



columns

with it the desired outcomes for patients. Davidson & Scott are right to be anxious about the quality of what is offered.¹

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Quality of dementia referrals

I was interested to learn from the audit of dementia referrals to a later life psychiatry service that only 13.2% of referral letters contained Mini-Mental State Examination (MMSE) results.¹ Findings from a neurology-led dementia service were little better, with around 20% of referrals from primary care containing evidence of cognitive test results, most commonly the MMSE.² These results contrast with those from a postal survey which claimed 79% use of dementia screening tests in three English primary care trusts.³ How can the discrepancy be accounted for?

It would seem unlikely that general practitioners (GPs) would not report MMSE results in a referral letter to a dementia service if the test had been undertaken. More likely, the MMSE is too time consuming in primary care and/or too difficult to interpret. If so, then the use of other, briefer, screening instruments with unambiguous cut-offs, such as Mini-Cog or GP-Cog,³ must be vigorously encouraged in primary care. No example of their use was encountered in the Fisher & Larner study.²

This could form one aspect of the 'raising awareness' strand in the implementation of the *National Dementia Strategy*.⁴

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Web information about electroconvulsive therapy

Joshi is understandably concerned about the bias to much of the information about electroconvulsive therapy (ECT) that can be found on the internet.¹ However, he and his patients do not need to look even as far as www.patient.co.uk to find reliable information for services users, carers and families, as the College has a range of such materials available on its website (www.rcpsych.ac.uk/mentalhealthinformation.aspx). It has gained a reputation for reliable content written in a style that is accessible to most readers. We have won several commendations at the British Medical Association awards over the past few years and receive consistently complementary feedback from our web readers.

Our ECT page is rather longer than most of our leaflets and perhaps not quite as readable because of the complexity of the issues involved. However, I think it holds up well against most such web-published information on the subject. Although we do not yet have a printed version, a copy can be printed off the internet. Many of our leaflets are available in paper form and I would commend the readers to have a look at these. They are free to individuals who request them and available to purchase in bulk through the Leaflets Department at the College.

- Joshi N. Internet electroconvulsive therapy (letter). *Psychiatr Bull* 2009; **33**: 155.

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What's right for older people

Hilton's article is a clear and challenging description of the current state of play.¹ I understand her declaration of interest – 'I work in a trust where I perceive older adults' services to be less well-funded relative to services for younger adults' – has been deemed controversial by some. How can this be? She is simply stating her perception of things and that perception is congruent with the truth of the matter in every mental health trust in the country, and in every setting in which older people receive sponsored care.²

Things were much worse before we created specialist services, when older patients were housed in 50-bed wards and received no therapeutic input.² It was deemed they did not need therapy because they would not benefit from it. Yet older people and those of us who have worked with them have never shouted loudly for equality, preferring to make modest best-use of the resources made available to us.

I was astonished, when working for a while in a learning disability setting, to find that individuals with dependency and behavioural profiles quite commonly seen in old age services were regularly being supported with care-packages costing several times the top rate payable for older people with dementia.

Perhaps now is the time to ask for more.

Sadly, the Healthcare Commission's review ducks the issue, preferring to cite commendable examples of good practice and pursuing the line that age-related services should be abandoned.¹ That should bury the problem and make it less visible – just as it was when we came in.²

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