



Mental health issues in Australian nursing homes

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BACKGROUND Mental illness is common, under detected and often poorly managed in residential aged care facilities. These concerns have achieved greater prominence as the worldwide population ages. Over 80% of people in nursing home care fulfill criteria for one or more psychiatric disorders in an environment that often presents significant difficulties for assessment and treatment.

OBJECTIVE This article aims to provide an overview of the important mental health issues involved in providing medical care for patients with behavioural and psychological problems in residential aged care facilities.

DISCUSSION Recent developments in education and training, service development and assessment and treatment strategies show some promise of improving the outcome for aged care residents with mental health problems. This is of especial relevance for primary care physicians who continue to provide the bulk of medical care for this population.



Most readers will have direct experience of life in a nursing home (NH) or hostel; or have indirect contact through the experiences of friends or relatives. Although only a small proportion (approximately 7%) of the elderly population lives in institutional care, lifetime use of such care is increasing along with the average lifespan. Most people will live beyond 65 years of age and recent projections suggest that 28% of all Australians who reach this age will spend some portion of their remaining years in hostels, and 34% in NHs (Table 1).

Nursing homes provide accommodation and services for people who need considerable assistance in the basic activities of daily living, and extensive nursing care that cannot be met through community based care services. The distinctions between NHs and hostels (which provide a wide range of personal care and sup-

ported accommodation for less dependent people) have become increasingly blurred due to new funding arrangements and 'aging-in-place' schemes. Both are now designated as 'residential aged care facilities (RACFs)'.

Government enquiries have cast doubt on the capacity of some RACFs to cater for the mental health needs of their residents. Many NHs are converted houses that are often crowded, cluttered and lacking modifications for those with physical or mental disabilities. Most patient care is provided by personal care attendants who are often on low wages and are minimally trained. Many of the staff are not knowledgeable about the aging process nor of the nature of psychological symptoms and behavioural problems experienced by residents, seldom seek appropriate mental health intervention once a problem is recog-

nized, and lack formal training in behaviour management strategies.¹

The lack of dementia specific accommodation and psychogeriatric services in general has been noted, as well as poor standards of training among doctors in the detection and treatment of depression and complications of dementia.²

The commonwealth government has introduced considerable regulations over the past two decades and has introduced a variety of measures to reduce the number of elderly people in NHs while upgrading community alternatives. The proportion of the elderly in NHs has dropped from 6.5% to 3% over the past two decades, however, it is unlikely this proportion will diminish. Relevant factors include financial pressures on state funded hospitals, downsizing of tertiary psychiatric facilities, increasing numbers of high dependency aged people, and the

Table 1. Probability of future hostel and nursing home use^{22,23}

Hostel use (permanent and respite care)	At birth	Age 65	Age 75	Age 85
Men	0.13	0.17	0.22	0.3
Women	0.28	0.33	0.41	0.63
All persons	0.21	0.28	0.42	0.53
NH use (permanent and respite care)				
Men	0.21	0.27	0.34	0.49
Women	0.35	0.41	0.50	0.78
All persons	0.28	0.34	0.43	0.67

Table 2. Mental health problems in a New Zealand nursing home sample (n=87)²⁶

• Dementia 67%
• Depressive syndrome 17%
• At least one problem behaviour 91%
• Four or more problem behaviours 46%
• Receiving any psychotropic 63%
• Psychotropic use rated as inappropriate 76%

decreasing levels of informal support as the number of potential carers falls relative to the number of disabled persons.

Despite acknowledged aged care reforms, there remain considerable concerns about the standard of medical and nursing practice and the adequacy of specialist support.³ Psychiatric epidemiological studies underlie some of these concerns.

Psychiatric epidemiology

Rovner and Katz⁴ have referred to NHs as ‘modern mental institutions for elderly people’ as they are places with a high prevalence of psychiatric symptomatology and widespread prescription of psychotropic drugs (Table 2).

The majority of people in NH care have dementia. Comorbid mental health problems are common in dementia, especially depressive and psychotic symptoms, delirium and behavioural disturbances. Dementia is associated with frequent use of antipsychotic medications and restraints, and use of nursing time, and is often poorly documented or diagnosed by physicians.

The next most common mental health problem is depression.⁵ Depressive symptoms appear to be persistent, are associated with significant medical morbidity, may be a major independent risk factor for mortality in NH residents, and are often not treated, despite some evidence of the potential for positive outcomes.

Behavioural disturbance is common and a major precipitant of admission to

residential care. While not all demented residents display behavioural disturbance and not all disturbed residents have dementia, cognitive function is the crucial determinant. Verbal outbursts, physical aggression, agitation and wandering are major problems. It is often confusing to primary care providers who can help and how severe behavioural disturbance should be managed. Not all areas have available specialist facilities for this group.⁶

Psychotropic medication

Inappropriate use of psychotropic medication has been found internationally including high prescription rates, excessive use of medication as a restraint, wide variation in prescribing practises across facilities, and inconsistencies with clinical indications.⁷

Over use and under use are both an issue. Psychotropics are associated with significant morbidity and there is no appreciable deterioration in the majority of those withdrawn from them, yet psychiatric pathology is often missed and those who might benefit may receive no treatment or ineffective doses.

Physical restraint

Restraint use is of interest as it is often used to try to reduce behavioural disturbance (particularly in those perceived at risk of falling or wandering). Restraints are a part of life for a large number of residents. Koch et al⁸ found restraints used in 26.4% of residents in Melbourne (Victoria) NHs. This is of concern because of increas-

ing evidence that their use increases agitation, may contribute to cognitive decline, causes death and paradoxically increases the risk of falling itself.⁹

Psychosocial issues

Residents

Relocation stress is an additional burden to the usual difficulties of aging for many entering RACFs. On the other hand, lack of privacy and other problems of institutional living are sometimes counterbalanced by increased socialisation for older people who had been isolated and lonely in their own home.

Additional complexities have been recognised for younger (usually with neurological illness), migrant and indigenous residents. Older migrants sometimes find double jeopardy in being cared for by Australian born registered nurses and personal care attendants, themselves migrant, but from differing ethnic backgrounds.

Staff issues

Working in a RACF presents significant stress for many staff. Financial constraints place pressure on the amount of social support that can be provided for residents limiting the provision of ‘best practice’. The duties of a registered nurse often involve dealing with grieving relatives and confronting their own fears of death, mental illness or disability. They must avoid extremes of excessive detachment or over involvement in the face of the inex-

orable decline of most of their charges.

Ethical issues familiar to those working in psychiatric settings are common and include informed consent and balancing the rights of the individual against those of the majority in what has now become 'home'. Work related injuries, voluminous paperwork, staff and other resource scarcity, and working with complex neurobehavioural problems without adequate training, support or supervision present further difficulties.

Detection of mental health problems is limited by training, finding time to talk with residents and being in a position to accurately characterise clinical problems (eg. residents with hallucinatory experiences often describe them best to the personal care attendant who showers them). The finer details of major depression are not always evident if the only opportunity for discussion with a trained nurse is across the afternoon pill trolley.

An under recognised issue is the likelihood of physical assault by residents generally toward personal care attendants. Recent United States work confirms this is 'expected, tolerated and accepted'.¹⁰

For the doctor, funding arrangements are a disincentive to the thorough assessment often required to intervene with confidence; this is especially so for behavioural problems which sometimes represent treatable mental illness or reversible medical conditions. Conflicting or unavailable history from multiple informants, sensory and cognitive impairment, limited availability of specialist opinion, lack of privacy and sheer complexity can also make this a difficult clinical environment.

Carers

It is hoped that those struggling with a severely impaired spouse or relative in the community will have an immediate burden lifted when NH placement occurs. However, for many relatives the decision to place a loved one in another's care can be very difficult and can continue to cause distress even after a successful transition

is made.

In the best circumstances, the carer becomes part of a team dealing with the resident's needs in a relaxed manner. At other times, inappropriate interaction can lead to worsening behavioural disturbance in a demented person, or nurse and carer can find themselves in significant conflict arising from different frames of reference.

The symptom of apathy exemplifies one such difference of perspective. While a relative may find disappointment in their loved one's inactivity and lack of motivation, some staff will be relieved at the absence of 'challenging behaviour' (which usually implies an excess or distortion of normal behaviour). This is one reason why severely depressed residents with psychomotor retardation get missed – they aren't challenging enough!

How are mental health issues addressed in Australian facilities?

The majority of psychiatric conditions in NHs are treated by general practitioners and NH staff. There is surprisingly little literature about primary care activity in these facilities.^{11,12} Snowden has noted of many doctors:

'They communicate to a senior nurse, but commonly they do not write down their opinions for others to see...(nor) record full details of diagnoses or assessments of disabilities ...write progress notes or say why they instituted a particular treatment...leave the results of tests, or discharge summaries from hospitals, or written opinions from specialists in their nursing home files'.¹³

Involvement of geriatric medical services varies considerably between states and from one district to another. Many NHs draw on aged care assessment services for expertise.

Behaviour support units or teams have been developed to provide specialist assessment, advice, training and one-off funding support to RACFs to deal with dementia complicated by 'challenging behaviours'. The coverage, operational

environment and nature of BSUs in each state differs and improving services to rural and remote communities is an acknowledged priority. Generally they are staffed by registered nurses with varying contributions from allied health, geriatricians and psychiatrists.

Most Australian psychiatrists with an involvement in geriatric care practise in metropolitan New South Wales and Victoria.¹⁴ Although there is clearly a potential clientele for psychiatric services in RACFs, there is little evidence to conclusively demonstrate better outcomes than those of nonspecialists despite the weight of expert opinion.^{15,16}

The challenge of improving mental health in residential aged care

A comprehensive summary of proposals to address the difficulties above is beyond the scope of this article. Clearly there are implications for research, education and training programs, models of service delivery, legislation and government policy including cooperation between different levels of government.^{17,18}

Where once little regulation existed, both state and federal governments have intervened extensively¹⁹ but improvements in mental health will require structural changes that imply significant leadership and commitment from government and other stakeholders.^{6,20}

Issues in the area of service delivery include the importance or otherwise of specialised stand alone or internally separated units housing people with major behavioural and mental problems. Options include 'dementia wings', specialised psychogeriatric NHs and psychogeriatric extended care wards. Community psychogeriatric services, where they exist, can look at liaison attachment models of service to RACFs and may choose to collocate with large facilities.

Some have pressed for improvements in medical expertise with implications for the extent to which GP contact with RACFs should be regulated, rewarded

and formalised.³ Should we limit patient choice and encourage a smaller number of better trained, better remunerated GPs attending NHs? The benefits could include better use of time and increased expertise through increased familiarity with geriatric care.

The 'greying' of our population implies increased emphasis on geriatric topics in undergraduate and postgraduate training of all health professions (the politically harder task is deciding what to de-emphasise). Teaching nursing homes are a type of educational facility not yet seen in this country.

Local guidelines on medical care in NHs have been published²¹ but readily available material on psychiatric care in these settings would be of further assistance to existing practitioners. Books and articles however, cannot fully redress the absence of local geriatric and psychogeriatric expertise in many parts of the country.

Information technology options include: telemedicine, email consultation, internet use, nursing and medical documentation and decision making software and information packages for the use of staff and informal carers. These impressive sounding solutions require training, supervision, coordination and substantial investment. Perhaps the potential of information technology lies more in its judicious application than its mere existence.

Substantial benefit may accrue from standardised assessment forms within a medical record shared electronically between local hospitals, GPs, health and social service providers and care facilities. However, threats to privacy alone would be a substantial hurdle for such efficiencies to cross.

For as long as we struggle to improve the delivery of mental health care in NHs, we should continue to develop community alternatives that prevent placement in the first place.

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