Comments on

SCOTTISH GOVERNMENT

MENTAL HEALTH STRATEGY FOR SCOTLAND: 2011-15

The Royal College of Physicians of Edinburgh (the College) is pleased to respond to the Scottish Government's consultation on the Mental Health Strategy for Scotland 2011-2015.

The College has the following comments on specific consultation questions, which reflect the importance of detection of dementia and delirium in patients admitted to an acute hospital.[1] These are common conditions, increasing in an ageing population.

Question 4: What further action can we take to continue to reduce the stigma of mental illness and ill health and to reduce discrimination?

Delirium (acute cognitive deterioration) and dementia (chronic cognitive deterioration) affect at least 25% of patients in acute hospitals. However, the current low rates of detection significantly affect quality of care. Education of acute hospital staff on how common these conditions are, the suffering they cause, and good management, is essential to reduce unintentional discrimination. It is particularly important that senior managers are fully informed of the magnitude of the problem so that resources can be directed proportionately.

Question 6: What other actions should we be taking to support promotion of mental wellbeing for individuals and within communities?

The community as a whole should be made more aware of dementia and delirium. The Scottish Government should consider setting up an information website for the public on delirium and dementia.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

In a typical 500-bedded hospital, 100 patients will have dementia. Of these 100, 50 will not have had a diagnosis of dementia ever made. People with dementia are frequently admitted to hospital. Therefore, detection of dementia in acute hospitals is a potentially extremely important way of increasing the overall rates of detection of dementia in the community as a whole.

Formal diagnosis is not always possible but screening and appropriate follow-up can be achieved in the vast majority of cases. Currently this is not done routinely. A practical approach would be to carry out a mandatory brief cognitive screening including assessment

for delirium for all patients over the age of 65, enforced by a formal system of external audits. Positive results on initial screening tests should prompt more detailed assessment with the aim of diagnosing delirium or detecting possible dementia. Additional evaluation could then be performed by geriatricians or specialist liaison mental health teams.

Delirium is another grossly-underdiagnosed mental illness, which affects at least 15% of acute hospital inpatients, but which is only formally detected in less than 25% of these cases. Screening for delirium should be mandatory in all over-65s in hospital. Diagnosis of delirium is generally much simpler and easier than dementia and the expectation should be that acute hospitals have the skills and systems to ensure that delirium is formally diagnosed when it occurs, as would be the expectation for other medical emergencies such as acute coronary syndromes, pneumonia, or stroke.

Question 13: What support do NHS Board and key partners need to put Integrated Care Pathways into practice?

Integrated Care Pathways for dementia must include acute hospitals. Within acute hospitals, a specialist Older People's Mental Health Liaison Team is absolutely essential to support the diagnostic process and post-diagnosis counselling and discharge planning. Such teams bring multiple other benefits, for example, education of wider hospital staff.

Question 14: How do we continue to develop service user involvement in service design and delivery and in the care provided?

Detection of dementia (either a pre-existing diagnosis, or making a new provisional diagnosis) is a prerequisite for service user involvement in acute hospitals.

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

Without detection of dementia and delirium, person-centred and values-based approaches are impossible. Therefore, systems to detect these conditions must be embedded in acute hospital care. Additionally, acute hospital staff should expect to look after patients with dementia and delirium rather than see these conditions as a matter for psychiatry. Thus, acute hospital staff require training in mental health.

Question 19: How do we support families and carers to participate meaningfully in care and treatment?

Families and carers are often extremely important in providing care for patients with dementia and delirium in acute hospitals. Staff knowledge is a prerequisite for this; information leaflets can also be beneficial.

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

Acute hospital staff need basic training on dementia and delirium to facilitate family and carer involvement.

Question 22: How do we ensure that information is used to monitor who is using services and to improve the accessibility of services?

Integration of primary care, mental health services, social work and acute hospital databases would allowing tracking of patients with dementia as they move through various settings. This would greatly facilitate more effective and more efficient management, for example by allowing easy access to individualised information.

Question 27: How do we support implementation of Promoting Excellence across all health and social care settings?

Older People's Liaison Mental Health Teams, focused on the 25% of acute hospital patients with dementia and delirium, as well as those with depression and other psychiatric disorders, are an essential component.

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge?

It would be very useful to have a system to "flag" dementia patients to allow tracking of patients through the system and different healthcare settings.

Electronic audit of rates of the terms 'delirium', 'dementia' and 'cognitive impairment' appearing in electronic discharge summaries from acute hospitals would also assist in this regard. We know how common these conditions are and this form of low-cost audit allows a simple but effective way of estimating how well hospitals are detecting these conditions. In LUHD 'delirium' appears in more than 2% of discharge summaries, up from 0.7% in 2009, but well short of the 5-10% that would be expected.

Question 33: Is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

Good care of dementia and delirium is more cost effective than poor care. For example, good anticipatory care of dementia is known to reduce the need for acute hospital admission, and also can delay institutionalisation. However, good care cannot be achieved without detection, and staff and systems geared to provide this care. Ensuring that acute hospitals detect dementia and delirium is a crucial first step. Lack of detection should be considered unacceptable. Older People's Mental Health Liaison Teams are essential in supporting increased rates of detection as well as good care.

Question 35: How do we ensure that staff are supported so that care and treatment is delivered in line with legislative requirements?

Older People's Mental Health Liaison Teams are skilled in capacity assessments and related assessments and associated aspects of the law. Having such a team in every acute hospital would greatly facilitate the upskilling of general staff.

All College responses are published on the College website www.rcpe.ac.uk.

Further copies of this response are available from Lesley Lockhart (tel: 0131 225 7324 ext 608 or email: l.lockhart@rcpe.ac.uk)

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