Community mental health teams:

Can they leaven the load of older adult psychiatry in care homes?

A consultation document is soon to be published that will give hotel-style ratings to care homes for older people. While this change is promising, **Dr Eamon Fottrell** illustrates by example how older people with psychiatric problems and their carers can benefit through the involvement of community mental health teams, and challenges GPs to become actively involved with such patients living in residential and nursing care.

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Arguably, the greatest challenge to the NHS is the increasing population of old people presenting with physical and mental health problems. Nearly 25 per cent of people aged 85 and over are living in care homes or occupying long-stay hospital beds. Many of the residents are not only physically frail, but also suffer from mental health problems. In the UK, the population of those 65-plus will increase from 9.3 million in 2000 to 16.8 million in 2051. Currently, it is estimated that over 33 per cent of people in care homes have dementia (maybe as high as 66 per cent) and over 40 per cent will have depression, very often undiagnosed and untreated[1]. These figures will increase as residents age and life expectancy in general increases.

The Commission for Social Care Inspection (CSCI) intend to give care homes hotel-style star ratings[2]. The ratings will range from 4-star for excellent to 1-star for poor. A consultation document is to be published and it is intended that star-ratings will be introduced from April 2007. Chair of the Commission Dame Denise Platt can envisage older people — and those with elderly relatives — moving home to reside in the catchment areas of 4-star homes, similar to the practice of parents who move into the areas of the best schools.

The number of stars are allocated on such scoring features as:

- rooms having en-suite facilities;
- visitors welcomed at any time; and
- encouragement of residents to have frequent ongoing contact with friends and family.

The 1-star home will be characterised by:

- restricted visiting;
- contact with the outside controlled by the manager;
- the home not always being clean, tidy and warm; and
- the presence of obvious hazards with a high risk of accidents.

Spot-checks will be carried out on all star-rated homes.

These changes are welcome. The risk remains that the actual psychiatric care of the resident, particularly the most vulnerable, will not get star-ratings. The psychiatric burden in care homes can only increase very considerably and will be exacerbated by the complete disappearance of continuing care beds in NHS facilities. An accelerating form of re-institutionalisation into care homes is taking place for older adults with mental health problems. Homes have deservedly attracted widespread adverse publicity when cases

Table 1. Common criticisms of care homes

- Overuse of medication
- Irregular or total absence of medication review
- Shortage of staff
- The lack of psychiatric training of any degree for staff, even in Elderly Mentally Impaired (EMI) registered homes
- The absence of diversional therapy
- Overcrowding, especially in non-purpose built homes
- Inadequate funding of placements by local authorities, which militates against good quality environments

Table 2. Abuse risks

Residents with mental health problems are at risk of ill-treatment and abuse when:

- Morning or evening when visitors are not about
- Staff must intervene to wash or dress them
- Staff get them in or out of bed and they are resistant and misinterpret the intentions of staff
- Medication is administered to unwilling recipients
- After recent admission, residents exhibit increased agitation and violence towards staff, in an effort to leave
- Residents undergo changes in their mental state; eg, if they develop paranoid delusions about staff or residents and become aggressive
- Residents present with what is generally described as 'behavioural disorders'

of physical abuse or gross ill-treatment receive media attention. Many, if not most, incidents however, are likely to go unreported unless a member of staff raises the alarm. Those incidents are most likely to arise in homes where other criticisms are valid, such as those listed in *Table 1 (overleaf)*. It is most important to emphasise that the vast majority of staff, trained and untrained, who work in these homes are caring and considerate — even though poorly paid — and go beyond the call of duty in caring for residents. Residents with mental health problems will be most at risk from abuse at specified times (*Table 2*). The demented resident will not be able to complain and if, during the course of a 'behavioural' problem, he exhibits aggression towards staff there is a risk that untrained staff may respond in like-manner towards him. There may be requests to put residents on tranquilisers because of such events, but evidence shows training staff in better communication skills with residents can have a substantial influence in reducing the number of residents that receive tranquilisers[3]. Alternatives to the use of medication for care homes have been described[4] in previous articles on the subject.

Team effort

Increasingly, members of the Mid-Surrey Community Mental Health Team for Older Adults (based at the 'The Meadows' West Park Hospital in Epsom, Surrey) are called to see residents not only for assessment of depression or dementia, but also for 'behavioural disorders'. The team is getting to know many, if not most, of the residents of some homes and decided to take a two-pronged innovative approach, which hopefully would result in better quality of care and perhaps fewer referrals. The central problem was perceived to be a lack of very basic psychiatric knowledge among the care home staff.

Firstly, the team decided an effort to increase the psychiatric understanding of staff, even to a basic level, would be worthwhile. They compiled a very basic information handbook on the common psychiatric conditions and problems that staff in homes would be likely to encounter in residents, entitled: *A Brief Information Handbook for Staff of Residential and Nursing Homes on the Principles and Practice of Management for Older Adult Mental Health Residents**. It is comprised of 16 pages of A4 paper using simple lay language as the team was aware that for many carers, English is not their first language. An introduction is followed by sections on dementia, depression, behavioural problems in older adults, medication in older adults, acute confusional states, the role of the visiting GP and, finally, the evolving role of the community mental health team.

Copies were given to every member of staff in a selected group of 11 homes that were making many referrals and they were encouraged to read it. A series of talks were then arranged by members of the team for each of the homes, oriented around the contents of the information handbook. It was realised this should not a be one-off exercise and will be repeated on at least yearly intervals. Talks were also given by the team's occupational

Table 3. Anticipated benefits of a community mental health team

- Residents receive better psychiatric supervision and care
- The risk of receiving unnecessary or excess medication is minimised
- Elderly carers will have less anxiety when those they cared for need admission to a home
- Homes are encouraged to admit more challenging residents, rather than pick and choose, as they know they have psychiatric back-up
- Discharge from general hospitals and elderly mental health assessment units may be facilitated
- More economical use of team time

References

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3. Fossey J, Ballard C, Juszczak E *et al*. Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: Cluster randomised trial. *BMJ* 2006; **332**:756-61
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7. Nurses as leaders in chronic care, their role is pivotal in improving care for chronic diseases. Editorial, *BMJ* 2005; **330**; 612-3
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therapists on the principles and practice of simple diversional occupational therapy that might be beneficial in behaviour modification.

Secondly, individual members of the team arranged to routinely visit these homes situated in their geographic areas as frequently as is consistent with their work commitments. It was anticipated this would occur on average at two-monthly intervals. They would review the mental health of residents already known to the team; if changes in management were indicated, including medication, they would discuss problems with the team doctor. Although individual members of the team were allocated to particular homes, each member had a back-up team member to consult with if needed, and it was arranged this duo would comprise a doctor supporting a nurse or vice versa. Occasionally they would do a joint visit to a home as need indicated. Flexibility was the keyword to the smooth functioning of this scheme.

The team is comprised of a long-term locum consultant psychiatrist for the elderly, a staff grade doctor, three community psychiatric nurses, (CPNs), one community support nurse (CSN), three community support workers (CSWs) and three occupational therapists (OTs) and two occupational therapy technicians. The team provides a service for a catchment-area population of approximately 19,000 patients aged 65 and over Anticipated benefits are listed in *Table 3*.

Discussion

This approach has been operative now for six months. The team perceptions are that the homes generally welcome the increased interest shown in their residents and were very glad to get the information handbook; staff enjoyed the talks by members of the team. This approach is in accord with the position statement of the specialist old age psychiatry faculty of the Royal College of Psychiatrists[5] that specialist teams should promote continuity of care for those in particular need in residential and nursing homes, and continuity of relationships with those providing such care. It is also in keeping with the spirit of a more recent publication[6] from them stressing the need for assertive in-reach teams to improve the interface with residential/nursing homes. Ideally, these in-reach teams would be jointly funded by a combination of social services, primary care and or mental health trusts.

There is a temptation for GPs to disengage from older adults presenting with mental health problems in care homes, especially if they are already known to psychiatric services. GPs should initially see residents presenting with depression, acute confusional states or suffering from the side effects of psychotropic medication. Unresponding or complex cases are always welcome when referred to the older adult team. This would greatly enhance the in-reach of the community teams. There are very fulfilling and exciting opportunities for GPs in large

Key points

- Arguably the greatest challenge to the NHS is the increasing population of old people presenting with physical and/or mental health problems.
- Twenty-one per cent of people aged 85 and upwards in the UK reside in long-stay hospitals or care homes, and the numbers are increasing.
- Unless there is in-reach by community mental health teams for the elderly and GPs, these homes are at serious risk of developing the regrettable features of the old institutional long stay wards of the mental hospitals or worse.
- GPs must resist the temptation to disengage from the ongoing commitment to the psychiatric care of older adults with mental health problems in care homes.

practices to develop a specialist role — 'interest in health-care of the elderly'. These GPs would supervise residents in the homes in the remit of the practice and liaise with the community mental health team for the elderly. Staff showed enthusiasm to learn more of the psychiatry of older adults.

Nurses are well established as leaders in chronic care when it comes to physical illnesses[7]. Likewise, there is also a central role for psychiatric nurses in supportive and liaison work with the burgeoning population of older adults with mental health problems in care homes.

Unless we act now some of the more deplorable features of the old long-stay wards of mental hospitals or, perhaps worse, may appear in our care homes. It is delusional to assume that a home designated as Elderly Mentally Infirm (EMI) will exhibit any significant expertise in psychiatric care compared with undesignated homes and, therefore, should not be exempt from input by the team. In practice EMI homes very often have one member of staff with psychiatric training that may be infrequently encountered on visiting. The old mental hospital wards were visited at least once or twice a week by a trainee psychiatrist, had psychiatric nurses on staff and were regularly visited by an old fashioned matron. By focusing on service provision wherever we find the need — whether in the individual's own home or in a care home — we are likely to optimise our resources. Working closely with carers in different settings will raise the quality of care. This approach is also within the spirit and the letter of the Department of Health guidance on older people's mental health services[8]. There is no time for delay.

**A limited number of copies of the handbook are available from:*

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Conflict of interest: none declared.