

ARTICLE

Home assessment in old age psychiatry: a practical guide

Bradley Ng & Martin Atkins

Bradley Ng is a consultant old age psychiatrist with the Older Persons Mental Health at Robina Hospital, Gold Coast, Queensland, Australia, and Assistant Professor, Faculty of Health Sciences and Medicine, Bond University, Queensland. He was a senior registrar in old age psychiatry in Auckland and an honorary lecturer at the University of Auckland, New Zealand. His interests include medico-legal psychiatry and pharmacological safety and vigilance. **Martin Atkins** is a consultant old age psychiatrist and Assistant Director of the Older Persons Mental Health at Robina Hospital and Associate Professor, Faculty of Health Sciences and Medicine at Bond University. He trained as an old age psychiatrist in the UK and worked as an NHS consultant in Salford before moving to Australia, working in Victoria and subsequently in Queensland. He has a long-standing interest in service development and medical education.

Correspondence Dr Bradley Ng, Older Persons Mental Health, Robina Hospital, Bayberry Lane, Robina, Queensland 4226, Australia. Email: bkwng@hotmail.com

SUMMARY

An initial psychiatric assessment of elderly people at home is an important component of many old age psychiatry services. This article explores the clinical aspects of conducting such assessments and the skills required in addition to those brought to a standard psychiatric interview. Safety considerations and risk management when conducting home assessments are also discussed.

DECLARATION OF INTEREST

None.

‘But, to my mind, it is really of no great import, when domiciliary assessment has revealed a positive and supportive environment, if the patient cannot name the current Prime Minister whose election is now a remote memory.’ (Fottrell 1989)

The psychiatric assessment of older people can be carried out in many environments, including out-patient clinics, hospital wards, care facilities for the elderly and the individual’s own home. Each presents advantages, disadvantages and challenges. An initial assessment conducted in the patient’s home remains an important aspect of many old age psychiatric services in high-income countries. Despite their importance, very little has been written formally on how to conduct such assessments.

This article discusses the clinical aspects of conducting an initial psychiatric assessment of an older person in their home. To ensure a safe and comprehensive assessment, there are several points to consider beyond a standard psychiatric interview. We draw on the literature in old age psychiatry, geriatric medicine and other disciplines as well as our own, and our colleagues’, clinical experience.

The economic, reimbursement and policy aspects of home assessments can vary from country to country and even between services in the same country. We do not cover these topics here, although the situation in the UK has been discussed in the literature (e.g. Benbow 1990; Shah 1994, 1997; Richardson 2002).

Several early studies (Arcand 1981; Currie 1981; Levy 1985), not all in old age psychiatry, suggested

the benefits of home assessments in detecting previously unnoticed or underappreciated problems, psychiatric or otherwise (Box 1).

In one study of 154 community geriatric patients, a home assessment by a nurse specialist revealed, on average, four new problems that were not detected in a clinic assessment by both a geriatrician and a psychiatrist. The problems included safety and psychiatric issues with significant potential morbidity and mortality, and baseline clinical information did not predict the yield obtained in the visit (Ramsdell 1989). In another study of 172 frail elderly with dementia, a clinic-based assessment of the patient’s home environment was not comparable to an actual home assessment, the latter uncovering isolation and safety and caregiver issues (Ramsdell 2004). Some of these studies specifically targeted patients with dementia, but many of the problems uncovered would have a major impact in any old age psychiatry population. However, not all of the evidence has favoured home assessment. One trial of 32 elderly patients with depression who were cognitively intact failed to demonstrate an improvement in assessment or outcomes when comparing home assessments with clinic assessments (Cole 1995).

Older people face several challenges attending an out-patient clinic. Physical disabilities, immobility, no driver’s licence or driving ability, the lack of family to assist with travel, unfriendly public transport or a bewildering hospital system may all contribute to poor attendance. Some frail patients may even need ambulance transportation (Burton 1985). Referral issues such as cognitive impairment, depression or psychosis are well-known impediments to insight, understanding and help-seeking.

There are several potential advantages of a home assessment. One witnesses first-hand how the person mobilises and operates in their environment, with less reliance on the patient’s or collateral accounts, which may be incomplete, biased or misleading (Levy 1985). The patient, their caregivers and family may be present and be more at ease and forthcoming in their own home (Scanameo 1995). Hence, history may be more forthcoming and behaviour more ‘natural’ than in

a clinic appointment. Relevant environmental and psychosocial factors and the role of other services may become more apparent (Koenig 1986).

The above information, not all of which can be gathered at an out-patient appointment, is essential in assessing whether the patient has any psychiatric illness. It can also reveal caregiver burnout and abuse of the patient, and give an idea of the family resources, strengths and dynamics (Scanameo 1995). A more comprehensive and holistic formulation can be generated, which prioritises the patient's problems, guides treatment and highlights non-psychiatric issues, medical or social, that require further assessment and referral outside of psychiatric services. The referred psychiatric problem may not be the most pressing matter, as other medical problems have a significant impact on an elderly patient's mental health (Grauer 1991; Simon 1984).

Attendance at home assessments by the patient and carers has been noted to be higher than at traditional out-patient clinics (Benbow 1990; Anderson 2002), with high patient and general practitioner (GP) satisfaction with home assessments for both medical and psychiatric problems (Arcand 1981; Jones 1987; Hardy-Thompson 1992).

There are disadvantages; some patients may be very uncomfortable with health personnel visiting their home, therefore an explanation for the visit must be given at initial contact, as well as the option of an out-patient appointment. The ability and equipment to conduct a physical examination is limited. Finding a mutually convenient time for all involved may lead to delays, although delays may not necessarily be reduced by using out-patient clinics (Arcand 1981).

Home assessments may be perceived as time inefficient because of the travel time required. They could also potentially be longer than out-patient assessments, because more issues may be uncovered. On clinical grounds, we believe that this is an advantage and well worth any extra time used. Finally, the safety of health personnel must be considered at the home and in the neighbourhood (Campion 1997).

Preparation

The referral

Although many old age psychiatric services accept and encourage referrals from a variety of sources, including patients and carers (Richardson 2002), we believe that the involvement or approval of the patient's GP is essential. The GP is the primary healthcare provider and frequently has an intimate and long-standing relationship with

BOX 1 Potential problems identified by home assessments

Psychiatric/medical

- Depression
- Cognitive impairment or dementia
- Behavioural and psychological symptoms of dementia
- Psychosis
- Alcohol misuse
- Acute medical illness
- Pain
- Polypharmacy issues

Geriatric

- Falls and other safety issues
- Incontinence

- Sensory impairment
- Poor nutrition
- Caregiver and family stress/conflict
- Neglect and abuse
- Medication errors
- Need for ongoing placement or care

Environmental

- Neglected household or squalor
- Inadequate utilities/heating
- Poor food availability
- Mobility challenges

(Adapted from Scanameo 1995 and Levine 2003)

the patient. There are occasions when a referral is received from another source, while the GP is already managing the situation well and views specialist input as unnecessary or inappropriate.

The GP has a central role in excluding delirium when a medical problem presents with psychiatric symptoms. The frequency and complexity of comorbid physical illnesses in elderly people means that an up-to-date list of their medical conditions and medications is essential. This is particularly pertinent in services where medical support is limited or lacking, and non-medical clinicians are required to triage or respond to the referral. Delirium or other complex medical problems may suggest an urgent or complicated situation that is inappropriate for a home assessment.

The reason for the referral and perceived urgency must be as clear as possible. Other information includes the details of involvement of other mental health services or practitioners, and government or non-government agencies, including social supports. Contact details for family and/or carers are essential. Any known risk factors relating to the patient, family, carers, community or attending mental health staff should be elicited. There may be significant risks other than the identified patient, such as a spouse with a history of violence or an adult child with significant substance misuse.

Allocation

Which, and how many, staff respond to a referral will depend on several factors, including staffing levels, the patient's history with the service and transport availability. Policies about the number of clinicians attending a home assessment will vary from service to service. If a patient was previously well known to a service or has accepted the referral

and has no identifiable risk issues, it may be appropriate for only one staff member to respond. If there are potential risks, the attendance of two staff on a home assessment is advisable. A joint assessment by two clinicians has the advantage of gathering information and developing an initial multidisciplinary formulation. In some situations, the second person can act as a chaperone during physical examinations.

The value of an initial medical opinion is obvious, given the physical comorbidity and polypharmacy frequently seen in the elderly. However, doctor involvement in the initial assessment is often dictated by availability. Whether or not an old age psychiatrist needs to go on every home assessment is debatable (Orrell 1998). Studies have shown non-medical staff to be equally skilled at providing initial assessments in old age psychiatry (Draper 2000).

Staff allocation by profession may have benefits in terms of the focus of an initial assessment. A referral indicating significant social stresses might be allocated to a social worker in the multidisciplinary team, whereas cognitive impairment or falls might prompt an occupational therapy perspective. Cases involving complex medical issues, polypharmacy or ill health in a spouse or carer might be best assessed by a nurse if no doctor is immediately available. These choices will be influenced by the composition of the responding team. Psychiatrists in training are discussed below.

Initial contact

Telephone contact with the patient should be made beforehand to obtain consent for a home assessment and permission to gather collateral history, and to facilitate participation in the assessment, if appropriate, of family, carers or other involved parties, such as social workers or visiting nurses (Zebley 1986). Issues of informed consent are influenced by the referrer's assessment of the patient's presentation. If the patient has significant cognitive impairment, it may be considered appropriate to contact family or carers without consent, or to visit without prior notification.

When contact is first made, it may emerge that the patient is unaware of the referral, or even of the referrer. How much is disclosed to the patient may depend on the referrer, their relationship with the patient, and the apparent willingness of the patient to engage in assessment. Clinical judgement will be required, and inexperienced staff should be appropriately supervised for these challenges. It may prove necessary to go back to the referrer

for clarification of some matters following initial telephone contact with the patient.

During the first telephone contact with the patient, the clinician should try to find out whether there are family members who may be able to assist in the assessment, to clarify the patient's own perceptions of their circumstances and to identify the patient's own priorities and concerns. It is common for patients to be concerned about issues other than those identified by the referrer. Finally, an appointment date can be confirmed, necessary directions elicited, and any problems regarding access discussed (e.g. bad roads, access to gated communities, building security controls).

Alternative approaches will need to be considered when the patient cannot be contacted by telephone, including writing to the patient or visiting unannounced. If the patient is from a non-English-speaking background, options may include a clinician who speaks their language, interpreter services or as a last resort, and certainly not ideal, ensuring an English-speaking family member is present to assist with the assessment.

Identified risks and safety issues

Potential risks to staff such as aggressive dogs, an abusive spouse/partner, hostile family members, poor mobile telephone reception and violent neighbourhoods should be identified prior to any home assessment, with strategies implemented to reduce or minimise them. These factors will dictate the arrangements and timing of the assessment, including the number and mix (professional background, gender) of staff and whether or not police need to be informed or even accompany staff.

Safety issues include the availability of mobile telephones or other telecommunications, ready access to relevant telephone numbers (home base, crisis response team, ambulance and police) and sufficient fuel (a major issue in more rural areas). Visits should be planned in accordance with service safety policies, including staff working alone, and there should be an effective system in place for tracking where staff have gone and their expected return time (Byrne 2010). Equipment that might be taken on home assessments is detailed in Box 2.

Commencing the assessment

Safety considerations

Awareness and re-evaluation of risk issues should be ongoing throughout a home visit. Visits to violent neighbourhoods should be timed to minimise the potential for antagonism by residents. Mornings are usually preferable in

BOX 2 Home assessment equipment

- Patient records and stationery
- Medical equipment, such as blood pressure cuff, stethoscope, thermometer
- Blood test request forms, radiology request forms, prescription pad
- Medication samples
- Antipsychotic depots and syringes (e.g. if the patient is known to have defaulted on a depot antipsychotic)
- Mental health legislation paperwork
- Patient educational materials and brochures introducing the service
- Dictaphone
- Introduction/business card
- Spare clothing, especially trousers, if squalid home circumstances are anticipated

(Adapted from Unwin 1999 and Levine 2003)

this respect. Local police can advise and provide support, if necessary. Vehicles should be parked to ensure rapid egress if this proves necessary, and it is unwise to use an ostentatious vehicle that may attract unwanted interest. A 'doctor's bag' may also attract the attention of individuals with drug-seeking behaviour, and a nondescript bag or rucksack may be preferable in such areas. Valuables should not be left in vehicles. Adequate telephone coverage should be monitored.

Owners should be asked to restrain or isolate potentially aggressive animals. This can be done by telephone from the front gate, if necessary. The general layout of the property should be considered, including routes of egress, alternative exits and barriers such as secured doors or excessive household items and refuse. Consideration of the situation of stairwells and functionality of lifts (elevators) is necessary in multistory residential blocks.

Any signs of aggression, anger or intoxication from substances in the patient or others should be monitored closely throughout the home visit, and note taken of any potential weapons in the environment. If necessary, the skills of clinicians in de-escalating confrontational situations can be utilised, but assessments should be politely terminated if there is evidence of escalation that poses a threat to staff, or indeed to the patient or any other people in the household. If it proves necessary to terminate the home visit, the degree and urgency of the situation, as well as risks to the person and healthcare staff, will dictate what subsequent response is required.

Before the front door

The cleanliness and general milieu of the neighbourhood, proximity of other houses or apartments, evidence of crime, lighting and the extent of local noise and disturbance will usually be evident (Box 3). The availability of local resources, such as shops, bus stops, public transport and medical services, may be identified in passing. Is the house hard to find and is it clearly identified with a number (Scanameo 1995)?

Valuable information can be gathered before approaching the front door. Uncollected mail in the post box may indicate cognitive, mood or mobility concerns. Refuse and recycling bins may point to the patient's overall level of organisation, alcohol use and functioning. The derelict state of the building and garden may raise similar concerns or indicate financial difficulties. Potential accessibility (stairs, ramps, handrails and lifts) and mobility risks (uneven, overgrown or slippery paths and lighting) can be assessed. Is there a car? What is its state and has it been used recently?

The general security of the home may give clues to cognitive problems (doors left open inappropriately) or delusion-based modifications (barricades or excessive numbers of locks), contributing to the risk assessment. Unexpected safety concerns include evidence of intrusion by others (graffiti, dumped rubbish) or the presence of apparently inappropriate persons in the dwelling. A delay in opening the front door may be due to patient frailty, deafness, poor mobility, fear or apathy (Fottrell 1989).

Starting the interview

How the interview commences depends on the circumstances and the individuals involved, especially their interpersonal skills and experience to put the patient at ease and establish a rapport. As

BOX 3 Case vignette 1: paranoia

A 79-year-old woman living alone in low-income housing was referred by a GP to a local older persons' mental health service because of her increasing paranoia and fearfulness at home. In the surgery she appeared highly anxious and teary, concerned people could enter her home in the middle of the night. A home assessment revealed loud and aggressive neighbours that had just moved in, with suspicion of dealing drugs as cars were arriving at all hours of the night. Other neighbours were fearful. The woman presented with no psychotic symptoms or other signs of mental illness. A social worker provided short-term counselling and acted on her behalf to raise these issues with the housing authority.

a 'guest' in their house, staff should informally and continually ask the patient's permission for their actions during a home assessment. Observations of the home are gently raised with the patient or other parties to allow explanation.

The patient may indicate a preference as to where the assessment should occur, although some prompting may be required (e.g. 'Where would you like us to sit?'). Occasionally, the patient will not want strangers entering the home, and may prefer to speak on the doorstep or in the garden. This should be respected to allow the patient to develop sufficient confidence to grant voluntary access into the home later to continue the assessment. If there are risk concerns, assessments conducted near exits or in relatively open spaces are advised.

A judgement will have to be made quickly about whether to interview the patient alone, with family/carers or both.

Joint assessments by two clinicians have several advantages in this regard, including the opportunity to 'spilt forces' and interview the patient and family/carers separately and simultaneously, thus saving time. This is valuable when the parties are uncomfortable speaking in front of each other. Consent to obtain collateral history is important, and in our experience, it is rarely withheld by patients. Such information is vital to corroborate the patient's account, especially when significant cognitive impairment is suspected.

The home assessment

General observations

An examination of the patient's home needs to have flexibility and respect for the patient's privacy. With an empathic and non-confrontational approach, most patients are very agreeable to a quick walk around the home, and it allows an opportunity for non-clinical discussions that many welcome. An overenthusiastic or intrusive approach may jeopardise the relationship with the patient, so the approach depends very much on the initial rapport with the patient.

Home environments can range from extreme tidiness, to hoarding or gross squalor. Are there piles of newspapers or magazines and how old are they? Is there refuse everywhere? What are the reasons for the extra security measures? Are there cigarette burns on the carpet? What is the general state of lighting, electricity, heating, water and ventilation (Zebley 1986)? There may be evidence of unpaid utility bills. The identification of potential fall hazards is important (Box 4). Unsecured valuables or money and offers of such or other payments may highlight risks of exploitation.

Unpleasant or rank odours may be early indicators of poor hygiene and squalor, with pets or toileting problems often being responsible. Does the house smell of bird droppings or urine? How many cats are there and are they being fed? The general condition of the home may reflect the financial circumstances of the occupant, but this can be misleading, especially in individuals with cognitive impairment or delusions of poverty (Unwin 1999).

The patient's strengths, hobbies and interests can be identified during a home assessment. These can provide a starting point for developing rapport and possible engagement in therapeutic activities outside of the home. The importance of the patient's spiritual or religious life may be apparent and an assessment of how this might affect any mental illness might be called for (Unwin 1999).

Finally, how does the patient communicate in the case of an emergency? Do they have a landline or mobile telephone and are they able to use it? Increasing numbers of elderly patients use the internet and this should also be considered.

The living room

The living room often provides a useful starting point for general discussions and establishing rapport with the patient. Family photographs are a good way of breaking the ice, demonstrating a personal interest in the patient, providing an initial idea of family relationships, and acting as a useful cognitive screen. Can they remember the names and ages of family members? Where do they live? Initiating conversations about apparent interests and hobbies allows an assessment of any changes in interest, enthusiasm or cognition.

The television provides a useful cue to enquire about interests and recollection of the latest football scores or what happened in last week's

BOX 4 Environmental risk factors for falls

- Slippery or uneven pathways, floors or stairs
- Very steep or narrow steps
- Loose carpets, mats and rugs
- Clutter, pets, cords or spilt liquid on the floor
- No handrails or bathroom/toilet grab rails
- Unsuitable furniture
- Shelves or cupboards too high or too low
- Use of ladders or step ladders
- Broken or rotting floorboards
- Poor lighting

(Adapted from Scanameo 1995, Lowery 2000 and Lord 2007)

episode of 'Coronation Street'. This does, naturally, require some awareness of these issues on the part of the assessing clinician – the newspaper's sports section and television promotions are invaluable here. A decline in the usual level of interest in television programmes may be related to cognitive decline or an affective disorder.

The kitchen

Despite an initial impression of cleanliness and hygiene, a more detailed kitchen assessment may be very revealing (Box 5). Insufficient or inadequate food in the fridge or cupboards is of obvious concern, and leads to questions about eating habits, shopping and cooking abilities. Is there evidence of poorly prepared meals or dietary quirks? If meals are being delivered, a quick glance in the fridge will reveal whether they are being consumed and their expiry dates. The kitchen may also reveal high levels of alcohol consumption and this evidence may be more accurate than the patient's account. It is hard for the patient to minimise alcohol consumption when faced with multitudes of empty cans or bottles.

The presence and state of kitchen appliances may indicate general hygiene levels and functional ability. Is there a smoke alarm? Are there burnt pots or pans or plumbing problems? Are there cockroaches in the kitchen cabinets (Zebley 1986)? Offers of cups of tea are common and should not be refused, as they allow immediate and meaningful insights into cognitive impairment and functional abilities (Fottrell 1989). It becomes readily apparent if the milk is fresh or not. It is easy to find an excuse not to drink the tea if hygiene levels appear worrying.

The bathroom and bedroom

Access to the toilet, bath and shower may reveal falls risks (Box 4), access problems and hygiene issues. Blocked toilets or drains can rapidly lead to squalor. A failure to keep plumbing in working order may reflect cognitive decline. Similar issues may also be seen in the laundry, resulting in the gradual accumulation of dirty clothing.

Except for a possible quick glance, do not enter bedrooms out of respect for the patient's privacy. Occasionally, patients are interviewed in their bed, because of physical infirmity, social withdrawal in the case of depression, or temporal disorientation or apathy in dementia. Malodorous conditions and unwashed bedding may indicate hygiene problems. Mobility issues may lead to alternative sleeping arrangements. Occasionally, it will emerge that patients do not sleep in their beds, but may do so on the sofa, in a chair, or more rarely, in bizarre

BOX 5 Case vignette 2: dementia

An 85-year-old widower of 15 years, living alone in his own home, was referred by his GP to a local older persons' mental health service for increasing short-term memory problems. His children were concerned about the state of the house and possible financial exploitation. One daughter had dropped in unannounced to find a complete stranger with shopping bags of groceries in her father's kitchen; she identified herself as his girlfriend, but her father had never mentioned any new relationship.

A home assessment revealed squalor, half-eaten meals, a dirty kitchen with many cockroaches and an overgrown garden. Mental state examination revealed gross short-term memory and executive functioning deficits. Safety concerns were obvious at the end of the assessment, when the patient became angry at the intrusion and drove off on his motorised scooter. The assessor saw him drive across a busy main street, oblivious to the cars that had to brake suddenly to avoid hitting him.

circumstances such as a wardrobe. Enquiry will generally reveal the motivation behind these actions.

The garden tour

The state of the garden, if there is one, may indicate the patient's functioning and leisure interests. This can be seen when coming to and from the home or as a separate tour. The latter can reinforce positive rapport with a patient who is enthusiastic about their garden. The degree of upkeep can contribute to the impression of physical abilities and limitations. In the case of physically able patients who express an interest in gardening but whose garden shows evidence of neglect, possibilities include cognitive decline, avolition or anergia related to depression, or avoidance of the garden associated with paranoid ideation related to neighbours. Neglect of the garden by a usually enthusiastic gardener may immediately signpost deterioration in the mental state of a patient previously known to a service, for example, with recurrent depression. Indeed, clinicians may become aware of such a decline even before a referral is received if they frequent a residential area regularly.

Medication

A home assessment allows a more comprehensive medication list and history. Patients often fail to bring all, or even any, of their medications to an out-patient clinic, despite specific instructions to do so. Medications are often not immediately to hand, so patients will have to get them. Accompanying and supporting the patient in this task allows the assessor access to other parts of the home.

The medications prescribed by a GP and the medications a patient actually takes sometimes do not match. A filled prescription does not mean it is being taken. The patient may not be prescribed

MCQ answers

1 b 2 c 3 e 4 b 5 d

opiates for pain but may be using their spouse's supply. Sometimes a medication container may be filled with a completely different medication (Zebley 1986). Over-the-counter medications, vitamins and herbal and dietary supplements are examples of other medications being omitted from lists provided by patients and carers. Simply asking why the patient takes each particular medication provides clues to their insight of their medical conditions.

The mode of dispensing medications varies considerably, including boxes, bottles, dosette boxes and blister packs. Can a patient with arthritis open medication bottles or read the print? How does the patient administer their medications and is there any supervision? Dispensing and expiry dates can be checked, and adherence can be approximated using these factors and an estimate of the number of tablets remaining.

In some countries, medications may have multiple trade names, leading many patients to inadvertently duplicate their medications. Actually looking at the patient's regular medication (the packets and bottles) may identify these potentially serious errors (Byrne 2010). Multiple prescriptions or an excess of medications may be due to 'doctor shopping', i.e. deliberately consulting a variety of doctors (Unwin 1999), import by family members from overseas or buying over the internet. In one case, we saw an elderly woman with schizophrenia, who was simultaneously taking risperidone, olanzapine and clozapine, which her family overseas had been buying over the counter for the previous 2 years.

Many patients forget or do not regard hypnotics as part of their 'tablets'. One explanation is that hypnotics are frequently kept in the bedroom, whereas other medications are stored in the kitchen or bathroom. It is worth enquiring about their use separately and the possibility of other medications in other areas of the house (Scanameo 1995). Finally, after any home assessment, the patient and their family should be encouraged to dispose of any expired, unnecessary or ceased medications.

Home help and family support

At some point it is routine to enquire about domestic support. The frequency and perceived quality of support, as well as the relationship with carers, should be explored. Patients will often show practical examples of their dissatisfaction. Exploitation of the elderly by informal carers, especially in the context of dementia, may be suggested by an obvious lack of evidence of the work supposedly being undertaken.

By now, there will be an initial impression of how the patient interacts with family members and *vice versa*. Are some family members more sympathetic or understanding than others? What are the non-verbal cues? Who has the power? Does the patient react with hostility to one particular family member? Is the nominated caregiver more frail or unwell than the patient? How does the family behave at home, a familiar environment, as opposed to a 'formal' appointment at a clinic? Legal issues such as an enduring power of attorney can also be raised.

The patient's relationship with their neighbours could be invaluable or fraught. If the patient identifies certain neighbours as support, consider obtaining permission to collect collateral history from them. Angry or hostile neighbours sometimes 'give' history, even when not approached, if one is easily identified as coming from a health service.

After the visit

Obtaining a corroborative history, as necessary, from informants such as the GP, other medical specialists, family members who were not available for the assessment and home service providers, will help to fill any gaps in the assessment. Often family members will provide an alternative perspective or emphasis that can substantially alter impressions gained from an unaccompanied patient, especially where cognitive impairment is significant. Family members are often also more forthcoming if they are not speaking in front of the patient.

Psychiatric training and home visits

Old age psychiatry provides an excellent opportunity for psychiatrists in training to experience home visits and to work with multidisciplinary teams, although the tendency for some services to relegate allied health practitioners to the role of generic case managers has the potential to undermine this. The previous experience of psychiatrists in training, exposure to infrequent but important issues particular to old age psychiatry (such as domestic squalor) and the potential learning opportunities of the referral, will inform their involvement. Coupling inexperienced trainees with experienced team members is obviously advantageous, and appropriate supervision of both the process and the clinical content is important.

Conclusions

This article has briefly highlighted the clinical challenges and strategies of conducting a home assessment in old age psychiatry. It provides a comprehensive and holistic overview of the patient and allows psychiatric services to provide

individualised interventions and utilise other appropriate resources. There are potential associated costs, in terms of time and resources, and occasionally a home assessment may entail risks to the assessors. However, many old age psychiatry teams feel that the costs and risks are outweighed by the enhanced quality of the assessment, in comparison with an out-patient assessment. The final decision as to whether or not a service undertakes home assessment ultimately depends on the resources and experience of the clinical team.

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MCQs

Select the single best option for each question stem

1 There is evidence that home assessments of elderly patients:

- a increase medication adherence
- b uncover previously undetected medical or psychiatric problems
- c always enhance rapport between clinician and patient
- d are undesired by patients and their GPs
- e are a major burden on patients.

2 The least important issue to consider before conducting a home assessment is:

- a the perceived urgency of the clinical situation
- b patient consent to a home assessment
- c the source of the referral

- d the risks to healthcare personnel
- e the number of staff to conduct the assessment.

3 The possible advantages of a home visit do not include:

- a assessing the patient in their own environment
- b avoiding the use of ambulance transport in frail patients
- c gathering information from other sources such as neighbours
- d assessing the role of other services in maintaining the patient in the community
- e being able to conduct a thorough physical examination.

4 The patient's medications:

- a are always only what their GP has prescribed

- b may reveal issues of obtaining prescription medications overseas
- c are kept in one place in the home
- d rarely include over-the-counter medications or other supplements
- e and purpose are always understood by the patient.

5 Which of these would not be a major clinical concern when viewing a patient's kitchen:

- a only having expired food in the fridge
- b burnt and dirty pots and pans
- c numerous bottles of alcohol
- d 2 days' supply of ready-made meals in the fridge
- e old and fresh pet excrement on the floor.