

SPECIALIST MENTAL HEALTH SERVICES FOR OLDER PEOPLE

**National Clinical Programme for
Older People: Part 2**

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Members of Mental Health Working Group

Dr Margo Wrigley (Chair)	Clinical Director Dublin North City/Mater Psychiatry of Old Age Service
Dr Damien Gallagher Vice-Chair	Senior Registrar in Old Age Psychiatry, St Vincent's University Hospital, Dublin
Ms Anna Boland	Community Mental Health Nurse, St Vincent's University Hospital, Dublin
Dr Colm Cooney	Consultant Old Age Psychiatrist, St Vincent's University Hospital, Dublin
Ms Martina Dolan	Senior Social Worker, St Vincent's University Hospital/HSE Dublin South East, Dublin
Dr Norma Harnedy	Consultant Geriatrician, Cork University Hospital
Ms Carmel Hoey	Nursing Service Planner NCPOP, Health Service Executive
Dr Tony Lee	General Practitioner, Waterford, Co. Waterford
Mr Adrian Lewis	Senior Occupational Therapist, St James's Hospital, Dublin
Dr Aideen Lewis	Principal Clinical Psychologist (Mental Health), St Vincent's University Hospital, Dublin/HSE
Ms Mary Manning	Nursing & Midwifery Planning & Development Unit, HSE
Dr Mia McLaughlin	Consultant Old Age Psychiatrist, St Luke's Hospital, Kilkenny
Dr Eleanor Mullan	Consultant Old Age Psychiatrist, Cork University Hospital
Prof Desmond O'Neill	Consultant Geriatrician, Tallaght Hospital, Dublin
Mr Michael Shasby	Director of Nursing, Dublin North City Psychiatry of Old Age Service
Dr Tom Reynolds	Consultant Old Age Psychiatrist, Clare Mental Health Services

Foreword

We welcome this document which encompasses two of the core principles of clinical practice now mandated by Sláintecare.

- Addressing mental health needs in addition to the physical health needs of older people thereby insuring equity between physical health and mental health care.

- Integration of service provision as evidence by the Specialist Mental Health Services Model of Care for Older People being designed as a component of the National Clinical Programme for Older People. It is a joint initiative between the HSE and the Royal College of Physicians in Ireland.

During the time this document was being completed and approved, the Chair of its Working Group was appointed National Clinical Advisor for the HSE Mental Health Division. This provided a vehicle for translating design into implementation through targeted funding through the Government's Programme of Funding for Mental Health Services. The outcome of this was the putting in place of new Mental Health Teams for Older Persons in Wicklow, Kildare, South Mayo, Roscommon, North Tipperary, Waterford/ Wexford, North Lee (Cork City) and North Cork. The only area without a team is West Cork; this should be addressed this year as should some additional staffing for the newer teams.

While substantial progress has been made, more needs to be done to address the needs of older people living in residential care or admitted to acute hospitals and there are clear recommendations on both the model of care for these settings and the staff required.

We endorse this model of care and its full implementation.



Dr Colm Henry

*Chief Clinical Officer,
HSE*

June, 2019



Dr Siobhan Ni Bhriain

*National Clinical Advisor and Group
Lead, Mental Health, HSE*

June 2019

Introduction

It is widely accepted that mental health services for older people should develop in tandem with geriatric medicine services given the inseparable relationship between physical and mental health. In recognition of this, the subgroup for mental health was formed as part of the **National Clinical Programme for Older People (NCPOP)**.

At this time it is intended that the NCPOP Model of Care document will be comprised of the two interdependent and complementary parts listed below.

Specialist Geriatric Services Model of Care		Published
Part 1	Acute Service Provision	July 2012
Part 2	Mental Health Service Provision	June 2019

This document, '**Specialist Geriatric Services Model of Care, Part 2: Mental Health Service Provision**', concerns itself with the provision of specialist mental health services for older people. These services interact with and complement general medical services for older people in primary and secondary care. The majority of older people with mental health issues are managed by a broad range of disciplines in the community with referral to specialist mental health services only if clinically necessary. The integration of care, including community services, is described in the Integrated Care Programme for Older Persons (HSE, 2018).



Dr Diarmuid O'Shea
*Clinical Lead,
National Clinical Programme
for Older People*

June, 2019



Dr Margo Wrigley
*Chair, Mental Health Working Group,
National Clinical Programme
for Older People*

June, 2019

Contents

Executive Summary	8
Recommendations	9
The service and its staffing	9
Facilities	10
Training	10
Interfaces with other Services	11
Governance	11
Glossary of Terms and Abbreviations	12
1 Overview of Mental Disorders in Later Life	13
1.1 Prevalence	13
1.2 Depression	13
1.3 Dementia	14
1.4 Other Disorders	15
1.5 Morbidity & Mortality	15
2 The Key Role of Specialist Mental Health Services for Older People	17
2.1 Why Older People require Specialist Mental Health Services	17
2.2 The Role of Mental Health Services for Older People in the Community	19
2.3 Mental Health Consultation-liaison Services for Older People in Hospital	19
2.3.1 The Benefits of a Consultation-Liaison Service	23
2.4 Mental Health Services for Older People and Memory Services	24
2.4.1 The Case for Developing Memory Services in Ireland	24
2.4.2 The Role of Mental Health Services within Memory Services	25
3 ‘A Vision for Change’ and Mental Health Care in Older People	27
3.1 Background to a ‘A Vision for Change’	27
3.2 Recommendations of ‘A Vision for Change’	27

4	Structure of Specialist Mental Health Services for Older People.....	28
4.1	Structures and Staff Required for Community Teams	28
4.2	Community Mental Health Team.....	28
4.3	Community Structural Requirements	29
4.3.1	Day Hospital – Psychiatry of Old Age	29
4.3.2	Acute In-patient Beds	29
4.3.3	Continuing Care Beds	30
4.3.4	Suitable Accommodation for Older People with Enduring Mental Illness .	31
4.4	Requirements for Consultation-liaison Teams in Hospitals	31
4.5	Requirements for Consultation-Liaison Services to Nursing Homes.	32
5	Care Pathways and Interfaces with Other Services.....	34
5.1	Care Pathways and Interfaces for Older Person in the Community	34
5.2	Criteria for Referral and Process of Assessment.....	34
5.3	Multidisciplinary Team Meeting and Process of Care	35
5.4	Discharge Back to Primary Care	36
5.5	Care Pathways and Interfaces for Older Person in Hospital.....	37
6	Roles of multidisciplinary team members.....	39
6.1	Doctors	39
6.2	Nurses	40
6.3	Clinical Psychologist.....	42
6.4	Social Worker	43
6.5	Occupational Therapist	44
6.6	Administrator	45
6.7	Pharmacy	46
7	Current Activity and Gaps in Service Provision.....	48
7.1	Activity of Community Services and Gaps in Service Provision	48
7.2	Activity of Consultation-liaison Services and Gaps in Service Provision	55

7.3	Composition of consultation-liaison services	55
7.3.1	Type of consultation-liaison services provided.....	56
7.4	Summary	57
8	Education	58
8.1	Medical Education	58
8.2	Nurse Education	59
8.3	Health care assistants	60
8.4	Education of Health and Social Care Professionals	60
8.4.1	Social Work	60
8.4.2	Clinical Psychologist.....	61
8.4.3	Occupational Therapy	62
8.4.4	All POA Health Professionals	63
8.5	Mental Health Education Competency Framework.....	64
9	Research	65
10	Governance	67
11	Performance Management.....	68
12	Appendix A - Recommendations of 'A vision for Change' and Older People	69
13	References	71

List of Tables

Table 1. Projected Prevalence of Dementia in Ireland (O'Shea et al., 2007).....	14
Table 2. Examples of Clinical Circumstances in which an Old Age Psychiatry Consultation - Liaison Service can Improve Care.....	23
Table 3. Resource Data per Service Jan – Dec 2010	51
Table 4. Activity Data per Service for the Year Jan – Dec 2010.....	53
Table 5. Psychiatry of Old Age: Resource and Referral Activity Data 2017	54

List of Figures

Figure 1. Prevalence of Common Mental Health Disorders in Community and Hospital Populations (adapted from 'Who Cares Wins', RCPsych 2005)	22
Figure 2. Community Mental Health Team – Recommended Staffing	28
Figure 3. Care Pathway for Older Adult Living in Community with Mental Disorder.	35
Figure 4. Care Pathway for Older Adult in Hospital requiring Psychiatric Assessment.....	36
Figure 5. Care Pathway for Older Adult with Mental Disorder leaving Hospital.....	37

Executive Summary

The population of older people (age 65 and over) in Ireland is projected to increase by more than 3 fold between 2006 and 2046 (i.e. from 460,000 to 1.4 million). Mental health problems are very common in this age group with 10% suffering from clinically significant depressive symptoms, 5% with dementia over the age of 65 and a far higher prevalence in those over 80 years. Other disorders are equally common with anxiety present in 13%, either alone or in association with depression, alcohol misuse in up to 4% and schizophrenia in 1%.

Mental health problems are associated with increased morbidity and mortality, either as a result of the direct effects of mental illness (e.g. suicide) or as a consequence of complicating physical illness. This underscores the necessity for developing specialist mental health services for older people to focus on the diagnosis and treatment of the full spectrum of mental illness which occurs in this age group.

Mental health services must be flexible and proactive, providing assessment and treatment where the older person is based, whether this is at home, in residential care or in hospital. They should address all care needs given the complicated and frequently multi-faceted nature of mental illness in later life. The services should also have a clear catchment area to ensure that they are accessible to those who need them most and to ensure consistency and clarity regarding responsibility and provision of care.

The recognition and treatment of mental health problems enhances quality of life for older people, reduces suffering and decreases stress on family caregivers and has a positive impact upon physical health. It is imperative to develop specialist mental health services to meet these needs, both in the community and in the hospital. This report makes clear recommendations on how this may be best achieved. This includes the following:

The clinical pathways in the community and in the acute hospital.

Key working relationships with primary care and with geriatric medicine.

The staffing and infrastructure requirements for service provision.

Recommendations on training, education and research to ensure a consistently high standard of service provision.

The governance and oversight of services.

Recommendations

The service and its staffing

1. Older people (65 years and over) require specialist mental health services to meet their specific needs. These include:
 - a) association with medical / surgical co-morbidities.
 - b) social circumstances.
 - c) increased prevalence of organic mental disorders.
 - d) the need to build good working relationships with primary care, social care and geriatric medicine in particular.
2. Services should be catchment area based (as well as equitable across catchment areas) and linked to geriatric medicine services.
3. Services must be multidisciplinary in nature with staff being specifically trained to meet the needs of the patient group.
4. It is essential that the multidisciplinary team members providing mental health services in the community and hospital work together to allow for a seamless service whether the patient is at home or in hospital.
5. Community staffing norms should be based on 10,000 people over 65 years with the recommendation for this population being:
 - a) 1 WTE Consultant in Psychiatry of Old Age.
 - b) 1 Non Consultant Hospital Doctor in Psychiatry (NCHD) as a minimum.
 - c) 1 Assistant Director of Nursing (ADON) for the entire service (community and hospital).
 - d) 1 social worker.
 - e) 1 occupational therapist.
 - f) 1 clinical psychologist.
 - g) 1 administrator.
 - h) 3 community mental health nurses / clinical nurse specialists
6. The recommended staffing requirements for Psychiatry of Old Age Liaison Service for a large hospital of 400 to 600 beds is 0.5 WTE Consultant, 1.0 WTE Clinical Nurse Specialist (CNS) and 0.5 Administrative Staff (RCPsych 2005).

Where there are more than 1,000 nursing home places in a service's catchment area, additional staffing should be provided as 0.5 WTE Consultant and 1 WTE CNS. This is based on the prevalence of mental disorders and dementia in the nursing home population which is 7.5 times that of older people living in the community (extrapolated from Blazer, 2003 and Cahill et al., 2010).

Facilities

7. The Mental Health Team must be based in an acute hospital setting, where possible, reflecting the recognised co-morbidity with physical illness and the close working relationship with Geriatric Medicine.
8. The day hospital providing mental health services should also be co-located with the acute hospital for the same reasons. It should provide 10 to 15 places per day for a population of 10,000 over 65 years.
9. The acute inpatient unit must be an Approved Centre (Mental Health Act 2001) providing 8 beds per 30,000 population over 65 years (A Vision for Change DOHC '06). It should be separate from the General Adult Psychiatry Acute Unit and staffed by psychiatric nurses trained/experienced in Psychiatry of Old Age.
10. Each service should have a long stay Approved Centre for people with severe and intractable behavioural problems associated with dementia, particularly physical aggression. The norm for this is 30 beds per 30,000 over 65 years (A Vision for Change DOHC, '06).
11. There must be equitable access to public and private nursing home places as for older people with physical problems. Likewise, there must be equitable access to community services such as home care packages, respite etc.

Training

12. Basic training in the core professional discipline with further training in Psychiatry of Old Age is required for each member of the multidisciplinary team (MDT). The formality of the latter differs depending on the discipline. It is most formal for Consultants in Psychiatry of Old Age and requires specifically that the doctor complete full training at Higher Specialist Level in Psychiatry of Old Age and is on the Medical Council's Speciality Register for Psychiatry of Old Age.
13. On-going training is essential. The training and education of staff in acute hospitals and nursing homes should be an important focus of the service. In particular, there should be ongoing training in the assessment and management of challenging behaviour in older people with organic mental health problems.

Interfaces with other Services

- 14.** Good interfacing with other services is a crucial aspect of every Psychiatry of Old Age service given the frequent co-occurrence of mental health problems with social, medical and physical problems and must be actively developed by each team.
- 15.** Within the community, the interfaces are with the GP and Primary Care Network Team and in Acute Hospitals with Geriatric Medicine in particular as well as hospital based health and social care professionals and pharmacy.

Governance

- 16.** Psychiatry of Old Age comes under the governance, including the clinical governance arrangements, of Mental Health Services. Close working relationships at primary care level, particularly with general practitioners, public health nurses, social workers and occupational therapists, and at secondary care level with geriatric medicine services are the key to a successful service.

Glossary of Terms and Abbreviations

Behavioural and Psychological Symptoms of Dementia (BPSD): This describes behavioural and psychological symptoms which may arise in the course of dementia and includes a broad range of psychological reactions, psychiatric symptoms, and behaviours occurring in people with dementia of any aetiology.

Consultation-Liaison (CL) services: Consultation-liaison services are specialist mental health services provided to individuals who remain under the care of another medical specialist in an acute or rehabilitation hospital.

Enduring Mental Illness (EMI): This refers to chronic or enduring mental illness which is severe or debilitating in nature.

Mental Health Services for Older People (MHSOP): Mental Health Services for Older People is the term used to refer to specialist mental health services for older adults in A Vision for Change. Psychiatry of Old Age (POA) is the formal name of the specialty and the term used by the Medical Council in Ireland. Both terms are used interchangeably in this document.

Whole Time Equivalent (WTE): This refers to one full time person allocated to a particular role.

AD	Alzheimer's disease
ADON	Assistant Director of Nursing
CMHT	Community Mental Health Team
CMHN	Community Mental Health Nurse
CNS	Clinical Nurse Specialist
DV	Domiciliary Assessment
LV	Liaison (acute hospital) Assessment
MDT	Multidisciplinary Team
NCHD	Non Consultant Hospital Doctor
OT	Occupational Therapist
POA	Psychiatry of Old Age

1 Overview of Mental Disorders in Later Life

1.1 Prevalence

Three main groups of disorders are commonly seen in later life. These include: depression, dementia and other disorders (such as anxiety, substance misuse, bipolar disorder and schizophrenia). The Central Statistics Office (CSO) predicts a rise in the population of people aged 65 years and over from 462,000 in 2006 to approximately 1.4 million by 2046 (CSO, 2011). This necessitates a considered and coordinated approach on the part of planners and providers to ensure that the increasing need for services will be met. Data from existing mental health services for older people indicate that depression and dementia with challenging behaviour are the two most common reasons why older people are referred to mental health services.

1.2 Depression

Depression is the most common mental health disorder in later life. A survey of community dwelling older people in the environs of St James's Hospital Dublin reported that 10.3% of older people had clinically significant depressive symptoms (Kirby et al., 1997). A more recent study of the Irish community dwelling population aged 50 years and over, The Irish Longitudinal study on Ageing (TILDA), reported a similar point prevalence of 10% (O'Regan et al., 2011). The prevalence among people in hospital and long term care far exceeds this and may range from 17 – 35% (Blazer, 2003). Fortunately, as these figures indicate, the majority of older adults enjoy good mental health and depression is no longer considered a 'normal part of ageing' as it may have been in the past.

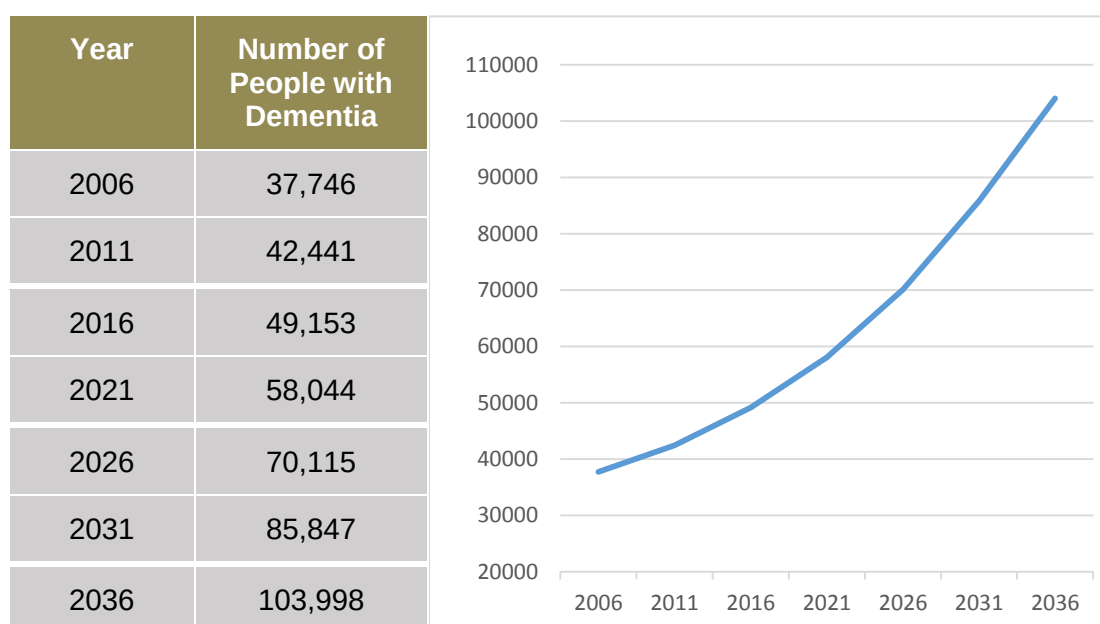
When depression does occur it has a devastating impact upon overall level of functioning and is associated with increased morbidity and mortality (Lenze et al., 2005, Schulz et al., 2000). The causes are complex and in general, depression in later life results from an interaction of biological, psychological and social factors. It is more prevalent in older adults with functional limitations and is proven to both cause and exacerbate physical decline (Penninx et al., 1998). Importantly, effective treatment of depression has been proven to both improve functioning and quality of life (Unutzer et al., 2002). The changing demographics of Irish society mean that there will be increased numbers of older adults with depression in Ireland who will have functional impairment and be more dependent on state services unless effective interventions are deployed.

1.3 Dementia

Dementia refers to a group of disorders which are typically characterised by cognitive decline associated with changes in function and behaviour. Alzheimer's disease and vascular dementia are the two most common causes. Over 90% of older adults with dementia experience behavioural and psychological symptoms of dementia (BPSD) at some point in the course of their illness (Steinberg et al., 2008). These symptoms include: anxiety, depression, aggression, hallucinations or paranoia and, if not correctly managed, are one of the most common reasons why family members are not able to continue caring for their relatives at home (Gallagher et al., 2011b).

The prevalence of dementia in Ireland is projected to rise from approximately 38,000 in 2006 to in excess of 100,000 by 2036 (Table 1) (O'Shea, 2007). The majority of people with dementia are currently cared for at home by family members with little input from formal services. Institutional care is the most costly phase of care and without adequate community supports for older adults with dementia there will be an increased and unsustainable demand for inpatient and long-term care beds. Pharmacological and psychosocial interventions help improve patient function, manage behavioural symptoms and help to maintain older adults in their own home environment for longer (Birks, 2006, Herrmann and Lanctot, 2007, Brodaty et al., 2003). Input from adequately resourced multidisciplinary teams specialising in provision of mental health services for older people, in association with other specialties with expertise in dementia in later life, such as geriatric medicine, will be critical in this regard.

Table 1. Projected Prevalence of Dementia in Ireland (O'Shea et al., 2007)



1.4 Other Disorders

Anxiety disorders are common in later life and data from The Irish Longitudinal study on Ageing (TILDA) indicate that approximately 13% of older people in Ireland experience broadly defined anxiety (alone and co-morbid with other conditions) which is clinically significant (O'Regan et al., 2011). Alcohol related disorders are also frequent in older adults and international community studies have estimated the prevalence for alcohol misuse or dependence to be between 2- 4% (O'Connell et al., 2003). This is higher in other populations and a prevalence of 18% has been reported for medical inpatients.

The lifetime prevalence of both schizophrenia and bipolar disorder has generally been considered to be approximately 1%. However, more broadly defined psychotic disorders are more common and psychotic symptoms frequently occur for the first time in later life. The reported increased lifetime prevalence of psychotic disorders in later life in part reflects increased vulnerability secondary to co-morbid medical and neurological disorders (Perala et al., 2007).

1.5 Morbidity & Mortality

Mental health disorders in later life are associated with increased psychological and physical morbidity and decreased satisfaction with life (Ni Mhaolain et al., 2012). Mental health disorders are independent causes of decreased function and disability and are associated with increased utilisation of healthcare resources (Alexopoulos, 2005, Lenze et al., 2005). Importantly, effective treatment of depression has been associated with improved functioning and quality of life (Unutzer et al., 2002). Older adults globally are at increased risk of suicide compared to younger adults (O'Connell et al., 2004). Depression is one of the most common causes of suicide and effective treatment is associated with reduced suicidal ideation (Bruce et al., 2004).

Poor mental health impacts adversely upon general physical health and complicates and exacerbates the course of many medical conditions. There are both direct and indirect mechanisms which may account for these associations. Older adults with depression are more likely to be physically inactive. They are less likely to adhere to prescribed medications and are more likely to engage in adverse health behaviours (Katon, 2011). In addition, mental health disorders such as depression are associated with increased activation of stress responses (endocrine, inflammatory and autonomic) which may impact adversely upon chronic conditions such as cardiac disease.

In the Irish context, depression in older adults has been associated with an 80% increased risk of co-morbid cardiovascular disease independently of other known risk factors (Gallagher et al., 2012). In international studies, depression has been associated with increased mortality independently of baseline health status and effective treatment of depression in later life has been associated with reduced mortality (Gallo et al., 2007). Good mental healthcare in the context of chronic disorders such as diabetes and cardiovascular disease has been shown to improve both physical and psychological health outcomes (Davidson et al., 2010, Katon et al., 2010).

2 The Key Role of Specialist Mental Health Services for Older People

2.1 Why Older People require Specialist Mental Health Services

Psychiatry of Old Age teams currently provide care to two broad groups of people:

1. Older adults who develop functional mental disorders e.g. depression for the first time over the age of 65 years.
2. Older adults with dementia who develop behavioural and/or psychological symptoms for which specialist mental health intervention is required.

In Ireland, it has become clear that specialist mental health services for older people are required for a number of reasons. These include:

- Many people develop mental illness for the first time over the age of 65 years. This may reflect bereavement, physical ill health, functional impairment and social isolation but also increased neurological vulnerability secondary to degenerative and vascular pathologies.
- More people are surviving to old age and, therefore, are at increased risk of age-related disorders such as dementia. In addition, the numbers of older adults with functional psychiatric disorders will necessarily increase given the ageing population.
- Older adults with mental health difficulties have special needs. The underlying causes and presenting symptoms are frequently different in later life compared to earlier life. There are often co-morbid medical conditions which must be considered. In many instances there are complex social circumstances and legal issues which require a particular approach.

All of these issues mandate the mental health specialist in later life must have specialist knowledge and skills to fully assess and meet the complex needs of older adults in collaboration with professionals from other disciplines.

The policy document for mental health services in Ireland *“A Vision for Change”* (DOHC, 2006) states that individuals with mental health disorders who reach the age of 65 years and are under the care of general adult mental health services should be afforded the option of transferring their care to their local specialist MHSOP team but that the final decision should be based on which team can best meet the particular needs of the individual. Age alone

cannot be a referral criteria as individuals with longstanding mental illness often have needs which differ from those with late onset mental illness: their needs may continue to be best met within general adult mental health services and, in particular, by Mental Health Rehabilitation Services. Resourcing of MHSOP services for this work also requires consideration with team and facility augmentation essential to meet the additional workload.

This document deals with specialist (secondary care) mental health services for older people and is one of two documents within the Older Persons Clinical Programme which together form an integrated care pathway for older people. Reflecting this and recognising that older people frequently have a combination of mental, physical and social problems, those in receipt of specialist mental health services must have equity of access to both primary care and acute hospital services. This is essential to ensure provision of crucial multidisciplinary inputs such as pharmacy, physiotherapy, dietetics and speech and language therapy. The provision of such professional inputs is outlined in detail in Part 1: Acute Service Provision document of the Clinical Programme. The integration of care, including community services, is described in the Integrated Care Programme for Older Persons, (HSE, 2018). The Community Healthcare Organisation document is now national policy for the provision of community services and clearly describes the provision of these services through primary care teams embedded in the primary care network structure. The latter include physiotherapy, speech and language therapy, dietetics and nursing amongst others. Each of these play a key role in providing a holistic, recovery focused approach to older people including those in receipt of secondary care mental health services.

In addition, the mental health service provides a pharmacy resource for mental health inpatient care, the expertise of which is also available to older people who have been admitted to acute inpatient mental health beds. More recently (2014) a dietetics resource has been allocated to mental health services to provide advice and guidance and this should also be available to older patients who are in acute and continuing care mental health units.

In reading the two following sections, it should be assumed that any primary care or acute hospital health and social care professional services listed above are available to the older person if clinically indicated. These services should be provided in tandem with the secondary care mental health service.

2.2 The Role of Mental Health Services for Older People in the Community

In accordance with the principles of A Vision for Change (DOHC, 2006), a critical principle in service provision for older people is that they should have access to the services most appropriate to their needs. Service providers addressing the needs of older people must subscribe to their inherent worth, respect their dignity and care for them on the basis of equity, fairness and accessibility. A prime consideration is that mental health services for older people should be person-centred and promote self-determination (DOHC, 2006) to enable active participation in their recovery where possible.

The aims of treatment are manifold and include alleviating distress, improving quality of life and increasing function and independence. These objectives complement and facilitate improved management of co-morbid medical conditions and help to maintain greater independence in the community for longer. Current best practice guidelines indicate that therapeutic interventions should adopt a holistic approach and include psychological, social and biological approaches to care (NICE, 2009). Critically, a number of meta-analytic analyses indicate that psychosocial and biological approaches are effective in treating psychiatric disorders in later life (Wilson et al., 2001, Pinquart et al., 2006, Herrmann and Lanctot, 2007, Birks, 2006).

2.3 Mental Health Consultation-liaison Services for Older People in Hospital

In Ireland, it is anticipated that the population aged 65 years and over will increase by 20,000 annually such that the proportion of the population over 65 will double over the next 30 years (DOH, 2011). Older people are currently admitted to hospital more frequently and for longer periods than any other age group, and this trend is set to increase.

Mental health disorders are very prevalent in older people in hospitals and the prevalence far exceeds that seen in people ordinarily resident in the community (Table 2). Data from the UK indicates that up to 60% of older people in hospital have or can develop a mental disorder during their admission. Depression, dementia and delirium together account for the majority of these disorders (RCPsych, 2005). Therefore, in a typical acute hospital with 500 beds, 330 may be occupied by older people of whom approximately 200 may have a mental disorder (RCPsych, 2005).

This high prevalence of mental disorders among older people in hospital results from numerous factors which frequently interact with each other (Lloyd, 2012).

These include;

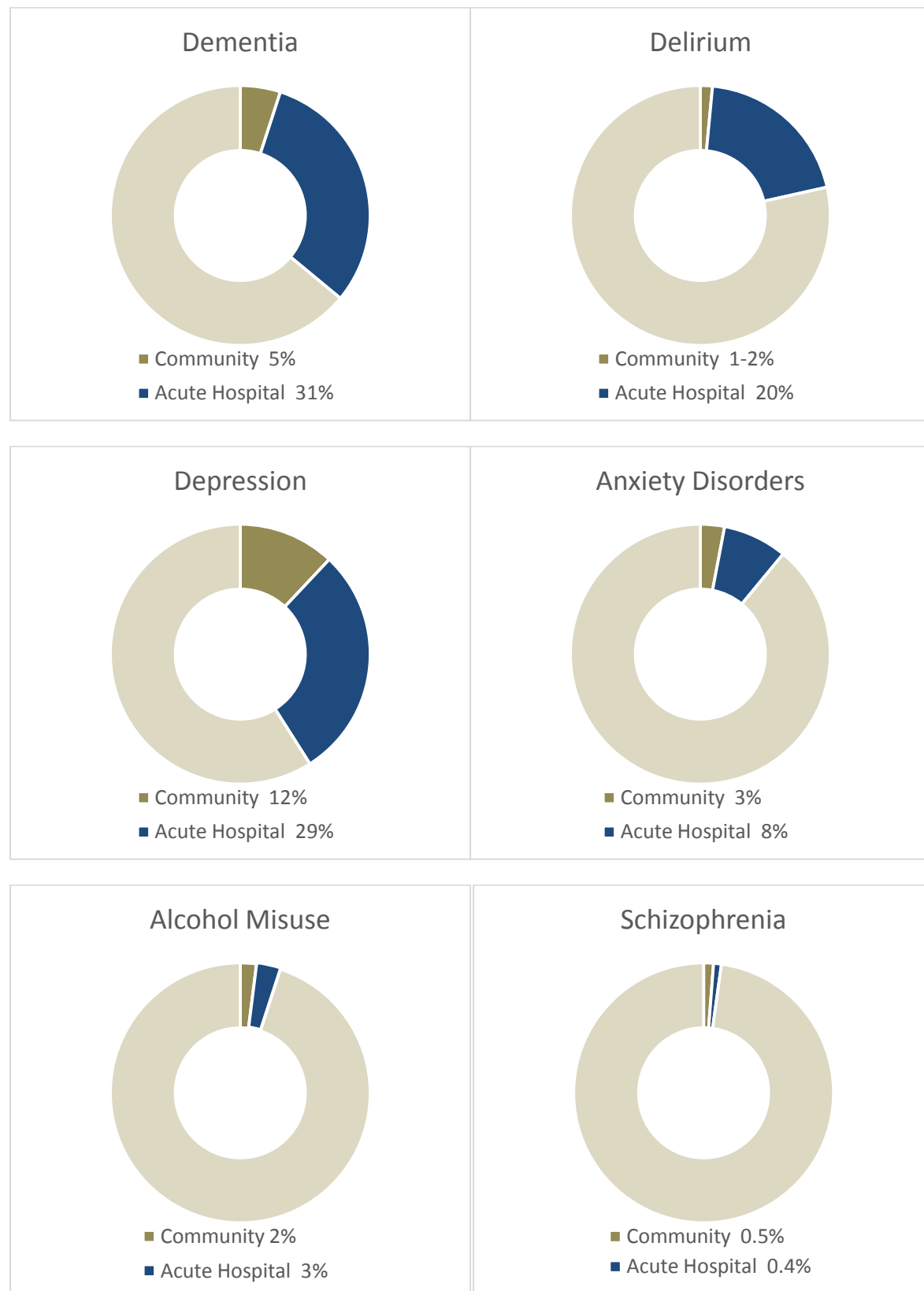
- Direct effects of physical illness on mental function e.g. delirium;
- Alcohol and drug misuse;
- The effects of prescribed drugs on behaviour and mental function;
- Psychological reaction to physical illness;
- Medically unexplained physical symptoms that mask an underlying mental illness;
- Pre-existing mental illness contributing to the development of physical illness.



Psychiatric co-morbidities complicate the course of general medical conditions and are independently associated with longer hospital stay, decreased function, increased institutionalisation and mortality. People diagnosed with dementia and chronic disturbances of cerebral function spend significantly longer in hospital (on average 41.1 days compared to an average of 10.9 days for people over 65 without such disorders). Unfortunately, these disorders may not be diagnosed and so remain untreated in many instances with consequent suffering and increased costs (Harwood et al., 1997, Cole and Bellavance, 1997). In the recent Irish National Audit of Dementia Care in Acute Hospitals, only 71% of acute hospitals reported access to liaison psychiatry or old age services (de Siún, A et al., 2014).

The poor coding for dementia in HIPE data has been criticized in the past (Curley J, 2003). Hospitals should ensure dementia and delirium are adequately coded in hospital discharge summary HIPE data given its importance in resource allocation.

Figure 1. Prevalence of common Mental Health Disorders in Community and Hospital Populations (adapted from 'Who Cares Wins', RCPsych 2005)



2.3.1 The Benefits of a Consultation-Liaison Service

To optimise the physical and mental health of older people it is essential that both aspects of health be addressed simultaneously. Mental disorders can be readily diagnosed and treated in older adults, and a systematic review of randomised trials of consultation-liaison interventions in older people concluded that these services are effective (Draper, 2000). Practical examples of how a liaison service can improve care are outlined in Table 3. The liaison model of service delivery is preferred to consultation only. The latter service is limited and reactive whereas a dedicated liaison service is proactive and affords greater time for engagement with general medical teams. A liaison service is more likely to succeed in having good mental healthcare adopted as the standard of care within a hospital (RCPsych, 2005). These services typically work closely with geriatric medicine services.

Table 2. Examples of Clinical Circumstances in which an Old Age Psychiatry Consultation - Liaison Service can Improve Care

Problem	Challenges faced in the hospital	How a consultation-liaison psychiatry team can help
Delirium	Poor identification and difficulty with behavioural & psychological symptoms of delirium.	Old Age Psychiatry consultation-liaison services can improve detection and management with better outcomes, reduced length of stay and costs. They can also provide support and training to medical and surgical colleagues to improve the standard of care throughout a hospital.
Dementia	Poor identification and management of behavioural & psychological symptoms of dementia.	The consultation-liaison approach can aid in efficient management of behavioural & psychological symptoms.
Depression & Anxiety	Depression and anxiety can precipitate or occur as a consequence of physical illness. Health outcomes are worse, if depression and anxiety are not identified and addressed.	The consultation-liaison team can optimise care thus potentially reducing length of stay and costs.
Self-Harm	Patients who are admitted are those who have made the most serious attempts to end their life and require specialised care.	Consultation-liaison services can effectively assess and treat underlying mental illness thereby reducing risk of reoccurrence and improving health outcomes.
Medically Unexplained Symptoms	These patients typically undergo multiple investigations and utilise significant healthcare resources with little or no benefit to their health.	A consultation-liaison service can address underlying mental health difficulties thereby reducing inappropriate and potentially harmful investigations with improved health outcomes.

In addition to these health-related improvements, consultation-liaison services are also associated with considerable economic advantages. In particular, they have been associated with decreased psychiatric morbidity, improved function, reduced length of stay, fewer readmissions and increased cost-effectiveness compared to usual care (Cole et al., 1991, Slaets et al., 1997, Strain et al., 1991). An economic assessment of a liaison service in Birmingham, which included both younger and older adults, reported estimated savings of £6.4 million annually. These savings reflected reduced admissions from the acute medical assessment unit, reduced length of stay and reduced readmissions. A notable finding from this analysis was that most of the cost savings were achieved in the subgroup age 65 years and over (Parsonage and Fossey, 2011).

2.4 Mental Health Services for Older People and Memory Services

2.4.1 The Case for Developing Memory Services in Ireland

The changing demographics of Irish society means that the prevalence of dementia in Ireland is projected to rise from approximately 38,000 in 2006 to in excess of 100,000 by 2036 (O'Shea, 2007). This increased demand will have predictable consequences for already strained healthcare resources and will place an increased burden of care upon families and individuals with dementia.

Many developed countries, including Ireland, now have dementia strategies in place which aim to provide a uniformly high standard of care in the most efficient way possible (O'Shea, 2007; DoH, 2014). At the heart of such strategies are memory services which are typically multi-disciplinary in nature and provide specialist input where and when it is most needed. These services initially provide a specialist multidisciplinary diagnostic assessment. Thereafter, a care plan is agreed with the patient and his or her carers with the objective of integrating optimal medical care with good social care to help improve quality of life and optimise function thereby maintaining older adults in their own home environment for longer.

It is now recognised that early recognition and diagnosis of memory disorders facilitates the correction of modifiable risk factors, treatment of cognitive and behavioural symptoms and early implementation of psychosocial and environmental interventions to support carers and help maintain people in their own home environment for longer. In particular, memory services have been shown to improve quality of life for those with dementia (Banerjee et al., 2007) and it is projected that such services could provide cost saving (Banerjee and Wittenberg, 2009). It is also proposed that such services would not only deliver excellent care but would also raise

the standard of care more generally through involvement in education and ongoing research into novel therapies and systems of care delivery.

2.4.2 The Role of Mental Health Services within Memory Services

Mental health services are particularly well placed to participate in the further development and implementation of memory services on a national basis. In some instances, this work is currently delivered on a smaller scale by geriatric medicine and mental health services around the country with considerable variability in local practices according to available skills and resource considerations.

Early assessment of cognitive symptoms and appropriate provision of multidisciplinary care has always been a core skill for health professionals working with older adults with mental health disorders. This reflects the almost ubiquitous occurrence of behavioural symptoms in the context of cognitive decline and dementia (Lyketsos et al., 2002, Gallagher et al., 2011a).

It is increasingly recognised that mental health disorders generally considered to be ‘functional’ in nature (such as late life depression) have a neuro-cognitive basis with over 50% of older adults with depression known to have mild cognitive impairment (Butters et al., 2004). It is also now recognised that there are bi-directional relationships between ‘functional’ disorders such as depression and cognitive decline in later life (Diniz et al., 2013). The boundaries are not distinct and provision of good mental healthcare must form an intrinsic component of any memory service which hopes to deliver effective care.

To date, professionals working in mental health services for older people in association with professionals from geriatric medicine, neurology and other healthcare disciplines such as nursing, social work, clinical (neuro) psychology and occupational therapy have been to the forefront of fostering and developing memory services for older adults in Ireland. The role of primary care is also paramount in developing comprehensive memory services and services based in secondary care must work collaboratively with General Practitioners and other members of the primary care team. It is also recognised that the development of such services should not detract in any way from the provision of services for older people who do not have a degenerative basis for their symptoms.

The relatively recently published **National Dementia Strategy (DOH 2014)** has emphasised the role of the GP as the usual first point of contact. The strategy states that while GPs play a key role in diagnosis, a confirmatory definitive diagnosis and

identification of dementia subtypes remains a specialist task. It further states neurologists, geriatricians, old age psychiatrists and memory clinics all have a role in dementia diagnosis and subtyping.

3 ***‘A Vision for Change’*** and Mental Health Care in Older People

3.1 **Background to a *‘A Vision for Change’***

The Minister of State in the Department of Health and Children with special responsibility for Mental Health appointed an expert group in August 2003 to prepare a comprehensive mental health policy framework. There was extensive consultation with service users, families and service providers. A report by the expert group on mental health policy “A Vision for Change” was published in 2006. It proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems.

The policy envisions an active, flexible and community based mental health service where the need for hospital admission will be greatly reduced. It noted that older people with mental health problems were being dealt with by general mental health services in some parts of the country. The latter are not configured or adequately equipped to meet the particular needs of older people with mental illness. It makes a number of recommendations regarding mental health services for older people.

3.2 **Recommendations of *‘A Vision for Change’***

The recommendations of *‘A Vision for Change’* are listed in **Appendix A**. Regrettably, the expert group did not have representation from Psychiatry of Old Age and this is evident in certain recommendations. There are also important omissions. However, most recommendations are very much in line with what best meets the needs of old people with moderate to severe mental health problems. Specific areas for clarification are:

- All norms should be quoted with reference to the older population, i.e. numbers over 65 years of age and not the total population.
- If older people currently under the care of the general adult psychiatry services were to transfer to mental health services for older people, there must be an equivalent transfer of resources (physical and personnel) together with equitable access to mental health rehabilitation services.
- *‘A Vision for Change’* includes no reference to the critical role of Psychiatry of Old Age in providing a liaison service to older people admitted to acute hospitals. This is a major omission that has been addressed in this Model of Care document.

4 Structure of Specialist Mental Health Services for Older People

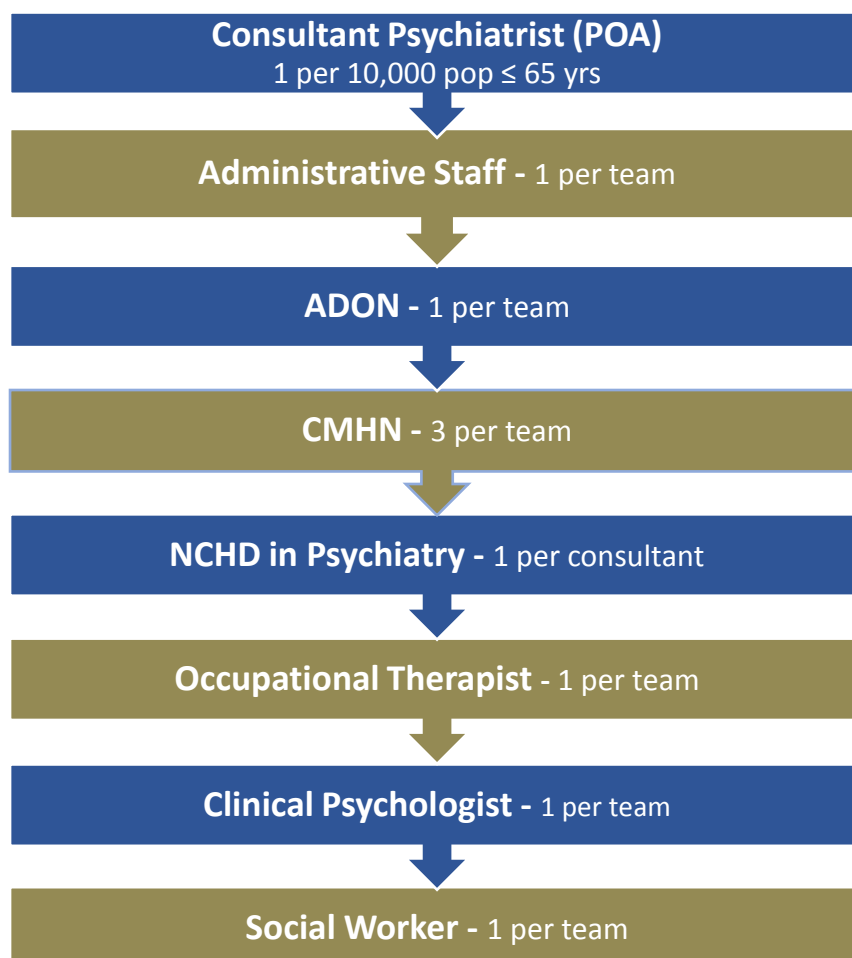
4.1 Structures and Staff Required for Community Teams

In order to function effectively, mental health services for older people must have adequate resourcing and infrastructure. There have been several recommendations in this regard both in the Irish and international context (DOHC, 2006, RCPsych, 2006). It is more accurate to consider service requirements in relation to the proportion of the population aged 65 years and over rather than the general population and this is the approach adopted below.

4.2 Community Mental Health Team

The following table (Table 4) lists the recommended core team required for the delivery of a Specialist Psychiatry of Old Age Service.

Figure 2. Community Mental Health Team – Recommended Staffing



The above staffing is for a core community mental health team providing for a catchment area population of 10,000 people over 65 years of age. However, given the emphasis on domiciliary assessments, services covering large geographical areas may require additional resources as may those in particularly deprived areas. One member of the team should be the team coordinator. In 2006, A Vision for Change recommended 39 community teams for a population of approximately 430,000 people of 65 years. The 2016 census shows there are now 637,575 people over 65 years. The number of teams should increase in line with the population. There will also be additional requirements for further services such as consultation-liaison services to the acute hospital or a memory assessment service.

4.3 Community Structural Requirements

4.3.1 Day Hospital – Psychiatry of Old Age

It is essential that day hospitals providing mental health services for older people are based on the acute hospital campus both for ease of access to the acute hospital and the community and to ensure that the physical aspects of assessment can be carried out. These day hospitals are a distinct separate entity to the day hospital providing assessment, diagnostic and treatment services to the older population as described in the Specialist Geriatric Services Model of Care, Part 1: Acute Services Provision. Day hospitals should be sufficiently spacious to provide room in particular for those who suffer from dementia who may be restless or aggressive. Staffing must be multidisciplinary and include mental health nurses, psychiatrists, an occupational therapist, clinical psychology and social work sessions together with a receptionist to ensure both good communication with others (GP, family etc) and that therapy sessions are not constantly interrupted by the telephone.

The day hospital should be of sufficient size to meet the needs of the local population. International guidance specifies that a day hospital providing mental health services should provide 10 – 15 places per day for 10,000 people aged 65 years and over (RCPsych, 2006).

4.3.2 Acute In-patient Beds

Acute beds should be in a separate acute psychiatric unit close to the general adult psychiatric unit for cover and support purposes or a designated but separate area within the acute general adult psychiatric unit for Psychiatry of Old Age. It is strongly recommended that beds for older adults be located separately to ensure care is

provided by appropriately skilled staff and to ensure the safety of vulnerable older people.

The unit should have sufficient capacity to meet the needs of the population with 8 acute beds for MHSOP in each Mental Health Area of 30,000 people over 65 years as specified in A Vision for Change. International guidance specifies 1 – 2 acute beds per 1,000 older adults according to availability of home treatment. In instances where a service accepts responsibility for 'graduates' or older adults with early onset mental illness this provision would need to be increased (RCPsych, 2006). Further adjustments for deprivation may be appropriate using tools based on recent census data (Haase et al., 2012).

4.3.3 Continuing Care Beds

It is crucial that there is access to different levels of continuing care for patients seen by mental health services for older people. The majority of patients, like those seen by geriatric medicine, have their needs fully met within generic nursing home settings in private or public facilities. However, a small number of people with dementia who are mobile may have very severe intractable behavioural problems (typically unpredictable, physically aggressive behaviour, persistent agitation or sexually disinhibited behaviour liable to put others at risk), and require ongoing care in a mental health setting.

These longer term settings must come within the protections of the Mental Health Act 2001 and specifically be in Approved Centres under that legislation. They must also have a very clear admission policy. Hence every Old Age Psychiatry service should have access to a continuing care unit specifically for people with dementia associated with severe and intractable behavioural problems who cannot be managed in any other setting. 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. A Vision for Change recommends that 30 such places should be provided for a total population of 300,000.

4.3.4 Suitable Accommodation for Older People with Enduring Mental Illness

A proportion of older people with Enduring Mental Illness (EMI) reach a point where they can no longer live independently in their own homes. This may occur due to deterioration in their mental illness or the death or ill health of a carer. Functional impairment in EMI may be secondary to chronic debilitating psychological distress, a degree of cognitive impairment or both. Cognitive impairment in this population is usually characterised by executive dysfunction which means that organisational skills, motivation, ability to solve problems, recognise risks and care for oneself adequately are impaired. Community services may not be able to provide suitable support for this group of people as the criteria used by public health nurses to allocate support services are focused primarily on physical care or dementia. Local services around Ireland have developed local solutions to accommodate this very vulnerable group of people.

Local solutions may include a voluntary sector sheltered housing supplier working with local services and mental health teams to support people with EMI or, in other instances, patients are cared for in nursing homes and remain under the care of mental health teams. However, the high proportion of older adults with dementia in nursing homes may make them unsuitable for people who have relatively less cognitive impairment. Similarly, older adults with EMI may struggle to fit into an environment that is focused on the physical health needs of the majority of the residents. As the aging population continues to expand and as a greater proportion of younger people with EMI live to be older, accommodation issues will continue to increase and should be addressed as a matter of urgency.

4.4 Requirements for Consultation-liaison Teams in Hospitals

The multidimensional nature of mental disorder in older people means that a multidisciplinary approach is best suited to optimal patient care. Core members of the team are similar to the community team and should include psychiatrists, mental health nurses, occupational therapists, social workers and clinical psychologists. The composition of the liaison team will be influenced by the hospital size, proportion of older people in the hospital, mental health needs of the hospital population and the configuration of local services for older people's mental health services and geriatric medicine.

Every MHSOP should have a designated consultant psychiatrist for consultation-liaison with sufficient protected time to fulfil this function. These sessions should be written into the

consultant's job plan. In general, older people occupy two thirds of acute hospital beds such that, in a typical acute hospital of 500 beds, at any time some 330 beds will be occupied by older people (RCPsych, 2005).

The prevalence of mental health disorders in this population is greatly increased compared to community dwelling older adults as previously discussed. It is, therefore, recommended that for a large acute hospital with approximately 500 beds that a minimum requirement to begin providing a consultation-liaison service would be 0.5 WTE Psychiatry of Old Age Consultant and a clinical nurse specialist with administrative support assigned pro-rata to consultant WTE. Structural requirements include appropriate office facilities and access to the facilities of the MHSOP as outlined above. Active engagement with geriatric medicine services should form a core element of the functioning of the team. This augmentation of the MHSOP specifically for acute hospital liaison work is in addition to the AVFC recommendations for generic Liaison Psychiatry Services for acute hospitals. The latter would continue to take responsibility for liaison work within an Emergency Department and out of catchment area patients admitted to wards with the MHSOP liaison sub team taking responsibility for MHSOP's catchment area patients.

4.5 Requirements for Consultation-Liaison Services to Nursing Homes

The number of private nursing homes in Ireland has increased greatly in the past 5 -10 years as a response to the increasing number of older people requiring such care and government policy advocating the use of private residential care with tax breaks facilitating this. Older people, and the very old in particular, require such facilities because of their increased physical and mental health problems compared to those still living at home.

The mental health morbidity of residents in nursing home is considerable:

1. The point prevalence of major depression in the community ranges from 1 – 4% with approximately 10% reporting clinically significant depressive symptoms. However, depression is much higher among nursing home residents with approximately 12% experiencing major depression and 35% reporting significant depressive symptoms (Blazer, 2003). This represents an approximate three-fold increase over the prevalence generally seen in community dwelling older adults.
2. The point prevalence of dementia is approximately 5% among community dwelling older adults while the prevalence of dementia among nursing home residents in the US and Europe has been reported to be between one half and two thirds of nursing home residents (Cahill et al., 2010). This represents an approximate ten to twelve-fold increase over the community prevalence frequently reported although clearly there will be some variation according to local demographics and admission policies.

Taking the increased prevalence of dementia alone it might be anticipated that the approximate prevalence of mental health disorders in this context could approach or exceed ten-fold that ordinarily seen in the community. In practice, this might mean that a 100-bedded nursing home would be equivalent to 1,000 older people living in their own homes. This has significant implications for service delivery.

In some Geriatric Medicine Services in Ireland, successful nursing home liaison has been developed by the deployment of an additional geriatrician on a 0.5WTE basis together with a senior nurse at Clinical Nurse Specialist level to respond to the secondary care physical health needs of nursing home residents on site. This has been shown to reduce referrals of nursing home residents to Emergency Departments and allow for more rapid discharge from acute hospitals of nursing home residents (Specialist Geriatric Services Model of Care, 2012). It is recommended this model be replicated in Psychiatry of Old Age services with a 0.5 WTE and 1 WTE clinical nurse specialist to provide for up to 1,000 nursing home beds (both public and private). The addition of the skills of a clinical psychologist in the assessment and management of behaviour problems in particular is also recommended.

5 Care Pathways and Interfaces with Other Services

5.1 Care Pathways and Interfaces for Older Person in the Community

This section describes the pathway of care for community based older people with mental health disorders who require referral to a specialist mental health service for older adults. The majority of mental health problems in older people living in the community are managed by the individual's GP in association with other members of the primary care team and will not require onward referral to a specialist mental health service.

However, in instances where the problem is moderate to severe, where initial interventions fail or where there are indicators of risk, the GP may consider onward referral to specialist Mental Health Services for Older People (see Fig. 1). Other specialties may also make referrals to MHSOP. This is particularly true for specialists in geriatric medicine who typically have a close working relationship with professionals working in MHSOP teams although a range of other medical or surgical specialties also frequently make referrals.

5.2 Criteria for Referral and Process of Assessment

Mental Health Services for Older People currently provide care to two broad groups of people and referrals should reflect one or other of the indications listed below.

- Older adults who develop functional mental disorders for the first time over the age of 65 years.
- Older adults with dementia who develop behavioural and/or psychological symptoms for which specialist mental health intervention is required.

There should be one clear point of referral to ensure clarity and ease of access for referring agents. Once received, a referral is triaged by an appointed team member (the team coordinator) working under the supervision of the responsible consultant. An appointment is scheduled according to urgency and an initial assessment normally takes place in the person's home and is usually carried out by the consultant psychiatrist or senior registrar (where available). In certain instances, it may be considered more appropriate to conduct an initial assessment in the outpatient clinic. The assessment should include a comprehensive assessment of an individual's psychological, social and biomedical care needs. A collateral history is an important part of this assessment process. Following this assessment a diagnosis is made, the person's needs identified and appropriate care and treatment advised. This is discussed with the person and, with consent, with his/her family.

5.3 Multidisciplinary Team Meeting and Process of Care

Post assessment all new or referred patients are discussed at the multidisciplinary team meeting and an individual care plan agreed and implemented. For those patients who are likely to require ongoing specialist mental health input, a community mental health nurse is assigned as the key worker with responsibility for clinical review, follow up and coordination of care. Where clinically indicated, another member of the multidisciplinary team may act as key worker. Where patients require input from health and social care professionals within the team, referrals are discussed and made at this point.

In addition to the type of care required, it must be considered where this care should be delivered. There are several options in this regard (listed below) and the choice is guided by clinical need and patient preference.

Community - Most patients will be cared for at home. In other instances, where an individual is residing in a nursing home, care will be delivered in that setting. The care will be delivered by the MHSOP team with relevant disciplines involved as determined by the clinical circumstances.

Psychiatry of Old Age Day Hospital - This is for individuals with more severe forms of illness or who have failed to progress with initial home-based treatment. The day hospital frequently provides community-based treatment for individuals who might otherwise require inpatient admission.

Acute Inpatient Care - Acute inpatient care is reserved for individuals with more severe forms of illness who present a risk to themselves or others in the community and who are thought likely to benefit from a period of inpatient treatment. Inpatient care may also be appropriate for individuals who have failed to improve in the community. In general, only a very small proportion of patients require a period of inpatient care as evidenced in current activity data. The main indications include:

- Moderate to severe mania.
- Depression associated with suicidal intent, severe weight loss or very distressing psychotic symptoms.
- Psychotic disorders where the person is putting themselves or others at risk.
- Dementia associated with severe behavioural symptoms.

Long Stay Care - In a small proportion of instances ongoing residential care in a long stay unit approved under the Mental Health Act 2001 will be required. This type of care is only required for the few dementia sufferers who have failed to improve despite all interventions and, therefore, require ongoing specialised psychiatric nursing care

which could not be delivered in a nursing home. In general, this small number of dementia sufferers will have severe and intractable behavioural problems, often characterised by aggression and will require greater nursing intervention. The great majority of dementia sufferers who require residential care will receive this in public and private nursing homes.

5.4 Discharge Back to Primary Care

All patients in the care of the service should be reviewed at clinically appropriate intervals by the key worker and other disciplines involved in their care. The responsible consultant, with advice from the team members involved, will discharge the patient back to the care of his or her GP when treatment has been completed.

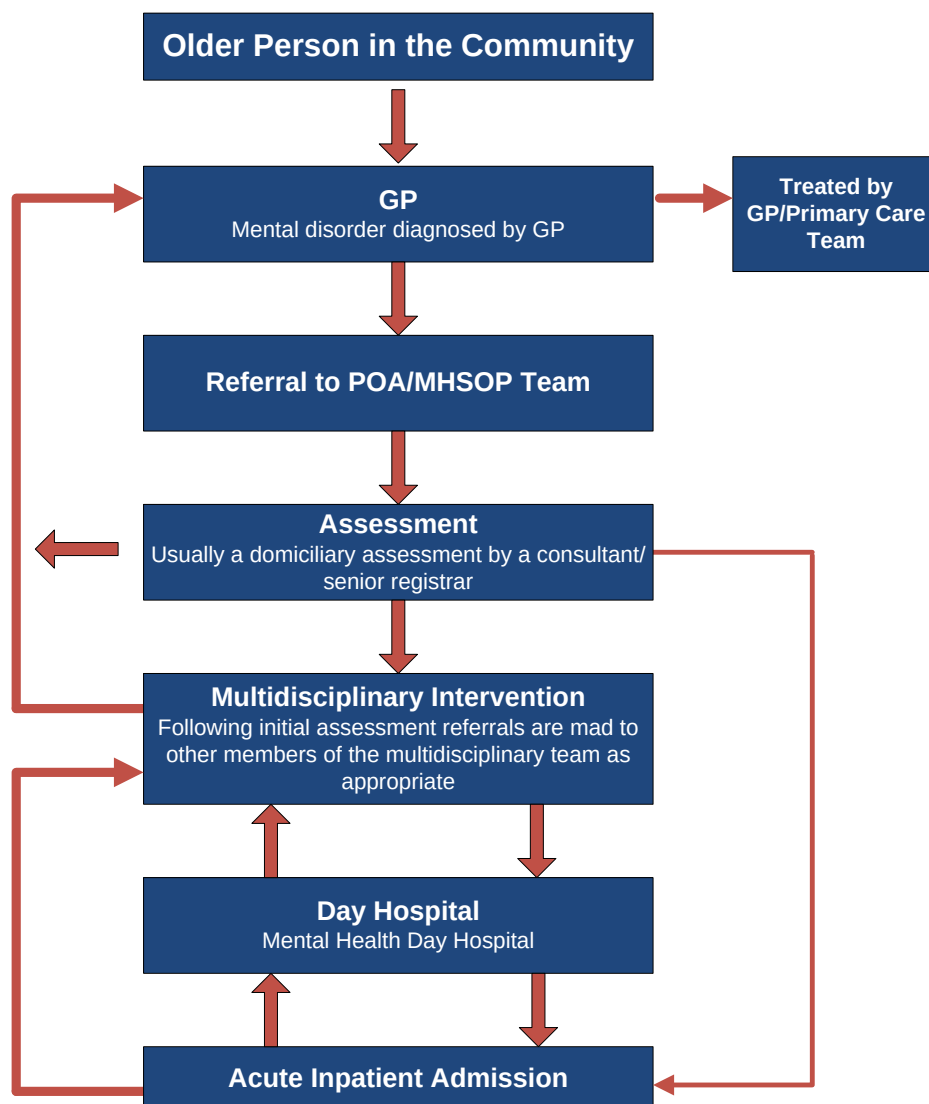


Figure 3. Care Pathway for Older Adult living in Community with Mental Disorder

5.5 Care Pathways and Interfaces for Older Person in Hospital

An older person in hospital is referred to the Consultation-Liaison (CL) service because a mental disorder is suspected and there may be several outcomes arising from this (Fig 2). If the older person remains in the hospital, the CL team may remain involved, if clinically indicated. When the older person is being discharged from the hospital and if specialist mental health follow up in the community is required, this is discussed and put in place at the weekly team meeting.

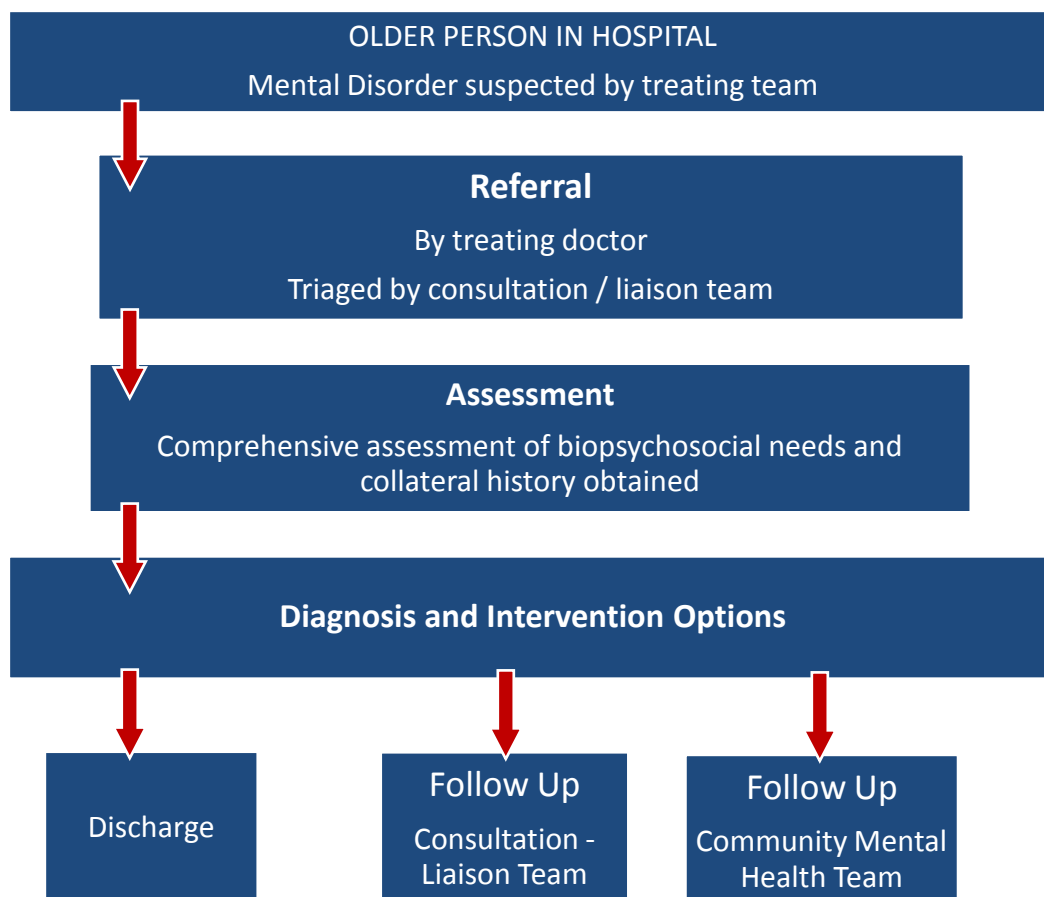


Figure 4. Care Pathway for Older Adult in Hospital requiring Psychiatric Assessment



Figure 5: Care Pathway for Older Adult with Mental Disorder leaving Hospital

6 Roles of multidisciplinary team members

6.1 Doctors

An Old Age Psychiatrist is a psychiatric specialist skilled in the prevention, diagnosis, treatment and rehabilitation of mental disorder in persons over the age of 65 years.

Clinical Expertise: As clinical experts, old age psychiatrists provide specialist psychiatric assessment based on history, clinical examination, together with all other relevant information to ensure early detection of mental illness using different models such as biological, psychological, sociological, developmental, behavioural and systemic. In so doing, they provide a diagnostic assessment including risk assessment to best guide effective evidence-based treatment planning, in collaboration with the multidisciplinary team. They practice within a multi-agency framework particularly in association with primary care and community old age services, geriatric medicine and whatever other bodies, both statutory and voluntary, that are relevant to this endeavour.

Communication Skills: The Old Age Psychiatrist depends on effective communication skills for obtaining and sharing clinical and other relevant information with patients, carers and other health professionals. The Old Age Psychiatrist is able to effectively handle challenging communication issues in a wide variety of clinical settings.

Management/Leadership and Strategic Planning: As highly trained professionals, consultants have a responsibility to provide leadership in their clinical setting. Efficient resource management requires an understanding of the organisational features of national, regional and local mental health care structure. Where resource constraints are impacting on the quality of care to patients, the Old Age Psychiatrist will act in the best interests of their patients to assertively communicate their concerns with management and seek an effective resolution. By so doing they will satisfy their ethical obligations to act as an advocate for patients and staff. Concerning multi-disciplinary working, the Old Age Psychiatrist will be aware of the limitations of his/her professional skills and acknowledge the separate but complementary skills of other professional members of the multi-disciplinary team.

Advocacy: The Old Age Psychiatrist will at all times defend, and within the limits of his/her powers, ensure the rights of patients to receive appropriate mental health

treatment based on best available evidence.

Scholarship: Lifelong learning is now both a necessity and a statutory obligation for medical professionals. Old Age Psychiatrists recognise the need not only for maintaining their clinical competence, but also for continually pursuing a mastery of their entire domain of professional expertise. They will also recognise that their own clinical practice can be a model for the learning of others.

Professionalism: Old Age Psychiatrists will conduct their practice in an ethically responsible manner that respects medical, legal and professional obligations.

6.2 Nurses

Community Mental Health Nurse: The Community Mental Health Nurse (CMHN) has a vital role in the delivery of comprehensive, efficient, high quality, recovery orientated care for individuals with mental health problems. Their role is to assess and treat the individual in the community through the delivery of appropriate care and recovery orientated interventions. In so doing, they collaborate with patients, family, carers and other staff in treatment/care planning and in the provision of support, advice and education. CMHNs work within a multi-disciplinary team to provide specialised assessment, planning, delivery and evaluation of care using local and national protocol driven guidelines. Care delivery and caseload management is delivered in line with core concepts such as clinical focus, patient advocacy, education and training, audit and research, consultancy.

The role of the Community Mental Health Nurse is to:

- Assess and manage patient care to ensure the highest professional standards using an evidence-based, person-centred approach.
- Develop recovery orientated plans with patients in collaboration with professional colleagues, families and carers.
- Provide appropriate treatment and recovery focused interventions (psychosocial, cognitive, behavioural and wellness action plans) to enhance mental health.
- Plan, implement, co-ordinate and evaluate care in collaboration with the patient, the family/carer and the multidisciplinary team.

- Communicate effectively with patients, families, carers, primary care services and voluntary service providers.
- Facilitate co-ordination, co-operation and liaison across multidisciplinary teams, primary care teams and voluntary organisations.
- Adhere to and contribute to the development and maintenance of nursing standards, protocols and guidelines consistent with the highest standards of patient care.
- Provide a high level of professional and clinical leadership.
- Evaluate and manage the implementation of best practice policy and procedures.
- Participate in the identification and delivery of education, training and development programmes for patients, carers, families and other healthcare professionals.
- Contribute to the formulation, development and implementation of policies and procedures.
- Initiate and participate in research and auditing to promote evidence-based best practice.

Consultation-Liaison Nurse (CL): The CL nurse is based in the acute hospital and has dedicated time to respond quickly to referrals from the acute hospital wards. The nurse is a member of the Old Age Psychiatry team and attends weekly team meetings and ward rounds with the Consultant in Old Age Psychiatry. The CL nurse may conduct preliminary assessments of referred patients under the supervision of the Consultant in Old Age Psychiatry. The CL nurse monitors patient progress and ensures that clinical recommendations are adhered to. The CL nurse plays a significant educational role in the identification and optimal management of common psychiatric conditions throughout the acute hospital.

In certain instances the role may be further developed to include devising nursing protocols, clinical research and audit. As a member of the multidisciplinary team, the CL nurse assists in bridging any gaps between the acute hospital and community arms of the MHSOP service. .

6.3 Clinical Psychologist

The role of the clinical psychologist, a key member of the MDT, includes the following:

Psychological assessment and intervention: This involves assessment and intervention with individual clients experiencing psychological distress due to a variety of conditions and developmental challenges. It also includes direct assessment and formulation of behavioural and psychological symptoms of dementia (BPSD) and the assessment of cognitive status for diagnostic purposes, to inform the treatment and management of clients in the service, in addition to the development of comprehensive and corrective attributions for BPSD.

Clinical psychologists work with families and staff who are caring for a person with dementia or a mental illness. This may involve the development of behavioural and psychosocial programmes to be implemented by carers to reduce psychological distress, BPSD and increase the well-being of clients with dementia and mental health difficulties.

Systemic work: This includes attendance at family meetings in order to evaluate the system within which the older client exists and to assess its strengths and vulnerabilities and how these impact on the client. Systemic work may also include work with couples and families to adjust to and accommodate changes in a client that appear to stress the system. It also includes evaluation of formal (residential) care systems within which older clients receive care as part of a macro evaluation of organisational and systemic factors that have a direct bearing on work practices and models of care that may be impacting negatively on the care of the individual. Recommendations for changes in organisational structure and practices are frequently made as part of this evaluation. The provision of tailor-made educational input may occur in order to develop skills to deal with BPSD in particular settings.

Education and Training: Clinical psychologists in Old Age Psychiatry play an important role in education and training. This occurs through direct provision of supervised specialist placements to trainee clinical psychologists. It also occurs through the provision of specialist teaching input into the four main university based programmes for training of Clinical Psychology in Ireland (Trinity College Dublin, University College Dublin, University College Galway and University of Limerick) co-ordinated, for efficiency, through the older adult clinical psychology special interest group. Clinical Psychology has developed education and skills training events for care staff in nursing homes to specifically address the care of older adults who have

dementia and BPSD. Educational input for other clinicians and the public is also provided.

6.4 Social Worker

Social workers have a key role to play in the provision of mental health services to older people and should be involved in assessment, care planning, and therapeutic service provision.

Psychosocial assessment: This includes assessment of social supports, physical and emotional needs of the client, nature and strength of personal and familial relationships, personal care, financial issues, legal issues and living conditions. This information is gathered directly from the client, from family (with the permission of the client) and from other professionals involved. This assessment forms the basis for social work recommendations and interventions in the case. The guiding ethical principles of social work practice include respect for the client's right to self-determination, unconditional positive regard for clients and confidentiality in practice.

Implementation of tailor made care plans to meet identified needs of clients and informal carers: This can involve mobilising resources through the Public Health Nurse such as home help, meals on wheels, day care, respite care and home care packages for older persons. It can also involve the social worker operating as a co-ordinator of the move to nursing home care for the client with reference to the Nursing Home Support Scheme Act 2009 (Fair Deal). The social worker may request family meetings and/or case conferences if the issues in the case warrant mediation via these channels.

A key element of meeting the identified needs of clients is multi-disciplinary and multi-agency cooperation and communication throughout the time of social work involvement in the case. The social work assessment is revised in accordance with new information that emerges, keeping the older person at the centre of practice at all times. The social worker must develop close working relationships with outside agencies to effectively advocate for resources to be provided in the interests of clients, including state agencies (e.g. housing authorities), voluntary agencies (e.g. Alzheimer's Society of Ireland) and private agencies (e.g. nursing homes).

Social workers perform a **consultative function** for colleagues on the multidisciplinary team, e.g. giving advice to colleagues in relation to professional obligations with regard to cases of vulnerable adults or children. Social workers possess a good working

knowledge of legislation relevant to older persons, financial entitlements of older persons and of government policies relevant to this age group.

Social workers are also engaged in **group work practice** e.g. support groups for carers, anxiety management groups for service users and psycho-educational groups. Individual social work counselling is provided, particularly in the area of bereavement counselling.

Social workers work at a macro level, advocating for positive change in government policy regarding older persons. This work is often channelled by the Irish Association of Social Workers. Social workers may be involved in research projects to help inform best practice.

6.5 Occupational Therapist

Occupational Therapists (OTs) work closely with the person recovering from a mental illness and provide specialised assessment, planning and treatment interventions to assist and optimise his/her functional independence and wellbeing. In general, the goal of OT treatment is to achieve an optimal interaction between the person, his/her occupations or purposeful activities, and the environment, to enable the client to live a meaningful life within their community.

This can be achieved through the following:

- Focus on the identification and therapeutic use of occupations or activities within a meaningful routine that promotes positive mental health.
- Provision of a structured assessment in conjunction with the person to review their level of function and cognitive performance both within the hospital and community setting, as required, to identify their strengths and goals. The OT may use a variety of standardised assessments, occupational analysis and outcome measures to achieve this.
- Community re-integration programmes, e.g. accompany client or work with families to achieve graded goals in relation to shopping, social clubs or public transport etc.
- Group facilitation (within in-patient or community day-hospital setting). This includes psycho-educational groups such as anxiety management or the Wellness and Recovery Action Planning (W.R.A.P.). In conjunction with OT Assistant staff, OTs also provide activity focused groups such as art, gardening,

meal preparation, cognitive stimulation therapy, cognitive rehabilitation and social groups.

- Liaison with community services; this includes identifying and encouraging social connections within the community e.g. referrals to day centres, luncheon clubs, social clubs, educational classes or volunteering roles.
- Facilitate implementation and modification of care plans within a recovery-oriented approach to care.
- Explore interventions for a person with dementia who may be experiencing difficulty with functional tasks such as self-care, home management and community access through the evaluation of a person's abilities and the potential contribution of environmental factors.
- Offer guidance to the service user and engage with caregivers regarding the performance of activities of daily living and level of assistance required.
- Advise on environmental modification and the use of the person's home or community environment to enable optimal occupational performance e.g. assistive technology.
- Conduct safety and risk assessments within the home or community as required. This will include liaison with primary care services about necessary aids and adaptations to promote function while minimizing risk.
- Enable structured goal-setting skills within the recovery model. This may include lifestyle redesign through the evaluation of a person's roles and routine to promote positive mental health.
- Provide caregiver education in addition to support in applying for and implementing formal supports e.g. home care packages in the community where recommended.

6.6 Administrator

The administrator in each MHSOP team is a core member of the multi-disciplinary team and is crucial to the smooth running of the service.

Specifically the role includes:

- Being consistently at the team base and hence the point of contact for the team at all times.
- Triaging of phone calls from patients and their families to ensure that their needs are met in a timely fashion.

- Receiving phone referrals from GPs and hospital doctors and again triaging them to ensure a timely response.
 - Alerting the relevant member of the multidisciplinary team in response to clinical situations.

The administrator is the first point of contact for the Old Age Psychiatry service and the public impression of the service depends on this role. It is essential in all mental health services that an administrator is available to patients and their families at the team base to respond to urgent phone calls. This is particularly relevant in an older person's service where older people are less likely to leave messages on an answering machine thereby increasing clinical risk.

The role also includes crucial functions to ensure the smooth and safe running of the service. These include:

- Office management
- Typing of clinical reports for referring doctors to ensure timely communication of patient needs.

6.7 Pharmacy

Pharmacists are not members of MHSOP teams but in acknowledgement of the importance and extent of their contribution to older person's services as a whole, their role is outlined in this section of this model of care. Pharmacy plays a central role in the healthcare of older people across all settings: community, hospital, mental health services and all forms of residential care. Major mental illness often requires psychotropic medication as a preliminary management to stabilise the person sufficiently to facilitate the other essential MDT interventions required to support recovery. Pharmacy is of particular importance to older people because they:

- have altered pharmacodynamics making them susceptible to side effects
- Are commonly on several medications for physical illnesses which may cause compliance issues and increased potential for interactions.
- Memory problems may also contribute to compliance issues.

The provision of pharmacy services for people attending specialist (secondary care) mental health services depends on the setting where the person is receiving care.

1. Within the home and community based residential settings, both public and private, provision is through the community pharmacy services. The increasing use of blister packs is helping to improve patient compliance with medication. Together with the GP, the community pharmacist is well placed to minimise the risk of drug interactions resulting from poly-pharmacy.
2. When patients are seen by POA in acute hospital wards, the hospital pharmacist is responsible for dispensing any medication suggested by the psychiatrist and subsequently prescribed by the treating consultant, physician or surgeon.
3. For acute mental health inpatient units there are two models. For acute mental health inpatient units based in acute hospitals, the hospital pharmacist normally fulfills this role. For psychiatric hospitals, a pharmacy service specifically for the hospital is provided.

Where patients are living in the community, POA services normally advise the GP on what to prescribe rather than directly prescribing. This is in line with the principle of ensuring only one doctor prescribes hence minimising the risk of drug interactions or duplication. This enhances safety. The same principle applies for acute hospital inpatients seen by the liaison component of POA services.

The use of psychotropic medication is a very important component of managing major mental health problems in older people. Pharmacists have an important role in this context and recognition and consideration should be given at a national level as to how in-house pharmacy expertise should be readily available within the mental health services including those for older people.

7 Current Activity and Gaps in Service Provision

7.1 Activity of Community Services and Gaps in Service Provision

Tables 5 and 6 outline the resources available and the activity data for each public service in Ireland in 2010. The tables show that the services then were very busy but often inadequately resourced with significant gaps in both key personnel and facilities. Some services had a population in excess of the recommended norm of one consultant and multidisciplinary team per 10,000 people over the age of 65. Low numbers in the other category reflected the lack of development of the multidisciplinary aspect of the teams with inadequate deployment of occupational therapists, clinical psychologists and social workers. There were also deficits in administrative support in many teams. However, the Mental Health Programme for Government funding (PFG) (2013 - 2015) has enabled the HSE Mental Health Division ensure all parts of the country will have a service once the staff have been recruited together with augmentation of existing teams. A total of 153.5 WTEs were allocated during this three year period.

Currently, there are thirty one public old age psychiatry services of which four are organized as double teams with two consultants, three as triple teams with three consultants and one has 4.5 consultants i.e. forty four teams in all. There is a new team being recruited for North Tipperary which is now partially operational. New teams have been put in place in Kildare, Wicklow, Kerry, South Mayo and Roscommon. There are also four private services all located in Dublin.

With regard to the public services, shortly West Cork will be the only part of the country where there is no community POA service. The very small team (0.5 consultant and two part- time staff) can only provide a limited service to four nursing homes . This requires urgent address. A number of the newer services require further team augmentation as they lack key disciplines or have only part- time staff. . These include Mayo B , North Lee , North Cork , Kerry , North Tipperary , Carlow/ Kilkenny and the two Waterford teams. Where the services operate as double or triple teams (reflecting the number of consultants) rather than being developed as stand- alone teams , there has not in general been an equivalent deployment of the other disciplines in the team . These staffing issues also require attention if a multidisciplinary specialist service is to be provided to older people.

Table 7 shows the number of additional teams together with improved staffing in existing teams nationally. It also shows the community activity now collected nationally as part of the

mental health service performance metrics. The POA liaison data (included only in the 2010: Table 6 data) was recently piloted nationally and routine collection has now commenced.

The business of the service is reflected in the high number of referrals particularly to the longer established services. Equally there is a low admission rate but very active day hospitals providing specialist mental health services, where such exist. Further evidence of these services' ability to manage the majority of patients in the community is the high number of community interventions as indicated by the high number of community mental health nurse visits. The reason for this is that most people are managed in their own setting with the provision of support, advice and treatment from the multidisciplinary team. Where there are day hospitals, they function either as an alternative to in-patient care or to facilitate early discharge. There are still, however, many services without a day hospital and this requires address.

AVFC recommends an eight bedded POA unit per 300,000 total population. There are just six units in the country. Two further units were provided several years ago: one was decommissioned and converted to a high observation area, the second was never commissioned but converted to a high observation area. There is substantial development clearly required in this regard. Two of the current six opened very recently in two new acute units. These are Cork University Hospital in 2015 and the Drogheda unit in 2016. Both have eight beds.

Whilst there are few admissions to psychiatric long-stay care, this is a vital resource when clinically indicated. Nine existing services do not have access to this form of care. Most people, including those with dementia associated with behavioural problems, are managed at home or, if they do require long-term care, this can be facilitated in non-psychiatric settings after their behavioural problems have been treated. In addition, many of the Old Age Psychiatry Services have provided education and training for residential care staff in caring for people with dementia. This is a service model which has been successful in many areas and a dedicated Consultation-Liaison service for nursing homes with large numbers of older adults with mental health needs can serve to enhance overall standards of care and reduce onward referral to inpatient care. However, dedicated psychiatric long stay beds remain necessary for a small proportion of patients with dementia and severe behaviour problems and are simply not available in many services. This too requires address.

With the rising elderly population there has been a consistent increase in the referral rate to these services over the last decade. This increase also relates to meeting a previously unmet need within the community. With this consistent increase it is important to continually

review activity together with growth in the older population and to adequately resource services to provide an effective, efficient and appropriate service. It is absolutely essential that each service be resourced to minimum standards.

Psychiatry of Old Age: Resource and Activity Data 2010

Table 3. Resource Data per Service Jan – Dec 2010

Service	Date Set up	Pop ≥65	Consultant	NCHD		ADON	CMH/NCS	Sec	Other ¹	Acute Psych Beds ³	Day Hospital	L/S Beds	
												Psych	Non-Psych
Dublin North City Area	1989	32,500	3.5	1	2	1 ²	4	2	0.5	6	√	34	67
Dublin South Central	1991	20,228	2.5	1	2	0.2	2	2	2.4	9	√	X	X
St. Vincent's Elmpark	1996	34,000	2	1	3	1	6	3	4.8	6 + access 4	√	X	67
Limerick	1996	19,000	2	1	1	0	3.6	2	1.5	6	1day/week	22 ⁴	X
Tallaght	1998	18,688	2	2	0	0.1	2	0.8	11.84 ⁵	Access	√	X	X
Laois-Offaly	1999	14,036	1	1	1	.75	6.6	3	1.5	Unit Closed	1	54	X
Cavan-Monaghan	2000	14,289	1	1	1	1	7	2	1	7	√	X	X
Waterford	2000	14,800	1	1	1	0	2	1	2	6	0	23	X
S. Tipperary	2000	10,200	1	-	1	0.2	3	1	1.31	Access only	X	18	X
Clare	2000	13,500	1	-	1	1	2.5	1	2	5	X	31	X
Wexford	2001	15,000	1	-	1	0	6	1	1.5	Access	X	14	X
Longford	2001	15,120	1.5	0	2	0.2	5.2	1.5	1	Access	√	38	X
Cork (South Lea)	2001	18,500	1.5	0	2.5	P/T	3	1	2	Access	2 days/week	X	X
Donegal	2002	17,300	1	0	1	1	5	1.5	2.5	Access only	X	X	X
Sligo/Leitrim	2002	14,600	1	1	2	1	4	1.5	3	4	√	X	X
North Dublin Area	2002	22,100	2	2	2	1	2.4	1	1	Access only	X	36	X
Kilkenny/Carlow	2002	16,000	1	-	1	0.5	2	1	1	Access 6	X	24	X
Mayo	2002	17,000	1	1	1	0.5	3	1.2	3	5	X	12	X

Meath	2003	13,000	1	1	1	0	1.8	1	1	4	X	X	X
Galway West	2004	16,700	1	1	1	0	2	.91	2.82	3	√	X	X
Louth	2007	14,200	1	-	2	X	3	1	1	Access only	X	X	X
East Galway	2009	18,100	1	-	2	0.5	4	1.8	2	Access	X	15	Access

X Resources not provided to the service.

¹ This includes OT, Clinical psychology, social work etc.

² Director of Nursing.

³ Access means access to beds in general unit (no POA unit available)

⁴ 18 extended assessment and 4 respite.

⁵ This also includes a homecare team.

Table 4. Activity Data per Service for the Year Jan – Dec 2010

Service	Referrals Seen			Acute Unit/s Admissions	Day Hospital (s) Admissions Attendances		Long stay Admissions (total)	Respite Admissions	CMHN visits	Other Services ⁴
	TOTAL	DV	LV							
Dublin North City Area	969	495	447	31	98	1925	5	14	3210	Carer Group
Dublin South Central	1098	315	783	32	98	1939	X	X	3318	Memory Clinic, AMT
St Vincent's Elmpark	786	575	211	50	94	787	4	25	5067	Anx GP, Carers GP
Limerick	567	338	229	32	13	391	12 ¹	100	2631	OPD, Carers Gp
Tallaght	589	251	338	30	52	911	X	-	1053 ²	Carer Gp, Anx Gp
Laois-Offaly	405	264	141	45	66	1168	4	38	2401	CBT
Cavan-Monaghan	565			29	11	1574	X	X		
Waterford	395	260	135	43	X	X	3	12	1640	Dementia coordinator/education
S. Tipperary	453	344	109	27	X	X	3	-	2798	OPD, Memory Clinic
Clare	315	272	43	20	X	X	2	4	3087	-
Wexford	292	285	7	40	X	X	3	-	5460	Groups eg AMT
Longford	513	385	129	24	19	1462	1	-	3967	-
Cork (South Lea)	440	260	180	28	20	702	X	-	2100	-
Donegal	681	510	171	27	X	X	X	-		OPD
Sligo/Leitrim	513	260	253	15	78	1683	X	X	2628	OPD
Dublin North Area	879	424	455	17	X	X	0	-	2081	-
Kilkenny/Carlow	424	311	113	37	X	X	0	5 ¹	2714	-
Mayo	381	316	65	6	X	X	13 ³	-	1761	-
Meath	218	146	66	13	X	X	X	-	558	Memory Clinic
Galway West	336	153	183	22	3		8	6	1166	OPD, Carers' Group
Louth	242	146	96	19	X	X	X	-	1391	-
East Galway ⁵	310	219	91	9	X	X	0	-	1076	-

X: Resource not available so service cannot be provided.

¹ Extended assessment admissions (dementia only).

² Further 2326 visits by home care team.

³ Intermediate care.

⁴ Other services include anxiety management and Cognitive behaviour therapy (CBT)

Table 5. Psychiatry of Old Age: Resource and Referral Activity Data 2017

CHO ¹	Service	Pop ≥65 ²	Consultant	NCHD		ADON	CMHN/CNS	Admin	OT	Psychol	Social Work	Referrals		
				SR	REG							DVs	% seen in 3 months	% DNAs
1	Donegal	22,978	1.0 (1)	-	1.0	1.0	9.0	1.5	(1)	(1)	2.0	306	83.5%	7.4%
	Sligo/Leitrim	18,263	1 + (.5)	1.0	1.0	1.0	4.5	1.0	1.0	1.0	1.0	608	100%	0%
	Cavan/Monaghan	18,822	1.5	1.0	1.0	1.0	8.0	2.0	1.0	1.0	2.0	334	99.7%	0.3%
2	Mayo A	11,650	1.0	1.0	2.0	0.25	3.0	1.8	1.0	1.0	1.0	270	97.8%	2.2%
	Mayo B	11,249	1.0	-	1.0	0.25	3.0	1.0	0.0	0.0	1.0	115	95.8%	4.2%
	East Galway	18,369	1.0	-	1.0	0.25	4.0	1.8	1.0	1.0	1.0	420	100%	0%
	Roscommon/ North Galway	10,743	1.0	1.0	2.0	0.0	4.0	1.0	1.0	1.0	1.0	163	98.2%	1.8%
	West Galway UHG	16,537	1.0	1.0	1.0	0.0	4.0	1.5	1.0	1.0	1.0	487	100%	0%
3	Clare	17,655	1.0	1.0	1.0	0.5	4.0	1.0	2.0	0 (1)	0 (1)	285	97.3%	2.7%
	Limerick	27,418	2.0	1.0	1.0	0.0	6.0	2.0	1.0	1.0	2.0	630	98.9%	1.1%
	North Tipperary ³	10,862	1.0	-	0.0	0.0	(2)	0.0	0.0	1.0	1.0	-	-	-
4	Kerry	25,034	0.8 (0.2)	-	1.0	0.0	3.0	0.0	1.0	0.5	1.0	(50) ⁴	-	-
	North Cork	13,610	1.0	-	1.0	0.0	1.0	1.0	0.5	1.0	0.4	n/a	n/a	n/a
	North Lee	23,943	1.0	-	1.0	0.0	2.8	0.0	0.5	1.0	0.4	147	94.8%	5.2%
	South Lee	25,947	1.5	-	2.5	0.0	5.8	1.0	0.8	1.1	0.8	155	77.5%	13.6%
	West Cork	10,343	0.5		0.0	0.0	0.0	0.0	0.0	0.6	0.2	(107) ⁵	-	-
5	Carlow/Kilkenny	19,404	1 (1)	-	1.0	0.1	4.0	1.0	1.0	0.0	0 (1)	317	100%	0%
	South Tipperary	13,536	1.0	-	1.0	0.0	2.7	1.0	0.8	0.5	0.8	198	96.1%	3.4%
	Waterford/Kilkenny	13,331	1.0	1.0	1.0	0.0	2.5	0.5	0.5	0.8	0.5	222	98.2%	1.8%
	Waterford/Wexford	9,836	1.0	-	1.0	0.0	2.5	0.5	0.5	0.8	0.5	214	99.5%	0.5%
	Wexford	18,195	1.0	-	1.0	0.0	4.0	1.0	1.0	0.4	1.0	321	100%	0%
6	South Dublin/SVUH	44,750	3.0	1.0	2.0	1.0	7.0	2.0	1.5	1.6	1.3	564	98.6%	0.4%
	Wicklow	16,153	1.0	-	1.0	1.0	3.0	1.0	1.0	1.0	1.0	250	99.6%	0.4%
7	Dublin South City	24,643	3.0	1.0	1.8	0.0	4.6 + (1)	2.4	1.0	0.8	1.0	141	97.2%	2.1%
	Dublin South West	30,262	2.4	1.0	0.0	0.5	8.5	1.0	1.0	0.0	1.0	226	95.4%	1.3%
	Kildare/West Wicklow	24,420	2.0	-	1.0	0.5	3.0	1.0	1.0	0.0	1.0	162	94.7%	4.7%
8	Laois/Offaly	20,199	1.6	-	2.0	0.0	3.6	2.5	1.0	0 (1)	2.0	278	98.9%	0.4%
	Longford/Westmeath	17,508	1.5	-	2.0	0.2	5.8	1.6	1.0	1.0	1.0	214	98.6%	0.5%

	Meath	9,331	1.0	1.0	0.0	0.0	3.0	1.0	1.0	1.0	1.0	230	97%	4.5%
	Louth/Meath	8,573	1.0	-	1.0	0.0	3.0	1.0	1.0	1.0	1.0	111	97%	11.5%
	North Louth	11,609	1.0	-	1.0	0.0	3.0	1.0	1.0	1.0	1.0	154	99%	2.5%
9	Dublin North	31,358	3.0	1.0	2.0	1.0	7.0	1.0	2.0	1.0	2.0	205	82.9%	3.9%
	Dublin North City/Mater	40,403	4.5	1.0	2.0	1.0	7.0	2.0	1.5	0.8	0.0	668	93.3%	6.7%

¹ Community Healthcare Organisation

² 2016 Census Data

³ North Tipperary started September 2018 with liaison service only pending allocation of team.

⁴ July-Dec 2017: referrals from General Adult Psychiatry as no admin in place

⁵ Nursing home assessments only as no team in place

() posts in brackets are funded but vacant

7.2 Activity of Consultation-liaison Services and Gaps in Service Provision

Consultation-liaison services (CL) for older people have been a relatively neglected aspect of service provision without the same systematic recording of activity data as occurs with community services. A national survey of Old Age Psychiatry services was completed in April 2013 to determine whether and how this service was provided in each area (Gallagher et al., 2013). All members of the Faculty of Old Age Psychiatry were contacted and requested to complete an electronic survey regarding the provision of CL services for older adults in their area. This is the first such survey of CL services for older adults in Ireland and addresses an important aspect of service provision which has been relatively neglected to date. Sixteen of a possible twenty two services (72.7%) completed the survey. The following data is based on survey responses from this sample which represents the majority of Old Age Psychiatry services in Ireland.

7.3 Composition of consultation-liaison services

A total of 93.8% services reported that they had an acute general hospital in their area and all of these services reported that they provided a CL service as part of their work. The median number of acute hospital beds in the relevant areas was 289 (range 150 – 851) suggesting a significant need for CL support. The CL services reported varying levels of consultant input with the majority of services (n = 10, 66.6%) reporting consultant input equivalent to one or two sessions per week. Two services (13.3%) reported consultant input equivalent to five sessions per week while the

remainder (n = 3, 20%) did not indicate any specified time for consultant input. Thirteen services (86.7%) reported some limited input from registrars (one or two sessions only in seven instances) while only six (40%) reported any kind of nursing input. Services were asked which professionals they believed should be integral members of the CL team in addition to the consultant psychiatrist. All services reported that they believed a registrar and liaison nurse should be integral members of the CL team while eight (53.3%) reported that a clinical psychologist and social worker should also be integral members.

7.3.1 Type of consultation-liaison services provided

The majority of services providing a CL service reported that they provided primarily a consultation (n = 12, 80%) rather than a liaison type (n = 3, 20%) of service. This service was limited to patients over 65 years with new onset mental health problems living in the catchment area in seven instances (46.7%) while another seven were able to provide this service to patients over 65 regardless of catchment area. The majority of services (n = 14, 93.3%) were not in a position to provide care to patients over 65 years with pre-existing mental health conditions (i.e. graduates). The majority of CL services did not provide input to the Emergency Department (n = 11, 73.3%) although six (40%) indicated that they would if the service was adequately resourced. Similarly only seven (46.7%) CL services saw people under 65 with dementia as part of their CL work while 14 (93.3%) indicated that they would be happy to do so with adequate resources. Ten services (66.7%) reported that they would be willing to see patients from outside their catchment area if this was adequately provided for.

Educational input to improve overall standard of mental healthcare in the general hospital is a key function of a fully operational CL service. Thirteen services (86.7%) reported that there was no dedicated time for teaching in their service. Despite this, nine services (60%) reported providing some type of educational input to the general hospital as part of their work. This largely consisted of case-by-case discussion with referring agents (n = 8, 53.3%) or traditional didactic lectures (n = 9, 60%). Only five (33.3%) were able to provide small group problem based educational input while eight (53.3%) had provided some type of ward based educational initiatives. Eleven services (73.3%) reported that they did not have any IT support for recording service activity and consequently were not able to provide detailed information regarding the nature of referrals received and seen.

7.4 Summary

In summary, it appears that all services with an acute hospital within their catchment area were endeavouring to provide some type of CL service to that hospital. However, the time and personnel allocated to provision of CL services were inadequate or non-existent in many instances. It is largely members of the MHSOP community teams who are providing the service. Consequently, the services provided were largely reactive and offered a consultation only service with few educational or pro-active initiatives to improve the overall standards of mental healthcare within the hospital. In addition, the services were provided to a restricted group of older adults and service activity was not adequately recorded in many instances. However, the majority of services did indicate a willingness to undertake a more extended role within the hospital assuming that this role was supported by adequate resource provision.

Since this survey, PfG funding has facilitated allocation of some medical and nursing posts to MHSOP for this function. These are in the process of being recruited. In 2015 this activity was collected for a six month pilot period. This showed each team was on average assessing an additional 25% referrals in acute hospitals. This data is now being collected routinely and should highlight the need to provide resources specifically for this function.

The pattern of engagement with geriatric medicine services was not explored in this survey and should be investigated given the common areas of interest. The findings indicate an opportunity to further develop CL services for older adults in Ireland. This will allow implementation of service models of proven efficacy and piloting of novel interventions. Ultimately this could lead to enhanced standards of care, reduced morbidity and increased cost-effectiveness in times of increased demands upon static or shrinking healthcare budgets. For instance, there is clear evidence that provision of such a specialist psychiatry service in acute hospitals reduces length of stay. In an independent economic evaluation of liaison psychiatry (Parsonage M and Fossey M, London School of Economics and Centre for Mental Health 2012), specialist psychiatric services in acute hospitals were shown to reduce the cost of medical care through reduced length of stay by £4 for every £1 invested in the service with most of the savings relating to reduced length of stay of older people.

8 Education

8.1 Medical Education

It is essential that training in Old Age Psychiatry is provided in both Psychiatry and other medical specialties.

(a) *Undergraduate Training*

Given the ageing population in Ireland, 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 with clinical experience also being included. This should cover both functional and organic mental illness in old age.

(b) *Basic Specialist Training in Psychiatry*

Each psychiatric trainee should have a minimum of six months training in Psychiatry of Old Age for completion of Basic Specialist Training. 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 Specialist Training in Psychiatry*

The College of Psychiatry of Ireland requires that trainees in Psychiatry of Old Age at higher professional level spend a total of three years in higher training. Two years should be in Old Age Psychiatry in two different services while a third year should be spent in General Adult Psychiatry or one of its relevant subspecialties e.g. Liaison Psychiatry. It is recommended that there should be access to other relevant experience such as geriatric medicine, neurology and consultation liaison psychiatry.

(d) *Trainees in geriatric medicine*

There should be reciprocity in training by which it is meant that registrars and specialist registrars in geriatric medicine 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 the ability to maintain people in their homes and

improve their quality of life and those of their carers. 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.

8.2 Nurse Education

Nurses should be equipped with management and leadership skills to support a culture of ongoing education and professional development. Training and education for mental health care professionals must continue to be developed in an integrated manner and in liaison with health care providers and professional bodies.

(a) *Undergraduate Training*

The B.Sc. Nursing Mental Health is a full-time four-year degree programme offered by the Departments of Nursing and Midwifery through the Higher Education Institutes in conjunction with the Health Service Executive. On successful completion of the programme, students will be eligible to register and practise as a Registered Psychiatric Nurse. The undergraduate degree programme is designed to equip students with the knowledge, skills and attitudes required to become an analytical and reflective practitioner able to provide a holistic and caring approach to people experiencing mental health problems. This knowledge is acquired through the study of nursing, biological sciences, social sciences and related disciplines. The Model of Care recommends that at undergraduate level the gerontology component is increased and clinical exposure prepares students to meet the needs of older people with mental health problems such as dementia, delirium, anxiety and depression (Higgins et al., 2010).

(b) *Postgraduate Training & Continued Professional Development*

Post graduate and ongoing continued professional development educational programmes are critical in providing nurses with the appropriate knowledge, skills, attitudes and competencies to care for the older person with mental health issues. The model of care recommends that all nurses attain high quality education and training that enables delivery of responsive, relevant, accessible and evidence based care (Higgins et al., 2010). The process of continuing professional development and clinical supervision continues throughout the nurse's career. Supervision is regular, protected time for facilitated, in-depth reflection of clinical practice which enables the

supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development.

(c) *Enhanced nursing roles*

Enhanced nursing roles are of critical importance to support the implementation of the model of care. Development of nursing practice should be in the context of multi-disciplinary, multi-skilled teams. Current legislation grants An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) the responsibility to accredit Registered Advanced Nurse Practitioner (RANP) posts. To be eligible to apply for registration as an RANP, the nurse must be educated to masters' degree level (or higher) and have relevant clinical experience. A Clinical Nurse Specialist (CNS) must similarly meet a minimum standard of training and have sufficient clinical experience relevant to his or her area of specialist practice. A Vision for Psychiatric/Mental Health Nursing 2012 aims to put collaboration with service users and families at the heart of nursing practice for every psychiatric/mental health nurse regardless of their location of practice and to ensure that nurses respond in a truly holistic way. This is equally relevant for all disciplines in MHSOP.

8.3 Health care assistants

Continuing education, training and up-skilling of healthcare assistants working with older adults with mental health needs is recommended. Relevant training for health care assistants includes the FETAC (NCVA Level 5) Healthcare Support Certificate and Understanding Mental Health Level 5 Care of the Older Person module.

8.4 Education of Health and Social Care Professionals

8.4.1 Social Work

All social workers employed in mental health services for older persons have attained a professional qualification and are registered with CORU (Health and Social Care Professions Regulator).

The training needs of individual social workers in these specialist posts are best identified within the context of clinical supervision with either a social work team leader or principal social worker practising in mental health. Not all social workers practicing in mental health for older persons have access to clinical supervision, as outlined above. This issue needs to

be addressed to better enable social workers to intervene in complex cases in a safe way that promotes the rights of the client, reflects a thoughtful examination of any risk issues and ensures accountability.

Examples of practice areas that some social workers have recently undertaken as part of their continuing professional development (CPD) include bereavement counselling; mindfulness; person centred dementia care; legal issues relevant to older persons; record keeping; human rights training. The requirements for CPD points have been formalised for the profession since CORU launched its CPD scheme in 2015.

8.4.2 Clinical Psychologist

The standard training in the discipline of clinical psychology for the provision of mental health services is that of Clinical Psychologist. This is a three year post graduate training course at Doctoral level for clinical psychology graduates who already have completed an undergraduate degree in clinical psychology. Many also have a Masters degree in a specialist area of clinical psychology which includes formal research training.

Training in Clinical Psychology provides for robust training across the life-span and this is reflected in both the academic modules and supervised clinical placements (this includes an elective specialist Older Adult Mental Health placement). The curriculum is designed to meet the specific needs of the mental health services through the attainment of specified core competencies. It provides for the development of assessment and intervention skills within the competencies required for working within mental health services that are relevant for mental health services for older adults also.

Training in the assessment, formulation and intervention skills required for mental health include areas such as enduring mental health (including chronic illness) and neuropsychology (organic psychiatry, brain injury and neurological disorders). There is a mandatory placement in Learning Disability which provides for exposure to dementia and to the framework of behaviour supportive environments which is a critical skill in dealing with the specifics of dementia and BPSD. In addition to this, trainees receive skill development in a range of specialist therapeutic skills for interventions such as cognitive-behaviour therapy, behaviour therapy and models of psychotherapy.

The comprehensive focus in clinical training on the development of theory-practice linking that is developmentally (lifespan) structured means the Clinical Psychologist has a broad

range of skills to provide specialist assessment and intervention in a wide range of clinical presentations that are often complex and intricate due to the organic-functional links.

Training promotes evidenced based practice and includes high level skills in the methodology and completion of clinical research. Training in systems theory provides for another layer of skill within the clinical psychologist's repertoire that is specifically applicable within older adult services. This training allows for the critical assessment of the impact of formal care systems (e.g. nursing homes and hospital settings) on the person as well as the assessment of family dynamics as they relate to case work and planning thereby contributing to complex case management.

The standard for Clinical Psychology in MHSOP is that of Senior Clinical Psychologist. This provides for the range of experience and specialist skills required for this complex and varied work with a multiplicity of presentations. Ideally the person will have completed a specialist placement in Older Adult clinical psychology/mental health and will have accrued lifespan experience as a staff grade.

8.4.3 Occupational Therapy

The basic standard for Occupational Therapists working in MHSOP is B. Sc (Hons - Occupational Therapy) or Postgraduate M. Sc (Occupational Therapy) which is required for registration with CORU. All Occupational Therapists have an understanding of psychological, psychiatric and physical conditions as they effect occupational engagement across the lifespan within an individual's social and physical environment. Therapists employed may be at Staff or Senior grades and the level of clinical supervision will be contingent on this grading. Occupational therapists continue their professional development through experience in primary, secondary and tertiary care settings. Therapists address their competence in specialist areas of practice such as mental health of older persons through relevant courses, self-directed learning and reflection on evidence-based practice.

8.4.4 All POA Health Professionals

There are several areas of broad relevance to all disciplines working with older adults with mental health difficulties where further training may be undertaken. Listed below are some where health professionals have undertaken further training and found this to be beneficial to patient care. This training may take the form of short or extended courses offered by professionals working in specific areas of care which may vary in depth and breadth. The need for further education in each area will be determined by the educational needs of the individual health professional and their area of practice. The list below should not be considered prescriptive but rather may serve to guide professional development. There are a number of broad categories within which are short lists which are by no means exhaustive.

- General gerontology: The normative experience of ageing, to include biological, psychological and social aspects, should underpin the training of all professionals specialising in the healthcare of older people.
- Organisation and delivery of care: Care models of proven efficacy in older adults, care planning and models of service delivery, economics of healthcare delivery in older adults.
- Legal aspects of care: Training in legal issues relevant to older persons including capacity, assisted decision making, mental health law, ethics and human rights.
- Social aspects of care: Social interventions of proven benefit in older adults with mental health disorders, caring for carers and improving quality of life for older adults with mental health disorders.
- Psychotherapeutic interventions: Training in psychotherapeutic modalities such as bereavement counselling, anxiety management, mindfulness, group therapy, motivational interviewing, cognitive behavioural methods, interpersonal psychotherapy, psychodynamic and integrative therapeutic approaches.
- General medical and specialist interventions: General medical care of older adults, principles of prescribing in older adults in the context of pharmacodynamics and pharmacokinetic considerations, pharmacological approaches in older adults including psychopharmacology and cognitive enhancing medication, updates regarding novel and emerging therapies.
- Research methods: Principles of research methods in older adults whether focused on service delivery models, health economics, individual therapeutic modalities, biostatistical methods, critical appraisal of health research or practice of evidence based medicine.

8.5 Mental Health Education Competency Framework

The Mental Health Education Competency Framework was developed by the **National Clinical Programme for Older People (NCPOP)** Part 2, Mental Health and Older People, working group. The framework was adapted from South West Dementia Partnership www.southwestdementiapartnership.org.uk/workforce-development/ and is aligned to the care pathways for Old Age Psychiatry. It can be accessed on www.hseland.ie. The use of this framework may be helpful to services in ensuring that staff have the necessary knowledge and skills to carry out their roles in caring for and supporting older people with Mental Health issues. Services may also use this framework as a guide to:

- Identify training needs
- Develop job descriptions
- Commission, design and deliver education
- Demonstrate skill mix and competence within a performance framework

Readers should also refer to the Comprehensive Geriatric Assessment Guidance Framework Document which supports the Specialist Geriatric Services Model of Care, Part 1: Acute Service Provision.

9 Research

Clinical research forms the basis of evidence-based health care delivery and in the absence of ongoing clinical research there can be no advances in the development and delivery of novel therapies or systems of care. It involves critically examining current methods of treatment and treatment delivery in a systematic and unbiased way with the aim of improving clinical care. Healthcare systems which support clinical research are more likely to be associated with improved health care outcomes (Selby and Autier, 2011).

There are several key areas where clinical research is of critical importance:

- The neurobiological and psychosocial origins of mental illness: Greater understanding of the neurobiological and psychosocial origins of mental illness has clear implications for both primary and secondary prevention. In the absence of advances in knowledge, there can be no new treatments or refinements to existing treatments. In the absence of innovation, current health care resources may not be sufficient to meet the needs of future generations. This is particularly relevant in Old Age Psychiatry and dementia research where current demographic trends threaten to overwhelm existing health care resources.
- The organisation and delivery of mental health care: There have been many changes in the delivery and organisation of mental health care services in recent decades with huge implications for patients, families and society more generally. In many instances, these changes were underpinned and supported by clinical research. It is of critical importance, given the dynamic nature of mental health care needs and the broader societal context within which these needs arise, that mental health services continue to examine new ways of service delivery to ensure that they can effectively and efficiently meet the needs of the populations they serve.
- Quality within mental health care: there are now many examples of positive advances in therapeutics and health care delivery. However, the standardised delivery of proven interventions and assessment of health care outcomes is of central importance. Clinical audit is one basic and readily applicable strategy to ensure improved outcomes and quality in health care delivery. A culture of clinical research and enquiry supports the conduct of clinical audit which helps maintain high standards of care.

- The cost-effectiveness of mental health care: In the face of increasing health care demands and sometimes static or dwindling resources, it is important that mental health care is delivered in the most cost-effective way possible. This involves targeting health care resources when and where they are likely to be most effective for patients, their families and society more generally.

In summary, mental health services should support and adopt a culture of clinical research which will ultimately ensure that mental health services remain effective into the future.

10 Governance

Nationally, Mental Health Services were managed within the Mental Health Division of the Health Service Executive, one of five divisions established in 2013 as the basis for running the health services. Since January 2018, the Divisions have been subsumed into Hospital and Community Operations with Mental Health in the latter. Mental Health Services are directly delivered through 16 geographic areas known as Mental Health Areas, each managed by an Executive Clinical Director (Consultant Psychiatrist). These Mental Health Services are now part of the Community Health Organisation Structure (CHO) as outlined in the HSE Report on this new structure (2013).

Psychiatry of Old Age (POA) teams are managed within the Mental Health Service as one of four mental health specialties; the others being Child and Adolescent Psychiatry, General Adult Psychiatry and Psychiatry of Learning Disability.

In some areas there is also a substructure of Clinical Directors managing a specialty and reporting to the ECDs. It is planned to extend this and it is recommended that in each CHO Mental Health Service Psychiatry of Old Age has a Clinical Director to ensure full representation and participation at management level.

It is very important that there is a forum for Geriatric Medicine, Old Age Psychiatry and Primary Care Older Persons Services to meet to ensure good collaborative working relationships between the clinical specialties relevant to older adults. These should be based on the acute hospital and the associated primary care and POA services. In some areas Older Persons Steering Groups have been established. These are essential to ensure comprehensive provision of care for older people encompassing physical, mental, social and personal care needs.

This approach is in line with the national clinical programmes and is critical in ensuring the successful implementation of both the National Clinical Programme and Integrated Care Programme for Older Persons.

11 Performance Management

Within the Mental Health Service, as in other services, performance is managed through the data collected by the HSE Business Information Unit. In 2013, the adult mental health specialties (General and Old Age) completed a pilot in which data was collected including number of patients seen, timeframes within which seen and number discharged. This gives a good indication of current access to the POA nationally. It is now collected monthly together with information on the composition of each CMHT. The 2015 figures indicate 95% of community referrals to POA were seen within three months. Maintaining this good performance remains the key performance indicator (KPI) for POA.

Old Age Psychiatry services have led the way nationally within Mental Health Services in collecting annual resource and activity data for the past 15 years. The POA data set is now collected monthly and includes the following:

- The number of staff in each MHSOP team
- The number of referrals seen and waiting times
- The number of discharges from the service

Acute inpatient data is collected by the Mental Health Research Board on a three monthly basis. It does not distinguish POA acute admissions from the generality of acute adult admissions. This should be addressed to give a more comprehensive picture of overall service activity, particularly if day hospital activity is also included.

The HSE Mental Health Service National Data Design and Optimisation Group in 2016 piloted collecting data on referrals from acute hospitals (i.e. consultation-liaison activity). Formal collection of this data will be helpful in supporting the case for CL services for older people in acute hospitals. However, quality metrics across all settings (community, hospitals and nursing home liaison services) should be included. It envisages these will be developed as a component of the HSE Integrated Care Programme for Older People.

12 Appendix A - Recommendations of ‘A vision for Change’ and Older People

“*A Vision for Change*” made fourteen recommendations regarding the provision of mental health services for older people as outlined below.

RECOMMENDATION 1

Any person, aged 65 years or over, with primary mental health disorders or with secondary behavioural and affective problems arising from experience of dementia, has the right to be cared for by mental health services for older people (MHSOP).¹

RECOMMENDATION 2

Mental health promotion among older adults should preserve a respect for the potential in older people to grow and flourish in later life and to counter negative myths of ageing that can become self-fulfilling prophecies.

RECOMMENDATION 3

Health promotion programmes and initiatives found to be beneficial to older adults should be implemented.

RECOMMENDATION 4

Primary health care teams should play a major role in assessment and screening for mental illness in older people and should work in a coordinated and integrated manner with the specialist teams to provide high quality care, particularly care that is home-based.

RECOMMENDATION 5

A total of 39 MHSOP multidisciplinary teams should be established nationally, one per 100,000 population, providing domiciliary and community-based care.²

RECOMMENDATION 6

Priority should be given to establishing comprehensive specialist MHSOP where none currently exist.

RECOMMENDATION 7

Physical resources essential to service delivery, acute beds and continuing care, service headquarters, community-based and day facilities should be provided for MHSOP within each sector.³

RECOMMENDATION 8

There should be eight acute assessment and treatment beds in each regional acute psychiatric unit for MHSOP.

RECOMMENDATION 9

There should be one central day hospital per mental health catchment area (300,000 population) providing 25 places, and a number of travelling day hospitals in each mental health catchment area.⁴

RECOMMENDATION 10

There should be an appropriate provision of day centres in each mental health catchment area, but their provision should not be the responsibility of the MHSOP.

RECOMMENDATION 11

There should be appropriate recognition and linkage with voluntary agencies in the field.

RECOMMENDATION 12

Carers and families should receive appropriate recognition and support including education, respite, and crisis response when required.

RECOMMENDATION 13

Older people with mental health problems should have access to nursing homes on the same basis as the rest of the population.

RECOMMENDATION 14

There should be 30 continuing care places for older people with mental disorders in each mental health catchment area.

¹This would require a transfer of resources from General Adult Mental Health Services and equity of access to rehabilitation resources to meet the needs of older adults with early onset enduring mental illness.

²A ratio of one team per 10,000 older people is also referred to within the report. This is now the accepted ratio and takes account of regional variations in the distribution of older adults given that the proportion of the population aged 65 and older may be greater or less than 10% in certain areas.

³A Vision for Change also specifies that the central day hospital should be integrated within the campus of the general hospital for proximity to basic investigative equipment and other healthcare expertise.

⁴International guidance specifies that a day hospital should provide 10 – 15 places per day for 10,000 people aged 65 years and over (RCPsych, 2006).

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