

Irish Association of Consultants in Psychiatry of Old Age

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John Saunders
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Hawkins House, Dublin 2.

Re: Response from the IACPOA to Independent Monitoring Group for Vision for Change Implementation Plan (VFCIP) Progress

We became aware the Independent Monitoring Group, chaired by Mr John Saunders, were seeking reports from various groups on their assessment of progress on implementation of Vision for Change and implementation priorities for 2010. I spoke to Margaret Mc Guinness about a submission and she advised that I could send our document to her.

These are the views of the IACPOA. This association represents the Old Age Psychiatrists in Ireland.

Many items in Vision for Change on psychiatric services for older people section (Chap 13) do not represent the views of the Irish Association of Consultants in Psychiatry of Old Age. Despite a number of requests the speciality of Psychiatry of Old Age was refused representation on the Expert Group. The IACPOA prepared a report for the expert group to the draft Vision for Change but this was ignored.

Vision for Change was produced without adequate consideration of the needs and, in particular, the differing needs of older people with dementia, those with late onset functional psychiatric illness and those with severe enduring or recurrent mental illnesses with onset below the age of 65 (often referred to as a "graduates").

There was no mention of the role of Liaison Psychiatry for older people, psychological therapeutic interventions or the close working relationship with Geriatricians.

The following points should be considered.

1. Factors determining Resource Requirements must include actual numbers of older people, level of deprivation and geographical size.

International guidelines and best practice recommend the norm of 1 Old Age Psychiatry team/consultant per 10,000 people over 65 years. In VFCIP (pg 63. para 4) two differing resource norms are suggested – i.e. one team per

100,000 general population and one per 10,000 older people. Each of these norms results in very different resource levels. For instance, in a catchment area where 14% of the population is over 65 years using the former norm would result in about 2/3 of the resources compared to using the latter. This distinction is all the more important as the proportion of the population over 65 years is set to double between 1995 and 2020 – making the norm based on a general population figure even less relevant.

In addition Child and Adolescent Service requirements use the updated 2006 census figures (pg.50). These more recent figures should be used to determine resources for all specialties.

Resources required cannot be based on actual population numbers alone. The level of deprivation in an area must be taken into consideration (Pg. 13 bottom of pg). More dispersed geographical areas require higher resources to deliver the same service level.

Recommendation

Acknowledge the importance of basing resources on actual numbers of older people and not on a fixed percentage of the general population – this is fundamentally incorrect on two accounts – the percentage of the general population made up by older people varies throughout the country and the percentage of older people is ever increasing

2. Referral Criteria to Psychiatry of Old Age Services.

The referral criteria for Psychiatry of Old Age Services are as follows:

1. Elderly people developing functional psychiatric disorders for the first time over the age of 65 years.
2. Dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required.

The draft implementation plan on Vision for Change states “This specialist mental health service (MHSOP) is provided to people over 65 who either have a lifelong mental health illness (graduates) or develop one in later life” (pg 22). The Psychiatry of Old Age Specialty was not set up to meet the needs of “graduates” and is not configured or resourced to do so. Studies looking at graduate populations show their differing needs when compared with those who present with mental health problems for the first time at 65 years and over. Published studies show that the characteristics of the former group include higher resource utilisation, increased OPD clinic time and increased length of stay in acute units. Rehabilitation Services can be as effective for older people with life long severe mental illness as for younger people and they should not be denied access to same by reason of age alone.

On this subject the views on the inspector of Mental Health Services 2008 are particularly relevant. Refer to the “Annual Report 2008 of the Mental Health Commission” which includes the report of the Inspector of Mental Health Services 2008:

6.9.2 Psychiatry of later life

Psychiatry of later life specialises in the treatment of the behavioural and psychiatric symptoms associated with dementia as well as new onset psychiatric illness after the age of 65. If recognised early, these types of conditions can be treated satisfactorily in the community. However, when hospitalisation is required, these patients require specialised units with staff specifically trained in dealing with old age problems. The practice, observed in many general and adult acute psychiatric units, of frail, elderly and demented individuals mingling in busy common rooms with psychotic, irritable, younger patients is, frankly, dangerous and should be discontinued. Purpose-built units for psychiatry of later life should be made available across the country.

It is preferable that the older-aged individuals suffering from long-term psychiatric illness should be cared for in an assertive manner by appropriate rehabilitation teams. These individuals should not, by default, be placed under the care of the psychiatry of later life services.

The service needed to meet the needs of graduates whether it is provided by General Adult Psychiatry, Psychiatry of Old Age or Rehabilitation Psychiatry or some combination of these has major resource and planning implications.

Furthermore, the resources required to continue the service to our current client group alone can be expected to increase given the projected doubling in size of the elderly population by 2030 (Chap X pg 63).

Inclusion of "organic brain disorders" (Para 2 pg 63) in the referral criteria is unacceptable. This is a very broad category and includes head injuries, alcohol related brain disease, etc. Currently the needs of these groups are not provided for by Psychiatry of Old Age services but by Physical and Sensory Disabilities services, Neurology and Neuropsychiatry services.

Recommendation

Acknowledge the vastly differing needs of dementia sufferers and the needs of those with late onset mental illness and graduates. Services for graduates need to be outlined, resourced and provided following involvement and consultation between General Adult Psychiatry, Psychiatry of Old Age and Rehabilitation Psychiatry.

3. Number of Psychiatry of Old Age teams

41 and 46 MHSOP teams are recommended in VFCIP (pg 63, para 4) using the 2 different norms (1 MHSOP team per 100,000 general population and 1 team per 10,000 older people). The latter is more appropriate and all the more relevant as the numbers of older people will double in the 25 year period (between 1995 and 2020).

Recommendation

The norm for determined resources should be based on actual numbers of older people and should be 1 team per 10,000 older people.

4. Acute Assessment/Treatment Beds

International guidelines and best practice recommend the norm of 1 bed per 1,000 people over the age of 65 years for dementia and 0.5:1,000 for functional mental illness for older people (ie. 15 beds per 10,000 people over 65 years).

There is a wide disparity between 8 acute beds per 300,000 (pg 64 para 4) for older people and the above norms.

Separate bed provision from General Adult Services is not emphasized in VFCIP – this is essential as the needs of the two patient groups differ enormously and a principle that is echoed in the Inspector of Mental Health Services 2008 (see above). We note with concern that two acute in-patient units for older people were closed within the last eighteen months.

The number of acute beds could be reduced if an active day hospital programme and a flexible, responsive fully resourced community team are available to provide rapid assessment and treatment of patients at home.

5. Long Stay Bed Requirements

International guidelines and best practice recommend the norm of 30 continuing care beds for severe dementia per 10,000 people over 65 years. It is the view of the Association that one third of these beds should be in an approved setting and two thirds in a non approved setting with regular review provided by the Psychiatry of Old Age Service to the latter.

The recommendation that 360 continuing care beds for Psychiatry of Old Age (Challenging Behaviour) (pg 38, Table 1.2) be provided nationally as part of the 10x50 bedded Community Nursing Units project (pg 19) is quantitatively and qualitatively inadequate. Furthermore some of our members are aware that discussions have taken place with groups other than mental health concerning the use of these beds. If a substantial proportion of these beds have been earmarked for other patient groups there will be even fewer available for older people with mental illness.

The long term care needs for older people with functional psychiatric illness and those with dementia are very different and require separate facilities. The location of these beds is critical for the convenience of older people and their carers.

6. Respite service

It is the view of the Association that the majority of respite care for patients accessing our services should be provided at primary care level as it is for those with physical illnesses. No norms have been suggested for respite services.

7. Day Hospital

International guidelines and best practice recommend the norm of 2 day hospital places per 1,000 people over the age of 65 i.e. 20 per 10,000 older population. The service required for those with functional mental illness differs

from that required by people with dementia. It is possible to provide the service for the two disparate groups in the same setting using different days for each of the groups. This is common practice in existing day hospitals in Psychiatry of Old Age Services here in Ireland

The VFC norm of 1 X 25 place Day Hospital per 300,000 is substantially less than the above recommended norm. Special consideration has not been given to meeting day hospital needs in geographically dispersed areas.

Recommendation

Style and quantity of acute assessment beds, specialist long-term care beds, day hospital places and respite facilities should be based on actual numbers of older people and on best practice recommendations.

8. A Consultation-Liaison service for Older People with Mental Health problems

The service provided by Psychiatry of Old Age specialty is based on the principal of continuity of care of older people within a specific catchment area. A key feature of this continuity of care is the provision of a specialist consultation-liaison service to those older people who have been admitted to acute hospitals (with co-morbid psychological and physical problems) within that area. There is no reference to Consultation-liaison work within Vision for Change or in VFCIP.

The resources required for Psychiatry of Old Age liaison services are not mentioned in VFC or the HSE's implementation plan. Liaison Psychiatry to older people forms a substantial part of the Psychiatry of Old Age workload, approximately 80% of medical admissions are aged 65 years and over. The workload is particularly high where a service is linked to a large general, regional hospital or tertiary referral hospital. This workload must be acknowledged and resourced.

Recommendation

Acknowledge the need for Consultation-liaison psychiatry for older people and adequate resourcing of same

9. Psychological Interventions

There is no mention of resources to deliver psychological therapies to older people though these therapies (CBT, addiction counsellors, family therapy, etc) are known to benefit this group. In contrast these therapies are acknowledged as a resource required for General Adult and Child & Adolescent Psychiatry.

Recommendation

Acknowledge the need for Psychological interventions for older people and adequate resourcing of same

10. Release/redistribution of Resources

Much emphasis is put on the redistribution of resources equitably across Psychiatry of Old Age teams (pg 66, para 1). There is extremely limited scope for this as all existing teams, except perhaps one, are under-resourced, some severely so. This was acknowledged in the recent "Amnesty Report on Mental Health Services in Ireland".

Recommendation

While release of and redistribution of resources should be accepted, the impression that this will generate substantial funds should not be given or accepted.

11. Screening in Primary Care

We acknowledge the principle of working closely with our Primary Care colleagues and indeed this is our practice. We are however concerned about the recommendations on screening as there is no evidence to support the benefit of mental health screening for older people in Primary Care (pg 66, pts 8 + 9).

Recommendation

Screening programmes should be based on evidence of their benefit

12. Early Onset (Presenile) Dementia

The Vision for Change proposal for this patient group which can be summarised as patients throughout the country being dealt with by a single neuropsychiatric service and then passed on to Psychiatry of Old Age for placement is unworkable and clearly not in the best interest of patients and their families.

Consideration should be given to Psychiatry of Old Age assuming responsibility for this group of patients since our services have specific expertise in the assessment and treatment of people with dementia associated with behavioural and psychological symptoms. This could not be done without the provision of the additional resources at both personnel and facility level.

Recommendation

Consideration should be given to resource Psychiatry of Old Age to develop services for this patient group

13. Training of future Psychiatrists for Old Age Psychiatry

There is no mention in VFC of recommendations for training in Old Age Psychiatry. Training opportunities for Specialist registrars is essential and all the more so if the future service style is going to be a Consultant delivered service.

Recommendation

Consideration should be given to resource training in Psychiatry of Old Age.

Conclusions

In response to the letter from Mr Fitzpatrick with regard to progress to date of implementation of Vision for Change and suggestions for recommendations we have the following to say.

Psychiatry of Old Age services, since their inception in 1989, have adhered to what are now referred to as the core principles of Vision for Change principles:

1. Providing multi-disciplinary assessment and treatment of patients in their homes (otherwise known as Domiciliary care or home treatment).
2. Low in-patient assessment bed use
3. Working in consultant teams, where there is more than one consultant in a catchment area.
4. Working closely with our medical, nursing and allied health professional colleagues in primary care.
5. Active day hospital management of mental illness.
6. Working closely with and providing support with carers and families

Other core principles of a Psychiatry of Old Age Service designed to best meet the needs of patients include our close working relationship with geriatricians reflecting the common coexistence of medical and psychological problems in older people and making a specialist consultation-liaison service available to those in general hospitals. This results in good team work across the specialties and continuity of care for patients – principles upheld by VFC. This is work that is currently being provided but not acknowledged in the VFC document.

Other than where existing practice was consistent with Vision for Change there has been limited progress with implementation.

Summary of Recommendations

1. Acknowledge the importance of basing resources on actual numbers of older people and not on a fixed percentage of the general population – this is fundamentally incorrect on two accounts – the percentage of the general population made up by older people varies throughout the country and the percentage of older people is ever increasing

2. Acknowledge the vastly differing needs of dementia sufferers and the needs of those with late onset mental illness and graduates. Services for graduates need to be outlined, resourced and provided following involvement and consultation between General Adult Psychiatry, Psychiatry of Old Age and Rehabilitation Psychiatry.

- 3. The norm for determined resources should be based on actual numbers of older people and should be 1 team per 10,000 older people.**
- 4. Style and quantity of acute assessment beds, specialist long-term care beds, day hospital places and respite facilities should be based on actual numbers of older people and on best practice recommendations.**
- 5. Acknowledge the need for Consultation-liaison psychiatry for older people and adequate resourcing of same**
- 6. Acknowledge the need for Psychological interventions for older people and adequate resourcing of same**
- 7. While release of and redistribution of resources should be accepted, the impression that this will generate substantial funds should not be given or accepted.**
- 8. Screening programmes should be based on evidence of their benefit.**
- 9. Consideration should be given to resource Psychiatry of Old Age to develop services for this patient group**
- 10. Resource for training in Psychiatry of Old Age must be made available.**

Thank you for taking these comments into consideration.

Yours Sincerely

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The reference for service and resource norms is from the Royal College of Psychiatrists, UK

On behalf of the Irish Association of the Consultants in Psychiatry of Old Age.