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.

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S59

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

S61

Sex offenders and intellectual disability

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

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Patients with an intellectual disability (ID) have a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains (according to the DSM-5). These deficits in adaptive functioning result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life. Therefore, it is not surprising that these patients cross physical/sexual boundaries quite often. Above that, a proportion of all sex offenders have an intellectual disability.

The treatment of these sex offenders with an ID has to focus on protective factors, next to risk factors in order to decrease the risk of recidivism. Due to the chronicity of their disorder, quality of life is an important issue in these patients.

In this paper, we want to address some ethical controversies:

– hormonal treatment in patients with ID who are sex offenders;

– the right to have a 'normal' sexual life in these ID offenders, and the Dutch experience of the Stichting Alternatieve Relatiebemiddeling (SAR, that can be translated as foundation of alternative relationship mediation).

The SAR is an alternative dating service, giving information about the sexuality of physically or mentally disabled people and organizing sexual encounters for them.

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S62

Assessment of people with intellectual disability for the court: What does a psychiatrist need to know?

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This presentation will focus on the importance of psychiatrists understanding that they operate at an interface between two very different disciplines; medicine and law. There will be consideration of what and why psychiatrists need to understand the law, the way it operates and the likely implications of their opinions. There will be consideration of an example from England and Wales to illustrate the way in which psychiatry and law might interpret the same information. The aim is that psychiatrists will be better equipped to face the challenges the law presents.

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S63

Use of risk assessment tools for people with intellectual disability: The latest evidence

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A relatively high proportion of people detained in forensic psychiatric hospitals have intellectual disabilities (up to 3000 people in the UK; Royal College of Psychiatrists, 2013), and people with intellectual disability are significantly over-represented among those psychiatric patients with long lengths of hospital stay (CQC, 2013; Vollm, 2015). People with mild to borderline intellectual disabilities are also prevalent in the UK prison system.

Although the relationship between intelligence and offending is complex, lower intelligence is a known actuarial risk factor for offending behaviour. Studies, which have investigated the prediction of re-offending risk in populations with intellectual disability, have nevertheless found lower rates of recorded re-offending compared to those in mainstream forensic populations (e.g. Gray et al., 2010). The relatively high rate of 'offending-like' behaviour, which is not processed through the criminal justice system in people with intellectual disability makes risk prediction a more complex exercise with this group of people. It also makes outcomes measurement more difficult.

This paper will give an overview of the current research evidence and clinical practice in the field of risk assessment, risk management and outcome measurement with offenders with intellectual disability. It will summarise the findings of a recent NIHR funded systematic review by the author, which pertains to this area, and will point to future developments in the field.

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S64

Prisoners with intellectual disability: How to adapt interventions and the environment

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There is an increasing interest in the Spanish prison to give the appropriate care when they are in prison. This situation has a special meaning in inmates with learning disabilities, as they are a vulnerable group inside prison. They are vulnerable in different areas as they have a high prevalence dual diagnosis (both with mental illness and drug misuse), they could suffer from abuse from other inmates, difficulties to understand prison regulations, etc. The prevalence of intellectual disability (ID) in the prison setting has been poorly evaluated. In Spain, despite various approximations or estimates regarding people with intellectual disabilities no reliable data is available.

In our presentation, we will give an overview of the care of this group of patients, presenting some data from an epidemiological study in Spain. The rate of learning disabilities was of 3.77% of the study population has an IQ below 70, and 7, 3% has borderline IQ rate. We also describe a new setting in one of wards of a prison of Barcelona where has a model of therapeutic community for treating offenders with intellectual disabilities. This resource open two years ago and is run between prison services and an organization "Accepta" (specialized in people with learning disability and penal law problems). This is an effort from the prison services to adapt to the needs of inmates and deliver a better service with a good post-release follow-up.

And finally, we present some data about learning disability in penitentiary psychiatric settings (the prevalence as a main diagnose is around 10%).

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