

# Everybody's Business

Integrated mental health services for older adults:  
a service development guide

- Improving people's quality of life
- Meeting complex needs in a co-ordinated way
  - Providing a person-centred approach
    - Promoting age-equality

[www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)  
November 2005

DH INFORMATION READER BOX	
<b>Policy</b>	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working
<b>Document Purpose</b>	Best Practice Guidance
<b>ROCR Ref:</b>	<b>Gateway Ref:</b> 5637
<b>Title</b>	Everybody's Business. Integrated mental health service for older adults: a service development guide
<b>Author</b>	DH/CSIP
<b>Publication Date</b>	November 2005
<b>Target Audience</b>	Web-based resource document to support commissioners and health and social care practitioners
<b>Circulation List</b>	
<b>Description</b>	This guide builds on the service models outlined in the National Service Framework for Older People and the principles promoted in Securing Better Mental Health for Older Adults, in describing the foundations and key elements of a comprehensive older adult's mental health service.
<b>Cross Ref</b>	Securing Better Mental Health for Older Adults Older People's Mental Health: 6 Key messages for Commissioners.
<b>Superseded Docs</b>	None
<b>Action Required</b>	None
<b>Timing</b>	n/a
<b>Contact Details</b>	Kate Hardy Older People & Disability Division, Directorate of Care Services Department of Health, 133 -- 155 Waterloo Road London SE1 8UG 020 7972 4039
<b>For Recipient's Use</b>	

## Contents

<b>Foreword</b>	4
<b>Introduction</b>	5
<b>Foundations for developing a comprehensive older adult mental health service</b>	
1) Involving service users and their carers	10
2) Health promotion	12
3) Assessment and care planning	14
4) Developing culturally appropriate services	17
5) Workforce development	19
6) A whole systems approach to commissioning integrated services	20
7) Leadership: champions, managers and leaders	22
<b>Primary and community care</b>	
1) Primary care	24
2) Home care	27
3) Day services	29
4) Housing	32
5) Assistive technology and telecare	34
6) Care in residential settings	36
<b>Intermediate care</b>	38
<b>Care for people in the general hospital</b>	41
<b>Other specialist mental health services</b>	
1) Integrated community mental health teams	44
2) Memory assessment services	47
3) Psychological therapies	49
4) Inpatient care	50
<b>Special groups</b>	
1) Younger people with dementia	54
2) Older people with learning disabilities	55
3) Mental health care for older prisoners	57
<b>Acknowledgments</b>	59
<b>References</b>	60
<b>Annexes</b>	
• Policy context: some key policy drivers	63
• Service assessment	67

### Foreword

This service development guide sets out the key components of a modern older people's mental health (OPMH) service.

The World Health Organisation says that a society can be defined by the way it treats its older citizens.

We can see this being acted out in miniature in our older people's mental health services. Therefore the dual principles of dignity and respect have been the underlying philosophy for this guide.

#### **So what might an older person's mental health service that is fit for purpose look like?**

Our service:

- recognises the dignity of individual service users. It respects and values their diversity as well as acknowledging their major role in the process of planning and developing services.
- is grounded in respect for all those people who engage with these services, not only those using them but also their supporters and carers.
- provides the practical advice and information service users and their carers need as well as developing a consistently high quality, comprehensive package of care and support which minimises bureaucracy.
- makes sure that the best and most effective treatments are widely and consistently available.
- is open to everyone. It responds to people on the basis of need not age and ensures that wherever older people with mental health problems are in the system they are not discriminated against and have their mental health needs met.

#### **Protection and support for older people**

Our service is one where the safety of service users is paramount. It makes sure that vulnerable people receive the protection and support that is their right as well as minimising the incidence of suicide in individuals and groups who are at risk.

And it employs properly trained and committed staff and has appropriate training systems that can deliver an age-inclusive and holistic service.

In short, older people with mental health problems deserve the kind of service we would want for our family members and ultimately for ourselves.

### Introduction

As we grow older we want to have good health and a good quality of life. We want to be respected for continuing to make a valued contribution to society. People of whatever age or background wish to maintain their dignity: to have self respect, to have their essential identity and independence preserved. Where mental and/or physical illness intervenes, it is the job of health and care services to support people in maintaining their dignity, autonomy and independence.

Older people with mental health problems also want to exercise control over their lives and to make choices, including decisions about their own care. They also need to be able to trust care staff with their mental well-being as well as their physical care.

#### **The importance of carers**

Older people with mental health problems may have an increased requirement for care. This is often provided by family carers, the majority of whom are old themselves. Although there are rewards associated with caring it can be very demanding on people physically and emotionally, and can have a negative impact on them financially. An Office for National Statistics study showed that one-third of carers have mental health problems<sup>1</sup> while two-thirds of carers who provide more than 50 hours of care a week report that their health has been affected by caring<sup>2</sup>.

Carers can be isolated, and less able to take part in the employment and social activities that they previously enjoyed. Primary care, social services and voluntary organisations all play a key role in supporting carers. This might include mainstream health promotion activities, providing appropriate and timely information, carer support groups and a range of respite care. Carers have a right to an assessment of their own needs and should be able to expect continuity of care for themselves as well as the person they care for.

Our aim is to ensure that older adults with mental health problems and their carers have their needs met wherever they are in the system, without encountering discrimination or barriers to access. The true cost of failing to meet this challenge is the unnecessary personal burden on older people, their carers and family members. However, in addressing these issues, there are also financial and performance rewards to be had.

Taking account of the mental health needs of older people should be an integral part of any strategy aimed at improving the overall performance of health and social care services. By working together to improve the care and treatment of older people with mental health problems, we should:

- improve outcomes for service users and their carers
- make savings by improving the efficiency of health and social care services and

- deliver on national priorities: to reduce emergency bed days, enable people to live independently at home, and reduce suicide (Annex 1).

### **Everybody's business: a whole system issue**

Conservative estimates of mental health problems in older adults suggest a prevalence of perhaps 40% of people attending their GP<sup>3</sup>, 50% of general hospital inpatients<sup>4</sup>, and 60% of care home residents<sup>5,6,7,8,9</sup>.

Two-thirds of NHS beds are occupied by people age 65 or over<sup>10</sup> and up to two-thirds of some inpatient groups either have mental health problems already, or will go on to develop them during their inpatient stay<sup>4</sup>.

Within the general community, depression is present in around 15% of older people<sup>11</sup> and dementia affects 5% of people over 65 years and 20% over 80 years<sup>12</sup>.

In the next ten years, the number of people over 65 will increase by 15%, and those over 85 by 27%<sup>13</sup>. Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60% of older people who suffer from long standing illnesses<sup>14</sup>.

In cost of illness studies, the direct costs of Alzheimer's disease alone exceed the total cost of stroke, cancer and heart disease<sup>15</sup>. In 2003/4 the NHS spent around 43% of its hospital and community health services budget (£16.471 billion) on people over the age of 65. In the same year social services spent nearly 44% of its budget (some £7.38 billion) on people over the age of 65. These figures are set to rise.

### **The development of older people's mental health services**

Despite the significant achievements of the National Service Frameworks (NSFs) for mental health and older people, there was agreement in National Directors' reviews of NSF implementation and national inspection reports<sup>16,17,18,19,20</sup> that there were particular challenges in delivering better mental health services for older people. Older adults with mental health problems have not benefited from some of the service developments seen for younger adults, and developments in older people's services are not always fully meeting people's mental health needs.

In July 2005 the Department of Health published *Securing Better Mental Health for Older Adults*<sup>21</sup> to mark the start of a new programme to bring together mental health and older people's policy in order to improve services for older people with mental health problems.

The National Directors for older people and mental health promoted the dual principles of:

- delivering non-discriminatory mental health and care services available on the basis of need, not age and
- holistic, person-centred older people's health and care services which address mental as well as physical health needs.

The publication highlighted the need for agencies to work together, for improved skills and competencies of staff in all mainstream care settings to enhance detection and management of mental health problems, and for appropriate investment to support a comprehensive specialist mental health service for older adults.

### **About this service development guide**

The publication of this service development guide is the next step in improving mental health and care services for older people. It builds on the service models outlined in the *National Service Framework for Older People* and the principles promoted in *Securing Better Mental Health for Older Adults*, in describing the foundations and key elements of a comprehensive older adult mental health service.

We hope this good practice guide will inform local discussions on commissioning services and will also be useful for health and social care practitioners in developing their understanding of how services can better meet the needs of older people with mental health problems. The term 'mental health problem' is used throughout as a summary term but this is not intended to trivialise the matter. The term includes anxiety disorders, mood disorders such as depression and mania, alcohol and drug misuse, psychotic mental disorders such as schizophrenia, acute confusion (delirium) and dementias.

Other useful approaches to commissioning OPMH services can be found among the comprehensive web-based resources that support this guide. These resources ([www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)) are for those people involved in planning services and for health and social care practitioners.

They include:

- best practice guidance and practice examples related to each section as well as links to relevant policy
- a summary of six key messages for commissioners with a commissioning checklist based on this guide.
- preliminary health economic data and some limited benchmarking data - more extensive data is expected from those services participating fully in the financial and service mapping exercise (see Annex 2).

### **Public service agreement targets**

There are a number of relevant key policy drivers that have emerged since the NSF for older people (outlined in Annex 1) and improving OPMH services will help deliver these. In particular, see:

- the public service agreement (PSA) targets on patient/user experience and supporting people with long-term conditions
- the White paper on improving community health and care services
- *Independence, Well-being and Choice*
- *Opportunity Age*
- *Commissioning a Patient-led NHS* and
- the *Community Care (Delayed Discharges Etc) Act 2003*.

The *Mental Capacity Act* is due for implementation in April 2007 and will extend the principles of empowerment and choice in legislating for people who lack capacity, and introduce new independent mental capacity advocates.

### **How we arranged this guide**

Given the complex needs and service requirements of older people with mental health problems, the material within this guide could have been organised in a number of ways.

The framework of service domains was chosen as it was felt that they would be easily recognisable to NHS, social care and local authorities. However, this approach has caused some problems in where to place services between the specialist and mainstream sections. It also potentially weakens understanding of how the components inter-relate, and so wherever possible the service development guide reflects the relationships between these service domains.

### **Implementation**

There are various initiatives to support the dissemination and take up of this guide, including a series of regional meetings to raise awareness of local issues and the development of educational resources for mainstream staff.

Ongoing support for implementation will be provided through the Care Services Improvement Partnership (CSIP) older people's mental health programme, both nationally and through its eight regional development centres. CSIP is part of the Care Services Directorate of the Department of Health and its main aim is to support improvements in services.

The guide will inform the older people's mental health service mapping exercise, starting in November 2005. Service mapping will support local commissioning discussions, in nationally benchmarking services alongside local activity data and improving understanding of local service models. It will also provide the basis of a local service directory for users and carers.

The Healthcare Commission and Commission for Social Care Inspection (CSCI) will use this guide to inform service inspection. It will also be important for all NHS trusts and primary care trusts (PCTs) when they undertake their self assessment of compliance with the core standards (and progress with developmental standards) in *Standards for Better Health*.

### **Improving practice at the front line**

Our guide does not set out to develop new policies - it aims to improve practice at the front line. We draw together existing work relating to older people's mental health to support the development of more consistent and coherent services. We also signpost good practice resources that may be useful to commissioners, providers, service users and carers.

The complex nature of older people's mental health requires a whole systems response that cuts across health and social care, physical and mental health, mainstream and specialist services.

We need strong leadership across health, social services, local authorities and voluntary organisations to co-ordinate and direct improvements in health and care services for older people with mental health problems. This leadership will communicate the vision of age inclusive and holistic services, and ensure the delivery of effective and lasting results.

Older people with mental health problems must not be allowed to fall between our services, but should benefit from the best possible non-discriminatory and integrated mental health and other older people's services.

## Foundations for developing a comprehensive older adult mental health service

### 1) Involving service users and their carers

#### Background

Older people want their views on their needs, goals, the balance of risk against independence, and their preferences over treatment and care approaches to be central to assessment and care planning.

Being involved in decision making about care received is the starting point for developing a relationship based upon partnership between the person and carer, and is the first step in delivering a person-centred service.

Older people, particularly those with mental health problems, have often not been fully involved in decision-making about their own care. They are often subject to stigma, stereotypical, ageist views and an assumption that older people with mental health problems are not capable of expressing their views.

We must challenge this discriminatory practice. Older people who use mental health services can improve the development and delivery of those services in the same way as other citizens. They also have an equal right to comment on their care but may need support and innovative approaches to be effective in all these areas.

#### A welcome to advocates

Carers' views are important in their own right, but may be different from those of the person with the mental health problem. The views of carers and service users need to be understood and acted on. Advocates, who support and help people find their voice, may challenge a service but should be welcomed in enabling the user's views to be represented.

Services for older people with mental health problems cannot become truly person-centred without incorporating the views of users and their carers in all aspects of service planning, development and care delivery. This key principle underpins the National Service Frameworks for Mental Health and Older People, and is a statutory duty of NHS organisations<sup>22</sup>.

#### Key messages

Involvement of carers and people who use services is a complex and challenging task. Although user and carer involvement is central to quality improvement within health and social care, there is still much to do. Overall, there has been better progress in involving carers than in involving people with mental health problems. (See resources for service user and carer involvement at [www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk))

Involvement should not be seen as a one-off activity, but as a process that becomes part of the way staff work and organisations operate. As care

should be based around the needs of the individual, so should the engagement process.

Mental health services for older people should:

- train staff at all levels in relevant communication techniques
- offer appropriate support, advice and information to enable people to make informed decisions about their treatment, support, and the ways in which these will be provided
- value and respect citizenship in the development of the care planned; and
- encourage a needs-based, flexible service that changes in line with people's unique needs.

The following issues will determine the success of involvement activity:

### **Organisational commitment**

The culture of an organisation will determine the success of involvement initiatives. Senior managers must make a commitment to the process and acknowledge the need for investment to develop and maintain this. Procedures and processes should be in place to regularly feed back users' and carers' views to decision makers.

### **Resource allocation**

Services should attach budgets to involvement activities to cover staff time, out-of-pocket expenses and any support people need to participate. They should consider fees to users and carers for their involvement.

### **Training**

Effective involvement requires training of staff and users and carers. Joint training is encouraged, and may be usefully supported by collaboration between the voluntary sector and statutory services. Staff need to be aware of ethical issues surrounding communication and consent with service users.

### **Time investment**

Involvement costs time. As well as allowing adequate organisational time to support activities, services should give users and carers enough time to prepare and understand their roles.

### **Feedback and recognition**

Users and carers need to know that their involvement is not tokenistic but has been taken seriously. Giving them clear expectations and getting their feedback on outcomes – even if nothing changes – is essential if people are to feel valued for their contributions. Procedures and processes should be in place to regularly inform users and carers of relevant action taken following their input.

## 2) Health promotion

### Background

Achievement and maintenance of good mental health are prerequisites for a fulfilling later life. Mental health has been defined as “the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others’, dignity and worth.”<sup>23</sup>

For older people in particular, physical health and mental health are inextricably linked. Discrimination on the basis of age and mental health, in both direct and indirect forms, presents a major risk factor to older people’s well-being and needs to be challenged and eradicated. The importance of health promotion in later life should not be diminished by stereotypical views on older people’s frailty and dependence.

### Planning mental health promotion

Promotion of good mental health needs to be planned across the whole of life. It should incorporate both physical health and mental well-being and be targeted at both the whole population of older people as well as those who have mental health problems. Health promotion should be seen as a continuum that includes maintaining good mental health, preventing problems, care and treatment, and recovery. Depression, the most common mental health problem of later life, can have a better treatment outcome when local partners work together<sup>24</sup>.

### Challenges to older people’s mental health

Certain transition points may challenge older people’s resilience and coping mechanisms, for example retirement, moving home, going into hospital, and life events involving change and loss such as bereavement or illness. However, the cumulative effect of day-to-day problems can also challenge the mental health of older people. Low-level preventative services, such as help with housework, gardening, laundry, and home maintenance and repairs, can help improve people’s quality of life and keep them independent<sup>25</sup>.

A call for evidence for the *Inquiry into Mental Health and Well-being in Later Life*, a joint project between Age Concern and The Mental Health Foundation, demonstrated five themes to be of particular relevance for mental health and well-being in later life<sup>26</sup>. These were: public attitudes, staying active, social networks, standards of living, and physical health. These factors are important whether the person is physically and mentally well or unwell, living at home or in care, and whether or not they are caregivers themselves.

### Key messages

Local partners should prepare a joint strategy for the promotion of older people’s mental health, both for the general population and also for at-risk groups. This should include attention to the needs of carers of people with

mental health problems. Local suicide prevention strategies should incorporate actions directed at the older population where suicide risk is high. The strategy should cover the following areas:

### **Information provision**

Older people and staff from health and care providers should have easy access to information about the range of health promotion and leisure activities offered locally, and options for transport.

### **Physical health**

Older people benefit from physical exercise - whether in a gym or digging the garden - improved diet and nutrition, not smoking or drinking too much. They should be supported in these healthy lifestyle choices with information and suggestions on where to get further advice.

Older people with mental health problems should be offered, and where necessary enabled to use, mainstream health promotion and disease prevention programmes in the same way as other people, without discrimination or bars to access. Local partners should ensure appropriate take up of mainstream health promotion and disease prevention activities amongst people with mental health problems, which may involve NHS trainers and community matrons.

### **Public attitudes**

Local partners should take a lead in combating the dual negative stereotypes of mental illness and ageing and in promoting positive attitudes. Training is required for all staff across community services. Staff need to use language that it is non-discriminatory, inclusive and positive. The contribution of older people to their communities and society should be celebrated and the media used effectively in this.

### **Staying active**

Staying mentally and physically active gives a sense of purpose and personal worth to people, as well as enabling people to make an effective contribution to their communities. Participating in valued activities can also provide an opportunity for social contact. Hobbies and leisure activities, lifelong learning, as well as volunteering, employment, and engagement in the development or delivery of local services should all be supported.

### **Social networks**

Older people may suffer from isolation from a variety of causes such as bereavement, dispersed family, lack of occupation, insufficient financial resources, poor transport services and the impact of poor health. Partners should ensure that older people in all settings can choose from and participate in a diverse range of stimulating one-to-one and/or group activities.

### **Standards of living**

All people need financial security and older people, especially those with mental health problems, can be particularly vulnerable. Retirement and

pension planning, advice on benefits and other financial issues should be available. The opportunities to provide benefits advice in health and social care settings should be explored. Adequate housing and low-level preventative services improve quality of life.

### 3) Assessment and care planning

#### Background

Older people who seek help from health and care agencies want a comprehensive holistic assessment and care plan that minimises duplication and includes the needs of key caregivers. Older people also need to know who to turn to and when to ask for help. Several professionals from different agencies may be involved in the care and treatment of older people with mental health problems, and co-ordinating their input is a major challenge.

#### Effective care planning

In keeping with the NHS and social care long term conditions model<sup>27</sup>, care planning should address people's needs across the spectrum of supported self care, disease-specific care management and case management for those highly vulnerable people with complex care needs.

Older people with mental health problems may be involved with two assessment processes: the single assessment process (SAP)<sup>10</sup> and the care programme approach (CPA)<sup>28</sup>. If they have a learning disability they may be supported to develop a Person Centred Plan (PCP)<sup>29</sup>. The Department of Health is now considering the possibility of further developing SAP, CPA and PCP to provide one tool for use with all people with complex needs.

#### The care programme approach

The CPA was introduced in 1991 as a framework to ensure systematic assessment of and care planning for the health and social needs of people accepted into specialist mental health services. It ensures a multi-disciplinary approach to community care provision following psychiatric admission, and provides a system to meet the various needs of Section 117 aftercare, care management and the supervision register. Up to four levels of CPA were developed, reflecting the numbers of staff and agencies involved, the frequency of monitoring necessary, the regularity of communication needed, and whether the supervision register, a form of risk register, is required.

The CPA involves users and carers in care planning, with a key worker responsible for overseeing the delivery and review of the care plan, recognising that a person's needs change. Advance contingency planning allows for swift intervention if a person's mental health deteriorates.

#### The single assessment process

The single assessment process (SAP) for older people served by health and social care services was first proposed in *The NHS Plan* in 2000<sup>30</sup>. The aims of SAP are to ensure a person-centred approach to assessment and care

planning for older people, across all areas and agencies, regardless of organisational boundaries.

Four levels of assessment (contact, overview, specialist and comprehensive) were introduced to match assessment to the complexity of a person's needs. Information is to be collected, stored and shared (subject to consent) in summary form. When more than one professional is involved, close communication is required and co-ordination of care may be best managed by one professional. The single assessment process should enable identification of potentially vulnerable older people, linking in with adult protection and long term conditions management.

Services are at different positions in integrating the specialist CPA and the more generic SAP methodologies. Some are maintaining the CPA as a separate specialist assessment and care planning framework, others are trying to incorporate key elements of the CPA as an integral part of specialist assessment and care planning under SAP.

### **Key messages**

CPA, SAP and PCP assessments have several factors in common:

- they should place the user at the centre of assessment and care planning. The service user's views of their own abilities and desired outcomes should be central to the process
- they aim to improve standards of assessment and care planning with a common method across agencies and care settings
- they are frameworks for multi-disciplinary/multi-agency working, which help co-ordinate the roles and responsibilities of different professionals across health, social care and other appropriate organisations
- level and type of assessment should be proportionate to need, and information should be shared and built on and
- carers are entitled to an assessment in their own right. Their needs and wishes may differ significantly from those of the user but the same principles should apply.

The CPA has additional safeguards for people at high risk and key features of CPA should be incorporated in all specialist services' assessments and care plans. If the service user perceives the care planning system is changing in name and process, for example when transferring from the care of a younger adult mental health service to an older people's service, they need to be given adequate explanation and reassurance about the new system. The two services should aim to have seamless care planning during transfer of care.

If the older person's first contact is with mainstream or non-specialist services, the overview and current summary record should be passed to the specialist mental health service when they are referred. Mental health specialists should add to, not repeat this information, and feed it into their assessment and care planning processes. Similarly, information gained from specialist service involvement should be fed back into the SAP. The same principles apply to Person Centred Planning.

Admission to hospital or other unfamiliar surroundings may exacerbate mental health problems. Transfer of assessment and care planning information from the community to the hospital will improve assessment and care planning by the inpatient team. The aim should be to return the person to their own home as soon as is appropriate without unnecessary delays.

### **Specialist old age mental health services**

A small proportion of older people will need to be referred to and treated by, specialist old age mental health services. The decision to refer for a specialist assessment should be based on information and understanding about the person's previous mental well-being. This will include talking to those people who know the person well, and the results of any investigations that might determine an acute physical cause for the problem.

Where the person's needs are predominantly mental health related (such as severe acute mental illness, psychotic episodes, or illness requiring admission to a psychiatric unit) then the specialist service will take the lead in assessment and care planning. Physical health screening must be included and appropriate plans made to meet the person's needs.

Where the person's needs are predominantly physical and the mental health problem can be managed by primary and community care, then SAP should be completed with mental health screening included and appropriate intervention organised.

### **Care co-ordination**

Older people want to know who to turn to for advice at any time and continuity of care planning. The priority is continuity of care rather than any one person having ongoing responsibility for someone's welfare. Once someone's needs are clear, there should be agreement as to who co-ordinates the care. This may involve a transfer of the co-ordinator role (sometimes temporarily). Under these circumstances there should only be one co-ordinator; someone may need to stand aside and hand over the role to another colleague. Close communication between professional colleagues as well as with the service user is essential to ensure that everyone knows what is happening.

The care plan should include arrangements for reviewing outcomes. Needs (and wishes) may change over time and care co-ordination arrangements should reflect this.

### **Advance statements**

Advance statements or directives (plans made by the service user to be put in place should they become ill and unable to make decisions) are one useful way to help plan for the future, and people should be supported in developing these where desired.

Consent to share information must be obtained from the older person. If they are not able to give consent, then decisions about information sharing may have to be taken in their best interests and the interests of those closely

involved in their care. Access to independent advocacy should be available to ensure the person's best interests are maintained.

### 4) Developing culturally appropriate services

#### Background

It is widely reported that people with mental health problems, black and minority ethnic communities and older people as separate groups experience social exclusion. It follows, then, that black and minority ethnic older people with mental health problems are a particularly vulnerable group at risk of social exclusion, which could lead to depression as well as exacerbating other mental health problems that may go untreated.

Unfortunately, access to mental health services for black and minority ethnic older people and their carers remains problematic. Barriers include issues of language, knowledge of what services are available, and the attitudes and practices of service providers, as well as cultural factors in the perception and understanding of mental illness.

#### Serving black and minority communities

Traditionally, there has been a view that black and minority ethnic communities do not wish to use services, as they prefer to care for elders themselves. However, research suggests that the idea that the extended family will look after their elders may be a myth and that in many cases the reality is that family networks are spread across continents not counties<sup>31</sup>.

Similarly, black and minority ethnic communities are often described as a hard to reach group. An alternative view is that these communities find services hard to access.

The number of older people from black and minority ethnic communities has risen sharply over the past few decades and is projected to continue to rise. Black and minority ethnic older people with mental health problems and their carers need to have access to appropriate and responsive services. There needs to be a balance between ensuring access to mainstream services and understanding the nature and extent of the need for specialist services.

*Delivering Race Equality in Mental Health Care (DRE)*<sup>32</sup> is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of black and minority ethnic status, including those of Irish, Mediterranean and East European origin.

Recent publications that have informed DRE include:

- *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*<sup>33</sup> and
- *Delivering Race Equality: A Framework for Action*<sup>34</sup>.

DRE is just one component of a wider programme of action bringing about equality in health and social care. For example *National Standards, Local*

*Action*<sup>35</sup> is the Department of Health's current care standards and planning framework. Core standards include:

- healthcare organisations must challenge discrimination, promote equality and respect human rights; and
- organisations must enable all members of the population to access services equally.

DRE will support the implementation of Sir Nigel Crisp's ten point race equality action plan<sup>36</sup> in the NHS, and will also help NHS trusts to fulfil their obligations under the *Race Relations (Amendment) Act 2000*<sup>37</sup>.

It is important that race equality initiatives are inclusive of older people with mental health problems; however, there may also be a need for specific initiatives focusing on older people with mental health problems where this will produce better outcomes for them.

### Key messages

In order to ensure that black and minority ethnic older people with mental health problems have access to appropriate and effective services, development plans should be based on the three building blocks highlighted within DRE:

- **more appropriate and responsive services** – achieved through action to develop organisations and the workforce (eg: culturally aware staff) and improving clinical services through setting benchmarks and monitoring the appropriateness of services
- **community engagement** – delivered through healthier communities and by action to engage communities in planning services. (Having specific OPMH community development workers could support this) and
- **better information** – from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services

A whole systems approach, which includes voluntary, statutory and independent organisations as well as black and minority ethnic older people with mental health problems and their carers is likely to be most effective.

Services may consider completing a baseline audit that focuses on older people with mental health problems (possibly using the audit tool recommended for the 2004/5 autumn self assessment local implementation team (LIT) themed review) and developing action plans that are agreed by both older people's LITs and mental health LITs.

Focused implementation sites that have been established around the country to help find and pass on best practice in DRE should also ensure that terms of reference are inclusive of older people with mental health problems. Lastly, diversity should be promoted and celebrated as a positive strength of local communities – through building confidence, encouraging participation and building relationships of trust, solidarity and friendship.

## 5) Workforce development

### Background

There can be few areas where the individual qualities, competencies and skills of the workforce matter more than in the care of an older person with mental health problems. Often presenting with complex co-morbidity and a diverse range of needs, older people and their carers require support and care from a whole range of agencies and within many different settings.

Older people with mental health problems are found throughout the health and social care system:

- in a typical GP surgery 40 per cent of people attending for any reason will have a mental health problem and in 20-25% of people a mental health problem will be the sole reason for attending<sup>3</sup>
- conservative estimates suggest that 60-70% of people in care homes have dementia and 40% have depression<sup>5,6,7,8,9;</sup> and
- up to 60% of people aged 65 and over have or develop a mental health problem during admission to a general hospital.<sup>4</sup>

Older people should be able to expect that all staff with whom they come into contact have a basic understanding of their mental health needs and those of their carers, and that when they require specialist care, staff are equipped to cope with their complex care needs.

### Key messages

#### Workforce development: education and training

It is essential to develop a coherent and cohesive whole-system strategy for workforce development, education and training for older people's mental health services that will:

- address the specific cultural needs of elders within black and minority ethnic communities
- ensure that staff have appropriate written and verbal language skills to communicate effectively with service users
- enhance the skills of all staff working in generic, non-specialist areas to better meet the requirements of older people with mental health problems across the board
- ensure staff working with older people with high levels of mental health problems eg: home carers, community matrons, care home workers, staff working on care of the elderly wards, A&E staff receive more in-depth training and development
- incorporate the 10 essential shared capabilities into pre- and post-registration education and training for all mental health staff (see resources at [www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)).
- explore working in new ways and with new roles – for example, through multidisciplinary liaison teams involving graduate primary care workers, support, time and recovery workers and community development workers

- consider leadership needs, both in terms of training and new roles and
- reflect collaboration with human resources / local higher education institutions co-ordinating all resources.

### **Recruitment and retention**

In addition to the challenge of attracting the right staff into what can often be both physically and mentally demanding care roles, services must develop and retain those already in post. Tasks include:

- scoping post-registration education opportunities and commissioning the right kind of courses in the future
- providing regular supervision and support opportunities for all staff, especially those working in challenging environments eg: care homes, continuing care, challenging behaviour wards/teams
- promoting integrated health and social care working and services that focus on the needs of the older person, providing truly flexible and individualised approaches to care. This is likely to include working across organisational and agency boundaries and may include jointly funded posts.

### **Workforce planning**

All areas are required to produce a coherent joint workforce plan as part of the local delivery planning process. It is essential that this strategic plan is developed by as many as possible of the relevant organisational, user/carer and professional stakeholders involved in the provision of that service.

This should also include providers of education and training. The six-stage cyclic model proposed is fully described in *Mental Health Services – Workforce Design and Development*<sup>38</sup> and highlights the need for whole system collaboration and the need to make workforce planning integral to the development of both new and existing services.

## **6) A whole systems approach to commissioning integrated services**

### **Background**

Commissioning is “the process of specifying, securing and monitoring services to meet needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies or by the private or voluntary sectors.”<sup>39</sup>

Commissioning is a cyclical process that involves:

- **understanding the market** – mapping, analysing and forecasting supply and demand to meet current and evolving need
- **aligning system partners** – ensuring there is some agreement on what needs to be achieved to meet demand
- **joint strategic planning** – involving all systems partners and service users in the development of plans and strategies to meet these goals
- **applying resources** – across the system for best effect to maximise attainment of agreed strategic goals and

- **reviewing and evaluating** – in order to adjust or re-provide to meet changing needs.

Commissioning a Patient-Led NHS<sup>40</sup> described a shift in the role of PCTs towards health promotion and commissioning, with a greater range of providers of primary and community care services to improve choice for service users. It also heralded a move towards greater congruence of PCT, local authority and social services boundaries. Practice based commissioning is intended to get commissioning better informed by professionals who know what people want from local services.

### **Key messages**

Commissioning better mental health services for older people improves quality of life and helps to meet key PSA targets (Annex 1) and standards (Annex 2).

Practice based commissioning offers great opportunities to develop more person-centred and integrated community based services. This new direction links with developments in the White Paper on improving primary and community health and care services, *Independence Well-being and Choice*, and the management of long term conditions, all of which have relevance for the implementation of this guide. Voluntary organisations have a role not only in advocating for people with mental health problems but also in providing or supporting the provision of services.

### **Commissioning strategies**

Effective commissioning of OPMH services demands that partners across health and social care economies, including the independent sector, voluntary sector, users and carers, have an agreed vision for future services and a strategy to implement it.

The commissioning strategy must be explicit about the population it serves and the needs that have been identified for that population currently and in the near, medium and longer-term futures. It must also have the resources available to direct towards meeting those needs.

A strategy's success will depend on all organisations coming together to agree:

- the means and processes required for establishing levels of unmet needs in local populations
- credible data on which to base joint / multi-agency service purchasing
- a common definition of commissioning, and clarity over the roles, functions and governance arrangements of the organisations involved
- the budgets and resources available for investment
- purchasing priorities and plans for achieving them (including agreement on any necessary disinvestment in existing services)
- methods of review and evaluation to inform future service planning and commissioning and
- geographical coherency in service provision.

There are various ways in which systems can work together to secure a broad range of services to meet local population needs. These include:

- single agency purchasing arrangements
- joint or multi-agency purchasing arrangements
- partnering arrangements, for instance using Section 31 Health Act Flexibilities<sup>41</sup> with pooled budgets and agreed lead responsibilities and
- integrated services, involving restructuring of existing service provision.

It is important to note that the four elements do not have to be put in place in any particular order, nor do they all have to be adopted. A single agency may purchase some services that meet local needs satisfactorily and that are not part of a joint agreement or partnership arrangement.

Before any commissioning arrangements are undertaken, it is essential that those involved know how this activity fits in with the stated objectives and desired outcomes of a commissioning strategy. One particular challenge is to achieve a strategic balance of investment to provide low-level preventative services for the general population alongside those for people with emerging and high-level complex needs.

### **Resources to aid commissioning**

A number of excellent resources are available to assist with commissioning health and social care services which meet the needs of older people with mental health problems. These include ones relating to issues of integrated health and social care working, a summary of six key messages for commissioners and a commissioning checklist based on this service development guide ([www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)). Some preliminary health economic data and some initial benchmarking data are also provided, with more extensive data expected from those services participating fully in the financial and service mapping exercise (see Annex 2).

The National Institute for Mental Health England (NIMHE) is involved in ongoing work to make the Modernisation Agency's 10 high impact changes<sup>42</sup> more relevant to mental health services.

## **7) Leadership: champions, managers and leaders**

### **Background**

The NSF for older people made much of the role of the champion, and a network of older people's champions was established. But all those working in or having responsibility for the mental health of older people are potentially champions. Some are users, involved in service planning, some are in the voluntary sector, some are frontline staff delivering the services, and others have management and leadership roles at local, regional or national level. Implementation of this guide will help some of the most vulnerable people in society with some of the most complex problems: prone to stigma, social exclusion, with under-detected and under-managed physical and mental health problems.

The needs of older people with mental health problems cross health and social care, physical and mental health, mainstream and specialist services.

To arrive at a truly person-centred, needs-led health and social care service, there are significant cultural, organisational and systemic hurdles to overcome. This requires strong and sustained leadership, working collaboratively with others to cross traditional organisational and professional boundaries and ways of working, towards a common goal. Strong strategic relationships need to be built, and translated into joint action. Service users and carers and voluntary organisations have a crucial role in ensuring the needs of service users are heard.

The nature of the work involved with older people's mental health demands and attracts some of the most exceptional and committed staff the NHS and councils have. They want to work in strong multidisciplinary and multi-agency teams and are motivated by serving the public well. Strong leadership is needed to encourage innovation and a drive for quality improvement, and to empower staff to realise their potential and rise to the challenges that working in services for this client group brings.

### **Key messages**

Older people's needs are complex and cross many organisational and cultural divides. The one thing that is needed above all else to improve older people's mental health is effective leadership across all health and social care organisations, at all levels.

Effective leadership requires a vision of where it is going, a strategy for how to get there, and involvement operationally in managing the translation of vision into reality.

Local leaders need development and support, and should be involved and empowered in decision making.

Strategic health authorities and councils need robust systems to ensure the delivery of age equality in mental health services for older people and holistic mental and physical health care in mainstream services.

## Primary and community care

### 1) Primary care

#### Background

Older people usually see primary care as one of the most accessible ports of call when needs arise. They and their families and carers may have relationships with a number of members of the team over a period of time. These staff are often well placed to help the person to define their own needs and their own goals in the context of living their lives as fully as possible in the local community.

Older people want their difficulties to be addressed holistically, and for staff in primary care to be able to help them navigate the range of health promotion opportunities and local services. If their problems are complex or urgent, people want timely specialist advice and referral where appropriate. Carers should be recognised as often essential to the well-being of the older person, and supported and empowered to provide this care.

Mental health problems are common in primary care: in a typical GP surgery 40% of people will have a mental health problem and in 20-25% of patients a mental health problem will be the sole reason for attending<sup>3</sup>. Depression is the commonest cause of suicide in older people<sup>43</sup>. Many older people who commit suicide have had recent contact with their general practitioner or primary care team member, but mental illness often goes un-recognised and treatment is not always the most appropriate<sup>44</sup>. For these reasons, all staff in primary care need adequate awareness training on mental health issues in later life.

#### Models of service delivery

In most cases primary care teams provide most of the help that people need. The particular tasks for primary care lie in:

- health promotion (see section in this guide), and helping people to care for themselves and their condition more effectively
- recognition of mental health problems
- formulation of a care plan and ongoing involvement for the majority, including support for family carers and
- referral to specialist services for the small proportion who have particularly complex needs or who pose high levels of risk, with ongoing collaborative care. Collaboration between primary and specialist care providers is known to produce better treatment outcomes for older adults with mental health problems<sup>24</sup>.

Increasingly, skilled workers in primary care are carrying out tasks that were previously seen as only in the realm of specialist services in secondary care. Graduate primary care mental health workers may play a key role in supporting the delivery of better mental health for older adults. They should help provide information about mental health disorders and local services, as well as carry out direct psychological work with clients. Community matrons,

whose role is to manage people with complex care needs, will be care co-ordinators for many people with mental health problems. GPs with a special interest in older people's mental health are emerging. All these developments require close co-ordination with local specialist and mainstream services.

### Key elements

#### **Recognition of mental illness**

Although many people are more aware of what mental health problems are, they are still subject to considerable ignorance and associated stigma among the general population. Often people will not seek help or even recognise that they are unwell.

There is little evidence for routine screening specifically for mental health problems in older people. Recognition will therefore occur only fortuitously unless as a result of a routine or planned assessment and the single assessment process.

Primary care staff need to remain alert to the possibility of mental health problems as the cause of presenting difficulties or complicating the course of other physical illnesses. They should become familiar with the common mental health problems of later life, and encourage older people with mental health problems to seek help. Training programmes for staff should include components on the recognition of and response to mental health problems in later life. Simple screening tests appropriate to primary care and other mainstream health and social care settings should be agreed with local specialist services, to be targeted when and where appropriate.

#### **Formulation of a care plan and ongoing care management**

Existing Department of Health guidance suggests that there should be protocols for the care and management for older people with mental health problems, agreed with secondary care and with input from service users. They should include guidance on at least the commonest mental health problems in later life; depression and dementia. They should cover detection, initial assessment (incorporating contact and overview assessment within the single assessment process wherever possible), initial management and guidance for referral to specialist services. There should be implementation arrangements for training and dissemination, and audits to assess their use.

General principles for ongoing care include:

- educating, informing and supporting people with mental health problems and their carers so as to involve them more in their healthcare decisions. This might include involvement in expert patient or expert carer programmes
- signposting the service user and carer to other resources
- taking a holistic approach
- working with statutory and voluntary health and social care organisations, in collaboration with carers

- appropriate ongoing assessment and intervention for physical co-morbidities, sensory deficits and other disabilities
- ensuring older people gain maximum benefit from their medicines, and take them appropriately. This includes people with depression taking an adequate course of antidepressants and ensuring people with cognitive impairment are supported to take medication reliably and
- promptly referring people who require specialist mental health care.

### **Management of long term conditions**

Older people with mental health problems not only often have a long term condition in their mental illness but are also more likely to have other long term conditions. People with long term conditions are more likely to suffer mental illness which worsens their prognosis. For people with more than one long term condition, costs are six times higher than those with only one<sup>42</sup>.

Evidence on better management of long term conditions indicates reduced pressure on hospital services through reduced morbidity, reduced admission, and reduced length of stay; reduced prescribing budgets, reductions in urgent care visits and visits to hospital<sup>42</sup>.

Older adults with severe mental health problems including dementia are amongst the most vulnerable people living in the community and are often likely to require case management due their highly complex needs (level 3 care in the NHS and social care long term conditions model<sup>27</sup>). Including older adults with mental illness in primary care disease registers can lead to more holistic and co-ordinated care and help avoid unnecessary admission to a hospital or care home.

### **Access to psychological therapies**

In the populations served by primary care there are large numbers of older people with significant psychological problems. Demand for psychological rather than drug treatments is likely to increase as more is learnt about their efficacy. Treatment options should include access to psychological therapies in primary care, which should not be determined by age. A stepped care approach is recommended, where low intensity, low cost treatments are delivered as a first option, with subsequent referral where necessary.

### **Referral to specialist services**

People with mental health problems should be referred to specialist services for expert advice, and for periods when:

- there are diagnostic issues that need clarification
- there is lack of response to initial intervention strategies
- distress or risk are particularly severe
- problems are complex and
- legal issues require their involvement.

Effective use of mainstream and specialist services requires that the latter should not have ongoing responsibility for care managing all people with mental health problems. However, users and carers often want continuity of a

key worker, and transfer of care co-ordination responsibilities should minimise disruption to care planning.

## 2) Home care

### Background

Older people with mental health problems usually want to continue living in their own home as long as possible. But sometimes a range of practical difficulties as well as physical and mental health problems can limit their independence and increase risk to themselves or others.

While people are choosing to remain living at home they should be offered support to enable them to live as full lives as possible. Assistance should be based on a care plan which puts the wishes of the person first, and recognises the role of family carers. Home care, also known as domiciliary care or community support, offers crucial personal support to those who live in their own homes. The Commission for Social Care Inspection now inspects and monitors all domiciliary care services.

### The range of home care services

Most home care services offer help with personal care (washing, dressing) and with daily living activities (preparing a meal, doing the shopping), but staff may be time limited in completing tasks. There are an increasing number of specialist domiciliary care services, often focusing especially on people with dementia. These have been invaluable in improving quality of care.

There are therefore significant opportunities to develop home care services that can meet the needs of older people with mental health problems, working with rehabilitation services to enable them to remain at home and reducing the need to move into hospital, long term residential or nursing care.

As with other users of home care services, people with mental health problems and their carers will be assessed for their liability to pay for home care services. Local authorities are required to assess a person's need and consider their eligibility to receive support against the *Fair Access to Care Services* (FACS) criteria. This may mean that service delivery is focussed on high levels of need rather than health promotion or preventative services. Support services to enable users to retain their independence may therefore not always be available.

### Models of service

Most people with mental health problems are looked after at home by mainstream services or family support. Low-level support such as enabling a person to continue to go swimming, to maintain their house or to tend their garden can be crucial in maintaining people with mental health problems and their carers in their homes.

Specialist home care services allow trained and experienced staff to offer help in a flexible way that allows for variations in people's moods that may be associated with mental ill-health.

Direct payments are being used increasingly by older people to arrange their own care. Older people with mental health problems may require additional support to help arrange their care, manage the financial aspects and safeguard them against potential exploitation or abuse. The use of individualised budgets, where people are allocated a notional amount of money rather than an actual transfer of cash, may prove to be a more appropriate route for older people with mental health problems to achieve more flexible and individualised care while avoiding the responsibilities of employment.

### **Key elements**

Given the high prevalence of mental health problems in older people, and the association of mental ill health with long term conditions, a high proportion of recipients of home care will have mental health problems. It is vital therefore for staff to have an adequate understanding of common mental health problems, the impact of loss and disability, sensory impairments and have good communication skills, particularly with people with cognitive impairment. This is especially important if services are to take on a role in supporting people with mental health problems in crisis.

Home care staff will often work with people who want to live at home despite some risk, and both staff and the service user may need to be supported in pursuing this choice.

In more traditional patterns of support, home care assistants visit a person for a prescribed period of time to carry out a specific task. Even in this limited role when visits are time-driven, isolated older people often value the opportunity this time affords them for social interaction.

A better model would have specialist home carers working alongside people, encouraging them to be as independent as possible rather than doing tasks for them. They will have a person-centred rather than a task-oriented approach, working creatively to meet the current needs of each person, which may change from day to day. They may visit them in respite or day care to maintain continuity.

Home care services should have good working relationships with specialist resources such as community mental health teams for older people and community rehabilitation teams who may be coordinating and supervising a care plan, so that access to advice and support is easily available if people's needs change. Occupational therapy advice on aids and adaptations to the property is vital.

There is an increasing move to ensure access to 24 hour, seven days per week home care support to minimise the need for unnecessary hospitalisation and to respond to crises. Examples include links to intermediate care,

community based response services linked to telecare alerts, and diversion schemes at A&E departments. People with mental health problems should have the same access to home based palliative end of life care services as others and home care will be an integral part of this.

### 3) Day Services

#### Background

Older people usually want to remain a part of their local communities. A range of community resources such as lunch clubs, drop-in centres, befriending schemes, home support services and specific social groups aims to reduce social isolation, maintain social contact and have a key function in the prevention of mental health problems.

The term day services describes a whole spectrum of care which aims to support older people with mental health problems to live as independently with as good a quality of life as possible. Day services offer a focus for people who are socially isolated and can help to maintain an older person's confidence, self-esteem and social skills. They may also provide specific activities to support independent living, and provide respite for carers.

Day services need to be flexible and centred on the needs of individuals and their carers. They should be seen in the context of social inclusion and health promotion.

Day services fall into two main categories:

- those for people with low to moderate needs who can access mainstream day services for older people or for people with mental health problems and
- specialist day care for people with moderate to severe mental health problems.

Services should be available on the basis of need, not age. This is particularly important for people with functional mental illnesses who may have been receiving support from younger adult mental health services; they should not have to transfer to an older person's service simply because they reach a certain age.

#### Models of service

The provision of seamless day services will rely on clear pathways and referral processes that enable people to receive appropriate assessment, care and treatment. Regular review of individual needs is essential to make sure that people are receiving the right care in the right place. In all settings, a holistic approach should be taken to the promotion of good health.

#### **Mainstream day centres and other mainstream community resources–**

The needs of people with mild and moderate mental health problems may be best met by accessing mainstream services provided in community locations

which are often run by councils, social services, voluntary groups, churches etc.

The focus will be to enable people to use community facilities in line with their interests and remain active participants in their local community. Specialist staff might be used to help people settle in and to support unqualified staff.

Key elements of service may include:

- a range of leisure and social activities
- resources such as advice and information
- opportunities for peer support
- education and support to providers to enable them to understand people with mild mental health problems and to make the necessary adjustments in the organisation of care to ensure inclusion and
- staff trained in the identification and support of people with mild mental health problems and who know how to access services if their condition deteriorates.

### **Day care at home**

Support workers may be employed to help meet a person's needs in their own home and so maintain independent living skills. This may be more helpful to certain groups: people with particular needs related to diet or religion, or people with dementia who may find leaving their home surroundings and routine particularly distressing and confusing. Day care at home can also be helpful in more rural communities, though should not be a substitute for the provision of appropriate transportation.

Key elements of service might include:

- trained support workers who can support people with a range of mental health problems
- practical help to engage in chosen activities
- personal support in meeting daily living activities but also promoting independence; and
- trained host families organising care in a home environment.

### **Specialist day centres**

Specialist day services provide care for people with more moderate and severe needs who may need specific personal support with day to day activities, including people with functional mental illnesses like depression, anxiety and schizophrenia; and people with moderate to severe dementia. Centres should have flexible operating hours, being able to offer care at weekends and in the evening if this is required.

These services are often provided on an ongoing basis, and may be run by statutory, voluntary or independent sector organisations working closely with specialist mental health services that can provide support and training. They provide an environment that is tolerant of people who may have unusual behaviour. They also provide ongoing assessment of need, respite, and support for carers by providing advice and information.

Key elements of service might include:

- needs assessment including that of their carer
- a person-centred care plan which takes account of the person's strengths, supports the person to be as independent as possible in aspects of daily living but is also sensitive to meeting the needs of their disability by providing personal support when required
- providing meaningful occupation taking account of the person's history and preferences, with practical help and support to engage in chosen activities
- providing support to carers through respite, information and advice; and
- ongoing assessment and review.

### **Day hospitals/ treatment services**

Day hospital/treatment services aim to offer intensive multidisciplinary assessment and treatment for older people with complex mental health needs so as to reduce the need for admission to hospital or to aid recovery following admission.

There should be a strong focus on rehabilitation, with people either attending on a sessional basis or receiving home based treatment. Interventions will generally be time-limited and will end when the person can be integrated into specialist day care or mainstream services, or discharged back to the care of their GP.

Key elements of service might include a comprehensive extended multi-disciplinary mental health assessment which will take account of any risk factors. There might also be a treatment plan that includes a range of individual and group based psychological interventions such as counselling sessions, anxiety management, cognitive behavioural therapy, and coping strategy groups dealing with living with depression or coping with loss.

Education and advice should be provided for carers, and staff should also monitor treatment with mental health medication.

The team should also be able to visit and treat people at home or within the setting where they are receiving support. Part of the outreach team's role is to support care staff in mainstream services in order to maintain people with mental health problems in the community, and help staff to identify and appropriately refer people if they need specialist mental health services.

As an extension of the concept of day hospital staff supporting mainstream and specialist day care, consideration should be given to flexibly combining specialist day care and day hospital/treatment models. This will enable better joint health and social care planning and a more seamless delivery of the services from the perspective of the user.

## 4) Housing

### Background

Older people want homes which can meet their changing needs. Decent accommodation is critically important for people's mental well-being.

The report by the Social Exclusion Unit and the ODPM, *Excluded Older People*<sup>45</sup>, noted that older people are at greater risk of depression when isolated or suffering from chronic illness, and that people with mental health problems are particularly likely to have housing problems too. Robust planning of housing for older people with mental health problems and their carers is therefore crucial.

People in later life may need help to:

- maintain existing accommodation or move out of homelessness
- avoid social exclusion
- access housing, care and support services that maximise independence, whether housing is provided by the state or through self-funding; and
- move as soon as they can to a suitable home which can be adapted around the person as they become mentally or physically more frail

Older adults with mental health problems should be able to access the same housing options and support as others: Supporting People funding, short-stay accommodation, supported housing or longer-term permanent housing.

### Models of service

#### Sheltered housing schemes

There is a variety of models of sheltered or retirement housing. They share characteristics of providing easy-to-manage accommodation with additional services to enable a person to live independently. A warden or scheme manager is usually available to offer advice and support, and can help arrange for any necessary services. An alarm system provides people with reassurance that help is available in an emergency.

A move to sheltered or retirement housing can help maintain social contacts and reduce the sense of loneliness and the feeling of vulnerability that some people feel in their own homes. There are many different types of sheltered housing, run by a range of organisations.

Schemes usually consist of between 15 and 60 self-contained units of accommodation and may appeal to people who like to live independently but want the reassurance of knowing that assistance is on hand if there is an emergency. Such accommodation can be of benefit to older people with mental health problems.

#### Extra care housing

This is housing designed with the needs of more frail older people in mind and with varying levels of care/support available on site. It may also be known as

very sheltered housing, part two and a half, close care, assisted living or retirement villages. The Department of Health has set aside £147 million (2004-08) to increase the provision of extra care housing for rent and sale.

In these schemes, people live in their own flat or bungalow which provides personal space and privacy. Some people can buy their own property should they want to invest. Buildings are usually designed with the needs of highly dependent people in mind. Facilities include a laundry, restaurant/dining room, domestic support, personal care, lounges/community facilities and access to 24-hour support from health and social care teams.

Some schemes feature a range of health development and intermediate care services. Many have links with local community mental health and well-being services to support older people with a mental health problem.

Given the growing number of people with dementia, such schemes are increasingly likely to accommodate people with dementia, either in accommodation specifically designed for their needs, or in accommodation that can be adapted to the increasing needs of people who develop dementia while resident.

There is a range of possible models for extra care housing to meet the needs of people with dementia, and the reader is directed to the resources accompanying this guide ([www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)).

### **Key elements**

A good housing service for older people with mental health problems will make better use of home improvement services to improve the condition and accessibility of existing accommodation, eg: upon discharge from hospital. It will work with partners across the health, social care and voluntary sectors to provide a range of housing-related support services to enable vulnerable people to live well in their own homes.

A good service should also have a range of housing options to allow an older person with mental health problems move when they need to, to a home that can be adapted around the person as they become mentally or physically more frail. It will ensure greater access to community equipment and telecare services to enhance independent living. Specialist community mental health housing advocacy and information services should be funded across local housing, social services and primary care agencies.

A service should also have the ability to develop outreach support to older people who are homeless and who have a history of mental health problems

## 5) Assistive technology and telecare

### Background

Aids and appliances have long been used to help people with disabilities to live more independent lives. More recently, the term 'assistive technology' has emerged to describe a range of devices that have been developed as a result of technological advances.

### What is telecare?

The term telecare is sometimes used to refer to all of these devices, or to describe just those aids that incorporate developments in communication technologies; a range of remote lifestyle monitoring solutions that help older people to live more independently.

Telecare is increasingly being seen as part of a care package with related services such as home care and community alarm / lifeline provision, to enable people to remain in their own homes with increased safety, confidence and independence.

Telecare, in its broadest sense, was highlighted by the Health Select Committee on delayed discharges as having a major contribution to make in developing alternatives to hospitalisation<sup>46</sup>. The Department of Health has allocated £80 million for the period 2006-2008 to support the development of telecare services in England.

Social services authorities will receive a grant to help transform the way social care and related health and housing services are designed and delivered to enhance the independence and autonomy of users of services.

### Models of service

Examples of ways in which assistive technologies and telecare can support older people with mental health problems include:

- the use of reminders/voice prompts and/or dispensers to aid medication management for those who need help to keep their mental health stable and prevent a relapse
- a programmed isolation switch to turn off the cooker if it is left on and/or a heat detector to generate an alert if it is overheating
- sensors set to turn off taps when there is a risk of water overflowing from sinks or baths
- infra-red sensors programmed with lighting controls to automatically come on or off in the bedroom and in the bathroom when someone gets up at night, to prevent falls or disorientation
- infra-red movement sensors and/or pressure mats that detect movement in any space, to alert staff when someone is either up or has been inactive for an unusually long period; and
- timed door sensors that will remotely alert a care service or family member if an external door is opened at night.

### **Key elements**

The provision of assistive technology, and telecare in particular, is of relevance to health, housing and social care services. Therefore a partnership approach is required to the development of a telecare strategy and joint planning. Partners should consider how telecare integrates with other local services and supporting infrastructure. To be most effective, the telecare strategy will link into local 24 hour/seven day community response services.

### **Procurement and finance options**

Authorities will want to consider issues of procurement and financing. Options include: direct purchase and ownership; leasing; rent/managed service; and self purchase.

Equipment may be provided free of charge, or a charge may be made against the service element and / or the equipment according to fairer charging and *Fair Access to Care Services* (FACS) policies.

It is vital that services are helped by telecare rather than led by them. Telecare should not be a substitute for helping service users gain skills and confidence or used as a substitute for lack of staff. Rather it should augment a person-centred care and support pathway. User involvement in telecare planning is essential.

The introduction of telecare is a cultural shift in the way services work and there is rapid development in these newer technologies. A local communication strategy would support provision of information and advice to care staff and people who might benefit from these devices.

### **Assessing the need for telecare**

The provision of appropriate telecare kit and the way it enhances the delivery of care for people with mental health problems needs to be assessed on an individual basis.

It should work alongside, not replace, the support of specialist mental health staff and services and support workers. This is a relatively new area for most services, and training will be required to develop staff to be able to advise and offer a range of choices to the person who will use the equipment.

Without adequate risk management strategies, telecare, by bringing problems more persistently to the attention of authorities, can reduce the tolerance of risk. This should be guarded against and the service user involved in decisions about the benefits and risks of independent living.

There are ethical considerations regarding consent for lifestyle monitoring equipment and devices that will automatically summon care, which need to be addressed when considering the development of local protocols for service implementation. Readers are encouraged to visit resources at [www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)

## 6) Care in residential settings

### Background

Care in residential settings offers support to people who are no longer able to live independently in the community. This may be because their mental health problems make them a risk to themselves and/or others and they need more intensive supervision. It may also be because it is not possible to deliver the intensity of personal care required in their own home.

Short stay breaks in care homes allow an introduction to a home and are also one way of providing respite for carers, often being a key component in maintaining their well-being. A move to residential care should enable an improved quality of life for the person with mental health problems and not just be facilitated for the benefit of family carers. The move should maintain dignity and the rights and ability of residents to make decisions about how they live their lives and the care they receive. Carers may also have particular needs at this time, and need support.

The type and standards of care offered are monitored by the Commission for Social Care Inspection (CSCI). This monitoring includes general care homes, specialist facilities and homes that provide different levels of nursing care.

### Models of service

Care homes are managed by a variety of agencies: local authorities; voluntary organisations; and for-profit and not-for-profit organisations in the independent sector. Some care homes specialise in caring for older people with mental health problems and they will be registered by the CSCI to provide this care.

However, many people with mental health problems live in non-specialist care homes. Estimates of the proportion of people with dementia in care homes are often in excess of 60-70%<sup>5,6,7,8</sup>. It is estimated that about 40% of people living in care homes have depression<sup>9</sup>. Commissioners of care home places will need to take these figures into account when planning for the needs of the local population. There are significant training needs of care staff.

### Moving people with dementia

Difficulties may arise if people's needs change and there may be an expectation that they will move to a specialist care home. Any decision to move a resident should be made after a full assessment of their needs and in close consultation with the local inspectorate. Moving people with mental health problems carries risks and needs to be carried out with care.

A diagnosis of dementia does not necessarily mean that the person with dementia has to move to a specialist home, and CSCI recognises that people with dementia have a range of support needs, and that a move to specialist provision may not always be the best option.

Even though a care home may not be registered to care for people with dementia, this can be added as a variation to registration within a day or two

and should not by itself be a significant barrier to readmitting a person who has received a diagnosis of dementia but whose needs have not changed. The most important issue is for the person's needs to be met by the service which cares for them and that staff are appropriately trained and skilled to provide the necessary level of care required. The CSCI is currently reviewing its policy in this area and is considering strengthening a reference to the issue of care in non-specialist homes in their guidance.

### **Key elements**

The overall purpose of residential care should be seen within the context of housing in general. The aim should be to enable older people with mental health problems to be as socially included and independent as possible: in their own homes, in familiar environments, or moving to extra-care housing, by providing support in the community.

Comprehensive assessment is a prerequisite to ensuring the appropriateness of a placement to meet a person's needs, and the most efficient use of resources.

People should be encouraged to have their own possessions (including furniture and possibly pets) with them, and the staff should seek to know more about their biographies and previous lifestyles so that they can provide personalised care and encourage the maintenance of interests and skills. Activity programmes will help reduce depression. Relatives and former carers should be encouraged to visit and maintain their relationships, and to participate in their care if they wish to do so. Visitor schemes can reduce social isolation. Homes should be able to cater for a wide range of cultural, dietary and spiritual needs. Staff recruitment should reflect the local population and links should be developed with the local faith communities.

### **The skills staff need**

Given the very high occurrence of mental health problems in non-specialist care, and the significant skills required to provide good quality person-centred care, staff require training and support in what can be an emotionally challenging area of work. This is a key area for workforce development and for commissioning.

Communication skills training is particularly important for staff working with people with dementia. Dementia care mapping can be a useful tool for evaluating the impact of the care provided on the resident, and as a staff development tool.

Homes should develop good links with local specialist services such as community mental health teams for older people. They can offer advice and support, coaching and training. Residents should have access to and involvement of GPs and other mainstream services in the usual way.

### Intermediate care

#### Background

Older people want to be treated effectively, as close to their homes as possible. If hospital admission is required, they want to return home as soon as is appropriate, with their family carers supported.

The term intermediate care includes a range of integrated services whose aim is to:

- Promote faster recovery from illness
- prevent avoidable deterioration
- maximise residual skills and independent living
- optimise choice and placement
- avoid unnecessary hospital admission and support timely discharge
- support someone's discharge following an inpatient stay and
- avoid inappropriate admissions to care homes.

An intermediate care environment, preferably in the older person's own home, will have an emphasis on:

- a 're-ablement' approach that helps service users to complete tasks themselves
- an assumption of capability rather than presumption of incompetence
- provision of a structured day, including rehabilitative activities and planned visits home or to other care settings on a trial basis; and
- normalising the situation. If it is not possible to provide home-based support, simple measures such as single bedrooms help.

#### Models of service

It is important to regard intermediate care schemes as integral parts of older people's services rather than add-ons. Intermediate care is supported by the NHS and social care long term conditions model<sup>27</sup>. It is a function rather than a specific set of services, and involves a care planning approach to encourage return home or placement in the least restrictive care home setting.

Intermediate care services may be bed-based or community based. Bed based schemes are typically in non-acute NHS settings, care homes or through creative use of supported housing schemes. If in community hospitals, special consideration will need to be given to the ward environment so that it is enabling for older people with mental health problems (with attention paid for example, to layout, décor, lighting and signage).

Rehabilitation in residential settings has the emphasis on homely and enabling environments that are more accessible and user friendly than acute hospital settings. They may be therapist or nurse led, though retaining access to medical review and other specialist input as required.

Care can also be given in the patient's normal place of residence. This requires home-based services that are available 24 hours a day, 7 days a

week for frail and vulnerable older people, including domiciliary and day treatment schemes. This might include rapid response services that can provide intensive short term support in a crisis, including taking people home from A&E.

### **Including older people with mental health problems**

Evidence suggests that older people with mental health problems are often excluded from mainstream intermediate care, particularly if they have a diagnosis of dementia. This practice is based on a combination of factors, including an assumption that older people with dementia cannot benefit from rehabilitation and a lack of confidence and skills in working with this group.

Two main models have developed in response to these circumstances:

- developing the skills of staff in mainstream services, with additional specialist support, where the primary need is for physical rehabilitation, but many people have underlying mental health problems; and
- developing separate specialist teams or resources where the primary need is the mental health problem.

The first model should include:

- basic training for the whole staff team on the needs of older people with mental health problems and how to work with them. Some staff might have specialist knowledge and expertise
- in-reach by link staff from the community mental health team to provide support, training and coaching on how to work with the user group and manage specific problems. They should be prepared to “roll up their sleeves” and get alongside staff to show how to deliver care; and
- access to a range of skills including medical, nursing, occupational therapy, psychology, physiotherapy and social work, management and support workers.

## **Key elements**

### **Assessment**

The Single Assessment Process should underpin all assessment activity for older people, including intermediate care. Professionals who may contribute to the assessment include liaison nurses/consultants and therapy staff. It is essential that information is shared between professionals to avoid duplication and unnecessary delay. This has enormous value as people move between services and systems, for example through A&E or between health and social care settings.

### **Flexible criteria**

All too often intermediate care becomes service driven, devising criteria which include, for example, “must be motivated to participate in rehabilitation” or “has known destination on discharge from service”.

For older people with mental health problems in particular these criteria are discriminatory and unhelpful. Criteria should be as flexible as possible and

framed around objectives of the service. The question should be: "Can the service meet the needs of this individual?" rather than "Does this individual fit our criteria?".

### **Education**

Myths remain that older people with dementia are beyond rehabilitation, and that those with other mental health problems such as depression are not the remit of general services.

The key principle must be to ensure that whenever older people with mental health problems are in intermediate care, a holistic approach is taken to their mental as well as their physical well-being, and the care options available to such individuals are improved.

### **Pre-emptive or proactive intervention**

There is strong evidence that a large proportion of older people who have repeated admissions to acute hospitals are not otherwise in touch with any statutory services.

Those with mental health problems are likely to be less able to recognise their own need or advocate for themselves. Within the group experiencing dementia, there will be some people whose impairment means they are neither aware of their disability nor ask for assistance.

Many admissions happen when people with dementia are unwell (but not acutely ill enough to need the specialist care provided in acute hospitals) simply because it is difficult to diagnose and manage their care within A&E target times without any prior knowledge of the person.

Essential elements of a responsive service include proactive searching for older people who may benefit from intermediate care; avoiding unnecessary admission but when that happens, enabling the older person to move through the system quickly.

This work should link with local initiatives relating to long-term conditions, such as disease registers and pro-active case management.

Carers and support staff should be trained to observe and recognise the early symptoms of some of the common causes of illness that often result in avoidable admission (eg: constipation, urinary tract infection) if left untreated.

### **Support**

Staff in mainstream intermediate care services will need ongoing support in dealing with mental health issues. Proactive liaison by teams specialising in the psychiatry of old age can support staff, as well as in-reach by CMHT members to advise on people already known to them.

## Care for people in the general hospital

### Background

Physical illness predisposes people to suffer from mental health problems and older people with mental health problems are more likely to be admitted to the general hospital. Older people with mental health problems in the general hospital have the same right to appropriate care as people outside hospital. This includes a right to dignity, and involvement in decision-making about needs, care and goals of treatment. They want their family carers involved where appropriate, and access to advocacy services if necessary.

However cognitive impairment and other mental health problems often go unrecognised in the general hospital or staff (because of their lack of training or experience) are uncertain of how to manage them. The person's needs do not get met and their admission is prolonged. People may be inappropriately labelled as suffering from dementia.

Precipitate and inappropriate decisions to transfer older people to permanent care home placements rather than return home take little account of the older person's own preferences and deny them the opportunity for recovery and rehabilitation. However, the longer the older person stays in an acute bed, the more disorientated they may become, the more independent living skills are lost, and attempts at rehabilitation way weaken.

A systematic review of the literature shows that up to 60% of people aged 65 and over have or develop a mental health problem during admission to a general hospital<sup>4</sup>. These disorders are independent predictors of poor outcome in terms of increased mortality and length of stay, loss of independent function and increased likelihood of transfer to long-term institutional care. They are also associated with increases in hospital-acquired complications, increased likelihood of re-admission and use of health and social care services. There is evidence that mental health problems are poorly detected and managed by general hospital staff.

Better management of these disorders can reduce their incidence, reduce the length of stay, increase the number of older people who return to independent living, and improve the quality of life of service users.

Given the high prevalence of mental health problems in the general hospital, its effect on quality of life and impact on health and well-being, increased attention needs to be paid to the knowledge and skills base of all mainstream staff in the general hospital on matters that relate to the mental health of older people.

Specialist mental health teams working within the general hospital aim to:

- support and train staff in the detection and initial management of mental health problems in later life
- proactively work with general care teams to avoid unnecessary admission

- improve the mental health care of older people while they are inpatients; and
- link with community organisations to improve follow-up and avoid unnecessary delay in discharge.

### Models of service

Most UK services provide a consultation style of service rather than liaison, and will not be able to provide the full range of support identified above<sup>4</sup>. The liaison style of service, involving a multi-disciplinary team, is the most complete and desirable, though several models have been described in detail<sup>4</sup> and should be adapted to serve local needs.

Essentially, consultation services fall into the following three types:

- **sector based:** referrals are made to the local mental health service and assessments are usually completed by psychiatric medical staff.
- **enhanced sector:** referrals are made to community mental health teams with enhanced staffing (usually nursing); and
- **outreach:** referrals are made to staff of the local older people's mental health wards.

Liaison services include the following elements:

- **specialist liaison mental health nurse:** referrals are made to a full-time mental health nurse, who usually works from the general hospital base and who has no other clinical responsibilities. The nurse will be supported by a designated consultant psychiatrist who runs dedicated sessions for this purpose.
- **liaison psychiatrist:** referrals are made to a psychiatrist who usually works from the general hospital base and has no other clinical responsibilities.
- **hospital mental health team:** referrals are made to a multi-disciplinary mental health team, based in the general hospital, who can provide the full range of functions of a liaison service; and
- **shared care ward:** this is an inpatient ward on the general hospital site, staffed by general and mental health staff who jointly manage clinical care. This is a useful addition to other service models, particularly for patients with mental health problems in the context of serious medical illness.

### Key elements

People with mental health problems in the general hospital can become nobody's responsibility. Commissioners should ensure that the role of each organisational partner is clear in looking after the mental well-being of inpatients, and adequate arrangements are in place to provide specialist support when needed.

### Resources

To be most effective, mental health services for the moderately sized and large general hospital (300-plus beds) need a liaison style service with the following features:

- a multi-disciplinary team, including dedicated medical, nursing, psychology, occupational therapy and social work time
- a base in the general hospital with sufficient office and administrative supports
- an electronic patient database and good communication links with general hospital and community services
- direct access to specialist domiciliary and intermediate care
- a shared care ward on the general hospital site and
- integrated management between mental health services and the general hospital.

### **Functions**

Mental health teams should be able to work collaboratively and proactively with general care teams to raise awareness of the importance of mental health and to integrate mental health care into general hospital culture.

They should improve knowledge, skills and attitudes through training programmes and promote routine assessment of mental health needs of all admissions.

They should jointly develop protocols to improve the management of uncomplicated mental health problems, with guidance to improve the appropriateness of referrals. They should also support and supervise general care teams dealing with common mental health problems.

The mental health team should be able to respond quickly to requests for assessment or advice concerning older people with suspected mental health problems presenting in A&E departments and provide rapid specialist assessment and management of severe and complex mental health problems on the wards, including those co-morbid with serious physical illness.

They should also facilitate good practice in discharge planning for older people with mental health problems through existing discharge co-ordination teams.

The team should provide an interface between the general hospital and mental health services through regular meetings with senior clinicians and managers.

## Other specialist mental health services

### 1) Integrated community mental health teams

#### Background

When necessary, people with mental health problems and their carers expect access to assessment, advice and the choice of a number of effective health and social care interventions to aid recovery, maximise independence and avoid unnecessary admission to hospital or a care home. They want a named worker available to guide and support them throughout their problems.

A community mental health team (CMHT) for older people is a multi-disciplinary health and social care team offering specialist assessment, treatment and care specifically to older adults with mental health problems and their carers in their own homes and the community. The community mental health team is the backbone of the modern specialist older people's mental health service. One of its key functions is to advise and support other health and social care professionals, both from mainstream services and mental health services for younger adults (including forensic services).

Older people with functional mental health problems such as depression and psychotic mental illness, and people with dementia should be referred to specialist services for expert assessment and advice, and for periods when:

- there are diagnostic issues that need clarification
- there is lack of response to initial intervention strategies
- distress or risk are particularly severe
- problems are complex; and
- legal issues require their involvement.

#### Models of service

The main difference in local service models will be in the functions that the team carries out. A team might provide the whole range of home and community-based services or be complemented by one or more teams providing more specific functions.

The most common examples of functions delegated to more specialised teams are:

- assessment of cognitive function in a memory assessment service
- psychological therapies
- in-reach support to the general hospital
- support to care homes and
- advice on alcohol and drug misuse. Pathways to this service should be clearly specified, as it is often neglected and age barriers exist.

A useful concept in integrating these diverse models is that of the virtual team, consisting of staff whose roles are closely co-ordinated, but who may not necessarily be based in the same location. Staff working within the community

mental health team may be core members, including the team manager, who work entirely in the CMHT, or part-time members who also work in other care sectors. Associate members work closely with the team but their work is generated from a variety of sources

The other main difference in service models will be in how services achieve functional integration with social care services (see resources at [www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)), mainstream older people's rehabilitation services and younger adult mental health services.

People should have access to services based on need and not age, and it should be possible to access components from a variety of services. Some of an older adult's needs might be better met locally by a younger adult service or vice versa. Out of hours community based services or crisis services might be organisationally situated in younger adult mental health services or generic older people's services. In any area, one will be better placed to meet the needs of an individual. Someone 'graduating' from a younger adult to an older adult mental health service will need careful transfer of key-working and care management arrangements, and guidance on this is available<sup>47</sup>.

### **Key elements**

In many ways, community mental health teams have been pioneers in delivering specialist health services to older people in their own homes. This achievement needs to be extended to ensure that all services are seen as accessible, with a focus on holistic health and social outcomes for service users and carers to maximise social inclusion and recovery where possible. Service users should be empowered to make choices and manage their own pathway of care where possible, encouraging autonomy and independence.

In order to achieve this, CMHTs need to have:

- easy accessibility, based on shared information systems, so that speaking to one duty person from the team through a designated line will trigger the appropriate response from any member of the team. Information and advice should be available 24 hours per day
- some provision for home based crisis support 24 hours per day. This may be as part of a younger adult mental health service or generic older people's service
- a broad skill mix across health and social care, so that the outcome of the individual's whole-person assessment can result in a combined health and social care plan
- information on services available and on legal and financial matters and
- a key worker system to ensure continuity of support for service users and carers.

### **Team function**

The team should act as the focus for referrals from primary care, secondary services, social services and users and carers. It should be able to conduct home-based multi-disciplinary specialist assessments, and provide timely information on a person's problem, available treatment and support. An easy

method should exist to return for advice and help when needed. Care plans should be monitored and reviewed, with the users' needs and goals central.

A good team should ensure that people's physical health needs, as well as their mental health needs, are being addressed, in co-ordination with mainstream older people's rehabilitation services. It should provide on-going care, support and treatment for older people with more complex mental health problems and their carers, provide outreach support to users of other services who have mental health problems, eg: residents in care homes, ensure timely access to a range of services for users and carers.

A team should provide support, advice and training to staff in the range of mainstream organisations that provide care to older people with mental health problems, including voluntary agencies and carers' organisations, as well as users and carers themselves. This may have implications for how CMHT professionals use their time, and for their own training requirements.

### **Team organisation**

The team should hold regular meetings, and include, as a minimum, a psychiatrist, a community mental health nurse, an occupational therapist, a social worker, and a clinical psychologist

The team should:

- allocate roles according to professional discipline – with defined responsibility but with flexibility, recognising both professional differences and overlap of skills
- improve the provision of information and support service users in accessing appropriate care by the development of care broker and care navigator roles. This is also likely to reduce the time spent on administration by professional staff.
- work towards the minimum of duplication of assessment between team members, with any team member being able to provide an initial assessment on behalf of the team as part of the single assessment process
- agree when and why service users need to see one particular member of the team
- clarify issues of professional and managerial leadership, responsibility and accountability
- be supported by joint health and social care policies, joint training, and common assessment and care management methodologies that support the single assessment process (SAP) and the care programme approach (CPA) where appropriate.
- link care planning with the NHS and social care long term conditions model, addressing people's needs across the spectrum of supported self care, disease specific care management and case management for those highly vulnerable people with complex care needs and
- help to deliver integrated health and social care standards and targets.

## 2) Memory assessment services

### Background

Older people who are concerned about their memory need easy and quick access to diagnostic assessment which is supportive in recognising strengths, and allows maximum dignity when revealing areas of weakness.

Although families and professionals often want to protect the person from receiving bad news, it is the right of people to be fully informed about their diagnosis and prognosis and to be offered appropriate information if that is their choice.

### Care for people with dementia

If a diagnosis of dementia is confirmed people want to continue to be respected and to contribute, to continue to make choices where they are able, but to know that they can trust that they and their family carers are being looked after when they are not in full control of their lives.

People with dementia should be supported to maintain independence and live as close to home as possible, and to take informed risks if that is their choice.

The main purpose of the memory assessment service is to aid the early detection and diagnosis of dementia, while identifying treatable causes of cognitive impairment. This allows early intervention to maximise quality of life and independent functioning and to manage risk and prevent future harm to older people with memory difficulties and their carers. It is essential that early intervention services are integrated with the memory assessment service.

### Models of service

There are two broad models of service delivery for memory assessment and early intervention services:

- extension of the community mental health team role and
- the establishment of a separate resource (commonly the memory clinic) as the focus for this work.

Extending the remit of the CMHT has the advantage of making efficient use of existing infrastructure and of integrating functions of the specialist team. The potential disadvantage, however, is that early intervention work, which might provide the greatest long-term health gain to the whole health and social care community, might take second place to more pressing emergency tasks.

The potential weaknesses of the traditional memory clinic model are its hospital focus, lack of integration with local services, and narrowness of intervention. But all of these can be addressed as part of a memory service with appropriate levels of support and redesign. Dedicated memory services can provide routine structured assessment, which improves diagnostic expertise and lessens stigma.

### Key elements

The memory assessment service should be able to:

- offer home based assessment where that is a person's choice
- give pre-and post diagnostic counselling where appropriate
- make the diagnosis of dementia, including the subtype of dementia (e.g. Alzheimer's, mixed, vascular, Lewy Body, frontotemporal) where this has treatment or prognostic implications. This will require access to specialist psychometric assessment, and timely brain imaging.
- explain the diagnosis to the person with dementia and any carers, giving relevant information about sources of help and support
- give information about the likely prognosis and options for care, signposting local services
- provide advice and support at the time of diagnosis and after as needed
- follow-up and review those people they have treated.
- enable understanding and build coping strategies for behavioural and psychological symptoms in dementia and
- provide pharmacological treatment of the dementia and of those behavioural and psychological symptoms that are severe, disabling or resistant to non-pharmacological treatment (including depression and psychosis).

The service should itself, or through other local organisations:

- ensure the person has access to mainstream health promotion and prevention
- provide or seamlessly facilitate the provision of help
- provide psychological and social interventions for people with dementia. This might be on an individual or group basis, as support or to enable maximum functioning.
- provide psychological and social interventions for family carers. This might be on an individual or group basis, as peer support and / or in the provision of advice and information.
- address fears and worries, practical, legal and financial issues that may affect the person with dementia and their carers
- give advice on assistive technology and telecare solutions to enable people to live as independently as possible
- minimise risk, by offering assessment of home environment and driving, while accepting it may be a person's right to take decisions that carry risk.
- highlight potential abuse within local adult protection procedures
- gain legal advice on such issues as mental capacity, power of attorney, and benefits entitlement and
- give people easy access to advocacy services.

People with possible or actual dementia need to know how to access the service or ask for advice again at times of need. If the service is separate from the community mental health team, there needs to be a close working relationship to ensure on-going follow up, or easy access to ongoing support and advice when necessary.

### 3) Psychological therapies

#### Background

Psychological well-being is an important factor in helping older people cope with daily 'hassles', as well as aiding recovery through empowerment of the individual. Users of mental health services consistently place access to psychological therapies at the top of their list of unmet needs: they are deemed a useful addition to other approaches, or are the therapy of first choice.

Specialist psychological therapies services for older people aim to alleviate psychological distress and promote the psychological well-being and health of older people with mental health problems, their families and carers, either through direct client work or through training, education and supervision of other health and social care professionals.

#### Making psychological therapies available

Best practice guidelines from the Department of Health state that psychological therapies are part of essential health care and recommend that they should be routinely considered as a treatment option when assessing mental health problems<sup>48</sup>.

The guidelines specifically recommend that particular attention is given to the needs of older people. It has been demonstrated that the person's age is not an important factor in choice of therapy, and need, not age, should determine access to therapies<sup>49</sup>. Older people should have access to a range of psychological services for which there is an evidence base, including assessment and interventions.

There is evidence to support the effectiveness of psychological interventions in the management of a wide range of mental and physical conditions in older people and their carers<sup>50</sup>. A number of guidelines from the National Institute for Clinical Excellence rely on good psychological care for their implementation, including those on depression, anxiety and post traumatic stress disorder.

#### Models of service

Depending on local circumstances and setting, psychological interventions within specialist mental health services for older people should be delivered as an integral component of mental health care – for example, by members of a community mental health team or through a formal psychological therapies service with clear and effective referral pathways.

The term 'psychological therapies' covers a wide range of models. These include psychodynamic, cognitive behavioural, arts-based and systemic approaches. The Department of Health provides guidance on the organisation and delivery of multi-professional psychological therapies<sup>48</sup>.

### **Key elements**

The provision of psychological therapies is a multi-professional endeavour. It may involve psychologists, psychiatrists, nurses, counsellors, social workers and others who have undertaken appropriate training in specific models of psychological intervention. A range of approaches should be available.

Psychological therapies should be routinely considered as a treatment option when assessing mental health problems.

There is a growing awareness of the importance of pre-assessment and diagnostic counselling for people with probable dementia.

Access should not be unreasonably restricted by waiting lists. Waiting times for access to other health services might act as useful benchmarks.

Psychological therapies should also be available to older people within mainstream services and their carers; for example people with:

- mental health problems (including dementia)
- physical disability
- stroke
- falls and
- challenging behaviours.

All staff employed in psychological therapies services should have formal clinical supervision and continuing professional development programmed into their work.

It is recommended that mental health trusts develop a psychological therapies clinical governance strategy to monitor the quantity and quality of psychological therapies within the organisation. This should include services for older people.

## **4) Inpatient care**

### **Background**

Services for older people should be provided as close to a person's home as possible, and it is unusual for older people to require inpatient admission for treatment of their mental health problem.

However, admission is essential on occasions for the assessment, treatment and rehabilitation of older people with a range of diagnoses, who cannot be cared for in the community or other settings due to the intensity and expertise of care required.

A proportion of people will be detained under mental health legislation for assessment or treatment. Many will have complex physical and mental health needs.

Inpatient services should form part of a spectrum of services that can be tailored to the needs of individuals. There are likely to be very high levels of need on in-patient wards and wards should be staffed accordingly, for the safety and well-being of service users and staff.

### **Models of service**

Inpatient care is needed for two main groups:

- older people who have an 'organic' brain disorder such as dementia; and
- older people with so-called 'functional' disorders, the most common of which is depressive illness, but also including people with schizophrenia and other psychoses.

Separate inpatient bed provision for these two groups is regarded as good practice<sup>9,51</sup>, although the distinction between organic and functional illness is often neither clear nor absolute and many people may have both. The important issue is to provide appropriate needs-based care in a flexible manner.

The care of frail older adults with complex needs on wards for younger adults is usually inappropriate<sup>51</sup>: it would place them at risk from robust, behaviourally disturbed younger adults and deprive them of the specialist nursing, medical and other care that they require.

To ensure bed availability, some beds are often designated for short admissions only. A few short stay beds may also be offered for patients whose needs cannot be met in mainstream respite services.

### **Key elements**

The ward environment should reflect the fact that, although this is a clinical area, it is also the patient's home for a variable period of time. Attention needs to be given to all aspects of well-being, with an emphasis on respect and dignity. There should be access to faith based communities and visitors should be encouraged.

Ward-based carers' groups support carers and provide useful feedback on strengths and weaknesses of a unit. There need to be strong links with a multi-faith chaplaincy and with outside organisations such as carers' groups, the Alzheimer's Society, Age Concern, a local school and faith centres.

If people are bored and inactive their recovery may be hampered. There should be sufficient staff to provide regular sessions of therapeutic activities and appropriate occupation for patients. Volunteers can often usefully supplement staff for such activities.

People who are admitted for assessment and/or treatment usually have multiple difficulties best managed by staff from a range of disciplines working together. The inpatient team should have the skills to appropriately meet the needs of the full range of psychiatric and general medical problems, with easily accessible support from staff in other disciplines that have a particular

interest and expertise in older people and those in long-term care. These include specialist physicians, a speech and language therapist, pharmacist, dietician, physiotherapist, chiroprapist and dentist, as well as advocacy and interpretation services.

The number of ward based nursing and care staff necessary will be contingent on the dependency level and needs of the patient group at any one time. It is essential that intensive and close supervision can be provided where necessary and that the environment is suitable for the client group. Other key disciplines will be medical, psychological therapies and occupational therapy staff who should be central in facilitating rehabilitation.

Inpatient old age psychiatry wards should have timely access to and links with the full range of investigative and treatment services. Where appropriate, a palliative model of care should be available for people with advanced dementia, supported where necessary with advice from general medical and palliative care services.

### **Continuing care**

NHS continuing care may be provided in inpatient settings, though is increasingly provided by care homes. Following the Coughlan Judgement, which deemed that a health authority's eligibility criteria for NHS continuing care were too strict, new guidance was issued, requiring health authorities to agree joint local continuing care and social care eligibility criteria with their local councils<sup>52</sup>.

In November 2003 the Health Ombudsman upheld a complaint made on behalf of a man with dementia. She highlighted the need for assessments to consider the mental health and psychological as well as physical need of people with dementia, and the need for national eligibility criteria.

The Department of Health is working with a range of stakeholders to develop a national framework for continuing care in order to simplify the assessment process and improve consistency of application of eligibility criteria.

Older people have a right to a care assessment which should consider their mental health, psychological and physical needs. Before discharge from hospital people should have an assessment against NHS continuing care criteria before any assessment is carried out for registered nursing care contribution.

There should be clear guidance available for service users and their families and carers on eligibility criteria and how to access NHS continuing care. The need for NHS continuing care should be an ongoing part of assessment and care planning.

### **Delayed transfers of care**

Research has demonstrated significant delays in transfers of care of up to 29% of dementia assessment beds<sup>53</sup>. While it is yet to be determined whether and how reimbursement will be extended to mental health beds, there is much

that can be done in the meantime to sharpen up discharge planning and to ensure that community resources are in place to ensure timely discharge<sup>54</sup>.

### **The 'Bournewood' judgement**

The European Court of Human Rights judgement on the 'Bournewood' case has highlighted the legal issues regarding the restriction and deprivation of liberty of people without mental capacity in their interests.

At the time of publication, definitive guidance from the Department of Health is awaited, though the resources section of the accompanying web page will be kept updated ([www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)). Good practice will always involve next of kin and appropriate others in care planning.

## Special groups

### 1) Younger people with dementia

#### Background

Younger people with dementia and their carers are likely to have particular needs which may differ from those of older people because they may:

- be in employment
- have dependent children
- be physically fit and active
- have financial commitments, such as a mortgage and
- have a rarer form of dementia.

Given these differences, and the fact that dementia is increasingly uncommon with younger age, there is a particular requirement for services to be available that are based around the personally defined needs and goals of the individual.

There are over 18,000 younger people with dementia in the UK<sup>55</sup>. Ironically, they are often subjected to a reverse form of ageism, where dementia services are designed around the needs of older people. There are only a few services specifically aimed at the needs of younger people.

#### Models of service

Service models will vary depending on the population distribution and other local circumstances. Services for younger people with dementia should be user-led. A dedicated service may be required or it may be possible to meet people's needs through the innovative use of existing resources.

Services should offer choice in any of the following:

- information and advice
- day care
- psychotherapeutic group support
- networks, including electronic support networks
- support for carers, including specialist support for children and young people, and for parents of a younger person with dementia
- respite care and
- long-term care.

#### Key elements

It is essential to clarify who is responsible for commissioning services for younger people with dementia, and identify a clinician with expertise in the area to take a lead for accepting referrals and developing the service.

A smaller service may well have a lead individual, and some dedicated sessions from existing team members, such as a nurse and social worker.

A larger conurbation may justify a dedicated younger persons' dementia service. A more fully developed service should be able to provide the full range of services available to older adults with dementia, including appropriate respite support for carers.

The service should span organisational boundaries through partnership working. Services should be flexible and based around the needs of the individual, with access to early diagnostic and counselling services as well as community based support.

Dedicated support workers can help maintain independence and avoid inappropriate placement with older and more physically frail people.

Young onset dementia is more likely to be caused by genetic factors and access to genetic counselling should be available for families. The relationship between the young onset dementia service and neurology services should be defined.

Useful publications on services for younger people with dementia can be found with the resources accompanying this guide at [www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)

## 2) Older people with learning disabilities

### Background

Older people with learning disabilities and mental health problems are at particular risk of social exclusion, but:

- have the same rights as everyone else
- have the right to make choices about their life, like everyone else
- want to be supported to be as independent as possible and
- want to be included in their community<sup>29</sup>.

*Valuing People: a New Strategy for Learning Disability in the 21<sup>st</sup> Century*<sup>29</sup>, maintains that people with learning disabilities should use the same services, resources and facilities as the rest of the population.

*Valuing People*<sup>29</sup>, *the Mental Health National Service Framework* (1999)<sup>56</sup> and *the National Service Framework for Older People*<sup>10</sup>, all signal how services for older people with mental health problems who have a learning disability should be developing.

The three policy documents apply to ALL adults and their provisions are intended to encompass everyone who has mental health problems and their carers, including people who have learning disabilities. Services should be delivered through a person-centred approach, based on good individualised planning, commissioning and provision.

### **People with learning disabilities and mental health problems**

There are about 210,000 people with severe learning disabilities in England. Approximately 25,000 of these are over 60 years old.

Most psychiatric disorders are more common amongst people with learning disabilities than the general population. People with Down's syndrome, for example, are at particularly high risk of developing dementia, with an age of onset 30–40 years younger than the general population<sup>57</sup>. At least 55% of people with Down's syndrome aged between 60–69 years are affected by dementia (compared with 5% of the general population aged over 65 years). With the increased life expectancy of people with Down's Syndrome, this is a growing area<sup>58</sup>.

### **Models of care**

Effective services for older people with mental health problems and learning disabilities will only be achieved through joint working and efficient partnerships. Success requires both older people's mental health and learning disability services (staff and professionals) to be prepared to do things differently.

### **Key elements**

Individual assessments of cognitive functioning in early adulthood are needed for all people with Down's syndrome to enable faster diagnosis of dementia.

Better provision of information and signposting of services for people with learning disabilities and their carers will allow greater involvement in decision-making about health and care choices.

The needs for ongoing support of family carers and other supporters should be recognised.

Older people with mental health problems and learning disabilities should be involved in the planning, delivery and monitoring of services.

Special consideration is required for the needs of people from minority ethnic groups.

Effective services for older people with mental health problems and learning disabilities will require a joined-up approach by health professionals between agencies, so that older people with mental health problems and learning disabilities do not fall between generic dementia services, specialist mental health services and learning disability services, none of which are able to meet the complex needs alone.

Increased joint training of staff between agencies is needed to raise awareness, share expertise and develop joint approaches to care and support.

Consideration should be given to the formation of joint teams, perhaps with team members from learning disability, mental health and older people's services working together for part of each week.

Joint protocols between agencies should be in place, covering care pathways, roles and responsibilities, and access and support arrangements.

Better collaboration is required between GPs, primary health care teams, older people's mental health services and specialist services for people with learning disabilities.

The needs of older people with mental health problems and learning disabilities should be considered in the planning of adequate transport services, aids and adaptations, and access to routine medical investigations.

### **3) Mental health care for older prisoners**

#### **Background**

Older people while in prison have the same right to healthcare as when they are living in the community, and should expect the same choices over care and treatment as younger adults. Better mental health care and health promotion while in prison will improve chances of independent living on returning to the community. From 2006, responsibility for the provision of healthcare within the 133 prisons in England formally transfers to the National Health Service.

It is known that the health of prisoners of all ages is significantly worse than that of the general population. Older prisoners are more likely to suffer mental health problems than all other age groups, estimated at 53%. Of these, 30% have a personality disorder and 30% a depressive illness<sup>59</sup>. The prison population is ageing even faster than the wider community. Most of this increase is accounted for by older males. However, many prisons have as few as 10 older prisoners in total, and few have more than 50<sup>60</sup>.

#### **Models of service**

Comprehensive health services are only available in the most secure establishments within the UK. Few have 24-hour medical cover or full-time nursing provision. Some healthcare is provided in-house by health staff within hospital wings, but this tends to relate more to the provision of physical rather than mental health care. Care is geared more to the needs of younger, more able-bodied prisoners. Some specialist units for older prisoners are beginning to emerge, including special residential accommodation within prison grounds.

However, certain problems remain:

- the transient nature of the prison population
- the relatively small numbers of older people within individual prisons
- the physical distance of older prisoners from family and friends

- the tension between providing fair access to appropriate care while in custody with curtailment of liberty and
- a physical environment and in-prison regimes designed for younger, more able-bodied prisoners.

These all point to the need to develop models of service that:

- provide effective in-reach of specialist mental health care
- are based on a true partnership between prisons and health and social care providers to ensure parity with the care available to the wider community; and
- promote the training and education of existing health and prison staff.

### **Key elements**

A starting point for developing better services for the future should be the determination of actual levels of mental health problems within local prisons.

Arrangements should be in place to seek the views and experiences of older prisoners with mental health problems and communicate their concerns to both commissioners and providers of health care.

Inter-agency co-operation between prisons, the NHS, probation, social services and relevant statutory and voluntary community agencies is needed to support older prisoners both in custody and on return to the community. There is likely to be a need for significant leadership in planning and developing new services.

Multi-disciplinary community services should be able to visit to ensure:

- specialist medical, nursing, psychological and occupational therapy services for older prisoners with mental health problems; and
- regular reviews of older prisoners' medication and care needs.

Protocols should be jointly developed for the assessment, care and management of the mental health needs of older prisoners. These should incorporate guidance on a comprehensive multi-agency assessment and follow-up as part of the Single Assessment Process for prisoners who are approaching release.

Training and education is needed for all new and existing prison staff, to enable them to use screening tools in depression and dementia, improve behavioural management and the assessment of suicide.

Younger and older prisoners should have different regimes so that they are able to participate in mental health-promoting activities such as exercise, and have equal access to prison facilities, free from fear of bullying or discrimination.

A prisoner carers scheme (like the Prison Listeners scheme) should be considered under health and social services' supervision, whereby selected prisoners are trained, supervised and accredited in personal social care.

Detailed consideration of forensic psychiatry units is beyond the remit of this guide. However, the principles of person-centred and needs-based care should apply. If there are needs that would be best met by the advice and input of general medical or older people's mental health specialists, this should be available.

## Acknowledgments

### **Editorial board:**

Andy Barker  
Susan Benbow  
Ruth Eley  
Jane Gilliard  
Kate Hardy  
Ian McPherson  
Nadine Schofield

The Department of health would like to thank the following people who also contributed to the development of this guide:

Dave Anderson  
John Ballatt  
Sube Banerjee  
Nicky Bradbury  
Patrick Brooke  
Julia Cream  
Ken Holland  
John Holmes  
Philip Hurst  
Steve Ilife  
Sheila Lakey  
Rachel Litherland  
Niall Moore  
Angela Richardson  
Sonia Richardson  
Sally Rogers  
Joan Smithies  
Judith Whittam  
Janet Woodhouse

Members of the Older People's Mental Health Programme Board

## References

1. Singleton et al Mental health of carers. Office for National Statistics. HMSO. (2002).
2. Primary Carers – identifying and providing support to carers in primary care. Princess Royal Trust for Carers. (2003).
3. Kendrick et al. Role of general practitioners in care of long term mentally ill patients. *BMJ*. (1991). 302:508-510.
4. Who Cares Wins. Improving the outcome for older people admitted to the general hospital: Guideline for the development of liaison mental health services for older people. Royal College of Psychiatrists. (2005). [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
5. Margallo-Lana et al. Prevalence and pharmacological management of behavioural and psychological symptoms amongst dementia sufferers living in care environments. *International Journal of Geriatric Psychiatry*. (2001).16(1):39-44.
6. MacDonald et al. Dementia and use of psychotropic medication in non-'Elderly Mentally Infirm' nursing homes in south-east England. *Age & Ageing*. (2002). 31:58-64.
7. Office of National Statistics. Social Focus on Older People. The Stationery Office.(1999).
8. Mann A et al. Depression and the response of residential homes to physical health needs, *International Journal of Geriatric Psychiatry*. (2000).15:1105-1112.
9. Audit Commission. Forget-me-Not. (2000).
10. National Service Framework for Older People. Department of Health. (2001).
11. Beekman et al. Review of community prevalence of depression in later life. *British Journal of Psychiatry*. (1999).174:307-311.
12. Hofman et al. The prevalence of dementia in Europe: a collaborative study of 1980-1990 findings. *International Journal of Epidemiology*. (1991). 20:736-748.
13. Government Actuary's Department. 2003-based national population projections.
14. General Household Survey. (2001).
15. Lowin et al. Alzheimer's disease in the UK: comparative evidence on cost of illness and volume of health services research funding. *International Journal of Geriatric Psychiatry*. (2001).16:1143-8.
16. Philp. Better Health in Old Age. London: Department of Health.(2004). [www.dh.gov.uk](http://www.dh.gov.uk)
17. Appleby. The National Service Framework for Mental Health – Five Years On. Department of Health. (2004). [www.dh.gov.uk](http://www.dh.gov.uk)
18. Social Services Inspectorate. Improving Older People's Services: an overview of performance. Department of Health. (2003).
19. Commission for Health Improvement. What CHI has found in mental health trusts. Department of Health. (2003).
20. Commission for Health Improvement. Investigation into matters arising from care on Rowan Ward, Manchester Mental Health & Social Care Trust. Department of Health. (2003).
21. Securing better mental health for older adults. Department of Health. (2005). [www.dh.gov.uk](http://www.dh.gov.uk)
22. Strengthening accountability - involving patients and the public: policy guidance Section 11 of the Health and Social Care Act 2001. Department of Health. (2003).
23. Health Education Authority. Mental Health Promotion: a quality framework. (1997).
24. Unützer et al. Collaborative care management of late-life depression in the primary care setting. *JAMA*. (2002). 288:2836-2845.
25. Clark et al. That little bit of help: the high value of low-level preventative services for older people. The Policy Press. (1998).

26. Things to do, places to go. Promoting mental health and well-being in later life. Third Sector First. (2005). [www.mhilli.org](http://www.mhilli.org)
27. Supporting People with long term conditions. An NHS and Social Care Model to support local innovation and integration. Department of Health. (2005). [www.dh.gov.uk](http://www.dh.gov.uk)
28. The care programme approach for people with a mental illness referred to the specialist psychiatric services HC (90)23/LASSL(90)11. Department of Health. (1990)
29. Valuing People: a new strategy for learning disability in the 21<sup>st</sup> Century. Department of Health. (2001). [www.archive.official-documents.co.uk](http://www.archive.official-documents.co.uk)
30. The NHS Plan: a plan for investment, a plan for reform. Department of Health. (2000). [www.dh.gov.uk](http://www.dh.gov.uk)
31. Joseph Rowntree Foundation. Black and minority ethnic older people's views on research findings. (2004). [www.jrf.org.uk](http://www.jrf.org.uk)
32. Delivering Race Equality in Mental Health Care. Department of Health. (2005).
33. Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England. National Institute for Mental Health England. (2003).
34. Delivering Race Equality: A Framework for Action. Department of Health. (2004).
35. National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006 - 2007/2008. Department of Health. (2005). [www.dh.gov.uk](http://www.dh.gov.uk)
36. Crisp N. Race Equality Action Plan. Department of Health.(2004). [www.dh.gov.uk](http://www.dh.gov.uk)
37. Race Relations (Amendment) Act. (2000)
38. Mental Health Services – Workforce Design and Development: Best Practice Guidance. Department of Health (2003). [www.dh.gov.uk](http://www.dh.gov.uk)
39. Making Ends Meet. Audit Commission. (2003).
40. Commissioning a patient-led NHS. London. Department of Health. (2005). [www.dh.gov.uk](http://www.dh.gov.uk)
41. Guidance on the Health Act Section 31 partnership arrangements. Department of Health. (2000). [www.dh.gov.uk](http://www.dh.gov.uk)
42. 10 High Impact Changes for service improvement and delivery: a guide for NHS leaders. NHS Modernisation Agency. (2004). [www.wise.nhs.uk](http://www.wise.nhs.uk)
43. Cattell et al. One Hundred Cases of Suicide in Elderly People. *British Journal of Psychiatry*. (1995). 166: 451-457.
44. Lebowitz et al. Diagnosis and treatment of depression in late life. *JAMA*. (1997). 278:1186-1190.
45. Excluded Older People. Social Exclusion Unit Interim Report. London. OPDM. (2005). [www.socialexclusionunit.gov.uk](http://www.socialexclusionunit.gov.uk)
46. House of Commons Health Select Committee Report – The Use of New Medical Technologies in the NHS. HMSO. (2005). [www.parliament.the-stationery-office.co.uk](http://www.parliament.the-stationery-office.co.uk)
47. The Interface between General and Community Psychiatry and Old Age Psychiatry Services: Report of a Working Group. Royal College of Psychiatrists. (2004). [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
48. Organising and delivering psychological therapies. Department of Health. (2004). [www.dh.gov.uk](http://www.dh.gov.uk)
49. Treatment Choice in Psychological Therapies and Counselling. Evidence based Clinical Practice Guidelines. Department of Health. (2001). [www.dh.gov.uk](http://www.dh.gov.uk)
50. Woods et al. Effectiveness of psychological interventions with older people. Pages 425 – 446 in *What Works for Whom?* Roth and Fonergy eds. 2<sup>nd</sup> Ed. New York. Guilford Press. (2005).
51. Forget me not 2002. Audit Commission. (2002).
52. HSC 2001/015 Continuing care: NHS and local councils' responsibilities. Department of Health. (2001). [www.dh.gov.uk](http://www.dh.gov.uk)
53. Barker et al. Delayed discharge in older people's mental health beds. *Old Age Psychiatrist*. (2005). autumn:9. [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

- 54.** Discharge from hospital: pathway, process and practice. Department of Health (Health & Social Care Joint Unit and Change Agents Team). (2003) [www.changeagentteam.org.uk](http://www.changeagentteam.org.uk)
- 55.** Harvey. Young onset dementia: epidemiology, clinical symptoms, family burden, support and outcome. Dementia Research Group. (1998).
- 56.** National service framework for mental health: modern standards and service models. Department of Health. (1999).
- 57.** Holland et al. Population-based study of the prevalence and presentation of dementia in adults with Down's syndrome. *British Journal of Psychiatry*. (1998). 172: 493-498.
- 58.** Puri et al. Mortality in a hospitalized mentally handicapped population: a 10-year survey. *Journal of Intellectual Disability Research*. (1995). 39: 442-446.
- 59.** Fazel et al. Hidden psychiatric morbidity in elderly prisoners. *British Journal of Psychiatry*. (2001).179: 535-9.
- 60.** No problems – old and quiet: Older prisoners in England and Wales. A thematic review. HM Chief Inspector of Prisons. (2005).
- 61.** Improvement, expansion and reform - the next 3 years: priorities and planning framework 2003-2006. Department of Health. (2002). [www.dh.gov.uk](http://www.dh.gov.uk)
- 62.** HM Treasury. 2004 Spending Review PSAs. Chapter 3. [www.hm-treasury.gov.uk](http://www.hm-treasury.gov.uk)
- 63.** The National Service Framework for long term conditions. Department of Health. (2005) [www.dh.gov.uk](http://www.dh.gov.uk)
- 64.** The Community Care (Delayed Discharges etc.) Act 2003. Guidance for Implementation. Health Service Circular, Local Authority Circular. Department of Health. (2003). [www.dh.gov.uk](http://www.dh.gov.uk)
- 65.** Independence, Well-being and Choice: Our vision for the future of social care for adults in England. Department of Health. (2005). [www.dh.gov.uk](http://www.dh.gov.uk)
- 66.** Choosing Health: making healthier choices easier. Department of Health. (2004). [www.dh.gov.uk](http://www.dh.gov.uk)
- 67.** Building Capacity and Partnerships in Care . Department of Health. (2001). [www.dh.gov.uk](http://www.dh.gov.uk)
- 68.** Fair Access to Care Services. Department of Health. (2002). [www.dh.gov.uk](http://www.dh.gov.uk)
- 69.** Opportunity Age – Opportunity and security throughout life. Department for Work and Pensions. (2005). [www.dwp.gov.uk](http://www.dwp.gov.uk)
- 70.** No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Department of Health. (2000). [www.dh.gov.uk](http://www.dh.gov.uk)
- 71.** The Mental Capacity Act 2005. [www.dca.gov.uk](http://www.dca.gov.uk)
- 72.** Advice on the decision of the European Court of Human Rights in the case of HL v UK (the “Bournemouth” case). Department of Health. (2004) [www.dh.gov.uk](http://www.dh.gov.uk)
- 73.** Draft Mental Health Bill. Department of Health. (2004). [www.dh.gov.uk](http://www.dh.gov.uk)
- 74.** The NHS Improvement Plan: Putting people at the heart of public services. Department of Health. (2004). [www.dh.gov.uk](http://www.dh.gov.uk)
- 75.** Healthcare Commission. Findings from local inspections. [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)
- 76.** The Better Metrics Project. Version 6. (March 2005). [www.osha.nhs.uk](http://www.osha.nhs.uk)
- 77.** Auditing age discrimination. A practical approach to promoting age equality in health and social care. King's Fund. (2003). [www.kingsfund.org.uk](http://www.kingsfund.org.uk)

## Annex 1

### Policy context: some key policy drivers

#### Public Service Agreement (PSA) targets

##### Planning and Priorities Framework 2003 – 2006<sup>61</sup>

##### Priority I: Improve the Health of the Population

##### iv) Reducing mortality from suicide:

Interventions which will help deliver this target are described in the National Suicide Prevention Strategy, the National Service Frameworks for Mental Health and Older People and in this guide. Health promotion is important for all. Depression is the commonest risk factor for suicide in later life, and is widely under-diagnosed and under-treated. Social isolation is also an important risk factor, and the Social Exclusion Unit reports on mental health and older people ([www.socialexclusion.gov.uk](http://www.socialexclusion.gov.uk)) set out ways to reduce this. PCTs should support access to assessment, treatment and care for all those at risk, paying particular attention to the needs of those from black and minority ethnic communities and other groups that may be hard to reach.

(The NHS plan also requires reduced mortality from suicide and undetermined injury by at least 20% by 2010<sup>30</sup>)

##### Public Service Agreement for the Department of Health 2005 – 2008<sup>62</sup>

##### Objective I: Improve the health of the population. By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

Substantially reduce mortality rates by 2010:

- from suicide and undetermined injury by at least 20%.

##### Objective 2: Improve health outcomes for people with long-term Conditions

To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/04 baseline), through improved care in primary care and community settings for people with long-term conditions.

##### Objective 4: Improve the patient and user experience

(i) Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys. The experiences of black and minority ethnic groups will be specifically monitored as part of these surveys.

(ii) Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:

- increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and

- increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

### Other key policy drivers

#### Long term conditions

The National Service Framework for Long-term Conditions<sup>63</sup> and Supporting people with long term conditions<sup>27</sup> puts people with long-term conditions (including people with mental illness) at the heart of the health and social care agenda. The NHS and social care long term conditions model matches service users to a stratified care management approach of supported self care, disease-specific care management and case management. Good management of people with long term conditions results in improvement in care and service quality as well as a reduction in costs.

**The Community Care (Delayed Discharges Etc.) Act 2003<sup>64</sup>** requires NHS bodies to notify the local authority of individuals who they believe are likely to need community care. The act introduced a scheme of reimbursement whereby acute general hospitals were reimbursed by social service departments for delays in transfer of care. It was the policy intention to roll out the reimbursement scheme to mental health beds, and consultation for implementation of this is ongoing. Service users requiring community-based care are likely to include a substantial number of older people with mental health problems.

**Independence Well-Being And Choice<sup>65</sup>**, published in 2005, was a consultation paper setting out proposals for the future direction of social care for all adults of all age groups in England. The findings from the consultation will be incorporated into the development of the white paper on health and care services outside hospital (see below).

This vision for adult social care was based on the principle that everyone in society has a positive contribution to make to that society and that they should have a right to control their own lives. It notes the need to make better use of technology to support people; have a shared agenda between social care and the NHS to help maintain the independence of individuals; ensure people with the highest needs receive the support and protection needed for their own well-being and the safety of society; and the need to share openly the risks and benefits of independence for individuals. It also emphasizes the importance of better information and signposting, putting people at the centre of assessing their own needs and how those needs can best be met. It suggests that direct payments as a method of giving people choice and control might be helpfully extended to people with mental health problems including the use of agents for those unable to consent.

The importance of a shared commissioning framework for health and social care partners is underlined, with a key leadership role for local government. This should balance a greater role for preventative services and early intervention for low-level needs while providing intensive care and support for

those with high-level complex needs. Whole systems regulation and performance management will be enhanced by the merging of CSCI and the Healthcare Commission, ensuring that local joint working achieves the objectives described.

**The developing White Paper** on improving community health and care services builds on the policy commitments on patient choice and empowerment described in **Choosing Health**<sup>66</sup> and Independence, Well-being and Choice. The White Paper will set out the vision for the care people need in the community and in their own homes for the next twenty years. Underlying principles include:

- services which start from the needs of the individual and the community. This should enable users and communities to exercise choice in how the services will be used
- services that are easy and convenient to understand, navigate, and use. It should be straightforward and intuitive and should allow the service user to focus on the things that matter
- a system which responds to the views and choices of its users as to how the system is designed, how it functions, and what decisions and trade-offs are made
- services which work towards supporting and maximising the well-being of the individual – ensuring that they live their lives as well as they can. The system should ensure that everyone (staff and users of the system) is treated with dignity and without discrimination
- a system which recognises that there is a range of important carers around each individual, and these carers (formal or informal) need empowerment and assistance from the system in order to provide this care

**The Social Exclusion Unit's Excluded Older People Project** aims to improve the well-being and quality of life of excluded older people. The project will pay particular attention to the needs of black and minority ethnic elders as well as older people with mental health problems. Its interim report "Excluded Older People"<sup>45</sup> identifies three main areas for further work: early support and preventative services; greater control and choice for older people; and more joined up services, from benefits to housing to health.

**Building Capacity and Partnerships in Care**<sup>67</sup> encourages a strategic and inclusive whole-systems approach to capacity planning across nursing and residential care, home care, ordinary and sheltered housing and other community based options

**Fair Access to Care Services**<sup>68</sup> (May 2002) has particular relevance to the issue of age-inclusive and equitable services for older people with mental health problems. This access guidance is reinforced by existing disability legislation and the forthcoming Disability Equality Sector Duty requiring public authorities to promote disability equality

### **Opportunity Age**<sup>69</sup>

This cross governmental paper details how the values of active independence, quality and choice should be embedded in all public sector policies directed at older people. Services should become increasingly focused on the promotion of well-being and independence, easy to access, customer focused, and aimed at tackling social exclusion.

### **Commissioning a Patient-led NHS**<sup>40</sup>

This recent document outlines how PCTs will focus on promoting health and commissioning services, and will use practice based commissioning as a way of devolving power to local doctors and nurses to improve patient care. Care pathways should be made more effective and a range of providers used. There should be greater congruence of local government and PCT boundaries to improve integrated working.

The Government regards abuse of vulnerable and older people as unacceptable in all its forms and is determined to root it out. **No Secrets**<sup>70</sup> provides a complete definition of abuse and a framework for councils to work with the police, the NHS and regulators to tackle and prevent abuse occurring. The **Protection of Vulnerable Adults Scheme** (July 2004) prevents dangerous or unscrupulous people from gaining access to older and vulnerable people in care homes or being cared for in their own homes.

The legal framework within which mental health care operates is undergoing a process of reform with significant implications for services:

**The Mental Capacity Act**<sup>71</sup> provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. It is due for implementation in April 2007. Guiding principles include:

- the presumption of capacity: 'A person must be assumed to have capacity unless it is established that he lacks capacity.'
- maximising decision-making capacity: 'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.'
- unwise decisions: 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision.'
- best interests: 'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.'
- least restrictive alternative: 'Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.'

It is likely that the Mental Capacity Act will ultimately include provision for the so-called 'Bournewood' gap; which relates to the deprivation of liberty in someone without capacity to consent to this. The finding of the European Court of Human Rights that the right to liberty and security had been violated in a person with autism in the absence of the use of the Mental Health Act, is

likely to have implications for inpatient units and care homes. Interim guidance is available from the department of health<sup>72</sup>.

**The Mental Health Bill**<sup>73</sup> has a series of general principles: that patients are involved in the making of decisions; that decisions are made fairly and openly; and that actions carried out on patients behalf without their consent should be the minimum necessary to protect their health or the safety or other persons.

## Annex 2 Service assessment

### Standards for better health

The NHS Improvement Plan (2004)<sup>74</sup> describes a healthcare system in which local organisations, working in partnership, have greater decision making responsibilities for local service prioritisation to improve personalised care not only for illness but health and well-being. To enable this, a shift was required from a system driven by national targets to quality improvement driven by standards.

National Standards, Local Action<sup>35</sup> describes the new standards framework. Seven domains broadly covering all facets of health and social care are described in terms of outcome. Two types of standard are described: core and developmental. Core standards are those based on pre-existing standards and targets, describing an acceptable level of service. Developmental standards are designed to aid continuous improvement over time, and allow services to demonstrate, and the public to see, progress made year on year. The Healthcare Commission through its "Annual Health Check" of all healthcare organisations will assess progress towards the developmental standards, with the addition of new national targets as they are described.

The annual health check will put the onus on healthcare organisations to self-assess to make sure they are meeting the expected standards and check their assessments with others in the local community. The Healthcare Commission will use nationally available data to cross check each Trust's declaration of compliance.

The Healthcare Commission is responsible for the monitoring and reviewing of implementation of standards set out in National Service Frameworks. Improvement reviews will do this while identifying the steps organisations can make towards meeting these standards. A joint Healthcare Commission, Commission for Social Care Inspection and Audit Commission improvement review of older people's services is nearing completion. Their national report is expected in December 2005, based on local inspections, good practice visits, stakeholder consultation, service user experience, and other national data. Findings from the mental health consultation and from the 10 local inspections are being published on the web as they are made available<sup>75</sup>. The Healthcare Commission and Commission for Social Care Inspection will use this service development guide to inform their inspection of services.

### **Better metrics**

The better metrics project is aimed at providing more clinically relevant measures of performance (metrics) and has published its suggestions<sup>76</sup>. The project has also produced some criteria for what makes a good metric, to assist local services in developing their own. The authors hope that the metrics will be useful for local target setting and as indicators for local quality improvement initiatives, as well as informing the Healthcare Commission in its development of assessment criteria. National clinical directors were involved in its development, and the document is divided by their areas of responsibility. Some metrics in both the older people and mental health sections are relevant for older people's mental health.

### **Service and financial mapping**

From 2005, financial and service mapping will be supported for older people's mental health services. Following the Mental Health NSF, the Autumn Assessment has been an annual event, comprising: a self assessment process, a themed review on a key topic, finance mapping and service mapping of services for younger adults.

A similar process of service mapping has been developed as part of the NSF for children. This has allowed monitoring of service development, but has also been invaluable for local providers and commissioners as a basis for commissioning discussions, as it is a transparent way of benchmarking service elements alongside local activity data.

The mapping of older people's mental health services will be organised by the same team at Durham University ([www.opmhmapping.org.uk](http://www.opmhmapping.org.uk)) and will aid understanding of local service style, in exploring how some service elements may substitute for others. It may assist in identifying an ageist pattern of service delivery<sup>75</sup>, as well as providing the basis of a local service directory for users and carers.

Services are identified by type, and described in some detail, including staffing, availability and functions. They can be ascribed to individual primary care trusts and councils with social services responsibilities.