Correspondence

Yorkshire and beyond: it's a new world

It is curious that Seymour and colleagues[1] feel we confuse community clinics with what they refer to as community-oriented mental health services. We regard community clinics as an important part of community-oriented older people's mental health services.

It is good to look at a range of models for delivering services to older people and we should routinely ask patients and carers for their views on all the services they receive.[2] Enthusiasm for early referral of patients with memory problems and transfer of 'graduates' to old age services have changed expectations, increased the number of people seen for initial assessment and posed quandaries regarding how to achieve responsible and responsive follow-up of patients with enduring or relapsing illnesses. At the same time there is increasing demand to work in teams and to liaise with a variety of colleagues, services and agencies. These are not alternatives; rather, old age psychiatrists have to find a balance in how they allocate their time, given competing priorities. Different individuals (and services) will reach different resolutions of these dilemmas.

Nevertheless, it is the case that many services experience high numbers of patients who do not attend appointments when out-patient clinics are hospital-based: transport problems and demands on time allocation from carers argue against their efficacy for older people. So does the absence of immediate appreciation of what life is actually like for the individual and family carers in the home. Much of the information gained on a home visit is non-verbal and lost when people are seen in a clinic.

Perhaps part of the problem here is that different people have different understandings of how teams operate and what the role of a doctor is in relation to other team members. The multiplicity of teams developing in some areas has advantages in making more services available to particular groups of patients and their families, but also introduces disadvantages, such as: access criteria may be rigid and problematic for patients who do not fit into neat categories; demands on the time of staff working with several teams may be considerable and may have impact on their commitment to other service areas; each team will need to devote time to liaise with others, which may detract from direct care.

We are in the process of preparing a proposal to review work patterns within old age psychiatry services following on from our earlier studies of workload and stress.[3] This should add further substance to the discussion.

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3 Benbow SM, Jolley DJ. Burnout and stress amongst old age psychiatrists. *Int J Geriatr Psychiatry* 2002; **17**: 710–4.

Susan Mary Benbow, Professor of Mental Health and Ageing, Centre for Ageing and Mental Health, Staffordshire University, email drsmbenbow@aol.com; **David Jolley**, Consultant Psychiatrist, Pennine Care NHS Foundation Trust, and Honorary Reader, Manchester University.

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Hospital treatment for substance misuse – differences among four age cohorts

Treating substance misuse in hospital places a considerable burden on patients and on the healthcare system. The cost of treatment and hospital stays for patients with substance use disorders is substantial. We examined the factors associated with the length of stay in hospital for such patients across four age cohorts in the USA by using the 2004 Nationwide Inpatient Sample (www.hcup-us.ahrq.gov/nisoverview.jsp).

The admission source and disposition type for patients with substance misuse differed by age cohort. A significantly larger proportion of older adult patients were admitted from the emergency room than were their younger counterparts. Higher proportions of young and middle-aged patients left the hospital against medical advice than did their older counterparts. Across all four age cohorts, the majority of patients admitted to hospital for substance use disorders were male and lived in an area with median household income less than US$60 000 (£39 000).

Income level was a significant factor associated with hospital length of stay for elderly patients with substance use disorders. Most of the elderly patients were insured by Medicare (health insurance for people age 65 or older, managed by the federal government), thus income became a significant factor in addition to their Medicare coverage. Low-income elderly patients could be financially disadvantaged in out-of-pocket spending for mental health services. Previous research indicates that low-income elderly people are worse off financially than non-elderly adults (aged <65) in the same poverty class and than their elderly peers in other poverty classes.[1] Underinsured adults are more likely to forgo needed care than those with more adequate coverage and have rates of financial stress similar to those who are uninsured.[2]

Non-elderly Medicaid (jointly funded, federal/state health insurance programme for people on low incomes and with various needs) patients had significantly longer hospital lengths of stay than their counterparts with commercial insurance. Recent research indicates that Medicaid recipients with substance use disorders were less likely to use community services.[3] Research based on the National Household Survey on Drug Abuse[4] indicates that the rates of substance use disorder are much higher among Medicaid recipients than among most other health insurance groups. Psychiatric disorders and substance misuse are major problems for the Medicaid population. Therefore, efforts to promote detection and treatment of these disorders in this group should focus on reducing barriers to education, family stability and departure from welfare.[4]

The study was limited to community hospitals across the USA, therefore the analysis does not include specialty psychiatric or substance misuse treatment facilities. However,

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it helps us to better understand the relationship between age cohorts and hospital treatment for substance use disorders, and provides a rationale for further exploration of the key factors associated with the most efficient care for adult patients with substance use disorders.

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3 Clark RE, Samnaliev M, McGovern MP. Treatment for co-occurring mental and substance use disorders in five state Medicaid programs. *Psychiatr Serv* 2007; **58**: 942–8.

4 Adelmann PK. Mental and substance use disorders among Medicaid recipients: prevalence estimates from two national surveys. *Adm Policy Ment Health* 2003; **31**: 111–29.

Wanqing Zhang is a researcher, University of Nebraska Medical Center, email: wazhang@unmc.edu; **Shinobu Watanabe-Galloway** is Assistant Professor, University of Nebraska Medical Center, USA.

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Old age psychiatry and the recovery model

We fail to see what all the fuss over the ‘recovery model’ is about. Nor can we appreciate why it has been so powerful in ‘influencing mental health service development around the world’.[1] Working with older people, especially those with dementia but also those with functional disorders, recovery has been the style of our work long before it became a jargon term.

Our day assessment unit aims to give both the patient and their relatives as much autonomy as possible despite progressive mental disability. Enhancing well-being and giving meaning to people’s lives, empowering patients and carers to make decisions collaboratively, and enabling activities salient to the patient and carer have been integral to our work for years. We run in-house educational courses and support groups for carers. Some carers’ courses have continued as informal groups who meet and support each other even after the relative they were caring for has died. An upmarket chain coffee emporium offers free drinks for one peer support group organised by a patient with a history of bipolar affective disorder that meets in their café; perhaps some would say this is unwarranted charity: the group does not think so. A ‘drop-in’ at a local church hall is popular. Carers contribute to our educational programme for staff.

To us, the recovery model represents standard high-quality old age psychiatric practice. Often we can see the quality of life of patients and their relatives improve, despite progressive illness and disability, as understanding and coping mechanisms increase. Scientific evidence is not always necessary, especially when it is measured in economic rather than person-centred terms. The recovery model is a humane, self-esteem, self-respect approach, perhaps one which all psychiatry can learn from older people’s services. We will not become complacent in our practices even if services for younger people are catching up with us.

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Claire Hilton is Consultant Old Age Psychiatrist, Bentley House Day Assessment Unit, Central and North West London NHS Foundation Trust, 15–27 Headstone Drive, Harrow HA3 5QY, email: claire.hilton@nhs.net; **Jo Hulman** is Day Services Manager at the same trust.

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Screening test for dementia

Screening for dementia or early cognitive impairment is of paramount importance. However, it should not be limited to patients in their seventies but should be done even for patients in their nineties. Otherwise we are going to create a biased service. We have to understand that screening for dementia will help with further investigations and treatment of reversible causes of this illness.[1]

Another important issue would be that of mild cognitive impairment which, although not formally classified, has received due attention as interventions at this stage will certainly delay the expression of clinical symptoms.[2] The National Dementia Strategy[3] is indeed a step in a right direction. With huge infusion of funds across England and Wales as well as establishing early diagnosis and intervention clinics, it is of paramount importance in identifying probable mild cognitive impairment early on by utilising various screening tests including blood test, scans and battery of neuropsychological testing. This will certainly help both patients and carers to be well prepared and informed, and reduces the risk of early institutionalisation.

Therefore, to say that patients in their nineties do not deserve full investigation is rather a Stone Age statement. Screening tests should be available to everyone regardless.

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3 Department of Health. *National Dementia Strategy*. Department of Health, 2009.

Sanjay Jain is a locum consultant psychiatrist of old age, Devon NHS Partnership Trust, email: sanjay.jain@nhs.net

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Religiosity gap in psychiatry

I thank the authors[1] for their well-considered and helpful article which argues for more understanding and discussion of people’s religious and spiritual beliefs. They make the point that ‘Individuals with religious beliefs may be extremely reluctant to engage with psychiatric services that they perceive to be atheistic, scientific and disparaging of religion’. They then cite the example of ultra-Orthodox Hasidic Jews that fear misdiagnosis.

How strange and very unfortunate then that in the very same month, the *British Journal of Psychiatry* publishes an article that basically diagnoses Ezekiel, a prominent Old Testament Biblical prophet, as having schizophrenia.[2] All of Ezekiel’s experiences are attributed to the illness, thus dismissing the possibility that God actually did communicate

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