special articles

Psychiatric Bulletin (2002), **26**, 24–26

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Old age psychiatry services: long-stay care facilities in Australia and the UK

We are old age psychiatrists; T.A. based in Britain, J.S. in Australia. A return visit by T.A. to Australia allowed us to focus attention on differences between the two countries in their provision of long-term care for old people with mental disabilities. What works well? What constrains development?

Background and contrasts

There are differences within countries as well as between them. In both countries, but particularly in Australia, service provision in urban areas differs from that in large but sparsely populated regions; and there are differences between states (e.g. New South Wales and Victoria) in the way services are funded and organised. Our observations relate primarily to facilities that we have visited in Melbourne and Sydney, and to what we know of the way long-term care has evolved in the two cities.

Fifty years ago, long-term care arrangements were similar in the two countries, although more was available in Britain because of its higher proportion of elderly people. In the 1960s there were large, usually crowded, wards for older people in large psychiatric and geriatric hospitals. During the 1960s and 1970s the nursing home population in Australia tripled, as it did in the US. Long-term supervised care in Britain was still in hospitals, and in residential ('Part III') homes run by local authorities.

In Britain the specialities of geriatric medicine and old age psychiatry evolved, with an emphasis on assessment and provision of care to people in their own homes. There was a similar but later evolution in Australia. Also in the 1970s, there was mounting enthusiasm for relocating patients of all ages from psychiatric hospitals to the community. This was not just because of growing recognition of the potentially harmful effects of being 'managed' in non-domestic environments, but because it was often assumed that it would be cheaper.

Much of the initial deinstitutionalisation was trans-institutionalisation – from hospitals to nursing or residential facilities, and away from the clinical responsibility of specialists and health services. The long-term beds were no longer components of geriatric or psychiatric services.

In the 1980s in Britain, there was a huge increase in the size of the private nursing home sector, at the expense of long-term hospital beds. In 2001 there are few long-term hospital beds left, geriatric or psychiatric, in Britain or Australia.

Solutions

So what happens to older people who have unremitting and distressing mental or behavioural problems requiring long-term continuous care?

Some have schizophrenia and not dementia. A decade ago it was difficult to arrange admission to a nursing home in Australia for people with long-standing psychotic symptoms who needed supervised care. The federal government funds nursing home care, while state governments are responsible for mental health care. There were sensitivities about 'cost-shifting'. Similar concerns were expressed in the US about patients with psychiatric problems being "inappropriately placed in nursing homes at Medicaid expense", thereby shifting costs from the state to the federal government (Streim *et al*, 1997). Mental health services in Australia still face difficulties when trying to arrange residential care for non-elderly people who do not have dementia who need a supervised environment because they have continuing and disabling schizophrenia or other psychiatric disorders.

Younger, cognitively intact people should not be accommodated in aged care facilities; group homes funded through mental health services may be appropriate. For older people with long-standing disabling psychotic conditions, nursing home care may be appropriate, especially if the individuals also have physical disability or dementia. In recent years Australian regulations have become less stringent, so that most 'graduate' survivors have been transferred from state-funded hospital beds to nursing homes. This is commendable, but only if patients with persistent or recurrent psychotic symptoms, and those with dementia who have marked behaviour disturbance, are cared for in facilities where staff have experience and understanding of psychiatric problems and behaviour disturbance.

People with moderately severe dementia who are ambulant and keen to be 'on the move' can usually be well cared for without recourse to tranquillisers or psychiatry. They need a secure environment, with attractive features to catch the interest, and routes to follow. Designers and architects have already contributed much (see Cohen & Weisman, 1991; Judd *et al*, 1998).

The majority of residents in nursing homes do not need specialised psychiatric care, though the high prevalence of depression and anxiety in aged care facilities requires that there should be regular, informed review and willingness to treat or refer. This depends on effective and easy working links with psychiatric services.

https://doi.org/10.1192/pb.26.1.24 Published online by Cambridge University Press

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New South Wales

In Sydney, our visits to nursing homes that were described by their senior staff as 'dementia-specific' led us to conclude that some, at least, of these facilities would not meet requirements for provision of therapeutic care for residents with behavioural disturbances. Since there are few long-term psychiatric beds left in Sydney, most such people have to stay in nursing homes. Short-term admissions to acute psychogeriatric units tend to provide only short-term solutions. Return to the nursing home commonly leads to recurrence of disturbed behaviour unless psychiatric expertise can be made continuously available. Shortage of staff in community old age psychiatry teams often precludes such a solution. The current situation is unsatisfactory.

In New South Wales in the 1980s, as part of a de-institutionalisation programme, nine state-funded 16-bed Confused and Disturbed Elderly (CADE) Units were built, but were not linked with catchment area old age health services. Those selected for admission tended to stay there for years, even though their behaviour soon settled. Increased throughput, and oversight by old age psychiatrists, might have allowed better use of the units.

Victoria

By contrast, Victoria has developed about 20 30-bed 'psychogeriatric nursing homes'. The federal government pays for the basic nursing home care and the state government provides 'top-up' funding for extra psychiatrically trained staff to be available. These homes are linked to, but not managed by, the local catchment area old age psychiatry service. The psychiatry team works with the general practitioners, with weekly case reviews to oversee treatment and to ensure there is appropriate 'throughput'. With only 600 such beds in the State it is seen as important that the beds are kept accessible for those who really need them.

Britain

In Britain most long-stay care of older persons is in private commercial homes, or (far less often than in Australia) in charitable homes, but the NHS retains a responsibility, variably interpreted in different localities, of paying for care of people needing 'specialist' medical and nursing care because of severe physical or mental disability. Long-stay psychogeriatric units, in effect dementia units, have been developed in association with local psychiatric services for old people. The inducement for collaboration with the latter is that they can provide the increased funding and act as the 'gatekeeper' – that is, admissions are through that service and after assessment by it.

In Britain the past 2 years have seen the report of the Royal Commission on Long Stay Care (1999) and the publication of new required national standards for care homes (Department of Health, 1999), with a Care Commission to supervise and enforce these standards, and along with these a heightening of debate concerning both the issues and the government's responses to them.

Features in common

The British and Victoria arrangements have some features in common. The link with now well-developed old age psychiatry services gives continuity and feeds in special skills. Concern is often expressed by those who wish to 'demedicalise' long-stay care, making it as 'domestic' as possible. However, as seen in the Victoria psychogeriatric nursing homes, it is perfectly feasible to provide a home-like setting and non-institutional attitudes in facilities that provide psychiatric treatment and are run by the health service; indeed, health services have often pioneered such domestic settings.

More contentious, however, is the question of 'throughput'. In Australia, 'dementia specific' units operate mainly as *behavioural* care facilities, patients being 'moved on' when physical disability predominates. But should psychogeriatric long-stay units be 'homes for life' or should they cater for people only until their special needs abate (e.g. because of physical deterioration or because their behavioural disturbance settles)?

The latter is the policy in Victoria, the former is favoured in Britain. The advantages of the former are that scarce resources are concentrated on those people thought most likely to benefit from them, through application of skills and facilities that are designed to minimise and delay the disability caused by the mental and behavioural features of the dementias, and to avoid the need for heavy physical nursing in units that are designed as 'domestic'. The cons are that old people and their families are faced with a likely further move as the natural history of dementia progresses, and are thus denied the security of knowing that they will be 'seen through' to the end once they are in a dementia unit. There is presumably also the threat that as the old person deteriorates physically, he or she will be 'moved on' – a fact that may, however wrongly, but nevertheless understandably, sometimes be seen as a punishment for getting worse.

Whether Victoria will maintain its current policy will depend in part on the availability of specialised units – as long as there are relatively few, it is likely that they will continue to admit and retain only those people thought likely to benefit from their special nature. But one important source of pride in the staff is then forfeited – the price in coping with all features of dementia, of being the ultimate 'long stop' and of guaranteeing that people will be 'seen through' the whole course of the disease.

A compromise would be to associate, both in siting and in overall staffing, units for individuals with behavioral disturbance with smaller nursing home units that cater for the last, often primarily physical, phase of care; part of the compromise would be that residents would stay in the unit even if their behavioural disturbance settled. Alternatively, psychogeriatric units could be built as separate wings of much larger nursing homes, rather than as stand-alone facilities. To be financially viable as a specialist resource, each unit would need at

https://doi.org/10.1192/pb.26.1.24 Published online by Cambridge University Press

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least 10 beds, and would need special funding arrangements. It may be that this is how New South Wales will approach the problem.

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Psychiatric Bulletin (2002), **26**, 26–28

JANE MORRIS

Interpersonal psychotherapy – a trainee's ABC?

Psychotherapy training for general psychiatrists

A recent article in the *Bulletin* (Rees, 2000) suggests that cognitive–analytic therapy (CAT) "may emerge as the preferred form of psychotherapy within the NHS". I would question Rees' claim that CAT "uses an understandable language and straightforward techniques". For many patients – and therapists – it is too ridden with jargon and complex diagrams. Moreover, as he admits, "formal CAT training is long [2 years for basic qualification] . . . this is impractical for most psychiatrists". In addition, "research has yet to provide a robust evidence base for its effectiveness". CAT in expert hands is an attractive and powerful model, but does not suit the needs of junior psychiatrists striving to rapidly acquire and integrate broad effective psychotherapeutic techniques. I suggest that another of the 'newer' therapies, interpersonal theray (IPT), would fit the bill better.

Background to IPT

The IPT of Klerman *et al* (1984) is both flexible and integrative. It is a time-limited, structured psychotherapy designed pragmatically but with theoretical roots in attachment theory. It has been manualised as a treatment for depression and for bulimia nervosa (Fairburn, 1997), and extended as a group treatment for binge eating disorder (Wilfley *et al*, 1993). Recent work has modified and extended the model for treatment of anxiety, dysthymia, primary care disorders, chronic fatigue, mood disorders associated with HIV, somatisation, adolescent disorders and depression of later life, and for use with couples and groups (all described in Weissman *et al*, 2000).

IPT, although relatively new to Britain, is welcomed enthusiastically by both patients and multi-disciplinary professionals. Unlike CAT, it has already been subject to large-scale randomised controlled trials involving CBT and medication, so it fits into mainstream medical research and evidence-based practice.

The model incorporates psychoeducation, it is 'medication friendly' and agrees with a medical model of psychiatric illness. Its rationale sits well with family and other systemic models of psychotherapy, and indeed offers a way of accessing systemic resources within individual therapy. Like CBT, it is structured and open, using a collaborative therapeutic relationship without invoking transference issues. Rating scales monitor each patient's progress. IPT does not involve formal 'homework' or rely on extensive paperwork. However, patients are encouraged to develop skills and experiment actively with these between sessions.

A full description is beyond the scope of this article (see Klerman & Weissman, 1993; http://www.interpersonal psychotherapy.org), but therapy (12–20 sessions, contracted in advance) has three parts, see Box 1. The first stage closely matches a standard psychiatric assessment. The medical model of depression is emphasised to the point of prescribing 'the sick role' to the patient. A key feature is the compiling of an interpersonal inventory that lists and examines all the patient's relationships. This is charted on rating scales or as a 'spider' diagram, which becomes a key resource for future therapy. By session four, one of four prescribed foci is selected: grief, role transitions, role disputes or interpersonal deficits.

The second and longest stage comprises active work on the chosen focus. The therapist becomes less active but holds the focus, relates symptom change to interpersonal events and encourages the patient to devise and experiment with new interpersonal strategies. Whereas CBT may conceptualise painful feelings as symptoms, and expect these to diminish when negative cognitions are

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