



Integrated mental health care could improve treatment of older hospital inpatients with complex health needs

Published Online
August 10, 2024
[https://doi.org/10.1016/S2215-0366\(24\)00246-3](https://doi.org/10.1016/S2215-0366(24)00246-3)
See **Articles** page 684

In *The Lancet Psychiatry*, Michael Sharpe and colleagues report on The HOME study, which investigated the effects and cost-effectiveness of Proactive Integrated Consultation-Liaison Psychiatry (PICLP) compared with usual care in patients aged 65 years or older who were admitted to hospital in an emergency. A novel care model that combines proactive consultation-liaison interventions with a team-integrated approach, PICLP was aimed at reducing the length of stay—defined as the time spent as an inpatient in the hospital within the 30 days after random allocation—by improving the treatment of older patients, who often present with complex illnesses with physical and psychological comorbidity, which can lead to difficulties in arranging post-discharge care and prolong the hospital stay. Participants in the intervention group had a biopsychosocial assessment from a consultant psychiatrist soon after their admission to a ward, which led to tailored intervention management of their problems by psychiatrists and assisting clinicians embedded in the medical team. The patients in the control group received usual treatment, including a consultation from a psychiatric service when necessary.

2744 patients were eligible and consented to be included in the study. 1373 patients were allocated to PICLP and 1371 were allocated to usual care. Patients had a mean age of 82.3 years. For those patients admitted from a private residence, 1943 (74.3%) of 2213 were discharged back to a private residence. The primary outcome of length of stay was 11.37 days (SD 8.74) in the intervention group and 11.85 days (SD 9.00) in the control group, a non-significant difference (mean difference -0.45 days [95% CI -1.11 to 0.21]; $p=0.18$). The rate of discharge per day in the PICLP group during the index stay was 8.5% higher than in the control group (rate ratio 1.09 [95% CI 1.00 to 1.17]; $p=0.042$), mainly accounted for by patients who were hospitalised for more than 2 weeks. The cost analysis showed a small saving in total inpatient costs when the quality-adjusted life year threshold was set at £20 000, including the costs of PICLP after 1 month and 3 months in the PICLP group compared with usual care, but not at the 12 month time horizon. This is by far the largest study

of its kind, and its methodology was sound, including a high follow-up rate.

The result regarding the primary outcome might disappoint many colleagues in the field of consultation-liaison psychiatry. Non-randomised studies in the USA have shown proactive consultation-liaison interventions can shorten length of stay.² The HOME Study shows this outcome is not replicated in a large, well-conducted, randomised controlled trial.

The authors discuss several reasons why the reduction in length of stay was not significant. I would like to highlight two of them: first, PICLP included working with the ward team to manage psychological comorbidity and psychosocial problems of the patients, and to respond to them appropriately. The action plan developed in each incidence was discussed with the medical team, and they therefore probably learned about patient-centred and discharge-focused interventions. It is probable that the patients in the control group also benefited from this, and were also able to be discharged earlier.

Second, the primary outcome depends on factors that cannot be influenced by hospital-based interventions, in particular the quality and availability of care after discharge. If adequate out-of-hospital care is not guaranteed, hospital doctors will tend to treat patients in hospital for somewhat longer than is medically necessary. For ethical reasons, the primary goal of clinicians is not, and should not be, to discharge patients as early as possible.

The treatment of older patients with complex illness and mental comorbidity and accompanying social problems is one of the greatest challenges for the health-care system. Fragmented treatment often leads to increased chronicity, frailty, impaired mental health, hospital readmission, increased burden on relatives, increased health-care costs, and frustration among health-care providers.³ Previous research indicated that more integrated consultation-liaison services might have a stronger effect on psychiatric symptoms and reduction of length of stay than consultation on request only.⁴⁻⁶ Compared to previous studies on proactive consultation-liaison interventions, the study by Sharpe and colleagues has one major innovation: the mental health-care providers

were largely integrated into the medical teams in order to support the ward teams in managing complexity. A qualitative evaluation of the intervention showed a high level of satisfaction with PICLP. Patients felt better and more comprehensively cared for, and better prepared for discharge, and ward teams felt supported, better trained, and relieved of their daily workload in the treatment of complex patients.⁷ At a time when one of the biggest problems in the health-care system is finding sufficiently qualified staff and keeping them in the job, it is extremely encouraging that the study has achieved a triple benefit. First, the inpatient treatment of older patients with complex illnesses can be improved through the integrated collaboration of mental health-care professionals; second, this treatment can be implemented without additional costs; and third, PICLP generates a high level of satisfaction among patients and hospital staff. Future studies might be most productive if they focused on these quality measures rather than shortening length of stay. In addition, studies could assess whether a proactive and integrated approach is successful in shortening the length of stay of those patients who particularly need it (eg, patients with high multimorbidity and high complex care needs). More structured interview methods for the biopsychosocial assessment of complexity that can be carried out by trained nursing staff (like the INTERMED

method⁸) could be used to identify such patients, which would make more resources available for the management of complexity, psychological comorbidity, and the transition to out-of-hospital care.

I declare no competing interests.

Wolfgang Söllner
wolfgang.soellner@pmu.ac.at

Department of Psychosomatic Medicine and Psychotherapy, Paracelsus Medical University Nuremberg, 90419 Nuremberg, Germany

- 1 Sharpe M, Walker J, van Niekerk M, et al. Proactive integrated consultation-liaison psychiatry and time spent in hospital by older medical inpatients in England (The HOME Study): a multicentre, parallel-group, randomised controlled trial. *Lancet Psychiatry* 2024; published online Aug 10. [https://doi.org/10.1016/S2215-0366\(24\)00188-3](https://doi.org/10.1016/S2215-0366(24)00188-3).
- 2 Oldham MA, Chahal K, Lee HB. A systematic review of proactive psychiatric consultation on hospital length of stay. *Gen Hosp Psychiatry* 2019; **60**: 120–26.
- 3 Kathol R, Saravay SM, Lobo A, Ormel J. Epidemiologic trends and costs of fragmentation. *Med Clin North Am* 2006; **90**: 549–72.
- 4 Desan PH, Zimbren PC, Weinstein AJ, Bozzo JE, Sledge WH. Proactive psychiatric consultation services reduce length of stay for admissions to an inpatient medical team. *Psychosomatics* 2011; **52**: 513–20.
- 5 Muskin PR, Skomorowsky A, Shah RN. Co-managed care for medical inpatients, CL vs C/L psychiatry. *Psychosomatics* 2016; **57**: 258–63.
- 6 Stein B, Müller MM, Meyer LK, Söllner W, C-L Guidelines Working Group. Psychiatric and psychosomatic consultation-liaison services in general hospitals: a systematic review and meta-analysis of effects on symptoms of depression and anxiety. *Psychother Psychosom* 2020; **89**: 6–16.
- 7 Sharpe M, Toynbee M, van Niekerk M, Bold R, Walker J. Patient and unit staff experiences of proactive and integrated consultation-liaison psychiatry in The HOME study: a qualitative investigation. *J Acad Consult Liaison Psychiatry* 2024; published online Mar 24. <https://doi.org/10.1016/j.jaclp.2024.03.005>.
- 8 Stiefel FC, Huysse FJ, Söllner W, et al. Operationalizing integrated care on a clinical level: the INTERMED project. *Med Clin North Am* 2006; **90**: 713–58.

Neuropsychiatric and work outcomes after COVID-19 hospitalisation



An estimated 37–76% of individuals treated in hospital for COVID-19 subsequently develop post-COVID-19 condition (also known as long COVID), variously defined as the presence of continuous or evolving symptoms following a SARS-CoV-2 infection.^{1–3} Neuropsychiatric symptoms are frequently occurring sequelae, with meta-analytical evidence suggesting a prevalence of 19.5% in patients admitted to hospital with COVID-19.⁴ Given the relative recency of the COVID-19 pandemic, longitudinal data on long-term neuropsychiatric symptoms of COVID-19 are only beginning to emerge. Information concerning functional outcomes, such as ability to return to work following acute COVID-19 illness, is also scarce.

In *The Lancet Psychiatry*, Maxime Taquet and colleagues⁵ report the results of their study that used

prospective longitudinal cohort data from adults who were treated in hospital for COVID-19 (PHOSP-COVID)⁶ to examine whether neuropsychiatric outcomes at 6–12 months after hospital admission predict symptom emergence and evolution 2–3 years following acute illness. They also examined predictors of occupational transition at follow-up. Study participants from the PHOSP-COVID study were invited to participate (19.2% responded; n=475); these participants had COVID-19 early in the pandemic (ie, before emergence of the delta variant).⁶ Outcomes included subjective symptoms of depression, anxiety, fatigue, and cognitive dysfunction as well as objective cognitive test scores.

At the 2–3-year follow-up, the majority of participants reported at least mild adverse

Published Online
July 31, 2024
[https://doi.org/10.1016/S2215-0366\(24\)00250-5](https://doi.org/10.1016/S2215-0366(24)00250-5)
See [Articles](#) page 696