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MENTAL HEALTH IN OLD AGE BULLETIN
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EDITORIAL

The care of older people with dementia on acute wards

One Wednesday afternoon the psychiatric team was urgently called to review an 86-year-old man, who had been very disturbed and aggressive during the night.

The man suffered from cardiac arrhythmia, he had congestive cardiac failure and he had indeed recently been resuscitated from cardiac arrest. When seen he had no recollection of the night's events and appeared to be settled. Was this man suffering from mental health problems? What was the best environment to manage him in, the medical ward or a psychiatric unit? This scenario is not uncommon.

How common are mental health problems in older people in acute wards?

- The population is ageing and people over 65 constitute around half of all general hospital inpatients
- High levels of psychiatric illness are found in general hospital settings
- Prevalence rates of up to 53% for depression, 35% for dementia and 61% for delirium are reported
- Co-morbidity is common. For example, one study (Ramsay *et al* 1991) of 119 consecutive admissions with a median age of 83 years, 12% had dementia with depressive symptoms, 6% had dementia and delirium and a further 7% had dementia, delirium and depressive symptoms.

Impact of mental health problems on outcome

- Increased mortality and morbidity
- Increased lengths of stay, and delayed discharges while appropriate care is arranged
- Increased rates of institutionalisation
- Persistent symptoms

Current psychiatric service models for older people in general hospitals

Holmes and colleagues (2003) recently surveyed mental health service provision for older people in general hospitals across the UK. Only about a quarter of services offered more than a general consultation service. This minority of services provided a range of liaison activities, such as proactively seeking referrals and educating the general hospital staff. Liaison nurse appointments are becoming more frequent, but few centres have consultant psychiatrists spending most or all of their time on liaison work.

Problems with current models

- Despite high prevalence, psychiatric illness is poorly detected by general hospital staff
- There may be perverse incentives not to recognise dementia, as this may make discharge planning more complicated
- Even when detected, rates of treatment are low, and suboptimal treatment is common
- Staff on acute physical care wards may not have the time or the skills to deal with someone with physical illness and psychiatric co-morbidity
- With the traditional sector based psychiatric team higher priority is given to community referrals, as they are perceived to be potentially at higher risk. The assumption is that ones in hospital are safe and sound, leading to slow response time.
- Inadequate liaison psychiatry training in old age psychiatry
- Liaison services are usually provided by medical staff only, in contrast to community teams, which are more multidisciplinary.
- Organisational barriers – general hospitals are run by acute NHS trusts but mental health services are usually provided by specialist mental health trusts, so there may be a lack of incentives for both organisations to improve services.

Effectiveness of services

Psychiatric interventions are effective in general hospital settings. For example, a study of psychiatric consultation liaison intervention in elderly patients with hip fracture brought about significantly reduced lengths of hospital stay and hospital costs (Huusko *et al* 2000). Other studies have reported a reduction in severity of confusion, depression, abnormal behaviour and anxiety. Older people currently consume 40% of NHS resources and as they constitute a significant proportion of general hospital inpatients, reduction in morbidity and length of stay will have a significant effect on NHS resources.

National Service Framework for Older People

Standard 4 of the NSF for Older People relates to general hospital care. Paragraphs 4.17 and 4.18 make specific reference to the importance of mental health problems and the need for appropriate mental health services. It is therefore disappointing that subsequent guidance and updates on recent work (www.doh.gov.uk/NSF/olderpeople/ongoingkeyareas.pdf) do not make any mention of dementia or mental health at all.

Future changes and development

Evidence from service providers suggests that the mental health needs of older people in general hospital wards are best met by a combination of

- Ward staff suitably prepared to care for patients with dementia (good knowledge, positive attitudes, adequate access to support and training)
- Multidisciplinary liaison support from older people's mental health services.

Clearly, this requires collaboration and communication between acute and mental health trusts, as service providers, and primary care trusts, as service commissioners. The precise configuration of services can be determined locally, but we suggest that at least some consultant psychiatrist time is needed to provide leadership and support to the liaison team. Training of general hospital staff in core knowledge, skills and attitudes related to diagnosis and management of common psychiatric illness should form a vital part of any service model.

Postscript

The psychiatrist thought that this was an episode of delirium caused by physical illness. She suggested that if he became agitated again the staff should give him a small dose of an antipsychotic drug. It might be necessary to review the patient when he is more settled to see if he also has dementia. If so, this will have clear implications for the level of help and support he will need after discharge.

References

Holmes, J., Bentley, K., Cameron, I.(2003) A UK survey of psychiatric services for older people in general hospitals. *International Journal of Geriatric Psychiatry* 18, pp.716-721.

Huuska, T.M., Karppi, P., Avikainen, V., Kautiainen, H., Sulkava, R. (2000) Randomised, clinically controlled trial of intensive geriatric rehabilitation in patients with hip fracture: subgroup analysis of patients with dementia. *BMJ* 321, pp.1107-1111.

Ramsay, R., Wright, P., Katz, A., *et al.(*1991) The detection of psychiatric morbidity and its effects on outcome in acute elderly medical admissions*. International Journal of Geriatric Psychiatry* 6, pp.861-6.

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ARTICLE

The long and winding road to … Incapacity Legislation

The problem

Everyone likes to think that they're in control of their own destiny, their money and their bodies. Interference by the state, by family and friends or by well meaning do-gooders is always bitterly resented. In the past there seemed to be a greater trust placed in people with authority, the decisions of doctors, nurses and social workers were rarely challenged. Nowadays people seem much keener to assert their basic rights and after Shipman and Alder Hey we cannot expect the same unquestioning trust in the medical profession. But older people, particularly those with dementia, are vulnerable to abuse, they may be incapable of making decisions about health and welfare matters for themselves. They are easy prey to those who wish to exploit them financially. For people who lack capacity to manage their finances there are two mechanisms to administer their affairs, the Court of Protection which offers considerable problems to would-be exploiters, but it's expensive slow and off-putting for the family. Alternatively there are Enduring Powers of Attorney, simple to set up and easy to administer but offering little protection to a wealthy person with rapacious friends and family. Any new law has to tread a difficult path between offering autonomy and protection to the vulnerable person, whilst at the same time minimising bureaucracy and cost to carers and professionals. Proposals to allow others to make health care decisions on behalf of patients are bound to encounter opposition from the euthanasia lobby at one end of the spectrum to pro-lifers at the other.

The solution?

The publication of the Draft Mental Incapacity Bill by the new Department of Constitutional Affairs initially looked like just another chapter in the long saga of Government delay in the introduction of proper legislation to protect the basic rights of vulnerable people in England and Wales. However on this occasion there does seem to be a little more ground for optimism that we may be nearing the end of the epic.

The story began in 1989 when the Law Society (the professional organisation representing solicitors, in the way that the British Medical Association represents doctors) convened a working party that subsequently produced a report. Their ideas were taken up by the Law Commission - a quango with responsibility for considering new legislation. They published as series of consultation papers and held extensive discussions before producing a final report in 1995 *"Mental Capacity "*[1]. The recommendations in this report have been very influential on judges over the last ten

years; many of the Law Commission's recommendations have found their way into common law. The report contains a Draft Incapacity Bill, which has been re-published without much amendment as the government's draft bill. The main difference has been the omission of some proposals offering public law protection to people at risk of abuse.

When the Law Commission's report was published, the Daily Mail published a scathing denunciation alleging that "Legal Commissars subvert family values." The government of the day hastily buried the report. The Blair government, shortly after its election published a Green Paper on the subject called *"Who Decides?"*[2] , two years later a further report *"Making Decisions"* [3] detailed public and professional responses to *"Who Decides?"*. They made a vague commitment to introduce new legislation "when Parliamentary time permits", but there has been little sign of any progress until recently. This contrasts sadly with the position in Scotland where one of the first achievements of the devolved Edinburgh parliament was to pass the Adults with Incapacity Act.

Shortly after the publication of the Draft Bill a Joint Committee of the House of Lords and House of Commons was charged with scrutinising the proposed legislation. They called for written submissions and collected oral evidence from interested parties. Their thoughtful and thorough appraisal of the bill has been collected together remarkably quickly, and was published on 28 November 2003[4] . Everyone in the health and social services should take time to consider their report.

What's in the Draft Bill?

To anyone who has followed the story over the last 15 years there are no surprises in the draft bill. The Law Commission's report has been a valuable source of academic legal opinion to High Court Judges ever since its publication and many of the concepts and definitions in the Bill have been incorporated in English case law. Its principles have been used in guidance issued by the Mental Health Act Commission in the *Code of Practice*[5] , the BMA and the Law Society in their book on *Assessing Mental Capacity* and the GMC in their pamphlets on medical ethics.

The general thrust of the proposals follows the views expressed in *Making Decisions*, and *Who Decides?* Part I of the Bill defines capacity, inability to make decisions and "Best Interests"; as well as establishing a general authority to act reasonably to provide care for person who lacks capacity. This part of the Bill also provides for a "Lasting Power of Attorney" to replace the current "Enduring Power of Attorney", but with broader powers to make decisions on matters of health care and social welfare as well as financial affairs. Receivers who are currently appointed by the Court of Protection under part VIII of the Mental Health Act will be replaced by "Deputies", also appointed by the Court of Protection, who will also have the authority to make health and welfare decisions. The Court will have the power to make decisions on particular matters. In *Making Decisions* it was stated that the Government would not introduce legislation on Advance Directives ("Living Wills"), but there seems to have been a change of heart and these now also appear in Part I of the Bill. Part II of the Bill re-defines the nature of the new Court of Protection and establishes the Office of the Public Guardian. It is envisaged that the new Court of Protection will have more regional offices rather than just in London (although cases

from the North West can now be heard by a District Judge sitting in Preston). The Court will be able to make decisions on individual matters of health and welfare as well as appointing deputies. There will be a Code of Practice for the Act when it is finally passed.

What difference will it make?

The purpose of this Bill is not so much to make changes in the rights of people who lack capacity, but to enshrine these rights in statute. As I have explained above, the way that we as doctors have to exercise our duty to treat patients in our care is currently controlled by the common law, and judges have used the principles which lie behind the new Bill in reaching their decisions in test cases. There is a good explanation of these principles as they apply to medical treatment in the *Code of Practice*[4] pp 64-70. The extension of powers of those who hold Powers of Attorney to include decision making about matters of health and welfare are likely to be helpful. The ability for the new Court of Protection to make judgements may save on families resorting to the High Court, but the more informal procedures is likely to result in more cases being taken to court.

What next?

There are no definite proposals in the Queen's Speech to give parliamentary time to debate the Incapacity Bill, but the Joint Committee recommend that this legislation should take priority over the proposed new Mental Health Act, echoing the views of the Junior Minister for Health (responsible for Mental Health) and the Lord Chancellor when they gave evidence. Whether or not there is a new law, we are all likely to be spending more time with families, colleagues and lawyers, debating issues of capacity and "Best Interests".

Further Information

The official papers referred to in this article can nearly all be accessed through the Department of Constitutional Affairs website:-

http://www.dca.gov.uk/menincap/intro.htm.

The guide for health care professionals is helpful for day-to-day clinical problems.

References

1. Mental Incapacity (1995) Law Com 231 London HMSO.

2. Lord Chancellor's Department (1997) *Who decides?* Cm 3803 London, HMSO.

3. Lord Chancellor's Department (1999) *Making Decisions* Cm 4465 London, HMSO.

4. House of Lords, House of Commons Joint Committee on the Draft Mental Incapacity Bill *HL paper 189-I, HC 1083-I Vol I Report together with formal minutes*
Available at: http://www.parliament.uk/parliamentary_committees/jcmib.cfm

5. Department of Health / Welsh Office (1999) *Mental Health Act1983 Code of Practice.* 3rd ed. London, HMSO.
Available at: http://www.markwalton.net/code/15.asp?

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BOOK REVIEW

Practical Dementia Care

Rabins, P.V., Lyketsos, C.G. & Steelen, C.T. (1999) *Practical Dementia Care*. Oxford, Oxford University Press. pp 278. ISBN 0195106253

The premise of this book is that clinicians need to unite a good understanding of dementia with a 'can do' attitude and a rational, systematic approach to their patients.

The first third of the text concentrates on the need for a comprehensive assessment of the dementia sufferer and the formulation of a specific diagnosis and describes the main clinical features, epidemiology and pathology/etiology of the most common forms of dementia. The material is organised into sections on the cortical and subcortical dementias and is clearly presented although this is more of a practical source book than a comprehensive reference work.

Subsequent chapters cover the provision of supportive care for the patient and their family and present a structured approach to the impairments of functioning and behaviour that people with dementia may experience. The emphasis is on the identification of workable strategies and this part of the book is densely packed with practical suggestions, if at times appearing overly prescriptive and overly cautious, as when determining whether a patient can be left alone from a list of 10 questions which if applied in the UK would result in a considerable proportion of people currently living alone being deemed in need of residential care. Other chapters consider the role of pharmacological treatments, the challenges raised by the physical care of late stage disease, legal and ethical issues and genetics. The legal framework cited is that of the United States and some of the drugs mentioned are not licensed in other countries, but the majority of the information covered has international relevance. A greater concern is the extent to which the section on medications in a text published some 5 years now needs updating.

At its best this book offers a range of practical interventions relating to situations which carers and clinicians typically find difficult such as the provision of personal

care to a ‘resistive’ recipient or informing a person with dementia that they should stop driving. In aiming to address so many areas within a moderately sized text some issues inevitably get less attention than they warrant however and the few paragraphs allocated are not sufficient to cover such important topics as depression, abuse, the need for care to be co-ordinated and person-centred or the provision of social and psychological therapies.

Finally, although described as an evidence-based text, the authors have foregone systematic referencing in an attempt to promote user-friendliness. The theoretical basis for the advice given is not always evident and the research cited has been integrated with suggestions arising from the authors’ extensive clinical experience. The result is indeed eminently readable but might prohibit the reader who would like to undertake a more in-depth examination of a particular area of interest from easily pursuing this, whilst some chapters may offer little new to the experienced specialist clinician. Most professional groups working in this area will nevertheless find much that is useful in this book.

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WEBSITE REVIEW

Free journals on the web (2)

Journal of advances in schizophrenia and brain research

This journal is aimed at psychiatrists and contains articles pertinent to clinical psychiatry. Full-text is available for current and past issues from Vol. 2 (1) in PDF format which requires Adobe Acrobat Reader. Published on the web by emental-health.com

http://www.emental-health.com/jasbr.asp

Age and Ageing

Age and Ageing is an international journal publishing refereed original articles and commissioned reviews on geriatric medicine and gerontology. Its range includes research on ageing and clinical, epidemiological and psychological aspects of later life. One issue may be viewed free of charge but registration required. Although whole issues are not available without subscription, there is an archive of numerous full-text articles, research papers, editorials, systematic reviews and case reports which may be downloaded if you have Adobe Acrobat. You may also register to have the table of contents emailed to you when a new issue is published.

http://ageing.oupjournals.org/current.shtml

Dementia and Geriatric Cognitive Disorders

The electronic version of the journal *Dementia and Geriatric Cognitive Disorders*, published and provided by S. Karger. Tables of contents and abstracts are available free of charge, and full text (in PDF format which requires Adobe Acrobat Reader) of articles to subscribers only. Alternatively, articles can be ordered online for a fee from Karger, or from other reprint services. *Dementia and Geriatric Cognitive Disorders* is a forum devoted to the study of cognitive dysfunction, concentrating on Alzheimer's and Parkinson's disease, Huntington's chorea and other neurodegenerative diseases.

http://content.karger.com/ProdukteDB/produkte.asp?Aktion=JournalHome&ProduktNr=224226&ContentOnly=false

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http://www.newscientist.com/

YOUR PROBLEM ANSWERED

"Dear Jane,
As a practising old age psychiatrist, I would appreciate your help in navigating a course through the maelstrom of documentation associated with the single point of access with referrals to social services.
Alistair"

Guidance on the Single Assessment Process (SAP) for Older People

The implementation of the SAP is part of the initiative to modernise services outlined in the National Service Framework for Older People. It is anticipated that the

implementation of these changes will, overall, lead to a more efficient assessment process for older people. This is defined as a process whereby the actual or potential needs of an individual are identified, the impact on their daily functioning and quality of life is evaluated in order that appropriate plans can be made. Government guidance identifies four types of assessment: contact, overview, specialist and comprehensive and suggests that old age psychiatrists (and geriatricians) will have a prominent role to play in the latter. Comprehensive assessments are required as a precursor to permanent admission to a care home and substantial packages of care at home. A number of professions will contribute to a comprehensive assessment. The unique contribution of an old age psychiatrist to the comprehensive assessment process is likely to be apparent in two guises:

- the provision of a diagnosis of treatable and other health conditions of an older person without which wider assessment and subsequent care planning is likely to be flawed;
- assistance in the development of assessment tools.

In return old age psychiatrists should, by virtue of the requirement for them to contribute to a comprehensive assessment, have a more central role in the decision-making process regarding the long-term care of older people with significant mental health problems. Moreover, research evidence suggests that this approach may contribute to long-term benefits for older people and carers together with cost savings for statutory agencies.

Interestingly, a recent survey of old age psychiatrists in England and Northern Ireland provides a unique picture of the range and prevalence of standardised scales used within old age psychiatry services. Conceivably this would be of use as a source document to facilitate the development of a local protocol regarding the use of assessment tools in comprehensive assessment of older people with mental health problems.

References

Department of Health (2001*) National Service Framework for Older People,* London,Department of Health.
Available at:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003066&chk=wg3bg0

Department of Health (2002) *Guidance on the Single Assessment Process for Older People* (HSC2002/001: LAC(2002)1). London, Department of Health.
Available at http://www.doh.gov.uk/scg/sap

Challis, D., Clarkson, P., Williamson, J., Hughes, J., Venables, D., Burns, A.& Weinberg, A. (2004) The value of specialist clinical assessment of older people prior to entry to care homes. *Age and Ageing* 33, pp.25-34 .

Reilly, S., Challis, D., Burns, A. and Hughes, J. (2004) The use of assessment scales in old age psychiatry services in England and Northern Ireland. *Aging and Mental Health* 8 (3), pp.249-55.

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