

acute hospitals  
social care  
day centres  
departments  
residential homes  
primary care  
primary care



resource  
centres  
nursing  
domiciliary care  
voluntary  
organisations  
nursing homes

# raising the standard

Specialist services for older people with mental illness

Report of the Faculty of Old Age Psychiatry





This document has been endorsed by the following organizations:

Age Concern

The Alzheimer's Society

The British Geriatrics Society

National Older People's Mental Health Programme

Care Services Improvement Partnership

The Royal College of Nursing



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# Foreword

This document had its origins in Council Report 69: *The care of older people with mental illness: specialist services and medical training*. This was the report of a joint working party of the Royal College of Psychiatrists and the Royal College of Physicians. The scope of the current report, which is released as a Faculty of Old Age Psychiatry document, has been reduced compared to the most recent edition of CR69 (1998), in focusing on service styles and practice, while giving medical training its own document. This decision was made largely in order to produce more timely publications. Health policy for NHS services, and specialists' education and training, are both changing quickly. A second consideration was that by focusing on services, it might be complementary to Department of Health guidance on Older People's Mental Health (OPMH) Services (Department of Health, 2005d). For this reason the scope of the document has been limited to services in England, though many of the service delivery issues will be similar across all of Great Britain and country specific versions are expected in due course.

In considering the particular expertise that specialist mental health services for older adults provide, the services described in this report should be targeted at people with all mental illnesses in later life, as well as younger people with dementia. We welcome developments from the Department of Health suggesting greater priority is being given to mental health services for older people though are keen to see some evidence that these aspirations result in better services on the ground. There is certainly a need to make services accessible on the basis of need not age, but there is also a greater need than ever to have strong specialist old age psychiatry services.



# Main recommendations

## Ageism

- Older people should have the same rights as all adults, particularly where, due to mental illness, their rights to dignity and respect are threatened.
- Ageist neglect of older people with mental illness must stop. Service expansion in specialist general and community psychiatry services should be matched by a similar funding increase for older people.
- Older people should have access to a similar range of health and social care services as younger adults.

## Discrimination on the basis of mental illness

- Discrimination against people on the basis of mental illness should not occur. Examples include the exclusion of older people with mental illness from intermediate care services, chronic disease management and choice initiatives.
- Consideration should be given to the impact of the implementation of reimbursement legislation on older people with mental illness, and to extending reimbursement to this patient group.

## Protection of older people with mental illness

- Specific attention should be paid to particularly vulnerable and socially excluded groups of older people, including the homeless, those with learning disabilities, ethnic and cultural minorities, and older people in institutions or elsewhere who are exposed to the risk of abuse. The responsibility for addressing the needs of such groups lies with both commissioners and providers of services.
- All clinicians and managers must have an understanding of the aetiology and therefore prevention of all forms of abuse. Abuse may be active maltreatment or neglect, a criminal offence or subtle denigration. It may be intentional, or unintentional through ignorance or thoughtlessness.
- Scrupulous monitoring against standards of good practice is required in all settings where older people are cared for. Without this, there exists the possibility of a culture of patient care that does not recognize abuse in its many forms.
- All staff working with older people require training on abuse in its widest forms, including recognition of non-accidental injury, the assessment of competence and decision making capacity, moral ethical and legal issues, and improving communication with people with cognitive difficulties.
- The National Suicide Prevention Strategy should address the particular issues related to older people and set specific targets.

## Appropriate prioritisation by the Department of Health and the Healthcare Commission to achieve NSF standards and beyond

- The National Service Framework for Older People (NSF-OP) requires that by 2011 every health district should have a fully resourced specialised service for old age psychiatry. The service should be responsive, comprehensive, and provide continuity and quality assurance. Significant additional resources must be allocated within both health and social care for this to be achieved.
- There is a need for clear national guidance detailing the priorities for OPMH, and performance management to ensure that these priorities are delivered.

- Despite the huge social, psychological, and financial burden of mental illness in later life, OPMH services are not given high priority by the Department of Health. The mental health of older people should be recognized in high level Department of Health performance targets which reflect both health and social care priorities, and in the General Practitioner's (GPs) General Medical Services contract Quality and Outcomes Framework (QOF).
- There should be increased attention to improving integration with social services.
- There should be increased attention to ensure that the implementation of the Single Assessment Process (SAP) will reflect OPMH issues.
- Clear guidance is required on how the Care Programme Approach (CPA), and SAP inter-relate, and indeed whether two separate care management systems are required.

## Continuing care

- Clear national guidance is needed on accessing continuing care for people with dementia and other mental illnesses. This should emphasise the need for good quality, flexible continuing health care including respite care. The system should be simplified, and allow users and carers easily accessible information to navigate their way through the system.

## Chronic disease management / long term conditions

- Mental illness in later life may be a long term disabling condition and in particular depression affects many people with other long term physical conditions. This should be recognized in policy development and implementation. For example, community matrons should have the training required to work effectively with older people with mental illness, and interface effectively with specialist OPMH services.
- GPs should be rewarded for setting up a disease register for dementia in the QOF. The QOF indicator relating to serious mental illness should include depression, and should explicitly relate to adults of all ages.
- Payment by results, if and when rolled out to mental health services for older people, should recognize the long term nature and complexity of care needs of older people with mental illness.

## Data collection on existing service provision and funding

- Publicly available data on OPMH service configuration and funding across the United Kingdom is urgently needed, to ensure equity of access, address ageism, and aid commissioning.
- Annual service mapping and financial mapping should be given the same priority as it has been given in younger adult services. Attempts to relieve the data burden on Mental Health Trusts should not extend so far as to lessen the priority which the Department of Health gives to this area. Its effectiveness will be proportionately reduced if few Trusts participate, and all efforts should be made to encourage services to participate.
- The Autumn Assessment process in working age adult services where self evaluation takes place across clearly defined criteria ensures ownership of priorities across the whole system as well as focused investment to reduce shortfalls in service. Consideration should be given to the introduction of a self-assessment framework building on best practice from the National Institute of Mental Health in England, CSCI and Healthcare Commission.
- Local Authority Scrutiny Committees should investigate service levels and quality across health and social care.

## Assistive technologies for dementia

- Given the impact of the demographic changes on increasing numbers of people with dementia and reducing potential workforce of care workers, urgent research and service support is required for assistive technologies in dementia. Such technologies should be made available through Integrated Community Equipment Stores.

## Care homes

- Mental illness is very common in all care homes, irrespective of their “specialist” status. In some areas care homes are still discharging people on the basis of diagnosis rather than need. There needs to be clear and consistently applied guidance on the registration of care homes: a diagnosis of dementia should not mean that the resident has to move to a different home.
- Improved training is needed for all staff working in care homes which specialise in the care of older people with mental illness. This should include training in the importance of a stimulating environment that will promote rather than hinder independence, the importance of the availability of suitable activities for all residents based on their individual backgrounds, and recognition of the fact that good care involves time and adequate numbers of well trained staff to provide the care.
- The Bournemouth guidance on the deprivation of liberty of people without mental capacity in in-patient settings should be extended to people in all care settings, irrespective of whether the funding for such placement derives from health and social care or from private sources.
- The local community should be encouraged to become involved in the life of care homes.

## Training

- Given the scale of the problem of mental illness in later life, it is essential that all health and social care professionals should have training in mental health for older people and in communication skills and capacity assessment. This includes staff in primary care and all medical and psychiatric staff who do not specialise in the care of older people.
- NVQ baselines should ensure that there is core knowledge and competencies on OPMH built into baseline training.
- Attention should be paid to ensure that all general hospital staff understand the prevalence, impact and potential for treatment of mental disorders, and that adequate training resource is available to facilitate such learning.
- There needs to be a focus on leadership development in OPMH services. Services have suffered as a result of lack of leadership skills.

## Research and Development

- Research in older adults with mental illness has been neglected, leaving many questions over the most effective treatments and service models. Funding needs to be targeted to address this.
- Greater research and development resource should be put into determining the impact of mental illness in later life on morbidity, quality of life, service use, carer health, and in establishing health economic models for the likely cost effectiveness of health and social care interventions.
- The public health agenda should extend to mental health in older people as well as physical health. More research is needed into the effectiveness of public health interventions for reducing the impact of mental illness.

## Service Standards

- Given a diagnosis of a dementia, clear, accurate and speedy information to support carers is vital. Named key workers, rapid response to support carers and advocacy services should be easily accessible via primary care.
- Greater involvement of the voluntary and not for profit sector is likely to bring benefits to users and carers; in particular advocacy, independent carer and patient support, and training of health and social care professionals. Commissioners should increasingly consider these agencies to be involved in this work.
- Housing, social services and commissioners together need to plan a range of accommodation options which can meet the needs of older people with mental illness.
- The impact of Fair Access to Care, free nursing care, continuing health care and the rationing boundaries around social and health care are confusing and difficult when planning single care pathways and trying to ensure fairness and appropriate choice. Following diagnosis there is a need to ensure that there is access to clear, and unambiguous information about eligibility criteria for services for older people with mental health difficulties.
- Health promotion activities and initiatives should include mental as well as physical health.
- A coalition of professional bodies and voluntary organizations interested in OPMH should be established to help promote this area.
- Health and social care commissioners should audit local specialist services against the recommendations in this report and produce a development plan.
- Old age psychiatry services should provide specialist community mental health teams for older people, memory assessment services, day hospital facilities, in-patient beds (with separate provision for people with functional and organic illness), access to psychological therapies, NHS continuing care, and alternatives to in-patient admission (intermediate care).
- A multidisciplinary liaison mental health team for older people is the preferred model for working with a moderate or large general hospital.
- Health and social care commissioners should review local service response and provision for special groups who have fallen between services in the past, particularly younger people with dementia, people growing old with a learning disability, and older prisoners, and produce a development plan.

# Introduction

## Background

In 1989, the Royal College of Physicians and the Royal College of Psychiatrists published *Care of Elderly People with Mental Illness: Specialist Services and Medical Training* (Royal College of Physicians & Royal College of Psychiatrists, 1989). This recommended that old age psychiatry should be officially recognised as a speciality within psychiatry. This was implemented within a few months of publication, and the recommendation that every health district should offer a specialised service for old age psychiatry has also been a success.

In 1995, the Colleges reconvened to review progress and problems. Their report, "The care of older people with mental illness: specialist services and medical training" recommended the establishment of "a national reference framework against which commissioners and the public can compare practice and standards in their localities", and by the time of its publication in 1998, the release of the Mental Health NSF had already been announced. The report hoped for a NSF for Old Age Psychiatry in due course.

In reviewing the need for this document, we have been mindful of the use that the previous reports have been put to, the publication and implementation of the Mental Health NSF (Department of Health, 1999) and the NSF-OP (Department of Health, 2001a), and the greater availability of information on OPMH to concerned members of the public.

## The purpose of this report

Previous reports on *The Care of Older People with Mental Illness* (1989 & 1998) have put forward recommendations that have made a considerable difference to the development of services, both in terms of promoting a specialist focus for old age psychiatry, and in paving the way for greater multi-agency and interdisciplinary working within the field. All reports effectively have a 'shelf life' beyond which their content and focus must be reviewed to ensure that they reflect contemporary practice, legislation and opinion. The revision of this report is timely, coming as it does at a time of national interest in old age psychiatry services.

The last report (June 1998) primarily referred to providing "concerned members of the public with a framework for debate" as its key purpose. Whilst recognizing the importance of keeping the general public fully and properly informed, this 2006 report must go beyond this both in terms of focus and impact in order to contribute to the much wider and ongoing debate on mental health services for older people. Much from both these previous reports remains relevant and is included here.

There is ongoing debate on the role of specialist old age psychiatry services within the range of health and social care services which support all older people with mental illness. A comprehensive and detailed consideration is required of how this specialist service links and has a reciprocal relationship with other non-specialist (generic) services for the benefit of those we serve. This report, in common with its predecessors, will have an important role in informing what 'best practice' looks like.

# Mental disorder in later life

## Prevalence

Dementia and depression are the most common mental health disorders of later life, though OPMH services also serve people with other psychotic, affective and neurotic disorders.

The prevalence of dementia increases exponentially with age, affecting one person in 20 over the age of 65 and one person in five over the age of 80 (Hofman et al, 1991). Dementia currently affects over 750,000 people in the UK (Alzheimer's Society). It is estimated that by 2010 this will rise to 870,000 people and by 2050 to over 1.8 million people (Alzheimer's Society).

Depression is the most common mental disorder in later life, affecting around 15% of older people (Beekman et al, 1999). The population of older people in the UK in 2003 was 10.9 million (Office for National Statistics (ONS), 2003), equating to 1.6 million older people with depression. Severe depression is somewhat less common, perhaps affecting 3% of older people.

While once highest of all age groups, age-specific suicide rates for the elderly have declined in England and Wales, with the 65-74 and 75+ groups in 2003 having lower rates than the 25-34, 35-44, and 45-54 age groups. Male suicide rates remain round 3 times higher than female rates (ONS, 2005).

The prevalence of schizophrenia in late life is around 0.1% – 0.4% (Henderson and Kay, 1997). First admission rates for schizophrenia, schizo-effective disorders and other paranoid states are around 1 in 10,000 per year in the over 65s (DHSS, 1985)

The prevalence of mania reduces with age, being present in 0.1% in the over 65s (Weissman et al, 1988), though accounts for perhaps 5% of all old age psychiatric admissions (Yassa et al, 1988).

It is uncommon for anxiety disorders to present for the first time in late life. However, there is a gradual accumulation of people with more chronic anxiety disorders (Lindesay, 1991).

Around 1-2% of over 55 year olds have alcohol dependence per year, though this is higher in clinical settings (up to 23%) (Atkinson, 2000). There is an apparent decline in prevalent alcohol abuse with age, though older people are likely to be more vulnerable to the physical side effects. Approximately 10% of patients having a domiciliary old age psychiatry assessment in Liverpool in 1984 had active alcoholism (Malcolm, 1984).

The prevalence of delirium increases rapidly with age. In one community study 14% of those aged 85 and older were found to be suffering from delirium (Folstein et al, 1991). Prevalence rates in the general hospital or in old age psychiatry admissions are significantly higher (Lindesay, 2000).

Personality disorders are less common in older adults, largely as a result of a reduction in anti-social, borderline, histrionic and narcissistic personality disorders (Cohen et al, 1994).

A typical general practice of list size 10,000 will include approximately 1500 people aged 65 and over. These are likely to include around 75 with dementia, 225 with depression (including 30 with severe depression), 30 with psychoses and 30 others with various less common though significant conditions. A service planning population of 250,000 will include 37 500 people aged 65 and over. Among these will be approximately 2,000 with dementia, 5,600 with depression (750 severe), 750 with psychoses and 750 with other conditions.

## Impact

### Dementia

Dementia is a progressive neurodegenerative disorder affecting cognitive functioning and personality, causing behavioural disturbance and reduced activities of daily living. These disabilities cause considerable loss of independent living skills and increased risk to self and others. People with dementia frequently neglect their personal health needs, have a high incidence of physical and other mental health problems, and are often non-compliant with medication. There is an increased requirement for care, both from family carers and statutory services. Care-giving is known to cause emotional stress. An ONS study showed one third of carers to have mental illness (Singleton et al, 2002) and two thirds of carers who provide more than 50 hours of care a week report that their health has been affected by caring (Princess Royal Trust for Carers, 2003). Carers of people with dementia experience greater strain, distress and higher levels of psychological morbidity than carers of other older people (Eagles et al, 1987).

### Depression

Depression is the third most common reason for consultation in UK general practice (Effective Healthcare Bulletin, 2002). Mental health problems are now implicated in possibly as many as one in four primary care consultations (Goldberg, 1991) making mental health second only to consultations in primary care for respiratory infection (McCormick et al, 1995).

### Financial burden

The financial burden of mental illness, and in particular depression and dementia, is considerable.

The economic and social costs of mental illness in England have recently been estimated as £77.4 billion pounds with the majority (£41.8 billion) related to the human costs of mental illness (Sainsbury Centre for Mental Health, 2003).


The World Health Organization (Murray and Lopez, 1996) estimates that, next to ischaemic heart disease, major depression will be the world's second most debilitating disease by 2020. The total cost of adult depression in England was over £9 billion in 2000 (Thomas and Morris, 2003).

In a literature search of cost of illness studies, Lowin et al (2001) estimated direct costs of Alzheimer's disease to be between £7.06 billion and £14.93 billion. This is greater than stroke (£3.2 billion), heart disease (£4.05 billion) and cancer (£1.6 billion excluding informal care).

### Benefit of interventions

Although there is evidence for interventions in the full range of mental disorders including anxiety disorders, alcohol dependence, schizophrenia etc, we will briefly comment only on dementia and depression.

Early and accurate diagnosis is important for people with dementia and their carers, in order to engage with support services and plan for the future, but is difficult in the early stages. Early diagnosis and intervention can reduce psychological distress in people with dementia and their close supporters (Levin et al, 1989), provide knowledge about medical and psycho-social support that improves morale (Briggs, 1993), and allow access to anti-dementia drugs which are more effective in the early stages (National Institute for Clinical Excellence, 2001). Educational initiatives to the family of people with dementia have been shown to lessen carer stress and reduce admission to care homes (Brodsky et al, 1997).



However, the majority of GPs feel inadequately trained in the diagnosis and management of dementia (Audit Commission, 2000). GPs also often feel they have little to offer people with dementia (Wolff, 1994), and find explaining the diagnosis of dementia particularly difficult (Glosser et al, 1985). Studies of relatives of people with dementia also report that physicians are reluctant to make a diagnosis (Morgan and Zhao, 1993; Haley et al, 1992).

These factors may explain why, despite the benefits of early diagnosis, in one large community study in north London only 18% of over-75 year olds with Mini Mental State Examination scores indicating possible or probable dementia had a diagnosis of dementia, or note regarding any cognitive impairment, in their medical records (Iliffe et al, 1990).

A range of antidepressant medications and psychological approaches have been shown to be beneficial in late life depression (Baldwin et al, 2003). When untreated, depression shortens life, increases health care costs as well adding to disability from medical illnesses (Penninx et al, 2000) and is the leading cause of suicide among older people. When treated, quality of life improves (Shmueli et al, 2001). Collaboration between primary and specialist care providers is known to be associated with better treatment outcomes (von Korff and Goldberg, 2001).

Despite the considerable impact of depression, and its positive therapeutic possibilities, depressive symptoms are not recognised in about half of attending patients with depressive disorders in UK general practice, and when recognised, treatment is often suboptimal (Gilbody et al, 2003). Depression in older adults is often missed because of lack of presentation of psychological symptoms, with detection rates of around 50% (Crawford et al, 1998), and screening tests are used by less than a third of GPs (Audit Commission, 2000).

# Context of this document

The period between the publication of the NSF Mental Health (1999) and the NSF-OP (2001a) had in many areas encouraged a cessation of planning for older people while plans for 'working age adults' had been pushed ahead and resourced. The brief chapter on mental health (Standard 7) in the NSF Older People focuses on dementia and depression. Other mental disorders were said to require care and attention as covered by the NSF Mental Health (although this was not the case at its publication). Commissioners and providers need to be aware that older people easily fall into the gaps between services and unless a service or resource is specifically aimed at older people they are unlikely to get their fair share of it.

## Independent reviews of OPMH services

Despite the dedicated work of staff in old age psychiatry services, they have often felt they are struggling against the odds in a healthcare economy that has neglected them and the people they care for. Several influential national reports have highlighted deficiencies in service provision for older people with mental illness.

The Audit Commission's reports "Forget-Me-Not" (2000), and "Forget-Me-Not 2002" (2002) demonstrated a number of areas that required improvement. More worryingly, 2 years after the publication of the NSF-OP, national inspection reports by the Social Services Inspectorate (SSI) and the Commission for Health Improvement (CHI) in 2003 noted deficiencies in services for older people with mental illness:

### **SSI Improving Older People's Services: an overview of performance (Social Services Inspectorate, 2003):**

"This report identifies the improvements that are needed in services to promote independence, assessment and care management and commissioning of services. It also highlights areas that require urgent attention such as services for older people with mental health difficulties..."

### **"What CHI has found in mental health trusts" (Commission for Health Improvement, 2003a):**

"The NSF-OP (2001) includes a specific standard around mental health in older people with the aim that older people with mental health problems have access to integrated mental health services. However, the focus of policy, local priorities and the national performance indicators remain centred around adult mental health services."

"There is a lack of priority given to services for older people."

"The performance management of older people's services is immature and trusts have limited information to satisfy themselves that they are providing high quality care."

### **Report into matters arising on Rowan ward (Commission for Health Improvement, 2003b):**

"Within the health community, older age mental health services have not been a priority and are not mentioned in the local delivery plan. Responsibility and accountability for the quality of care is unclear. Service level agreements have not been in place. There is no agreed performance monitoring framework and very limited monitoring of the quality of services by the trust, the joint commissioning team, primary care trusts (PCTs), the local authority or strategic health authority. Implementation and monitoring of the relevant national service frameworks is confused and ineffective."

In their reviews of progress of implementation of the NSFs for mental health and older people, National Directors highlighted this area as requiring particular attention:

### **Professor Ian Philp: “Better Health in Old Age” 2004**

“Mental health services for older people need further attention. The widespread introduction of the single assessment process will allow early detection of depression, dementia and loneliness in old age. Suicide rates in older people have fallen greatly in the last ten years but older people remain a high risk group, so the detection and treatment of depression in old age is a priority.”

“Age discrimination in mental health services needs further attention, so that services developed for working adults are available to older adults on the basis of need, not age and vice versa.”

“Mainstream primary care, intermediate care, hospital care, residential and other long-term care services all need to be able to accommodate the care of older people with mental health problems as these often co-exist with other problems.”

“Further investment in specialist old age mental health services is required to provide care for those with greatest needs as well as providing advice and support to mainstream services.”

### **Professor Louis Appleby: “The National Service Framework for Mental Health – Five Years On” 2004**

“This review has followed the remit of the mental health NSF – adults of working age. Comprehensive mental health care needs to go beyond this, to provide similar benefits for older people...”

The Healthcare Commission, with the Commission for Social Care Inspection (CSCI) and the Audit Commission, are carrying out a whole systems inspection of older people’s services. A single joint report is expected in March 2006. A series of 10 local inspections is being carried out to inform this report. Based on the local inspection reports published at the time of going to press, mental health services for older people are likely to be a focus of concern (see healthcare commission website: [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)). Future inspections will result from a performance screening methodology as part of a wider inspection framework. Age Concern and the Mental Health Foundation are carrying out a three year, UK-wide “Inquiry into Mental Health and Well-Being in Later Life” (see <http://www.mhilli.org/inquiry/>). Its aims are to:

- raise the profile of mental health and well-being in later life;
- involve older people and mental health service users with a view to empowerment;
- create better understanding and provide an evidence and knowledge base;
- influence policy and planning;
- improve services;
- serve as a good model of partnership and UK-wide working.

## **Recent developments of particular relevance for OPMH from the DH / other policy drivers**

In response to these various concerns, the Department of Health National Directors for Mental Health and Older People have joined forces to focus attention on this area. A joint statement, “Securing Better Mental Health for Older Adults” (Department of Health, 2005a), describes an intention to help prioritise mental health services both within the Department and in local service development through better inter-departmental working. A Programme Board for OPMH has been established, a service development guide ‘Everybody’s Business’ was published in 2005 (Department of Health, 2005d), and there is a programme of support through the Care Services Improvement Partnership, a governmental agency

that incorporates the National Institute for Mental Health (England) and the Change Agent Team, and supports the improvement of health and social care services. In addition from 2005-2006 for the first time national data collection will be supported for financial and service mapping. The White Paper Our health, our care, our say: a new direction for community services (Department of Health, 2006), indicates that commissioners and providers of services need to become familiar with the contents of Everybody's Business.

The Faculty welcomes these developments but is keen to see that good intentions are converted into action, and services on the ground receive adequate funding to meet the increased expectations.

## Shifting the balance of power

"Shifting the balance of power" (Department of Health, 2001b) is an attempt to decentralise authority and responsibility from government to local (patients and frontline staff) stakeholders. As part of this, Primary Care Trusts continue to be given greater power and control over resources and purchasing of services with a shift in culture from central control to enablement and support of service development at a local level.

This means that Department of Health will not issue such extensive must-do targets, and will not tightly performance manage development in OPMH services as it had done during the time of the implementation of the NSF for mental health. Even though we understand the flexibilities needed in tailoring local services, we believe it is valuable to issue indicative service levels for a standard service, as done in this document (see Appendix) to aid local service development. We hope that these may be used as the starting point for discussions on the local circumstances that may necessitate increasing or reconfiguring the resources required in different components of a specialist old age psychiatry service.

## Suicide

The Department of Health (2002a) produced a National Suicide Prevention Strategy for England. The strategy's aims were to support the Saving Lives – Our Healthy Nation target of reducing death rate from suicide by at least 20% by the year 2010.

The strategy has six overarching goals:

- To reduce risk in key high risk groups.
- To promote mental well being in the wider population.
- To reduce the availability and lethality of suicide methods.
- To improve the reporting of suicidal behaviour in the media.
- To promote research on suicide and suicide prevention.
- To improve monitoring of progress towards Saving Lives – Our Healthy Nation target for reducing suicide.

Suicide in older people is strongly associated with depression, physical pain or illness, living alone and feelings of hopelessness and guilt. Community surveys suggest that from 10 per cent to over 20 per cent of older people may be experiencing depression, but that only a fraction of these may be known to the GP or psychiatric services. (Department of Health, 2002b).

Community old age psychiatry services were seeing fewer than 25 per cent of older people with depression who later went on to kill themselves, and most of these people had not seen their family doctor within the month prior to suicide (Cattell and Jolley, 1995).

## Legislation

### Mental Capacity Act / Mental Health Bill / Bournemouth

#### Mental Capacity Act 2005

This statute will come into force in 2007. The Act takes as its starting point the presumption of capacity, providing legal definitions of "Capacity to make a decision" and "Best Interests". It will codify many of the current common law rulings on the medical treatment of adults who lack capacity. In certain situations health and social care providers will be required to consult with independent advocates before making decisions on serious medical treatment or long term care. It will introduce Lasting Powers of Attorney to enable people to nominate substitute decision makers for health and welfare matters, as well as the management of property and finances. It will extend the powers of the Court of Protection to make rulings and appoint managers where required, replacing the existing powers under the Mental Health Act. Decisions on medication for mental disorder and other treatments regulated by Part IV of the Mental Health Act will not be affected. The Faculty of Old Age Psychiatry is preparing guidance on the role of old age psychiatrists in relation to the assessment of capacity.

#### "Bournemouth"

The Bournemouth judgement, on a man with autism who was admitted and treated on the common law basis of necessity, was ultimately ruled upon by the European Court of Human Rights who found that in the absence of the use of the Mental Health Act, HL's right to liberty and security had been violated. The Faculty of Old Age Psychiatry issued interim guidance to clinicians while awaiting a definitive response from the Government (<http://www.rcpsych.ac.uk/college/faculty/oap/Bournemouthfinalinterim.pdf>). The critical issues were felt to be in the definition of deprivation as opposed to restriction of liberty, and with regard to good practice in involving carers and next of kin in care planning. The issues regarding incapacity and deprivation of liberty would seem to be most relevant to care homes, where large numbers of people are at risk of being cared for without adequate consent or safeguards to ensure people's liberty being applied.

#### The Mental Health Bill

In 1998 the Government announced their intention to undertake the first comprehensive review of mental health law since the 1950s, taking into account developments such as the adoption of the European Convention of Human Rights. A draft bill was published in 2002 but was widely criticized, and a new draft bill was published on 8 September 2004. The Joint Parliamentary Committee on the Draft Mental Health Bill, advised by the Mental Health Alliance (which included the Royal College of Psychiatrists) produced its report in 2005 with many suggestions for amendments and the Government announced in March 2006 that they intend to produce a streamlined Bill, which will amend the Mental Health Act (1983) and introduce Bournemouth safeguards by amending the Mental Capacity Act (2005).

## Abuse / protection

The Rowan report (Commission for Health Improvement, 2003) and previous investigations into allegations of abuse have identified similar and known risk factors. It would appear that the NHS has not thus far been able to learn the lessons of previous inquiries, which suggest that a whole systems failure has contributed to maltreatment. The abuse of older people has its roots in the way we as a society view old age and people in later life. Each member of staff is responsible for his or her own actions. However, organizational and management factors will increase or decrease the likelihood of abuse occurring. Staff caring for patients who are seriously disabled psychologically need particular personal skills. Clinical leadership needs to be strong and visible with an understanding of the subtleties and complexities of the aetiology and manifestation of abuse.

The health select committee report on elder abuse (<http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/111/111.pdf>) recommended reviewing the frequency and effectiveness of the inspection of NHS establishments providing care for older people, raised concerns over training on elder abuse and over-prescription of medication as a method of managing care home residents, and recommended the Healthcare Commission and the Commission for Social Care Inspection attend to these areas in their regulation and inspection functions. The Healthcare Commission has committed to doing all it can to eradicate elder abuse.

## Reimbursement

The Community Care (Delayed Discharges etc) Act (Department of Health, 2003) introduced a system of reimbursement by social services departments to acute general hospitals for discharges that are delayed due to slow assessment or care coordination by social services. Although it was intended that this should be rolled out to mental health beds in due course, this has not yet happened. The result has been a diversion of social care resources away from those people with mental illness cared for in psychiatric hospital, to those without mental illness or those with mental illness occupying a general hospital bed. Significant numbers of mental health beds are thereby occupied by people whose discharge has been delayed: 13.3% of functional mental illness beds and 28.6% of organic assessment beds in a national survey by the Faculty of Old Age Psychiatry (Barker and Bullock, 2005). Psychiatric hospitals could be said to be looking after significant numbers of people with stable mental health problems, while being unable to admit people with more severe mental illness who are currently in general hospitals or in the community.

## Chronic disease management, long term conditions and care outside of hospital

There appears to be a welcome shift in health policy away from the access and capacity driven focus on the acute general hospital sector to community based care of people with longer term conditions.

A model was released in January 2005 to help care manage the most vulnerable people in the community (Department of Health, 2005b) with community matrons to case manage the most complex cases. However, even though the original chronic disease management policy documents referred to dementia as one such disease and older people with mental illness could lay reasonable claim to being some of the most vulnerable people in society, there has been little mention of them, with a focus on physical ill health such as diabetes, chronic obstructive airways disease etc.

Independence, Wellbeing and Choice (Department of Health, 2005c) was a consultation document setting out the Governments' vision for adult social care. Responses to the consultation are now being included in the preparation of a white paper on health and care outside of hospital, expected late 2005 / early 2006.

## New ways of working

The consultant has traditionally been seen to be 'responsible' for everything that happens in the catchment area served. This view is now being questioned and the roles and responsibilities of a consultant psychiatrist are being defined and refined by a national steering group looking at new ways of working in a multidisciplinary multi-agency context. It is likely that four domains of activity will be described –

- As a personal clinician.
- As a member of the team.
- As a medical manager/clinical leader.
- As a resource for the wider NHS.



The consultant is likely to be supported by non consultant career grade doctors, as well as trainees.

Specialist old age psychiatry services need to be able to provide holistic assessment and implement holistic care, and therefore the specialist team within which the consultant works will need the skills of many different professionals. These should include: nursing, medical, occupational therapy, psychology, social work as core members, with access to physiotherapy, speech and language therapy and dietetics amongst others.

Leadership within an integrated team is likely to be spread across different disciplines for different purposes, whether for operational management, clinical supervision or for medical responsibility.

# Components of a specialist OPMH service

## Underpinning themes

Standard 7 of the NSF-OP (Department of Health, 2001a) sets out a service model for a comprehensive OPMH service. Components of the service should include the following:

- Mental health promotion.
- Early detection and diagnosis.
- Assessment and treatment.
- Support for carers.
- Specialist old age psychiatry services, which will include acute admission and rehabilitation beds, day hospitals and memory clinics, domiciliary and outreach care, and out-patient / community clinics.

There is a range of ways in which services can be provided and this report cannot be prescriptive. Examples of local service delivery stories are available at <http://kc.nimhe.org.uk>. The Faculty recommends that planning should continue to be based on the population aged over 65 years in a given locality and should recognise that teaching, training and support are integral aspects of the work of a modern specialist service.

This report describes the components of specialist old age psychiatry services for older adults. Four underpinning themes running through all these components are:

- user involvement;
- sensitivity to ethnic diversity;
- support for carers;
- mental health promotion.

## User involvement

If a service involves its users fully in its decision making processes, the service will become better equipped to serve those users. Practical and meaningful involvement is not simple:

- time is needed to build up trust, a key factor in success;
- energy is vital as a variety of engagement mechanisms need to be deployed to ensure that as many people as possible have their voices heard;
- resources are essential: effective involvement has costs attached.

The Government's modernisation agenda sets out a requirement to consult and involve users and carers in improving and planning services. The NHS circular 'Patient and Public Involvement in the new NHS' supported by the National Service Frameworks (Department of Health, 1999; Department of Health, 2001a) and the White Paper 'Valuing People' (Department of Health, 2001c) all support that requirement; thus the views and choices of service users and carers will not only be at the centre of their own assessments and care plans, but will also feed into overall service planning and development.

## Sensitivity to ethnic diversity

The population of elders from Black and Minority Ethnic (BME) communities has increased from 97,430 (population census 1991) to approximately 250,000 (population census 2001), and continues to increase.

- The DH report "From Lip Service to Real Service" (2001d) recommends equal access for BME elders to services and that "councils should be planning to mainstream services either through ensuring all services can meet the needs of all people effectively without a fuss; or through sustained funding and support of proven local voluntary organizations and independent providers."

- Acute psychiatric services for BME elders involving assessment and treatment should remain within mainstream psychiatric services, with ethnic awareness and sensitivity emphasised by training staff in culturally sensitive issues (Royal College of Psychiatrists, 2001).
- Services providing continuing care in the community could be developed specifically for the appropriate user group.
- Efforts should be made to recruit a racial mix of multi-disciplinary staff members reflecting the population served.
- There should be increased involvement and commitment by all interested stakeholders including primary care to establish appropriate services for BME elders.

## Support for carers

The majority of the care of older people with mental illnesses is provided by unpaid carers, often family members, many of whom are older people themselves. By the time they come into contact with mental health services, carers may have developed physical or emotional health problems as a result of their caring role, and may also have experienced financial problems. The Carers (Equal Opportunities) Act (2004: available at <http://www.opsi.gov.uk/acts/acts2004/20040015.htm>) introduced three new measures:

- A duty on local authorities to inform carers of their right to an assessment (carers also have the right to an assessment of their needs, even if the person they care for refuses an assessment).
- A duty on local authorities when undertaking an assessment, to consider the wishes of carers concerning employment, training, education or leisure activities and to take these into account when providing services.
- A duty on PCTs, NHS trusts and foundation trusts, local health boards, local education authorities and local housing authorities to give due consideration to requests by the local authority to become involved in planning services to carers, or to provide assistance to individual carers.

Mental health services for older people should ensure that carers are provided with:

- Information about the mental illness concerned and the best way of caring for an older person with the illness.
- Information about how to access support through statutory and voluntary agencies.
- Signposting to sources of financial support.
- Advice to carers about looking after their own physical and mental health.
- Flexible respite care and support, including evening and weekend provision.

Mental health services should be aware of:

- Organizations which provide support to carers.
- The cultural diversity in their local population and the ways in which this may impact on caring.
- The role and status of carers from non-legally binding relationships, such as same-sex partners and 'families of choice' of older lesbians, gay men and bisexuals.
- The potential for abuse of older people with mental illness by their carers. Services should have training on identifying abuse and clear policies on how to handle suspected cases of abuse.

## Mental health promotion

Promoting mental health is as important in older people as in younger people, in all settings and throughout life. Specialist mental health services should:

- Promote positive attitudes towards older people.
- Facilitate the involvement of older people with mental health problems and their carers in the planning, design and delivery of services.
- Celebrate the contribution that older people have made and continue to make to their families, communities and society as a whole.
- Take a lead role with the local community and media in increasing the understanding of, and reducing the stigma associated with, mental illness in older people.
- Proactively identify risk factors which influence mental health in later life, and ensure that practical support is made available.
- Promote healthy lifestyles .
- Take the opportunity when people transfer into specialist older people's services to explore engagement in meaningful activities and identify sources of ongoing support, if needed.
- Support older people and carers after the diagnosis of a long term mental illness to make long term plans.
- Ensure that older people with mental health problems and carers have access to benefits advice.
- Ensure that family and informal carers receive practical and emotional support to protect their own physical and mental health.
- Encourage the maintenance of social networks for older people with long term mental health problems.
- Ensure that day care and residential settings provide a range of stimulating activities both in groups and on a one-to-one basis.
- Provide expert advice on the design and development of the built environment for older people with mental health problems.

# Components of a psychiatry service for older adults

Components of a specialist old age psychiatry service will include:

- a specialist community mental health team for older adults;
- community/ out-patient clinics;
- memory assessment services;
- a day hospital service;
- alternatives to in-patient care;
- in-patient beds;
- provision of continuing care in a range of settings.

## Community Mental Health Team for Older People

The aim of a community mental health team for older people (CMHT-OP) is to provide integrated assessment, care planning, psychiatric treatment, care co-ordination and follow up to older people with mental health problems in the community. This will include working with people, their families and carers in their own homes and in other community settings, including residential and nursing care, and acting as a gateway to other services. Good practice will involve the identification of a key worker and regular review.

**Range of models in use:** There are three main variables in models of CMHT-OP (Bedford, personal communication):

- source of referrals to the team (ranging from consultant old age psychiatrist only, to open referral);
- multidisciplinary nature of the team (ranging from CPNs only, to health and social services multidisciplinary staff);
- skill mix (in larger teams). Smaller teams tend to have E grade nurses and above, whereas larger teams are more likely to include lower grade nurses, who may not do the initial assessment but can supervise an agreed care plan.

Team styles can be described as follows:

- Consultant referral teams: these teams only accept people referred by the consultant (usually because the team is small and is perceived to have insufficient resources for open referral). The system depends on the consultant acting as a gatekeeper and only referring people with more complex needs to the team. This model requires that the consultant psychiatrist within the team carries responsibility for large numbers of patients and other professionals are less autonomous. It is anticipated that this style of working will lead to continuing workload problems for psychiatrists.
- GP referral teams: these teams take referrals from any source, but with the proviso that each is agreed to be appropriate by the person's GP. Consultants may be consulted by team members regarding individual patients or know nothing about them, in which case medical responsibility remains with GP. Thus responsibility for individual patients may be distributed amongst members of the team. The consultant old age psychiatrist is therefore directly responsible for fewer patients and, in theory at least, is freed up to concentrate on high risk or complex cases. The consultant's relationship to other team members is that of a consultant and other professionals are more autonomous in this model.
- Multidisciplinary health teams ie teams which include several health disciplines. Benefits of this model may include closer multidisciplinary working, a more comprehensive service, better coordination, improved efficiency of assessments, less duplication (for example, sometimes referral to another professional is avoided through discussion at the team meeting).
- Multidisciplinary combined social and health care teams. This model covers a range of degrees of collaboration, from very little at one extreme, to shared base, joint management and full integration at the other. Benefits include better coordination of services, more flexible service response and

more rapid response in an emergency. Access to a social worker specialising in elderly mental health improves the service further. Potential drawbacks of the model include different management styles and approaches between health and social services, and the impact of changes in one organization on the other. Some integrated multidisciplinary teams have been dissolved for reasons which may include conflict over resources and other subtle disputes, regarding issues such as whether CPNs should do financial assessments. Non-integrated teams, which have close stable relationships with a social worker, might achieve similar results with more stability over time.

**Access:** A single referral point is good practice and secretarial cover should be sufficient to minimize the use of answerphones. Speed of response is an important factor: teams need to be capable of responding to crises within four hours or less. Routine referrals should normally be seen within two to three weeks. Most old age psychiatry services aim to see the majority of people referred in their own home, and appointments made by telephone allow for flexibility and negotiation over appointment times. Once initial contact has been made there should be easy progress through the care pathway without delays for care packages to be set up or day care initiated. Arrangements with social services should allow for care packages to be set up within 24 hours in a crisis in order to prevent admission to an institution. Non-urgent care packages should normally commence within 2 to 4 weeks. General and community psychiatry services have developed home treatment teams and crisis intervention teams over recent years. These service options need to be available to older as well as younger adults, but importing the younger adult model unchanged into older adult services, or making a token number of places available within teams which are staffed to provide a service to younger adults may not be the best approach, and some areas are looking to develop the CMHT-OP to provide home treatment and crisis intervention. Other areas have crisis intervention teams in general and community psychiatry which also support older people.

## Community / out-patient clinics

Some older people may be happy to be seen in a traditional hospital based out-patient clinic, but in many services most patient contact will take place in the community using a community clinic model (Benbow, 1990). In addition there may be specialist clinics eg:

- clinics carried out jointly with geriatricians;
- memory clinics (see below);
- clinics carried out in GP surgeries, day centres, nursing or residential homes;
- clinics specialising in psychological therapies eg family therapy (Benbow and Marriott, 1997).

## Memory Assessment Services

Memory assessment services aim to provide early diagnosis, treatment / management (psychological and social as well as pharmacological) and aftercare for people with dementia and their families. This will involve:

- making the diagnosis of dementia;
- explaining the diagnosis to the person with dementia and any carers, giving information about help and support that are available;
- giving advice about prognosis and the options for packages of care;
- providing ongoing advice and support as necessary;
- making appropriate referrals to help with fears and worries, distress, practical and financial issues that may affect the person with dementia and their carer;
- providing psychological and social interventions for people with dementia and their carers to provide support, to enable understanding and to build coping strategies for behavioural and psychological symptoms;

- providing pharmacological treatment for cognitive impairment and those behavioural and psychological symptoms that are severe, disabling or resistant to non-pharmacological approaches (including depression and psychosis); and
- following-up and reviewing those people who are receiving treatment.

**Range of models in use:** In 1993 a survey identified 20 memory clinics, largely offering a multidisciplinary specialized hospital-based assessment service (Wright and Lindsay, 1995). By 1999-2000 58 active memory clinics were identified in a second survey (Lindsay et al, 2002), over a quarter of which were partly or wholly based in the community. The growth in memory clinics is thought to have been stimulated by the licensing of anti-Alzheimer drug treatments which moved the use of these drugs into mainstream clinical services after NICE published guidance in 2001 (NICE, 2001). Since then the concept of 'memory clinic' has extended to a heterogenous range of service models, with a less academic, more service orientated focus. They are not only closely associated with anti-dementia drug treatments, but also with psychosocial interventions: over half of the clinics surveyed offered memory training and anxiety management. Memory clinic development has also probably been driven by a need for services for people with younger onset dementia syndromes.

Memory clinics are a way of reaching people with mild dementia for early intervention. Recently established clinics are generally smaller, with less of a research or training focus, and are more likely to be part of a conventional OPMH service rather than geriatric, neurology or academic services. Memory clinics have continued to expand over the last five years but many of these very recent services may be re-badged out-patient clinics designed to manage follow-up of those people initiated on anti-dementia medication.

The three main potential criticisms of the traditional memory clinic model are:

- secondary care focus (but there are now clinics based in primary care, and most successful memory clinics have moved towards home-based assessment of people with dementia rather than a hospital-based service);
- lack of integration with local health, social and voluntary services (but successful clinics often have close reciprocal links built into their operation);
- narrow focus on pharmacological treatments and on people with Alzheimer's disease only (but broad-based intervention is readily included in the service remit to ensure that comprehensive care and support is provided for people with dementia and their families).

It may be useful to use the term **memory assessment service**, rather than memory clinic, for integrated community-based services provided as part of a comprehensive package of mental health care for older people.

## Day Hospital

Day hospitals play an important role in the assessment and management of people living in the community and the rehabilitation of patients suffering from acute and severe mental illness, who are recently discharged from hospital.

**Range of models in use:** The provision of a day hospital offers additional choice for patients, with ready access to a range of disciplines without the need for overnight stays or relying on one member of the community team's ability to recognise when other expertise is required. They provide:

- intensive and rapid assessment and management;
- longer-term support of a small minority of patients with complex and chronic problems;
- provision of respite and carer support in times of need;
- an environment for therapeutic group work and other psychological treatments.

There is a developing trend for day hospitals to provide domiciliary 'out reach', supporting community mental health teams in the management of acute and complex cases in the community. This should be particularly valuable for the management of crisis in the community, the maintenance of high-risk patients and those suffering from behavioural disturbance or requiring long term, intensive engagement with mental health services. Each patient should have a specific care plan based on a comprehensive assessment of needs. Day or sessional attendance should be available, catering for the specific needs of the individual. The day hospital should have an agreed philosophy of care, operational policies and evidence of quality improvement through clinical audit. Generally, day hospitals have separate days for people with a functional illness and for those with a dementia, as this seems to work better. Day hospital services should complement the day care services provided within a given locality. Close liaison between day hospital and day care is essential, including equitable transport and costing arrangements, and some day care/ day hospital services are integrated health and social care resources. There should be a range of day care options available to a community provided by health, social services, private or voluntary agencies. Some provide the base for other services eg memory assessment services, psychological treatments.

## Provision of Psychological therapies

People with mental health needs in later life (including those with an organic brain disorder) will need access to a range of treatments in the various settings where services are delivered, ie within the community (including residential and nursing care), in-patient, day hospital and other services. A particular issue in all these areas is the provision of psychological treatments which are often underdeveloped.

The purpose of the service is:

- To provide a comprehensive range of psychological treatments to older adults on an equitable basis to that available to adults of working age. This marks the end of discrimination on the grounds of age and fulfils a key principle of the NSF-OP (Department of Health, 2001a).
- Such a service should address the complex and particular psychological needs of older people with mental health problems who have difficulties in negotiating later life; especially those facing loss, clinical depression, cognitive impairment, physical illness, isolation and poverty.

**Range of models in use:** An integrated mental health service for older people will offer psychological treatments as an essential core function, separately from, or supplementary to, other treatments such as pharmacotherapy, and across the full range of psychiatric diagnoses, including dementia. These will be provided in a variety of settings: outpatient clinics, day hospitals, in-patient wards, residential/ nursing homes or in people's homes. Psychological treatments will be available to older people in the general hospital, funded if necessary by the acute hospital Trust. Treatments will range from supportive counselling through to more specialised ones such as CBT, group therapy and family therapy. Choice will be an important factor along with suitability. Using the Single Assessment Process people will, if necessary, be able to be cross-referred to the relevant specialist. In line with Clinical Governance, supervision arrangements will be robust.

The service flows from the growing evidence base for psychological treatments for older people and reflects the conclusion of the NHS Executive's (1996) review that there is no evidence to suggest that older people benefit less than do younger patients. From the user perspective, a recent survey indicated that psychological approaches to help were what older people missed most. (Evans, 2004). Users are not the only people to benefit from a holistic and individualised care plan, within which psychological treatments form an essential aspect: staff morale is higher where there is a cohesive and divergent range of treatment options, thus aiding recruitment and retention.

Best practice suggests that the majority of non-specialist psychological treatments will be provided by a multidisciplinary team (MDT) consisting of psychiatrists, mental health nurses, allied therapists, “Admiral” nurses, social workers and trainees from each discipline. This team will be supported by a fully operational psychology service and have a close working arrangement with a specialist Psychotherapy department; offering individual/group/family therapies from a range of cognitive-behavioural, psychoanalytic and systemic theoretical backgrounds. Psychotherapists will also offer supervision to members of the core MDT.

## Alternatives to in-patient care

### Intermediate care

Intermediate care is a developing concept in health and social care, which may offer alternatives to in-patient hospitalisation. Originally it developed in response to the burgeoning demand for acute hospital services, with a high proportion of acute hospital beds being occupied by older adults. Despite a generous national allocation of £900M in the NHS Plan (Department of Health, 2000), intermediate care funding largely by-passed older people with any form of mental illness. Planners seemed to assume that people with dementia would not possibly benefit from a rehabilitation approach, and people with depression would pose unmanageable risks in community units – and that both groups would stay longer than the six week limit initially suggested.

The British Geriatrics Society (2001) has defined intermediate care as ‘delivered by those health services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team’. The development of intermediate care has offered the opportunity to explore a range of options for flexible community assessment, treatment and support.

Intermediate care is highly relevant to older adults with mental health needs and the services caring for them. In the past this group has commonly been excluded from access to intermediate care, but this is now recognized to be unacceptable: older people with dementia and other mental disorders must have appropriate access to intermediate care whether or not they have concurrent physical illness. There are a range of ways in which this can be done, eg. by setting up specialist provision, by ensuring close links between specialist OPMH service and generic intermediate care services, and by placing mental health staff within generic intermediate care services. To some extent the model developed in any locality will depend on what other services are available.

**Range of models in use:** Standard 3 of the NSF-OP states that it should provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. The two main drivers of developing intermediate care services have therefore been:

- Prevention of admission, eg;
  - home-based respite services;
  - assertive in-reach/out-reach projects;
  - flexible, and rapid access to intensive home care;
  - provision of specialist home care/community support;
  - access to specialist community nursing.
- facilitation of early discharge, eg;
  - liaison services which work across the interfaces of care;
  - rapid easy access to short periods of post-discharge intensive home support.

## In-patient Care

Old age psychiatry services need in-patient beds for the assessment and treatment of older people with a range of diagnoses who cannot be cared for in the community. A small proportion of these people will be detained under mental health legislation for assessment or treatment. The ward will normally offer a few short stay beds for people, often with behavioural problems, whose needs cannot be met in other respite services.

In addition a small proportion of people will need continuing NHS care which might constitute part of in-patient bed provision, alongside assessment and treatment beds for people with organic and functional illness in late life.

**Range of models in use:** The main distinction in terms of in-patient care is between people who have an organic brain disorder and those with so-called functional disorders, the most common of which is depressive illness. The provision of separate in-patient beds for these two groups is regarded as good practice (Audit Commission, 2000: Audit Commission, 2002). In practice, however, the distinction between organic and functional illness is often neither clear nor absolute, and many people may have both. Flexibility and tolerance is needed to accommodate the varied and changing needs of very ill older people. The ward environment should also reflect that, although this is a clinical area, it is also likely to be the patient's home for a variable period of time, and attention needs to be given to all aspects of emotional, psychiatric, physical, social, spiritual, and cultural wellbeing. All staff need to be able to imagine what it may be like to be one of their patients on the ward.

It is inappropriate to care for older adults with complex needs on wards for younger adults (Audit Commission, 2002): this could place them at risk and deprive them of the specialist nursing, medical and other care that they require.

In-patient old age psychiatry wards will have access to and links with other investigative, treatment and management services, alongside which a palliative model of care should operate for people with advanced dementia. 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 team will have the skills to manage behavioural and psychiatric problems; to communicate with people with cognitive impairment; to provide adequate nutrition and assistance with eating and hydration; to manage continence problems; to provide appropriate activity and levels of stimulation and to provide psychological treatments. They will have the knowledge and understanding to help patients and their relatives deal with a move to an alternative community placement or a long term placement, and to deal with issues around death and dying, including sensitivity to cultural and spiritual aspects of care.

Some people do not want a move away from familiar comforts and some families wish care to be provided at home. This may not always be possible: to meet the criteria for an admission the situation at home will often have been difficult and it may not be possible to care for someone safely, or to deploy sufficient appropriately trained staff, in the patient's own home.

The number of ward based nursing and care staff necessary for an in-patient service will be contingent on the dependency level and needs of the patient group. Occasionally someone may need an extra nurse to be brought in for one-to-one monitoring and care. Sufficient OT staff need to be employed to provide therapeutic activities 7 sessions per week and advice to nursing staff on appropriate occupation for the rest of the time. The ward will have access to senior and junior medical staff time, such that every patient is seen as necessary once a week on acute wards and three monthly on long-stay wards for an in-depth consideration of their further needs. Psychology time should be available for advice and interventions in managing emotional and behavioural difficulties and in supporting and training other staff in what is difficult work. The ward needs to have access to staff in other disciplines who have a particular interest and expertise with older patients and those in long-term care; for example a speech

and language therapist, pharmacist, dietician, physiotherapist, chiropodist and dentist. There need to be strong links with a multi-faith chaplaincy and also with outside organizations, e.g. carers groups, the Alzheimer's Society, Age Concern, local schools, faith centres, etc.

In order to have the option of rapid response to emergencies in the community it is unwise to aim for occupancy around 100% and there should be some permanent bed availability. This may be achieved by having some beds designated for brief admissions which could be used at short notice.

## End of life care

End of life care may take place in a range of settings, including in-patient wards, nursing and residential homes and in the community. The appropriate place for providing palliative care should be considered when an illness enters its later stages: there are hazards associated with admission to hospital or transferring patients between units. With appropriate medical support it may be possible to manage the dying process in the patient's own home (including care home) or on a psychiatric ward (often for individuals with an advanced dementia). For an individual who is dying, whatever the cause, liaison with geriatric or palliative care services should be considered to ensure appropriate management of pain, constipation and other symptoms.

Where an individual has not planned ahead for 'end of life decisions', clinicians should, in a sensitive manner, initiate discussion with the individual, assuming they are competent to make such decisions, with their health advocate in Scotland, or with family members about end of life decisions, e.g. assisted feeding and hydration due to complicating dysphagia, or cardiopulmonary resuscitation. If an individual is no longer competent to engage in such discussions, the views of family members may help clinicians formulate their management strategy, but they are not legally binding in England, Northern Ireland and Wales. In these circumstances it is the clinician's responsibility to act, in accordance with the law, in their patient's best interest. The decision-making process will be much easier if an individual has previously expressed their views, so that they may be taken into account, and if their family has been counselled over end of life decisions as the disease progresses to its palliative stage.

Living wills, if appropriately worded, can help health professionals manage the end of life in a humane and dignified way, when people are unable to give instructions regarding their wishes. In Scotland, a health advocate can undertake the same function. Often clinicians focus on the immediacy of the condition without discussing with the patient and their family the natural course of irreversible and progressive conditions: this can deny people the opportunity to consider such issues, whilst they are still able.

Where end of life decisions relate to co-morbidities other than the underlying psychiatric condition, the expertise of a geriatrician or other appropriate specialist should be sought.

## Continuing Care

NHS continuing care involves a package of care that is arranged and wholly funded by the NHS. Older people with mental illness should be entitled to access to NHS continuing care, with consistent access in every area of the country. Criteria for eligibility to NHS old age psychiatry continuing care are set locally, though according to national guidance (Department of Health, 2004. The Alzheimer's Society position statement on NHS Continuing Care, 2004, is available at [http://www.alzheimers.org.uk/News\\_and\\_Campaigns/Policy\\_Watch/NHSContinuingCare.htm](http://www.alzheimers.org.uk/News_and_Campaigns/Policy_Watch/NHSContinuingCare.htm)). To qualify for NHS continuing care the nature, complexity, intensity, unpredictability or deterioration of the condition is assessed as requiring constant or regular attention and supervision by a member or members of the multidisciplinary psychiatric team – often the requirement is for specialised nursing support. Consideration of the need

for NHS continuing care should be an ongoing part of assessment and care planning, not just at discharge from hospital.

Continuing care is for people with long-term complex health needs, often towards the end of their lives. Within an old age psychiatric service those needing this care are likely to have a diagnosis of dementia with behavioural or other psychiatric difficulties or to have a long-term functional illness with continuing management problems.

**Range of models in use:** Continuing care should be provided in a range of settings, for example in a private nursing home with NHS funded beds, in the patient's own home, or in an NHS unit. As is the case for non hospital provision, where old age psychiatry services provide continuing care beds, the need for continuing NHS care should be regularly reviewed, and alternative placement, whether at home or in 24 hour staffed accommodation, should be considered when continuing NHS care is no longer required. It is inappropriate to move someone who is so frail that the move itself might precipitate death, or when death is likely to be imminent.

Good continuity of care is an essential ingredient of quality care for older people with mental illness, no matter where or for what reason specialist services are involved. Continuity of care should be provided, and includes the involvement of as few different staff (consistent with the persons needs), maintenance over time of key relationships, continuity of information and seamless transfer between services.

Wherever care is provided, continuing care patients with long-term organic or functional illnesses have multiple difficulties best managed by staff from a range of disciplines working together. The team will have the skills to:

- manage behavioural and psychiatric problems;
- communicate with people who have cognitive impairment;
- provide nutrition and assistance with feeding;
- manage incontinence;
- provide appropriate activity and level of stimulation;
- help patients and their relatives deal with a longer-term placement and with issues around death and dying, including sensitivity towards cultural and spiritual aspects of care.

# Interface issues

Specialist services will need to address a number of interface issues, including interfacing with:

- geriatric medicine;
- the acute hospital;
- general and community psychiatry;
- primary care;
- residential and nursing homes;
- social services;
- voluntary agencies.

Provision of specialist services across these interfaces will have implications in service design.

## Interface with geriatric medicine

The management of dementia, depression and delirium is important in the treatment and care of older people in acute, rehabilitation (including intermediate care) and out-patient settings, so training in old age psychiatry is crucial for trainees in geriatric medicine (Forsyth, 1992: British Geriatrics Society, 1997). Trainees in both geriatric medicine and old age psychiatry should undertake training in the sister specialty: this is good practice, and should be mandatory, for accreditation for higher professional training. The relationship between the specialties should be a partnership based on trust and mutual understanding. Revalidation for geriatricians should include evidence that they have kept up to date with the psychiatry of old age (British Geriatrics Society, 1997). Mutual confidence requires understanding of both disciplines. The presence of a geriatrician as an additional member on the appointment panel for an old age psychiatrist, and vice versa, should be the norm (British Geriatrics Society, 2004).

'Liaison' means a link, connection, cooperation or association: all these nouns should describe collaborative working between colleagues in old age psychiatry and geriatric medicine. Ease of contact (verbal, written, telephonic, or electronic) is essential and beneficial to services and patients. Mutual education of consultant colleagues, trainees, nursing staff and therapists is also fundamental to good services.

If a geriatrician has a grounding in old age psychiatry, then psychiatric liaison should involve a senior opinion, via consultant old age psychiatrist, specialist liaison nurse or Specialist Registrar with consultant supervision as required. Speedy systems of cross-referral need to be established to expedite a patient's passage through the care management process. Referrals should specify the problem or question that needs addressing, the urgency of the matter, what has been tried already and why. A dedicated liaison team can provide continuity of care and a quick and reliable service, as well as continuing education to the transient population of junior doctors and nurses.

Old age psychiatry services should be as close as possible to the geriatric services in order to facilitate close working. Ideally they should have a presence in the acute unit, either in a shared ward or separate facility. Older people occupy two-thirds of general and acute NHS beds and up to 60% have a mental health need. This mental health problem predicts a poor outcome for the patient. Better management of these problems improves outcome and has major implications for the care of older people, the efficiency of acute hospitals and the utilisation of health and social care resources. Any strategy to improve the performance of acute hospitals (including the business plan for geriatric medicine) is seriously deficient if it ignores the mental health needs of older people. True liaison between the two specialties must encompass both clinical and management issues. Thus, geriatricians and old age psychiatrists have a dual responsibility in providing leadership to ensure that acute hospital trusts, OPMH services and commissioners of health and social care have clear plans to meet the mental health needs of older people in general hospitals, intermediate care and domiciliary support services.

Liaison cuts both ways – geriatricians must also be prepared to provide medical input to old age psychiatry wards. With appropriate medical support many medical problems may be manageable on psychiatric wards, thereby reducing the additional delirium and associated hazards associated with transferring patients between units.

## Interface with the acute hospital

### Liaison Old Age Psychiatry Services

The purpose of the liaison service is to work collaboratively with general care teams within general hospitals to improve general care skills, attitudes and knowledge about mental disorder through training and education, and to provide rapid access to a specialist mental health team to assist with the management of severe and complex cases. This incorporates functioning as advocates for older people with mental health problems, and promoting the routine assessment of mental health needs of all people admitted to the general hospital, leading to integration of physical and mental health care.

**Range of models in use:** The preferred model within a moderate or large general hospital involves a multidisciplinary liaison mental health team based in the general hospital, working proactively and collaboratively with general care teams and close links with geriatric medicine services. The provision of a shared care ward is an advantage. The service would cover all in-patient areas during normal working hours. Close links with community mental health services are essential.

Strengths of the model include easy access to mental health expertise, rapid response, access to multidisciplinary skills, integration with the general hospital, provision of education and multi-professional training, frequent review of patients on general hospital wards, link between general hospital and community mental health teams, collaborative working, proactive approach, improved detection of mental disorder and improved care of patients with coexisting physical and mental health problems.

Weaknesses of the model include the need to manage professional conflicts within the team (as all teams) and between the team and general hospital professional groups, effects of inadequate office space, lack of a 24 hour service, lack of continuity of care between hospital and community teams, pressures of recruitment, demands on staff, and use of different patient information systems. All of these can be overcome.

Resources required include adequate office space in the general hospital, electronic patient database, access to patient information systems for mental health and general hospital, pagers, telephones, fax, email, internet, photocopier and other office equipment to support secretarial and administration activity, shared care ward (8-12 beds).

## Interface with general and community psychiatry

People who enter later life with established mental disorders (chronic schizophrenia, manic-depressive psychosis, brain damage or personality disorders) are likely to live within the community, often in hostels or nursing homes. They may have remained in touch with mental health services, but many will have dropped out of contact. In the past, OPMH services have commonly adopted a cut-off age criterion for entry eg age 65 and above. There may have been good arguments for this, for example when retirement occurred almost inevitably at a fixed age. Retirement is likely to become a more flexible transition, and a rigid age-related service boundary is likely to be increasingly inappropriate in both health and social services.

In 2002 the Royal College of Psychiatrists published a Council Report (Royal College of Psychiatrists, 2002) which aimed to ensure good practice within mental health services for people who have been under the care of working aged adult mental health services with an enduring or relapsing mental illness and are 'graduating' from general and community psychiatry to old age psychiatry services (Jolley et al, 2004). 'Graduates' is the term sometimes used to describe this group. Previous practice in many services has been to transfer 'graduates' automatically to old age psychiatry services on or around their 65th birthday. A key feature of the Royal College of Psychiatrists' guidance is that a person's 65th birthday should act as a trigger for reassessing their needs, and not a trigger for automatic transfer from working aged to older adult services. Assessed need will then guide the decision on which service is best placed to meet an individual's needs. An 'interface' document (Royal College of Psychiatrists, 2004), agreed by the Faculties of General and Community Psychiatry and Old Age Psychiatry aims to clarify this process.

## Interface with primary care

Most people with mental health problems in late life are never seen by a specialist service. Many remain unrecognized despite contact with primary and social care services. Nevertheless, family doctors are well placed to identify mental health problems of late life early, to provide people and their families with information, and to organise further investigation, treatment and support when necessary. When older adults with physical problems are seen by primary care professionals, this is an opportunity to assess and monitor a person's mental health, eg. family doctors screen people routinely for cardiovascular disease and this group is likely to be at high risk of developing a vascular dementia, so adding a cognitive test to the cardiovascular assessment may provide early detection of cognitive problems. An established relationship with a primary care professional may also help an older person accept the need for referral to social services, voluntary organizations, or specialist services.

The NSF-OP (Department of Health, 2001a) required PCTs to ensure that every general practice was using a protocol agreed with local specialist services for the diagnosis, treatment and care of older adults with depression or dementia by April 2004. Physical investigations and cognitive testing instruments are included in many protocols for the treatment of people with Alzheimer's disease, and facilitate both early detection of cognitive impairment in primary care and rapid access to anti-dementia drug treatment where appropriate.

Some services are developing new models of linking in to primary care. These include:

- CMHT nurses who link with specific practices.
- Regular formal meetings between secondary and primary care staff.
- Consultant led clinics held in primary care.
- CPNs who work across the primary care/ secondary care interface.
- Memory clinics held in primary care.

## Interface with residential / nursing homes

Estimates of the numbers of older people in residential and nursing homes with mental health problems vary: the proportion of people with dementia in care homes varies between 33% and 66%, and for people with depression (mostly undiagnosed and untreated) it is estimated that the proportion in care homes is about 40% (Audit Commission, 2000). Some will be in specialist homes, but the majority is in non-specialist care homes for older people. Whichever sort of home, support from specialist services may help prevent admissions to hospital or transfer to another home, and may promote better care practice and boost staff confidence and morale.

Links with Community Mental Health teams (CMHTs) can be vital. (For further information about CMHTs see page 22). A named qualified specialist mental health professional linking between the CMHT and each home can be especially helpful, building relationships and mutual trust. They can provide prompt assessment in order to identify key problems and to propose ways to resolve them. They can offer appropriate support and work with residents on specific care programmes, and they can provide regular training and support to staff.

Some areas have developed this further and have established assertive in-reach teams to work with care homes. These teams link with specific homes in a locality, providing support in the care of individual residents and more widely to the staff group of each home. Assertive in-reach teams are often jointly funded by a combination of social services, primary care trust and/ or mental health trust.

Similarly, liaison services can link between hospital and care homes by supporting staff in hospital to facilitate the discharge process. (For further information about liaison services see page 31).

There are protocols which describe good practice in moving older people with mental health problems from one care setting to another (see for example [www.changeagentteam.org.uk/\\_library/docs/MentalHealthInOlderPeople/moving\\_pwd.pdf](http://www.changeagentteam.org.uk/_library/docs/MentalHealthInOlderPeople/moving_pwd.pdf)).

Old age psychiatry services may be involved in training and education with care homes in their locality. Training is a major area of need and is important to avoid staff reliance on medication. It is also essential that homes have personal information about all residents and that staff have insight into the experience of living in care.

## Interface with Social Services

It is vital to ensure that the interface with Social Services is seamless, whether within integrated or jointly managed health and social care services, or via jointly agreed protocols.

Social Services have statutory responsibilities for information, advice, assessment, care management and provision of social care and support, monitoring and review of services.

Older people with mental health problems, following diagnosis, often experience a long wait for transfer to specialist services. An information, advice and support service from the voluntary sector (Age Concern, Alzheimer's Society) can help provide vital face to face support and advocacy during this period.

Intermediate Care services are designed to provide short-term health and social rehabilitation for up to six weeks free of charge. Local protocols should be in place to ensure open access to intermediate care for older people with mental health needs. This is particularly important for the domiciliary elements of these services.

Similarly, crisis resolution services, along the lines of those designed for working age adults, should be available for older people with mental health needs, especially those with functional mental illness.

Assessment of need, within the Single Assessment Process, should be initiated following first contact with professionals from health or social care services. Health checks/ screening for early signs of mental health need should be an integral part of overview assessment processes.

Community care assessment may also take place during contact with acute hospital services, community care teams or specialist older people's Community Mental Health Teams. The process and outcome should be identical in each area of service and should lead to seamless provision of identified health and social care services to meet identified need.

Social workers (and social care support staff) should be an integral element of Community Mental Health Teams. Ideally these Community Mental Health Teams will be jointly managed working to agreed integrated Care Programme Approach/ Care Management systems. All services should work within the local Fair Access to Care Services (FACS) eligibility criteria (Department of Health, 2002c). It may be that locally negotiated eligibility criteria for specialist community mental health services are also in place.

Social Services have a responsibility to ensure services are available to meet assessed need. This may be through Local Authority provision of residential, day and domiciliary care services. Often it is provided through commissioning and purchasing independent or voluntary sector provision, in people's homes, in day services or in residential and nursing homes.

Regulation of social care services is the responsibility of the Commission for Social Care Inspection (CSCI) whilst Local Authority Social Services also retain the responsibility for the quality of the service via contract monitoring and care management reviews at least on a yearly basis.

An important element of Social Services strategic responsibility is to ensure adequate provision in a locality to meet projected need. This ideally takes place within joint/ integrated Commissioning Strategies agreed with the local Primary Care Trust.

The Carers legislation places a statutory responsibility on Local Authorities to ensure that carers who provide substantial care for a service user are informed of their right to assessment of need and support services to meet identified needs.

'No Secrets' guidance (Department of Health and Home Office, 2000) placed a responsibility on Local Authority Social Services to establish Multi-agency Adult Protection Procedures which ensure agreed risk assessment/ risk management arrangements designed to protect vulnerable older people from all forms of abuse or exploitation. Specialist old age psychiatry services should have clear and easy access to procedures, practice guidance and multi-agency training in this context.


## Interface with voluntary agencies

Voluntary agencies aim to bring together people with mental health problems including those with dementia, their carers, family and friends, health and social care professionals, researchers, scientists and politicians to work towards improving the lives of all concerned. It is vital that OPMH services link closely with voluntary agencies which are active within their locality.

**Range of models in use:** Voluntary sector organizations may provide:

- members / supporters working through a network of branches or affiliated groups throughout the country;
- helplines;
- information and advice on services, caring, legal and financial matters;
- independent advocacy services;
- innovative services and projects to meet identified needs;
- funding for research;
- support for families in financial need;
- courses and conferences;
- materials for professionals and care service providers;
- day, home, and residential care services.

In addition they may campaign for the needs and interests of people with mental health problems and their carers to be recognised in improved health and social care and for greater public awareness and will normally involve patients and carers in all aspects of work.



The voluntary sector has a strong body of knowledge and experience about mental health problems. It can offer an extensive network of peer support to people with mental health needs and is able to advise on best practice. An additional strength is that the sector can be innovative in new methods of support and service delivery and is independent from government and commercial interests, which fosters trust.

However, voluntary sector models may experience challenges in delivering consistent quality support across the country. The availability of short term funding streams may lead to service closure and reliance on recruitment and retention of volunteers can bring difficulties.

# Special issues / groups

Special issues/ groups include:

- younger people with dementia;
- people with a learning disability;
- prisoners.

## Services for younger people with dementia

It is well recognised that younger people with dementia, that is those people presenting with dementia below the age of 65, and their carers, frequently fall between existing health and social care services. A dedicated service enables them to receive the care they deserve. Old age psychiatrists are often best placed to undertake the co-ordination of the management of this group, unless other specialities such as neurology, or psychology have a local lead role. Prevalence rates of dementia in younger people are estimated at between 0.6 -1 per 1,000 population between ages 40-65. New services are likely to experience referral rates of 2-3 per month per 500,000 population. Established services may receive 4-5 referrals per month. Not all of these will be suitable for the service. It is good practice to aim to assess newly referred people within 2 to 4 weeks but extensive investigation, and pre and post diagnostic counselling, may be required.

The identification of a named clinician and rearrangement of current resources enables:

- identification of patients already known to services but not managed in a co-ordinated manner;
- early assessment and diagnosis;
- efficient use of available resources;
- development of a streamlined pathway to care, which local referring agencies are familiar with;
- development of local resources and expertise;
- raising of awareness of the needs of this group.

People with dementia should be involved in the planning of services whenever this is appropriate. In addition, carers and voluntary organizations dedicated to patients with these disorders should be involved at every level. Services could consider developing their own local forum involving key stakeholders, users and carers. These have proved extremely helpful in raising awareness and developing services. Services should also consider making links with an appropriate regional forum. These have improved communication between disciplines and professions, as well as general awareness of younger people with dementia regionally and nationally. Regional forums meet regularly, usually on a quarterly or six-monthly basis, and allow service providers or interested individuals to meet with others, share experience and good practice, and learn about developments within the region as well as nationally. Contact can be made through the Alzheimer's Society.

**Range of models in use:** There is a range of service models from those services with a dedicated full-time consultant post in the subspecialty through services which enable greater coordination of services for younger people with dementia, and those which rely on the development of community-based teams to provide an essential focal point for the care and management of this group.

There should be good links to neurology. This will assist in earlier, accurate diagnosis, referral to appropriate services and long-term management. Easy access to the investigation of genetic factors and to genetic counselling is essential. Collaboration with medical genetics, neuropsychiatry, liaison psychiatry, rehabilitation and learning disabilities is essential for establishing accurate diagnosis and dovetailing of services. Collaboration also needs to be established between substance misuse services and the dementia service for younger people.

Initial developments should focus on the organization of diagnostic and community services, to provide flexible and individualised care plans. Specialised services should be developed only where traditional services are found to be deficient. After the basics have been established, the development of all essential parts of a comprehensive service should follow. Access to a day hospital, respite care and long-stay provision are required. Community-based services, such as community support workers, may also be considered appropriate. There should be a named individual at the level of the commissioning authority with responsibility for these developments. The recommendations set out here are in addition to services currently available for people with dementia. The Royal College of Psychiatrists and Alzheimers Society have produced a joint report on services (Royal College of Psychiatrists, 2006).

## People with a learning disability

There are about 1.2 million people with mild or moderate learning disability in England and about 210,000 people with severe learning disabilities. Approximately 25,000 of these are over 60 years old. Most psychiatric disorders are more common amongst people with learning disabilities than amongst the general population. Anxiety and depression are generally reported to be at least as prevalent amongst people with learning disabilities as in the general population; people with Down's syndrome have an even higher prevalence (Cooper, 2003). The risk of developing dementia is high amongst people with Down's syndrome with an age of onset 30-40 years younger than the general population. About 5% of the general population aged over 65 years are affected by dementia but for people with Down's syndrome aged between 60 and 69 years the corresponding figure is around 55%. The life expectancy of people with Down's Syndrome is increasing so this is a growing concern (Puri et al, 1995).

Three policy documents apply to services for older people with mental health problems who have a learning disability. They are 'Valuing People: A new strategy for learning disability in the 21st Century (Department of Health, 2001b), the Mental Health National Service Framework (Department of Health, 1999) and the NSF-OP (Department of Health, 2001a).

Valuing People emphasises social inclusion and states that people with learning disabilities should use the same services, resources and facilities as the rest of the population. It sets out some important principles which apply to older and younger adults with learning disabilities:

- have the same rights as everyone else;
- have the right to choices about their life, like everyone else;
- want to be supported to be as independent as possible;
- want to be included in their community.

A person centred approach is the foundation of good individualised planning, commissioning and provision, and joint working and partnership are the keys to effective services for older people with mental health problems and learning disabilities. In order to provide individualised services to older people with mental health needs and learning disability both learning disability services and OPMH services need to be prepared to work differently.

**Range of models in use:** Key features of effective services will include the following:

- Better co-ordination between agencies. Older people with mental health problems and learning disabilities may have complex needs and may need to draw on expertise from a number of areas including specialist mental health, OPMH, generic dementia services, and learning disability services.
- Protocols covering care pathways, roles and responsibilities, access and support arrangements agreed jointly by relevant agencies.
- Joint training between agencies, staff and professionals.

- Better financial planning and commissioning for the provision of adequate and appropriate person-centred services.
- Better planning for transport services.
- Better planning for aids and adaptations.
- Flexibility and planning for routine medical investigations.
- Close collaboration in primary care, involving GPs, primary health care teams, OPMH services and specialist services for people with learning disabilities.
- Involvement of older people with mental health problems and learning disabilities in the planning, delivery and monitoring of services.
- Recognition of, attention to, and ongoing support for family carers and their needs.
- Attention to and recognition of the needs of people from minority ethnic groups.
- Development of joint working practices between learning disability, mental health and older people's services: in some places this may involve the formation of joint teams.
- All people with Down's syndrome should be offered routine individual assessments of cognitive functioning in early adulthood to facilitate the earlier diagnosis of dementia.
- Information relevant to mental health problems in late life should be available in accessible formats.

## Prisoners

From 2006, Primary Care Trusts will have responsibility for the provision of health care within the prisons in their localities (HM Chief Inspector of Prisons, 2005). Currently there are over 1,200 older people in prison aged over 60, although many prisons have as few as 10 older prisoners and few have more than 50. It is generally accepted that older prisoners experience accelerated biological ageing and report higher levels of chronic ill-health compared with the general population: much of the literature uses the age of 50 to define older age. It has been estimated that 53% of older prisoners have a psychiatric diagnosis, and, of these, 30% have a personality disorder and 30% have depression (Fazel et al, 2001).

**Range of models in use:** There are some specialist units for older prisoners, but in-house health care in prison hospital wings relates primarily to physical health care and the needs of younger prisoners. Only the most secure prisons have comprehensive health services. There will inevitably be tension between providing fair access to appropriate mental health care and the restriction of liberty associated with imprisonment. The small numbers of older prisoners, their distribution across the prison estate, and the often short term nature of imprisonment mean that equitable and effective mental health care for older prisoners will require:

- Collaborative working between prisons and other bodies to ensure prisoners have access to the range of care available to the wider community, and to health-promoting activities.
- In-reach of specialist multi-disciplinary old age psychiatry staff to provide specialist medical, nursing, psychological and occupational therapy services, including aids / adaptations and regular reviews of treatment and care needs.
- Training and education of health, social care and both existing and new prison staff.
- Attention to the physical environment and routines, which are currently better suited to younger, fitter prisoners.
- Inter-agency co-operation between prisons, probation, health and social services, relevant statutory and voluntary community agencies to support older prisoners whilst in custody and on return to the community.
- Joint development of standards and protocols for the assessment, care and management of the mental health needs of older prisoners.
- A prisoner Carers Scheme (like the prison Listeners Scheme) would involve training, supervising and accrediting selected prisoners in personal social care.

# Appendix

## Indicative service provision

It is difficult to give an exact figure for each and every service element, since the composition of any one service will be influenced by demographics and strengths and weaknesses in support services locally. In particular, consideration needs to be given to:

- a) areas of high socio-economic deprivation;
- b) responsibility for young onset dementia, liaison psychiatry and 'graduate' services, specifying how this responsibility is determined;
- c) effectiveness of social services and geriatric medicine services;
- d) services within the not-for profit-sector;
- e) population concentration/ travel time/ multi-centre services.

In practice service provision will vary widely and the following figures are therefore largely indicative. Argument could be made for greater or lesser levels of service elements based on strengths or weaknesses within other elements of the service or support services locally. When reliable results from the national service mapping are available it should be possible to benchmark against good quality services in comparable areas.

## Consultant

The advice for regional advisers in old age psychiatry is a target of a maximum population of 10,000 over 65s per 10 Programmed Activity (PA) consultant post (including 7 clinical PAs), and a post with more than 15,000 over 65s population is unlikely to be approved.

**Non consultant doctors:** 1 wte per 10,000 (this probably equates to 8 clinical sessions to allow for training)

## Community Mental Health Team Staff (per 10,000 over 65s)

Note: The following staffing is for a core CMHT. Additional resources will be required for psychological therapies and running a memory assessment service (see Clegg et al, 2000).

2.5 wte Community Psychiatric Nurses (trained)  
1.0 wte Support Workers or equivalent  
1 wte Occupational Therapist  
1 wte Social Worker  
0.5 wte Physiotherapist  
0.5 wte Clinical Psychologist  
1.0 wte Team Secretary  
CMHT Manager

There should be access to translation services, chiropody, speech and language therapy, dietetics and pharmacy advice.

## in-patient beds

Assessment beds:

The number of beds for acute care should be 1-2 per 1000 elderly persons but this may be adjusted according to the local resources eg availability of home treatment etc. For a service planning population of 250,000 this will equate to 40-80 acute assessment beds, no more than 20 per ward with ready access to geriatric medicine support and a range of investigative facilities. It is recommended that functional acute assessment beds should be separate from organic acute assessment beds and the ratio of bed numbers required is likely to be around 1 functional care bed to every 2 organic care beds. Where a service accepts responsibility for 'graduates' and early-onset dementia, the provision will need to be increased.

Continuing care and respite:

NHS continuing care eligibility criteria require all services to provide access to continuing care, whether at home or in 24-hour staffed settings. In many areas most continuing care beds are not within NHS.

Attention should be paid to:

- the assessment and criteria for admission to these beds;
- the process by which a decision about continuing care is made (which should always involve an old age psychiatrist when care is needed by reason of mental health problems);
- responsibility for ongoing monitoring of the persons care.

An important aspect of continuing care provided in care homes is the need for ongoing availability of, and access to, specialist OPMH services, and it is recommended that services specifically address this area of need and make clear arrangements for providing a liaison service.

Services providing care for younger people with dementia will require additional resources.

**Staffing & Resources required for a Day Hospital:** There is considerable variability in day hospital function and required staffing. The following guideline is a recommended minimum staffing level and excludes staff that might be associated with out-reach support, transport and specialist activities such as memory clinics and specialised therapies. These recommendations are derived from the World Health Organization standards of care and exclude staff relating to out-reach services.

Day Hospital places; 10-15 places per day for 10,000 people aged 65 and over.

For 20 patients per day:

- 4.0 wte Registered Mental Health Nurses
- 1.0 wte Occupational Therapist
- 0.5 wte Psychiatrist (including Consultant input)
- 0.5 wte Social Workers
- 0.5 wte Clinical Psychologist
- 1.0 wte Secretary
- 2.0 wte Support Workers.

**Staffing required for a Liaison Old Age Psychiatry Service:**

For a moderate sized general hospital (300-500 beds):

- 2.0 wte Registered Mental Health Nurses
- 1.0 wte Senior Occupational Therapist
- 1.5 wte Social Workers (ideally able to fulfil responsibilities of mental health legislation)
- 1.0 wte Support Worker or 1.0 wte OT Technical Instructor
- 2.0 dedicated weekly old age psychiatry consultant sessions
- 1.0 wte Medical Secretary
- access to clinical psychology (equivalent to 1 weekly session).

All senior staff need experience in older peoples mental health.

For a large (teaching) hospital (500-1000):

- 3.0 wte Registered Mental Health Nurses
- 2.0 wte Occupational Therapists (1 Senior 1 and 1 Senior 2 grade)
- 2.5 wte Social Workers (ideally able to fulfil responsibilities of mental health legislation)
- 2.0 wte Support Worker/ OT Technical Instructors
- 1.0 wte Medical Secretary
- 1.0 wte administration secretarial support
- 3 weekly dedicated consultant old age psychiatry sessions
- access to clinical psychology (equivalent to 2 weekly sessions).
- All senior staff need experience in older peoples mental health.

All teams should have the necessary requirements to allow training of juniors and students for all professional groups.

### **Staffing & Resources required for a Service for Younger People with Dementia**

These staffing figures relate to community developments:

A named consultant, usually an old age psychiatrist with extensive experience of working with people with dementia. For a total population base of 500,000 at least one PA or sessional equivalent should be allocated for planning, development and organization and a minimum of one PA or sessional equivalent for diagnostic and follow-up services. For smaller populations, collaborative arrangements may be necessary across providers

for a population of half a million or more, a specialist multi-disciplinary team (MDT) is justified, and provider units should be encouraged to create dedicated MDTs and services.

- 1.0 wte Registered Mental Health Nurse
- 1.0 wte Community Support Worker
- 1.0 wte Clinical Psychologist
- 1.0 wte Occupational Therapist
- 0.5 WTE Social Worker

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