Table 2. Level of disability and discharge status

	Level of disability (re-coded variables)			Legal status (re-coded variables)			
	χ^2	Percentage of group		χ^2	Percentage of group		
Discharge group		Borderline–mild	Moderate–profound		Informal	Criminal (Section 37 or 37/41)	Civil (Section 2 or 3)
Discharge planned (n=22)	χ^2=13.8	90.9	9.1	χ^2=8.02	45.5	31.8	22.7
Discharge delayed (n=44)	P=0.0002	43.2	56.8	P=0.02	79.5	13.6	6.8
Discharge delayed (n=20)	χ^2=1.77	55	45	χ^2=0.24	80	15	0
Discharge delayed, still in hospital (n=23)	P=0.2	34.8	65.2	P=0.9	78.3	13	8.7

which proved wanting in some constituent of the package, deteriorated and required readmission.

Poor inter-disciplinary communication can lead to unnecessary hospital care, delays in the provision of patient needs, and delays in locating appropriate community placements (Patterson *et al*, 1995). As a result we have moved on to review the quality of our communication with external agencies during discharge planning. In the meantime, the Trust is monitoring the progress of patients towards discharge more closely.

That legal constraints affect discharge status implies the framework of the Mental Health Act may assist smooth discharge. A similar framework is included in the Care Programme Approach and, it is hoped that a joint commitment to this procedure will reduce the proportion of patients delayed.

After 16 months, 43 of the 66 patients who were ready to be discharged (including those planned and those delayed) had been discharged, and in only five cases was it necessary to alter the clinical judgement that they were ready for discharge. This reflects the stability and predictability of this group of patients, and that most people with a learning disability are discharged readily. However, the changing pattern of care has led to the expectation that people with far more complex needs who previously would have remained in hospital, will live in the community. This study suggests that the community is not yet equipped to cope with the complex, and consequently expensive needs of this service user group.

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R. V. Watts Clinical Audit Assistant, ***P. Richold** Quality Officer, **T. P. Berney** Consultant Psychiatrist, Clinical Audit Department, Medical Centre, Northgate Hospital, Morpeth, Northumberland NE61 3BP

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SIOBHAN MURPHY

Provision of psychotherapy services for older people

AIMS AND METHODS

A postal questionnaire was sent to 100 departments of psychotherapy within the UK in an attempt to gauge the use of psychotherapy services by patients in the third and fourth age.

RESULTS

Eighty-seven per cent of respondents felt that the needs of this group for psychotherapy were not met as well as those of younger people in their catchment areas. This is most marked in people over 65 years of age who are infrequently referred to psychotherapy departments. Suggestions are made for improving services.

CLINICAL IMPLICATIONS

The psychotherapy needs of this group need to be considered in service planning. All professionals need educating about the availability and applicability of the psychotherapies for the older patient. Without additional resources it seems unlikely that the needs of this patient group will be met.

Throughout our lives internal and external events demand that we change and adapt. The developmental specific struggles and necessary alterations in internal object relations associated with childhood and early adulthood

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are widely recognised, while those associated with the third and fourth age (Carnegie Enquiry Report, 1993) seem less familiar in clinical discussions. The third age is defined as the period between 50 and 74 years when there is increasing freedom from the structures of work and of a family with dependent children and precedes what for some is a period of increasing disablement and disability after 75 in the fourth age. Typical later life developmental tasks have been derived by Hildebrand (1990) from King (1974).

(a) The threat of redundancy or displacement in work roles by younger people and awareness of the possible failure of effectiveness of professional skills. This is linked with anxieties about managing retirement, with a feared loss of self-worth and identity with the loss of professional or work roles. This involves recognition that what can now be achieved in life may be limited, with resultant feelings of depression and deprivation.

(b) The need to re-examine and remake relationships after children leave home and can no longer be used to mask difficulties in the relationship. This will include the impact on the relationship of the fear of the diminution or loss of sexual potency and the potential loss of a partner with the associated intimacy and identifications.

(c) Recognition that one might have failed as a parent and the impact of this on one's children, with a consequent loss of perpetuating aspects of the self if children do not recognise or identify with these.

(d) The awareness of one's own ageing with possible illness and consequent dependency and the fact of one's own death and its associated narcissistic and object-related loss and pain.

The psychoanalytic world has moved on since Freud's comment that "Near or above the age of 50 the elasticity of mental processes, on which the treatment depends is, as a rule lacking – old people are no longer educable" (Freud, 1905). The dynamics of ageing (King, 1974; Hildebrand, 1990), psychoanalytical (Cohen, 1982; Hildebrand, 1988; King, 1974, 1980; Segal, 1958) and psychotherapeutic work from different theoretical orientations with older people (Myers, 1984; Nemiroff & Colarusso, 1985; Hess, 1987; Sadavoy & Leszcz, 1987; Hunter, 1989; Porter, 1991; Sadavoy, 1994; Haley, 1996; Bouklas, 1997; Terry, 1997) are now extensively described. Has this body of work percolated through to clinical psychotherapy practice in the NHS? Difficulties in satisfactory adaptation to developmental tasks in younger people often underlie referrals to psychotherapy services, but does this happen in older people? The present survey was undertaken to address these questions.

The study

A questionnaire requesting basic service data and details of the referrals, assessment process and treatment of patients over the age of 55 was sent to psychotherapy departments with consultant psychotherapists in the UK. As the Royal College of Psychiatrists could not provide a list of consultant psychotherapists the sample was gathered by asking contacts in each region for known services. Questionnaires were confidential and respondents non-identifiable. A reminder letter was sent to all departments to maximise the response rate.

Findings

Service responders

Of 100 questionnaires sent, 58 services responded initially and 66 following the reminder. Five questionnaires were unanswered, giving a usable response rate of 61%. The majority (83.3%) represented services offering treatments to a predominantly local, not regional or national catchment area. Of the respondents 41% were in community trusts, 31% in mental health trusts, 15% in mental health and community trusts, 10% in general hospital trusts and 3% in mixed hospital and community trusts. In general hospital trusts, services were provided solely in hospital settings, whereas approximately 50% (range 45–56%) of other services were community-based. Departments varied enormously in terms of staffing, ranging between a single handed part-time consultant with special responsibility for psychotherapy to national units with numbers of consultants, adult psychotherapists, specialist registrars in psychotherapy, psychologists, social workers and clinical nurse specialists. Similarly, there was a large range of treatments offered within departments (mean seven, range 2–12).

Services for the elderly

Of the 61 services, only eight (13%) felt that the psychotherapy needs of the elderly in their catchment area were being met as well as those of younger patients. Of these eight; three described established psychotherapy services within departments of old age psychiatry, linked but separate from the departments of psychotherapy, three described areas of special interest within departments of psychotherapy and the other two well established consultation and supervision links with old age psychiatry services.

There were a number of reasons given by those respondents who felt that the needs of the elderly were not being met as well as those of younger populations. The most common comment was that patients were not being referred in numbers which reflected demography. This is particularly the case in people over 65 (see Table 1).

This imbalance was often attributed to purchaser issues and the separation of departments of psychotherapy and old age psychiatry in different trusts. To some extent, the figures support this view as the discrepancy between referrals and population figures is most stark after the age of 65, the most common cut-off point between general and old age psychiatry services. Old age psychiatrists and physicians also refer less often than general adult psychiatrists, physicians and GPs (see Table 2).

However, psychotherapy departments also took some responsibility for this discrepancy. A common

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Table 1. Comparison between psychotherapy referrals and population figures by age

Age (years)	Percentage of referrals (range)	Percentage of population[1]
55–65	1–15	12.6
65–75	0–5	11.1
75+	<1.0	8.7

1. Carnegie Inquiry Report (1993). Population over age of 16, 1991 census.

Table 2. Referral sources of patients over 55 to psychotherapy departments

General practice	89%
General adult psychiatrists	77%
Old age psychiatrists	47%
Old age physicians	3.8%
General adult physicians	24%

picture was of poorly resourced departments who had identified this need but lacked the resources to address it. Seventy-six per cent of respondents felt that they would be unable to meet the needs of the elderly within their present resources. Of the 24% who felt that this was possible, a number commented that this would only remain the case if the present low level of referrals was maintained.

Once referred, there was little evidence that older patients were being discriminated against in the assessment for, or provision of, treatment. There was no upper age limit for referrals in 87% of departments and all the departments with upper limits cited contractual links with adult services with shared age cut-offs as the reason for such limits. Treatments offered to the older patients reflected the full range of those available within each unit, although the very small samples in the majority of replies makes it difficult to make knowledgable comparisons with younger age groups. For the sample as a whole the waiting times for assessment (mean 3.0 months, range 0.3–12 months) and treatment (mean 7.5 months, range 0.5–24 months) were the same for all ages. In places who felt the psychotherapy needs of the elderly were as well met as those of younger people, the median waiting times for assessment were 1.75 months (interquartile range 2.8 months) and 2.0 months for treatment (interquartile range 11.5 months). Where treatment needs were not felt to be met as well as in a younger group the median waiting time for assessment was 3.0 months (interquartile range 1.25 months) and treatment 6.0 months (interquartile range 5.1 months). There was no significant difference in waiting times for assessment ($Z = -1.1655$, non-significant, Mann–Whitney U) or treatment ($Z = 1.7515$, non-significant Mann–Whitney U) between services who felt needs were being met and those that felt they were not.

When asked how psychotherapy units might help to meet the needs, responses fell into the following broad categories.

Define the need

While there was a feeling that the needs of the elderly were not being met, this was based on examination of referral patterns and anecdotal knowledge of local services. Many replies identified the lack of a needs based assessment and suggested collaboration between psychotherapy departments and old age psychiatry units to clarify this.

Developing links

The striking feature of units who felt that needs were being met was the presence of staff with a particular interest in psychotherapy of the elderly who had developed a service in either old age psychiatry or psychotherapy services. Many of the other replies echoed this theme with a recognition of the need to make strong links between the two services and develop a culture of joint working. This was not only to encourage referrals, but to develop a range of opportunities to think about patients and develop knowledge and skills in staff from both services.

Education

Many respondents related their anxiety about seeking referrals of older people to their own lack of experience in treating this group and a need for further training. Some comments were made about the need to educate general practitioners, psychiatrists and multi-disciplinary teams about the use of the psychotherapies with older people.

Specific developments

The areas of consultation and liaison were most frequently mentioned with the establishing of work discussion groups and staff supervision more prominent than specific treatment proposals. This, in part, probably reflects the picture of overstretched services with little capacity to easily assimilate more referrals without more manpower, but, more positively, also reflects awareness of the need for an increase in 'Level A' and 'Level B' psychotherapy expertise (Department of Health, 1996).

Comment

Despite growing interest in psychotherapy for the third and fourth age within the NHS (Garner, 1999), the provision of services to this group remains woefully lacking. Any recognition that this population needs psychotherapeutic services to help them with the particular difficulties that ageing brings, is not reflected in service availability. Garner describes many of the societal, organisational and individual difficulties in engaging with this task and has many helpful suggestions to begin to think about these. Many of these ideas are broadly similar to those suggested by the psychotherapists in this study.

The present study suggests that staff in psychotherapy departments do not consciously ascribe to Freud's view that older people are untreatable psychologically, because when patients are seen there is no difference in the treatments offered to them and a younger age group. They also spend the same amount of

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time on waiting lists as younger people. It is, however, difficult to be clear about this as the numbers referred, particularly in the over 65-year-old age group, are tiny. Patients in the 55–65-year-old group, while more commonly referred are still underrepresented in demographic terms. This reflects the recent Gallup survey for Age Concern (Gallup & Age Concern, 1999) finding that one in 10 people had noticed a difference in the way they were treated in the NHS after their 50th birthday. This suggests that there is a pressing need for education about the availability of psychotherapy for this population and their capacity to use it, particularly within old age psychiatrists and physicians.

There is also some suggestion that psychotherapists are either unaware of the extent of the needs of this group, or fearful that their services would be swamped if a full acknowledgement of these needs was made. The majority of respondents were not able to envisage fulfilling these needs within services as they presently stand. These needs are growing. The percentage of the population in these age bands is forecast to rise steadily with predictions that 41% of the adult (over 16) population will be over 55 in 2031 (Carnegie Inquiry Report, 1993). This has obvious resource implications.

A more hopeful reading of this study is that psychotherapeutic needs of this patient group are being met, but psychotherapy departments are unaware of this activity. On balance, however, this seems a vain hope. While respondents were mindful of the lack of needs-based assessment, they also demonstrated sufficient knowledge of local old age psychiatry services to make informed comments about service provision. It is also possible that units offering adequate services were either not contacted or did not respond. Sadly, a more realistic reflection of the present state of psychotherapy provision for this group might be contained in the comment of one respondent that "they just get forgotten". It is worrying that some of this group of patients believe that this 'forgetting' is a more active process of discrimination (Gallup & Age Concern, 1999). It seems timely to begin to hold them in mind.

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Siobhan Murphy Senior Lecturer and Consultant Psychotherapist, Department of Psychological Medicine, St Bartholomew's Hospital, West Smithfield, London EC1A 7BE

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J. LAIDLAW, P. BENTHAM, G. KHAN, V. STAPLES, A. DHARIWAL, B. COOPE, E. DAY, C. FEAR, C. MARLEY AND J. STEMMAN

A comparison of stimulus dosing methods for electroconvulsive therapy

AIMS AND METHODS

A prospective study comparing initial electroconvulsive therapy treatment doses determined by empirical dose titration with estimates derived from two simple dose prediction methods and a fixed-dose regimen (275 mC).

RESULTS

Thirty-three patients had seizure thresholds between 25 mC and 403 mC. The dose titration method led to a mean initial treatment dose of 195 mC that was intermediate between those predicted by the age method (275 mC) and the half-age method (137 mC). Estimates were within acceptable limits in 33% of cases for the age method, 64% for the half-age method and 40% for the fixed-dose method.

CLINICAL IMPLICATIONS

Either dose prediction or dose titration methods may be more appropriate in different clinical situations. The half-age method appears to be a more accurate predictor of optimum initial treatment dose.

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