Correspondence

Old age psychiatry risks turning into a dementia-only service

I read Hilton's editorial[1] with interest and write as a practising old age psychiatrist and clinical director for adult and older peoples' mental health service in my trust, as well as local dementia lead and regional advisor for the Mersey region.

Although a lot is being done to improve dementia services across the Merseyside region and the country too, we are in danger of neglecting the important issue of providing functional mental health services for the elderly. And even though the Faculty of the Psychiatry of Old Age is to be applauded for doing a huge amount of work in raising the issue of discrimination and need for age-appropriate services, it has not clearly defined what an older person's need is and how it varies when a patient beyond the age of 65 years newly presents with a first episode of functional mental health problems.

Ongoing work in primary care trusts and shadow clinical commissioning groups in long-term care and integrated care pathways between primary and secondary care also focuses primarily on dementia in older people.

Trusts across the country have taken different approaches to solving this problem. Some adult mental health services have raised the cut-off age for functional illness from 65 to 70 or 75 years. Others are combining adult and older peoples' functional mental health teams, thus trying to give access to crisis resolution home treatment (CRHT) or assertive outreach team (AOT) services to older people. The problems with either of the approaches are that Department of Health policy implementation guidelines for specialist services such as CRHT and AOT are still age defined (16–65 years); Social Services still work on the age boundary of 65 years; general adult psychiatry colleagues are reluctant to accept new referrals for functionally ill patients over the age of 65 years citing that their Certificate of Completion of Treatment is in general psychiatry; and the national experience that current adult CRHTs are poor at dealing with functionally ill older patients (who often have a combination of physical, cognitive and social care needs) and often do not have the capacity to pick up extra demand, however small it may be.

There is no money in the system to develop new, specialist, CRHT-type services for older patients with functional and organic illnesses (our recent Quality Innovation Productivity Prevention (QIPP) bid to develop such a service in our trust was rejected, whereas general hospital and care home liaison bids attracted new money as these services primarily deal with patients with dementia).

As adult mental health services are much larger in size than older adult services in most mental health trusts, senior non-medical managers tend to overrepresent the former group. Faced with annual cost improvement plans of 4–5%, it is tempting for them to try to convert old age services to dementia-only and combine the functional mental health services for adults and older adults in one team. Although this may create financial efficiency, the actual needs of functionally ill older adults are increasingly getting neglected. Morale in existing community mental health teams for older adults, who traditionally have provided extended hours of services for all older patients across the diagnostic groups (including crisis resolution, home treatment and managing urgent social care needs), is at an all-time low as many are getting dis/rebranded thus losing or diluting their skills.

It is time to wake up to these challenges and the Old Age Faculty would do well to articulate clear views and provide directions in this area.

1 Hilton C. No scope for complacency: time to improve healthcare for older people. *Psychiatrist* 2012; **36**: 441–3.

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Response: Dr Sikdar's letter is a timely reminder of the issues facing old age psychiatry and I welcome the opportunity to outline what the Faculty is doing to meet the challenges. First, we must accept that defining entry to a service by age alone is simply not logical and now probably unlawful; services which continue to do so need to think urgently about this. Possibly as a consequence of the definition vacuum, some trusts are moving to 'ageless services'. Older people with mental disorders (not just dementia) are entitled to have their care and treatment managed by professionals who have specific expertise in that area. This principle is supported by the National Institute for Health and Clinical Excellence, the Department of Health, the Royal College of Psychiatrists and the British Psychological Society. In January this year, the Faculty sent a letter to all mental health trust chief executives and medical directors requesting a pause in conversion to ageless services pending agreement of new criteria.

The Faculty is also leading work on redefining service criteria based on need rather than age. Draft criteria are: (1) people of any age with a primary dementia; (2) people with functional mental disorder and significant physical illness or frailty which contributes to or complicates the management of their mental disorder; (3) people with psychological or social difficulties related to the ageing process, or end-of-life issues, or who feel their needs may be best met by an older adults' service. This would normally include people over the age of 70.

For people under the age of 60, it would be unusual for old age psychiatry services to have a lead role, although the provision of expertise to individuals under conjoint management arrangements would be welcomed in appropriate cases. For people between the ages of 60 and 70, conjoint management should be explored, particularly where comorbidity dominates the clinical presentation. The principles of conjoint management are that one team takes responsibility for the overall care and treatment of the patient, but draws on physical support from other services rather than simply opinions. Patient choice is pivotal and patients in crisis should not be transferred from one team to another unless in exceptional circumstances.

These criteria allow for local variation (e.g. whether Korsakoff's syndrome is included in criterion 1) and are based on judgement rather than reductionism. Consequently, they may lead to disagreements about individual patients which are probably best addressed through conjoint management. On the whole, however, they are seen as logical and utilitarian. Modelling suggests workload of old age services would be similar to now if they are implemented.

I agree with Dr Sikdar that it is really important to preserve management of functional illnesses in old age teams. Almost 50% of my directorate's workload is non-organic and the crossover between dementia and functional illness is very common and complex. Many people with dementia present with functional symptoms and many more will develop severe functional symptoms once dementia is established (psychosis 25%, depression 40%). Many people with long-established functional illness will develop dementia. For these reasons, the only way it is possible to preserve continuity of care is to have old age teams providing care across the spectrum.

The disproportionate funding gap (old age services are underfunded by over £2 billion compared with adult services) is an outrage, especially as we face real growth in demand owing to demographic change. The fact that trusts' cost improvement plans are equally applied to old age services is unconscionable and illogical; but would be up to local clinicians to argue this point.

The Faculty has done much over the past few months to address these issues, for example through a national survey of our members to establish baseline service provision and map changes, lobbying politicians and trusts and development of new service criteria. There is much still to do and the support of our members in this work remains pivotal.

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Trainees want to work out of hours!

We welcome Oakley *et al*'s timely contribution to the debate around the future of psychiatric training.[1] The issue of decreasing exposure to emergency assessments out of hours has been of concern to the Psychiatric Trainees' Committee for several years.[2] Originally a fear prompted by the introduction of working time regulations, our unease is now focused on the impact of widespread service reconfigurations; in some areas these are resulting in rotas which dramatically restrict trainees' exposure to emergency learning experiences.

Are presentations qualitatively different out of hours? Research in this regard is limited, but it is our unanimous opinion that outside of 9am to 5pm working hours and particularly at night, patients tend to present with more complex and challenging problems, often involving dual diagnoses, drug and alcohol intoxication and higher rates of self-harm and overdose. Services available are also more limited, making decisions about care more demanding.

We concede that out-of-hours rotas which involve trainees working off site, or not at all, may increase the trainee's time spent with patients in day hours, providing continuity of care and the opportunity to attend teaching and academic programmes. However, daytime work is often centred on service provision and routine tasks, rather than acquiring essential emergency competencies required to be a successful and accountable higher trainee and consultant.

Decreasing trainees' work out of hours may also serve to further devalue the image of psychiatry to other medical professionals – when seeking advice on a complex issue of risk, capacity or consent, for example, they expect to be able to speak to a medically qualified professional. As is well recognised, improving the image of psychiatry as a specialty is key to reducing professional stigma and promoting recruitment.

In this same edition of *The Psychiatrist*, Tadros *et al* describe a revolutionary and highly successful 24-hour, 7-days-a-week method of working.[2] We are of the opinion that the more services are designed with well-supported core trainees working at the coalface, particularly out of hours, the more training standards will improve and the more our specialty will be valued within the multidisciplinary environment.

We also believe that having medically trained professionals on the frontline makes for safer services.

The Psychiatric Trainees' Committee has established a working group to look into the provision of out-of-hours services across the UK, with a particular aim of understanding how training might be affected by reductions in out-of-hours experience. We will present the findings to the College and hope to work towards a shared understanding of the future of out-of-hours training.

Submitted on behalf of the Psychiatric Trainees' Committee.

1 Oakley C, Jenkinson J, Oyebode F. Psychiatric training for the next generation. *Psychiatrist* 2013; **37**: 25–9.

2 Royal College of Psychiatrists' Psychiatric Trainees Committee. *Finding the Balance: The Psychiatric Training Value of Out of Hours Working*. Royal College of Psychiatrists 2008 (www.rcpsych.ac.uk/pdf/PTC%20The%20training%20value%20of%20OOH.pdf).

3 Tadros G, Salama RA, Kingston P, Mustafa N, Johnson E, Pannell R, et al. Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model. *Psychiatrist* 2013; **37**: 4–10.

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