

normative data for the Brazilian population. *Arquivos de Neuro-Psiquiatria*, 70, 960–966.

- Miotto, E. C., Sato, J., Lucia, M. C. S., Camargo, C. H. P. and Scaff, M. (2010). Development of an adapted version of the Boston Naming Test for Portuguese speakers. *Revista Brasileira de Psiquiatria*, 32, 279–282.
- Nielsen, T. R., Vogel, A. and Waldemar, G. (2012). Comparison of performance on three neuropsychological

tests in healthy Turkish immigrants and Danish elderly. *International Psychogeriatrics*, 24, 1515–1521.

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### Observations of a traveling fellow: consultation–liaison psychiatry versus joint units for delirium management

There are various approaches to providing specialist care for patients with delirium in general hospitals. Those described in the literature include joint geriatric/psychiatric units and consultation–liaison (CL) psychiatry services. The Ferdinande Johanna Kanjilal Travelling Fellowship, from the Royal College of Psychiatrists, UK, provided an opportunity to more fully understand each model. This letter outlines observations of the Australian Fellow (AW) of different service structures in the care of hospitalized older people with delirium in the United Kingdom and Ireland.

#### Joint units

Joint geriatric/psychiatric units have emerged to better meet the needs of medically unwell (including delirious) functionally dependent patients who need both medical and psychiatric inpatient care (George *et al.*, 2011). The key features of such units are co-located collaborative care between psychiatry and geriatrics, access to acute hospital facilities, a multidisciplinary approach to individualized care with staff who are highly skilled in managing behavioral problems and restoring function, a secure elder friendly ward environment, and comprehensive discharge planning (George *et al.*, 2011). They may also provide a setting for specialized teaching and advice. Key disadvantages of joint units are the high cost in maintaining them, potential deskilling of other wards, and inevitable inability to admit all inpatients with delirium.

Five UK joint units were visited in 2011 (Nottingham, York, Carlisle, Gateshead, and Stirling). A detailed comparison of the composition (staffing, patient mix, and bed numbers) and the advantages and disadvantages as perceived by the unit staff and the Fellow, and outcome data are available in Appendix 1 (available as supplementary material attached to the electronic version of this paper at [www.journals.cambridge.org/IPG](http://www.journals.cambridge.org/IPG)).

Although all the joint units visited appear to have been founded on the same general principles, they varied considerably in their staffing, patient profile and acuity, and the extent to which they actually share care. For example, some joint units had combined psychiatry/geriatric medicine/allied health ward rounds and meetings (Gateshead, York, and Carlisle), and one had an equal proportion of mental health and general nurses in each shift (Nottingham), whereas some joint units appeared to have psychiatry involved as an enhanced consultation service (i.e., dedicated psychiatrist sessions, but limited regular collaboration, for example Stirling). Few joint units had any regular mental health nurses (MHNs), who could provide ongoing support to general staff and specialist skills to patients with comorbid mental health problems. In some places this appeared to be secondary to a lack of resources, in others due to continued separation between medical and mental health services.

Interestingly, few joint units thought they could provide adequate care for patients with major mental illnesses (such as psychosis or severe major depression requiring electroconvulsive therapy) and co-morbid active physical illness. This was attributed to the acute ward environment and lack of mental health nurses. Many units felt they were only equipped to care for people with delirium and dementia. Thus, a significant proportion of patients with major mental illnesses, for whom such units were originally conceived to include, are still unable to be adequately cared for within these specialized wards. Given the cost involved in establishing and maintaining joint units, it is worthwhile examining whether these units achieve improved care and better patient outcomes, particularly in relation to mental health. Randomized controlled trials, such as the one underway in the Nottingham unit, may help answer this question (Harwood *et al.*, 2010).

#### Consultation–liaison psychiatry services

Consultation–liaison psychiatry services for older people are similarly heterogeneous. Previous studies have highlighted the lack of good quality evidence and systematic planning of services to guide how

best to provide psychiatry services to older people in general hospitals (Royal College of Psychiatrists 2005; Holmes, 2010). There appears to be some advantage in the hospital-based, old age psychiatry liaison model in terms of response times, frequency of reviews, and specific old age psychiatry expertise (Holmes, 2010). However, evidence for mental health outcomes is lacking (Draper and Low, 2005).

Clinical time was also spent in three CL-type services: Psychiatry of Old Age at St James Hospital, Leeds, UK and Limerick, Ireland; and a general CL service with psychogeriatric liaison at the Royal Infirmary, Edinburgh.

The fulltime old age psychiatry consultation team in Leeds was well resourced with staff, including psychiatric, general medical, MHNs, and occupational therapy. In contrast, the CL team in Edinburgh was a general service with part-time psychogeriatric liaison to geriatric medicine. This service also had MHNs, but they had clearly defined roles which did not include elder care. In Limerick there was also a multidisciplinary psychiatry of old age CL team, which was community-based. Each team commented on the benefits of allied mental health staff in improving patient care and reducing length of stay. Most services could not provide a liaison attachment to geriatric medicine due to time constraints and the large size of each hospital's geriatric medicine service. None of the CL services visited had specific programs to prevent delirium. However, the liaison psychiatry and geriatric medicine teams in Edinburgh have jointly developed the "4AT Test" to improve the detection of delirium (MacLulich *et al.*, 2011). This quick bedside screening test for delirium does not require special training and can be used for patients who are difficult to assess cognitively (e.g., severely drowsy or agitated).

### General observations

There were some striking differences in the structure of clinical services in the United Kingdom, Ireland, and Australia. For example, in Australia, an inpatient's medical, nursing, and allied health notes are recorded in the same medical record, whereas in the United Kingdom medical and nursing notes were in separate files. Consequently, delirium symptoms documented by nurses may be more readily missed by treating physicians. There were also separate electronic records for patients' mental health, general hospital, and outpatient contacts. By contrast, in Sydney these contacts are captured in the same electronic record of each patient within an Area Health Service and information is readily accessible from either setting. Another notable

difference was the location of social work services. In Australia and Ireland social workers are considered allied health staff of the hospital and generally "belong" to multidisciplinary teams, whereas in the United Kingdom social workers are most often based externally and employed by local councils to provide consulting services to hospitals. When social work services were delivered as part of a hospital team rather than by an external service, there were more focused and prompt reviews of patients, improved collaborative relationships with clinical staff, and shorter lengths of stay.

### Conclusions

Delirium is an issue for all clinical staff. While specialist intervention is valuable and often required, a more sustainable approach is needed to deal with the ageing population. Emphasis must therefore be placed on improving the skills of all general hospital staff to manage older patients with delirium and, where possible, utilizing specialist old age psychiatry services through a liaison model. This includes coordinated service development and co-management of complex cases and implementing effective, hospital-wide delirium prevention programs, regular education, practical training, and support for all staff (Siddiqi *et al.*, 2006). Specialist multidisciplinary old age liaison psychiatry services are well placed to coordinate and deliver such interventions in partnership with geriatricians.

Joint geriatric/psychiatry units may have a place in managing the most complex, vulnerable, or behaviorally challenging patients. Although they share a common philosophy, in practice joint units differ markedly and controlled outcome data are limited. Joint units may too improve the care of older patients in hospital generally by providing an example of high quality care, specialized training experiences, and outreach to other wards. Further research is required to clarify the merits and suitability of each of the approaches to joint units in different settings and with variable staff mix in terms of mental health and functional outcomes for patients. Service delivery in the United Kingdom could be improved by restoring social workers as full members of the multidisciplinary team and integrating medical and mental health records.

A traveling fellowship provided a unique opportunity to gain an in-depth understanding of how different service approaches work in practice.

## Conflict of interest

JG is the Director of one of the joint units (Carlisle) described in the paper.

## References

- Draper, B. and Low, L.-F.** (2005). What is the effectiveness of acute hospital treatment of older people with mental disorders? *International Psychogeriatrics*, 17, 539–555.
- George, J., Adamson, J. and Woodford, H. J.** (2011). Joint geriatric and psychiatric wards – a review of the literature. *Age and Ageing*, 40, 543–548.
- Harwood, R. H. et al.** (2010, November). Development of a specialist medical and mental health unit for older people in an acute general hospital. *Medical Crises in Older People. Discussion Paper Series*, Issue 5. Available at: <http://www.nottingham.ac.uk/mcop/>; last accessed 4 November 2012.
- Holmes, J.** (2010). *Liaison Mental Health Services for Older People: A Literature Review, Service Mapping and In-Depth Evaluation of Service Models*. NIHR SDO Programme Report, Queens Printer and Controller of HMSO.

Available at: <http://www.sdo.nihr.ac.uk/files/project/100-final-report.pdf>; last accessed 4 November 2012.

**MacLulich, A., Ryan, T. and Cash, H.** (2011). *The 4AT Test: Screening Instrument for Cognitive Impairment and Delirium*. Available at: <http://www.the4at.com/>; last accessed 4 November 2012.

**Royal College of Psychiatrists** (2005). *Who Cares Wins. Improving the Outcome for Older People Admitted to the General Hospital*. Available at: <http://www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf>; last accessed 4 November 2012.

**Siddiqi, N., House, A.O. and Holmes, J. D.** (2006). Occurrence and outcome of delirium in medical in-patients: a systematic literature review. *Age and Ageing*, 35, 350–364.

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