
Chapter 13:

Future Directions

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Introduction

Recent changes in the NHS, particularly the move towards community care, and research advances, have produced a number of positive developments in speech and language therapy services for older people with mental health problems:

- Legislative changes have provided an opportunity for services to be reconsidered and, in some cases, restructured. Occasionally this may involve additional funding, but innovation is also evident in the flexible use of existing resources, for example, as we saw in Chapter 8.
- Clinical managers have more flexibility to consider options for the use of limited resources (although the fact that resources are limited might not be considered as positive).
- Clinical specialists in the psychiatry of old age are now recognised as necessary.
- Speech and language therapy input to the multidisciplinary team is now more evident.
- Innovations in clinical practice such as memory clinics to which people can self-refer are evident.
- Special interest groups in old-age psychiatry now exist to support clinicians and to promote research and high-quality clinical practice.
- Research interest in this area is growing, with papers on the speech and language disorders in the dementias appearing in academic journals and on conference agendas.
- The need for training initiatives for care staff in the residential and nursing care sectors is now recognised by both care staff and their managers. Speech and language therapists have the requisite skills and knowledge to carry out such training.
- Research is beginning to differentiate between different subgroups of disorders which is leading to clinically useful indicators for management, for example in multi-infarct dementia, semantic dementia and the progressive aphasias as well as in Alzheimer's disease.

- Community care has produced an increased role and an increased burden for carers. There is now government interest in and research on this burden and growing awareness of the need for carer support as a vital part of care packages.

Despite these improvements, there is no doubt that for speech and language therapy, as for other health and social services, the service to older people with psychiatric disorders is scarce, fragmented and variable owing to reliance upon local initiatives and resources.

Issues for service provision

A number of issues which have been raised and discussed elsewhere in this book are worth returning to as they are likely to be the key to improvement of services for older people with mental health problems.

Access to services

Access to rehabilitation services is not automatic for older people with mental health problems. There are a number of issues surrounding the local service:

- Is there a service to the elderly with psychiatric problems?
- Is the service restricted, i.e. assessment only?
- Is domiciliary care available?
- Are there restrictions on treatment options such as time limits or geographical constraints such as hospital-based treatment only?
- Is there efficient and effective coordination between health and social services elements of care packages?

A further issue of vital importance is whether or not there is access to services such as rehabilitation, for older people who are in residential and nursing homes. In some areas of the UK there is still no provision for older people who are in care; in other areas this is restricted to social services homes but does not extend to the private sector and in a few areas it is extended to all older people who are registered with local GPs regardless of where they live. The quality of the care offered is also variable. Given recent research findings into the dementias and the fact that treatments for dementia are likely to become available which may slow or even arrest the progression of the symptoms of dementia (Perry and Perry, 1993), the acceptability of 'assessment only' services must be questioned. Some clients with progressive disorders such as multi-infarct dementia can benefit from direct therapy (Swinburn and Maxim, Ch. 10). The continuity of care offered and the provision for training care staff, working with them for a short period of time to illustrate how

to communicate effectively with a new resident and professional support for carers are all issues which need to be addressed in quality control initiatives by speech and language therapy managers.

Referral arrangements

Hall and Channing (1990) reported that many older people did not receive the help that they needed at home because they were reluctant to discuss non-specific or strictly 'non-medical' issues with GPs. Thus older people, almost invariably, consult their GPs ostensibly about some specific ailment. Their general condition may then go unregarded as doctors are often reluctant to embark on detailed questioning about functional problems in case this awakens latent fears and leads to negative thinking. Referral for services such as rehabilitation and indeed social provision such as home help and meals on wheels may then be rather arbitrary. Older people themselves may try to manage without seeking help. Studies have shown that elderly people accept a degree of impairment that they would have found unacceptable during middle age (Wells and Freer, 1988). Some older people may be well aware that they need help but may be reluctant to ask. Some doctors may not favour referral until as late a stage as possible, there may be budgetary constraints, although there is, as yet, no evidence that this restricts referral, or the doctor may just not have the necessary information to realise that extra help is needed (Hall and Channing, 1990). It may be that the present GP screening arrangements for over-75s need to be expanded or more carefully geared to allow older people to discuss their problems and worries rather than just addressing medical issues.

It may be that medical access, i.e. GP or geriatrician/psychogeriatrician referral to social services is not sufficient. At present many health care workers such as speech and language therapists would have to request referral to social services via a doctor. Although this referral might help with coordination of services, this is not always the case. Health care professionals such as speech and language therapists will often have a very clear idea of the problems that an older person has because they will have discussed daily routines, problems and priorities etc. in gaining a communicative history and in formulating an assessment of communicative needs.

Questions can be raised regarding the cost effectiveness of early referral to rehabilitation and social services. It has been shown in other areas, such as carer support, that early intervention allows the carer to cope more effectively and longer, therefore saving costs of expensive residential care (Brodaty and Peters, 1991). It may be the case that early referral to speech and language therapy for impairments such as word-finding difficulty or mild dysarthria will facilitate the preservation of independent living in older people by helping to prevent problems such as social

isolation and depression. It is essential that methods of therapy audit which take account of qualitative gains, such as increase in general well-being and ability to cope with daily living, are accepted as valid indicators of therapy value.

Research involving clinical audit of services is needed in order to evaluate the most efficient and cost-effective way of ensuring adequate referral of older people to the help and support that they need.

Coordination of services

Services for the elderly mentally ill involve a range of provisions including health, social services, voluntary sector and family involvement. Problems are evident in coordinating these services (Webb, 1991) to achieve the best possible care package for the older client. An example is discharge from hospital: in a survey conducted in 1992, Neill and Williams found that one in five elderly people experienced a 'bad' discharge and that 59% were experiencing self-care difficulties. They state criteria for a good discharge which consist of:

- at least 24 hours' notice;
- an opportunity to discuss how they would manage after discharge;
- somebody with them on the journey home;
- somebody waiting for them at home;
- somebody to call and see them on the day of discharge.

Yet Jones and Lester reported in 1994 that 46% of carers could not recall discussion of the discharge taking place.

Examples of good discharge quoted above always involve visits to the home, provision of aids and adaptations prior to discharge and synchronisation of health and domiciliary provision to accomplish key tasks. This always involves expensive professional time and resources, but could allow very disabled older people to return home successfully thus avoiding expensive residential care and allowing the older person to achieve their goal of returning home. Professionals such as speech and language therapists may or may not be involved in such procedures with their clients. It may be that the role of rehabilitation professionals, such as speech and language therapists, needs to be discussed and defined, ratified by efficacy studies and then included in good practice guidelines, ensuring that high standards of service provision are generalised across the country.

Services for older people

Cassel (1994) stated that there is a need to recognise that for most elderly people the quality of life after age 75 is more important than the length of life. Therefore research and service provision need to be

prioritised to address diseases that result in long-term disability such as dementia, depression, and visual and hearing disorders. Advances in preventing or delaying the onset of such disorders or in managing the resulting disabilities more effectively could greatly increase the independence and productivity of people in their older years (Cassel, 1994).

Age-based access to services is also questionable in its effectiveness at maintaining older people as independent and self-caring. In some cases, access to particular treatments might allow an elderly person to remain independent rather than needing to enter expensive residential care. Lack of rehabilitation services for the elderly mentally ill might be cited here as of particular concern. 'Ageism' is rife in the western world, and because there are increasing numbers of older people aged 85+, it is important to ensure that this increase does not lead to 'age rationing' of health resources. 'Age rationing' implies that older people are denied access to services which are of expected benefit to them; this is distinguished from cost containment where services that are not expected to be of benefit are withheld (Wicclair, 1993).

Services also need to be organised so that the elderly can benefit from them. Issues such as transport can determine whether older people can gain access to services which are provided. Speech and language therapists are starting to become involved in initiatives such as community-based services and training projects in residential homes but such initiatives need to become more widespread. The majority of specialist speech and language therapists who work with the elderly mentally ill remain hospital based, so there is a need for flexibility and outreach services to accommodate the older client and to give him or her the best possible chance of benefiting from therapy.

Perhaps therapy practices need to be evaluated in terms of their suitability for the elderly generally and for the elderly mentally ill in particular:

- Are the assessments that we use designed specifically for this client group or validated to use with this sector of the population?
- Is sufficient known about the effects of normal and pathological ageing on language and communication?
- Do we know enough about how the elderly use language and what their priorities are for functional communication?
- Do we know enough about what happens to language usage when older clients enter residential or nursing care?
- Do we have methods of therapy which have been designed for use with the elderly and/or validated with older clients?
- Do we organise speech and language therapy services for older clients to facilitate continuity of care for clients with needs which progress and result in changing needs such as entering day care and later full residential care?

The answer to most of the above is, sadly, only partially yes. But improvements are being made and increasing awareness is resulting in those issues being afforded greater prominence.

Future speech and language therapy services

We need to consider what an ideal health and social service for the older person would consist of, and then how speech and language therapy services would fit into this. An important starting point is health screening.

Under the new GP contract (Department of Health, 1989b) patients over the age of 75 were to be offered an annual assessment. It was envisaged that such screening would be carried out by practice nurses (UKCC, 1990) but there has been debate as to who should be involved (Nocon, 1992). The practice nurse would seem to be well placed to carry out the screening as he or she has the required skills (Mackereth, 1995) and the process would be time-consuming for a GP. The screening could therefore consist of a home visit by a trained practice nurse who is part of the team from the local GP's surgery. The nurse would use a structured questionnaire to interview the older clients. She or he would try to address general concerns such as housing, coping with activities of daily living, social isolation etc. as well as carrying out some basic health screening such as blood pressure and tests for diabetes. The nurse practitioner would then report to the GP and would be able to make referrals directly (in consultation with the GP) to social services, geriatrician or psychogeriatrician, physiotherapy, speech and language therapy and any other services deemed necessary. Once the referrals were implemented, reports would come back to the nurse practitioner via the GP. At this early stage, a key worker should be appointed if the elderly client has complex problems or if there is no regular carer available to check on arrangements, etc. At present, key workers for clients in the community are primarily social workers. It may be appropriate for other professionals to become involved in this role, for example a physiotherapist for someone whose primary problem is physical difficulty and a speech and language therapist if an elderly client has difficulty in communicating. The role of key workers with regard to advocacy for people who are unable to make their needs known should be clarified. Perhaps key workers need to have a client-representing role that is divorced from service provision concerns. This would then leave social workers to assume a more clearly defined care-manager role where matching needs to local service availability will be necessary.

The elderly person should then receive the required treatments following the health screening. It is essential that treatments are available in the community, perhaps being day-hospital based with outreach for elderly clients who do not need to attend hospital. Current research

into drug treatments (Farlow et al., 1992) to slow down or even partially arrest the decline in dementia is promising. It would then follow that a larger number of relatively well older people will be based in the community and these people will require help and support from health care professionals for extended periods of time.

All professionals would report back to the nurse practitioner via the GP. She or he would then ensure that the elderly client has a review of their progress at a recommended time and that any treatments are followed through. Because many elderly people have multiple problems which necessitate contact with many agents, in both the professional and voluntary sectors, it may be necessary for contacts to be logged, especially where language or cognitive problems may make it difficult for the client to report on recent visits. A health log book could be used so that all contacts are recorded. The nurse practitioner would then have a way of easily checking on the client's level of support.

The nurse practitioner might review the elderly client regularly if problems are ongoing or would revert to annual review if the problems were acute and responded to remediation. This would give the system some continuity so that a nurse going back to an elderly client would notice changes in the person's circumstances, or the onset of a condition such as depression which might not be so obviously evident on an initial visit. The majority of over-75s will be essentially fit and well so that the review process will not be time-consuming. Resources can then be targeted at those who need help. A further advantage is that if an older person has had several annual reviews prior to developing problems, they will have a contact, a person that they know and who will, it is hoped, be seen as non-threatening and sympathetic. This may assist in enabling elderly people to seek the help that they need at an early stage rather than after a crisis such as hospitalisation following a fall that could have been prevented.

As the older person develops medical problems or needs more help with activities of daily living, care might be transferred primarily to either:

- medical care under a geriatrician or psychogeriatrician;
- social services care under a care manager or social worker.

In either case, for as long as the elderly person remains in the community, the nurse practitioner needs to remain involved and to monitor the situation, with the GP being alerted when problems are occurring. Perhaps the nurse practitioner should assume the key worker as 'advocate' role once care is not entirely GP based. The nurse would be in a strong position to be an 'advocate' as he or she would know the elderly person, would have detailed records on their previous care, social situation etc. and would provide the elderly person with some continuity of

care. Also the key worker would be informed of changes in care such as discharge from hospital which require careful coordination. The nurse could also alert the GP to any problems that were occurring after discharge from hospital and could carry out routine monitoring for the GP. The nurse practitioner would therefore still be involved with the care of older people with multiple or complex problems, but this would be more contained so as not to duplicate efforts.

Many elderly people, even those with multiple problems and severe levels of disability, can remain in the community if sufficient help and support are locally available. Others will need to enter residential or nursing home care, the majority of which is now in the private sector. At this point the nurse practitioner would have a vital role. She or he would be able to give the residential or nursing home staff information about the elderly person and his or her care. If the home was local, the elderly person would probably remain under the GP's care, so the nurse practitioner's monitoring and key worker 'advocate' role could continue. If transfer into residential care involved a change of GP, then the nurse practitioner could refer the person to the relevant doctor's nurse practitioner, again being able to transfer information and provide some continuity of care.

Advantages to a nurse practitioner scheme are that:

- nurses are cheaper to employ than GPs and screening may not be the best use of a GP's time where there are no significant medical problems;
- if the nurses could provide a primarily home-based service, then this might be much less threatening for elderly people. There are also some indications that elderly people might be more comfortable with the idea of speaking to a nurse rather than 'wasting the doctor's time';
- regular reviews would allow older people to get to know the nurse, in the case of the vast majority, before problems occurred. The nurse would then be well placed to monitor changes;
- nurse practitioners who are GP-surgery based should ensure that inputs to the older clients are better coordinated and that older people are not 'lost in the system';
- nurse practitioners can provide continuity of care as the elderly person's needs change;
- the nurse review system should facilitate problems coming to light before medical problems which require expensive treatments, i.e. hospitalisation, occur.

So far we have advocated services for older people being locally based and GP surgery coordinated via a nurse practitioner review system. Let us now consider how speech and language therapy services would

operate within this system and how they would extend through the range of care options that an elderly person might require, ranging from domiciliary service to a person who lives independently in the community to a service for highly dependent people resident in a nursing home.

Speech and language therapists would assess elderly people from medical referrals and also people referred as a result of the screening process detailed here. Self-referral should also be possible, perhaps via an accepted route such as a memory clinic. Assessment would look at language, cognition and communication. Where necessary a carer interview would be included. The speech and language therapist would report to:

- the referring agent;
- the GP via the practice nurse;
- the social worker or care manager if the client has one.

The issue of whether speech and language therapists (and other professionals) should be able to make direct referrals to social services or whether this should continue to operate through the GP needs to be evaluated. Perhaps the type of fast and efficient screening and monitoring process by a practice nurse that has been advocated above would mean that delays in referral that occur today could be avoided whilst preserving 'GP' coordination of referrals.

Speech and language therapy services would then provide the necessary management and treatment for the elderly client with psychiatric problems. Access to treatment should not be age based but should be based on needs and ultimately on proven efficacy. A code of practice for older clients with psychiatric disorders might include:

- adequate assessment;
- assessment for treatment, for example assessment of learning potential in multi-infarct dementia (see Chapter 10);
- access to direct treatment of language and communication difficulties using treatments found to be most effective;
- access to indirect treatment via (a) communication groups; (b) support groups; (c) initiatives for carers; (d) volunteer schemes;
- speech and language therapy follow up if required or a specific request to the practice nurse to follow up language and communication in subsequent general reviews.

Speech and language therapists also have an important information-giving role. This involves information carefully tailored in terms of content and method of presentation for:

- clients;
- carers;
- other professionals;
- day centre and other staff/personnel involved in aspects of community care;
- residential and nursing home managers;
- residential and nursing home staff.

The information should include a written summary encompassing specific actions that can be taken. An example might be the *Action for Dysphasic Adults* booklet specifically designed for residential care staff (Lester and Ashley, 1995). It should also include recommendations to other staff and carers for general communicative needs, for example needing to socialise or needing access to pen and paper when 'talking'.

The speech and language therapist would therefore need to maintain an input when the care provision for an elderly person changes. If home care becomes involved, then the home care workers may need help in learning how to communicate with the person. If a client subsequently enters a residential or nursing home, then a period of intervention may be needed in order to assess how the elderly person adapts to communicating in the new environment, possibly some input from the therapist to maximise this and some input to the care staff on how to manage the communication disorder and how to achieve the best possible level of effective communication with the client.

Community care recommendations for speech and language therapists

If care practices for older people with psychiatric problems are to reach the levels advocated above, it will be necessary for speech and language therapy services to change and adapt to the philosophy of care provision and to the funding method. The profession will need to initiate or take part in the following:

- There needs to be a 'national-level' agreement on the role of speech and language therapists in private sector residential and nursing care. We would advocate equal access for older people to rehabilitation irrespective of whether they have public or private sector care. For many elderly people, private residential care is the only option available to them, so this should not constitute a barrier to public sector services. Rehabilitation should be available in the 'homes' so that issues such as lack of suitable transport do not constitute a further barrier.
- The profession needs to press for a statutory requirement for the provision of rehabilitation in the private care sector.

- There should also be support for a statutory requirement for providers of residential and nursing care to include provision for staff training in their contracts.
- Speech and language therapy services need to be more involved in working in the community. The current emphasis on hospital-based services might need to be reconsidered with national guidelines agreed to promote the development of clinical specialists in the psychiatry of old age, and to recommend ways of extending services into the community, perhaps including more flexibility in working practices.
- Speech and language therapy involvement in the multidisciplinary team needs to continue to develop, again with isolated examples of practice excellency being adopted as recommended standards throughout the UK.
- Speech and language therapy clinical specialists and/or managers need to continue to be involved in local planning of all services for elderly people with psychiatric problems so that the needs of the communicatively impaired are represented and addressed.
- The profession needs to promote a clinic-based research programme to develop and evaluate working practices.

A research agenda for the future

Many changes in working practices for speech and language therapists have been advocated here, mostly based on trying to promote particular examples of good practice, which have been discussed throughout this book, as standards for national service delivery aims. All of these developments need to be supported by data from clinically based research. Some of the key areas for the future research agenda are:

- joint research initiatives with practice nurses and GPs to develop structured interview 'conversational' formats for health screening for older people;
- studies of the language breakdown in non-Alzheimer dementias where there is currently very little available information, for example multi-infarct dementia, Pick's disease, Parkinsonian dementia, progressive supranuclear palsy, multi-system atrophy, cortical Lewy body disease;
- in the absence of more specific medical diagnosis among the dementias, assessments which accurately define clients' strengths and weaknesses are needed so that therapy input can be targeted;
- more assessments for the elderly are needed; these include currently used tests which need to be standardised on older populations, specialist tests for the dementias and shorter more effective screening tests for language and cognitive functioning which might include a carer questionnaire;

- more therapies for the treatment of language and communication disabilities in the elderly mentally ill need to be developed;
- treatment interventions need to be evaluated from quantitative and qualitative perspectives;
- efficacy guidelines for intervention and management of elderly clients with psychiatric problems need to be developed.

We hope that the issues raised or highlighted here will provoke debate. Speech and language therapists and other health care professionals are committed to improving services and therapeutic interventions for older clients with psychiatric problems and this commitment should continue to provide service innovation and research.