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WORLD HEALTH ORGANIZATION
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ORGANISATION MONDIALE DE LA SANTÉ
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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

DEVELOPMENT OF PSYCHOGERIATRIC SERVICES IN EUROPE

Report on a Study

by

R.J. Daly
University Department of Psychiatry
Cork Regional Hospital
Cork, Ireland

and

Report on a Working Group
Cork, Ireland
3-7 October 1983

ICP/MNH 063
ICP/MNH 063(1)
WANG NO 5206F
UNEDITED
ENGLISH ONLY

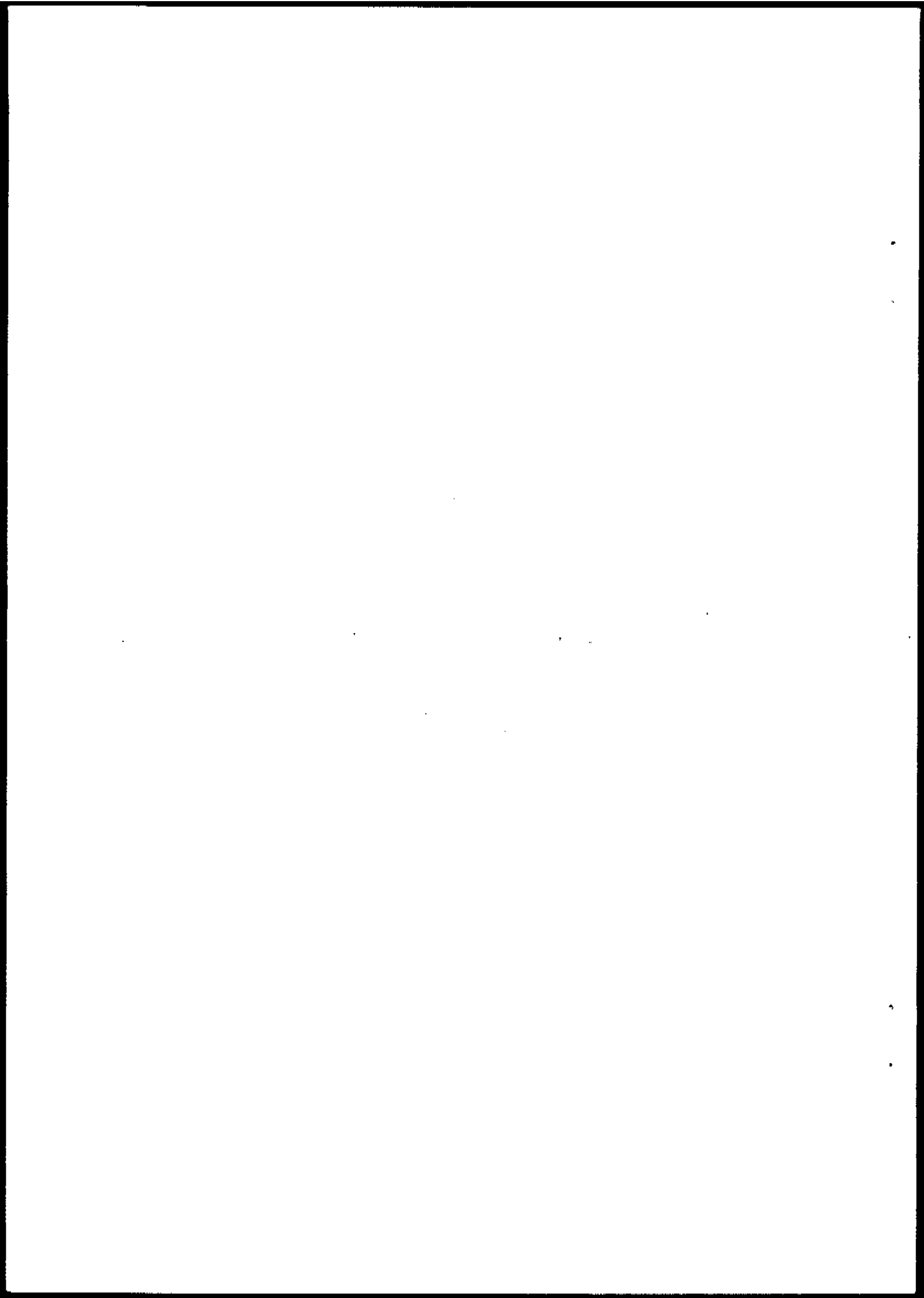
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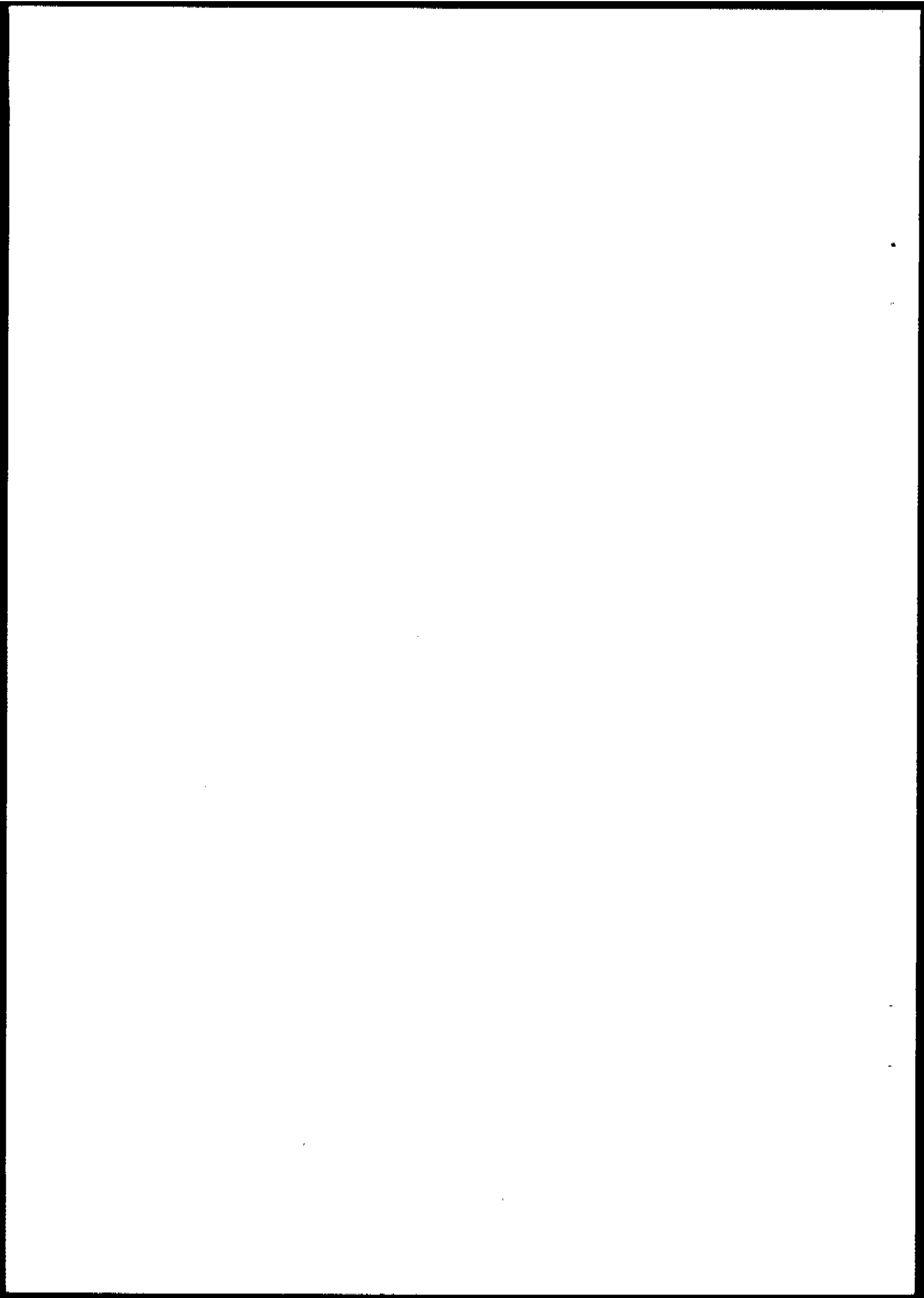
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This report is based on a review of some of the literature and on visits to units in Britain, Denmark and the Federal Republic of Germany by Professor R. Daly and upon the outcome of a WHO Working Group held in Cork in October 1983.



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THE WHO WORKING GROUP ON MENTAL HEALTH CARE OF THE ELDERLY
Cork, 3-7 October 1983.

This Working Group was convened as part of the WHO Regional Office for Europe medium term programme on mental health, to consider the mental health needs of the elderly in the European Region. The group was composed of 20 temporary advisers from 10 countries, including 7 from the host country, and 4 representatives of non-governmental organizations. Representatives for the WHO Collaborating Centre for Research and Training in Mental Health, Central Institute of Mental Health, Mannheim, Federal Republic of Germany and the WHO Collaborating Centre on Psychosocial Factors and Health, Belgium, also attended. The disciplines represented were geriatrics, gerontology, health administration, nursing, psychiatry and the voluntary field.

The purpose of the meeting was to advise on the development of comprehensive community based mental health services for old people and to prepare guidelines for the prevention and reduction of mental disabilities in the elderly.

A working paper commissioned by the Regional Office on the organisation of comprehensive community based mental health services for the elderly with mental disabilities provided an overview of issues and priorities for consideration and discussion by the group. In addition, eight working papers were presented together with a selection of background documents and publications pertinent to the scope of the discussions of the working group.

Members of the group outlined in a general way the organisation of services in their countries. All acknowledged the growing problem of very old people with mental disorders and the increased prevalence of mental disorder in the very old. Epidemiological evidence of this was given. A number of principal topics were highlighted for discussion and the final recommendations of the group are listed on page 26.

1. THE MAGNITUDE OF THE PROBLEM

In developed countries, particularly in Western Europe, there has been a great increase in the number of people, aged 65 and over who now comprise approximately 13-16% of the population. In the United Kingdom there are more than 7.5 million people aged 65 years or more; a third of them are over 75 years, and a further large increase is projected. The elderly have high physical, social and psychiatric morbidity and consequently make heavy demands on health and social services (1). In the countries of Europe several surveys have been carried out showing similar findings to those of Kay et al (2). It is estimated that approximately 5% of the elderly have severe psychosyndromes, 5% mild or early psychosyndromes and 3% have major functional psychoses, with 10% having neurotic and character disorders. Surprisingly only 5% of the total elderly are in institutions. Kay et al found that half of all dementia cases had progressed to a severity equal to that found in demented hospital patients, but fewer than one fifth were in hospital. Cases of depressive illness were in the majority and not receiving any form of treatment.

Approximately 25% of all referrals to all psychiatric departments are now aged 65 and over and include many of the more intractable problems. 10% of people aged 65 and over and 20% of those over 80 show evidence of dementia (3). In the United States approximately 25 million people are 65 years of age or older, and 80% of them reside in the community. 75-80% have no significant psychiatric symptoms, but 20-25% (6-9 million) require some form of psychiatric intervention. It has been estimated that in 25 years the number of elderly will double to approximately 20-25% of the general population, with the greatest increase in the older age groups (over 75 years). 85% of American elderly have at least one chronic medical illness and 50% have two or more medical conditions (4).

Senile dementia Alzheimer's Type (SDAT) is reported as the fourth leading cause of death in the United States and approximately 3% of the elderly currently suffer from this dementing process.

2. INFORMATION SERVICES

The Working Group in Cork considered that a wide range of information would be required for the economical deployment of scarce resources. However, in view of the need of financial stringency such information would need to be carefully selected. It could be collected under four headings:-

- i. Scientific research. Studies on the prevalence of mental illness have already been successfully undertaken in a number of countries and broadly agree. However, in the case of dementia there is little information available on incidence, on the outcome of recognised cases and the large number of so called mild cases. Longitudinal studies will be required to elicit this information. Such studies will require the use of standardized instruments for screening and the reliable recording of mental state and other data. It should be possible in the interests of economy for non-medical staff to undertake these interventions and for computer diagnostic systems to be applied. Such instruments are now becoming available.
- ii. Health Services. Much has still to be learned from case registers about the outcome of illness and the movement of patients between different facilities. Further data will also be required on manpower and other resources and economic data for cost benefit studies of experimental services. Special emphasis should be given to the different methodology of these and studies on the quality control of services including consumers and relatives satisfaction. The traditional statistical information on bed usage and patient flow should continue to be provided.
- iii. Communications. It will be necessary to continue to define technical terms clearly. For international comparative studies three areas need attention: the possibility of a glossary of general health terminology and of ageing itself and an international classification of impairment, disabilities and handicaps.
- iv. Education. The training of both professional and non-professional workers will require an evaluation of their needs and the preparation of suitable training programmes. In some countries little instruction is given on ageing to doctors and nurses or to staff working with old people in other settings. This situation will need to be improved. The types of information needed for training of voluntary workers will also require consideration.

An example of an educational innovation lies in the quite unique Department of Health Care of the Elderly in Nottingham University. The Professor of Health Care of the Elderly was appointed in 1977. The Department is at the new University Hospital and there are two academic wards, one medical and one psychiatric. The Professor of Health Care of the Elderly, appointed in 1977, is a psychiatrist, but the post could well have been held by a physician, orthopaedic surgeon or another doctor with a special interest in the elderly.

Working with the Professor are two senior lecturers, one psychiatric, the other medical and their supporting medical and teaching staff are in parallel with senior registrars and two lecturers. Doctors in general professional training in internal medicine, psychiatry and general practice rotate through the unit. The department has a part-time psychologist, two social workers, a health visitor, a community nurse, remedial therapists and a demographer/research officer.

The Department is a unity, but their services are differentiated and the roles of psychiatrists and physicians are not inter-changeable. Nevertheless, they closely collaborate, perform joint ward rounds and look after patients in each other's wards.

The team feel that the joint enterprise is necessary because disorders of the elderly, particularly the very elderly, are mixed and do not fall into neat compartments. Also they point out that care should be afforded where needed rather than compartmentalised. There is the added advantage that admissions occur through a single point of entry and sorting out can occur in a flexible manner thereafter. Lastly, there is a considerable advantage from the point of view of continuing education, vocational training, under-graduate teaching and research.

It was pointed out that in the Federal Republic of Germany, only in Berlin (West) and Heidelberg were there special university departments of psychogeriatrics, and this meagre provision is reflected elsewhere in Europe.

3. PUBLIC AND PROFESSIONAL ATTITUDES TO THE ELDERLY WITH MENTAL DISABILITIES

All psychiatric services are affected to a greater or lesser extent by the problem of stigmatisation of the mentally ill. This is especially so for the elderly whose status has already been eroded by social change.

A WHO Working Group (Behavioural Studies Related to Care of the Aged) (5), concluded that much more information was needed on:-

- (a) attitudes among the general public (including the elderly) towards elderly people;

- (b) attitudes of care givers;
- (c) behaviour of other groups towards the elderly;
- (d) different approaches and methods of changing attitudes towards the elderly, both among the general public and professionals.

They concluded that a wide range of studies was required related to the above. These included the formation of attitudes and levels of knowledge about the topic of the elderly etc. It was suggested that their recommendations should be implemented urgently.

An apparent and universal need is the development of an integrated scheme of education for old people, their families, and the lay public, so that maximum use is made of the knowledge already available on the health, care and well-being of the elderly; and, in particular, so that people can benefit from primary and preventive health care programmes. The mass media should be involved in educational activity for the general public.

Educational programmes for health professionals should also be reviewed to ensure an adequate gerontological content at both pre- and post-graduate levels. "Action-research" programmes directed towards (a) maintaining the integration of older people in their home environment for as long as possible and (b) the development of planning for health and social care programmes for the aged should be initiated. The implementation of the results of this research and planning should be actively encouraged. Behavioural sciences could make further studies of the functional capacity of the elderly to work and learn and cross-cultural studies should be conducted to give a better understanding of the positive and negative aspects of the processes of aging in different societies and cultures.

Programmes ought to be developed to identify and to respond to the needs of families and others who provide support while in the planning of national programmes for the improvement of the quality of life, care for older people should be an important priority.

4. DEVELOPMENT OF SERVICES

Whilst there is now clear and widespread epidemiological evidence of the rising numbers of old people with mental health problems and particularly dementia, the response of many countries has been uncertain and tentative. This is compounded by the present serious economic problems affecting service development generally. That these difficulties are likely to continue for some time to come emphasises the urgency of formulating an overall strategy for the creation of short, medium and long-term plans. The problems of the elderly mentally ill must always be seen in the context of services for the elderly in general with which they must be closely integrated. In that sense there is a need for an acceptance and understanding by all agencies concerned, and in particular by health and social services, of the unique and growing problems which the developing epidemic will bring. The primary care and psychiatric services have a special role to play. It is clear that the extent and perception of the problem varies from country to country and it is evident that no clear blueprint can serve the differing organisations and resources of different countries.

For these reasons the Working Group felt there is an urgent need for the preparation by each country of a coherent national strategy for the development of mental health care services for the elderly. This should take account of the following key items:-

- A statement of present and future need based on demographic and epidemiological information.
- An analysis of the likely needs of the elderly and the capacity of existing services to cope with demand.
- A proposal for how a comprehensive range of services may be jointly planned and operated. Comprehensive services should provide for prevention, early detection, assessment and treatment and care in various ways. They will contain many elements of service from health, social service, housing, voluntary and other sources.
- Recommendations for how educational and research strategies may be developed to promote good practices and seek innovations in service delivery.

A National strategy might best be drawn up by central government appointing a group of experts representing the major professional, administrative and lay interests. Present structural differences in the organisation and delivery of services must not prevent the development of such a

strategy. The varied needs and problems of the elderly mentally ill present the most positive reason for new approaches and new professional relationships.

5. TREATMENT OPTIONS FOR THE ELDERLY MENTALLY ILL

Too often in the past the care of the elderly mentally ill has involved considerable and prolonged inactivity. Miller (7) suggested that such immobilisation of the elderly resulted in adverse physical and psychological phenomena including anorexia, malnutrition, weight loss, worsening of psychosis and depression, fear and panic, exacerbation of organic brain syndrome, loss of ability to speak coherently, regressive behaviour, social withdrawal, eating problems, contractures, decubiti, incontinence and stupour. He suggested that all of these symptoms were reversible with prompt and appropriate treatment. Similarly, sensory deprivation occurs particularly in the elderly living alone. The symptoms of social isolation and sensory deprivation simulate senile dementia and are frequently diagnosed as such. Butler & Lewis (8).

5.1 Residential care

An example of therapeutic optimism was seen in a nursing home in Munich which formerly held 600 inmates, looked after by the St. Vincent's Sisters. The orientation was a home for the "incurables waiting for death". The numbers had now been reduced to 300 with 36 patients in the closed geronto-psychiatry rehabilitation area. In addition there were 70 nursing beds and the rest of the patients were in apartments. They were visited by a nurse each day and each nurse had to visit 36 patients. Physiotherapy plays a major part in the care of these patients. Considerable effort is made to involve relatives in visiting. In addition some of the inmates are given jobs within the establishment. There are seven elderly couples living in the nursing home. In the apartments the nurse is familiar with the plan for each of the patients. The patients generally choose their own doctor who visits them in the nursing home. However, in the nursing beds, a doctor visits three times weekly for a two hour session yet the attendants felt that more time was needed. A neuropsychiatrist also visited the nursing home together with an eye doctor and there was also a dental clinic. There is an in-service training programme operated for the staff but the rapidly changing staff produces something of an educational problem. The senior nurses carry out the training programme but in the closed area there is a training session (with a psychologist) on the theory of illness and on psychotherapy. The chief nurse explained that she often began programmes without having sufficient money but found that she was always able to get it on the merits of the programme. There are in total 130 staff for 320 patients. The average age of the patients is 85 years and in the closed areas, 79 years of age.

The nursing home visited had an orientation of "reality therapy", with considerable emphasis on pictorial messages, improving feeding habits, making sure people wherever possible were surrounded by their own furniture; the aim was rehabilitation to self-care. The enthusiasm of the nurses in charge was manifest in the quality of the rehabilitation unit and the improvements being carried out throughout the entire nursing home. A positively optimistic approach employing this reality therapy and emphasising self-care and attention was practised. Throughout the rehabilitation unit there were clocks, mirrors and signs which help orientation in time and place. A strong positive effort was made to reduce medication for the patients.

Nursing activities were highly organised via a nursing plan work board with definite assignments for each patient and nurse.

5.2 Sensory stimulation

There have been many reports of the efficacy of sensory stimulation for the prevention, maintenance and treatment of old people, and these have been reviewed by Shaw (10). She felt the programmes reflected "a curious optimism". There was general agreement that therapeutic programming should not be prematurely abandoned and that attainable goals should be set. Shaw also emphasised the importance of touch, since the elderly become "touch hungry". Some would suggest that the demented elderly can perceive touch as indicating a caring attitude.

5.3 Group work

It appears that almost any type of group work can be psychosocially beneficial in the sense of improving behaviour and enjoyment for the patient as well as being cost effective Shaw(10). While the rationale for group workers is eclectic, the group should provide an empathic atmosphere where the individuals can be stimulated and encouraged to use their faculties. Behaviour modification and "reality" approaches are both advocated. All of the centres visited practised group therapy or group work with their patients.

5.4 Medication and the elderly mentally ill

Thompson et al (11) point out that in the United States of America persons over 65 years now make up 11% of the population, but receive about 30% of all prescriptions. It was suggested that almost 70% of elderly patients regularly used over-the-counter medications as compared with 10% of the general population. About 55% of over-the-counter preparations account for at least 40% of all drugs used by the elderly. They also receive a disproportionately large percentage of psychotropic medication.

Physiological changes in elderly patients lead to pharmacokinetic differences. Thus changes in distribution and elimination of drugs alter plasma concentrations, prolong half lives and lead to a higher percentage of unbound metabolically active substance.

They advocated careful screening procedures before use of psychotropic medications in the elderly. Thus a careful history was required to exclude physical causes of apparently psychiatric symptoms. The doctor should determine if a current medication causing the psychiatric symptom and previous exposure to psychotropic medication should be enquired into. A physical examination should seek evidence of neurological, renal, hepatic or other medical illnesses. The mental state examination should seek evidence of psychiatric illness of recent onset or evidence of dementia or delirium. Laboratory studies should seek evidence of hepatic and renal function and careful watch should be kept on possible drug interactions due to prescribing.

In general psychotropic medication should be prescribed at 30-50% of the doses appropriate for younger patients and the duration of treatment should be carefully watched.

Antianxiety medications are often required in the elderly, but benzodiazepines should only be prescribed for short term relief of anxiety and psychotherapy or counselling was the treatment of choice. Benzodiazepines with a short half life are preferable and barbiturates should be avoided.

Where hypnotic medications are needed they should be prescribed only for short periods of time. Benzodiazepines with a short half life had advantages, but again barbiturates were unsuitable as were antihistamines.

Shamian (12) points out that major tranquilising medication is often required in the elderly, but is hazardous because of the common and often serious side-effects such as orthostatic hypotension, sedation, extrapyramidal symptoms, blurred vision, dry mouth, urinary retention and confusion. He also points out the danger of missing the effect of atropinic psychoses caused by the anticholinergic side effects of the antipsychotic agents. This often worsens the psychosis whereupon even more medication is prescribed instead of a reduction.

Tardive dyskinesia is often missed in the elderly or is incorrectly diagnosed because of poor dentition. Even in relatively small drug doses, orthostatic changes can occur causing falls in the elderly with serious complications such as fractures and subdural haematoma.

Antidepressant agents are often indicated for the treatment of recurrent episodes of depression as well as treating symptoms in the initial stages of SDAT (senile dementia, Alzheimer's type).

Lithium may be used safely in the elderly, although geriatric patients appear to be more susceptible to its side-effects and are helped by lower than normal serum levels.

In summary, many elderly people have functional illnesses, other than dementia, which should be treated by, inter alia, psychoactive drugs. High suicide rates underline the importance of early and adequate intervention. Smaller doses of psychotropic medications are required. Polypharmacy decreases compliance and drug interactions are common occurrences in the elderly. Psychotherapy should be considered seriously as an alternative to psychoactive drug prescription. Multiple utilisation of services, overlapping of medical care provision, inadequate continuing education of staff and poor communications, all contribute to this ubiquitous hazard for the elderly.

The WHO Ninth European Symposium on Clinical Pharmacological Evaluation on Drug control was held on the topic of the control of drugs for the elderly (13). The Report was directed towards the drug regulatory agencies of the member states. The recommendations included the following:-

- (1) They suggested there was no longer a place for the category of remedies alleged to provide relief for the symptoms of ageing, since they are likely to be entirely ineffective.

- (2) There was a particular need to evaluate drugs from the point of view of their effects in elderly subjects.
- (3) Treatment adherence problems are common, therefore:-
 - (a) it was suggested that the regulatory agencies should ensure that, wherever possible, any drug likely to be used by an elderly person was packaged and labelled in such a manner that it was easy to use by the old person.
 - (b) Education of doctors should be undertaken to ensure that they understood the problem of prescribing for the elderly in order to avoid multiple prescriptions and anticipated compliance problems are now altered to drug responses.
 - (c) The elderly should be better informed about the proper use of drugs at their stage of life.

5.5 Psychotherapy services for the mentally ill

For most authors psychotherapy has a low priority amongst suitable treatments for the elderly mentally ill, e.g. Pitt lists it even lower than Leucotomy (14). This is somewhat surprising in view of the enormous literature on ill-effects of pharmacotherapy of the elderly. Sparacino (15) points out that while elderly individuals are still under-represented in facilities providing psychotherapy services, interest in psychotherapeutic intervention with such patients has gradually risen. The literature suggests that descriptions of psychotherapy have generally been global and that research reports, while collectively pointing to the feasibility of individual psychotherapy, have been infrequent and methodologically weak. In fairness it should be remembered that this might be said of psychotherapy for all age groups.

The Group for the Advancement of Psychiatry (16) refers to the negative attitudes towards treating the elderly. Among the reasons for a nihilistic attitude were:-

- (1) The stimulation of therapists' fears regarding their own eventual old age;
- (2) therapists conflicts about their own parental relations;
- (3) a feeling of impotence stemming from a belief in the ubiquity of untreatable organic states in the elderly;
- (4) desire to avoid "wasting" their skills on persons nearing death;
- (5) fears that an aged patient may die during treatment; and
- (6) desire to avoid colleagues' negative evaluation of efforts directed towards the aged.

Franz Alexander (17), an early writer on the topic, recommended the use of supportive approaches where no insight was sought, i.e. offering guidance, reassurance, dealing with the patient's sense of inferiority and off-setting guilt through permissive attitudes.

Sparacino (15) has pointed out that most reports concerning psychotherapy with the aged fail to use any measures of outcome or efficacy. Very often the techniques are described in the most general terms and the studies would be impossible to replicate. Nevertheless, most reviews are optimistic about the importance of considering psychotherapy for elderly patients. Butler & Lewis (18) point out that the elderly quite spontaneously review their lives in a manner analogous to psycho-therapeutic activities. The elderly express a more acute sense of time, and a need to focus on the present more than the future. They point also to the value of even very brief individual or telephone contacts for therapeutic encounters. It would be wrong to rule out individual psychotherapy for the elderly on false premises such as the often described personal rigidity of old people and lack of cost benefit justification.

An example of measuring efficacy of psychological treatment was shown at the Department of Psychiatry, Free University of Berlin. They have been involved in a pilot study funded by the VW Foundation comparing two groups of elderly patients with and without client centred psychotherapy.

5.6 Day care

Arie (19) suggested that "the main function of day care in geriatric psychiatry is as a long-term, indeed one might almost say a permanent - supportive facility for patients with chronic psychiatric disability". However, Greene & Timbury (20) felt a more pessimistic attitude was

required. In a five year review of a day unit it was found that its main function had become that of providing an immediate short-term supportive facility to demented patients, mainly in the 75 years and over age group, and to their relatives, until such time as beds in the long-stay psychogeriatric wards of the hospital became available. Thus the role of the Day Hospital had not really been to avoid admission, but rather to cope with the inadequacy of provision of long-stay geriatric psychiatry beds. In view of this role of helping the families to cope with their demented elderly they felt that the day hospital had to be developed in a wider context which would include improved transportation to the day hospital, week-end opening, "night sitter" services at home, greater use of reality orientation and other behavioural interventions and the dispersal of day hospitals into the community they serve rather than concentrating them in the grounds of psychiatric or other hospitals.

Ross (21) has demonstrated that the cost of providing good quality day care for the elderly is considerably higher than that of providing accommodation in a geriatric hospital or a residential home. Greene & Timbury emphasised that not only financial considerations should determine the planning of services, but also social, psychological and humanitarian advantages for the elderly had to be considered.

All of the centres visited had day care facilities or day hospital services for the elderly mentally ill. In the Department of Geronto-Psychiatry at the Free University of Berlin, there are 12 to 15 places in the Day Hospital with a three months average stay. It is staffed by one male nurse, one psychiatrist in training, one occupational therapist and one social worker. There is a shared physiotherapist who also works in the polyclinic. Many of the patients referred to the Day Hospital and polyclinic have been in-patients in the Klinikum Charlotenburg or other psychiatric hospitals prior to their referral for aftercare to the psychogeriatric unit. The unit has no beds of its own and if patients require in-patient care they are referred to psychiatrists running the general psychiatric in-patient service, i.e. a different team. The large mental hospital has a catchment area; the psychogeriatric department does not, and most patients come from close-by. The sex ratio is 20% male and 80% female. This, Professor Kanowski explained, as being partly due to survival and widowhood, but also there seemed to be a bias against males accepting psychiatry and there was a strong stigma for them. They were willing to go and see general practitioners and medical services other than psychiatry.

At Department "O", Amtssygehuset Nordvang, Copenhagen, the Day Hospitalisation is provided for in two wards, and one of the wards is purely for day hospital patients. It was feared that by early 1984 the day hospital might have to stop functioning because of cuts in expenditure on transporting patients by taxi (300 Danish Kr. per day per patient).

At Northwick Park Hospital, Harrow, many of the at risk population are already in day care and because of this the level of out-patient follow-up is not high. There is a Community Psychiatric Nurse and the catchment area is approximately five by four miles. Day care facilities for functional illness are integrated with those for other age groups and provided on site in the psychiatric unit of the District General Hospital. There are approximately 80 or 90 patients of all ages in the day hospital, including the elderly with functional illness. The day care facilities are "tiered" for segregation particularly for example for dining, so that those who are unsuitable for integration with others can be treated separately. There are approximately 12 in-patients and 15 day patients under the psychogeriatrician's care and a quarter to a third of patients over 65 in the day hospital are so integrated. Shared facilities include occupational therapy and many of the elderly require domestic re-training which is also shared. The day care facilities are used as a primary source of admission or as a stepping stone to discharge of those in in-patient care. Approximately half of the day patients have been in the in-patient ward and half admitted directly. There are very few neurotic patients in the day hospital. The small number of neurotic patients include the elderly disabled for example with severe phobias. In addition, the local authority provides day care facilities (approximately 50 places) at a day centre at which the psychogeriatrician consults. These are mostly for the chronically handicapped and this facility will admit chronic dependent patients, mostly the elderly living alone.

There are also local authority work centres totalling 50 places. These were started on a voluntary basis but later taken over by the local authority. Many of the patients or clients are stroke or ex-psychiatric patients not needing psychiatric supervision. A meal and transport is provided and it appeals particularly to men who find the ambience of the ordinary day centre unacceptable if they have been doing physical work during their lives. It is especially useful if there is conflict with the family.

There are, in addition, local authority residential homes all offering some day care. The day care provided in the residential homes is usually for the elderly within walking distance and people at risk by reason of physical or mental frailty. These facilities at present have no organised day programme and provide social relationships only, but the consultant hopes to extend the level of day programme to these facilities in the future.

There is special day care provided for the elderly confused. It is felt that when day care is shared between different categories of diagnoses, provision should be made for segregation because of the danger of the ambience being unacceptable to the functionally ill.

There is a specialised day centre for the elderly mentally ill provided within a few miles of the in-patient unit, the Herga Centre. It was originally provided in rundown premises on the site of a war-time delousing centre. Joint funding monies between the health services and local authority services were used to provide capital to build the present purpose-built centre which is a particularly useful resource. All referrals are carefully assessed with physical examinations, laboratory and psychiatric assessment. There is a strong emphasis on working with the family and most of the patients (three-quarters) live with another carer. Most of the clients are handicapped with dementia, but there are others, approximately half, who live with a similar aged spouse, three-quarters being over 75 and two-thirds over 80. It is the base for a relatives' support group and the facility provides a break of approximately five to six hours daily which is important since most have a disturbance in their relationships with relatives. The Respite Service is provided through the local authority, the geriatric department or the G.P. beds in the Cottage Hospital (20 beds). All beds are thus used for this service. With regard to appropriateness of admission, all effort is made to direct patients to the most appropriate beds. If they are confused and pleasant they are admitted to local authority residential care. If they are "irritating and difficult" they are sent to the psychogeriatric beds, and if they are "frail" and have medical illnesses (such as Parkinsonism) they are sent to the G.P. beds or geriatric beds. There is also planned relief care for emergencies or planned holidays of relatives. There is a problem in the sense that there is a morbidity and mortality attached to residential care and also the risk that the family will not take the patient back, but this is rare.

With regard to the terminology of "day centre" versus "day hospital", approximately half of the patients are categorised as day centre patients. The patients with less severe disturbance are encouraged to attend to improve the level of the milieu and to encourage the most disturbed elderly patients. It is felt that the severely dysphasic and dyspraxic patients would be discouraged if they were segregated. Only a minority have severe apraxia and approximately half have adequate social skills. The mixture of the two groups facilitates occupational and recreational activities and the less severely disturbed provide behavioural models for the more severely disturbed. It is found to be appropriate to send the functionally ill chronic psychogeriatric patients to the local authority day care services, and psychiatric day care services for the confused severely ill chronic patients. This arrangement is felt to be appropriate since the highest physical morbidity occurs in the latter group and a better track can be kept of their medical progress via the medical case conference review; thus a more rapid response can be provided than in the local authority conference.

Attendance allowances are an important component in helping the families to keep patients at home. These are non-means-tested and amount to 17 to 18 pounds per week (day time) and 23 to 24 pounds per week (for day and night care) and are provided under social security. It helps particularly to enable relatives e.g. to afford a taxi three times weekly, to send the relative to the day care centre. "Voluntary" cars and ambulances are also used for this purpose. The disturbed individuals are provided with a nurse escort in the ambulance or taxi.

6. TRAINING AND MANPOWER CONSIDERATIONS

It has been pointed out that in the past many leading centres of medical education looked on the teaching hospitals as the only source of patients of educational interest and value (22). This resulted in the chronically disabled receiving poor representation in the population being used for teaching. Similarly, preventive aspects were also neglected as was work in the community. Amongst those most neglected were the elderly, particularly regarding aspects of care of the elderly with mental illness.

Cohen et al (23) suggest that in view of the difficulties of overcrowded curricula that post-graduate trainees in psychiatry should have a brief clinical rotation of working with the elderly mentally ill. They felt that although this was not the ideal way of imparting geriatric psychiatry skills, it was an effective use of limited time to improve the psychiatrists' approach to the older patient.

Recommendations concerning organic mental impairment in old age were published in the July, 1981, Journal of the Royal College of Physicians of London. They emphasised that every physician must be capable of doing a mental assessment and every trainee must also get this type of training. It is particularly important for G.P. trainees.

It appears that until recently very little was provided in the way of training for nurses in emotional problems of the elderly.

The teacher of psychiatric care of the elderly mentally ill faces a daunting task. Brooke (43) has pointed out that many of the psychiatric trainees in his survey would prefer to emigrate than work in psycho-geriatrics. But there are encouraging signs that this is changing, at least in the United Kingdom. (Wattis et al (24)).

At the Technical University of Munich, besides the Professor and Chairman of the Department there are 14 doctors, a) two Associate Professors, b) two trained psychiatrists, and c) ten post-graduate trainees at various levels of training and experience. There are two psychologists, three occupational therapists, one and a half social workers and 24 nurses. It was explained that this level of staffing was unusually generous and in keeping with the University Department's responsibilities. Two of the psychiatric staff were completely taken up with the liaison service which has a special responsibility for the Toxicological Unit where 700 suicide attempters are trained each year.

Formerly there was only an option to become a neuro-psychiatrist. This involved:-

- (1) Two years neurology.
- (2) Two years psychiatry.
- (3) Two years in a relevant professional subject.

Now the usual form of training is to get three years training in psychiatry and one year's training in neurology or three years of neurology and one of psychiatry to become a neurologist.

With regard to psychogeriatrics this is not compulsory, but it is expected that a person presenting himself for the qualification of being a psychiatrist would have had such experience. It was estimated that in most University Departments the percentage of patients over 65 years old would not be higher than 8-9%. The doctor working in the University clinic can only stay for two years because of the number of beds, after which time he must seek a post elsewhere for other experience. There are approximately 200 applicants each year for new posts and it is extremely difficult to find suitable training experience.

At the Department of Health Care of the Elderly of the University of Nottingham, the emphasis on the unit is on teaching, particularly on altering attitudes of undergraduates and doctors in training. It is significant that there were 14 trainees in the department, three psychiatric and eleven medical. Between psychiatry and geriatrics, there were four general practitioner trainees. There is a total of five university doctors. As well as the Professor, there is a senior lecturer and lecturer on both the medical and psychiatric side. Therefore, the team concentrates on special issues applying to the elderly including organizational and social problems along with clinical ones. The undergraduate medical teaching is centred in the clinical years when all undergraduates spend a month's full-time attachment in the Department. They are offered a course of three components:-

- (1) A traditional clinical apprenticeship to the department and all its aspects both inside and outside the hospital.
- (2) Systematic teaching.
- (3) The opportunity to learn a particular topic in depth with a tutor leading to the preparation of a report at the end of the course.

As regards Post Graduate teaching in Nottingham, trainee physicians, psychiatrists and general practitioners rotate through the department usually for a period of six months. Thus the department has no fixed staff in these grades. The belief is that doctors should not specialise at the general professional training phase in their careers. Because of its reputation the unit attracts large numbers of visitors from outside Nottingham and from abroad.

The Working Group in Cork felt that educational and training programmes for the wide range of people, both trained and untrained, who provide and work in services with the elderly with mental illness are essential. By providing a framework for understanding and learning they heighten personal commitment, confidence and ability. The feedback of information they provide promotes better services and facilitates the monitoring and evaluation of them. Meeting the mental health problems of the elderly calls for special knowledge and some countries have developed specialised services for mental illness in old age in the context of existing mental health and general medical services. Caring for very old people is often seen as a low prestige and low priority area and there is value in the differentiation of specialised services for them. By this means a body of skill and knowledge is built up and this becomes codified in principles of good practice. These form a basis for practical and effective education and training programmes.

Most long-term care of the elderly is provided by relatives or by untrained staff. Their contributions and those of voluntary workers are enhanced where professional staff offer education and training services as well as active intervention where necessary. Where there are insufficient trained people to provide direct care services for all who need them, their expertise should be used as a source of consultation and training for others. Good services have a high philosophy of care, good staff ratios and growing knowledge sharing systems.

The spreading of knowledge through education must not be confined to carers and professional workers with the elderly. Education must also be aimed more widely in order to secure both public and political awareness and concern. In this way society and its leaders will come to recognise the problems and the possibilities and consider its responsibility towards its older members.

With regard to manpower, with the exception of the U.K., very few countries have many full-time psychogeriatricians. Wattris et al (24) suggested that in Britain by 1980 there was a core group of "psychogeriatricians numbering about 106, 39 of whom were working full-time with the elderly, 52 more than half-time, and a further 15 were running clearly defined psychogeriatric services". They estimated that there were additional psychiatrists on whom information was not available who might provide a total of at least 120 consultant psychiatrists providing special psychiatric services for the elderly. More than half of their respondents had started this work in the five years preceeding 1980. They felt that proper training and improvement in services might be facilitated by the formal definition of psychogeriatrics as a new sub-specialty of psychiatry.

7. PSYCHIATRIC CONSULTATIONS FOR THE ELDERLY

While the model of provision of services under the direction of a specialist psychogeriatrician continues to gain ground in the U.K., other European countries and the U.S. are unlikely to adopt this pattern, particularly when manpower expansion cannot occur for economic or other reasons. Krakowski (25) has emphasised that the general hospital liaison service is an appropriate model for provision of psychiatric consultation for the elderly. He suggested that the doctor, irrespective of specialty, needs to be reminded of the psychosomatic truism regarding the multicausality of illness before he becomes useful to his elderly patients".

He pointed out that the psychiatrist is under-utilised in out-patient care because emotional illness is frequently denied by the family for reasons of group adaptation and family homeostasis, or because the family tries to avoid psychiatric treatment to protect the parent from the stigma of mental illness. Additionally, elderly patients are unwilling to accept the stigma themselves of being seen by psychiatrists.

Like Krakowski, Lipowski (26) drew attention to the need to integrate liaison psychiatry and gerontopsychiatry. He pointed out that about 30% of medical and surgical in-patients were 65 years or older and accounted for about 30% of referrals for psychiatric consultation. The author therefore suggested that liaison psychiatrists should take over the role of psychogeriatric consultants in general hospitals and that joint training should be provided for the psychogeriatrician-liaison psychiatrist. Krakowski suggested also that there was a similar reluctance to refer the problems of management of terminal patients and the dying to the psychiatrist.

It is certainly true that in the elderly patients with dementia, much physical illness is hidden. A British Medical Journal Editorial (27) highlighted the need to detect silent physical illness in elderly patients who often did not communicate their symptoms. Such detection helped them maintain physical independence at home, minimised the amount of help and services they required, reduced the load on relatives by improving their behaviour and avoided and deferred the need for chronic institutional care.

8. DIAGNOSIS AND ASSESSMENT

Miller (28) reviewed the psychometric tests and associated techniques which may be used in the diagnostic assessment of dementia. While these may contribute to the overall differential diagnosis he warned against the use of psychological criteria as the sole grounds for a diagnosis of dementia. Nevertheless, Naguib & Levy (29) found that in a follow-up study for a mean period of 28.78 months comparing deceased (27) with survivors (12), the survivors had significantly better performance on a number of clinical and psychological tests, particularly those involving speech functions and constructional ability. Using computer tomography (CT) they found that measures of radiological density were significantly lower in the right parietal region of the original CT scans of those who subsequently died. They felt that a more directly quantitative approach to computed tomography might yield results which were more useful than those obtained from visual reconstructions.

With the possible development of such techniques (30) coupled with existing demands to improve the accuracy of assessment of the elderly, it seems likely that assessment units must continue to develop in association with major medical facilities.

Kaprio (31) has pointed out that over the last hundred years the total health care system, including primary health care, has evolved in parallel with social and economic development reflecting not only advances in medical science but also the wishes of the population. There has been an over-emphasis on sophisticated hospital based care often to the detriment of primary care.

In a report entitled "Services for the Elderly with Mental Disability in Scotland" (6), it has been pointed out that the general practitioner is the key figure in domiciliary care programmes. It is assumed that he provides not only primary care for illness but also surveillance for those needing help but unable to seek it. He may thus be aware of other needs and may meet these by providing appropriate referrals to Social Work Departments, Domiciliary Nursing Services and Hospitals. In Scotland the number of single handed general practitioners has declined in recent years with emergence of group practices in centralised premises. The proportion of G.P. consultations required by the elderly has remained high and the proportion of these carried out in the patient's home has also remained high, increasing with increasing age. In addition Health Visitors attached to the practices routinely visit the elderly quite frequently on behalf of the primary care team. District nursing services have a higher rate of visiting to the elderly, but it is feared that they will not be able to keep pace with home nursing demands on the elderly. A major problem arises for the primary care team in those elderly patients who are out of touch with relatives. Here the onset of mental disability may not be detected early enough to enable appropriate action to be taken and the delay often results in institutionalisation. It is often alleged that domiciliary care has economic advantage over residential care. But the Report points out that, for the elderly with high levels of disability requiring constant support by a number of agencies, there is no revenue cost advantage in domiciliary care.

Boyd, Woodside and Zealley (32) feeling that satisfactory data on domiciliary visits were not available reported on the characteristics of 100 elderly patients seen on such visits. The most common reason for general practitioners requesting a visit was disturbed behaviour such as aggression and violence (25%), being confused or deluded (29%), and wandering out of house (9%). Only 8% of domiciliary visits were requested because of depression and other psychiatric crises, common in the younger age groups, such as suicidal attempts or alcoholism accounted for only 5% of requests. Approximately 70% of their domiciliary visits resulted in a diagnostic classification of dementia for confusional state or paranoid reactions, while 14% had affective disorder and 2% alcoholism. The remaining 15% received no psychiatric diagnosis.

The authors questioned the value of psychiatric consultation when the diagnosis is often so obvious and where some of the patients could have been looked after very effectively in an old folks home if only the places had been available. Earlier and wider use of community services, particularly Home Helps, could have alleviated a great deal of stress.

They were particularly concerned at the danger of the Mental Health Act being misused to forcibly admit elderly mentally ill patients because the family doctors often saw hospital admission as the only way to ensuring adequate care and friends and neighbours insisted that "something must be done".

Krakowski (25) reported an extensive study of geriatric referrals from within the general hospital population. These referrals came from internists and family practitioners. The diagnoses by the referring doctors were usually correct with the exception of psychotic depression often being mistaken for dementia. The author suggested it was "unfortunate that some primary care physicians still centre their attention mostly on their respective areas of competence and accept the psychic part of the illness as a bad necessity". He found that referrals occurred primarily when behaviour became disturbing and that organic causes and functional disorders were underestimated. Furthermore, psychopharmaceutical agents and vasodilators were overused while psychotherapy and other forms of treatment were underutilised. He suggested that attitudes towards consultations amongst these patients and their families and consultees did not differ from those of younger groups. He concluded that liaison psychiatry was well suited to the needs of psychogeriatric referrals.

Godber (33) drew attention to the need to improve the training of general practitioners and the recognition and treatment of psychiatric disorders, particularly depression in the elderly. He felt the major priority was for increasing the preventive approach through screening the very elderly and those with particular risk factors. He felt that this could best be achieved by training primary care nurses to carry out such tasks.

The Working Group felt that since the great majority of people live at home, often alone and psychiatric disorder plays a major role in their morbidity, all necessary statutory as well as voluntary services should be available at the primary care level in order to provide the domiciliary support they may need. Such a prospect demands that between the primary care workers and those in the specialist services a joint working relationship must be carefully organised and managed in order to strengthen and enhance their inter-dependence.

Most primary care services are based on the concept of a multi-professional team working in the community. Here the general practitioner is sometimes the most important professional contact, often the first point of contact and generally deals with most problems. However, the local policy should provide for specialist health or other staff to visit the old person's home when necessary. Self-help groups and other structured means of providing counsel and support are an important adjunct to the range of domiciliary care and provision outlined in Organisation of Local Services. With this emphasis on domiciliary care for mentally ill elderly people the needs of the family supporters and other carers must also be taken into account.

Whilst the abilities of old people are often underestimated, careful decisions must be taken to ensure that scarce resources are not used unreasonably in attempts to maintain in their homes, those very old people with dementia who live alone. It may be better to admit them to residential care and this must be available for those who cannot continue to be cared for adequately at home.

In the Northwick Park Hospital Catchment Area of Harrow, the majority of patients are known to the social services and although the psychogeriatric team has a psychiatric social worker the locally based local authority workers are encouraged to follow their patients. Only where there is a severe problem is the patient referred to the psychiatric team social worker. The day centre conferences and meetings provide a review forum for exchange of information. The general practitioners are also encouraged to follow the case and no prescribing is carried out in the day centre. There is a "psychiatrically trained G.P." working part-time in this day unit; the general practitioners are regarded as the primary care givers in this psychogeriatric service. The G.P.s are kept closely informed and given advice in the care of their patients.

Another example of close links with primary care is seen in Department "O" of Amtssygehuset, Nordvang, Copenhagen. The County Hospital had three catchment area teams for adult psychiatry. All the teams provided services for the elderly mentally ill in different ways. But only in Department "O" was there a "special psychogeriatric team". The team consists of a district nurse trained in psychiatry, a social worker and a psychiatrist.

Department "O" has two wards for the elderly with 18 or 20 beds in each, i.e. 36 beds for patients aged 65 and over. Exceptionally some younger cases are taken into this service, e.g. with SDAT. 18 of these patients had finished their treatment and were awaiting a placement in nursing homes which are at present unavailable. Six beds were available for current treatment of new cases. There were numerous nursing homes throughout the county and also day centres and sheltered housing. Patients are referred from neighbouring hospitals, from general practitioners and psychiatrists working in the community. All of the elderly mentally ill from the catchment area are sent to the Department "O" Team from the north of the county and the Island of Amegan, forming a catchment area of approximately 600,000 people (it is estimated that in 1984 the population of the county and city of Copenhagen would be approximately 1.7 million). Domiciliary visits are frequently carried out by a team of three, (psychiatric nurse, psychiatric social worker and the doctor). Approximately 60% of the patients reviewed at home area treated at home.

9. COMMUNITY CARE OF THE ELDERLY MENTALLY ILL

The WHO Report "Psychogeriatric Care in the Community" (34) listed the following possible range of community services:-

- (1) A visit from a psychiatrist.
- (2) A visit from a social worker.
- (3) A visit from a health visitor.
- (4) A visit from a psychiatric social worker.
- (5) Home nursing care.
- (6) Suicide prevention.
- (7) Alcoholics Anonymous or out-patient clinic.
- (8) Incontinent laundry service.
- (9) Domestic help.
- (10) Meals on wheels.
- (11) Vitamin or food supplements.
- (12) Sheltered housing.

- (13) Subsidised holidays.
- (14) Legal aid.
- (15) Help with tax returns.
- (16) Social clubs.
- (17) Neighbourhood groups.

A considerable variation was found in the range of services provided in the eight participating countries. Furthermore rural areas and urban areas were not markedly different in the provision of services. They concluded that there was a need for development in most areas which required proper organization and co-ordination. Furthermore, information about the services must be readily available to old people who should be encouraged to make use of, and participate in, the services provided.

With regard to misplacements in services there was a surprisingly high level of appropriate placement (85%). They concluded that a facility for which there was a considerable demand in most countries was the nursing home and it was considered on the basis of that study that the number of places in mental nursing homes would need to be doubled. Perhaps more importantly they concluded that the essential requirement of the psychogeriatric patient would appear to be nursing, no matter where it is carried out. They also drew attention to the high prevalence of physical handicap and somatic illness in old people, especially in old people who were in psychiatric institutions.

Pitt (35) has suggested that the family is still the main-stay of the elderly psychiatric patient at home, although the number of middle aged to elderly women has dropped and the proportion who work out of home has increased. Bergmann (36) reported that 80% of the demented elderly were not institutionalised and that family support was the most important factor determining continuing life in the community. He felt that the psychogeriatric services' task is to provide suitable treatment for the patient living at home, to try to increase the social services, and to improve community nursing for the elderly. Allied with this the other important facilities for community care are out-patient consultation, day hospital attendance and short-term admission for holiday relief as part of community care.

Relatives support groups are advocated to provide self-help for those facing the common problem of dementia, by Fuller et al (37). Relatives may be helped in other ways through personal support by social workers or other members of the primary care team, and economic assistance (through taxi allowance and laundry services for the incontinent).

Other voluntary agencies can also be helpful e.g. organizations to help the bereaved, widow's organizations, home helps, 'paid good neighbours', sheltered housing and boarding out. The well elderly can be important in providing such voluntary services.

9.1 Organisation of local services

The general principle should be that elderly people should continue to live at home wherever this is reasonably possible and be provided with such primary care and specialised services as they require. When life at home is no longer possible short-term or longer-term residential care should be available locally. To achieve these aims it is necessary that a planned comprehensive network of services should be developed which will function to provide for prevention whenever possible, early identification of those at risk and skilled assessment, treatment and care in various ways.

Generally the provision of services must take account of the rights of old people to choose and of their capacity to understand and exercise their choice.

There are a number of key factors which will assist in drawing up a local plan for action.

- A definition of the population to be served locally, its size and its likely needs;
- an appreciation of the present resources and deficiencies;
- the setting up of a local joint planning group;
- this should include key personnel from psychiatry, geriatric medicine, primary medical care, nursing, remedial professions, social services, administration and the voluntary sector;
- it should produce a strategy for the development and operation of a local service and should form clear policies for such items as joint professional working, referrals and admission to residential care.

A comprehensive service will have many elements. There are many different ways in which a variety of good services can be developed according to the local resources available and the style of the workers.

On the health side, medical and nursing staff should have the back-up of day hospitals and beds. Beds should be available in the general hospital for those who require special assessment and treatment and longer stay beds should be provided in a local setting. A wide range of help should be available from the social services agencies and this may include meals on wheels, home helps, social work services, day centres and residential accommodation of various kinds. Voluntary agencies are playing an increasing part in providing care and support. It is important, however, that presence of voluntary workers should not encourage statutory agencies to reduce adequate levels of trained staff employed by them.

To ensure that a comprehensible and co-ordinated service is operating calls for skilled planning, good working relationships and the maintenance of high morale. Adequate staff ratios, positive expectations and careful sharing of knowledge can result in a good service in an area of work which has for long been regarded by professional staff as unattractive and of low status. High standards of care must be set taking account of what local advice is available on good practice and provision. The achievement of high standards must be vigorously pursued and maintained.

Examples of planning groups were seen in Munich and Harrow. Approximately seven years ago the Munich City Council formulated their Altenplan - for the care of ambulant elderly people. There was a decision to set up "Service Centres" in different districts of the municipality to provide meals on wheels and other services, including day care, etc. Thirteen service centres are functioning at present. Three more are in planning, one is to be opened in 1983 and two in 1984. However, a change of Government coupled with the change in the economic situation in 1978, has caused a "denk pause" to reconsider the situation and to institute cost control. There has been a change in policy generally from providing such centres to self-help principles. In Harrow the planning group is more informal and is based on close links between the local authority social services, psychiatric services and primary care services.

10. PREVENTION

The WHO Working Group on the Organization of Services to Prevent Disability Among the Elderly (38) reported in 1982, that the high prevalence of disability, locomotor problems, mental deterioration and sensory disabilities were a marked challenge to the Health Services. Psychosocial factors played a key role both aetiologically and as an accompaniment to most of the disabilities. Disability prevention required a wide range of joint activity by the Health & Social Services at various levels, both lay and professional. Primary care played a major part in prevention while secondary and tertiary services provided help for worsening disability.

Interdisciplinary studies were required in priority areas of prevention and rehabilitation for the elderly, including the consequences of disease, viz impairment, disability and handicap. It was felt that the public should be made aware of their own responsibility throughout life, to maintain health and prevent disability in themselves and family members. Unfortunate negative attitudes, occurring in the majority of lay and medical people, included the expectation that elderly people inevitably become increasingly unwell. This was a self-fulfilling prophecy which acted against the elderly seeking early advice on remediable problems.

The WHO publication on "Preventing Disability in the Elderly" (39) recommends that:-

- (1) Contracts and collaborative mechanisms should be developed between WHO, United Nations agencies and non-governmental organizations concerned with disability, prevention and rehabilitation.
- (2) Scientific centres involved in research and documentation on disability should be identified and drawn together.
- (3) Knowledge in the field of disability prevention and rehabilitation should be promoted and disseminated in Member States in 1982/83.
- (4) Member States should be stimulated to share the initiative in disability prevention and rehabilitation.
- (5) The options for interventions as stated in Annex 1 should be promoted.

- (6) Studies should be undertaken to examine the interface between the individual and the environment to establish how the environment could be adapted to improve the quality of life for people with a disability.
- (7) Research should be promoted on the education of professionals and the general public on disability prevention and management.
- (8) Where data are not available, epidemiological studies of impairment and disability in elderly populations, including cohort and longitudinal studies, should be vigorously promoted. Where data already exist, systems for monitoring the changing patterns should be developed or strengthened. Existing epidemiological data should be evaluated within the framework of the ICIDH with particular emphasis on handicaps.
- (9) Member States should examine the value of age-related screening programmes for early detection of morbidity and disability in the general population.
- (10) Member States should define and develop the role of the primary care team and of individual primary care professionals in the prevention of impairment and disability.
- (11) Member States should recognize the value of self-help activities which should be encouraged as part of a therapeutic process. However, it is essential that self-help activities are not seen as an alternative to professional care.
- (12) Attention should be paid to the multidisciplinary and interdisciplinary nature of the problems, in view of the fact that multiple disabilities are more often the rule than the exception among the elderly.
- (13) Whenever possible, assessment of needs and resources of an elderly person should take place in his normal surroundings, not in a clinical setting, as there is substantial evidence that accurate assessment is best made in familiar milieu.
- (14) In order to evaluate and accurately address and compare the impact of alternative interventions, and to ensure that their effects can be determined, a system should be used, which accurately describes the intervention in terms of its specific generic components. This applied to prevention measures among the non-disabled as well as intervention strategies concerned with treatment, and strategies for care among the disabled.
- (15) Recognizing the role that the mass media play in keeping the elderly informed of developments concerning themselves, especially in relation to the goal of health for all by the year 2000, national governments as well as WHO should involve the mass media whenever possible as full partners rather than as mere spectators in activities designed to promote these aims.

Concerning the International Classification of Impairments, Disabilities and Handicaps the WHO publication (39) recommended that:

- (16) Member States should stimulate through discussions in appropriate settings regarding the underlying concepts, and develop corresponding terminology to be used in each country.
- (17) Member States should promote studies of practical applications of the ICIDH to identify strengths and weaknesses of the system.
- (18) Member States should exhort any organization in their own country using the ICIDH to contribute data for evaluation to WHO.
- (19) A follow-up of studies in Member States should be undertaken, including those by intergovernmental organizations in application and simplification of the ICIDH.
- (20) A system of classification of types of intervention should be developed taking into account the existing ICPM, the forthcoming ISO classification of aids (in press) and ICIDH.
- (21) Ways of categorizing the problems encountered by individuals should be explored (rather than focused on their impairments, disabilities etc.) in relation to the ICIDH.

The WHO Meeting concerning "Services to Prevent Disability in the Elderly", held in Sokobanja, October, 1982, recommended:-

- (1) The development of screening of the elderly.

- (2) Early detection and intervention.
- (3) Technical aids and resource centres.
- (4) Organization of services. Services research was required into innovations in providing services and in the use of technology with special reference to systems analysis, including cost effectiveness. They felt that ways should be found to develop communication and links between primary health care, institutions and other major elements in the service system, including self-help groups.
- (5) Manpower development at primary level. The importance of the Primary Care Team was highlighted. It was also stressed that the older patient must be kept actively involved in his care through self-help and voluntary groups. It was felt that Member States should promote the organizational model of the Primary Health Care Team which worked best in the local community and was designed to identify the needs of the elderly.

However, gaps in the activities of primary care workers suggested that further education was required to develop their sensitivity to the needs of elderly people and their awareness of individual rights. Primary care workers should also be helped to develop a comprehensive knowledge of the services available locally and to identify the responsible contacts and agents of all relevant services and organizations.

- (6) Studies should be carried out into morbidity, multiple pathology and the effects of the environment.
- (7) Inter-country communication and co-operation should be promoted at national meetings on various aspects of the prevention of disability.

Arie (40) deals with possibilities for prevention of dementia through further research into the pathogenic mechanisms, particularly the pharmacological aspects, involved in dementia. He also refers to the importance, particularly in dementia, of stimulation and reactivation of residual faculties. This has been described by Wood and Holden (41). Arie refers to the scanty evidence of efficacy of such treatments but does not suggest that they should not be tried. Arie also points out that depression and paranoia are preventable through early treatment and simple provisions, e.g. of hearing aids for older people.

Prevention of multi-infarct dementia is widely discussed but it is still controversial as to whether control of blood pressure in late life is preventive (42).

The WHO Eight Countries Study referred to in the report "Psychogeriatric Care in the Community" (34) recommended the following immediate measures for the prevention of mental disorders in the elderly:-

- (a) Systematic teaching of geronto psychiatry with its preventive and therapeutic implications to all medical and nursing students, including post-graduate students.
- (b) Establishment of efficient services for the detection and early assessment of the elderly at risk.
- (c) Development of social services able to meet the needs of the elderly for contact, activity, emotional support and practical help.
- (d) Community geronto psychiatry teams to prevent illness and start early treatment in the patient's residence, and thereby minimise the dangerous removal of the elderly from their family environment.

The primary prevention of mental illness in the elderly is at present limited suggesting that a research commitment in this field is an urgent requirement. The Working Group in Cork welcomed the scientific group on dementia convened by the WHO with the co-operation of the French Government in Paris in September 1983.

Secondary preventive practice - the treatment of previously undetected psychiatric disorder - if possible. Major surveys have shown a high prevalence of psychiatric disorder in the elderly. The screening and routine assessment of vulnerable groups by primary care services should result in early case finding and prompt treatment. The vulnerable groups include those aged 75 and over living alone, those recently bereaved and those requiring domiciliary services.

Tertiary prevention is very feasible and depends upon the better management and treatment of known psychiatric disorders. Essential to this is early medical evaluation, a multi-disciplinary approach and continuity of care. It requires a knowledge of what constitutes normal ageing processes and what does not. It demands positive and enthusiastic therapeutic attitudes. Depressive illness calls for prompt diagnosis and adequate treatment and in dementia even if no correctable cause can be treated, awareness of and attention to accompanying problems can significantly influence the impact of the illness. Crucial at all this is the development of good comprehensive care services.

Two examples of preventive interventions are seen in the senior programme of the Social Department of the city of Munich, in the service centre at Haidhausen and the Munich Senior Programme.

10.1 The Service Zentrum at Haidhausen

Haidhausen has a population of 38,000 people, of whom 5,000 are over 65. 750 of these are known to the centre and through the course of the week approximately 350 attend at least once at the service centre. They operate a first come first served policy. They currently have economic difficulties in the provision of the meals on wheels service.

This unit, one of ten such units in existence in the city already caters for a neighbourhood and because the elderly would tend not to call and ask for help (they felt it would be degrading), the unit operated an out-reach policy. Thus the staff go to the homes of the elderly to offer help. There are three staff, consisting of one social worker, one educator, and one Altenpfleger (a nurse for the elderly with one and a half years of training). In addition two young people, completing civil service as an alternative to military service, worked in the service centre for one and a half years. The Service Centre provides food, gymnastic classes, educational classes, e.g. teaching English to the elderly. The latter is a particularly popular option since many of the elderly have relatives living in English speaking countries and it enables them to keep contact with grandchildren, etc.

In addition the staff go out to the homes of the old people in the district providing social care and household help. They go to the bank, help them with meals or shopping and in addition they have recruited 30 to 40 volunteers, many of whom are also elderly, to help in this work. These volunteers have difficulty in handling the disorientated demented elderly patient. One of the objectives of the centre staff is to build up the motivation of the elderly in their district.

The building is owned by the municipality. It is a two storey structure, attractively decorated. It is run by the Protestant Church, but 95% of the personnel and administrative costs are paid for by the municipality.

The staff operate a policy of carrying out only what is necessary for any particular client. There is a heavy emphasis on avoiding the creation of dependency. Approximately once per month the elderly are seen with their families to whom the illness can be explained. Many of the apartments occupied by the elderly have no water or baths, therefore, showers and washing machines are provided in the Centre. Good liaison is maintained with the social workers of the city and with the medical services so that it is easy to contact the hospitals and doctors concerned. A choice of doctor system is operated. Many of the clients have not received a very thorough education and therefore there is emphasis on activation for these people. They carry out many programmes to improve the health of the elderly such as gymnastics, swimming etc. In addition sometimes the educational programmes operate with some difficulty because the particular teachers are interested more in the subjects they are teaching than in the problems of the elderly. It was emphasised that the 13 Service Centres all operate somewhat differently.

The Munich Senior Programme is administered by the Cultural Department with money provided by the Senior Programme of the Social Department of the City. The Director explained that the Service Centres were part of the Munchener Altenplan providing help for the elderly via clinic and nursing homes. Part of this plan was the provision of a senior programme for "cultural activation and animation". It had been planned that these should be integrated in each Service Centre, but in his particular area there was no Service Centre. A considerable sum had been set aside for the construction of a Service Centre with gardens etc. Unfortunately, the recession stopped that development. Instead rooms were now provided in a renovated old building to provide a first pilot programme.

The programme has three parts:-

- (a) Language courses together with arts and crafts.

(b) Services provided for conversation with the elderly regarding television programmes, tapes, current affairs discussions, socio-political discussions, health care and prevention of illness, amusement, "training in thinking" and "learning by playing".

(c) Free communication: the clients of the Centre elected representatives of the elderly to a parliament. They elected a spokesman who is the Director's partner, with a strong emphasis on their feeling of participation in running the unit.

The Director explained that the elderly generation were not used to speaking out or taking partnerships and responsibility in this way. However, this programme was being organised by the elderly for themselves. They had an orchestra of the elderly, they discussed their own creations versus younger peoples, they organise exhibitions of their work. The aim is to promote activity, independence, integration and self-esteem improvement. They are involved in organising the child minding and theatrical productions, and the staff of the Centre remain particularly "neutral", i.e. non-directive.

In 1982 they had over 70,000 visits per year to the unit from four and a half to five thousand visitors in four centres in Munich. Doctors can and do refer their patients to the programme. The Director felt there was no need to have a psychogeriatric consultant, because of his feeling that old people fear psychiatrists. He had an idea that an "incognito psychiatrist" would be of benefit to the service. A psychologist already does some informal group therapy with the programme, but there is heavy emphasis on maintaining the activity of the elderly and avoiding any institutionalisation. The orientation of this treatment was to activate the healthy part of the ego of the elderly person, "to enable him to live with his past and master his own history".

11. CONCLUSIONS

A very varied spectrum of services for the elderly mentally ill was seen in the centres visited. This variation occurred, not only between countries, but also between services even within the same city. Very often the growth of such services had been dependent on historical and statutory factors as well as on the special interest of the individuals and authorities involved with the development of services.

There is obvious merit in having such a varied range of support available. The variety of services between units provides a richness of resources as well as interest adding to the job satisfaction and even possibly contributing to healthy competition between teams.

However desirable, such variety tends to increase the hazard of lacunae in the provision of services in the area. For this reason considerable planning is needed to ensure equitable allocation of resources between catchment area teams and to ensure quality control.

While this report shows that the same task can be completed in so many different ways, nevertheless, there are predictable hazards and preferred modes of operation.

Severe illness in the elderly mentally infirm is most often treated in long-stay wards of large and frequently isolated psychiatric hospitals. Large numbers increase the hazards of institutionalisation with poor individual levels of care, low staff morale (causing recruitment problems), isolation from family and community. Thus it is desirable that the severely ill elderly to be cared for in smaller units. Furthermore, it is the training, dedication, imagination and skill of the staff which ultimately determines what happens in terms of rehabilitation and quality of care.

Underlying themes emerged between these differing services for the elderly mentally ill, all of such variety and high quality.

- (1) The dual medical and psychological pathology found in the elderly demands a close working relationship between physicians and psychiatrists caring for the elderly. This seems to be best provided close to major medical facilities with the full range of diagnostic resources.
- (2) Development of good day care facilities is not in itself sufficient to cater for the variety of problems seen. Emphasis in most areas is placed on good home visiting for diagnosis and continuing assessment of patients cared for in the community.
- (3) Because the elderly are reticent and fear psychiatric services, considerable imagination is required in the development of "out reach" services for the elderly.
- (4) With few exceptions very little effort is being placed on preventive services which have enormous potential impact on the psychogeriatric cases.

- (5) There is general agreement that considerable and continuing work needs to be carried out on changing attitudes particularly of professionals with whom the elderly mentally ill may come into contact.
- (6) The quality and range of provision of services seems to depend largely on the therapeutic enthusiasm and imagination of leaders in the field.
- (7) In many areas primary care for the elderly is not closely allied with psychiatric and social services.
- (8) In many areas visited, marked constraints are placed on mental health professionals' ability to influence allocation of financial resources to meet rising community expectations in quality of care.

12. RECOMMENDATIONS OF THE WORKING GROUP ON MENTAL HEALTH CARE OF THE ELDERLY, CORK, October 1983.

In the context of Health For All by the Year 2000 and the development of regional strategies, mental health needs of the elderly must be incorporated. Essential aspects of national policies are under the heading of Development of Services.

Health information systems at each level of health care provision should include data collection referable to mental health care of the elderly. Categories of data and information requirements are given under the heading of Information Services. [WHO should consider what further comparative data referable to the elderly mentally ill might be sought on a Regional basis].

The group welcomes the Report of the Working Group on First Contact Mental Health Care at Tampere. It endorses the recommendations of that group and emphasises the importance of training workshops in mental health practice at the primary care level. [The group would like to see WHO take a lead on this].

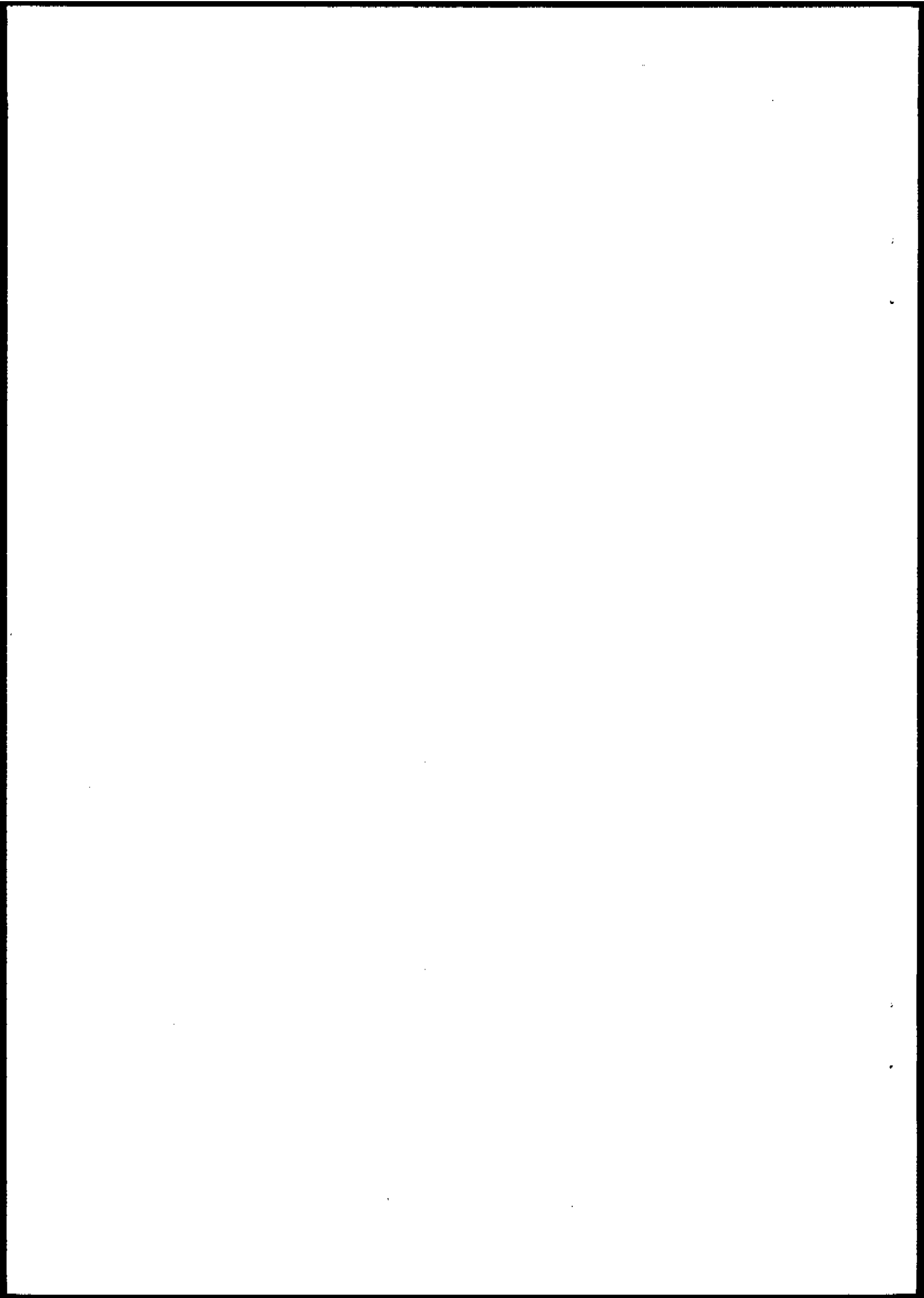
A collaborative study is recommended of intervention practices in different countries and health care settings with the objectives of identifying effective strategies for prevention of mental disorder in the elderly. [The group would like to see WHO be the lead agency in this].

WHO should consider the feasibility of the preparation of guidelines for training manuals referable to various categories of health care personnel charged with health care of the elderly.

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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Working Group on Mental
Health Care of the Elderly

Cork, 3-7 October 1983

ICF/MNH 063(1)/5
2318F

7 October 1983

ENGLISH ONLY

LIST OF PARTICIPANTS

TEMPORARY ADVISERS

Professor Annie Altschul
University of Edinburgh
Department of Nursing Studies
Adam Ferguson Building
40 George Square
Edinburgh EH8 9LL
United Kingdom

Dr Tom Arie**
Professor and Head of Department
Department of Health Care of the Elderly
University of Nottingham
Sherwood Hospital
Hucknall Road
Nottingham NG5 1PD
United Kingdom

Dr Enda D. Bannan*
St. Finan's Hospital
Killarney
Co. Kerry
Ireland

Dr W.D. Boyd*
Royal Edinburgh Hospital
Mackinnon House
Morningside Place
Edinburgh EH10 5HF
United Kingdom

Professor J. Copeland*
Director of the Institute of
Human Ageing
University of Liverpool
P.O. Box 147
Liverpool L69 3BX
United Kingdom

Professor R.J. Daly (Chairman)
Department of Psychiatry
Cork Regional Hospital
Wilton, Cork
Ireland

*) Participation expenses not paid by WHO

**) Representing also the World Psychiatric Association

Mr Donal Devitt*
Principal Officer
Mental Health and Services for the
Mentally Handicapped Division
Department of Health
Custom House
Dublin 1
Ireland

Dr René Jaak Dom
Assistant Professor
University Psychiatric Institute
"St. Kamilius"
Krykelberg 1
B-3043 - Bierbeek
Belgium

Dr Elisabeth von Essen*
National Board of Health and Welfare
S-106 30 Stockholm
Sweden

Dr Rolf Gabrielsen*
Medical Director
Oslo Health Board
St. Olavs Pl. 5
Oslo 1
Norway

Dr J. Hadjiantoniou*
Public Mental Hospital of Athens
Ypsilantou 11 Kolonaki
Athens
Greece

Dr Michael Hyland*
Cork Regional Hospital
Wilton, Cork
Ireland

Dr Marianne Kastrup
Senior Registrar
Psychiatric Department P
FAC - Hillerød
DK-3400 Hillerød
Denmark

Professor Dj. Kozarevic
Institute of Chronic Disease
and Gerontology
Slobodana Penezica Krcuna 35/II
11000 Belgrade
Yugoslavia

Dr Christoph Kulesa**
Federal Ministry for Youth,
Family Affairs and Health
Postfach 200 490
D-5300 Bonn 2
Federal Republic of Germany

*) Participation expenses not paid by WHO
+) Unable to attend

Dr John Owens*
Chief Psychiatrist
St. Davnet's Hospital
Monaghan
Ireland

Dr D. Ringoir
Chief Inspectorate of Mental Health
Inspector of Psychogeriatrics
Staatstoezicht op de Volkgezondheid
Geneeskundige Hoofdinspectie voor de
Geestelijke Volksgezondheid
Postbus 439
NL-2260 AK Leidschendam
Netherlands

Dr M.G. Scirina+
All-Union Scientific Centre of Mental Health
Academy of Medical Science
Moscow
USSR

Mr Shaun Trant*
Principal Officer
Planning Division
Department of Health
Custom House
Dublin 1
Ireland

Dr Dermot Walsh*
Medico-Social Research Board
73 Lower Baggot Street
Dublin 2
Ireland

Dr R. Wilkins* (Rapporteur)
Principal Medical Officer
Department of Health
and Social Security
B312, Alexander Fleming House
Elephant and Castle
London SE1 6BY
United Kingdom

REPRESENTATIVES OF OTHER ORGANIZATIONS

International Council of Nurses

Ms Brigit Butler*
Superintendent Public Health Nurse
and First Vice-President of the
Irish Nurses Organisation
19 Garden Villas
Kilkenny
Ireland

* Participation expenses not paid by WHO
+ Unable to attend

REPRESENTATIVES OF OTHER ORGANIZATIONS

World Federation for Mental Health

Ms M. O'Mahony*
Chief Executive Director of the
Irish Association for Mental Health
2, Herbert Avenue, Merrion Road
Dublin 4
Ireland

Dr Richard J. Whitty*
St. Brendan's Hospital
Dublin 7
Ireland

WHO Collaborating Centre for Research
and Training in Mental Health (Mannheim)

Dr Anita Riecher*
Central Institute of Mental Health
J 5, P.O. Box 5970
D-6800 Mannheim
Federal Republic of Germany

WHO Collaborating Centre for Psychosocial
Factors and Health, (Leuven)

Represented by Dr René Jaak Dom

WORLD HEALTH ORGANIZATION

Regional Office for Europe

Dr John H. Henderson (Secretary)
Regional Officer for Mental Health

*) Participation expenses not paid by WHO
) Unable to attend



Groupe de travail des soins de santé mentale
aux personnes âgées

Cork, 3-7 octobre 1983

ICP/MNH 063(1)(S)

3548F

19 décembre 1983

ORIGINAL : ANGLAIS

RAPPORT SOMMAIRE

Introduction

Le groupe de travail a été organisé dans le cadre du programme à moyen terme de l'OMS relatif à la santé mentale pour examiner les besoins des personnes âgées en matière de santé mentale dans la Région européenne. Le groupe était composé de 20 conseillers temporaires venus de 10 pays, dont sept du pays d'accueil et de quatre représentants d'organisations non gouvernementales. Le centre collaborateur de l'OMS pour la recherche et la formation relatives à la santé mentale à l'Institut central de santé mentale de Mannheim, République fédérale d'Allemagne, ainsi que le centre collaborateur de l'OMS pour la santé et les facteurs psychosociaux en Belgique étaient également représentés. Les disciplines représentées étaient la gériatrie, la gérontologie, l'administration sanitaire, les soins infirmiers, la psychiatrie et le travail bénévole.

Le but de la réunion était de formuler des conseils sur la mise au point de services complets de santé mentale en collectivité pour les personnes âgées, et de rédiger des principes directeurs en vue de prévenir et de diminuer les incapacités mentales chez les personnes âgées. On a présenté un document de travail donnant une vue d'ensemble de l'organisation de ces services, et les participants ont fourni un aperçu général de l'organisation de services de ce type dans leurs pays. Tous ont reconnu l'importance croissante des problèmes des personnes très âgées souffrant de troubles mentaux, et la prévalence accrue de ces troubles chez les personnes très âgées.

Etablissement de services

Les données épidémiologiques démontrent aujourd'hui qu'il y a un accroissement manifeste et général du nombre de personnes âgées atteintes de troubles de santé mentale, à savoir surtout la démence.

Les services destinés aux personnes âgées mentalement atteintes doivent toujours être considérés dans le contexte des services destinés aux personnes âgées en général, auxquels ils doivent être étroitement intégrés. Les services de soins de santé primaires et les services psychiatriques ont un rôle spécial à jouer. Il est certain que l'importance du problème et la manière de le voir varient d'un pays à l'autre et qu'aucun plan stéréotypé ne peut s'appliquer aux organisations et aux ressources diverses de pays différents.

Chaque pays doit préparer d'urgence une stratégie nationale cohérente afin d'établir des services de santé mentale pour les personnes âgées. A cet égard, il faudrait tenir compte des facteurs clés suivants :

- une définition des besoins présents et futurs sur la base des données démographiques et épidémiologiques;
- une analyse des besoins probables des personnes âgées et de la mesure dans laquelle les services actuels sont capables d'y satisfaire;
- une proposition de procédure permettant de planifier et d'exploiter conjointement une gamme complète de services. Des services complets devraient assurer la prévention, le dépistage précoce, l'évaluation, le traitement et les soins de diverses manières. Ils incluront de nombreux éléments des services de santé, des services sociaux, du logement, et des services bénévoles ainsi que d'autres services;
- des recommandations sur les moyens de mettre au point des stratégies de la formation et de la recherche pour promouvoir les pratiques rationnelles et la recherche des innovations dans la dispensation des services.

Services d'information

Une grande variété de renseignements est nécessaire pour assurer l'affectation optimale de ressources limitées. Des renseignements pourraient être recueillis dans quatre domaines principaux.

Recherche scientifique. On a déjà réalisé avec succès dans plusieurs pays des études sur la prévalence des maladies mentales et les constatations faites ont été en gros acceptées. On est toutefois peu renseigné sur la démence, sur son incidence ou sur l'aboutissement de cas reconnus, surtout de nombreux cas dits bénins. Il faudra, pour obtenir ces renseignements, effectuer des études longitudinales qui nécessiteront l'usage d'instruments normalisés pour le dépistage et l'enregistrement fiable de l'état mental, ainsi que d'autres données.

Services de santé. Il reste encore beaucoup à apprendre sur l'aboutissement de la maladie chez les personnes âgées, les déplacements des patients entre les divers services. On devra donc obtenir un complément de données sur les personnels et les autres moyens et sur les facteurs économiques pour pouvoir faire des études du rapport coûts-avantages de services expérimentaux. On insistera particulièrement sur les différentes méthodologies dans ces études et dans d'autres études sur le contrôle de qualité des services, y compris la satisfaction des consommateurs et de leurs proches. L'information statistique traditionnelle sur l'utilisation des lits et le flux de patients ne devrait pas cesser d'être fournie.

Communication. Il faudra continuer de définir clairement les termes techniques. Pour les études comparatives internationales, trois domaines sollicitent notre attention : la rédaction éventuelle d'un glossaire de la terminologie sanitaire générale et d'un glossaire du vieillissement proprement dit; ainsi que le développement ultérieur de la Classification internationale des déficiences, incapacités et handicaps.

Enseignement. Pour assurer la formation de travailleurs tant professionnels que non professionnels il faudra évaluer leurs besoins et préparer des programmes de formation adaptés. Dans certains pays, les médecins et infirmières ainsi que le personnel travaillant avec des personnes âgées dans d'autres cadres reçoivent très peu de formation en matière de vieillissement. Il faudra corriger cette situation. On devra également étudier les types d'informations nécessaires pour la formation des travailleurs bénévoles.

Organisation de services locaux

Il y a un accord général sur le principe que les personnes âgées doivent continuer de vivre chez elles, sauf impossibilité réelle, tout en bénéficiant des soins primaires et des services spécialisés qui peuvent leur être nécessaires. Lorsque la vie à domicile n'est plus possible, il faudrait qu'il existe localement des moyens de soins avec séjour à court terme ou à plus long terme dans un établissement. Il faudrait, pour atteindre ces objectifs, mettre sur pied un réseau complet et organisé de services permettant de pratiquer la prévention chaque fois qu'elle est possible, et le dépistage précoce des personnes à risque, avec des services compétents d'évaluation, de traitement et de soins chaque fois qu'il est besoin.

On a identifié, pour aider à établir un tel plan d'action local, un certain nombre de tâches nécessaires, comme la définition de la population à desservir, une estimation des ressources et des lacunes existantes et la création d'un groupe mixte de planification à l'échelon local, qui comprendrait les personnels clés : psychiatrie, médecine gériatrique, soins médicaux primaires, soins infirmiers, réadaptation, services sociaux, administration et secteur bénévole.

Le fonctionnement d'un service complet et coordonné nécessite une planification experte, de bonnes relations de travail et un haut degré de motivation. Il faudra fixer les normes de soins à un niveau élevé, en tenant compte des conseils disponibles localement sur les pratiques rationnelles. Il faudra activement s'efforcer d'atteindre et de maintenir ces normes élevées.

Soins primaires

La plupart des personnes âgées vivent à leur domicile, souvent seules, et les troubles psychiatriques jouent un rôle de premier plan dans leur morbidité. Tous les services nécessaires, officiels ou bénévoles, devraient être disponibles au niveau des soins primaires, pour donner à ces personnes l'aide à domicile qui peut être nécessaire. Il faut pour cela qu'il existe entre les agents de soins primaires et ceux des services spécialisés, des relations de travail en commun soigneusement organisées et gérées en vue de renforcer et rendre plus efficace leur action conjointe.

La plupart des services de soins primaires sont fondés sur la notion de l'équipe pluriprofessionnelle travaillant au sein de la collectivité. A ce niveau, le généraliste est parfois le point de contact professionnel le plus important, souvent en tout cas le premier, et c'est lui qui traite généralement la plupart des problèmes. La politique locale devrait toutefois prévoir la visite de personnel de santé spécialisé ou d'autre personnel auprès des personnes âgées lorsque c'est nécessaire. Les groupes d'auto-assistance et autres moyens organisés de conseil et d'aide sont un complément important de la gamme des soins et services à domicile étudiés dans la rubrique "Organisation de services locaux". Avec l'accent ainsi mis sur les soins à domicile pour les personnes âgées atteintes de maladie mentale, il faut également tenir compte des besoins des membres de la famille et d'autres personnes qui apportent leur soutien et donnent des soins.

Enseignement

Les programmes d'enseignement et de formation sont essentiels pour les catégories très diverses de personnes, formées ou non, qui fournissent les services aux gens âgés atteints de maladie mentale. En leur donnant un cadre pour comprendre et apprendre, ils renforcent l'engagement personnel, la confiance en soi et la capacité de ces personnes. Le retour d'information qu'ils permettent favorise l'amélioration des services en facilitant leur surveillance et leur évaluation. Des connaissances spéciales sont nécessaires pour faire face aux problèmes de santé mentale des personnes âgées et certains pays ont mis au point des services spécialisés pour ce genre de maladies mentales dans le contexte des services de santé mentale et de médecine générale déjà existants.

Le plus souvent les soins de longue durée aux personnes âgées sont fournis par des proches ou par un personnel sans formation. Leur contribution et celle des travailleurs bénévoles sont plus efficaces si un personnel professionnel peut assurer des services d'enseignement et de formation en même temps qu'une intervention active lorsque c'est nécessaire. Lorsque le personnel formé est en nombre insuffisant pour pouvoir donner lui-même des soins à tous ceux qui en ont besoin, on devrait tirer parti de ses compétences en lui faisant jouer un rôle de conseil et de formation aux autres.

La diffusion des connaissances par l'enseignement ne devrait pas s'adresser seulement aux gens qui donnent les soins et aux travailleurs professionnels. L'enseignement doit aussi viser, de façon plus large, à sensibiliser et motiver le grand public et les milieux politiques. C'est ainsi que l'on amènera la société et ses dirigeants à reconnaître les problèmes et les possibilités, et à prendre conscience de leur responsabilité à l'égard des membres les plus âgés de la collectivité.

Prévention

La prévention primaire des maladies mentales chez les personnes âgées est peu développée actuellement, une recherche dans ce domaine s'impose donc d'urgence.

La prévention secondaire - le traitement de troubles psychiatriques non détectés par le passé - est possible. D'importantes études ont montré une forte prévalence des troubles psychiatriques chez les personnes âgées. Le dépistage et l'évaluation régulières des groupes vulnérables par les services de soins primaires devraient permettre de découvrir tôt et de soigner vite les cas à traiter. Les groupes vulnérables comprennent les personnes âgées de plus de 75 ans et vivant seules, celles ayant récemment perdu leur compagnon et celles qui ont besoin de services à domicile.

La prévention tertiaire est tout à fait faisable, à condition qu'il y ait une meilleure gestion et un meilleur traitement des troubles psychiatriques connus. Pour cela, une évaluation médicale précoce, ainsi qu'une approche pluridisciplinaire et une continuité des soins sont essentielles.

Recommandations

1. Les besoins des personnes âgées dans le domaine de la santé mentale doivent être pris en compte dans le développement de la stratégie régionale de Santé 2000.
2. Les systèmes d'information de santé devraient inclure, à chaque niveau de la fourniture des soins de santé, une collecte des données relatives aux soins de santé mentale aux personnes âgées.
3. Le groupe a approuvé les recommandations du groupe de travail OMS des soins de santé mentale de premier contact qui s'est réuni en avril 1983^a à Tampere et qui a souligné l'importance de la formation à la pratique des soins de santé mentale au niveau des soins primaires.

^a Document MNH 059(1)(S).

4. Il est recommandé une étude coopérative des pratiques d'intervention dans différents pays et différents cadres dans lesquels se situent les soins de santé, afin d'identifier des stratégies efficaces pour la prévention des troubles mentaux chez les personnes âgées.

5. L'OMS devrait étudier la possibilité de rédiger des principes directeurs pour la rédaction de manuels à l'intention de diverses catégories de personnels de soins de santé chargés des soins de santé aux personnes âgées.



Arbeitsgruppe über psychiatrische Betreuung
der älteren Menschen

Cork, 3.-7. Oktober 1983

ICP/MNH 063(1)(S)

3399F

19. Dezember 1983

ORIGINAL: ENGLISCH

KURZBERICHT

Einleitung

Diese Arbeitsgruppe war eine Veranstaltung im Rahmen des mittelfristigen WGO-Programms für geistig-psychische Gesundheit und diente dem Zweck, die psychischen Gesundheitsbedürfnisse der älteren Menschen in der Europäischen Region zu erörtern. Die Arbeitsgruppe setzte sich aus 20 Beratern auf Zeit aus 10 Ländern zusammen, darunter 7 Beratern aus dem Gastgeberland und 4 Vertretern nichtstaatlicher Organisationen. Ferner waren das WGO-Kollaborationszentrum für Forschung und Ausbildung auf dem Gebiet der geistig-psychischen Gesundheit am Zentralinstitut für seelische Gesundheit in Mannheim, Bundesrepublik Deutschland, sowie das WGO-Kollaborationszentrum für psychosoziale Faktoren und Gesundheit in Belgien vertreten. Anwesend waren Vertreter der Fachgebiete Geriatrie, Gerontologie, Gesundheitsverwaltung, Pflegewesen, Psychiatrie und Freiwilligenarbeit.

Zweck der Tagung war, Empfehlungen für die Entwicklung umfassender, gemeindeorientierter psychiatrischer Dienste für Betagte zu geben und Leitlinien für die Verhütung und Verminderung geistig-psychischer Behinderungen bei älteren Menschen auszuarbeiten. Ein Arbeitsdokument gab einen Überblick über die Organisation solcher Dienste, und die Teilnehmer schilderten in kurzen Umrissen die Organisation dieser Dienste in ihren Ländern. Alle Teilnehmer anerkannten, dass die Problematik geistig-psychischer Störungen bei sehr alten Menschen immer grössere Bedeutung erlangt und dass die Prävalenz geistig-psychischer Störungen bei hochbetagten Menschen zunimmt.

Verbesserung der Dienste für ältere Menschen

Es gibt heute zahlreiche eindeutige epidemiologische Unterlagen dafür, dass die Zahl der Betagten mit geistig-psychischen Gesundheitsproblemen, insbesondere Demenz, im Steigen begriffen ist.

Die Probleme der Dienste für psychisch kranke Betagte müssen stets im Zusammenhang mit den geriatrischen Diensten im allgemeinen betrachtet werden und müssen eng in diese integriert sein. Dabei spielen die Primärversorgungs- und Psychiatriedienste eine besondere Rolle. Sowohl das Ausmass des Problems als auch das Problemverständnis sind offensichtlich von Land zu Land verschieden, weshalb es kein allgemeingültiges Schema für die verschiedenen Organisationen und Ressourcen der verschiedenen Länder geben kann.

Es ist dringend nötig, dass jedes Land eine zusammenhängende nationale Strategie für die Verbesserung der psychiatrischen Dienste für die Betagten ausarbeitet. Dabei müssen die folgenden Hauptpunkte berücksichtigt werden:

- eine Definition der gegenwärtigen und künftigen Bedürfnisse auf der Grundlage demographischer und epidemiologischer Daten
- eine Analyse der wahrscheinlichen Bedürfnisse der Betagten und der Fähigkeit der bestehenden Dienste, der Nachfrage gerecht zu werden
- ein Vorschlag, wie ein umfassendes Dienstleistungsspektrum gemeinsam geplant und durchgeführt werden kann. Umfassende Dienste müssen verschiedene Aufgaben auf dem Gebiet der Prävention, der Früherkennung, der Bewertung, der Behandlung und Betreuung wahrnehmen. Dazu gehören auch zahlreiche Elemente des Gesundheits- und Sozialdienstes, des Wohnungswesens, freiwillige und andere Dienstleistungen
- Empfehlungen für die Entwicklung von Ausbildungs- und Forschungsstrategien zur Förderung erwünschter Praktiken und zur Suche nach Innovationen auf dem Gebiet der Dienstleistung.

Informationsdienste

Um eine wirtschaftliche Verwendung der knappen Mittel zu gewährleisten, ist eine Vielfalt von Informationen erforderlich, die unter den vier folgenden Titeln gesammelt werden kann:

Wissenschaftliche Forschung: Studien über die Prävalenz geistig-psychischer Krankheiten sind bereits in einer Reihe von Ländern erfolgreich durchgeführt worden, und ihre Ergebnisse haben breite Anerkennung gefunden. Was die Demenz betrifft, verfügt man jedoch nur über wenige Informationen betreffend die Inzidenz bzw. den Verlauf der erkannten Fälle und insbesondere über die grosse Zahl der Fälle mit einem "milden" Verlauf. Um diese Informationen zu ermitteln, sind Longitudinalstudien nötig, die die Verwendung standardisierter Screening-Methoden und eine zuverlässige Aufzeichnung der Daten über den Geisteszustand und anderer Daten erfordern.

Gesundheitsdienste: Die Kenntnis des Krankheitsverlaufs bei älteren Menschen und der Patientenbewegungen zwischen verschiedenen Betreuungseinrichtungen ist noch ganz ungenügend. Auch über die Arbeitskräfte und andere Ressourcen sind bessere Daten erforderlich, desgleichen wirtschaftliche Daten für Kosten-Nutzen-Analysen experimenteller Dienste. Besonderes Gewicht muss auf verschiedene Methoden bei diesen und anderen Studien über die Qualitätskontrolle der Dienstleistungen gelegt werden, so z.B. auf die Zufriedenheit der Benutzer dieser Dienste und ihrer Angehörigen. Auch die herkömmlichen statistischen Daten über die Bettenbelegung und die Zahl und Aufenthaltsdauer der Patienten sollten weiterhin erhoben werden.

Kommunikation: Eine klare Definition der technischen Begriffe wird auch in Zukunft notwendig sein. Für internationale vergleichende Studien sind drei Gebiete zu beachten: Möglicherweise ein Glossar über allgemeine Begriffe des Gesundheitswesens, ein Glossar über das Altern als solches sowie die weitere Ergänzung und Verfeinerung der International classification of impairments, disabilities and handicaps.

Ausbildung: Die Ausbildung des professionellen wie auch des nichtprofessionellen Gesundheitspersonals erfordert eine Bewertung ihrer Bedürfnisse und die Ausarbeitung zweckdienlicher Ausbildungsprogramme. In einigen Ländern werden die Ärzte, Pflegefachkräfte und das übrige Personal, das die Betagten unter anderen äusseren Bedingungen betreut, nur ungenügend über Fragen des Alterns ausgebildet. Diese Lage muss verbessert werden. Zu überlegen ist auch, was für Informationen freiwilligen Helfern in ihrer Ausbildung vermittelt werden müssen.

Organisation örtlicher Dienste

Die Arbeitsgruppe war prinzipiell darüber einig, dass die Älteren Menschen grundsätzlich stets zu Hause leben sollen, wo immer dies möglich ist, und mit den primären Betreuungsdiensten und Spezialdiensten versorgt werden sollen, deren sie bedürfen. Falls sie nicht mehr zu Hause leben können, sollte am Wohnort eine stationäre Betreuung für kürzere oder längere Dauer zur Verfügung stehen. Um diese Ziele zu verwirklichen, muss ein gut geplantes, umfassendes Netz von Dienstleistungen entwickelt werden, das in der Lage ist, wo immer möglich einer Pflegebedürftigkeit vorzubeugen, Risikopersonen frühzeitig zu erkennen und die Betagten wenn nötig kompetent zu beurteilen, zu behandeln und zu betreuen.

Es wurde eine Reihe von Schlüsselfaktoren ermittelt, die die Aufstellung eines solchen örtlichen Aktionsplans erleichtern, wie etwa die Definition der zu versorgenden Bevölkerung, die Abschätzung der vorhandenen und fehlenden Ressourcen und die Bildung einer gemeinsamen örtlichen Planungsgruppe, in die leitendes Personal aus den Gebieten der Psychiatrie, der Geriatrie, der ärztlichen Primärversorgung, des Pflegewesens, der Heilberufe, der Sozialdienste, der Verwaltung und des Freiwilligensektors einbezogen werden muss.

Der Betrieb eines durchschaubaren und koordinierten Dienstes erfordert eine kompetente Planung, ein gutes Arbeitsklima und die Aufrechterhaltung eines hohen Arbeitsethos. An den Betreuungsstandard müssen hohe Anforderungen gestellt werden, wobei zu berücksichtigen ist, was für Beratungsmöglichkeiten für eine gute Betreuungspraxis an Ort und Stelle zur Verfügung stehen. Die Einhaltung dieses hohen Betreuungsstandards muss energisch angestrebt und aufrechterhalten werden.

Primärversorgung

Die grosse Mehrzahl der Betagten lebt zu Hause, oft in einem Einpersonen-Haushalt; psychische Störungen spielen eine wichtige Rolle für ihre Morbidität. Alle nötigen gesetzlich festgelegten und freiwilligen Dienstleistungen sollten auf der Ebene der Primärversorgung zur Verfügung stehen, um den Betagten zu Hause die nötige Unterstützung zu geben. Dafür ist es erforderlich, zwischen dem Gesundheitspersonal der Primärversorgung und den Angehörigen der spezialisierten Dienste eine umsichtig organisierte und geleitete gemeinsame Arbeitsbeziehung zu schaffen, die darauf abzielt, ihre gegenseitige Verflechtung zu verstärken und zu vergrössern.

Die meisten primären Betreuungsdienste beruhen auf dem Konzept eines multiprofessionellen Arbeitsteams auf Gemeindeebene. Hier ist der praktische Allgemeinarzt in vielen Fällen die wichtigste fachliche Kontaktperson, oft sogar die erste Kontaktstelle, und hat im allgemeinen die meisten Probleme zu bewältigen. Auf örtlicher Ebene sollte jedoch eine Strategie betrieben werden, die es ermöglicht, dass auch Fachärzte oder Spezialisten anderer Berufsrichtungen die Betagten wenn nötig zu Hause besuchen. Selbsthilfegruppen und andere strukturierte Arten der Beratung und Unterstützung sind eine wichtige Ergänzung des Spektrums der häuslichen Betreuung und Versorgung, die im Abschnitt "Organisation örtlicher Dienste" umrissen wurde. Bei dieser Betonung der häuslichen Betreuung geistig oder psychisch kranker Betagter müssen auch die Bedürfnisse der betreuenden Familienangehörigen und anderer Pflegepersonen berücksichtigt werden.

Ausbildung

Aus- und Fortbildungsprogramme sind eine unerlässliche Voraussetzung für das breite Spektrum der Fach- und Hilfskräfte, die geistig oder psychisch kranke Betagte betreuen oder in solchen Betreuungsdiensten arbeiten. Sie bilden einen Rahmen für das Lernen und Verstehen und tragen damit zu einem stärkeren persönlichen Engagement, gesteigertem Selbstvertrauen und verbesserten Fähigkeiten bei. Der dadurch bewirkte Informationsrückfluss kann zu einer Verbesserung der Dienstleistungen führen und ihre Überwachung und Bewertung erleichtern. Um den psychischen Problemen der Betagten gerecht zu werden, sind besondere Kenntnisse nötig, weshalb einige Länder Sonderdienste für psychische Krankheiten im hohen Alter im Rahmen der bestehenden psychiatrischen und allgemeinmedizinischen Dienste eingerichtet haben.

Die langfristige Betreuung der Betagten wird grösstenteils von Angehörigen oder unqualifiziertem Personal erbracht. Die Arbeit dieser Betreuer und freiwilliger Helfer kann wirksamer gestaltet werden, wenn sich qualifizierte Fachkräfte ihrer Ausbildung und Schulung annehmen und wenn nötig auch aktiv eingreifen. Wenn das ausgebildete Personal für die direkte Betreuung aller Pflegebedürftigen nicht ausreicht, sollte die Erfahrung und Sachkenntnis dieser Fachkräfte genutzt werden, um andere Helfer zu beraten und auszubilden.

Die Vermittlung von Wissen durch Ausbildung darf sich nicht auf die Betreuungspersonen und die ausgebildeten Fachkräfte beschränken; vielmehr muss angestrebt werden, auch das öffentliche und politische Bewusstsein und die öffentliche Anteilnahme zu wecken und zu verbessern. Dadurch werden sich die Gesellschaft und ihre massgebenden Kreise der Probleme und Möglichkeiten bewusst und können ihrer Verantwortung gegenüber ihren betagten Mitgliedern besser gerecht werden.

Verhütung

Die Primärprävention von geistig-psychischen Erkrankungen der Betagten ist z.Z. sehr begrenzt, woraus folgt, dass auf diesem Gebiet dringend eine verstärkte Forschung nötig ist.

Sekundäre Präventionsmassnahmen, d.h. die Behandlung bis dahin nicht erkannter psychischer Störungen, sind möglich. Grössere Erhebungen haben gezeigt, dass psychische Störungen bei älteren Menschen sehr häufig sind. Durch Reihenuntersuchungen und routinemässige Erfassung gefährdeter Gruppen durch die Primärversorgungsdienste sollten solche Fälle frühzeitig erkannt und unverzüglich behandelt werden. Zu den gefährdeten Gruppen gehören über 75jährige alleinlebende Personen, Betagte, die vor kurzem Angehörige verloren haben, und solche, die zu Hause betreut werden müssen.

Auch die Tertiärprävention ist durchaus praktikabel; sie hängt weitgehend von der besseren Erfassung und Behandlung der bekannten psychischen Störungen ab. Ausschlaggebend sind in diesem Zusammenhang eine frühzeitige medizinische Bewertung, eine multidisziplinäre Behandlungsmethode und die Kontinuität der Betreuung.

Empfehlungen

1. Der Bedarf der Betagten nach psychiatrischer Betreuung muss in die Entwicklung der Regionalstrategie "Gesundheit für alle bis zum Jahr 2000" eingegliedert werden.
2. Die Gesundheitsinformationssysteme auf jeder Ebene der Gesundheitsversorgung müssen sich auf die Sammlung von Daten erstrecken, die auf die psychiatrische Versorgung der Betagten Bezug haben.
3. Die Arbeitsgruppe billigte die Empfehlungen der WGO-Arbeitsgruppe über die psychiatrische Erstkontaktbetreuung, die im April 1983 in Tampere abgehalten wurde^a, und unterstrich die Bedeutung der praktischen psychiatrischen Ausbildung auf der Ebene der Primärversorgung.

^a Dokument MNH 059(1)(S)

4. Es wird empfohlen, durch Kollaborationszentren eine Studie über die Interventionspraxis in verschiedenen Ländern und unter verschiedenen Rahmenbedingungen der Gesundheitsversorgung durchführen zu lassen mit dem Ziel, wirksame Strategien für die Prävention psychischer Störungen bei älteren Menschen zu ermitteln.

5. Die WGO sollte prüfen, ob Leitlinien für Ausbildungshandbücher für die verschiedenen Kategorien von Gesundheitspersonal aufgestellt werden können, die sich mit der Gesundheitsversorgung der älteren Menschen befassen.



Рабочая группа по охране
психического здоровья престарелых

Корк, 3-7 октября 1983 года

ICP/MNH 063(1)(S)
0758A

19 декабря 1983 года
ОРИГИНАЛ: АНГЛИЙСКИЙ

КРАТКИЙ ОТЧЕТ

Введение

Данная Рабочая группа была создана в рамках среднесрочной программы ВОЗ по охране психического здоровья для рассмотрения потребностей в этой области при обслуживании престарелых в странах Европейского региона. В ее состав входили 20 временных советников из 10 стран, включая 7 представителей страны - устроительницы совещания, а также 4 представителя неправительственных организаций. Кроме того, в работе совещания принимали участие специалисты Сотрудничавшего центра ВОЗ по научным исследованиям и подготовке кадров в области охраны психического здоровья при Центральном институте охраны психического здоровья в Мангейме, Федеративная Республика Германии, и Сотрудничавшего центра ВОЗ по изучению психосоциальных факторов и здравоохранению в Бельгии. В Рабочей группе были представлены специалисты в следующих областях: гериатрия, геронтология, руководство здравоохранением, сестринское дело, психиатрия. В нее вошли также представители добровольных организаций.

Рабочая группа ставила своей целью разработку рекомендаций относительно развития комплексных коммунальных служб охраны психического здоровья престарелых и подготовку руководящих указаний по профилактике и сокращению числа психических нарушений среди престарелых. В рабочем документе совещания был дан обзор организации такого рода служб, а участники совещания в своих выступлениях дали краткую характеристику общей организации работы в этом направлении в их странах. Рабочая группа признала растущее значение проблем, связанных с возникновением психических нарушений среди престарелых, и отметила увеличение числа случаев такого рода нарушений у наиболее пожилых представителей этой возрастной группы.

Развитие служб

К настоящему времени собран значительный эпидемиологический материал, который со всей очевидностью свидетельствует о том, что в странах Региона отмечается рост числа престарелых, страдающих психическими заболеваниями, в частности деменцией.

Проблемы охраны психического здоровья престарелых всегда следует рассматривать в контексте общей деятельности по охране здоровья престарелых, поскольку работа по решению этих проблем является составной ее частью. Особая роль здесь принадлежит службам первичной медико-санитарной и психиатрической помощи. Очевидно, масштабы данной проблемы различны в разных странах Региона и вряд ли существует определенная модель, которая могла бы быть применима в условиях различных систем организации работы и неодинаковых возможностей тех или иных стран.

Настоятельно необходимо в каждом из государств Региона разработать единую национальную стратегию развития служб охраны психического здоровья престарелых. При этом первостепенное внимание должно быть уделено нижеследующему.

- Определению на основе демографической и эпидемиологической информации потребностей в обслуживании престарелых в настоящем и будущем.
- Анализу вероятных потребностей престарелых и возможностей их удовлетворения в рамках действующих служб.
- Разработке предложений относительно возможностей совместного планирования деятельности комплексных служб охраны здоровья престарелых и управления ими. Деятельность комплексных служб должна обеспечивать профилактику заболеваний, их раннее выявление и лечение, оценку проводимой работы и использование разнообразных методов обслуживания. Она должна включать в себя многие элементы работы в медико-санитарной и социальной областях, сфере обеспечения жильем, а также в рамках деятельности добровольных и других служб.

- Рекомендации по разработке стратегий в области образования и научно-исследовательской деятельности для содействия внедрению позитивной практики и нововведений в деятельность служб.

Информационные службы

Для эффективного использования ограниченных ресурсов следует обеспечить наличие самой разнообразной информации. Такого рода информация необходима по четырем основным направлениям работы.

Научные исследования. В ряде стран успешно проводятся исследования частоты возникновения психических заболеваний среди престарелых, и результаты этих исследований хорошо известны. Что же касается деменции, то к настоящему времени накоплен лишь незначительный объем информации о частоте возникновения этого заболевания и особенно о тех многочисленных случаях, которые характеризует слабовыраженный характер течения болезни. Необходимо проведение длительных исследований для получения такого рода информации. В этих целях будет необходимо использование унифицированной аппаратуры для проведения скрининга, а также надежных методов сбора данных о состоянии психического здоровья пациентов и другой информации.

Медико-санитарные службы. Многие еще предстоит узнать об исходе психических заболеваний среди престарелых и обрабатываемости пациентов в различные медико-санитарные учреждения. Необходимы также дополнительные данные о кадровых и других ресурсах, а также информация о результатах исследования экономической эффективности экспериментальных служб. Особое внимание следует уделить различным методологиям, используемым при проведении тех или иных исследований в области контроля качества служб, включая рассмотрение вопросов удовлетворенности потребителей предоставлением этих служб. Следует также продолжить сбор традиционной статистической информации о потоках больных и об использовании больничных мест.

Контакты. Необходимо продолжить усилия по разработке точных определений технических терминов. При проведении международных сравнительных исследований следует уделить внимание трем вопросам: возможности подготовки глоссария по общей медико-санитарной терминологии; выпуску глоссария по проблемам старения; а также продолжению работы над Международной классификацией нарушений, физических и других дефектов.

Обучение. Подготовка как профессионального, так и непрофессионального персонала потребует проведения оценки их потребностей и составления соответствующих учебных программ. В отдельных странах врачебный и сестринский персонал, а также лица, работающие с престарелыми вне медико-санитарных учреждений, проходят недостаточный инструктаж по проблемам старения. Такое положение дел требует исправления. Необходимо также подвергнуть изучению те виды информации, которые необходимы для подготовки добровольного персонала.

Организация деятельности местных служб

Участники совещания пришли к согласию относительно того, что в принципе престарелым следует, если это возможно, жить дома при условии их обеспечения соответствующим первичным медико-санитарным и специализированным обслуживанием, в котором они нуждаются. Если проживание дома не является возможным, необходимо обеспечить возможности их пребывания в течение короткого или продолжительного периода времени в домах для престарелых по месту жительства. Для достижения этих целей необходимо создание четко спланированной комплексной сети служб с целью выявления, когда это возможно, и раннего определения лиц, подверженных факторам риска, а также проведения квалифицированной оценки лечения и обслуживания, в котором нуждаются престарелые.

Для содействия разработке плана мероприятий был рассмотрен ряд ключевых факторов, в частности вопросы, связанные с определением групп обслуживаемого населения, оценкой имеющихся ресурсов и проблем, а также созданием местной группы комплексного планирования с включением в нее специалистов в области психиатрии, гериатрической медицины, первичной медико-санитарной помощи, сестринского дела, различных лечебных дисциплин, социальных служб, а также представителей администрации и добровольных организаций.

Хорошо скоординированная деятельность комплексных служб требует квалифицированного планирования, тесных рабочих контактов и утверждения соответствующих моральных качеств. Необходимо добиваться высокого уровня обслуживания, при этом следует учитывать разработанные на местах рекомендации по совершенствованию практической работы. Достижение высокого уровня обслуживания должно стать основной и постоянной задачей.

Первичное обслуживание

Значительное большинство престарелых живут дома, нередко в одиночестве, поэтому для них характерны психические нарушения. В этой связи необходимо предоставить в распоряжение пожилых людей соответствующие профессиональные и добровольные службы на первичном медико-санитарном уровне,

обеспечивающие необходимое обслуживание по месту жительства. Это предполагает тщательную организацию, развитие взаимодействия и тесных рабочих связей между персоналом первичных медико-санитарных и специализированных служб.

Деятельность большинства служб первичной помощи основывается на концепции многопрофессиональной бригадной работы по месту жительства. В таких случаях врач общего профиля порой является наиболее опытным профессиональным работником, к которому нередко обращаются в первую очередь и которому приходится решать большую часть возникающих проблем. Работа на местах должна предполагать, в случае необходимости, посещение пациента на дому специалистом в той или иной медицинской области или персоналом других служб. Важным вспомогательным элементом обслуживания по месту жительства является деятельность групп самопомощи и других организаций, предоставляющих консультативную и иную помощь престарелым, что уже отмечалось выше, в разделе об "организации местных служб". Уделяя внимание вопросам обслуживания пожилых людей, страдающих психическими расстройствами, по месту жительства, необходимо также учитывать потребности членов их семей и других лиц, оказывающих помощь престарелым.

Обучение

Большую роль для различных категорий профессиональных или непрофессиональных работников, обеспечивающих обслуживание престарелых, страдающих психическими расстройствами, играют программы обучения и подготовки. Повышая свои знания и компетенцию, они расширяют свои возможности, берут повышенные обязательства, совершенствуют свои навыки. Информационная отдача от их работы содействует улучшению деятельности служб, а также мониторингу и оценке проводимой работы. Решение проблем, стоящих перед пожилым населением, страдающим психическими расстройствами, требует специальных знаний. В некоторых странах созданы специализированные службы охраны психического здоровья престарелых в рамках действующих специализированных или общих медицинских служб.

Значительную часть обязанностей по каждодневному обслуживанию престарелых берут на себя родственники и не подготовленный в профессиональном плане персонал. Действенность такого обслуживания, а также эффективность усилий добровольных работников существенно возрастают, если проводится соответствующая учебная и подготовительная работа и предоставляется практическая помощь, если она необходима, со стороны профессиональных медицинских работников. Если ощущается нехватка подготовленного персонала для оказания непосредственной помощи престарелым, нуждающимся в обслуживании, опыт и знания этого персонала должны использоваться для консультаций и подготовки других работников.

В деле распространения знаний в рамках обучения и подготовки должны участвовать не только лица, предоставляющие помощь, но и профессиональный медицинский персонал. Обучение должно проводиться на более широкой основе для привлечения к решению стоящих проблем как широкой общественности, так и политических деятелей. Общественность и руководители стран должны признать наличие стоящих проблем, осознать свою ответственность за их решение и рассмотреть возможности оказания помощи престарелым.

Профилактика

Первичная профилактика психических нарушений среди престарелых носит в настоящее время ограниченный характер, что свидетельствует о настоятельной необходимости проведения научных исследований в этой области.

Вторичная профилактика, то есть лечение ранее невыявленных психических нарушений, вполне возможна. Значительные исследования, проведенные в этой области, показывают, что психические нарушения среди престарелых являются достаточно частым явлением. Проведение скрининга и оценки состояния здоровья уязвимых групп населения силами служб первичной медико-санитарной помощи позволило бы обеспечить раннее выявление заболеваний и их соответствующее лечение. К уязвимым группам следует отнести лиц в возрасте свыше 75 лет, живущих в одиночестве, а также престарелых, недавно потерявших родных или близких и нуждающихся в обслуживании по месту жительства.

Третичная профилактика легко осуществима и зависит от уровня руководства работой по лечению известных психических нарушений. Важными элементами такой работы являются проведение своевременной медицинской оценки, многодисциплинарный подход и непрерывность предоставляемого обслуживания.

Рекомендации

1. Задачи по охране психического здоровья престарелых должны быть включены в региональную стратегию достижения здоровья для всех к 2000 году.
2. Деятельность систем медико-санитарной информации на любом уровне медицинского обслуживания должна включать сбор данных о состоянии психического здоровья престарелых.

3. Участники совещания одобрили рекомендации, подготовленные на проходившей в апреле 1983 года в Тампере Рабочей группе ВОЗ по первому контакту в системе охраны психического здоровья^а, и подчеркнули значение подготовки кадров для практической деятельности по охране психического здоровья на первичном уровне.
4. Представляется целесообразным проведение совместного исследования лечебной практики в различных странах и в рамках различных систем медико-санитарного обслуживания с целью определения эффективных стратегий профилактики психических нарушений среди престарелых.
5. ВОЗ следует рассмотреть возможности подготовки руководящих указаний по составлению учебных материалов для различных категорий медико-санитарного персонала, занимающегося обслуживанием престарелых.

^а Документ MNH 059(1)(3).