

Reducing depression among older people receiving care

North Yorkshire and York Primary Care Trust

This passage is an extract from:

Sallie Moxon: *The role of care staff in identifying and managing depression in Residential Homes – an investigative study*. PhD Thesis, University of York, 2003.

The author gratefully acknowledges the contribution of Professor Ian Sinclair, Dr. Jake Lyne, Dr. Philip Young, Dr. Christine Kirk, Maggie Browne, Eryk Grant, Susan Gildener and the training team.

Funding was received from the NHS Executive of the Northern & Yorkshire Regional Health Authority, Research & Development Directorate. York Health Services NHS Trust and North Yorkshire Social Services endorsed participation in the study.

Chapter 8.0

The development of the project

Introduction

We have seen that depression among older people is a major problem of public health. This is particularly so among the residents of elderly care homes – a form of provision that is almost certainly set to grow. We have also rehearsed the arguments that any intervention designed to reduce depression should:

- Be eclectic – the causes of depression are various and any intervention needs to encompass a variety of approaches
- Be inclusive – there is no clear definition of depression and the intervention needs to encompass the grief stricken and sad as well as those with ‘endogenous illness’
- Be inter-disciplinary – only an inter-disciplinary approach is likely to encompass the different skills and approaches required
- Respect the strengths and views of older people and not treat them as dependent objects
- Use a psychosocial approach which incorporates many of these features
- Involve the staff in elderly care homes – they are uniquely well-positioned to pick up depression and to respond to it in the course of their work
- Be cost-effective – specialist staff have to be sparingly used in tackling a problem that is so widespread.

The author wanted to produce a programme of this kind and had the opportunity to do so in York. As has been seen, in improving care, much depends on local circumstances, local initiatives and the ability to make changes in the light of growing local experience. From this perspective, York is an appropriate place in which to trial an innovative solution to the management of the very serious problem of depression in older people in residential homes.

This chapter describes the background to the project in York and gives reasons for thinking that it was an appropriate setting for the project. It then outlines the training programme which, along with the provision of mentors, was the central feature of the intervention itself.

Role of York

The closure of the big mental hospitals in the early 1990s, resulted in a significant decrease in hospital based continuing care places. As a result, residential homes, originally set up to provide hotel-type care for older people with mild degrees of physical frailty, started to admit increasingly dependent people and became used more exclusively by those with severe mental and/or physical disabilities. As has been seen, there is now the recognition that resident mental health problems are a major challenge to care-staff. They do not receive training to care for people with such problems and consequently have little understanding of the signs and symptoms of depression, or how it presents in older people.

Whilst this is a national problem, senior staff in York expressed their concern that care-staff were becoming increasingly demoralised and frustrated at feeling unable to cope appropriately with the situation. Care-staff found it difficult to understand the behaviour and attitudes of residents who could be viewed as 'awkward', 'difficult' or 'demanding' and this was having a negative influence on the staff group's approach to the residents. In turn, this set up inappropriate reactions or responses from residents resulting in deteriorating relationships between themselves and care-staff; a cycle tending to be perpetuated. Whilst managers and professional staff involved with the care of older people in York agreed that something ought to be done to improve practice in this area, they were unsure of what could be done about the problem. This dilemma provided the impetus for the research. The problem had to be tackled.

Staff in the different agencies in York are committed to providing high quality mental health services for residents in their care homes and the Community Mental Health Team for the Elderly (CMHT) has a history of innovative working. The fact that York is relatively small and compact makes it ideal for collaborative working within and between agencies. Staff are, however, well aware of the constraints on such working and see the need for service change and development of different strategies to deliver these services more appropriately and effectively. Enthusiasm for improvement certainly exists but

this has to be converted into positive impact on services. Members of the CMHT know the problems, are familiar with each other, have a shared philosophy on desired standards of mental health care and, when the proposal for the study was put to them, were supportive of the investigation and keen to become involved in innovative research with potential to improve the services they deliver.

At the moment, the CMHT in York provides services to residential homes on an 'as and when required' basis with different members of staff going in to a home at different times as requested or, conversely, residents visiting out- or in-patient mental health facilities. Despite the best will of senior staff in the homes in feeding back information to the CMHT, it is not easy for a professional mental health worker to make a holistic assessment of a resident from ad hoc visits.

A psychiatrist in York points out the difficulties of making a diagnosis on a resident's depressive state if background information on the resident is inadequate (Kirk 1992). She contends that care-staff, who are in the company of the residents more than any other staff in the home, particularly sharing 'private' time, are in an ideal position to notice discreet changes and manifest signs of depression. Were they able to feed quality information into a care-plan this would be viewed as a valuable contribution by the psychiatrist. The question is, can care-staff be enabled to contribute to the production of such strategies? If they could be trained for such a role then, under supervision, they could contribute to the assessment and care-planning of residents as integral members of the care team.

Any study training care-staff for such a role would need to consider what sort of trainers might be most appropriate for this specific job. Included in the requirements would be a need for mental health expertise, familiarity with the constraints of residential care, a 'feel' for the culture of the home, an understanding of the problem of depression in older residents, an ability to gauge the potential for change and to communicate with care-staff. The multi-disciplinary mental health staff of the care team in York meet these criteria. Unfortunately, whilst having supervisory skills, they do not have teaching qualifications or experience which would be the ideal.

In implementing such an approach much depends on the quality of the staff. Historically, York has been able to recruit care-staff from a broad spectrum of people with little competition from industry but the situation is changing fast. With the introduction of shopping malls, employment can be found which offers better pay and conditions – more sociable hours and less challenging work - and competition for good staff is keen. If quality staff are to be attracted to work as carers in the residential homes in York, then facility for such training may prove to be a positive incentive.

For CMHT members to work as trainers and supervisors of care-staff in the alleviation of depression would be a very different way of working for them to

their usual role. If, however, a model incorporating this way of working was to prove to be acceptable and effective, then it would integrate mental health professional staff more directly into non-specialist homes.

As will be seen, the study explored the potential of using the CMHT members in this way. It assessed how effective professional multi-disciplinary staff could be in training care-staff to become more aware of depression and also in supporting them through an intervention with a depressed resident. The study also assessed how well professional mental health staff could adapt to this role of working with a resident through care-staff rather than directly with the resident. Whilst quantitative measures of depression informed on the alleviation of resident depression at the end of the process, which in itself reflects on the model's effectiveness, qualitative measures were put in place to illuminate the particular facets of training and supervision, so that the CMHT member and care-staff roles could be evaluated.

Whilst substantial research has been undertaken in the fields of mental health and the elderly as discrete areas of concern, research looking at the interaction of the two is in its infancy and this investigative study, dedicated to the management of depression in older people, is the first of its kind in the country. It reflects an innovative attempt to utilise current resources in a more constructive way to provide better mental health services to more older people with increased satisfaction for care-staff but without significant disruption of current organisational arrangements within the home. This was the particular challenge taken up by the author.

The Training Programme

Recognising and reducing depression in older people

Developing skills - Improving practice

Introduction

One of the aims of this investigative study was to see whether the training programme devised for the project would be acceptable to trainers and to those who were trained and whether it would be judged favourably by an independent observer. It was important that it should pass these tests before any further study was mounted. It needed to be known to what extent it captured the interest of care-staff and home managers and whether it would be perceived by them and health and social services professional staff to be worthwhile. Judgement of its success from a care-staff perspective would depend on whether the approach was understood and put into practice effectively rather than on care-staff' ability to write about it, although they could be encouraged to do so.

There is evidence that theoretical training undertaken in an external location tends to be perceived by care workers as not directly relevant to their own particular day-to-day work practice and consequently less effective in its application in situ (Collins and Price 1990); nor is the outcome found to be successful if there is little opportunity to put theory into practice under guidance e.g. Gask et al. (1994; 1998); Goudie and Pirie (1996). This training programme was therefore designed on the basis of implementation in a naturalistic setting with opportunity for care-staff to develop their skills within their capabilities under supervision.

The programme was expected to have three principal outputs:

- A training package i.e. an effective programme of education and training for improving competence of care-staff in the recognition and reduction of depression in older residents
- A demonstrable improvement in the competence of care-staff to recognise and reduce depression in older residents
- An evaluation of the training package, diary records and case notes from which to construct and develop a set of hypotheses for a major study

The training programme was developed with consideration of links at an educational level with other training that care-staff may be undertaking, such as National Vocational Qualifications, so that it enhanced and was compatible with other input, rather than duplicating it.

Compilation of the Training Programme

Needs assessment of residential care-staff

There was a need to identify priorities for the development of the training programme in the context of residential care-staff practice from a group/individual perspective. A needs assessment of residential care-staff was therefore carried out. It was designed on the lines of Bramley (1991) to identify the skills requirement for the construction of a needs based care programme by the care-staff/key-worker for an assigned resident. The objectives of the needs assessment were to identify:

- Care-staff current knowledge base on depression and its management
- Care-staff deficits in knowledge about depression and its management
- Care-staff perceptions on what they consider they need to know, if anything, to a) improve their recognition of depression and b) be able to manage older depressed people more easily

The needs assessment was implemented by the researcher and a community psychiatric nurse with nine care-staff in a local authority residential home which was not participating in the study. The officer-in-charge of the home was sympathetic to the study initiative. She suggested that senior staff, as well as care-staff, are needing assistance to get help for depressed people. This opinion was based on her experience of residents “being shipped off for treatment” and her concern that resident depression “can go on for months and months before GPs do anything about it”. She welcomed a programme with potential to ameliorate these problems.

Objectives of the Training Programme

Following the evaluation of the needs assessment of residential care-staff, objectives for a training programme designed to improve the depressive status of elderly residents could be identified. It was apparent that any training programme for care-staff would need to facilitate their learning on two major issues. Firstly, to improve their recognition of depression in elderly residents and secondly to enhance their ability to facilitate its reduction in these people.

Objectives for these two major components of the training programme were then formulated by the researcher with members of the training team as follows:

i) The recognition of depression:

- To perceive there is a problem
- To identify the problem as depression rather than e.g. uncooperativeness
- To have some view about what could be done to deal with the problem
- To use a simple check list to assess depression

ii) The reduction of depression:

- To understand the principles of care-planning intervention
- To be able to use the care-planning approach with support
- To increase confidence that depression can be reduced in older people

The Experimental Programme

As there are no training packages available which are designed to meet such objectives in the reduction of the prevalence of depression in homes for older people, it was necessary to design a specific package for study purposes. This was done by the researcher with the training team.

The programme was developed with two distinctive elements: a period of direct training for all care-staff to establish the necessary skill base; followed

by a period of skills development through mentor supported learning to reinforce the training. The approach to the management of depression combines both psycho-social and medical insights.

The first element of the programme consists of a training course offered to all care-staff in a home. The syllabus incorporates definitions of depression; recognition of depression; getting to know the individual person; communicating with depressed older people; the effects of loss; the effects of depression on thinking, feeling and behaviour; the care-planning intervention from medical, psychological and social perspectives, and the use of specialist resources. The programme aims to alert care-staff to the signs of depression, to enhance their ways of responding to these and to give them confidence in tackling depression within their capabilities.

The second element in the programme consists of mentoring for care-staff/key-workers of depressed residents. This offers a series of contact meetings between care-staff/key-worker and a skilled mentor. The mentor supports and further trains the care-staff/key-worker in a care-planning approach with a depressed resident (*see below*) and provides telephone back-up where necessary. Mentors also discuss with care-staff/key-workers referrals to other professionals should these be needed.

The care-planning approach to the management of depression

The essence of the care-planning approach evaluated is that care-staff work through a systematic process of assessment and treatment with a resident who is depressed. The framework for the approach is based on the work of Barrowclough and Fleming (1986) where the principle is to develop a more positive and person centred approach to people in care. The Barrowclough approach emphasised the importance of objectivity and observability in working with residents' strengths to meet their needs by means of achieving goals. The study experimental programme, however, extends that approach to include making inferences about emotions and psychological need as it is felt that these are crucial factors in encouraging care-staff to see the world from a resident's point of view. Although care-staff may be aware of a resident's disabilities and deficits, they may not be aware of the resident's existing strengths or supports. In the study approach, therefore, care-staff talk to the resident and identify their existing supports and strengths. Through discussion and observation many problem areas may be detected. Care-staff then learn how to reframe problems a resident may have in terms of identified needs. From this assessment, in conjunction with the resident, they identify clear and objective goals for 'treatment'. Care-staff discuss with the resident the reasons for their unhappiness and agree with them what might practically be done about it within the constraints of their current situation. Finally care-staff devise a plan for achieving these goals, tailored to the individual, which they can then work towards by using the resident's strengths. The notion is that if a goal is defined then it will be known when it is achieved. With the focus on identified needs rather than depressive symptomatology, the assumption is that if needs are met, mood will improve. Interventions may include medical help, social

support, psychological support and practical steps to maintain independence and self-esteem. The steps that may be taken are various and might involve adjustment to hearing aids, encouragement to engage more with other residents or make outside visits and so on. In more severe depression, referral for assessment by the GP or psychiatrist may initiate medical intervention.

Differential effects of the intervention programme on the range of care-staff/key-workers need to be identified, together with factors likely to lead to a more successful outcome in implementation of the programme. It would be useful to know whether working through this process enables care-staff to not only recognise depression and develop strategies for minimising this problem, but also to perceive residents as individual personalities with particular needs, rather than members of one homogenous group.

An inter-agency/multi-disciplinary service

The need to work across organisational boundaries in order to deliver joined up services is a key theme of public policy, although it is not always clear what this means in practice. This training programme addresses the current partnership agenda by testing a variant of inter-agency/multi-disciplinary working with potential to inform on the effectiveness of such collaboration and on its value as efficient use of mental health professionals' time.

The Training Team

The idea of experienced mental health professional staff being used as trainers and mentors in a programme working with a depressed resident through a member of care-staff, rather than meeting with the resident face-to-face is a new concept and one which it is acknowledged may not appeal to all psychiatric staff, nor indeed may they be able to operate comfortably in this way. It was important for the study therefore that only people who were sympathetic to the idea and enthusiastic to experiment with a different way of working, should be recruited as trainers. The challenge was considerable. They had to feel that there was potential for value to the resident, to the care-staff member, to health services' resource use and ultimately to the ambience of the home. Moreover, as volunteers to the study, they had to be willing to negotiate time for their involvement with their managers so that their input to the project fit around their clinical work. Trainers for the team were all members of the Community Mental Health Team for the Elderly (CHMT) who met these criteria. The group was multi-disciplinary and included a consultant psychiatrist for the elderly, a consultant psychologist for the elderly, an occupational therapist and four community psychiatric nurses. The study therefore made optimum use of National Health Services' (NHS) staff working alongside those of Social Services in normal practice. All members of the training team were trained on the application of the package to ensure that they could provide for a natural cascading of both information and good practice.

Integration of clinicians into this service development approach

The programme provided an opportunity to increase understanding on a range of issues that would have to be taken into account were services to be developed in this way. These include clarification of the mentor role; the expectations that care-staff may have of the role; the significance of the care-staff/mentor relationship; differences in approach to facilitation of care-staff learning between para-medical professional groups; the ease of integration of the different agencies and the differences of opinion on resident state between the 'expert' and the facilitator. Clarification on these issues will be valuable when considering further study on the integration of clinical staff into such a service development approach.

Procedures for implementation

Training: The theoretical training course is designed to be presented to care-staff by members of the training team in a room in the home in which they work. It is delivered in four group-based three-hour sessions in consecutive weeks. For practical reasons there is need for two sets of sessions per home to enable some care-staff to be free to care for residents whilst their colleagues attend the training. This procedure was incorporated into the study design. Care-staff are encouraged to bring their own case studies for use as examples in the training. Both trainers and care-staff maintain structured logs throughout the training period and provide a review on their work post-training.

Mentoring: Members of the training team provide mentoring support of up to eight one-hour weekly sessions for care-staff/key workers whilst the care-planning 'treatment' is carried out with depressed residents. Mentors meet with care-staff/key-workers on a one-to-one basis in the home in which they work, facilitating shift patterns and other organisational arrangements of the home. Unlike traditional methods of treatment, where a mental health professional works with a resident directly to treat depression, in this programme the mentor does not meet with the resident but works through the care-staff member. Mentors and care-staff/key-workers maintain structured logs throughout the intervention period and provide a review of their work post-mentoring.

Conclusions

York was seen as suitable for this project for a variety of reasons. It was facing the same difficulties in the field of mental health for the elderly as could be found nationally. Senior staff were keen to tackle this problem. The compact nature of the different services meant that the potential for collaboration between them was high. The Community Health Team was well developed

and keen to take part. The staff recruited to the homes were thought to be of high calibre, a situation which the project might help to maintain.

The training intervention proposed brings together a potential service development using mainstream services and involving partnerships not only within agencies but also across agencies and beyond agencies with a way of involving essential users and their carers. It has potential to inform on the reality of such collaboration at a local level and how much confidence there could be in its value as a way forward whereby older people could benefit, in at least one service area, where there is willingness to make changes in the light of growing local experience.

The training intervention is ethical and human based. In the current state of knowledge, it seems to be a logical way of tackling the problem and the most plausible approach for people in residential care. There is evidence to suggest that such an approach is feasible but it needs testing. As will be seen, the study put in place the design and all measures to explore the approach.

REFERENCES

Barrowclough C and Fleming I (1986) *Goal planning with elderly people: making plans to meet individual needs*. Manchester, University Press.

Bramley P (1991) *Evaluating Training Effectiveness: Translating Theory Into Practice*. New York, McGraw Hill.

Collins M and Price P (1990 January 4) A step in the right direction. *Community Care*, 18-19

Gask L, Usherwood T, and Thompson H (1994) Evaluation of a training package in the assessment and management of depression in primary care. Report submitted to the Department of Health.

Gask L, Usherwood T, Thompson H and Williams B (1998) Evaluation of a training package in the assessment and management of depression in primary care. *Medical Education* **32** (2), 190.

Goudie F and Pirie Z (1996) *Depression in older people in the community: evaluating a staff training package*. Sheffield, Family and Community Services.

Kirk C (1992) Diagnosis and treatment of depression in older residents: there must be more effective ways? Personal communication.