14 Liaison

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Epidemiology ● Psychiatric disorders ● Screening ● Attitudes ● Liaison practice ● Relationship between geriatric physicians and old age psychiatrists ● Conclusion

Much of the psychiatry of old age takes place in the general hospital. This is because a large proportion of patients on these wards are elderly, and their morbidity for psychiatric disorder is high. There is also a high morbidity for physical illness and disability in those who present with psychiatric disorder in late life; so these patients might be seen as having the first claim to accommodation on a general hospital site.

Epidemiology

The consensus from several studies is that dementia prevails in up to 30% of those over 65 in general hospital wards (Feldman *et al*, 1987; Johnston *et al*, 1987; Pitt 1991*a*); that is six times the rate in the community.

Between 10 and 20% of elderly patients on medical wards have delirium (Bergmann & Eastham, 1974; Seymour *et al*, 1980; Cameron *et al*, 1987; Rockwood, 1989). The nature of the ward and the procedures to which the patient is subjected affects the frequency. Gustafson *et al* (1988) found delirium in 61% of patients operated on for fractured neck of femur. Delirium may be present on admission or arise later, a quarter of patients judged to be cognitively intact on admission may be expected to develop delirium in the ensuing month (Hodkinson, 1973).

It might be expected that the prevalence of depression in general hospital wards would be a good deal higher than in the community but not all surveys agree that this is markedly so. Studies show a range from 5% to more than 40% (Pitt, 1991*c*). The variation may be due to different screening instruments, different cut-off points on the same instruments or different diagnostic criteria; to whether or not cognitively impaired patients were excluded; to the nature of the area served by the hospital and its alternative resources; and to whether the hospital is acute or long-stay, and takes its patients from a defined catchment area or selectively from further afield.

Psychiatric disorders

Dementia

People with dementia fail to look after themselves adequately, to take prescribed medications, and are at risk of accidents and hypothermia. Therefore, while admission to hospital is usually for a sufficient medical reason, it may also reflect the limitations of care; hence the (often pejorative) label 'social admission'. Once the medical problem has been solved, there is the need to establish that adequate care will be available. The momentum of previous support may have been lost and former carers may be reluctant to take up the burden again, which may mean discharge to a home or transfer to a longer-term ward. The time this takes increases the prevalence of patients with dementia on general hospital wards.

Delirium

Delirium is far more common in hospital than in the community, being associated with the serious physical illnesses, pneumonia, metabolic upsets, major surgery, for which admission is required (see Chapter 3). A major risk factor for delirium, as well as severity of physical illness, is pre-existing dementia. Koponen *et al* (1989) looked at the computerised tomography scans of the brains of delirious elderly patients and found significantly more cortical atrophy, focal changes and ventricular dilatation than in controls. It is generally expected that patients will either recover from their delirium or die (Bedford, 1959), though there is rather more information about mortality than recovery (Pitt, 1991*b*). Rockwood & Fox (1992) point out that some features of delirium are less transitory than others (e.g. memory impairment lasted a mean 28 days in their study).

Depression

Depressive illness may cause or arise from physical illness, or may lead to deliberate self-harm (Pitt & Nowers, 1986); all of which may result in admission to general hospital wards. Severe depression may result in malnutrition and dehydration from food and fluid refusal, gross self-neglect and failure to take medication for concomitant physical disorders such as heart failure and diabetes. Deliberate self-harm (unlike suicide) is much less common in the elderly than in young adults, but is still not rare as a cause of admission to medical or surgical wards.

Physical illness has long been identified as a major factor in late-life depression (Post, 1962; Murphy, 1982). Stroke (Robinson *et al*, 1983; Dam *et al*, 1989), malignant disease (Evans *et al*, 1991), myocardial infarction (Koenig *et al*, 1988) and chronic obstructive airways disease (Kukull *et al*, 1986; Borson & McDonald, 1989) seem to be especially depressing.

Box 14.1 Physical illnesses associated with depression

Stroke
Cancer
Myocardial infarct
Chronic obstructive airways disease
Cushing's syndrome
Hypothyroidism
Hypoparathyroidism

Usually the depression is an adjustment disorder (American Psychiatric Association, 1980) or a major depressive illness precipitated by the stress of physical illness, but occasionally it is intrinsic to the physical disorder: endocrine disease such as Cushing's syndrome (Cohen, 1980; Haskett, 1985), hypothyroidism (Tappy *et al*, 1987) and hyperparathyroidism (McAllion & Paterson, 1989); occult carcinoma (Whitlock & Siskind, 1979); and stroke where the cerebral lesion is in the anterior left hemisphere (Robinson *et al*, 1984).

Iatrogenic factors related to the treatment of depression or physical illness are considered below. Other ways in which depression could contribute to admission to general hospital wards are by the prominence of such somatic symptoms as atypical pain, anorexia and weight loss, which may suggest physical illness; and by lowering the threshold for physical illness, possibly by effects on the immune system (Anonymous, 1987).

Anxiety

Anxiety is rife in a hospital, at all ages (and not only among the patients). Apart from the reason for being in hospital, there are unfamiliar procedures, possibly uncomfortable investigations, strange staff and fellow patients and considerable scope for distorted communication. Bigger fears are of pain, disability, dependence and death. Anxiety contributes to insomnia, and the panacea of a hypnotic has often in the past led to habituation. On the other hand, the unwitting withdrawal of a sedative (including alcohol) after admission to hospital may precipitate acute anxiety, if not a fit. Anxiety is a common legacy of myocardial infarction and probably contributes much to the 'fear of falling' syndrome (Isaacs, 1992) where, after an attack of giddiness, dizziness or a transient ischaemic attack the patient is afraid of walking without having something or someone to hold on to. Anxiety may arise from thyrotoxicosis, hypoxia in those with cardiorespiratory disease (Schiffer *et al*, 1988) and cardiac

arrhythmias, and the manifold somatic manifestations of anxiety may suggest a host of physical disorders, through hyperventilation, tachycardia, tachypnoea, diuresis, diarrhoea, pallor, faintness and palpitations.

Alcohol dependence

Alcohol dependence is often overlooked in the elderly (Schiffer *et al*, 1988). Atkinson (1991) points out that clinicians trained with the view that people with lifelong alcohol dependence either die prematurely or recover spontaneously, and that late addiction is rare, do not expect to encounter the disorder in old age. Also the symptoms may mimic the findings of other medical and behavioural disorders, leading to misdiagnosis. Faulty recall and shame limit disclosure by patients and families. Alcohol use contributes to falls, burns, cognitive impairment of various degrees, peripheral neuritis and hepatic cirrhosis, with oesophageal varices and liver failure. The CAGE screening questions (Ewing, 1984) are useful in diagnosis (see Chapter 1).

Iatrogenic comorbidity

Comorbidity may be iatrogenic. Drugs given for psychiatric disorder may cause physical morbidity and vice versa. Tricyclic antidepressants, for example, may cause hypotension and drowsiness (both resulting in falls and other accidents (Blake *et al*, 1988), cardiac arrhythmias, dental problems, glaucoma and retention of urine because of anticholinergic effects and fits. Selective serotonin reuptake inhibitors (SSRIs) may induce hyponatraemia. Steroids, propranolol, some anticonvulsants and anti-cancer drugs may cause depression. Anti-parkinsonian and some hypotensive agents may occasion a variety of psychiatric syndromes, including confusion, visual hallucinations, depression, mania and paranoia.

Box 14.2 Psychiatric disorders found in older patients on general hospital wards

Dementia
Delirium
Depression
Anxiety
Alcohol dependence
Iatrogenic comorbidity
Personality disorders
Paranoid disorders
Graduate schizophrenia

Other disorders

'Difficult' old people, those with personality disorders, paranoid disorders or 'graduate' schizophrenia, though rarely mentioned in morbidity surveys, probably because of the difficulty in devising suitable screening instruments and agreeing diagnostic criteria, are likely to be over-represented in general hospital wards because they neglect themselves or they have alienated or estranged themselves from those who might give care at home. In a prevalence study of patients, over 65, in the general wards of hospitals serving the London Borough of Hackney (Pitt, 1991*a*), 30% of the subjects were single, which might reflect such over-representation.

Screening

Goldberg (1985) explains that the recognition of psychiatric illness in general wards by physicians and surgeons may only come about either because a cue suggests such a disorder, or the patient's complaints cannot be accounted for by a known organic disorder. However, in over half such patients, with illnesses diagnosable according to research criteria, the diagnosis is not made. Goldberg suggests five reasons:

(a) The patients provide no cue (although they will readily describe their symptoms if asked).
(b) The cues are not picked up.
(c) Patients lack privacy.
(d) Having found an organic psychiatric disorder, the doctors look no further.
(e) Even when they suspect psychiatric disorder, the doctors may lack the confidence to pursue the assessment.

Consequently, Goldberg advocates screening tests, with which general hospital doctors may become familiar and comfortable, thus increasing their alertness. Some of the more widely used ones are listed in Box 14.3.

Attitudes

In the general ward, the old person with psychiatric disorder is at risk of getting too little attention or too much of the wrong kind.

Too little results from failure to diagnose the disorder, or labelling and dismissing the patient because of it. Labels such as social admission, bed-blocker, or the adjectives 'geriatric' or 'psychogeriatric' used as nouns, carry the risk that the one so stigmatised will not be seen as a proper patient, let alone a person, and will be abandoned in a corner while there is a long, exasperated and sometimes inept search for 'disposal'. Evidence

Box 14.3 Screening instruments

Abbreviated Mental Test Score (AMTS) (Hodkinson, 1972): cognitive impairment
Mini-Mental State Examination (MMSE) (Folstein *et al*, 1975): cognitive impairment
Geriatric Depression Scale (GDS) (Yesavage *et al*, 1983): depression
Brief Assessment Schedule Depression Cards (BASDEC) (Adshead *et al*, 1992): depression
CAGE (Ewing, 1984): alcohol dependence

of consultation with such patients about their future is often lacking and, unwittingly, institutionalisation and dependence are insidiously induced. The momentum of care in the community seems rapidly to be lost once the patient is admitted to hospital, and neither patient nor carers may be very ready to start it up again if at long last there are moves to effect a discharge.

Too much attention takes the form of oversedation, isolation in a side-room and even physical restraint. Binding the elderly, especially those who are confused, even if they are near to death, is not unknown in the USA (Frengley & Mion, 1986; Robbins *et al*, 1987), while in the UK the favoured form of restraint has been the geriatric Buxton chair, which can not only be tilted backwards to thwart attempts to leave it but also has a table which can be locked across the patient's lap. In one of the worst scenarios there is precipitate referral to the psychiatrist who arrives to find the patient unrousable after an intramuscular injection of chlorpromazine, while the notes only record the absence of significant physical signs and the mental state as 'confused', 'restless', 'wandering' or 'aggressive'.

Occasionally psychotropic drugs are peremptorily withdrawn when the patient is admitted, without a proper enquiry into their rationale, the assumption being that they are unnecessary or actually harmful. The attitudes which give rise to these abuses include:

(a) Ignorance: the lessons learnt during a psychiatric attachment or clerkship seem easily forgotten (partly from lack of reinforcement) in the hurly-burly of life on a busy general ward or, in the case of old psychiatry, they may never have been learned in the first place.
(b) Prejudice: 'mental disorder means madness, trouble, unpredictable, erratic behaviour, attention-seeking or even malingering. If the ward is upstairs, then suicidal patients may hurl themselves from the windows. If it is on the ground, restless old people may wander away and get run over or be lost'.

(c) Paranoia: 'we're being used as a dump for problems which belong to the general practitioner, social services, rejecting families, administrators, the geriatricians or the psychiatrists, who do not pull their weight and pass the buck'. The beleaguered house officer (intern) or registrar (resident) subjects the referring doctor to a hostile interrogation if the patient is old, which may leave all parties bruised and aggrieved.

(d) Anxiety: 'we have not the staff, the training or the facilities to deal with these sorts of problems. The other patients, who are really ill, will be upset by noisiness and interference. There will be a disaster, a drip will be pulled down, or someone recovering from a myocardial infarction will have a cardiac arrest, and we will be blamed'.

White's (1990) analysis of why medical patients with psychiatric disorder may not be referred to psychiatrists is worth citing (Box 14.4).

Such attitudes may to some extent be prevented by proper training, and the realisation that in any general hospital two-fifths of the in-patients are likely to be old, and half of these to be confused, depressed or to have

Box 14.4 Reasons why medical patients are not referred to psychiatrists (adapted from White, 1990)

The psychiatric service dissatisfies the physician
Psychiatric language is useless to the physician
The physician is unaware of the need for psychiatric intervention
The physician is unaware of the possibility of psychiatric intervention
The physician believes the psychiatric disorder to be incurable.
The physician fears the patient's emotions
The physician feels he or she does not know the patient well enough
The significance of psychological issues is denied
There is a poor working relationship between the physician and the psychiatrist
The physician believes that the patient is disadvantaged by being labelled as a psychiatric case
The patient refuses psychiatric referral
The physician considers the patient too physically ill
The physician believes that every doctor should be able to treat psychiatric illness
The physician cannot or will not spare the time for psychological issues

some other form of psychiatric disorder (Pitt, 1991*a*). A potential corrective is good liaison with the psychiatric services.

Liaison practice

The late Richard Asher, consulting physician at the Central Middlesex Hospital, London, remarked of psychiatrists: "We don't know them – they don't lunch with us!" He was referring to the days when psychiatrists, coming some distance from a mental hospital, would make a 'hit-and-run' ward consultation and be seen by hardly anyone except the patient, leaving just a case note behind them. Now that many psychiatrists are based in general hospitals, there is scope for rather better liaison, though doctors' dining rooms belong to the past, and communications in the hospital canteen tend to be rather rushed and economical.

Ward consultation

At the most basic level there is the ward consultation when the psychiatrist receives a note explaining the problem more or less adequately and goes to see the patient. The psychiatrist may have given notice of the visit, in which case he will hope that the patient will be in the ward, and not at X-ray. He might also meet the house officer or registrar, but almost certainly not the consultant. If in luck, there will be a detailed referral in the case notes explaining how the patient came to be in hospital. Otherwise he may well find the nursing notes more informative than the medical. If very lucky, he will meet a relative who happens to be visiting at the time of the consultation, or has been asked to attend for the occasion. At the end of the consultation he will make a note, indicating the probable diagnosis, how it was reached and what further information and investigations are needed, and make some recommendations, indicating that these are provisional and may be modified after further discussion in the light of better knowledge. The more consultations given, the better the psychiatrist will be known and the more open the ward staff are likely to be.

Box 14.5 Problems which may occur with ward consultations

Inadequate referral
Patient absent, at X-ray etc.
Lack of private, quiet area for interview
Patient frail, fatigued or deaf
Carer not present
Nursing staff unaware of the situation
No direct communication with the referring consultant

Regular meetings

This basic model is enhanced when the psychiatrist has a regular meeting with the medical firms. He or she is unlikely to have the time for this with every consultant whose patients are seen, but should at least aim to meeting the geriatrician. Such meetings may be at set times, or in the context of ward or day hospital rounds or out-patient clinics involving some joint working. It is important that, if possible, the status of those meetings is comparable. For example, if it is always the medical registrar who meets the consultant psychiatrist, then the commitment of the consultant may be in doubt, and while day-to-day problems can be tackled, matters of policy may be hard to resolve. It is good, too, if the respective teams can meet, rather than just representative individuals.

However, less comprehensive liaison can still have measurable effects. Scott *et al* (1988) describe how a senior registrar in old age psychiatry started attending the weekly multi-disciplinary ward round and case conferences and reviews of a geriatric unit. After two years referrals doubled, from the whole hospital, not just the geriatric unit. The recognition and referral of depression, in particular, increased more than five-fold.

Joint wards

Further up the hierarchy of desiderata is the joint geriatric/ psychogeriatric ward. This was commended by the Department of Health and Social Security (1970) Circular HM (70) 11, which was issued in the wake of Kidd's (1962) study suggesting that there was considerable misplacement of old people with psychiatric disorder in geriatric wards, and of those with physical illness in psychiatric wards, and that this was to the patients' disadvantage. These observations were not confirmed by Hodkinson *et al* (1972), but nevertheless the idea of joint units seemed attractive. It was hoped that avoiding misplacement would reduce the need for long-stay beds and that dual expertise would meet the complex needs of older people with their multiple pathology and comorbidity for physical and psychiatric disorder.

Box 14.6 Improved practice

Direct liaison with the medical team.
Full referral with background information.
Arrange appointment with the ward staff.
An unhurried interview in a quiet room.
Speak to carer, general practitioner, social worker and other involved individuals.
Liaison clinics can speed up consultations.

An account of the operation of such a unit is given by Pitt & Silver (1980). A joint admission ward in the satellite of a London teaching hospital took all acute geriatric admissions and selected patients with psychiatric disorders. These were:

(a) delirium;
(b) probable dementia;
(c) those with significant comorbidity (e.g. Parkinson's disease and paranoia, severe dehydration and depression); and
(d) patients with non-specific disorders such as not eating, falling, failure to thrive.

These were patients for whom the availability of geriatric expertise was especially relevant. Patients with uncomplicated functional psychiatric disorder and dementia were admitted to a small psychiatric hospital close by.

The consultant geriatrician and psychiatrist each did their own ward round, and they held a joint multi-disciplinary meeting every week. Advantages and disadvantages are listed in Box 14.7. The role of the old age psychiatrist in such a unit is shown in Box 14.8.

Box 14.7 Advantages and disadvantages of a joint medical and psychiatric unit

Advantages

Medicine and psychiatry are simultaneously available to patients who often need both.

The threshold for referral from one service to the other is eliminated.

Psychiatric patients are made more acceptable on the medical wards.

Mutual teaching and training are enhanced.

Liaison and reciprocity are intrinsic to the modus operandi

Patients do not fall between stools – 'too ill for a home, too disturbed for a geriatric ward, too feeble for a psychiatric ward'.

Disadvantages

Considerable senior involvement is required, including time, some spent as a spectator.

Uncertainty about who is in charge.

Mentally normal patients may be upset by those who clearly are not (though this is so on almost any general ward) The unit complements other resources, but does not necessarily replace them.

Box 14.8 The roles of the old age psychiatrist in a liaison service

Identifying psychiatric disorder.
Assessing its relevance to any physical disorder.
Estimating its effect on prognosis.
Implementing its treatment.
Helping staff to understand the possible psychodynamics of dependence, attention-seeking, manipulation, undue disability, aggression and failure to cooperate.
Helping with the management of common losses – dying, bereavement, amputation, being rejected.
Arranging transfer to a psychiatric ward when appropriate.
Arranging follow-up.
Teaching nurses and junior doctors about psychiatric illness in old age.

Joint departments

The ultimate in joint working is the integrated department of health care of the elderly (Arie, 1983), where psychiatrists and physicians work together not only on the same ward but in the same department to provide a seamless service. This adds to the advantages of other forms of joint working: a coherent, comprehensive service for the consumer and the trainee; constant cross-fertilisation, to the advantage of research; and a powerful voice within the health district to assert the needs of the elderly, for whom resources of staffing, expertise and 'real estate' rarely suffice.

Relationship between geriatric physicians and old age psychiatrists

In 1979 a joint committee of the British Geriatrics Society and the Royal College of Psychiatrists approved and published the *Guidelines for Collaboration between Geriatric Physicians and Psychiatrists in the Care of the Elderly*, which had been prepared by Professor Tom Arie (1979). Examples of the clarity and directness of this guidance are:

(a) Services for the elderly should be a unity for 'consumers'... Patients should not be bounced back from one part of the service merely because they seem more appropriate for another part: such distribution of referrals should be the internal responsibility of the service.

(b) Responsibility should be determined by the assessed needs of the patients and not by the quirks of the referral. If a patient with a severe stroke is referred to a psychiatrist, he is no less the responsibility of the medical service through having first made contact with a psychiatrist.
(c) Lack of resources does not alter the definition of responsibility. Once a patient's needs are recognised as falling within the province of one service, that service should support that patient within the limits of the feasible, even if this is less than ideal: a 'psychiatric' patient does not become 'geriatric' simply because there are no psychiatric beds or vice versa.
(d) Experience suggests that the best criterion for the placement of people with dementia needing longer term care is whether they are ambulant or not, always provided that there is flexibility necessary for the odd case that does not fit in.
(e) Patients with a psychiatric history who develop physical illness or gross physical deterioration at home should be assessed again. None should be labelled as a 'psychiatric patient' by virtue merely of some previous psychiatric episode.

Kaufman & Bates (1990) looked at working relations between consultants in the two specialities 10 years later. Opinions were obtained from 30 of 33 consultants in geriatric medicine in two health regions, 25 (83%) of whom were aware of the guidelines. Seventeen (57%) felt that relations were unsatisfactory; this was mainly attributed to lack of resources. Twenty-one (70%) reported particular problems with dementia

Box 14.9 Key points for clinical practice

The high comorbidity for physical and psychiatric disorder in late life should always be in the minds of clinicians who work with old people
Screening for psychiatric disorder, mainly depression and dementia, improves its recognition by those who are not psychiatrists
The higher training of specialist psychiatrists for the elderly should include secondments in geriatric medicine
Liaison, especially with general practitioners and physicians in the medicine of the elderly, is an essential component for a psychogeriatric service
An old age psychiatric presence is desirable in any substantial general hospital, not only to ensure proper treatment for elderly psychiatric patients with physical disorder, but also for the larger number of old people with psychiatric problems on the general wards.

beds. The presence or absence of a psychogeriatrician did not necessarily improve relations; if the psychogeriatrician had been given too few beds, problems remained. However, there was a marked association between the presence of collaborative activity (joint meetings or rounds, regular visits to each other's units, research, education, stall rotations) and an absence of substantial problems with demented patients.

Conclusion

Old people with psychiatric disorder form a substantial proportion of the patients in a general hospital. In such a hospital with 500 beds (excluding obstetric, paediatric, psychiatric and geriatric) they could well number 100. Psychiatric disorder is associated with a higher mortality, a longer stay in hospital and less likelihood of being at home after discharge (Pitt, 1991*a*). So, those who deal with older patients in the general hospital need to be trained, and their attitudes and practices adapted, to accept and accommodate these realities. At the same time, psychogeriatric expertise needs to be available for speedy consultation, including diagnosis, treatment, management and placement. There should be an old age psychiatric team in every substantial general hospital, which should be closely affiliated with the department of geriatric medicine.

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