were affected.[1] Electricity and water supplies were interrupted, roads were blocked. Bad weather, powerful aftershocks, and landslides were secondary disasters for stricken areas.

Chengdu Military Region established an earthquake-relief headquarters 18 min after the earthquake, and the Chinese Government established a class 1 natural-disaster response. On April 20, 5000–6000 military and medical rescue workers were sent to the area within a few hours along with the national emergency relief team, according to the China Seismological Bureau. Non-governmental rescue forces were also deployed to the area, bringing strong and important support.

Is history repeating itself? Ya'an is located just 100 km south of Wenchuan, in the same seismic zone, (the so-called Longmen Shan zone) part of a very active seismic belt, and both earthquakes happened in the same season. However, there is no evidence so far that Ya'an earthquake is an aftershock of Wenchuan earthquake.[2]

Importantly, Wenchuan earthquake has given the Chinese Government experience in medical disaster relief and has strengthened the capability of self-rescue among the population.[2]

Another Wenchuan earthquake is unlikely, but more efforts should be made to reduce losses to a minimum.

We declare that we have no conflicts of interest.

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Psychiatry for the elderly in the UK

The introduction of the Equality Act in the UK[1] has brought into focus issues of how old-age psychiatry is defined. For some time it has been neither logical nor reasonable to use older than 65 years of age as a criterion for access to (or denial of) a service; now it is probably unlawful to do so. The absence of a robust definition for old-age psychiatry is leading to erosion and fragmentation of services, with some health providers in the UK creating generic all-age (so-called ageless) services.

To assess the development of ageless services, we did an online survey of old-age psychiatry consultants in the UK who were members of the Old Age Faculty of the Royal College of Psychiatrists.

Of the 81 organisations providing mental health services for older adults in the UK, we received responses from 76. Of the 415 respondents who completed the survey, 196 (47%) reported development of some elements of ageless services in their organisation. Of these, 34 (17%) reported that plans were ongoing to convert to wholly ageless services. In some cases these changes were regarded as positive (eg, access to adult crisis-resolution services), whereas some were regarded as negative (eg, ageless psychology or liaison services). The move to ageless services was regarded as very good or good by 16% (37/230) of respondents, and bad or very bad by 52% (121/230) of respondents.

Old-age services are traditionally community based, with teams understanding the social, physical, and psychological consequences that ageing brings into the management of mental illness, which is essential for appropriate management. Old-age psychiatry is needed to provide a service that understands the complexities of managing people with dementia, severe comorbidity, or psychological effects of ageing and end of life.[2]

The trend for ageless services will disadvantage further a growing, already disadvantaged part of society.[3] We believe that old-age psychiatry services should be preserved and enhanced.

We declare that we have no conflicts of interest.

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Frailty assessment in elderly people

Ocean/Corbis

Andrew Clegg and colleagues (March 2, p 752)[1] present an excellent overview of frailty. We would like to further highlight the link between frailty and cardiovascular diseases, and a clinical application of frailty assessment.

Frailty is a heterogeneous condition, which might account for variations in definitions, phenotypic features, and assessment methods. The concept of disease-specific, or even procedure-specific, frailty is emerging as a clinical paradigm particularly in relation to very specialised treatments including cardiac interventions (angioplasty or bypass surgery). Cardiovascular frailty is an important problem in the elderly. Frailty is an independent risk factor for development or progression of cardiovascular diseases, and cardiovascular diseases (or their invasive management) can lead to frailty.[2] Conversely, treating one might improve the other, and the