

# Everybody's Business

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

### Setting the scene

Providing services for people with mental health problems can be complex, as they cut across health and social care, physical and mental health and mainstream and specialist services. Making sure that people's needs are met in a co-ordinated way, and that they don't fall between gaps in the system, is essential.

The aim of the Service Development Guide 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.

Produced by the Department of Health, it is being rolled out by the Care Services Improvement Partnership, which was established in 2005 to support improvements in services and in the wellbeing of a number of service user and patient groups.

**The Guide is not about developing new policies – it is about improving health and social care practice at the front line.**

We need to bring together existing policies and examples of good practice to develop co-ordinated services that focus on people's mental health and physical needs - not their age - and promote respect and dignity.

The Guide is committed to:

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

It has been developed to inform local discussions on how services should be commissioned and delivered. It should also help health and social care professionals to make continuous improvements to local services so that they meet the needs of older people with mental health problems more effectively.

### Background to the new Guide

The 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* (May 2001) and supports the principles promoted in *Securing Better Mental Health for Older Adults* (June 2005), by describing the foundations and key elements of a comprehensive service for older adults with mental health needs.

The Older People's Mental Health Mapping framework, launched in November 2005 to coincide with the publication of the Guide, will support local commissioning decisions by providing national benchmarking for local services.

### Supporting material and guidance

The Guide is also supported by a comprehensive web-based resource, which provides valuable information for anyone involved in health and social care for older people with mental health problems. The web site includes guidance on best practice, local service examples and links to relevant policy.



This fact sheet provides an initial overview of the sections of the document most relevant to health and social care professionals.

Action points and guidance include:

### Primary Care

- Training all practice staff to recognise and deal with mental health problems.
- Carrying out special screening tests as agreed with local specialist services.
- Agreeing care protocols with secondary care providers and service users.
- Ensuring that access to psychological therapies is determined by need, not age.
- Involving service users and carers in healthcare decisions, signposting them to other resources and working closely with statutory and voluntary organisations.
- Providing ongoing assessment and intervention for physical co-morbidities, sensory deficits and other disabilities.
- Ensuring older people gain maximum benefit from medications and take them appropriately, especially if they have cognitive impairment.
- Referring patients who require specialist mental health services promptly.
- Developing best practice management of long-term conditions, including physical illnesses that can lead to mental illness and worsen the patient's prognosis
- Including older adults with mental illness in primary care disease registers, which can facilitate better co-ordinated care and help avoid unnecessary admissions to hospitals or care homes.
- Referring patients to specialist services when clarification of diagnosis is needed or there are concerns about lack of response to other strategies, severe distress or risk, complex problems or legal issues.

### Home care

- Encouraging people to be as independent as possible, rather than doing things for them.
- Using experienced specialist workers to carry out informal assessments and work with service users to support them.
- Developing good links with specialist resources such as community mental health teams for older people and community rehabilitation teams.

### Day services

- Providing flexible, socially inclusive services which are centred on the needs of service users, support independent living and promote good quality of life.
- Basing services on need, not age and not moving younger people with mental health problems to another service just because they've reached a certain age.
- Developing clear pathways and referral processes, regularly reviewing individual needs and adopting a holistic approach to health promotion.
- Evaluating if the needs of people with low and moderate mental health problems can be best met by existing services run by councils, voluntary groups etc.
- Considering day care at home for people who feel distressed out of their normal environment, have dietary or religious needs or live in rural communities.
- Offering flexible hours at specialist day centres, such as evenings and weekends.
- Continuing to focus on people with complex needs through day hospitals and treatment services, by offering multi-disciplinary assessment and treatment and a strong focus on rehabilitation.

### Care in residential settings

- Providing comprehensive assessment and person-centred services that cater for a wide range of cultural, dietary and spiritual needs.
- Ensuring that recruitment reflects the diversity of the home and staff receive training in all aspects of dementia care, including communications.
- Developing good links with local specialist services such as community mental health teams for older people.
- Promoting social inclusion.

### Intermediate care

- Treating intermediate care as an integral part of service provision, not an add-on.
- Ensuring that people are not excluded from mainstream intermediate care by providing additional training in mainstream services or developing specialist teams or resources.

- Making sure that the Single Assessment Process underpins all assessment activity for older people, including intermediate care, with information shared between professionals to avoid duplication and delays,
- Providing intermediate care that is flexible enough to be people-centred, not service driven.
- Training carers and support staff to recognise illnesses that lead to unnecessary admissions.

### Care in a general hospital

- Recognising that up to 60 per cent of people aged 65 plus have, or develop, mental health problems when they are admitted to hospital.
- Integrating mental health care into the everyday workings of the hospital and ensuring that there is a good interface between clinicians and senior managers working in mental health and general care.
- Providing better mental health training for mainstream staff and encouraging them to work closely with specialist mental health teams.
- Developing a liaison style of service, which involves a multidisciplinary team, as the most complete and desirable service model.
- Encouraging mental health teams to work collaboratively and proactively with general care teams to raise awareness of mental health and provide support and supervision of staff dealing with common mental health issues.
- Ensuring that teams can also provide rapid assessment of older people with suspected mental health problems who present to A&E.
- Promoting routine assessment of mental health problems of all admissions and better management of straightforward mental health problems.
- Providing rapid access to specialist assessment and management of complex mental health problems, including patients with serious physical illnesses.
- Facilitating good practice in discharge planning.

### Integrated community mental health teams

- Promoting the teams as the focus for referrals from primary care, secondary services, social services and users and carers.
- Providing services that are accessible, focus on holistic health and social care outcomes for service users and maximise social inclusion and recovery.
- Offering 24-hour, home-based crisis support, a key worker system and a broad skill mix across health and social care.

### Memory assessment services

- Providing services through the community mental health team role or a separate resource, such as a memory clinic, and ensuring close links with other local health or social care.
- Offering comprehensive support, ranging from home-based assessment and counselling through to pharmacological treatment if required.

### Psychological therapies

- Considering psychological therapies as a matter of routine when assessing mental health problems.
- Delivering interventions as an integral component of mental health care provided by members of a multi-disciplinary health and social care team. This could be done by expanding existing community mental health team or developing a formal psychological therapies service with clear and effective referral pathways.
- Ensuring that access is not unreasonably restricted by waiting lists, that therapies are available within mainstream services and that mental health trusts develop a clinical governance strategy for this provision.

### Inpatient care

- Encouraging close working between inpatient old age psychiatric wards and investigative and treatment services.
- Operating a palliative care model for people with advanced dementia.
- Addressing all aspects of the patient's emotional, psychiatric, physical, social, spiritual and cultural wellbeing.
- Providing occupational therapy and forging strong links with local faith centres and carers' groups.

### Special groups

- Clarifying who is responsible for commissioning user-led services for younger people with dementia, identifying lead clinicians and defining the relationship with neurology services.
- Providing effective services for older people with mental health problems and learning disabilities through joined-up working by health professionals and better planning.
- Providing effective mental health care for older prisoners through in-reach specialist care, strong partnerships with health and social care and training and education of prison staff.

## Mental health problems in England

Mental health problems become more common as people get older and England's population is ageing. The number of people over 65 will increase by 15 per cent in the next ten years and the number of people over 90 is expected to double in the next 30 years.

It is estimated that:

- 40 per cent of older people attending GP surgeries, 50 per cent of general hospital patients and 60 per cent of care home residents have mental health needs.
- Between 12 and 15 per cent of people over 65 suffer from depression - this is more common in people suffering from long-term physical disorders
- Dementia affects one person in 20 over the age of 65 and one person in five over 80.
- It costs more to look after people with dementia than stroke, cancer and heart disease added together.

In a typical district of 250,000 people, there will be 45,000 (18%) who are aged 65 or over. Of these:

- 4,500 to 6,750 will have depression – including 1,500 with severe depression
- 6,000 will have anxiety-related disorders
- 900 will have psychosis-related disorders
- 2,250 will have dementia
- 2,000 will be living with the consequences of stroke – 1,000 of these will experience mood disorders and 700 will need to adjust to living with reduced cognitive skills.

## About the Care Services Improvement Partnership (CSIP)

Established on 1 April 2005, after formal consultation, CSIP's main goal is to support improvements in services and in the wellbeing of:

- People with mental health problems
- People with learning disabilities
- People with physical disabilities
- Older people with health and social care needs
- Children and families with health and social care needs and
- People with health and social care needs in the criminal justice system.

We are part of the Care Services Directorate of the Department of Health and most of our staff and services are based in eight regional development centres across England. This enables us to respond flexibly to the needs of people, locally, regionally and nationally.

## More information

You can download copies of the Service Development Guide and further copies of this fact sheet from [www.everybodysbusiness.org.uk](http://www.everybodysbusiness.org.uk)

If you don't have access to the internet please call 020 7972 4606. For further information, please contact your regional office.

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To find out more about CSIP's work please visit our website [www.csip.org.uk](http://www.csip.org.uk) or contact your local regional office.

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