

CR222

Caring for the whole person

Physical healthcare of older adults with mental
illness: integration of care

COLLEGE REPORT

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Foreword

“ Whilst there has been an increasing focus on better integration of services to improve the physical and mental health of patients, much of this has centred around people who are under the age of 65. The number of people aged 65 and over in England is expected to have increased by around 30% by 2030, so it is essential we draw attention on this group.

The needs of those over the age of 65 are often different from others', with increasing frailty, multi-morbidity and an increased prevalence of cognitive impairment and dementia. The presentation of psychiatric illness in older people can be very different to working age adults, and the management of these conditions needs to take into account other co-morbidities. In addition, those with physical health problems are more at risk of developing a mental disorder. It is therefore important that services become more integrated and that the specific needs of the older population are recognised. Geriatricians and old age psychiatrists are both experts in the needs of this patient group.

This report highlights the physical health issues that older adults with mental illness can have, and recommends access to specialist medical advice for those in older people's in-patient wards, similar to the acute hospitals where older people with medical issues can access older adults' liaison psychiatry services.

This update to [Occasional Paper 100 \(OP100\)](#) provides an opportunity for improving care for older people. We hope that it encourages service managers, commissioners, and policy makers to consider the needs of this group.

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Executive summary

This College Report describes the importance of meeting the physical healthcare needs of patients with a mental disorder who are over the age of 65. Some are increasingly frail and have multi-morbidity. As the proportion of older people in the general population increases, it is essential that the NHS meets the needs of older people in a timely and effective manner. Integration of services is vital as poor physical health impacts on mental health, and poor mental health can both increase the risk of other health problems and limit chances of recovery from them.

The report is primarily written as a guide for psychiatrists working with older people. It will also be useful to staff of other disciplines providing clinical care to older people. In addition, the aim is to assist all staff who are involved in the planning and delivery of services. It is a useful document for commissioners, policy makers, and for training providers to consider the needs of the workforce, and it illustrates the importance of geriatricians and psychiatrists working in an integrated manner to support older patients with complex health needs.

The report outlines common illnesses that may be experienced by older people, with the focus being on the impact of ageing and mental illness on accessing appropriate help for those conditions. It also documents the impact of cognitive impairment and sensory impairment on the health and well-being of the older person, and considers additional needs such as end of life care provision.

Primary recommendations

1. A history and examination of physical co-morbidities should be completed for all patients under the care of mental health services.
2. A physical cause should be established where possible in cases of delirium.
3. Pain needs to be asked about and recognised better. The use of screening tools should be considered, especially when a patient is non-verbal. In addition, family and carers should be asked about whether they believe their relative is in pain if the patient is unable to communicate.
4. Mental health personnel should work with other relevant teams and agencies to reduce risk from physical ill health where appropriate.

5. Medications should be checked for compliance and for side effects. Risks of polypharmacy should also be considered and any medications which are no longer required should be stopped.
6. Improved monitoring of blood tests and expert advice on detection and management of abnormalities is required.
7. Venous thrombo-embolism risk needs to be considered, especially in in-patient units, and most particularly when mobility is impaired.
8. For end-of-life care, early discussion of advance care planning, ceiling of care plans and 'do not attempt cardio-pulmonary resuscitation' status is required, especially in patients with dementia. This discussion should include the management of nutrition when a patient's swallowing is deteriorating, and management of associated chest infections.
9. All patients aged over 65 should be assumed to be at risk of falls and should undergo multi-factorial assessments to inform plans to try to reduce this risk.
10. Training providers should consider training in geriatric medicine for old age psychiatrists, and training in psychiatry for geriatricians, with a similar overlap for nursing staff.
11. Commissioners should consider the importance of the role of a liaison geriatrician in older adult psychiatric in-patient settings to improve the quality of physical healthcare; this could have the added benefit of potential cost-savings from reduced transfer of the patients to acute trusts.
12. Commissioners should consider the importance of the role of a liaison geriatrician working with the older adults' mental health team in the community and memory clinics, given the medical complexity of many patients who are referred to the psychiatric team.

Introduction

[OP100 'Improving the physical health of adults with severe mental illness: essential actions'](#) is an Intercollegiate Report, published in October 2016, which focused on people aged 18–65 years of age who have a severe mental illness (Royal College of Psychiatrists, 2016a). It refers to 'the stolen years', where people with severe mental illness (SMI) die 15–20 years younger on average compared with the general population (Royal College of Psychiatrists). It is felt that many premature deaths would be avoidable with the right care. These issues are clearly important, but it is also important to consider particular challenges in improving the physical health in the older age group with severe mental illness. Whilst there are some similarities with those under the age of 65, and the overlapping principles were acknowledged in OP100, those aged over 65 are more likely to have multi-morbidity and increased rates of polypharmacy, in addition to an increased risk of cognitive impairment, falls, incontinence, and delirium.

The evidence for premature mortality in this older age group is weaker; however, the difficulties in accessing appropriate services and care remains. Managing the complexities in this group of patients needs to be considered differently to the younger age group. It is also important to recognise that many older patients present in atypical ways with common problems, related to both physical and mental health (Besdine, 2016). Among over-65s, 10% have frailty and this frequency increases with age (Clegg, 2013). In addition, around a quarter of patients over 65 admitted to hospital experienced an adverse drug event, many of which had contributed to the hospital admission (Hamilton *et al*, 2011). One study found that physical co-morbidities amongst those aged over 60 were more common for those with psychiatric illness compared with an age-matched group without psychiatric illness. Hypertension, osteoarthritis, and diabetes were also higher amongst the patient group with psychiatric illness (Meena, 2011).

This College Report does not repeat the OP100 but focuses on additional needs of older patients. In addition to multi-morbidity and risks from polypharmacy, other factors that are essential to consider are the impact of dementia and delirium, and the risk to the patient's physical health from other psychiatric illness, e.g. severe depression and the physical effects of the mental illness. Issues around the capacity to determine advanced care plans, treatment, and complex discharges are also of particular importance in older adults.

Whilst this report does not cover all of the possible co-morbidities experienced by older adults, it covers those most commonly

encountered and provides both practical advice for frontline staff, as well as recommendations for teaching, training, and commissioning of services that might enable better management and hence better outcomes for older patients. It is intended as a follow-up to the recommendations in OP100, but with a greater emphasis on the additional challenges faced by older patients, who often have more complex needs and greater multi-morbidity.

Summary of OP100 recommendations

[Occasional Paper 100 \(OP100\)](#) provided recommendations to improve physical healthcare for those with severe mental illness due to concerns about shortened life expectancy; increased rates of physical ill health; increased rates of risk behaviours, such as smoking and obesity amongst those with mental disorder; and the likelihood of them developing a long-term physical condition (Royal College of Psychiatrists, 2016a).

Recommendations from the report include the formation of a new national steering group to ensure key areas of physical health are addressed and monitored. This recommended steering group would work with the Royal Colleges of General Practitioners, Pathologists, Physicians, Psychiatrists and Nursing and the Royal Pharmaceutical Society to assist in implementing national standards, set standards for the training of their members, and advocate for the reduction in disparity of physical health outcomes. Commissioners should ensure that patients with severe mental illness are not disadvantaged in their access to physical health services, and continuous quality improvement of physical healthcare services should be enabled. Training for healthcare staff should ensure that those looking after patients with severe mental illness are able to recognise physical illness and assess, investigate, and monitor appropriately and refer on when required. The use of technology to improve care should be addressed, including better access to investigation results (Royal College of Psychiatrists, 2016a).

Physical healthcare of older adults with mental illness

Falls/instability

The risk of falls increases with age. Of those aged over 65, 28–35% experience a fall each year, increasing to 32–42% of those aged over 70 (WHO, 2007). It is known that falls occur frequently in mental health settings for older people, and the underlying mental disorder and associated treatment can increase the falls risk. Falls during admission can also impact on length of stay and discharge destination (Burn *et al.*, 2014). The Royal College of Physicians and the Healthcare Quality Improvement Partnership (HQIP) support a national audit of in-patient falls. However, many mental health trusts do not currently participate in this process despite older adult in-patient psychiatry wards being a key group who would benefit from the process. A national audit of in-patient falls is just beginning in all mental health units. All patients over 65 should be regarded as being at risk of falls and should have a multifactorial risk assessment to try to reduce the risk, without the need for preliminary screening to identify those at risk (NICE, 2013). A clear post falls policy should be in place across all organisations, and access to physiotherapy and occupational therapy to help manage falls risk is essential. Interventions such as low-rise beds and slipper socks (or other appropriate footwear) should be considered, as well as technological aids such as pressure sensors.

Medication side effects from both psychiatric treatment and treatment for co-morbid medical conditions increase the risk of falls, particularly if patients take more than one drug. Drugs that result in a high risk of falls include benzodiazepines, zopiclone, antidepressants, and antipsychotics, and there is also evidence for increased falls resulting from the use of mood stabilisers such as carbamazepine and sodium valproate. The mechanism for these drugs causing falls is a mixture of the sedative side effects, ataxia, orthostatic hypotension, psychomotor slowing, extra-pyramidal symptoms, and, in some cases, alpha-receptor blocking activity (Darowski, Dwight and Reynolds, 2011; and Quigley *et al.*, 2014). Long-term use of any sedatives should be reviewed regularly and discontinued when safe to do so. An assessment of modifiable factors for a patient's falls risk should form part of any comprehensive geriatric assessment. There is no evidence to support referral for visual correction as a single intervention to prevent falls, but assessment of impairment should form part of a multi-factorial visual assessment (NICE, 2013). Patients with dementia remain at risk of falls secondary to their lack of hazard awareness. Assessment and management of bone health and methods of alerting

people to falls (e.g. falls alarms) should be considered to minimise the risk of morbidity and mortality from falls.

In the out-patient setting, strength and balance training, such as the Otago programme, have shown a significant reduction in falls. However, they have only been validated when ongoing community support has been made available (Later Life Training, 2013). Utilisation of community services should be considered for out-patient populations. However, a pre-existing diagnosis of dementia often limits interventions that could be offered, so these patients are frequently not reviewed in a full multidisciplinary team clinic. Whilst patients with dementia will benefit from a comprehensive geriatric assessment, this assessment does not necessarily need to occur within a specialist falls clinic.

Cognitive impairment, dementia and delirium

Diabetes, heart disease, vascular disease and cancer are associated with poor cognitive performance. In addition, cognitive impairment is often associated with poorer health (Frisoni, 2000).

Dementia is increasingly common as people age, and as many as 29.6% of women and 27.5% of men aged 90–94 years have this condition. Behavioural and psychological symptoms in dementia can increase the rate of falls, polypharmacy, and nutritional deficits, which can, in turn, increase the risk of delirium and further complications. Any medication used for the behavioural symptoms should be given at as low a dose as possible and for the shortest time possible.

Just over a third of people over the age of 80 admitted to an acute hospital have delirium (Ryan *et al*, 2012). Delirium and dementia are often not recognised in acute hospital settings. It is also important to ensure that delirium is not missed in the psychiatric setting, to ensure that appropriate treatment for the underlying physical cause is given. The Confusion Assessment Method (CAM) can be a helpful tool in screening for delirium; it considers the acute onset and fluctuating course, inattention, disorganised thinking, and altered levels of consciousness. The 4-AT screening tool is now recommended as part of the pathway for neck-of-femur fractures (Royal College of Physicians, 2016).

A thorough physical examination and appropriate investigations are required to determine the cause of delirium, and a medication review should be undertaken. Urine should not be routinely tested using a dipstick for urinary tract infections in the older population unless there are objective symptoms of urinary frequency, dysuria, or systemic evidence of infection such as pyrexia, or raised inflammatory markers where no other source of infection is found. One third of urine dipsticks from women aged over 65 years of age are positive for

nitrites and leucocytes, but this is not necessarily indicative of urinary tract infection (Beveridge *et al*, 2011; and NICE, 2015a). Infection is a common cause of delirium, especially urinary and respiratory infections, but there are many other causes including alcohol withdrawal, malnutrition, dehydration, and a range of biochemical abnormalities including hypo/hypernatraemia, and hypo/hypercalcaemia.

A formal delirium policy should be in place to improve prevention, identification, and treatment of delirium. This should be based upon the NICE quality standards or equivalent (NICE, 2014a). Prevention is better than cure, with appropriate environments and support from relatives playing a big part in reducing delirium rates for in-patients.

Patients with dementia may struggle to articulate or accurately present their symptoms of concurrent physical illness or disease. As is noted in other sections of this report, approaches to patients with dementia should be adapted to help pick up concurrent problems, such as pain scales, management of continence, and thorough review of pressure areas.

Sensory impairment

Patients with any form of sensory impairment are at increased risk of morbidity and mortality. Sensory impairment is present in 70% of those aged over 70. One in five people aged 75 and over have visual impairment, which increases with age to 50% of people aged over 90 years old (RNIB, 2017). Sensory impairment can impact on mental health and can affect people's confidence, communication, and independence (Du Feu and Fergusson, 2003). Charles Bonnet syndrome is more common in those with later life visual loss and auditory hallucinations are common in those with hearing loss (Linszen *et al*, 2018).

It is important, where possible, for sensory deficits to be corrected. Sometimes this may be relatively straightforward, for example through hearing aids or glasses, and it can make a large difference to the person's quality of life. All members of the MDT who work with older patients should receive training to ensure they know how common hearing aids work, how batteries are changed, and how to check at the bedside whether they are working. Loss of hearing aids during an in-patient stay is detrimental to a patient's wellbeing as well as a potential large cost for the trust if it is deemed responsible for replacement. As such, hospital trusts should ensure that the ownership of hearing aids by patients is documented as part of routine handovers, to help reduce the frequency with which they are mislaid (Oliver, 2017). Whilst adequate lighting will give benefit to patients with poor vision, potential impact on disruption of circadian rhythms should be borne in mind in areas with poor natural light and/or areas requiring continuous artificial lighting (such as nurse stations).

Where sensory deficits cannot be corrected, other options to aid with communication with people with sensory impairment can be considered, for example through the use of technology.

Oral health

The oral health of patients with mental illness is often worse than those without mental health problems. Oral hygiene may be neglected in conditions such as psychosis, depression and dementia, and people with mental illness are more likely to smoke. If there is poor oral health, it can lead to pain and poor nutrition, with associated complications. It may also impact on speech. Additionally, many psychiatric medications have side effects including dry mouth, which can lead to poor oral health (Denis, *et al*, 2017). An oral health assessment is recommended on older adults in in-patient wards

Diabetes

Patients with severe mental illness tend to have a poorer diet and less active lifestyle than the general population and are 2–3 times more likely to develop diabetes. In addition, the side effects of some medications, such as the second-generation antipsychotics, can lead to an increased risk of diabetes (Holt and Pendlebury, 2010). Patients with diabetes are at greater risk of developing a mental illness, such as depression or psychosis, whilst problematic blood sugar management can lead to a chronic delirium.

In-patient wards should have well-established pathways for the management of hypoglycaemic episodes. Standard practice is the administration of oral quick-acting carbohydrate, such as glucostabs or glucojuice, in patients whose swallowing is not impaired; or 75–100mL IV 20% glucose or 1mg IM glucagon where swallowing is impaired or where there are complications such as seizures. Appropriate monitoring of subsequent blood sugar levels should be performed, with assessment from diabetic support teams following the acute episode (Joint British Diabetes Societies for Inpatient Care, 2018).

NICE guidance on preventing type 2 diabetes in high-risk groups should be followed (NICE, 2012) and, in those who have developed diabetes, the NICE guideline on the management of diabetes should be utilised (NICE, 2015b). There are significant health complications of poorly controlled diabetes, including cardiovascular disease, nephropathy, neuropathy, infections, retinopathy, and amputations. Patients with diabetes should receive an annual care review that includes retinopathy screening; bloods to look for nephropathy, cholesterol, and diabetic control; and foot examinations (Diabetes.co.uk). Staff working in mental health settings need to be familiar with the complications of diabetes and be aware of how to manage diabetic emergencies. A liaison

geriatrician would be able to advise on the management of diabetes. Closer working with diabetic services, dieticians, primary care and mental health services would be beneficial. Tissue viability services to support the healing of neuropathic ulceration should be as easily accessible in mental health units as they are in acute hospital trusts.

Cardiovascular disease

Cardiovascular disease (CVD) is the second most common cause of death in the UK (Bhatnagar, *et al*, 2015). Individuals over 65 years old account for 82% of deaths attributable to coronary heart disease, and age is a strong independent risk factor for ischaemic heart disease (Lloyd-Jones *et al*, 2009). The incidence of CVD in those aged 85–94 years has been estimated as 65–75 per 1,000 person-years (Yazdanyar and Newman, 2009). In those aged 70 years, the lifetime risk of a first ischaemic cardiac event is 35% in men and 24% in women (Lloyd-Jones *et al*, 1999).

The relationship between coronary artery disease and mental health is complex. A mental health condition is found in 19–66% of patients presenting with a myocardial infarction (Khawaja *et al*, 2009). Longitudinal cohorts have shown that depression is an independent risk factor for the development of coronary artery disease (Barefoot and Schroll, 1996), including in older adults (Penninx *et al*, 1998). However, depression and other mental health conditions may be confounding factors due to their association with cardiac risk factors (e.g. smoking). Depression is also associated with reduced survival after ischaemic cardiac events (Nicholson *et al*, 2006). This may be related to social isolation and/or non-adherence to medication (Ruberman *et al*, 1984; and DiMatteo *et al*, 2000).

In those with chest pain, evaluation for ischaemic heart disease primarily involves clinical history, electrocardiography, and cardiac enzymes. Assessment of older individuals for ischaemic heart disease must be done with care. The prevalence of electrocardiographic abnormalities (including T-wave inversion, ST-segment depression, and left bundle branch block) increases in older adults even in the absence of significant ischaemic heart disease (Molander *et al*, 2003). Further, high-sensitivity troponin levels are often raised in older patients without acute cardiac syndrome (Webb, *et al*, 2015). As a result, ECGs and troponin levels should be used judiciously in this population and only when the presence of an acute coronary event is suggested by the history.

Service provision for older adults with mental health conditions at risk of ischaemic heart disease can be improved through relatively simple measures. Any patient with identified cardiovascular disease, or with a QRISK2 score over 10%, requires primary and secondary prevention. Patients should be given advice on how to reduce their risk of cardiovascular disease.

Older patients can experience both hypertension and hypotension and there is an increasing risk of autonomic dysfunction. Many medications can impact on blood pressure control and it is important to check lying and standing blood pressure to assess for any postural drop.

For those requiring acute psychiatric care, transfer to an acute medical hospital environment can be distressing. As a result, where possible, provision should be made for undertaking an initial assessment of chest pain prior to determining a need for transfer to the emergency department. This assessment should include a chest pain history, electrocardiography, and the presence of appropriately trained medical personnel to interpret this information. However, if the patient does appear acutely unwell, rapid transfer to the acute hospital may be appropriate.

Whilst patients with heart failure may suffer from symptoms such as shortness of breath due to pulmonary oedema, leg swelling in isolation should not automatically lead to the initiation of diuretics. Confirmation that the leg swelling is the result of heart failure should be sought, rather than as the result of other conditions (e.g. side effect of calcium channel blockers). If leg swelling is the result of heart failure, then the benefits of diuretics should be weighed up against the side-effects of increased urinary frequency (and its potential to cause incontinence and falls if mobility is poor), orthostatic hypotension, electrolyte disturbances, and renal function changes. Geriatric medicine liaison teams, in conjunction with both acute hospital and community heart failure teams, should be utilised to support patients with heart failure. Furthermore, psychiatric liaison support should be readily available for the assessment of older patients within cardiac care units.

Cerebrovascular disease

There are more than 100,000 strokes every year in the UK, with the average age of people suffering strokes in the UK being 72 for men, and 78 for women (The Stroke Association, 2018). As noted in OP100, people with severe mental illness are more likely to have high risk behaviours such as smoking, and a higher prevalence of diseases which increase the risk of stroke such as diabetes mellitus. The effects of stroke can be severe, with 84% of stroke survivors requiring assistance for activities of daily living, whilst a third suffer from depression subsequent to the event, and a third develop vascular dementia within 5 years (The Stroke Association, 2018).

Early recognition and intervention are the key components to an improved outcome in the event of stroke. Thrombolysis is currently licensed for severe and debilitating ischaemic strokes within the first 4.5 hours following onset of symptoms. For severe and debilitating

strokes, treatment with thrombolysis led to improved levels of disability at 3–6 months, with the best outcomes seen in those who received treatment early. More recent data has demonstrated that this treatment may even be beneficial when initiated within 6 hours, and that the effect was not diminished in older patients (The IST-3 collaborative group, 2012). A small number of centres have started offering thrombectomy services, with this technology also approved by NICE (NICE, 2016). In order to minimise potential delays to initiation of treatment, which may be detrimental to long-term outcomes and disabilities, mental health facilities should have a detailed action plan in place to enable rapid transfer of suspected strokes to appropriate local hyper-acute stroke units (HASU). Training and education to improve the diagnosis and detection of strokes should be provided for mental health practitioners.

Improvements in the management of modifiable risk factors such as type 2 diabetes, or support to reduce at-risk behaviours, such as smoking, can help reduce the risk of stroke (O'Donnell *et al.*, 2010). Recommendations on how this is best achieved is included in both OP100 as well as elsewhere within this report.

Use of both typical and atypical anti-psychotics is associated with an increased risk of stroke, with a further relative increase in stroke risk in those patients with dementia compared to those without (Douglas, 2018). As such, the overall risk of cerebrovascular disease should be taken into consideration when considering initiation of treatment, with regular review and cessation of medications in future if indicated. Should a patient require long-term treatment with an antipsychotic, then optimisation of other modifiable risk factors should be undertaken.

Patients who suffer transient ischaemic attacks (TIAs) are at increased risk of a completed and debilitating stroke in the future. Risk stratification using the ABCD scoring system has been shown to perform poorly when applied to patients with known baseline risks for completed stroke (Sanders *et al.*, 2012), and the latest version of the NICE guidelines advocate assessment within 24 hours by a specialist, or within 7 days if a TIA occurred more than 7 days previously, irrespective of risk stratification (NICE, 2017a). If a TIA is strongly suspected, then immediate treatment with 300mg aspirin should be administered. Transient loss of consciousness (TLOC) should, in general, not be referred as a possible TIA, as this would physiologically require a transient thrombotic occlusion causing global hypoperfusion of the brain (which is highly unlikely). Alternative causes for TLOC should instead be investigated, including cardiogenic or orthostatic, as well as non-syncopal causes of TLOC (e.g. psychogenic).

Atrial fibrillation (AF) is a common cause of embolic stroke. When identified, a patient's risk of stroke should be assessed using the CHADSVASC scoring system, and their risk of bleeding if

anti-coagulated assessed using HASBLED. An informed decision on whether or not to anti-coagulate should be made, with direct oral anti-coagulant drugs (DOACs) now available as first-line choice, in addition to warfarin (NICE, 2014b). Warfarin has multiple drug interactions which alter its efficacy, and DOACs are less prone to these interactions, so may be preferable in older patients with polypharmacy, or in whom regular INR testing is not practical.

Chronic obstructive pulmonary disease (COPD)

COPD is used to describe a number of progressive lung conditions, including emphysema, chronic bronchitis and refractory asthma. Smokers are more likely to get COPD, and it is known that cigarette smoking contributes to a significant number of preventable deaths. Moreover, patients with mental illness are more likely to be smokers and are therefore at an increased risk of developing COPD (Ziaaddini, Kheradmand., and Vahabi, 2009).

People who suffer from COPD can have high rates of anxiety and depression and, due to repeated infections or periods of hypoxia, they may also be susceptible to episodes of delirium. Symptoms of anxiety and depression symptoms are often not recognised in those with COPD and can be challenging to treat. It has been found that less than a third of older patients receive appropriate treatment for their COPD (Yohannes and Alexopoulos, 2014). It is essential to maintain optimal control of the COPD whilst addressing the symptoms of depression and anxiety. The British Thoracic Society advocates admission and discharge care bundles for patients admitted to hospital with acute exacerbations of COPD, and these should be utilised for patients with severe mental illness who may suffer exacerbations as either the primary reason for hospital admission, or where an exacerbation is suffered whilst undergoing in-patient treatment for other conditions (British Thoracic Society, 2017).

The successful delivery of inhaled therapy in COPD can be technique dependent, with devices such as spacers improving efficacy in older patients in whom traditional methods are challenging (e.g. due to difficulty in operating devices with hands affected by arthritis, or the timing of when to activate the device whilst inhaling in patients with cognitive impairment). Minimising the number and type of inhaler devices that each patient uses and regularly assessing ability to use the inhaler is helpful (NICE, 2018a).

Incontinence

Urinary incontinence affects 3.2 million people over the age of 65, including 50% of care home residents. Moreover, 10% of older people are affected by faecal incontinence (Age UK, 2017). Incontinence

can be both a sign and symptom of psychiatric illness, as well as a consequence of pharmacological therapy used to treat it. People with depression can be demotivated to the extent that they become incontinent, whilst those with delirium or dementia may lack the insight into the need to get to the toilet in a timely fashion. Similarly, drugs with anti-cholinergic effects can lead to bladder dysfunction and retention, whilst sedatives can decrease a person's independence in terms of toileting. Incontinence can lead to a loss of dignity and should be approached as a symptom that something is wrong, rather than being accepted as part of the ageing process or part of a psychiatric illness.

An appropriate review of the causes of a patient's incontinence should be undertaken. The management strategies for urge incontinence differ to that of stress incontinence, for example, and should be tailored to the individual. If a patient is admitted to a psychiatric unit, it is essential that they are still able to access the appropriate support and treatment, which could be provided to a degree by a liaison geriatrician.

Non-pharmacological interventions, such as regular toileting regimes for those with cognitive impairment, could be of benefit. Catheters and other in-dwelling devices should be used with caution as they lead to an increased risk of infection and, in the long-term, can lead to worsening incontinence due to deconditioning of bladder training. However, in cases of outflow obstruction, such as prostatism in men, they may be required. Similarly, if there are areas of skin breakdown for which good hygiene is required, catheters could be considered.

If pharmacological therapy is to be trialled, e.g. for urge incontinence, then consideration should be given to the potential impact on mental health that anticholinergic-based medications could have. Newer, non-cholinergic, medications, such as Mirabegron, are emerging that can be considered first-line care in cases of known cognitive impairment.

Constipation

Constipation is common in the older population. In those aged 84 and older living in the community, the prevalence is 34% in women and 26% in men but can be as high as 80% for those living in long-term care (Schuster, Kosar, and Kamrul, 2015). Constipation can lead to pain and discomfort, problems with loss of appetite, haemorrhoids, faecal impaction, rectal prolapse, urinary retention, and delirium. In severe cases, constipation can lead to stercoral colitis, which is an inflammatory colitis secondary to raised intraluminal pressure from constipation. Non-pharmacological treatment, such as ensuring adequate hydration; eating whole grains, fruits high in sorbitol and vegetables; regular toilet routine; and light exercise can be helpful. Constipation can be a side effect of many drugs, so a review of

medication may be required, and laxatives can also be prescribed. NICE suggests that the laxative doses should be titrated up or down with the aim of producing soft, formed stools without straining at least three times per week (NICE, 2017b). Other causes should also be considered as should referral to a colorectal surgeon or gastroenterologist if a serious underlying cause is suspected.

Pain

Fifty per cent of people aged over 65 have some degree of pain or discomfort (Kumar, and Allcock, 2008). The WHO pain ladder is a sensible approach to pain management, but should be tailored to the older patient with additional consideration of potential side effects. NSAIDs should be avoided, given the risk stroke, as well as GI, cardiovascular and renal side effects. Opiates can cause delirium, both through their direct effects on the central nervous system, and via side effects such as constipation. In addition, opiates can increase the falls risk. Neuroleptics can be useful in treating neuronal pain, whilst caution is required with amitriptyline due to the risk of confusion.

Cross-reactivity between some analgesics and psychoactive medications should be considered. Tramadol and SSRIs can lead to serotonin syndrome and should be avoided as a combination when possible.

Patients with dementia may lose the ability to articulate their pain to their carers. Despite a similar physical disease spectrum, the self-reported level of pain has been found to be lower in patients with dementia than in the general older population (Tan *et al*, 2015). Pain can manifest itself as unsettled behaviour, which may be inappropriately treated with sedatives and anti-psychotics. In addition, behavioural pain reactivity and response to pain are reported to be reduced in schizophrenia, although this finding has been debated (Bonnot *et al*, 2009). Pain assessment tools can be used to assist in the detection of pain, and some of these tools are designed for those who are unable to communicate their pain. Common pain scales used in dementia are observational tools, such as PainAD, Dolopus 2, Abbey pain scale, and the DisDat. A trial of regular paracetamol can sometimes be worthwhile in patients with dementia to assess the impact on behaviour. Indeed, adequate pain control strategies in patients with moderate to severe dementia have been shown to reduce levels of agitation, and hence the number of unnecessary prescriptions of psychotropic medications (Husebo *et al*, 2011).

Cancer

The diagnosis and management of cancer in the older patient is already recognised as an area where standards do not match those of younger, comparable patients, let alone with the additional burden of severe mental illness. A perfect storm combining a lack of clinical evidence of some therapeutic strategies in older patients, sub-optimal identification and management of co-morbid conditions, inadequate social support, and a disproportionate focus on age rather than physiological frailty as the bedrock of decisions to treat have been identified as the main issues this area of medicine faces (MacMillan Cancer Care). The British Geriatric Society have formed a special interest group in this area, whilst MacMillan have an older people's oncology expert reference group.

Data from the National Cancer Patient Experience Survey in 2014 notes that older people are less likely to be given a named clinical nurse specialist to support them through treatment and are less likely to be told who to contact over concerns related to treatment following an in-patient admission. However, explanations as to diagnosis were noted as best explained in the older population groups. Data from 2014 also demonstrated that patients aged 16–25 were over twice as likely to be offered the opportunity to take part in cancer research than those aged over 75. The diagnosis of malignancy is more likely to occur during an emergency presentation in the older patient, rather than through screening or GP 2-week wait referrals, and it is associated with poorer outcomes (Public Health England, 2014). Later presentation is associated with an increased likelihood of cancer spread by the time of diagnosis, and hence poorer outcomes.

Development of services for better support of older patients who are diagnosed with cancer, should include consideration of the need for support and management of concurrent severe mental illness. A cancer diagnosis should not preclude patients from being offered the same treatment as a comparable patient without a mental disorder. Doctors caring for patients with severe mental illness within psychiatric units should be aware of common signs and symptoms of potential malignancy, and the appropriate pathways for investigating this, in order to increase the chances of early detection and, hence, better outcomes.

Hyponatraemia

Hyponatraemia is the most common electrolyte disturbance seen in clinical practice, with a prevalence across the general hospital population of 15% of all in-patients, 14% of out-patient attendances, and 18% of all nursing home patients, compared to 8% of comparable non-institutionalised patients (NICE, 2015c). The type of hyponatraemia can be categorised by severity:

- Mild (130–135 mmol/L)
- Moderate (125–129 mmol/L)
- Severe (<125 mmol/L).

It can also be sub-categorised by the speed of onset:

- Acute (<48 hours)
- Chronic (>48 hours).

If the exact speed of onset is unclear, it is safest from a patient's management point of view to assume it is chronic, as too rapid a correction can lead to central pontine myelinolysis.

Hyponatraemia has particular relevance to the older patient for a number of reasons. Part of the physiological changes of ageing include a reduced renal concentrating capacity, increased baseline anti-diuretic hormone (ADH), as well as increased circulating atrial natriuretic peptide (ANP) (Chan, 1997). This loss of the ability to concentrate urine, particularly overnight, has the effect of increasing nocturia and associated issues with incontinence or even falls, from trying to get to the toilet in the dark.

As noted in the section on polypharmacy, the older patient can be more prone to the side-effects of medications, for example thiazide diuretics. The hyponatraemia risk associated with thiazide use increased two-fold with every 10 years of age, whilst a 5kg increase in body mass decreased the risk by around a third (Chow, et al., 2003). Other important classes of drugs that are associated with a risk of hyponatraemia are carbamazepine and selective serotonin reuptake inhibitors (SSRIs) (Liu et al, 1996). The exact prevalence is unclear, but the older patient has been shown to be at increased risk.

As the severity of hyponatraemia worsens, the risk of adverse features also increases. Hyponatraemia can be associated with an increased risk of falls, gait disturbances, cognitive impairment, osteoporosis, and fragility fractures. The most severe cases can be associated with seizures and death as a result of cerebral oedema and raised intracranial pressure. Hyponatraemia is associated with an increased length of hospital stay of 2–3 days vs comparable patients ($p<0.005$), and a 27% in-patient mortality rate vs 9% in comparable patients ($p=0.009$) (Gill *et al*, 2006).

Management of hyponatraemia requires a thorough assessment of a patient's fluid volume status, paired serum and urine osmolalities, urinary sodium levels, as well as medication reviews and evidence of other underlying issues (e.g. lung malignancy) in order to accurately determine the aetiology of the low sodium. There can be a tendency to always revert to fluid restriction as the go-to treatment for hyponatraemia, although this is not always the right solution. Whilst a patient with polydipsia (such as lithium-induced or primary psychogenic) as a cause of their hyponatraemia would benefit from fluid restriction, an unwell patient with gastroenteritis and dehydration would require IV fluids (e.g. 0.9% saline or similar).

Unless there are severely worrying features about a patient's hyponatraemia, an admission to an acute medical hospital would not necessarily be required. As per recommendations in OP100, improved availability of medical liaison teams within mental health hospitals could improve the assessment and management of hyponatraemia, whilst improved availability of laboratory tests to mental health hospitals could help support management without requiring transfer to an in-patient hospital trust.

Hypernatraemia

Hypernatraemia is, broadly speaking, the result of either dehydration or, less commonly, salt poisoning. As with hyponatraemia, a thorough history and clinical examination is required to determine the underlying aetiology, and hence treatment. Patients with poor oral intake over a chronic period of time due to underlying psychiatric conditions, such as depression or catatonia may require maintenance fluids whilst their underlying problem is managed. At present, this requirement may necessitate a transfer to an acute hospital for bloods monitoring and intravenous fluids, potentially to the detriment of their ongoing psychiatric management. Improved provision of laboratory testing and improved monitoring within a psychiatric unit may help to reduce these transfers. If the underlying psychiatric condition is not treatable, such as advanced dementia, then there is questionable benefit in providing artificial rehydration, and frank discussions should be held with families where possible, as dehydration due to stopping eating may represent the terminal phase for their dementia.

Dehydration can also occur due to excessive fluid loss rather than sub-optimal intake. Diabetes insipidus is a condition resulting in the generation of large quantities of urine due to the loss of either the central production, or the effect on the kidneys, of the hormone vasopressin. Lithium and clozapine are known to cause diabetes insipidus (Bendz and Aurell, 1999). This condition should be regarded as a medical emergency, with urgent transfer to an acute hospital setting for management.

Some patients with impaired swallowing, for example, due to advancing dementia, may have their regular medications in soluble form, which can have a significantly higher sodium content. Many soluble paracetamol-containing medications have more than 16 mmol of sodium per dose which, if taken at the maximum of 1 g QDS, already exceeds the recommended daily sodium intake in an adult of 100 mmol before dietary intake or other sources are considered (UK Medicines Information, 2016). This should be borne in mind when other causes of persistent hypernatraemia have been ruled out (Adams *et al*, 2004).

Other electrolyte abnormalities

Hyper- and hypokalaemia, depending on the severity and chronicity, can also have potentially life-threatening consequences, largely due to subsequent arrhythmias. The need for emergency transfer to an acute hospital for corrective treatment is based on the severity of the abnormality in addition to the presence of adverse signs such as ECG changes, clinical manifestations (such as muscle weakness or paralysis) or evidence of ongoing conditions that will likely further impair renal homeostasis of potassium (such as rhabdomyolysis following the development of neuroleptic malignant syndrome). Delays in processing blood samples can result in pseudohyperkalaemia as a result of failure of the ATP pump and the leak of intracellular potassium into the serum. Off-site processing of blood tests can lead to spuriously high potassium levels and may result in decisions on how to further manage these test results being made by out-of-hours clinicians who do not know the patient. The provision of on-site testing, or even point-of-care testing, would help reduce the risk of these spurious results. Although point-of-care testing has been proven to be cost-effective in multiple situations, such as treating respiratory tract infections in primary care (Hunter, 2015), there is currently a lack of evidence to confirm its cost-effectiveness in mental health trusts when dealing with electrolyte disturbances.

Although these are the most common electrolyte disturbances encountered in older patients, other frequently occurring problems include: hypercalcaemia, for example due to myeloma or other metastatic cancers; hypocalcaemia, for example due to dietary insufficiency or lack of vitamin D, particularly in institutionalised patient; hyper- and hypo-phosphataemia; and hyper- and hypo-magnasaemia. The ability to monitor these parameters and correct as required without the need to transfer to acute medical sites would be beneficial for older patients within mental health institutions. Provision of both testing facilities and the availability of liaison geriatricians to support mental health staff in assessing these patients and making decisions on their management can help reduce unnecessary and potentially detrimental transfers to acute medical centres, although cost-effectiveness would need to be confirmed.

Polypharmacy

The STOPP/START programme (Screening Tool of Older People's Potentially Inappropriate Prescriptions, and the Screening Tool to Alert doctors to Right Indicated Treatment) are a set of 65 and 22 criteria respectively, for common medication issues in a person aged over 65. Of the STOPP criteria, 13 relate specifically to the central nervous system and psychotropic drugs (e.g. anti-cholinergic medications to treat the extra-pyramidal side-effects of neuroleptic medications), which superseded the Beer's criteria as it more accurately relates to UK prescribing practices (American Geriatric Society, 2019). Implementation of STOPP/START criteria has been shown in the older population to reduce the number of adverse drug reactions (O'Mahony et al., 2015).

Studies have shown that potentially inappropriate medications have been prescribed for 80% of older patients in in-patient psychiatric care (Rongen, 2016). Whilst a focus on the potential psychological benefits of such treatment may be appropriate, the criteria should ideally still be utilised to minimise the risk of adverse drug events.

Where possible, geriatricians and old age psychiatrists should work together to reduce polypharmacy to minimise complications and side effects. It is also important to check with patients about adherence to medication, as they may not be taking medications properly or at all. Pharmacists provide a vital contribution to the MDT in supporting and reviewing prescribing practices. This approach would be in keeping with the Academy of Medical Royal Colleges' 'Choosing Wisely' campaign (Choosing Wisely UK, 2016).

Parkinson's disease

Parkinson's disease affects 1% of the over 60s, and 4% of the over 80s, and is associated with psychiatric abnormalities, which may even precede the onset of motor symptoms (e.g. depression, hallucinations) (De Lau, and Breteler, 2006). Identifying the underlying cause of a patient's Parkinsonism is key to their appropriate management (e.g. Parkinson's disease, Lewy body dementia, vascular parkinsonism, drug-induced parkinsonism, and Parkinson's plus syndromes).

The overarching aim of the current treatment for Parkinson's disease is to increase the levels of dopamine in degenerating neurones. The side effects of dopamine can include impulse control disorders, such as pathological gambling and hypersexuality, as well as orthostatic hypotension, visual hallucinations, and even psychosis. The psychiatric complications of Parkinson's Disease can include depression, which should be managed step-wise with a review of regular Parkinson's disease medications, then antidepressants (being aware of potential worsening of motor symptoms, or serotonin syndrome when mixed

with selegeline), and potentially ECT in resistant cases. Psychological treatment may also be helpful. Psychosis should also be reviewed in a stepwise approach; any superimposed delirium should be investigated and ruled out, and the medication regimen should be reviewed as the side effects of Parkinson's medication includes psychosis. Quetiapine is the first line antipsychotic in patients without cognitive impairment, and clozapine can also be considered, although this will require haematological monitoring. Rivastigmine should be utilised in patients with cognitive impairment (NICE, 2017c). The non-motor complications of Parkinson's disease also include anxiety, hyper-salivation (which can be socially embarrassing for a patient), sleep disorders, and gut motility problems. The approach to managing Parkinson's disease should therefore include the MDT, with a focus on the management of the non-motor symptoms, psycho-social problems, as well as the physical symptoms.

The prevalence of dementia in patients with Parkinson's disease is around 40% (Svenningsson *et al*, 2012). If the onset of dementia is within one year of the onset of motor symptoms, then the diagnosis changes to one of Lewy Body dementia. This diagnosis is important as levodopa therapy is less efficacious in Lewy Body dementia than in Parkinson's disease. Close collaboration is recommended between physicians and older people's mental health teams in the management of parkinsonism.

Venous thromboembolism (VTE) risk

Being aged over 60 is an independent risk factor for venous thromboembolism (VTE) and, combined with reduced mobility relative to normal, would be a sufficient indication for VTE prophylaxis (NICE, 2018b). Mortality from VTE in older adults is increased. However, the risk of side effects of bleeding secondary to low molecular weight heparin is also increased, particularly if the patient has renal failure. A study has shown that the incidence of VTE on psychiatry wards is comparable with VTE rates in general hospitals (Zyl *et al*, 2013). It is known that antipsychotics and benzodiazepines increase the risk of VTE, whilst SSRIs have an associated increased risk of gastrointestinal bleeding. It is important that processes are in place in psychiatric in-patient units to consider VTE risk. Many units do consider prescribing low molecular weight heparin prophylactically, despite there being little evidence to support that treatment in mental health settings (Patel, 2015). NICE guidance has been updated to include information for patients on psychiatric wards (NICE, 2018b).

Pressure area care

All adults are at risk of developing pressure area damage, and in-patients should undergo a risk assessment using an appropriately validated scale, such as the Waterlow Score. Older patients are

more likely to have comorbidity that increase their risk of pressure damage, such as diabetes and associated neuropathy, peripheral vascular disease, sub-optimal nutritional status, and poor mobility. Prevention is better than treatment, and utilisation of pressure-relieving equipment where appropriate, regular repositioning, and optimisation of nutritional status are all factors that can help reduce damage occurring. Processes should be in place to document the presence of pressure damage, and to investigate the causes of severe pressure ulcers. Pressure ulcers can be signs of abuse by neglect, and their presence should not be assumed to be part of the ageing process (Voss *et al*, 2005).

Frailty

An area of rapidly progressing research is that of frailty, which is defined as a state of increased vulnerability to poor resolution of homeostasis following a stressor event (British Geriatrics Society, 2018). It is a condition where the body's reserves are eroded, meaning people are vulnerable to sudden changes in their health triggered by events, such as a minor infection or a change in medication. Delirium is common in people who are frail.

Frailty should not, however, be regarded as an inevitable consequence of ageing, rather a syndromic condition – the development of which can be mitigated and the risks from the established condition reduced. Although frailty is not solely associated with age, it is more prevalent in older people, with around 10% of people aged over 65 currently living with frailty, rising to between a quarter and a half of those aged over 85.

Old age psychiatrists work with older people living with frailty on a daily basis. Identifying patients with frailty can be challenging, but it is important to do. An increasing number of diagnostic tools are being developed and validated. PRISMA-7 (Raïche *et al*, 2008) and the electronic frailty index (eFI) (Lansbury *et al*, 2017) can be useful screening tools to help identify patients at high risk of having frailty in multiple settings (Other scoring systems such as the Rockwood (Rockwood *et al*, 2005) and Edmonton (Rolfson, 2006) frailty scales can assign a more specific level of frailty for specific patients.

Healthy ageing can lead to a decreased likelihood of developing frailty, and this is more likely to be achieved where a person has good nutrition, remains physically active, has a reduction in risk behaviour such as smoking and substance abuse, and where they have strong social support

Patients identified as being at risk of having frailty from the above screening tools would benefit from a detailed review, such as via a comprehensive geriatric assessment (CGA) This could be instigated

at any time, with referrals to appropriate services (e.g. falls clinic, multi-disciplinary assessment units, out-patient clinics) from those identified as being at risk of frailty within the community, or at a point of discharge from in-patient psychiatric services.

End-of-life care

Eighty-five per cent of deaths are in people over the age of 65 (ONS, 2017). Although a third of all deaths occur in those over the age of 85 years, only 15% gain access to palliative care (National Council for Palliative Care, 2013). The Care Quality Commission report 'A different ending' reported inequalities in end-of-life care in those with dementia, older people, those with mental health problems, and those with intellectual disabilities (Care Quality Commission, 2016).

The six ambitions described in end-of-life care are applicable to those with mental illness, including dementia. These ambitions are that each person is seen as an individual, they get fair access to care, their comfort and wellbeing are maximised, the care is co-ordinated, all staff are prepared to care, and each community is prepared to help (National Palliative and End of Life Care Partnership, 2015).

End-of-life needs are increasingly recognised in dementia. Often, conversations are not happening early enough in the person's illness. In conditions that may affect the ability to communicate needs and wishes towards the end of life, it is particularly important to be able to have the conversations earlier in the illness. Identifying when someone is approaching the end of life is often more challenging in patients with dementia, and people in these groups can struggle to access the right care.

In addition, quality of care at the end of life is key and has not received as much recognition as it deserves. There are different needs to consider with advance care plans in patients with dementia, and capacity considerations are of particular importance. Consideration should be given to early advance care planning in those with dementia. Older adult psychiatry wards caring for patients with dementia should be able to recognise the end stages of dementia and consider the palliative care needs of the patient. Sufficient support should be available for families and ward staff. Ceilings of care and DNACPR orders should be discussed to gain the patient's and carers' views, and ensure that decisions are made that would reflect the patient's wishes.

A common concern for families is whether an older relative, with impaired swallowing due to dementia, would be starving. The literature shows that there is no long-term benefit from the use of artificial feeding in older patients suffering dysphagia as a result of their dementia (Sampson, Candy and Jones, 2009), and sensitive discussions should be held around other plans such as 'risk feeding' on the safest food

and fluid consistencies for a patient, as determined by a speech and language therapist. If a risk feeding approach is being adopted, then advance care plans should also refer to management of future chest infections as a result of aspiration, when a palliative approach should be adopted, and whether admission to an acute hospital is in the best interests of the patient.

Where a patient lacks the capacity to make decisions about their end-of-life care, their treatment should be in accordance with the Mental Capacity Act 2005 and best practice guidelines. Advanced decisions to refuse treatment should be followed, and either lasting power of attorney or independent mental capacity advocate (IMCA) utilised where appropriate.

Commissioning

Commissioning holistic care, including input from a liaison geriatrician as part of a multidisciplinary team, is important for in-patients and community patients. Benefits of such input include improvement of patient care and potential costs saved through reducing acute admissions, avoiding unnecessary investigations, being better able to interpret blood results in the community, and ensuring that physical health problems can be identified and treated more promptly, and preventative measures implemented to avoid physical and mental deterioration. The importance of ensuring that only appropriate investigations are performed is emphasised in the recent 'Choosing Wisely' campaign by the Academy of Medical Royal Colleges (Choosing Wisely UK, 2016).

Integration

The benefits of integrated care were outlined in the King's Fund document (Naylor, *et al*, 2016). The importance of integration is emphasised as there are high rates of mental illness amongst those with long-term physical illness and there is also poor physical health in those with mental illness. In addition, the Faculty of Old Age Psychiatry report emphasises the advantages of integration, with a particular focus on older adults with multi-morbidity, where a holistic approach is required over a disease-specific model (Royal College of Psychiatrists, 2016b).

Psychiatric in-patients experience common medical problems, such as infections, cardiovascular disease, and fluid, electrolyte and nutritional imbalances (Goh *et al*, 2016). The medical co-morbidities are important to identify and treat as they can exacerbate psychiatric symptoms, lead to increased morbidity and premature mortality, and affect the length of a hospital admission, including to a psychiatric ward. Goh explored whether having a physician in the multidisciplinary team was helpful, with the aim that they would conduct a medical review and

complete a physical examination within 24 hours. Although the study had a small sample size, the argument was made that integrating the physical and mental health care was beneficial (Goh *et al.*, 2016).

Training

Training in geriatric medicine should be routinely given to old age psychiatry trainees, to ensure that the basic physical healthcare needs of the patients are met. In addition, better awareness of old age psychiatry amongst geriatric trainees would be useful and would enable both specialties to work together in a more integrated way. In addition, general nurses working with older patients should receive training in common mental health issues in older people, and registered mental health nurses should receive training on common physical health conditions that they will encounter in addition to detecting and managing medical emergencies. There is an example from an integrated ward in Nottingham where there is a combined older adult medicine and older people's mental health ward in an acute trust; there are three registered mental health nurses who are supernumerary and the other nursing staff are registered general nurses. There is a consultant geriatrician leading the ward, with some input from an old age psychiatrist. This staffing facilitated improved care and education of other staff groups, mainly through modelling (Royal College of Psychiatrists, 2016b).

Liaison geriatrician role

In addition to the OP100 recommendations, it was felt that there were specific recommendations required for patients aged over 65. The OP100 recognised the importance of a culture of quality improvement of physical healthcare services, and for liaison psychiatry services to be commissioned in the acute setting, which would enable early identification of people with severe mental illness. However, 70% of admissions to acute hospital beds are for those over the age of 65 (Department of Health, 2001) and those with dementia often have an increased length of stay, higher mortality and a risk of institutionalisation (Department of Health, 2009). For older people in the general hospital, it is recognised that an old age liaison psychiatrist can be a useful addition to the team, as there are particular skills required for working with this group of patients. This is discussed in [Position Statement on the provision of liaison psychiatry services across the lifespan](#) (Royal College of Psychiatrists, 2019).

OP100 also suggested that a liaison physician was required who had relevant experience in the management of the physical health of people with severe mental illness. However, the needs of older adults, especially those with multi-morbidity and frailty, require the management and expertise of a geriatrician. The geriatrician could

provide training to other members of the MDT to improve their ability to provide the best care for the patient.

One proposal to ensure better integration of physical and mental healthcare is a liaison geriatrician, particularly for older psychiatric in-patients, where access to experienced practitioners to ensure appropriate physical healthcare can be harder. Many psychiatric hospitals are now on different sites from the general hospitals, and they are also run by different trusts. This disintegration has many disadvantages: if a patient deteriorates, they often need to be transferred to the acute trust for appropriate treatment, as obtaining urgent bloods and other investigations can be more challenging from a psychiatric hospital, whilst most psychiatric hospitals will not be able to provide intravenous or subcutaneous fluids. Commissioning the role of a liaison geriatrician would help to identify physical health needs of older patients with severe mental illness and would improve patient care and reduce the risk of unnecessary hospital admission and Accident and Emergency attendance.

Recommendations

Recommendations for clinicians and service managers

- 1 A history and examination of physical co-morbidities should be completed in patients under the care of older adult mental health services.
- 2 A physical cause should be established where possible in cases of delirium.
- 3 Pain needs to be asked about and recognised better. The use of screening tools should be considered, especially when a patient is non-verbal. In addition, family and carers should be asked about whether they believe their relative is in pain if the patient is unable to communicate.
- 4 All patients aged over 65 should be assumed to be at risk of falls and should undergo multi-factorial assessments to try to reduce this risk.
- 5 Medications should be checked for compliance and side effects. Polypharmacy should also be considered and any medications which are no longer required should be stopped.
- 6 Regular consideration of side effects of medication is needed.
- 7 Improved monitoring of bloods and expert advice on detection and management of abnormalities is required.
- 8 Venous thrombo-embolism risk needs to be considered, especially in in-patient units.
- 9 For end-of-life care, early discussion of advance care planning, ceiling of care plans and DNACPR status is required, especially in patients with dementia. This discussion should include the management of nutrition when a patient's swallowing is deteriorating, and management of associated chest infections.
- 10 Appropriate referrals to relevant teams and agencies to reduce risk from physical health should be considered.

Recommendations for training providers

- 1 Training in geriatric medicine for old age psychiatrists, and training in psychiatry for geriatricians would be valuable.
- 2 Training for older adult psychiatric nursing staff in physical health issues, and training for older adult nurses in psychiatry of older adults may be useful.

Recommendations for commissioners

- 1 Better integration between mental health trusts and acute trusts to provide patient care.
- 2 Recognition of the importance of the role of the liaison geriatrician in older adult psychiatric in-patient settings to improve the quality of care; commissioners may also wish to evaluate the likely benefit of cost savings when a liaison geriatrician is present from reduced transfer of the patients to acute trusts.
- 3 Commissioners should consider the importance of the role of a liaison geriatrician working with the older adults mental health team in the community and memory clinic settings, given the medical complexity of many patients who are referred to the psychiatric team.

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