

LETTERS

doi:10.1017/S1041610213000100

Neuropsychological tests for assessment of healthy ethnic minority elderly population

I read with great interest the paper “Comparison of performance on three neuropsychological tests in healthy Turkish immigrants and Danish elderly” authored by Nielsen *et al.* (2012) in *International Psychogeriatrics*. In their study, 73 Turkish with lower educational level and 36 Danish older subjects were assessed on the Recall of Pictures Test (RPT), Clock Reading Test (CRT), and supermarket fluency (SF). They found significant effects of age and years of education on the Turkish performance, and significant differences between the Turkish and Danish samples on the CRT and SF performances, but not on the RPT. Despite these differences in performance, the authors suggested that these three tests are important neuropsychological instruments for the assessment of dementia in ethnic minority people. As the elderly population is increasing globally, the need for reliable cross-cultural measures suitable to assess this population at risk to develop dementia is also growing. In particular, normative data need to be appropriated ethnically and in terms of educational level, for example, to determine valid cut-offs for mild cognitive impairment (MCI) and patients with dementia. I would like to provide evidence on further neuropsychological instruments sensitive to memory and language deficits for different ethnic groups of Portuguese-speaking Brazilian individuals within the large geographical area of Brazil. Although they all speak Portuguese, they are of different ethnic background and therefore differ in their educational levels significantly. We assessed 411 healthy older subjects (61 to 85 years old and 0 to 17 years of education) from different states in Brazil on the Hopkins Verbal Learning Test – Revised (HVLT-R; Brandt and Benedict, 2001), a verbal episodic memory test, and on the Brief Visuospatial Memory Test – Revised (BVMT-R; Benedict, 1997), a visuospatial episodic memory test (Miotto *et al.*, 2012). The results showed a significant influence of age on both tests, as well as in the original American normative data. Education also showed significant influence on the results, possibly due to the different levels of education of the sample, including illiterate subjects. Gender had no influence on subjects’ tests results.

In another study, we assessed 416 healthy elderly Portuguese-speaking Brazilians (60 to 80 years old and 0 to 17 years of education) on the Boston Naming Test, a language test (Miotto *et al.*, 2010). The results showed an effect of gender, education, and age on the total scores. Those with lower educational level produced, in general, fewer correct responses. This can possibly be explained by the fact that subjects with higher educational levels are more exposed to information, reading material, and knowledge about cultural and linguistic features of Portuguese and foreign languages. These results are in line with those from Nielsen *et al.*’s (2012) study, where age and years of education were negatively correlated with performance on most of the tests only in the Turkish sample who had lower educational level.

In conclusion, these findings indicate the importance of adequate normative studies when assessing different ethnic populations, particularly when including subjects with lower educational levels. Larger studies which incorporate different ethnic groups would need to (even if the same language is used) generate first their normative data in the same population to have valid cut-offs. Finally, these findings also suggest the cross-cultural applicability of a number of widely used neuropsychological tests to assess the presence of MCI and dementia in elderly patients from ethnic minority populations.

Conflict of interest

None.

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doi:10.1017/S1041610213000124

Observations of a traveling fellow: consultation–liaison psychiatry versus joint units for delirium management

There are various approaches to providing specialist care for patients with delirium in general hospitals. Those described in the literature include joint geriatric/psychiatric units and consultation–liaison (CL) psychiatry services. The Ferdinande Johanna Kanjilal Travelling Fellowship, from the Royal College of Psychiatrists, UK, provided an opportunity to more fully understand each model. This letter outlines observations of the Australian Fellow (AW) of different service structures in the care of hospitalized older people with delirium in the United Kingdom and Ireland.

Joint units

Joint geriatric/psychiatric units have emerged to better meet the needs of medically unwell (including delirious) functionally dependent patients who need both medical and psychiatric inpatient care (George *et al.*, 2011). The key features of such units are co-located collaborative care between psychiatry and geriatrics, access to acute hospital facilities, a multidisciplinary approach to individualized care with staff who are highly skilled in managing behavioral problems and restoring function, a secure elder friendly ward environment, and comprehensive discharge planning (George *et al.*, 2011). They may also provide a setting for specialized teaching and advice. Key disadvantages of joint units are the high cost in maintaining them, potential deskilling of other wards, and inevitable inability to admit all inpatients with delirium.

Five UK joint units were visited in 2011 (Nottingham, York, Carlisle, Gateshead, and Stirling). A detailed comparison of the composition (staffing, patient mix, and bed numbers) and the advantages and disadvantages as perceived by the unit staff and the Fellow, and outcome data are available in Appendix 1 (available as supplementary material attached to the electronic version of this paper at www.journals.cambridge.org/IPG).

Although all the joint units visited appear to have been founded on the same general principles, they varied considerably in their staffing, patient profile and acuity, and the extent to which they actually share care. For example, some joint units had combined psychiatry/geriatric medicine/allied health ward rounds and meetings (Gateshead, York, and Carlisle), and one had an equal proportion of mental health and general nurses in each shift (Nottingham), whereas some joint units appeared to have psychiatry involved as an enhanced consultation service (i.e., dedicated psychiatrist sessions, but limited regular collaboration, for example Stirling). Few joint units had any regular mental health nurses (MHNs), who could provide ongoing support to general staff and specialist skills to patients with comorbid mental health problems. In some places this appeared to be secondary to a lack of resources, in others due to continued separation between medical and mental health services.

Interestingly, few joint units thought they could provide adequate care for patients with major mental illnesses (such as psychosis or severe major depression requiring electroconvulsive therapy) and co-morbid active physical illness. This was attributed to the acute ward environment and lack of mental health nurses. Many units felt they were only equipped to care for people with delirium and dementia. Thus, a significant proportion of patients with major mental illnesses, for whom such units were originally conceived to include, are still unable to be adequately cared for within these specialized wards. Given the cost involved in establishing and maintaining joint units, it is worthwhile examining whether these units achieve improved care and better patient outcomes, particularly in relation to mental health. Randomized controlled trials, such as the one underway in the Nottingham unit, may help answer this question (Harwood *et al.*, 2010).

Consultation–liaison psychiatry services

Consultation–liaison psychiatry services for older people are similarly heterogeneous. Previous studies have highlighted the lack of good quality evidence and systematic planning of services to guide how