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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doi: 10.1192/pb.37.3.116

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.