would be politically unpopular. Competition was manacled.[8] And in the United States, where the market rips more than anywhere else, tighter controls on spending—for example, by managed care organisations—have greatly reduced individual choice.[7]

Finally, would stakeholder insurance competition "fail" the poor any less than now? It is difficult, from Green's description, to understand what the incentives would be for people to opt out of the NHS into stakeholder insurance. People with lower ability to pay top-ups would be excluded. It is hard not to believe that stakeholder insurance is a way to allow the well off to opt out of tax payments that, through the NHS, are redistributed to the less well off, who tend to be sicker.

Equity, efficiency, responsiveness

The effect of stakeholder insurance on equity and responsiveness to individual choice is largely dealt with above. What about efficiency? Green cites evidence that suggests that administrative costs for an insurance scheme would be as low as 5.5%—not much more than current administration costs in the NHS. But it is hard to see how stakeholder insurance transaction costs could be kept to this level given the scale of annual tendering and contracting outlined.

Who wins, who loses?

Plans for reforming health care are often little more than thinly disguised attempts to redistribute resources by socioeconomic class.[7] What is the right balance between, on the one hand, individual choice in health care consumption, and on the other, equity of access to health care by those most in need, is fundamentally a question of values and political belief. Green wants to tilt the balance towards choice, and therefore towards those who can pay. It is clear who the losers are intended to be—Green's aims are disingenuous at best.

Competing interests: None declared.

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Care of older people

Mental health problems

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This is the third in a series of four articles

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BMJ 2001;322:789–91

Specialist mental health services for older people have grown rapidly and successfully over the past two decades, aiming to offer services that are comprehensive, accessible, responsive, individualised, multidisciplinary, accountable, and systematic. As with all mental health problems, the burden falls on primary care (where minor morbidity often goes undetected) and specialist services tend to be reserved for those conditions and patients where diagnosis and management is problematic. The total cost of caring for people with dementia in the United Kingdom is estimated at £6bn ($9bn) a year[1]—a figure whose impact is diluted by the fact that it combines both health and social services. We outline the current evidence of benefit in four areas: services currently available; interventions that have been shown to be effective; rating scales that should be recommended to clinicians for detecting common mental health problems; and the needs of carers.

Summary points

- Recent reports have highlighted the needs of older people with mental health problems
- Mental health problems are underrecognised and undertreated in primary care
- The use of guidelines and standardised screening instruments may improve this
- Caring for a person with dementia is stressful, and carers' needs are being increasingly recognised
- Carer interventions in people with dementia have been shown to be effective in randomised controlled trials
- Depression, the commonest mental health disorder in later life, is eminently treatable, but psychological therapies are underused

Services for older people

A recent report by the Audit Commission surveyed 850 carers and 1005 general practitioners by visiting 12 areas of the United Kingdom and conducting face to face interviews.[2] The results showed that the range of services in health authorities was patchy and varied between the different authorities; in addition, coordinated care between health and social services was lacking. Individual components of old age psychiatry services have been evaluated and described in the literature. Memory clinics, for example, improve significantly the quality of life in carers of people with dementia because of the treatment and advice they offer.[3 4] In dementia, there has been a particular

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emphasis on earlier and more open diagnosis to enable individuals to make choices and decisions about their future care at an earlier stage and to offer possible opportunities for treatment.[5] Considerable interest has also been shown about improving care for people with established dementia—for example, using the person centred approach advocated by Kitwood.[6] Effective liaison services at the interface between old age psychiatry and old age medicine lead to workable models, with some early indications of good efficacy.[7]

What interventions are effective?

Several interventions have been described in randomised controlled trials to assess particular interventions in older people with mental health problems. The prevalence of psychiatric morbidity in medical inpatients is high, and the negative effect of depression and cognitive impairment on rehabilitation is well recognised.[8] A randomised controlled trial of a psychiatric liaison intervention for medical inpatients aged over 75, showed that those in the intervention group had improved physical function, fewer readmissions to hospital or nursing home, and a shorter length of stay.[9] A similar intervention was shown to be effective in frail, older people living at home.[10]

Older people in nursing and residential homes commonly have agitation and challenging behaviours, and behavioural management of these individuals, without using drugs, has beneficial effects on their mental state and on staff morale.[11] When older people in nursing and residential homes are prescribed drugs to control these behaviours a review by a multidisciplinary team, including a pharmacist, can be successful in reducing the number of medicines prescribed—to the benefit of the resident.[12]

Several randomised controlled trials have shown that cholinesterase inhibitors produce significant effects on cognitive and global function.[13–15] These effects seem to be clinically important outside the clinical trial situation,[16] and last for at least 18 months.[17] Treatment of depression with antidepressants is effective,[18] not just in the community but also in medical inpatients,[19] though antidepressants probably need to be continued for two years or more in cases of major depression.[20]

Evidence based reviews examining the effectiveness of interventions for dementia in particular[21 22] and old age psychiatry services in general[23] are available. In general, the evidence for many interventions is patchy, and good data from randomised controlled trials is often lacking, but positive evidence exists for the effectiveness of several areas of work, such as psychogeriatric inpatient units, consultation liaison interventions, and outreach visits to nursing homes.[23]

How to increase recognition and treatment of mental health disorders

Ample evidence exists that depression is underrecognised in primary and secondary care and is undertreated when recognised.[24–26] One answer lies in the systematic use of valid, reliable, and user-friendly screening instruments to detect the common mental health disorders of old age, such as depression and dementia; they can be used successfully and effectively in primary care.[27] Although a plethora of scales are

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available, training for primary care staff is possible if the appropriate assessment scale is identified and used.[28] Good evidence exists that general practitioners should perform cognitive testing as an aid to the diagnosis of dementia.[29] Similarly, screening for depression in settings where it is common, such as general hospital wards and nursing and residential homes, is worthwhile.[26] The choice of assessment scale should be determined by local agreement and protocols.

Mood disorders constitute the commonest group of mental health difficulties in later life. Antidepressants are as effective in older people as in younger people,[30] although more efficacy data are needed for very old and very frail people.[31] Psychological therapies are not used as much as they should be; evidence suggests they are as effective in older people as they are in younger people.[32] The reasons for this underuse are unclear but, regrettably, suggest ageism.

The introduction of clinical guidelines into old age psychiatry is welcomed. A review has reported some 125 guidelines, which cover all aspects of old age psychiatry.[33] They cover all aspects of the assessment, diagnosis, and management of dementia[34–36]; management of depression[37]; and the diagnosis of schizophrenia in later life.[38] Old age psychiatrists should take a lead in ensuring that guidelines are appropriate to local needs and conditions.

In future, services will need to find innovative ways of providing more help to high risk groups—for example, people with depression in care homes—or those who are less able to use existing services, such as older people from ethnic minority communities.[39]

Needs of carers

The needs of carers have been well described, particularly in terms of the stress and strain resulting from

caring for a person with dementia.[40] Factors predicting stress and strain have been documented and provide information for setting up intervention studies to examine those carers in most need.[41] Studies support the view that these interventions are effective in terms of individual benefit for carers and their economic worth.[42–44] The Audit Commission reported that carers were invariably experiencing stress by the time they asked for help and that information about mental health problems and knowledge of services—in particular respite and home care—were instrumental in enabling relatives to carry on caring for an older person at home.[2]

Carers have an important role in advising on service development and in evaluating services.[45] The UK government has also recognised the essential contribution of carers. The Carers Act of 1999 is intended to ensure that carers receive better information and are consulted about services and that local authorities receive grants for carers to take breaks from their care duties.

Conclusions

Services for older people with mental health problems need adequate funding, a multidisciplinary approach to assessment and to the management and integration of services—notably between health and social services. The services have received more careful evaluation in recent years. Several studies have shown that mental health care and treatment for older people can be effective, and several randomised controlled trials have provided supportive evidence. The use of standardised screening instruments should be encouraged in primary care and targeted in secondary care; there are diagnostic and management guidelines, both for detection and management, for the most common mental health disorders in later life.

Funding: No special funding.

Competing interests: AB has received consultancy fees and educational grants from companies involved in the manufacture and distribution of drugs for treatment of dementia, depression, and schizophrenia in older people. TD is a senior professional adviser to the Department of Health in London, but his contribution is in a personal not official capacity. RB has received funding for research into ageing and received a fee for speaking about the national service framework at a Psynergy Dublin conference.

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