



Section for the Psychiatry of Old Age
Irish College of Psychiatrists

Submission to the
Expert Group on Mental Health Policy

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December 2003

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SUMMARY OF RECOMMENDATIONS

1 Public Old Age Psychiatry Services

These must be set up in catchment areas within the country currently without access to such services.

- ERHA – Kildare, Wicklow
- SHB - Kerry, Cork (West Cork, North Lee)
- WHB - Galway East, Roscommon
- MW - North Tipperary

2 Consolidation of Existing Old Age Psychiatry Services

Existing public services must be consolidated. This involves:

(i) *Providing essential basic facilities.*

For instance, acute old age psychiatric units where none exist and long stay psychiatric beds designated under the Mental Health Act where none exist.

(ii) *Full resourcing of the multidisciplinary team.*

This includes increasing the number of consultants to ensure there is one Consultant per 10,000 population over 65 years e.g. the Limerick service requires an additional consultant and North Dublin Old Age Psychiatry Service two additional consultants. There are also significant gaps in the multidisciplinary teams as evidenced from the resource data (attached) e.g. ACNO, CPNs, Occupational therapists etc. and this needs to be addressed.

3 Staffing in Old Age Psychiatry.

Staff within Old Age Psychiatry multidisciplinary teams must have appropriate line management. For instance, Community Mental Health Nurses must report to line managers (Assistant Director of Nursing and Director of Nursing) within the psychiatric service. This is a serious problem in the Limerick service unresolved for many years.

4 Memory Clinics

Memory clinics must be set up within each service based on the recommendations outlined earlier. Ideally, they should be in conjunction with Geriatric Medicine and, if possible, Neurology.

5 Early Onset (Presenile) Dementia.

Consideration should be given to Old Age Psychiatry Services assuming responsibility for this group of patients. This could not be done without the provision of the additional resources as outlined earlier.

6 Acute psychiatric beds for Old Age Psychiatry.

Each service requires a separate acute psychiatric unit designated under the Mental Treatment Act staffed with psychiatric nurses and with an appropriate number of such staff.

7 Longstay psychiatry beds.

Each service must have longstay psychiatric beds designated under the Mental Treatment Act. The number must be based on the norm of 3 beds per 1,000 population over the age of 65 years.

8 Access to generic services for elderly people.

All Old Age Psychiatry Services must have access to generic services for elderly people such as community based day centres, including some specifically for dementia sufferers, and also longstay facilities in Health Board run homes and private nursing homes.

Section 1:

THE PSYCHIATRY OF OLD AGE

Specialist Psychiatric Services for Elderly People - A Proposal for the Development of Services in Ireland.

Introduction

The Psychiatry of Old Age is a recognised psychiatric speciality which is concerned with mental disorders arising anew in people over the age of 65 years. Broadly, it deals with two groups of people:-

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

The Psychiatry of Old Age is a relatively young psychiatric speciality. The first services developed in the early 1960's in Great Britain as a response to the increasing recognition of mental health problems in elderly people. At that time there was also an appreciation that most elderly people with such problems were living in their own homes (approximately 95%) and so the thrust of such services has been to provide a community oriented approach offering domiciliary assessment and treatment where practical. Experience with these services over the years has shown that it was essential that the services should focus on both functional psychiatric illness as well as dementia in old age. It has also become apparent that such conditions are very amenable to treatment. Treatment has been evaluated and refined by the development of academic centres in Psychiatry of Old Age such as the Institute of Psychiatry in London and the highly regarded units in Liverpool and Nottingham.

Interestingly, in sharp contrast to developments in Psychiatry of Old Age in Great Britain, the United States initially focused on research into ageing and brain changes particularly with regard to dementia and the affective disorders of old age. Research has been fruitful in illustrating that such problems can be helped by appropriate treatment in its broadest sense to include biological as well as social and psychological techniques and from this has developed Psychiatry of Old Age Services, which are commonly referred to as Geriatric Psychiatry Services, in the United States of America.

In Ireland, it is increasingly becoming apparent that specialist psychiatric services are required for elderly people for a number of reasons. These include:-

- changing demographic factors - more people are surviving to old age and therefore more at risk of developing dementia. 5% of people aged over 65 years are likely to suffer from dementia and this increases to 20% of those aged over 80 years.
- the special needs of elderly people with psychiatric problems - these include the increased likelihood of co-morbidity in terms of co-existing medical problems and the often atypical presentation of depression in old age. Likewise the identification and

treatment of psychiatric and behavioural disturbance in dementia sufferers requires specialist skills.

- changes in family structures - families are smaller so fewer children are available as carers. The increasing trend for women to work outside the home again reduces the number of available carers for elderly people with mental illness.
- emigration - again reducing the pool of potential carers.

The Service Philosophy

It is important that Psychiatry of Old Age services develop in conjunction with services for Medicine for the Elderly particularly because of the co-morbidity of medical and psychiatric problems in old age. However, it is equally important that Psychiatry of Old Age should be grounded in psychiatry so that skills in treating psychiatric disorders and behaviour problems are retained and, indeed, enhanced by adopting any new treatments developed in General Psychiatry. These can then be used, albeit sometimes in a modified form, in Psychiatry of Old Age. To quote the Joint Report of the Royal College of Physicians and the Royal College of Psychiatrists on the care of elderly people with mental illness "Psychiatry of Old Age belongs to the family of psychiatry but is married to geriatrics".

Close relationships with both Medicine for the Elderly and General Psychiatry can best be maintained by siting the Psychiatry of Old Age services in general hospitals. General hospitals should be the base for the team, the site of the acute beds, the day hospital and out-patient clinics. Furthermore, general practitioners are familiar with making referrals to general hospitals and this will facilitate their referrals to Psychiatry of Old Age when necessary.

Close relationships with general practitioners are crucial. This involves frequent liaison, particularly by phone, so that general practitioners become familiar with the mental health problems in elderly people which are appropriately referred to the service and the benefits of making an early referral but at all times emphasising the role of the general practitioner as the doctor primarily caring for the patient. This close liaison would educate general practitioners in the recognition and treatment of depression in old age and, likewise, the management of dementia. Whilst they are very aware of both these problems, research shows that often awareness does not lead to treatment. The liaison would, of course, work both ways with the Old Age Psychiatry Service becoming aware of the needs of general practitioners and their patients in a particular area and then developing services which respond best to these needs.

Service Model

As already stated, Old Age Psychiatry Services should be developed in conjunction with pre-existing Geriatric Medicine services or simultaneously with such services taking into account regional, geographic and demographic factors in individual cases. The population of elderly people for which such a psychiatrist is responsible must be kept to a reasonable number. To fail to do so would limit severely the effectiveness of the psychiatrist to the detriment of patients and their families. In practice, this means appointing one whole time equivalent consultant in Psychiatry of Old Age per 100,000 population assuming 10% of the population will be over 65 years

(a) Service organisation.

It is essential that the organisation of the service is clear. This includes clear guidelines on the relationship between Psychiatry of Old Age and General Psychiatry in terms of both clinical responsibility, administrative interaction and resource allocation.

Clinical Responsibility: The groups of patients appropriately dealt with by Psychiatry of Old Age Services have already been listed i.e.

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

Despite the apparent clarity of this, misunderstandings may occur. In particular, chronic schizophrenia is dealt with by General Psychiatry services - such patients on reaching the age of 65 years are not automatically transferred to Psychiatry of Old Age. Delirium is a medical problem even when it occurs in the setting of dementia and, therefore, requires assessment and treatment in a medical or surgical setting depending on the underlying physical cause of the delirium.

Administrative Interaction: This is a complex area. Psychiatry of Old Age must look in two directions. Whilst clinically it makes sense for the Psychiatry of Old Age consultant to relate closely to colleagues in General Psychiatry in his/her catchment area to ensure a comprehensive psychiatric service is provided, Psychiatry of Old Age services must also relate closely together in geographic regions for the purposes of service delivery, sharing clinical experience and, crucially, for resource allocation. The latter will be dealt with later.

In terms of out of hours cover, practice indicates that the Psychiatry of Old Age consultants and their NCHDs should take part in the General Psychiatry rota because numbers would make it impractical for separate Psychiatry of Old Age and General Psychiatry rotas to operate.

Resources: Resources always seem insufficient in psychiatry and experience shows that when specialities advocate for themselves they are more likely to be successful in obtaining adequate resources in terms of both personnel and facilities. It is, therefore, strongly recommended that the resource requirements of Psychiatry of Old Age are considered separately from those of General Psychiatry and to facilitate this it would be necessary for the consultants in Psychiatry of Old Age in individual health boards to form administrative groups to deal with resource allocation in particular. This should not detract from their role in catchment area teams.

In general, special interest posts in the Psychiatry of Old Age have been found to be an unsatisfactory method of service delivery particularly for elderly people. Experience in Britain particularly has shown that with special interest posts consultants become overly involved in the General Psychiatry moiety where problems tend to be more robust in their presentations, more chronic and where patients have greater numbers of advocates to support them. Many mental health problems in elderly people present quietly with the person involved being the last to complain and

so it is very important that the consultant psychiatrist should be in a position to devote all his/her clinical time supervising and providing a service for this vulnerable population. This often means being proactive in seeking out sufferers rather than waiting for them to come for assistance.

(b) Service delivery

Domiciliary Assessment: Domiciliary assessment has been described as the lynch pin of Psychiatry of Old Age Services. Its particular advantages are that it ensures assessment is provided for the many elderly people who are reluctant to avail of psychiatric services or who by reasons of their abnormal mental state (e.g. if they suffer from dementia) are not able to keep an outpatient appointment. It means that a very comprehensive assessment of the person to include their social as well as their psychiatric status is possible. It ensures that comprehensive information is obtained from informants as well as the patient and also that one is aware of the other people involved with the patient. This is essential knowledge in dividing a care plan. Specifically in the case of people who suffer from dementia, it means a more valid assessment of their mental state is obtained since they will be at their best cognitively in the familiar surroundings of their own home. However, for domiciliary assessment to be an effective form of assessment it must be readily available and flexible in its approach.

The Day Hospital: The day hospital plays an important and, indeed, pivotal role in Psychiatry of Old Age Services. Its role is assessment and treatment of those with both dementia and functional psychiatric illness. It means a rapid response to referral is possible. It provides an alternative to inpatient admission in many cases and it also facilitates discharge. The day hospital should be sited on a general hospital so that physical screening, which is essential in this age group, can be carried out efficiently. It also assists in administration of the service particularly where charts are concerned.

In very thinly populated rural areas a mobile day hospital model, whereby particular days are spent in different locations, may be a more practical method of providing access to a day hospital.

Out-patient Clinics: Like day hospitals, it is essential that out-patient clinics for Psychiatry of Old Age are based in the general hospital as this will facilitate easy access to hospital and community referrals. Out-patient clinics are particularly useful for follow up of elderly patients with functional psychiatric disorders such as depression who do not require the intensive treatment modalities available in the day hospital setting.

Consultation Liaison Service: This is an integral part of any Old Age Psychiatry Service. The rationale for this is that it permits specialist psychiatric liaison with geriatricians and other consultants in the general hospital. Since a substantial number of admissions to general hospitals are of elderly people this is a valuable contribution to the general hospital. It also permits the development of a seamless service whereby patients are followed into and out of hospital and whatever support services are required for management of their psychiatric problems can be arranged by the service.

(c) Personnel

Medical: All Old Age Psychiatry services should be led by a consultant with appropriate training in this speciality. As in General Psychiatry, the consultant should be hospital based but community oriented and service delivery should be based on a well trained multidisciplinary team with appropriate resources.

The level of NCHD underpinning required by individual consultant will depend both on the catchment area for which he/she is responsible and also other commitments. These may involve teaching, training and research. It is important that there is flexibility to accommodate these other requirements but each consultant in Psychiatry of Old age should have at least one NCHD. Such NCHD placements are important, indeed essential, training placements for them particularly now that we are confronted with a rapidly ageing population and, therefore, an increasing need for specialist Psychiatry of Old Age services.

Nursing: The community psychiatric nursing ratio recommended for the population over 65 years is 1 CPN:4,500. The importance of the role of CPNs in Old Age Psychiatry cannot be described adequately. The majority of the patients seen are home based and often reluctant to leave their homes so monitoring by CPNs ensures the smooth functioning of the service and a rapid response to problems. A response which ensures that crises are kept to a minimum.

Nursing staff for the day hospital and acute and long stay in-patients beds must be psychiatrically trained and adequate in number to deal with the often frail elderly people with whom they are working.

Other disciplines: As in General Psychiatry, essential disciplines in the multidisciplinary team include occupational therapy, psychology and social work. These are required not only in in-patient settings but also in the community and day hospital aspects of the service.

(d) Facilities

Day hospital: As already described, it is essential that day hospitals in Psychiatry of Old Age are based on the general hospital campus both for ease of access to the general hospital and the community and to ensure that the physical aspects of assessment can be carried out. Day hospitals should be sufficiently spacious to provide room particularly for those who suffer from dementia who may be restless or aggressive. Their staffing should be multidisciplinary and include psychiatrically trained nursing staff, the number required include an occupational therapist, psychology and social work sessions and last but not least a receptionist to ensure both good communication with carers and that therapy sessions are not constantly interrupted by the telephone. The receptionist would also ensure that the administrative work of the day hospital is kept up to date.

Acute in-patient beds: The acute beds for Psychiatry of Old Age should be an integral part of the acute psychiatric unit ideally with a separate or designated area within the unit for Psychiatry of Old Age. Such a unit should be based in a general hospital.

Long stay beds: It is crucial that there is easy access to different levels of long stay care for the patients seen by Old Age Psychiatry Services.

Ideally long stay care should be provided within the person's community so that links with family and friends are easily retained and maintained thereby improving the quality of life of residents, particularly those who suffer from dementia.

The range of care required by dementia sufferers include welfare, general nursing and psychiatric care. Welfare and nursing care is required by those with personal care needs, who also require 24 hour care and a safe environment so that habits such as wandering can be managed. Psychiatric long stay care is required for people with dementia who have severe behavioural problems such as aggressive. However, it would be anticipated that people would be able to move once their behaviour problems have settled provided that the move is within the same area. There is also a requirement for psychiatric beds for elderly people with treatment resistant depression.

Again taking the pragmatic approach to long stay care, private beds funded by nursing home grants, where appropriate, should be used by health boards.

The Eastern Health Board proposes to develop Community Care Units in a various areas around it's region. There are four modules planned for each unit: one for the physically inform, one for respite, one for respite, one for people who suffer from dementia and one providing day care. This seems to be an excellent concept because it would permit people to move between different modules depending upon their different care needs whilst remaining in the same unit. Also the units would be developed to serve particular catchment areas which would enable people to remain integrated within their communities. This is a significant advance on the previous model of using large geriatric hospitals or asyla for continuing care.

It is of the greatest importance that there should be equality of access to all long stay facilities.

The personnel and facilities required for an Old Age Psychiatry Service are summarised in Appendix I.

Training.

It is essential that training is provided within Old Age Psychiatry Services for medical and non-medical specialities.

Training in Old Age Psychiatry

(a) Medical Students

Given our ageing population an appropriate emphasis must be given to exposure of medical students at both pre-clinical and clinical level to Psychiatry of Old Age. All students should have access to a didactic module in Psychiatry of Old Age in the clinical medical school curriculum and, where possible, clinical experience should also be available. This should cover both functional and organic mental illness in old age.

(b) General professional training in psychiatry

Each psychiatric trainee should have a minimum of six months training in Psychiatry of Old Age. They should gain experience in several aspects of Psychiatry of Old Age particularly domiciliary, day hospital and acute in-patient work as well as continuing care.

(c) Higher professional training in psychiatry

The Royal College of Psychiatrists recommends that trainees in Psychiatry of Old Age at higher professional level spend two years in Old Age Psychiatry ideally in two different services. The other two years are spent in General Psychiatry. The College also recommends that there should be access to other relevant experience such as Medicine for the Elderly, neurology and consultation liaison psychiatry.

It is important to develop a number of senior registrar posts to meet the need for consultants in this country and also to provide general psychiatry and mental handicap trainees with experience in this speciality. However, the number of posts should be monitored carefully as we are very aware that in Ireland a certain proportion of our trainees travel abroad to train at higher level and we consider such experience gained elsewhere a valuable contribution to psychiatry in Ireland.

(d) Trainees in general medicine.

There should be reciprocity in training by which is meant that registrars and senior registrars in medicine for the elderly should obtain some training in Psychiatry of Old Age. This may be done by means of exposure in consultation liaison settings, combined clinics or accompanied domiciliary assessments.

(e) Training in research relevant to mental illness in old age.

Recent advances in the assessment and treatment of mental illness in old age are significant and have contributed to our ability to maintain people in their homes and improve their quality of life and those of their carers. For these reasons it is essential that academic centres providing training in research in mental illness in old age are developed and that interested trainees in psychiatry and other disciplines should have the opportunity of working in such centres.

Appendix 1

PSYCHIATRY OF OLD AGE SERVICES RESOURCE REQUIREMENTS 1, 2, 3.

(1) Personnel Requirements:

Consultant	1 : 10,000 pop over 65 yrs.
Secretary	1 per consultant
C.P.N.s N.C.H.D.s	1 : 4,500 pop over 65 yrs. minimum of 1 per consultant
Occupational Therapist	1 per service
Psychologist	.5 - 1 W.T.E. per service.

(2) Structural Requirements:

Acute Beds

- | | |
|-------------------------|-----------------------------|
| (i) dementia | 1 : 1,000 pop over 65 yrs. |
| (ii) functional illness | .5 : 1,000 pop over 65 yrs. |

Day Hospital Places	2 : 1,000 pop over 65 yrs
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Continuing care places for severe dementia	3 : 1,000 pop over 65 yrs.
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The number of acute beds can be reduced if an active day hospital programme together with a rapid, flexible response to referrals and active follow up of people in their homes is available.

REFERENCES

1. Care of Elderly People with Mental Illness - Specialist Services in Medical Training. A joint report by the Royal College of Physicians and the Royal College of Psychiatrists. 9th February 1989.
2. Specialist Services for the Elderly Mentally Ill. Section of Psychiatry of Old Age. Jolley 1992.
3. Psychiatry of Old Age Services - Resource Requirements. The Royal College of Psychiatrists, Section of Old Age Psychiatry. 1994.

Section 2

GREY AREAS AND THE PSYCHIATRY OF OLD AGE

The Psychiatry of Old Age is a recognised psychiatric specialty which has responsibility for mental health problems arising anew in those aged 65 years and over. The patients involved fall into two broad groups:-

1. Those developing functional psychiatric illnesses such as schizophrenia, depression, alcohol abuse etc. for the first time over the age of 65 years.
2. Dementia sufferers who also have problems with behaviour such as aggression or psychiatric symptoms such as depression or delusions.

Despite the clarity of the above statement, grey areas arise concerning the respective responsibilities of Old Age Psychiatry, General Psychiatry, Medicine for the Elderly and Community Care services. On examination it is quite clear that the reason for these grey areas is a lack of resources. The effect is seen in two ways:-

1. questions arising as to who is responsible for particular groups of patients
2. a lack of definition as to the use and site of particular service facilities. The latter particularly concerns day centres/day hospitals, acute psychiatric beds and long-stay care for people with dementia and long-term functionally ill people who grow old and frail.

These issues will now be addressed in turn.

GREY AREA GROUPS

Uncomplicated dementia

This group of people consists of a large number of people with dementia who do not have either severe behavioural problems or severe physical illnesses, who are mobile and who may have a tendency to wander. A problem arises when these people need long-stay care. They do not require care in a specialist psychiatric unit, neither do they require care in a geriatric medicine setting and, indeed, can be difficult to manage in the latter setting where most of the people are physically ill and bed-bound. It is quite clear that difficulties arise because there is very often no particular provision for this group of people and this will be addressed in the section under long-stay care.

Presenile dementia

While dementia occurring under the age of 65 years is unusual, nevertheless, there are a substantial number of people in Ireland who suffer from this condition and it is particularly tragic because of the relative youth of the person, the implications when the person is the

family bread-winner or is still in the process of bringing up children and, of course, the implications for the family in terms of inheritance of the condition with some of these presenile forms of dementia such as Pick's Disease or Huntington's chorea. By definition, since presenile dementia occurs in those under 65 years of age these patients are the responsibility of General Psychiatry services if psychiatric intervention is required. However the case could be argued that presenile dementia would be better dealt with by Old Age Psychiatry services since they have particular expertise in managing people with dementia. This is an area where transfer of responsibility between the two services might be considered if Old Age Psychiatry services are provided with the personnel and facilities required to deal with people with presenile dementia. This would need to be negotiated with Old Age Psychiatry services on an individual basis.

People over the age of 65 years with longstanding psychiatric illnesses e.g. schizophrenia or recurrent mood disorders.

These people have usually been involved with the General Psychiatry services for many years. Where rehabilitation services exist they may come within this brief. They require a combination of close follow-up by community psychiatric nurses, psychiatric out-patient attendance, day centre attendance and for a substantial number long-stay care in psychiatric hostels of various levels of support. General Psychiatry services, therefore, are responsible for a proportion of elderly people with psychiatric illnesses. It is important to ensure that in planning General Psychiatry services, the latter continue to have access to day centre and hostel places for this group of people. Furthermore, a proportion of them as they grow older will become physically frail and so provision should be made within the general psychiatry service for long-stay accommodation which is able to care for physically frail elderly people with chronic psychiatric illnesses. This is a problem that is well recognised by the General Psychiatric services but in many is not adequately dealt with and it means that on occasion when this group of people become physically frail and can no longer be managed in hostels they are readmitted to acute psychiatric beds purely because of the need for nursing care and not because they require acute psychiatric treatment. It is essential that proper provision is made for these people within the General Psychiatric services.

An allied issue is where people with chronic psychiatric illnesses under the care of general psychiatrists develop dementia and for this reason can no longer be managed in hostels or in their home setting. Currently these people are the responsibility of the General Psychiatry services and again their problems need to be acknowledged and appropriate long-stay care provided for them.

It cannot be emphasised too strongly that the resources, particularly long-term care beds, must be provided for this group if problems between General Psychiatry and Old Age Psychiatry with regard to the provision of beds are to be avoided.

GREY AREAS FACILITIES

Day hospitals/Day Centres

A day hospital is an important element of all Old Age Psychiatry services. It provides a very real alternative to acute hospital admission for both dementia sufferers who have severe behavioural or psychiatric symptoms and people with functional illness such as depression. Active psychiatric treatment involving biological, social and psychological approaches takes place in day hospitals. So far as Old Age Psychiatry is concerned, a day hospital should be based in general hospitals so that adequate access is available to permit:-

1. a full physical work-up which is important in this age group because of the close coexistence, for instance, between depression and physical illness.
2. easy access to geriatric medicine service so consultations can be provided.

Day centres have quite a different role. Their functions include:-

1. socialisation for older people
2. carer relief

Problems arise in the delineation of the roles of day hospitals vs. day centres for older people with dementia. Day centre availability and attendance is extremely important for people with dementia because they benefit from the opportunity to socialise and, in addition, their carers benefit greatly for the respite from care. Day centres for people with dementia should be provided throughout the community and are a primary care service. Unfortunately they are not widely available and where day hospitals for Psychiatry of Old Age are present the pressure may be placed on such day hospitals to continue providing on-going attendance for people with dementia who do not require active psychiatric intervention. The outcome of this is that the day hospitals places become blocked and they are unable to take on the people with dementia who really require psychiatric intervention. It is essential, therefore, that day centres for people who have dementia are available within the community to allow free movement to occur between the day hospitals and the day centres i.e. between secondary and primary care level. In addition, many people with dementia do not need to attend a day hospital at all other than for initial screening and can be referred directly to the day centre and this, again, would ensure that active therapeutic places are available for people with dementia or with functional psychiatric illness.

Long-stay care for people with dementia

This has been an extremely contentious area in recent years and again it is related very much to a lack of resources which has been hugely exacerbated by:-

1. The 'Planning for the Future' policy which states that people with dementia will no longer be routinely admitted to psychiatric hospitals for long-stay care. Whilst correct in its approach, it has left a hiatus in service provision for dementia sufferers. For instance, the closure of the Lower House of St Brendan's Hospital has meant that 400 long-stay places were lost in North Dublin.

2. Again concentrating on the Eastern Health Board area, the closure of small hospitals such as Sir Patrick Dun's, Mercer's and Baggot Street Hospital as well as the Richmond and Jervis Street Hospitals resulted in the loss of approximately 1,000 beds from the hospital system. Many of these beds in the smaller hospitals had been used in their later years when the hospitals were being run down, to provide long-stay care for elderly people, particularly for those with dementia. This was not a policy but occurred by default.

As a consequence of this loss of beds in the overall bed pool, difficulties have arisen in the placement of elderly people particularly those with dementia. This is very evident in the bed crises which occur in the acute hospital every winter but which are present at some level throughout the year. It is also manifested as difficulties in delineating responsibility for people who are quietly demented i.e. who do not require specialist psychiatric nursing or long-stay care in a geriatric medicine setting.

The solution to the problem is to examine the precise needs of people with dementia who require long-stay care. These can be divided into three broad groups:-

1. People with dementia who have severe behavioural problems unamenable to treatment. These people require long-stay care in a psychiatric setting with psychiatric nurses and currently this is acknowledged and this group is in general terms provided for although there are constraints in the number of places available.
2. People with dementia who are immobile and may also have severe physical problems. These people are accepted into the geriatric medicine service.
3. The grey area concerns people with dementia who are mobile and who do not have severe psychiatric or physical problems. Very often they may indulge in such activities as wandering which is really a reflection of their inability to employ themselves in their usual interests. The needs of this group of people are for care in a safe, supervised environment which allows them to move around but under supervision and also provides personal care. There are various ways in which care may be provided for this group of people. For instance:-
 - (i) special dementia units may be provided. These would be designed to allow safe wandering and would be staffed by nurses together with care attendants and would have a nurse manager.
 - (ii) alternatively people with dementia might be admitted to the generality of units for elderly people that are available. This is the approach that is being taken in community units being built by the Eastern health Board.

There are advantages and disadvantages to both approaches. In the first instance, it may be said that people with dementia are being 'ghettoised' into dementia units and in the second that those who do not have dementia are being upset by having confused people living with them. Probably a combination of both approaches should be used. Whichever approach is chosen the important principle is that these residential settings are available at primary care level. Assessment for admission would be by either the Medicine for the Elderly or Psychiatry of Old Age services but the day to day management of such units would not come within the brief of either of those two secondary level care services. In essence, this means there would have to be very close co-operation between Community Care, Medicine for the Elderly and Psychiatry of Old Age services.

Acute Psychiatric Beds for Psychiatry of Old Age.

With good day hospitals, community psychiatric nurse back up and access to long-stay beds, it is possible for Psychiatry of Old Age services to manage with relatively few acute psychiatric beds.

However, there are a number of important principles to be adhered to with regard to acute psychiatric beds for Psychiatry of Old Age.

1. The beds should be on the same site as the acute General Psychiatry unit bed but clearly distinct from the latter e.g. in a separate unit adjacent to the acute General Psychiatry unit. The reason for this is that many Old Age Psychiatry patients are particularly frail and may be at risk in large General Psychiatry units. However, close proximity of the two acute psychiatric units is important in facilitating close professional relationships between General Psychiatry and Old Age Psychiatry. This is important for a number of reasons such as the provision of on-call cover, skill enhancement and the training of junior doctors.
2. The acute Psychiatry of Old Age beds / unit must be designated under the Mental Treatment Act.
3. The beds must be ring fenced for Psychiatry of Old Age.
4. The beds must be staffed as acute psychiatric beds with trained nurses in psychiatry.
5. Good access to various types of long-stay facilities both psychiatric and non-psychiatric must be available if the service is to function efficiently.

Section 3

Current Situation

There are 18 public old age psychiatry services, two private services (Highfield Hospital Group and St. Patrick's Hospital, both in Dublin) and two further public services likely to start in 2004 (Louth and Galway West).

Data on the operational public services in Table 1: Resources and Table 2: Activity shows clearly that the services are very busy but often poorly resourced with significant gaps. For instance, the South West Area Health Board service based in Tallaght Hospital has no acute psychiatric beds.

It is the view of the Consultant Psychiatrists working in Old Age Psychiatry in the public services that the startling resource deficiencies and failure to consolidate existing services where the level of activity clearly warrants it is a direct consequence of the speciality of Psychiatry of Old Age being lost between General Adult Psychiatry and Geriatric Medicine. In our opinion, Old Age Psychiatry must be identified separately at both Department of Health and Health Board level to ensure appropriate resources are ringfenced for these services.

Memory Clinics

The advent of specific treatment for Alzheimer's disease, mixed Alzheimers / Vascular Dementia and Lewy Body Dementia in recent years is a much welcomed advance in treatment for this vulnerable patient group. The use of these drugs requires specialist assessment, diagnosis, investigation and monitoring to ensure all those likely to benefit are identified early and treated. It is recommended that this is done by means of memory clinics offering the range of expertise essential for this task which includes multidisciplinary input and access to technologies such as scanning (CT and MRI). Memory clinics are ideally run jointly by Psychiatry of Old Age and Geriatric Medicine Services and preferably also with input from Neurology.

As yet no specific resources have been allocated for this essential purpose with the result that many likely to benefit from these effective treatments are being excluded or inadequately monitored.

Minimal resources required for a memory clinic in each service include:

Personnel

Consultant sessions – Old Age Psychiatry	– 2 sessions per week
Geriatric Medicine	– 2 sessions per week
Neurology	– 1 session per week
Nurses	– 0.5
Psychology	- 0.5
Administration	- 0.5
Genetic Counselling	- access to

Structures

- Clinic to be based in general hospital.
- Access to comprehensive investigations include scanning facilities.

Early onset dementia

While dementia occurring under the age of 65 years is unusual, nevertheless, there are a substantial number of people in Ireland who suffer from this condition and it is particularly tragic because of the relative youth of the person, the implications when the person is the family breadwinner or is still in the process of bringing up children and, of course, the implications for the family in terms of inheritance of the condition with some of these presenile forms of dementia such as Pick's Disease or Huntington's chorea. By definition, since presenile dementia occurs in those under 65 years of age these patients are the responsibility of General Psychiatry services if psychiatric intervention is required. However the case could be argued that presenile dementia would be better dealt with by Old Age Psychiatry services since they have particular expertise in managing people with dementia. This is an area where transfer of responsibility between the two services might be considered if Old Age Psychiatry services are provided with the personnel and facilities required to deal with people with presenile dementia. This would need to be negotiated with Old Age Psychiatry services on an individual basis.

Resources Requires For Early Onset Dementia (250,000 Total Population)

Personnel

- Consultant in Old Age Psychiatry - 0.5
- Clinical Nurse Specialist (Psychiatric Nurse) - 1
- Psychologist - 0.5
- Social Worker - 0.5

Resources

- Acute psychiatric beds - 4
- Day hospital - 1 day per week
- Longstay psychiatric beds - 10
- Access to non psychiatric longstay - Health Board general provision for elderly people (including private nursing homes)

Table 1: resource data per service for the year Jan -Dec 2002

Service	Pop ≥65	Con	Snr. Reg	SHO	ACNO	CPN	Sec	Other	Acute Beds	Day Hosp	L/S Beds	Comm Assess	Comm Rx	Gen Hosp Liaison	Other Services
NAHB Areas 6 & 7	30,000	1	1	3	1	3	2	1	6	16	40	Yes	Yes	Yes	
NAHB Area 8	14,100	2	1	1	1	2	1		6	No	120	Yes	No	Yes	
SWAHB Areas 3 & 1/2 of 4	19,000	1	1	2	0	2	2	2	9	20	24	Yes	Yes	Yes	OPD
ECAHB Areas 1& 2	30,000	2	1	3	1	4	2	0	4	Yes	64	Yes	Yes	Yes	
MWHB Limerick	19,000	1	1	1	0	3	1	1.5	16	2	19	Yes		Yes	700
SWAHB Areas 5 & 1/2 of 4	13,500	1	0	2	0	0	1	1	0	1	0	Yes	Yes	Yes	13,506
MHB Laois-Offaly	12,000	1	0	2	0.5	4	1	2	6	10	72	Yes	Yes	Yes	N/A
NEHB Cavan-Monaghan**	14,289	1	0	1	1	8	2	5.5	7	12	38	Yes	Yes	Yes	0
SEHB Waterford	13,000	1	0	1	0.0	2	0.5	2	6	0	23	7	7	7	
SEHB S. Tipperary	10,200	1	0	1	1	2	1	1	4	1	25	Yes	Yes	Yes	10,237
MWHB Clare	13,000	1	0	1	0	2	1	0	5	0	0	Yes	Yes	Yes	0
SEHB Wexford	15,000	1	0	1	0	2	1	1	0			Yes	Yes	Yes	0
NWHB Donegal	15,595	1	0	1	1	4	1	0	0	0	0	148	210	28	
NWHB Sligo/Leitrim et al	14,500	1	0	2	1	2	1	0	4	No	No	Yes	Yes	Yes	OPD
MHB Longford/Westmeath															
SHB South Lee															
SEHB Kilkenny															
WHB Mayo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 2: Activity data per service for the year Jan-Dec 2002

Service	Referrals	Acute Unit		Day Hospital(s)			Long stay / Respite		CPN visits
		Admission	Discharge	Admission	Discharge	Attendance	Admissions		
NAHB Areas 6 & 7	573	38	38	118	0	1623	5	9	3307
NAHB Area 8	108	11	7	0	0	0	0	0	340
SWAHB Areas 3 & 1/2 of 4	407	72	66	187	184	2092	10	27	2463
ECAHB Areas 1 & 2	444	84	84	23	11	304	4	20	3557
MWHB Limerick	394	30	30	15	0	534	19	110	2143
SWAHB Areas 5 & 1/2 of 4	169	72	66	187	184	2092	10	27	2463
MHB Laois-Offaly	314	33	33	57	66	1319	6	40	2392
NEHB Cavan-Monaghan	267	24	24	34	0	1101	1	0	4997
SEHB Waterford	228	44	41	N/A	N/A	N/A	3	N/A	1473
SEHB S. Tipperary	204	36	34	N/A	N/A	N/A	5	31	1501
MWHB Clare	108	24	23	na	Na	na	na	na	461
SEHB Wexford	222	36	33	N/A	N/A	3	3	N/A	1731
NWHB Donegal	252	92	92	N/A	N/A	N/A	N/A	N/A	391
NWHB Sligo/Leitrim et al	223	1	1	N/A	N/A	N/A	N/A	N/A	259
MHB Longford - Westmeath									
SHB South Lee									
SEHB Kilkenny									
WHB Mayo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A