

**Mental Health in Old Age Bulletin
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MENTAL HEALTH IN OLD AGE BULLETIN ISSUE 11

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EDITORIAL

What is the Department of Health doing for older people's mental health?

When the NSFOP was originally published, I was dismayed, not by the content, which by and large people do not disagree with, and which in some places (such as person centred care and the SAP) has huge potential, but by the lack of any levers to allow promotion of OPMH services against other priorities.

Reports in 2003 from the Social Services Inspectorate and CHI highlighted a relative neglect of older people's mental health (OPMH) services. In October 2003 a Department of Health "summit" was arranged to discuss the state of mental health services for older people. This included the National Directors for older people, mental health, emergency care and primary care, was opened by Health Minister Stephen Ladyman, and had stakeholders from a range of relevant organisations. A range of possible actions was identified, and although some of these are aspirational or await the right opportunities for implementation, some significant developments have taken place in the year since the summit. Encouragingly, when £5 million was released in 2004 for bids related to NSFOP Standard 4 (general hospital care), of 40 successful bids, 6 were specifically aimed at mental health issues, another 2 employed mental health staff, and many others were generic but included mental health as part of the person centred care approach.

To assist in mainstreaming mental health into older people's programmes and improving age-inclusiveness of working age adult services, a new DH programme for OPMH is being established across the divisions of mental health and older people. Ian Philp will still be responsible for the implementation of the NSFOP and its MH elements, as well as those priorities such as care homes that naturally fit in with older people's services, but Louis Appleby will take a greater responsibility in ensuring an age-inclusive approach to mental health service provision through DH underpinning programmes of work, such as R&D, NICE, workforce development and performance management.

The timescale in R&D development is slow, but a number of projects are now being considered in OPMH. Alzheimer's disease is one of four areas targeted to benefit from an extra £100 million per year R&D funding by 2008, most likely through a national research network. As well as the forthcoming NICE Technology Assessment on antidementia drugs, there is an ambitious guideline in development which will examine health and social care interventions for dementia, for the first time combining NICE and the Social Care Institute for Excellence, expected February 2007. The next edition of the national workforce strategy for mental health will include older people's mental health services. There is a commitment to improved performance management around targets within the new national programme within DH.

At a time when data collection burden on the NHS must be seen to reduce and many centrally driven targets are being removed, there have been two developments of note: there is ongoing work with the Health Care Commission to consider a PI around integrated working between health and social care in community mental health teams; and service mapping will now be supported as an annual data

collection. If fully completed, this would provide an inventory for local commissioning, give national benchmarking information, monitor temporal change in services, help combat ageism, and would give opportunities for the development of local and national performance indicators.

As of April 2004, there is a new work programme within NIMHE on Older People's Mental Health, in conjunction with the Change Agent Team. In addition, older adults are being considered within all existing NIMHE work programmes. NIMHE regional development centres have identified OPMH leads. The programme will initially focus on supporting organisations with their review of old age psychiatry services following the Rowan report, producing guidance and support for a "whole-systems" integrated approach to commissioning and delivering OPMH services, intermediate care for OPMH, and in supporting local champions with key facts to aid arguments for service prioritisation. A range of other initiatives are being supported through the regional development centres.

The culture of centrally driven targets and performance management by DH has now become less potent, and has shifted to one of support and facilitation. The dominance of the access and capacity agenda has also waned with more focus on integration of services around the needs of users, on chronic disease management and long term conditions. As a policy advisor I can see real opportunities for the development of OPMH with the shifting responsibilities within DH, and with the NIMHE / CAT programme of work. However, the test will be whether rhetoric and planning is translated into increased resources and prioritisation of services for older people with mental illness.

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ARTICLE

Quality of Life in Residential and Nursing Care

The provision of high quality care in residential and nursing homes is a source of concern for societies around the globe. Quality indicators have been seen in terms of Donabedian's (1980) criteria of structure, process and outcome. In the UK, early measures of quality in care homes were concerned purely with structure, using factors such as allocation of space and fire regulations. The introduction of a code of practice for residential care, Home Life (CPA, 1984), following the Registered Homes Act 1984 introduced more process-based measures providing standards for physical and social care, with a focus on residents' dignity. National Minimum Standards for Care Homes for Older People were established following the Care Standards Act (2000) containing structural measures such as 'environment' and 'staffing', and process measures such as 'health and personal care', and 'daily life and social

activities' (Department of Health, 2001). Defining quality is elusive and the most usual strategy is to focus upon quality of care. In Donabedian's terms this would be an assumption that presence of positive facets of structure and process is associated with a more positive experience for the resident, and hence improved quality of life. However, this relationship is far from consistent (Gibbs and Sinclair, 1992), and few studies have attempted to unravel the determinants of outcome, or quality of life, following admission to care homes.

This article reports some of the key findings from a study of quality of life of older people newly admitted to residential and nursing homes. The study, based at the University of Manchester, aimed to identify the particular characteristics of care associated with a good outcome for residents. By looking at change over time in a large cohort of residents following admission to care homes, and using a longitudinal design, the study set out to determine whether achievement of the desired outcomes was more likely in some care environments than in others. Thirty nursing and residential homes were recruited from three geographical areas in the north-west of England including homes in the private, voluntary and statutory sectors. All new admissions to the homes were approached, producing a cohort of 308 residents. Residents were interviewed three times, within 14 days of admission, and five and nine months later. Aspects of the care environment were investigated using methods including; staff, manager and relatives questionnaires; a non-participant observation study; a researcher rated evaluation of the home environment, and a staff-rated 'Sheltered Care Environment Scale'. Residents were screened using the Mini Mental State Examination (MMSE, Folstein *et al.*, 1975) and the Geriatric Depression Scale (GDS-15, Yesavage *et al.*, 1983). Those scoring 10 or more on the MMSE also completed an adapted version of the Lancashire Quality of Life Profile (Oliver *et al.*, 1996). Their physical functioning and health status were measured by care staff interview, using the Barthel ADL Index (Wade and Collin, 1988), Crichton Royal Behaviour Rating Scale (Wilkin and Thompson, 1989), and Health of The Nation Outcome Scale (HONOS-65+) (Wing *et al.*, 1998). Details of residents' prescribed medication were also recorded.

The results of the study showed that depressed mood was experienced by a substantial number of residents although antidepressant medication was rarely prescribed to residents identified as depressed. At baseline, only 19 per cent of depressed residents were prescribed antidepressants, although there appeared to be some increase over time (around 26 per cent at 5 and 9 months). However, in about one third of these cases antidepressant medication was prescribed in doses below the therapeutic range. There was also considerable evidence of co-morbidity of cognitive impairment and depression but no evidence of any such diagnoses. A high rate of prescription medication and polypharmacy was also found. Over 50 per cent of residents were receiving four or more drugs and this figure did not fluctuate greatly across the three periods. At baseline, 40.5 per cent of residents were prescribed 5 or more drug items and this had increased to 46 per cent of residents by 9 months. These figures indicate lower levels of prescribing than previously reported (Corbett, 1997; Lunn *et al.*, 1997).

There were very low rates of recognition of depression in residents by the care staff, with no apparent differences between qualified nursing staff and unqualified staff in their rates of recognition. Moreover, from the staff questionnaire replies, it appeared

that less than half of nursing and care assistants had had received basic care skills training and less than ten per cent had received training in any aspects of psychiatric or psychological problems including dementia or in the recognition or management of depression, or in terminal care.

There was no evidence that aspects of care had a particular impact on dependency as measured by the Barthel over a period of nine months since there were no significant changes in these scores over time. There was no evidence of general reduction in dependency during the period of care however nor was there any general increase, although it could be argued that, for residents receiving long-term care, lack of deterioration is a positive outcome. A statistically significant difference was found between the group who survived throughout the data collection period, that is approximately 9 months after admission, and those who died before 5 months with those who died being more dependent on admission.

One year after the end of the study, a telephone follow-up identified study survivors, and survival analysis from admission to 12 months was undertaken using resident characteristics and environmental measures. Dependency as measured by the Barthel was the most significant predictor of death (with lower dependency increasing survival likelihood), and included diagnosis of cancer, prescription of drugs to treat infection and prescription of endocrine system drugs (receipt of these drugs linked with lower likelihood of survival). In this analysis, depression was, however, not linked to survival. This contrasts with several reported studies (for example, Murphy *et al.*, 1988) in which, even when physical illness was controlled for, depressed older people were more likely to die. No environmental features proved to be significant predictors of survival.

As part of the quality of life interview, residents were asked to rate their satisfaction with a number of domains relating to their living situation. It was apparent that many did not wish to complain about or criticise the care they received. One-third of residents were dissatisfied with the opportunities available for keeping themselves occupied in the home. Twenty-seven per cent reported dissatisfaction with the opportunities for going out. Just over one-quarter were dissatisfied with the amount of influence they had in the home. Overall well-being was higher for residents with less cognitive impairment, less depression and less dependency. Similarly, questionnaires sent out to relatives of the residents also elicited a high level of satisfaction with almost three-quarters of relatives very happy with the home, despite the fact that a number of specific criticisms were reported in some questionnaires. The observation study carried out in 'public space' revealed little evidence of residents engaged in activities in either nursing or residential homes. There was little evidence of contact, either physical or verbal between staff and residents. Residents observed in public space were rarely seen in conversation with other residents or staff.

In terms of the longitudinal data on residents surviving throughout the study, over 50 per cent reported feelings of boredom at each assessment period. Those who reported being bored were significantly more likely to be depressed. Survival analysis showed that for residents who completed a quality of life interview, higher levels of dependency, less satisfaction with leisure in the home, and receipt of cardiovascular drugs contributed to a reduced likelihood of survival. Satisfaction with

the amount of pleasure from things done in the home was related to survival, suggesting that residents who experienced less pleasure in their daily lives were more likely to be depressed and die sooner. The findings of the study from all sources of information, have suggested that a good home may consist of a number of components shown in Figure 1. This may be a setting that provides - satisfaction with pleasure from things done in the home; forms of chosen and appropriate valued activity; opportunities for keeping occupied in the home; where staff work in a cohesive fashion and resident conflict is uncommon, and one with good physical comfort.

The results of this study are to be published in a book, *Towards Quality Care: Outcomes for Older People in Care Homes* later this year. A number of important issues in the long-term care of older people are addressed in this book. These include: access to specialist expertise in the diagnosis and management of psychiatric conditions for residents in care homes; the need for more systematic assessment procedures in care homes; implementation of rehabilitation programmes particularly in response to intermediate care initiatives; better training of staff, and the importance of the perspective of service users in service development and evaluation. The conclusions drawn from this study and reported in the book are particularly relevant since quality of life and quality of care are areas of concern in terms of the focus upon quality in recent government policy.

Figure1: Qualities of a good home

A good quality care home provides residents with:

- opportunities for keeping occupied in the home
- activities that are appropriate and valued
- satisfaction with pleasure from things done in the home
- staff working cohesively
- lack of resident conflict
- good physical comfort.

Quality of Life publications

Bagley, H., Cordingley, L. Burns, A., Mozley, C.G., Sutcliffe, C., Challis, D. and Huxley, P. (2000) Recognition of depression in long term care facilities for older people: a comparison of qualified nurses and other care staff. *Journal of Clinical Nursing*, **9** 445-450.

Challis, D., Mozley, C.G., Sutcliffe, C., Bagley, H., Price, L., Burns, A., Huxley, P., Cordingley, L. (2000) Dependency in older people recently admitted to care homes. *Age and Ageing* **29**, 255-260.

Mozley, C.G., Huxley, P., Sutcliffe, C., Bagley, H., Burns, A., Challis, D. and Cordingley, L. (1999) 'Not knowing where I am doesn't mean I don't know what I like': Cognitive impairment and quality of life responses in elderly people. *International Journal of Geriatric Psychiatry* **14** 776-783.

Mozley, C.G., Challis, D., Sutcliffe, C., Bagley, H., Burns, A., Huxley, P. and Cordingley, L. (2000) Psychiatric symptomatology in elderly people admitted to nursing and residential homes, *Ageing and Mental Health* **4**, 2, 136-141.

Mozley, C., Sutcliffe, C., Bagley H., Cordingley, L., Challis, D., Huxley, P. and Burns, A. (2004/forthcoming) *Towards Quality Care: Outcomes for Older People in Care Homes*, Ashgate, Aldershot.

Sutcliffe, C., Cordingley, L., Burns, A., Godlove Mozley, C., Bagley, H., Huxley, P. and Challis, D. (2000) A new version of the Geriatric Depression Scale for nursing and residential home populations: the Geriatric Depression Scale (Residential) (GDS-12R), *International Psychogeriatrics*, **12**, 2, 173-181.

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Centre for Policy on Ageing (1984) *Home Life: a code of practice for residential care*. London, Centre for Policy on Ageing.

Corbett, J. (1997) Provision of prescribing advice for nursing and residential home patients, *Pharmaceutical Journal* **259** (6960) 422-424.

Department of Health (2001a) *Care Homes for Older People: National Minimum Standards*, The Stationery Office, London.

Donabedian, A. (1980) *Explorations in quality assessment and monitoring Vol I: the definition of quality and approaches to its assessment*. Ann Arbor, Health Administration Press .

Folstein, M.F., Folstein, S.E. and McHugh, P.R. (1975) Mini-Mental State: A Practical Method for Grading the Cognitive State of Patients for the Clinician, *Journal of Psychiatric Research* **12** 189-198.

Gibbs, I. & Sinclair, I. (1992) Consistency: a pre-requisite for inspecting old people's homes. *British Journal of Social Work*, **22**, 541 -549.

Lunn, J., Chan, K., Donoghue, J., Riley, B. and Walley, T. (1997) A study of the appropriateness of prescribing in nursing homes. *The International Journal of Pharmacy Practice* **5** 6-10.

Murphy, E., Smith, R. and Lindsay, J. (1988) Increased mortality in late life depression, *British Journal of Psychiatry* **152** 347-353.

Oliver, J., Huxley, P., Bridges, K. and Mohamad, H. (1996) *Quality of Life and Mental Health Services*. London, Routledge.

Wade, D.T. and Collin, C. (1988) The Barthel ADL Index: a standard measure of physical disability? *International Disability Studies* **10** 64-67.

Wilkin, D. and Thompson, C. (1989) *Users' guide to Dependency Measures for Elderly People*. Social Services Monograph, University of Sheffield.
Wing, J., Beevor, A., Park, S., Hadden, S. and Burns, A. (1998) Health of the Nation Outcome Scales (HoNOS). *British Journal of Psychiatry* **172** 11-18.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Day, M. and Leirer, V.O. (1983) Development and validation of a Geriatric Depression Screening Scale. *Journal of Psychiatric Research* **17** 37-49.

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CURRENT KEY ISSUES

Rural practitioners' experiences in dementia diagnosis and treatment

Teel, C.S. Rural practitioners' experiences in dementia diagnosis and treatment. Aging and Mental Health. 2004; 8(5): 422-429.

This paper reports the experiences of diagnosing dementia and its management in rural practitioners. Interviews were carried out with 19 practitioners in an attempt to develop an understanding of the barriers encountered by people providing that service in non-city areas. Participants estimated that the time from symptom onset to diagnosis ranged from a few months to a year and was largely dependent on recognition of symptoms by the family. Limitations and access to consultants and few and far between community support and education resources were major impediments to diagnosis and treatment. Denial amongst family members of the problems and the positive effect of supportive and motivated families were very similar to experiences in metropolitan areas and, in general, the comparative lack of resources was seen as major issue.

Life-long intellectual activities mediate the predictive effect of early education on cognitive impairment in centenarians

Kliegel M, Zimprich D, & Rott C. Life-long intellectual activities mediate the predictive effect of early education on cognitive impairment in centenarians: a retrospective study. Aging and Mental Health. 2004; 8(5) 430-437.

This study examined the hypothesis of whether early education and/or maintenance of intellectual activities over the life course had the power to predict the presence of cognitive impairment in elderly people. Ninety centenarians from the Heidelberg Centenarian Study were assessed using the Mini-Mental State Examination, and information about their education, occupational status, and intellectual activities in four areas were obtained. 52% of the sample showed mild to severe cognitive impairment and, using a logistic regression analysis, independent, significant and strong influence on current cognitive performance was found for school education and intellectual activities, even after controlling for occupational status. However, about a quarter of the effect of early education and cognitive status was exerted

indirectly via assessed intellectual activities. The study provides the first evidence for the conclusion that, even with regard to cognitive performance in very elderly people, early education and lifelong intellectual activities are of importance.

The place of memantine in the treatment of Alzheimer's disease

Livingstone G, Katona C. International Journal of Geriatric Psychiatry. The place of memantine in the treatment of Alzheimer's disease: a number needed to treat analysis. 2004; 19: 919-925

Memantine is the only treatment currently licensed for the management of moderately severe to severe Alzheimer's disease, and the authors adopted a number needed to treat (NNT) approach to assess the benefits that had been reported in clinical trials. Double blind randomised controlled trials of memantine in Alzheimer's disease were assessed using a standard protocol. Two trials were found, and the NNTs for global outcome were 3 and 6, those for cognitive outcome 7, and those for activities of daily living 4 and 8. The effect size of memantine was between 0.32 and 0.62. In terms of the number needed to harm, memantine was no more harmful than placebo and significantly less harmful for the outcome of agitation. The conclusion was that the small NNTs and the lack of harm suggests that memantine has a valuable place in the current clinical management of Alzheimer's disease. The effect sizes are in the medium range for clinical effect, but emphasis was made that more studies are needed to examine carer burden, behavioural and psychological symptoms, and quality of life.

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BOOK REVIEW

Vascular cognitive impairment: preventable dementia

Bouller, J.V. and Hachinski, V. (eds) *Vascular cognitive impairment: preventable dementia*. Oxford U.P. 2003. 368 pages.

The editors make the point that cerebrovascular disease may be the most important global factor which causes or contributes to cognitive impairment. They say that..... 'obsolete time-encrusted definitions' prevent the field going forward, and while generally applauding the use of vascular cognitive impairment, they say that the term 'vascular dementia' is still often used.

Over the next 350 pages, everything about vascular cognitive impairment is dealt with. The current criteria for vascular dementia receives an in depth analysis by the editors, the historical evolution of the concept is dealt with, and there then follow a series of intertwined and probably overlapping chapters on epidemiology, pathology, symptoms, assessment, neurochemistry, treatment, and prevention.

There is no doubt that there is increasing awareness of the implications of the role of cerebrovascular disease in the genesis of dementia (whoops, cognitive impairment), and the editors ably bring together an important contribution to the field. Everyone, whether they be a neurologist, an old age psychiatrist, a geriatrician, a clinical nurse specialist, a physiotherapist, an occupational therapist, or a social worker, would benefit from being aware of the implications of this disorder.

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WEB SITE REVIEW

Ethnic minorities and dementia

Differences in the manifestation of dementia between racial groups have been known about for some time and with 7.9% of the population of the UK originating in a non-White ethnic group according to the 2001 Census and with their numbers set to rise dramatically in the next decades, awareness of the issues is important for many practising Consultant Psychiatrists.

Here we present a starting point for any wishing to explore the area, starting from a Google search.

There is quite a lot of research into this area underway. The **Institute of Psychiatry** <http://www.iop.kcl.ac.uk> has an ongoing research program into dementia and cognitive function in African-Caribbean elders in London, Toronto, Barbados and Tobago. One of two completed research projects in this area is a project on the Mental Health of Ethnic Minority Elders in West London. The other deals with the development of a cross-cultural methodology. They have published a Maudsley Discussion Paper (no. 8) which poses the question whether there should be specialist services for minority ethnic groups. You are invited to make your contribution to the debate.

The Policy Research Institute on Ageing and Ethnicity (PRIAE)

<http://www.priae.org> is an organisation dedicated to improving the quality of life of black and ethnic minority elders in the UK and Europe. It conducts research on behalf of policy makers, mainstream providers and professionals. Their three year research project Minority Elderly Care (MEC) is due to be completed in September 2004. It will provide a comprehensive analysis of the health, social care, income and access requirements of elders from some 26 minority groups in ten European countries (including the UK). The project has three foci and examines the needs and usage of services by black and ethnic minority elders, statutory service providers and voluntary organisations working in this area. The aim is 'to propose a direction of care that policymakers may find useful in responding to the growth of the minority elderly'.

The **Royal College of Psychiatry's** Council Report CR103 discusses current provisions for black and ethnic minority groups and discusses possible ways forward. It includes a helpful list of references. This is available as a pdf file from: <http://www.rcpsych.ac.uk/publications/cr/council/cr103.pdf> . They also published in 1999 under the Gaskell imprint Ethnicity: an agenda for mental health edited by D.Bhugra and V. Bahl.

The **Royal College of Psychiatrists** publish a valuable bibliography on Mental Health of Ethnic Minorities. Though dated (it was published in 1999) it is aimed at clinicians and researchers and provides an annotated bibliography of 'recent important papers which describe research on mental health of minority ethnic groups in the UK'. They also publish Psychiatry in multicultural Britain . This was brought out in 2000 and 'brings together a wealth of current knowledge on cross-cultural psychiatry and offers theoretical and practical perspectives on the practice of psychiatry in multi-cultural Britain'.

The **Mental Health Foundation** have a useful resources list produced in connection with a Learning network Event: Dementia, Ethnicity and Culture Seminar held in May 2003. This is available as a pdf file from http://www.mhilli.org/network/ethnicity_seminar_may03_refs.pdf

For a view of the US situation where cultural specific services are already in place the **American Society on Aging** <http://www.asaging.org> is a useful site.

A sponsored link on the Google search is for **Ethnos**, a research and consultancy agency. They specialise in research with the ethnic minority population and provide organisations with the knowledge and understanding they need to develop products and services that truly meet the needs of the diverse communities that make up multi-cultural Britain. They have a varied brief: to give opportunities to ethnic minority people, to help businesses tap into ethnic minority markets and support public organisations to provide and deliver services which meet the needs of ethnic minority communities. Their expertise lies in the design of research strategies. Clients include the DH, The Home Office and the Chief Medical Officer.

Reading List

One of the first calls for attention to this area came around eight years ago with a piece in the BMJ by G.Rait, A.Burns *et al.* Entitled Age, ethnicity and mental illness: a triple whammy, it set out the multiple difficulties experienced by black and ethnic minority old people in obtaining adequate attention to their problems.

For a view of the US situation the **American Society on Aging** makes reference to the following article:

Chi, H. (2003) Dementia among diverse ethnic groups: comparing incidence rates and risk factors. **Dimensions**, 10(4) Winter, pp.4-7:

<http://www.asaging.org/>

Under Publications

Click ASA Article Search

From Search by Category box

Choose Ethnic Minority
Click Article Search
Scroll down to Dementia among diverse ethnic groups
Click

You may view the full-text from this point after you have registered with ASA (this is free).

The Institute of Psychiatry <http://www.iop.kcl.ac.uk>

have a Discussion Paper (no. 8 Specialist Services for Minority Ethnic Groups) which poses the question whether specialist services for minority ethnic groups should be provided.

Completed research programs:

1. Mental Health of Ethnic Minority Elders in West London has been published as:
Bhugra, D. et al. (2003) Mental health of ethnic minority elders in West London : pathways into secondary care. Indian Journal of Psychiatry 45, pp.27-30.

2. Developing cross-cultural methodology published as:
Patel, V. Transcultural and international psychiatry. In: College Seminars in General Psychiatry (ed. Stein, G. et al.). Gaskell: London (in preparation)

3. Patel, V. (2003) Cultural issues in measurement and research. In: Practical psychiatric epidemiology (eds Prince, M. et al.). Oxford: Oxford UP, pp.43-64.

There is also an ongoing research program: A study of dementia and cognitive function in African-Caribbean elders in London, Toronto, Barbados and Tobago.

List the following relevant publications:

Milne, A. Ethnic minority populations and dementia. (2002) Updates 3(11).
Available as a pdf file from:
<<http://www.mentalhealth.org.uk/html/content/Updatev03ill.pdf>>

There is also a resources list in connection with a Learning Network Event: Dementia, Ethnicity and Culture Seminar held in May 2003.
Available as a pdf file from:
<http://www.mhilli.org/network/ethnicity_seminar_may03_refs.pdf >

Bhugra, D. (1999) Mental health of ethnic minorities: an annotated bibliography. London: Gaskell: ISBN 1901242315
A bibliography of recent important papers which describe research on mental health of minority ethnic groups in the UK.

Bhugra, D. & Bahl, V. (eds) (1999) Ethnicity: an agenda for mental health. London: Gaskell. ISBN 0901242153
Sets the scene for identifying and meeting the mental health needs of Black and other minority ethnic groups.

Bhugra, D. & Cochrane, R. (2000) Psychiatry in multicultural Britain. London: Gaskell ISBN 1901242455

Brings together a wealth of current knowledge on cross-cultural psychiatry and offers theoretical and practical perspectives on the practice of psychiatry in multi-cultural Britain.

Ong, Y.L. (2001) Psychiatric services for Black and minority ethnic elders. Council Report CR103. Royal College of Psychiatry.

Discusses current provisions for the Black and ethnic minority groups including possible ways forward. List of references. Available as pdf file from:

<<http://www.rcpsych.ac.uk/publications/cr/council/cr103.pdf> >

Practice guides. Assessing mental health needs of older people. Section 7. Black and ethnic older people in communities.

Available from:

<<http://www.scie.org.uk/publications/practiceguides/bpg2/section07/index.asp>>

References from databases:

A search on their SCIE CareData database yielded the following reference:

Daker-White. G. et al. (2002) Serving the needs of marginalised groups in dementia care: younger people and minority ethnic groups; final report. Bristol: Dementia Voice/University of the West of England. Available from:

<http://www.dementia-voice.org.uk/Projects/finalreport/pdf>

One of the aims of this study is to examine the needs and provision of services to people with dementia from Black and ethnic minorities.

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YOUR PROBLEM ANSWERED

My mother has become confused. What shall I do?

'Confusion' is a non-specific term with a variety of meanings. Older people may be 'confused' when they are physically very unwell, when they are depressed or because of the side-effects of medication.

The first question is; when did it start? If it is of short duration (days or a week), then it is likely to be due to acute confusion (delirium). Your mother needs to see her doctor right away. The commonest causes of acute confusion in older people are infection (chest or urinary tract), side-effects of medication and circulatory problems.

If the duration has been weeks or months then it is more likely that the confusion is due to depression, 'silent stroke' or early dementia (chronic confusion). Your mother needs to see her GP.

The commonest causes of chronic confusion (dementia) are Alzheimer's disease and vascular dementia. The National Service Framework for older people is committed to improving the diagnosis of confusional states in older people. It includes advice for all doctors on how to detect these conditions and how to manage them and when to refer people to specialist services.

There are some very clear and informative leaflets produced by the Alzheimer's disease Society, on memory problems which explain what the problem may be and give advice for carers on what kinds of help are available.

Some of the issues of concern to carers when an older person gets confused are safety and loss of independence. Social Services and Health Services are working together in "the single assessment" process – basically this means that an older person who asks for help (or for whom help is requested) from either service, should have an assessment of their health and social care needs. Most services are now also assessing the needs of the carers. There is a wide range of help available although there are differences from area to area in some respects.

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Mental health disorders remain widely under-reported – in our section on Data Quality & Definitions we discuss the challenges of dealing with this data. This is true across all countries, but particularly at lower incomes where data is scarcer, and there is less attention and treatment for mental health disorders. Figures presented in this entry should be taken as estimates of mental health disorder prevalence – they do not reflect diagnosis data (which would provide the global perspective on diagnosis, rather than actual prevalence differences), but are imputed from a combination of medic