

**Mental Health in Old Age Bulletin
Issue 16**

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MENTAL HEALTH IN OLD AGE BULLETIN ISSUE 16

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EDITORIAL

Caring alternatives for patients with dementia in the Belgian public and health policy

All health services are confronted with difficulty of caring for the older people suffering from senile dementia of the Alzheimer's type and related disorders. This disease has a severe impact on the patient, who gradually loses cognitive and functional ability, but also on the informal caregivers.

The main alternative existing methods of caring for dementia patients with their informal caregivers in the Belgian public health and social policy context are addressed below. Assistance in the framework of home social service, daily relief for caregivers through day centres, lodging in service flats, caregiving in nursing homes for the elderly, hospitalisation program and continued/palliative care are discussed. These alternatives aim to take into consideration not only the patient but also the informal caregiver in the caring process. Especially, the theory according to which burden of the informal carer is positively linked to the well being of the patient, had progressed.

Home social services assume the care given to patients living at home. The care giving program, for people with dementia including shopping, cooking or meals on wheels delivering, is backed up by visits from nurses, home-helps and general practitioners.

Day centres are for those who wish to keep the patient at home. Daily relief is proposed in the form of half days to full days, five days a week. By means of a interdisciplinary work, the ultimate goal of the interventions is to facilitate the patient's autonomy in activities of daily living. The goal of these interventions is to optimise the performance of each patient by making the most of its preserved abilities. Another goal of day care centre is also to support caregivers, by giving them advice in order to adequately face difficulties presented by the patient.

In **service flats** caregiving is based on the lodging of patients in housing which groups around a common living area. Life is organised around domestic activities led by a registered nurse or housekeeper. There is no immediate service attached to this structure. This alternative should be considered only for patients with mild cognitive deficit and a relatively preserved general condition.

Nursing homes assume follow up caregiving from both a medical and social point of view. This caregiving program is backed up by visits from general practitioners.

Hospitalisation program – in this setting the caregiver is temporarily relieved, the patient diagnosed and given a treatment. Solutions for a better caring program are studied when the patient returns home or when he is admitted in an institution.

Continued/palliative care assumes extended, comprehensive and outcome based care to patients with complex behavioural and/or medical problems. This caregiving system includes care related to pain and symptom management, advanced directives and living wills and co-ordination to primary care.

Constant support represents a crucial element in any program for Alzheimer patients and their informal caregivers, during all the course of the disease, whether patients stay at home or move in an institution. When addressing the effects of administrative care programs on the caregiver's burden, it is important to consider the patient level of disability, the caregiver position and the living place of the patient.

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ARTICLE

The development of old age psychiatry services

The range of activities expected of an Old Age Psychiatry Service include:-

- -service delivery
- -education
- -training
- -audit and research

Service Delivery

Assessment and Support Work within the Community

This includes being available for early response to people identified as having probable mental health problems and difficulties arising from them within the community.

Identification may be made through primary health care or other agencies, and initial contact is likely to be by a member of a multi-disciplinary community mental health team supported by a Consultant Old Age Psychiatrist. This should provide a user-friendly assessment in conjunction with the patient's family and other agencies already involved within their own homes. In addition, those people with enduring or on-going problems will receive support at home and this may in some part be monitored and progressed by the specialist team.

Much of the day to day on-going care comes from people's families supported by other agencies, particularly the local authority who might sponsor much of the hands on care.

Clinic Based Work including Memory Clinics

Whilst much can be done in assessing and managing people in their own homes, refinements of assessment including physical examinations and more detailed psychological assessments may be better undertaken in a clinic. A clinic might be based in a traditional hospital, be it a general hospital, geriatric hospital or a mental

health hospital, or alternatively might be based in a primary health care centre, resource centre, etc.

Over the past four to five years, the concept of the Memory Clinic, which began as a research initiative, has progressed to become a necessary component of every Old Age Psychiatry Service. Such clinics provide a focus for a multi-disciplinary team to undertake more detailed, careful assessment, physical health assessment and mental health assessment of people with cognitive problems. There is now a range of treatments available for people with Alzheimer's Disease, whose introduction and monitoring of these and their effects is underpinned now by guidance from NICE.

In addition to this new therapeutic potential, there is increasing expectation that people with progressive memory problems associated with other pathologies, be it multi-infarct dementia, Lewy body dementia, frontal lobe dementia or other similar conditions, are supported in a thoughtful and well informed way. This support includes training for the patients and training for their families in how best to manage situations.

Memory clinics may be associated with the work of each community mental health team, or there may be advantage in having one clinic covering a number of sectors.

Day Care/Day Hospitals

The concept of Day Hospital care is an innovation attributed to Psychiatry. The provision of assessment and treatment in a Day Hospital is an approach now used in many other disciplines including Geriatric Medicine, Rehabilitation and even Surgery.

Whilst it is fairly straightforward to see assessment and treatment of short-term conditions as a hospital function, when it comes to the support and maintenance of individuals with chronic or progressive problems, the boundaries between what is properly a health service interest and responsibility and what might be provided elsewhere, either through the local authority or through voluntary or independent sector agencies, is less certain. Evaluations of day hospital for people with mental health problems in the adult working age demonstrate that in many instances they can be used as alternatives to inpatient care. Similar evaluations have not been attempted for older people with mental health problems. The literature on evaluation of day hospital care for older people with physical health problems is ambivalent, yet there remains strong support for the inclusion of day hospitals within the spectrum of facilities provided by Old Age Psychiatry. These day hospitals are certainly used for assessment and investigation of people, treatment and monitoring of progress in response to the treatment, and also for support of severely damaged individuals, particularly those with advanced dementia.

There is considerable literature suggesting that individuals can be sustained at home and admission to hospital or other long-term care delayed or avoided by such means, particularly where they are supported at home by others and particularly where it becomes clear that the provision of such respite reduces tension and distress in the family carers.

There is increasing support for the concept of multi-disciplinary, multi-agency resource centres run jointly by health service and local authority and addressing the needs of people across the boundary of health and social care, and across the interfaces of support at home; support through day care; respite care with a possibility of longer term care.

Continuing Care

It is a generally accepted principle of all services that they aim to support people in their own homes.

What is 'home' to an older person may be a place in which they have lived for decades, either alone or with other members of the family. It may be a home shared with younger generations who have taken them in at a time when they cannot cope, or it may be a home that they have moved to fairly recently in pursuit of sheltered and supported housing.

The range of sheltered and very sheltered housing schemes available within this country has increased over the past five to ten years, and is impressive. There remains a role for residential care, much of which is provided by the independent sector, though some local authority provision remains.

There has been a substantial increase in most parts of the country in the provision of nursing home care and specialist EMI nursing home care. Concerns for the quality of care within residential and nursing homes has given rise to a series of publications requiring improvements in standards. These standards are monitored by inspection teams. Pressures from these approaches have meant that in many places small providers have found they cannot cope and have gone out of business, so that increasingly, provision, particularly in the nursing home sector, is by large multi-national companies often in very substantial sized nursing homes.

Quality requirements include staffing ratios and skill mixes within the staff, but also require defined physical facilities most notably single rooms for almost all residents, often with en-suite bathing and toileting facilities.

Changes through the late 1980s into the 1990s meant that, whilst the nursing home and residential care sector was expanding, NHS long-stay beds for older people, older people with mental health problems and other people with mental health problems, declined very spectacularly.

Nevertheless, there is a requirement on health authorities to provide continuing care within the NHS for those people who have very severe problems, whose needs cannot be appropriately met within the nursing home sector, i.e. that their needs are complicated and severe, often progressive and usually requiring regular input from a specialist physician or a psychiatrist.

Whilst no equivalent standards for the quality of physical provision within continuing care are yet available, the generally accepted expectation is that the quality of environment within NHS continuing care facilities will be at least as high as that within the nursing home sector, and that the advantage to be gained from care within

an NHS continuing care facility derives from higher staffing ratios and a skill mix which is skewed towards the involvement of more disciplines, including paramedics and medical staff than is available within a nursing home.

It is generally accepted that in managing people with severe dementia, providing for groups of more than twenty within one unit is not appropriate.

In terms of bedroom accommodation it is usually accepted that single bedrooms with en-suite facilities are the only acceptable standard.

Assessment and Treatment Wards

Most services will operate with what amount to acute admission wards for older people. They serve the dual purpose of assessment/investigation and treatment. Admissions usually occur only after careful assessment of the patient at home or elsewhere, and admission occurs only when interventions elsewhere seem unlikely to meet the patient's needs.

The problems may be because of complexity or, more often, because of severity of symptoms producing risk as a consequence of behaviour characteristics such as confusion, wandering, self-neglect or severe anxiety and depression. Admissions are less likely to require orders of the Mental Health Act than is the case for younger people coming into hospital for mental health problems.

Wards must be clinically equipped and appropriately staffed to provide for the probable combination of physical health problems and physical dependency and psychiatric disorder. Thus staffing requires not only junior doctors (psychiatrists and consultants or their equivalent) but also qualified nursing staff, occupational therapy staff, physiotherapy staff and clinical psychology staff. There is a need for input from other paramedics as indicated.

Day space should include access to occupational therapy areas and physiotherapy areas, as well as day sitting rooms, dining room and bedroom space. Bedrooms should usually be single rooms preferably with en-suite accommodation. Experience shows that wards should not aim to cater for more than twenty individuals. There is a requirement to take account of the needs of the sexes for privacy.

Some services make a point of dedicating particular wards for organic brain syndromes, including dementia, with other wards catering for people with so-called functional or non-organic disorders. In other services the syndromes are mixed with a view to facilitating a working relationship with a particular geography and community mental health team or teams.

The most usual siting for acute admission beds is on a general hospital site, either in association with general psychiatry or elderly care services.

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CURRENT KEY ISSUES**Is vascular depression a distinct subtype of depressive disorder: a review of causal evidence**

Baldwin R. (2005). Is vascular depression a distinct subtype of depressive disorder: a review of causal evidence. *International Journal of Geriatric Psychiatry* 20: 1-11.

It is widely accepted that vascular depression is an important concept from a clinical and a conceptual point of view, and the author presents a literature review showing that there is considerable evidence linking depression in later life with vascular brain disease but that the interaction is bidirectional and that the association between the two could be mediated by factors other than vascular risk factors such as an inflammatory process. The interaction between depression and vascular disease provides a useful backdrop by anyone considering the interaction between physical and mental health problems.

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BOOK REVIEW**The Central Nervous System: structure and function**

Per Brodal. *The Central Nervous System: structure and function*. 3rd ed. Oxford University Press.

This excellent book is aimed primarily at students of medicine and allied subjects. Its purpose is to provide them with an account of nervous system structure and function which is readily comprehended even if they are approaching this complex subject for the first time and also to provide a basis for understanding the many disorders of neural function encountered in clinical practice. It achieves these goals in exemplary fashion.

The text is divided into six main sections – Main Features of Structure and Function, Sensory Systems, Motor Systems, The Brain Stem and the Cranial Nerves, The Automatic Nervous System, Limbic Structures and the Cerebral Cortex. Within each section, the relevant regional anatomy is presented and this is well-integrated with a systems approach to explaining the functions of complex neural networks. The text is written to a high standard and is always articulate and clear. The need for a didactic approach in an undergraduate text is well-modulated by pointing out the limits of understanding in many areas and the need for future research. This huge field is one of rapid progress in which there is breath-taking accumulation of new

information. Professor Brodal is to be congratulated on the currency of the text. There are numerous clinical examples which further explain and give relevance to the main text, most of these sections being laced in coloured boxes. The book is richly illustrated with sectional photographs and line drawings which are usually clear, uncluttered and well-labelled.

My criticisms of this book are few. In some areas, one could argue that the level of detail is greater than one can reasonably expect an undergraduate medical student to assimilate in the restricted time usually available for the study of basic neuroscience. The fundamental principles of neuroanatomy and neurophysiology necessary to understand the most common neurological conditions to the level required when entering clinical training could be presented in a more concise text. There is a somewhat unimaginative use of colour in the book, with a predominant use of pink for the clinical boxes and in the line drawings. These are, however, minor detractors from what is easily-read and erudite text. Overall, this book is one of the best of its genre and is to be highly recommended.

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WEBSITE REVIEW

Cochrane reviews and protocols on dementia 2

Reviews

Cholinesterase inhibitors for dementia with Lewy bodies

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Galantamine for vascular cognitive impairment

D Craig and J Birks

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