Mental health in nursing homes: Current best practice

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Organizing mental health care in nursing homes: How, by whom and what for?

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Though care should be provided in patients' homes for as long as possible, it must be recognised that care in an alternative residential setting may be the only way of meeting some patients' needs effectively or avoiding intolerable carer burden. Such care will always be necessary, for people who have no relatives available. The residential care may be useful for respite care including a range of time limited services, to support the carers. Residential care should also be available for those patients whose physical, psychological, and/or social dependencies make living at home no longer possible. This provision includes a range from supported accommodations with low level supervision, medium level care facilities and full nursing facilities. There is a high prevalence of mental disorders in nursing homes and very often the staff is not adequately educated, trained and supported to care these individuals. Psychiatric consultation liaison services should be provided not only for residents but also to support the staff of these facilities. The most recent international documents point out the necessity to offer the best available care [1] for these vulnerable persons in the deep respect of their dignity [2]. It becomes urgent to launch a deep debate on this subject in order to recommend to authorities the best guidelines to support policies to be adopted in this field.

Disclosure of interest The author has not supplied his declaration of competing interest.

References

[1] OMS. Rapport mondial sur le vieillissement et la santé. Genève: OMS; 2015 [WHO/FWC/ALC/15.01].
[2] WHMH. Dignity in mental health. World Mental Day Report 2015. Occoquan: WFMH; 2015.

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Treating chronically psychotic patients in nursing homes

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The increase of aging patients with schizophrenia becomes a public health issue. The exponential demography of the elderly, the improvement of cares associated with better physical follow-up directly impact the number of old patients with chronic psychiatric disease. Deinstitutionalization associated with a dramatic enhancement of ambulatory and community cares has led to a reduction of beds in psychiatric hospitals. When dependency occurs, due to physical comorbid illness or a worsening of the negative symptoms, psychiatric teams should find appropriate housing and no longer the psychiatric hospital. Nursing home and sheltered housing for the elderly dependent persons become a solution, but geriatric staffs are not always prepared to receive resident with schizophrenia and other psychotic disorders. They often are at a loss when faced with the expression of psychiatric symptoms or with the specificity of caring for often-younger patients whose behavior is different from older people with neurodegenerative disorders.
How psychiatric teams could long-term assist the sheltered housing and nursing home and bring a psychiatric know-how within staffs often reluctant to deal with psychotic patients who could burden caregivers. How could they be trained to cope with complex cognitive functions impairments of schizophrenia, far from cognitive impairments of Alzheimer dementia? How to change the representation of psychiatric illness, which often leads to a double stigmatization (old age and madness)? Improving the quality of life of aging patients with severe chronic mental illness in homes for seniors is a great challenge for psychiatric teams in collaboration with geriatric caregivers.

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Modell Donaustadt: A best practice example for treatment of mental and physical comorbidity in long-term care

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Evidence consistently demonstrates that people with long-term mental health conditions develop serious physical comorbidities at an earlier age than the average population. These physical comorbidities are often exacerbated because long-term psychiatric conditions reduce the patient's ability to manage somatic symptoms effectively, thus hindering treatment. This highlights the critical importance of continuous support by primary care physicians and nursing staff. People with persistent mental illnesses typically require long-term care significantly earlier than people without mental illness.
As a consequence, elderly patients with chronic mental illnesses who are essentially unable or unprepared to function in the outside world or are in need of constant medical attention are typically placed into long-term care facilities and nursing homes geared to serving physically disabled elderly.
These LTC institutions have no capacity to provide specific care for mentally ill patients. Difficulties in treating psychiatric patients in these LTC facilities often result in transfers to and repeated admissions in acute psychiatric hospitals.
In an effort to resolve the "revolving-door" situation of these patients and reduce the rates of re-admission to acute psychiatric hospitals, Modell Donaustadt was developed. In the talk, Modell Donaustadt will be presented as a best practice example for the treatment of mental and physical comorbidities in long-term care.

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Offenders with intellectual disability: Best practice update

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Sex offenders and intellectual disability

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Ethical controversies in patients with intellectual disability who are sex offenders.

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