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MENTAL HEALTH IN OLD AGE BULLETIN
ISSUE 3

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EDITORIAL

The Value Of Specialist Clinical Assessment Of Older People At Risk Of Care Home Admission

Debate as to the role of secondary health care clinicians, such as those in old age psychiatry and geriatric medicine, in the admission of older people to residential and nursing homes has continued ever since the early development of policy towards this group. The Anderson Report (1947) and the work of Marjory Warren (1946) long ago made a case for the proper classification and diagnosis of older people at this point. Support for the involvement of such clinicians in assessment prior to admission is supported by a number of UK studies (Brocklehurst *et al*., (1978); Peet *et al*., (1994); Sharma *et al*., (1994)). There has also been a tradition on a local basis of engaging specialist staff in placement decisions (Hutchinson *et al*., (1984); Rafferty *et al*., (1987)). Findings from these studies have suggested that a clinical assessment may be useful in identifying potentially treatable health conditions which might obviate the need for placement given the proper intervention and may redirect inappropriate applications to other forms of care.

However, these interventions have not been systematically evaluated and in particular, they were conducted before implementation of the community care reforms of the 1990s, which altered the process of placement. Clinicians in old age psychiatry and geriatric medicine were not systematically involved in the reforms and, at present, their inclusion in assessments at this critical point in an older person's care varies locally. A stronger focus upon multidisciplinary assessment, through such policies as the Single Assessment Process (SAP), suggests that such inclusion could be of benefit to the care of older people. Other international studies (Stuck *et al*., (1993)) also provide evidence confirming the possible benefits of including a clinical component to the formal social services assessment process in the UK.

The Personal Social Services Research Unit (PSSRU) in the School of Psychiatry and Behavioural Sciences, University of Manchester has recently conducted a research study to assess the value of just such an integrated assessment approach (Challis *et al*.). The study, conducted in the City of Manchester and part of the Macclesfield borough of Cheshire, followed up 256 older people considered to be at risk of entering care homes. Subjects were randomised into either an experimental group, who received both the care management and additional clinical assessment by an old age psychiatrist or geriatrician, or a control group, who received the usual care management assessment only. Exclusion criteria were used to ensure that participants in the study could be legitimately viewed as at risk of permanent care home placement. Older people and, where appropriate, their carers were interviewed using a range of standardised measures at baseline assessment and at 6 month follow up. Service use, including the use of hospital, emergency treatment and care home admissions, was also monitored over 6 months and the costs of these services were comprehensively measured.

The specialist assessment was integrated into the care management assessment process in the two areas by means of a feedback system operated by the research team. This gave information to care managers concerning the clinician's assessment

for each patient with regard to a diagnosis of their condition(s) and indication of prognosis in the short term (3 months) and longer term (1 year), an outline of the older person's care needs and recommendations including treatment options. A copy of each assessment was sent to the older person's GP. All clinicians conducting the assessments were specialists in old age psychiatry or geriatric medicine operating at consultant or specialist registrar level.

The results of the study confirmed that a range of conditions were newly identified by the specialist clinicians, in particular cognitive impairment and depression. Older people receiving the specialist assessment also had less contact with nursing home care and emergency services and experienced less decline in their physical functioning over a 6 month period. The carers of the older people receiving the specialist assessment experienced reduced levels of distress. Overall, the costs of care for those receiving the assessment were no greater with NHS costs actually lower.

This study showed the potential benefits of involving specialist clinicians in the assessment process for older people at this critical point in their lives. The approach is commensurate with good clinical practice and the present focus on multidisciplinary work. The findings suggest that such an assessment could be provided at a modest extra cost but that this could bring about savings in other areas of provision, notably acute hospital care and the cost to social services of nursing home placements. The study has been reported in Age and Ageing along with a specially commissioned editorial advocating it as essential reading for professionals in the field.

Further evidence from the study indicates that, although provision of the specialist assessment resulted in no overall reduction in the numbers of older people entering care homes, the uncovering of hidden morbidity may have led to more appropriate admissions for those in high need groups. This was particularly the case in terms of diagnosing conditions that subsequently play a large part in deciding that an older person should be admitted to a care home. The similarity in the numbers of older people actually placed in homes, between those receiving the additional specialist assessment and those receiving the standard social services assessment, has implications for the way in which such an integrated assessment approach could be implemented in practice. Only by restricting care home placement to those cases where it had been recommended on the basis of the full multidisciplinary assessment might this have reduced admissions overall. Such a system has operated through the Aged Care Assessment Teams in Australia, where reductions in the numbers entering hostel and nursing homes have followed as a consequence.

The lesson for the UK is that an intervention such as this will only impact on overall admissions once placements are made conditional on the multi - disciplinary assessment and only if this is combined with other policies such as control over the supply of places and the development of realistic community based alternatives.

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CURRENT KEY ISSUES

The prevalence and causes of dementia in people under the age of 65 years.

This epidemiological catchment area prevalence study aimed at determining the prevalence of dementia in people under the age of 65 and to use these figures to estimate the number of younger people affected by dementia in the UK. The study was conducted in the London Boroughs of Kensington and Chelsea, Westminster, and Hillingdon with a total population of 567500 people and included the residents of this catchment area with dementia beginning before the age of 65 years. They identified 185 participants who had developed dementia before the age of 65. The analysis of results showed that the prevalence of dementia between the ages of 30 to 64 was 54.0 per 100,000 and for those aged between 45 and 64 it was 98.1 per 100,000. From ages 35 onwards the prevalence of dementia approximately double with each 5 year increase in age thus suggesting that there are approximately 18,319 (15296 to 21758) people with dementia under that age of 65 in the UK. The

study concludes that these results are consistent with previous smaller surveys and that these prevalence figures will allow health planners to accurately estimate the needs of the population in planning dementia services.

Harvey, R.J., *et al*. (2003) The prevalence and causes of dementia in people under the age of 65 years. *Journal of Neurology, Neurosurgery & Psychiatry*, 74 (9), pp.1206-9.

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Anger and depression management: psychoeducational skill training interventions for women caregivers of a relative with dementia

There is a growing body of evidence reporting the effectiveness of skilled training in improving coping strategies for dementia caregivers. Coon and colleagues examined the short-term effect of two theoretically based psychoeducational group interventions with distressed caregivers. They also examined the role of specific moderator and mediator variables on caregiver's outcomes. The study included 169 females aged 50 and above caring for a relative with a dementing illness while living in the community. The participants were randomly assigned to one of three treatment interventions which included anger management, depression management or a wait-list control group. These interventions lasted for 3 to 4 months and anger, hostility, depressed mood, frequency of use of positive and negative coping strategies and perceived care giving efficacy were examined as the primary outcomes. The results indicated a significant reduction in the levels of anger, hostility and depression amongst the anger and depression management groups before and after they had gone through the intervention. The anger management group showed an increase in the use of positive cognitive coping strategies. Self-efficacy was significantly increased in both intervention groups and was demonstrated to function as a mediator of intervention effects. Pre-treatment levels of depression symptoms and anger expression style were detected as moderators of the relative effect of the two interventions on mood and coping. This study emphasises not only the use of psychoeducational skills and training interventions for carers of dementia but also underscores the need to evaluate key pre-treatment variables in order to determine which form of intervention may be more compatible with the characteristic of the individual caregivers.

Coon, D.W. *et al*. (2003) Anger and depression management: psychoeducational skill training interventions for women caregivers of a relative with dementia. *Gerontologist*, 43 (5), pp.678-89.

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Neuropsychological performance and dementia in depressed patients after 25 year follow-up: a controlled study

Research studies done in the past have yielded conflicting evidence regarding the long-term cognitive outcome of depression. Some studies have found evidence for a higher incident of subsequent cognitive impairment or dementia while others have refuted this.

Brodaty and his colleagues studied a group of 71 patients who were hospitalised for depression 25 years ago and assessed them on levels of depression, neuropsychological performance, functional ability and clinical variables. They compared them with 50 non-depressed controls. No significant differences were found between the depressed subjects and controls on any of the neuropsychological measures. Only 10 patients from the depressed group were found to have dementia at follow-up and vascular dementia was the most common type, predicted by older age at baseline. The study concluded that no evidence was detected for early onset depression to be a risk factor for Alzheimer's disease but there appears to be a link for a small sub-group with vascular dementia.

Brodaty, H. *et al*. (2003) Neuropsychological performance and dementia in depressed patients after 25 year follow-up: a controlled study*. Psychological Medicine*, 33 (7), pp.1263-75.

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ARTICLE

Geriatric Mental State Examination

The Geriatric Mental State Examination has been developed over the last twenty years. It is one of the most commonly used interview systems to aid the diagnosis of mental health problems in older people. It consists of a series of questions lasting about forty-five minutes. A computerised version has been developed which makes it much easier to use as at the finish of the interview it automatically generates a mental health diagnosis. The strength of the interview lies in the fact that it is relatively easily taught, can be used by non-medically trained people and has been translated in to a least sixty languages and used in numerous countries across most continents of the world. The most recent series of studies have continued to improve it through modifying it so that it is able to identify early dementia in people in the developing world with little education. In addition we have been able to demonstrate that depression has a similar profile across Europe and we are currently conducting further studies in other continents. More recent developments of the Geriatric Mental State Examination include the conversion in to a new computer language enabling it to be more accessible and easily used by most software systems. The instrument has played an important role in examining the problems concerning mental health and older people in a variety of developing countries. We now have centres for training and development of mental health services in a variety of continents

including India, the Americas, the Far East, the Middle East and Asia. We are always trying to adapt and change the instrument to suit the needs of local communities yet maintaining a basic standard so that we can compare mental health problems in different countries.

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BOOK REVIEW

Dementia care

Adams, T. & Manthorpe, J. (2003) *Dementia care*. London, Arnold. 260pp.

People with dementia are supported by a wide range of lay and professional carers. This clearly written paperback presents a major strand of thought about how this care should be delivered and is aimed at both students and practitioners. The editors have brought together twenty-one authors from nursing, social work and clinical psychology and ensured considerable uniformity of perspective based on Kitson's 'person-centred' approach. Although there is brief mention that the evidence validating 'person-centred' practice is limited, *Dementia Care* is largely polemic rather than apologetic in tone. Indeed, in some chapters it verges on the dogmatic with large numbers of 'shoulds' and 'musts' occurring in many paragraphs. Perhaps this is unsurprising given that the introductory chapter attempts to 'construct dementia' on a Foucaultian basis. What Foucault's influence brings that is positive throughout the book is the insight that Unreason is no less valid than Reason, something that many practitioners will recognise in everyday care situations where 'evidence-base' is lacking and decisions are not always rational. It is also a pity that so few disciplines are represented in a book that seeks to offer 'multi-disciplinary perspectives'. The absence of clinicians may be explained by the editors apparent antagonism to traditional medical models of dementia, but occupational therapists will miss detailed discussion of practical issues of aids and carer education etc. Similarly, although Malcolm Goldsmith's work is cited as important in several chapters, there is no pastoral or spiritual perspective offered. This exposes the innate difficulty of the 'person-centred' approach in a condition where the identity of 'person' is continually questioned. Reading this book will help students and practitioners understand much that underpins current dementia care and, hopefully, set us all thinking about the limitations of our own practice.

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WEBSITE REVIEW

National Electronic Library for Mental Health

This site, www.nelmh.org is one of the Specialist Libraries formed as part of the National electronic Library for Health and it can be accessed from the NeLH Home Page www.nelh.nhs.uk as well as directly using the URL above. The site is led by the Centre for Evidence-Based Medicine in Oxford and is funded by NeLH. It has been developed for mental health and primary care professionals but also contains information of interest to the general public and this has obvious implications for the level of some information offered. There is, however, much of value to *Bulletin* readers here. Its aims are to provide 'comprehensive, unbiased and up-to-date content', to promote knowledge sharing in the mental health community and to integrate the knowledge base in the field of mental health.

There is a search facility which provides the opportunity to see what the site has on a particular topic. It also offers a prominently displayed direct link to new reviews about mental health issues in the Cochrane Library: visiting this site obviates the need, therefore, of performing a subject search on the main Cochrane site, a valuable time saver if you are restricting your search to the mental health field.

There are links to information on particular types of mental illness e.g. affective disorders, eating disorders, schizophrenic disorders, suicide and self-harm as well as to resources concerned with the management of mental health (including evidence-based practice). There is also a link to details about medication in the treatment of mental health disorders; summaries of drug treatments are given which include normal daily dosage, usual and less common side effects. These pages also have links (on the right hand side) to the Drug Info Zone. Choosing 'Dementia' from the options of topics given produced a list 28 of articles about the use of drugs in the treatment of dementia, the majority published in the last three years. Clicking on the highlighted link in the title of one of them gave access to an abstract of this paper that had been published in the Cochrane Library.

Other direct links on the right hand side of the NeLMH Home Page include those to the parent site of NeLH, the NSF for Mental Health, the Centre for EBM, the National Institute for Mental Health in England, the NHS Plan, the Department of Health website, the Mental Health Information Strategy and the Royal College of Psychiatrists.

Via the Site Map (link across top of Home Page) there is also access to audio interviews. A selection of these includes one given by Muir Gray from the Centre for Evidence-Based Practice in Oxford, on the subject of EBP, one from Rachel Jenkins, the Director of WHO Collaborating Centre at the Institute of Psychiatrists speaking on mental health issues in the developing world and one by Monty Don, TV personality, who gives a personal account of his experience of depression.

It is a developing site and feedback is actively encouraged, giving the opportunity to influence the kind of information accessible from the site. Is there some information you would appreciate having ready access to on a site like this? Let them know –

there are numerous links to the email form on which to submit your comments throughout the site, generally found at the bottom of the page.

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YOUR PROBLEM ANSWERED

A 6-month review of admissions to our acute in-patient service for older people with mental health problems revealed that nearly 25% came from residential or nursing homes - most commonly for the management of disturbed behaviour. Whilst we have run a number of teaching sessions for care home staff, we are aware that they continue to find it difficult to care for people with dementia who present with challenging behaviours and would like more frequent input from our (already stretched) community service. Are you able to suggest how we might make our outreach service more effective?

Obtaining good quality information about the use of current services is the first step in any service evaluation/development work and it is good to hear that you have been reviewing the use of your in-patient beds. As you are probably aware the Audit Commission (2000) also found that care home residents formed a significant proportion of acute admissions and it is widely acknowledged the increasing elderly population and decreased number of long-stay NHS beds has led to a rise in the number of care home residents who have dementia with concurrent psychiatric morbidity or behavioural problems.

Whilst it is generally accepted that specialist mental health services should provide support and advice to this sector, there has been relatively little UK work assessing the effects of such input on resident outcomes, although the research does give some initial pointers. One approach, as you suggest, is to try and improve the mental health of care home residents through the education of care home staff, and the message that emerges from the literature is that such training has more impact when it is accompanied by ongoing staff support (Moniz-Cook, 1998). The provision of a seven session teaching programme followed by regular supervision led to significant improvements in residents' levels of depression and cognitive impairment for example -if not for behaviour *per se* (Proctor *et al*., 1999).

It is suggested that in order to produce a significant impact educational input be combined with resident-specific advice/interventions, and a US randomised controlled trial of a programme of structured activity, pharmacological treatments and education resulted in the halving of the number of residents displaying disturbed behaviour (Rovner *et al*., 1996). This work was undertaken by a well resourced research team and would not necessarily transfer to routine clinical practice, but both Opie *et al*. (2002) and Ballard *et al*. (2002) have recently assessed the input of smaller multidisciplinary teams. Both studies formulated individual care plans for residents, in one case based on detailed evaluations of antecedent, behaviour and consequence diaries, and whilst further work is needed the results are encouraging. The former, Australian, work reported a modest but statistically significant decrease

in residents' challenging behaviours, whilst the latter UK team found that, when compared with a control group receiving usual clinical care, the study group received significantly less neuroleptic medications and had a three-fold lower number of days in psychiatric in-patient facilities.

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