Patients age 65+ LOS in US and English hospitals (BMJ, 2004)

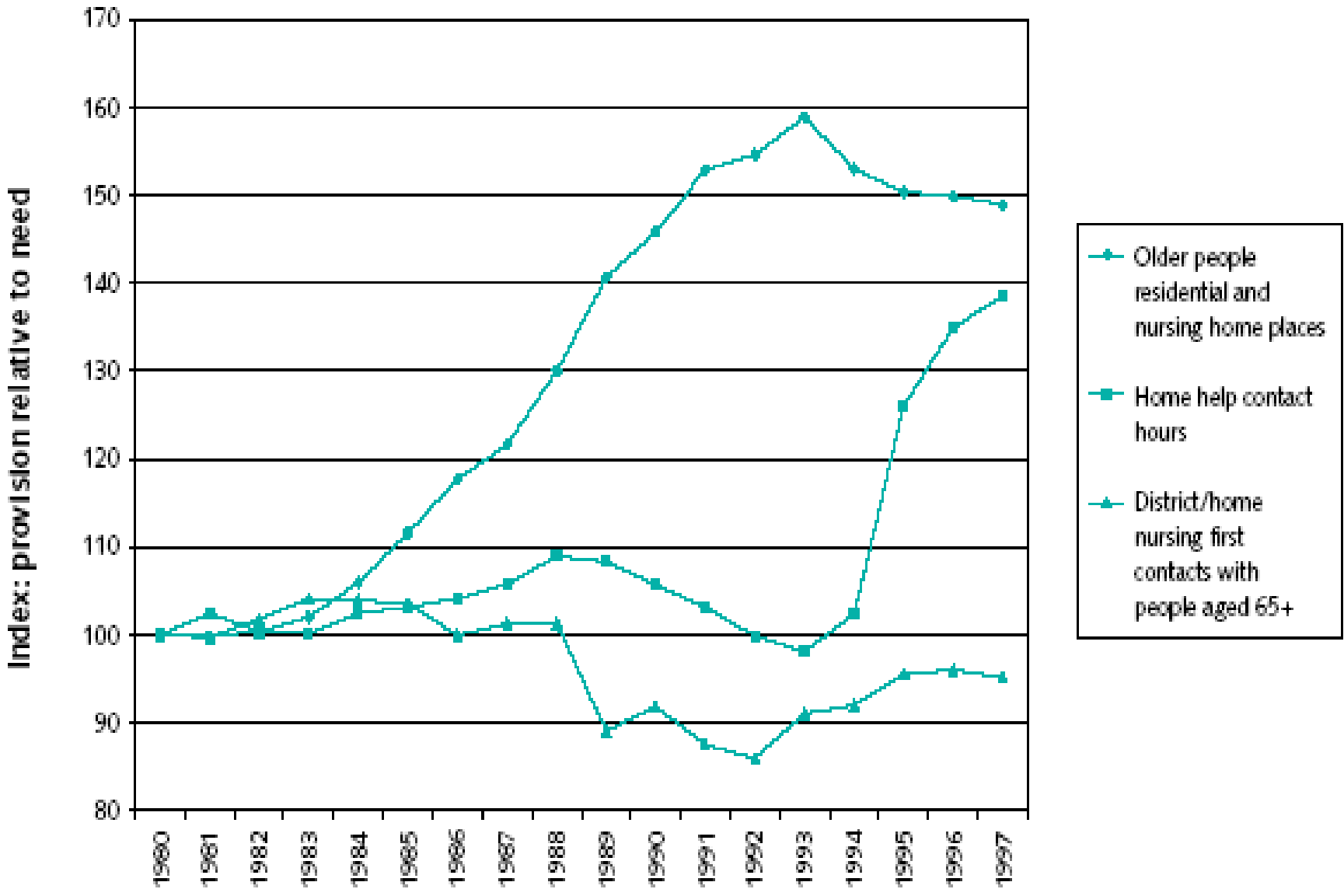
	% died	Median LOS days	Mean LOS days	% discharge home	% discharge intermediate care
England	9.3	14.8	7	79.7	10.3
US	4.9	5.9	4	55.4	39.4

Chart 3.5 Total ordinary admissions per head: annual average % change (1989–1998)



Source: Department of Health

Chart 3.7 Community health and social services provision for older people



Source: Department of Health

# Projected UK Service requirements 2004-2020

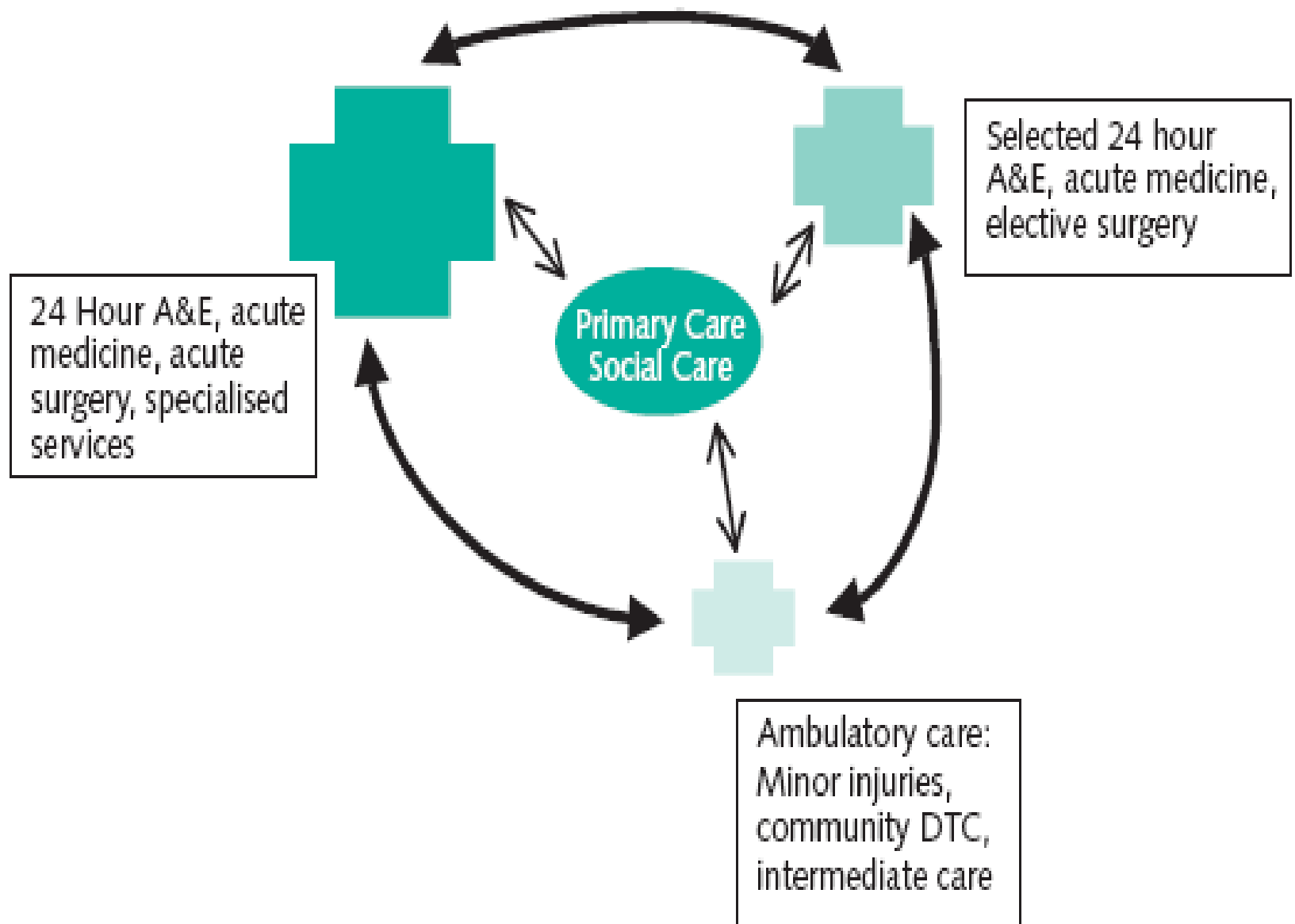
Service	Maintain	Acute bed	Closer to home
GP	↑18%	↑11%	↑32%
District nurse	↑21%	No change	↑72%
Home help	↑53%	↑27%	↑59%
Day cases	↑85%	↑85%	↑85%
Intermediate care	↑4.7%	↑4.7%	↑4.7%
Acute beds	↑4%	↑24%	↓10%
All beds	↑4.5%	↑9%	↑1%

**Table 10A.6 Assumptions for the care closer to home scenario**

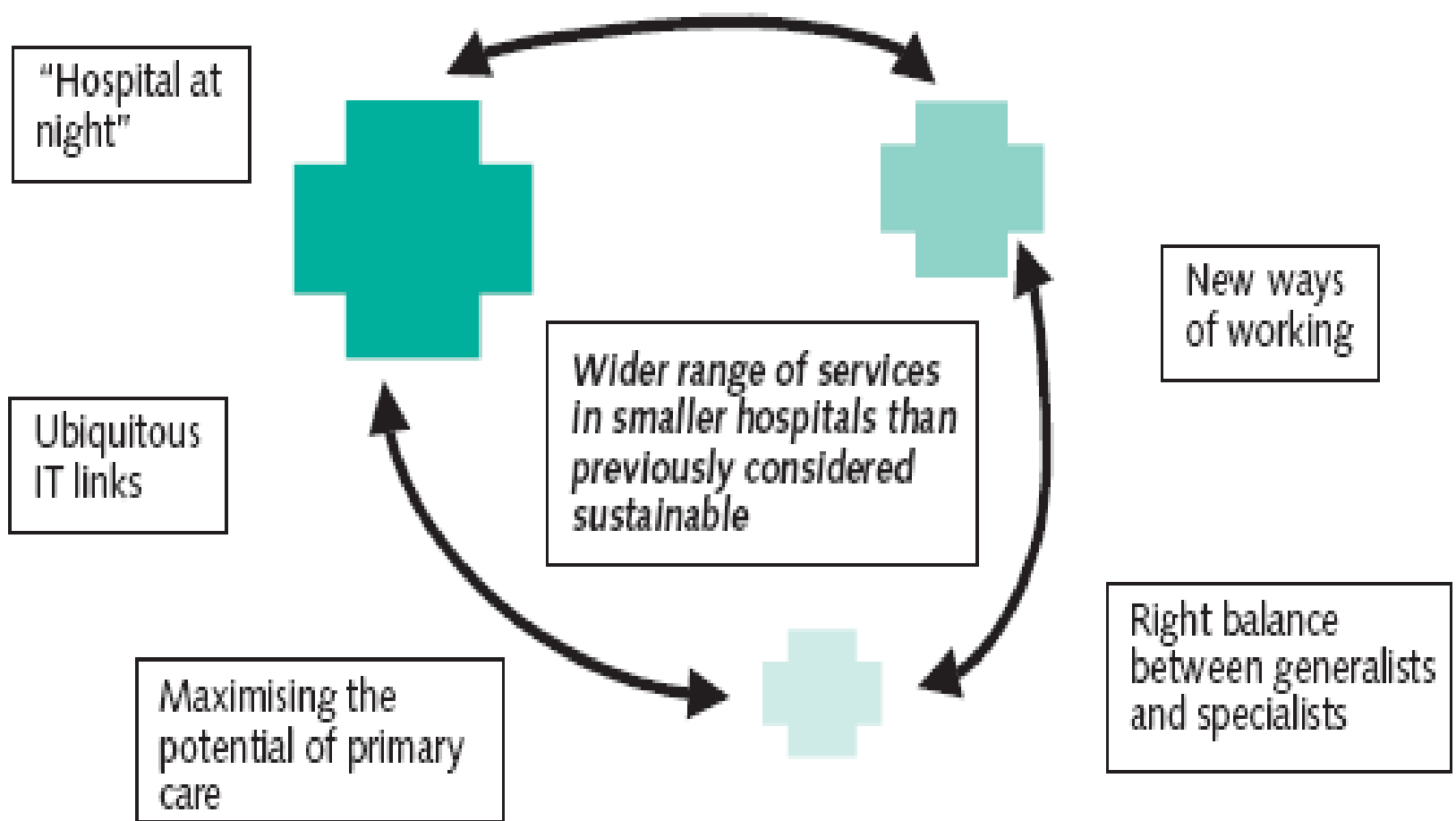
Figures in **bold** indicate differences from the maintain scenario

<i>2019/20 Closer to home</i>								
	<b>0-4</b>	<b>5-14</b>	<b>15-44</b>	<b>45-64</b>	<b>65-74</b>	<b>75-84</b>	<b>85+</b>	<b>All ages</b>
All admissions/1000	307	85	172	359	637	798	880	323
Ordinary admissions/1000	256	46	91	133	264	425	604	157
Ordinary ALOS	1.83	1.47	2.24	4.23	5.51	7.68	10.08	4.82
Day Case/1000	51	38	82	226	373	373	276	167
Emergency admissions/1000	179	36	59	90	162	289	462	106
Emergency ALOS	1.10	1.44	1.79	3.54	4.94	6.67	8.22	4.08
Elective admissions/1000	64	48	96	266	466	490	383	204
Proportion as Day Cases	80%	80%	85%	85%	80%	76%	72%	82%
Ordinary elective admissions/1000	13	10	14	40	93	118	107	37
Ordinary elective ALOS	1.78	1.33	1.92	2.53	2.93	3.75	4.94	2.89
All Day Cases								8,924,060
G&A beds/1000								2.32
G&A beds								123,743
Maternity beds								10,890
Intermediate/Residential and Intermediate/Nursing Beds								447,000
Whole System Beds Total								581,633
<b>2003/4-2019/20</b>								
Emergency admissions/1000	1.8%	0.1%	1.4%	2.2%	<b>1.0%</b>	<b>1.0%</b>	<b>1.0%</b>	<b>1.8%</b>
Emergency ALOS	-2.8%	-1.9%	<b>-3.0%</b>	<b>-3.2%</b>	<b>-3.5%</b>	<b>-3.5%</b>	<b>-3.5%</b>	<b>-3.1%</b>
Elective admissions/1000	0.7%	0.4%	0.9%	2.0%	2.7%	2.7%	2.7%	2.5%
Ordinary elective admissions/1000	-2.7%	-3.1%	-2.7%	-2.1%	-0.5%	0.0%	0.4%	-0.8%
Ordinary elective ALOS	-1.6%	-2.0%	<b>-2.6%</b>	<b>-2.9%</b>	<b>-3.6%</b>	<b>-3.6%</b>	<b>-3.6%</b>	<b>-2.8%</b>
<b>All Ordinary Admissions</b>	<b>1.8%</b>	<b>-0.9%</b>	<b>0.6%</b>	<b>1.2%</b>	<b>1.2%</b>	<b>1.5%</b>	<b>1.6%</b>	<b>1.5%</b>

*Networks of care – providers working in partnership to exploit the capacity of the whole system*



How service modernisation can help: more staff working differently



# CL services for older people – the future



January  
2005



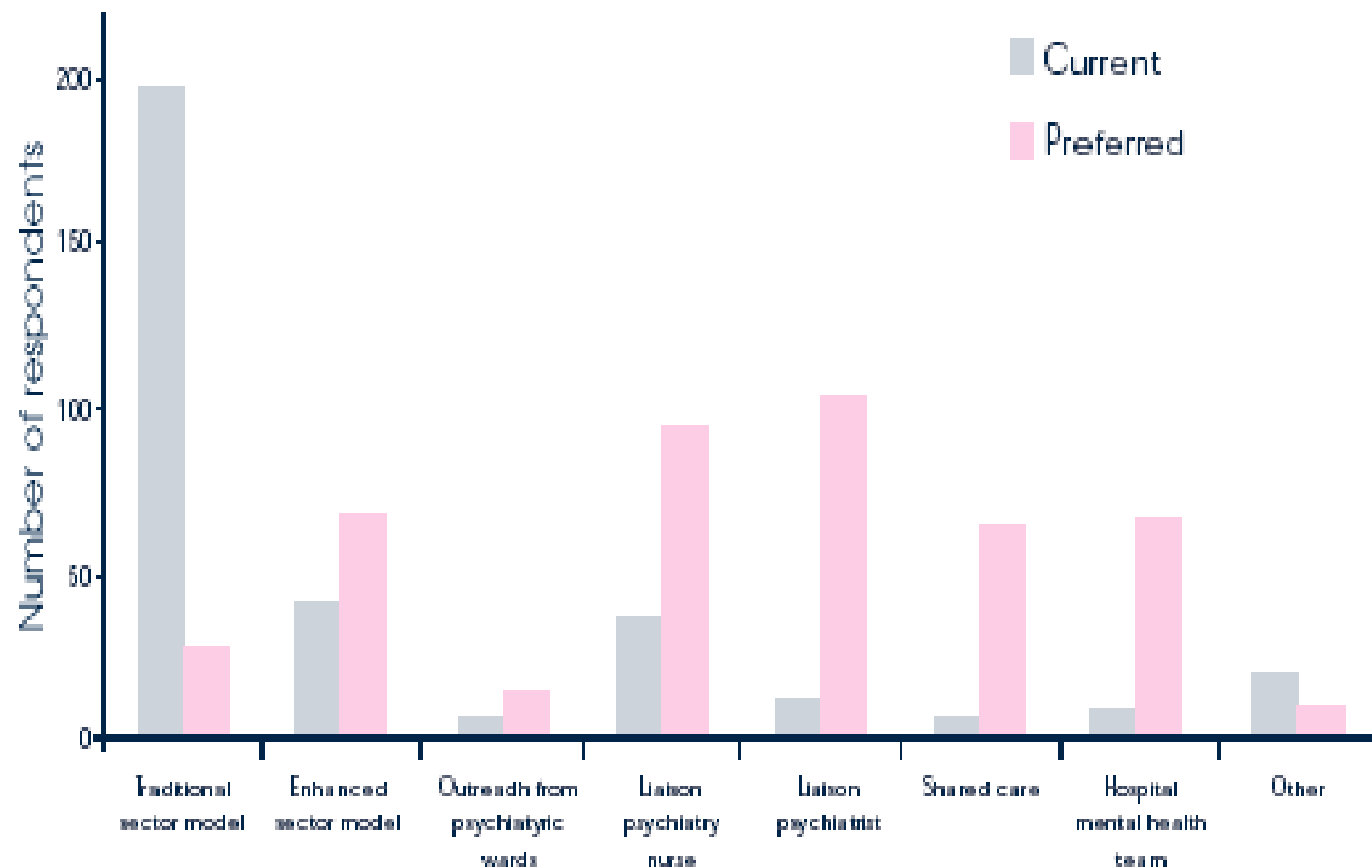
# whocareswins

**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.



Figure 6.3 The range of current and preferred service models



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

Lipowski (1983)

# Challenges for Old Age Mental Health Services in Developed Countries

- How will existing specialist or secondary services (psychogeriatric, adult mental health or aged care services) cope with the increased workload of older people?

# Resource availability – Funding implications

- Increase in the 'Aged Dependency Ratio' e.g. in Australia in 2050 there may be only 2.5 people of working age for every person aged 65 and over, compared with 5 currently
- Increase in costs of old age mental disorders e.g. in Australia dementia costs about 1% of GDP and this is projected to rise to 3% by 2040 (Access Economics, 2003)
- To maintain the status quo, services will have to increase or be delivered more efficiently and/or the demand for services will need to decrease.

# Workforce Issues

- Current worldwide shortages in old age & liaison psychiatrists are likely to continue e.g. training programs in North America are not growing though continued growth in Australia & New Zealand
- Better training of primary care – GPs, nurses etc
- Increased use of nurse practitioners



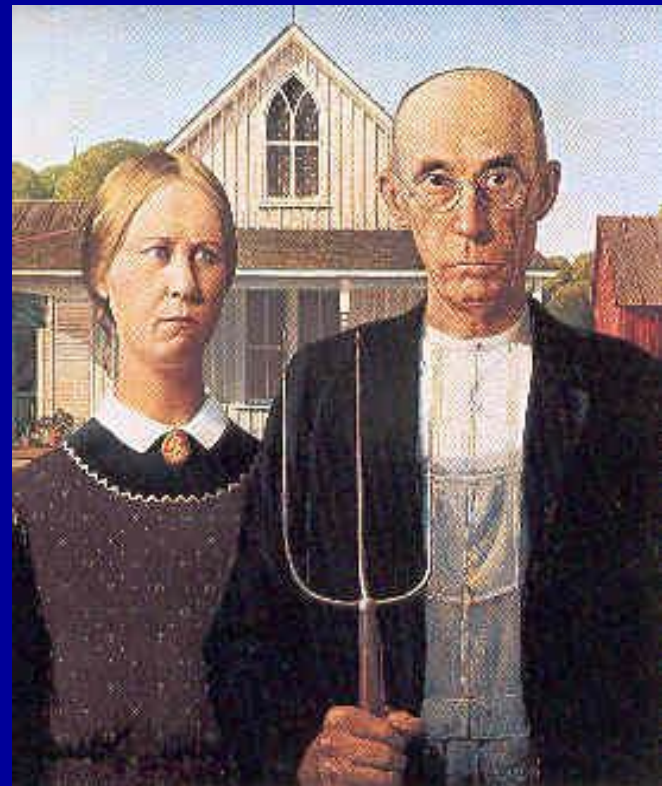
# Funding Models

Bartels et al (1999) have suggested that the following features may be important in an optimal model:

- integration of mental health and general medical services to enable collaborations between primary care, aged care and psychogeriatrics;
- integration of hospital and community care to form a comprehensive model of acute and long-term care;
- capitated care arrangements to contain costs and to encourage use of cost-effective services;
- reallocation of expenditures to support home and community-based alternatives to long-term care;
- risk adjustment strategies that account for the huge costs associated with comorbid physical and mental disorders in old age
- ensuring accountability, advocacy and outcomes.

# Consumer and carer involvement

- Increased involvement in service planning and administration
- Greater transparency of decision-making
- Patient and consumer rights receive more attention
- Coalface service delivery



# What Principles Should Shape Future CL Development for Older People?

- ✓ Multidisciplinary
- ✓ Comprehensive
- ✓ Integrated
- ✓ Defined catchment area / population
- ✓ Accessible, available and responsive
- ✓ Close relationship with other services - geriatric medicine, GPs, community services

Jolley & Arie 1978

# Future CL Services for Older People

- 1) Equity in access - currently older people in acute hospitals have inequitable access
- 2) Responsivity to needs – a triage process to ensure the most needy are seen first irrespective of setting
- 3) Greater use of non-medical staff
- 4) Integrated care between hospital/community settings
  - 1) Primary & Specialist Care collaborations (shared care)
  - 2) Outreach to long term residential care
  - 3) ‘Hospital in the home’
  - 4) Discharge Planning

# Best-Practice in Service Delivery - Prevention

- Population based approaches attempting to reduce a whole community's level of mental disorders (e.g. Llewellyn-Jones et al, 1999)

# Seven-tiered model of management of behavioural and psychological symptoms of dementia (BPSD)

Brodaty et al, *MJA*,  
2003: 178:231-234



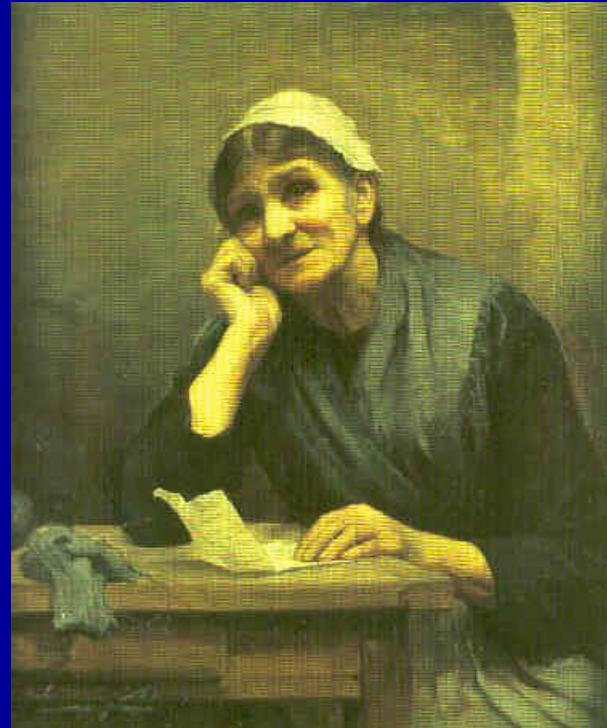
\* Prevalence is expressed as estimated percentage of people with dementia who currently fall into this category.

† Estimate based on clinical observations. ‡ Estimate based on Lyketsos et al.<sup>2</sup>

# Mental Health Prevention Strategies in Later Life

## 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



# Prevention in Hospitals

- Improve hospital design for older people that are confused or suicidal
- Involve family and friends in patient care to reduce confusion and dysphoria



# Conclusion

- The older population is increasing
- Mental disorders in old age are increasing
- The health system is changing with hospital roles altering
- Future CL service developments for older people need to reflect these changes

# Thank You!

## Brian Draper

[B.Draper@unsw.edu.au](mailto:B.Draper@unsw.edu.au)

[www.med.unsw.edu.au/adfoap/](http://www.med.unsw.edu.au/adfoap/)

