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Community Mental Health Teams and Specialist Day Services for Older People: An Integrated Development

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Community Mental Health Teams, Assertive Outreach and Day Hospital for Older People: An Integrated Development Model

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Abstract

Study - Service re-design for older people with mental health difficulties is described, where the addition of an Assertive Outreach Team integrated with Day Hospital, Community Mental Health Teams (CMHTs) and existing in-patient facilities was implemented to decrease the reliance on hospital services and provide a greater emphasis on community intervention.

Method - Comparison of audit data before and after service re-design.

Main findings - Following implementation capacity for community contact increased from 48% to 66%. Bed occupancy decreased from greater than 100% to less than 61%. Assertive Outreach staff spent 55% of their working week in face-to-face contact activity compared to 34% in CMHTs.

Conclusion - Data indicate a shift in balance toward community oriented services. Further research is required to provide evidence this was as a result of implementation strategy and that service change resulted in more effective treatment.

Key words: Mental Health, National Service Frameworks, Older People, CMHTs, Day Hospital, Assertive Outreach, Service Design.

Introduction

In the last five years Mental Health Services for Older People have been challenged with shifting the balance of service delivery from hospital to the community, mainly through the creation of Community Mental Health Teams for Older People (CMHTOP). The resultant service re-design is presented, detailing both what influenced decision-making and the outcomes of service change 18 months after implementation.

Policy perspective

National Service Frameworks (NSF) outline the Government's key policies on Mental Health Services development in England. Reflecting typical service configuration, the NSF Mental Health (Department of Health 1999) targets working age adults up to age 65 and the NSF for Older People (Department of Health 2001a), though less arbitrary regarding a definitive age range, regularly refers to people aged 65 and over.

Both have in common a move away from relying on traditional hospital-based service delivery, with a greater emphasis on providing interventions in the community. For working age adults the NSF guidance is exclusive to mental health, whereas for older people, mental health is set within a more generic care context as one of eight standards and concentrates on two

diagnostic conditions, dementia and depression. Perhaps unsurprisingly the focus for Older Peoples Service development has been on meeting the objectives in the NSF Older People. However, a direct link is made between the two policies, albeit in little more than a sentence. Reference is given to other conditions such as schizophrenia advising that care packages should be made available for older people that are similar to those for working age adults.

Service design

The service changes recommended for working age adults, i.e. developing Community Mental Health, Assertive Outreach and Crisis Resolution Teams, were followed with comprehensive guidance on their component parts, target groups and potential outcomes (Dept. of Health 2001b, Dept. of Health 2001c). Within NSF Older People the recommendations are less explicit, outlining the development of "Community Mental Health Services" with advice on broader elements of service design and advocating closer working with Local Authorities.

With the possible exception of Memory Clinics, developed to support people receiving anti-dementia medication, where operational function is underpinned by an evidence-based intervention, targeting a distinct population and accompanied by clear outcomes (NICE 2001), service design for older people with mental health problems lacks unambiguous guidance on delineating the different functions of core service components.

For example, Day Hospitals merit little more than a paragraph in NSF Older People but are a significant part of older people's mental health services; a national survey revealed there were at least 354 facilities in England (Audini et al 2001). However, in the absence of clearly defined operational directives, it is difficult to ascertain how Day Hospital function differs from CMHTOP other than where the client is seen, i.e. in their home or day facility. Commonly, both have input from multi-disciplinary teams and both are intended as an alternative to in-patient care. The World Health Organisation suggest Day Hospitals have a clearly defined target group (WHO 1997) but there is no suggestion from any national guidance what this might be or how it might differ from CMHTOP. (Further information on Day Hospitals is available at www.dayhospitals.net.)

Only late in 2004 did the Department of Health support more detailed guidance, in a resource document for the development of CMHTOP (Lingard & Milne 2004). However, this did not provide any clear direction on differentiating CMHTOP from Day Hospitals, nor did it suggest developing additional community oriented teams such as Assertive Outreach.

Inter-professional working

Despite the potential ambiguity of how CMHTOP might operate in relation to other specialist mental health teams, it is clear that they should be multi-disciplinary, including nurses, social workers, doctors, therapists, psychologists, support workers and secretarial staff. However, this highlights another omission from national guidance, that of avoiding inter-professional conflict. For over a decade this issue has been well documented in Community Mental Health Teams for adults of working age,

resulting in uncertainty about team function, professional relationships and operational policy (Onyett et al 1994). Later studies indicated confusion about roles and responsibilities and the persistence of uni-professional cultures in the absence of a shared philosophy (Peck & Norman 1999).

The way forward?

Faced with pressure to develop CMHTOP, despite the absence of detailed guidance on how they should operate and uncertainty regarding the relevance of the NSF Mental Health, it became evident that a local strategy was required to address the issues of adjusting the balance of service, identifying target groups for teams and distinguishing operational function. This would also serve as a baseline against which change could be measured and further audit indicated, with the intention of generating local evidence where this was lacking in national policy.

Needs Assessment

Before re-designing services it was necessary to assess the potential need in the community served and consider this against what was currently being offered. There are a number of ways to carry out this exercise, some specific to mental health (Thornicroft & Tansella 1999). On this occasion a crude epidemiological methodology was employed, whereby studies of prevalence and incidence from published research were applied to local information on population, diversity and deprivation, then considered over four domains; promoting health & well being, mainstream services, specialist mental health services and continuing care. Reassuringly, an earlier assessment in England employing an analogous method and supported by the NHS Executive produced relatively similar results, (Williamson et al 1995). Though for the purposes of this paper the emphasis will be data regarding specialist mental health services, the needs assessment took a whole systems approach (Pratt et al 1999), allowing services to be designed not only in response to the demands of the population but also with sensitivity to existing resources locally.

Clearly, as can be seen in Table 1, the service was not community oriented as suggested in the NSF Older People.

Critical Analyses of Existing Services

In 2002 the main components of service provision were Consultant Psychiatrists and Community Psychiatric Nurses (CPNs) allocated to geographical sectors, supporting Day Hospitals and In-patient units. More recently two additional services had been developed, a joint health and social care team for people under 65 with dementia that provided a discrete community and day service function along similar lines to services for people over 65, and the Memory Monitoring Service designed specifically to support people prescribed cholinesterase inhibitor drugs. A detailed description of this latter team is provided elsewhere (Timlin et al 2005). Overall the service was configured in what could be described as a traditional medical model, where each area had allocated resources, i.e. CPNs, day places and beds, attached to the sector Consultant Psychiatrist. None of the component teams had devised an operational policy that articulated its unique function in relation to other parts of the service, nor

was there any clear indication that this service configuration was based on a needs assessment of the population.

Table 1. Summary of needs assessment 2003

Population >65 = 34,343
Estimated Population >65 with Mental Health Problem = 9,500

	Budget £	***Budget %***	***Capacity for contacts per week***	***Capacity %***
Hospital Services	£2,177,765	85%	308	52%
Community Services	£373,955	15%	284	48%
Totals	£2,551,720	100%	592	100%

Despite generous provision (see Table 2), when compared against guidance produced by the Royal College of Psychiatrists (RCP 1995) there was no evidence that the day hospitals were effectively providing an alternative to in-patient admission, bed usage being typically in excess of 100%.

Table 2. Day Hospital & Admission Unit Capacity 2003

Population >65 = 34,343

	Functional Conditions	***Organic Conditions***	***Total places per day***
RCP Guidelines 2/3 places per 1,000 >65, per week	41 (40%)	61 (60%)	102
Local provision 5/6 places per 1,000 >65, per week	120 (60%)	80 (40%)	200
Local admission beds	24	20	44

Indeed, this misconception reflected the lack of published evidence, with only one review of day hospital studies finding reduced in-patient care a likely outcome, and this for adults of working age (Marshall et al 2002., Other reviews have not demonstrated any advantage over alternative forms of care in this respect for day hospital attendance (Forster et al 2001, Marshall et al 2001).

Day Hospitals for people with functional mental health problems were configured in a tiered system. The most intensive provision was based at the main hospital site but was complemented by step down units, at an outlying hospital and friendship centres in local communities. The rationale for this design was that the main hospital unit would cater for people with more severe problems who, once stabilized, could be moved through the system as their condition improved and their needs became less. In reality people with a diagnosis indicating a more severe and enduring condition, e.g. schizophrenia, were monitored through prolonged attendance at one of the step down facilities whereas the main day hospital site was predominantly to treat people experiencing anxiety and depressive disorders. An audit of this latter population over one week revealed that the average attendance was 5 months and at time of audit 80% were rated as having either no significant or only mild symptoms of anxiety or depression using validated assessment tools. Further audits within this group suggested that during an average attendance individuals spent less than 50% of their day in structured therapeutic activity and when asked in a survey, over 60% indicated they would attend on a sessional basis rather than for a full day if offered.

This process of critical analysis compensated for lack of direction in the NSF Older People, by reviewing published evidence and producing data generated locally to facilitate service redesign. Specifically, it identified day services as a key target for change.

Service Redesign

Two challenges presented themselves, firstly to design services that shifted the balance of provision in favour of delivery in the community and, secondly, to achieve this in the absence of any significant new funding. The Local Authority contributed two social workers and therapy staff were either moved from hospital based posts or recruited to vacant CPN posts in order to form three CMHTOPs with a geographical catchment area containing 9,000 to 12,000 people over 65. The formation of three teams was designed to better manage the potential demand as identified in the needs assessment.

However, it would also be achieved by reducing the number of day hospital places, with the subsequent release of staff time utilized to form a team that provided assertive outreach to augment CMHTOPs (see Table 3).

Following consultation with partner agencies, operational policies were drafted for both CMHTOPs and Day Services. In line with guidance for working age adults (Department of Health 2001b), for CMHTOPs people with severe and enduring needs were the focus for ongoing work with briefer interventions provided for older people with other conditions, such as anxiety and depression, in support of primary or social care teams.

Two further sources were utilized to provide operational criteria for day services. Firstly, for older people with dementia the focus for interventions would be people experiencing Behavioural and Psychological Symptoms of Dementia (BPSD). Studies have suggested that approximately 75% of people with dementia will experience BPSD (Borson & Raskind 1999, Lyketsos et al 2002) and an international consensus statement released in 1996 by the International Psycho geriatrics Association and accompanied later with an educational pack (IPA 2002), has indicated that not only do BPSD respond positively to intervention but in so doing offer the greatest opportunity to alleviate suffering, reduce carer stress and decrease economic burden in dementia care.

Table 3. New Service Model

Team	Target Group	Team Function
CMHTOPs	Severe & Enduring Needs	• Ongoing individual case management • Brief interventions out-with target group • Mental Health assessment of any older person
Memory Monitoring Service	Older People with suspected dementia	• Assessment of cognitive impairment • Early intervention
Day Service & Assertive Outreach	Organic Conditions • BPSD, • Difficult to engage Functional Conditions • Severe & Enduring conditions with complex needs, • Difficult to engage	• Intensive or specialist intervention • Team management • Out of hours, (7 days 8am – 8pm) • Prevent admission/facilitate discharge
Admission beds	In crisis or at severe risk	• Stabilise crisis • Place of safety

Secondly, and including older people with severe and enduring mental health problems other than dementia, operational function would reflect an assertive outreach approach. Though widely perceived as a service for working age adults who are difficult to engage, when the detailed guidance is considered (Department of Health 2001c), it largely reflected the group this team intended to target. Namely, those who had a severe and persistent mental health problem, that was disabling, with a history of frequent admissions or intensive support, who may have had difficulty maintaining contact with services and had multiple complex needs. Whilst the Day Hospital facility was retained, care was predominantly offered in the community utilizing whatever opportunities for contact the client's situation afforded. The assertive approach was purported to improve

engagement, reduce admissions or length of stay, increase stability, improve social functioning and could be a cost effective alternative to hospital treatment. Though there is little research in the UK aimed at evaluating this approach with older people it was clear that the operational criteria closely reflected the team's aspirations and despite the lack of direct empirical support there seemed nothing to suggest that the mechanisms inherent in its effective implementation were age specific.

Given the scope of change, particularly in day hospitals, it was vital to ensure support and enthusiasm from the staff involved. It became fundamental therefore to equip them with new skills and a supporting model that encouraged a community perspective that challenged any rigid adherence to traditional professional cultures.

Implementation

Two key mechanisms for successful implementation were, replacing the existing narrow biological philosophy of service delivery and employing strategies to facilitate inter-disciplinary working.

To counter the former a bio psychosocial model was promoted, a more inclusive paradigm that views both psychological and social factors in mental health as equally important to biology, significantly, it has been supported internationally in moving services away from institutional and paternalistic care, (Saraceno 2004). This model was embedded in the operational policies of Day Services and CMHTOP and utilised in inter-disciplinary team building sessions as a format for case discussions (see Table 4).

Even with an operational policy in place that had a shared philosophy embedded within it, the potential for conflict within the newly formed CMHTOPs was significant. To facilitate team building an inter-professional dialogue was initiated prior to team formation. Based on work carried out within working age adult mental health teams in London and supported by the Kings Fund (Peck & Norman 199b), the individual disciplines, i.e. doctors, nurses, therapists, social workers, assistants and administrative staff, were afforded time during two team building days. During the first day they gathered together in their disciplinary groups and reported their fears for their own discipline and the concerns they had for others. This was collated and shared prior to the second day where again staff were given time to meet within their own disciplines but on this occasion they were invited to respond to the fears and concerns expressed by others. This dialogue had a number of important outcomes. It provided a record of team building, it allowed sensitive issues to be aired without individual conflict and it demonstrated that many of the disciplines shared similar fears. It also articulated the regard that each of the disciplines held for their colleagues and, lastly, it highlighted the importance of leadership within the teams. This latter had been previously reported in a national survey of community teams (Onyett et al 1994) and cemented the need to recruit team leaders from within the staff group as opposed to providing external management.

With service re-configuration established by April 2004, it was important to begin demonstrating the impact of change, both in acknowledgement of staff effort and in shifting the balance of service toward the community.

Table 4. Embedding the bio-psychosocial model in Operational Policy

A bio-psychosocial model brings together three equally important perspectives for the development of mental health difficulties.		
Biological	**Psychological**	**Social**
Theories of disorder due to the dysfunctional development or malfunction of anatomical structures. Detect and diagnose these disorders and consider chemical or other biological interventions to correct or compensate for deficit.	*Theories pertaining to the mental processes by which people understand both themselves and the environment in which they live. Interventions are targeted toward assisting the person identify which processes are helpful or unhelpful.*	*Theories assessing the individuals' strengths to overcome difficulties, help them to recognise these and regard the community in which they live for opportunities to support this.*
People should be referred to specialist services for older people when their mental health problems are presenting significant risk and are compounded by, or due to, one of the following.		
Biological	**Psychological**	**Social**
Conditions may occur characterised by progressive cognitive impairment, mental health is complicated by physical health problems or when treatment/support in mainstream settings may have been unsuccessful or impractical	*Ageing is often accompanied by loss, e.g. loss of ability, status, relationships. Mental processes may need to accommodate these changing circumstances.*	*Cultural expectations change and support network opportunities may be limited. Environment may need adaptation due to ageing or changing physical needs*

Table 5. Capacity for community contact

Base measure from 2003 Needs Assessment as follows: in-patients 75+ five admissions, three day hospitals working at maximum capacity with only one attendance per week 200; friendship centres 31; CPN's 235 pro rata staff making 5 visits per day; Consultants 13 new referrals & 15 follow-up appointments at out-patients plus 3 home visits – 31; Memory Monitoring Service 15 visits per week.

2003	Contacts per week	2004	Contacts per week
Hospital Contacts		Hospital Contacts	
All in-patient beds	80	All in-patient beds	80
Consultant Out-patients	28	Consultant Out-patients	28
Day Hospitals	200	Day Hospitals	100
Hospital Total	308 *(52%)*	Hospital Total	208 *(34%)*
Community Contacts		***Community Contacts***	
Assertive Outreach	0	Assertive Outreach	47
CPNs	235	CMHTs	316
Consultant Home visits	3	Consultant Home visits	3
Memory Monitoring Service	15	Memory Monitoring Service	15
Friendship Centres	31	Friendship Centres	31
Community Total	284 *(48%)*	Community Total	412 *(66%)*
Total	592		620

Evaluation

Within 6 months of implementation the majority of clients were now seen in the community rather than at hospital sites (see Table 5).

A simple case-mix audit system had been devised to measure impact on in-patient facilities and give an indication whether CMHTOPs were reaching their target groups. Each month all members of CMHTOPs reported their caseload by 4 categories: category A were people in target group [severe and enduring mental health problems or BPSD] who had a history of in-patient admission in the last two years, category B were people in target group, category C were people with less severe conditions and category D those who had been referred and assessed only.

Within six months of the service redesign staff reported that 72% of their caseload were in categories A or B, i.e. in target group, with an increase in the number of people who had a history of hospital admission. Over the corresponding six months there had been a 14% increase in the number of bed days available at the two in-patient assessment units (7% functional and 7% organic) (see Table 6).

Some twelve months after service change was implemented bed use had fallen on both admission units, despite fewer Day Hospital places, and, with occupancy rates ranging from 48% to 61% between January and May 2005, a plan to reduce bed numbers was agreed (see Table 7).

Table 6. Available bed days, Admission Units 2004

		Feb	Mar	Apr	May	Jun	Jul
Functional	Available Bed Days	696	744	720	744	720	744
Organic	Available Bed Days	580	620	600	620	600	620

Another key outcome measure was implemented to ascertain how both CMHTOPs and Day Services differed in their activity and nature of interventions. Over random sample weeks, each team member recorded the type of activity, be it face-to-face contact with clients or carers, contact with other professionals or telephone contacts. They recorded the duration of each episode and the nature of any intervention that was offered. This data collection tool was adapted from a previous study (UK700 Group 2000) that had compared a typical Community Mental Health Team with a newly resourced Assertive Outreach Team. This study was targeted for two reasons: firstly, it included people up to age 75 and, secondly, it had a negative result finding little improvement in the key outcome measure of increased face-to-face contact for the Assertive Outreach Team despite additional resources and smaller caseloads. Locally the audit revealed that staff within CMHTOPs spent up to 34% of their working time in face-to-face

contact with clients or carers compared to 55% in the Assertive Outreach Team, see Figure 8 below.

Table 7. Proposed Admission Unit and Day Hospital Capacity 2005

	Population >65 = 34,343		
	Functional Conditions 50%	Organic Conditions 50%	Total places per week
Day Hospital places per week	40 (50%)	40 (50%)	80
Admission beds	20 (62%)	12 (38%)	32

Table 8. Team activity comparison

Team	**CMHT1**	**CMHT2**	**CMHT3**	**AOT**
Staff time per week in minutes	10,327	9,653	5,837	16,164
Face to Face contact in minutes	2,645	2,850	2,005	8,925
% Of working time	26%	29%	34%	55%

As regards uptake of a bio-psychosocial model, a sample (46) of Day Services care plans were audited. 35% (16) of these were in support of prescribed medication compared with only 9% (4) that offered psychological or social interventions. This audit was repeated on a similar sample of care plans (31) some six months later, with staff now writing 55% (17) of their care plans in support of psychological and social interventions and 23% (7) in support of prescribed medication.

This change in practice was further evidenced in a specific assessment for BPSD, the Neuro-Psychiatric Inventory (Kaufer et al 1998) routinely administered and a cognitive-behavioural family approach being developed to reduce caregiver stress in dementia (Marriot et al 2000). For other conditions staff now utilized specific assessments such as the KGV (Krawiecka, Goldberg & Vaughn 1977) to assess psychosis and the Lunsers (Day et al 1995) to rate side-effects of neuroleptic medication. Subsequent interventions were based on a Stress/Vulnerability Model, (Zubin & Spring 1977, Neuchterlein & Dawson 1984) and targeted relapse

prevention (Birchwood & Tarrier 1992) and a cognitive-behavioural family intervention for psychosis (Smith & Birchwood 1990).

It appeared from the data collected that not only had there been a shift toward a community-oriented service but also that the new model was targeting people with more severe and enduring needs.

Discussion

Clearly, the methodology and subsequent data does not conclusively rule out confounding factors that may have been responsible for the outcomes indicated. For example, reduced bed use could have been a result of changed admission criteria or staff may have reported activity and case-mix differently in response to organizational pressure. However, attempts were made to offer corroborating support either from external reporting, as in the case of bed occupancy rates, though this still would not detect diversion to other sectors such as care homes. Ensuring bias was not purposefully introduced in the activity, audit staff were focused on quantifying different interventions rather than face-to-face contact. Also, the case-mix criteria were originally introduced as a tool for line management supervision.

Crucially, the comparison of individual outcomes rated before and after change has not been studied. The data does not indicate whether older people received more effective care, such as reduced relapse rates, improved well-being or more timely access, nor indeed if they found the style of service delivery more acceptable.

Perhaps the most obvious omission from the process was not involving service users and carers in the service re-design. This is one of the greatest challenges presented to older people's services, but whether the target population would perceive themselves as one homogenous group based on diagnosis, age or any other demographic variable is doubtful. There was a danger of addressing this complex issue poorly, resulting in tokenism or misrepresentation. Once these limitations were acknowledged, it allowed debate on designing involvement strategies from a more productive standpoint rather than rushing to pay lip service to a key target area. However, though central government places this as a vital process in service development there is no additional funding provided. This contrasts with approaches elsewhere, for example in Scotland where centralized funding is provided to support independent groups to further service user involvement (Partners in Policymaking 2005).

Several references have been made about the lack of national guidance throughout this report when, arguably, the Assertive Outreach approach that was adopted may seem very similar to the Intermediate Care strategies outlined in the NSF Older People standards. Whilst there is a degree of overlap, in as much both are intended to offer more intensive input to those most at need, Intermediate Care does not support prolonged contact. By definition, it is designed as a brief intervention to either facilitate rehabilitation or prevent hospital admission. Assertive Outreach does suggest a prolonged contact with clients, and given the nature of the mental health difficulties this group experience the ability to engage and work slowly with people over time seems advantageous.

This last point highlights one of the main difficulties facing service planners, a lack of clear direction on service design. There is a palpable resistance within the specialty to accept what is perceived as prescriptive guidance from central government, in contrast with Working Age Adult services. There is substance in supporting this on the basis that the evidence base for one model over another is poor, However, two further conclusions should be considered: First, central government will be reluctant to invest funds where there are no measurable national parameters and, second, without this funding, and some uniformity, it will be nigh on impossible to evaluate any model with sufficient significance to have a sustained national impact. If this is in doubt then consider that the NSF Mental Health was published in 1999 and with its subsequent policy implementation guidance continues to be the measure of service design for working age adults some 7 years later. The NSF Older People was published in 2001 and continues to be re-invented in publications, such as Securing Better Mental Health, (Department of Health 2004) and Everybody's Business, (Care Services Improvement Partnership 2005).

Conclusion

Whatever mechanisms were responsible, services in the area studied are now delivering a more community-oriented approach as indicated in national policy. And though the decisions that influenced this process may be open to debate, they were at least based on evidence rather than opinion.

This change in service design reflects the evolution of mental health services over the last 30 years. The hospital is no longer the mainstay of provision, where treatment is initiated then "followed-up" or monitored in the community. Nor can the needs of a diverse group such as the one targeted be met by just one large all encompassing team dominated by one profession.

These have been difficult but interesting times for Older Peoples Mental Health Services; we should expect nothing less of the time ahead.

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