The ultimate goal of our generation is to live long and be healthy. Despite prolonged life expectancy (the second half of the last century added 20 years to the average life span, and this will increase by another 10 years by 2050) [1], the health problems we face remain similar to those of the last century. Furthermore, the number of ‘unhealthy’ days (in terms of physical or mental ill health as well as activity limitation days) over the last 8 years seems to be on the increase, especially in the older population [2], and worsening health appears to affect equally both institutionalised and community-based elderly adults [3].

During the last four to five decades, we have witnessed a dramatic epidemiological transition in the leading causes of death from infectious and acute diseases to chronic and degenerative illnesses including cardiovascular diseases and cancer, respiratory diseases and injuries, diabetes and Alzheimer’s disease [4]. These conditions also cause severe disability, which when measured via limitations in activities of daily living is a common factor leading to the need for long-term care [5]. These physical problems are usually accompanied by a worsening of mental function in the elderly: (i) depression following cerebrovascular accidents, heart problems and hip injury; (ii) delirium due to various physical problems; and, above all, (iii) cognitive impairment underlying many sustained injuries and predisposing the elderly to delirium.

In many frail elderly adults, many highly prevalent symptoms due to multiple diseases and risk factors (e.g. immobility, instability, impaired cognition and incontinence) are frequently reported. The concept of these geriatric syndromes can be a useful theoretical framework to guide diagnostic analysis and education in medical practice and teaching and also needs to include the diagnosis, treatment, teaching and awareness of mental health problems associated with these syndromes. Not surprisingly, the Education Committee Writing Group of the American Geriatric Society recommended that undergraduate medical training should include at least five psychiatric or psychiatrically related symptoms and problems out of the 13 most common geriatric syndromes, including depression, delirium, dementia, failure to thrive and sleep disorders [6]. This stresses the importance of both psychological skills and the role of liaison psychiatry services in the treatment of physical illness. Indeed, pharmacological and behavioural treatments of depression improve activities of daily living function post-stroke, protect against myocardial infarction, improve glycaemic control and give relief from physical symptoms in somatoform disorders. Furthermore, psychosocial interventions and programmes significantly reduce cardiac mortality and recurrence of myocardial infarction and have a positive effect on blood pressure, cholesterol and body weight [7]. The Interdisciplinary Behaviour Management Programme is also beneficial in the management of behaviours for people with dementia, functional psychiatric illnesses and medical illnesses [8].

Liaison psychiatry for older adults (LPOA) has begun to establish itself as a new discipline in psychogeriatrics. The joint seminar between the faculties of Liaison Psychiatry and Old Age Psychiatry in 2004 outlined the lack of both dedicated services and training positions for LPOA in the UK and produced recommendations for endorsement to the clinical speciality in LPOA. Most recently, the Royal College of Psychiatrists’ document Who Cares Wins [9] provided a comprehensive view of mental health care for older people in a general hospital setting, including service modelling, outcomes, liaison mental health teams, education and training and strategic planning. This document is in line with the National Service Framework for Older People (http://www.dh.gov.uk), which calls for a skill-mix able to meet the complex needs of older people. The implementation of LPOA meets at least several of the National Service Framework standards and has now been acknowledged in the recent National Institute for Clinical Excellence (NICE) guidelines for depression, which incorporate screening for depression in general medical hospitals. The role of psychiatric input in the medical care of elderly individuals in general medical settings has been further stressed in a recent document Everybody’s Business (http://www.everybodysbusiness.org.uk). This is a service development guide that sets out the key components of a modern older people’s mental
health service, aiming towards improving people’s quality of life, meeting complex needs in a co-ordinated way, providing person-centred approach and promoting age equality.

LPOA: Team composition for efficient service?

A recent review in the UK outlined that, despite the increasing number of specialist teams, most of the LPOA services were provided via a generic, sector-based psychiatry model (73%). The role and composition of the liaison services varied, with dedicated liaison psychiatry nurses for older people engaged in only 14% of the services, whereas all of them had medical psychiatric input [10]. A recent randomised control trial on nurse-led mental health liaison service for older people failed to find a reduction in general psychiatric morbidity but reported a modest effect on depression [11]. Undoubtedly, the biggest contribution of the liaison nursing teams lies in facilitating effective discharge planning and continuity of care [12] as well as improving nursing care for older patients on medical wards [13].

Changes in health care delivery and increasing diversity of the elderly population in both urban and rural settings, together with high expectations from families and home care needs, put additional pressure on social services to meet existing needs. There is a lack of social workers with sufficient knowledge and experience in dealing with medical and mental health problems and therefore a need to develop educational programmes to integrate the demands on the service and incorporate them into field practice [14]. Introducing dedicated specialist skills (e.g. mental health social workers, occupational therapists or psychologists) to the LPOA will not only further strengthen the multidisciplinary team approach but also facilitate transferring these skills to other disciplines involved in medical care of the elderly. In this respect, interdisciplinary team training may be beneficial since it has proved to result in a change of attitude across medical, nursing and social work professions and a change in team dynamics, although there has been no major influence on care planning measures [15].

LPOA: Who benefits?

To date, there has been no survey of the need for these services in a general medical setting or any estimate of their usefulness. One recent review attempted to address the effectiveness of psychogeriatric services in the acute hospital setting but reported very little information on the outcomes [16]. The values of LPOA seem to be somewhat contradictory. Thus, geriatrically led multidisciplinary teams with training and clinical experience in old age psychiatry appear to have a beneficial role in treatment of delirium [17], although contrary reports have also been published [18]. Similarly, LPOA services appear to have a modest impact on improvement in measures of depression and anxiety [19, 20].

How to measure the effectiveness of this type of service? Substantial reductions in length of stay and hospital costs as a result of LPOA services involvement, as well as intervention effect on measures of quality of life, have been reported [21, 22]. Similarly, early liaison with social services also reduces unnecessary hospitalisation, especially in stroke patients [23]. Interestingly, involvement of the LPOA even at the screening stage significantly reduces length of hospital stay, although it does not have major bearings on discharge placement [21]. Other measures of cost effectiveness also need to be brought into the wider picture: how to estimate the value of talking to relatives and providing support for carers and nursing staff? Facilitating access to other medical and supporting services? Supporting (and educating?) new medical graduates in their first jobs? Promoting function and prevention of decline? Advocacy for medically ill patients? What difference does it make whether elderly people are being seen by LPOA or not? These are only a few of the many roles undertaken by the LPOA. The complexity of the speciality is further reinforced by the importance of the special knowledge of ageing individuals and their health status based on geriatric medicine and gerontology. This needs to be incorporated in the Mental Health for Older Adults curriculum, to provide the optimal treatment of medically ill patients with mental health problems.

Challenges for the LPOA service

Although most patients referred to LPOA services are already known to mental health professionals [e.g. currently or previously engaged with Old Age Psychiatry (OAP) services], about 10–20% of new patients are identified by the LPOA, who will require further engagement with OAP services (Mukaetova-Ladinska et al., unpublished). Screening for mental health illnesses in secondary care, as incorporated in the NICE guidelines, may also contribute to an increase in newly diagnosed mental health problems that may well require continuous specialist care. It is still unknown how the rapid expansion of LPOA services will impact on workload, and how much pressure this will put onto the available OAP services. Furthermore, there is a lack of such services for the elderly with learning disability, who in some areas are first referred to the LPOA service. Most of this elderly group will present with chronic illness, a high rate of cognitive impairment and frequently with no previous contact with psychiatric services, which places them in the vulnerable category of undiagnosed and easily overlooked group of mental retardation.

Facilitating hospital discharge is becoming an important role for the LPOA services, with involvement in decision making and assisting medical professionals to ‘take up’ risks. Effective discharge planning largely depends on good communication between hospital, community staff, patients and their carers [12], a role that the LPOA is increasingly taking up.

Palliative care is usually provided by specialist palliative care services, to which patients are referred directly from the acute medical wards, and an occasional contact will be established with the LPOA service. As depression, paranoiac-psychosyndrome, delirium and even dissociative states are frequently reported in this category of patients, under-involvement of the LPOA service in this area comes as a surprise. We may also expect increased awareness from
emergency services. Outpatient LPOA clinics and bridging the gap between hospital discharge and long-term involvement of the mental health team (a facility that is available for general adult liaison services) are other possibilities for expansion of the services.

The newly established LPOA services have increasingly become part of the complex health care assessment offered to older adults in addition to the routine medical approach to health care: that of pathophysiology, pharmacology and/or aetiology. This model of a comprehensive health assessment contributes to the patient-oriented evidence for health care, deals with the somewhat neglected issue of quality of life and impacts on mortality and morbidity. As part of service development, now is the right time to start thinking about how and whether the LPOA services will influence our current clinical practices, patients and staff engaged in their care, quality of care, among many others.

Acknowledgements
I thank Mrs Caroline Kirk for secretarial support and for editing the text and my colleagues from the Older Peoples Liaison Psychiatry Team in the Newcastle General Hospital, Dr Ann Scully, Miss Glynis Cosker, Miss Andrea Hill and Mr Mick Coppock, for useful comments.

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