NHS

London Clinical Networks

Management of mental health problems in physically frail people living in care homes

London Dementia Clinical Network

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This talk

- The issues
- Importance of stepped models of care
- The Newcastle model and its application
- The future- training and integration

Care Homes

- 70% of residents have dementia
- 300k people with dementia live in care homes in the UK
- 40% have depression
- Diagnosis of these problems less likely if you live in a care home
- People in care homes have reduced access to NHS primary and secondary care (AlzSoc Fix Dementia Care, 2016) eg GPs charging for regular visits, reduced access to dentistry, physiotherapy.
- Services not tailored to the needs of the ill in care homes eg Parkinson's disease clinics
- Traditional mental health services (CMHTs) traditionally are more interested in "functional illness" and diagnosis
- Polypharmacy common and a cause of 10% or more of acute hospital admissions

Polypharmacy

- Polypharmacy
  - is frequent - average of 8 drugs per resident in UK care homes (Shah *et al* 2012)
  - is dangerous -the more drugs people with dementia take the higher their mortality SHELTER study (2013)
  - Is not necessary -20% of drugs "potentially inappropriate" in care home residents (Shah *et al* 2012)

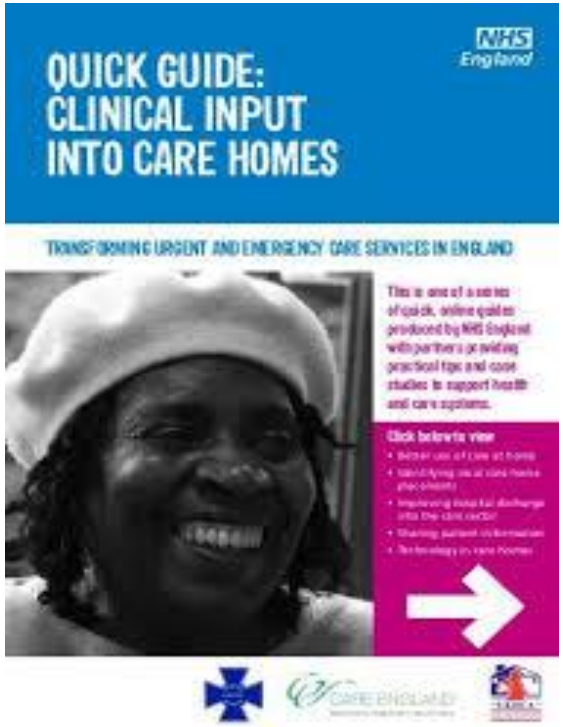
Drugs and falls

Odds ratios for fall risk in older people (Woolcott et al 2009)

Antidepressants	1.68
Antipsychotics	1.59
Hypnotics	1.47
Antihypertensives	1.24
NSAIDs	1.21
Diuretics	1.07
Opiates	0.96

Models of NHS care in care Homes

- GPs
  - One GP practice per care home
  - Regular visits at set times
- Medicines management
  - Pharmacists doing medicines management
  - Working with GPs
- MDTs and shared care
  - Joint working with geriatricians, CMHTS and GPs
  - Evidence that MDT approach does reduce admissions
- Staff development
  - Can the care home staff do more if they have support?
  - Specialist mental health teams



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Behavioural and psychological symptoms

- Almost universal in dementia
- Fluctuate- but 80% of severe presentations persist over 6 months
- Tend to increase with severity of dementia
- Types
  - Biological- sleep, appetite
  - Motor- restlessness, pacing, vocalisation, aggression- these are often termed “agitation”
  - Psychological- depression, anxiety, irritability, delusions, hallucinations

Behaviour in dementia as unmet need

Distressed or distressing behaviour represents an unmet need

A person-centred care plan is needed to understand and address this need

BPS briefing document (2013)

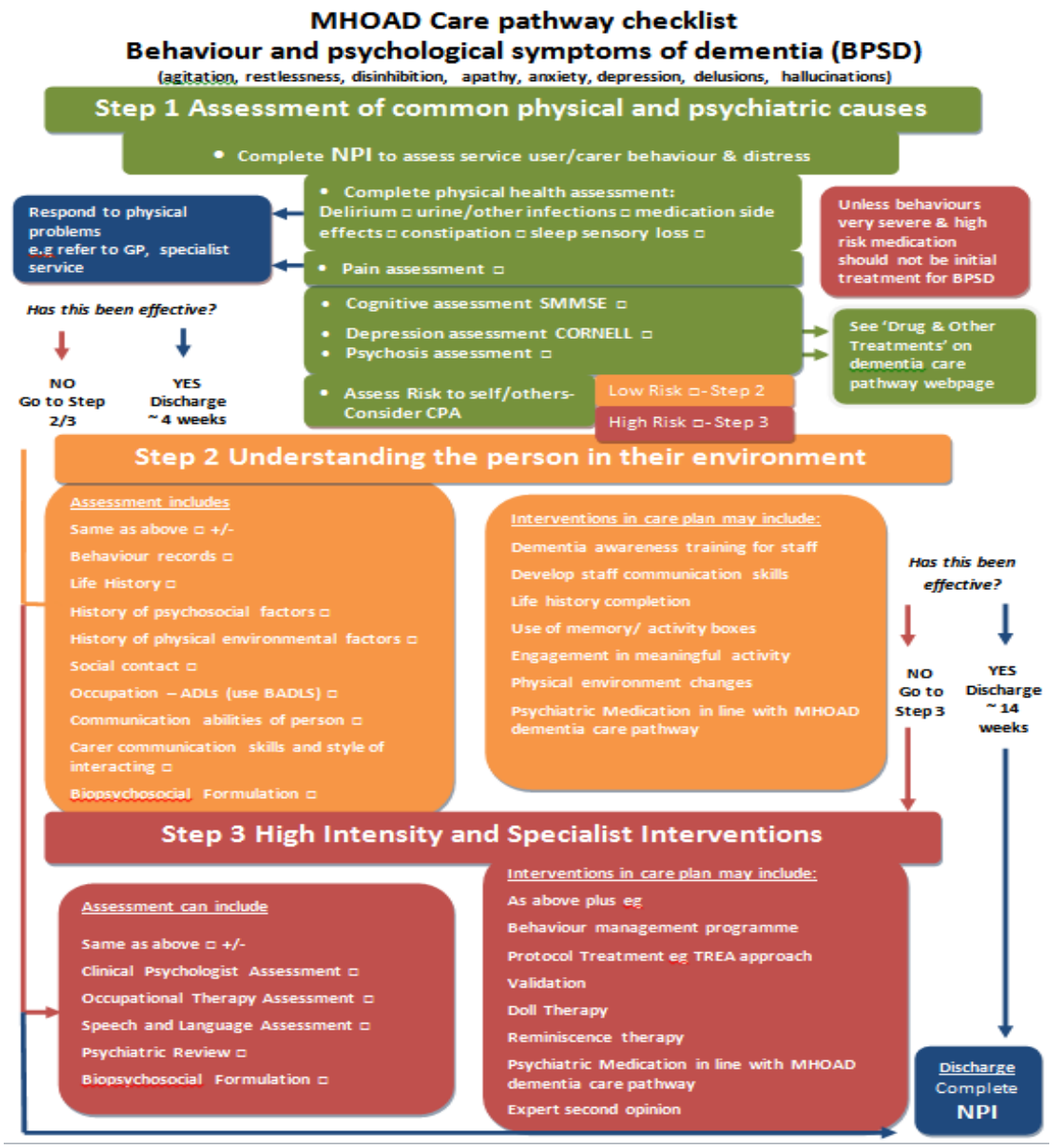
Can be applied to other disorders eg LD, schizophrenia, depression

The SLAM dementia care pathway for BPSD in care homes

- Care pathways in SLAM Mental Health of Older Adults (available at this link http://mhoad.slam.nhs.uk/)

- **Assessment** requires life history, history from carers supplemented by accurate recording (eg sleep, food charts, ABC charts, clinical outcome measures) observation
- A **formulation** session with care home staff informs the development of a person centred, holistic care plan that addresses quality of life and identified unmet needs (Cohen-Mansfield et al. 2007, British Psychological Society, 2013). Communication issues are often key.
- **Review**- regular visits to assess use of behaviour support plan and re-formulate where necessary

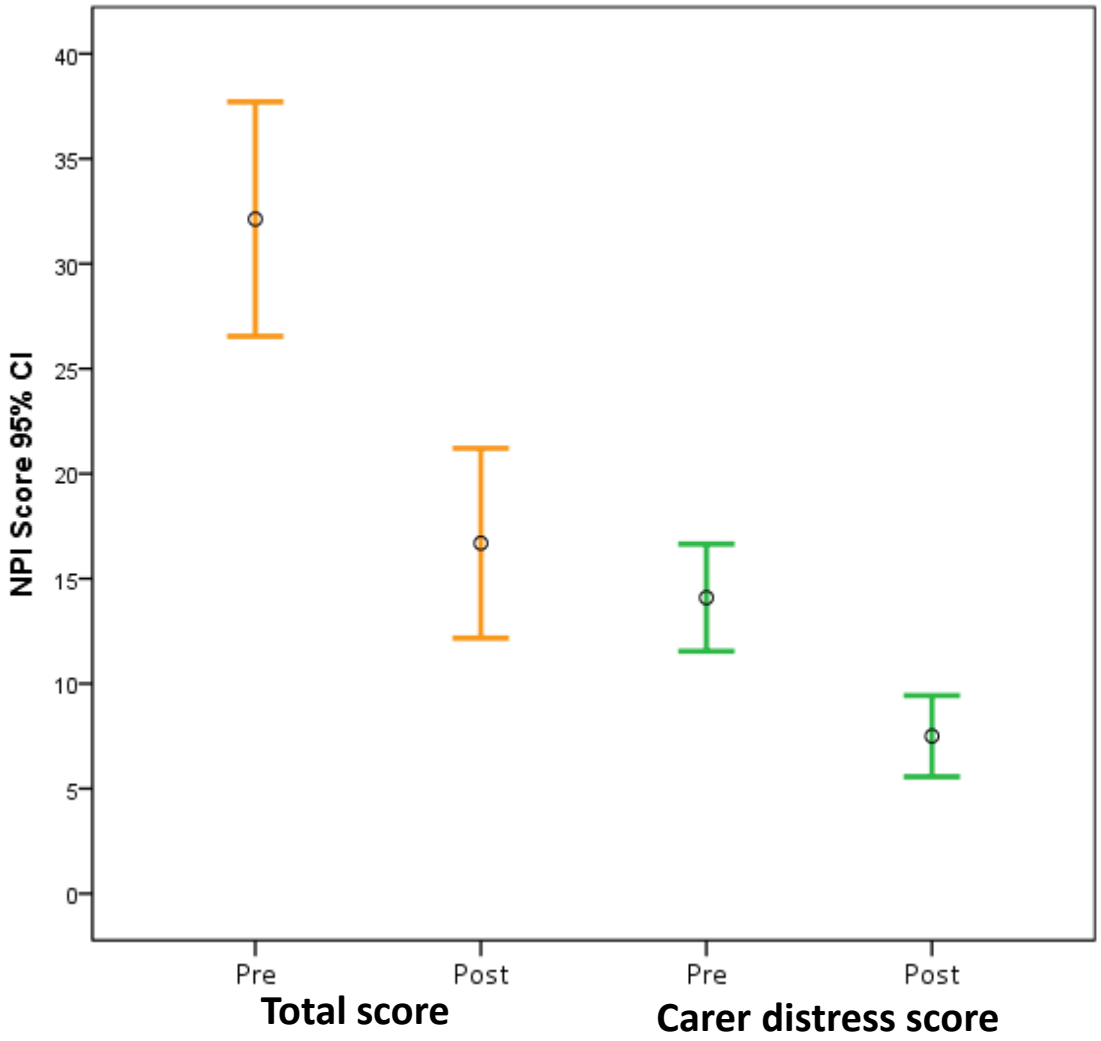
SLAM care pathway for BPSD



Validation

- “Correcting” patients (“I’ve told you before , your mother’s dead”) increases distress
- Lying to patients is usually unethical and can make things worse (“You said my mother was visiting me this afternoon- where is she?”)
- Validation is acknowledging the emotion that is driving the question and can open the way to a more therapeutic interaction (“You must be missing your mum. Tell me about her…”)
- Can be used with distraction (“I think you’ve got a photo of your mum in your mum, shall we see if we find it?..)

Does it work? NPI scores pre and post intervention



66% female
66% ≥ 81 years old
56% Alzheimer's Disease

What's the evidence?

Livingston et al, 2014 – systematic review

- Training care staff in person-centred care techniques and communication skills can reduce agitation
- **Interventions may be best directed at care homes rather than individual residents**
- Multicentre WHELD study – dementia champions to deliver simple structured interventions
- Need for more research on BPSD in non-care home settings

Conclusion

- Get basics in place first- A named GP who visits regularly. This is not optional
- Pharmacists to support GPs can implement quick and important wins- reduce fall risk, reduce delirium (Medichec.com), audit etc
- Ideally- MDT with GP pharmacist and geriatrician or psychiatrist – but keep it brief, monthly is fine, and no rambling on- decisions and actions!
- Specialist teams have a place – eg mental health teams to manage complex residents but also to deliver training interventions eg WHELD
- In all these service models empower the care home manager and staff eg DEAR-GP, Kent care pathways