Correspondence

Yorkshire and beyond: it's a new world

It is curious that Seymour and colleagues[1] feel we confuse community clinics with what they refer to as community-oriented mental health services. We regard community clinics as an important part of community-oriented older people's mental health services.

It is good to look at a range of models for delivering services to older people and we should routinely ask patients and carers for their views on all the services they receive.[2] Enthusiasm for early referral of patients with memory problems and transfer of 'graduates' to old age services have changed expectations, increased the number of people seen for initial assessment and posed quandaries regarding how to achieve responsible and responsive follow-up of patients with enduring or relapsing illnesses. At the same time there is increasing demand to work in teams and to liaise with a variety of colleagues, services and agencies. These are not alternatives; rather, old age psychiatrists have to find a balance in how they allocate their time, given competing priorities. Different individuals (and services) will reach different resolutions of these dilemmas.

Nevertheless, it is the case that many services experience high numbers of patients who do not attend appointments when out-patient clinics are hospital-based: transport problems and demands on time allocation from carers argue against their efficacy for older people. So does the absence of immediate appreciation of what life is actually like for the individual and family carers in the home. Much of the information gained on a home visit is non-verbal and lost when people are seen in a clinic.

Perhaps part of the problem here is that different people have different understandings of how teams operate and what the role of a doctor is in relation to other team members. The multiplicity of teams developing in some areas has advantages in making more services available to particular groups of patients and their families, but also introduces disadvantages, such as: access criteria may be rigid and problematic for patients who do not fit into neat categories; demands on the time of staff working with several teams may be considerable and may have impact on their commitment to other service areas; each team will need to devote time to liaise with others, which may detract from direct care.

We are in the process of preparing a proposal to review work patterns within old age psychiatry services following on from our earlier studies of workload and stress.[3] This should add further substance to the discussion.

1 Seymour J, Negi R, Flemons C, Impey M, Thomas N, Witrylak R. Home visits for older people: a practical model outside Yorkshire. *Psychiatr Bull* 2009; **33**: 480–1.

2 Clark M, Benbow SM, Moreland N, Scott V, Jolley D. Copying letters to older people in mental health services – policy with unfulfilled potential. *Qual Ageing* 2008; **9**: 31–8.

3 Benbow SM, Jolley DJ. Burnout and stress amongst old age psychiatrists. *Int J Geriatr Psychiatry* 2002; **17**: 710–4.

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Hospital treatment for substance misuse – differences among four age cohorts

Treating substance misuse in hospital places a considerable burden on patients and on the healthcare system. The cost of treatment and hospital stays for patients with substance use disorders is substantial. We examined the factors associated with the length of stay in hospital for such patients across four age cohorts in the USA by using the 2004 Nationwide Inpatient Sample (www.hcup-us.ahrq.gov/nisoverview.jsp).

The admission source and disposition type for patients with substance misuse differed by age cohort. A significantly larger proportion of older adult patients were admitted from the emergency room than were their younger counterparts. Higher proportions of young and middle-aged patients left the hospital against medical advice than did their older counterparts. Across all four age cohorts, the majority of patients admitted to hospital for substance use disorders were male and lived in an area with median household income less than US$60 000 (£39 000).

Income level was a significant factor associated with hospital length of stay for elderly patients with substance use disorders. Most of the elderly patients were insured by Medicare (health insurance for people age 65 or older, managed by the federal government), thus income became a significant factor in addition to their Medicare coverage. Low-income elderly patients could be financially disadvantaged in out-of-pocket spending for mental health services. Previous research indicates that low-income elderly people are worse off financially than non-elderly adults (aged <65) in the same poverty class and than their elderly peers in other poverty classes.[1] Underinsured adults are more likely to forgo needed care than those with more adequate coverage and have rates of financial stress similar to those who are uninsured.[2]

Non-elderly Medicaid (jointly funded, federal/state health insurance programme for people on low incomes and with various needs) patients had significantly longer hospital lengths of stay than their counterparts with commercial insurance. Recent research indicates that Medicaid recipients with substance use disorders were less likely to use community services.[3] Research based on the National Household Survey on Drug Abuse[4] indicates that the rates of substance use disorder are much higher among Medicaid recipients than among most other health insurance groups. Psychiatric disorders and substance misuse are major problems for the Medicaid population. Therefore, efforts to promote detection and treatment of these disorders in this group should focus on reducing barriers to education, family stability and departure from welfare.[4]

The study was limited to community hospitals across the USA, therefore the analysis does not include specialty psychiatric or substance misuse treatment facilities. However,