National Council for the Elderly

PROCEEDINGS OF CONFERENCE

MENTAL DISORDERS IN OLDER IRISH PEOPLE: INCIDENCE, PREVALENCE AND TREATMENT

ROYAL MARINE HOTEL, DUN LAOGHAIRE, CO. DUBLIN

11TH OCTOBER 1996

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The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June 1981. The terms of reference of the Council are:

To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on,

- measures to promote the health of the elderly,
- the implementation of the recommendations of the Report, The Years Ahead - A Policy for the Elderly,
- methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,
- ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly,
- meeting the needs of the most vulnerable elderly,
- ways of encouraging positive attitudes to life after 65 years and the process of ageing,
- ways of encouraging greater participation by elderly people in the life of the community,
- models of good practice in the care of the elderly, and
- action, based on research, required to plan and develop services for the elderly.

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The National Council for the Elderly is an advisory body to the Minister for Health on all aspects of ageing and the welfare of the elderly. One of its terms of reference is to advise the Minister on measures to promote the health of the elderly.

As one of its contributions towards the realisation of this objective the Council published a report in October 1996 entitled, Mental Disorders in Older Irish People: Incidence Prevalence and Treatment. The report provides a profile of mental disorders in the older Irish population by bringing together in one publication the information which exists on the prevalence, incidence and treatment of mental disorders in older people. It will be a valuable source of information for planning and developing mental health services for older people.

A Conference at the Royal Marine Hotel, Dun Laoghaire, Co. Dublin on 11th October 1996 provided a platform to discuss the findings of the report and to focus attention on the priorities for mental health services for older people in Ireland. We are very grateful to Anne Roche, a co-author of the report, for preparing this summary of the proceedings of the Conference. On behalf of the Council, I would like to thank her for bringing together the papers presented at the Conference in such an expert fashion. Though not pretending to record in detail everything said by invited speakers or from the floor, we are confident that this report provides a useful account of the main issues discussed.

I would also like to express our thanks to the speakers for preparing such interesting papers and to the participants for their contributions at the Conference.

Michael White
Chairman
December 1996
INTRODUCTION

Mr. Michael White
Chairman, National Council for the Elderly

On behalf of the National Council for the Elderly, I want to welcome you all here this morning, especially those of you who have travelled many miles to be with us today. There has been great interest in this conference which has been booked out for over three weeks. This interest springs from a growing recognition that the mental health of older people is central to all other aspects of their lives and in many cases to the quality of life of their families.

Consequently, the mental health of our older population needs to be closely examined, together with the support that those with mental illness receive from their families, their community and the State. This is important for three reasons: (1) the number of older people is due to increase significantly in the foreseeable future; (2) the mental state of older people has not received the serious consideration that it deserves and (3) there is an implicit acceptance of a level of mental illness among older people that is unacceptable in other age groups.

The study upon which this conference is based, *Mental Disorders in Older Irish People: Incidence Prevalence and Treatment* does not present any new information on the mental state of older Irish people, but it does draw together in one publication, all the information that exists at this time. This serves to consolidate work already completed and to identify areas for further research. I hope that the report and this conference will highlight areas where future action in mental health promotion is required and that they will provide valuable information for planning and developing mental health services for older people.

The report on mental disorders is number forty five in the Council’s list of publications and although in the past we have concentrated on the physical health of older people, it is not the first time that the Council has considered the mental health of older people. Three years ago, at a similar gathering in this hotel, the Council advocated the need for a Dementia Services Information and Development Centre in Ireland, based on the Scottish model. There was overwhelming support for its establishment and I hope that progress will be made in this regard in the near future.
This will be particularly important because sufferers of dementia and their carers are in urgent need of community support. Although today's conference focuses on the mental health of older people, it does not do so to the exclusion of all the other elements in older people's lives. Mental health must be seen in the context of their entire well-being. Strong links exist between psychological well-being and physical health status. Ageing is not a disease, but it does bring challenges to one's physical and mental health, for which we, as individuals and as a community, must prepare.

Older people who consider their health quite good, nevertheless experience steady loss of fitness, mobility and strength, as the ageing process develops. This can have major effects on the daily pattern of their lives and on their psychological well-being. The psychological coping mechanisms which older people need in order to come to terms with the ageing process must be encouraged through health promotion campaigns. Huge resources dedicated to the medical treatment of illness and disease reflect the seriousness with which the physical dimension of this problem is regarded. Maintaining the mental health of older members of our population must be given equal priority.

Older people must have confidence in the support of their communities to maintain their physical and mental health, when the ageing process brings its challenges. Older people must also have confidence in the support of their communities when they feel threatened by criminal elements. There is a danger arising out of irresponsible media coverage that older people will, out of fear, cut themselves off from the community. This has negative implications for their physical and mental health.

The report upon which today's conference is based, highlights yet again the need for integrated planning and co-ordinated delivery of services to provide the support older members of our community need. I hope that your consideration of the issues arising from the report will help you along that path.
OPENING ADDRESS

Mr. Brian O'Shea, T.D.

Minister of State at the Department of Health

I am very pleased to have the opportunity to address you at this conference this morning, at the kind invitation of the National Council for the Elderly. The Council plays an important role in contributing to policy on the elderly, and their reports have been very useful to the Department of Health in determining policy and priorities for the development of services for the elderly.

*Shaping a Healthier Future* (1994), the Department’s strategy for the health services recognises that care of ill and dependent elderly people is going to be one of the key issues to be addressed by the health services in the next decade. The challenge is to reorganise existing services and develop new services to ensure effective care for our growing number of elderly people. The strategy endorses the principles and recommendations of *The Years Ahead - A Policy for the Elderly* (1988), which are to maintain older people in dignity and independence at home, and when this is no longer possible, to ensure that there is a high quality of hospital and residential care available. Priority will also be given to promoting healthy ageing, with the assistance of the National Council for the Elderly and in co-operation with the statutory and voluntary bodies involved with older people. I am pleased to see that the Council has embarked on a programme for healthy ageing.

In recent years, services for ill and dependent elderly people have improved, both in hospital and in the community. Respite and day care have eased the burden of caring for many relatives. There has also been a rapid expansion of specialist departments of medicine of old age attached to general hospitals. It is my Department’s aim to continue this good work. The report, *Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment*, addresses the specific challenges facing old age psychiatry.

The loss of physical health, the loss of loved ones through death and the loss of occupation through retirement are integral parts of the ageing process. However, such experiences can lead to a vulnerability amongst the elderly and a susceptibility to mental illness, particularly depression. Indeed, physical ill health and mental illness in old age are often linked.
In 1994, 4,195 persons aged over 65 were admitted to psychiatric hospitals and units, 1,116 of which were first time admissions. The highest rate of first-time admissions among all age groups occurred in the 75 years and over age group. Over 40 per cent of all admissions were for depressive disorders. These statistics highlight the significant incidence of mental illness among the elderly and the need to provide a comprehensive and specialised service to respond to their needs.

Current policy in relation to the development of mental health services, including services for the elderly, is derived from the recommendations contained in Planning for the Future (1984). A key objective of this policy is the improvement of services to meet the special needs of particular categories such as the elderly with mental health problems.

In recent years, the recruitment of consultant psychiatrists and other health professionals with particular interest in the care of elderly persons with mental health problems has been accelerated. However, it is recognised that further progress is required and additional numbers of consultants and other health professionals with an interest in this area will be appointed in the future.

The prevention of mental illness is also an important policy issue. Cooperation between key figures in the community and health personnel, particularly GPs, is of primary importance in identifying elderly persons at risk and in setting up preventative programmes.

Another issue of growing national concern is the increase in the number of suicides and parasuicides in Ireland over the past two decades. A National Task Force on Suicide was established in November 1995, and its Interim Report identified the elderly as a particular suicide risk group. Specifically, elderly men aged between 65 and 74 years have shown a significant increase in their rate of suicide. These are issues that the Task Force will be further investigating in the formulation of its final report which will be a national suicide prevention/reduction strategy.

In conclusion, I would like to thank the Council for their report, and in particular to express the Department’s gratitude to the authors, Fiona Keogh and Anne Roche, for all their hard work. I wish you all well with your deliberations as I now officially declare this conference open.
THE STUDY FINDINGS

Chair: Professor Faith Gibson

Senior Lecturer in Social Work,
University of Ulster at Jordanstown and Member, National Council for the Elderly
PRESENTATION OF THE STUDY FINDINGS
Ms. Fiona Keogh
Co-Author of the Report

Thankfully mental illness is not something to be hidden any more, it is now something to be recognised, diagnosed and treated, like any other illness. At a Council conference last year, Dr. Tony Fahey detailed how the population of people over 65 in Ireland is projected to increase by about 30 per cent in the period 1991-2011. Mental disorders are common in this growing population. The present study was undertaken because we do not have a detailed picture of the level of disorder in older Irish people nor the arrangements for treating it. The need for detailed information to plan a comprehensive range of mental health services for older people with mental disorders, that includes care in people’s homes, out-patient care, in-patient care and residential care, also prompted this study.

Scope of the study
A detailed brief was given by the Council which outlined the areas to be covered. Our aim was to describe the incidence, prevalence and treatment of mental disorders in older Irish people, incidence being the number of new cases that occur and prevalence being the total number of cases in the population, including new and pre-existing cases. As with all studies, there were several issues that were not included, or at least were not examined in great detail, simply because we were producing a one volume and not a ten volume report. But I want to emphasise that it is not because we consider these issues unimportant. We have attempted to draw a picture, using the best information available, as to what types of disorders affect older people, how they are treated and where they are treated. Despite the many information gaps in the present study, there is enough information to see the overall picture and general pattern.

Methodology
Documentary information, both published and unpublished, and perhaps not previously presented in a format that focused on older age groups, was reviewed. The major data sources used in the study were computerised databases which contain information on the use of various levels of psychiatric service. Three databases were sourced:

- The National Psychiatric In-Patient Reporting System (NPIRS)
- Psychiatric Case Registers
- The Hospital In-Patient Enquiry System (HIPE)
NPIRS covers in-patient activity only, while the psychiatric case registers cover all parts of the psychiatric service, including out-patient clinics, day hospitals, domiciliary visits and in-patient care.

**How do people come in contact with the psychiatric services?**

One way of describing how people come into contact with the psychiatric services is Goldberg and Huxley’s ‘Pathways to Care’ model in Table 1.

<table>
<thead>
<tr>
<th>Table 1: Five levels and four filters on the ‘Pathway to Care’</th>
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<tr>
<td><strong>Level</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

The important point conveyed in this table is the description of the different levels of service contact and the estimates of prevalence that might be expected at each level. It illustrates how different estimates of prevalence can be obtained depending on the sample of people. For example, a low estimate will be obtained if psychiatric in-patients are examined, whereas examination of the community population yields a high estimate. The movement from one level to another serves to filter some people out. For example, of all those people in the population who might have a mental disorder, only a proportion will decide to consult their GP about the problem. Therefore the number of people with mental health problems in a sample of GP attendees will be smaller than the number of people in the population who might be affected by a mental disorder. And so on down the line, filters are operating at each point, so that only a fraction of people with mental disorders, (usually those with more severe disorders who need specialist care), will get into the psychiatric services.

I have explained this in some detail as much of the data in the report is concerned with this specialist end of the pathway, that is, those people who come into contact with the psychiatric services. There are many others suffering from mental disorder who never reach these services. Service-use figures can be influenced by many things other than the actual level of illness or disorder in a population. For example, the accuracy of detection and diagnosis of the disorder, and issues relating to service utilisation such
as the availability and accessibility of services, can also produce a selective group of people who are seen more than others.

However, service-use data is often used to provide estimates of incidence and prevalence because it is the only comprehensive data available. It can be argued that this is not very useful since we still do not know how many people in the general population are suffering from mental illness. However, if we are interested in the planning and provision of services, then data on current service use and service users will go a long way in providing the relevant information. Obviously, the best way to measure true incidence and prevalence is to have measures at all five levels as described in Table 1.

Finally, in discussing mental disorders in older people, a distinction is generally made between three groups, those with long-standing mental illness, those with functional mental illness and those suffering from dementia.

**Treatment**
The importance of a detailed assessment of an older person who presents with a mental disorder has been stressed throughout the report. The assessment should ideally take place in the individual’s home as this is the environment where the person functions every day. A detailed physical assessment is particularly important for older people for whom physical illness is common. There are also features of the assessment procedure which apply specifically to older people, including active enquiry after symptoms, an evaluation of the ability to perform activities of daily living and the necessity of speaking to family members or carers. This assessment would usually be carried out by a GP or a psychiatrist.

Once a disorder has been diagnosed, an individual care plan is usually drawn up. Treatment can take place in a variety of settings, including the individual’s own home, in an out-patient clinic, in a day hospital or day centre. Alternatively the individual may be admitted for a short time to a psychiatric hospital. Close liaison between the GP and primary care team is essential for the optimum care of the individual. While community services have been developed around the country, there remains a shortage of day hospital and day care places for adult psychiatric patients (i.e., for all adults including those over 65). For older people specifically, there are very few places available. Only three psychiatry of old age services have been developed in Ireland to date, with a fourth service just recently established in Limerick.
Treatment settings
While most cases of mental disorder are treated at the primary care level, for older people who are acutely mentally ill, or who cannot be managed in primary care, the treatment settings available are: in-patient admission to a psychiatric hospital or unit, treatment within a psychiatry of old age service, or admission to an acute general hospital.

In addition to acute treatment, older people with mental disorders can at times require long-stay care. There are important resource implications in the provisions of long-stay care and there is evidence of some difficulty in obtaining such places for people with a mental disorder.

However, the specialist psychiatry of old age services which have been developed are catchment area based, so that only those living in the catchment area can access the service. The three services currently available in Dublin serve about 15 per cent of the national population over 65. We certainly have a long way to go to provide these services to the remaining 85 per cent and to address the inequitable situation regarding access to services which currently exist.

Treatment options
The treatment options available to older people with mental illness can be broadly categorised into three groups: biological, psychological and social/environmental treatments. These treatments are not mutually exclusive. In fact the most effective treatments usually involve combined use of these therapies.

In general, the same treatments are used for all people with a mental disorder, regardless of age. However, there is evidence that older people may not have access to the complete range of treatments and are more likely to be given biological treatment and less likely to be given psychological treatment. There is a misperception that psychological therapies are less effective with older patients or that this group are not willing to participate in such treatments. Conversely, several studies have found that not only are psychological treatments equally effective with older as with younger patients, but that older patients drop out less often than younger patients.

However, resources are a limiting factor here. The availability of what are collectively known as the ‘allied professions’, for example, psychologists, social workers and occupational therapists, is very limited in Ireland. Thus the opportunity for older people to be referred to, or have access to psychological or social treatments is limited.
In summary, treatment follows a detailed assessment from which an individual care plan is devised. Comprehensive, integrated care is needed with a high degree of flexibility and movement between treatment settings.

**Depression among older Irish people**

A common perception when we think about older people and mental disorder is that we are talking about dementia, but in fact older people are affected by the whole range of mental disorders. Depression is the single most common disorder in those over 65, affecting up to 20 per cent of those over 65 compared to five per cent for dementia.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Under 65 years</th>
<th>Over 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6 - 8</td>
<td>8 - 11</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>9.4 - 12</td>
</tr>
<tr>
<td>Total</td>
<td>9 - 10</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 2 shows the incidence (number of new cases) of depression expected in any one year. These are contact figures from the case registers and are, therefore, likely to be an underestimate. However, it can be seen that new cases of depression are just as common among those over 65 as among those under 65, at a rate of about 10 per 10,000 population. However, there is a more equal gender distribution in those over 65.

Prevalence figures from a community study carried out by Professor Brian Lawlor and his colleagues in Dublin, reveal that 14 per cent of people aged 65-69 had depression (moderate to severe), 16 per cent of those aged 70-74, 15 per cent of those aged 75-79 and 10 per cent of those aged 80-84. This community study gives a total prevalence rate of 13 per cent for depression among those over 65 years.

The data we collected from various sources enabled us to estimate the number of people affected by depression at the different levels of service contact as described in Table 1. By extrapolating these figures to the total population aged over 65, we can crudely estimate the possible number of people over 65 living in Ireland who are affected by depression. I must emphasise that these are very crude estimates and should not be taken as definitive. However, they do provide us with a starting point and a ‘working estimate’.
In summary, depression is common in older people, with an incidence rate of about one per cent (international data) and a prevalence rate of about 13-23 per cent, depending on the severity of the case. However, there are a wide range of effective treatments for older people with depression. We need to ensure that these treatments are made available to older people. Another interesting finding is the gender difference, with more women than men affected by depression. The fact that depression can be associated with physical illness, such as stroke or Parkinson’s Disease - diseases which affect older people - is also an important observation.

## Dementia among older Irish people

Dementia is a very disabling condition which has a huge impact on the quality of life of the individual. Dependence also increases as the condition worsens and this has important implications for carers. The prevalence of dementia is high and increases with age. The number of people over 65 years is projected to increase by 30 per cent by the year 2011, as already mentioned. The number of people over 80 years is projected to increase by two thirds. Since the prevalence of dementia increases with age, the number of people affected by dementia is expected to increase significantly in the future.

The incidence of dementia is around 2-3 per 10,000. This estimate is from the Irish case registers. As I have previously noted, these service-use statistics are probably an underestimate. In fact data from one of our psychiatry of old age services confirms this, as can be seen in Table 4.

### Table 3: Estimates of the prevalence of depression in those over 65 years from Irish data, 1994

<table>
<thead>
<tr>
<th>Level</th>
<th>Irish data</th>
<th>Extrapolated to total population over 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: The community</td>
<td>1,310 per 10,000</td>
<td>52,793</td>
</tr>
<tr>
<td>Levels 2 &amp; 3: GP attendees</td>
<td>900 per 10,000</td>
<td>36,270</td>
</tr>
<tr>
<td>Level 4: Psychiatric services</td>
<td>79 per 10,000</td>
<td>3,184</td>
</tr>
<tr>
<td>Level 5: Psychiatric hospitals</td>
<td>45 per 10,000</td>
<td>1,814</td>
</tr>
</tbody>
</table>

### Table 4: Incidence of dementia

<table>
<thead>
<tr>
<th>Irish case registers</th>
<th>Old age psychiatry service</th>
<th>International studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3 per 10,000</td>
<td>65 per 10,000</td>
<td>100-150 per 10,000</td>
</tr>
</tbody>
</table>
International studies put incidence at around 1-1.5 per cent, which is the same rate as for severe depression. So the number of new cases per year is roughly the same for both of these conditions.

Table 5 shows a summary of the estimated prevalence of dementia at the different levels of service contact, again with extrapolations to the total population over 65. Again, these are crude estimates and are not definitive.

<table>
<thead>
<tr>
<th>Level</th>
<th>Irish data</th>
<th>Extrapolated to total population over 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: The community</td>
<td>550 per 10,000</td>
<td>22,165</td>
</tr>
<tr>
<td>Level 2 &amp; 3: GP attendees</td>
<td>1,600 per 10,000</td>
<td>64,480</td>
</tr>
<tr>
<td>Level 4: Psychiatric services</td>
<td>21 per 10,000</td>
<td>846</td>
</tr>
<tr>
<td>Level 5: Psychiatric hospitals</td>
<td>14 per 10,000</td>
<td>564</td>
</tr>
</tbody>
</table>

We can see the 'pyramid' of prevalence, with most cases being at lower levels and fewest at the highest level of service contact. The figures for GP attendees in Table 5 are from a study which did not diagnose dementia according to strict criteria, but used a measure of cognitive impairment. This probably accounts for the high figures at these levels. Another level which might be added to this table is the prevalence of dementia in nursing homes and other institutional care settings which affects over half of residents.

Throughout the report psychiatric admission rates were used as a proxy for prevalence. An examination of admission rates from past years revealed an interesting trend. We chose comparative figures for 1984 (because this was the year Planning for the Future was published) and for 1994 in the report. We found a significant reduction in admissions for dementia over the 10 year period from 1984 to 1994 of around 50 per cent. Planning for the Future recommended that people with dementia should not be routinely admitted to psychiatric hospitals. Our interest in the reduction in admissions is not to make any value judgement as to whether this was a good or bad policy, although in many cases people with dementia are more appropriately treated somewhere other than a psychiatric hospital. Our concern is that since there has been such a large reduction in admissions, where are these individuals now being treated? There have only been two psychiatry of old age services operating for any appreciable time within that 10 year period and both are in Dublin. The information to answer that
question was not available. However, it did shed some light on information we obtained from many different people relating to the difficulties in obtaining admission for people with dementia.

In summary, approximately one per cent of people over 65 will develop dementia in any year, with about five per cent of those over 65 affected at any one time. Comprehensive services are required for people with dementia.

Schizophrenia among older Irish people
When considering older people with schizophrenia, there are two groups with whom we are concerned: older people who developed schizophrenia in early adulthood, forming the largest group; and those who develop schizophrenia in late life at a low rate of around 1-2 per 10,000. However, because most people who develop schizophrenia early in life live to old age, we can expect about one in 100 people over 65 to suffer from this disorder. A proportion of this group have been institutionalised, many for long periods of their adult life. They need ongoing sheltered accommodation. The new cases need acute treatment and management of their disorder. Thus, in general, the needs of these two groups are quite different and this needs to be taken into account in service planning.

<table>
<thead>
<tr>
<th>Incidence of schizophrenia</th>
<th>1-2 per 10,000 approximately</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of schizophrenia</td>
<td>1 per cent approximately</td>
</tr>
</tbody>
</table>

Neuroses among older Irish people
The neuroses, which refer collectively to such disorders as nervousness, anxiety and phobias, are also common among older people. The rate of new cases per year is around one per cent and prevalence is about 10 per cent. There are a wide range of effective treatments available for these disorders, which are usually administered by GPs. However, people with more severe levels of neuroses may need hospitalisation. It is interesting to note a similar decrease in psychiatric admissions for this condition, as observed for dementia. Admission rates for those under 65 showed a slight increase between 1984 and 1994, while for those over 65, admission rates decreased by almost 50 per cent. The concern is not the reduction per se, but the consequences in terms of treatment for these individuals. Again we have no information about where these individuals received their treatment, if it was not in a psychiatric hospital.

One way of measuring anxiety or psychological distress in a broad manner is to use the General Health Questionnaire (GHQ). Dr. Tony Fahey did this as part of a study for the Council and showed that almost a quarter of all of
those over 65 reported significant distress. Among those over 65, distress was associated with physical illness, being widowed and being female. While many neuroses are considered to be minor mental disorders, for the affected individual they can be very distressing, affecting the individual’s quality of life. Furthermore, neuroses are generally very treatable.

**Alcohol abuse and dependence among older Irish people**

Like schizophrenia, there are two groups of older people affected by this condition. Those who develop the problem in late life and those who have had the problem since adulthood. The incidence and prevalence of alcohol problems in all adults has consistently been higher in males than females, but some studies have shown that for those over 65 the incidence among women can be the same as for men. There are also factors which have been shown to be associated with this problem in older people such as loneliness and isolation. Alcohol disorders can often mask or complicate other disorders such as anxiety or depression.

It is difficult to obtain accurate estimates of the incidence and prevalence of alcohol disorders. Estimates from contacts with psychiatric services show an incidence rate in those over 65 of 2-3 per 10,000 population although this is likely to be a significant underestimate. Prevalence rates from the same source suggest about 18 cases per 10,000 which would also seem to be a considerable underestimate when compared to international studies.

<table>
<thead>
<tr>
<th>Incidence of alcohol abuse</th>
<th>2-3 per 10,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of alcohol abuse (Irish)</td>
<td>12-18 per 10,000 population</td>
</tr>
<tr>
<td>Prevalence of alcohol abuse (international)</td>
<td>70-300 per 10,000 population</td>
</tr>
</tbody>
</table>

**Mental handicap**

Many more people with a mental handicap are living to old age, which is defined as over 55 years for this group. The prevalence of people with a moderate, severe or profound mental handicap is approximately two per 1,000. An Irish census estimates that around one third of people over 55 with a mental handicap also have a mental disorder. The prevalence of dementia is quite high and people with Down's Syndrome are at greater risk of developing dementia than the general population. An Irish study found a prevalence rate of eight per cent, which is low compared to rates of up to 40 per cent reported by international studies. Most important perhaps is the need for careful consideration of the services required for older people with mental handicap and specifically for those with both a mental handicap and a mental disorder. Whether these individuals should
be treated within the generic psychiatric services or within a specialist service is an issue currently being debated.

Suicide
Research on suicide trends carried out by Dr. Michael Kelleher (1996), describes the increasing Irish suicide rate, especially among males in the period from the late 1970s to the early 1990s. Older males had the highest suicide rate for many years and it is only in recent times that this rate has been overtaken by younger males. The rate of suicide for females over 65 is also higher than that for younger females.

Table 6: International comparisons for rate of suicide among those over 60 per 100,000 population in 1985/6 by gender

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>16.1</td>
<td>5.1</td>
</tr>
<tr>
<td>Belgium</td>
<td>85.8</td>
<td>26.2</td>
</tr>
<tr>
<td>Denmark</td>
<td>72.5</td>
<td>29.5</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>19.9</td>
<td>17.7</td>
</tr>
<tr>
<td>France</td>
<td>93.7</td>
<td>26.2</td>
</tr>
<tr>
<td>W. Germany</td>
<td>59.2</td>
<td>23.1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>37.7</td>
<td>12.5</td>
</tr>
<tr>
<td>US</td>
<td>43.4</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Table 6 shows a comparison of the Irish suicide rate in the late 1980s with that in other European countries and the US (Diekstra 1989). It shows that Ireland has a very low suicide rate for older people by international standards. The recent increases in Irish suicide rates have rightly prompted concern and the establishment of the Task Force on Suicide is welcomed.

Suicide prevention
There are some measures that can be taken to prevent suicide. Of those who commit suicide, half or more have some type of mental disorder. The timely recognition and effective treatment of these disorders probably offers the best single measure in preventing elder suicide. Suicide, particularly in those over 65, has been found to be associated with physical illness, chronic pain, loneliness and isolation. Measures which tackle these factors may also help to prevent suicide. Finally suicide among older people can be seen as somehow 'less regrettable' than that of a young person, as their life has been lived and so on. There is perhaps some scope
for a change in attitudes so that the suicide of any individual, young or old is seen as regrettable and something to be prevented if possible.

Mental health promotion
The importance of mental health promotion for older people cannot be underestimated. The ageist attitude that health promotion is not relevant to older people because they are not open to change is inaccurate. Preparation for retirement courses and other educational initiatives have been found to be both popular and successful with older people. General measures aimed at improving well-being through social contact have also been recommended. While there are strategies for mental health promotion and strategies for health promotion in the general population, there is no single national strategy for mental health promotion in older people. Such a strategy might help to co-ordinate the various measures being undertaken by a wide variety of bodies.

While there is a limit to primary preventive strategies in mental illness as so little is known about causative agents, there are some concrete secondary and tertiary preventive measures which can be undertaken. The importance of early detection and diagnosis and recognition of mental disorders in older people cannot be stressed enough. Those who have received some training in the assessment and diagnosis of mental disorders in older people are likely to play an important part in the early detection of disorders. The treatment of concurrent psychiatric and physical illness is also important in reducing the impact of the primary disorder on the individual, thus preventing further disability. For example, the treatment of depression or psychotic symptoms in individuals with dementia can improve the quality of life of both the affected individuals and their carers. The treatment of chronic pain or physical illness can address some of the risk factors for disorders such as depression, alcohol abuse and suicide. Maintenance treatment and ongoing monitoring and follow-up of individuals with a mental disorder acts as a prevention, by reducing relapse.

Summary
Table 7 presents a summary of the findings of prevalence estimates from all the Irish data we could access, and compares these with international estimates. As can be seen, the Irish prevalence rates are within those obtained in other studies.

An important point which I hope has become clear is that people over 65 suffer from the complete range of mental disorders, and considering all
these disorders together 100,000 people over 65 are affected by a mental disorder of some severity.

Table 7: Prevalence of psychiatric disorders in the community population over 65. Estimates from Irish and international studies. Rates per 10,000.

<table>
<thead>
<tr>
<th>Mental disorders</th>
<th>Irish data</th>
<th>International data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>550-790</td>
<td>520-1,000</td>
</tr>
<tr>
<td>Depression</td>
<td>1,310-2,280</td>
<td>910-2,200</td>
</tr>
<tr>
<td>Mania</td>
<td>0</td>
<td>0-20</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0-40</td>
<td>10-30</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>no data</td>
<td>20</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Neuroses</td>
<td>110-1,480</td>
<td>60-1,790</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>no data</td>
<td>0-10</td>
</tr>
<tr>
<td>Mental handicap*</td>
<td>20</td>
<td>14-22</td>
</tr>
</tbody>
</table>

*Estimates for over-55s
Good morning ladies and gentlemen. I would like to discuss some of the comments and recommendations of the National Council for the Elderly arising from the wealth of information that has been compiled by Fiona Keogh and Anne Roche. I refer you to pages 21-36 of the report for the Council comments and recommendations in full.

To set the scene in demographic terms, there are over 400,000 people over 65 in Ireland and it is projected that by the year 2011, this figure will be around half a million. So the number of older people are increasing, while at the same time, there is a decrease in family support with smaller families and more women working outside the home.

1. It is recommended that a national strategy for the future of mental health services for older people be developed by the Department of Health, in consultation with all concerned parties in this area. Such a strategy should provide clear national guidelines for future developments.

2. Irish information on the incidence of mental disorders in older people is very poor, which of course limits service planning. Patient-focused information systems, modelled on the National Psychiatric In-Patient Register (NPIRS) should be developed to remedy this. These systems would enable service providers to track individuals through all the care sectors.

3. Information on the overall prevalence of mental disorders is also far from ideal. It is estimated that about a quarter of older Irish people have a mental disorder of some kind, with about five per cent suffering from dementia. This means that at present there are roughly 100,000 elderly people in Ireland with a mental disorder of some severity. If this prevalence figure remains constant and if recent population projections are accurate, there will be 120,000 older people with a mental disorder by the year 2011. In the absence of better information, future service provision should be based on these estimates.
4. While public and professional attitudes to both old age and psychiatric illness have improved in recent years, education is still required to reduce the stigma and misunderstanding surrounding some disorders. This is evidenced by the poor detection of mental health problems amongst older people. Education programmes for the public and professionals on the nature of mental disorders in old age should be developed by the health boards in conjunction with the Department of Health, relevant voluntary agencies and professional bodies. The professionals to be targeted include those at primary care since most older people (about 95 per cent) live in their own homes.

5. The needs of older people with mental disorders are multiple: psychological, social and physical. This highlights the need for co-ordination between primary care, psychiatric care and medicine for the elderly services. Co-ordinated procedures for access to secondary level services such as day care centres, acute psychiatry and medical services, and long-stay facilities must be identified at a local level. An ethos of co-ordination among policy makers is required, which will then filter down through the services. Integrating service districts between health care programmes would be a starting point. This was advocated in *The Years Ahead* eight years ago, with little national development to date.

6. People with a mental handicap are more likely to reach old age now than they were in the past, due to medical advances. In particular, people with Down's Syndrome are living longer and developing dementia of the Alzheimer's type in their 40s and 50s. People with a mental handicap are therefore likely to require a range of services because of multiple problems that develop as they age. In addition to mental handicap services, the person will also require primary health care to deal with minor mental and physical problems, and may need consultant-led specialist services for major problems. The establishment of clear guidelines at health board level, governing the treatment of older people with a mental handicap and specifying points of access and criteria for referral to the various services, is recommended.

7. The burden, both practical and emotional, of caring for people with dementia has been very well described over the years. The appointment of designated case managers who would take responsibility for the assessment of needs of people with dementia and their carers and for the planning and delivery of appropriate services, is recommended.
8. Community support services for people with dementia and their carers need to be enhanced through the establishment of specific services such as: day centres for people with severe dementia (provided with transport), flexible respite care, day care, night care, short-term care (should carers suddenly become ill) and day sitting services.

9. The need for specialised psychiatry of old age services has been well described over the past 10 years. There is concern at the slow rate of progress in developing these services with just four psychiatry of old age services in Ireland at present; three in Dublin and one recently established in Limerick. It is recommended that consultant-led psychiatry of old age services be developed as the core of mental health services for older people. They would have responsibility for providing specialist assessment, treatment and rehabilitation services and facilities. In the absence of an Irish norm for these services the Royal College of Psychiatrist's norm of one consultant per 10,000 people over the age of 65, might be used.

10. The next issue concerns residential care and there are a number of points to be made here. First, there is a lack of data on the actual number of people with mental disorders in residential care due to the high number of different institution types that are available within the health boards. Where information is gathered it is relatively poor. Future research on older people in residential care should be qualitative rather than quantitative and should look specifically at mental disorders, in relation to the numbers of people affected, the type of disorder and the reasons for admission to residential care.

11. The second issue is that older people living in residential care are more likely than the general elderly population to suffer from psychiatric disorders, particularly dementia and depression, so obviously these people should have access to specialist psychiatric services. It is recommended that all elderly people have access to specialist psychiatric services, where necessary.

12. Other issues concerning residential care have come to light with the resettlement and closure of psychiatric institutions. Some older people still living in psychiatric institutions would benefit from being re-housed in more homely domestic-type settings. An adequate amount of appropriate housing should be available for older people with mental disorders who need to be resettled in the community.
13. On the other hand, there will be a number of older people who will not be able to move from a psychiatric setting because of their behavioural problems and will continue to enter long-stay psychiatric care. Therefore, the accommodation and standards of care within long-stay psychiatric institutions for older people needs to be maintained.

14. The numbers of people being admitted to psychiatric care have decreased considerably since Planning for the Future was published, but the number of people with dementia requiring residential care has not decreased. Since no alternative residential services have been provided, the development of appropriate residential care settings, that meet the care needs of elderly demented people in a safe environment, are required.

15. There is a disparity in the number of older people with psychiatric disorders in institutions across the different health boards, which is in part related to different admission policies across health board regions. It is recommended that national guidelines for the placement of older people with mental disorders in long-stay care be established. These guidelines should take into account the level of behavioural disturbance, physical health and life circumstances.

16. Finally, in accordance with the White Paper on Mental Health, it is recommended that the mental health of older people should be specifically promoted by health boards in conjunction with voluntary organisations and that health promotion policies should take particular cognisance of the strong link between psychological well-being and physical health status in older people.
RESPONSE 1: A DEPARTMENT OF HEALTH PERSPECTIVE

Mr. Noel Usher

Principal Officer, Mental Health Services and Services for the Elderly, Department of Health

I would like to thank the National Council for the Elderly for inviting me here today and to congratulate them on the publication of this study on mental disorders in older Irish people. The information contained in the study is extensive and it will, I believe, become an important source of reference. I welcome this opportunity to offer the Department of Health’s perspective on the findings of the study.

National strategy

I would like first, to respond to the Council’s recommendation for the development of a national strategy for the future of mental health services for older people. The various policy papers that have been published over the years including, Planning for the Future, The Years Ahead, the Nursing Home Act and my Department’s Strategy for Effective Healthcare - Shaping a Healthier Future, should not be seen as separate stand alone documents, but rather as integral components of an overall integrated framework for the development of services. Planning for the Future contains a detailed analysis of the nature and extent of psychiatric illness among the elderly and makes recommendations for the development of a community-based service to meet their needs. This policy is underpinned in Shaping a Healthier Future, which acknowledges the significant rise in numbers of elderly people and the challenge of developing health services, to meet their needs over the coming years. I believe, having regard to the significant progress which has been made in the implementation of the recommendations of Planning for the Future, progress to which Government is committed to continue, that the mental health services are capable of meeting that challenge.

One of the key elements of Shaping a Healthier Future, is the recognition of the need to determine and set down attainable targets for the development of services. Of particular importance is the need to develop specialist assessment and community support services in each health board for people suffering from dementia, including Alzheimer’s Disease, and their carers.
Information
To meet the needs of our elderly population, we must first determine what that need is. Realistic forecasts can only be achieved where adequate data is available concerning the service needs. The study comments on the inadequacy of incidence and prevalence data available. The collation of particular data on the delivery of the mental health services is undertaken by several parties: the Inspectorate of Mental Hospitals, the Department of Health and the Health Research Board. While the information supplied by each of these agents is extremely useful, more can be done and all three parties have recently agreed to adopt a new approach to the collection of data. In fact, several adaptations have already been made.

Surveys of long-stay beds
The Department recognises the need for improved data on the number of older people with mental disorders in long-stay institutions. The latest version of the Department’s long-stay survey is based on a more detailed questionnaire which includes information on subventions and dependency levels. In particular, the analysis of the long-stay population by medico-social status has been improved. However, it should be noted that the long-stay survey covers over 400 institutions and is therefore limited in the level of detail that can be included in the questionnaire, if the maximum level of response is to be achieved. Detailed analysis is best achieved through a sample survey, which facilitates more intensive investigation of a proportion of the overall population.

With regard to determining the incidence and prevalence of various mental health problems among the elderly, the Inspectorate of Mental Hospitals intends to evaluate the activity levels in the psychiatry of old age services, in order to estimate the number of patients presenting to that service. This may lead to a detailed study of the actual level of morbidity in those aged over 65 years in the community. The current data on the level of mental disorder set out in Table 13.1 of the report represents a good foundation. However, it may be necessary to capture the information initially on a pilot basis in selected areas. The Department will discuss the feasibility of pilot studies with the Health Research Board.

Breaking down taboos
Another priority area for the health services is the promotion of healthier living. We have seen tremendous changes in attitudes towards mental illness, thanks to care providers and voluntary organisations, such as AWARE, Grow, Schizophrenia Ireland, and the Mental Health Association of Ireland. However, as the Minister pointed out earlier, over 40 per cent of admissions among the over 65 age group in 1994, were for depressive
disorders. This is a sizeable group, especially when depression is a treatable illness. The biggest hindrance to getting the most out of present day treatments is a misunderstanding about mood disorders and how they should be treated. Society’s view of both mental illness and the ‘mental hospital’ is changing, but clearly more needs to be done.

Role of the GP and health promotion
I would like to pay tribute to the work of GPs, most of whom are much better equipped to diagnose and treat depression nowadays. However, studies suggest that only two out of four people who are depressed seek assistance and that the diagnosis of depression is often obscured by medical problems and thus missed. Raising levels of awareness amongst GPs through continuing medical education, probably constitutes the best approach to this problem.

Healthy Ageing
The Health Promotion Unit of the Department has been involved for some time on a consultative committee of the National Council for the Elderly looking at ‘measures to promote the health and autonomy of the elderly in Ireland’. Arising out of the work of the consultative committee, the Council plans to develop a three stranded healthy ageing programme:

1. The development of a health promotion strategy for older people.
2. The development of an information and support network for promoting the health and well-being of older people in Ireland.
3. Establishing models of good practice for healthy ageing.

This healthy ageing programme will offer support to both planners and service providers by offering a sound basis for the development of a modern day service to meet the needs of the elderly population.

Co-ordination
There has been considerable progress made in relation to the co-ordination of services since 1984. The establishment of catchment area services in conjunction with community care areas has now been completed in most areas and the concept of sectorisation is widely accepted in the area psychiatric service. This process will continue as more capital and revenue resources become available. The old age psychiatric service in Dublin areas 6 and 7 is just one example of an impressively developed sector where day hospitals are provided specifically for the care of those aged over 65 years.
Co-ordination of services for the elderly
The Department has endeavoured to implement the recommendations contained in the Council’s 1992 report entitled, Co-ordinating Services for the Elderly at the Local Level, but not with the degree of success that we might have wished for. A clearer up-to-date picture on co-ordination may emerge in the Council’s up-coming review of The Years Ahead report.

General manager
It is also noteworthy that there is a proposal at an advanced stage to establish a post of General Manager of community services. The proposed post will be responsible for service provision in geographical areas equivalent to health board community care areas. While the proposed remit of the post will be extensive - management of all non-acute health and personal social services provided by the relevant health board within a community care area - it will ensure better co-ordination in service delivery, including psychiatric services for the elderly.

Dementia
There is now a greater awareness of the need to develop services for dementia sufferers and all health boards have been instructed to cover this aspect in their annual service plans. The Department recognises the need for better co-ordination of care across health board programmes and the use of shared facilities where appropriate, is vital. The Rathmore Social Action Group in Kerry, is an example I have recently seen, of voluntary and health board co-operation across programmes and the sharing of facilities. The effectiveness of day centres is noted and the Department is committed to helping agencies in the establishment of an adequate network of such centres. This year’s capital budget for the elderly provides for the building of a number of such centres and this policy will continue in the coming years.

Perhaps in this context, I might mention the forthcoming European Conference on, Alzheimer’s Disease - Related Disorders, Practical Management and Prevention to be held in Limerick. The purpose of the conference is to exchange information and to highlight areas of specific practical interest in relation to management and prevention of the disease. We recognise that dementia poses one of the biggest challenges to the provision of care for older people. In this context the need for better co-ordination of care across health board programmes and the use of shared facilities when appropriate, is vital.
Involuntary admissions
As you are aware, the Government has accepted the core principle of the new mental health legislation, that the criteria governing involuntary admissions of persons with a mental disorder to an in-patient facility needs to be updated to reflect modern thinking on the care of people with a mental disorder and to bring current legislation into conformity with the European Convention for the Protection of Human Rights and Fundamental Freedoms.

It is widely accepted that the current criteria for involuntary admission for in-patient psychiatric care are too wide in scope. It is no longer acceptable to detain people who are in need of care, but who would benefit from an alternative programme of care than that provided in an in-patient setting. In the case of the elderly with mental disorders, it is important that unnecessary or inappropriate admissions to psychiatric hospitals or units are avoided and their problems are treated with the minimum disruption to their lives.

Involuntary admission of persons who suffer from severe dementia will be restricted to the minority of persons whose condition is associated with severe psychiatric or behavioural symptoms. In common with all other age groups, the provision of psychiatric care and treatment to elderly people will be provided in the vast majority of instances outside the in-patient setting. The underlying principle of services for the elderly, including those who suffer from dementia, is to maintain them at home or in a home-like environment wherever possible. The majority of elderly people with dementia can be cared for at home with adequate GP, home help, day care and respite facilities. The introduction of consultant/psychiatrist-led multi-disciplinary teams specialising in the psychiatry of old age in Dublin, along with further developments under way outside the Dublin area, will assist in the reduction of inappropriate admissions.

What level of service should be provided?
The Years Ahead drew attention to the urgent need to provide services for elderly people with psychiatric problems and for their families. Since the majority of elderly patients with psychiatric problems live at home, dedicated old age psychiatry services, introduced initially in the Dublin area are being developed to provide assessment, treatment and support to the elderly at home rather than sole dependence on in-patient care. The ethos of the service is the provision of a comprehensive, community-based psychiatric service to elderly people.
A short-term objective would be the placement of dedicated consultant-led specialist teams in old age psychiatry, in each health board area, with an underlying principle of domiciliary assessment and close liaison with the patient’s family doctor. The service provision norms are set out in *The Years Ahead* for the development of such a service. The Department attaches particular importance to this development, and will be pursuing it as quickly as the resources available to us allow.

**Appropriate settings**
The majority of elderly people in psychiatric hospitals have been there for a long time. Recent data suggests that over 50 per cent of long-stay patients in psychiatric hospitals (hospitalised for a year or more), are aged 65 years or over. Many of these elderly patients have virtually no active psychiatric component to their illness, and could live, with appropriate rehabilitation, in more suitable accommodation in the community, such as supervised hostels and sheltered accommodation. Efforts will continue to transfer patients to such community settings as resources permit.

The ‘de-designation’ of wards of psychiatric hospitals so that technically, the elderly in such wards are no longer part of the psychiatric services, is underway. Before agreeing to ‘de-designate’ a ward, the Department has insisted on evidence that the change will lead to an improvement in the quality of life for the patients. There is a danger though, that as the focus of the psychiatric services moves from the hospital to the community, the elderly in long-stay care will be left behind in deteriorating accommodation and standards will fall. This must not be allowed to happen. I agree with the Council that many of our residential units and community residences need to be appropriately staffed and adapted to meet the specific needs of older people. These units are continually being developed over time as resources permit. Although more patients are discharged into community settings, it is important that the in-patient facilities maintain high standards of care and treatment.

I do agree that there is a need for national guidelines concerning the care of elderly persons in mental health facilities and I look forward to working with the Council and service providers in the drafting of these guidelines. The Inspectorate of Mental Hospitals is currently drafting new guidelines on ‘Good Practice for the Care of the Mentally Ill.’

**Suicide**
An issue of growing national concern is the increase in the incidence of suicide. The Minister for Health, Mr. Michael Noonan, T.D. established a National Task Force on Suicide in November 1995 to address this concern.
While the increase in the incidence of suicide among young people and in particular young men has been particularly publicised, the Task Force Interim Report also identified the elderly as a particular risk group. Specifically, young elderly men (i.e., those aged 65 to 74) have shown a significant increase in their rate of suicide over the past number of years. The factors that give rise to these suicides are not clearly understood. While it is too early to identify definitive cause and effect relationships, depression, loneliness, the loss of physical health and recent bereavement are being considered as possible contributing factors. These are issues which the Task Force will be returning to in its final report.

On behalf of the Task Force, I would like to thank the Council for its very comprehensive written submission and oral presentation. This has helped to identify issues specific to the elderly which will be fully considered by the Task Force in the formulation of the national suicide prevention/reduction strategy, which is expected to be completed by the end of the year.

Conclusion
In conclusion, I would like to stress that I did not set out this morning to give the definitive response from the Department to all of the conclusions and recommendations contained in this fine report. Rather, it is a preliminary and general reaction to the various issues raised therein. The report warrants much more detailed analysis and consideration on the part of policy makers, in particular. I can assure you that it will be an invaluable asset to policy formulation across a range of service issues. For this we are indeed grateful to the authors and to the National Council for the Elderly.
RESPONSE 2: A HEALTH BOARD PERSPECTIVE

Mr. Stiofán de Búrca

Assistant Chief Executive Officer, Mid-Western Health Board

The publication of the National Council for the Elderly’s report, *Mental Disorders in Older Irish People: Incidence Prevalence and Treatment* is a very welcome piece of research at this time. In the context of the national health strategy and the current processes which are being utilised by health boards and associated agencies in formulating corporate and specific care group strategies, this report is very significant. The study highlights the strengths and weaknesses of our current epidemiological data, which requires immediate attention. We need accurate data in order to support strategic choices and the resulting service planning implementation. Comprehensive and accurate information and data also facilitate effective evaluation of services.

**Strategy**

Strategy is better informed by a comprehensive stakeholder process which assesses multiple perspectives on the needs and service responses required for a target group. Benchmark systems and known best practices, both in organising arrangements and provider competencies and skills, provide general direction. The expectations of users, that is, those who hope to benefit, must also be considered. Evidence of clear insights on the nature of the present strategy is not always apparent. For example, we must ask ourselves, what is our business and what influences the way we deliver it?

It is essential to know where we are first, before we start taking steps in a new direction. Individual stakeholders usually have a singular view of where they are and what they want for their constituency of interests. A synthesis of knowledge dimensions, both subjective and objective, is required to support strategy formulation.

The national health strategy’s focus on the mentally ill and the elderly is informed by the established planning frameworks contained in, for example, *Planning for the Future* (1984) and *The Years Ahead* (1988). The Council’s report recognises the value of the strategies inherent in these approaches. However, it also recognises strategic gaps where changes need to be made. These gaps can only be adequately addressed by a specific strategy for older persons with mental disorders. This has to be comprehensive, integrated and supported by the principles and standards of quality, equity and accountability. These hallmarks of the national health
strategy underpin the strategic aims of health and social gain for older people with mental disorders. However, current health and social status data is incomplete.

Information
While good information is available regarding people who access specialist and various in-patient services, there are serious gaps in knowledge about morbidity among the Irish elderly in other settings. For instance, at community level, which includes those who avail of GP and primary care services, there is generally very little data collected on psychiatric morbidity. There are also gaps in service data on community specialist services for the elderly and mentally disordered. Projected population growth in older persons, particularly the very old, makes it imperative that comprehensive patient-centred and integrated information systems are developed and made available.

General incidence and prevalence rates have to become more disease specific in order to inform focused strategies in care provision. The Goldberg and Huxley model, ‘Pathways to Care’ (1988, 1992) referred to in the Council’s report, provides a general model of levels and filters in the care system. For health gain purposes it has to be explicated for gender and other variables and the SMI and dementia categories. We cannot measure health gain without routinely collected clinical data, supported and enhanced by good quality research and evaluation studies. Data collection should focus on different context groups and care arrangements. The expectations and satisfactions of users and providers of care also need to be known. There is a priority need to design and implement information systems which can help service providers, managers and policy makers to become more evidence-based in their decision making.

Strategy fit
Strategy fit is dependent on the match between informed local approaches and nationally adopted normative approaches in designing and implementing care for older persons with mental disorders. Issues of access, appropriateness and responsiveness have to be addressed by complementary strategies for quality and positive service impact for the individual and the care group.

Service model
The service model advocated by the report is a model for good practice, associated with the specialist old age psychiatry service, that is, specialist assessment, rehabilitation and treatment. Its emphasis on domiciliary assessment reflects the complexity of accurate diagnoses of mental
disorders in the elderly and the importance of context and carer inputs in the process. The rate of progress in providing this service is limited. At present three Dublin areas and Limerick are the only providers of this specialist service. The start-up costs relate to minimum medical and nursing resources for short-stay in-patient and domiciliary assessment supported by day and respite care. While the capital investment requirement is subject to the availability of adaptable existing accommodation and the re-assignment of designated in-patient beds in acute psychiatric units and elderly care hospitals, the additional revenue presents a limiting factor. Existing adult psychiatry and medicine for the elderly services require flexible adjustment to facilitate the establishment of the old age psychiatry services.

**Change in provision**

The provision of alternative care in mental health services has focused attention on continuing dementia care. The report raises concerns about the reduction in psychiatric hospital in-patient facilities and the policy differences which give rise to different levels of provision for older persons with mental disorders, for example, the health board elderly care hospitals and homes and private nursing homes. It is suggested that access criteria and general policy matters require national guidelines. The report generalises the issue of long-stay care, in relation to the low supply of residential beds, for example. Clearly this study is inhibited by the poor quality of information on medico/psycho/social status of residents in a variety of hospitals and homes. Availability is not linked to the other service components, for example, facilities and services within mainstream mental health and elderly care. Particular reference is made to the need to increase housing and hostel accommodation for the elderly mentally ill. This raises some fundamental questions. For example, is the housing function inappropriately assigned to health boards and supplemented by the efforts of voluntary agencies? Perhaps the social housing function needs to be redefined.

Care provision is complex. Access to treatment options is an important issue, but the options must be there in order to avail of them in the first instance. Early filtering into in-patient care may be determined by inadequate carer and primary care supports. Prioritising and rationally distributing resources across service elements has not been a strong feature of our service planning. Cost effectiveness is rarely demonstrated. There is a paucity of Irish literature to inform a resource distribution model.
Collaboration
A multi-agency collaborative approach is required to deal with social support systems and accommodation for the elderly, particularly those with mental disorders. Again, there is little evidence of concerted action on a formal basis which is strategic or purposeful. This is a necessary first step in determining integrated approaches with multi-agency commitment and funding. The growth of voluntary effort is a community response to meet perceived needs and service gaps.

Objective criteria and service principles informed by a care group strategy should pinpoint the role relevance of various agencies, both voluntary and statutory, in targeting priority issues.

Implementation
An implementation strategy must be concerned with the design of an appropriate organisation structure. Patient-centredness and local population focus concepts have implications for the type of structure. This is a developing form of organisational arrangement in community mental health care. Similar population sector focused arrangements are developing in elderly care services. The objective is to improve local cohesion and responsiveness between the primary care and specialist services in servicing local care needs. The Council's report refers to problems of service co-ordination which may be aggravated by the addition of old age psychiatry services. Inter- and intra-team functioning is dependent on an effective role dynamic in and between disciplines. Mental health and elderly care teams need to develop case management strategies, which would involve designated key workers working with both carers and patients. Until old age psychiatry services are developed to 'case manage', they have to be proxied by existing mainstream services. They must have clear policies for managing the care of older persons with mental disorders. This also applies to GPs and to public health nurses. Again the Council’s report emphasises the education and training needs of the latter in detecting and screening such persons and their role in the treatment process.

Conclusion
Returning to the ‘Pathways to Care’ model, the levels of access to the psychiatric services can be utilised in formulating a care group strategy. This should address elements and target groups within the various levels. The focus should be to improve health and social status through people, systems and interventions. Emphasis on prevention and community support should be reflected in financed, integrated service practices and organisational arrangements. Performance management as opposed to
control management must be adopted as the new style in action. Information, involvement and evaluation, combined with flexibility and imagination are necessary components of change in creating services with limited resources. The strengths and weaknesses are disclosed throughout this excellent report. This is the beginning.
RESPONSE 3: A PSYCHIATRY PERSPECTIVE

Professor Brian Lawlor

Consultant Psychiatrist in the Psychiatry of Old Age
St. James’s Hospital, Eastern Health Board

First and foremost, I would endorse what the Council has stated with regard to the establishment of an integrated national strategy for mental health and ageing services and resources. I agree that it is a matter of urgency, but this sense of urgency must not force us into impulsively planning services without accurate and reliable information on the pattern and prevalence of mental illness in our elderly population. If a rational mental health and ageing strategy is to be developed across care programmes, we need accurate mental health and mental illness figures.

Demographic context
The Council’s report highlights the shifting demographic trends and the fact that the number of older population has increased from 402,921 people in 1991 to 412,500 in 1995; that the elderly population is projected to grow by up to almost 120,000 in the period 1991 to 2011; that the greatest increase in older people will be in the very old (people over 80); and that people with mental handicap are also living longer and that many of these people are likely to survive with multiple disabilities, including dementia. The report also underscores the fact that the demographic characteristics of relatives and friends who are the main carers in our population are also changing and that the burden of care will change from relatives and friends to the State in the years ahead.

These population figures and projections fail to reflect the true nature and cost of this demographic shift because they do not include a measure of disability. People are living longer, but with increased life expectancy there is an emerging tension between living longer and quality of life. The years which many older individuals have gained in terms of increased life expectancy are being spent in disability. Older people are most likely to have depression and dementia, but these illnesses will frequently co-occur with decreased mobility, heart and cerebrovascular disease and cancer. Thus our mental health parameters, on which we are to base our future policies and services, will need to reflect not only rates of occurrence of mental disorders, but also the disability and impact of these illnesses on individuals’ lives.
With regard to older people with learning disabilities, of particular concern is the ageing population of Down’s Syndrome people who are at increased risk of dementia of the Alzheimer type. We have a high incidence and prevalence of Down’s Syndrome and the challenge posed by the care of people with learning disabilities who suffer from Alzheimer’s Disease will have major implications for future services for people with learning disabilities.

Incidence
The report highlights the fact that we have no real incidence data on mental illnesses in the elderly. Proxy data on incidence is available through the National Psychiatric In-Patient Reporting System (NPIRS) and the case register system. The report suggests that the solution to the lack of incidence data lies in the development of information systems to routinely collate the activities of all health and social care services in a particular district. They suggest a more comprehensive development of the NPIRS.

Incidence figures are important if we are to have a firm basis for planning annual requirements of specialist and non-specialist services. From a methodological point of view, incidence studies in elderly people need to:

1. Investigate representative community samples.
2. Include institutionalised and non-institutionalised elderly.
3. Use standardised, structured methods of assessment specifically designed for the elderly.
4. Use standardised diagnostic criteria and ‘case level’ of illness.

Most mental disorders exist undetected, undiagnosed or untreated in the community. Less than 10 per cent of mental illness is referred to specialists and only 1-2 per cent are admitted to hospital. If we were to adopt, and even comprehensively modify either the case register or the NPIRS system, we could never arrive at an accurate and meaningful incidence figure and any services or policy development that was derived from such figures would be fatally flawed. If we are to seriously tackle this issue, we need to use methodologies that will allow us to calculate true incidence, which includes not only those requiring specialist and non-specialist services, but also those elderly people who are undiagnosed and undetected in the community.

Prevalence
The report finds that data on the prevalence of mental disorders in the elderly in Ireland, though better than incidence data, is also far from ideal. The report suggests that a patient-centred integrated information system
should be put in place to improve the quality of the prevalence data. The report also states that there is no evidence that older Irish people have a higher or lower prevalence of mental disorders compared to international figures, and that in the absence of better information, future service provision should be based on these estimates.

The prevalence picture is far from ideal. None of the prevalence data reflect rates in community (non-institutionalised) and institutionalised elderly. Furthermore, we have no prevalence studies in institutionalised elderly that represent case level of illnesses, as opposed to measuring symptom levels with screening instruments. Our own study from St. James’s Hospital, on prevalence rates in the community dwelling elderly, was methodologically flawed in that it did not use a randomised sample and excluded institutionalised elderly.

With regard to the statement that there is little evidence for difference in prevalence figures in different regions or countries, the emerging information from studies such as EURODEP, indicates that there is widespread variation in prevalence figures for depression throughout a number of different European sites, including Ireland. Prevalence figures for depression can be remarkably unreliable in that they can be distorted by mortality, migration and recovery from illness. Thus, to base future service provision and development on the current estimates could be problematic.

According to EURODEP prevalence figures, hot spots for mental illnesses such as depression tend to go hand in hand with urban decay and social deprivation and the prevalence of, for example, depression in older people is likely to be much higher in the inner city of Dublin than it would be in rural Kildare. We have found some variation in prevalence figures for depression between GP practices, with higher rates of depression in more socially deprived areas. Because we do not have regional community-based prevalence data, we cannot say whether service demands will be higher or lower in particular regions, health board areas, or even catchment areas.

One of the difficulties with the classical measurements of disease (mortality, incidence, prevalence) is that they give no indication of disability, quality of life, service utilisation and costs. While we need to improve our data collection methodology, we also need to look at how we can develop health parameters that more accurately measure population, mental health and illness, and the impact and cost of mental illness and its associated disabilities in our elderly population.
Traditional health parameters such as incidence and prevalence are unable to capture the increased morbidity and disability associated with living longer. Health expectancy, a measure of health at a population level, simultaneously combines three levels of health indices: disease, disability and quality of life; and mortality. To date, the only health expectancy measurement applied to the mental health field has been the dementia free life expectancy (DemFLE). In the Netherlands, the DemFLE at 65 is 14 years for males and 17.7 years for females: 96 per cent of life expectancy at 65 for males is dementia free, whereas only 93.2 per cent of female life expectancy at 65 is dementia free. Thus, while women live longer, part of that longevity is taken up in disability. Other health expectancy measures that are more meaningful to policy makers and can be calculated from accurate data include years with dementia in nursing homes versus at home. For example, in the Netherlands, 75-80 per cent of dementia years are spent at home and 20-25 per cent are spent in a nursing home. These health parameters provide a clearer picture of the impact and cost of illnesses such as dementia. It is likely that health expectancy measures will become very important in the planning and costing of services for the elderly with mental disorders and we need to consider how we can collect data to derive these figures in the future.

Thus, rather than expand the NPIRS and the case register systems, I would suggest that a comprehensive system to measure prevalence, incidence, and mental health expectancy be developed within each health board area across the different care programmes that deal with older people. This could be managed, as are the NPIRS and case register systems, through the epidemiological unit at the Health Research Board. Refinement and development of such resources would allow the calculation of disease and mental health expectancy estimates. This would help immeasurably in the development and costing of services.

Public and professional attitudes
The report recommends that comprehensive public education programmes on the nature of mental health and ageing be undertaken by the Department of Health in conjunction with the Mental Health Association of Ireland and AWARE. I would wholeheartedly agree with such an approach. We need to dispel the myth that ageing per se is a disease and educate professionals and lay people alike that mental disorders in older people are treatable and/or reversible.
Training
This is an extremely important area, which is appropriately emphasised in the report. Most mental illnesses exist under-detected, under-diagnosed or under-treated in the community. Professionals need to be trained to detect and diagnose and treat or refer. Areas that need to be addressed in training include the different presentation of mental illness in older people, the importance of ignoring the ‘understandability’ factor, and the dispelling of ageist myths. Perhaps most importantly, we need to have a rethink on where and how we train medical students and nursing students on mental disorders in older people. Such training must occur very early in the professional’s education. Teaching mental health to medical or nursing students from a hospital base gives the wrong impression of mental illness in older people. The patients seen in hospitals are a very select group of people with mental illness and represent the very severely affected who require hospitalisation.

However, hand in hand with training is the provision of resources and services for people who are diagnosed with mental illness. Often times, patients can be detected and diagnosed but are not referred or treated because of a lack of community-based resources. Why make an early diagnosis of Alzheimer’s Disease if there are no specialist memory clinics, resource centres, day centres, respite or basic education for carers? These resources must be put in place to facilitate referral for older people with mental disorders and their carers.

Old age psychiatry services
The report outlines the development of old age psychiatry services in Ireland and bemoans the slow progress in the appointment of consultant psychiatrists with only four to date, in this area. It is estimated that at least 30 more appointments need to be made before the speciality is adequately covered in this country. The old age psychiatrist plays a role not only in the provision of services, but also in education and the promotion of mental health for older people. However, it is important to remember that if 30 old age psychiatrists were to be appointed tomorrow, this would not remedy the problems facing us. Only 10 per cent of people with mental illness are in contact with services. While the proportion of people in contact with the services might increase if better services were available, the majority of people with mental illness are undetected and undiagnosed in the community. Old age psychiatrists need to be appointed as part of a national strategy which includes an integrated programme devolved across the different care programmes dealing with elderly people. However, comprehensive treatment of mental disorders in older people must involve
a concerted action by local government, social services, health services, the voluntary sector, local residents and specialist services.

**Long-stay care**
The report notes the lack of information regarding mental illness in older people in long-stay care and points to the fact that older long-stay residents of psychiatric facilities are often moving from one form of institution to another. Psychiatric morbidity in people residing in nursing homes is high, though once again we have no incidence or prevalence data on this significant section of our older population. This data would be very important in the planning of resources and services, and must be collected as part of an ongoing system.

**Conclusion**
The report calls for the urgent development and implementation of a national strategy for services for people with mental illness and their carers. In order to develop and effect such a plan, we must first acknowledge the dearth of epidemiological data available on which to base such a strategy. A key first step must therefore be to remedy this deficiency by establishing a central unit that has responsibility for epidemiological studies of mental disorders in older people. Because of the likely regional variation in prevalence and to a lesser extent incidence figures, each health board area must be involved in the ongoing collection of data which can be co-ordinated through a central unit. The structure of such a unit can be along the lines of the NPIRS model and could in fact be an extension of the Health Research Board Epidemiology Unit. However, the studies that are needed must sample from community and institutionalised populations and cannot be based only on psychiatric in-patient reporting and case register systems. Health expectancy calculations can then be derived from these data and, when available, this information will provide the cornerstone for a national strategy for future service and policy developments for older people with mental illness in Ireland.
KEYNOTE ADDRESS

Chair: Dr. Liam Hanniffy

Assistant Inspector of Mental Hospitals, Department of Health
I am very grateful to the National Council for the Elderly for dragging me out of retirement to give you this talk today. I very much enjoyed reading the report, which has been praised so often today. It is very comprehensive and will be very useful.

I am going to be a little bit saucy and say that like sexual intercourse, which according to Philip Larkin began in the mid-1960s, so did old age psychiatry, and that was with my appointment as the first psychogeriatrician at Claybury Hospital in 1966. It is remarkable that there are now well over 400 psychogeriatricians in the UK, and potential posts for up to another 300. In Ireland, there are at present four. You are a smaller country, but not that much smaller. I think you could reasonably aim to have about 40 psychogeriatricians in Ireland, so you have some way to go.

Why did the United Kingdom lead the way in the development of psychogeriatric services?
There are a number of reasons as follows:

The population of those over 65 was higher in Britain than anywhere else in the world. In 1966, 14 per cent of the population were over the age of 65 and that was due to good public health, birth control and to a lesser extent the triumph of geriatric medicine keeping people alive in their 60s, 70s and 80s.

Another reason for the rapid development of old age psychiatry in the UK was the existence of the National Health Service (NHS). The NHS aimed to provide an equitable health service for all, in which all consultants were equal and got equal salaries. Therefore, they were not financially disadvantaged working as psychiatrists or as old age psychiatrists.

We also had an excellent lead given by geriatric medicine, which really began in the UK as well, some 10 years previously, with the pioneering work of Margery Warren and Ferguson Anderson.
We also had mentors, men of considerable eminence, who were very influential in the training of psychiatry; Felix Post at the Mortuary Hospital and Sir Martin Roth in Newcastle. They helped many psychiatrists in training to understand that the psychiatry of old age could be absolutely fascinating. There were also some very energetic pioneers at Severalls Hospital, in particular Russell Barton who, along with Tony Whitehead, put old age psychiatry on the map.

As we began to be recruited in more and more numbers, we formed a section for the psychiatry of old age within the Royal College of Psychiatrists, which became a very important body both professionally to exchange ideas and experiences, and to lobby for what we needed.

Another helpful factor in the development of old age psychiatry in the UK was the eventual recognition of senile dementia as a disorder, by the Medical Research Council (MRC) in the late 60s. Very soon after this, came what I term, the ‘Alzheimerisation’ of senile dementia. There was an impression that senile dementia was an inevitable part of ageing. When it became ‘Alzheimerised’, however, it became recognised as a disorder, which one in 20 elderly people suffered from. This was particularly recognised by people like Jim Corsellis in the MRC unit and in Newcastle, where studies concluded that there was actually a quantitative relationship between the brain changes and the clinical changes. Other exciting discoveries took place in Newcastle by the Perrys and by Gary Blessed and Bernard Tomlinson, under the general direction of Sir Martin Roth.

In those days the Department of Health actually provided guidelines for what an old age psychiatry service should have. For example, they suggested a quota of three beds per 1,000 population for the care of demented persons over the age of 65 in psychiatric wards. I noticed your report today had the same figure.

There was also a body, called the Health Advisory Service, which arose out of various scandals about the ill-treatment of people with mental handicap, and of old people in mental hospitals and geriatric hospitals. It was basically an inspectorate, which regularly visited psychiatric and geriatric services nationwide, offering critiques and promoting good practice.

The development of the Alzheimer’s Disease Society made a huge contribution to public awareness of the disease along with organisations like Age Concern. At last psychogeriatrics was recognised as a speciality.
Principles of a psychogeriatric service
The early psychogeriatricians working near to London, Tom Arie, Raymond Levy and myself, met informally for ‘coffee-house’ discussions and worked out some principles for running a service. These included:

- The provision of an age-related service, targeting those over 65 specifically.

- The establishment of catchment areas, in line with general psychiatry and geriatric medicine. This meant service providers would get to know the area and it would be clear who was responsible for whom. This in turn would encourage the development of relations between GPs, geriatricians and social workers and provide a more co-ordinated service.

- The development of a comprehensive service, which would deal with the full range of psychiatric disorders in older people, and not just dementia.

- The establishment of an accessible, responsive service, that would respond efficiently to the referring person. It was felt that the referring person should be assured that the problem, its nature and urgency be communicated and that action would be taken immediately, if necessary.

- The need for assessment before accepting an admission was another principle identified, without which an irreversible process is often started, which is quite damaging to the person. Often information on a person is sketchy and it is necessary to fill in the gaps in a patient history, by going to the person’s home for domiciliary assessment. Not only does this establish clearly whether admission is required at all, but it also enables the service to prioritise its referrals.

- Treating the person at home as far as possible, was suggested to maintain the identity of the person. Treatment at home suits most old people best. This also often translates into admissions, of a short duration at an early stage, rather than longer admissions at a later stage.

- Another principle was not to over-treat a person, in particular for disorders such as dementia, which require management rather than medication.

- The alternative principle not to under-treat was also advocated. This often happens in the case of depression, which often responds to anti-
depressants. ECT improves memory in the depressed and saves lives. Psychological treatments are also often appropriate.

- Seek the least disruptive solution to the elderly person’s life.

- Remember the carer, whose wishes may not be the wishes of the patient.

- Work in a multi-disciplinary team, which would include a psychiatrist, community nurses, occupational therapists, a social worker and perhaps a psychologist. Each of these professionals have differentiated roles, but they also need to have a readiness to blur the boundaries of those roles. To share and to specialise is the key to a good multi-disciplinary team.

- Develop co-operation and co-ordination between the services. Liaise with the primary health care team, the social services, the psychiatric services and any other services.

The relationship between old age psychiatrists and geriatricians was regarded as critical, since both specialties have much in common. It was felt they needed to support and complement each other, rather than work in isolation. In the UK, old age psychiatry formed a group, then a section and finally a sub-speciality within the Royal College of Psychiatrists. One of the first tasks was to establish a liaison group with the British Geriatrics Society. This led to two working groups between the Royal College of Psychiatrists, the later of which, in 1989, confirmed guidelines for the provision of staff, day places and beds which many old age psychiatrists still wish to use. Joint psychogeriatric assessment units enabled old age psychiatrists and geriatricians to work closely and collaboratively in general hospital wards. The establishment of an academic Department of Health Care of the Elderly in Nottingham marked the high tide of joint working.

Day hospitals were developed widely and perhaps prevented admissions or shortened stays in hospital. Chris Gilleard showed that they significantly reduced the strain on carers of demented people, and Pearl Hettiaratchy developed the ‘travelling day hospital’, suitable for less densely populated areas. Respite admissions are an excellent use of beds for demented patients.

Improved diagnostic rating scales suitable for older people began to develop at an accelerated level. The ‘mini-mental state’ took over from the
‘abbreviated mental test score’ as a favoured screening and monitoring instrument for delirium and dementia. Pattie and Gilleard, developed the CAPE, a cognitive test and a rating scale. Yesavage and Brink developed the Geriatric Depression Scale (GDS-15), while Montgomery and Asberg devised a rating scale for depression more suitable than the Hamilton scale for older people. John Copeland devised a standardised questionnaire for research purposes, the Geriatric Mental State (GMS) and Sir Martin Roth helped create the CAMDEX and CAMCOG.

There is now a host of questionnaires and rating scales for old age psychiatry, improving diagnostic accuracy and communication between clinicians and most importantly, providing a wealth of epidemiological data. Those from the classic Newcastle study, carried out by Roth and his colleagues in 1964, are still considered reliable.

Una Holden and Bob Woods pioneered ‘Reality Orientation Therapy’ in the UK and showed that demented old people can be re-taught some forgotten old tricks. Reminiscence and Validation Therapy are now perhaps more favoured, and will be licensed in the UK by the end of the year.

Academic departments in most medical schools ensured that most medical students should learn at least a smattering of old age psychiatry and promoted research. There are now exciting developments going on in chromosome research in terms of treating Alzheimer’s Disease. Memory clinics have developed in the last 15 years, which play a key role in the early detection of dementia. They are a luxury though, without the other basic services.

Change and decay
However, some people today feel that old age psychiatry has taken a turn for the worst with recent service developments and policy changes:

- Social work was divorced from health by Seebohm, and has thus rarely made a full contribution to the care of the elderly mentally ill. Many social workers have been transformed into care managers under the Community Care Act, and sadly spend much of their time on administration and form filling, to the neglect of their social work skills.

- The Thatcherian reform of the NHS has rendered many old age psychiatrists less in charge of their resources, particularly their access to general hospital beds.
The Government guidelines have been abandoned.

The Health Advisory Centre is also much diminished now.

The privatisation of continuing care, though it led at first to some interesting innovative designs, has led to many trusts failing to provide it under the NHS altogether. The expertise of specialists is no longer guaranteed to long-stay patients.

Purchasers do not understand that the needs of demented and of functionally mentally ill old people are fundamentally different.

Fundholding GPs may give a low priority to purchasing old age psychiatry.

Geriatricians seem more interested in their roots in general medicine than in psychiatry.

There are many balancing conflicts between clinical requirements and resource constraints.

The pressure to prove efficacy is especially challenging to old age psychiatry, where appropriate outcomes are hard to devise.

The availability of old age psychiatry has become far too patchy and newly fledged consultants tend to go where the services are best provided. Elsewhere, there may be early retirement, burn out and premature death and excessive reliance on non-doctors to make diagnoses. Community Psychiatric Nurses end up diagnosing patients, which in effect undermines the importance of the patient.

Old age psychiatry in Ireland - the way ahead

A substantial elderly population warrants a specialist psychogeriatric service, which must be adequately resourced. There are plenty of well trained old age psychiatrists who want to return to their Irish roots. This is a precious asset which should not be wasted by stretching them too far. Geriatricians should be encouraged to make them welcome. Finally, I would suggest not putting too much trust in community care. It may be even less available in Ireland than in the UK, since it is so costly.
PARALLEL SESSIONS
Epidemiological studies of mental disorders in older people must use appropriate samples and appropriate instruments. Most older people with mental disorders do not present to specialist services or to primary care. Consequently studies of incidence or prevalence in these settings have a major bias. To obtain accurate data, a community-based sample is essential, along with the use of standardised instruments. There are three clinical areas which must be standardised: the collection and recording of symptoms, the differential diagnosis and the case level or severity of illness.

Depression has consistently been shown to be the most common mental disorder in older people. There is broad agreement that it is under-diagnosed and under-treated. However, the barriers to the detection and treatment of depression in older people are complex and include factors relating to (1) the individual’s perception of depression, (2) the presentation of depression in older people and (3) the perception of late life depression among health professionals.

1. The individual may not recognise their symptoms as a depressive illness, possibly attributing them to a physical disorder or normal ageing. Even if recognised, the person may not seek help in the belief that nothing can be done.

2. The older person who does present for help may not have their depression diagnosed due to the frequent atypical presentation of depression in later life. The prominent symptoms may be somatic, such as lack of energy or pain. This can often result in the psychological distress being obscured and the diagnosis of depression being missed. Alternatively, the depression may present with prominent anxiety symptoms which can lead to a diagnosis of anxiety disorder rather than the underlying depressive illness.
3. If all these potential barriers are avoided or surmounted, the perception of late life depression by the professional may come into play. An interesting contribution to the debate on the extent of untreated depression in the community has been the suggestion that a major contributory factor is a reluctance to treat depression, once diagnosed, as opposed to a failure to diagnose the condition in the first place. Health professionals may perceive depression in later life to be ‘understandable’ in the light of the many life events or losses that occur with ageing and consequently not warranting treatment. Furthermore, there may be a perception that depressive episodes in older people are frequently brief with minimal effect on quality of life.

Similar barriers may hinder the diagnosis of dementia:

1. In particular, the pattern of symptom presentation plays an important role in dictating whether an individual presents to services. The presence of behavioural or psychiatric complications of dementia, rather than the severity of cognitive impairment, may be the crucial factor. Informal social support will also play an important role.

2. The perception of dementia among health professionals will greatly influence the rate of detection. A frequent assumption may be that nothing can be done and therefore there is little point in diagnosing dementia. This ignores the beneficial effect of controlling risk factors, such as hypertension, in vascular dementia, the treatment of behavioural or psychiatric complications, the benefit of education for the family and the importance of early diagnosis for personal and legal reasons such as competence to make a will.

Discussion
Possible approaches aimed at increasing the detection of mental disorders in older people, including improving the awareness of both health professionals and the public were opened up for discussion. There was agreement that there are three main barriers to the detection of mental illness in later life. In essence, these were described as ageism on the individual’s part, ageism on society’s part and ageism on the part of professionals.

The main issues to emerge were:

1. Increase public awareness of ageing in general, and in particular among older individuals and/or their carers, so that they can seek help.
2. Increase health care staff awareness of the variety of atypical presentations of mental disorders in the elderly, in order to dispel management negativity. A change in the perception of dementia among health professionals would greatly influence the rate of detection, it was agreed. Family doctors, in particular were identified as playing a key role in the detection of mental illness among the elderly and need to be especially targeted.

3. Intervention research and intervention awareness should be increased.

4. A holistic approach in the treatment of the elderly mentally ill should be emphasised.

5. It was also noted that the report does not cover the detection of mental disorders in the acute general hospital setting. This was highlighted as another priority area that should be added on to the report, because of the high burden of depression, delirium and dementia among older people in such settings.
RESIDENTIAL CARE FOR OLDER PEOPLE WITH MENTAL DISORDERS: WHAT ARE THE APPROPRIATE SETTINGS?

Chair: Professor Joyce O’Connor
President, National College of Industrial Relations

Speaker: Mr. Michael Walsh
Programme Manager, Special Hospital Care, Eastern Health Board

When discussing appropriate residential care settings for older people with mental disorders, a number of factors must first be taken into account:

• The various categories of patients presenting for residential care and the level of support required, medical or otherwise.
• The range of residential facilities available at present and the manner in which these facilities are utilised.
• The range of alternative responses and support structures available, or those requiring development.
• The gaps which may exist in service provision.

The assessment of individual need is particularly important in this context as the nature of the illness itself and whether there are co-existing problems, medical or social, will be an important determinant in the overall placement of the person in an appropriate setting.

It is useful to look back to 1984 when Planning for the Future was published to trace how services for the elderly mentally ill have developed. Planning for the Future categorised the elderly mentally ill into three groups.

1. Old long-stay psychiatric patients
2. Elderly persons with a functional mental illness
3. Elderly patients with dementia

The first group, old long-stay psychiatric patients, are now mainly being supported by the psychiatric services. Whilst the majority of such patients were, at the time Planning for the Future was published, being cared for in psychiatric hospitals, they are currently residing in a range of facilities including long-stay wards in psychiatric hospitals, community residential accommodation, de-designated psychiatric facilities or private nursing
homes. This follows from policy recommendations in *Planning for the Future*, that old long-stay psychiatric patients should remain the responsibility of the psychiatric service and that programmes of activation and rehabilitation should be developed which would enable those for whom it would be appropriate to take up residence in the community.

The second group, elderly persons with a functional mental illness are mainly supported by the acute psychiatric service, their needs generally being psychiatric assessment, diagnosis and treatment as out-patients or in-patients. The in-patient requirement for this group is generally of a short-stay nature, although some may require longer-term continuing care.

The third group, elderly patients with dementia, were subdivided into: people with dementia with significant physical illness; and people with dementia with no significant physical illness.

*Planning for the Future* made a number of key recommendations with regard to services for the elderly mentally infirm, which included:

- that the medical needs of the majority of elderly persons with dementia should be met by the primary care services or by geriatric medical services, with psychiatric support for patients who develop serious behavioural difficulties.

- that the practice of routinely admitting elderly patients with dementia to psychiatric hospitals should discontinue.

- that a planning norm for continuing care beds for new long-stay patients aged over 65 requiring such care should be set at 2.5 beds per 1,000 population aged 65 and over, which would approximate to 0.3 beds per 1,000 total population. Two thirds of these beds were to be in high-support hostels and one third in separate small nursing units, suitable for elderly demented persons with severe behavioural disturbance, but separate from those used for persons without disturbance. Both types of accommodation were to be located close together in a geriatric setting.

A review of services for the elderly was carried out by a Department of Health Working Party and in 1988, *The Years Ahead - A Policy for the Elderly* was published. The recommendations in *The Years Ahead*, with regard to elderly persons with mental illness, reflect many of the principles set out in *Planning for the Future* and include:
that functional mental illness in older people should be managed in the same way as younger people, with the majority being treated by their GP with referral to a psychiatric team when necessary. In the context of provision of accommodation for this group it supported the recommendation in Planning for the Future that dedicated high support hostels be provided.

that the majority of patients with dementia should be manageable for most of the time in a community setting with support from statutory and voluntary services, with referral to a psychiatrist for specialist advice and institutional care during crises or in the final stages of the condition.

in the context of provision of accommodation for elderly people with dementia, it recommended the provision of welfare-type places for those who can no longer be supported at home, with a norm of six beds per 1,000 elderly for this type of accommodation. Residential facilities should be provided in a community setting and not in the grounds of a psychiatric, geriatric or general hospital. For those with severe forms of dementia, the provision of high support hostels was recommended with a norm of three beds per 1,000 elderly population. It recommended that disturbed and demented elderly persons should be cared for in small nursing units separate from the accommodation used for less severely demented persons. Both types of accommodation should be located close together in a geriatric setting.

**Eastern Health Board Services**

In the Eastern Health Board region, elderly services have been and continue to be developed in line with the recommendations contained in The Years Ahead. Whilst our board’s services are provided within each of the three programmes: general hospitals, community care and special hospitals, there is a unified cross-programme approach to the delivery of services with a full-time co-ordinator who has board-wide responsibility and who works with a nominated representative from each of the three programmes. The psychiatric needs of the elderly are catered for within special hospital care by both the general psychiatric services and three specialist old age psychiatric services, which have been established in North Dublin, Dublin South Central and Dublin South East.

Appropriate referrals to the specialist old age services fall into two broad groups:
1. Elderly people developing functional psychiatric disorders such as depression/schizophrenia for the first time over the age of 65.
2. Dementia sufferers with behavioural or psychological problems, for which psychiatric intervention is indicated.

The specialist services provide early intervention, assessment, treatment and support of elderly people at home rather than custodial care. They operate on a multi-disciplinary model led by a consultant psychiatrist. Management of the patient is community-based, where possible and community psychiatric nurses play a key role in supporting patients and carers. The services are supported by a full range of facilities, such as day hospitals, assessment beds, respite and continuing care beds.

Our general psychiatry services provide for the needs of those persons who have already been receiving psychiatric care prior to reaching age 65 and for those aged 65 and over in areas where specialist old age services have yet to be developed.

In relation to long-stay residential care options for the elderly mentally ill, the following options are available in the Eastern Health Board region:

- Long-stay units (psychiatric hospitals)
- Purpose-built community units
- Community homes (psychiatric hostels)
- Geriatric hospitals/homes
- Welfare homes
- Community units for the elderly
- Nursing homes

**Discussion**

The main issues to emerge were:

1. Overall the appropriate settings for elderly people with mental illness were considered to be in the community. The community needs resources and many people felt that too much money was being spent on residential care at the expense of the community. With new approaches and structures, the community is being overlooked, which is after all where most services are delivered. If community services are not adequately resourced there will be a knock-on effect for other services. Therefore, day care centres, day hospitals, assessment centres, respite care and long-term care were considered appropriate settings which must be seen within the context of the community.
2. There was general consensus on the need to maintain the focus on the individual when planning services and in particular when planning residential care. However, the fact that adequate funding and resources are needed was also emphasised.

3. Changes in the psychiatric services, in terms of approach and management structure, raise questions about the distribution of services, and the co-ordination of services. There was consensus on the urgent need for greater co-ordination of services.

4. There is a need for a better public-private mix of care for the elderly mentally ill.

5. There is a need for staff to be properly trained to deal with the elderly mentally ill.

6. The fundamental role of the voluntary sector and in particular the role of the carer were discussed. The level of support they each receive was seriously questioned by the audience.
Historically people with dementia had little support available to them or their carers until institutional care was necessary. Institutional care was then provided in the local psychiatric hospital, since few other facilities existed. This led to the situation whereby all psychiatric hospitals in Ireland had large numbers of people suffering from dementia in long-stay wards. These people, for the most part, required basic or general nursing care rather than psychiatric care or treatment.

The existence of large institutions, such as St. Brendan’s in Dublin which inappropriately cared for large numbers of elderly people, is one of the reasons why the development of old age psychiatry services in Ireland has lagged some 20 years behind the UK. However these large institutions have now ceased to accept such people, which has major consequences for the elderly in need of care. In 1985, *Comhairle na n-Ospideal* looked at medical aspects of long-term institutional care and recommended the creation of three posts of consultant psychiatrist with special interest in the care of the elderly.

**What does a psychiatry of old age service do?**

The psychiatry of old age service broadly deals with two groups of people: (1) elderly people developing functional psychiatric disorders for the first time over the age of 65 years and (2) dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required.

Most elderly people live in their own homes and so services tend to be community-oriented, offering domiciliary assessment and treatment where possible. Domiciliary assessment has been described as the lynch pin of psychiatry of old age services. By going to the patient, it provides assessment for the many elderly people who are either reluctant or unable to present to psychiatric services. In the case of people with dementia,
domiciliary assessment is more effective since patients are best assessed in their own familiar surroundings.

**Personnel and structural requirements**
All psychiatry of old age services should be led by a consultant with appropriate training. The consultant should be hospital based, but community orientated, and service delivery should be based on well trained multi-disciplinary teams with appropriate resources. The role of community psychiatric nurses or psychiatric nurses working in the community is vital in psychiatry of old age services. Other essential disciplines include occupational therapy, psychology, social work and physiotherapy.

The role of the day hospital in psychiatry of old age services has always been seen as a very important one. Its functions include assessment and treatment of people with dementia and functional psychiatric illness. It provides an alternative to admission in many cases and it also facilitates discharges. It plays a role in the long-term support of patients and their carers. The day hospital should be located in or near a general hospital so that physical screening, which is essential to the elderly mentally ill, can be carried out efficiently. In sparsely populated rural areas, a more practical method of providing day hospital services is a mobile or travelling day hospital whereby particular days are spent in different locations. Outpatient clinics are particularly suitable for follow-up of elderly patients with functional psychiatric disorders such as depression, who do not require day hospital treatment.

It is crucial that there is easy access to different levels of long-stay care for patients seen by the psychiatry of old age service. The range of care required by dementia sufferers include welfare, general nursing and psychiatric care. Psychiatric long-stay care is required for people with dementia who have severe behavioural problems such as aggression. However, once the behaviour problem has settled it should be possible to move the person to another setting. Some elderly people with treatment resistant depression also require long-stay beds. Ideally long-stay care should be provided within the person’s community in order to allow him/her to remain in contact with his/her family.

A consultation liaison service is an integral part of any psychiatry of old age service. It permits specialist psychiatry liaison with geriatricians and other consultants in the general hospital. It promotes the development also of a seamless service whereby patients are followed into and out of hospital. A consultation liaison service is dependent on communication and
co-operation between the various professionals involved in the care of older people with mental illness.

Relationships
It is important that psychiatry of old age services develop in conjunction with services for medicine for the elderly. This is particularly important because of the co-morbidity of medical and psychiatric problems in old age. However, it is equally important that psychiatry of old age retains its relationship with general psychiatry so that skills in treating psychiatric disorders and behaviour problems are retained and updated constantly. These relationships with geriatric medicine and psychiatry can best be maintained by siting the psychiatry of old age service in general hospitals, where the other two services are based. Close liaison with GPs is also crucial so that patients are appropriately diagnosed and treated.

A close working relationship also needs to be established with community care to ensure that elderly people living in the community are provided with all possible aids and support services available. Privately run nursing homes have become an important component of care and improvements in the amount of subvention granted have made access possible for a greater number of people.

The Society for Old Age Psychiatry in Ireland plays an important role in influencing the development of the speciality in Ireland. For example, one of its important tasks will be to examine and comment upon those aspects of the new mental health legislation when published which affect older people with mental health problems.

Research and education
Finally, an old age psychiatry service plays an important role in public education at local level, in GP training and in training in medicine for the elderly. Where possible, old age psychiatry services should be affiliated with an academic department and should carry out research and epidemiological studies.

In conclusion, there is evidence that properly organised specialist old age services can succeed in making contact with greater numbers of the potential patient group, meet them at an earlier stage of the illness and enable them to be managed at home for most of the course of their illness.
Discussion
The main issues to emerge were:

1. The need for more old age psychiatry posts to be created in Ireland was highlighted. The complex needs of older Irish people cannot be met by any one professional group; hence the necessity of a multi-professional team. It is also very important that academic posts in old age psychiatry be recognised and that universities give serious consideration to providing more professors in old age psychiatry posts.

2. A range of services are needed to provide a comprehensive old age psychiatry service. It was considered important that in the rush to community care, the necessity of adequately resourced acute in-patient beds is not forgotten. The provision of proper long-stay facilities for people with severe behavioural problems was also recommended.

3. There is a greater need for liaison across different agencies providing health care for the elderly. Different professional groups need to see the common objective which unites them, to provide quality services for the elderly. One way to encourage liaison between different agencies and professionals is to base old age psychiatric services on needs, rather than on very restrictive guidelines.

4. Finally, psychotherapy services for older people were considered very important. These are currently under-provided, perhaps due to Freud’s idea that psychotherapy was not appropriate for older people. There has been very little research carried out in this field and it is an area that demands further investigation.
Extending and Improving Services for People with Dementia and Their Carers

Chair: Dr. Finbarr Corkery
General Practitioner, Cork

Speaker: Dr. Murna Downs
Dementia Services Development Centre, University of Sterling

The purpose of this paper is to describe developments in services for people with dementia and their families in the context of the social model of disability. The first part of the paper distinguishes between the impairment and disability associated with dementia. The second part of the paper discusses current developments in dementia care. The paper concludes with a list of mechanisms which may assist in extending and improving services for people with dementia and their carers.

Dementia

Dementia is a syndrome or collection of illnesses characterised by a loss of cognitive abilities. The most prominent early impairment is amnesia or forgetting, particularly of recent events. People with dementia also have difficulty learning new material and with abstract thinking, planning, judgement and language (e.g., aphasia). They can also display challenging behaviour including wandering and restlessness, mood disturbances (depression and anxiety), psychotic symptoms and personality changes (Absher and Cummings 1994). These impairments can cause significant disruption to everyday living skills (e.g., shopping, handling finances), work and social roles. Despite the decline in intellectual functioning associated with dementia, certain abilities remain, including the capacity to respond to social interactions and to experience sensation (e.g., touch and music). Services to date have not paid sufficient attention to these remaining abilities.

In general, most people with dementia are supported by their families. Family carers are generally women, either a daughter or spouse, although there are a significant number of male spouse carers. The families’ experience of caring for their elderly relative with dementia has been the subject of the majority of research on dementia care. There is ample documentation indicating that caring may be associated with mental health problems, such as depression and anxiety (Gilleard 1984; Levin et al. 1983; Schulz et al. 1995). A causal link between caring and physical ill health in
the carer is less clear. Some of the negative psychological effects of caring can be prevented (e.g., feelings of emotional exhaustion from caring around the clock) or treated (e.g., depression associated with witnessing declining independence in a family member).

**Impairment and disability**
The level of disability associated with dementia depends not only on the degree of brain cell loss but also on the surrounding environment, including the availability of social supports (American Psychiatric Association 1994). As such, dementia is described as being a biopsychosocial syndrome: the result of an interaction between the disease (aetiology, degree of damage to brain), the individual (personality and previous coping style) and the environment (both physical and social). Dementia is largely, although not exclusively, a disorder of old age. People with dementia commonly have co-existing medical conditions (e.g., arthritis and cardiovascular difficulties) and experience difficulty with activities of daily living such as cooking and walking due to physical impairment (Levin et al. 1983). Failure to attend to these concomitant difficulties can lead to excess disability for people with dementia (Reifler and Larson 1989).

**Challenge for dementia services**
There are at least four challenges for dementia services:

1. To decrease the disability associated with impairments by providing therapeutic social and physical environments.

2. To decrease excess disability caused by untreated physical and mental health conditions.

3. To promote quality of life for people with dementia.

4. To alleviate families’ difficulties.

**Developments in dementia services**
Developments in dementia services can be classified under five broad headings: assessment and diagnosis; community-based care; long-stay care; palliative care; and therapeutic interventions including communication with the person with dementia.

**Assessment and diagnosis**
There is a growing acknowledgement of the need for GP and primary care training. The primary care training initiative at the Dementia Services
Development Centre is one approach. There is growing discussion about sharing the diagnosis with the person with dementia (Drickamer and Lachs 1992; Fortinsky et al. 1994; Maguire et al. 1996). The recent Carers' (Recognition and Services) Act, among other provisions, entitles the family carers to an assessment. The recent instrument called CARENAP-D, developed by Gregor McWalter and colleagues for both people with dementia and their families, provides a useful protocol for such assessments.

Community-based care
Home-based day care and respite services are proving to be an invaluable addition to services. While no formal evaluation exists, they present families with a less disruptive break. Housing Associations are providing housing for people with dementia who meet the criteria for residential care. This tends to be group living arrangements, although a more recent development has been the provision of individual tenancies. The potential for technology to support people with dementia and their families in the community is beginning to receive attention (Marshall 1995).

Long-stay care
There has been a growth in the number of special care units in nursing and residential care settings. This approach to providing specialist care for people with dementia has been more fully developed in the US than in Britain or Ireland (Gold et al. 1991). A recent development in Scotland has been the registration of single family homes as residential care homes by the Social Work Department. The availability of single family homes as long-term care settings provides families with expanded service options.

The therapeutic potential of physical design and domestic, homely environments continue to be stressed. A study being conducted by the Dementia Services Development Centre will shed some light on how residents and staff from a hospital environment make the transition to a small-scale domestic care setting.

The use of technology in long-term care settings has tended to over-emphasise the use of monitoring and surveillance devices to the neglect of more compensatory and reminder technologies. It is expected that in coming years this imbalance will be addressed.

Palliative care
The needs of both people with dementia and their families for palliative terminal care have not yet been articulated. This area will no doubt receive increasing attention in coming years.
**Therapeutic interventions**

Therapeutic optimism has replaced the nihilism formerly associated with dementia care (Woods 1995). The range of therapeutic interventions has been growing and includes the use of Snoezelen therapy, aromatherapy (Reed 1996) and life story work (Murphy 1994). There is consensus that, in general, non-pharmacologic approaches to challenging behaviour are favoured (Raskind and Peskind 1992), while guidelines on the judicious use of psychotropics are available (Lawlor 1995).

The need for communication with, and attention to the views of people with dementia is being increasingly noted. Goldsmith’s (1996) recent book is a useful guide for practitioners.

**Strategies for extending and improving dementia services**

There are three key strategies to extend and improve services:

1. Establishing a Dementia Services Development Centre in Ireland which could provide information, training and consultancy to practitioners and providers.

2. Conducting evaluations of existing services which include the viewpoints of various stakeholders, including the person with dementia and their family. It is important to identify the aims of the services prior to evaluation.

3. Conducting a policy scrutiny on dementia services following the example of the Department of Health and Social Services in Northern Ireland.

**Discussion**

The main issues to emerge were:

1. The importance of minimising the disabling effects of the environment, both social and physical, was considered a priority in the management of people with dementia. It was agreed that an appropriate physical environment and a supportive social environment coupled with positive professional and service intervention would contribute significantly to minimising the disabling effects of dementia and to maximising the quality of life for both the individual and his/her carer.

2. Focusing on the positive abilities that a person with dementia retains was a new idea to many. It was considered an important idea worthy of
incorporation into the planning of services which are responsive to the needs of the individual with dementia. There was great interest expressed in the recent developments in Snoezelen and Memory Clinics.

3. Many family members do not recognise themselves as carers and are reluctant to label themselves as such. Since they feel a duty to care for their demented relative, this creates a cycle of guilt, which often prevents them from accessing services which could improve an otherwise disabling environment. It was pointed out that the work of carers often serves to hide the environment or the degree of disability associated therein, which in some cases only becomes apparent when the carer dies.

4. The concept of one person residential care units was applauded. Smaller accommodation units were considered to be less disruptive to individuals with dementia and therefore a good option.
FINAL SESSION

Chair: Ms. Mary O’Mahony
Chief Executive Officer, Mental Health Association of Ireland
SUMMING UP
Dr. Cillian Twomey
Consultant Physician in Geriatric Medicine, Southern Health Board

The key points emerging from the conference deliberations were in the following areas.

Policy
- Several national inter-departmental publications such as Planning for the Future, The Health Strategy and The Years Ahead, have identified what needs to be done in relation to the needs of the elderly mentally ill. What is now required is a greater commitment, including specific resource allocation to implement these policies.

Services
- The challenge is both to reorganise existing services and to develop new services. Clearly additional resources will be required but some redeployment of resources from the existing psychiatric budget towards improving old age psychiatry services should be possible.

- There is a need to appoint more consultants in old age psychiatry. The current number of four specialists in old age psychiatry (three in Dublin and one in the Mid-Western Health Board area) is totally inadequate. The papers presented at the conference suggest that the appropriate number for the entire Republic could be as many as 40. Each health board should appoint one, if not two consultants in old age psychiatry. This would go some way towards developing a comprehensive service for the elderly mentally ill and their carers. The urgency in establishing these appointments is particularly acute in terms of co-ordinating care for patients with dementia.

- Services for the elderly mentally ill need to be integrated and co-ordinated across all health care programmes. There is a need for greater co-operation and understanding between the various health care professionals, not just doctors. There is a need to move beyond the futile arguments of trying to identify whose responsibility a particular patient is. Discussions as to whether the patient being referred is ‘a geriatric patient’ or ‘a psychiatric patient’ or ‘no one in particular’s patient’ is both unseemly and wholly inappropriate. These barriers are
much less likely to exist with proper development of services in collaboration with all professionals working with and for the elderly.

- There is a selective bias against older people with behavioural disturbance when referred for any particular service. This is often based on the mistaken presumption that older patients are much more likely to be a ‘long-term care’ or placement problem. This is frequently untrue as many of these patients have reversible physical and/or psychiatric illness. Such negative and ill-informed ageist attitudes need to be corrected both amongst health care professionals and also within society in general. Information campaigns, greater general awareness, promoting more positive health, together with appropriate training of professionals at undergraduate and postgraduate levels should begin to redress this imbalance. The elderly in general are a vulnerable group and it is therefore appropriate and necessary to bias legislation in their favour to ensure that they get a fairer deal.

- There is a need to give greater thought to the design of residential care accommodation for the elderly mentally ill. There has been a deliberate policy to reduce the numbers in institutional care for all age groups, including the elderly, for some time now. Whilst accepting that, in principle, this is a laudable objective, there will always be a need for some long-stay care facilities. Separate purpose-built accommodation is badly needed for the behaviourally disturbed elderly, whose physical health is often quite good. These patients must not be placed in the same facilities as are provided for those elderly whose dominant disabilities are of a physical nature. Such placement is grossly unfair to both groups. Their requirements are quite different.

- It is a cause for concern that the statistics reported for hospital inpatient services indicate that whereas the numbers of elderly people admitted to psychiatric hospitals have fallen steadily over the last 10 years, the numbers of elderly admitted to acute general hospitals has increased. It begs the question, are elderly people with mental illness getting fair access to in-patient psychiatric care?

- That people should ideally be managed in the community, in their own homes, is clearly a commendable objective. Nevertheless, this principle needs to be balanced by the reassurance that appropriate intervention would be prompt if and when management in the individual’s own home was no longer either possible or desirable.
Diagnosis and treatment

- The importance of always establishing a diagnosis is fundamental to the provision of any service. One must guard against attributing symptoms in older people as being a manifestation of "normal ageing". Depression and dementia can present with similar and overlapping circumstances. One of the challenges of old age psychiatry is to unravel these two quite separate diagnoses which have quite different treatment options and prognoses. The warning signs of early mental illness should be more widely known both to health care professionals and to the general public. Intervention at an early stage will benefit patients and their carers enormously.

- Health professionals need to be aware of the overlap in symptom presentation of physical and mental illness in older age. There must be awareness of the wide range of treatment options (pharmacological and psychological) that exist and that should be equally available to older patients. The value and success of treating elderly mentally ill patients was stressed.

- Nobody should be admitted to continuing care without having first been fully examined and evaluated. This assessment can be done on a domiciliary basis in the person's own home or in a hospital out-patient facility. It requires the participation of community-based and hospital-based personnel.

Further research

- Services need to be planned in such a manner that they focus on the individual in addition to the population in general. It is now popular to talk about quality outcome measures. Skills which are relevant to older people need to be developed.

- Further epidemiological work is necessary to get accurate information on the incidence of mental disorders in the elderly in Ireland. Adequate prevalence data exists from other jurisdictions but information on disease incidence is lacking. Accessing this type of information will require some funding. The findings will inform precise service requirements and subsequent planning.

Responsibility

- The trojan work of voluntary agencies such as the Mental Health Association of Ireland, AWARE, and the Alzheimer Society of Ireland must be acknowledged, affirmed and supported. This voluntary effort cannot be seen as a substitute for the state's responsibility in relation to
older people with mental illness. The growth in private nursing homes and the major investment of public moneys in them, by way of subventions, should not mean that publicly funded care should be compromised. The more severely incapacitated patients, physical or psychiatric, are more likely to be looked after in public accommodation. Whichever accommodation is availed of, it is essential that it be appropriately designed and purpose-built. The standards that have been laid down in law in the *Health (Nursing Homes) Act, 1993* should apply to all facilities for older people, public and private. Ultimately the State has the responsibility to ensure that all citizens have access to appropriate institutional care when it is required.

**Conclusion**

- The overwhelming message of the conference was that services which exist in Ireland today are inadequate in meeting the needs of the elderly mentally ill. There is a sense of frustration and justifiable anger amongst carers and relevant health care professionals. And yet there is no room for despondency or despair. A proactive campaign highlighting the deficiencies must be embarked upon with our public representatives and health care managers.

- There is an unanswerable case for improved resource allocation to facilitate the development of a more comprehensive service. The services introduced must be flexible enough to meet the needs of individual patients and their carers. We should leave this conference confident that the issues that have been discussed can and will be acted upon. Hopefully, the National Council for the Elderly will, amongst others, ensure that the needs of the elderly will remain to the forefront of the political agenda, thus ensuring that the necessary service developments will be acted upon by those charged with the responsibility and authority.
NATIONAL COUNCIL FOR THE ELDERLY PUBLICATIONS

1. Day Hospital Care, April 1982
3. First Annual Report, December 1982
4. Community Services for the Elderly, September 1983
5. Retirement Age: Fixed or Flexible? (Seminar Proceedings), October 1983
6. The World of the Elderly: The Rural Experience, May 1984
8. Report on its Three Year Term of Office, June 1984
10. Housing of the Elderly in Ireland, December 1985
11. Institutional Care of the Elderly in Ireland, December 1985
12. This is Our World: Perspectives of Some Elderly People on Life in Suburban Dublin, September 1986
14. "Its Our Home": The Quality of Life in Private and Voluntary Nursing Homes in Ireland, September 1986
15. The Elderly in the Community: Transport and Access to Services in Rural Areas, September 1986
17. Choices in Community Care: Day Centres for the Elderly in the Eastern Health Board, September 1987
18. Caring for the Elderly. Part I. A Study of Carers at Home and in the Community, June 1988
20. Sheltered Housing in Ireland: Its Role and Contribution in the Care of the Elderly, May 1989
22. The Role and Future Development of Nursing Homes in Ireland, September 1991
23(a) Co-ordinating Services for the Elderly at Local Level: Swimming Against the Tide, A Report on Two Pilot Projects, September 1992
23(b) Co-ordinating Services for the Elderly at Local Level: Swimming Against the Tide, Summary of an Evaluation Report on Two Pilot Projects, September 1992
24. The Impact of Social and Economic Policies on Older People in Ireland, January 1993
25. Voluntary-Statutory Partnership in Community Care of the Elderly, January 1993
26. Measures to Promote Health and Autonomy for Older People: A Position Paper, August 1993
27. Co-ordination of Services for the Elderly at Local Level, (Seminar Proceedings), September 1993
28. Voluntary-Statutory Partnership in Community Care of the Elderly, (Conference Proceedings), September 1993
29. Dementia Services Information and Development, (Seminar Proceedings), September 1993
30. Bearing Fruit, A Manual for Primary Schools, September 1993
31. In Due Season, A Manual for Post Primary Schools, September 1993
32. Measures to Promote the Health and Autonomy of Older People in Ireland, (Conference Proceedings), February 1994
33. Theories of Ageing and Attitudes to Ageing in Ireland, (Round Table Proceedings), May 1994
34. Third Term of Office Report, July 1994
35. The Economics and Financing of Long-Term Care of the Elderly in Ireland, August 1994
36. Home Help Services for Elderly People in Ireland, November 1994
37. Older People in Ireland: Social Problem or Human Resource, A Submission to the National Economic and Social Forum, November 1994
38. The Economics and Financing of Long-Term Care of the Elderly in Ireland, (Seminar Proceedings), November 1994
39. Health and Autonomy Among the Over-65s in Ireland, December 1994
40. Support Services for Carers of Elderly People Living at Home, December 1994
41. Home Help Services for Elderly People in Ireland, (Conference Proceedings), March 1995
44. Elderly Return Migration from Britain to Ireland: A Preliminary Study, May 1996
45. Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment, October 1996
46. Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment, (Conference Proceedings), December 1996