it helps us to better understand the relationship between age cohorts and hospital treatment for substance use disorders, and provides a rationale for further exploration of the key factors associated with the most efficient care for adult patients with substance use disorders.

1 Xu KT. Financial disparities in prescription drug use between elderly and nonelderly Americans. *Health Aff* 2003; **22**: 210–1.

2 Ross JS, Bradley EH, Busch SH. Use of health care services by lower-income and higher-income uninsured adults. *JAMA* 2006; **295**: 2027–36.

3 Clark RE, Samnaliev M, McGovern MP. Treatment for co-occurring mental and substance use disorders in five state Medicaid programs. *Psychiatr Serv* 2007; **58**: 942–8.

4 Adelmann PK. Mental and substance use disorders among Medicaid recipients: prevalence estimates from two national surveys. *Adm Policy Ment Health* 2003; **31**: 111–29.

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Old age psychiatry and the recovery model

We fail to see what all the fuss over the 'recovery model' is about. Nor can we appreciate why it has been so powerful in 'influencing mental health service development around the world'.[1] Working with older people, especially those with dementia but also those with functional disorders, recovery has been the style of our work long before it became a jargon term.

Our day assessment unit aims to give both the patient and their relatives as much autonomy as possible despite progressive mental disability. Enhancing well-being and giving meaning to people's lives, empowering patients and carers to make decisions collaboratively, and enabling activities salient to the patient and carer have been integral to our work for years. We run in-house educational courses and support groups for carers. Some carers' courses have continued as informal groups who meet and support each other even after the relative they were caring for has died. An upmarket chain coffee emporium offers free drinks for one peer support group organised by a patient with a history of bipolar affective disorder that meets in their café; perhaps some would say this is unwarranted charity: the group does not think so. A 'drop-in' at a local church hall is popular. Carers contribute to our educational programme for staff.

To us, the recovery model represents standard high-quality old age psychiatric practice. Often we can see the quality of life of patients and their relatives improve, despite progressive illness and disability, as understanding and coping mechanisms increase. Scientific evidence is not always necessary, especially when it is measured in economic rather than person-centred terms. The recovery model is a humane, self-esteem, self-respect approach, perhaps one which all psychiatry can learn from older people's services. We will not become complacent in our practices even if services for younger people are catching up with us.

1 Warner R. Does the scientific evidence support the recovery model? *Psychiatrist* 2010; **34**: 3–5.

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Screening test for dementia

Screening for dementia or early cognitive impairment is of paramount importance. However, it should not be limited to patients in their seventies but should be done even for patients in their nineties. Otherwise we are going to create a biased service. We have to understand that screening for dementia will help with further investigations and treatment of reversible causes of this illness.[1]

Another important issue would be that of mild cognitive impairment which, although not formally classified, has received due attention as interventions at this stage will certainly delay the expression of clinical symptoms.[2] The National Dementia Strategy[3] is indeed a step in a right direction. With huge infusion of funds across England and Wales as well as establishing early diagnosis and intervention clinics, it is of paramount importance in identifying probable mild cognitive impairment early on by utilising various screening tests including blood test, scans and battery of neuropsychological testing. This will certainly help both patients and carers to be well prepared and informed, and reduces the risk of early institutionalisation.

Therefore, to say that patients in their nineties do not deserve full investigation is rather a Stone Age statement. Screening tests should be available to everyone regardless.

1 Boustani M, Peterson B, Harris R, Lux LJ, Krasnow C, Sutton SF, et al. *Screening for Dementia. Systematic Evidence Review*. Agency for Healthcare Research and Quality, 2003 (http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat3.chapter.28271).

2 Callahan CM, Hendrie HC, Tierney WM. Documentation and evaluation of cognitive impairment in elderly primary care patients. *Ann Intern Med* 1995; **122**: 422–9.

3 Department of Health. *National Dementia Strategy*. Department of Health, 2009.

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Religiosity gap in psychiatry

I thank the authors[1] for their well-considered and helpful article which argues for more understanding and discussion of people's religious and spiritual beliefs. They make the point that 'Individuals with religious beliefs may be extremely reluctant to engage with psychiatric services that they perceive to be atheistic, scientific and disparaging of religion'. They then cite the example of ultra-Orthodox Hasidic Jews that fear misdiagnosis.

How strange and very unfortunate then that in the very same month, the *British Journal of Psychiatry* publishes an article that basically diagnoses Ezekiel, a prominent Old Testament Biblical prophet, as having schizophrenia.[2] All of Ezekiel's experiences are attributed to the illness, thus dismissing the possibility that God actually did communicate