PROGRAMME ON MENTAL HEALTH

ORGANIZATION OF CARE IN PSYCHIATRY OF THE ELDERLY

A TECHNICAL CONSENSUS STATEMENT

DIVISION OF MENTAL HEALTH AND PREVENTION OF SUBSTANCE ABUSE
WORLD HEALTH ORGANIZATION

WORLD PSYCHIATRIC ASSOCIATION

GENEVA
This document has been printed through a generous grant from Pfizer Pharmaceuticals Group.
ORGANIZATION OF CARE
IN PSYCHIATRY OF THE ELDERLY:
A TECHNICAL CONSENSUS STATEMENT

This is a technical consensus statement on the organization of care in psychiatry of the elderly, jointly produced by the Geriatric Psychiatry Section of the World Psychiatric Association and WHO, with the collaboration of several other NGOs and the participation of experts from countries in several WHO Regions.

It is the final version of a previous draft issued under reference MSA/MNH/MND/97.1.

KEY WORDS: psychogeriatrics / elderly people / care / organization of services / mental health care.
SERVICES FOR THE ELDERLY WITH MENTAL DISORDERS

I am pleased to support the distribution of this technical consensus statement on the organization of services for the elderly with mental disorders. It is a second document in a planned series of three, developed by a group of representatives of non-governmental organizations and the World Health Organization during a meeting organized by the Geriatric Psychiatry Section of the World Psychiatric Association and hosted by the Lausanne University Psychogeriatrics Service, held in Lausanne, Switzerland, 14-16 April 1997.

The importance of this subject is indicated by the number and quality of NGOs who sent representatives to the meeting and later endorsed the final text. These NGOs include some of the most relevant organizations interested in this area, and to which we are deeply grateful: Alzheimer's Disease International (and its local branch, the Swiss Alzheimer Association), the International Council of Nurses, the International Federation of Social Workers, the International Psychogeriatric Association, the International Union of Psychological Science, Medicus Mundi Internationalis and the World Federation for Mental Health.

Our appreciation goes to Professor Jean Wertheimer, Professor of Psychogeriatrics at the Lausanne University and President of the Geriatric Psychiatry Section of the World Psychiatric Association, who organized and hosted the meeting; to Professor Raymond Levy, President of the International Psychogeriatric Association, who chaired the meeting; and to both Dr Nori Graham, President of Alzheimer's Disease International, and Professor Cornelius Katona, from the University College London Medical School, who excelled in producing the final report of the meeting. The text of the statement produced by the meeting has been sent to all member societies of the World Psychiatric Association for comments. Dr José Manoel Bertolote, from the World Health Organization's Mental Disorders Control Unit, was responsible for the final editing of this document. We gratefully acknowledge a grant from Pfizer Pharmaceuticals Group for the printing and distribution of this document.

It is our hope now that, through the implementation of the principles included in this document, the lives of the elderly with mental disorders and of their carers will be brighter and better.

Dr J. A. Costa e Silva
Director
Division of Mental Health and Prevention of Substance Abuse
World Health Organization
INTRODUCTION

I am very grateful to the Section on Geriatric Psychiatry of the World Psychiatric Association and its Chairman, Professor J. Wertheimer for agreeing to take a leading role in the development of a consensus of opinion on several issues in the development of health care for the elderly with mental disorders.

The proportion of the population reaching old age is growing in developed and developing countries and the resources available to deal with health care for this group of people are becoming more and more restricted. It is necessary therefore to develop strategies of care that will be both effective and rational. The first step to their formulation must be an examination of scientific evidence and a unanimous statement about the most desirable course of action by those most concerned with the implementation of such strategies - the organizations representing the health and social service professionals, governmental agencies, patients and non-professional carers.

The Geriatric Section of the WPA has approached this task by inviting representatives of leading nongovernmental organizations and of the World Health Organization to meet and produce a draft of three consensus statements - the first dealing with the limits of the field of concern for the psychiatry of old age, the second addressing the organization of services for the elderly with mental disorders, and the third presenting views on research and training in relation to the management of these disorders. The participation of international organizations such as the International Psychogeriatric Association, Alzheimer's Disease International, the International Federation of Social Workers, the International Union of Psychological Science, the World Federation of Mental Health and Medicus Mundi Internationalis made this a truly international effort. The first two texts produced by this group have been widely circulated to individual experts for comments and suggestions. In addition, they have been forwarded to the Member Societies of the World Psychiatric Association in some 80 countries and their views and opinions have also been taken into account in finalizing the texts. The third text of the series will be produced in early 1998 using the same procedure.

It is my hope that the other Sections of the World Psychiatric Association will follow the example set by the Section on Geriatric Psychiatry. The development of consensus statements is one of the explicitly stated goals of the WPA - a goal that has never been of greater importance for psychiatry than now at a time when the prevalence of mental disorders is growing worldwide and when psychiatry has acquired the knowledge and techniques to deal with them in an effective manner.

Professor N. Sartorius
President
World Psychiatric Association
A CONSENSUS STATEMENT ON THE ORGANIZATION OF
PSYCHIATRIC SERVICES FOR THE ELDERLY

Care of older people suffering from mental disorders is growing in importance, at the same
time as life expectancy is increasing. The latter phenomenon, which is already a significant reality
in developed countries, will progressively end up playing an important role in developing countries
as well. The implications of this increased longevity are widespread and will greatly affect our
society which must adapt itself to the political and socio-economic environment, while at the same
time adhering to rigorous ethics that protect the individuals, whatever their age.

It is with full awareness of the interests at stake, that this consensus statement has been
prepared by representatives of the primary professional organizations concerned with mental health
of the elderly. This document, which is a follow-up of a first Consensus Statement on Psychiatry
of the Elderly, gives the broad outlines of the organization of care for the aged. It is intended to be
sufficiently flexible to allow local adaptations of the basic principles.

Psychiatry of the Elderly is a complex discipline, confronted with intricate problems
pertaining not only to mental health and behavior, but also to physical health and relational,
environmental, spiritual and social matters. The situations which this discipline is facing are thus
closely linked to the family nucleus, the local customs and culture, the general organization of Public
Health and social assistance. The organization of care in Old Age Psychiatry must be worked out
along the perspectives of the Primary Health Care Strategy of the WHO (Declaration of Alma Ata,
1978), focus on the patients and their families, and yet be integrated into the medical and social
network designed for the population in general and the elderly in particular. However, this
integration must not be synonymous with dilution and loss of specificity. On the contrary, since
collaboration is necessary, it is therefore indispensable that competences, specific care and
structures adapted to Old Age Psychiatry, be solidly developed. Care of the elderly requires a
strong contribution from Old Age Psychiatry.

Professor J. Wertheimer
Chairman
Geriatric Psychiatry Section
World Psychiatric Association
ORGANIZATION OF CARE IN PSYCHIATRY OF THE ELDERLY:
A TECHNICAL CONSENSUS STATEMENT

The World Health Organization and World Psychiatric Association have recently produced a consensus statement on the scope of psychiatry of the elderly. That consensus statement defines the specialty of psychiatry of the elderly as a branch of psychiatry that forms part of the multidisciplinary delivery of mental health care to older people. In order to fulfil the scope of psychiatry of the elderly we need recommendations as to the organisation of care within it.

The objectives of this document are to:

* promote debate at the local level on the mental health needs of older people and their care givers;
* describe the basic components of care to older people with mental disorders, and their coordination;
* stimulate assist and review the development of policies, programmes and services in psychiatry of the elderly according to the framework of the WHO Primary Health Care Strategy, and
* encourage the continuous evaluation of all policies, programmes and services to older people with mental disorders.

This document is intended for use by all those involved in the development and implementation of policies, programmes and services for promoting the mental health of older people. It is therefore expected that this document will be widely distributed.

1. GENERAL PRINCIPLES

Good health and life of good quality are fundamental human rights. This applies equally to people of all age groups and to people with mental disorders.

All people have the right of access to a range of services that can respond to their health and social needs. These needs should be met appropriately for the cultural setting and in accordance with scientific knowledge and ethical requirements.

Governments have a responsibility to improve and maintain the general and mental health of older people and to support their families and carers by the provision of health and social measures adapted to the specific needs of the local community.

Older people with mental health problems and their families and carers have the right to participate individually and collectively in the planning and implementation of their health care.

Services should be designed for the promotion of mental health in old age as well as for the assessment, diagnosis and management of the full range of mental disorders and disabilities encountered by older people.

Governments need to recognise the crucial role of non-governmental agencies and work in partnership with them.

Preparing for increasing life expectancy and ensuing health risks calls for significant social innovations at the individual and societal level, which must be founded on a knowledge base drawn from contributions by, and collaboration among, the medical, behavioural, psychological, biological and social sciences.

In developing countries it may be difficult to provide resources for the provision of care. This, however, does not invalidate the aims of helping the elderly by the application of the principles listed above and the specific principles that follow.

2. SPECIFIC PRINCIPLES

Good quality care for older people with mental health problems is:

- Comprehensive
- Accessible
- Responsive
- Individualised
- Trans-disciplinary
- Accountable
- Systemic

A comprehensive service should take into account all aspects of the patient’s physical, psychological and social needs and wishes and be patient-centred.

An accessible service is user-friendly and readily available, minimising the geographical, cultural, financial, political and linguistic obstacles to obtaining care.

A responsive service is one that listens to and understands the problems brought to its attention and acts promptly and appropriately.
An **individualised** service focuses on each person with a mental health problem in her/his family and community context. The planning of care must be tailored for and acceptable to the individual and family, and should aim wherever possible to maintain and support the person within her/his home environment.

A **transdisciplinary** approach goes beyond traditional professional boundaries to optimise the contributions of people with a range of personal and professional skills. Such an approach also facilitates collaboration with voluntary and other agencies to provide a comprehensive range of community orientated services.

An **accountable** service is one that accepts responsibility for assuring the quality of the service it delivers and monitors this in partnership with patients and their families. Such a service must be ethically and culturally sensitive.

A **systemic** approach flexibly integrates all available services to ensure continuity of care and coordinates all levels of service providers including local, provincial and national governments and community organisations.

### 3. CARE NEEDS

**PREVENTION**

There are several specific circumstances within the psychiatry of old age where preventative strategies may be useful. Vascular dementia may be prevented by appropriate measures that reduce risk of cerebrovascular accident. These include identification of those at high risk of CVA (screening for hypertension and atrial fibrillation, early identification and good control of diabetes), low-dose aspirin and encouragement towards healthy lifestyle (diet, exercise, nonsmoking). Similarly depression may be prevented by facilitating meaningful social contact and recognising circumstances that increase individual risk (bereavement, social isolation, institutionalisation, poverty). Encouraging continued social and intellectual activity in old age may protect against both depression and dementia. Recognition of impending carer burnout and provision of appropriate support can prevent crises of care.

**EARLY IDENTIFICATION**

Early identification of mental disorders of old age (such as depression, dementia, delirium, delusional disorders, anxiety disorders, alcohol and substance abuse and dependence) may facilitate access to services and effective management and reduce stress both for the individual and the carer(s). Abrupt change in behaviour or personality should alert the clinical team to the possibility
of treatable mental disorder. Carers and families are in the best position to recognise such change. Screening (e.g., MiniMental State Examination for dementia, Geriatric Depression Scale for depression) may have a role but requires training in true case recognition as well as in administration of screening instruments.

COMPREHENSIVE MEDICAL AND SOCIAL ASSESSMENT (INCLUDING DIAGNOSIS)

Wherever possible, initial assessment should be in the individual's home environment. All care professionals should be trained in comprehensive initial assessment and good record keeping. The purposes of such assessment are to identify problems (including practical difficulties), resources and needs (from the points of view of the individual and the care network), to make a working diagnosis and to generate an initial management plan (which may include further assessment or specialist referral). A diagnostic formulation is important both to allow rational care planning and to inform patients and carers as to the current situation, management options and outlook. Timely referral as appropriate (to hospital specialists, social services, voluntary organisations etc.) is integral both to the initial assessment and to subsequent management (see below).

MANAGEMENT

Management is more than treatment in the medical sense. A coherent and comprehensive care plan should critically review diagnoses and address the individual's physical, psychological, social, spiritual and material needs as well as specific psychiatric diagnoses. The needs of the carer network and of the local community must also be addressed. Progress must be monitored in follow-up and risk of relapse considered. Prophylactic treatment may play an important role. The primary goal of management is, as far as possible, to maintain or improve the quality of life of patients and their carers while respecting their autonomy. Quality management also includes special care for dying persons and their families.

CONTINUING CARE, SUPPORT AND REVIEW OF THE INDIVIDUAL AND CARER(S)

Patients with severe mental illness, particularly those with dementia, may need considerable support in maintaining self-care and activities of daily living. In some cases continuous supervision may be necessary. The ability of informal carers to meet these needs, and the resultant burdens on carers need to be monitored closely and emerging problems addressed promptly. Practical and regular help with household and personal care may considerably enhance quality of life. Counselling and emotional support for carers may play a crucial role. A proactive approach is more efficient as well as more humane than one that is crisis-driven. Emerging physical problems may require active medical treatment.
INFORMATION, ADVICE AND COUNSELLING

Patients and carers need easy access to readily understandable and accurate information concerning diagnosis, management options and implications and available support resources. Educating patients and carers and promoting discussion are important components in care planning which may facilitate compliance, particularly in the context of long-term prophylaxis. A systematic multidisciplinary approach to record keeping and information sharing (within the confines of confidentiality) is highly desirable.

REGULAR BREAKS (RESPITE)

The provision of breaks from caring may be crucial in enabling informal carers to continue in their caring role. Such respite may take many forms and should be as flexible and responsive as possible to individual needs and circumstances. Respite may be required at different times of day or night and may be offered both in the patient's home and in appropriate alternative settings such as day centres, day hospitals and residential facilities. Using scarce residential facilities for respite rather than exclusively for continuing care may increase their effectiveness considerably.

ADVOCACY

The legal rights and financial and other personal interests of such patients must be protected. Some older people with mental disorders (particularly those with dementia) may not be able effectively to represent their interests, manage their affairs or agree to what is proposed for them. This is particularly problematic for patients who are alone and where there is a conflict between individual and family interests. Patient advocates (who have neither a carer nor a service provider role for the patient concerned) may be important, as may reference to advance directives.

RESIDENTIAL CARE

Though care should be provided in patients' homes as long as possible, it must be recognised that care in an alternative residential setting may be the only way of meeting patients' needs effectively or avoiding intolerable carer burden. Such care will always be necessary, particularly for people who have no relatives available or willing to look after them.

SPIRITUAL AND LEISURE NEEDS

Older people with mental health problems need the opportunity to express and discuss spiritual needs and observe their religious practices. Meaningful and appropriate recreational and leisure activities may contribute substantially to quality of life. Appropriate provision and support in these areas should be considered in both community and residential settings.
4. DESCRIPTORS OF COMPONENTS OF SERVICES

The components of services can be summarised in Figure 1, which portrays the concept that individual patients, together with family and carers are surrounded by care services; these are flexibly interlocking, overlapping and integrated to provide an unified system for continuing care and best possible quality of life. Structural obstacles are minimised, as represented by the dotted lines of the figure, enabling the smooth movement of the patient from one service component to another as changing circumstances require.

This section describes the components which can be put into place to address the care needs described in the previous section.

The following components ideally should be the responsibility of specialised teams of trained health care professionals working in psychiatry of the elderly. Where there is a scarcity of trained staff and of resources it will be necessary to use ad hoc solutions in order to provide the necessary components - while trying to fully develop services.

Figure 1: Surround with care
A. Community Mental Health Teams (CMHTs) for Older People

The lead in organising the following components of the service should ideally be taken by Multidisciplinary Specialist Teams working in psychiatry of the elderly. The CMHT may consist of doctors, psychiatric nurses, psychologists, social workers, therapists, secretaries. Referral to the CMHT is usually from primary care. One of the main responsibilities of the CMHT is the specialist assessment, the investigation and the treatment of people in their home setting. In situations where such personnel are not available, the responsibility may be taken by general psychiatric or geriatric medicine teams.

B. Inpatient services

Acute inpatients units need to provide specialist assessment and treatment for the full range of mental disorders. This may in some cases include rehabilitation before return to the community.

C. Day hospitals

This is an acute service which offers assessment and treatment to older people who can be maintained at home supported by the multidisciplinary team. The day hospital team could include doctors, nurses and therapy staff. Transport may need to be available.

D. Out-patient services

These provide assessment, diagnosis and treatment for people fit enough to live in the community and get to and from the hospital base. Out-patient services should be close to the in- and day-patient units. They may involve subspecialty clinics (e.g., memory or mood disorder clinics) and mobile clinics.

E. Hospital Respite Care

Hospital beds may be used to provide a respite service for people with chronic and severe mental illness and difficult associated behavioural problems in order to give their carers a break and enable care at home to continue as long as possible.

F. Continuing Hospital Care

Care for life in a hospital setting may be required for people with chronic and severe mental illness and difficult associated behavioural problems. Such care should be provided in as relaxed and homely an environment as possible, with carers encouraged to participate.
G. Liaison Services

Consultations and/or liaison services should be provided between facilities for elderly people with mental disorders and those serving general and geriatric medicine, general psychiatry, residential facilities and social agencies. This relationship should be of a reciprocal nature.

H. Primary Care

The primary care team has the initial responsibility for identifying, assessing and managing mental health problems in older people. The decision to refer to the CMHT is usually made in primary care.

I. Community and social support services

Services (both formal and informal), to enable the elderly person to remain at home. This includes a range of activities (home care, day care, residential care, respite care, self-help groups etc) provided by voluntary or government/social services.

_Respite facilities._ A range of short term, time limited, in-the-home and out-of the-home services (residential services, other carers, day programmes) to support the carers.

_Residential care._ For those patients whose physical, psychological, and/or social dependencies make living at home no longer possible, a spectrum of residential facilities should be provided. These range from supported accommodations with low level supervision, medium level care facilities, to full nursing facilities. These should be organised to achieve the best possible quality of life.

J. Prevention

The mental health team for the elderly should engage in the prevention of relapse of disorders by careful follow up. They should also identify the risk factors for mental disorders in the elderly (e.g. hypertension, alcohol and substance abuse) and ensure these are effectively managed by appropriate medical, social strategies.

Within each service, preventative activities need to be coordinated in collaboration with relevant public health and other health care professionals. These may include educational activities to improve early identification of mental health problems by carers, families and primary care personnel in the community.
5. CONCLUSIONS

This document is not meant to be either totally comprehensive or prescriptive. Detailed descriptions of methods of treatment and care, for example, have not been included in this statement. Treatment and care are consistently evolving in the light of advances in research and services have to be continuously evaluated to ensure that they follow these advances of knowledge. New structures may well be required to enable new treatments to be used successfully.

This statement identifies care needs of older people with mental disorders and some of the ways by which these are currently met in some parts of the world. Where this is not the case, the consensus is that it is urgent that people responsible for health care policy development and implementation take note of the requirements cited and act accordingly.

Responsive action should lead to the development, appropriate to local conditions, of the components of services which will adequately address these needs.

Such components should be integrated and co-ordinated to serve older people with mental health problems and their carers and should be supported by adequate resources.

The attainment of the best possible quality of life of elderly people with mental disorders and their carers is paramount and is the ultimate guiding principle in organisation of care.

Good services should always be underpinned by good research, evaluation and training. These will be dealt with in subsequent consensus reports, the next of which will discuss exclusively the question of teaching and training in the specialty of psychiatry of the elderly.
Consensus Meeting on Organization of Care in Old Age Psychiatry
Organized by the World Psychiatric Association, Section of Geriatric Psychiatry
Co-sponsored by the World Health Organization
Hosted by the Lausanne University Psychogeriatrics Service
Lausanne April 14 - 16 1997

List of participants

<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
<th>Position</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer's Disease International</td>
<td>Dr Nori Graham, President</td>
<td>(Co-Rapporteur)</td>
<td>London, England</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swiss Alzheimer Association</td>
<td>Mr Oskar Diener, General Secretary</td>
<td></td>
<td>Yverdon-les-Bains, Switzerland</td>
</tr>
<tr>
<td>International Council of Nurses</td>
<td>Ms Anne-Françoise Dufey</td>
<td></td>
<td>Lausanne, Switzerland</td>
</tr>
<tr>
<td>International Federation of Social</td>
<td>Dr Carlos de Mendonça Lima</td>
<td></td>
<td>Lausanne, Switzerland</td>
</tr>
<tr>
<td>Workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International Psychogeriatric</td>
<td>Dr Kojo Koranteng</td>
<td></td>
<td>Basel, Switzerland</td>
</tr>
<tr>
<td>Association</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ms Beverly Benson Long, President</td>
<td></td>
<td>Atlanta, USA</td>
</tr>
<tr>
<td></td>
<td>Prof. Raymond Levy, President</td>
<td></td>
<td>Liverpool, England</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
World Health Organization

Dr José Manoel Bertolote
Mental Disorders Control
Division of Mental Health and Prevention of Substance Abuse
Geneva, Switzerland

Dr Juliet Dube-Ndebele
Consultant, Regional Office for Africa
Harare, Zimbabwe

Dr Helmut Sell
Regional Advisor, Health and Behaviour
Regional Office for South-East Asia
New Delhi, India

World Psychiatric Association

Prof. Norman Sartorius, President
Geneva, Switzerland

Prof. Jean Wertheimer, Chairperson
Geriatric Psychiatry Section (GPS)
Lausanne, Switzerland

Secretariat

Prof. Oluwafemi Agbayewa
Member, GPS
Vancouver, Canada

Prof. Edmond Chiu
Member, GPS
Melbourne, Australia

Prof. Cornelius Katona
( Co-Rapporteur)
Member, GPS
London, England

Prof. Jean-Marie Léger
Member, GPS
Limoges, France

Mrs Suzanne Scheuner
Mrs Tina Anderson