PSSRU

Mental Health in Old Age Bulletin
Issue 14

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Discussion Paper M129
April 2005

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MENTAL HEALTH IN OLD AGE BULLETIN
ISSUE 14

EDITORIAL

The future of old age psychiatry

Any writing on the future of anything is doomed to fail. If it is bleakly pessimistic (and thus probably prescient) it will be dismissed as curmudgeonly grumpiness; if glowingly optimistic as sadly autistic, and if anywhere in between as boring. So I had better stop here- if I care. I don't, so I won't.

What exactly is old age psychiatry? This is not as easy as it might seem- practice and organisation varies across the UK, Europe and the world. Clearly the recipients will not go away but will grow in number, so wherever the specialty and its cognate disciplines have taken root the future should be bright. But even in the UK there are claims on our clientele- from geriatricians and a new breed of neurologist (interested in care as well as cure - still rare) on dementia, from neuropharmacologists and psychologists on anxiety and depression, from neuropsychiatrists and neuropsychologists on other organic and mixed disorders, and finally from general psychiatrists on persecutory and delusional states. Why should we resist them? After all, they are specialists in their fields, and if they are better than us we should surely stand back, let them take their pick and be content with whoever remained and who needed our particular approach. How particular is our approach anyway? Multidisciplinary teamwork is now fully established in many specialties, and our penchant for home visits – at least medical ones- will surely be dented by the probable disappearance of the domiciliary visit fee under the new Consultant contract. In the UK the genesis of our specialty represented an aspect of affirmative action (or positive discrimination) against ageism in general psychiatry staff. Such ageism is far less obvious than it was, but ageism in distribution of resources in psychiatry and healthcare remains rampant. What is the point of affirmative action when the service provided to those over 65 is worse than the service provided to younger people? Positive discrimination then becomes age discrimination with us as its architects and defenders.

So now it's prediction time - first, how I want things to be in the future. If you look at what I have written above, the phrases "better than us", "the service ...is worse than" are crucial. We should only stand aside when the outcomes for our patients are likely to be better with another specialty or approach, and we will only be able to guess this when we know what they are at the moment. So I see the whole specialty developing an outcomes-orientated culture, in which evidence of our effectiveness is routinely gathered, analysed, fed-back and discussed. This is tough but not impossible, and in my view essential. Only then can we ask of alternative approaches "Here is the effectiveness of our interventions. What evidence do you have that the outcomes for patients would be better with yours?" Without outcomes information we (or rather our patients) are at the mercy of the fads and fashions that have always determined the shape of our services. But we must not stop there. We need to stimulate other psychiatric specialties to develop in this direction too, and, eventually, all health services, so that decisions become more and more evidence-based. Only then might it be clear that we should stand aside - our work done.

What do I think the future of old age psychiatry will be? I don't know enough about this world-wide to say, but this is an easy prediction for the UK. If we take up the

torch of outcomes measurement, the future is bright, perhaps even orange. If we continue to bumble along like everyone else in effectiveness darkness, the specialty will be forcibly amalgamated back into general psychiatry in keeping with Standard 1 of the UK National Service Framework for Older People. Quite right too? We will never know.

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ARTICLE

Planning a Cochrane Review

The Cochrane Library

The Cochrane Library consists of several evidence-based databases, including the Cochrane Database of Systematic Reviews, which holds over 3,500 reviews. The aim of these is to provide professionals and patients with reliable and up-to-date information on the effects of interventions in healthcare. The Library is an electronic publication, and therefore has no practical constraints on space, allowing the reviews to be described in detail.

To conduct a systematic review takes time, organisation, dedication and, as I have particularly found, a huge amount of support. I was first interested in writing a review for the Cochrane Library when I became involved in a randomised controlled trial (RCT) studying the effectiveness of Rivastigmine in delirium. I wanted to know what work, if any, had previously been done in this area. A MEDLINE search drew a blank but as studies have shown that 30-80% of RCTs are not identified by MEDLINE (Dickerson 1994) I realised that my investigation was not complete. Further exploring led to only a few small studies. What was needed was a systematic review. There wasn't one. I therefore decided to write one myself.

The CDCIG

The systematic reviews in the Cochrane Library have been produced through collaborative Review Groups. The Review Groups are composed of people around the world who share an interest in a particular health area and in developing systematic reviews relevant to this field of interest. There are currently fifty Cochrane Review Groups, ranging from the Acute Respiratory Infections Group to the Wounds Group. The Group I have become involved with is the Cochrane Dementia and Cognitive Improvement Group (CDCIG), based in Oxford. Their remit includes both global cognitive impairment and local cognitive impairment as well as delirium and non-specific, and age-associated, cognitive impairment. They have produced over fifty reviews of interventions covering treatments aimed at interrupting the disease process, management of manifestations of dementia (e.g. agitation, wandering) and interventions for the enhancement of normal cognitive function.

Initial Planning

The CDCIG's editorial team offers administrative, clinical and statistical assistance. They appreciate that reviewers are giving their own time to conduct the reviews and are therefore very accommodating and supportive. The group has produced a topic list of areas and interventions that they wish to develop reviews for. When considering becoming a reviewer the first step is to check that the area you wish to review hasn't already been registered by someone else. It is important to be quick so you are not disappointed. Registering a title with the CDCIG is akin to ownership and the group will not sanction anyone else to review the subject.

It is obviously important to choose an intervention and a field that clinicians and patients would find useful. There are many new treatments that offer hope where the evidence base hasn't been comprehensively evaluated. The titles of the reviews tend to be short and snappy and include the intervention and the area of interest, for example, the review that I'm involved in is 'Rivastigmine for delirium'. Cochrane Review Groups tend to be either 'splitters' or 'lumpers', that is they either like the reviews to study interventions as a group or individually. The CDCIG generally tend to be 'splitters'; there are separate reviews for each of the cholinesterase inhibitors in Alzheimer's disease. This is however not universal and the cholinesterase inhibitors are 'lumped' together for the review for dementia with Parkinson's disease. Whether you wish to 'lump' or 'split' must be considered very carefully as it has implications for the number of studies that could be included in your review and potentially the usefulness to other parties. Clinicians may wish to know, for example, which cholinesterase inhibitor has the strongest evidence base for a particular condition.

If a question is too narrow then the conclusions of the review may not be generalised to multiple settings, populations of other forms of the intervention. A broader focus however raises the possibility that you are mixing apples and oranges which should be avoided if there is evidence that different forms of an intervention behave differently, or that different aspects of the condition under study would respond differently to the intervention. A broad focus may also generate a large set of heterogeneous studies that may make interpretation of data difficult and reduce the value of the review.

Developing a Protocol

It is important to develop a robust protocol so the review answers a clinically relevant question, but also to reduce the opportunity of the review being biased. Prior knowledge of studies in a specific area may influence the criteria for study selection or the outcomes to be reported. On the pragmatic side it is likely that if a reviewer is interested in a topic area they are likely to be aware of some of the studies that have been conducted. The Cochrane Group also accepts that it is sometimes necessary to change the review protocol, but shouldn't be made on the basis of how they affect the results of a review.

There are a number of important decisions to be made during the protocol stage and I feel it is essential to have a co-reviewer involved so these matters can be discussed fully. It is also worthwhile having available a third reviewer so, if a compromise can not be found, a decision can still be made.

The protocols for a Cochrane Review have a set structure beginning with the 'Background' which provides the context of the review. The background should explain the rationale for the review and why the questions being asked are important. It will usually include information regarding the biology, epidemiology and clinical relevance of the subject being focused on. It sets the tone for the protocol and therefore for the review. The protocol formulates the questions being asked which you hope the review will answer. The questions should address the choices people face when deciding about healthcare. The outcomes reported should therefore be meaningful to those making healthcare decisions. The questions being asked of an intervention will be about adverse effects as well as benefits.

Formulating the Questions

The questions a review answers are closely associated with its objectives. What is the review trying to achieve? It is important to be clear about which participants, settings, types of intervention and outcomes are of interest. When developing a protocol the question that must be continually asked is 'what is the relevance'?

A reviewer has to decide what the explicit criteria should be for establishing the presence of the disease or condition they are interested in. Further decisions need to be made on the age and gender of the participants in the studies. The review may concentrate on patients in a particular setting e.g. nursing home, outpatients or hospitalised. These are all decisions that need to be made at the protocol stage. Choices should be based on the usefulness and relevance of potential results. Is there any worth, for example, in limiting your review to only female patients with Alzheimer's disease and the intervention of a cholinesterase inhibitor?

The protocol must also specify the form of the intervention that it is studying. Will studies using only the higher dose of a medication be included? It is also important to define the interventions against which these will be compared, placebo control group. The protocol also needs to be explicit in which particular outcomes will be sought. Reviewers should avoid overwhelming readers with data that has little clinical relevance and only important outcomes should be included. These outcomes need to be well defined to avoid ambiguity in the results. The reviewer also needs to consider how they will include data on adverse effects of the intervention. Some outcomes may be combined and it may be possible for the reviewer to acquire unpublished data from the investigation to disentangle these.

The Cochrane Group places RCTs at the top end of desirable study designs. It does however appreciate that other study designs are appropriate for addressing certain types of questions. For example, questions of aetiology/risk factors and core-control/cohort studies. It is important to include only studies that are relevant to the proposed question. There is little worth in looking at studies of short duration if you are interested in long-term outcomes of a study.

Summary

I have tried to highlight some of the main areas that need to be considered when planning a Cochrane Review. It is important to be stringent when developing the review's protocol as this will help avoid difficulties and keep the review focussed on

answering relevant questions from clinicians and patients. You have to be very precise about the question you want answered and be clear on the population, setting, intervention and condition or disease you are interested in. The CDCIG have been very helpful and supportive in the development of our protocol and have shared their experience so pitfalls could be avoided.
The Group is equally supportive in identifying relevant studies for a review and in the statistical analysis. I would recommend to others to get involved with CDCIG as it is an excellent way to learn about the process of systematic reviews as well as enabling you to answer that burning question you may have. The main ingredients in being successful are time, thought and support.

Further Information

Cochrane Collaboration: www.cochrane.org

Cochrane Dementia and Cognitive Improvement Group (CDCIG): www.jr2.ox.ac.uk/cdcig

National Electronic Library for Health: www.nelh.nhs.uk/cochrane.asp

References

Dickerson K, Scherer R, Lefebvre C (1994) Identifying relevant studies for systematic reviews. BMJ, 309, 1286-1291.

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CURRENT KEY ISSUES

Psychiatric issues and retrospective challenges of testamentary capacity

Shulman K. *et al*. (2005) Psychiatric issues and retrospective challenges of testamentary capacity. *International Journal of Geriatric Psychiatry* 20: 63-69.

A summary of the literature and case law relevant to testamentary capacity were reviewed by the authors as well as some medico-legal reports based on the specific issue of challenges to wills, on the basis of lack of testamentary capacity. There would doubtless be an increase because of a combination of a high prevalence of mental disorders in old age and the complexity of modern families, and it is likely that old age psychiatrists and others will be asked to provide expert assessments in cases where wills are challenged retrospectively. The results show that the typical profile of these challenges related to a radical change from a previous will, where undue influence was alleged in a person with no children who had executed a will less than a year prior to death and was suffering from dementia, alcohol abuse and other neurological and psychiatric conditions. A sound basis for providing an

assessment for testamentary (tasks specific) capacity is provided by case law, but the complexity and subtlety of many of the issues in the cases presented underscored the need to go beyond the traditional criteria and assess not just task specific capacity but situation specific capacity and factors. There will be a need for assessors to determine whether someone making such a will can fully appreciate the consequences of executing or changing it, and there needs to be basic research looking at the relationship between testamentary capacity and cognitive function.

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BOOK REVIEW

Training and development for dementia care workers

Anthea Innes (1999) *Training and development for dementia care workers* Jessica Kingsley. £13.95 ISBN 1853027618

This book is about facilitating training and education programmes in care homes. The main focus is on the importance of student-centred learning. Anthea Innes has used her own experience of working with Anchor Trust positively. She has blended theoretical aspects with a practical approach. The approach has been designed in a user-friendly way. Each chapter is well presented with case illustrations. Ms Innes provides a concise guide to running a training programme. This includes key factors such as the design, delivery and evaluation of a programme.

There are six chapters beginning with “Getting started” and the chapters that follow flow naturally and this makes it an easy read. The book uses case material to illustrate the training process and the writing is lucid.

The importance of the person-centred approach is also emphasised. Running courses in nursing/care homes needs careful planning and the evaluation process is important. The writer has emphasised this throughout the book.

However, the title of this book is rather misleading as it implies the book is about dementia care training. This training book could be used by trainers on other client groups living in a care home. The book is more about training in general rather than dementia. Only chapter five briefly deals with dementia. Residential workers working across the client groups will benefit by the approach advocated by Innes.

The table 0.1 is rather provocative denouncing the “Old culture of care” which treated people with dementia as “inhuman”(?). How old is the old culture? Where is the evidence that this attitude was prevalent across care homes? How far back is the author going?

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WEBSITE REVIEW

Studies undertaken within the last three years from the Cochrane Database of Systematic Reviews

Here is a selection of studies undertaken within the last three years from the Cochrane Database of Systematic Reviews.

Hudson S, Tabet N. Acetyl-l-carnitine for dementia. The Cochrane Database of Systematic Reviews: Reviews 2003 Issue 2 John Wiley & Sons, Ltd Chichester. 2003

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003158/frame.html

Sauer J, Tabet N, Howard R. Alpha lipoic acid for dementia. The Cochrane Database of Systematic Reviews: Reviews 2004 Issue 1 John Wiley & Sons, Ltd Chichester, UK DOI: 10.1002/14651858.CD004244.pub2

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004244/frame.html

Bains J, Birks JS, Dening TR. Antidepressants for treating depression in dementia. The Cochrane Database of Systematic Reviews: Reviews 2002 Issue 4 John Wiley & Sons, Ltd Chichester

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003944/frame.html

Clare L, Woods RT, Moniz Cook ED, Orrell M, Spector A. Cognitive rehabilitation and cognitive training for early-stage Alzheimer's disease and vascular dementia. The Cochrane Database of Systematic Reviews: Reviews 2003 Issue 4 John Wiley & Sons, Ltd Chichester, YR: 2003

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003260/frame.html

McGuinness B, Todd S, Passmore P, Bullock R. The effects of blood pressure lowering on development of cognitive impairment and dementia in patients without apparent prior cerebrovascular disease. The Cochrane Database of Systematic Reviews: Protocols 2003 Issue 1 John Wiley & Sons, Ltd Chichester, UK

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004034/frame.html

Lonergan E, Luxenberg J, Colford J. Haloperidol for agitation in dementia. The Cochrane Database of Systematic Reviews: Reviews 2002 Issue 2 John Wiley & Sons, Ltd Chichester, UK

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002852/frame.html

Thompson CA, Spilsbury K, Barnes C. Information and support interventions for carers of people with dementia. The Cochrane Database of Systematic Reviews: Protocols 2003 Issue 4 John Wiley & Sons, Ltd Chichester, UK

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004513/frame.html

Vink AC, Birks JS, Bruinsma MS, Scholten RJS. Music therapy for people with dementia. The Cochrane Database of Systematic Reviews: Reviews 2003 Issue 4 John Wiley & Sons, Ltd Chichester,

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003477/frame.html

López-Arrieta , Birks J. Nimodipine for primary degenerative, mixed and vascular dementia. The Cochrane Database of Systematic Reviews: Reviews 2002 Issue 3 John Wiley & Sons, Ltd Chichester, UK

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000147/frame.html

Lee H, Cameron M. Respite care for people with dementia and their carers. The Cochrane Database of Systematic Reviews: Reviews 2004 Issue 1 John Wiley & Sons, Ltd Chichester, UK

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004396/frame.html

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