Adding Life to Years

Dementia and Mental Health Services for Older People
A Service Strategy for the Northern Area

APRIL 2007
Executive Summary
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The 25 years added to life expectancy may be considered one of the greatest achievements of the 20th century. A natural consequence of this is an increase in the population of older adults with the proportion in the Northern Area projected to rise by 30% between 2003 and 2015.

This Strategy describes the types of service, which people who use the Northern Health and Social Care Trust's mental health services for older people tell us they need. It also reflects the experiences of people who provide those services and draws upon evidence of accepted best practice. It sets out a vision for a specialist, integrated mental health service for older people. To make this vision a reality requires a commitment to reshaping existing services combined with sufficient new resources.

Central to the vision is the creation of multi-disciplinary Community Mental Health Teams for Older People. These will provide a service to those with a functional mental illness such as depression and to those with dementia. They will work with primary care and community services to ensure early diagnosis and an efficient care pathway through services.

Individuals referred to the team will receive a comprehensive assessment and care plan, including the needs of their carers. People and their carers will receive accessible information on their diagnosis and available support services in ways, which are accessible to them. Staff will demonstrate respect, understanding and care for patients, clients and their carers.

Older people with a mental health problem will stay in their own homes for as long as possible. Carers will have access to services at short notice during a crisis. This will include specialist psychiatric home treatment, behavioural nursing services and a rapid response service. A range of flexible and responsive respite services will offer a menu of support to carers both in the home and in respite beds. Where a move to residential or nursing accommodation becomes necessary this will be to more domestic style living environments.

Through increased staff training a choice of psychological and other specialist therapies will be available, based upon need. Non-specialist staff will be provided with education and training on dementia or functional mental illness.

Where older people in a general hospital setting have a mental health problem access to a liaison psychiatry service will help ensure appropriate care. This will reduce lengths of stay and increase the numbers of people returning to their own homes. The use of intermediate care units will help more people to return home with support.

The development of community services will reduce the requirement for psychiatric inpatient admissions. Where admission occurs this will be to a specialist facility reflecting contemporary accommodation standards.
Younger people with dementia will have age appropriate services including access to a specialist team for younger people with dementia. This team will ensure that their needs are assessed and detailed in a comprehensive assessment and care plan. The team will develop links with a range of providers to give ongoing support to the person and their family.

That is the vision. We realise that developing and delivering this vision is a major challenge. The service it describes is however no less than each of us would want for our families and for ourselves. Whilst it will require additional resources, of equal importance is the will to change and to work creatively in partnership with service users, their carers and staff at all levels.
1.0 Background

The 25 years added to life expectancy may be considered one of the greatest achievements of the 20th century. A result of this is an increase in the population of older adults, with the proportion in the Northern Trust Area projected to rise by 30% between 2003 and 2015. Mental health problems in later life are a significant and often neglected reality for many older people. A mentally healthy old age is as important as a physically healthy old age.

This is the background to the decision taken by Homefirst and Causeway Health and Social Services Trusts and the Northern Health and Social Service Board to undertake a review of their mental health services for older people. The Review covers services provided by the Trusts both for those with a dementia (organic mental health problem) and for those with a mental illness (functional mental health problem).

This strategy document, Adding Life to Years, sets out the Review’s findings and recommendations for the modernisation and development of these services. A summary of the Review’s recommendations is listed at Annex 1. The Terms of Reference and project structures for the Review are described at Annex 2.

Adding Life to Years has been amended following a public consultation process and has received the approval of the Northern Health and Social Care Trust and the Northern Health and Social Services Board.

1.1 Review and Service Principles

The Review established a number of principles to inform the completion of its work. These are as follows:

- Patient and Carers at the centre – service design and delivery must be patient and carer centred, provided in partnership with users and carers, putting their needs at the forefront and respecting each individual’s autonomy.

- Integrated service model - current specialist services are fragmented and would be improved through the integration of functional and organic services into a single management structure.

- Care Pathways – the new integrated service model must provide a range of readily accessible services developed around patients and clients care pathways reflecting their experience of services.

- Innovation/Achievability – Whilst investment in services is required we must also look towards innovation and new ways of working to achieve improvement within existing resources.

- Care in the Community – care should wherever possible be delivered locally in community settings.

- Mixed economy of care – the Review should seek to maximise the contribution of the statutory and independent sectors based upon their relative strengths and advantages.

- Evidence based – The new model of service delivery should be informed by the available evidence base to ensure the delivery of high quality, effective treatment, care and support.

1.2 Legislative, Policy and Planning Context

The Review Team’s considerations were informed by relevant legislation, policy initiatives and planning documents. This strategic context is summarised in Annex 3.

Key themes include the need to reduce discrimination and stigma around mental health in later life and to promote positive mental wellbeing as people get older. Older people must have equal access to the level and quality of support and treatment available to other age groups. Carers must be supported both in their role as carers and in helping them to access the opportunities in life that anyone might expect.

The current DHSS&PS Regional Strategy, A Healthier Future, (DHSSPS 2004), sets out a number of targets and objectives relevant to the provision of mental health services to older people. This includes the target, ‘to have improved the mental health and wellbeing of people aged 65 or over by a fifth between 2001 and 2025 as measured by the General Health Questionnaire (GHQ) 12 score’.

The report of The Dementia and Mental Health Issues of Older People, working group of the Bamford Review of Mental Health and Learning Disability is currently (March 07) being finalised. The service strategy and new model of service set out in this document is broadly consistent with the deliberations of the working group.

1.3 Standards – Good Practice

The Review Team considered recommendations from a wide range of published resources on standards and best practice as follows:

- ‘National Services Framework for Older People’ (DoH, March 2001)
- ‘Forget Me Not: Mental Health Services for Older People’ (Audit Commission, 2000 and 2002 update)
- ‘Ringing the Changes’ (NHSSB, 2003)
- ‘Care of older people with mental illness’ (Council Report CR69, Royal College of Psychiatrists June, 1998)
Mental health problems in old age must be given the same priority as physical health problems in old age and as mental health problems in younger people.

Mental health problems in old age may be classified into two broad groups – organic and functional. Organic conditions or dementias are those directly resulting from physical brain malfunction such as Alzheimer’s disease. Functional conditions or mental illnesses are those that may not be attributed to physical abnormalities of the brain e.g. depression.

**Dementia**

Dementia is a set of symptoms with evidence of a decline in memory and thinking which is of a degree sufficient to impair functioning and daily living and is present for six months or more. Dementia is linked to major physical changes in the brain. It is associated with changes in behaviour, motivation and personality (Audit Commission 2000).

**Mental Illness**

Mental illness is mostly unrecognised in older people and even when recognised often does not receive adequate or appropriate management. It can be difficult to recognise depression in older people because they often focus on physical problems such as low energy or difficulty in sleeping. Depression can also be confused with the effects of other health problems, which are more common in older people and these problems in themselves may cause depression.

Suicide is strongly related to untreated depression in the general population. Older men aged 75 years+ have a particularly high rate.

People who developed severe and enduring mental health problems such as schizophrenia when in their youth are now living longer and continue to require support.

**Prevalence of Mental Health Problems in Older Adults**

Mental health problems can affect anyone at any time of life, but in later life can be a significant and often neglected reality for many people.

- Forty per cent of GP attendees, 50 per cent of general hospital patients and 60 per cent of care home residents are older people with mental health problems.
- Two thirds of NHS beds are occupied by people aged 65 or over and up to two-thirds of these people already have or will develop mental health problems.
- Dementia affects one in 20 people aged over 65 years, one in five people over 80 and one in four people over 85.
One in six people develop clinical depression after they reach 65, and this figure can rise to more than one in three for people living in care homes. (Mind, 2005)

These estimates of morbidity are based on research in England. Functional mental illness prevalence rates in Northern Ireland are estimated to be 25% higher than in England linked to higher levels of social and economic deprivation, unemployment and the impact of the troubles. (DHSSPS, 2003)

1.6 Current Services - Issues

A description of the service provision, asset conditions and service delivery structures across the two legacy Trusts of Homefirst and Causeway is contained in Annex 4. This highlights a number of issues, which the recommendations contained within Chapters 4-8 of this documents aim to address. Key issues identified include:

- A fragmented organisation of service delivery,
- Lack of development of multi disciplinary team structures,
- Shortage of specialist nursing home provision,
- High levels of inpatients awaiting discharge from dementia assessment units,
- No separate inpatient provision for older people with a functional mental illness,
- Outdated and/or inadequate facilities for service delivery,
- Separate funding streams and budgetary arrangements across services.
2.0 Introduction

The Review is indebted to service users and carers for their enthusiastic participation in helping us to develop a shared vision for the service. This included membership of the Project Board and participation with the Project Team in key planning workshops.

A User and Carer Advisory Panel provided invaluable user and carer perspectives and contributed to the emerging work of the Review (see Annex 2).

In order to ascertain views from a broad range of users and carers on current service provision and areas for improvements, a major postal questionnaire survey was also completed. The Key themes from Users and Carers are summarised below and presented in more detail at Annex 5.

User and carer comments and suggestions for improvements are included through the text of subsequent chapters.

2.1 User and Carers - Key Themes

In reviewing the findings from the survey and feedback from the Review’s User/Carer Advisory Panel, the following have been identified as the main issues for users and carers in relation to improving current services. We should seek to:

- Provide more accessible information for clients and carers on dementia or functional mental illness and the support available to them;
- Cultivate a change in professional staff attitudes to demonstrate more understanding, support and caring for patients, clients and carers;
- Ensure that professional staff listen more and take account of the views of relatives and carers;
- Improve access to services, in terms of locality and frequency and length of visits with professional staff;
- Provide education and training for non-specialist staff in relation to either dementia or functional mental illness and their treatment and care;
- Provide more support in general hospitals to ensure people with dementia receive appropriate treatment and care.

These themes inform the recommendations contained in Chapters 4 - 7 where a vision for the future service is developed around the client and patient care pathway through the service. Chapter 8 subsequently pulls the recommendations and themes together into a single integrated model of service.
3.0 Introduction

Primary Care is the collective term used within this document to describe a range of health and social care services that are available in the community. These include GP, community nursing, occupational therapy and social services. These services are tailored to meet general health and social care needs and act as a referral point for more specialist advice or intervention.

3.1 Role of Primary Care Services

For most older people primary care is the most appropriate contact point when needs arise. Many are in contact with GPs, community nursing or social care services prior to the onset or deterioration of dementia or mental health problems.

Primary care staff often already have knowledge of the individual’s circumstances and have established a working relationship with them.

It is important therefore to maintain this relationship when an individual’s condition changes, as it is most likely that he/she will continue to need ongoing input from these services.

Given the anticipated growth in the numbers of older people in the community outlined in Chapter 1, it is even more important to develop and strengthen primary care services with specific inputs from specialist services including mental health services for older people.

It is anticipated that the majority of older people with dementia or mental health problems will continue to be supported in primary and community care. Social work services for older people will provide a key worker role to older people with dementia or mental health problems unless they require ongoing specialist support.

Primary care services will refer to the Community Mental Health Team for Older People for specialist input. This will include early assessment and diagnosis, contributing to the establishment of care plans and joint working with social work and nursing staff in therapeutic input, where appropriate.

The following Chapters describe how specialist mental health services for older people will be developed within the Northern Health Board area. It will also outline how those specialist services will support professionals in primary and community care settings to meet the mental health needs of older people.
problems and socio-economic difficulties associated with retirement constitute significant risk factors for emotional distress in older people. Sensory loss and the greater likelihood of illness and disability make older people particularly vulnerable to mental health problems.

Caring for someone can be physically, emotionally and financially draining. Sixty-five percent of carers admit that their own health has suffered. Carers often feel isolated, unsupported and alone. Many carers are themselves older people.

Mental and physical health promotion needs to be targeted at all ages. The Trust must develop an approach aimed at promoting good mental and physical health, preventing mental ill health and ensuring early intervention when mental health problems occur.

**Recommendations - Promoting Health, Preventing Illness**

1. The Trust and Commissioners will work in partnership with Voluntary, Independent and Community Sector partners and the Health Promotion Agency to increase awareness of mental health issues and to reduce the stigma associated with them.

2. The Trust will ensure that health and social care staff are aware that each encounter with a patient or a client is an opportunity to promote mental and physical well being and to promote a healthy lifestyle.

3. The Trust will work in partnership with all sectors and local authorities to promote activities, which improve physical and mental well being.

4. The Trust will work in partnership with voluntary organisations to promote the development of support groups and befriending schemes. The aim is to reduce isolation for carers of those with dementia or other mental or physical illness. This will require improved transport arrangements.

4.0 Introduction

Mental health has been defined as "the emotional and spiritual resilience, which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others', dignity and worth" (Health and Education Authority 1998).

Maintaining a healthy lifestyle is beneficial at all life stages. Health promotion in later life, both physical and mental, should not be influenced by stereotypical views of older people’s frailty and dependence.

When people need help then this should be locally available with prompt access to generic and specialist services based upon need. As stated in Chapter 3 it is anticipated that the majority of older people with dementia or mental health problems should continue to be supported by health and care professionals in primary and community care settings. They should receive a comprehensive assessment and a care plan, which includes a plan for the needs of carers.

Service users and carers have indicated to the Review reasonable levels of satisfaction with the assessment process with 80% indicating that it was adequate or better. When asked what could be improved users and carers stressed the importance of:

- receiving an early and accurate diagnosis,
- having appropriate and accessible information,
- good communications with services and professionals and
- ensuring appropriate carers involvement in assessment processes.

As indicated in Chapter 1 the current delivery of mental health services to older people is organisationally fragmented across directorates and programmes. This in turns leads to a less coherent patient care pathway with consequent communications difficulties as users, carers and professionals seek to negotiate their way through an often complex and variable system.

4.1 Health Promotion - Awareness Raising and Preventing Illness

The Health and Social well being survey (2001) shows that people in Northern Ireland are at a greater risk of mental ill health than people in England and Scotland.

There are many factors that contribute to social isolation and increased risk of mental health problems. These include a decline in social activity, death of a partner, family or friends, transportation and mobility problems and less support due to small family size and living alone (DHSSPS 2003). Life adjustment

4.2 Awareness Raising & Early Detection

‘Depression was not diagnosed for 1 yr - 18mths when my father’s anxiety and panic attacks worsened.’

User/Carer view

Those caring for older people with mental health problems are usually the first to call for help often as the result of growing stress. The way services respond can make a significant difference to the carer’s ability to continue caring. People with mental health problems and their carers usually want to know the diagnosis, the future outlook and what treatment is available.
However many people with mental health problems and their carers have to wait a long time before they receive any practical help.

GPs and other primary care staff play a very important role, as they are usually the first port of call for accessible information and help. They should provide advice and support, as well as prescribe medication, before specialist care is needed (Audit Commission 2000).

Various audits in England and Wales (Audit Commission 2000, 2002, Regional Value for Money Study 2003) and the user & carer survey undertaken by the Review have identified that obtaining a diagnosis can be a difficult and prolonged process. Reasons for this are as follows:

- Some GPs do not look actively for signs of dementia to make an early diagnosis.
- Some GPs stated that they had not received sufficient training to help them diagnose dementia.
- Some GPs felt there was no point in looking for an incurable condition.
- Some GPs felt ill prepared to deal with mental health problems in older people.

Users and carers have indicated to the Review that an early diagnosis is important to them. This view is borne out in good practice guidelines, which tell us that:

“For older people with suspected dementia, early diagnosis gives access to treatment, allows planning for future care and helps individuals and their families come to terms with the prognosis”. (DoH 2001)

“For people with depression, anxiety and other functional mental health conditions early diagnosis gives access to treatment and to therapies which can alleviate suffering and distress for users and their families”, (DoH 2001).

### Recommendations – Awareness Raising and Early Detection

1. The Trust will implement an education programme for staff working in primary health and social care settings including the private and voluntary sectors to enable them to identify early symptoms of dementia, depression and other mental illnesses and provide accessible information regarding referral.

2. The Trust and Board will actively promote and support the development of GPs with Specialist Interest (GpwSI) in dementia to assist in service provision and future service development within a primary care setting.

3. The Trust will take the lead in developing care pathways which ensure clear communications between health care professionals.

4. The Trust will offer training and support to encourage GPs and Primary Care Teams to use standard assessment tests such as Mini Mental State Examination and Geriatric Depression Scale.

5. The Trust will make representations to the Universities to promote more training on mental health issues in later life for all Health and Social Care students.

6. The Trust will take the lead in developing care pathways which ensure clear communications between health care professionals.

7. The Trust will monitor and promote the development of GPs with Specialist Interest (GpwSI) in dementia to assist in service provision and future service development within a primary care setting.

8. The Trust will offer training and support to encourage GPs and Primary Care Teams to use standard assessment tests such as Mini Mental State Examination and Geriatric Depression Scale.

9. The Trust will make representations to the Universities to promote more training on mental health issues in later life for all Health and Social Care students.

### 4.3 Specialist Assessment and Diagnosis

‘As someone who sits in with the patient on these assessments I think things could be explained a lot clearer not using so many big words.’

‘It took some time to be given Aricept which made a considerable difference to the progression of memory loss.’

User/Carer views

The majority of people with mild to moderate severity mental illness are managed in primary health and social care services. A key function of secondary mental health services is provision of guidance on the detection and initial management of mental illness in later life. They should also ensure that there are clear referral pathways for specialist support services for older people with mental illness.

The Dementia Policy Scrutiny Team (1995) recommended that an early, accurate diagnosis should be available to all people developing dementia. Anyone suspected of having a dementia should be immediately referred to a specialist diagnostic team. Providing a diagnosis should initiate a continuing process of providing care and support, and not be an end point in itself.

For people to be supported in their own homes effective assessment is an essential first step. Assessment at home is often better, (WHO, 1997), as people are more likely to behave and communicate in their normal way in familiar surroundings. Staff can build a more accurate picture of their needs and obtain the views of their carers (Audit Commission 2000). A domiciliary pre-screening system piloted in the Homefirst Trust has had many benefits in reducing waiting times at clinics and initiating early response to user need.

Older people who seek help from health and care agencies want a comprehensive holistic assessment and care plan that minimises duplication and includes the needs of the key caregivers. Older people also need to know who to turn to and when to ask for help, (DOH 2005). Carers are also entitled to have their individual needs assessed (Ref. Chapter 5).

A key theme from the Review’s workshops with staff, users, and representative groups is the need for multi-disciplinary Community Mental Health Teams for Older People to work across the Trust, on a sectorised basis. These teams are central to a coherent patient and client care pathway and should adopt best practice in multi-disciplinary team working incorporating:

- Single point of contact into services for carer / user;
- team referral system;
- screening of referrals;
- allocation to appropriate professional;
- multi-disciplinary assessment.
The task of helping a person to come to terms with their diagnosis and to learn to live with it requires a great deal of skill, patience, sensitivity and time.

**Recommendations – Information Needs**

13. The Trust will ensure that accessible information about locally available services is available in GP surgeries and other public places e.g. libraries, community centres etc.

14. The Trust will ensure that at the point of assessment and diagnosis people, and their carers where appropriate, are given accessible information about their condition and its likely progress.

15. The Trust will ensure that the person and their carer are given a named contact that they can approach for further accessible information and advice following diagnosis.

16. The Trust will work in partnership with voluntary organisations to provide support groups for people with mental health problems and for their carers.

**4.4 Information Needs**

‘Make accessible information about the possible progression of the disease and the disease itself available as its very difficult for the carer to ask relevant questions at this time.’

‘I would have liked him to explain what was wrong with me.’

*User/Carer views*

Users and carers stressed to the Review the vital importance of high quality, timely accessible information and communications at all stages of the patient or client care pathway.

“Caring about Carers” (DoH 1999) stated that support for carers is essential and should include “being prepared for the task that is going to happen and having the right kind of accessible information”. However it is not only carers who should be prepared for the journey ahead but also the person with the condition. The National Service Framework for Older People states “treatment of dementia always involves: explaining the diagnosis to the older person and any carers and where possible giving relevant accessible information about resources of help and support. (NSF Standard 7, DoH 2001).

Not informing a person of their diagnosis can deny that person the opportunity for future planning, preparation and treatment. Best practice would indicate that legal and financial matters should be addressed whilst a person has the ability to understand and the capacity to consent.
5.0 Background

Older people want their difficulties to be addressed holistically. Staff should be available to help them navigate the range of treatment and support services available. The whole system will only operate effectively through an appropriate balance of services and clear protocols for engaging with these services.

The Trust covers significant rural areas, which will influence how services are developed in order to respond effectively.

“Informal carers”, mainly family, make a major contribution to the care of people with dementia. By and large they provide full time care. If these carers were not available the impact on health and care services would be immense; it is unlikely that we could manage the increased demand. It is essential that statutory and voluntary agencies recognise and value the input of informal carers and provide support to enable them to continue in their caring role.

The Dementia Policy Scrutiny Report (1995), stated, “support should be provided before a crisis point is reached. Timely service intervention makes good sense”. Noting the serious gaps in service provision and the uneven spread and availability of services, the report recommended “an orderly development of a full repertoire of care and support services over the next strategic period. At the outset purchasers must assess actual and unmet need and plan new services in partnership with carers and people with dementia”.

There is an increasing recognition of the inequity of service development and availability of services for older people with mental health problems. There can be a perception that older people only need assessment and care packages. The importance of exploring relationship issues, offering counselling support and facilitating the development of coping strategies for carers and individuals with dementia and mental health problems is often underestimated.

Upper limits imposed on care packages to maintain older people at home are often lower than for younger disabled people.

Service users and carers highlighted to the Review reasonable levels of satisfaction with support and community services. Suggestions for improvement however included:

- improved carer support;
- more frequent contact with social workers/community psychiatric nursing;
- easier access to equipment;

- better training for domiciliary and residential/nursing care staff;
- more accessible information on diagnosis and accessing support.

5.1 Home Care

‘By providing adequate support during the night in the home so allowing the patient to remain in their home rather than having to move to residential care.’

‘Mum sometimes didn’t open the door or allow the carer’s to wash her so often it wasn’t done. I realise that patients can’t be forced to have care but in the case of confused elderly some amount of persuasion should be used.’

User/Carer views

Domiciliary Care is support provided to individuals in their own homes. It is the lynch pin for maintaining people in the community. However many staff have little or no training in mental health issues. The Dementia Policy Scrutiny Report (1995) commented, “Dementia services must be staffed by people with the necessary training and skills to provide quality care. So too, staff providing generic services require training on dementia and mental health issues. The level of training must reflect the complexity of the special needs of these patient groups.”

Service users and carers emphasized the importance of access to flexible and responsive domiciliary support available when needed. Within the Trust, domiciliary care services are developing more flexibly with greater access to services at night and at weekends. Developments have included Floating Support Schemes which help people to maintain their independence. There will, however, never be sufficient resources to meet fully the level of demand for services.

The Trust must therefore work creatively with families, carers, voluntary and community organisations and the private sector to encourage the development of a wide range of accessible support services.

Failure to provide domiciliary support at short notice during a crisis can lead to a breakdown in care, and premature admission to residential care. It is often difficult for an individual to return home from these situations. There is a need for a rapid response domiciliary support service, which can provide personal care, supervision or sitting support at short notice. In some parts of Northern Ireland Age Concern has successfully developed such services. These work closely with statutory services, to support people in their own homes during periods of crisis.

Extra Care provides a Northern Trust family training and support scheme. This assists carers by providing advice and training in areas such as moving and handling, continence management, personal care, communication, and understanding and responding to challenging behaviour. This scheme is of benefit to carers and has, through the training of carers, allowed people with dementia to be discharged earlier from hospital.
In the Newtownabbey sector Homefirst Trust developed a range of daytime activities and support groups. This community development project has highlighted the range of resources already available and the potential to further develop community support networks. Causeway Trust developed specialist day care as part of the Brook supported living complex in Coleraine.

The opportunity to socialise in Day Care and other settings helps to reduce mental ill health and to maintain individuals’ sense of wellbeing.

Recommendation - Day Support

22. The Trust will develop a day support strategy to ensure a co-ordinated and comprehensive range of day support services. The strategy will seek to improve access to day support in the person’s home through individually tailored packages. The strategy will promote a mix of providers through investment in the private, voluntary and community sectors.

5.3 Respite Care

‘More help at the weekends.’
User/Carer view

Carers express a preference for home based respite services yet the majority of respite is provided in institutional settings. Within the Trust domiciliary sitting services have increased in recent years, but there is still a waiting list for this service.

Respite tends to be more available at a time of crisis, rather than as a preventative measure. Carers have limited opportunities to access respite to “recharge their batteries”. Feedback from carers, to the Review, highlighted the need for early, regular access to respite so it is seen as part of the caring process rather than being used only when carers are at breaking point.

Research on day and overnight respite found that carers reported that services lacked flexibility. Residential respite was often offered in 1 - 2 week blocks. Day care was mostly provided between mid morning and mid afternoon and sitting services were usually provided for a set number of hours. These times were not viewed as being as helpful as other times such as evenings and weekends. Respite should be flexible and available when needed.

Feedback from the consultation process showed the critical importance of day support for people with mental health problems and their carers. The importance of employment for older people and benefits derived from continuing to enjoy paid work were also stressed throughout the public consultation feedback on the strategy. Meaningful activity should actively integrate individuals into local community life. Day support includes support at home and care provided in other settings.

Day care services are essential for older people with mental illness and their carers providing therapy, stability, maintenance and respite. For carers in particular it can be a lifeline in providing relief and time out.

Age Concern’s daytime home support service provides specific help to individuals either in their own homes or by taking the individual out to maintain social functioning, eg shopping, attending a leisure activity, visiting a library etc. This service is not yet available in the Northern Trust.

The Trust is progressing work to develop Integrated Care services for older people to enable many more to be cared for in their own homes. All aspects of this service must be open to people with mental illness or dementia.

Recommendations - Home Care

17. The Trust will expand its training for Domiciliary Care Staff to enable them to provide support to older people with mental health problems in a flexible and competent manner.

18. The Trust will seek to extend the availability of appropriate domiciliary care provision based on assessed need over a 24hour, 7day period.

19. The Trust will improve access to training for carers in their caring role.

20. The Trust will involve carers and other partners in developing, delivering and evaluating additional support services to provide individuals with greater choice.

21. The Trust will establish Rapid Response Domiciliary Support Teams to provide timely responses during crisis periods.

5.2 Day Support

‘More help with day care and more opportunities for the elderly is needed - there is a general lack of facilities and venues...’
User/Carer view

Age Concern’s daytime home support service provides specific help to individuals either in their own homes or by taking the individual out to maintain social functioning, eg shopping, attending a leisure activity, visiting a library etc. This service is not yet available in the Northern Trust.
Within the Trust there are currently very successful Assistive Technology pilot schemes. In one approximately forty individuals with dementia are being supported in their own homes with a range of technologies including; falls detectors; wandering alerts; pressure pads and door guards. Carers report that the technology gives great peace of mind and has improved the safety of many individuals.

An increasing range of technologies is available to help support people in their own homes. There is also considerable potential for the development of telemedicine. Systems already exist that can remind individuals to take medication, or alert a carer if medication is not taken within an agreed timeframe. In England and Scotland, local authorities are investing in the installation of technology in homes of older people. The Department of Health has allocated £80million for the period 2006-2008 to support the development of Telecare Services in England.

There are however ethical considerations regarding consent for Lifestyle Monitoring equipment and devices that will automatically summon care. These need to be addressed when considering the installation of equipment in individuals’ homes.

**5.4 Direct Payments**

Individuals or their carers can use Direct Payments to independently purchase their care and support services. This can provide greater flexibility in procuring help to meet individual circumstances. The uptake of Direct Payments in Northern Ireland for people with mental health needs is very limited. There has been much greater take up in England where people can access support systems to help them deal with employment issues.

The Trust is committed to providing a range of services and choices to assisting people to live at home.

**Recommendations - Direct Payments**

25. The Trust will through the use of accessible information and support promote the greater use of Direct Payments for carers to ensure they can access support in their own right.

**5.5 Assistive Technology**

Assistive Technology may be defined as “an umbrella term for any device or system that allows an individual to perform a task they would otherwise be unable to do, or increases the ease and safety with which the task can be performed”.

Housing adaptations and timely provision of community equipment will enable people with dementia to enjoy a better quality of life and enable their carers to provide their caring role with greater ease.

Assistive Technology was highlighted by the Health Select Committee on delayed discharges as having a major contribution to make in developing alternatives to hospitalisation.

**Recommendations - Assistive Technology**

26. The Trust will increase awareness of assistive technology by providing more accessible information to staff and members of the public.

27. The Trust will work in partnership with the Commissioner, housing providers and Supporting People, to increase accessibility to the range of assistive technologies within the Northern Area.

28. The Trust with the assistance of users and carers will establish a protocol for the assessment, installation, and management of assistive technology.

**5.6 Supported Living, Residential and Nursing Care Services**

Ageing in an Inclusive Society (OFMDFM, 2005) highlights the fundamental need to improve the lives of older people in their own homes and communities.

For many, decisions about institutional care are taken at a time of crisis when an individual is feeling most vulnerable, or in a hospital setting where one is less likely to be able to make an informed choice.

User/Carer view

‘Some homes are excellent - some are poor, consistency of practice would be helpful. In the poor homes it is the attitude of the staff which is the biggest problem. No one wants to leave their loved ones in a place where the staff don’t care.’
Considerable strides have been made in recent years to better support people in their own homes. The introduction of “Supporting People” legislation has led to an increase in housing support for approximately 9,000 older people in Northern Ireland. However lack of appropriate accommodation remains a significant problem for older people.

It is essential for the Commissioner, Trust, Northern Ireland Housing Executive and Housing Associations to work together with others such as Community Safety Partnerships to maximise the opportunities for older people to remain in their own homes with appropriate levels of support.

New housing for older people should be designed to adapt to people’s changing needs and to make best use of assistive technologies and other support services.

For some people however residential or nursing accommodation becomes essential, as they are no longer able to live in their own homes. People with dementia tend to require higher levels of supervision and consequently there is a need for more staffing in homes for people with dementia. This is not reflected in tariff rates for homes and it is becoming increasingly difficult to access residential accommodation for people with dementia.

The Dementia Policy Scrutiny Report (1995) recommends smaller domestic type units for between 8-10 people in a group living environment. This recognises that people with dementia need to see staff and be able to contribute to domestic chores to enable them to feel relaxed and comfortable.

There is a shortage of Elderly Mentally Infirm (EMI) nursing and residential care within the Trust and this greatly contributes to delays in discharge from inpatient dementia assessment units. Further efforts need to be given to stimulating the Independent Sector to develop EMI nursing care particularly in the Cookstown & Magherafelt and Causeway areas.

Asset condition surveys indicate that the Trust’s EMI Units require major work to bring them up to an acceptable standard (ref. Annex 4). The Trust should consider the development of EMI Resource Centres that would include assessment, residential, intermediate care (step up/down beds), day care, and domiciliary support teams. If feasible these should be sited in the vicinity of housing developments for people with dementia, so that continuity of care can be provided.
5.8 Vulnerable Adults

Older people with mental health problems form one of the most vulnerable groups in society. Many are prone to abuse and discrimination. Individuals can be subjected to physical, emotional, sexual or financial abuse or may simply be neglected.

“No Secrets” (DoH 2000) highlights the prevalence of abuse of Vulnerable Adults and raises the need for health and care staff to be trained to recognise signs of abuse. A primary function of social work within mental health and dementia services for older people is to provide support and protection to vulnerable adults who have experienced or are at risk of abuse.

This is a significantly increasing area of work for social work staff, which requires to be adequately resourced.

Recommendation - Vulnerable Adults

36. The Trust will work closely with Commissioners to secure the resources required to meet both the needs of increasing numbers of vulnerable adults and effective implementation of regional procedures and protocols for vulnerable adults.

5.9 Support for Carers

User/Carer views

'My husband was referred to a psychiatrist regarding memory loss and his GP seemed to feel it was therefore no longer his problem. I would have appreciated more support.'

'By helping more with my problems and my family who care for me.'

Recent government legislative and policy initiatives recognise the major role informal carers play in supporting people at home and the need to value them as individuals and support them in their caring role (ref. Annex 3). Carers have a legal right to an assessment of their own needs under the Carers and Direct Payments Act (NI) 2002. Despite these initiatives carers of people with dementia, and those they care for, are amongst the most socially excluded groups in society. Carers must be given choice and support to continue in their caring role.

Enhanced domiciliary care services where carers receive emotional support, advice, accessible information and practical help, result in the person with dementia living longer in the community (Riordan et al, 1998).

Homefirst Trust established groups for carers of people with dementia. These provide practical accessible information for carers with support workers also providing reflexology and massage. Carers report that time for themselves and individual attention has made them feel valued in their own right. Community care support workers play a key role in helping carers. A number of carers stated this has helped them continue caring longer than may otherwise be the case. Causeway Trust established links with the Alzheimer’s Society carers support group as a means to address the needs of carers.

Some carers are deeply affected by the emotional trauma of caring for an increasingly disabled relative. Many describe feelings of loss, guilt, anger or frustration. Active intervention and support is essential for carers who often struggle to come to terms with this massive change in their lives. Organisations such as the Alzheimer’s Society continue to provide great support to carers.

In order to truly support people with mental health problems and their carers, a full range of services must be developed for the individual and the carer in his or her own right.

Recommendations - Support for Carers

37. The Trust will ensure carers’ are made aware of their rights to be offered an assessment and direct provision, or services to address their needs.

38. The Trust will work with partner organisations to develop a broader range of support services to carers including training and advocacy.
Chapter 6
Specialist Treatment and Therapies
People with functional mental illness and early dementia can benefit from access to grief and bereavement counselling, anxiety management, interpersonal therapy, cognitive behavioural therapy and other therapies, such as family therapy or dynamic psychotherapy.

Those with organic illness can benefit from access to Sonas therapy and exercise therapy, aromatherapy, reminiscence therapy, validation therapy, reality orientation, pet therapy, music therapy, activity therapy and psychological techniques to help cope with memory impairment or related symptoms.

Even patients with quite severe dementia can engage in simple tasks and it is rewarding to see an older person who has been diagnosed as suffering from severe behavioural problems, behave differently when given simple household tasks to do. The key is often to keep the person active and active rather than allowing them to withdraw into somnolence or inactivity.

Dementia Care Mapping is a skill that recognises good practice and high quality care. It helps in the assessment of deficits in care and the ways in which these may be remedied.

Currently obstacles to older people receiving these services include arbitrary cut-off age limits, inadequate numbers of trained staff and lack of financial resources. The Trust is committed to addressing these equity issues. Multidisciplinary teams working with older people also need to be prepared to engage therapeutically with patients in a variety of ways. These may involve a certain loosening of strict professional boundaries. There can also be an over emphasis upon physical care at the expense of emotional, occupational and spiritual aspects of well-being.

6.2 Liaison Psychiatry

Recommendation - Therapies

39. The Trust will make a range of appropriate therapies available, in both community and inpatient settings, to older people with mental health problems. Access to this range of therapies depends on recruitment of therapists and training of existing staff. Contracts with independent providers will also be explored.

User/Carer view

‘Quicker referral to psycho-geriatric help. Inadequate means of restraining for own safety. As a result great distress was caused to mum, myself and the nurses’

‘Ward unable to deal with an Alzheimer’s patient, staff were not trained and did not want to deal with this type of patient’

‘Medication for behavioural problems was stopped suddenly by the hospital thereby having an adverse effect. Hospitals seem to deal with dementia at arms length’

User/Carer views
Users and Carers expressed particular concern to the Review on their experiences in general acute hospitals. It has been estimated that up to 60% of people aged over 65 admitted to general hospital beds have, or will develop a mental disorder during their admission. This means that on an average day, in a typical district general hospital with 500 beds, older people will occupy 330 beds. Of these 330 people it is estimated that on average, 86 will have depression, 56 will have delirium, 43 will have dementia and 15 will have other major mental health problem (Royal College of Psychiatrists 2005).

The presence of a mental health problem positively predicts an increase in resource use and length of stay and results in institutionalisation and increased mortality. (Holmes and House 2000; Leslie et al 2005; Nightingale et al 2001).

People’s needs may be overstated or inappropriately labelled as dementia. The consequence may be premature and inappropriate decisions to discharge older people to permanent care home placements. This provides little opportunity to take account of the older person’s wishes and negatively influences recovery and rehabilitation. The longer the older person stays in an acute bed, the more confused they may become. Living skills are lost, and attempts at rehabilitation may weaken.

Current requests for consultation amount to around 150 a year from the Antrim Area Hospital and 100 from Causeway Hospital. The actual need, however, is much greater than this and a liaison psychiatry team would help identify and meet this need. The most effective model of liaison care, requires a consultant-led team, which works closely with acute hospital staff. (Royal College of Psychiatrists 2005; DoH 2005).

The team should include a consultant in old age psychiatry, community psychiatric nurses, occupational therapists, psychiatric social workers with input from pharmacists, psychology and physiotherapy. A base in Antrim Area hospital with access to IT systems and secretarial support will be necessary.

The impact of this service would be:
- to promote better care for older people admitted to acute settings,
- shorter durations of inpatient care,
- more effective decision-making for future care,
- increased numbers of older people returning to independent living,
- enhanced independence and well being of older people person.

A consultant-led service is the best way to provide training and avoid fragmentation in the delivery of an effective liaison service. If this cannot be provided immediately then consideration will be given to which elements of this service could be provided in the first instance, for example through an identified liaison nurse, supported by the current Consultant workforce.

There must also be a focus on education of medical/nursing/social work teams in acute hospital settings to enable them to identify and initiate appropriate treatment and make capacity assessments. Education is an essential role of a specialist liaison team from the outset.

Recommendation – Liaison Psychiatry

40. A consultant lead Liaison Team should be established at Antrim Area Hospital. This team would provide a liaison service to Antrim Area, Causeway hospital and would resource other general hospitals in the Board area. Reciprocal liaison services could be provided for mental health patients to avoid long delays in A&E.

6.3 Community Based Specialist Assessment and Treatment Services

Over the past thirty years, government policy and regional strategies have seen a shift of service provision away from hospital settings towards community-based provisions. This change reflects:
- the preference of service users to remain at home and in their own communities;
- a developing evidence base on a range of effective community based alternatives to inpatient care;
- a philosophical shift within society towards normalisation and integration of care for those who would previously have been segregated in institutional care settings.

As indicated in Chapter 1 demographic trends in the Northern Area show that the number of people over 65 is set to increase by over 30% in the next 10 years. The prevalence of dementia is estimated to increase by over 25% in the Trust’s area, by 2015. Other estimates indicate that the population of people with dementia in N. Ireland as a whole is set to double by 2031 (Dementia and Mental Health issues of Older People, Regional Review of Mental Health and Learning Disability, in draft). (DSSSPS 2006A)

Currently inpatient services at Holywell hospital for dementia patients and for those with functional mental illness in Holywell and the Ross Thomson Unit are stretched. There are waiting lists to come into hospital and delayed discharges in moving on from hospital care (Ref. Annex 4).

People with dementia are admitted to Holywell hospital for assessment and treatment of a range of challenging and disturbed behaviours, associated with their dementia, which carers find difficult to manage at home or in a community settings.

Most people diagnosed with a functional mental illness will be managed in a community setting. However for a relatively small number, presenting with a high level of risk to themselves or to others, an inpatient admission is required. Older people who live alone, in poor social circumstances or with poor support from others usually present with greater risks.

It is essential that investment be made in a range of community alternatives to inpatient assessment and treatment in order to meet increased needs in the future. This includes establishing community mental health teams for older people (Ref. Rec 10 & Chapter 8). Workshops with staff, users, and
6.3.2 Intermediate Care

It has been demonstrated that, through the use of an intermediate care (step-up, step-down) unit around 40% of patients, who would previously have been sent to residential or nursing care, could be returned to their own home.

Intermediate care units for patients with dementia help avoid admissions into hospital and facilitate early discharge. They differ from day hospitals in that they offer 24-hour care for a limited period of time, which will usually be of the order of a few weeks.

These units should be staffed to meet the personal care, nutritional and mobility needs of patients. Input to them from district nursing services, the acute care at home team/rapid response and the rehabilitation team enables the management of a range of conditions, e.g. a person with dementia admitted with a medical condition/accident that has reduced their level of mobility, could be discharged to the intermediate care unit and receive rehabilitation input from appropriate community teams. This would help them regain their previous level of functioning or at least sufficient improvement for them to return home.

The intermediate care units should be visited weekly by Consultant Old-Age Psychiatrists. Geriatricians should be involved in helping carry out joint assessments. Local General Practitioners would provide medical cover. Each unit should include staff from the following disciplines: Medical (as above), nursing, community psychiatric nursing, occupational therapy and psychiatric social work. Physiotherapists and psychologists should be available on a regular basis. It is important that key members of staff are trained in the management of behaviours associated with dementia.

The aims of an Intermediate care unit are as follows:

- To allow the assessment of the older person to take place in a detailed manner, in a homely and quiet environment, which is similar to the person’s own home.
- To allow for the gradual reduction of unnecessary medication.
- The careful assessment and treatment of patients by a skilled multi-disciplinary team.
- Appropriate discharge planning, which will often result in the person being able to return to his or her own home.
- To facilitate the development of outreach schemes for dementia care operating from the unit.

Recommendation - Day Hospitals/Day Treatment Units

41. Three small 12-place Day Hospitals/Day Treatment units should be established for the needs of the functionally ill elderly. These should be sited close to psychiatric inpatient services. One of these could be a travelling day hospital which travels to sites more adjacent to the patient population.

6.3.1 Day Hospitals/Day Treatment Units for Older People

Day hospital services aim to offer intensive multidisciplinary assessment and treatment for older people with complex mental health needs so as to reduce the need for admission to hospital or to aid recovery following admission (DoH, 2005).

A recent survey carried out by the Royal College of Psychiatrists indicated that over 80% of practising Old Age Psychiatrists in the United Kingdom have access to psychiatric day hospitals. These are, however, poorly provided for in Northern Ireland. There is none, for example, in the Northern Board Area. Nevertheless access to day hospital services is an element of a comprehensive community based mental health service for older adults. (DoH 2005; DoH 2001)

A day hospital for the older person with functional mental illness offers a number of benefits:

- Accurate Assessment. Research clearly demonstrates that use of assessment protocols within day hospital settings led to greater recognition of the needs of older people and led to appropriate treatment for these.
- Prevention of Admission. Day hospitals have a role in preventing admission to hospital through allowing treatment of mental illness in older people in a way that keeps the person in their own home environment for the greater part of the day.
- Relevant therapies can be introduced to the patient in the context of the day hospital. The patient can be assessed, for example, for suitability for cognitive behaviour therapy or inter-personal therapy.
- Mobility and daily living skills can be enhanced by arranging treatment with a physiotherapist and occupational therapist.
- Day hospital admission also allows for careful social assessment and interventions leading to an optimal package of care with reduced burden on carers.

Psychiatric day hospitals/treatment units for older people
- Intermediate care units
- Home treatment options

representative groups identified the further components of a range of effective community based specialist assessment and treatment services as follows:
Currently 60% of admissions to the Tardree inpatient dementia assessment units come from a care environment. Patients with dementia who develop behavioural problems are best managed with the support of a behavioural management team in residential or nursing settings or in their own homes. The Newcastle model, piloted in Homefirst, promotes the use of a behavioural nursing team to support staff in care homes to work with people who have dementia and challenging behaviour. The team assists homes using validated methods that include training in the understanding of dementia, skilled facilitation and ongoing support. This service should be extended to people living in their own homes. It could work alongside Rapid Response Support Teams.

**Recommendations - Intermediate Care**

42. Three 8-bed Intermediate care (step-up/step-down) units should be established. These could be achieved in two areas through changing the use of a wing or part of current residential or EMI residential homes or through links with Independent Sector providers. Community Rehabilitation could support meeting peoples needs both at home and in these care settings.

43. Intermediate care units and liaison psychiatry services should be planned as a joint exercise between Geriatric and Psychiatry of Old Age services. Similar approaches would also prove beneficial in assessments of patients in community settings and this should be further explored through the development of patient care pathways and managed clinical networks.

**6.3.3 Home Treatment**

The aim of Home Treatment services are to provide treatment for the person experiencing mental health problems, in their own homes or community placement thus preventing admission to hospital. It may also enable earlier discharge from hospital and facilitate recuperation at home.

Everybody’s Business (DoH, 2005) indicates that crisis support 24 hours per day, 7 days per week, is a key element of a mental health service for older people. This may be provided as part of a younger adult mental health service or be a separate generic older people’s service

Within Homefirst Trust, as a result of the mental health change management programme and the reduction of acute admission beds, a Crisis Response team was established within adult mental health services. The Northern Trust has plans to extend this service across the Trust area and to further develop it to provide home treatment.

In January 2005 a Home Support team was formed in Homefirst Trust to provide high-level support to people over 65 experiencing mental health crisis with a view to preventing admission to hospital and facilitating early and safe discharge from the acute admission ward. This team can currently facilitate no more than 15 patients at any one time. The review of this service showed that it had succeeded in preventing or delaying some hospital admissions and allowed others to be discharged more quickly than before. Patients have expressed satisfaction with the service.

The Home Support service for older people was developed as an extension to existing teams. This has caused significant difficulties for staff within teams. It is recognised that a dedicated team should provide this service.

**6.4 Inpatient Psychiatric Care**

44. Older people with mental health problems experiencing a crisis should have access to a 24hr, 385-day crisis resolution/home treatment service. This should be considered as an element in the future development of a general adult mental health home treatment service.

45. A behavioural team based on the Newcastle model of care should be established within the Trust to provide support to care home staff. CMHTOP will work alongside Rapid Response domiciliary Support teams to provide Home Treatment Service for people with Dementia.

**Recommendations - Home Treatment**

44. ‘I would like staff to take time to talk to patients about their problems’

**User/Carer view**

**6.4.1 Short-Term Assessment and Treatment**

It is relatively uncommon for older people to require admission for treatment of their mental health problems. However there will continue to be occasions where inpatient admission is necessary for assessment, treatment and rehabilitation of older people with a range of diagnoses, including dementia where they cannot be cared for in the community. A number of older people will also be detained under the provisions of The Mental Health (Northern Ireland) Order 1986 for assessment or treatment.

Units for the care of older people at Holywell hospital and the Ross Thomson Unit are inadequate in terms of the design and quality of accommodation provided to patients, relatives and staff (ref. Annex 4).

The current practice where older mentally ill people are accommodated in various acute units within Holywell hospital and the Ross Thomson Unit is inappropriate and can expose older people to greater risk in terms of their health and safety. Assessment and provision of therapies becomes more difficult if patients are accommodated in several units. Older people have a right to dignity in the in-patient care that they receive. This is much more easily provided in a separate unit.
6.4.2 Dementia - Medium Term Treatment and Care

A further 24 beds are currently provided in Inver 4 ward Holywell hospital for people requiring medium term inpatient care where community services cannot meet their needs. These individuals require intensive support with a number of them being detained under the provisions of the Mental Health Order.

Currently the needs of these individuals cannot be met in the community. However it is undesirable for patients and their carers that medium term care is provided in a single central location. Physically Inver 4 ward cannot be made fit for purpose and alternative provision needs to be explored.

Ideally this should be through more local, non-institutional facilities sited in two or three locations across the Northern Area ideally in proximity to EMI facilities. This would require a significant skilling up of staff coupled with support from specialist community based services. It would also require to be facilitated by a change to the provisions of the current mental health legislation. If the change in legislation does not occur then these beds will require to be provided in an inpatient setting. The legislation is under review as part of the Bamford Review.

“Everybody’s Business” (DoH 2005) indicates that:

‘The care of frail older adults with complex needs on wards for younger adults is usually inappropriate: it would place them at risk from robust, behaviourally disturbed younger adults and deprive them of the specialist nursing, medical and other care that they require.’

This view is consistent with the recommendations of the National Service Framework for Older Adults (DoH, 2001) and the views expressed at the User and Carer panel for the review.

Current inpatient bed usage in the Northern Area for functionally mentally ill patients under the care of psychiatry of old age would suggest a need for a 22-bedded unit (please see Annex 4). It is considered that with the development of day hospital and home treatment services and factoring in provision for a 30% increase in the population of over 65s this could reduce to 18 beds. If day hospital and home treatment services are not in place then the current in-patient provision would need to increase to 29 beds to take account of population growth. These figures assume that those older people under the care of general adult psychiatry continue to access general adult beds.

At any time a significant portion of the Tardree dementia assessment unit beds are occupied by patients awaiting discharge or transfer elsewhere (please see Annex 4). The development of a range of specialist community based services will facilitate reduced reliance on hospital admissions, for shorter periods of time. This will help prevent the institutionalisation that can occur in older people as a result of delayed discharge. Recommendation 35 addresses the need to develop appropriate nursing and residential care in the Trust’s area. It particularly highlights the need for additional nursing and residential EMI provision to facilitate discharge from the Tardree units. These developments would allow a reduction in overall dementia assessment bed numbers, and allow inpatient care to be provided in homelier, more person-friendly units than are currently available.

Recommendations - Short-Term Assessment and Treatment

46. The Trust will develop a separate inpatient provision for the functionally mentally ill elderly across the area comprising 18 beds. This assumes access to day hospital/treatment and home treatment services. In the absence of day hospital/treatment and home treatment services then a capacity of 29 beds is required.

47. The specialist inpatient team will have the skills to meet the needs of the full range of psychiatric problems, with support from staff in other disciplines that have an expertise in older people. These include specialist physicians, speech and language therapy, pharmacy, psychology, dietetics, physiotherapy, podiatry and dental. Advocacy, pastoral support and interpretation services should be readily available.

48. Following the development of a range of specialist community based services the number of inpatient dementia assessment beds should reduce to 24 beds. These would be provided in one or two units for the Northern Area population. Within this provision there needs to be adaptable environments with interconnecting units to allow the nursing of a few patients with severe problems in separate areas, when required.

49. The Trust will develop clear protocols regarding admission and discharge of patients and the way in which the in-patient assessment unit links to the Intermediate Care Units.
Inpatient bed numbers for older adults as projected above range from 42 to 69 in total, which is below Royal College of Psychiatry norms for the population and the current 88 in-patient bed usage. In light of the demographic change this is an extremely ambitious plan that can only be realised with the implementation of the full model of care including specialist community mental health teams for older people, intermediate units, day hospitals, home treatment and community support services, and an effective liaison psychiatry service.

6.4.3 Inpatient Accommodation

Asset condition surveys indicate that current inpatient units for older adults at Holywell hospital and the Ross Thomson unit do not meet contemporary standards for accommodation (Ref. Annex 4). Whilst significant capital investments to improve inpatient environments have recently been made in Holywell hospital, older adults services were unfortunately not included in these plans.

Inpatient accommodation provided for older adults should reflect modern standards as recommended in the “Forget Me Not” publication (Audit Commission 2000)

“All units for the elderly should be provided in as homely a way as possible and the use of dormitory-type accommodation with large day rooms is inappropriate in the modern care of the elderly in-patient. An appropriate physical environment should include having space for people to walk round safely, coloured doors to help people to identify rooms, single bedrooms that people can use when they wish, facilities for those with physical or sensory disabilities, somewhere quiet for relatives to meet with residents, privacy for bathing and the availability of facilities such as chiropody, dental care and hairdressing. The decoration should be homely and welcoming. Space for therapeutic and other activities and a garden are also important. Residents should be encouraged to bring their own furnishings and belongings. Providing a variety of appropriate and stimulating activities is also important.”

(Audit Commission 2000)

The ward environment should reflect the fact that, although this is a clinical area, it is also the patient’s home for a variable period of time. Attention needs to be given to all aspects of well-being, with an emphasis on respect and dignity. (DoH, 2005)

Large units tend to be noisier and unsettling for patients. These beds should be provided in one or two
Chapter 7
Younger People with Dementia
7.0 Introduction

Dementia, although often portrayed as an inevitable aspect of ageing, can also affect younger people. Dementia in people under the age of 65 is relatively rare; the Alzheimer’s Society estimates that there are about 18,500 younger people with dementia in the UK (Alzheimer’s Society, 2002).

It is possible to make an accurate assessment of local prevalence and level of need by extrapolating the findings of existing studies. A study by Dr Richard Harvey (1998) found a prevalence of 67.2 cases per 100,000 in persons between the ages of 30 and 64. These figures would suggest an estimated 130 younger people with dementia in NHSSB area with between 6 and 14 people being newly diagnosed each year.

The social environment and psychological needs of younger people with dementia are different from those of older people.

7.1 Assessment and Diagnosis

Obtaining an accurate diagnosis can be a difficult and prolonged process for many younger people with dementia (Alzheimer’s Society 2001). There are many reasons for this:

- Dementia is not always considered in people under 65 years.
- GPs may not always look for it in younger people.
- Carers may delay seeking help as they may not recognise symptoms.
- People may be reluctant to seek help.
- Referral for diagnosis may be made to a wide range of services e.g. neurology, younger adult mental health services, psychiatry of old age or physicians.

It is essential that people are given their diagnosis sensitively. Consideration must be given as to who will be present at the time of diagnosis and who will be available to answer questions and offer emotional support afterwards.

A specialist team should be established with a lead community psychiatric nurse (CPN) and social worker to act as single point of referral for all younger people with dementia (excluding people with a learning disability) and to establish a co-ordinated referral pathway including clear links between neurology, psychiatry and psychology. The leads will be responsible for raising awareness and training in primary care settings and will liaise with neurologists.

Recommendations - Assessment and Diagnosis

52. A specialist team for younger people with dementia should be established in line with good practice guidelines (Royal College of Psychiatrists, 2000).

53. The Trust will ensure that appropriate accessible information, support and counselling services are available to support the person with dementia, their carer and family through the diagnostic stages. This will include clear accessible information at the time of diagnosis about emotional support and how to access it.

7.2 Following Diagnosis

Following diagnosis people in the early stage of the disease require more accessible information and help in coming to terms with the illness.

Specialised genetic counselling and support may also be required since genetic problems are responsible for early onset dementia in a small number of families.

Younger people with dementia will often have different family and life circumstances than older people. They are more likely to be in full-time employment and as their condition worsens they may be made redundant or forced to take early retirement. Their spouse or partner may also have to give up working. Combining paid employment with carer responsibility can be a source of considerable emotional and physical strain.

Older family members (eg parents) can have strong feelings of guilt and a sense of “it should have been me”. This may require specialist counselling and grief therapy.

There are many issues related to children when a parent is diagnosed with dementia. It may be very difficult for them to adjust to the loss of the father or mother they once knew.

At the same time they may be embarrassed by the behaviour or frightened by the aggression of the parent. The caring role may fall on young teenagers and this may affect their social and educational development. They may also harbour feelings of blame for the parent’s illness, which can impact on their own health. Children may also worry about inheriting the illness.
7.4 Services

Younger people with dementia present unique challenges to service providers and require different approaches when providing care and services (Beattie et al 2002).

Most of the literature emphasises the need for specialist age appropriate services. Younger people say that they don't want day care provided in older people settings; instead they wanted to mix socially with people of their own age in the community (Jubb et al 2003). Younger people are more likely to be energetic and may enjoy walking and sport. They may benefit more from activity club-like approaches to services. Younger people need purposeful activities, which match their levels of fitness and capabilities. (Beattie et al, 2002)

Work is central for people under retirement age. Younger people with dementia should be considered for specially designed sheltered workshops where dignity and identity can be maintained. (Mulligan, 1994).

Within Homefirst Trust support workers currently provide day care activities tailored to meet the individual needs of the younger person with dementia. Group and individual day care activities are provided depending on the users needs and preferences. The majority of younger people prefer 1:1 sessions sometimes in their own home. Support workers also provide assistance with budgeting, paying bills, structuring household activities and encouraging the individual to remain independent in personal care and other activities of daily living.

7.5 Accommodation

The N.I. Dementia Forum survey indicated that within Homefirst Trust, 5 of the people known to the dementia team resided in Inver 4 ward Holywell hospital and 17 out of the 35 people known to the team (just under 50%) were in some form of care.
50

At the time of the survey there were no special units for younger people with dementia in Northern Ireland. Those in institutional care outside hospital will be in residential or nursing homes, which are mainly for older people. This is far from ideal.

Supported housing could be an alternative, enabling people with dementia to maintain independence with the provision of 24-hour care and supervision. More recently a supported scheme for younger people with alcohol related dementia has been established in Newry and initial findings have demonstrated positive outcomes for the residents.

As indicated in Chapter 5, Assistive Technologies may also extend the length of time that the person with dementia can remain living independently.

**Recommendations - Accommodation**

60. The Trust will work in partnership with housing agencies and Supporting People to ensure appropriate supported housing for younger people with dementia.

61. The Trust will work in partnership with appropriate agencies and providers to increase accessibility to assistive technologies.

62. The Trust will engage in discussion with the independent and voluntary care providers to investigate development of an area wide, six-bedded, domestic style care environment for younger people with dementia.

**7.6 Continuing Health Care Needs**

Dementia when it develops in younger people has a quicker progression than dementia in later life (Woods 1991). Younger people with dementia may be more severely impaired and may have more extensive brain damage. (Tindall and Manthorpe, 1997).

Continued support by the specialist team to persons with dementia and their carers is essential.

**Recommendations - Continuing Health Care Needs**

63. The Trust will ensure ongoing monitoring and support from the key worker with input from other members of the team and other agencies as required. This will include access to all other appropriate health professionals and services eg Acute care at home team/rapid response, rehabilitation teams and Mental Health Home Treatment teams.

64. The Trust will provide carers with training to support them in caring for the younger person with dementia.

65. The Trust will ensure specialist training is given to staff providing palliative care to younger people with dementia.

**7.7 Hospital Services**

Some younger people with dementia may require time in hospital to treat psychiatric or behavioural problems. Some who are more dependant may need longer term specialist care provided by highly trained and skilled professionals.

As stated earlier the survey carried out by the NI Dementia Forum indicated that there were 5 younger people with dementia in Inver 4 Ward Holywell. At the time of the data collection none of these people had attained their sixtieth birthday. It is inappropriate for these younger people to be cared for with the frail elderly.

**Recommendations - Inpatient Care**

66. A separate ward or unit needs to be provided for younger more physically fit people with dementia who have high challenging needs. This will need to be sited close to the other wards providing care to people with dementia and would be part of the satellite unit described in Chapter 6.
Chapter 8
People with a Learning Disability
8.0 Introduction

The Learning Disability Report “Equal Lives” (2005) developed as part of the Bamford Review, points out that the numbers of people with a learning disability who are aged over 50 years is increasing significantly in Northern Ireland. The report indicates that whilst many will experience a long and healthy old age the physical signs of ageing may affect some people with a learning disability at an earlier age. Research evidence indicates that people with Down’s Syndrome show neurological changes resulting from Alzheimer’s disease at a much younger age than others with virtually all people with Down’s Syndrome who live long enough developing this form of dementia.

Equal lives indicates that planning needs to start now to meet the needs of people with a learning disability who also experience dementia and or depression, anxiety states and other functional mental illnesses as well as the other difficulties and challenges of aging.

8.1 Service Provision

Recommendation 53 of the Equal Lives Report indicates that:

‘Arrangements should be developed to enable people with a learning disability who have dementia to access support and expertise from mainstream dementia services. This will include mechanisms to provide a skills boost between dementia services and dedicated learning disability services.’

The Bamford Review report on Dementia and Mental Health Issues of Older People, Living Fuller Lives (2006, in draft) indicated that:

‘People with learning disability who develop dementia should be supported to access mainstream dementia services if that is their choice. Continuity of service provision for both the individual and their carer should be taken into consideration. “in-reach” expertise and support from the specialist team should be available in either case.’

This Review endorses that approach, which recognises that many people with a learning disability will have received support from specialist learning disability services for much of their adult life and that user choice and continuity of care are important.

Recommendations - People with a Learning Disability

67. The Mental Health Teams for Older People will work closely with services for people with a learning disability to enable user choice in dementia service provision and to provide appropriate ‘in-reach’ expertise and advice on dementia care to learning disability services.
9.0 Introduction

The most innovative and imaginative ways of meeting the specialist needs of older people with mental health problems are achieved through integrated specialist services.

Integration means the provision of a specialist mental health service for people with organic and functional mental health problems. It also includes the integration of the professionals who provide these services into multi-disciplinary teams under one management structure.

The majority of older people with mental health problems including dementia will not require ongoing support from a specialist mental health service. As stated in Chapter 3 they will continue to receive this ongoing support through generic primary and community care services. Specialist services are for those conditions and patients where diagnosis or management is complex or challenging.

At those times when people require access to specialist treatment and support then the vision is that this is from a comprehensive, integrated, mental health service for older people. The elements and attributes of this service have been described in the preceding chapters and are presented in Figure 9.1 opposite.
9.1 Development of a Specialist Service

As indicated in Chapter 1 a significant increase in the number of people suffering from a dementia is predicted over the next 10 years. Figure 9.1 indicates that people will be referred into the specialist service from primary care services/teams and will be referred back to those services for ongoing support. Fundamental to this model is the concept that the majority of people with a dementia or a mental illness will have their needs met through primary care services. It is clear therefore that capacity in generic services for older people will require investment to meet the demands of a growing population of older people with mental health problems.

Referral from primary care services are required for reasons of severity of disturbance, or of risk to the individual, staff or to others. Stakeholder workshops undertaken by the Review indicated that the key elements of a specialist service should include:

- service user and carer support services,
- memory assessment services,
- community mental health team for older people,
- specialist support to care homes,
- home treatment services
- inpatient assessment and treatment ,
- liaison psychiatry (psychiatric services to the general hospital),
- intermediate care services (or support to generic intermediate care services),
- psychological services,
- services for young onset dementia and
- services for people with terminal illness.

These services should be combined within a single structure lead by an overall programme manager and working alongside generic and primary care services. In order to ensure maximum benefit from this structure joint commissioning arrangements should be agreed upon at Board level.

Recommendations - Development of a Specialist Integrated Service

68. A specialist integrated service will be established for the Northern Trust lead by an overall manager for Mental Health Services for Older People.

69. The Trust will continue to review capacity in generic services for older people in light of a growing population of older people requiring support.

70. Joint commissioning arrangements for Mental Health Services for Older People should be established at Commissioner level.

9.2 The Community Mental Health Team for Older People (CMHTOP)

Recommendation 10, Chapter 4 indicated that the Trust will establish six sector based multi-disciplinary Community Mental Health Teams for Older People. “Everybody’s Business” (DoH. 2005) states that, ‘The community mental health team is the backbone of the modern specialist older people’s mental health service.’ Therefore the formation of these CMHTOP is central to the creation of the new model of care for the Northern Trust. These teams will be established through the transfer of staff from existing structures.

Stakeholder workshops considered the role and function of the CMHTOP as an element of the Trust’s overall mental health service for older people.

9.2.1 Role of the CMHTOP

The CMHTOP will provide services for people with dementia irrespective of age, and people with mental illness over 65, who require specialist skilled interventions to:

- Assist with diagnosis of dementia & where the diagnosis of any mental illness is in doubt.
- Support the management of challenging behaviour.
- Support the management of risk to the patient or staff.
- Support the management of very complex mental health needs. It is envisaged these service users will and the named worker role will remain within the team.
- Assist with the management of vulnerable adults.
- Implement the Mental Health Order

9.2.2 Relationship of CMHTOP with Other Services

It is important that there are sound referral criteria to and from the CMHTOP and its relationship to other services is clearly defined.

For those with a severe and enduring mental illness there would be no automatic transfer from younger adult mental health services to older adult services at the age of 65. Good practice guidelines suggest that as people approach their 65th year in adult mental health services their needs should be reassessed and their care provided by the service which best meets those needs.

The CMHTOP will include psychiatrists, social workers from mental health and dementia backgrounds, community psychiatric nurses and occupational therapists as core members of the teams. Other professions will work closely with the team as required based on need. These should include psychology, pharmacy, speech and language therapy, physiotherapy, CBT, podiatry, wheelchair specialists.
9.2.3 Features of the CMHTOP

The CMHTOP will have clearly defined roles and responsibilities and will provide timely response to crisis situations. The team will be made up of highly skilled professionals who will remain involved with a small number of people who have particularly complex and challenging needs.

Other individuals will be treated for brief periods when their needs are particularly acute, before care is transferred back to the primary care team.

The team will support mainstream services by meeting with staff in primary care teams on a regular basis for training and advice. Team members may develop more specialised roles. These may include working with users and carers to develop appropriate interventions, and including the provision of psychological therapies to prevent distress and help maintain independence and quality of life for the patients/clients and their carers.

9.3 New Model of Specialist Service Conclusion

The model and recommendations set out in this document describes the type of service, which people who use Homefirst and Causeway dementia and mental health services for older people, including carers, told us they need. It also reflects the experiences of people who provide those services and draws upon evidence of accepted best practice. It sets out a vision for an integrated patient centred, specialist mental health service for older people. Making this vision a reality requires our commitment to reshaping existing services combined with adequate new resources.

We realise that developing and delivering this vision is a major challenge. The service it describes is however no less than each of us would want for our families and for ourselves. Whilst it will require additional resources, of equal importance is the will to change and to continue to learn from and work creatively with service users, their carers and staff at all levels.
Promoting Health, Preventing Illness

1. The Trust and Commissioners will work in partnership with Voluntary, Independent and Community Sector partners and the Health Promotion Agency to increase awareness of mental health issues and to reduce the stigma associated with them.

2. The Trust will ensure that health and social care staff are aware that each encounter with a patient or a client is an opportunity to promote mental and physical well being and to promote a healthy lifestyle.

3. The Trust will work in partnership with all sectors and local authorities to promote activities, which improve physical and mental well being.

4. The Trust will work in partnership with voluntary organisations to promote the development of support groups and befriending schemes. The aim is to reduce isolation for carers of those with dementia or other mental or physical illness. This will require improved transport arrangements.

Awareness Raising and Early Detection

5. The Trust will implement an education programme for staff working in primary health and social care settings including the private and voluntary sectors to enable them to identify early symptoms of dementia, depression and other mental illnesses and provide accessible information regarding referral.

6. The Trust and Board will actively promote and support the development of GPs with Specialist Interest (GpwSI) in dementia to assist in service provision and future service development within a primary care setting.

7. The Trust will take the lead in developing care pathways which ensure clear communications between health care professionals.

8. The Trust will offer training and support to encourage GPs and Primary Care Teams to use standard assessment tests such as Mini Mental State Examination and Geriatric Depression Scale.

9. The Trust will make representations to the Universities to promote more training on mental health issues in later life for all Health and Social Care students.

Specialist Assessment and Diagnosis

10. The Trust will establish a total of six sector based multi-disciplinary Community Mental Health Teams for Older People. These teams are central to the provision of an integrated, patient-centred, mental health service for older people. The role and function of this team is further detailed in Chapter 8.

11. The Trust will ensure that the patient pathway through services is as seamless as possible including a single point of receiving referrals linked to a single referral tracking system. Referrals will be allocated to the most appropriate member of the team to undertake initial assessment, which should take place in the patients home.

12. The Trust will implement a single holistic assessment of user and carer’s needs. This will include guidance on communicating sensitively and effectively with users and carers. Accessible information from the assessment will be standardised to include timely reports to GPs stating diagnosis, follow-up arrangements, and how to access key worker details.

Information Needs

13. The Trust will ensure that accessible information about locally available services is available in GP surgeries and other public places eg libraries, community centres etc.

14. The Trust will ensure that at the point of assessment and diagnosis people, and their carers where appropriate, are given accessible information about their condition and its likely progress.

15. The Trust will ensure that the person and their carer are given a named contact that they can approach for further accessible information and advice following diagnosis.

16. The Trust will work in partnership with voluntary organisations to provide support groups for people with mental health problems and for their carers.

Home Care

17. The Trust will expand its training for Domiciliary Care Staff to enable them to provide support to older people with mental health problems in a flexible and competent manner.

18. The Trust will seek to extend the availability of appropriate domiciliary care provision based on assessed need over a 24 hour, 7 day period.

19. The Trust will improve access to training for carers in their caring role.

20. The Trust will involve carers and other partners in developing, delivering and evaluating additional support services to provide individuals with greater choice.

21. The Trust will establish Rapid Response Domiciliary Support Teams to provide timely responses during crisis periods.
Day Support

22. The Trust will develop a day support strategy to ensure a co-ordinated and comprehensive range of day support services. The strategy will seek to improve access to day support in the person’s home through individually tailored packages. The strategy will promote a mix of providers through investment in the private, voluntary and community sectors.

Respite Care

23. The Trust will promote respite as a preventative measure to support carers, rather than being perceived by carers as an admission of defeat.

24. The Trust will develop their range of respite services to offer a flexible and responsive menu of support to carers. These would include:
   - Further investment in sitting services to provide respite in the person’s home.
   - Increased availability of emergency short-term respite, particularly in the individual’s home, to prevent carer breakdown.
   - Further investment in dedicated respite beds to increase availability.

Direct Payments

25. The Trust will through the use of accessible information and support promote the greater use of Direct Payments for carers to ensure they can access support in their own right.

Assistive Technology

26. The Trust will increase awareness of assistive technology by providing more accessible information to staff and members of the public.

27. The Trust will work in partnership with the Commissioner, housing providers and Supporting People, to increase accessibility to the range of assistive technologies within the Northern Area.

28. The Trust will with the assistance of users and carers will establish a protocol for the assessment, installation, and management of assistive technology.

Residential Care and Supported Living Services

29. The Trust will develop protocols and services to help ensure that long-term decisions about Institutional Care are not made inappropriately in an acute setting or at a time of crisis.

30. The Trust will work with the NHSSB to develop a strategy for housing for older people. The Trust will work in partnership with a range of agencies and organisations to stimulate the development of a wider choice of quality housing and support services, including floating support, for older people with mental health problems or dementia.

31. The Trust will work with the Independent Sector to ensure adequate levels of appropriate Residential and Nursing Care and particularly EMI nursing care.

32. The Trust will develop an Outline Business Case for the development of EMI Resource Centres that would include assessment, residential, intermediate care beds, day care, and domiciliary support teams.

Palliative Care

33. The Trust will ensure training for staff providing palliative care to individuals with advanced dementia and people with mental health problems.

34. The Trust will make provision for palliative care for people at home if that is their wish.

35. The Trust will provide accessible information and advice to patients and client on the use of advance directives.

Vulnerable Adults

36. The Trust will bring to Commissioners attention the increasing number of Vulnerable Adults experiencing abuse and the resources required to implement regional procedures and protocols for vulnerable adults.

Support for Carers

37. The Trust will ensure carers’ are made aware of their rights to be offered an assessment and direct provision, or services to address their needs.

38. The Trust will work with partner organisations to develop a broader range of support services to carers including training and advocacy.
Therapies

39. The Trust will make a range of appropriate therapies available, in both community and inpatient settings, to older people with mental health problems. Access to this range of therapies depends on recruitment of therapists and training of existing staff. Contracts with independent providers will also be explored.

Liaison Psychiatry

40. A Consultant lead Liaison Team should be established at Antrim Area Hospital. This team would provide a liaison service to Antrim Area, Causeway hospital and would resource other general hospitals in the Board area. Reciprocal liaison services could be provided for mental health patients to avoid long delays in A&E.

Day Hospitals/Day Treatment Units

41. Three small 12-place Day Hospitals/Day Treatment Units should be established for the needs of the functionally ill elderly. These should be sited close to psychiatric inpatient services. One of these could be a travelling day hospital which travels to sites more adjacent to the patient population.

Intermediate Care

42. Three 8-bed Intermediate care (step-up/step-down) units should be established. These could be achieved in two areas through changing the use of a wing or part of current residential or EMI residential homes or through links with Independent Sector providers. Community Rehabilitation could support meeting peoples needs both at home and in these care settings.

43. Intermediate care units and liaison psychiatry services should be planned as a joint exercise between Geriatric and Psychiatry of Old Age services. Similar approaches would also prove beneficial in assessments of patients in community settings and this should be further explored through the development of patient care pathways and managed clinical networks.

Home Treatment

44. Older people with mental health problems experiencing a crisis, should have access to a 24 hr, 365-day crisis resolution/home treatment service. This should be included as an element of the future development of the adult mental health service crises response and home treatment service.

45. A behavioural management team based on the Newcastle model of care should be established within the Trust to provide support to Care home staff and who will work alongside Rapid Response Support teams to provide Home Treatment Service for people with Dementia.

Short-Term Assessment and Treatment

46. The Trust will develop a separate inpatient provision for the functionally mentally ill elderly across the area comprising 18 beds. This assumes access to day hospital/treatment and home treatment services. In the absence of day hospital/treatment and home treatment services then a capacity of 29 beds is required.

47. The specialist inpatient team will have the skills to meet the needs of the full range of psychiatric problems, with support from staff in other disciplines that have an expertise in older people. These include specialist physicians, speech and language therapy, pharmacy, psychology, dietics, physiotherapy, podiatry and dental. Advocacy, pastoral support and interpretation services should be readily available.

48. Following the development of a range of specialist community based services the number of inpatient dementia assessment beds should reduce to 24 beds. These would be provided in one or two units for the Northern Trust population. Within this provision there needs to be adaptable environments with interconnecting units to allow the nursing of a few patients with severe problems in separate areas, when required.

49. The Trust will develop clear protocols regarding admission and discharge of patients and the way in which the in-patient assessment unit links to the Intermediate Care Units.

Dementia - Medium-Term Treatment and Care

50. There is a need for 18 specialist beds for patients with dementia who require medium term intensive support. The Trust will work in partnership with the Commissioner, service users and carers to provide the most appropriate form of specialist care.

51. Inpatient beds must be provided in facilities reflecting contemporary standards. The Trust will consider options for the provision and location of these services through the development of an overall Outline Business Case for inpatient mental health services in the Northern Trust area.
Younger People with Dementia

Assessment and Diagnosis

52. A specialist team for younger people with dementia should be established in line with good practice guidelines (Royal College of Psychiatrists, 2000).

53. The Trust will ensure that appropriate accessible information, support and counselling services are available to support the person with dementia, their carer and family through the diagnostic stages. This will include clear accessible information at the time of diagnosis about emotional support and how to access it.

Following Diagnosis

54. Younger People with dementia will receive ongoing support from the specialist team for younger people with dementia.

- The team will work with other practitioners to identify people with dementia who may benefit from attending support groups. These will work alongside voluntary organisations to develop and provide supportive networks for this client group.
- The team will develop links with Department of Employment and Learning to promote continuing opportunities for employment.
- The team will establish strong links with other agencies and groups to provide ongoing support to family members e.g. Children’s Services and links to education services to support teenage children.
- The team will ensure links are established and maintained with Genetic counselling services.
- The team will be aware of specific issues for younger people and will establish links with other agencies to address these needs.

Care Planning

55. The Trust will ensure that the needs of the younger person with dementia are assessed and detailed in comprehensive assessment and care plan. This assessment must involve the individual in key decisions and must be regularly reviewed.

Services

56. The Trust will ensure that within conventional day care younger people are be grouped together and participate in age appropriate activities.

57. For those who do not wish to, or cannot avail of, group activities the Trust will explore opportunities for similar activities on an individual basis.

58. The Trust will improve access to a range of complementary therapies for persons with dementia and their carers.

59. The Trust will ensure that carers have their needs assessed.

Accommodation

60. The Trust will work in partnership with housing agencies and Supporting People to ensure appropriate supported housing for younger people with dementia.

61. The Trust will work in partnership with appropriate agencies and providers to increase accessibility to assistive technologies.

62. The Trust will engage in discussion with the independent and voluntary care providers to look at development of an area wide six-bedded domestic style care environment for younger people with dementia.

Continuing Health Care Needs

63. The Trust will ensure ongoing monitoring and support from key worker with inputs from other members of the team and other agencies as required. This will include access to all other appropriate health professionals and services e.g. Acute care at home team/rapid response, rehabilitation teams and Mental Health Home treatment teams.

64. The Trust will provide carers with training to support them in caring for the younger person with dementia.

65. The Trust will ensure specialist training is given to staff providing palliative care to younger people with dementia.
Inpatient Care

66. A separate ward or unit needs to be provided for younger more physically fit people with dementia who have high challenging needs. This will need to be sited close to the other wards providing care to people with dementia and would be part of the satellite unit described in Chapter 6.

People with a Learning Disability

67. The Mental Health Teams for Older People will work closely with services for people with a learning disability to enable user choice in dementia service provision and to provide appropriate ‘in-reach’ expertise and advice on dementia care to learning disability services.

Development of a Specialist Integrated Service

68. A single specialist integrated service will be established for the Northern Trust lead by an overall manager for Mental Health Services for Older People.

69. The Trust will continue to review capacity in generic services for older people in light of a growing population of older people requiring support.

70. Joint commissioning arrangements for Mental Health Services for Older People should be established at Commissioner level.

Annex 2
Terms of Reference, Project Structure and Methodology
The Remit for the Review was:

"to refine and quantify the future requirement for Mental Health services for older people (including younger people with dementia) in the Trust’s area, consistent with the analysis and parameters identified in the Northern Board’s “Commissioning a Modern Mental Health Service”. This includes consideration of the needs of those services provided by the Trust on an Area wide basis and would be completed through the preparation of:

1. Project Initiation Plan.

The Service Strategy and Implementation Plan will set out the options for the future of inpatient and community-based mental health services to meet the needs of older people.”

Project Structure

Project Board

A Project Board was established with membership from Homefirst Trust, the Northern Health and Social Services Board, Causeway Trust, GP representative and carers.

Mr R Trainor ATM Consultants (Chair)
Mr O Donnelly Director Mental Health, Homefirst HSS Trust
Ms B Bigley Project Manager
Ms N Barton Asst Director Social Care, Homefirst
Mrs M Beare Principal Officer, Mental Health, Homefirst
Ms A Brownlee Finance Department, NHSSB
Dr S Critchlow Consultant Psychiatrist, Homefirst
Mr L Cromie Asst Director, Mental Health, Homefirst
Dr S Doherty Consultant Psychiatrist, Causeway
Mr J Erwin Asst Director Finance, Homefirst
Mr T Fleming Asst Director, Mental Health Nursing, Homefirst
Mrs P Hughes Principal Officer, Dementia, Homefirst
Mrs M Kane Senior Nurse Advisor, NHSSB
Mrs K Lambe Asst Director, Mental Health Services, Causeway
Mrs L Lee NHSSB, Commissioning Team for Older People
Mr S Logan Principal Social Worker, NHSSB
Mrs S Magee Clinical Specialist Physiotherapist
Mrs M O'Boyle Asst Director Social Work/Social Care Homefirst
Dr G Waldron Chair, Mental Health PoC Team, NHSSB
Prof J Watson Director, Public Health Medicine, NHSSB

User/Carer Advisory Panel

The Project Team was assisted by a User/Carer Advisory Panel, which was consulted at key decision stages of the project. A list of Panel members is as follows:

Ms B Bigley
Mr J Dempster
Ms A Finlay
Mrs S Gemmell
Mrs P Harkin
Mrs I Kidd
Mr P Lundy
Mrs M McCready
Mr W Mooney
Mrs N Nixon
and six other members not named above.
Project Methodology

A project methodology was adopted to ensure that:

- various stakeholders, including older people with mental health problems and their carers, had an input into the process;
- front-line staff and their managers were involved in and had ownership of proposed new structures and ways of working, and
- the strategy whilst broad in its scope was sufficiently focused to effect meaningful change.

The review was progressed through a series of project team meetings, stakeholder workshops, User/Carer Advisory Panel meetings and a user & carer survey.

The DHSS&PS Regional Strategy sets out a number of targets and objectives relevant to the provision of mental health services to older people. This includes the following target, ‘to have improved the mental health and wellbeing of people aged 65 or over by a fifth between 2001 and 2025 as measured by the General Health Questionnaire (GHQ) 12 score’.

Key Actions include:

- Putting in place multi-disciplinary dementia teams, with specialist staff, such as nurse consultants.
- Providing for early diagnosis and support services for people with dementia and their carers.
- Ensuring appropriate housing with care, residential and nursing home accommodation for people suffering from dementia.
- The development of mental health services which respect individuals’ autonomy and are based upon partnership with users and carers in delivering high quality, effective treatment, care and support.

Review of Community Care (DHSSPS 2002B)

Research consistently shows that around 80% of older people would prefer to remain independently in their own homes. The first report of the Review of Community Care (2002) highlighted good practice in the identification and assessment of need and in the co-ordinated delivery of services in the community.

The report contains recommendations on:

- enabling people to live in their own homes
- spreading best practice
- developing services to provide practical support for carers
- care management processes and assessment tools
- promoting the development of a flourishing independent sector alongside good quality public services
- accountability of agencies
- funding structure for community care.

Caring for People Beyond Tomorrow (DHSSPS 2005A)

This document sets out the DHSS&PS Strategic Framework for the development of primary health and social care services in N. Ireland. The majority of people with a mental health need have their needs meet through primary care services. The strategy identifies the need to look critically at the care pathways for people to ensure the best possible configuration of expertise and use of available resources in the most appropriate setting. Objectives and actions include:

- Provision of a comprehensive primary care out of hours emergency care service to general medical, general dental, community pharmacy, community nursing, mental health, and other social care services.
- Development and implementation of strategies to provide for effective, community based and person-centred services for people with learning disabilities and mental illness.
Primary care reform and modernisation providing for a greater range of services and level of activity in the community. For example, in the area of mental health, stress, depression, and in particular suicide prevention.

By 2008 to develop a single assessment tool for the care of older people and implement across the HPSS.

Caring for Carers (DHSSPS 2006B)
The DHSSPS document Caring for Carers 2006, sets out a strategy which addresses the support that carers want, and need, to allow them to continue caring, and to give them as much access as possible to the opportunities that anyone might expect. The strategy provides a vision of what needs to be done to give carers the quality of life they deserve. The basic rights of carers to accessible accessible information, employment and training opportunities, and stronger support networks are addressed through this strategy.

Dementia Policy Scrutiny Report (DHSS 1995)
The scrutiny identified policy deficit and established a strategic direction for the development of Dementia Services. It also provided guidance on good practice for purchasers and providers. The report made thirty-two recommendations, twenty of which should be implemented immediately and 12 were described as “medium term”. The scrutiny recognised the financial implications of some of its recommendations and felt these should be addressed within a Regional Dementia Strategy.

The recommendations outlined in the report have been reviewed within the current Regional Review of Dementia and Mental Health Issues for Older People. It is anticipated that the recommendations of this review will subsume any outstanding recommendations of the Dementia Scrutiny Report.

Commissioner Strategies

Commissioning a Modern Mental Health Service, 1999
This document sets the Northern Health and Social Services Board’s vision for adult and old age mental health services (excluding dementia). Many areas for change, development and modernisation are identified in primary care, community services and inpatient services. In particular it sees the development of specialist community services as a necessity to reduce increasing pressures on inpatient services. It envisages the community based team at the centre of services supporting and drawing support from a wide network including primary care and hospital services.

Ringing the Changes: A Strategy for Older People 2002
Ringing the Changes sets out the Board’s plans to develop and improve services for older people including services for younger people with Dementia. It includes a comprehensive selection of recommendations ranging from Health promotion and disease prevention through primary and community care, hospital care and rehabilitation. It sets out specific recommendations in respect of Dementia care. This highlights the importance of early detection and diagnosis, an integrated approach to the delivery of services and support to carers.

Homefirst Trust Strategies

Mental Health Services
A major reform and modernisation programme in the Homefirst mental health service commenced in 2002. Phase 1 led to the development of community services to reduce the requirement for inpatient services and the enhancement of the quality of psychiatric inpatient services particularly in relation to staffing ratios and physical environments. However mental health services for older adults did not benefit equitably from these developments, which were primarily focussed upon ‘adult’ services.

Homefirst Trust Strategy for Older People, 2006
The aim of the Strategy is to develop services that are person centred, integrated, and provide choice to individuals. There is a commitment to developing a single path into a range of local services and an integrated assessment process that will reduce duplication and ensure that individuals can access support quickly and efficiently. Specialist Care will be provided to individuals who want to remain in their own homes and are very frail or have complex needs. This will be achieved through the extension of a range of services such as community rehabilitation, acute care at home and domiciliary support over a 24 hour period.

The Strategy for Mental Health Services for Older People will dovetail closely with the Trust’s Strategy for Older Peoples Services to ensure that the needs of residents in Homefirst are met in a flexible and comprehensive manner.
Annex 4
Current Services
Introduction

In the Northern area services are provided to a population of just under 59,000 people aged 65 years and over (NISRA, 2004).

These include a range of community and inpatient services to older people with a mental health problem. At the heart of community based services is the dementia teams and the community mental health teams. These include social workers, community psychiatric nurses, consultants in the psychiatry of old age and occupational therapists. Membership of these teams is drawn from a range of different departments and programmes depending upon the patient’s diagnosis.

The Trusts in EMI nursing homes in the Northern area. Many people with dementia are cared for in non-specialist residential and nursing homes. The Trusts also contracted for people with either dementia or mental illness in homes outside the Northern areas (86 no., 2005). There is no specialist EMI provision in the Magherafelt and Cookstown locality.

Domiciliary Care: In the Northern area a range of domiciliary care services are provided. These include home care services, cooked-chill meal services and to a lesser extent access to specialist assistive technology. Within the former Homefirst area, domiciliary care is also provided by the independent sector through Crossroads and Extracare. There is no contract for independent provision within Causeway.

Respite Care Services: Respite care is provided in several ways. These include booked respite nursing bed in the Newtownabbey and Coleraine sectors, ad hoc respite in a range of nursing and residential homes and home based respite in the form of sitting services.

Carer Support: Respite, sitting services and day care provide some support for carers. In addition, community care support workers provide a range of alternative therapies and support visits to carers. In the Causeway locality links have been developed with the Alzheimer’s Society Carers’ Support Group to address the needs of carers. The NHSSB have funded a Board wide family and carer training and support scheme, provided by Extra Care. Through this scheme carers are provided with individualised training which includes manual handling, continence management, the impact of the illness on the user and carer and stress management.

Crisis Response: This is a multi-disciplinary community mental health team in the former Homefirst area, providing a rapid 24hr, 365-day response and assessment service for adults, including older adults, with functional mental health difficulties who present to services in crises.

Hospital Services

There are currently three wards in Holywell Hospital providing services to people with dementia, Tardree Assessment Unit 1 and 2, and Inver 4 - Medium Term Care. Older people with a functional mental illness who require inpatient services are admitted to acute inpatient beds across the Tobernaveen Wards at Holywell hospital and to the Ross Thomson Unit at Causeway Hospital.

Dementia Assessment: The Tardree Unit, comprising two 24 bedded wards, provides a Trust wide assessment service. The unit was initially designed as an assessment and respite in-patient unit with day care facilities. People who require admission now generally will previous have had a diagnosis of dementia assessed through community services. They are frequently in a crisis situation where their care in the community has or is breaking down and they will require admission for assessment and treatment of behavioural problems. During 2004/05, 79 people were admitted to the Tardree Unit. Just under half of these were men with three-quarters over 75 years of age. Diagram A4.2 illustrates that the greater number were previously in care prior to admission.
There is a waiting list for admission to the ward. Among those on the waiting list are patients currently accommodated in Tardree unit, which further reduces the capacity of this unit.

**Functional Mental Illness:** There is currently no separate unit within the Northern Trust for people over 65 years of age with functional mental illness. These patients are currently accommodated in the Tobarvanean wards, mainly Tobarvanean Centre at Holywell and to the Ross Thomson Unit at Causeway Hospital. Overall bed provision in the Tobarvanvens is 72 and 34 in the Ross Thomson Unit.

During 04/05 there were 90 admissions or transfers in of people under the care of old age psychiatry at Holywell. These people occupied just over 4,600 bed days. At an 85% occupancy level this equates to 15 beds. This figure may be contrasted with the figure prior to the acute bed reductions in Holywell where acute bed usage by over 65s was 29 beds. The extent of the reduction in the level of usage is due in part to the current lack of bed availability and the consequent impact on the ability to admit when required.

During 04/05 there were 33 admissions to the Ross Thomson unit. A total of 2032 bed days were used which at an 85% occupancy level equates to 7 beds.

**Finance**

Currently funding for dementia services comes through the Northern Health And Social Services Board’s Elderly Programme of Care. As there is no separate funding for functional mental illness in older people the funding for this service comes through the Board’s Mental Health Programme of Care along with funding for general adult mental health services.

During the year 04/05 approximately £27 million was spent on Mental Health services to Older People in the Northern area. This figure excludes significant elements of service provision which are tied in with generic services and are consequently difficult to extract separately eg home care services, day care, non-specialist residential care and Mental Health services provided through adult Community Mental Health teams.

**Estate Condition**

Asset condition surveys for functional suitability were completed for the Tardree and Inver 4 inpatient units and for Ferrard House and Moylinney residential units for the elderly mentally infirm.

In the absence of any specific guide for inpatient dementia units the inpatient units were assessed using the standards in NHS Health Estates, HBN35 Part 1 - The Acute Unit, accommodation for people with Mental Illness. The residential units were assessed using ‘Residential Homes Registration and Inspection Standards - A Consultation Document’ (DHSSPS 2004A)

The reasons for the high levels of delayed discharge are either the lack of availability of or capacity in, homes able to meet the needs of patients whose behaviours challenge services.

**Medium Term Care:** Medium term care is provided in Inver 4 ward for those patients with dementia and challenging behaviour for whom assessment has shown that community services would be unable to meet their needs. The ward has capacity for 24 patients, with current accommodation for 16 male beds and 8 female beds. Over time people are discharged from this ward to appropriate community facilities as the level of risk posed by their behaviours diminishes.

The majority of patients are discharged to institutional care with a smaller number either returning home or being transferred to medium term care in Inver 4 ward at Holywell. Diagram A4.3 below illustrates that at any one time there is a significant number of people in the Tardree units awaiting discharge or transfer. This means people have to remain in the assessment units for longer than is either necessary or in the best interest of their health.
The outcome of these surveys was that the units were found to require either major capital expenditure or replacement to allow them to conform to contemporary standards.

Issues in the inpatient units included:

- Few single bedrooms with the majority of people in dormitory accommodation;
- Lack of wheelchair accessibility, including accessible toilet and bathing facilities;
- No or inadequate, cramped dining facilities;
- Large noisy dayrooms with no separate quiet areas, activity rooms etc.;
- No provision for visiting;
- Inadequate and cramped staff accommodation;
- Cramped overcrowded facilities with inadequate spatial levels overall;

Issues in the residential units included:

- Bedroom sizes do not meet requirements;
- No ensuite bathrooms;
- Not all doors are wheelchair compatible;
- No alert system between staff;
- Inadequate bathroom facilities;
- No separate smoking room for residents;
- Cramped dining room;
- Kitchen outdated needing proper ventilation and modern equipment;
- Additional storage required for residents' belongings, and equipment;
- Poor and inadequate staff accommodation.

Condition of Estate - Causeway

Brookgreen EMI home in Coleraine has closed and in its place a housing with care project with care is being developed. The first phase of this development, The Brook opened in 2005 and the remainder will open in 2007. It provides accommodation in line with quality standards.

Issues in the Ross Thomson Unit inpatient psychiatric unit include:

- Few single bedrooms;
- Cramped over crowded conditions with inadequate spatial levels;
- No separate quiet areas;
- No provision for visiting.
User and Carer Survey

The views of users and carers were sought on five elements of services provision as follows:

- GP services.
- Specialist assessment services.
- Support services.
- Specialist inpatient services.
- General acute hospital.

Questionnaires were sent to a sample of 500 users and carers with a total of 119 responses received. A summary of the outcome is as follows.

GP Services

- Eighty-five (71.4%) people had an examination when they first had contact with their GP in relation to their mental health or memory problem.
- Following their initial visit, 97 people (81.5%) were subsequently referred by the GP to a specialist for further tests.
- Forty-eight people (40.3%) stated they were given no accessible information by the GP regarding support services.

When asked to indicate ways in which GP services could be improved the main areas were:

- Provide more accessible information about health problem and support available.
- More time for clients/contacts/check-ups.
- More personal service/understanding.
- Improved awareness by GPs of mental health issues.
- Quicker diagnosis.

How Users and Carers said we could improve services:

‘I know it is difficult to diagnose a particular dementia without consultation with a psycho-geriatrician but I believe GPs should give the patient/carer a rough idea of what to expect and give some accessible information regarding support organisations.’

‘Some accessible information on support services would have been of benefit there was no advice on what was the best way to cope/care for dementia.’

‘More accessible information to patients. There is a lack of awareness of mental health issues by GP, and there is not enough time with patients.’

‘I felt that once the GP had made referrals to hospital and social services he didn’t want much more to do with it.’

Specialist Assessment Services

Just over half of respondents felt that they were given accessible information at the end of their assessment on how their condition was likely to develop. Just under half of respondents felt that they were given accessible information on support services. Figure 3.1 indicates people’s feedback on their satisfaction with the assessment process.

When asked to suggest improvements that might be made to specialist assessment services the main themes from dementia carers were to:

- Provide more accessible information.
- Provide more frequent visits/contacts.
- Listen more and improve communication with relatives and carers.
- Improve the assessment process.

How Users and Carers said we could improve services:

‘Explain stages of Alzheimer’s. Give family or carer’s a pack with accessible information.’

‘Better communication with relatives. The nature of Alzheimer’s means that patient can’t take in or remember what the nurse/doctor said. I always accompanied her but was not always consulted or told how the examination went.’

‘By listening to the members of the family about their concerns for their elders.’

‘Encourage consultants/GPs to listen more to the carers and teach them to understand the ripple effect that a lack of understanding of that [care] role can have on day to day relationship between patient and carer.’

How Users and Carers said we could improve services:

‘I know it is difficult to diagnose a particular dementia without consultation with a psycho-geriatrician but I believe GPs should give the patient/carer a rough idea of what to expect and give some accessible information regarding support organisations.’

‘Some accessible information on support services would have been of benefit there was no advice on what was the best way to cope/care for dementia.’

‘More accessible information to patients. There is a lack of awareness of mental health issues by GP, and there is not enough time with patients’.

‘I felt that once the GP had made referrals to hospital and social services he didn’t want much more to do with it.’
For those with a functional mental illness, the main areas for improvement were:

- Reduce waiting times
- Provide more support and accessible information
- Spend more time with patients
- Make services more accessible

**How Users and Carers said we could improve services:**

- ‘By being more supportive.’
- ‘Didn’t know what questions to ask and didn’t know if assessment was satisfactory.’
- ‘When reached age 65 handover from abbey house to old age psychiatry was not well managed, I had to initiate referral to old age psychiatry myself and was not told I was being discharged from Abbey House.’
- ‘See people in their own home.’

**Support Services**

When asked if someone had been identified to provide them with support services, 89 respondents (74.8%) confirmed this to be the case. Of these respondents 86 (96.6%) indicated they were told they could contact this person if they had any problems. Support services received are shown in figure 3.2 below.

In respect of support services suggestions for improvements from Carers and Users are as follows:

- Providing more accessible information/support/advice to carers
- Quality and availability of Services
- Continuity of care
- Providing training for non-qualified staff

**How Users and Carers said we could improve services:**

- ‘By giving advice to carer on how to handle situations.’
- ‘If relatives of people with dementia could talk initially to people with first hand experience this would be as much help as seeing a memory clinic or other as there is so much that medical people don’t tell you.’
- ‘Home helps to make breakfast and lunch were in teams of three or four so my mother was very confused at all the different people coming in to her home.’
- ‘Staff are often untrained and unable to read the situation. A lot of questions asked and recorded but not followed up. Generally only a job to be got through.’

**Residential or Nursing Home Care**

Thirty-six respondents relative (30.3%) resided permanently in a residential or nursing home. Of these carers 39% stated they were very satisfied, 44% were satisfied and 17% felt services were adequate.
Suggestions for improving residential/nursing homes services included:

- Providing training for staff
- Improving staff attitudes
- Providing additional staffing

How Users and Carers said we could improve services:

- ‘More dementia trained nurses in homes’
- ‘Giving the patient more to eat’
- ‘I am surprised at how little care staff know about dementia when an outreach worker from Alzheimer Assoc. came to the residential home to talk to carer’s/family reps’

Inpatient Services

Tardree Dementia Assessment Wards

Figure 3.5 below indicates the levels of overall satisfaction with the Treatment and Care provided on the Tardree Dementia Assessment Units at Holywell.

How Users and Carers said we could improve services:

- ‘Patients could be treated as individuals similar to Tobernaveen rather than collectively, although this wouldn’t be as cost effective it would reduce infection and be beneficial to patients’
- ‘Train the staff, as junior staff questioned my wife about her illness till she broke down in tears. I refuse to let her back into that unit’

Acute Psychiatric Units

Twenty-nine respondents with functional mental illness reported having spent time on the Tobernaveen wards at Holywell Hospital. Their degree of satisfaction with the service provided is indicated in Figure 3.6 below.

Eight of the 29 respondents suggested that they would want improved accessible information for and communication with carers and a more supportive and caring approach to patients.

How Users and Carers said we could improve services:

- ‘More dementia trained nurses in homes’
- ‘Giving the patient more to eat’
- ‘I am surprised at how little care staff know about dementia when an outreach worker from Alzheimer Assoc. came to the residential home to talk to carer’s/family reps’

Inpatient Services

Tardree Dementia Assessment Wards

Figure 3.5 below indicates the levels of overall satisfaction with the Treatment and Care provided on the Tardree Dementia Assessment Units at Holywell.

Eight respondents made suggestions for improvements to services in the Tardree Wards, which included:

- Providing more training for junior staff
- A larger unit with more facilities
- Improving staff attitudes
- Getting staff to communicate better with one another
- Providing more accessible information and reducing assessment times for patients.

How Users and Carers said we could improve services:

- ‘All cases for treatment were lumped together. It would be an advantage if they were graded. Also there was no place for visitors’
- ‘By communicating with carer and giving them more accessible information when things get bad’

General Acute Hospital Services

Sixty-eight respondents, or their relatives, (57.1%) had been admitted to a general hospital. Ratings for assessment and treatment, care and support and the discharge process showed that those with functional mental illness were more satisfied with the care they received in general hospitals than those with dementia.
Whilst levels of satisfaction were generally good there were nevertheless significant comments on areas for improvement. These comments were positively endorsed by the Review User/Carer panel and are as follows:

- need for training of non-specialist staff in dementia and its care
- need to provide improve communication
- need to provide ward for dementia patients
- need to improve standards of hygiene.

Specific suggestions for carers to improve patient care in acute general inpatient wards are given below.

**How Users and Carers said we could improve services:**

- 'I think a small ward for people with this problem would be good'
- 'By providing care staff skilled in care of elderly/confused patients or better still a ward suitable. No matter how often we told staff mum was suffering from dementia it was never passed on and the staff continued to take medical history from her'
- 'By treating someone of 80 years the same way you would treat someone of 40 years'
- 'Educate staff to talk to relatives and carers as well as patients'
- 'People with dementia admitted to hospital and general nurses seem unable to cope with dementia problems. Moved from ward to ward - very confusing for patient'

Three of the 16 respondents with a functional mental illness who stayed in a general hospital, indicated areas of improvement including hygiene, quality of food and the need to promote 'more understanding by staff of mentally ill patients and their illnesses'.
References


Department of Health, Social Services and Public Safety and Public Safety (2003) Mental Health Services for Older People - Regional Summary Value for Money


Homelife Strategies


