PSSRU

Services for Older People with Mental Health Problems: The Balance of Care in Cumbria

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PREFACE

A longstanding concern amongst policy makers and managers responsible for the care of the most vulnerable adults is to achieve the best use of resources. In this context much of the concern is about achieving the best possible balance of care, between care within hospital and residential settings on the one hand and a variety of community based resources on the other. This report summarises a study examining possible changes in the balance of care in services for older people with mental health problems in Cumbria. It was designed to assist local commissioners and managers, in partnership with key stakeholders, to examine ways in which the pattern of provision might be changed so as to achieve a better use of the available resources for care and treatment.

Unlike some balance of care studies, which are predominantly broad brush planning exercises, this work has involved a range of key stakeholders in the locality in surveys, discussion groups and expert panels so as to ensure that the evidence is grounded in local realities and that estimates of the potential for change are set 'in vivo'. For this we are indebted to many staff in the Mental Health Trust and Social Services Department, GPs as well as users and carers who generously gave of their time and expertise to make this exercise possible. Not all can be mentioned in the space available. We are particularly grateful to Vernon Watson for his support as commissioner of the work.

At the PSSRU Sue Tucker took the lead in collecting data and writing the report and Jane Hughes developed the balance of care approach used in the study. Sue Martin helped to prepare the manuscript.

I am grateful to all who have contributed to a piece of work which represents a real move towards evidence based service development.

David Challis
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EXECUTIVE SUMMARY

INTRODUCTION

This study was commissioned by Eden Valley NHS Primary Care Trust working in partnership with Cumbria Social Services Department and North Cumbria Mental Health and Learning Disabilities NHS Trust. It aimed to evaluate the current provision of services for older people with mental health problems in North Cumbria and to provide data to inform local commissioners' decisions about the mix of services needed, thereby underpinning future strategic planning.

The study found that older people with mental health problems in contact with the social and specialist mental health services have a wide and diverse range of needs and preferences which do not always correspond with the organisationally fragmented, inflexible and relatively limited range of services available. If enhanced community services were available, a number of people currently admitted to residential or hospital beds could be more appropriately supported in their own homes at a cost that is no greater than that local agencies currently incur. However, in order for the balance of care to be shifted in the direction of the community, a number of building blocks will need to be in place. In effect these constitute an agenda for action.

AGENDA FOR ACTION

1. The creation of integrated community mental health teams (CMHTs) for older people

Systems to facilitate the integration of health and social care are not well developed, in Cumbria or elsewhere. The creation of adequately resourced multidisciplinary CMHTs specialising in the care of older people is fundamental to the maintenance of elderly people with complex mental health needs at home. The achievement of the wide-ranging remit such teams must fulfil will depend upon:

- The successful integration of specialist social work staff with existing health personnel;
- The setting of clear and realistic objectives agreed with key stakeholders;
- The explicit definition of each team member's role; and
- Their acquisition of appropriate skills and knowledge.

2. The development of intensive care management arrangements

The provision of intensive care management by members of the specialist CMHTs is a prerequisite for the delivery of the multi-faceted packages of care needed if older people are to be diverted from institutional care. In essence, intensive care management is an effective strategy for organising and co-ordinating community-based services for people with complex needs. Six factors are considered to be particularly salient:

- Assessment, where local agencies must incorporate the Single Assessment Guidance into the CMHTs' organisational policy, and develop a common, standardised framework that will deliver high quality assessment of a breadth and depth proportionate to clients' needs.

- Targeting, where the establishment of more reliable and valid eligibility criteria for community and institutional care is critical to ensuring that people with severe/complex needs receive services which differ in content and intensity from those received by people with lesser needs.

- Regular monitoring and review, which are needed to inform the timely and appropriate adjustment of care plans as circumstances change.

- Financial management, where the devolution of budgets to care managers, the setting of clear expenditure limits and the availability of explicit unit costs for purchased services will all contribute to effective financial arrangements.

- Protected caseloads, which are essential if practitioners are to balance the provision of intensive care management with the other demands made on the team.

- Appropriately qualified staff, who, regardless of their discipline, have the necessary level of experience and training to act as care managers.

3. The growth of community services

The community resources available to older people with mental health problems in North Cumbria are patchy and inconsistent. There are relatively few services tailored to the specific needs of this population and real concern about the quality of some of those services currently used to support them. This study suggests that in order to achieve a shift in the balance of care local agencies must develop:

- A discrete home care service for older people with mental health problems; and

- A range of specialist day care.

In the longer-term, a strategy will also be required to develop the provision of respite services and the stock of extra care housing. Whatever form such community resources take the same issues will be important, i.e. the provision of mental health training for staff and the development of funding arrangements which are able to support more flexible services.

4. The development of a strategy to support carers

The high level of strain, distress and depression associated with caring for someone with a mental health problem is well documented. The frequency with which carer stress contributed to an older person entering institution-based care in North Cumbria is, however, still striking.

More information is needed about carers' needs and views if their experience is to carry proportionate weight in future planning exercises. In the meantime, a number of bodies in the public and voluntary sectors are well placed to offer them more support. This is something carers themselves saw as a priority, along with the development of more respite care and the expansion of community mental health teams. Carers' assessments are one route into such services, with individually tailored responses having the best evidence of effectiveness.

5. The provision of specialist mental health service support for generic services

The mental health trust will need to provide support and education for those personnel whose responsibilities include the care and treatment of older people with mental health problems within generic services. This will include staff working in:

- Primary care, where particular attention must be paid to promoting the identification and management of people with dementia and the regular use of agreed care protocols, since the vast majority of older people with mental health problems are cared for by their GP.
- Social services older people's teams, where the fostering of the broader links between the specialist mental health service and the local authority social services department will be important as older people with mental health problems constitute approximately 45 per cent of the older people on these teams' community caseloads.
- Care homes, where two levels of input are needed: general education/training and resident specific advice/interventions. This advice and support must be available throughout the area, since whilst nearly 85 per cent of the older people admitted to a care home in this study had a mental health problem, the majority were admitted to a non-specialist long-term care facility.
- General hospitals, where local agencies must give particular attention to how inpatients with depression will be identified and cared for, as the profile of those older people discharged from hospital to a care home suggests that a number of this group may be depressed.

6. **The development of an information network which can support front line staff and service planning**

   The starting point for the integrated commissioning and delivery arrangements fundamental to the provision of person-centred care is the availability of good quality data about local demographics, activity levels, resources and costs. This will need to be produced on a regular basis.

   The intention of local agencies to invest in a range of electronic information systems, and to use existing systems more effectively, is thus supported. Such systems will need to be consistently available throughout the area and to take account of the National Programme for Information Technology. More detailed information about the quality of service provision would also help strategic planning. This should include regular consultation with users and carers.

THIS REPORT

This report begins with a selective review of the literature about the effective provision of services for older people with mental health problems. Further to a brief description of the study's methods in Chapter 2, five central chapters then detail the local findings. In Chapter 3 existing information about recent service provision in North Cumbria is compared with published national data. The characteristics of four core groups of older people with mental health problems, as depicted in a specially undertaken local data collection exercise, are then described in Chapter 4, whilst Chapter 5 explores the possibility of caring for certain groups of these people in more appropriate ways. Chapters 6 and 7 then present a survey of stakeholders' perspectives of services for older people with mental health problems, and a diary exercise that detailed the key activities undertaken by staff caring for this client group. In Chapter 8 the findings are then summarised and their implications discussed in the light of lessons from the literature.

The agenda for action set out above was derived directly from this material which in effect forms an evidence-based, whole-systems approach to the balance of care needed by older people with mental health problems in North Cumbria.

CHAPTER 1
LITERATURE REVIEW

This literature review was undertaken to ascertain what is known about the effective provision of services for older people with mental health problems. It does not attempt to provide an exhaustive analysis of the vast body of work concerned with individual therapies or treatments, but rather concentrates on the way in which individual service elements, or their organisation, might facilitate better outcomes for both service users and their carers, as well as for providers. It is thus deliberately selective in terms of the client group who form the focus of the discussion and in its orientation towards the ways in which their care might be provided.

This chapter has been organised into 13 sections. The majority of these consider those studies which have addressed the effectiveness of just one service, such as home care, day care or respite. The obvious problem with such work is that, in practice, many people receive care packages containing a mixture of two or more services, and that it may be particular combinations of help that prove beneficial rather than any one service on its own. There are, furthermore, a number of difficulties interpreting the information available, and the extent to which any differences in their findings can be accounted for by the various ways in which services have been defined, populations sampled or outcomes measured. Not all of the studies were undertaken in the UK and, of those that were, several were published prior to the community reforms of the late 1980s. Where there is particular concern about such issues, these have been highlighted.

Despite the above, the literature does offer some clear messages for service planners and each section of this chapter begins with a summary of key points. It is hoped that, when considered in combination with the local findings presented in the following five chapters, these lessons will form the basis for evidence-based commissioning in North Cumbria.

THE DEVELOPMENT OF HEALTH AND SOCIAL SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS

Key Points:

- **The development of specialist services for older people with mental health problems dates from the 1940s**

- **Recent decades have seen an emphasis on care in the community and on a person-centred approach**

- **The National Service Framework for Older People (DoH, 2001a) states that older people with mental health problems should have access to integrated mental health services provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and their carers**

- **It is clear that the services in many areas do not live up to such aspirations**

Whilst the majority of older people with mental health problems have always been cared for in their own homes, the demand for specialist services for elderly people with mental health problems only emerged after World War II and the inception of the National Health Service (Philpot & Banerjee, 1997). This was stimulated by four main factors: the increasing proportion of the population that were living into their 60s, 70s and 80s, the differentiation of clearly demarcated syndromes of psychiatric disorder in old age, the recognition of the inadequacies of existing care for the elderly mentally ill and the success of geriatric medicine (Jolley & Arie, 1978; Dening, 1992; Wattis, 1994).

Defining the patient group in *Services for Mental Illness Related to Old Age* the Department of Health and Social Security highlighted the needs of older people with dementia and/or functional disorders as well as those of patients who had entered mental hospitals before modern methods of treatment were available and had subsequently grown old in them (DHSS, 1972). Until this time both these groups of patients had been cared for by general psychiatrists, but in the late 1960s and early 1970s the first consultant psychogeriatricians were appointed and reports of specialist services began to emerge (Arie, 1970; Philpot & Banerjee, 1997; Wattis, 1988). These services took a community orientation in keeping with the shift in policy towards care in the community which stemmed from the post war soaring of the mental hospital population, the development of new psychotropic medications and the increasing criticism of dehumanising long-stay institutions (Goffman, 1961; Townsend, 1962; Nolan, 1993). Indeed, according to Dening (1992), their three key features were:

- a commitment towards the assessment of patients within the community;
- close liaison with geriatric services; and
- a utilitarian perspective.

In 1971 the government set out early guidelines for the provision of beds and day services for older people with mental health problems and following encouragement by the Royal College of Psychiatrists and the British Geriatrics Society, steady service development followed (DHSS, 1971). In contrast to psychiatry's traditional emphasis on diagnosis and physical treatments, the 1970s saw the mounting influence of a social work model of care which emphasised the identification of social problems and the use of therapeutic interpersonal interventions, whilst the voice and influence of psychologists and occupational therapists in mental health care also increased (Nolan, 1993). Only limited progress was made in moving patients out of the large institutions however and the concept of community care was said to lack clarity (Norman et al., 1996). Whilst the 1975 White Paper *Better Services for the Mentally Ill* acknowledged that community services were not adequate (DHSS, 1975), it gave no indication of how care in the community would be paid for, nor how to ensure it proved effective (Nolan, 1993). Not all staff groups were in any case prepared for the proposed changes. The excitement that the arrival of chlorpromazine had caused amongst medical practitioners back in the 1950s had been matched by apprehension amongst nurses who feared that their role might reduce to the administration of medication. Although a small number of nurses had begun to work outside of the hospital in the mid 1950s, it soon became apparent that large numbers would need training to enable them to make an effective transition out of the institutions. The first courses for community psychiatric nurses were thus established, and it was only as they acquired specialist clinical skills that they also began to gain recognition as practitioners in their own right (Nolan, 1993).

By the time the first systematic survey of specialist mental health services for older people was undertaken in 1979-80 there were approximately 120 consultant psychiatrists with a substantial commitment to the elderly (Wattis et al., 1981). These new consultants still tended to be hospital based however, with beds located in long-stay wards containing a high proportion of chronically ill patients. Indeed the shortage of acute beds and day hospital places was so marked that the Health Advisory Service warned that unless appropriate measures were taken, "the flood" of Britain's ageing population's mental health needs was "likely to overwhelm the entire health care system" (HAS, 1982 p1).

This period also saw concerns about the balance of services for the general elderly population. Alongside the measured development of community services to support older people in their own homes, the 1970s saw a marked increase in the scale of residential living. The provision of such services dated from the 1948 National Assistance Act. This required local authorities to make residential accommodation available for any person who by reason of age, infirmity or other circumstances was in need of care and attention not otherwise accessible, and whilst building materials had been in short supply in the 1950s, the early 1970s saw a big new building programme (Peace et al., 1997). The following years witnessed rising rates of unemployment and a decline in the economic base however, and as part of their commitment to the reduction of public expenditure, the Conservative governments of the 1980s expressed their support for the development of supposedly less expensive community care. Indeed the 1981 White Paper, *Growing Older* (DHSS, 1981), particularly emphasised the role that was to be played by family/informal carers giving rise to the concern that 'care in the community' might become a euphemism for 'care by the family' (Peace et al., 1997 p 73).

The early 1980s nevertheless witnessed a huge boom in the private home sector. The magnitude of this could only partly be explained by demography (Audit Commission, 1997) and was mainly attributable to financial incentives towards long-term care, people eligible for supplementary benefit able to have their care in private and voluntary sector homes paid for by social security (Challis, 1993; Cotter et al., 1998). No medical or social work assessment was required and day or home care could not be funded in this way, whilst the lack of development of private domiciliary services meant that there were few alternatives available to maintain vulnerable people at home (Grundy & Glaser, 1997; Cotter et al., 1998; Challis et al., 2001a). At the same time, the role of the NHS in the provision of long-term care reduced dramatically, there a 38 per cent fall in the number of acute and long-stay beds for older people between 1983 and 1996 (Audit Commission, 1997). Long-term general nursing care, as distinct from specialist nursing care, no longer seemed to be considered an NHS responsibility, and the nursing home sector grew accordingly (Cotter et al., 1998).

In 1986 the Audit Commission issued a further strong warning that all was not well with community care and the government responded by asking Roy Griffiths to put forward a plan to address the outstanding issues of funding and organisation. The key features of his proposals (Griffiths, 1988) were accepted by the government in the White Paper *Caring for People: Community Care in the Next Decade and Beyond* (DoH, 1989) and led to the 1990 NHS and Community Care Act which was fully implemented in April 1993. This advocated the continued development of a market approach to care provision, but changed the role of local authorities from providers to arrangers/purchasers of care, whilst admission to long-term care was to be preceded by a comprehensive review of individuals' health and social care needs. The new language was of care management, purchaser-provider splits and contracting (SSI/SWSG 1991a, 1991b). Mechanisms to promote choice and flexibility, match services with need and promote accountability and quality control were described, and a special transitional grant was made available to fund community care packages as well as care home placements, this seen as a corrective to the institutional bias of the previous decade (Challis, 1993; Norman et al., 1996; Cotter et al., 1998).

Two years prior to the implementation of the above reforms the Department of Health had responded to concerns about the difficulties (and perceived failures) of providing care in the community for people with severe and enduring mental health problems, irrespective of age, through the introduction of the Care Programme Approach (CPA). This initiative gave health authorities responsibility for ensuring that the health and social care needs of each patient were systematically assessed, that a care plan was formulated to address them, that a single keyworker co-ordinated their care and that their needs, progress and care plan were regularly reviewed (DoH, 1990). The subsequent introduction of social services-led care management, the core tasks of which included case finding and screening, assessment, care planning, monitoring and review (Challis, 1993) thus caused some very understandable confusion, for there were significant areas of overlap between the two models approach to the care of older people with mental health problems (Hughes et al., 2001). Although assigning different responsibilities and having differently devolved budgets, both aimed to ensure vulnerable people received adequate community care and it was widely felt that they should be integrated.

Despite little government guidance on the role of mental health services for older people, such services continued to grow rapidly throughout the 1980s (Burns et al., 2001), and in 1989 old age psychiatry was formally recognised as a speciality within the NHS (Philpott & Banerjee, 1997). A further survey by Wattis et al. (1999) found that services had smaller catchment areas and increased numbers of medical, nursing and social work staff, and the pattern of service development was described as a move away from the monodisciplinary assessment of patients in a predominantly hospital-based service towards the multidisciplinary assessment, treatment and support of patients at home (Von Abendorff et al., 1994). The early 1990s also saw the evolution of an approach embracing clients with dementia as worthy of attention in their own right, based upon the sociopsychological theory of personhood in dementia (Kitwood, 1993), whilst, following ongoing concern about the closure of large numbers of long-term beds, the Department of Health (1995) now issued guidance on meeting continuing care needs. No national standards were set however, nor any guidance given on the division of health and social care.

By the end of the 20th century districts aimed to offer mental health services that were "comprehensive, accessible, responsive, individualised, multidisciplinary, accountable and systematic" (Burns et al., 2001). However *Forget Me Not*, a high profile analysis of mental health services for older people in England and Wales (Audit Commission, 2000), found many that many services could not live up to such aspirations and identified much divergence in practice. This was confirmed in their later, wider review: specialist teams for older people with mental health problems were fully available in less than half of all areas and there was a general need for more day and respite care (Audit Commission, 2002). Although it has been suggested that such variation may have arisen from differing patterns of social provision and local circumstances, sustained by a lack of comparative service model evaluations (Philpot & Banerjee, 1997), Wattis et al. (1999) argue that, in the light of guidance from professional bodies, such diversity is indefensible. This is a view also taken by the Alzheimer's Disease Society who revealed similar patterns of variation in investment (ADS, 1997).

The latter half of the 1990s was also notable for the increasing public recognition given to the important role carers play in making a reality of community care. The Carers' (Recognition and Services) Act (1995) formalised the right of people providing 'substantial' informal care to ask for an assessment of their own needs and required local authorities to take their views into account when assessing the needs of those they cared for, whilst in 1999 a national strategy for carers was launched (DoH, 1999). One study of older people with dementia found that few carers had heard of, or been offered, a separate assessment of their needs however (Moriarty & Webb, 2000), whilst other work concluded that carers often did not know if their needs had been assessed (Arksey et al., 2000).

The publication of the *National Service Framework for Older People* (NSFOP) was thus widely welcomed as an attempt to address these concerns and inconsistencies and drive up the quality of care (DoH, 2001a). An essential component of the NHS Plan (DoH, 2000) the NSFOP set national standards for better and fairer services, Standard Seven stating that older people with mental health problems should have "access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers"

(DoH, 2001a p90). In order to achieve this standard the NSFOP detailed a number of key services those planning mental health services needed to provide, gave examples of possible care pathways and set out specific actions the NHS and councils should undertake in order to reach given milestones.

The NSFOP also sought to clarify the process of assessment and care co-ordination for older people, including those with mental health problems, as with the introduction of the Single Assessment Process (SAP) it became clear that vast majority of older people with mental health problems should now be subject to the assessment and care management aspects of SAP (DoH, 2001a). The only exceptions were those older people with severe mental illness whose particular circumstances were considered to make it more appropriate for CPA to be applied. The aim was to ensure there was a standardised assessment framework in place that would deliver good quality assessment matched to individual circumstances and targeted, active care management (DoH, 2001a), but as with CPA, no direct funding accompanied this initiative. Although it had previously been relatively unusual for health staff to act as care managers for older people, the guidance also stated that, regardless of the agency they were employed by, the professional who had the most appropriate level of experience, qualifications and training to match the needs of the client should act as their care manager. Indeed, there was a clear expectation that health staff would become more involved with assessment and care management tasks (DoH, 2001a; Weiner et al., 2003).

If the SAP was designed to promote the integration of health and social services at the team level, the NSFOP also drew attention to the need for their closer integration at the macro level in highlighting the 1999 Health Act flexibilities. This legislation placed a duty on health and local authorities to work together for ‘the common good’ and promoted the development of new financial and organisational arrangements for the provision of care services including pooled budgets, joint/lead commissioning and the development of Care Trusts whereby a single organisation managed both health and social care. It would appear that these have not been widely taken up as yet however, one early monitoring exercise finding that only two per cent of 130 partnerships created using the Health Act flexibilities were specific to older people with mental health problems (Hudson et al., 2002). The NSFOP is nevertheless clear that such integrated commissioning and delivery arrangements are fundamental to the ultimate achievement of person-centred care, a goal to which all agencies commit (DoH, 2001a).

HOME CARE

Key Points:

- **Low level cleaning and shopping services emerged in the aftermath of World War II to help housewives and maintain an intact labour force**
- **By the end of the 1960s the population who used these services most were the elderly**
- **The late 1980s witnessed major shifts in the amount and nature of the services provided with the explicit intention of maintaining vulnerable older people in the community**
- **Home care is the service most frequently provided to people with dementia but many people who might benefit from services do not use them, or use them only in small/inadequate amounts**
- **The evidence that home care input reduces carer burden and/or promotes quality of life is somewhat equivocal but there is a more consistent body of work to suggest that it can delay institutionalisation**
- **Very little is known about the impact of providing specialist versus generic home care for older people with mental health problems**

Like specialist mental health services, home help services first emerged in the aftermath of the Second World War and were intended to relieve housewives in times of sickness and childbirth so as to maintain an intact labour force. Over the following twenty years the sociodemographic profile of the population changed however, and by the close of the 1960s around 90 per cent of the users of home help services were older people. In fact, approximately one in five of those over 75 years benefited from the low level cleaning and shopping services offered (Gorbach & Sinclair, 1989; Salvage et al., 1988; Godfrey et al., 2000).

This situation remained relatively unchanged for the next fifteen years and research in the 1980s found that home help users typically received two hours support a week, regardless of their level of dependency (Davies et al., 1990). Indeed, at a time of great expansion in the residential sector, the provision of home care per head of population aged 75+ actually fell (Audit Commission, 1997). The appropriateness of this was coming under increasing challenge from the Social Services Inspectorate however, who argued that the home help service should explicitly aim to enable vulnerable older people to remain in the community and that adequate levels of help were not being provided. In fact, in order to meet the needs of those on the threshold of institutional care, major shifts were needed in both the intensity and the nature of the services provided, this involving a move away from the concentration on household tasks towards the broader provision of personal care (SSI 1987, 1988; Challis, 1993).

Although this movement from 'home help' to 'home care' predated the community care reforms of the early 1990s, the latter both reinforced and accelerated their implementation, whilst other policy objectives of the time sought to develop a market approach to the provision of care and to prioritise carer support (Godfrey et al., 2000). Huge shifts in the organisation and delivery of care resulted and between 1992 and 1998 the number of home care hours either purchased or provided by local authorities rose by more than 50 per cent. The number of households receiving home care fell simultaneously, and by the end of the century the average number of hours per household per week had risen to seven, a higher level of help being provided to fewer users (Government Statistical Service: Community Care Statistics). The independent sector's share of local authority funded care in England meanwhile rose from just two per cent in 1992 to 46 per cent in 1998 (Godfrey et al., 2000) and whilst home help services had customarily been provided free or at a flat rate, the proportion of the social services' budget derived from charging now increased (Moriarty, 1999).

Despite the trend to provide a more intensive service for those people most in need, the local reality is more complex and there is undoubtedly significant variation in the content, amount and allocation practices of different authorities (Godfrey et al., 2000; Wistow & Hardy, 1999). Indeed, even the meaning of targeting has been variously interpreted, having been applied to both the level of clients' needs and/or the prioritisation of particular tasks regardless of level of need (Godfrey et al., 2000; Askham, 1997). Furthermore, research has repeatedly shown that domiciliary care is primarily focused on people who live alone. The client's living situation is then more influential than their level of disability in determining their receipt of services (Moriarty, 1999; Pickard, 2004) whilst there is also some suggestion that male caregivers are more likely to receive home care support than female caregivers (Askham, 1997).

Further concern has been expressed that, in concentrating on the provision of high intensity care packages, authorities have overlooked the possible preventative role that the provision of relatively low levels of help with tasks such as housework, shopping and laundry can play, and that this may ultimately be counterproductive (Wistow & Hardy, 1999; Clark et al., 1998). Indeed, in some areas the local authority no longer provides such services (House of Commons Health Committee, 1996 para. 38). Still more concern has been expressed about the quality of those services that are provided, particularly in the independent sector, whose rapid expansion did not always go hand in hand with the investment infrastructure needed to support it (SSI, 1997).

Despite the above, the use of home care continues to increase (Audit Commission, 1997) and in 2001 approximately 400,000 households in England received domiciliary care services (Government Statistical Service: Community Care Statistics). Indeed domiciliary care has been described as the 'mainstay' for many older people living at home (SSI, 2002) and the numbers needing such a service via the local authorities are projected to increase by nearly 50 per cent between 1996 and 2031 (Pickard et al., 2000).

Although there are only a handful of studies based on representative community samples since the community care reforms, it would appear that the receipt of home care services by older people with mental illness is higher than in the older population as a whole (Moriarty, 1999). Whilst Bennett et al. (1996) found that 15 per cent of all people aged 75+ in Great Britain received home care, two studies of people with dementia aged 65+ reported rates of 31 per cent and 44 per cent in Gwynedd and Islington respectively (Burholt et al., 1997; Livingston et al., 1997). Older people with depression or anxiety were rather less likely to received home care, with only about 20 per cent using such services, but this is still more than in the general population (Livingston et al., 1997). As is the case with many aspects of service provision for older people with mental health problems however, considerably more attention has been paid to the situation of people with dementia than to those with other forms of mental illness, and the remainder of this discussion will thus necessarily concentrate upon the former.

Although home care is the service most frequently provided to older people with dementia (SSI, 1997) and there is some evidence that it is targeted at those who are most impaired (O'Connor et al., 1989), many of the concerns about its delivery detailed above are equally applicable to people with dementia. Thus considerable variation has been found between the services delivered in different parts of the country (Moriarty, 1999), as has a clear association between receiving home care and living alone (Levin et al., 1989; O'Connor et al., 1989; Webber et al., 1994).

As with other services, home care is nevertheless generally well received, with carers almost universal in their praise of both the service itself and the staff who deliver it (SSI, 1997; Zarit et al., 1999). That is not to say there are not criticisms however, particularly about consistency and reliability (Levin et al., 1989; Zarit et al., 1999), problems which can only be exacerbated when, as is commonly the case, older people receive fragmented packages from more than one provider (Audit Commission, 1997). Research has also shown that services are not always flexible in meeting clients' or carers' needs (Levin et al., 1989; Zarit et al., 1999) and that many people feel they do not receive enough care (Askham, 1997; Zarit et al., 1999).

That people with dementia who might benefit from services often do not use them, or use them only in small and/or inadequate amounts, is a recurrent theme in dementia care research and it is thought that many factors contribute to this situation (Zarit et al., 1999). One fundamental one is limited availability (Sinclair et al., 1990; Askham, 1997), whilst budgetary constraints may further limit care managers ability to put together substantial and/or innovative care packages, many authorities capping the cost of domiciliary care at the gross or net cost of residential care (Audit Commission, 1997; Godfrey et al., 2000). As the Audit Commission have pointed out, such practices discourage staff from putting together intensive short-term packages for clients who are, say, being discharged from hospital, or at risk of care home admission, and greater flexibility might improve both outcomes and unit costs (Audit Commission, 1997).

Other explanations for the limited use of services made by people with dementia include a lack of knowledge on the part of families as to what services are available, caregiver guilt about relinquishing care of their relative, the charges made for help and refusal of services. The latter may be in response to some of the criticisms of services noted above, or to lack of insight on the behalf of the client (Zarit et al., 1999; Askham, 1997).

Beyond questions of satisfaction or quantity however is the issue of effectiveness. The first problem here is how this should be judged, for whilst the majority of studies have looked at the extent to which the provision of home care services may prevent or delay the need for institutionalisation, or its effect on carer burden, there are concerns about the appropriateness of using evaluation criteria originally designed to measure health care interventions (Baldock, 1997; Zarit et al., 1999). There has, furthermore, been very little consideration of the impact of such services on the wellbeing of the person with dementia. This may in part be due to the problems of measuring this (Donaghy, 1999), although an alternative explanation is that carers are perceived to be the primary beneficiaries of services for people with dementia. Indeed there is an ongoing debate about whether formal services should focus on meeting the needs of clients or carers – or whether these are the same – although either way it would seem important to document the outcomes for both parties (Moriarty, 1999; Zarit et al., 1999).

Unfortunately there are a number of other difficulties in assessing the evidence about home care. These include the many different ways in which home care has been conceptualised within the literature and the fact that much of the relevant work has been undertaken in the United States where not only is terminology different, but so too is the way in which health and social care is organised (Donaghy, 1999; Tester, 1999; Godfrey et al., 2000). Methodologically there are also concerns about both small sample sizes (Donaghy, 1999) and sources of bias in sample selection, the identification of people with dementia from Social Services' information systems remaining problematic (Moriarty, 1999; SSI, 1997), whilst practical and ethical reasons make it difficult to employ randomised designs (Challis & Darton, 1990). There is furthermore a problem with the contemporariness of some of the evidence as many of the studies cited were published in the 1980s prior to the community care reforms described above and we know little about the effects of the changes in commissioning and purchasing activity initiated then. Indeed some issues do not seem to have been addressed at all, including whether the provision of domestic support for people who are less dependent has any effect on their subsequent need for services (Godfrey et al., 2000).

With regard to the effect of home care services on carer stress, the evidence both pre and post the community care reforms is somewhat equivocal. One Scottish study in the 1980s found no association between the provision of home care for people with dementia and caregiver wellbeing as measured by the General Health Questionnaire (Gilleard et al., 1984). However, in Levin et al.'s (1989) longitudinal study of people with dementia and their carers in the London area, which used the same measure, carers who had a home help were less likely to show an increase in strain over a one-year period, although this association was not significant on its own. More recently, another London study of an augmented domiciliary service for people with dementia failed to find any evidence that home care benefited carers' psychological health (Riordan & Bennett, 1998), but the very small sample size may well have influenced this result. A much larger study by Davies and Fernandez (2000) did find that subjective carer burden declined significantly with increases in the level of home care input for people with mild and severe cognitive impairment. That said, this study, in which nearly half of the recipients of home care were cognitively impaired, concluded that home care by itself accounted for a smaller amount of the decrease in carer stress than day care and institutional respite services and might not be a cost-effective way of addressing carer burden (Davies & Fernandez, 2000).

In a review of the effectiveness of home care for the Audit Commission, Pickard (2004) states that the main evidence concerning the impact of home care on the older person themself also comes from the study by Davies and Fernandez (2000). This found that clients' satisfaction with the service increased quite markedly with relatively small amounts of help, but failed to increase much more with further inputs of home care. In the one UK study identified in which functioning was measured no association was found with the provision of home care however (Riordan & Bennett, 1998), although, interestingly, a large American study targeting the frail elderly, reported a significant decline in abilities such as dressing, bathing and continence (Hughes et al., 1984).

The research about the importance of home care to older people with depression is also hard to assess. One London study (Evans et al., 1991) found an inverse relationship between having a home help and being depressed, and the authors hypothesised that the service might thus have a protective function. Other work has suggested that there are generally higher levels of psychiatric morbidity in those receiving home care services, but as most studies only show an association between receipt of services and affect, and not the direction of the link, little can be drawn from these findings (Askham, 1997).

There is, however, more consistent evidence to suggest that home care can be effective in delaying the institutionalisation of older people, including older people with dementia. In the 1980s Levin and colleagues found that the provision of standard home help reduced the likelihood that older people with dementia who had male carers would be admitted to residential care (Levin et al., 1989). Two post community care studies also found that the receipt of home care significantly increased the length of time older people remained at home (Andrew et al., 2000; Davies and Fernandez, 2000). Indeed one of these reported that home care inputs were the most influential factor on the length of time spent in the community and had a positive effect for clients with and without informal carers in all dependency groups (Davies & Fernandez, 2000; Pickard, 2004). Riordan and Bennett (1998) similarly found that recipients receiving an augmented domiciliary service which emphasised the provision of social and personal care were able to continue living at home for significantly longer than those receiving traditional services, although the evidence from other countries seems more mixed (Vernooj-Dassen et al., 1995; Zarit et al., 1999; Gaugler et al., 2003).

Although very little is known about the impact of providing specialist versus generic care for older people with mental health problems such as dementia (Chappell & Reid, 2000) the Social Services Inspectorate (1997), Audit Commission (2000) and *National Service Framework for Older Pe*ople (DoH, 2001a) have all supported the development of specialist services for this group.

In most areas older people with dementia continue to be dependent on generic services however (SSI 1997, 2002), and interestingly, a survey of home care services provided for people with dementia in the North West found little evidence that the specialist agencies were in any case providing a fundamentally different form of service. Indeed there were no significant differences between the two service types' approach to assessment, care planning, the provision of culturally appropriate care for clients from ethnic minorities, the degree of integration of the service or the level of staff training, and it was the generic services that offered the more flexible care. They were significantly more likely to provide 24 hour, live-in, evening, night and weekend care (Venables et al., forthcoming). It should be borne in mind that the specialist services were generally smaller however, and that as of yet we cannot say anything about relative outcomes for clients and carers.

INTENSIVE CARE MANAGEMENT

Key Points:

- **Intensive care management is a strategy for organising and co-ordinating services for people at the client level**

- **A number of studies have shown that it offers an efficient way of providing health and social care for older people with multiple and complex needs**

- **Core tasks include case finding and screening, assessment, care planning, monitoring and review**

- **Key elements associated with positive outcomes include a differentiated response to need, appropriate targeting, devolution of budgets and continuity of involvement**

- **The provision of care management by members of a specialist multidisciplinary team is seen as a prerequisite for the delivery of the complex packages of care needed to enable older people with mental health problems to continue to live in their own homes**

A number of studies on the outcomes of community care in Britain have utilised a care management approach to deliver a multidimensional package of care. Whilst the research process has typically focused on care management as a structure for delivering an integrated and co-ordinated package of care, the services offered have tended to focus on help with personal care and activities of daily living (Godfrey et al., 2000; Pickard, 2004), hence these schemes inclusion at this point.

As noted earlier, care management is essentially a strategy for organising and co-ordinating care services at the client level and incorporates a series of key tasks including case finding and screening, assessment, care planning, monitoring and review (Challis, 1993). These alone are not sufficient to define the nature of intensive care management however, and Box 1 sets out its key characteristics.

Box 1. Intensive Care Management: Characteristics

Functions	Coordination and linkage of services
Goals	Provision of continuity; integration of care; increased opportunities for home-based care; promotion of client wellbeing; better use of resources
Core tasks	Case finding and screening; assessment; care planning; monitoring and review; case closure
Characteristics of recipients	Complex and/or severe needs; long-term care needs; multiple service need
Main features	Intensity of involvement; length of involvement; breadth of services spanned

Source: Challis et al., 1995

Although originally developed in the USA, the introduction of the care management approach to the UK is associated with a string of studies undertaken by the PSSRU prior to and spanning the community care changes of the late 1980s/early 1990s (Hughes & Challis, forthcoming). The pioneering Kent Community Care Scheme and the subsequent developments of this model were intended to address some of the criticisms of community care in the previous decade, including the poor co-ordination, fragmentation and inflexibility of the limited range of services available (Challis, 1993; Askham, 1997). Employing quasi-experimental designs, four pilot studies each aimed to compare the experience of a group of older people receiving 'usual care' with a group receiving a particular model of intensive care management in which social workers with devolved budgets acted as case managers for a protected number of frail elderly people, paying for help not available from existing services to supplement traditional provision (Challis, 1993). This shift in the control of resources was designed to enable care managers to respond more flexibly to the individual needs of vulnerable older people and to integrate fragmented services into a planned pattern of care. By enhancing the performance of the core tasks of care management it was hoped to improve both effectiveness and efficiency and to provide a realistic alternative to institutional care (Hughes & Challis, forthcoming).

The first two exemplar schemes in Kent and Gateshead focused upon case management in social care and targeted frail older people who were considered to be on the verge of entry to a care home. The results were encouraging; the services provided more closely matched clients needs, yet were no more expensive, admissions to care homes were significantly reduced and there were marked improvements in both clients' and carers' levels of satisfaction (Challis & Davies, 1986; Challis, 1993). A pilot health and social care scheme developed around the primary care service in Gateshead that incorporated the input of a nurse care manager and junior doctor also reduced rates of institutional placement (Challis et al., 2002a). One of the groups for whom this approach seemed especially cost effective was of socially isolated older people at high risk of depression and there was some suggestion that these sorts of arrangements might be more effective than standard services in improving clients' mood (Challis & Davies, 1988).

The third pilot scheme tested a similar approach in a multidisciplinary geriatric team in Darlington whose members included a number of care managers employed by social services. This study targeted elderly people at risk of requiring long-stay hospital care and the case managers not only deployed flexible budgets but were also able to draw upon the input of generic care workers who undertook the role of home help, nursing assistant and therapy aide. Indeed large proportions of the case managers' budgets were spent on such input, although, as in the earlier schemes, they also purchased additional services from members of the community in order to facilitate more flexible care. When compared with a group receiving (more expensive) long-stay hospital care, improvements were seen in the wellbeing of the elderly people receiving this targeted approach, whilst their carers had lower levels of stress (Challis, 1993; Challis et al., 1995).

Although some people with cognitive impairment were included in the above schemes, a later study in Lewisham specifically aimed to evaluate the feasibility of providing an intensive care management service to people with dementia who were perceived to be on the margins of institutional care. The degenerative nature of this illness and the changing nature of sufferers' needs make them a group for whom intensive care management appears to be particularly appropriate. Forty-three individuals receiving a care management service based in a community mental health team for older people were matched with the same number of people under the care of a similar team without such a service (Challis et al., 2002b). The receipt of community services was high in both groups with 98 per cent of the experimental group and 81 per cent of the control group receiving home based care. A greater number of home care hours per week were supplied to the experimental group however – thirteen versus five – and they received more care at home from almost all sources, including special paid helpers. Positive outcomes for the experimental group included significant improvements on ratings of aspects of daily living and level of risk, whilst there were also decreases in the subjective stress experienced by carers. The cost of care at home was significantly more expensive for the experimental group however and the scheme only appeared to have an impact on the rate of institutional placement after 18 months of support. At the end of the second year 51 per cent of the experimental group and 33 per cent of the comparison group remained at home (Challis et al., 2002b).

Although encouraging, these findings might suggest that the community tenure effect of intensive care management is more muted in this population than in the other subgroups of vulnerable older people studied by the PSSRU. Two possible explanations for these findings have been suggested however. Firstly, as the old age psychiatry services in Lewisham were relatively resource rich, the comparison was not between a care management service within a typical mental health service and a typical range of mental health services, but rather between a care management service located within an enhanced mental health service and an enhanced mental health service. Such a context was bound to minimise any gains associated with the intervention and caution should thus be taken in generalising these results to other, less well-resourced, areas of the country. Secondly, it was suggested that anticipation of the new service might have shaped practitioners' behaviour. At the start of the study a number of referrals to the scheme appeared to be people who were at a point of crisis which could only be resolved by care home placement, but who had been retained at home for inclusion in the project (Challis et al., 2002b; Hughes & Challis, forthcoming).

The results of other early UK evaluations of care management services for older people with dementia have been said to be less encouraging. The evaluation of the Home Support Scheme for Dementia Sufferers for example (Askham & Thompson, 1990) suggested that such arrangements were no more effective at keeping people at home than were standard services. However, the key element of this service was the employment of new support workers who offered previously unavailable practical assistance and sitting services to people with dementia and the brokerage and coordination of services so central to care management were not prioritised. Indeed, the Age Concern development officers who organised this new service understandably lacked influence over the allocation of mainstream resources and, in the absence of a clear care co-ordinator, found themselves duplicating the work of existing social services staff (Askham & Thompson, 1990; Challis, 1994).

Considerable variability has also been reported in the ability of multidimensional care schemes to replace institutional care in the US (Challis, 1993). One recent example is the Medicare Alzheimer Disease Demonstration and Evaluation (Fox et al., 2000). This large-scale study tested a care management approach designed to assist families caring for people with dementia in eight different sites across the US and focused on relieving carer burden and stress. However, when all the sites were considered together, it failed to show any significant benefits to carers or to delay institutionalisation (Fox et al., 2000). In contrast, an earlier American care management study, The Channeling Experiment, found that the elderly people and their families in the experimental group did benefit from reduced needs and higher morale. This project, which concentrated on providing carefully managed home care for disabled older people at risk of nursing home placement, reported no difference in the institutionalisation rates of the experimental and control groups though, whilst savings on nursing home placements failed to offset additional community costs (Kemper, 1988; Thornton et al., 1988). Three different models of care management were explored in this piece of work however, and it is important to note that secondary analysis of the data specifically relating to people with dementia revealed that they used less health care when a ‘neighbourhood’ model of care management was implemented. This was characterised by case managers working within a defined geographical locality, facilitating knowledge of local resources, holding much smaller caseloads, making more home visits and regularly referring clients to other services whilst, interestingly, this model was less costly than the others trialled (Eggert et al., 1990; Zimmer et al., 1990).

In essence both the UK and US research illustrate the importance of a differential approach to the assessment of need, the appropriate targeting of care management on clients with complex needs for whom it is likely to be beneficial in terms of outcome (and, if possible, cost-effectiveness) and the need for regular monitoring and review (Challis et al., forthcoming). The PSSRU work also highlights the importance of establishing close links with healthcare colleagues in primary and/or secondary settings. In practice, however, the lack of specificity of the national guidance on care management (SSI/SWSG 1991a, 1991b) permitted local authorities considerable discretion in its implementation which resulted in a variety of patterns of provision (Weiner et al., 2002). Contrary to the lessons learned from the pilot projects, the preliminary advice implied that care management should be applied to all service users. Furthermore, the emphasis placed on adherence to what were seen as the key tasks of the care management process, including determining the level of assessment, assessing need, care planning, monitoring and review, led local authorities to focus on these as discrete entities (if often neglecting the latter two functions) rather than developing arrangements more in keeping with the concept of care management as a model of long-term care. Specialist care management arrangements for older people with mental health problems have struggled to emerge ever since (Challis et al., forthcoming) and the remainder of this section will briefly explore some of the organisational factors which must be addressed if this is to change, concentrating on financial and commissioning arrangements.

As has already been noted, the separation of the purchaser and provider functions within social services departments was central to the community changes of the early 1990s. Although a number of the demonstration projects had shown that budgetary devolution to front line workers facilitated a more flexible response to complex needs, this was not seen as a requirement of the new arrangements (Challis et al. 1995, forthcoming). The hope was that extending social services' purchasing and contracting roles would increase their use of independent sector providers, expanding the range of options available to service users. However, as social service departments often lacked accurate information about the numbers of older people with mental health problems receiving services, or the money spent on these, there was no reliable data to inform the commissioning process.

The fact that responsibility for older people with mental health problems was often vested in different divisions in both local authorities and mental health trusts added to the difficulties of developing integrated commissioning arrangements, although more recently there have been a number of initiatives designed to improve the commissioning of services for vulnerable adults (DoH/SSI, 1997; Challis et al., forthcoming). Thus the government statement on *Fair Access to Care Services* (DoH, 2002a) confirmed that councils had a duty to have services in place to meet eligible needs and that specialist services for particular groups of service users should be developed where there is justification for these, whilst the 1998 White Paper *Modernising Social Services* (DoH, 1998) outlined measures to improve service commissioning processes.

The financial arrangements consequent on the introduction of the care management process can also be said to have found expression at the micro and the macro level. At the individual level, three aspects of practice observed in the exemplar studies may be seen as contributing to effective financial management: the devolution of budgets to care managers as noted above, the setting of clear expenditure limits and the availability of explicit unit costs for purchased services. The latter are essential if care managers are to make informed choices about the likely costs and benefits of alternative packages of care. A national study of care management arrangements found that less than two-thirds of local authorities costed both internal and external service elements however (Challis et al., 1999) and current care management arrangements for older people are not typically characterised by care managers purchasing individually tailored/costed services within a specified budget (Challis et al., forthcoming).

At the macro level, the introduction of the 1999 Health Act flexibilities placed a duty on health and local authorities to work together for ‘the common good’ as noted earlier, and the development of new financial and organisational arrangements were promoted to facilitate this. These included pooled budgets, joint/lead commissioning arrangements and the establishment of new Care Trusts whereby a single organisation manages both health and social care. The benefits that these new structures might be expected to bring to the operation of the care management process for older people with mental health problems include the development of more flexible packages of care, improved arrangements for the commissioning of services and greater continuity of care. Indeed care management systems devised in agency isolation and lacking access to appropriate expertise for assessment are unlikely to be effective (Challis, 1999). Such opportunities have not been widely taken up however, and although the provision of care management through specialist teams might be said to be a prerequisite for the delivery of the complex packages of care needed to enable older people with dementia and other severe and enduring mental health problems to live at home, such arrangements are not ubiquitous (Challis et al. 2001b, forthcoming).

In conclusion, it would appear that intensive care management arrangements offer an efficient way of providing social care for older people with severe and complex needs, producing improved outcomes at similar or slightly lower costs. Key elements associated with these outcomes include a differentiated response to need, appropriate targeting, devolution of budgets, continuity of involvement and appropriate links with specialist health care expertise. This evidence cannot be generalised to the care of less vulnerable individuals for whom such arrangements, with the inevitable overhead costs of the case manager, will tend to be cost raising and other social care responses are thus needed here, including effective organisational procedures for assessments, care planning and reviews (Challis, 1999). The challenge for those working with more vulnerable older people, however, is to develop of a model of intensive care management based on the eight standards set out in Box 2 (Hughes et al., 2004).

Box 2. Intensive Care Management: Standards of Good Practice

- Care management should be provided by members of a multidisciplinary team specialising in the care of older people with mental health problems
- Services for older people with complex mental health needs require an integrated and informed approach to commissioning embracing both their health and social care needs
- Financial arrangements are required which facilitate an integrated approach to the provision of health and social care for older people with mental health problems
- A differentiated approach to care management is necessary to ensure that older people with mental health problems receive a level of response appropriate to their health and social care needs
- Targeting within care management arrangements is required to ensure that vulnerable older people with complex needs, such as those with dementia, receive the care packages they require to enable them to live at home
- Assessment as a precursor to a care plan must be multidisciplinary and appropriate in terms of content and timing to ensure that older people with mental health problems receive the requisite assistance to maintain their community tenure
- Care plans are required to support, sustain and enhance the quality of life of older people with mental health problems in their own home and to provide assistance to their carers
- Monitoring and review in care management is required to ensure the timely and appropriate adjustment of the care plan in order to maintain older people with mental health problems at home in response to changing circumstances

Source: Hughes et al., 2004

COMMUNITY MENTAL HEALTH TEAMS

Key Points:

- **Community mental health teams (CMHTs) are perceived to be at the core of specialist mental health provision for older people and need a mix of specialist staff including consultant psychiatrists, community mental health nurses, clinical psychologists, occupational therapists and social workers in order to fulfil their wide remit**

- **Studies of services for working age adults suggest that better functioning CMHTs have adequate resources, clear and realistic aims and objectives, a detailed operational policy and a single team leader**

- **CMHTs should ensure that they use their specialist skills with the clients who need them most**

- **CMHTs should support other services in meeting the mental health needs of those older people who do not fall within their own remit**

Community mental health teams (CMHTs) are perceived to be at the core of specialist mental health provision for older people and have been given a wide-ranging remit which includes:

- the provision and monitoring of antidementia medication for people in the early-moderate stages of dementia, this necessarily accompanied by wider diagnostic, educational and support roles

- the specialist care of people suffering from behavioural and psychological symptoms of dementia and of people with severe or complex functional mental health problems, employing psychological, social, physical and pharmacological therapies

- the provision of outreach and advice to primary, residential, domiciliary, general hospital and day care services, and

- the promotion of mental health and the detection of mental illness in the wider population (Audit Commission, 2000; DoH, 2001a).

In order to fulfil such functions it is generally accepted that CMHTs need a mix of specialist staff. These include consultant psychiatrists specialising in mental health problems of old age, community mental health nurses, clinical psychologists, occupational therapists and social workers (Audit Commission, 2000; DoH, 2001a), although the abilities and motivation of individuals may at times be more important than their precise professional background. The number and mix of specialist community-based staff available however has been found to vary considerably, both between and within areas (Dening, 1992; Audit Commission 2000, 2002). Of the more than seventy sites studied by the Audit Commission, fewer than half had specialist multidisciplinary teams, and in several areas teams consisted solely of community mental health nurses, whilst within every region the number of staff from each profession varied by a factor of at least four per 10,000 population over 65 (Audit Commission 2000, 2002). The Audit Commission (2000) thus recommended that local agencies review the composition of specialist teams and adjust this 'where necessary', but no explicit guidance was offered as to what 'where necessary' might mean.

In fact there has as yet been remarkably little evaluation of the structure, processes or effectiveness of CMHTs for older people (Woods et al., 2003; Keady & Adams, 2001) and the majority of the literature consists of descriptive reports of individual practice/services (Keady & Adams, 2001). The principles of team working, leadership and management have however been more closely examined in services for working age adults. The next section of this report therefore outlines the main points that are made in this work, prior to reviewing a list of practice issues for CMHTs for older people compiled by Dening (1992) nearly 15 years ago. The last part of this section then attempts to summarise those few intervention studies undertaken in older adult CMHTs that do include some measure of clinical effectiveness.

Structure

In talking about the structure of CMHTs we are talking about both the composition of the team and the way in which it is managed (Ovretveit, 1993). One author who has written extensively about this in CMHTs for working age adults is Onyett (Onyett, 2003; Onyett & Ford, 1996; Onyett et al., 1994) and this section will draw heavily on his experience. According to Onyett (2003), teamworking within any locality is likely to include a range of configurations, the design of which should be informed by the geographic and demographic characteristics of the area, local needs assessment and existing strengths as well as by what the research says about effective teamworking. It is the latter which will be considered here.

In summary, studies have found that better functioning CMHTs have:

- Adequate resources – in terms of staff, money and accommodation (Chalk, 1999; Onyett et al., 2003).

- Clear and realistic aims and objectives. Unclear team objectives are said to be the biggest contributor to the poor functioning of teams (Borrill et al., 2000; Onyett, 2003) and it is suggested that the defined and stated role of CMHTs should ideally form part of a mental health strategy drawn up by a range of key stakeholders including health, social services and primary care (Onyett, 2003).

- A single clear leader with sufficient authority to ensure that all disciplines within the team work to an agreed operational policy (Borrill et al., 2000; Onyett, 2003). Ovretveit (1993) saw this as core to the development of 'formal teams' and contrasted such teams with 'network association teams' in which practitioners rather come together on a voluntary basis, each managed by their own professional line manager.

- An operational policy which is agreed from the inception of the team and which includes explicit and detailed statements about staffing (appointments and disputes/disciplinary procedures), mechanisms for conflict resolution (including those between disciplines and agencies) and support and administration (Onyett, 2003).

- A mix of team members who have an appropriate breadth of skills and diversity of experience to meet the needs of their clients (Weaver & Patmore, 1990; Muijen et al., 1994; Onyett, 2003), better functioning teams typically having few part-time workers (Borrill et al., 2000; Onyett, 2003).

- Clarity about the role of each team member, their tasks and their place within the team which is organised such that shared core roles are separated from the specific and unique roles which individuals and disciplines fulfil (Norman & Peck, 1999; Onyett & Ford, 1996; Onyett, 2003). Role conflict has been found to be a significant predictor of stress and job dissatisfaction in CMHT members and social workers in CMHTs have been shown to experience higher levels of this, suggesting that particular attention should be paid to clarifying the social work contribution within such teams (Carpenter et al., 2003). Interestingly Carpenter et al. (2003) also found that in districts where health and social services staff were fully integrated social workers experienced significantly less role conflict and suggested that this may be due to fewer conflicts over accessing resources and fewer contradictory demands.

- Explicit models of care supported by joint training and ongoing team development, a strong commitment to quality and support for innovation (Borrill et al., 2000; Onyett, 2003).

Practice and Process

In 1992 Tom Dening wrote an article setting out what he saw as being the main issues for the organisation of specialist community services for older people with mental health problems on the basis of visits to a number of old age psychiatry services. Perhaps not surprisingly many of these remain equally pertinent today, and this section will revisit four of the questions he asked to see what can be said about these issues now.

Who should be referred to the CMHT?

In essence the question that Dening was asking here was whether old age psychiatry services should be responsible for all referrals who were aged 65 and over, or whether the needs of clients who were already known to the general adult psychiatry services were better met by their staying within that service. He found that whilst most services accepted referrals of all over 65s, some did not routinely accept ‘graduates’.

Whilst more than a decade later most services continue to use age as a criteria for entry (although with increasing life expectancy some areas now set this at 70 instead of 65) the question of who should be referred to specialist mental health services for older people is perhaps less about age per se and more about needs. The distinction Challis and Davies (1986) made between two different forms of service accessibility is useful here, they contrasting: ‘horizontal target efficiency’, the extent to which the service engages with all those people who might benefit from it, with ‘vertical target efficiency’, the degree to which the service engages only those people it was set up to serve. The question then becomes whether an old age psychiatry service should serve <u>all</u> older people with mental health problems or only a subgroup of these – and if focusing on a subgroup, who this consists of?

In answer to this question the *National Service Framework for Older People* (DoH, 2001a) clearly states that specialist mental health services should concentrate on diagnosing and treating more complex cases and lists the characteristics of people with dementia and depression who it expects would fall within this category, although there is of course much room for local discretion. According to these criteria a person with dementia might be appropriately referred if diagnosis is uncertain, for consideration of antidementia drugs or if they present with certain behavioural or psychological symptoms such as aggression. Similarly, a person with depression might need input from the specialist services if they have had an inadequate response to first line treatments, are considered to be a suicide risk or have complex symptoms such as multiple physical problems. The message here is that specialist services should utilise their specialist skills with the clients that need them most, although they are also given a clear educational and support role in working with other services to enable them to meet the mental health needs of those older people who do not fall within their own remit (Dening, 1992; DoH, 2001a).

Who should be able to make referrals to the CMHT?

As many as 14 years ago Dening found that whilst some services accepted referrals only from general practitioners or hospital staff, others also accepted referrals from social workers and other sources, including self-referrals. The arguments for an open referral system include concerns that older people may not get the specialist help they need through failing to present to general practitioners, or that general practitioners, for whatever reason, may fail to refer them. Restricted access is seen as particularly inappropriate in light of the important roles played by families and the social and voluntary sectors in the care of the elderly, whilst if ease of access to health services is seen as an indicator of quality, the open access option also has intrinsic merit (Macdonald et al., 1994; Philpot & Banerjee, 1997).

The worry about open access is that it may release a flood of inappropriate or trivial referrals (Macdonald et al., 1994; Philpot & Banerjee, 1997), but such fears have not been borne out by the research evidence. In a study of more than 1400 referrals in which patients referred to a CMHT via traditional medical sources were compared with those referred under an open access policy, no evidence was found that the wider access route produced more inappropriate referrals (Macdonald et al., 1994). There was a change in the nature of the referrals though: whilst general practitioners referred disproportionately more patients with delirium and depressive illness, social workers referred disproportionately more people with alcohol problems and paranoia. The authors acknowledged that the presence of a psychiatric disorder (their measure of whether a referral was appropriate or not) was at best only a crude indicator of whether a referral warrants specialist mental health intervention. However, except for the referrals from relatives and voluntary agencies, of which there were few, there was no indication that the people referred did not need specialist input. Indeed almost half the patients with paranoid states, who generally responded well to treatment, were referred by non-traditional services, and it is suggested that a traditional referral service may well have failed these patients, they in good physical health and not in contact with their general practitioners (Macdonald et al., 1994). A subsequent study by Gupta et al. (1996) reported similar findings.

Where should patients be seen?

Dening found that the vast majority of patients within the services that he visited were initially seen and assessed at home, and there was general agreement that this was advisable. There was however less consensus about the assessment of geriatric medical patients, with most consultants seeing such referrals on the wards, but some psychiatrists preferring to see patients at home once they had been discharged if this were possible.

An initial assessment at home is still perceived as desirable today (DoH, 2001a), it reasoned that this facilitates assessment of the person in their usual environment, as well as assessment of the home environment itself (Orrell & Katona, 1998). Others argue that older people may be reluctant to attend outpatient clinics and that home-based assessments increase the proportion of referrals seen without increasing the time required (Benbow, 1990; Anderson & Aquilina, 2002). Further studies have suggested that domiciliary assessments are comparable in cost to those undertaken in the clinic, at least in services with relatively small geographical catchment areas (Shah, 1994; Aquilina & Anderson, 2002).

The extent to which home assessments lead to better patient outcomes has not however been well evaluated and one comparison of initial home and clinic assessment in a randomised controlled trial of the treatment of older people with depression found no significant difference in outcome (Cole et al., 1995). Furthermore, a second randomised controlled trial comparing traditional community care with outpatient assessment for a sample of geriatric patients found that the latter identified greater numbers of people with depression and cognitive impairment and that at one-year follow-up this group were less anxious and their carers less distressed than the traditionally treated group (Silverman et al., 1995).

Who should assess the patient?

The question of who should perform initial assessments proved to be the most contentious issue in Dening's study. Whilst the majority of services argued that all referrals should initially be seen by medical staff, opponents of this view felt that assessments could be undertaken by all members of the CMHT and that this was more efficient and cost-effective.

The evidence today would seem to suggest that not all initial assessments need to be performed by a doctor. In one study in which all CMHT members used a standardised assessment form when seeing new referrals the diagnoses reached by non-medical staff closely tallied with the clinical and research diagnoses of psychogeriatricians (Coles et al., 1991; Collighan et al., 1993). Seymour et al. (1994)

similarly found a good level of agreement between the diagnosis of a community mental health nurse who used a structured interview and a psychogeriatrician's diagnosis. There were, however, minor disagreements in the ratings of the severity of dementia and in the distinction of vascular from mixed vascular and Alzheimer's dementia in the latter study and subsequent work at a memory clinic in Leicester found that although the nurse assessment accurately detected dementia, it had difficulty differentiating subtypes (Dennis et al., 1998).

Junaid and Bruce (1994) have suggested that, in practice, models of assessment for older people may vary according to the characteristics of the area. Describing a rural service in Huntingdon, Tym (1991) noted that nursing time was more available than consultant time and the community mental health nurses took up an intermediary station between the GP and consultant for both assessment and treatment purposes. In the more urban setting of South Manchester, where nursing staff were perceived to be low in numbers compared with declared need, they became involved with patients only after assessment by a medic (Lennon & Jolley, 1991). Some clinicians have expressed concern about non-medical assessments altogether however, arguing that older people with mental health problems have the right to a specialist medical opinion and that sending other professionals downgrades them and is ageist (Jolley, 1993).

In services in which non-medical staff do undertake initial assessments the case is often then presented to the community team (including medical staff) who collectively formulate a care plan. As Orrell and Katona (1998) have noted, the appropriateness of care planning undertaken in this way has not been adequately evaluated, nor compared with that from consultant home visits. One audit of referrals to a CMHT found that in any case nearly half of the people assessed by community mental health nurses then required a medical review. This clearly has resource implications, but the fact that the majority of reassessments were carried out in an outpatient setting and that much of the required information had already been collected allowed a saving of consultant time (Gupta et al., 1996).

Interventions

As stated above, there has to date been very little evaluation of the interventions undertaken by CMHTs for older people, with only a handful of controlled studies providing some measure of clinical effectiveness (Draper, 2000; Keady & Adams, 2001; Woods et al., 2003). Moreover, in comparison with the diverse nature of CMHT work, the scope of these studies is narrow, the majority of the identified work focusing on outcomes for clients with depressive disorders. Three such studies are briefly described here, along with two further pieces of work which rather concentrated on outcomes for people with dementia living in the community. Additional studies concerned with outcomes for people with dementia living in care homes, and for carers of people with dementia, are detailed later in this chapter.

In a controlled study of elderly attenders at GP surgeries Jenkins and Macdonald (1994) used the depression scale of the Comprehensive Assessment and Referral Schedule (Gurland et al., 1977) to identify 65 older people with depression. These were then randomised into two groups, and a multidisciplinary CMHT implemented individual treatment plans for members of the intervention group whilst the control group continued to be managed by their GP. At nine months follow-up there were no significant differences in the outcomes of the two groups, although the elderly men seen by the CMHT improved more than those seen by their GP. It is likely that the small size of the sample contributed to the lack of effect (Draper, 2000).

A second randomised controlled trial identified 96 older people probably suffering from pervasive depression by screening a household-enumerated population in Inner London and then randomly allocated them to either a community mental health nurse intervention group or to normal general practitioner care (Blanchard et al., 1995). A multidisciplinary team again generated individual treatment plans for the intervention group, but the community mental health nurse had some difficulty implementing aspects of these, particularly the introduction of antidepressant medications and the commencement of day care. Nevertheless, at three-month follow-up the nurse-intervention group showed significantly improved depression scores when compared with the controls and it was people with long-standing depression who appeared to benefit most, this improvement seeming to be associated with the support and behavioural work undertaken. A subsequent follow-up study confirmed some lasting benefit for the community mental health nurse group at between six and 23 months post-intervention (Blanchard et al., 1999). Whilst it is probable that the majority of these people would not have needed (or wanted) referral to the specialist mental health services, the authors argue that there is a need for specialist services to transfer specific skills into primary health care teams for the detection and management of these people (Blanchard et al., 1999). This argument is lent further support by Banerjee’s work as reported below.

In this third randomised controlled trial Banerjee et al. (1996) considered the efficacy of intervention by a CMHT in the treatment of depression in frail elderly people receiving home care. Their results were very encouraging. At six months follow-up 58 per cent of the intervention group had recovered in contrast to just 25 per cent of the general practitioner control group and once again the effect appeared to be about more than the prescription of medication, the use of antidepressants at follow-up not having a significant effect. However, although the interventions were said to reflect normal clinical practice and the management plan was formulated by the CMHT, in every case it was the psychiatrist who implemented the interventions which would not usually be the case.

As far as could be ascertained, just two randomised controlled trials have considered the impact of a CMHT on people with dementia. In the earlier of these studies O’Connor et al. (1991) identified people with dementia via a primary care screening process and offered half input from the mental health team. The only outcome studied appears to have been admission to a care home or to hospital however, and interestingly, over a two year period, admission rates were greatest for those people who lived alone and received input from the specialist services. There was no significant difference in outcome between the two subgroups of people who lived with family carers (O’Connor et al., 1991). As Woods et al. (2003) have noted, remaining at home is a relatively unsophisticated index however, and without evidence to the contrary, the concern arises that this may be at the cost of carers’ emotional health.

One further small randomised controlled trial considered the effect of CMHT input for people with dementia who presented with behavioural disturbance (Hinchliffe et al., 1995). The majority of studies in this area have focused on people in institutions and have had small sample sizes and no controls, if reporting encouraging findings (e.g. Woods & Ashley, 1995; Moniz-Cook et al., 2001). The study in question recruited 40 people who lived at home with their carer and who were not in contact with specialist mental health team. These were randomly allocated to an immediate intervention group or to a waiting list control group. Subsequent to assessment, a multidisciplinary team then generated an individual plan which aimed to reduce the most distressing behaviours presented by the subjects and included pharmacological, psychological and social approaches. These were implemented by a psychiatrist over a course of 16 weeks. Whilst a significant improvement was seen in the immediate intervention group, this was not replicated when the waiting list group subsequently received the same package, despite there being little change in their presentation over the waiting period. The implication is that the longer the duration of the problem, the more intractable it becomes, and it is noted that other work has also reported a lack of efficacy when interventions are delayed, there obvious lessons for the organisation of specialist services here (Brodaty & Gresham, 1989).

Although randomised controlled trials offer the most conclusive evidence on which to base clinical practice, it is recognised that purchasing guidelines and clinical decision-making will never be totally reliant on their findings (Brooker et al., 1996). In some instances it will be ethically inappropriate to withhold interventions strongly suspected of being effective from a control group, whilst with infrequently occurring problems randomised controlled trials are simply impractical. In a review of the clinical effectiveness of community mental health nurses working with younger adults Brooker et al. (1996) concluded that purchasers and service providers should base their activity on the following key clinical questions:

- Is an intervention safe?
- Does it work (assessed on the basis of other sources of evidence in the absence of randomised controlled trials)?
- Is it valued by the consumer?
- Is it worth it?

There would seem to be no reason why such an approach should not be equally applicable in older adult services.

DAY CARE AND DAY HOSPITALS

Key Points:

- **There is much variation in the nature and quantity of day care provided for older people with dementia whilst few if any areas offer specialist day care for older people with other mental health problems**

- **Carers place a very high value on the receipt of day care and, in adequate amounts, it has been shown to improve their emotional health**

- **There is also some suggestion that day care benefits the person with dementia, although its effectiveness in delaying institutionalisation is less clear**

- **Historically, older people with dementia were the main users of day hospitals, their attendance providing valued respite for their families. In more recent years however the emphasis has been on the provision of intensive assessment and time-limited treatments and therapies**

- **There is as yet little evidence to suggest that day hospital attendance reduces the need for inpatient or residential placement although there may be other benefits in terms of improved symptoms and quality of life. It is not clear that this is necessarily a function of attendance at a particular building/facility however**

Day care services were first pioneered over 50 years ago and grew rapidly, if in piecemeal fashion, from the 1970s onwards (Levin et al. 1989, 1994). A distinction has traditionally been made between the NHS-funded care provided in day hospitals and the more socially orientated care historically provided by local authorities and more recently supplemented by the private and voluntary sectors (Levin et al., 1994; Furness et al., 2000). This section therefore considers each separately before attempting to summarise their differences.

Day Care

Although people with dementia have been eligible for day care from the start of its provision, places were initially available only within integrated centres for the elderly and there was no alternative for those who did not ‘fit in’. The subsequent introduction of special days for people with dementia did increase the options, but such services were often available just one day a week and tended to be viewed as a form of respite for carers. This was a focus that persisted even when dedicated specialist facilities were developed and it is only since the 1980s and the emergence of a new culture of dementia care that serious attention has been given to the needs and wishes of the clients themselves (Cunningham & Kesterton, 1995). No comparable services have been developed for older people with long-term functional mental health problems however, and although these people are sometimes accommodated in centres for younger adults with mental illness, many find them disturbing (Audit Commission, 2000).

According to the *National Service Framework for Older People* community mental health services "should include… day care providing a range of stimulating group and one to one activities" (DoH, 2001a p105) but across the country there is a wide variation in the amount, source and type of provision (Levin et al., 1994; Audit Commission, 2002). The Audit Commission found that social services departments typically catered for some people with mental health needs in their generic older people services and that the number of specialist day care places (health and social care provision) varied by a factor of at least two between different areas within the same region (Audit Commission 2000, 2002). Availability was often inadequate, and it has been suggested that the fact that many elderly people receive day care at more than one venue, whether in the same or different sectors, provides further evidence of the limitations of this provision as few professionals believe such arrangements are in the clients' interests (Levin et al., 1994). Weekend day care, which may be of particular interest to carers in paid employment (Levin et al., 1994; Campbell & Travis, 1999) is even harder to find and tends to be restricted to one day and a small number of places, whilst home-based day care is available to only a very limited number of people. Although some areas run specialist day centres for people from ethnic minorities, it is reported that user groups generally express a preference for mainstream services as long as these are sensitive to their dietary, religious and communication needs (Audit Commission, 2000).

Studies show that people with dementia usually commence day care relatively late in the course of their illness and this may suggest that the decision to use day services reflects the caregivers' rather than the clients' needs (Zarit et al., 1999; Levin et al. 1989, 1994). Indeed, despite the long-standing support for day care services for older people with mental illness, there is a surprising lack of clarity as to whether they are primarily designed to help the client or the carer and their specific role (Levin et al., 1989; Jarrott et al., 1998). This may be because they serve a number of important functions simultaneously, including the provision of social stimulation, basic personal care, support, advice and carer relief (Furness et al., 2000). Furthermore, whilst it is generally agreed that day care aspires to promoting care in the community by delaying or preventing institutionalisation (Collier & Baldwin, 1999; Audit Commission, 2000), there is very little quality literature on its effectiveness in meeting these aims (Curran, 1995) and particular gaps in the evaluation of outcomes for people with functional mental illness and of home-based or travelling day care services, although there are some encouraging descriptive reports as seen in Box 3. The following review will thus necessarily focus on that work which has evaluated the provision of care for people with dementia in traditional day centres. A number of the studies cited were undertaken in countries which may have different services and terminology from the UK however, whilst others had relatively small samples, both limiting their generalisability.

Box 3. New Models of Day Care

Urban models of day care do not readily transplant to rural areas where there may be small numbers of dispersed, relatively isolated potential users (Gibson et al., 1996). One response has been the establishment of a number of home-based day care schemes such as that in Falkirk. In this ‘Home from Home’ project a number of volunteers open their homes to between three and six local people with dementia on one or two days a week, acting as their host. The day is spent is a leisurely way and includes the preparation and sharing of a meal. The important features of such schemes are their high ratio of care, small size and ready accessibility, their emphasis on choice and independence and their domestic style environment (Mitchell, 1998).

An alternative option in rural areas is the provision of a travelling day care scheme such as ‘Daybreak’ in Nottinghamshire. This scheme is jointly managed by health and social services and operates in different village community centres on each of the three weekdays it runs. The accommodation is thus familiar to the users and their families and has no prior association with mental health services, whilst a van transports both the staff and equipment so that a range of activities for physical and mental stimulation is available (Audit Commission, 2000).

In other areas more traditional day care services are being complemented by new ways of providing social support for people with dementia, these often offering the opportunity for the dementia sufferer and their carer to socialise together. A companions club in Edinburgh arranges monthly social events for clients and their same-generation carers for example (Murphy & Sharp, 2000), whilst an ‘Alzheimer Café’ in Hampshire, provides an evening out for everyone interested in Alzheimer’s disease and related illnesses, an educational presentation forming just part of a primarily social evening complete with candlelight, music, food and drink (Redwood, 2001).

The literature would suggest that carers of people with dementia like day centre services (Askham, 1997; Zarit et al., 1999; Furness et al., 2000). A UK study of the problems and stresses faced by the families of 150 people with dementia and the effectiveness of services in relieving these found that the proportion of carers who placed a very high value on day care was far greater than that for other standard services for example. All carers using this service saw it as being of help to them, and three-quarters considered it to be a lot of help. Indeed about half would have liked their relatives to attend more often, the main benefits cited including the increased opportunity to get on, get out or to concentrate at work, the relief from caring, and the company and stimulation offered to the attendee (Levin et al., 1989).

There is some concern about using satisfaction as a measure of a service’s effects however (Cox 1997) and it is noted that past studies using standardised measures of carers’ health and wellbeing have had mixed results. Levin et al. (1989) found no significant differences between the psychological health of carers using or not using day services for example, although Wells et al. (1990) reported that carers using specialist dementia day care experienced a small improvement in wellbeing as measured by the General Health Questionnaire. A review of the benefits of community-based services concluded that more recent research evaluating carers who used adequate amounts of day care on an ongoing basis (defined as at least two days a week) had had more positive results though, reporting improvements in carers' burden levels and psychological health (Zarit et al., 1999).

Although most accounts are anecdotal, it would appear that day care can also benefit the person with dementia in terms of decreased confusion, improved mood and wellbeing, enhanced self-esteem, satisfaction with life and increased engagement in activities (Levin et al., 1989; Wimo et al. 1990, 1993; Curran, 1996). In one study of new attendees at a specialist dementia day centre in Scotland, for example, caregivers were asked to note any changes in their relative post the commencement of day care. Forty-two per cent were said to show a marked improvement in mood and/or behaviour and this was, in most cases, maintained at nine months follow-up (Curran, 1996). Interestingly, women who either lived alone, or were left alone during the day, and had milder degrees of cognitive impairment (i.e. were at an earlier stage in the dementia process) appeared to benefit most, although only tentative conclusions may be drawn given the study's small size and its reliance on carer reports (Curran, 1996; Zarit et al., 1999).

As is discussed later in this chapter, there is more uncertainty as to whether the provision of day care can delay/prevent the institutionalisation of people with dementia, whilst it is also difficult to draw any conclusions about its cost-effectiveness as very few studies have considered this. In the most cited work, a Swedish study by Wimo et al. (1990), the use of institutional care was reduced, but the costs of day care exceeded the savings from delayed placement. There has been some concern about the measures used in this study however (Zarit et al., 1999).

In summary then it might be said that day care for people with dementia is a promising service that is liked by carers and, if provided in adequate amounts, may potentially benefit both carers and users. We currently know very little about the point in the disease process at which people with dementia (and their families) would benefit most from such services however, or under what conditions they represent a good investment of resources (Jarrott et al., 1998).

Day Hospitals

The provision of day hospital care has been said to have a long and honourable history (Murphy, 1994) and the government explicitly supported the establishment of day hospitals for older people in their policy document *Better Services for the Mentally Ill*, setting targets for the number of places per head of population that each district should provide (DHSS, 1975).

Whilst having always acted as a resource for the assessment and treatment of elderly people with mental health problems, the main users of day hospital services were traditionally older people with dementia, whose attendance provided valued daytime respite for family carers and a means of long-term support (Fasey, 1994; Murphy, 1994; Furness et al., 2000). In more recent years the emphasis has been on the provision of intensive assessment and time-limited treatments/therapies however, although day hospitals are also seen to have a role in the aftercare of inpatients and in the rehabilitation and support of older people with long-term mental illnesses such as schizophrenia (DoH, 2001a).

Although the Audit Commission (2000) found that all twelve of the areas they studied had some form of day hospital provision, in places this was limited to just a couple of days per week or to a small number of places on a ward. The accommodation of people with functional disorders on different days from those with dementia (which is generally seen as good practice, the two groups having different needs) clearly further limits the number of days any one person may attend, and many services lack separate facilities for these two groups. Wattis et al. (1999) found that, on average, day hospital places were available for three days per week (range 1-7) for people with functional illness, and four days per week (range 1-7) for those with dementia.

The past decade has witnessed an ongoing debate as to the effectiveness of day hospitals. Proponents argue that they provide a desirable alternative to inpatient hospital admission, promote earlier inpatient discharge and, in concentrating specialist resources, facilitate the undertaking of comprehensive assessments and high intensity activities (Creed et al., 1990; Howard, 1994; Collier & Baldwin, 1999). They have also been advocated as an effective means of providing monitoring, rehabilitation and relapse prevention, especially for people with chronic or recurrent conditions, whilst it has been argued that they can delay institutionalisation (Howard, 1994; Collier & Baldwin, 1999).

Opponents have queried how closely practice reflects such objectives however, and state that many day hospitals are no more than day centres providing respite care for people who are either too dependent or too challenging for other forms of day care, and which, despite often being staffed by expensive health professionals, provide little in the way of specific care or treatment (Tester, 1989; Fasey, 1994). It is furthermore suggested that where assessments are undertaken, these may fail to reflect how people function in their own homes, or with their own families (Fasey, 1994), and that for longer-term clients day hospitals are costly, inflexible institutions that breed chronic symptomatology and dependence (Ball, 1993; Fasey, 1994). Still further objections concern their poor utilisation, it noted that day hospital facilities are often used only between the hours of 10 a.m. and 4 p.m. Monday to Friday, and are rarely full (Murphy 1994; Collier & Baldwin, 1999).

Although much opinion has been voiced, there is little actual information, as very few day hospital service evaluations have been undertaken (Zarit et al., 1999; Collier & Baldwin, 1999; Kitchen et al., 2002). One UK review which compared the practice of ten day hospitals with the World Health Organisation guidelines and Health Advisory Service 2000 standards did identify a number of common problems however. These included low utilisation (all bar one running at between 45 and 70%, and four below 50%), the lack of an appropriate range of clinical disciplines, unsuitable physical environments and, because of a lack of alternative social day care, inappropriate referrals (Kitchen et al., 2002). Indeed a key reason for not meeting the Health Advisory Service standards was a tendency to focus on social care, a criticism also made by the Audit Commission (2000) who found that at some day hospitals the average length of patient attendance was more than eight years. It is unlikely that time-limited interventions were being provided here!

The evidence for the effectiveness of day hospital treatment is also limited. Whilst, as above, it has been suggested that day hospitals may reduce the need for inpatient admissions, the evidence for this is flimsy and uncontrolled (Draper, 2000). Although two studies which compared working age adults receiving either day treatment or inpatient care reported no difference in outcome and clear evidence for the superiority of day care respectively (Hertz et al., 1971; Creed et al., 1991), these findings may not be readily transferable to an older population (Fasey, 1994) and there would appear to be no equivalent studies. When two new day hospital facilities were opened in Dublin a lower number of inpatient admissions than would be expected from regional figures were reported (Corcoran et al., 1994). A direct comparison with pre-existing services was not possible however, and in another before and after study the opening of a new day hospital for older people did not appear to affect the number of inpatient admissions of people with dementia (Ballinger, 1984).

A further consideration is whether day hospital care is preferable to the care provided in outpatient settings or by community mental health teams. Those studies identified again relate to younger adults, the vast majority of whom will have functional mental illnesses. One comparison of intensive day hospital provision with outpatient care suggested that intensive day treatment programmes were superior to outpatient care in terms of improved psychiatric symptoms for example (Dick et al., 1991) whilst another found that patients recently discharged from inpatient care remained more engaged in day hospital treatment than in outpatient care (Glick et al., 1986). There was not enough evidence to say that day hospital programmes were better or worse than outpatient care on any other clinical or social outcome variable, or on costs however, and a review of the literature concluded that there was only limited evidence to justify the provision of day treatment programmes for this population (Marshall et al., 2001).

The extent to which day hospital attendance is of itself therapeutically beneficial to older people with mental health problems has been considered in two German papers which reported significant improvements in attendees' mood, satisfaction with life, social contact levels and general health (Bramesfield et al., 2001; Wormstall et al., 2001). Only patients with a diagnosis of depression were included in one of these studies however, in which being male and having a shorter life time duration of depressive illness were predictive of remission (Bramesfield et al., 2001). A retrospective chart review of day hospital patients in America also reported clinical improvements in approaching 60 per cent of attendees without cognitive impairment (Plotkin & Wells, 1993). It is not clear to what extent these findings are transferable to the UK however, and whilst a further Irish records study reported 'improvement' to be the primary reason for the discharge of 40 and eight per cent of patients with functional and organic mental illness respectively, the reader is not told how this was determined (Corcoran et al., 1994).

Some studies have found that day hospitals relieve strain on carers. For example, Jerrom et al. (1993) examined the stress levels of the carers of 63 people with dementia who had attended an assessment day hospital for 12 weeks and found that these had fallen to normal population levels. This was thought likely to be due to the respite day hospital attendance provided for carers and the acknowledgement of their problems, as there was no significant change in the dementia sufferers' behaviour. A second study also found that day hospital care was associated with significant reductions in relatives' stress levels, particularly during the early months of attendance (Gilleard, 1987), but these findings are not supported in other work. Gilhooly (1984) found no association between day hospital attendance and carers' morale or mental health for example, whilst Berry et al. (1991) reported that preparing the patient for the day hospital can actually add to the workload of caring.

There is even less support in the literature for the suggestion that day hospital attendance may have a positive effect on people's eventual need for residential care

(Woods & Phanjoo, 1991; Howard, 1994). One study in which 63 per cent of patients with dementia were in residential care or dead eight months after commencing attendance concluded that day hospital treatment provided only short/medium term care for people with dementia for example (Corcoran et al., 1994). Another found that just nine per cent of attendees were still in the community three years on (Woods & Phanjoo, 1991). Although there is a lack of studies, it is thus not surprising that a previously mentioned review of community care concluded that enrolment in day hospital services does not affect institutionalisation (Zarit et al., 1999).

In summary, it can be said that whilst there are few empirical studies on the effectiveness of day hospitals, there is as yet very little evidence to suggest that they reduce the need for inpatient or residential care. There may however be other benefits for carers and for clients (particularly those with functional mental illness) in terms of improved symptoms and quality of life. It is not clear that this is necessarily a function of attendance at a particular facility/building however and it might be that such improvements reflect the clients' engagement in a therapeutic programme which could be provided in alternative ways and/or in other settings.

Box 4. A Comparison of Day Hospital and Day Care Provision

- NHS day hospitals are better used for time-limited assessment and treatment, while day centres can cater for people's longer-term needs (Audit Commission, 2000)
- Studies have found that staff see the focus in day hospitals as being on assessment and throughput compared with a focus on social support in day centres (Collier & Baldwin, 1999; Furness et al., 2000)
- Day centre users are more likely to attend on four or five days per week over a long period of time, whilst day hospital attendees are more likely to attend for one or two days and for a shorter period (Audit Commission, 2000)
- Not all day hospital attendances are brief however, and some day hospitals continue to provide long-term respite for those people with dementia whom other facilities find it difficult to care for (Collier & Baldwin, 1999; Furness et al., 2000)
- The average level of dependency is generally higher in day centres than in day hospitals. This is to be expected if day hospitals are primarily used for short-term assessment and treatment. People with functional illnesses who use day centres generally have greater and longer-term needs for support, stimulation and social interaction than those using day hospitals (Audit Commission, 2000)
- Studies have found that there is a considerable degree of overlap in the behavioural profiles of people attending day centres and day hospitals. In the main those attending day hospitals are more disturbed and have more memory problems, but the differences tend to be fairly modest (Warrington & Eagles, 1996; Collier & Baldwin, 1999; Furness et al., 2000)
- The degree of similarity between day hospital and day centre attendees, particularly those with dementia, has led some people to suggest that much of the work currently done in day hospitals could be done in day centres (Fasey, 1994). The fact that their clients have similar characteristics does not necessarily mean that the two facilities are doing (or could do) the same work however (Currie et al., 1995)

RESPITE SERVICES

Key Points:

- **The provision of residential respite has evolved patchily and it is difficult to quantify the precise amount available**
- **Residential respite is said to be carers' top priority unmet need**
- **Anecdotal accounts suggest that respite care is both valued and helpful**
- **Objective indicators of the impact of respite on recipients and carers are less equivocal**

Definitions of respite in the community care literature are multiple and broad, encompassing almost any service that provides a temporary break for the caregiver (Brodaty & Gresham, 1992). Sitting services and attendance at day care are examples of such provision, but the focus in this section is on what is sometimes termed residential respite. This is defined as a short-term admission to an institution, with a specified date of return to the community, whose explicit purpose includes giving the carer a break (Brodaty & Gresham, 1992; Levin et al., 1994). The latter point helps differentiate respite admissions from those which take place for other purposes, such as assessment, although it is noted that carer relief may not be the *sole* reason for such admissions (Levin et al., 1994).

The development of respite care for older people with mental health problems originated in the 1940s and was endorsed by the Health Advisory Service Report *The Rising Tide* (1982) and the White Paper *Caring for People* (DoH, 1989). Indeed a number of schemes for relieving caregivers received special funding as part of the central government initiative on developing services for mental illness in old age (Crosby, 1986) and the 1980s saw a sharp increase in short stays in homes and hospitals for social reasons (Levin et al., 1989). More recently the Audit Commission (2000) have described the provision of respite care for people with mental illness as 'essential', and it is one of the core services advocated by the *National Service Framework for Older People* (DoH, 2001a).

Like many developments, respite services have evolved patchily (Moriarty, 1994). Such provision may be offered by health or social services, or, less frequently, by the voluntary or private sectors (Levin et al. 1989, 1994; Askham, 1997). It is difficult to quantify the precise amount available however, for whilst there are a number of specifically designated beds, additional short-term placements may be arranged in hospital or care homes depending on the pressure on acute or long-stay beds at any point in time (Audit Commission, 2000). Thus although the Audit Commission found that most areas provided some respite places, the quantity of beds they offered appeared to vary enormously. At least a third of the 73 areas they reviewed lacked consistently available social services-funded respite beds, i.e. dedicated beds reserved and paid for on a continuous basis, whilst only a little over half had consistently available hospital respite provision (Audit Commission 2000, 2002). The Audit Commission see both as necessary, for the former give home managers a guaranteed income and allow care managers to arrange placements several months ahead, whilst the latter cater for people with severe behavioural problems or additional needs for physical care (Audit Commission 2000, 2002). Emergency respite care (within 24 hours), which is also advocated, is even scarcer, and was consistently available in only half the areas visited, whilst overall less than two-thirds of carers reported being able to get the respite they needed (Audit Commission, 2002).

The suggestion that respite is under-provided finds support within the wider literature where it frequently emerges as carers' top priority unmet need (Lawton et al., 1989). It would seem that a significant proportion of carers of people with dementia have used respite at least once (Levin et al. 1989, 1994). This may conceal wide variations in the type and intensity of breaks provided however and a distinction should be made between regular respite care, where breaks occur at fixed intervals in standard packages (say two weeks respite, six weeks at home) and occasional respite care, where breaks are typically arranged just once or twice a year, often covering a caregiver's holiday (Levin et al., 1994; Moriarty, 1994).

It is perhaps not surprising that elderly people with severe dementia are more likely than those with mild or moderate dementia to have regular respite care. As a result, those carers who have the heaviest load in terms of personal care and trying behaviours are most likely to get regular breaks (Levin et al., 1989; Adler et al., 1995). Interestingly however, in one large retrospective German study no relationship was found between the extent of the help the caregiver provided and their receipt of respite care, it rather that the subjective burden of the caregivers utilising respite was significantly greater than that of the non-users (Grasel, 1997).

Indeed, as has been stated above, the main aim of respite care is usually considered to be the provision of a break for a stressed caregiver, and with regard to older people with mental health problems the literature focuses exclusively on the carers of people with dementia. The assumption is that carers of people with dementia experience stress; that stressed caregivers are less effective and more likely to give up their caring role; that respite care will 'keep them going'; and that permanent institutionalisation is therefore delayed (Brodaty & Gresham, 1992; Nolan, 1994; Flint, 1995).

Certainly carers offer consistent praise for respite provision (Burdz et al., 1988; Brodaty & Gresham, 1992). Amongst the 850 carers surveyed by the Audit Commission respite was the service sought or valued most (Audit Commission, 2000). Four in five of the carers who had used this service in Levin et al.'s (1989) study considered that it had been a lot of help to them, and two-fifths of those without relief breaks would have liked them. Carers frequently speak of feeling refreshed and better able to cope after a break, whilst they also value the opportunity to undertake a range of household tasks not possible when the care-recipient is at home and to meet up with family and friends (Brodaty & Gresham, 1992; Nolan, 1994).

Such subjective outcomes are undoubtedly positive, but more objective indicators of the impact of respite on carers are less equivocal (Grasel, 1997; Zarit et al., 1999). Whilst Scharlach and Frenzel (1986) found that overnight respite reduced the physical and mental strain on caregivers, including those of people with dementia, one Canadian study found that a two-week nursing home respite programme had no effect on the burden scores of family caregivers of people with or without dementia (Burdz et al., 1988). Still others have suggested that any benefits gained are strictly short-term; that residential respite temporarily reduces caregiver strain and burden, but that levels quickly return to baseline once the person cared-for returns home (Adler et al., 1993; Larkin & Hopcroft, 1993). One UK study failed to find even transitory improvements in most measures of the emotional health of caregivers of people with strokes or dementia (Homer & Gilleard, 1994). Given that carers want and seem to value respite care however, it has been queried whether it is necessary for its effects to "spill over into other sectors of wellbeing" to justify its existence (Lawton et al., 1989 p15), or whether giving caregivers a well-deserved break is sufficient reason in itself (Griffith, 1993)?

While most forms of respite care are seen as having positive or at least benign effects for the recipients, there has been concern that residential respite might be detrimental for people with dementia, placing them in unfamiliar environments and disrupting their normal routines. This may potentially lead to a loss of skills and the expression of distress which would impact negatively upon their subsequent relationship with the caregiver and lead to an earlier need for long-term institutional care (Seltzer et al., 1988; Brodaty & Gresham, 1992; Zarit et al., 1999). If outcomes for carers are unequivocal, there is no greater consensus regarding those for the cared-for however (Nolan, 1994).

In two UK studies reported by Levin et al. (1989, 1994), the view most commonly held by carers who had used residential respite was that it had made no difference to their relatives' functioning or behaviour. In fact only about one in five carers in the earlier study felt that it had adversely affected the person with dementia, they variously referring to a general deterioration or to specific changes such as increased confusion, whilst about a quarter considered that the breaks had benefited their relative, stating that an illness had been diagnosed and treated, medication had been changed, the person had enjoyed the company, or, in a few cases, that the person had disliked the stay and had as a result become more cooperative upon their return home (Levin et al., 1989). A rather higher proportion (48%) of the carers of people with dementia in Burdz et al.'s Canadian study thought that the recipient's condition had worsened post-respite however, and having dementia was associated with a post-respite deterioration of the caregiver:care-recipient relationship, although the numbers involved were very small (Burdz et al., 1988).

Somewhat paradoxically, the latter study also reported that, when compared with a control group, respite actually made no difference to the recipients' cognitive functioning and had a positive effect on their behaviour (Burdz et al., 1988). This is not to say there was any absolute improvement in their presentation though, whilst it has been queried whether such staff-observed differences were maintained upon the clients return home (Brodaty & Gresham, 1992). Another study of stroke and dementia patients did report marked and significant improvements in respite recipients' social behaviour however (Homer & Gilleard, 1994). In contrast, Larkin and Hopcroft (1993) found that the functioning of a third of their small sample of Alzheimer's disease sufferers had deteriorated post-respite, whilst in another US study of 39 veterans admitted to an inpatient respite facility, the majority were said to have experienced a small but statistically significant decline in self-care and behaviour at two days after discharge. Many had returned to their pre-respite status after fourteen days at home though (Hirsch et al., 1993). Interestingly, the people who deteriorated most substantially in this latter study tended to be those who were initially least impaired, it queried whether, in being most aware of their changed environment, they may have reacted most negatively to it? Another possible explanation is that, being more stressed, the carers of the more dependent group exaggerated their problems at the time of admission, resulting in a factitiously small difference between admission and post-discharge scores (Hirsch et al., 1993). Similar findings were reported in an earlier, uncontrolled study by Seltzer et al. (1988), but still other work has found little or no difference in clients' functioning pre and post-respite (Adler et al., 1993). Despite concerns that respite care may increase mortality in the frail elderly, the balance of evidence strongly refutes the suggestion that this is true of people with dementia (Levin et al., 1989; Brodaty & Gresham, 1992; Flint, 1995).

If there is little evidence that respite care for people with dementia significantly affects caregiver burden or the respite recipients' presentation, does it prevent, or even delay, institutionalisation? High rates of transfer to permanent care shortly after, or directly from, respite care have been noted by Brodaty and Gresham (1992), but these are not easy to interpret. As the authors suggest, whilst respite care may cause premature institutional placement, an alternative explanation is that the need for institutional care is manifested by the arrangement of respite, whilst a third interpretation is that both have a common cause, such as a lack of home care services (Brodaty & Gresham, 1992).

In their review of care services for people with dementia, Zarit et al. (1999) found that most evaluations of respite care have shown that such programmes are indeed associated with increased, rather than decreased rates of care home placement. In the first of Levin et al.'s UK studies for example, 12 (80%) of the 15 surviving elderly people with regular respite care were in permanent residential care at follow-up as against approximately 20 per cent of those who had occasional or no respite ($p \leq 001$). The conclusion that regular respite care strongly increased the likelihood of entry into permanent institutional care remained even after the combined effects of other factors associated with entry to care, such as the carers' willingness to institutionalise their relative and the care-recipients' functioning and behaviour, had been allowed for (Levin et al., 1989). An uncontrolled study by Larkin and Hopcroft (1993) similarly found that people with dementia who participated in an in-hospital respite programme had increased risk of institutionalisation. However one much cited randomised trial in the US found that offering respite services to the caregivers of people with Alzheimer's disease was able to increase the length of time they remained in the community by an average of 22 days when compared with a control group (Lawton et al., 1989). This finding should be treated with caution though: the study used a wide definition of respite which included day care; services such as care management and counselling were also offered to the intervention group which may have improved their clinical outcome; and caregivers in the control group were also able to receive respite services.

As touched on above, various reasons why respite care may hasten institutionalisation have been postulated (Scharlach & Frenzel, 1986; Levin et al.

1989, 1994; Flint, 1995). The carer may recognise that others can look after their relative and thus feel less guilty about giving up care, or, having had a break, the carer may feel more resentment at resuming a caregiving role. There may be a deterioration in the care-recipient's behaviour, or, their assessment in care may have made their difficulties more visible to professionals who are thereafter more likely to advocate permanent care. Alternatively, some professionals use the provision of respite breaks as preparation for, a pathway to, permanent care, allowing both the supporter and the care-recipient to get used to separation, whilst in other cases it may be that there is an immediate need for permanent care and respite is used simply as a holding position until a suitable place becomes available. The association in these latter two cases is coincidental rather than causal therefore.

In summary it can be said that whilst anecdotal accounts suggest that respite care is both valued and helpful, empirical support for this view is lacking. Brodaty and Gresham (1992) suggest five reasons for this conflicting picture and urge caution in accepting the research findings to date. The first is methodological; the study samples are often small and include people with different diagnoses, levels of impairment and behaviour, whilst the definitions of respite used are not consistent. Furthermore if respite is to be meaningful, it needs to be of sufficient frequency and duration to make a difference, with studies long enough to detect cumulative effects, and not, as some have, concentrating solely on the aftermath of an initial respite break which may, because of its newness, cause particular anxieties (Flint, 1995). The timing of the respite offer is a second consideration, it possible that participating carers have not been engaged early enough to influence their future behaviour, whilst, thirdly, it is suggested that it is not sufficient to simply make carers aware of the existence of relief care, they also needing education about how best to use it. That residential respite is just one form of a spectrum of respite services and may not of itself meet the needs of all carers/cared-for is the fourth caution, whilst, lastly, it is noted that professionals do not really know how best to prescribe such breaks i.e. for whom, how long, where and how? If respite is to have a preventative effect then it may be that it should be offered before the carer becomes overtly stressed for example, but not too early that it demoralises the cared-for. At present it is more often offered as a palliative when supporters are already stressed (Levin et al., 1989).

Pursuing this latter point Nolan (1994) emphasises that given that one of the main aims of respite care is to reduce carer stress, it is vital that professionals have a clear understanding of the nature of stress. The widely accepted transactional model originally proposed by Lazarus (1966) hypothesises that stress will only develop when an event is seen as threatening/challenging and the individual does not feel they have the resources/ability to cope with it. Stress is therefore determined by a subjective, individual interpretation of events, but eligibility for services such as respite care is often determined by objective factors such as the degree of impairment experienced by the person with dementia or the amount of help they need with various activities. More subjective factors such as the nature and quality of the carer:care-recipients relationship may therefore be a more sensitive indicator of need (Nolan, 1994).

Other issues that appear to have been overlooked include the effect of the quality of the respite placement on its outcome, this potentially influencing the reaction of both the carer and the cared-for, and the impact that respite placements may have on other residents living/staying in the institutions providing the service (Nolan, 1994). Whilst respite is most usually provided in designated beds within homes or hospital wards (Levin et al., 1994) it can be upsetting for long-stay residents to have new people arriving each week (Audit Commission, 2000). There may be good reason to choose such a setting if it is geographically convenient for a carer, or if it is anticipated that the respite recipient might ultimately move there permanently (Levin et al., 1994). However Nolan (1994) has suggested that positive outcomes are more likely for both users and carers where respite is the sole purpose of a unit. The desired interface between respite and residential provision is therefore another issue that must be addressed by those responsible for planning and commissioning services.

Box 5. New Models of Respite

The Audit Commission (2000) state that institutional respite should be just one of a range of high quality options available to carers, with respite care at home being an alternative option. This was in fact available in three of their twelve original study sites and in a quarter of places in their wider review (Audit Commission 2000, 2002). Whilst night sitter services have been reported to be successful in providing respite to carers of people with dementia (Twigg et al., 1990) no outcome studies of such input have been identified.

Night respite, where people with dementia go to a centre for just one or two nights in a row to enable their carer to have a reasonable night's sleep is another, less common, service model. Both Watkins and Redfern (1997) and Treloar (2001) have described such services, with recipients collected around 8 p.m. in the evening and returned home between 8 and 9 a.m. the following morning. Both schemes were well received by users. There was no suggestion that they were effective in delaying permanent institutional care or controlling psychological morbidity in carers or service users however (Askham, 1997), although as breaks are provided so frequently, carers may be less prone to the rapid return to baseline stress levels seen in studies of residential respite care (Treloar, 2001).

CARER SUPPORT

Key Points:

- **Studies report high levels of strain, distress and depression amongst the carers of people with dementia although the social and economic toll borne by carers of older people with other mental illnesses has received scant attention**
- **The non-cognitive features of dementia, including hallucinations, low mood and behavioural disturbance, are the most difficult for carers to cope with**
- **Interest in the use of psychosocial interventions to support carers is high, but many studies are of poor quality**
- **The best evidence of effectiveness is provided by individually tailored interventions that include problem-solving strategies and/or behaviour management techniques**

The important role that family carers play in making a reality of community care has been widely acknowledged in recent years. The 1995 Carers' (Recognition and Services) Act introduced the right for a informal carer supporting a person entitled to a community care assessment to have their own needs assessed and in 1999 a national strategy for carers was launched, pledging to raise the level and quality of support that carers received (DoH, 1999).

An extensive literature documents the stresses faced by the carers of older people and particular attention has been paid to the impact of caring for someone with dementia (Jerrom et al., 1993; Levin et al., 1994; Audit Commission, 2000). Studies have consistently reported high levels of strain, distress and depression amongst these carers, who also have poorer physical health than population norms (Schulz et al., 1990; Donaldson et al., 1997; Pusey & Richards, 2001). The large social and economic toll borne by carers of older people with other mental illnesses, has, in contrast, received scant attention from researchers, although it is recognised in policy documents like the *National Service Framework for Older People* (DoH, 2001a). This section will thus necessarily focus on options for supporting carers of people with dementia.

The factors that make caring for someone with dementia stressful have been well described. Non-cognitive features such as hallucinations, low mood and behavioural disturbances have been shown to be the most demanding to cope with (Donaldson et al. 1997, 1998). It is however less clear whether there is a significant relationship between cognitive disturbances and caregiver burden, whilst limitations in daily activities of living seem unrelated to psychological outcomes for carers (Donaldson et al., 1997). In general the situation is worse when the carer lives in the same house as the person with dementia and the closer the blood/role relationship (Jerrom et al., 1993; Parker, 1997). There is also some evidence that female spouses and daughters both find the caring role more stressful than their male counterparts, and it is suggested that males take a more practical approach to caregiving (Zarit et al., 1986; Jerrom et al., 1993).

The humanitarian implications of alleviating carer burden are self-evident, but the relief of carer stress may also have important economic implications, for, as will be seen later, higher levels of carer stress are associated with a greater tendency to institutionalise the cared-for. There are then three main ways in which services might try to reduce carer strain: through reducing the carer's exposure to the symptoms that are distressing, as in the provision of respite, home or day care; through altering the symptoms that are found stressful by the carer, perhaps by the use of medication; and/or through changing the caregiver's response to the symptoms that are perceived as troublesome, as by the provision of education/training and/or psychological therapies (Donaldson et al., 1998).

Whilst the provision of respite, home and day care has been considered elsewhere in this review, the pharmacological treatment of mental health problems lies outside its scope. The remainder of this section will therefore concentrate on exploring those intervention studies which have sought to change the caregiver's reaction to the symptoms of dementia which they find difficult in terms of either modifying their perceptions of, or changing their response to, such symptoms.

Interest in the use of psychosocial interventions to reduce distress, burden and strain in family carers of people with dementia is high (Woods et al., 2003). A systematic review by Pusey and Richards (2001) identified thirty controlled studies (randomised and non-randomised) of supportive individual or group interventions for carers of people with dementia of which 16 were undertaken in the US, eight in the UK, four in Canada and two in Australia. Unfortunately many were poor in quality, there particular problems with small sample sizes, group allocation and short follow-up periods, but the authors nevertheless found indications that positive outcomes were possible for both the caregiver and the person with dementia.

According to Pusey and Richards (2001), most early attempts to help carers utilised general education groups. There is little evidence that information alone can significantly reduce carer burden however, and whilst support groups are usually well received and highly valued, they have generally been found to be less effective than structured individualised approaches (Marriott et al., 2000; Arksey et al., 2002). Indeed one review of carer support groups for the family and friends of people with dementia found no evidence of any significant change in carer experience across a range of outcome measures (Arksey et al., 2002).

More recently a much wider range of individual and group interventions has been heralded. These have included attempts to improve carers' social networks and to teach them stress management, problem-solving, cognitive restructuring and behavioural management techniques. Of the studies reviewed by Pusey and Richards (2001), 14 evaluated an intervention delivered in a group format, many of which were portrayed as successful. The reviewers concluded that their results were subject to numerous and critical methodological weaknesses however, and that the overall evidence for their effectiveness was poor. Nevertheless, a relatively robust Australian evaluation of a highly structured ten-day residential training programme which included educational sessions, family therapy and techniques to cope with problem behaviour reported reductions in carer stress (Brodaty & Gresham, 1989), and an American paper by Baldwin et al. (1989) offered reasonable evidence that a semi-structured psychotherapy group could reduce a measure of carer strain.

Nine further studies took the form of individualised interventions, but many of these also had major methodological weaknesses. The ‘best’ evidence was said to come from an American study by Mittelman et al. (1995) who found that a four-month period of individual and family counselling followed by attendance at a support group and ad hoc counselling reduced both depression in family caregivers and, over a three year period, rates of institutionalisation. Another study by Teri et al. (1997) also reported lower levels of depression in two groups of carers who used structured behavioural techniques to reduce depression in patients with Alzheimer’s disease, with one group emphasising the provision of pleasant events and the second focusing on caregiver problem-solving. Hincliffe et al. (1995) offered similar quality evidence of reductions in carers’ psychological morbidity following individual psychological support so long as this was implemented without delay.

Five further studies evaluated the efficacy of particular models of service configuration, but these were felt to be particularly weak, not least because their nature made it implicitly difficult to recruit from the same population. The most robust work was felt to be that by Woods et al. (1999, 2003) who reported that carers referred to the Admiral Nurse Service (a specialist mental health nursing service for carers of people with dementia) displayed lower levels of anxiety than those referred to a traditional community mental health team. Both groups showed a reduction in their general level of distress however and there was no significant difference in their scores on the General Health Questionnaire. Interestingly, carers’ anxiety levels were higher when an assessment was offered and the person was then referred back to primary care or social services than when the service remained engaged with the carer and/or person with dementia (Woods et al., 2003).

In conclusion, it would appear that the best evidence of effectiveness is provided by individually tailored interventions that include problem-solving strategies and/or behaviour management techniques (Pusey & Richards, 2001). Even so it is difficult to specify precisely what is helpful, for the interventions in many of the studies described had more than one element, whilst the situation is further compounded by the differing and complex nature of the problems faced by carers, and the variety of ways in which they respond. Indeed when Brodaty and Gresham (1989) asked carers which component of their training programme they had found most helpful, no element consistently emerged as the most helpful and virtually all elements were considered by at least some carers to have been especially beneficial! It is perhaps thus not surprising that interventions designed specifically for the individual case seem to be more promising than either group or service approaches (Hincliffe et al., 1995; Pusey & Richards, 2001).

ALTERNATIVE HOUSING

Key Points:

- **The provision of sheltered accommodation was a core feature of housing policy for older people in the latter part of the 20th century, but the interest today is on the role of very sheltered schemes**
- **Very sheltered or 'extra care' schemes are typically characterised by the presence of an on-site care team, the provision of some meals and their high specification design**
- **The stock of very sheltered housing is currently very small and there are major differences in the availability and nature of provision between areas**
- **Research to date suggests that providers and residents are highly satisfied with extra care housing. The outcomes and costs of living in such accommodation are key areas for further investigation**

Sheltered housing has been a dominant feature of housing policy for elderly people for much of the last 50 years (Tinker et al., 1995). Defined as grouped accommodation with shared communal facilities, warden supervision and an alarm system (Tinker, 1987), it was originally conceived of as a response to the needs of council house tenants who, as they aged, were no longer seen to need (or justify) a large family home, and might benefit from the help of a warden who would take on the role of a good neighbour (Peace et al., 1997). Such initiatives were strongly promoted by the government in the late 1960s and 1970s. Indeed, they were seen as an essential part of a continuum of care in which elderly people could stay at home and receive a little care if they needed it, move into sheltered housing if they were more vulnerable or infirm and be admitted to residential care only if they required intensive support. Whereas residential care had previously been the sole option for people who needed monitoring, sheltered housing now offered an alternative, and was seen to have advantages in terms of both cost and quality of life (Nocon & Pleace, 1999).

This envisaged substitution did not really materialise. Sheltered housing was still primarily a form of housing rather than of care and for many people its attraction was the provision of modern, dry and warm accommodation (Tinker et al., 1995; Nocon & Pleace, 1999). Criticisms began to be voiced that, if anything, the older people living in sheltered housing were less frail than those living in their own homes, or at the least, no more impaired (Cooper, 1991; Nocon & Pleace, 1999) and a 1994 study of the housing needs of elderly and disabled people reported that whilst there was a growing core of high dependency residents in sheltered schemes, the proportion who had no physical or mental health problems was also increasing (McCafferty, 1994). It is perhaps then not surprising that the new community care arrangements of the early 1990s, with their emphasis on enabling people to stay at home, did not really identify a place for sheltered housing with its limited warden support, and the government have been discouraging the development of new schemes for some years (Nocon & Pleace, 1999).

In the 1980s a new form of sheltered housing known as 'very sheltered housing' or 'extra care' began to emerge (Tinker, 1989). These terms, which have been used synonymously in this report, encompass a range of models of housing with care which can be differentiated in terms of their funding arrangements, costs and accommodation, as well as by the range of support and activities they offer (Croucher, 2005). They are however typically characterised by the presence of an on-site care team who provide flexible day and night care in people's flats, by the provision of some meals, by their high specification designs which commonly incorporate such features as full wheelchair access, level access showers and height adjustable units, and by their commitment to the principle of independent living (Tinker, 1989; Gatward, 2002; Vallelly & Evans, 2004).

This provision did blur the lines between residential care and sheltered housing and gave people with relatively high care needs the option of living in a housing setting (Nocon & Pleace, 1999; Evans, 2003; Vallelly & Evans, 2004). Furthermore, whilst such schemes were found to be more expensive than caring for someone in their own home, it was reported that they did not cost as much as residential placement (Tinker, 1989). It is not clear how comprehensive these costing exercises were however.

In the community care reforms referred to above very sheltered housing was therefore seen as having a role as a relatively cheap replacement for some residential care (Nocon & Pleace, 1999) and over the last ten years there has been a rapid increase in the number of extra care schemes provided by both local authorities and housing associations. A number of these have specialised in the care of people with dementia (Tinker, 1989) and the authors are aware of a small number of schemes that specifically support older people with functional mental health problems, although no reviews of such models could be identified.

Across the UK only about five per cent of elderly people live in sheltered housing however (Cooper, 1991; Sutherland et al., 1999) and in 1997 still only three and a half per cent of the half a million units of sheltered housing were very sheltered, such that the total stock of this accommodation is currently small. There are, moreover, major differences in provision between areas, which appear unrelated to the number of older people in the locality (Sutherland et al., 1999).

Although it would seem that both providers and residents, including residents with dementia, are highly satisfied with very sheltered housing (Sutherland et al., 1999), there is extremely little research on the outcomes of living in such accommodation. In fact most of what has been written consists of descriptions of individual schemes or reports of conferences (Tinker, 1989). There is a particular lack of research examining the ability of very sheltered housing schemes to care for people for life, or to provide an alternative to institutions, whilst the little evidence we have on the latter is mixed (Sutherland et al., 1999; Evans, 2003). Thus although elderly people in residential care have generally been found to be older and more dependent than those in very sheltered housing schemes, some complexes do cater for people with as high a level of needs as those in institutions (Tinker, 1989). Furthermore, the true social costs of very sheltered housing have yet to be fully investigated, as have the range of financial products and tenure arrangements available to potential residents (Darton & Muncer, forthcoming).

Whilst nothing has been found to suggest that very sheltered housing schemes for people with dementia are any more or any less successful than those for the frail elderly, little work has focused on this client group (Tinker, 1989). There are indications that when confused tenants are mixed with people without cognitive impairment this does cause problems however (Tinker, 1989), and a three-year research project is currently being undertaken to evaluate the optimum levels of support for people with dementia and the boundaries and limitations of such provision (Evans, 2003). In the meantime a local charity in Newcastle have taken the concept of very sheltered housing for people with dementia one step further in providing ‘independent living houses’. In this scheme a very small number of people, functioning at similar levels to residents in mental health nursing homes, have been empowered to live ‘ordinary’ lives in ‘ordinary’ flats supported by a round-the-clock team of care workers (Svanberg, 1998; Svanberg et al. 1998, 1999). The initial evaluation of this initiative, although descriptive and with small numbers, suggests that the service is able to support people with moderate and severe dementia, high levels of dependency and difficult behaviour at a cost that is higher than that for residential care, but less than that for a nursing home. There is, furthermore, some evidence of improvements in residents’ quality of life, in terms of reduced levels of behavioural disturbance and reductions in medication, whilst it has rarely been necessary to transfer tenants into institutional nursing care (Svanberg, 1998; Svanberg et al. 1998, 1999).

SPECIALIST SUPPORT TO CARE HOMES

Key Points:

- **The mental health problems experienced by elderly care home residents are frequently unrecognised despite their high prevalence**
- **When mental health problems are identified, the response, in terms of the provision of medication, psychological therapies and social support, is not necessarily appropriate**
- **Specialist mental health services should provide education and advice for care home staff**
- **Such training has more impact when it is combined with resident specific interventions and ongoing staff support**

Whilst up to 85 per cent of UK care home clients experience dementia (Harrison et al., 1990) and around 40 per cent have been found to be depressed (Ames et al., 1988) both the Department of Health (2001a) and the Audit Commission (2000) have recently highlighted the under-detection of mental health problems in care home residents. Even where depression is identified, the response, in terms of the provision of medication, psychological therapies and/or social support is often inadequate (Schneider & Mann, 1997). There has, furthermore, been growing concern in recent years about the indiscriminate use of psychotropic medications to treat challenging behaviour in people with dementia, such drugs often having unpleasant side-effects and only modest efficacy (McGrath & Jackson, 1996; Furniss et al., 1998; Margallo-Lana et al., 2001).

Moniz-Cook et al. (1998) state that referral to mental health services commonly follows the experience of a crisis within the care home, and the Audit Commission (2000) found that an average of 14 per cent of the people in acute mental health inpatient beds were admitted from residential homes, although such admissions accounted for 33 per cent of the total in one site. This is perhaps not surprising given that care home staff will generally have received little specific training in the care of older people with mental health problems (Moniz-Cook et al., 1998). In high profile reports both the Audit Commission (2000) and the Department of Health (2001a) have thus called for specialist mental health services to make support, education and advice consistently available to staff in residential settings, the Audit Commission (2002) finding that this was currently provided in just over a quarter of areas. Whilst there has to date been relatively little UK work assessing the effects of such input on resident outcomes, the research does give some initial pointers.

One approach is to try to improve the mental health of care home residents through the education of care home staff and Ballard et al. (2002) highlighted four controlled studies that have demonstrated positive results from training (Smyer et al., 1992; Rovner et al., 1996; Moniz-Cook et al., 1998; Proctor et al., 1999). The messages which emerge from this literature are that those interventions that had a greater, lasting effect employed more staff time, and that such training has more impact when it is accompanied by ongoing staff support (Moniz-Cook, 1998). The provision of a seven-session teaching programme followed by regular supervision led to improvements in residents' levels of depression and cognitive impairment for example, if not improving behaviour per se (Proctor et al., 1999).

It is suggested that in order to produce a more significant impact such educational input should be combined with resident specific advice/interventions and Ballard et al. (2002) have noted that what are needed are simple measures that can be incorporated into routine clinical practice. There is some evidence suggesting that regular psychiatric consultation may increase care home staff members' understanding and acceptance of emotional problems, increase the frequency of therapeutic programmes offered, and reduce requests for urgent intervention or hospital admission (Tourigny-Rivard & Drury, 1987; Jackson & Lyons, 1996).

More rigorous studies have shown that proactive intervention programmes can actually decrease the number of residents presenting with challenging behaviours or depressive symptoms (Llewellyn-Jones et al., 1999; Cuijpers & van Lammeren, 2001). One US randomised controlled trial of a programme of structured activity, pharmacological treatments and education, for example, resulted in a halving of the number of residents displaying disturbed behaviour (Rovner et al., 1996). The interventions in these studies have mainly been implemented by well-resourced research or clinical teams however, as have those reporting positive results from the use of specific psychosocial approaches to challenging behaviours (see Moniz-Cook, 1998; Forbes, 1998 or Allen-Burge et al., 1999 for reviews). It is not yet clear whether similar results could be achieved by less intensively staffed services. The findings of Opie et al. (2002) and Ballard et al. (2002), who both assessed the input of smaller multidisciplinary teams, are however promising. For example, in the latter, UK work, a liaison team consisting of a full time community mental health nurse, a consultant psychiatrist (2 sessions a week) and a clinical psychologist (1 session a week) used Antecedent, Behaviour, Consequence diaries as the foundation for the development of individual resident care plans. Each participant also received a psychiatric assessment that encompassed a medication review. When compared with a control group receiving usual clinical care, the intervention group received significantly less neuroleptic medications, had significantly less contact with GPs and spent a three-fold lower number of days in mental health inpatient facilities (although the latter was not statistically significant).

SPECIALIST SUPPORT TO GENERAL HOSPITALS

Key Points:

- **The prevalence of mental health problems in older people admitted to general hospital beds is high**
- **Staff in general hospitals detect only a small proportion of this disorder and even when mental health problems are identified patients do not necessarily get appropriate care and treatment**
- **There is much demand for specialist mental health input to general hospital patients and some evidence that this can improve psychiatric outcomes**
- **Whilst various service models exist, little is known about their relative effectiveness**

About 60 per cent of general hospital beds in the UK are occupied by older people (DoH, 2001a). There are wide variations in the reported rates of psychiatric co-morbidity in this population, at least in part resulting from the differing ways in which morbidity is defined (Ramsay et al., 1991), but a review of the literature would suggest that the prevalence rate may be as high as 60 per cent (Baldwin, 1998). This is composed mostly of people with dementia, acute confusion (delirium) and depression (Baldwin, 1998; Scott et al., 1988). The reported prevalence rates of dementia and delirium range between 25 and 60 per cent and 15 and 60 per cent respectively, whilst significant depression has been found in between 9 and 45 per cent of older medical inpatients and depressive symptoms in as many as 73 per cent (Ramsay et al., 1991; Jackson & Baldwin, 1993; RCP/RCP, 1995; Holmes & House, 2000; Linka et al., 2000).

Such disorders impair quality of life and it has been found that general hospital inpatients with depression are likely to stay depressed post discharge (Koenig et al. 1992, 1997). Studies also suggest that older people with psychiatric co-morbidity have a greater length of stay in hospital, use more resources and have a higher mortality rate than those without (Ramsay et al., 1991; Holmes & House, 2000; Stevens et al., 1998). The Royal Colleges of Physicians and Psychiatrists (1995) suggest that whilst such findings may in part be attributable to difficulties arranging suitable placements upon discharge, they may also reflect the fact that the presence of psychiatric disorder can limit compliance with medication and make management more complex.

Despite this high prevalence, medical and nursing staff in general hospitals are poor at recognising mental illness in older people (Jackson & Baldwin, 1993). It is suggested that dementia may easily be overlooked in acute medical settings, particularly if the individual has a good social façade (Ramsay et al., 1991) whilst Koenig et al. (1997) have reported that only a small proportion (9-26%) of depressed elderly patients are recognised as depressed. Unfortunately, even when psychiatric disorder is detected, the patient may not get appropriate care and treatment (Jackson & Baldwin, 1993; Orrell et al., 1995; Koening et al., 1997; Packer, 2000).

Given this situation, the demand for specialist mental health input to general hospital patients is perhaps not surprising. In 1997 Wattis reported that referrals from medical and surgical wards constituted between 15 and 20 per cent of all referrals to old age psychiatry services. The numbers would moreover appear to be growing. More than two-thirds of old age psychiatrists who responded to a recent national survey of psychiatric services for older people in general hospitals (Holmes et al., 2003) described an increase in referrals over the previous three years and the median number of referrals was 115 per year, comprising 25 per cent of total referrals. In one large, three-year study of medical referrals to a psychogeriatric team, the main reasons for referral were said to be presentation with confusion/behavioural problems, a desire for advice about failure to cope/discharge plans and requests for assessment of depression (Scott et al., 1988).

Various service models exist, although as of yet we know very little about the relative effectiveness of these (Holmes et al., 2003; Mujic et al., 2004). Liaison psychiatry was the term originally used to describe the type of clinical practice developed in the USA whereby a psychiatrist attended medical ward rounds and other clinical meetings (RCP/RCP, 1995). Its aims have been said to include the diagnosis, treatment and prevention of psychiatric morbidity in the physically ill (Liposwki, 1981; Swanwick et al., 1994). Alternative models of service include consultation, whereby general hospitals clinicians refer individual patients to the specialist mental health service for an assessment which often takes place without involving the referrer, and consultation-liaison, a compromise arrangement in which individual consultation still takes place, but the psychiatrist and physician meet to discuss specific patients and general aspects of clinical care (RCP/RCP, 1995). A less common option is shared care, whereby psychiatric input is provided in a dedicated ward within the general hospital staffed by psychiatric nurses, general nurses, psychiatrists and physicians (Holmes et al., 2003). It is argued that this overcomes the difficulties of persuading medical teams to implement the mental health team's recommendations (Slaets et al., 1997).

Holmes et al. (2003) set out to map the provision of specialist mental health input for older people in general hospital wards in the UK as well as clinicians' views on future service priorities and found that the majority of services (73%) were provided through a generic, sector-based, consultation model. Such teams typically had a strong community focus, despite the significant proportion of their referrals that came from the general hospital, and were medically led. Whilst input from mental health nurses was available in 35 per cent of services, only 14 per cent had specialist liaison psychiatry nurses.

In total nearly 90 per cent of respondents were unhappy with the service they offered to older people in general hospital wards, with slow response times said to be a particular weakness of the consultation approach (Holmes et al., 2003). In such a model hospital referrals compete with those from the community and it is difficult to assess and meet the needs of both groups (Collinson & Benbow, 1998). Indeed a number of services have reported improvements in their response times upon changing to an on-site liaison model (Collinson & Benbow, 1998; Mujic et al., 2004) and the vast majority of consultants aspire to providing hospital-based, multidisciplinary models, proactively seeking referrals and educating general hospital staff (Holmes et al., 2003). Such a view is in keeping with the recommendations of a joint report by the Royal College of Physicians and Royal College of Psychiatrists (1995), who argue that liaison psychiatric services are best developed by a multidisciplinary team of staff whose major commitment is to this work. Teams moving towards such services have reported increased numbers of appropriate referrals (Collinson & Benbow, 1998; Scott et al., 1988; Mujic et al., 2004).

As has already been noted, there have as yet been very few controlled trials of liaison services for older people in general hospitals, and in his review of the effectiveness of old age psychiatry input Draper (2000) concluded that the overall results in terms of psychiatric outcomes have at best been modest. The most encouraging findings come from a large American multi-site consultant liaison study by Strain et al. (1991) in which the psychiatric screening of elderly hip fracture patients together with appropriate treatment and advice about discharge produced a significant reduction in their length of stay, and hence hospital costs. A further study in the Netherlands (Slaets et al., 1997) also found that integrating the psychiatric and geriatric teams resulted in better physical functioning at discharge and shorter length of stay, whilst a smaller Canadian trial (Cole et al., 1991) reported that a consultation service had a small positive (if non-significant) effect on psychiatric symptoms and functional status. Patients with delirium and depression, perhaps not surprisingly, showed most improvement. A pilot randomised controlled trial that looked at the efficacy of the early identification of depression and intervention by psychogeriatric consultation in the UK found no differences on any of their outcome measures however, but the sample was small and the geriatricians frequently failed to implement recommended interventions (Shah et al., 2001).

A nurse-led model may be an alternative way of responding to the increases in demand, for, as Baldwin (1998) has argued, the clinical issues that arise, including the support and education of patients and staff and the provision of advice on placements and behavioural management, seem particularly suited to the skills of mental health nurses. Some support for such an approach is offered by a randomised controlled trial which compared a mental health liaison nursing service with usual clinical care and reported modest improvements in depression scores if not in other outcome measures (Pratt et al., 2003; Baldwin et al., 2004). This study suggests that selecting patients on the basis of screening tests in acute medical facilities is probably not the most efficient approach however, and that more might be achieved by targeting specific clinical areas such as orthopaedics or by addressing specific disorders such as depression (Baldwin et al., 2004).

ACUTE INPATIENT ADMISSIONS: OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS ADMITTED TO HOSPITAL FOR ASSESSMENT AND TREATMENT

Key Points:

- **Inpatient care is indicated for older people with severe and complex mental health problems, particularly when there is a significant risk to safety or when intensive assessment and treatment are needed**
- **The past twenty-five years have witnessed a marked fall in the provision of NHS inpatient beds and it is vital that the people admitted to this very expensive resource are those who need it most**
- **Contemporary reports of older people admitted to acute mental health inpatient beds are rare, but there is some suggestion that not all admissions are appropriate**
- **Few studies have considered the outcome of admission to acute old age psychiatry wards, but the findings are generally encouraging, especially for people with depression**

As has already been noted, government policy for the care of older people with mental health problems is underpinned by the principle of community care. The primary assumption is that most older people, including those with complex needs, can, and would prefer to be, treated/supported in their own homes (DoH, 2001a), but however comprehensive the community resources, there will always be a significant minority of patients who require specialist mental health inpatient care (Brimblecombe, 2000; Audit Commission, 2000). According to the *National Service Framework for Older People* (DoH, 2001a p93) inpatient admission is indicated for older people with “severe mental illness, especially if there is a risk to the safety of the patient or others, or where particular problems require more intensive assessment and treatment”. The Audit Commission (2000 p65) have suggested that admission may also be necessary to “stabilise behaviour problems that are unmanageable in any other setting”.

Alongside the promotion and development of community mental health services there has been a dramatic decline in the provision of NHS beds for older people with mental health problems. Bed numbers fell by 38 per cent between 1983 and 1996 (Audit Commission, 1997). Whilst many of the beds that have closed will have been for long-stay patients, when one considers the overall reduction within the context of the rising demands imposed by demographic ageing, it is not surprising that the threshold for admission is reported to have increased (Sainsbury Centre, 1998). Indeed The Tomlinson Report (Tomlinson, 1992) found that inpatient services for the elderly mentally ill in London were seriously overstretched. In the context of a decreased supply of residential accommodation, this position has more recently been compounded by difficulties arranging care home placement for patients who no longer require acute inpatient care, but whose needs dictate that they cannot return home (Koffman et al., 1996; Stewart et al., 1997).

In such a situation it is vital that the people who are admitted to a hospital bed are those who most need this provision, but there is some suggestion that this is not the case. A lack of alternative residential options can result in pressure to admit people for primarily social reasons, whilst in light of the government's recent emphasis on the reduction of suicide rates and the protection of the public, there are worries that risk, rather than potential health outcome, may determine decisions about care (Moore, 1998; Strong, 2000; Petch, 2001). This is a matter of great concern, for admissions have high human and economic costs, being potentially disruptive and distressing (Fottrell, 1996) and accounting for the vast majority of specialist mental health care expenditure (Audit Commission, 2000).

Contemporary descriptions of people admitted to acute old age psychiatry beds in the UK, or reports of the reasons for their admission, are however rare, and it appears that we know relatively little about who receives such inpatient care or why. In the recent Audit Commission reviews of services for older people with mental health problems in England and Wales very little was reported about the inpatient population and minimal information was given about the data collection or analysis process, severely hampering interpretation of those findings which were presented (Audit Commission 2000, 2002). Concentrating almost exclusively on the experience of people with dementia, they nevertheless concluded that: the dependency levels of admissions varied from site to site; areas with more developed community services admitted less people with dementia; most inpatients were admitted from their own homes; the decision to transfer someone from another setting usually arose when their behaviour caused problems that couldn't be managed where they were; and the varying number of admissions for people with dementia was primarily a consequence of the divergent views of consultants as to when admission was appropriate (Audit Commission, 2000).

This focus on the care of people with dementia echoed a prospective study by Neville et al. (1999) which explored the reasons precipitating admission to acute dementia care beds in Leicesteshire over a six-month period from November 1994. Reporting on a total of 231 inpatient episodes, they identified a group of elderly people (mean age 80 years), of whom approximately 60 per cent were female. Just over 50 per cent lived at home with a carer, 26 per cent lived at home alone and 21 per cent resided in care homes. Approaching two-thirds of the sample had current involvement with the mental health services, and 'behavioural problems' accounted for over half of all reasons given for admission (Neville et al., 1999).

One earlier Irish study which sought to explore the appropriateness of the local mental health service's very specific admission criteria also profiled inpatient admissions (Freyne & Wrigley, 1997). From a retrospective review of the notes of 205 first admissions between 1989 and 1993, the researchers found that, excluding six patients who had no psychiatric disorder, 53 per cent had an organic mental illness, and 47 per cent a functional disorder, whilst their sociodemographic profiles were remarkably similar to those reported by Neville et al. (1999) above. Most of the admissions were for reasons defined within the service's admissions policy, which was intended to ensure that beds were used for treatment purposes only and the presence of marked behavioural disturbance, severe delusions and the need for ECT most commonly underlay the need for inpatient care (Freyne & Wrigley, 1997).

A more recent, unpublished and naturalistic study of patients admitted to the acute old age psychiatry beds in West Suffolk between October 2000 and March 2001 captured 105 admissions. Forty per cent of these were to wards for people with organic disorders and 60 per cent to wards for people with functional mental health problems (Tucker, 2001). Although they had a similar age profile to the samples reported in the studies above, a rather higher proportion of the admissions in this study were female (75%). It was thought that this may have been due to the higher prevalence of affective disorders in women (Beekman et al., 1999), as a larger percentage of the people in this study had a functional disorder. This may also explain why rather more of this sample lived at home alone than had been reported in previous work (about 40%), although an alternative interpretation is that this was a consequence of the increasing drive to use formal services to support people in the community (Tucker, 2001).

In keeping with the findings of Neville et al (1999), the vast majority of the Suffolk admissions (more than 80%) were already known to the mental health service, whilst approaching 40 per cent received some form of social care. Although this could be seen to support the argument that community care is failing (Alzheimer's disease Society, 1994), viewed in a more positive light, it may simply reflect the very complex needs of this population. The latter interpretation is supported by the fact that around 15 per cent of the cohort were transferred directly from the district general hospital, there a high degree of co-morbidity in the older population, and the picture developed from the data was of a group of people with a mixture of severe psychological and behavioural symptoms. More than 40 per cent were said to be agitated, and over 30 per cent of the patients entering wards for people with functional mental illness experienced delusions and/or paranoia. Similarly high percentages of the people admitted to wards for patients with organic mental health problems displayed nighttime disturbance, incontinence, poor mobility, wandering and/or aggression (Tucker, 2001).

Across the whole sample the three most commonly given reasons for admission were the need for diagnostic assessment, the need for treatment and the presence of concerns about medication. These were also the most frequently cited reasons for admission to wards for people with functional mental health problems. The need for general diagnostic assessment was also a common reason for admission to wards for people with dementia. However, the most frequently reported reason for admission to the latter wards was the desire to determine future care needs, whilst the management of behavioural disturbance and the breakdown of the home situation also featured highly here. The extent to which a significant minority of these admissions was appropriate was queried (Tucker, 2001).

Interestingly, in the light of the observations made by the Audit Commission about the influence of consultants' views on the use of inpatient beds, this study also explored the extent to which different groups of clinicians shared a common view on the appropriate use of inpatient beds using a series of case vignettes developed from the data. Given eight scenarios, staff unanimously agreed about the care of only one patient. Whilst one of the seventeen respondents supported the admission of six of the cases depicted, three practitioners were in favour of admitting only one of the clients portrayed and none of the four consultants agreed with admission in more than three cases, if not necessarily the same ones (Tucker, 2001).

No other UK study specifically focusing on the characterisation of the acute old age psychiatry inpatient population has been identified, nor any further work explicitly considering the process of, or reasons for, admission, although Salib and Sharp (1999) did look at the potential influence of one other variable on admissions – the weather! No evidence of any statistically significant association between a number of weather parameters and the rates of admission of people with dementia was found however. Published studies are also scarce in the international literature; just a handful were identified (e.g. Lesage et al., 1994; Moss et al., 1995; Draper & Luscombe, 1998) and, not withstanding their methodological limitations, differences in service provision raise big questions about the appropriateness of generalising their findings to the UK. For this reason they are not detailed here. Indeed, according to Reifler and Cohen (1998), only two countries other than the UK have a comprehensive range of hospital and community provision for older people with mental health problems – the Netherlands and Switzerland, but none of the identified international studies came from these.

There are however two further UK studies of interest. These report detailed pluralistic evaluations (involving patients, carers and practitioners) of the outcomes of admission to acute old age psychiatry wards (Wattis et al., 1994; Riordan & Mockler, 1996). The findings from the first of these were generally positive for people with depression, but did not identify any significant changes for patients with dementia (Wattis et al., 1994). The second showed clear evidence of positive symptom change and problem resolution, but noted that staff rated their effectiveness more highly than did patients or carers (Riordan & Mockler, 1996). Other naturalistic outcome studies have reported similar encouraging improvements, particularly in ratings of depression, but the absence of controlled comparisons makes it difficult to generalise from their findings (Draper, 2000). Furthermore, none of these studies seem to have considered how appropriate or necessary the admissions were in the first place!

CARE HOME ADMISSIONS: FACTORS ASSOCIATED WITH ADMISSION TO RESIDENTIAL AND NURSING HOME CARE

Key Points:

- **Older people with mental illness are at high risk of admission to a care home and at any one time about a third of people with moderate or severe dementia will be in institutional care**

- **Studies suggest that risk factors for care home admission include degree of cognitive impairment, need for help with daily activities and presentation of disruptive behaviour**

- **The institutionalisation of people with dementia has also been found to relate to the characteristics of their caregivers and the breakdown of caregiver arrangements**

- **Few studies have considered which aspects of functional mental illness predict care home entry, but service receipt may be significant**

- **Identifying those most at risk of care home placement may enable professionals to offer them the assistance to prolong their stay at home, improve their quality of life at home and/or facilitate a smooth transfer to a care home**

Approximately one in five men and one in three women who reach the age of 65 will at some point require institutional care (Heath, 2000). This risk is enhanced for those with mental illness, and people with dementia have been found to be up to eight times more likely to enter a care home than their non-cognitively impaired contemporaries (Philp et al., 1997). Indeed, it is estimated that about a third of people with moderate or severe dementia will be in hospital, residential or nursing home accommodation at any one time, whilst a further third need constant care or supervision, but live in the community (Melzer et al., 1997).

Around 443,000 older adults live in care homes in the UK (Royal College of Physicians, 2000). In England there are only 23,000 residential places specifically designated for the elderly mentally infirm however, whilst the number of older people with mental illness who occupy specialist nursing home beds is in the order of 21,000 (DoH, 2001b).

There is a growing body of evidence to suggest that an increasing proportion of the residents of non-specialist residential and nursing homes have mental illness. For example, in one study more than 85 per cent of the residents of Part III residential homes in Waltham Forest were found to show evidence of moderate-severe cognitive impairment (Harrison et al., 1990), whilst 74 per cent of the 445 residents of non-specialist nursing homes studied by Macdonald et al. (2002) were said to have dementia.

Levels of depression of around 40 per cent have also been reported amongst people living in non-specialist care homes (Ames et al., 1988; Schneider et al., 1997), although there has been some suggestion that these rates may fall as a consequence of the government's policy of community care. Neville et al. (1995) found less than 20 per cent of the residents of part III homes in Leicester to be depressed for example, and hypothesised that community services may now be supporting a proportion of those people who would formerly have entered a care home following a major life/loss event.

Prevalence studies do not distinguish between people suffering from mental disorder at the point of admission, and those becoming mentally unwell whilst resident in a care home. However, in a selective review of the literature relating to psychiatric disorders in nursing homes, Rovner and Katz (1993) concluded that the vast majority of patients had either dementia, or physical illness complicated by depression, on admission. Whilst much attention has been given to the role that various aspects of dementia may play in influencing the risk of institutionalisation, few studies appear to have considered symptoms of functional mental illnesses as predictors of care home entry. This part of the literature review will thus necessarily concentrate on those factors found to be associated with the entry to care homes of people with dementia. It is important to stress that this is not to say these features cause admission however, for findings based on correlational analysis do not allow judgements of causality to be made, being rather concerned with the development of models of prediction and the identification of relative risks.

According to the Alzheimer's Disease Society (2000), most people with dementia will ultimately require some form of residential care. Although a number of studies have confirmed that the likelihood of being admitted to an institution increases with increasing cognitive impairment, it may not be the impairment itself which is the determining factor (Hope et al., 1998) and researchers have examined a wide array of variables that it was thought might precipitate the timing of placement (Gaugler et al., 2003). It is difficult to provide a synthesis of the information available however, as the studies have used a range of methodologies and have focused on particular populations and subgroups of older people in a wide variety of geographical settings as detailed in Box 6 below.

Despite the above, there is a degree of consistency in the factors that have been found to predispose or precede the admission to care of people with dementia. The following sections of this chapter will therefore look in turn at the sociodemographic, functional, carer and system variables that have been shown to be of interest in this respect, prior to drawing some conclusions about the usefulness of the information reviewed. The chapter will then conclude with a brief consideration of the literature relating to older people with other mental health problems and those transferred from long-term hospital care.

Box 6. The Admission to Care Homes of People with Dementia: Methodological Difficulties

- Whilst some studies have considered the admission of older people to a variety of care home settings, others have specifically concentrated on either residential or nursing home placements
- Most of the published work has focused on samples of people with Alzheimer's disease and the extent to which the findings can be transferred to people with other forms of dementia is unclear as different forms of dementia have varying symptomatology and courses
- Many studies have further restricted their sample to people with significant informal carers, excluding those who live alone without the benefit of regular support from family or friends
- Caution should be taken in comparing samples of people known to specialist mental health services with those identified from population-based surveys, for the former are unlikely to be representative of the general population
- The majority of work has been undertaken in the United States and comparisons with the UK should be made with caution, as populations, services and practice may differ
- The studies offer both cross sectional and longitudinal perspectives, the former providing a view at a particular point in time (point of entry to care) and the latter following a cohort of cases over time
- Study sample sizes and follow-up periods also vary considerably, the relatively small scale of many limiting their sensitivity to detect the real effect of the variables considered i.e. their statistical power, whilst
- Further differences may be seen in both the studies' foci, and in the set of possible variables they consider.

Sociodemographic characteristics

Numerous studies have considered the role of variables such as advanced age, gender, marital status and living alone as predictors of institutionalisation among both older adults and older adults with dementia (Greene & Ondrich, 1990; Fisher & Lieberman, 1999; Gaugler et al., 2003).

Whilst it is commonly accepted that there is a relationship between increasing age and the probability of entering a care home amongst the general frail elderly population (Sinclair et al., 1988; Greene & Ondrich, 1990), the picture for people with dementia is less clear. One large American longitudinal study found that people with dementia who were aged 90 or older were 1.46 times more likely to be institutionalised sooner (Gaugler et al., 2003), whilst in Germany, Haupt and Kurz (1993) also found older age to be a predictor for placement. Conversely, Heyman et al.'s (1987) prospective investigation of people with early-onset Alzheimer's disease in America, found that age, whilst not a significant predictor of admission of itself, appeared to have a modifying effect on those functional variables that were significant predictors. Thus younger patients were at greater risk of institutionalisation than older participants with the same degree of dysfunction. Most work has quite simply failed to find any significant association between the age of the person with dementia and the risk of admission however (Colerick & George, 1986; Cohen et al., 1993; Fisher & Lieberman, 1999; Spruytte et al., 2001).

Studies considering the relationship between the gender of the dementia sufferer and care home admission have also yielded somewhat mixed findings. Although most care home residents are female (Peace et al., 1997), one study found that males with dementia were more likely to be institutionalised (Gaugler et al., 2003) whilst most studies have failed to find any significant association (Colerick & George, 1986; Severson et al., 1994; Fisher & Lieberman, 1999; Spruytte et al., 2001).

Part of this inconsistency may be related to the fact that as women live longer than men do, often outliving their spouses, no partner is available when these women need care at home (Fisher & Lieberman, 1999). Thus although only one study was identified in which marital status predicted the institutionalisation of people with dementia (Severson et al., 1994), it may be that in this population it is the person's living situation, i.e. whether they live alone or with others which is the more important factor. Indeed Gaugler et al.'s (2003) three-year longitudinal study found that people with dementia who lived alone were 1.55 times more likely to be institutionalised earlier, whilst other work reported that caregivers had a higher desire for institutionalisation when the person with dementia lived alone (Morycz, 1985; Spruytte et al., 2001). This association did not persist when the latter study considered the variables predictive of actual institutionalisation however (Spruytte et al., 2001), whilst other work has also failed to show a significant relationship here (Colerick & George, 1986; Fisher & Lieberman, 1999; Hébert et al., 2001).

Level of functioning and/or dependency

Although there is no simple relationship between level of functioning and entry to a care home, with some of those remaining in their own homes more incapacitated and dependent than those already in care (Warburton, 1994; Grundy & Glaser, 1997), several studies have reported significant, positive relationships between various indicators of the severity of disability or cognitive impairment experienced by the dementia sufferer and placement in a care home (Fisher & Lieberman, 1999; Hébert et al., 2001; Gaugler et al., 2003). Two studies found lower scores on the Mini Mental State Examination (a measure of cognitive functioning) to be predictive of institutionalisation for example (Cohen et al., 1993; Gaugler et al., 2003), whilst another identified severity of cognitive impairment as the most important predictor of entry to long-term care in a cohort of 141 older people referred to UK Social Services departments (Andrew et al., 2000). A Canadian population-based study of 326 people with dementia similarly found severity of disability to be significantly associated with institutionalisation (Hébert et al., 2001), whilst Steele et al. (1990) identified greater impairment of activities of daily living as one of four variables predictive of care home entry.

Concentrating on more specific aspects of daily functioning, Hope et al. (1998) identified immobility or difficulty in walking as one of a small number of characteristics predicting institutionalisation in a longitudinal UK study of 100 people with Alzheimer's disease living at home with a carer. Other studies have found incontinence to be associated with a higher risk of care home placement (O'Donnell et al., 1992; Haupt & Kurz, 1993). Interestingly however, Gaugler et al. (2003) found that deterioration in the dementia sufferer's ability to undertake various activities of living was a more important predictive variable than their absolute level of functioning, even when dependency was high, and it may be that carers find such change in function particularly challenging.

The above findings are not unequivocal, for a number of researchers have failed to identify any significant association between severity of disability or cognitive functioning and care home entry (Colerick & George, 1986; Lieberman & Kramer, 1991; Fisher & Lieberman, 1999). Furthermore, in Spruytte et al.'s (2001) study of 144 cognitively impaired people known to community nurses, a higher level of functioning was predictive of nursing home placement. This echoed the earlier findings of Vernooijdassen et al. (1997), it postulated that the caregivers of people functioning at a very low level may feel it is 'not worth' or too risky to move them (Spruytte et al., 2001).

Much attention has been given to the role that behavioural disturbances play in determining the decision to place a person with dementia in an institution and in their actual placement, and behavioural problems are generally agreed to be an important risk factor for entry to long-term care (Cohen et al., 1993; Hope et al., 1998). Not all studies have used recognised measures of behaviour however (Morris et al., 1996). One study that did, reported that a greater amount of generalised behaviour problems predicted admission in 74 per cent of 417 new residents to nursing homes in the United States (Morris et al.,1996) and another identified generalised behaviour problems to be one of the strongest predictors of time to institutionalisation (Gaugler et al., 2003). Cohen et al. (1993) similarly found both caregivers' and independent assessors' appraisal of troublesome behaviours to be significantly associated with the termination of community care, but although Spruytte et al. (2001) found a greater degree of behavioural disturbance to be predictive of a caregiver's desire to institutionalise the care receiver, it was not predictive of actual institutionalisation in this study.

Focusing on specific behaviours perceived as troublesome, the presence of aggression (O'Donnell et al., 1992; Cohen et al., 1993; Haupt & Kurz, 1993) paranoia (O'Donnell et al., 1992), depression (Steele et al., 1990; Haupt & Kurz, 1993) and delusions (Magni et al., 1996) have all been identified as particular risk factors for institutionalisation. In another, small UK case control analysis, excessive nighttime activity was found to be an important predictor of entry to long-term care for people with dementia who lived at home with a carer (Hope et al., 1998).

In contrast to the wealth of studies considering the behaviour of people with dementia, there appears to be little or no information about the potential impact of their physical health status on the risk of care home admission. This omission may be due to the difficulty of establishing a valid and reliable measure of physical health status, with ratings of subjective health, an option often employed with the physically frail elderly, potentially problematic in this client group. It is nevertheless thought likely to be an important variable (Hope et al., 1998; Gaugler et al., 2003) and future work is clearly needed here.

Caregiver characteristics

The institutionalisation of older people with dementia has been found to relate not only to the characteristics of the subjects themselves, but also to those of their caregivers, and the breakdown of caregiver arrangements is a major reason for entry to long-term care (Power, 1989; Cohen et al., 1993). According to Pot et al. (2001), there are at least three sets of caregiver characteristics that can contribute to our understanding of why certain people with dementia are admitted to care homes: the commitment of the caregiver, the degree of psychological distress the caregiver experiences, and their personality traits. Whilst the potential role of sociodemographic carer-related factors is not included in this categorisation, these will also be considered here.

Many studies have assessed the importance of the age of the caregiver on care home placement. Hébert et al. (2001) and Gaugler et al. (2003) reported that caregivers who were older (60 plus and 80 plus respectively) were more likely to institutionalise care-recipients earlier for example, and it is suggested that the intensive nature of care provision may become more taxing with age. The parallel effects of deteriorating health could also play a part here, and a number of studies have found that caregivers in poorer health are more likely to both express a desire to institutionalise the care-recipient, and to place them in a care home (Cohen et al., 1993; Hébert et al., 2001; Gaugler et al., 2003).

In Pot et al.'s (2001) analysis of 138 dementia sufferer–caregiver pairs, the people admitted to long-term care tended to have younger caregivers however, this echoing the findings of Gilhooly (1986), although, as the author herself acknowledged, the small scale of this Scottish study precluded multivariate analysis which could have disentangled any intercorrelations amongst the variables. One obvious contender is the potential importance of having a co-resident as opposed to a non-resident carer, with (older) spouses more likely to be co-residents than (younger) offspring or other caregivers. The implications of continuing to care may be quite different for these two groups. For non-resident caregivers, not institutionalising the dementia sufferer could mean moving the care-recipient into their own home and/or giving up work (Cohen et al., 1993), whilst, conversely, the consequences of institutionalising the person with dementia might be seen as more far-reaching for the co-resident caregiver (Pot et al., 2001).

Most studies have failed to identify any significant relationship between the gender of the caregiver and the placement of the care-recipient (Severson et al., 1994; Fisher & Lieberman, 1999; Spruytte et al., 2001). However Hope et al. (1998) found that being cared for by a female was a significant predictor of care home placement at 12 months, whilst Cohen et al. (1993) reported a trend in the same direction. This might imply that men and women participate differently in care-giving, and surveys have found that women become more emotionally and intimately involved whilst men concentrate on the practical tasks in hand (Morris et al., 1988), although an alternative interpretation is that community services are more effective in helping male caregivers (Levin et al., 1986).

The consequences for the caregiver of the person with dementia being institutionalised are one of the factors that Pot et al. (2001) felt underpinned the commitment of the carer to the care-giving relationship, along with the carer's sense of duty, their investment in the care-giving relationship (in terms of both time and emotion) and social pressures (Johnson, 1982; Pot et al., 2001). Pot et al. (2001) hypothesised that in comparison to non-spouses, spouses would be more likely to be strongly committed to the care-giving relationship, and that the institutionalisation rate of older people with dementia cared for by their husband or wife would thus be lower than that for those cared for by non-spouses. The results of their community-based epidemiological study supported this hypothesis, and were in line with Colerick and George's (1986) prospective study of 209 people with Alzheimer's disease or a related disorder in the United States. Other work (Hébert et al., 2001; Andrew et al., 2000) has similarly found that having a carer who was a spouse or an offspring (a daughter only in the latter's work) was a protective factor from institutionalisation. In Cohen et al.'s (1993) work with 196 caregiver/care-receiver dyads in Canada however, spouses tended to prefer community care more often than non-spouses, but did not always succeed in providing this, whilst still other studies have failed to find any relationship between spouse and non-spouse carers and the rate of institutionalisation (Spruytte et al., 2001; Gaugler et al., 2003).

Although not explicitly mentioned by Pot et al. (2001), the quality of the relationship between the caregiver and care-recipient might also be thought to contribute to the commitment of the carer. According to both Zarit et al. (1986) and Gilhooly (1986), a poor premorbid relationship between caregiver and care-recipient is associated with a greater likelihood of residential placement. Other researchers have failed to find such an association however (Hamel et al., 1990; Cohen et al., 1993; Spruytte et al., 2001) and a similar ambiguity exists regarding the quality of the relationship at the point of study. Only Wright (1994) and Spruytte et al. (2001) have found nursing home placement to be predicted by low present marital happiness in multivariate analyses.

The second group of caregiver characteristics that Pot et al. (2001) suggested may explain institutional placement concerns the carer's level of psychological distress. This concept has been operationalised in so many different ways, encompassing a range of measures of the caregiver's burden, stress and psychopathology, that interpretation of the findings is difficult. The general expectation is that caregivers who experience more psychological distress will be more likely to institutionalise the care-recipient however (Pot et al., 2001).

The results of most studies would seem to support this hypothesis. For example, in the large sample of people with dementia and their carers recruited by Gaugler et al. (2003), caregivers scoring highly on the Zarit burden scale (Zarit et al., 1980) were 1.5 times more likely to expedite placement of the dementia sufferer within a three-year period when compared with caregivers scoring lower on this measure. Cohen et al. (1993) similarly found that carers experiencing greater burden were both more likely to express the desire to institutionalise the cared-for person with dementia and to have actually placed them at follow-up, whilst other studies reporting such associations include those of Morycz (1985) and Hébert et al. (2001). Neither Fisher and Lieberman (1999) nor Spruytte et al. (2001) found any empirical support for this relationship however, although this could simply be a vagary of sampling, with carers in good mental health and coping well less likely to be recruited into study samples identified through service receipt and those in poor mental health more likely to decline study participation.

As a further illustration of the complexity of this issue, whilst several studies have identified a significant positive relationship between the challenging behaviours exhibited by the person with dementia and caregiver burden (Cohen et al., 1993; Schulz et al., 1995; Hébert et al., 2001), the links between this association and institutionalisation remain poorly understood (Morris et al., 1996). It would seem that the burden of behaviour problems on caregivers has at least two elements: the amount of time taken up by the behaviour, and the degree to which the behaviour is intolerable to the caregiver (Morris et al., 1988), but not all studies distinguish between these (Morris et al., 1996). Meanwhile Spruytte et al. (2001) have questioned whether carer burden and carer satisfaction might be two sides of the same coin, finding that the more satisfaction the caregiver gained from caring, the less their preference for institutional care, this echoing the findings of Pruchno et al. (1990).

The final dimension of caregiver characteristics that Pot et al. (2001) felt could help explain institutional placement relates to their personality, but few studies have considered this. However, Pot et al. themselves found that having a more extravert non-spouse caregiver increased the likelihood of entry to long-term care and suggested that such carers may more readily ask for professional help (Pot et al., 2001).

Whilst the above discussion has concentrated on the characteristics of the principle carer, Gaugler et al. (2000) also explored the potential influence of the dementia sufferer’s broader informal support network. Looking at the impact the provision of family help had on the timing of entry to long-term care, they found that the number of hours aid the primary caregiver received was not significant, echoing the results of Colerick and George (1986) and Aneshensel et al. (1995). However, assistance with the care-recipient’s daily activities of living, including eating, dressing, housework, cooking and transportation, and overnight respite, did significantly delay care home placement. This may be an important finding, for it would tend to suggest that the total amount of help provided may not be as important as the specific type of assistance given (Gaugler et al., 2000).

Service receipt

This section concerns the relationship between the formal community support services that are received by older people with dementia and their carers and the likelihood of a subsequent admission to care. The reader will not be surprised to learn that the findings are equivocal, although there are surprisingly few empirical studies (Zarit et al., 1999).

UK work reporting that the provision of formal services to people with dementia does promote the capacity of carers to maintain them at home includes that by Levin et al. (1984) and Andrew et al. (2000). The latter, for example, found that of 141 people referred to Social Services departments, just 47 per cent of home care users were in long-term care at follow-up, compared with 67 per cent of non users (p=0.001). In

Holland, Vernooj-Dassen et al. (1995) similarly found significantly fewer care home admissions in families receiving a 10-week package of emotional and practical help from a home-health aide, although the researchers considered only a small number of covariates and the intervention was short-term. In the Andrew et al. study (2000) the receipt of day care was also associated with remaining at home, with just 33 per cent of day care users entering institutional care, compared with 76 per cent of non-attenders (p=0.000).

Other studies have found the use of formal services such as home care, day care or overnight respite to be associated with an increased risk of institutionalisation however (Cohen et al., 1993; Aneshensel et al., 1995; Hope et al., 1998; Spruytte et al., 2001). One possible explanation for this relationship is that community-based support is experienced as a stepping stone to institutionalisation, with caregivers becoming used to handing over responsibilities to formal care providers (Zarit et al., 1999), whilst Hope et al. (1998) interpret the use of day care as an indicator of carer stress. An alternative explanation is that community services are only used when family caregivers are at/near the point of breakdown and prove too little, too late (Gaugler et al., 2003), or that they are accessed only in a crisis, acting as a stopgap until residential care is organised (Cohen et al., 1993).

Gaugler et al.'s (2003) study is suggestive of a rather more complex relationship however, for here care-recipients receiving moderate levels of personal care services or day care were less likely to enter long-term care than those receiving either lower or higher levels of service. This suggests that there may be a number of different processes at work, whilst a number of system variables may also influence outcomes. Formal support services may be provided too uniformly for example (Gilhooly, 1986), the relatively small amount of services available may not be sufficient to have any meaningful impact (Gaugler et al., 2003), and/or older people and their carers may use formal services inconsistently, perhaps feeling that what is available does not meet their needs. Interestingly, Gaugler et al. (2003) also reported that carers who reported greater unmet need were more likely to institutionalise care-recipients earlier. This is an important finding, for as Philp et al. (1997) have argued, if there were an adequate supply and effective targeting of appropriate services, then studies should find no association between service provision and institutionalisation, the provision of more help to those in greater needs negating any increased risk of care home entry.

The availability of care home beds clearly adds a further dimension to the equation, although this sort of information is all too rarely given in the literature. It has been reported that there is an increased likelihood of admission to care in areas with a larger bed supply however (Greene & Ondrich, 1990; Cohen et al., 1993), and it may be that the availability of a care home place empowers an individual to control whether an admission or exit from care occurs, at least for those whose needs could be met in either setting (McCoy & Edwards, 1981; Greene & Ondrich, 1990).

The role of those professionals who play a part in making the decision to place an older person with dementia in a care home is another consideration, but as Greene and Ondrich (1990) state, we do not yet know much about these decision-making processes. Fisher and Lieberman (1999) found that the greater the number of management problems, and the larger the number of hours care provided by the family, the greater was the probability that the staff of an American memory clinic they studied would recommend nursing home placement. The professionals' recommendations were unrelated to the families' decisions however, which would tend to suggest a disjunction between the reasons clinicians consider placement and the reasons informing families' actions (Fisher & Lieberman, 1999). This may help to explain why in Dellasega and Mastrian's (1995) small qualitative study the advice health care professionals gave to family caregivers considering the option of institutionalisation was viewed as inadequate, or even detrimental.

What does seem clear is that the systematic evaluation of the impact of community services in preventing admission to residential care is only just beginning (Spruytte et al., 2001; Gaugler et al., 2003) and that we need to know a lot more about why older people and their families decide to use formal community-based supports and the extent to which they meet their needs.

Motivational Factors and Crises

Having considered the rather complex range of personal, social, clinical and service receipt factors that predispose admission to a residential setting, it is important to also look at what older people think about the prospect of care home entry. As no studies specifically targeting the views of older people with mental health problems were identified, the work cited refers rather to the general elderly population.

In Warburton's (1994) much cited study of care home admission 'fear' was found to be a motivating factor for nearly half of the older people entering care. This included the fear of being alone, of being a victim of crime, of falling, of not recovering from an illness and of becoming a burden. Carers were meanwhile found to have their own set of worries about both their relatives' survival and safety, and their own ability to cope with the caring situation (Warburton, 1994).

Many people who enter care have recently experienced a catastrophic event such as a stroke or heart attack, burglary or bereavement and it has been suggested that the process of becoming a resident often centres on a set of events which undermine the person's ability to remain at home (Warburton, 1994; Peace et al., 1997). Placements precipitated by admissions to hospital are the most obvious example. Peace et al. (1997) noted that older people may be particularly vulnerable to the influence of others during periods of crises or stress, whilst there is also evidence to show that when an older person goes into hospital the carer may reassess their situation. The older person's desires and needs may then be overridden by other people's agendas (Peace et al., 1997).

Salvage et al. (1989) suggested that not all admissions were negatively motivated however, and 15 per cent of their community sample were 'not averse' to the thought of some form of communal care, many considering it preferable to struggling on at home. Another study of the different perceptions of institutional care held by older people and professionals found that the older people were the more positive (Victor, 1992). In their comprehensive re-evaluation of residential care however, Peace et al. (1997) concluded that although in some instances the move to a care home may be motivated by a willingness to opt for the supports of residential living, for the majority of older people continued struggle against admission is the norm, the ‘residential option’ being the ‘residual option’.

Implications for Older People with Dementia

The placement of older people with dementia in a care home is clearly a complex process, involving multiple factors from several domains. After accounting for the various methodologies used by different studies there would seem to be sufficient evidence to suggest that certain aspects of the person’s daily functioning (level of cognitive impairment, need for help with daily activities and disruptive behaviours) and characteristics of the caregiver and/or care setting are probably significant risk factors for admission.

In planning the services and resources that are needed by the total population of older people with dementia, it is important to be able to make as accurate predictions as possible (Hope et al., 1998). Although individual characteristics like mobility status or level of cognitive functioning are important in themselves, the development of models using combinations of variables will provide more accurate information about the size of the target population, the type of services required and the potential costs involved (Shapiro & Tate, 1988).

At the individual level, identifying those most at risk of care home placement may enable professionals to offer them the assistance to prolong their ability to remain at home, improve the quality of their life at home and/or facilitate a smooth transfer to a care home should this be timely (Cohen et al., 1993; Hébert et al., 2001). Moreover, as Hope et al. (1998) have noted, some of the factors associated with later institutionalisation may play a causal role, such that identifying those at risk and putting in place preventative programmes would decrease the risk of care home placement. This may include altering some aspect of the client’s presentation and/or the consequences of their presentation for caregivers as discussed earlier in this chapter, whilst, as Gilhooly (1986) has pointed out, the variable perhaps most amenable to change, is the level of formal support services provided.

Older people with functional mental illness

Whilst a number of studies have focused upon older people with dementia and the particular characteristics that predispose their institutionalisation, the same attention has not been given to older people with other mental illness, perhaps because they constitute a smaller proportion of care home entries. Indeed the little the literature does tell us about those older people with functional illnesses who need some form of residential care is largely limited to statements about their numbers (rather than their characteristics) and is contained in studies considering the effectiveness of specialist mental health provision in which care home entry is just one of many outcome measures. It is reiterated that, because of their contact with specialist services, these people are unlikely to be representative of the wider population of older adults experiencing functional mental illness.

One example of such a study is that by Brown and colleagues (1996) who followed-up a random sample of 120 people on the caseloads of two UK community mental health teams over a period of 18 months. Of those still alive, three out of the 40 (7.5%) people with affective disorders and two out of nine (22.2%) with schizophrenia entered long-term care, compared with six out of 21 (28.6%) with dementia. Bedford et al. (1996) undertook a similar six-month follow-up of referrals to four mental health resource teams in Cambridge and reported that just three out of 67 (4.5%) clients with functional mental illness had moved into residential/nursing home care compared with 16 out 58 (27.6%) people with dementia.

Neither of these two studies tells the reader anything about what differentiates those older people with functional mental illness who enter institutional care from those remaining in the community. In an exploratory retrospective case notes study of 131 patients with depressive disorders discharged from acute inpatient mental health care in two neighbouring London services however, Philpot et al. (2000) suggest that the nature of service receipt may be significant. Whilst outcome was not affected by measures of social deprivation, clinical and historical features of depression or management as an inpatient, patients from the more traditionally hospital-based service were at greater risk of being discharged to institutional care than those seen in the more community-orientated service, even when type of residence prior to admission was controlled for.

Long-stay hospital patients

As has already been noted, mental health policy in recent years has been to care for people with mental illness in as homely an environment as possible and the steady closure of long-stay hospital beds has resulted in the transfer of a number of long-stay patients to alternative residential environments (McAuslane & Sperlinger, 1994). The majority of these people will have been elderly patients with dementia (Clifford et al., 1991; Pryce et al., 1991; Shergill et al., 1997).

Decisions about relocation seem to have been determined at the organisational rather than individual level, as it was necessary to identify a group of patients who could move in order to close wards (Challis & Darton, 1990; Knapp et al., 1994). This would appear to have led to the selective discharge of the most able patients (Shepherd et al., 1996; Wills et al., 1998), but there is relatively little information available about how those patients who were relocated compared with those remaining in hospital. Indeed, the literature has rather concentrated on the effects of relocation on patients' subsequent wellbeing (e.g. Knapp et al., 1994; Wills et al., 1998) and in the main outcomes have been positive. The vast majority of studies have shown no change in mortality, particularly when disruption to the patient group and nursing staff is minimised (Borup, 1983; Bledin & Riordan, 1998) and a number have reported improved environmental conditions (McAuslane & Sperlinger, 1994; Shergill et al., 1997) and/or a greater degree of user and carer satisfaction (Knapp et al., 1994; Wills et al., 1998).

THE BALANCE OF CARE

Key Points:

- **Balance of care studies seek to identify groups of people whose care needs could be met in more appropriate settings and to determine the resource implications of providing such care**

- **Their defining features include the use of data about the dependency and service receipt characteristics of these groups of people and the provision of information about the costs of care in different settings**

- **This approach allows purchasers and planners to incorporate the feasibility and costs of changes in the provision of care/services into the planning process**

The approach adopted in this research is derived from a number of studies which have attempted to identify older people whose dependency characteristics are such that they are at the 'margins of care'. In essence this means that their care needs can appropriately be met in more than one way, the alternatives often involving a choice between community-based and institutional care.

One of the first studies to address this issue was undertaken by Essex County Council in the early 1970s. Realising that the development of care home places was falling substantially below the numbers envisaged in their ten-year plan, the Council sought to ascertain whether the provision of enhanced domiciliary services could provide a feasible alternative for at least some elderly people who might otherwise enter residential care. Social welfare officers (as local authority social services department staff working with older people were then known) were thus asked to complete detailed questionnaires on the functioning of all elderly people on the residential home waiting list (but not in hospital) in January 1971 and to specify the care packages that would be needed to enable them to continue to live at home should this be deemed possible. The council then embarked on an ambitious costings exercise of the various options, eschewing the usual practice of considering only local authority expenditure and attempting to take account of the real resource costs to the community as a whole. They were not able to assess the relative merits or demerits of residential and domiciliary care however, and acknowledged that the population sampled was not necessarily typical of the wider population of elderly people in the community (Wager, 1972). Despite these limitations, this pioneering use of a cost-benefit analysis was subsequently hailed as bridging "the often unfathomable chasm between the norms, experience and data which are the everyday working material of the social worker, and the norms, experience and data which are the everyday working material of the accountant" (Williams, 1972 p5) and the project concluded that it would be financially viable for a significant proportion of older people who would normally enter residential care to remain in the community if intensive domiciliary care were provided (Wager, 1972).

From a theoretical perspective, Mooney (1978) pursued the use of a similar economic framework to facilitate the effective use of resources for older people and illustrated this with a sample of elderly people in Aberdeen. This study was primarily concerned with the balance of care between individual clients' homes, residential homes and hospital and examined the cost implications of changes in the supply of services. Whilst concentrating on individuals who could potentially be cared for in more than one location, individuals he described as 'close to the boundaries' between different care locations and categorised as 'marginal', the focus of the work was not on individual clients per se but on informing the future provision of services. As Mooney himself acknowledged, this approach still did not address the issue of the relative value or effectiveness of different policy options. It did however provide cost data for, and information about, the dependency of elderly clients likely to be affected by possible changes in service supply, the overall objective being to maximise the benefit to older people by equating marginal social cost and marginal social benefit within each care location.

In a commentary on this model, Knapp (1980 p293) described it as "an interesting approach to policy making in the health and personal social services", and proposed a number of ways in which he felt it could be strengthened. Whilst Mooney (1978) had used the number of elderly people receiving any given service as an intermediate indicator of output, according to Knapp final output indicators such as measures of health status, psychological wellbeing and mortality were needed. This in turn necessitated a more complex measurement of costs. Knapp further suggested that in limiting the considered options to domiciliary, residential and hospital care Mooney did not take sufficient account of alternative forms of care, particularly sheltered housing, and that the differential costs of moving between different forms of care should be acknowledged. For example, the cost of moving from residential to domiciliary care is different from that entailed by a move in the reverse direction because of the need to obtain accommodation which is generally relinquished on moving into long-term care. The calculation of the balance of care was thus seen as being rather more complex than had previously been suggested.

The question of the extent to which alternative patterns of support were practicable for older people became the focus of a research initiative established by the Department of Health and Social Security and a multi-site study was initiated to try to calculate the relative costs of each of the main options (Wright et al., 1981). The approach was similar to that used by Mooney (1978), with the researchers using a specially designed measure of dependency to identify people with similar requirements for help in long-stay hospital, residential and community settings and then comparing the costs of their statutory, private and informal support in each environment. This work paid considerable attention to the way in which different methods of measuring costs would result in different outcomes and in particular sought to contrast the public expenditure or financial approach and the economic concept of opportunity cost whereby the cost of a resource is deemed to be the value of the best opportunity foregone by its present use. Both were acknowledged to have their own problems, including how capital and housing costs should be shown in the former, and how to identify the value of foregone opportunities in the latter - particularly those of informal support, which this study did not attempt to cost. The researchers nevertheless came out strongly in favour of the concept of opportunity costs because of its comprehensiveness and concern for the use of all the community's resources. Like earlier work, this study concluded that there were a number of fairly dependent people being maintained in the community at costs beneath those of institutional care and a smaller number of very dependent people in the community whose care costs exceeded those of the other two alternatives.

In 1981 Borley et al. reported on how the balance of care approach was being used to inform the strategic planning of health and social services for older people in two pilot projects in the south of England. In their experience the main value of the approach had come from bringing together the core features of care and the planning alternatives. Within each locality multidisciplinary Professional Advisory Groups first classified the overall client group (elderly people) into categories of patients having similar needs for care and then agreed alternative ways in which each category's care needs could be met, detailing their resource requirements. Meanwhile large-scale survey work was undertaken to establish the number of people actually in each category and their service use. Joint Management Teams consisting of senior members of health authorities, social services departments and housing oversaw these projects and, supported by a team of technical advisors, subsequently modelled the information collected to guide future decisions about finance. Taking account of the likely amount of resources that would be available, they could then consider the effects of maintaining current patterns of care (reflecting the preferences of field workers), of following the 'ideal' care plans proposed by the Professional Advisory Group, or any option in between.

McClenahan et al. (1987) noted that the balance of care approach had first been developed in the relatively unconstrained financial environment of the early 1970s when the emphasis was on growth and plans were based on health and social services practitioners' views of how care could best be provided. By the early 1980s, with severe constraints on finance and manpower in the public sector, management objectives had shifted towards achieving value for money, but the basic aim of obtaining a balance between different ways of caring for a group of people remained unchanged. The authors reflected on their experience of using the balance of care approach in five joint planning projects in which the main objective was to achieve a balance between institutional and community services on the one hand, and health and local authority funded services on the other. Most of these studies concerned the appropriate resource mix for older people and were based on the principles set out in Box 7.

Each of these elements were evident in a project described by Bebbington et al. (1990) who were commissioned to advise on the distribution of social services resources for older people in Oxfordshire in the light of the county's future service aims. These included increasing the use of community care and sheltered housing, greater targeting of clients with higher dependency levels, the development of a case management service and the provision of carer support. Using a computerised model the authors first estimated the numbers of people who fell within sixteen distinct categories of need as defined by physical and mental frailty, incontinence and informal support, basing their figures on projections of the age structure for each district and the numbers of elderly people living alone. Taking account of the county's service development strategy, appropriate care plans were then determined

Box 7. Balance of Care: Principles

- Review of groups of people with similar care needs as defined by combinations of factors such as physical and mental health, social circumstances and housing

- Consideration of different methods of care (provided as a single service, such as a hospital bed, or as any combination of services, such as home help and community nursing)

- Use of local and national data to build up a picture of the current situation ('what is') detailing the number of people with similar needs receiving a specific method of care

- Use of local and national professional views/practice to build up a picture of 'what ought to be' and

- Comparison of 'what is' and 'what ought to be', identifying major differences and developing policies for change.

Source: McClenahan et al., 1987

for each of these sixteen needs groups, and their resource consequences estimated. This culminated in the combination of numbers, services and unit costs needed to construct a total resource requirement. When considered alongside the availability of services provided by the health, independent and voluntary sectors, this information then formed the basis for a detailed prescription for services for each district.

O'Shea and Corcoran (1990) considered the dependency characteristics, placement variables and costs of care for two groups of elderly people said to be on the margins of domiciliary and institutional care in Ireland. Whilst acknowledging that it would be more correct to discuss a continuum of care encompassing respite, day and sheltered housing services, they suggested that important insights could be gained by focusing on domiciliary versus long-stay residential care for the marginal elderly, and that this was in fact often the reality in Ireland. Concentrating on the costs of care, the pair argued that an opportunity cost evaluation of both domiciliary and residential options would provide a sounder foundation on which to base policy direction than a public expenditure model capturing only those costs falling on the exchequer. They paid particular attention to the value of informal care. Whilst it was generally agreed that in the absence of unpaid carers society would have to pay the market rate for care of the elderly, the authors claimed that it was equally reasonable to consider the effect the caring role had on the social and employment opportunities of the carer. The relevant opportunity costs would thus include not only market work-time foregone, but also foregone non-market work and leisure time.

Looking at the bigger picture, work reported by the Personal Social Services Research Unit (PSSRU) considered the costs, effectiveness and balance of care for older people with dementia across England as a whole (Kavanagh et al., 1995). Drawing upon secondary data contained in the Office of Population Censuses and Surveys of Disabilities from 1985 and 1986 the authors estimated the likely numbers of people with advanced cognitive impairment living at home (alone or with others), in care homes or in hospital in 1992 and the accompanying resource and cost consequences. From this baseline it was then possible to explore and cost the potential effects of seven broad policy options changing, and hopefully improving, the balance of services. These were selected on the basis that they were commonly found in England at the time or had been shown to be effective in pilot projects, and included extending the availability of respite care, the delivery of enhanced home care support and the move of hospital inpatients to care home settings. Whilst Kavanagh et al. (1995) acknowledged that gaps in the available information forced them to make certain assumptions about both dependency profiles and costs, their methodology was transparent and the analysis was based on the best available evidence, considering not only the overall cost implications but also the distribution of the cost burden between agencies.

Concentrating on a rather different client group, Knapp et al. (1997) looked at the cost consequences of changing the hospital – hostel/residential care balance for younger adults with functional mental illness. Noting that it had long been government policy to alter the balance between hospital and community care for this population, they argued that progress towards this had been hindered by the insufficient development of appropriate community accommodation for people with long-term needs for care and support. This led to the silting up of many hospital beds by people admitted because there was no alternative (as opposed to on clinical grounds) and by people no longer needing a hospital bed but for whom there was no appropriate placement available, potentially wasting resources by unnecessarily pushing up health service expenditure. This was then a situation not unlike that experienced by many older people in general hospitals more recently. Drawing upon an existing data set, the authors set out to compare the costs of care for people with mental health problems resident in community facilities with those for inpatients who had been assessed as being capable of moving from hospital to the community and/or who had been resident in hospital for more than six months. This involved testing a number of hypotheses about the association between the costs of care and resident characteristics using multiple regression analyses, the pursuit of an appropriate balance of care requiring the matching of resources with identified needs.

The work that has contributed most substantially to the present study aimed to estimate the cost and feasibility of shifting the balance of care from residential to community support for specific client need groups within a local social services authority (Challis & Hughes, 2002; Challis et al., 2002a). Implicit in this was the recognition that the authority, like many others, did not have enough information about the dependency and needs of clients receiving different forms of care, nor about the costs of their care. The research strategy had a number of components as detailed in Box 8.

Box 8. Gateshead Balance of Care Study: Components

- Collection of data on a cohort of admissions to long-term care over a nine-month period in a way facilitating comparison with national findings
- Identification of the characteristics of groups of clients most likely to be admitted to long-term care
- Involvement of local practitioners and managers in an expert panel exercise to estimate the cost of community care packages for people hitherto placed in long-term care, and
- Projection of the data in order to estimate the cost of alternative care arrangements.

(Challis & Hughes, 2002; Challis et al., 2002a)

The strengths of this work included the detailed local information the study was able to provide about such significant areas as the assessment of risk, the contribution of informal carers and the discharge of people from hospital to long-term care, whilst the ability to place this in a national context facilitated key decision makers' consideration of future options within a broader framework.

This approach subsequently formed the basis for a further study commissioned by the Department of Health and undertaken by the PSSRU to examine the potential impact of the proposal to change the method of payment of the Residential Allowance on admissions to care homes (Clarkson et al., 2005). This work supplemented an earlier project ascertaining social services managers' perspectives of the extent to which this change would influence patterns of admissions and, ultimately, the balance of care in a locality and was designed to consider the impact of change at the micro/practitioner level. It was thus concerned with how individual decision thresholds would be influenced by the apparent changes in the cost of placement arising from the financial transfer. The study had three stages. In the first, the characteristics of service users were identified from national survey data and twenty typical case types produced. In the second, care managers in five authorities participated in a simulation exercise to create care plans for these case types, which were then costed and validated for feasibility. In the third, the scale of the potential change resulting from the transfer of the allowance was estimated by applying the data collected from the simulation exercise to the national picture (Clarkson et al., 2005).

The studies described above serve as an illustration of the many ways in which the balance of care approach has been applied. It is clear that they vary in both methods and objectives. Whilst some of the studies provide data to inform strategic planning processes at a local level, others demonstrate the potential of the approach to inform policy implementation at a national level. The majority employ primary data, collected purposively for the study, but some use secondary data sources. However, all are concerned with the identification of groups of people who could receive care in more appropriate settings and the resource implications of providing such care (Hughes & Challis, forthcoming). Each also displays at least two of the three characteristics which might be seen as defining features of balance of care studies: the inclusion of data on the dependency characteristics of those groups of people at the margins of care, details of service use, and data on the costs of care in different settings at the level of the individual (Mooney, 1978). The utility of this approach, which allows both purchasers and planners to incorporate the feasibility and costs of changes in the provision of care/services into the planning process, facilitating the exploration of possible policy changes, is thus apparent.

CHAPTER 2
METHODS

STUDY AIMS

This study was designed to evaluate the current provision of services for older people with mental health problems in North Cumbria and to provide data which could inform local commissioners' decisions about the mix of services needed, thereby underpinning future strategic planning. It was intended that the work should take a bottom-up approach, grounded in the experience of practitioners, users and carers. Whilst existing information sources were to be used wherever possible, the collection of further local data was seen as integral to the facilitation of evidence-based planning and there was a commitment to engaging key stakeholders in this process to facilitate service development.

OVERVIEW

The study was undertaken by the PSSRU at Manchester, who received ongoing strategic advice from a small local reference group consisting of members of the North Cumbria Local Implementation Team for the *National Service Framework for Older People* (DoH, 2001a). The proposed strategy was also considered at the inaugural meeting of the Mental Health Services for Older People Reference Group in March 2003.

The study design had four stages:

- Comparison of existing information about recent service provision in North Cumbria with published national findings;
- Collection of local data about the characteristics of four core groups of older people with mental health problems, the key activities associated with caring for older people and the perspectives of GPs and other key stakeholders;
- Exploration of the feasibility of caring for specific groups of older people with mental health problems in alternative ways; and
- Consideration of possible service options in consultation with a range of local stakeholders.

The study commenced in January 2003. Details of the project were submitted to the North Cumbria Local Research Ethics Committee but the study team were advised that ethical permission was not required to undertake this work, which was viewed as a mixture of audit and service development activity. The remainder of this chapter will describe each of the four main stages of the study in detail.

STAGE 1. BENCHMARKING SERVICE PROVISION IN NORTH CUMBRIA WITH NATIONAL DATA

Existing information about recent service provision for older people in North Cumbria was compared with published national findings. This included data routinely collected in the mental health trust and social services department as well as local responses to national surveys previously undertaken by the PSSRU at Manchester which was benchmarked against national data reported by the Department of Health, the Healthcare Commission and the PSSRU. In order to provide context, material was also sourced from earlier service evaluations undertaken by the District Audit (Bruce, 2001) and the Nuffield Institute for Health (Herber, 1998), from local planning and strategy documents supplied to the study team and from the 2001 national census (National Statistics, 2003).

STAGE 2. LOCAL DATA COLLECTION

Clients / Service Users

The second stage of the study was designed to identify who currently gets what services, in which setting and at what cost. The main activity was the collection of local information about the sociodemographic, functional and service receipt characteristics of four groups of older people:

- Admissions to acute mental health inpatient beds;
- Admissions to residential and nursing homes;
- People on the community caseloads of social services staff; and
- People on the caseloads of community mental health staff.

This information was used to profile those clients in contact with the formal services who were expected to have the most severe mental illness and associated complex needs, and will serve as a benchmark in any future service evaluations. The employment of a number of standardised measures was facilitated by the use of specially designed proformas, copies of which are included in Appendices A1-A4.

Box 9 sets out the key characteristics of the data collection. This had two strands, the first establishing the ongoing collection of data about older people admitted to mental health inpatient and care home beds, and the second taking a one-off ‘snapshot’ of the people on the community caseloads of social work and mental health staff. The different amounts of time required for the completion of these two activities had implications for the amount of data that it was reasonable to expect already busy practitioners to collect. Thus whilst all questionnaires facilitated the estimation of the modified Barthel ADL Index (Mahoney & Barthel, 1965; Collin et al., 1988) and the MDS Cognitive Performance Scale (Morris et al., 1994), the two ongoing data collections included more items about the receipt of services.

Box 9. Key Components of the Local Data Collection

Population of Interest	Inclusion/Exclusion Criteria	Approach to Sampling	Time Frame and Information Source	Information Domains
Admissions to acute mental health inpatient beds	All people admitted to the Trust's acute admissions wards for older people (Windermere, Oakwood and the Pennine Unit) excepting those admitted for planned respite	Six month series of consecutive admissions	September 2003 - February 2004. Information provided by nominated ward staff	Age, gender, living arrangements, service receipt, daily functioning, clinical presentation and reasons for admission
Admissions to residential and nursing homes who had mental health problems	All people admitted to a care home with social service's assistance by the older people's teams, excepting those admitted for planned respite	Six month series of consecutive admissions	July 2003 - January 2004. Information provided by service user's care co-ordinator	As for acute mental health inpatient admissions
Older people with mental health problems on the community caseloads of social services staff	Service users aged 65+ on the caseloads of the older people's teams who were not long- term residents of residential, nursing or NHS inpatient accommodation	One in eight systematic random sample from a computer-generated list of users organised by staff member (allocated cases) or by team (deallocated)	Sample taken on 3rd November 2003. Staff to return completed proformas within six weeks	A more limited range of sociodemographic, functional and service receipt characteristics
Older people on the caseloads of community mental health staff	Clients on the caseloads of community mental health nurses or community support workers in the older people's service	One in six systematic random sample from a clinician-generated list of clients organised by practitioner and stratified by broad diagnostic group	Sample taken on 10th November 2003. Staff to return completed proformas within one week	As for people on the community caseloads of social services staff

As might be expected in any 'real world' evaluation, a number of problems were encountered in the data collection process. These were predominantly concerned with the information systems used by the participating organisations and Box 10 briefly summarises these issues and how they were addressed.

Box 10. Obstacles within the Social Services Department Data Collection Process

Issue	Approach Taken
The social services department made no clear organisational separation between older people with mental health problems and other older people	Information was initially collected about all older people. The population of interest was subsequently identified by the use of mental health indicators contained within the dataset
Deallocated social services cases had no named practitioner and some had not been reviewed for many months. A number of files lacked care plans	The time frame for this element of the data collection was extended and a team leader facilitated the collection process
The computer generated list of social services users contained people who did not meet the study's inclusion criteria as well as a number of duplicates	The data file was 'cleaned' and any clients who did not meet the project's inclusion criteria were excluded from the exercise

Two additional elements of the proposed data collection were abandoned in light of concerns about their implications for the workload of social services staff. These concerned the situation of older people awaiting an initial assessment and of younger people with dementia, whilst, for reasons of both cost-effectiveness and utility it was decided not to include the relatively small numbers of older people with mental health problems on the caseloads of the mental health or learning disability teams. Although these specialist subgroups have not been considered within the present study, the provision needed to meet their future needs will undoubtedly require detailed consideration.

Fewer problems were encountered in the collection of information about people known to the specialist mental health service. However, one of the mental health inpatient wards was closed to new admissions for part of the data collection process and another had a number of 'blocked beds' such that the threshold for admission in this period is likely to have been somewhat higher than normal.

Key Activities Associated with Caring for Older People

In addition to collecting data about the characteristics of those older people with mental health problems detailed above, the study also sought to gather information about the key activities associated with caring for this client group within Cumbria Social Services and the North Cumbria Mental Health and Learning Disabilities NHS Trust. All social workers, social care workers/review officers, community mental health nurses and community support workers who primarily worked with older people were thus asked to participate in a time use exercise. A copy of the data collection tool, a weekly diary schedule, is given in Appendix A5. Participating staff completed this during a one-week period in late April/early May 2004. Practitioners who had both clinical/front line and managerial responsibilities recorded only clinical/ front line work. In order to allow important comparisons to be made about the roles undertaken by staff in different agencies and different teams, information was also collected about each participant's job title and base.

Perspectives of GPs and Other Key Stakeholders

A postal questionnaire was sent to all GPs within the three participating PCTs in February 2004. This was designed to ascertain their perspectives of the services currently provided for older people with mental health problems and their priorities for future development. A copy is included in Appendix A6.

At a series of workshops held in the autumn of 2004 and early 2005 a number of specialist mental health staff, social services staff, older people, carers and their representatives were invited to complete suitably modified versions of the same proforma. Such convenience samples do not produce representative findings, but do offer a quick and easy way of getting a feel for the issues perceived. Assistance in creating the older people's and carers' questionnaire was provided by members of the West Cumbria Branch of the Alzheimer's Society and copies of the respective data collection tools are included in Appendices A7-A10.

Data Entry and Refinement

All four sets of client related information were entered onto SPSS for Windows (version 10.1) and were checked for errors. Scores for the two formal measures incorporated within the client questionnaires were calculated from their constituent elements. The staff time use data was entered onto an Excel database. The GP responses to the stakeholder questionnaire were entered onto SPSS for Windows, whilst the smaller amount of information collected from other key stakeholders was analysed manually.

The majority of the variables in all three arms of the data collection were either categorical and unordered (e.g. gender, marital status) or hierarchical/ordinal (e.g. the dependency and cognitive rating scale items). Frequency counts and percentages were used to explore the categorical variables and means, ranges and standard deviations were calculated for the small number of ratio level variables (e.g. age). Cross-tabulations facilitated further exploration of the relationship between categorical variables, and Pearson's chi-square test and Fisher's exact test were used to assess the significance of differences in categorical variables between client or staff groups. Differences between client or staff groups in the quantitative variables were explored using the non-parametric Mann-Whitney U test. All tests were two-tailed and outcomes were regarded as significant at or below the 0.05 probability level.

STAGE 3. EXPLORING ALTERNATIVE PACKAGES OF CARE

This stage of the study was designed to explore the desirability and feasibility of changing the existing balance of services and considered whether the needs of a certain proportion of those older people with mental health problems who presently receive inpatient care or enter a care home in North Cumbria could be more appropriately met in other settings.

Characterising the Care Home Data

Older people with mental health problems were identified from the wider group of care home entrants about whom it had been necessary to collect data. A broad approach was adopted in which, for the purposes of this study, all clients with one or more of the following characteristics were classified as having a mental health problem:

- Had a formal diagnosis of mental illness;
- Received input from the specialist mental health services;
- Were admitted at least in part because of their mental health status; and/or
- Had cognitive impairment and/or low mood as identified by indicators within the study data.

Whilst this generous definition is obviously open to the risk of capturing some people without a formal mental illness, including those experiencing cognitive impairment attributable to causes other than dementia (e.g. a stroke), feedback from practitioners suggested that it did accurately identify those older people with mental health problems who commonly presented for care home admission.

The information collected about older people with mental health problems admitted to care homes was then analysed and five variables were used to produce a number of representative case studies/vignettes which exemplified these entrants:

- The source of admission (home or hospital);
- The presence or absence of a significant informal carer;
- Gender;
- The presence or absence of behaviours known to be difficult for carers to cope with; and
- A grouped rating of dependency derived from the Barthel index (least, medium, most).

The different possible combinations of these five variables produced 48 cells or case types as shown in Appendix A11. These were used to categorise all new care home entrants and to identify the most common combinations of characteristics found in this population. The people in each of the most prevalent case types were then divided into those who had, or did not have, significant cognitive impairment and individual cases representing the larger sub-group in each cell were randomly selected. Vignettes, based on the data provided in the relevant questionnaires, were then constructed for each. Examples can be found in Appendix A12.

Characterising the Inpatient Data

The information collected about older people admitted to acute mental health inpatient beds was analysed and four variables were used to produce a number of representative case studies/vignettes exemplifying this population. These were:

- The presence or absence of a significant informal carer;
- The presence of a primarily organic or functional mental illness;
- A binary variable concerned with whether the admission was at least in part for assessment of the client's future care needs (yes/no); and
- A hierarchy of risk/concern.

The latter two variables were created following the undertaking of an exploratory factor analysis in which the clients' clinical symptoms, and the reasons said to account for their admission to hospital, were examined. Five clusters of variables were repeatedly suggested by this work. The first of these was solely concerned with whether the person had been admitted for an assessment of their future care needs, whilst the latter four were perceived to represent a hierarchy of risk/concern. These were: admitted because of the risk of deliberate self harm (highest risk/concern); admitted for the management of disturbed behaviour and/or presented with aggression; admitted because of the risk of self-harm or neglect; and presented with disturbed sleep and agitation. With the addition of a 'none of these' category, this produced an ordinal variable with five levels.

The different possible combinations of these four variables produced 40 cells or case types as shown in Appendix A13. These were used to categorise the inpatient admissions and to identify the most common combinations of characteristics found in this population. Case studies were then constructed to represent the people captured in each of the most populated cells, these taking the gender of the majority of the clients in their group. Examples can be found in Appendix A14.

Constructing Alternative Packages of Care

Alternative ways of meeting the needs of the people depicted in the above vignettes were explored in a series of workshops.

At the first of these, a group of staff from the specialist mental health service including the four consultant psychiatrists, managers and ward-based nurses were initially asked to read the inpatient vignettes and to indicate whether they believed that it was completely, possibly or not appropriate to admit each of the clients described to an acute mental health inpatient bed. In the case of those patients for whom at least one consultant (who in reality act as gatekeepers to the inpatient wards) felt that inpatient admission was not appropriate, participants were then asked to work in small groups to identify what resources would need to be in place to enable hospital admission to be avoided. For the purposes of the workshop, participants were asked to put aside current constraints in the provision of community services and to be creative, whilst remembering that all services inevitably have funding implications. In order to help with this exercise, each group was given a list of services which were already available in most of the region, or were deemed to be possible elements of future services, as shown in Appendix A15. An independent expert panel with considerable experience in the community care of older people with mental health problems then used the respective services highlighted to create a weekly care plan for each client.

A mixture of community mental health nurses and social workers who predominantly worked with older people were invited to two further workshops. At these, the care home vignettes were distributed to small groups of staff consisting of two social workers and one mental health nurse, who were asked to create packages of care that would enable these clients to remain in the community. For the purposes of these workshops, participants were again asked to put aside constraints in current services and to be imaginative yet realistic. In order to help with this exercise, the groups were given weekly care plan sheets to be completed for each client. These contained the prompt list of services referred to above. This tool is included in Appendix A16.

Lastly, at two final workshops, a mixture of older people, carers and their representatives worked in pairs to review appropriately modified vignettes for those inpatients identified by at least one consultant psychiatrist as not necessarily needing hospital admission, and all of the care home entrants. In the first instance, the couples were simply asked to say whether, if services were able to provide a bit more help for the client described, they believed it would, might or would not be possible to continue to care for them in their own home. Having completed this exercise, each pair then chose at least one case study whom they had felt could be cared for in the community and formulated a weekly care plan for them using the planning sheet described above. The participation of older people and carers was felt to be particularly important in the light of studies showing that the variables associated with professionals' advice as to when care home entry is appropriate differ from those associated with carers'/families' decisions (Fisher & Lieberman, 1999). It was hoped that their involvement here would act as a 'reality check' on the planning undertaken by practitioners.

Validating Alternative Packages of Care

The packages of care that practitioners believed would enable those older people who are currently admitted to a care home or inpatient bed to remain at home were then costed. At least two care plans had been formulated for each case vignette. As the services received by any one client will to some extent depend on the views and experience of their care co-ordinator, a single care plan for each case type was now randomly selected to reflect this variability. The costs used can be found in Appendix A17. Wherever possible these were sourced from local agencies.

The selected care plans for the care home entrants were then submitted to the independent expert panel referred to above. The panel was asked to act as gatekeeper for access to social services resources and to decide whether it was prepared to fund the proposed community care packages. The intention was to mirror local decision-making processes; the material presented to the panel utilised local proformas (examples of which are given in Appendix A18) and their decisions were explicitly informed by common practice in North Cumbria. A parallel exercise constructed a hierarchy of appropriateness for the inpatient admissions based on the perspectives of the specialist mental health staff, with each case type scored according to the number and mix of practitioners who believed their admission to be completely or possibly appropriate.

STAGE 4. CONSIDERATION OF POSSIBLE SERVICE OPTIONS

The final stage of this study consisted of a sensitivity analysis of the potential for the agencies in North Cumbria to shift the balance of care for older people with mental health problems i.e. to provide more community-based care as an alternative for care currently provided in residential or hospital settings. In essence this explored the resource implications of caring for different combinations of those care home and inpatient case types thought to have most potential for diversion from institutional to community care.

The information needed to facilitate this exercise was drawn from three main sources. Details of the services actually received by clients prior to their institutionalisation were taken from the local data collection; the enhanced community care services it was considered would be appropriate to maintain them within the community were collated from the care plans constructed at the practitioner workshops; and the costs of institutional care were provided by local agencies.

Two further variables were built into the calculations. The first of these was time, both the length of time it might prove possible to keep certain types of older people out of residential care and the length of time that those people admitted to hospital remain there. The second was quantity, that is the quantity/proportion of older people currently entering an inpatient bed or care home whom it was felt could realistically be cared for within the community. When these were combined with the costings above it was then possible to estimate the implications of various changes in the balance of care and to simulate alternative policy options.

CHAPTER 3
FINDINGS I: BENCHMARKING SERVICE PROVISION IN NORTH CUMBRIA WITH NATIONAL DATA

STUDY SETTING

The geographical area covered by the three primary care trusts by whom this study was commissioned (the Eden Valley, Carlisle and West Cumbria PCTs) covers an area of some 2,000 square miles stretching from the Solway Coast in the west to the Pennines in the east and from the Scottish border in the north down through the Lake District national park. Whilst commonly pictured as an area of outstanding lakeland scenery, it in fact incorporates a diversity of landscapes, including a number of former coastal mining villages and deprived industrial communities (Wood, 2004).

The population of North Cumbria numbers approximately 313,000 people and the majority live in the more settled periphery of the region whose towns include Carlisle (the largest settlement in the area with a population of around 115,000), Whitehaven, Workington and Penrith. Much of the area is rural and sparsely populated however and Eden Valley has the lowest population density in England at just 0.23 residents per hectare (National Statistics, 2003). Indeed over 40 per cent of people across the county live more than 7.5 miles from a hospital (Wood, 2004), whilst research undertaken several years ago by the University of Newcastle showed that in approaching one in five general practices over half the patients lived more than three miles from the main surgery.

Whilst the age structure in North Cumbria is already older than the national average, the proportion of the population who are elderly is growing, and the 2001 census captured 55,773 people aged 65+ of whom 36 per cent lived within the area covered by Carlisle PCT, 24 per cent in Eden Valley and 40 per cent in West Cumbria. The number of residents from minority ethnic groups is however very small (approximately 0.7%), Chinese the largest ethnic minority group and the population dispersed throughout the district (National Statistics, 2003).

A recent report by the Commission for Health Improvement (2002) described the population of North Cumbria as having middling levels of affluence, but any aggregate measure will hide local pockets of need and it has been said that the real variation in rural deprivation is at household level (Wood, 2004). Severe deprivation (as shown by high unemployment rates and low levels of car ownership) is found along the west coast of Cumbria as well as in groups of wards in urban areas, whilst approximately 50 per cent of all pensioners in the Carlisle and District PCT are in receipt of income support. As is noted in the local Health Improvement and Modernisation Plan, similar inequalities are found in health, both within and between North Cumbria's four local authority districts. In Allerdale, Carlisle and Copeland life expectancy for both men and women is worse than the national norms, but the converse is true in the Eden area.

In terms of the provision of health services, the populations of the east and west of North Cumbria have historically been viewed separately and served differently and it is widely acknowledged that this has resulted in an uneven distribution of resources across the district. Today North Cumbria is said to be substantially one single health economy, with the constituent organisations working together to plan and manage services. Nevertheless, whilst health services are commissioned and provided by the three primary care trusts (Eden Valley taking lead commissioning responsibility for mental health services for older people), just one specialist trust provides mental health services (North Cumbria Mental Health and Learning Disabilities NHS Trust), social services provision is managed by Cumbria County Council, who span the whole of Cumbria, and other local authority services are provided by four district councils: Allerdale, Carlisle, Copeland and Eden.

Whilst many older people will, of course, lead healthy, fulfilling lives, a significant minority will experience the decreased quality of life associated with mental illness. According to prevalence estimates approximately:

- 4,300 older people (65+) in North Cumbria will have dementia, one-third of whom will be moderately-severely impaired (Hofman et al., 1991; Melzer et al., 1994)

- 7,500 older people (65+) will have depression, around 1,000 severely (Beekman et al., 1999) and

- still others will be affected by anxiety, adjustment reactions after stressful life events, schizophrenia, paranoid states and substance misuse.

At the time this study was commissioned there was considerable doubt about the ability of local services to adequately meet these people's needs. Two earlier reviews by the Nuffield Institute for Health (Herber, 1998 - covering West Cumbria only) and the District Audit (Bruce, 2001) had highlighted many examples of good practice in the locality and a desire to move towards a model of closer, more formal, joint working. They also identified a number of significant weaknesses however and the particular concerns put to the PSSRU are detailed in Box 1 below.

Many of these issues are not specific to Cumbria, but rather reflect the challenges and complexities of providing good quality care for older people with mental health problems in a rural area. For example, *Care in the Country* (Brown, 1999), the first comprehensive inspection of rural social services, found that rurality almost invariably brought problems with recruiting and retaining staff, with providing service choice and with the efficient use of staff time. It is then pertinent to consider how the services provided in Cumbria compare with those provided elsewhere, particularly in areas with similar demographic, socioeconomic and geographical profiles (Cumbria's 'nearest neighbours' or 'comparators'), as well as with 'best practice', and the remainder of this chapter is devoted to this issue.

Box 1. The Provision of Mental Health Services for Older People in North Cumbria: Local Concerns

Re. Social Services:

Issues around the availability/capacity and capability/quality of home care, there a high staff turnover rate and no specialist provision

The dearth of specialist day care in relation to need and the varying quality and availability of generic day care provision

The low number of specialist care home beds for older people with mental health problems (as compared with the relatively comprehensive numbers for older people generally) and the difficulties of recruiting qualified staff to the independent sector, this limiting development

The low number of reviews being undertaken by social services

The perception that social services assessments are resource rather than needs driven, being primarily concerned with checking people's eligibility for services

Re. Specialist Mental Health Services:

The extent to which specialist mental health service resources are concentrated in hospitals

The inappropriateness of the mental health service inpatient facilities in West Cumbria and of the mix of people they care for

The lack of consensus as to the appropriate use of day hospital facilities, different models operating in different areas

The lack of relationship between the size and composition of community teams and local needs and their perceived inability to manage highly dependent clients within the community and

The limited provision of occupational and psychological therapies and the absence of specialist social work staff

General Concerns:

Issues about communication and co-ordination both within and across agencies

Issues about the inability of information management systems to support front line staff

A belief that commissioning sometimes focuses too narrowly on particular aspects of service provision, failing to consider the wider implications

A belief that the independent and voluntary sectors need to be more involved in the planning of services and

The need for users and carers to be more involved in service planning and development

NORTH CUMBRIA IN CONTEXT

As the reader is undoubtedly aware, the Department of Health routinely collects a range of data from councils with social services responsibilities and from the NHS. There are some problems with such information. Differences in interpretation and changes in definitions can contribute to the variation reported between respondents and years respectively, whilst, as is the case with the social services data reported here, the presentation of aggregated information (for Cumbria as a whole) may mask significant differences in local practice. As the database is updated on an ongoing basis, so as to incorporate new information, the figures also tend to be somewhat volatile. Such indicators do facilitate direct comparison between areas and over time however, and providing that one remembers that they only ever offer a partial picture of the whole situation, they can be useful.

In Table 2, Cumbria's performance on a number of social services care management indicators has been compared with the national average for England. It is noted that whilst the figures given relate to service users aged 65+, they do not specifically relate to older people with mental health problems.

In general these indicators are concerned with the extent to which people get the services they need. As social services are accessed via assessments, the first indicator considers whether there is a fair distribution of assessments for older people, and it is seen that Cumbria's performance is close to the national average, and similar to that of its comparator sites, if slightly below the range identified for 'best practice'. The percentage of assessments which lead to a service being provided (70.1%) is also similar to the national mean and suggestive of good performance.

Table 2. Social Services: Care Management Indicators

Indicator (source)	**Date**	**England Average**	**Cumbria**	**% Var.**
Number of assessments of older service users per head of population aged 65+ (PAF_E49)	2002/3	109.33	103.52	**-5.31**
Adults and older clients receiving a review as a % of those receiving a service (PAF_D40)	2002/3	51.32	8.23	**-83.96**
Number of informal carers receiving an assessment as a proportion of the total number of clients and carers receiving assessments (PAF_D42)	2002/3	25.73	37.77	**+46.79**
Gross expenditure on assessment and care management for older people per capita aged 65+ (EX75)	2002/3	78.89	61.93	**-21.50**

Source: DoH (2004a)

The indicator for the number of clients receiving a review confirms practitioners' concerns about this element of the care management process however. Cumbria's performance here is not only very poor in comparison with the national average, but is more than 40 per cent worse than that of the worst of its nearest neighbours. Whilst there is no way of knowing from these figures if older people with mental health problems are a particularly neglected subgroup, it is noted that the District Audit review in North Cumbria described formal case reviews for this client group as very limited, and observed that reassessments were often prompted by crises. Given the degenerative nature of the illnesses that many of these people experience, and the changing nature of their needs, this is clearly of concern. It might be argued that the provision of Direct Payments, enabling clients to arrange and change their care packages as they see fit, to some extent removes the need for such reviews, and interestingly Cumbria is performing better than most other areas in terms of the number of older people receiving these (2002/3 data). The absolute numbers are still very small however and it is not known to what extent the take-up includes older people with mental health problems.

The third indicator reported here is designed to show whether carers' needs are being taken into account in care planning and measures the number of formal assessments completed under carers' legislation. Separate user groups are not distinguished. In comparison with the national average, and with its nearest neighbours, Cumbria performs well here, although there is still considered to be some room for improvement. This would also seem to be the message from the District Audit review, which reported that only 45 per cent of carers of older people with mental health problems in North Cumbria believed their own needs had been assessed (Bruce, 2001).

Table 3 looks at those indicators concerned with the provision of social services which enable clients to be cared for in their own homes. The figures cited again refer to Cumbria as a whole.

These indicators suggest that, compared with the national average, a smaller proportion of the elderly people in Cumbria are helped to live at home, although the figures for the provision of day care, respite and meal services are all above the national average. The proportion of older people receiving home care is significantly beneath the national average however, with the authority falling into the Department of Health's 'ask questions about performance' banding, and the total number of contact hours provided are relatively low, if not out of keeping with those provided in Cumbria's comparator sites. Tellingly, a smaller than average proportion of households receive more than ten contact hours per week and six or more visits per week (intensive home care), although in terms of the proportion of high service users being maintained in the community, as opposed to in residential care, the picture is more positive. Cumbria performs better on this measure than any of its comparator sites, and although the figures reported for 2002/3 represent a slight drop on those for 2001/2, the trend appears to be for an for an increasing proportion of high need clients to be cared for in their own homes. These figures do encompass service users of all ages, but the vast majority will be over 64 years of age.

Table 3. Social Services: Care in the Community Indicators

Indicator (source)	**Date**	**England Average**	**Cumbria**	**% Var.**
Elderly people (RAP* based) helped to live at home per 1,000 population aged 65+ (PAF_C32R)	2003/4	84.01	70.64	**-15.91**
Number of older clients receiving home care at 31st March per 1,000 population aged 65+ (OA122)	2002/3	42.83	32.15	**-24.94**
Number of contact hours per 1,000 population aged 75+ (AA65)	2003/4	821.76	718.42	**-12.58**
Households receiving intensive home care per 1,000 population aged 65+ (PAF_C28)	2003/4	11.05	9.79	**-11.40**
Number of older clients receiving day care at 31st March per 1,000 population aged 65+ (OA123)	2002/3	15.39	19.66	**+27.75**
Number of older clients receiving meals at 31st March per 1,000 population aged 65+ (OA124)	2002/3	17.48	20.37	**+16.53**
Number of nights respite care provided or funded by the local authority per 1,000 adults (AC_L4)	2000/1	81.00	96.60	**+19.26**
Gross expenditure on home support services per capita aged 75+ (EX26)	2002/3	371.00	330.39	**-10.95**
Of households receiving intensive home care and supported residents, the percentage receiving intensive home care (PAF_B11)	2002/3	23.90	27.34	**+14.39**

* Information on referrals, assessments and packages of care provided by the local authority

Source: DoH (2004a)

Table 4 next considers the extent to which older people are cared for in residential or nursing home settings in North Cumbria. It is seen that whilst the number of residential beds available per head of population is not dissimilar to that elsewhere, Cumbria does have a particular lack of specialist residential facilities for elderly people with mental health problems. Indeed, the proportion of residential care places available to older people with mental health problems (1.31%) compares badly with that in all Cumbria's comparator sites whose figures range from 2.10 – 15.94 per cent (median 6.74%). Although the information reported here relates to Cumbria as a whole, this is clearly a problem in North Cumbria and whilst the mental health trust have developed a very successful Care Home Education and Support Service (CHESS), this cannot be expected to compensate for an undersupply of the specialist long-term care facilities deemed appropriate to care for this client group. Although no national data could be found about the provision of specialist nursing home facilities for older people with mental health problems, local sources would suggest that this provision is also scarce in North Cumbria.

The two indicators for supported admissions in Table 4 are concerned with the number of new admissions to care homes who receive financial support from social services. It can be seen that whilst the number of admissions to residential care in Cumbria is a little higher than the national average (and relatively high in comparison with its nearest neighbours) the number of admissions to nursing homes is considerably lower than average. The balance between the two may simply reflect the relative availability of each type of provision. Some encouragement can be taken from the fact that, at a time when Cumbria are striving to expand their home support services and enable more dependent people to remain in their own homes, the figures suggest that the number of admissions to residential care per 1000 population is decreasing. Furthermore, compared with other areas, the authority also seems to be providing such services at not unreasonable cost.

Table 4. Social Services: Institutional Care Indicators

Indicator (source)	**Date**	**England Average**	**Cumbria**	**% Var.**
Residential places in residential homes for older people per 1,000 population aged 75+ (OA01)	2000/1	69.57	74.81	**+7.53**
% of residential care places in homes for older people which are in homes for elderly mentally infirm people (OA07)	2000/1	8.96	1.31	**-85.38**
Permanent supported admissions of older people to residential care per 1000 population aged 75+ (OA95)	2003/4	12.21	12.71	**+4.10**
Permanent supported admissions of older people to nursing care per 1000 population aged 75+ (OA86)	2003/4	8.10	4.94	**-39.01**
Gross weekly cost for supporting an elderly person in residential and nursing care (PAF_B13)	2002/3	380.09	370.34	**-2.57**

Source: DoH (2004a)

Table 5. Health Services: Indicators

Indicator (source)	**Date**	**England Average**	**North Cumbria**	**% Var.**
% of psychiatric admissions that are emergency psychiatric readmissions (older people)	2003/4	9.19	8.05	**-12.40**
% of out of catchment area treatments (older people)	2003/4	2.1	0.0	**-100.00**
% of patients whose transfer of care from hospital was delayed				
Carlisle PCT	2003/4	3.3	3.6	**+9.09**
Eden Valley PCT	2003/4	3.3	1.7	**-48.48**
West Cumbria PCT	2003/4	3.3	3.5	**+6.06**
Average length of old age psychiatry inpatient stay in days (mean / median)	2003/4	80.3 / 30	65.8 / 50	
% of patients with copies of their own care plan (working age adults)	2003/4	97.0	90.0	**-7.22**

Sources: DoH (2004b); NCMHLDT; Healthcare Commission [2004]

In Table 5 we turn our attention to those performance indicators currently included in health trusts' reporting schedules. The majority of data gathered from specialist mental health trusts relates to services for adults of working age however, and little meaningful information is collected about services for older people with mental health problems.

The first of the indicators noted in Table 5 above reports the percentage of older mental health inpatients readmitted as an emergency within 28 days of discharge and is designed to measure the extent to which community services are able to support people at home following a hospital stay. Unfortunately, areas in which high numbers of people are discharged to care homes, perhaps because there are inadequate community services to support them in their homes, can appear to be functioning well on this indicator, as such people are less likely to be readmitted to hospital (Lingard & Milne, 2004). Although the figures given here suggest that the trust is doing fairly well in this respect, this should not be accepted at face value therefore. However, the above social services indicators did not suggest that North Cumbria were admitting unusually high numbers of older people to care homes, and the absence of any out of catchment area treatments indicates that where people are being admitted (or readmitted) it is to local inpatient services. The transition of care between services for younger and older adults is also reported to be good.

Although the figures for the number of delayed transfers of care do not include mental health service patients, and this is an all adult indicator, these statistics will nevertheless include many older people with mental health problems, as a large proportion of delayed discharges are over 75 and the rate of psychiatric comorbidity in this population is high (Baldwin, 1998). Following the introduction of the Community Care (Delayed Discharges) Act 2003 the number of delayed discharges has been falling nationwide, and it would appear that this is as true in North Cumbria as elsewhere. It has been suggested that this indicator may help to interpret the effectiveness of local community care services, as well as the quality of the service received in hospital and the mechanisms in place to facilitate a timely discharge. However, it would seem open to the same misinterpretation as the psychiatric readmission rate if people on the margins of community/institutional care are discharged to care homes where such beds are more readily available than community services.

Although the length of stay of older people in mental health inpatient units is not currently a health performance indicator, Hospital Episode Statistics do report the national average and it was thought that this information would help to further characterise the service. Data provided by the trust's information department has thus been used to calculate the mean and median length of stay for people admitted to the three acute assessment and treatment wards in North Cumbria between August 2002 and January 2003, this period thereby overlapping with that for which the national figures are given. Whilst there will undoubtedly be differences not only in the two time periods compared, but in the way these figures have been put together, they do provide a benchmark with which future time periods can be compared.

In spite of the fact that the rationale for patients having their own care plans includes a reference to older people with severe mental illness, the final indicator shown, for the percentage of patients with copies of their care plan, is actually calculated only for people aged 16-64 who receive the enhanced level of the Care Programme Approach. The fact that in North Cumbria one in ten of this group, for whom care co-ordination arrangements are most developed, do not hold copies of their care plans is however probably bad news for older clients, the Commission for Health Improvement (CHI) reporting that care planning was less developed and offered less opportunities for involvement for this group. Indeed, in their most recent clinical governance review CHI did not meet any older service user who was aware of having a care plan setting out the health services they would receive – let alone the fuller details of their wider care package (CHI, 2002).

This leads us neatly to two studies undertaken by the PSSRU that, amongst other things, examined the extent to which health and social care for older people is integrated – the first from the perspective of the local authority and the second from that of consultants in old age psychiatry.

In the first of these studies, senior social services staff were asked to provide a range of information concerning the organisational arrangements for, and performance of, a number of core tasks undertaken by practitioners working with older people (including, but not exclusively, older people with mental health problems) as shown in Table 6. Although this data was collected in 1997/8, follow up visits in 2000 found stability of arrangements, and it is suspected that the picture today has not greatly changed.

Table 6. Care Management Arrangements in Services for Older People in England: Indicators of Integrated Provision

Characteristic	Proportion of Authorities in England Displaying this Characteristic %	Situation in Cumbria
Had specialist teams for older people	39	Had specialist teams for older people, but not specifically for older people with mental health problems
Had joint arrangements for initial screening with at least one health trust	56	No such arrangements
Had common health and social services assessment documentation for people with dementia	24	Didn't have shared assessment documentation or accept care programme approach assessments for care management
Proportion of care plans to which NHS staff had input	37% ≤20% 33% 21-40% 13% 41-60% 13% 61-80 4% >80%	Health staff contributed to between 21 and 40% of care plans
NHS staff acted as care managers	21	Whilst health staff contributed to assessments, they did not act as care managers
Average (active) caseload size	31% <30 52% 30-50 18% > 50	The average (active) caseload size in older people's teams was more than 50
Front line practitioners purchased community care packages	33	Whilst front line practitioners were able to allocate meals on wheels and day care services provided in-house, other elements of care packages had to be approved by at least first line managers

Refs: Hughes et al., 2001; Challis et al., 1999; Weiner et al., 2002

It is clear from Table 6 that there is little evidence to suggest that systems to facilitate integrated health and social care were well developed in any systematic way – in Cumbria or elsewhere. Indeed nationally such arrangements were found to be the exception rather than the rule. Whilst Cumbria reported that they had specialist teams for older people these also provided services for a number of younger people with disabilities, and there were no specialist multidisciplinary and/or multiagency teams for older people with mental health problems. This is not of itself necessarily prohibitive of the provision of co-ordinated care, but the lack of common access and assessment procedures probably is. The information about caseload size and the purchase of care packages has been included in the light of research indicating that better outcomes for older people with mental health problems are achieved when practitioners work with protected numbers of clients and hold devolved budgets allowing them to more flexibly match services to needs. This is not presently the situation in North Cumbria. On a more positive note however, it was reported that health staff in Cumbria contributed to a number of assessments and care plans, and that social services staff often attended multidisciplinary locality meetings where information about particular clients was shared. It was also said that health and social services participated in a joint planning process, although they had no jointly managed services and did not pool budgets.

The second study referred to took the form of a cross-sectional survey of consultants in old age psychiatry in England in 1999/2000 and aimed to describe and compare service arrangements according to three broad domains: levels of professional autonomy, degree of community orientation, and degree of integration between health and social care provision.

Table 7. Old Age Mental Health Services in England: Indicators of Integrated Provision

Characteristic	Percentage of Consultants Reporting this Characteristic %	Situation in North Cumbria
Social services staff worked full time as part of the team/service	59	None of the three consultants who responded said social services staff were full time members of their team
Hospital based social workers formed part of the mental health service	53	Just one of the three consultants saw hospital based social workers as part of their service
Mental health team staff visit social services team for review meetings	65	Two of the consultants reported such liaison
Social services staff visit mental health team for review meetings	88	All three consultants reported such liaison
Mental health services provide formal training for social services staff	54	Just one consultant reported the existence of such training

Refs: Challis et al., 2002c

With reference to the latter domain, Cumbria's situation was typical of the national picture, which found that links between health and social care were least developed on items indicative of greater integration such as shared management and team policies and strongest in terms of liaison. Interestingly, liaison between teams was more commonly facilitated by social services staff visiting mental health services teams than vice versa, and only just over half of specialist mental health teams nationally (one in three in Cumbria) provided formal training for their social services colleagues on mental health problems in older people. As a slight aside, the information collected also suggested that professionals from different disciplines within the community mental health teams in North Cumbria were themselves acting fairly autonomously, only one of the three consultants saying that their team had an agreed set of procedures/policies covering the various professional groups or a single point of access.

CHAPTER 4
FINDINGS II: USER CHARACTERISTICS AND SERVICE RECEIPT

This chapter explores the key characteristics of the four groups of older people with mental health problems about whom information was collected in this study, namely:

1. People on the community caseloads of social services staff
2. People on the caseloads of community mental health staff
3. Admissions to residential and nursing homes and
4. Admissions to acute mental health inpatient beds.

The material is presented in a series of tables and necessarily represents only a proportion of that collected. It is hoped that it will nevertheless serve to assist the reader to develop a better understanding of the characteristics of those older people with mental health problems who are in contact with the formal services in North Cumbria, and to illustrate the way in which this local material has informed the study's conclusions. Where it is thought that further detail may be of potential interest to local agencies, this has been presented within the Appendices.

CLIENTS/SERVICE USERS IN THE COMMUNITY

Social Services Department Users

All Older People

Working from information supplied by Cumbria Social Services, in November 2003 there were approximately 4,200 older people on the caseloads of the older people's teams in North Cumbria, excluding care home residents. The distribution of these people across the four area teams is shown in Appendix A19. Just over half the service users (51.2%) were allocated, i.e. active cases open to a named practitioner. The remainder were deallocated, i.e. open to social services but inactive and without a named practitioner.

As was described in Chapter 2, the study sought to collect detailed information about the sociodemographic, functional and service receipt characteristics of a 1 in 8 random sample of this population. Adequate data was in fact obtained for 309 service users, who constituted approximately 1 in 12 allocated, and 1 in 20 deallocated, cases. The distribution of responses varied somewhat between teams, and whilst for the purposes of this study the data has been aggregated, Appendix A20 shows the response rate per team.

In the absence of any reliable way of identifying older people with mental health problems from previously existing information, the sampled cases necessarily included people both with and without mental health problems. Whilst this study is primarily concerned with the presentation and needs of that subgroup of older people who have mental health problems, we will start with a brief look at the complete sample, who may be considered to be representative of all older people living in the community in contact with the social services older people's teams in North Cumbria.

Table 8. Social Services Department Community Caseload. All Users: Characteristics

	Allocated Number (%)	**Deallocated** Number (%)	**Total** Number (%)
Gender			
Male	55 (30.4)	37 (30.1)	92 (30.3)
Female	126 (69.6)	86 (69.9)	212 (69.7)
Age (years)			
Mean	82.1	82.3	82.2
Standard deviation	7.1	7.5	7.3
Usual place of residence*			
Home alone	109 (60.9)	87 (75.7)	196 (66.6)
Home with other adult(s)	70 (39.1)	28 (24.3)	98 (33.3)
Presence of informal carer			
Yes	137 (75.7)	77 (69.4)	214 (73.3)
No	44 (24.3)	34 (30.6)	78 (26.7)
Dependency (Barthel Scale)			
Low	114 (64.0)	74 (69.2)	188 (66.0)
Medium	38 (21.3)	26 (24.3)	64 (22.5)
High	26 (14.6)	7 (6.5)	33 (11.6)
Cognitive impairment (Cognitive Performance Scale)**			
No/mild	123 (71.5)	103 (95.4)	266 (80.7)
Significant	49 (28.5)	5 (4.6)	54 (19.3)
Mood*			
Not usually sad/depressed	108 (61.7)	76 (78.4)	184 (67.6)
Usually sad/depressed	67 (38.3)	21 (21.6)	88 (32.4)

Allocated cases: max n=183; Deallocated cases: max n=126
* Significance ≤0.05 Pearson's Chi-Square
** Significance ≤0.001 Pearson's Chi-Square

Please note that in all tables:

- The 'max n' is the number of people in each group about whom data was collected. Not all questionnaires were completed fully however. When the numbers of responses to each item are summed, the total may be less than the 'max n' therefore.
- The figures have been rounded to one decimal point. When the percentages for all responses to each item are summed, they may not total exactly 100 per cent therefore.

Table 8 sets out the sociodemographic and functional characteristics of the social services caseload, both as a whole and by allocated/deallocated caseloads. The people sampled were aged between 65 and 100 years old (mean 82 years) and females outnumbered males by approximately two to one. In comparison with the wider population of older people in Cumbria as a whole, in which about a third of older people live alone (DoH, 2004a), about two-thirds of this sample lived on their own, including three-quarters of the deallocated cases. Furthermore, although approximately three-quarters of the total caseload were said to have a significant informal carer, just over a third of those people living alone did not have this support. Whilst the majority of the sample were relatively independent, as measured by the Barthel Activities of Daily Living Index (Mahoney & Barthel, 1965; Collin et al., 1988), around a third had moderate or severe dependency needs.

Although the sociodemographic situation and dependency levels of the older people on the department's allocated and deallocated caseloads did not appear to be very different, a significantly greater proportion of the allocated than of the deallocated cases had appreciable cognitive impairment and/or usually appeared low in mood. Indeed, only five out of the 108 deallocated cases scored three or more on the cognitive performance scale, which would be indicative of moderate-severe impairment. This might suggest that practitioners either recognise the complex needs of these people and do not deallocate them post-assessment, or that when they are deallocated, they are later re-referred.

Tables 10 and 11 below explore whether there was also a difference in the services received by the allocated and deallocated cases. However, in order to be able to cost the care received, Table 9 first sets out the unit costs of the main community services about which information was collected.

Table 9. Community Services: Unit Costs

Service	**Cost** £
Help at home / hour	
Home care*	9.50
Day Care / day	
Day centre*	17.32
Day centre (specialist)*	28.13
Day hospital (mental health)**	79.38
Professional Visits / visit	
District nurse***	18.00
Community mental health nurse**	50.53
Community mental health support worker ***	18.00

Sources: *Cumbria Social Services; **NCMHLDT; ***Curtis & Netten (2004)

Table 10. Social Services Department Community Caseload. All Users: Service Usage

	Allocated		Deallocated	
Service	**Mean Frequency**	**Mean Cost** £	**Mean Frequency**	**Mean Cost** £
Help at Home: hours per week Home care, including the provision of personal care, meals and domestic assistance	6.6	62.75	4.7	44.58
Day Care: days per week				
Day centre	0.6	9.85	0.4	7.29
Day hospital (mental health)	0.1	7.06	0.0	-
Professional Visits: visits per week				
District nurse	0.3	5.18	<0.1	0.44
Community mental health nurse	0.1	3.89	<0.1	0.61
Community mental health support worker	0.1	1.37	0.0	-
Total Community Care Package		90.10		52.92

Allocated cases: max n=183; Deallocated cases: max n=126
Information on quantities of service received as reported by social services staff in local data collection

In Table 10 the average cost of each service when spread across all social services users is presented, whilst Table 11 looks at the average cost of each service only for those people who were reported to be receiving it. It is acknowledged that a number of heroic assumptions have been made in arriving at these figures and that they should therefore be treated with a degree of caution. This was in large part due to gaps in the information collected. It was, for example, not unusual for practitioners to indicate that a particular user was seen by a community mental health nurse or support worker, but not to state how frequently. For the purpose of these calculations the study team has thus allotted such cases the average visiting frequency of those cases for whom such information was available. As was discussed in Chapter 2, there were also concerns about the reliability of some of the data collected for the deallocated cases, but notwithstanding these cautions, these tables do give some indication of the extent to which, on average, more social and health resources are committed to allocated than to deallocated social services cases.

Table 11. Social Services Department Community Caseload. Users in Receipt of Services: Service Usage

	Allocated		Deallocated	
Service	**Mean Frequency**	**Mean Cost** £	**Mean Frequency**	**Mean Cost** £
Help at Home: hours per week Home care, including the provision of personal care, meals and domestic assistance	10.9	103.65	8.1	76.57
Day Care: days per week				
Day centre	1.9	32.59	1.5	25.50
Day hospital (mental health)	1.6	127.01	0.0	-
Professional Visits: visits per week				
District nurse	1.9	33.37	1.0	18.00
Community mental health nurse	0.4	20.61	0.2	12.63
Community mental health support worker	0.7	12.32	0.0	-

Allocated cases: max n=183; Deallocated cases: max n=126
Information on quantities of service received as reported by social services staff in local data collection

Older People with Mental Health Problems

As has already been noted, the identification of those older people with mental health problems on the teams' caseloads was complicated by the fact that the social services department make no clear organisational separation between older people with mental health problems and other older people. This meant that it was necessary to collect data about all older clients and to then make this separation on the basis of mental health indicators derived from the information gathered. In the absence of any precedents for doing this, a number of possible indicators of mental health problems were explored, including the report of a formal diagnosis of mental illness, the receipt of input from the specialist mental health service and the experience of cognitive impairment or low mood as identified by screening questions within the data collection. The numbers of people thereby classified as having mental health problems are given in Table 12.

Each of these operational definitions has its own advantages and disadvantages. The advantage of the first option, which identifies only those service users reported to have a formal diagnosis of mental illness, is that we could be fairly confident that the people identified would have significant mental health problems. The resultant figure of 14.9 per cent is very likely to underestimate the population of interest however. Not only does it rely on social services practitioners knowing that such a diagnosis has been made, but it excludes the considerable number of people with mental illness who have never been formally assessed/diagnosed. In fact, if one considers the general prevalence of mental illness in older people, to employ this definition would be to suggest that those older people known to social services in North Cumbria are less likely to have mental illness than older people generally. As there are a number of studies showing that social service utilisation by older people with mental health problems is greater than that by the older population as a whole, this does not seem likely. Indeed, the indicators within the local data collection (Option 3, Table 12) suggest that nearly 40 per cent of the caseload have significant cognitive impairment and/or usually appear low in spirits.

Table 12. Social Services Department Community Caseload: Different Indicators of Mental Health Problems

Operational Definition of Mental Health Problem	**Allocated** Number (%)	**Deallocated** Number (%)	**All** Number (%)
1. Reported to have formal diagnosis of mental illness	36 (19.7)	10 (7.9)	46 (14.9)
2. Reported to have input from the specialist mental service			
Consultant psychiatrist	51 (27.9)	10 (7.9)	61 (19.7)
Community mental health nurse	34 (18.6)	6 (4.8)	40 (12.9)
Mental health day hospital	11 (6.0)	1 (0.8)	12 (3.9)
Mental health inpatient admission	6 (3.3)	-	6 (1.9)
Any of the four above	64 (35.0)	13 (10.3)	77 (24.9)
3. Reported to have significant cognitive impairment and/or low mood*			
Significant cognitive impairment	49 (26.8)	5 (4.0)	54 (17.5)
Often sad or depressed	67 (36.6)	21 (16.7)	88 (28.5)
Either (or both) of these	95 (51.9)	26 (20.6)	121 (39.2)
4. Any of the above	111 (60.7)	29 (23.0)	140 (45.3)

Allocated cases: max n=183; Deallocated cases: max n=126

* It is noted that the figures in Table 12 and Table 18 have been calculated in a slightly different way from those reported in the other tables. In the majority of tables, where no information was provided about a particular item, that case was not included in the figures presented and the number of cases included in the analysis is given for each item. In Tables 12 and 18 however, the responses have been recoded into reported/not reported binary variables. For example, the percentage of clients who are not reported to have low mood includes those people for whom no information about this item was given, as well as those cases where the practitioner specified that the client did not have low mood. These figures thus relate to all cases. It is recognised that this may have resulted in an underestimate of the proportion of the caseload that have mental health problems, and the figures offered should thus be considered conservative estimates.

Given that the majority of people with mental health problems are cared for by their general practitioner, it is not surprising that this figure (i.e. 40%) is also greater than the 25 per cent of service users who have, or have recently had, input from the specialist mental health service (Option 2, Table 12). This second operational definition is subject to the same weaknesses as the first, whilst the extent to which the roles of social services and mental health staff overlap, the former substituting for the latter, will also contribute to an underestimate of the population of interest here. If the screening questions (Option 3, Table 12) were used alone however, certain groups of older people with mental health problems, including those with very early dementia, schizophrenia or elevated mood, may not be captured. This study has therefore utilised the fourth and most generous operational definition, whereby clients identified by Options 1, 2 or 3 have been included in the population of interest.

According to this definition, approximately 45 per cent of the older people on the caseloads of the social services older people's teams who lived in their own homes had mental health problems. The 140 clients identified in this way were not equally distributed across the teams' allocated and deallocated caseloads however. Indeed, whilst just over 60 per cent of the allocated cases were found to have mental health problems, less than 25 per cent of the deallocated cases did so. Further comparison of these two groups revealed that the people with mental health problems on the deallocated caseload were more likely to live alone and to appear sad/depressed than the people with mental health problems who were allocated, whilst they were also less physically dependent. However, the only statistically significant difference between the two groups was that a smaller percentage of the deallocated than the allocated group had significant cognitive impairment as shown in Appendix A21.

In the following tables, the characteristics of the older people with mental health problems on the community caseloads of social services staff have been compared with those of the older people on the caseloads of specialist mental health staff. In order that both groups consist of active cases with named keyworkers, only allocated social services users have been described. The fact that only a very small proportion of the already small number of deallocated cases who have mental health problems appear to have complex needs suggests that this will not exclude significant numbers of relevant service users for the main purpose of this study. Firstly, however, we must briefly describe the mental health sample.

Community Mental Health Team (CMHT) Clients

According to information supplied directly by community mental health nurses and support workers, there were a total of 794 clients on their caseloads in November 2003. This included 129 people (16%) who were long-stay residents of either care homes or hospitals. As was described in Chapter 2, the study sought to collect detailed information about the sociodemographic, functional and service receipt characteristics of a random sample of 1 in 6 of these clients. In the event adequate data was obtained for 122 clients (about 1 in every 6.5) of whom 21 (17%) lived in an institutional setting.

A Comparison of People with Mental Health Problems on the Caseloads of the Social Services Department and/or CMHT

Tables 13-16 compare the characteristics of the 101 CMHT and 111 allocated social services clients with mental health problems who lived in their own homes. Although only a small amount of information was available about the formal mental health status of the social services users, diagnostic information was provided for 84 of the CMHT clients. Of these, 65 per cent had a primarily organic mental illness (this classification including seven people with co-existent functional mental illness), whilst 35 per cent had a primarily functional mental illness. Five further clients were awaiting diagnosis.

Table 13 would suggest that, in terms of their sociodemographic characteristics, the older people with mental health problems seen by social workers and their colleagues are significantly older than those on the caseloads of community mental health nurses and support workers. This may to some extent be an artefact of the different sampling criteria used for the respective agencies, as people under 65 were specifically excluded from the social services, but not the mental health, sample. Only three of the latter were under 65 however, and if one looks at the people in the 65-69 age range, it is seen that these constituted more than ten per cent of the mental health sample compared with less than five per cent of the social services group.

All 192 of the older people for whom ethnicity data was supplied were described as European-Caucasian. Although not statistically significant, a slightly higher proportion of the social services than the mental health caseload were males, and a greater percentage lived alone. The greater proportion of the social services clients who had informal carers is statistically significant, but it is not immediately apparent why this might be the case. In keeping with the earlier District Audit findings (Bruce, 2001), the clients known to social services were also more physically dependent than those seen by the mental health practitioners as measured by the Barthel index, it suspected that this is at least in part due to the different referral criteria the two agencies operate. The specialist mental health team will, for example, see a number of people who are in the very early stages of dementia (referred for treatment with anti-Alzheimer medications) who may to all intents and purposes be functioning independently, this not a group usually seen by social services.

Whilst no significant difference was found between the proportion of each agency's caseload who experienced significant cognitive impairment (as defined by a score on the Cognitive Performance Scale of three or more) this broad grouping encompasses people who are very severely impaired, as well as those with more moderate impairments, and those somewhere in between. The proportion of each agency's caseload who fell within each of these finer bands was also very similar however, as can be seen in Table 14. Interestingly though, whilst very few of the most cognitively impaired people known to social services had a community mental health nurse or support worker, the majority of the most cognitively impaired clients on the mental health caseload had social workers. Furthermore, although we are not able to say anything about the severity of their problems, a significantly higher proportion of the social services than the mental health caseload usually appeared sad or depressed. Indeed, the 67 people captured here represent approaching 40 per cent of the allocated cases seen by social services, which, even if not all are clinically depressed, must give cause for concern given the decreased quality of life associated with low mood.

Table 13. Social Services Department and CMHTs' Community Caseloads: A Comparison of the Characteristics of Older People with Mental Health Problems

	Social Services Number (%)	**Mental Health Services** Number (%)	**All**[1] Number (%)
Gender			
Male	35 (31.8)	28 (27.7)	62 (29.8)
Female	75 (68.2)	73 (72.3)	146 (70.2)
Age (years)*			
Mean	81.2	78.2	79.8
Standard deviation	6.8	7.7	7.4
Usual place of residence			
Home alone	63 (57.8)	54 (55.1)	114 (55.9)
Home with other adult(s)	46 (42.2)	44 (44.9)	90 (44.1)
Presence of informal carer**			
Yes	87 (78.4)	61 (62.9)	147 (71.7)
No	24 (21.6)	36 (37.1)	58 (28.3)
Dependency (Barthel Scale)***			
Low	63 (58.3)	87 (87.9)	148 (72.5)
Medium	25 (23.1)	6 (6.1)	31 (15.2)
High	20 (18.5)	6 (6.1)	25 (12.3)
Cognitive impairment (Cognitive Performance Scale)			
No/mild	54 (52.4)	64 (64.0)	117 (58.5)
Significant	49 (47.6)	36 (36.0)	83 (41.5)
Mood***			
Not usually sad/depressed	40 (37.4)	62 (61.4)	99 (48.3)
Usually sad/depressed	67 (62.6)	39 (38.6)	106 (51.7)

Social services users: max n=111; Mental health service clients: max n=101
[1] Note that 3 clients featured in both agency's samples
* Significance ≤0.05 Mann Whitney U
** Significance ≤0.05 Pearson's Chi-Square
*** Significance ≤0.001 Pearson's Chi-Square

Table 14. Social Services Department and CMHTs' Community Caseloads: A Comparison of the Proportion of People with Significant Cognitive Impairment

CPS* Score	**Social Services** Number (%)	**Mental Health Services** Number (%)
3: Moderate impairment	30 (61.2)	23 (63.9)
4: Moderate-severe impairment	4 (8.1)	1 (2.8)
5: Severe impairment	13 (26.5)	12 (33.3)
6: Very severe impairment	2 (4.1)	-

Social services users: n=49; Mental health service clients: n=36
* CPS: Cognitive Performance Scale

In Tables 15 and 16 the level of services received by older people with mental health problems known to social workers, community mental health nurses and support workers are compared, and the costs of their respective care packages calculated.

Table 15. Social Services Department and CMHTs' Community Caseloads: A Comparison of the Service Usage of All Users with Mental Health Problems

	Social Services		**Mental Health Services**	
Service	**Mean Frequency**	**Mean Cost** £ per week	**Mean Frequency**	**Mean Cost** £ per week
Help at Home: hours per week				
Home care, including the provision of personal care, meals and domestic assistance	6.7	63.52	4.6	43.82
Day Care: days per week				
Day centre	0.6	17.27	0.8	22.00
Day hospital (mental health)	0.1	11.75	0.2	19.45
Professional Visits: visits per week				
District nurse	0.2	4.13	0.1	1.45
Community mental health nurse	0.1	6.50	0.4	21.58
Community mental health support worker	0.1	2.17	0.6	9.93
Total Community Care Package		105.34		118.23

Social services users: max n=111; Mental health service clients: max n=101
Information on quantities of service received as reported by social services staff in local data collection

Table 16. Social Services Department and CMHTs' Community Caseloads: A Comparison of the Service Usage of All Users with Mental Health Problems in Receipt of Services

	Social Services		Mental Health Services	
Service	**Mean Frequency**	**Mean Cost** £ per week	**Mean Frequency**	**Mean Cost** £ per week
Help at Home: hours per week				
Home care, including the provision of personal care, meals and domestic assistance	11.2	106.66	9.5	90.57
Day Care: days per week				
Day centre	1.9	52.74	2.1	58.48
Day hospital (mental health)	1.6	127.01	1.4	108.04
Professional Visits: visits per week				
District nurse	1.9	33.65	1.6	28.80
Community mental health nurse	0.4	20.66	0.4	22.70
Community mental health support worker	0.7	12.32	1.3	22.78

Social services users: max n=111; Mental health service clients: max n=101
Information on quantities of service received as reported by social services staff in local data collection

As with Tables 10 and 11 above, whilst Table 15 first examines the average cost of each service when spread across all cases in the group, Table 16 then presents the average cost of each service only for those clients reported to be receiving it. It can thus be seen that, as might be expected, the older people known to social services received more hours home care than did the mental health clients, whilst the latter received more frequent input from the community mental health team. Overall however, there is little evidence of marked differences.

CLIENTS/SERVICE USERS IN CARE HOMES OR HOSPITALS

CMHT Clients

Before moving on to a consideration of the cohorts of older people entering care homes and specialist mental health inpatient wards, Table 17 first briefly sets out the sociodemographic, functional and clinical characteristics of those older people on the caseloads of community mental health nurses and support workers who are long-term residents of care homes or hospitals. As noted above, such people constitute approximately 16-17 per cent of these teams' total caseload. However, they are not equally distributed across practitioners, as some teams have dedicated staff specialising in the care of this client group.

Table 17. CMHT Caseload. Long-Term Residents of Care Homes or Hospitals: Characteristics

Characteristic	Number (%)
Broad diagnostic grouping	
Functional mental illness	5 (23.8)
Organic mental illness	13 (61.9)
Mixed organic and functional mental illness	3 (14.3)
Gender	
Male	7 (33.3)
Female	14 (66.7)
Age (years)	
Mean	81.6
Standard deviation	4.8
Dependency (Barthel Scale)	
Low	14 (66.7)
Medium	4 (19.0)
High	3 (14.3)
Cognitive impairment (Cognitive Performance Scale)	
No/mild	5 (23.8)
Significant	16 (76.2)
Mood	8 (38.1)
Not usually sad/depressed	13 (61.9)
Usually sad/depressed	
Presentation with behaviour perceived to be difficult for carers to cope with on at least a weekly basis	
No	7 (33.3)
Yes	14 (66.7)

n=21

Comparison of the information given in Table 17 with that presented above suggests that there are no significant differences in the broad diagnoses, age or gender of the CMHT clients who live in institutional and community settings. The care home clients do seem to be differentiated by the severity/complexity of their situations however. A significantly greater proportion of this group were low in mood (Pearson's chi-square $p \leq 0.05$), had significant cognitive impairment (8 of the 16 clients with organic illness rated as severely or very severely cognitively impaired, Pearson's chi-square $p \leq 0.001$), or were more physically dependent (Pearson's chi-square $p \leq 0.05$). The majority also displayed behaviour perceived to be difficult for carers to cope with on at least a weekly basis, with six (28.6%) residents said to display three or more such behaviours. In total, ten of the residents appeared agitated, seven were said to display aggression, six had regularly disturbed sleep patterns, five experienced delusions and four were said to wander.

Admissions to Residential and Nursing Homes

In this strand of the data collection, information was gathered about the sociodemographic, functional and service receipt characteristics of those older people with mental health problems who were admitted to care homes with social services assistance between July 2003 and January 2004. In the absence of any reliable way of identifying those elderly people who had mental health problems from data routinely collected by the social services department, information was initially collected for all 179 older people who entered institutional care in this period. The population of interest was then identified on the basis of mental health indicators derived from the information gathered, using a modified version of the operational definition discussed earlier in this chapter. Thus, where practitioners had highlighted that the client's mental state had contributed to their need for residential care on a list of reasons for admission, this too was taken as an indicator of mental health problems.

As can be seen in Table 18, just over one in three of the care home admissions had a known diagnosis of mental illness, which, in the vast majority of cases, was some form of dementia. Indeed, of the 67 people with a formal psychiatric diagnosis, 63 (94%) had a primarily organic mental illness, whilst the remaining four had either depression (3) or a bi-polar disorder (1). Rather more, in fact nearly half, of the cohort had, or had recently had, contact with the specialist mental health services, whilst the screening indicators within the data collection suggested that as many as three-quarters had significant cognitive impairment and/or usually appeared low in spirits. When all these items were amalgamated together, plus that indicating that the presence of mental health problems had contributed to need for residential care, 152 people, constituting nearly 85 per cent of all admissions, were considered to have some form of mental health problem.

Further exploration of this data revealed that six of these people were already care home residents whose condition was such that they were felt to need more specialist/intensive care in a different, more expensive, setting, whilst two were moving out of long-term NHS hospital care. It is the remaining 144 people, who had been living in their own homes, who were of interest in this study. This is not to say that all of these people moved into a care home directly from their own homes however. Indeed more than 40 per cent were transferred from hospital following an inpatient stay, whilst, as shown in Table 19, four further people were approved for permanent care home residence when already in respite or emergency care home placements.

Table 18. Admissions to Residential and Nursing Homes: Different Indicators of Mental Health Problems

Operational Definition of Mental Health Problem	Number (%)
1. Reported to have formal diagnosis of mental illness	67 (37.4)
2. Reported to have input from the specialist mental service	
Consultant psychiatrist	72 (40.2)
Community mental health nurse	50 (27.9)
Mental health day hospital	9 (5.0)
Mental health inpatient admission	14 (7.8)
Any of the four above	89 (49.7)
3. Reported to have significant cognitive impairment and/or low mood	
Significant cognitive impairment	108 (60.3)
Often sad or depressed	75 (41.9)
Either (or both) of these	139 (77.7)
4. Mental health problems highlighted as a reason for admission	94 (52.5)
5. Any of the above	152 (84.9)

Max n=179

Table 19. Admissions to Residential and Nursing Homes. Older People with Mental Health Problems: Residence Immediately Prior to Admission by Usual Place of Residence

Residence Immediately Prior to Admission	Usual Place of Residence		
	Home alone	Home with others	Total
Home alone	48	-	48
Home with others	1	29	30
NHS hospital inpatient care	39	18	57
Temporary residential placement	2	2	4
Total	90	49	139*

* No information was provided about a further five clients' place of residence

The sociodemographic, functional and service receipt characteristics of those older people with mental health problems who usually lived at home and were admitted to a care home are described in Table 25 below, where we compare this client group with those older people admitted for acute mental health inpatient care. Before going on to introduce the latter group however, Tables 20 and 21 first set out the type of care home these service users entered and the factors practitioners saw as contributing to their admission. It is noted that more than two-thirds of the sample were admitted to non-specialist accommodation.

Table 20. Admissions to Residential and Nursing Homes. Older People with Mental Health Problems: Type of Home

Type of Home	Number (%)
Specialist mental health nursing home	6 (4.2)
Specialist mental health residential home	39 (27.1)
Other nursing home	25 (17.4)
Other residential home	74 (51.4)

n=144

Although the information reported in Table 21 does not enable us to say anything about the relative importance of particular factors in determining any one client's entry to a care home, it does show us how frequently each factor was mentioned. All the factors listed were identified from the literature as contributing to the institutionalisation of older people, but some clearly played a more prominent role locally than others.

The most commonly cited reason for care home admission was the client's inability to undertake daily activities of living, which, of itself, might suggest that if there were an adequate supply of appropriate support services available for people at home, it would not be necessary for some of this group to move into care. In practice however, this was never the only factor implicated. Risk, for example, featured highly in practitioners' reports, with just over two-thirds of users considered be at some sort of unacceptable risk in their own homes, usually of falls or of self-neglect, whilst approximately one in five clients were said to be presenting with disruptive behaviours not manageable in their home setting. Interestingly, physical health problems were cited as a reason for admission more often than mental health problems. This might suggest that the physical health problems experienced by this group were more severe/complex than their mental health problems, as it is not the simple presence/absence of one or the other that determines the need for admission. It is however not always easy to separate the two - people with primarily physical disorders may develop psychological problems, whilst people with mental illness frequently experience physical changes, as with the progressive weight loss and weakness often seen in Alzheimer's disease.

Table 21. Admissions to Residential and Nursing Homes. Older People with Mental Health Problems: Factors Contributing to Admission

Factors	Number of Times Indicated (%)
Inability to perform daily activities of living	120 (83.3)
Physical health problems	98 (68.1)
Mental health problems	89 (61.8)
Carer stress	87 (60.4)
Unacceptable risk of falls	67 (46.5)
Unacceptable risk of self-neglect	64 (44.4)
Lack of motivation to care for self	58 (40.3)
Unacceptable risk of accidental self-harm	51 (35.4)
Loneliness/isolation	41 (28.5)
Client's desire for residential care	40 (27.8)
Anxiety/fear	38 (26.4)
Other breakdown of care	38 (26.4)
Usual place of residence physically unsuitable	31 (21.5)
Presenting with disruptive behaviour	29 (20.1)
Recent catastrophic event	19 (13.2)
Unacceptable risk of abuse/exploitation	12 (8.3)
Unacceptable risk of harming others	6 (4.2)
Unacceptable risk of deliberate self-harm	5 (3.5)
Need for rehabilitation	4 (2.8)
Homelessness	1 (0.7)
Client's desire to join spouse or partner	1 (0.7)
Other	4 (2.8)

Max n=144

The number of instances in which carer stress was cited as contributing to the need for care home admission will probably not surprise practitioners working with older people, as such carers, whether they be spouses, siblings or children, are often elderly themselves. Indeed, in 25 out of the 26 instances in which the client was living with their spouse, and 17 out of 19 where the carer was the client's sibling, carer stress was highlighted as a reason for admission. Other factors affecting at least one in five admissions included loneliness/isolation and anxiety/fear, these understandably affecting a higher proportion of people living alone than those who lived with other adults (approximately 35% and 15% respectively in both cases), the client's lack of motivation to care for themselves (which for at least some people is likely to be a symptom of depression) and the unsuitability of their current accommodation. On a more positive note however, approaching three out of ten clients actively desired to move into residential accommodation.

Whilst only a very small number of 'other' reasons were cited, three of the four described a scenario in which the client's care needs could not be met in a domestic setting due to gaps in the supply of community services. From the comments made by practitioners, it was clear that in a number of instances this was also the reason why 'other breakdown of care' was highlighted. This takes us back to our earlier point and the question we have later sought to answer – if more help had been available, how many of these people might have been able to stay in their own homes?

Admissions to Acute Mental Health Inpatient Beds

In this element of the data collection, information was ascertained about 69 older people admitted to the Trust's acute admissions wards (Windermere, Oakwood and the Pennine Unit) between September 2003 and February 2004. The sociodemographic, functional and service receipt characteristics of these patients will be described in Tables 25-27 below, where we compare this client group with those older people admitted to care homes in a comparable period. Before this however, Tables 22-24 describe this population in terms of their broad diagnoses, the reasons given for their admission and their residence immediately prior to admission.

Although approximately one in five admissions had no specific diagnosis at the point of hospital admission, broad diagnostic information was supplied for all patients. Thus, as shown in Table 22, approaching 45 per cent of the cohort were said to have a primarily organic mental illness and more than 50 per cent a primarily functional mental illness. These proportions were similar at both hospital sites, and whilst rather more of those patients with a primarily functional illness admitted to the Carleton Clinic had psychotic symptoms (8/25 v. 2/10), this difference was not statistically significant.

Table 22. Admissions to Acute Mental Health Inpatient Beds. Older People with Mental Health Problems: Diagnoses

Diagnosis	**West Cumberland Hospital** Number (%)	**Carlton Clinic** Number (%)	**All** Number (%)
Organic mental illness	9 (42.9)	17 (35.4)	26 (37.7)
Organic mental illness with co-existent functional illness	-	5 (10.4)	5 (7.2)
Functional mental illness	10 (47.6)	25 (52.1)	35 (50.7)
Acute confusional state	2 (9.5)	-	2 (2.9)
No mental illness	-	1 (2.1)	1 (1.4)

West Cumberland admissions: n=21; Carleton Clinic Admissions: n=48

Table 23 considers the reasons perceived as contributing to this cohort's admission. It is noted that this information was provided by ward nurses who were encouraged to draw on a wide range of sources including the person's medical notes and the accounts of the patient and their carers, as well as those of community staff. As with the care home data, the information collected does not enable us to say anything about the relative importance of these factors in determining admission to hospital, but does give us a feel for how frequently various reasons were mentioned. Whilst the 'planned respite' option was originally included as a means of double-checking that the admissions captured were all acute, two people admitted for a time-limited break did not return home as scheduled, hence their inclusion here.

As can be seen in Table 23, the three most commonly given reasons for admission to hospital were the need for general diagnostic assessment, the need for treatment and the risk of self-neglect should the person remain in their current environment. These reflect the reasons most frequently given in the larger, Carleton Clinic group, the two reasons most commonly reported for the smaller West Cumberland Hospital cohort being the desire for an assessment of the person's future care needs and carer stress. However, the only three reasons for which there were statistically significant differences between the two sites were the need for general diagnostic assessment, the need for treatment and the presence of carer stress.

Table 23. Admissions to Acute Mental Health Inpatient Beds. Older People with Mental Health Problems: Factors Contributing to Admission

Factors	**West Cumberland Hospital** Number of Times Indicated (%)	**Carlton Clinic** Number of Times Indicated (%)	**All** Number of Times Indicated (%)
Unacceptable risk of self-neglect	7 (35.0)	26 (54.2)	33 (48.5)
Treatment*	5 (25.0)	28 (58.3)	33 (48.5)
General Diagnostic assessment*	5 (25.0)	26 (54.2)	31 (45.6)
Assessment of future care needs	9 (45.0)	16 (33.3)	25 (36.8)
Other breakdown of care	8 (40.0)	16 (33.3)	24 (35.3)
Unacceptable risk of accidental self-harm	4 (20.0)	14 (29.2)	18 (26.5)
Concerns about current medication	4 (20.0)	14 (29.2)	18 (26.5)
Management of behavioural disturbance	7 (35.0)	10 (20.8)	17 (25.0)
Carer stress*	9 (45.0)	4 (8.3)	13 (19.1)
Unacceptable risk of deliberate self-harm	1 (5.0)	10 (20.8)	11 (16.2)
Unacceptable risk of harming others	2 (10.0)	2 (4.2)	4 (5.9)
Planned respite	2 (10.0)	-	2 (2.9)

West Cumberland admissions: n=20 (no information was given about the reasons for one further admission)
Carleton Clinic admissions: n=48
* Significance ≤0.05 Pearson's Chi-Square

A similar proportion of the inpatient cohort were said to be at some form of unacceptable risk at home or presenting with behaviours perceived as being difficult to cope with as was found in the care home admissions sample (63.2% v. 68.1% and 25.0% v. 20.1% respectively). Carer stress was less commonly perceived as contributing to the need for admission in the inpatient population however (19.1% v. 60.4%), whilst other breakdowns of community care were more frequent (35.3% v. 26.4%). This might suggest that this is a group the formal community services find particularly difficult to support as currently resourced/organised, a hypothesis to which further weight is lent by the number of instances in which concerns about medication contributed to the need for inpatient care. It is not clear to what extent a lack of community services might also be contributing to the use of inpatient beds for assessing patients' future care needs. This is an important question to answer, for it is widely acknowledged that hospital admission can be both disorientating and deskilling, particularly for people with dementia, whilst the necessary disruption to community support arrangements can itself result in a breakdown of care.

Whilst Table 23 focuses on the similarities and differences between the reasons for admission to the two hospital sites, there are also differences in the reasons people are admitted from different forms of accommodation. The most commonly cited reason for the admission of the relatively small number of people from care homes, for example, was concern about their medication. A need for general diagnostic assessment or treatment, and the presentation of challenging behaviours were also commonly reported however, whilst, perhaps not surprisingly, carer stress and the assessment of future care needs came much lower down the hierarchy.

As can be seen from Table 24, all eight of the admissions from care homes were to the Carleton Clinic, although, probably because of the small numbers in the sample, this was not statistically significant. The proportion of admissions transferred from elsewhere within the NHS hospital system (just under 1 in 5 of the 64 clients for whom this information was provided) was the same at both sites however.

Table 24. Admissions to Acute Mental Health Inpatient Beds. Older People with Mental Health Problems: Usual Place of Residence

Usual Place of Residence	**West Cumberland Hospital** Number (%)	**Carlton Clinic** Number (%)	**All** Number (%)
Home alone	8 (38.1)	20 (41.7)	28 (40.6)
Home with other adult(s)	13 (61.9)	19 (39.6)	32 (46.4)
Residential or nursing home	-	8 (16.7)	8 (11.6)
Other	-	1 (2.1)	1 (1.4)

West Cumberland admissions: n=21; Carleton Clinic admissions: n=48

A Comparison of Admissions to Care Homes and Admissions to Acute Mental Health Inpatient Beds

In the final three tables in this chapter we compare the sociodemographic, functional and service receipt characteristics of the two cohorts of people admitted to care homes and to inpatient wards respectively.

Table 25. Admissions to Care Homes and Acute Mental Health Inpatient Beds: A Comparison of the Characteristics of Older People with Mental Health Problems

Characteristic	**Care Home Admissions** Number (%)	**Inpatient Admissions** Number (%)
Gender		
Male	46 (31.9)	18 (30.5)
Female	98 (68.1)	41 (69.5)
Age (years)*		
Mean	83.4	77.1
Standard deviation	6.9	8.3
Usual place of residence**		
Home alone	92 (64.3)	28 (46.7)
Home alone with other adult(s)	51 (35.7)	32 (53.3)
Presence of informal carer		
Yes	118 (82.5)	50 (83.3)
No	25 (17.5)	10 (16.7)
Dependency (Barthel Scale)***		
Low	41 (28.9)	48 (81.4)
Medium	47 (33.1)	7 (11.9)
High	54 (38.0)	4 (6.8)
Cognitive impairment * (Cognitive Performance Scale)**		
No/mild	43 (29.9)	37 (66.1)
Significant	101 (70.1)	19 (33.9)
Mood		
Not usually sad/depressed	71 (49.7)	22 (37.3)
Usually sad/depressed	72 (50.3)	37 (62.7)
Presentation with behaviour perceived to be difficult for carers to cope with on at least a weekly basis***		
No	54 (37.8)	2 (3.8)
Yes	59 (62.2)	51 (96.2)

Care home admissions: max n=144; Inpatient admissions: max n=61
* Significance ≤0.001 Mann Whitney U
** Significance ≤0.05 Pearson's Chi-Square
*** Significance ≤0.001 Pearson's Chi-Square

For the purpose of this analysis those eight inpatients who were themselves care home residents have been omitted, although their presentation will be briefly discussed within the text.

As can be seen from Table 25, more than twice as many women as men were admitted to both care homes and to hospital in the study period. As men account for more than 40 per cent of the general elderly population in North Cumbria, this may at least in part reflect the greater prevalence of affective disorder in women. All of the 191 people for whom ethnicity data was supplied were described as European-Caucasian. The care home cohort were a significantly older and more physically dependent group however, which, given the (usually) permanent nature of a care home admission as opposed to the (hopefully) transient nature of an inpatient episode would seem to make sense. These two institutions should serve different purposes and thus care for different populations.

Whilst the proportion of older people who lived alone was greater in the care home group, both samples contained large numbers of people without a resident companion/supporter compared with the wider population. However, more than four in five of the sample had a significant informal carer. As is seen in Table 26, for the care home entrants, this was most typically one of their children, and for the inpatient admissions, their spouse.

Table 26. Admissions to Care Homes and Acute Mental Health Inpatient Beds: A Comparison of the Informal Carers of Older People with Mental Health Problems

Relationship to Client*	**Care Home Cohort** Number (%)	**Inpatient Cohort** Number (%)
Spouse	26 (22.2)	22 (44.0)
Sibling	19 (16.2)	2 (4.0)
Child	63 (53.8)	20 (40.0)
Other	9 (7.7)	6 (12.0)

Care home admissions: max n=117; Inpatient admissions: max n=50
One further care home entrant had a significant informal carer, but their relationship to the client was not specified
* Significance ≤0.05 Pearson's Chi-Square

As was seen previously, almost half the care home admissions with mental health problems were described as generally low in mood, whilst more than 70 per cent were found to have significant cognitive impairment. More than one in three of these were severely or very severely impaired. Approaching two-thirds of the cohort also regularly presented with behaviours that tend to be perceived as difficult to cope with in the community, with more than 45 per cent reported to be agitated and a little over 40 per cent unsettled at night. Approximately a quarter of the group were said to wander, whilst more than 15 per cent were noted to display aggression and a similar proportion experienced delusions, hallucinations or paranoia. When one considers that more than 70 per cent of the sample also needed considerable help with daily activities of living it is clear that this is a group of people with a complex mixture of physical and psychological symptoms.

The inpatient cohort was generally more physically able, with more than four in five said to be independent or nearly independent in terms of coping with activities of daily living. As would be expected given the proportion with a predominantly functional mental illness, they were also more cognitively able, and the majority of people who did have cognitive impairment were classified as moderately or moderately to severely impaired. Approximately 50 per cent of the patients with a primarily organic illness and 75 per cent of those with a primarily functional illness were said to be low in mood, whilst all bar two of those 53 patients for whom behavioural information was supplied, regularly presented with behaviours perceived to be difficult to cope with. Thus more than 85 per cent of this group experienced disturbed sleep (73% of those patients with a primarily organic illness and all of those with a primarily functional illness) and more than 70 per cent were said to be agitated, whilst approximately 45 per cent were said to display aggression. A similar proportion were reported to wander and more than 40 per cent were experiencing delusions, hallucinations or paranoia.

Whilst there were too few people admitted to hospital from care homes to detect statistically significant differences between these clients and the larger numbers of people who usually lived in their own homes, they would appear to be a distinct sub-group, the majority being male and their average age just 73.5 years. Whilst largely independent/near to independence in the performance of activities of daily living, five of the group were said to be sad/depressed, whilst the same proportion had significant cognitive impairment and all regularly presented with behaviours carers find it difficult to cope with. Indeed, most presented with a number of these behaviours.

In the following chapter we will explore whether the needs of a certain proportion of those older people with mental health problems currently admitted to care homes or to acute mental health inpatient care could have their needs more appropriately met in other settings. Before we proceed to this analysis however, Table 27 first summarises the formal care received by these clients immediately before their respective admissions, the figures presented representing the number of clients receiving each service and the amount they typically, on average, received. Although the different constitutions of the two groups make comparisons of service use difficult, it is clear from the above that the care home cohort tended to be more physically dependent and in need of greater assistance with activities of daily living, whilst the inpatient group presented with more behavioural symptomatology. It is therefore not surprising that much greater proportions of the care home cohort received help at home than did the inpatient admissions, and that bigger percentages of the inpatient cohort received specialist mental health services than did the care home admissions. However, it is more difficult to judge whether the differences in the quantities of services received reflect true differences in need, whilst perhaps the most striking thing about the figures in Table 27 is how low they are. Thus whilst nearly half of the care home entrants had received no formal help with their personal care prior to their institutionalisation, only one in two had been assessed by a consultant psychiatrist.

Table 27. Admissions to Care Homes and Acute Mental Health Inpatient Beds: A Comparison of the Community Service Usage of Older People with Mental Health Problems in Receipt of Services

	Care Home Admissions		Inpatient Admissions	
Service	**Clients Receiving** Number (%)	**Mean Quantity** Days/week	**Clients Receiving** Number (%)	**Mean Quantity** Days/week
Help at Home				
Personal care	79 (56.0)	6.8	6 (10.0)	6.6
Help with domestic tasks/shopping	33 (23.6)	3.7	6 (10.0)	3.4
Help with meals	61 (43.3)	6.1	7 (11.7)	5.3
Carer relief (Crossroads or similar)	9 (6.4)	1.0	-	-
Day Care				
Day centre	49 (34.8)	2.4	4 (6.7)	I/D
Day hospital (mental health)	9 (6.3)	1.9	13 (21.7)	2.0
Respite				
Short-term break	41 (29.3)	N/C	5 (8.3)	N/C
Professional Visits				
District nurse	27 (19.1)	1.1	2 (3.4)	I/D
Community mental health nurse	46 (32.2)	0.4	39 (66.1)	0.6
Consultant psychiatrist	71 (50.0)	N/C	47 (79.7)	N/C

Care home admissions: max n=144; Inpatient admissions: max n=61
N/C: Not collected; I/D: Insufficient data

CHAPTER 5
FINDINGS III: CHANGING THE BALANCE OF CARE

This section of the report explores the way in which the local data reported in the previous two chapters can be used to inform local commissioners' decisions about the mix of services needed in any future re-configuration. The approach adopted is that of the balance of care as detailed within the literature review and, in essence, this chapter forms a practical demonstration of this concept as a strategic planning tool. As such, the approach described there has been modified to make the best use of local data and to ground the work in the experience of local practitioners, users and carers, thus ensuring that the results are relevant to local agencies and of practical use to the decision-makers within them. It does however borrow heavily from the concept of the 'margins of care' (Mooney, 1978).

The limitations of this approach, including its failure to reflect on the relative merits of different service options, were discussed in Chapter 1. These limitations are not significant in this context however, where the assumption is made that most older people, including those with complex needs, would prefer to be treated/cared for within their own homes, a principle supported by earlier PSSRU research (Challis et al., 2002a) and endorsed within the *National Service Framework for Older People* (DoH, 2001a). It is also assumed that the overall level of expenditure by the health and social services departments on services for older people with mental health problems is unlikely to vary a great deal from year to year, and that the age structure of the local population, and their associated needs for care, will not radically change. A steady state of supply and demand thus sits within a policy context which dictates that, as far as possible, people receive care at home.

Whilst Chapter 2 outlined the approach taken to this balance of care analysis in general terms, the reporting of the data requires that certain process issues are now described in more detail, as it would be difficult to appreciate the significance of the findings without this context. This section thus commences with a further consideration of the way in which the care home admissions were characterised before then exploring the possible use of alternative care settings for these groups and their potential for diversion. A similar approach is applied to the inpatient data.

CARE HOME ADMISSIONS: OPTIONS FOR SOCIAL SERVICES

Characterising the Care Home Admissions

As was described in Chapter 2, five variables were used to characterise those older people with mental health problems admitted to care homes in North Cumbria:

- The source of their admission (home or hospital);
- The presence or absence of a significant informal carer;
- Gender;
- The presence or absence of behaviours carers find it difficult to cope with; and
- A grouped rating of dependency derived from the Barthel index (least, medium, most).

Working with these five variables produced 48 cells or possible case types as detailed in Appendix A11 and, as can be seen there, when these were applied to the study cohort it was found that 37 cells were populated, capturing 139 of the 144 total admissions. Those cells which contained at least four admissions were considered to be most representative of the cases admitted to care homes during the study period, and it is these 17 case types which were used in this balance of care analysis.

Table 28 details the combinations of characteristics presented by these 17 case types and gives additional information about the proportion of them who experienced significant cognitive impairment. It is noted that nine of the case types depicted people who were admitted to a care home directly from their own homes, whilst the other eight captured people whose admission was immediately preceded by a hospital inpatient stay. More than three-quarters of the case types were women, and in all but one case type the service user was noted to have support from a significant informal carer. Whilst seven of the case types were deemed to be highly dependent as classified by their Barthel score, five further types had moderate, and five low, dependency levels, with three of the latter groups being amongst the admissions from hospital. Nine of the case types displayed behaviours that are perceived to be difficult for carers to cope with, and in six of these the majority of admissions had significant cognitive impairment. There were 12 case types in total where the majority of people had significant cognitive impairment.

Table 28. Care Home Admissions. Characteristics of 17 Case Types

Case Type	Source of Admission	Carer	Gender	Behaviours Carers Find Difficult to Cope With	Level of Dependency	Majority Have Cognitive Impairment
1	Community	No	Female	No	Most	Yes
2	Community	Yes	Female	No	Least	Yes
3	Community	Yes	Female	No	Medium	Yes
4	Community	Yes	Female	No	Most	Yes
5	Community	Yes	Female	Yes	Least	Yes
6	Community	Yes	Female	Yes	Medium	Yes
7	Community	Yes	Female	Yes	Most	Yes
8	Community	Yes	Male	No	Most	No
9	Community	Yes	Male	Yes	Medium	No
10	Hospital	Yes	Female	No	Least	No
11	Hospital	Yes	Female	No	Medium	Yes
12	Hospital	Yes	Female	No	Most	Yes
13	Hospital	Yes	Female	Yes	Least	Yes
14	Hospital	Yes	Female	Yes	Medium	No
15	Hospital	Yes	Female	Yes	Most	Yes
16	Hospital	Yes	Male	Yes	Least	No
17	Hospital	Yes	Male	Yes	Most	Yes

Table 29 provides details of the prevalence of the 17 most common case types in the six-month study period and their estimated annual prevalence. One hundred and four (approximately 72%) of the 144 cases in the total study cohort were represented by these typologies, 40 per cent of which were admissions via hospital. When these figures were projected over a 12-month period to facilitate calculations about the balance of care over a year, it was estimated that there would be 288 older people with mental health problems admitted to a care home with social services assistance annually, of whom 208 would be represented by these typologies.

Table 29. Care Home Admissions. Prevalence of 17 Case Types

Source of Admission	Case Type	6 Month Total	12 Month Estimate
Community	1	4	8
	2	5	10
	3	9	18
	4	5	10
	5	10	20
	6	12	24
	7	8	16
	8	4	8
	9	5	10
Total		62	124
Hospital	10	5	10
	11	5	10
	12	5	10
	13	4	8
	14	8	16
	15	5	10
	16	4	8
	17	6	12
Total		42	84

Exploring Alternative Care Packages

In Table 30 the estimated costs of the packages of care that local practitioners felt would enable these case types, as depicted in a series of vignettes, to remain in their own homes have been presented. It is noted that these drew heavily on the ready availability of home care, day care tailored to the needs of older people with dementia and the input of community support workers. This table also shows whether the community care packages were approved by an expert panel. Further information about the decisions made by the latter is included in Appendix A22, whilst Appendix A23 shows the extent to which these were in accordance with the views of a group of users, carers and their representatives.

A number of factors influenced the decisions of the expert panel when considering the proposed care plans. In the light of information provided about common practice in North Cumbria, the first of these was how the gross costs of the proposed care

Table 30. Care Home Admissions. Estimated Costs of Community Care Packages to Social Services and Agency Approval

Case Type	Cost of Community Care Package to Social Services £ per week	Panel Approval
1	138.12	Yes
2	337.23	No
3	291.68	Yes
4	310.42	No
5	840.83	No
6	779.85	No
7	829.83	No
8	485.90	No
9	251.13	No
10	141.56	No
11	254.58	No
12	419.42	No
13	539.28	No
14	770.46[1]	No
	268.34[2]	Yes
15	-[3]	-
16	103.24	Yes
17	387.44	No

2003/4 costs

[1, 2] Practitioners proposed two alternative community care packages for Type 14

[3] Practitioners considered that community care was not a feasible option for Type 15

package compared with those of the appropriate residential care banding at the time of the data collection as given in Appendix A24. Further local guidance was provided in the form of Cumbria's Fair Access to Care Criteria and the panel were aware of the counsel of other internal departmental documentation. In addition to this, the panel members themselves had a view, refined and developed over an extensive period in the field, of what constituted an appropriate and feasible care package for older people with mental health problems, both absolutely and in relation to the care received by other service users. Hence, as detailed in Appendix A22, in addition to the four care packages approved without reservation, the panel members stated that they would support the community care of a further five of the typologies (cases 2, 5, 10, 11 and 13) if changes were made to their proposed care packages. The care plans for these cases typically proposed a potentially confusing and disorientating plethora of service inputs, including multiple home care visits, frequent day care and numerous assessments and the panel suggested that very sheltered housing might be a more appropriate setting in which to meet these case types' long-term care needs. Alternatively, in at least one case in which the client desired to stay at home but the carer was extremely stressed, it was suggested that the option of 'two in, two out' respite be considered. For the purposes of this project however, only those care packages which the expert panel approved without reservation have been included in the balance of care analysis, i.e. cases 1, 3, 14 (option 2) and 16.

The next table, Table 31, highlights the number of service users represented by the four case types whose community care packages were approved without reservation. The information about source of admission and annual numbers was derived from Table 29, whilst that about each case type's placement was taken directly from the local data collection and was the actual placement of the service user randomly selected to represent that case type. It is noted that all four cases entered some form of residential (as opposed to nursing) home care. A total of 50 admissions are represented here, of which 26 are admissions directly from the community, and 24 admissions upon hospital discharge.

Table 31. Care Home Admissions. Four Case Types with Potential for Diversion from Residential Care

Case Type	Source of Admission	12 Month Estimate	Placement
1	Community	8	Residential
3	Community	18	EMI Residential
14 [option 2)	Hospital	16	Residential
16	Hospital	8	Residential

Table 32 gives further details of the characteristics of these case types. It can be seen that those service users admitted from the community were relatively dependent females, most of whom had cognitive impairment, but who did not present with any of the behaviours which carers typically find difficult to cope with. In contrast, the admissions from hospital were not usually cognitively impaired and, overall, had lower levels of dependency, but did display some of these behaviours, most typically disturbed sleep and/or agitation, whilst the majority were also described as being low in spirits. Although only one of the case types admitted from the community had the support of a significant informal carer, both of the hospital case types did.

Table 32. Care Home Admissions. Four Case Types with Potential for Diversion from Residential Care: Characteristics

Case Type	Source of Admission	Carer	Gender	Behaviours Carers Find Difficult to Cope With	Level of Dependency	Majority Have Cognitive Impairment
1	Community	No	Female	No	Most	Yes
3	Community	Yes	Female	No	Medium	Yes
14	Hospital	Yes	Female	Yes	Medium	No
16	Hospital	Yes	Male	Yes	Least	No

In Table 33 the annual cost to social services of providing enhanced community care packages for each of the four case types for whom this was deemed viable is compared with the cost of their residential placement using 2003/4 costings. There are a number of assumptions implicit in this table. The most important of these is that of a steady state, based on the fact that the social services department fixes its budget on an annual basis, and that there is a fixed level of demand in so far as any care home vacancies are immediately filled by new admissions. It is further assumed that the department's budget is set annually and that the increases year on year are small, reflecting increased costs, whilst the income generated by the local authority through charging for residential and domiciliary care is ignored for the purpose of this analysis, it being understood that this reflects practice in North Cumbria.

The costs used in Table 33 are therefore gross costs and suggest that if it were possible to maintain all four case types within the community for a 12-month period the department might expect to make a gross saving of more than a quarter of a million pounds (£876,200.00 minus £596,677.12). Obviously, this sum would be expected to change if account were taken of income from charging. Other local authorities, for example, use a rule of thumb which states that, on average, one would expect to recoup £20 a week from each person receiving a community care package and £120 a week from those in residential care. If such an assumption were applied to the above case types there would still seem to be potential for a shift in the balance of care towards the community at no extra cost to social services. Indeed, as shown in Appendix A25, what this net costing approach suggests is that whilst it would be more expensive to care for case types 3 and 14 (option 2) in the community than in a care home, the savings made by also caring for case types 1 and 16 at home would more than offset this. For the purposes of this analysis, from here on forwards, a gross costings approach will be presented.

Table 33. Care Home Admissions. Four Case Types with Potential for Diversion from Residential Care: Estimated Community and Residential Costs to Social Services

Case Type	12 Month Estimate	Residential Cost (gross) £		Community Cost (gross) £	
		Weekly / User	Annual / All	Weekly / User	Annual / All
1	8	325.00	135,200.00	138.12	57,457.92
3	18	377.00	352,872.00	291.68	273,012.48
14 [option 2)	16	325.00	270,400.00	268.34	223,258.88
16	8	283.00	117,728.00	103.24	42,947.84
Total	50		876,200.00		596,677.12

2003/4 costs

The key variables in Table 33 are the number of service users represented by each case type, the estimated costs of the enhanced community care packages constructed by local practitioners for the randomly selected cases chosen to represent them, and the weekly cost of residential care in North Cumbria. As can be seen, in this gross costs analysis it is less expensive to care for each of the four case types in the community, although the savings per service user are significantly greater for cases 1 and 16 than for cases 3 and 14 (option 2), as reflected in the discussion of net costs above. However, in view of the greater number of service users represented, the potential for the greatest annual gross savings comes through maintaining those people in case type 3 at home.

It is of course not realistic to believe that, even with the benefit of enhanced community services, it would be possible to enable all 50 of these service users to remain at home over the course of a year. This is a population with changing needs, some of whom, in the light of increasing mental or physical incapacity, will inevitably need care home placement. Table 34 takes account of this fact, and provides an estimate of the savings that might result from different periods of successful community tenure for each of the case types. If, for example, it were possible to support all those people in case type 1 in the community for an additional 17 weeks, the expected saving would be in the region of £25,000, this representing the difference between the cost of a years residential placement for this group (£135,200) and the costs of 17 weeks care in the community (17 x 8 x £138.12 = 18,784.32) plus 35 weeks residential care (35 x 8 x £325 = £91,000). It is noted that whilst the figures represent the number of weeks it proves possible to maintain the people in any case type within the community prior to admission to long-term care, they may also be viewed as proxy indicators of the costs of care for the proportion of service users within a case type who remain in the community in any one year. Thus the figures for 17, 26 and 34 weeks also represent the costs of care if approximately a third, a half and two-thirds of service users in a case type remain in the community over the course of a year.

Table 34. Care Home Admissions. Four Case Types with Potential for Diversion from Residential Care: Estimated Savings to Social Services for Different Periods of Community Tenure

Case Type	12 Month Estimate	Number of Weeks in the Community			
		17 weeks £	26 weeks £	34 weeks £	52 weeks £
1	8	25,415.68	38,871.04	50,831.36	77,742.08
3	18	26,107.92	39,929.76	52,215.84	79,859.52
14 [option 2)	16	15,411.52	23,570.56	30,823.04	47,141.12
16	8	24,447.36	37,390.08	48,894.72	74,780.16
Total		91,382.48	139,761.44	182,764.96	279,522.88

2003/4 costs

It is important to treat these figures with caution. They do not, for example, take into account the increased costs of care management associated with successfully maintaining vulnerable older people in the community, or the expense of developing any additional services needed to meet their care needs. Table 34 does however enable us to make a range of estimates of the effects of changes in the balance of care ranging from the pessimistic to the optimistic. For example, if, with additional support, it was possible to keep all those people in case type 3 at home for just 17 additional weeks the department might expect to recoup savings of around £26,000, whilst if they all remained in their own homes over the course of a year, the savings to the department would amount to nearly £80,000. Similarly, if all 50 cases remained at home with enhanced support as specified in the care plans approved by the expert panel for just 17 additional weeks, the social services department might make savings of just over £91,000. In essence then, this table provides essential information to facilitate future strategic planning and it is suggested that in order to make best use of it, the social services department consider various combinations of the figures given to simulate alternative future policy options and their resource implications.

INPATIENT ADMISSIONS: OPTIONS FOR THE SPECIALIST MENTAL HEALTH TRUST

Characterising the Inpatient Admissions

As described in Chapter 2, four variables were used to characterise those older people admitted to acute mental health inpatient beds in North Cumbria:

- The presence or absence of a significant informal carer;
- The presence of a primarily organic or functional mental illness;
- A binary variable concerned with whether hospital admission was at least in part for assessment of the person's future care needs (yes/no); and
- A hierarchy of risk/concern.

The different possible combinations of these four variables produced 40 cells or case types as shown in Appendix A13 and, as can be seen there, when these were applied to the study cohort it was found that 20 cells were populated, capturing 67 of the 69 total admissions. Those cells which contained at least three admissions were considered to be most representative of the cases admitted to inpatient care during the study period, and it is these 13 case types which were used in this balance of care analysis.

Table 35 details the combinations of characteristics presented by these 13 case types and gives additional information about the gender of the majority of clients within each group. It is noted that six of the cells depicted people with a primarily organic mental illness, whilst the other seven captured people with a primarily functional mental illness. The majority of people represented in all of the latter cells were women, but there was a predominance of men in two of the case types depicting people with an organic mental illness. All bar two of the case types had a significant informal carer. Whilst just one of the case types represented people considered to be at risk of deliberate self-harm (the top element of the risk/concern hierarchy), four case types (two with an organic and two a functional mental illness) were said to present with disturbed behaviour, whilst five others were deemed to be at risk of accidental self-harm/self-neglect within their home environment. Of the five case types for whom the admission was stated to be at least in part to assess their future care needs, four represented people with dementia.

Table 35. Inpatient Admissions. Characteristics of 13 Case Types

Case Type	Broad diagnosis	Carer	Predominant Risk / Concern	Admission for Assessment of Future Care Needs	Gender of Majority of Cases
1	Organic	No	Risk accidental self-harm / self-neglect	Yes	Female
2	Organic	Yes	None of list	Yes	Male
3	Organic	Yes	Disturbed behaviour	No	Equal
4	Organic	Yes	Disturbed behaviour	Yes	Female
5	Organic	Yes	Risk accidental self-harm / self-neglect	No	Male
6	Organic	Yes	Risk accidental self-harm / self-neglect	Yes	Female
7	Functional	No	Risk accidental self-harm / self-neglect	No	Female
8	Functional	Yes	None of list	No	Female
9	Functional	Yes	Risk of deliberate self-harm	No	Female
10	Functional	Yes	Disturbed behaviour	No	Female
11	Functional	Yes	Disturbed behaviour	Yes	Female
12	Functional	Yes	Risk accidental self-harm / self-neglect	No	Female
13	Functional	Yes	Disturbed sleep and agitation	No	Female

Table 36 provides details of the prevalence of these 13 case types over the six-month study period and estimates their annual prevalence. Fifty-eight (approximately 84%) of the 69 admissions in the total study cohort were represented by these typologies, of which almost 45 per cent were people with a primarily organic mental illness and just over 55 per cent people with a functional mental illness. When these figures were projected over a 12-month period to facilitate calculations about the balance of care over a year, it was estimated that there would have been 138 admissions to the acute inpatient wards, of whom 116 would be represented by these typologies. However, as one of the mental health inpatient wards was closed to new admissions for part of the data collection process, and another had a number of ‘blocked beds’, these figures may underestimate the number of people admitted for inpatient care over a more representative period.

Table 36. Inpatient Admissions. Prevalence of 13 Case Types

Broad Diagnosis	Case Type	6 Month Total	12 Month Estimate
Organic	1	3	6
	2	3	6
	3	6	12
	4	7	14
	5	3	6
	6	4	8
Total		26	52
Functional	7	3	6
	8	3	6
	9	8	16
	10	5	10
	11	4	8
	12	4	8
	13	5	10
Total		32	64

Exploring Alternative Care Packages

Table 37 details the number of practitioners who believed that it was completely, possibly or not appropriate to admit each of these case types, as depicted in a series of vignettes, to an acute mental health inpatient bed. In order to construct a hierarchy of appropriateness each case type was scored as follows: four points were given for each consultant, plus two for any other member of staff, who felt that admission was completely appropriate, and two points for each consultant, plus one for any other member of staff, who felt that admission was possibly appropriate. This weighting was designed to take account of the fact that, nationwide, the variable number of inpatient admissions, at least of people with dementia, is considered to be primarily a consequence of the divergent views of consultants as to when admission is appropriate (Audit Commission, 2000), whilst the fact that there is such divergence suggested it would be prudent to also take into account the views of other experienced staff. Indeed in more than a quarter of the 13 case types depicted below, whilst at least one consultant believed admission to be completely appropriate, another believed it to be inappropriate. The extent to which these practitioners' views were echoed by a group of users, carers and their representatives is shown in Appendix A23.

Table 37. Inpatient Admissions. Practitioners' Views of the Appropriateness of Admission

Case Type	Completely Appropriate: Consultants Only	Possibly Appropriate: Consultants Only	Not Appropriate: Consultants Only	Completely Appropriate: Other Mental Health Service Staff	Possibly Appropriate: Other Mental Health Service Staff	Not Appropriate: Other Mental Health Service Staff
1	-	2	2	1	4	4
2	-	-	4	-	2	7
3	1	3	-	2	2	5
4	1	3	-	3	2	4
5	2	1	1	1	7	1
6	-	4	-	-	5	4
7	-	3	1	-	7	2
8	1	2	1	2	2	5
9	1	2	1	4	5	-
10	2	2	-	4	5	-
11	2	2	-	3	2	4
12	1	3	-	-	8	1
13	1	1	2	-	6	3

In Table 38 the 13 case types are then ranked in order of appropriateness, from least to most, according to the beliefs of local staff, whilst Table 39 reminds the reader of their characteristics. Thus case type 2, which was deemed least appropriate for inpatient admission, scored just two points (two non-medical members of staff feeling admission was possibly appropriate) and represents a group of people, mostly males, who have an organic mental illness and whose admission was at least in part intended to inform decisions about their future care needs. In contrast, case type 10, which represents the group seen as most appropriate for inpatient care, scored 25 points (admission being unequivocally supported by six of the 13 staff) and represents a group of people, mostly females, with a primarily functional mental illness who were admitted, at least in part, for the management of disturbed behaviour which typically included aggression.

Table 38. Inpatient Admissions. Hierarchy of Admissions by Appropriateness

Ranking of Appropriateness: Least - Most	Points Scored	12 Month Estimate	Cumulative 12 Month Estimate	Proportion of all Admissions %	Cumulative Proportion of all Admissions %
1. Type 2	2	6	6	4.3	4.3
2. Type 1	10	6	12	4.3	8.7
3. Type 13	12	10	22	7.2	15.9
4. Type 6	13	8		5.8	
4. Type 7	13	6	36	4.3	26.1
6. Type 8	14	6	42	4.3	30.4
7. Type 3	16	12	54	8.7	39.1
8. Type 4	18	14		10.1	
8. Type 12	18	8	76	5.8	55.1
10. Type 5	19	6	82	4.3	59.4
11. Type 11	20	8	90	5.8	65.2
12. Type 9	21	16	106	11.6	76.8
13. Type 10	25	10	116	7.2	84.1

Table 39. Inpatient Admissions. Hierarchy of Admissions by Appropriateness: Characteristics

Case Type	Broad diagnosis	Carer	Predominant Risk / Concern	Admission for Assessment of Future Care Needs	Gender of Majority of Cases
2	Organic	Yes	None of list	Yes	Male
1	Organic	No	Risk accidental self-harm / self-neglect	Yes	Female
13	Functional	Yes	Disturbed sleep and agitation	No	Female
6	Organic	Yes	Risk accidental self-harm / self-neglect	Yes	Female
7	Functional	No	Risk accidental self-harm / self-neglect	No	Female
8	Functional	Yes	None of list	No	Female
3	Organic	Yes	Disturbed behaviour	No	Equal
4	Organic	Yes	Disturbed behaviour	Yes	Female
12	Functional	Yes	Risk accidental self-harm / self-neglect	No	Female
5	Organic	Yes	Risk accidental self-harm / self-neglect	No	Male
11	Functional	Yes	Disturbed behaviour	Yes	Female
9	Functional	Yes	Risk of deliberate self-harm	No	Female
10	Functional	Yes	Disturbed behaviour	No	Female

Table 38 also details the proportion of admissions accounted for by each of these case types, and thus, by definition, the proportion of admissions that might be avoided if it were possible to care for the people represented by them through the provision of enhanced community support. Depending upon how successful this proved, the targeting of resources on people falling within case types 1, 2 and 13 might be expected to reduce admissions by up to 16 per cent. If it were also possible to support groups 6, 7 and 8 in the community, one would be looking at a fall in admissions of up to 30 per cent. It is noted that if one assumed that each case type had an equal length of stay, these figures would also represent the proportion of beds that would not be needed were these admissions to be avoided, but it is not known if this is so.

In Table 40 we take these ideas one step further by calculating the estimated annual costs of inpatient care for the three case types local practitioners considered least appropriate for admission, and on whom the trust might therefore wish to focus any initial attempt to change the balance of care. The costs used are those for 2004/5 as given in Appendix A17, with each day of inpatient care costing £196.21. As with the care home analysis, a number of assumptions are implicit in this table, the most important of which is that of a steady state whereby the overall number of inpatient beds remains constant over the year and any vacant beds are immediately filled by new admissions. Further to the comment above about the perceived atypical availability of inpatient beds in the data collection period, and hence the likely atypical length of stay, it is also hypothesised that the case types have the average length of stay for old age psychiatry beds in England i.e. 80.3 days (DoH, 2004b). However, the calculations have also been presented using the median length of stay for old age psychiatry beds in England i.e. 30 days (DoH, 2004b), as this figure may potentially be more useful for those case types where there is a relatively quick throughput of patients. If, for example, one assumed that the average length of stay of case type 2 mirrored the England mean, the annual cost of their inpatient care would be £94,534 (6 x 80.3 x £196.21), whilst if it were thought that case type 13 had an average length of stay of 30 days, their annual inpatient care would cost £58,863 (10 x 30 x £196.21).

Table 40. Inpatient Admissions. Three Case Types with Potential for Diversion from Inpatient Care: Estimated Inpatient Costs

Case Type	12 Month Estimate	Annual Cost of Inpatient Care if Average Stay 30 Days £	Cumulative Annual Cost of Inpatient Care if Average Stay 30 Days £	Annual Cost of Inpatient Care if Average Stay 80.3 Days £	Cumulative Annual Cost of Inpatient Care if Average Stay 80.3 Days £
2	6	35,317.80	35,317.80	94,533.98	94,533.98
1	6	35,317.80	70,635.60	94,533.98	189,067.96
13	10	58,863.00	129,498.60	157,556.63	346,624.59

2004/5 costs

It should be noted that the figures above represent the costs of the inpatient care of these case types rather than the potential savings which might result if their admission was to be avoided, as to care for/treat them within the community would of itself involve additional costs. The extent of these is suggested in Table 41, in which the costs to the mental health trust of the community care packages deemed appropriate to maintain these people in the community for a period of time equivalent to that of an inpatient stay are presented. These drew heavily on the support of the community mental health team, and, in particular, the input of community mental health nurses, support workers and occupational therapists. For the purpose of this table, and in the remainder of this balance of care analysis, the length of inpatient stay is assumed to be the mean for England. The annual cost to the trust of providing an enhanced community care package to the people in case type 1 for the time that they would otherwise have been in hospital is thus just over £12,000 (6 x 80.3 x £24.95).

Table 41. Inpatient Admissions. Three Case Types with Potential for Diversion from Inpatient Care: Estimated Community Costs to the Mental Health Trust

Case Type	12 Month Estimate	Daily / User £	Annual / All £
2	6	8.62	4,153.12
1	6	24.95	12,020.91
13	10	28.87	23,182.61

2004/5 costs

In Table 42 we are then able to give some estimate of the annual potential savings to be made by diverting the care of each of these three case types from hospital to the community by subtracting the costs to the trust of their enhanced community care packages (as shown in Table 41) from those of inpatient care (as shown in Table 40).

Table 42. Inpatient Admissions. Three Case Types with Potential for Diversion from Inpatient Care: Estimated Savings to the Mental Health Trust

Case Type	12 Month Estimate	Estimated Saving Annual / All £
2	6	90,380.86
1	6	82,513.07
13	10	134,374.02
Total	22	307,267.95

2004/5 costs

It is thus suggested that, if it were possible to prevent the admission of all three of these case types, the trust might expect to make savings in the region of £300,000 a year. These figures must be treated with caution however. They do not, for example, take into account the expense of developing the additional services needed to meet the care needs of these people at home, whilst in practice it is not realistic to believe that, even with the benefit of enhanced community services, it would be possible to keep all 22 of these people out of hospital. This is a population with complex and changing needs, some of whom will inevitably need inpatient admission. There is, furthermore, a difference between the monies that would accrue to social services upon diverting people from residential care and those, which might be realised by the trust in preventing admissions. Thus whilst if just one or two care home admissions were prevented, the social services department might still expect to see savings in their budgets over the course of a year, if just one or two inpatient admissions were avoided, this would be unlikely to release any resources which could be invested elsewhere. Indeed the number of hospital admissions prevented will need to reach a critical mass before any transfer of monies may be contemplated, although below this efficiencies may still be gained, perhaps facilitating ward staff to spend more time with each patient, or to be released for training, for example.

Where Table 42 is helpful therefore, particularly if used in conjunction with Table 38, is in enabling us to make a range of estimates of the effects of changes in the balance of care. Thus, if with additional support, it only proved possible to keep half of those people in case type 2 at home, the trust would be preventing just two per cent of admissions, a figure probably beneath the critical mass referred to above. If the admission of all those people in case types 1 and 2 were to be avoided, one would be looking at preventing nearly nine per cent of admissions and potentially releasing in the order of £170,000 (£82,513.07 + £90,380.86) for reinvestment elsewhere in the service. In the same way as Table 34 then, this table provides essential information to inform strategic planning. Again it is suggested that in order to make best use of such material, various combinations of the figures are used to simulate alternative policy options and their resource implications.

The options available for the care of older people with mental health problems who would at present be admitted to an inpatient bed are not of course limited to the provision of care at home. It is understood that the trust are, for example, already investing in a specialist unit attached to a nursing home that provides care and treatment for older people with dementia who present with challenging behaviours and who might otherwise have received this input in hospital, and are considering an expansion of this model. The data collected in this study would seem to provide some support for this proposal, which would enable the health service to use its resources more efficiently whilst enabling older people to be cared for in a more sympathetic environment closer to home.

Looking back to Table 39, it can be seen that six of the most prevalent case types currently admitted to specialist mental health inpatient beds depict people with dementia. The above discourse has explored the possibility of caring for two of these case types within their own homes. In Table 43 the estimated resource implications of caring for most or all of the remainder in a specialist unit in the community are presented. It must be noted that the previously made assumptions about the existence of a steady state, the average length of stay and the need to divert a critical mass still hold.

In Table 43 the annual inpatient care costs have again been calculated by multiplying the 12-month estimate for each case type by the mean number of days inpatient stay for England by the cost of each days inpatient care in North Cumbria. The annual cost of providing inpatient care for the people in case type 6 for example is thus 8 x

80.3 x £196.21. The calculation of the costs of care within a specialist residential unit is more complicated, but is in essence composed of two elements: the standard cost of specialist nursing home care plus the additional cost to the specialist mental health service of supporting such a unit. The former of these has been derived from the 2004/5 costs of institutional care supplied by Cumbria Social Services as given in Appendix A24, the maximum potential weekly cost to the health and social care economy of £514 per person (£389 for the social care element and £125 for the nursing care element) having been divided by seven to give a daily cost of £73.43 per person. In order to calculate the second element a number of assumptions have been made. The first of these is that the additional support provided to the unit by the specialist mental health trust would consist of weekly input from a consultant psychiatrist or specialist registrar (who would visit alternate weeks) plus a weekly visit from a community mental health nurse. These visits have been costed from figures given by Curtis and Netten (2004) as shown in Appendix A17, with each assumed to account for three hours practitioner time. The total of £186 per week will be spread across all the people within the unit however, which for the purposes of this exercise has been taken to be six, giving a weekly cost per resident of £42.50 or a daily cost of £6.07. The substitute annual cost of providing residential unit care for the people in case type 6 in this instance then becomes 8 x 80.3 x £79.50 (£73.43 + £6.07).

Table 43. Inpatient Admissions. Four Case Types with Potential for Diversion to a Specialist Mental Health Residential Unit: Estimated Inpatient and Residential Costs

Case Type	12 Month Estimate	Inpatient Cost £		Residential Unit Cost £	
		Daily / All	Annual / All If Average Length of Stay 80.3 Days	Daily / All	Annual / All If Average Length of Stay 80.3 Days
6	8	1,569.68	126,045.30	636.00	51,070.80
3	12	2,354.52	189,067.95	954.00	76,606.20
4	14	2,746.94	220,579.28	1113.00	89,373.90
5	6	1,177.26	94,533.98	477.00	38,303.10
All	40		630,226.51		255,354.00
2/3	27		425,402.87		172,363.95

2004/5 costs

Given the number of assumptions made in coming to these figures they must be treated cautiously. Nevertheless, it is clear that there might be substantial savings to be made by undertaking the assessment and care of these case types within an enhanced residential setting. Indeed, if it were possible to treat all of these case types in such a model, Table 43 would suggest that, even if it funded all these beds itself, the mental health trust might expect to make an annual gross saving of more than £350,000 (£630,226.51 - £255,354.00). As with the other parts of this analysis however, it is probably unrealistic to expect to be able to divert all these admissions in this way. Thus Table 43 also offers an estimate of the potential savings to be made if one could successfully provide the care of around two-thirds of these people in this setting, which, incidentally, if the assumed length of stay is appropriate, would generate about the right number of admissions to fill the hypothesised six-bedded unit. With resulting annual savings of around £250,000 (£425,402.87 - £172,363.95), even allowing for substantial start up training costs and the underestimation of ongoing costs, this appears an attractive option if deemed clinically appropriate.

CARE HOME AND INPATIENT ADMISSIONS: THE MARGINAL COSTS

The above sections suggest that it would be possible for the social services department to care for a significant proportion of those people who currently enter residential care with enhanced community care packages in their own homes at a cost that is, at worst, no greater than that they are currently incurring. Indeed, over the course of a year, there would appear to be the potential for them to make substantial savings that could be invested in developing community resources. It would similarly appear that the mental health trust could meet the needs of a proportion of those people they are currently caring for in hospital in their own homes, or in supported residential settings, without incurring any additional expense, and that again, this change in provision would free resources which could be invested in the community.

Looking at the wider health and social care economy however it is clear any changes in the balance of care made by one of these two agencies is likely to have implications (and costs) for the other. If the social services department were to commit to maintaining a greater proportion of the older people with mental health problems known to them in the community for example, this would surely increase demands on the community mental health service. Correspondingly, if the specialist mental health service should commit to treating and supporting some of those people who are currently entering inpatient care in their own homes, this would undoubtedly make additional demands on the resources held by the social services department. The final two tables in this chapter, Tables 44 and 45 attempt to estimate these ‘marginal’ costs.

In Table 44 the costs of the additional input that local practitioners felt would be needed from the specialist mental health services if each of the care home entrants included in this balance of care analysis were to be maintained in the community with an enhanced community care package rather than enter a care home are presented. Whilst the client randomly selected to represent case type 1 for example had not received any support from the specialist mental health service prior to their actual entry to care, the package proposed to maintain them in the community included a weekly visit from a community mental health support worker and referral to a memory clinic, the estimated costs of which averaged out at £69.96 per week. Interestingly, it is noted that three of the four service users representing the case types in Table 44 had not in fact had any contact with the specialist mental health services prior to their care home admission, and none was included in the enhanced community care plan proposed for case type 3. For only case type 16 does the figure reported (£106.38

per user per week) represent an increase in input for a person already known to the mental health team therefore.

Table 44. Care Home Admissions. Four Case Types with Potential for Diversion from Residential Care: Estimated Community Costs to the Mental Health Trust

Case Type	12 Month Estimate	Cost of Additional Demands on the Mental Health Service £	
		Weekly / User £	Annual / All £
1	8	69.96	29,103.36
3	18	-	-
14 [option 2)	16	129.91	108,085.12
16	8	106.38	44,254.08
Total	50		181,442.56

2004/5 costs

As can be seen from Table 44, if it did prove possible to maintain all four of these case types within the community for a 12-month period it might be expected that the specialist mental health service would incur additional costs in the region of £181,000. These should be set beside the approximately £280,000 gross savings that the social services might potentially make from such a change in the balance of care as detailed earlier. As has been said many times however, in reality it is likely that these services would only be able to maintain a proportion of these people at home, for a proportion of the year. These costings are therefore likely to prove most useful if they are built into an across-agency strategic planning model which explores various policy options and their resource implications over a range of time scales.

The same can also be said for the information presented in Table 45 which considers the costs of the additional resources that it is expected social services would need to provide if each of the three specified inpatient case types were to be maintained in the community with an enhanced community care package rather than enter hospital. As can be seen however, these costs are small, the main substitution here, at least at this point, being between the mental health trust's own community and hospital resources, and even if it were felt appropriate to continue to provide the enhanced care package over a longer period, this would seem unlikely to put undue stress on social services resources.

Table 45. Inpatient Admissions: Three Case Types with Potential for Diversion from Inpatient Care: Estimated Community Costs to Social Services

Case Type	12 Month Estimate	Cost of Additional Demands on the Social Services £	
		Daily / User £	Annual / All £
2	6	11.98	5,771.96
1	6	-	-
13	10	-	-
Total	22		5,771.96

2003/4 costs

CHAPTER 6
FINDINGS IV: STAKEHOLDER PERSPECTIVES

This chapter examines the perspectives key stakeholders have of the services currently provided for older people with mental health problems in North Cumbria and their priorities for future development. As is described in Chapter 2, the original intention was to collect this information only from GPs, but it was subsequently decided that it would be useful to extend the exercise to three other key stakeholder groups: specialist mental health services staff, social services staff and users/carers and their representatives. Whilst the latter groups have been involved in many aspects of the study, this was the only aspect of the work to which GPs have had a substantive input. This chapter therefore begins with a detailed examination of their views, which are then compared and contrasted with those of the other key stakeholder groups.

THE PERSPECTIVES OF GENERAL PRACTITIONERS

The data presented in this section was collected by means of a postal questionnaire sent to all GPs working within the Eden Valley, Carlisle and West Cumbria PCTs in February 2004. A copy of the data collection tool is given in Appendix A6. Responses were received from 88 practitioners (approximately 40% of GPs) who between them worked at 47 practices (85% of surgeries). All bar five of the respondents worked in partnership with at least one other GP, and roughly equal numbers described the geographical areas they covered as predominantly urban, predominantly rural or a mixture of urban and rural. Respondents were asked about five aspects of the mental health provision for older people registered with their practice. The first two of these, reported in Tables 46 and 47, were concerned with the current provision of services for older people with mental health problems, whilst the latter three, as described in Tables 48 and 50 and Box 49, were designed to help inform future practice. (Please note that as not all GPs completed all sections of the questionnaire there are not necessarily 88 responses to each item. Furthermore, as figures have been rounded to one decimal point, when the percentages for all responses to each item are summed, they may not total exactly 100 per cent. These qualifications apply to all the tables in this section.)

Table 46. GPs' Views: The Current Availability of Services for Older People with Mental Health Problems

Service	**Fully/Mostly Available** Number (%)	**Partly/Not Available** Number (%)
NHS inpatient beds for assessment/treatment	45 (52.9)	40 (47.1)
NHS inpatient beds for rehabilitation	29 (35.8)	52 (64.2)
NHS inpatient beds for continuing care	20 (23.8)	64 (76.2)
NHS inpatient beds for respite	10 (12.7)	69 (87.3)
NHS day hospital places for people with dementia	69 (79.3)	18 (20.7)
NHS day hospital places for people with other mental illness	59 (69.4)	26 (30.6)
Routine assessments by consultant psychiatrists	75 (86.2)	12 (13.8)
Urgent assessments by consultant psychiatrists	80 (92.0)	7 (8.0)
Community mental health team input for people at home	74 (85.1)	13 (14.9)
Community mental health team input for care home residents	63 (75.9)	20 (24.1)
Psychological therapies for older people with mental illness	25 (30.9)	56 (69.1)
A memory clinic for people with potential dementia	39 (49.4)	40 (50.6)
Anti-Alzheimer drugs for older people with dementia	82 (94.3)	5 (5.7)
Specialist services for younger people with dementia	20 (27.0)	54 (73.0)
Nursing home beds for older people with mental illness	55 (66.3)	28 (33.7)
Residential home beds for older people with mental illness	57 (67.9)	27 (32.1)
Non-NHS respite care for older people with mental illness	29 (39.2)	45 (60.8)
Day care places for people with dementia	65 (75.6)	21 (24.4)
Day care places for people with other mental illness	55 (64.7)	30 (35.3)
Homecare services for older people	67 (76.1)	21 (23.9)
Carer support services	48 (58.5)	34 (41.5)

Min n=79, Max n=88

Table 46 describes the perceived availability of 21 core services for older people with mental health problems. The responses from the GPs working in each of the three PCTs have been amalgamated, as it was noted that in many instances their perceptions of service availability were very similar. Thus whilst some services, such as assessments by consultants, day hospital care and the provision of antidementia drugs, were perceived to be generally available across the whole catchment area, others, such as NHS respite or continuing care were felt to be at best only partly available, regardless of PCT. There was however a difference in the perceptions of the GPs working in each of the three PCTs regarding the availability of psychological services. Whilst 11 of the 21 GPs working in the Eden Valley area stated that psychological therapies were generally available to their patients, only six of the 31 respondents from West Cumbria and eight out of 28 in Carlisle did so. Two further respondents did not specify which PCT they worked in. Similarly varied responses were given with regard to the availability of NHS inpatient beds, which the majority of GPs in Carlisle and West Cumbria, but not in Eden Valley, saw as generally available, and memory clinics, which were perceived to be generally available other than in West Cumbria. The provision of carer support was seen to be patchy in all three areas.

In the second section of the questionnaire GPs were asked about their experience of working with the specialist mental health service in caring for this client group, and Table 47 shows the extent to which they agreed with seven statements about the relationship between primary and secondary care services.

Table 47. GPs' Views: The Relationship between Primary Care and the Specialist Mental Health Service for Older People

Statement	**Completely Agree** Number (%)	**Tend to Agree** Number (%)	**Tend to Disagree** Number (%)	**Completely Disagree** Number (%)
The mental health service for older people responds promptly to routine referrals	26 (29.9)	45 (51.7)	15 (17.2)	1 (1.1)
The mental health service for older people responds promptly to urgent referrals	43 (49.4)	41 (47.1)	3 (3.4)	-
The mental health service for older people provides prompt feedback following assessments	28 (32.6)	54 (62.8)	4 (4.7)	-
The mental health service for older people provides ongoing feedback about patients' care and treatment	22 (25.3)	55 (63.2)	10 (11.5)	-
The mental health service for older people provides support and training for primary care staff	5 (5.8)	22 (25.6)	49 (57.0)	10 (11.6)
The mental health service for older people has offered GPs guidance in the use of assessment scales	2 (2.4)	13 (15.5)	46 (54.8)	23 (27.4)
The mental health service has agreed protocols with primary care for the identification and management of older people with mental illness	2 (2.4)	10 (12.2)	49 (59.8)	21 (25.6)

Min n=82, Max n=87

Although the vast majority of GPs were positive about the specialist mental health service's response to their referral of individual clients, only a relatively small percentage felt that it provided general support and training for primary care. It is noted that only one GP completely disagreed with any of the first four statements and that those tending to disagree mostly worked within the areas covered by the Carlisle and West Cumbria PCTs. Many more GPs in all three PCTs completely disagreed with the latter three statements however, and whilst a number wrote about the prompt and reliable service they received from consultants, particularly in West Cumbria, and the good relationships they had with the community teams, no one made any positive comment about the mental health service's wider educational and support role.

In the third section of the questionnaire the GPs were asked to consider who was most appropriately placed to take the lead role in the care of eleven subgroups of older people with mental health problems: themselves i.e. GPs/primary care, the specialist mental health service or the primary and secondary services together i.e. 'shared care'. Their responses are shown in Table 48 from which it is clear that there was a fair degree of consensus. Thus more than seven in ten GPs felt that people with recurrent mild depression or moderate depression post-bereavement should be managed by primary care. Substantial majorities also believed that the specialist mental health service should take the lead in caring for: i) people with dementia who had psychotic symptoms; ii) people with dementia who presented with challenging behaviours; iii) people with severe depression; and iv) people with severe and unstable mental illness such as schizophrenia. More than two-thirds of GPs similarly advocated shared care for those people with moderate dementia whose carer was experiencing stress and for people with severe but stable mental illnesses. There were, however, three groups of people about whom the GPs had more mixed views i.e. people with early signs of Alzheimer's disease or vascular dementia and people with moderate depression not responsive to first line treatment.

Table 48. GPs' Views: The Responsibility of Caring for Older People with Mental Health Problems

Clients	GP/Primary Care Number (%)	Specialist Mental Health Service Number (%)	Shared Care Number (%)
People with early signs of Alzheimer's disease	27 (31.0)	15 (17.2)	45 (51.7)
People with early signs of vascular dementia	35 (40.2)	11 (12.6)	41 (47.1)
People with moderate dementia where the carer is experiencing stress	8 (9.2)	21 (24.1)	58 (66.7)
People with dementia who are experiencing delusions/hallucinations	2 (2.3)	60 (69.0)	25 (28.7)
People with dementia who present with challenging behaviours	3 (3.5)	61 (70.9)	22 (25.6)
People with recurrent mild depression	78 (89.7)		9 (10.3)
People with symptoms of moderate depression post bereavement	64 (74.4)	3 (3.5)	19 (22.1)
People with moderate depression who have not responded to first line treatment	18 (20.9)	20 (22.7)	48 (55.8)
People with severe depression including loss of appetite, disturbed sleep and suicidal ideation	1 (1.1)	71 (81.6)	15 (17.2)
People with a severe but stable mental illness such as schizophrenia	9 (10.3)	15 (17.2)	63 (72.4)
People with a severe and unstable mental illness such as schizophrenia	1 (1.1)	78 (89.7)	8 (9.2)

Min n=86, Max n=87

In a fourth section of the questionnaire GPs were asked to specify which of the 21 core services listed in Table 46 they would prioritise for development in any long-term service reconfiguration. Interestingly, all bar one were in at least one GP's top three, the exception being the provision of antidementia drugs. There was clearly more support for some services than for others. However, the GPs' four main priorities were the development of further NHS inpatient beds for assessment and treatment; increased input from community mental health teams for people at home; more NHS respite provision; and further day care places for people with dementia. These were chosen by 27, 25, 15 and 14 GPs respectively as shown in Appendix A26. The amalgamated responses reported there do mask some local differences of opinion however, and in Box 49 the GPs' priorities are therefore given by PCT, along with a typical selection of their comments.

Box 49. GPs' Views: Priorities for Service Development by PCT

Priorities	Comments
Carlisle PCT	
Carer support services Community mental health team input for people at home Specialist services for younger people with dementia Urgent assessments by consultants	*'It is essential to develop community mental health services. Urgent (same day) assessments by CPN services in the community must be maintained. Waiting lists for CPN assessments in the community are unacceptable'* '*Carer support is slowly increasing after some years of being missed out'*
Eden Valley PCT	
NHS inpatient beds for assessment and treatment Community mental health team input for people at home Day care places for people with dementia	*'We HAD inpatient beds at Penrith hospital and they were VERY useful'* *'Community support is vital'*
West Cumbria PCT	
Community mental health team input for people at home NHS inpatient beds for assessment and treatment NHS inpatient beds for respite	*'With the ageing population more resources are needed for both inpatient assessment and treatment and then community support'* '*Respite care is essential to avoid carer stress burn out'*

The final table in this section, Table 50, details GPs' preferences for the way in which mental health services for older people might be organised. The doctors were presented with a number of paired statements, one of which was intended to describe a broadly traditional model of service provision, whilst the other reflected a more integrated, community-orientated perspective as portrayed within the *National Service Framework for Older People* (DoH, 2001a). The GPs were asked to prioritise one statement from each pair, it recognised that in some instances both options may be perceived as desirable.

Table 50. GPs' Views: Preferences for Future Service Organisation

Option	GP Votes Number (%)
a. Consultant psychiatrists undertake most new assessments in people's homes	48 (56.5)
b. Consultant psychiatrists undertake most new assessments in outpatient clinics	37 (43.5)
a. Consultant psychiatrists undertake most follow-up assessments in people's homes	12 (14.1)
b. Consultant psychiatrists undertake most follow-up assessments in outpatient clinics	73 (85.9)
a. Community mental health staff are based in primary care	60 (69.8)
b. Community mental health staff are based in separate community teams	26 (30.2)
a. GPs refer directly to consultants and/or other staff	21 (25.0)
b. GPs refer to the mental health team who decide on the most appropriate person to undertake any assessment	63 (75.0)
a. More assessments and treatments are carried out at day hospitals	58 (67.4)
b. More assessments and treatments are undertaken within people's homes	28 (32.6)
a. The staffing for community mental health teams Mondays-Fridays 9 a.m. – 5 p.m. is increased	24 (29.3)
b. The community mental health team hours are developed to cover evenings and weekends	58 (70.7)
a. Specialist social workers become core members of community mental health teams	56 (67.5)
b. Community mental health nurses develop stronger links with existing social work teams	27 (32.5)
a. Residential home places for people with mental illness are increased	33 (40.7)
b. Specialist home care services for people with mental illness are developed	48 (59.3)
a. Community mental health teams develop the service they provide to care homes	58 (70.7)
b. Inpatient services for people with challenging behaviours are expanded	24 (29.3)
a. The balance of care between hospital and community services remains largely unchanged	37 (44.6)
b. The balance of care between hospital and community services is weighted in favour of the community	46 (55.4)

Min n=81, Max n=86

This section of the questionnaire generated considerable comment, and whilst there was a degree of consensus about the majority of the items, in some instances opinion was more mixed, different GPs making strong arguments for both options. Thus whilst the vast majority of GPs felt that consultant psychiatrists should undertake most follow-up assessments of older people in outpatient clinics rather than in patients' homes, the respective ratio for initial assessments was approximately 45:55, this seeming to reflect the differing weightings various GPs gave to *'efficiency'* versus *'desirability'*. Perhaps not surprisingly, roughly 2:1 GPs supported the idea of community mental health staff being based in primary care, it felt that this would improve *'accessibility, liaison etc'*. However, a number of GPs cautioned that this would inevitably result in more work for GPs and the primary health care team, which would not be sustainable unless adequate resources accompanied such arrangements.

Other statements receiving the support of more than two-thirds of respondents included those suggesting that more assessments be carried out in day hospitals, that community mental health teams develop the services they provide to care homes and that all referrals be made to the mental health team, rather than to specific professionals within it. It would seem likely that these reflect the GPs' satisfaction with existing arrangements in their locality, whilst the latter may reflect a move away from a 'doctor-led' perspective of teams. There was also considerable support for two new proposals however – the expansion of community mental health team hours to cover weekends and evenings (one GP describing this as being *'desperately needed'*) and the integration of specialist social workers within community mental health teams. From the GPs' comments, the division of opinion as to whether an increase in residential home places for people with mental illness was preferable to the development of specialist home care, and whether the balance of hospital and community services should be changed, was interpreted as a desire for more of all such services!

THE PERSPECTIVES OF SPECIALIST MENTAL HEALTH STAFF, SOCIAL SERVICES STAFF, OLDER PEOPLE/CARERS AND THEIR REPRESENTATIVES

As has been noted above, further to preliminary analysis of the GPs' responses, it was decided to extend this element of the data collection process to three further key stakeholder groups: specialist mental health services staff, social services staff and older people/carers and their representatives. In the recognition that not all of the original questions would be relevant to the people within each of these groups, a number of modified versions of the original proforma were produced and all participants attending a series of workshops held in the autumn of 2004 and early 2005 were asked to complete these. Whilst it is acknowledged that such convenience samples do not produce representative findings, they do offer a relatively quick and easy way of getting a feel for the issues involved. Copies of the respective questionnaires are included in Appendices A7-A10.

Table 51 reports the social services and specialist mental health staff members' perceptions of the availability of services for older people with mental health problems. A total of 17 social services staff, mainly qualified social workers who predominantly worked with older people, and 21 mental health service staff, including a range of community, inpatient and managerial personnel, contributed to this part of the study.

Table 51. Social Services and Specialist Mental Health Staff Members' Views: The Current Availability of Services for Older People with Mental Health Problems

Service	Staff Viewing Service As Fully/Mostly Available Social Services Number (%)	 Mental Health Number (%)
NHS inpatient beds for assessment/treatment	5 (33.3)	8 (42.1)
NHS inpatient beds for rehabilitation	3 (21.4)	2 (10.5)
NHS inpatient beds for continuing care	- (0.0)	- (0.0)
NHS inpatient beds for respite	- (0.0)	- (0.0)
NHS day hospital places for people with dementia	7 (46.7)	8 (42.1)
NHS day hospital places for people with other mental illness	4 (30.8)	5 (26.3)
Routine assessments by consultant psychiatrists	8 (53.3)	18 (94.7)
Urgent assessments by consultant psychiatrists	9 (64.3)	16 (84.2)
Community mental health team input for people at home	11 (73.3)	18 (94.7)
Community mental health team input for care home residents	5 (35.7)	16 (84.2)
Psychological therapies for older people with mental illness	2 (15.4)	7 (36.8)
A memory clinic for people with potential dementia	3 (25.0)	9 (47.4)
Anti-Alzheimer drugs for older people with dementia	10 (66.7)	18 (94.7)
Specialist services for younger people with dementia	- (0.0)	1 (5.3)
Nursing home beds for older people with mental illness	8 (47.1)	5 (27.8)
Residential home beds for older people with mental illness	9 (52.9)	8 (44.4)
Non-NHS respite care for older people with mental illness	7 (46.7)	4 (22.2)
Day care places for people with dementia	7 (41.2)	10 (55.6)
Day care places for people with other mental illness	2 (14.3)	2 (10.5)
Homecare services for older people	13 (76.5)	10 (52.6)
Carer support services	9 (52.9)	8 (42.1)

Social Services Responses: Min n=12, Max n=17; Mental Health Responses: Min n=18, Max n=19

As the staff participating in this exercise worked in teams located across North Cumbria it is difficult to interpret the responses detailed in Table 51. The very high proportion of the mental health services staff (all bar one respondent) who felt that routine assessments by consultant psychiatrists, community mental health team input for people at home and the provision of antidementia drugs were generally available is striking. However, these perspectives were not entirely shared by social services staff. Conversely, whilst three-quarters of social services staff thought that home care was generally available, only about half of the mental health service staff perceived this to be the case and there were marked disparities between the two groups' perceptions of the availability of nursing home beds and non NHS respite care. These findings raised questions about each agency's knowledge of the services provided by the other.

Table 52 considers the way in which the specialist mental health service works with social services in caring for older people with mental health problems. Whilst the mental health trust were generally perceived to act quickly on urgent referrals, less than half the social services staff felt that they responded promptly to routine referrals or provided timely feedback about individual clients' care and treatment. Furthermore, less than one in four saw them as taking a wider role in supporting social services to care for this client group. This information was gathered only from the perspective of social services staff, as the mental health staff were asked about their relationship with primary care.

Table 52. Social Services Staff Members' Views: The Relationship between Social Services and the Specialist Mental Health Services for Older People

Statement	**Generally agree** Number (%)
The mental health service for older people responds promptly to routine referrals	7 (43.8)
The mental health service for older people responds promptly to urgent referrals	12 (75.0)
The mental health service for older people provides prompt feedback following assessments	7 (46.7)
The mental health service for older people provides ongoing feedback about patients' care and treatment	6 (40.0)
The mental health service for older people provides support and training for social services staff	3 (20.0)
The mental health service for older people has offered social services staff guidance in the use of assessment scales	1 (6.7)
The mental health service has agreed protocols with social services for the identification and management of older people with mental illness	2 (14.3)

Min n=14, Max n=16

Table 53 therefore reports on the mental health trust staff members' views of the services they provide to GPs and other primary care practitioners. It is noted that their responses closely mirror those of the GPs themselves. Thus whilst most mental health staff felt that the trust responded quickly to GPs referrals, rather less believed that it provided prompt or ongoing feedback about individual clients' care and still less perceived the service to be taking a wider educational role in primary care.

Table 53. Specialist Mental Health Staff Members' Views: The Relationship between Specialist Mental Health Services for Older People and Primary Care

Statement	**Generally agree** Number (%)
The mental health service for older people responds promptly to routine referrals	15 (88.2)
The mental health service for older people responds promptly to urgent referrals	16 (94.1)
The mental health service for older people provides prompt feedback following assessments	12 (70.6)
The mental health service for older people provides ongoing feedback about patients' care and treatment	11 (68.8)
The mental health service for older people provides support and training for social services staff	7 (43.8)
The mental health service for older people has offered social services staff guidance in the use of assessment scales	3 (21.4)
The mental health service has agreed protocols with social services for the identification and management of older people with mental illness	5 (31.2)

Min n=14, Max n=17

Of the additional stakeholder groups surveyed, only the specialist mental health staff were asked who was most appropriately placed to take the lead in caring for specific subgroups of older people with mental health problems and their responses are set out in Table 54. From this it can be seen that there was a high degree of consensus with respect to the care of those groups of people who might be considered to have the most acute mental illness, with a substantial majority of the specialist mental health staff believing that they should manage their care. This includes people with a severe and unstable functional mental illness such as schizophrenia, people with severe depression at risk of self-harm and people with dementia who present with challenging behaviours or psychotic symptoms. There also appeared to be a common view about the care of patients who had a severe but stable mental illness or moderate dementia and stressed carers, with more than two-thirds of staff suggesting that in these instances the primary and specialist mental health services should share their care. There was less consensus about the care of the remaining five client groups however, which seemed to reflect a lack of agreement about when shared care is appropriate. If this is the case, GPs are likely to be receiving mixed messages about appropriate referrals, and/or referring different types of clients in different parts of the trust.

Table 54. Specialist Mental Health Staff Members' Views: The Responsibility of Caring for Older People with Mental Health Problems

Clients	**GP/Primary Care** Number (%)	**Specialist Mental Health Service** Number (%)	**Shared Care** Number (%)
People with early signs of Alzheimer's disease	7 (33.3)	4 (19.0)	10 (47.6)
People with early signs of vascular dementia	10 (47.6)	4 (19.0)	7 (33.3)
People with moderate dementia where the carer is experiencing stress	3 (14.3)	4 (19.0)	14 (66.7)
People with dementia who are experiencing delusions/hallucinations	1 (4.8)	15 (71.4)	5 (23.8)
People with dementia who present with challenging behaviours	- (0.0)	15 (71.4)	6 (28.6)
People with recurrent mild depression	11 (52.4)	3 (14.3)	7 (33.3)
People with symptoms of moderate depression post bereavement	11 (55.0)	1 (5.0)	8 (40.0)
People with moderate depression who have not responded to first line treatment	1 (4.8)	11 (52.4)	9 (42.9)
People with severe depression including loss of appetite, disturbed sleep and suicidal ideation	1 (4.8)	17 (81.0)	3 (14.3)
People with a severe but stable mental illness such as schizophrenia	2 (9.5)	4 (19.0)	15 (71.4)
People with a severe and unstable mental illness such as schizophrenia	1 (4.8)	18 (85.7)	2 (9.5)

Min n=20, Max n=21

Each of the three additional key stakeholder groups were asked about their priorities for service development and Box 55 details their choices.

Box 55. Social Services, Specialist Mental Health Staff Members', Users' and Carers' Views: Priorities for Service Development

Specialist Mental Health Services Staff
Specialist services for younger people with dementia
NHS inpatient beds for assessment and treatment
Community mental health team input for people at home
Nursing home beds for older people with mental illness

Social Services Staff
Specialist services for younger people with dementia
Day care places for people with dementia
Day care places for people with other mental illness
NHS inpatient beds for respite

Older People/Carers and their Representatives
Specialist services for younger people with dementia
Carer support services
NHS inpatient beds for respite
Community mental health team input for people at home

Mental Health Responses: n=20; Social Services Responses: n=13; Users' and Carers' Responses: n=35

As was the case with the GPs' responses, nearly all of the 21 services listed in Table 46 were prioritised for development by at least one member of the specialist mental health service, with only NHS day hospital places for people with dementia and routine assessments by consultant psychiatrists failing to get any votes. Indeed whilst Box 55 lists only those services prioritised by at least six staff, there were a number of other services whose expansion was supported by three or more practitioners. There was however a much greater degree of consensus amongst the social services staff, with more than half of those who expressed a preference identifying the development of specialist services for younger people with dementia as one of their top three priorities. Indeed, this aspect of service provision garnered the most support across all three of these stakeholder groups, despite not having been perceived as a priority by most GPs as was seen in Box 49.

Whilst in Box 55 the priorities of all the users, carers and their representatives who attended the two workshops held in Wigton and Millom have been amalgamated, it is noted that the attendees at both events were keen to stress the particular needs of their locality. Interestingly there was a fair degree of overlap in their experiences, and both groups prioritised the development of specialist services for younger people with dementia and the need for increased carer support. Whilst the attendees at the Wigton workshop also highlighted a need for more NHS inpatient beds for assessment, treatment and respite however, the participants at the Millom event saw a greater need for more day care places for people with dementia, community mental health team input for people at home and NHS continuing care beds. A selection of the messages these groups wanted to put before commissioners is given in Box 56.

Box 56. Older People, Carers and Their Representatives: Messages from Workshops

Wigton

- It is difficult to get into the 'care system' - primary care don't seem to be engaged
- Services need to be flexible rather than 'take it or leave it'
- New developments / pilot schemes are always in the same (urban) areas – other places are always forgotten
- Respite care at night would be helpful

Millom

- There is a lack of care home places in the Millom area
- Local GPs are not available in the evenings or at weekends such that people often face an hours drive just to see a GP
- The centralisation of equipment has resulted in delays obtaining wheelchairs etc
- Night care would be helpful, but it is difficult to recruit and retain carers – this needs investment

In the final table, Table 57, the three stakeholder groups' views on the way in which mental health services for older people might be organised are detailed, each participant having been presented with a number of paired statements as described earlier in this chapter and asked to indicate their preference. It is observed that there were many items on which the three groups differed. In fact there were only three items on which they were clearly in agreement. Thus, more than two-thirds of each stakeholder group were in favour of consultant psychiatrists undertaking most new assessments in people's homes, more assessments and treatments being carried out within clients' homes and the future balance of care being weighted in favour of the community. As was shown in Table 50, none of these three items were unequivocally supported by GPs however, and it is noted that whilst the majority of GPs, social services staff and users and carers felt that it would be preferable to expand community mental health team hours to cover evenings and weekends, the majority of staff within the specialist mental health service were rather in favour of increasing the staff available during their current working hours. Similarly, although the specialist mental health staff were undoubtedly in favour of social workers becoming core members of their teams, there was only partial support for this idea from the social services staff themselves.

As has already been noted, the views of the three groups of people surveyed in the latter part of this exercise are not necessarily representative of the wider body of staff working within the social or specialist mental health services, or of older people and carers generally. The participants may be considered to be people with a particular interest in the development of mental health services for older people however and as such it is important that their voices are heard in the planning of any future service configuration.

Table 57. Social Services, Specialist Mental Health Staff Members', Users' and Carers' Views: Preferences for Future Service Organisation

	Specialist Mental Health Staff	Social Services Staff	Older People, Carers & Their Representatives
a. Consultant psychiatrists undertake most new assessments in people's homes	18	15	24
b. Consultant psychiatrists undertake most new assessments in outpatient clinics	1	1	10
a. Consultant psychiatrists undertake most follow-up assessments in people's homes	10	14	25
b. Consultant psychiatrists undertake most follow-up assessments in outpatient clinics	9	2	10
a. Community mental health staff are based in primary care	8	5	21
b. Community mental health staff are based in separate community teams	11	11	13
a. GPs refer directly to consultants and/or other staff	2	3	not
b. GPs refer to the mental health team who decide on the most appropriate person to undertake any assessment	17	13	asked
a. More assessments and treatments are carried out at day hospitals	1	2	8
b. More assessments and treatments are undertaken within people's homes	18	13	27
a. The staffing for community mental health teams Mondays-Fridays 9 a.m. – 5 p.m. is increased	11	1	1
b. The community mental health team hours are developed to cover evenings and weekends	8	15	34
a. Specialist social workers become core members of community mental health teams	18	6	16
b. Community mental health nurses develop stronger links with existing social work teams	1	9	18
a. Residential home places for people with mental illness are increased	5	1	16
b. Specialist home care services for people with mental illness are developed	14	15	18
a. Community mental health teams develop the service they provide to care homes	18	15	17
b. Inpatient services for people with challenging behaviours are expanded	-	1	17
a. The balance of care between hospital and community services remains largely unchanged	-	4	5
b. The balance of care between hospital and community services is weighted in favour of the community	19	12	29

Mental Health Responses: Min n=18, Max n=21; Social Services Responses: Min n=15, Max n=16; Older People's and Carers' Responses: Min n=34, Max n=35

CHAPTER 7
FINDINGS V: KEY ACTIVITIES ASSOCIATED WITH CARING FOR OLDER PEOPLE

This chapter explores the principal activities undertaken by core groups of specialist mental health and social services staff caring for older people with mental health problems in North Cumbria. It is based on the information collected during a diary exercise undertaken in April/May 2004 as described in Chapter 2. In this activity all social workers and social care workers/review officers employed by Cumbria Social Services Department and all community mental health nurses and community support workers employed by North Cumbria Mental Health and Learning Disabilities NHS Trust who primarily worked with older people were asked to complete a diary schedule on each working day within a one week period. This involved inserting a code for the activity in which they had been predominantly engaged for each 30-minute period from a list of 45 activities grouped under six broad headings:

- Face to face care with clients;
- Face to face care with carers;
- Telephone contact with clients/carers;
- Indirect care (activities undertaken away from the client and/or carer but on their behalf);
- Team/service work; and
- Travel.

Twenty-six members of the community mental health service and 37 social services staff completed diary sheets. A summary of the way in which these staff members' time was distributed between the above broad areas of activity is presented in Appendix A27. The information provided by three social services staff who held specialist roles within the hospital has been excluded from the main analysis however, as has that provided by seven non-qualified social services staff, a group whose role was in transition at the time of the data collection. The data reported in this chapter thus relate to 27 qualified social services staff, 15 qualified mental health nurses and 11 mental health support workers.

In view of the fact that the social services department make no clear organisational separation between older people with mental health problems and other older people, it is recognised that the information provided by the social services staff will have related to mixed caseloads. However, the findings reported in Chapter 4 suggest that people with mental health problems constitute at least 60 per cent of the cases open to social services staff, and many of these clients will have changing presentations and complex needs necessitating regular social work input. There is, moreover, no reason to suppose that the activities social services staff undertake in caring for older people with mental health problems in the community will be markedly different from those undertaken in caring for other older people. Preliminary analysis of the social services time use information furthermore suggested that there was generally little difference between the proportion of time community and hospital based social services staff spent in each of the six main areas of work and the data for these two groups have thus been aggregated.

The tables below represent a total of 1,913.5 hours of recorded activity. Hours recorded as sick or annual leave are not included in this total, but time recorded as lunch or breaks has been retained as part of the calculations of the working week. Even if this were to be excluded however, practitioners worked an average of nearly three hours per week above the official working week of 37 and 37.5 hours for full time employees of the social services department and mental health trust respectively.

Table 58 details the percentage of time each staff group devoted to the six broad categories of activity. The first three categories in Table 58 are concerned with the proportion of time staff spent in direct contact with clients and carers. Overall, social services staff spent approximately 17 per cent of their time in face to face contact with clients and/or carers and a further six per cent of their time in telephone contacts with them. Almost a quarter of their time at work was thus spent in 'direct care'. If one then includes the 44 per cent of their time that was spent in activities undertaken on behalf of clients and carers, but not in their presence, we can see that a total of just over two-thirds of these social care staff members' time was spent in client related activities. Mental health nurses spent more than twice as much of their time in face to face contacts with clients and carers (39%), but slightly less on telephone contacts, such that a total of 43 per cent of their time was spent in direct care. Considerably less of their time was occupied by indirect care activities however (26%), so that the total percentage of time they spent in client related activities (69%) was not dissimilar to that reported by social services staff. Whilst the mental health support workers spent a very similar proportion of their time in direct care as their mental health nurse colleagues, they spent rather less on indirect care so that overall 63 per cent of their time was spent in client related activities.

As might be predicted from the above, social services staff spent considerably less time on travel than did the mental health staff, with mental health support workers spending nearly a quarter of their time travelling. However, a greater proportion (25%) of the social services staff members' week was spent in team/service work, whilst such activities occupied 17 and 14 per cent of the community mental health nurses and support workers time respectively.

Table 58. The Proportion of Staff Time Spent in Six Aspects of Work

Activities	**Qualified Social Services Staff** %	**Mental Health Nurses** %	**Mental Health Support Workers** %
Face to face care with clients	12.6	33.7	34.4
Face to face care with carers	4.6	5.1	2.7
Telephone contact with clients/carers	6.2	4.1	6.2
Indirect care	43.8	25.8	19.7
Team/service work	24.8	17.4	13.9
Travel	7.9	13.9	23.1

Social Services Staff: n=27; Mental Health Nurses: n=15; Mental Health Support Workers: n=11

In Table 59 the specific activities the different professional groups undertook when in direct contact with clients and carers are explored. In the light of the prominence given to assessment and care management arrangements within community care policy it is perhaps not surprising to see that assessment and care planning/review activities (items 1, 2, 3, 4, 5, 6, 12, 13, 14 and 17 on the proforma as given in Appendix A5) accounted for the vast majority of the time social services staff spent with clients and carers. Indeed, these amounted to more than 14 per cent of their total work time. Interestingly, the qualified mental health nurses spent a similar proportion of their time in such activities (17%), whilst the additional time they spent with clients and carers was largely accounted for by the provision of interventions addressing people's emotional and psychological needs, or monitoring their health and medication, activities which accounted for only one per cent of the social services staff members' time. As would be expected, the mental health support workers were far less involved in core assessment and review activities, the two activities accounting for most of their time being the provision of counselling/support and the monitoring of mental health and/or medication. Whilst it is clear from Table 59 that all three staff groups spend considerably more time with clients than with carers (this being especially marked in the health service), it is likely that the information presented underestimates the input received by carers, for they will often have been seen together with clients.

Table 59. The Proportion of Staff Time Spent in Direct Contact with Clients and Carers

Activities	Qualified Social Services Staff %	Mental Health Nurses %	Mental Health Support Workers %
Face to face care with clients			
Assessment interview	3.4	5.8	0.4
Financial assessment	<0.1	-	-
Completion of forms (non financial)	1.2	0.4	-
Completion of forms (financial)	0.2	-	-
Discussion of care plan options	2.2	0.8	-
Review of needs/care plan	3.9	6.6	0.6
Provision of counselling or support	0.7	6.9	12.0
Provision of information or education	0.4	0.6	-
Provision of psychological therapies	-	3.8	1.9
Monitoring mental health/medication	<0.1	7.5	14.4
Assistance/supervision with ADL's)	0.1	0.8	2.5
Accompanying client for appointments	0.5	0.6	2.6
Face to face care with carers			
Gathering information about client	2.3	2.6	0.4
Assessing carers' needs/completing forms	0.7	0.5	-
Provision of counselling or support	0.8	1.7	1.6
Provision of information or education	0.7	0.4	-
Accompanying carer for appointments	0.1	-	0.7
Telephone contact with clients/carers			
Pre-assessment information gathering	1.0	1.1	0.7
Assessment	0.5	0.4	0.2
Review of needs/care plan	2.0	1.1	0.9
Provision of support or information	2.8	1.4	4.4
Total direct care	23.4	42.9	43.3

Social Services Staff: n=27; Mental Health Nurses: n=15; Mental Health Support Workers: n=11

In Table 60 we turn to the activities undertaken by staff on behalf of, but not in the presence of, clients and carers. From this we can see that the gathering of information about clients and the completion of assessment documentation of itself occupied a further 13 per cent of the social services staff members' time. Altogether therefore, assessment related activities (items 1, 2, 3, 4, 13, 14, 18, 19, 22, 23, 24 and 25 on the proforma as given in Appendix A5) accounted for 22 per cent of their working week. In contrast, care planning and arranging services accounted for 11 per cent of their time (items 5, 12, 17, 28, 29 and 30 on the proforma), whilst review and monitoring activities took up a further nine per cent of their week (items 6, 20, 31, 32 and 33 on the proforma). The same assessment and care management activities occupied a little over 30 per cent of the community mental health nurses' working time, but it is difficult to discern the extent to which the two staff groups are working collaboratively. Whilst the majority of social services personnel (70%) noted that they had gathered information from health services colleagues in the week in question, a smaller proportion of health staff (40%) recorded such activity, and both groups spent very little time monitoring the provision of care by the other agency.

It is probably no surprise to practitioners that client and carer related paperwork was the single activity which occupied most of their time. Indeed, when considered together, the completion of documentation and the undertaking of administrative tasks (items 3, 4, 25, 26, 34 and 42 on the proforma as given in Appendix A5) accounted for nearly 32 per cent of social services staff members' time and a little over 17 per cent of the community mental health nurses and support workers working week.

Table 60. The Proportion of Staff Time Spent in Activities Undertaken on Behalf of Clients and Carers

Activities	**Qualified Social Services Staff** %	**Mental Health Nurses** %	**Mental Health Support Workers** %
Assessment – gathering information from health/social services staff*	2.4	1.1	0.6
Assessment – gathering information from other agencies	1.4	1.6	0.6
Assessment – gathering information from records/colleagues	1.6	0.6	0.5
Assessment – completing documentation	7.5	3.4	3.7
Other client/carer related paperwork	17.1	11.2	11.8
Discussing case in supervision/clinical team meetings	2.5	4.6	0.9
Discussing case with front line care staff e.g. home carers	4.1	0.8	-
Arranging social care	3.4	0.3	-
Arranging health care	0.7	0.6	0.1
Monitoring social care provision	1.2	0.2	0.1
Monitoring health care provision	0.4	0.1	1.3
Review of care plan/care provision in conjunction with other agencies/providers	1.6	1.4	0.1
Total indirect care	43.8	25.8	19.7

Social Services Staff: n=27; Mental Health Nurses: n=15; Mental Health Support Workers: n=11

* Forms provided to health staff asked about liaison with social services staff
Forms provided to social services staff asked about liaison with health staff

Table 61. The Proportion of Staff Time Spent in Organisational Activities

Activities	**Qualified Social Services Staff** %	**Mental Health Nurses** %	**Mental Health Support Workers** %
Administration and reading of departmental documents	4.4	1.8	1.9
Team meetings (non-clinical)	2.3	2.6	2.1
Service development	3.3	1.9	-
Training (participant)	2.9	3.8	3.7
General telephone enquiries	4.9	2.3	1.3
Filing, photocopying, faxing etc	1.1	0.5	0.1
Lunch/breaks	5.2	4.5	4.6
Other	0.7	-	0.3
Total team/service work	24.8	17.4	13.9

Social Services Staff: n=27; Mental Health Nurses: n=15; Mental Health Support Workers: n=11

Table 62. The Proportion of Staff Time Spent in Travel

Activities	**Qualified Social Services Staff** %	**Mental Health Nurses** %	**Mental Health Support Workers** %
Travel – directly client and/or carer related e.g. home visits	4.2	11.8	17.2
Travel – indirectly client and/or carer related e.g. to meeting about client	1.6	0.3	1.0
Travel – other	2.1	1.9	4.9
All travel	7.9	13.9	23.1

Social Services Staff: n=27; Mental Health Nurses: n=15; Mental Health Support Workers: n=11

Whilst the above discussion has concentrated on the differences between the activities undertaken by mental health and social services staff caring for older people with mental health problems in North Cumbria, it may also be helpful to examine how each individual discipline's pattern of time use compares with that of practitioners elsewhere. Few systematic studies have been undertaken however, whilst the lack of a common means of defining and measuring staff activity makes it difficult to be sure that one is comparing like with like. The approach used in this study is acknowledged to have a number of limitations. The use of 30-minute time slots is likely to have contributed to under-reporting of activities which take only a few minutes and there is inevitably an element of subjectivity in the judgements made by staff as to which activity code best describes the work undertaken at any one time. Furthermore, the categorisation itself is open to debate, and cannot purport to capture all the complexities and nuances of client:practitioner relationships. It does however provide information that is ‘close to the ground’, and uses a transparent process developed within the PSSRU which allows us to make comparisons with two earlier studies undertaken by PSSRU staff.

In 1999, 34 community-based social care staff working with older people in Manchester undertook a similar diary exercise (Weinberg et al., 2003). The proportion of their working week spent in direct contact with clients and carers was almost identical to that reported by social services staff in Cumbria, with personnel in both services spending roughly three times as much time with clients as with carers. The percentage of time spent in telephone contacts in Cumbria was almost double that found in Manchester however, and it is not clear to what extent this may be a reflection of the difficulties of travel in a large rural catchment area, the development of a more ‘administrative’ form of care management practice, or of differences in the two services’ caseloads. Certainly the Manchester personnel spent a greater proportion of their time in assessment (27% compared with 22%) and care planning activities (13% compared with 11%) and rather less in reviews and monitoring (7% compared with 9%). However, a specialist review team undertook most of the care home reviews in Manchester at that time, and they were excluded from this research, which was undertaken prior to the publication of statutory guidance on the conduct of reviews and the Single Assessment Process (DoH 2002a, 2002b). Administration and documentation took up nearly a third of each team’s time.

A later study by Tucker (2004) reported on the time use patterns of a small team of community mental health nurses working with older people in West Suffolk. Overall the nurses there spent rather less time in direct contact with clients and carers than did practitioners in Cumbria (33% compared with 43%), but a very similar proportion of their time in client related activities (71% compared with 69%). It seems probable that the higher percentage of time taken up by indirect care activities in West Suffolk is due to the fact that the community mental health nurses there had a care management role, the time taken fulfilling this function seen as competing with that available for direct clinical work. This may also explain why they spent rather more time on administration and paperwork than did staff in Cumbria (25% compared with 17%) and less time on travel (9% compared with 14%) despite also covering a large rural area.

CHAPTER 8
CONCLUSIONS AND AGENDA FOR ACTION

As the preceding chapters exemplify, those older people with mental health problems who are in contact with the specialist health and social services in North Cumbria have a wide and diverse range of needs. These stem from the degree and type of mental impairment they experience, the extent of any physical ill health they suffer, the nature of their home situation and the amount of family and neighbourly support they have available. It is also apparent that, as in the rest of the UK, the services which exist to support this population have developed in a somewhat haphazard fashion and are organisationally fragmented, being planned and delivered by a variety of sources within the public, voluntary and independent sectors. It is therefore not surprising that the relatively inflexible and limited range of services available does not always seem to correspond with these people's needs and/or preferences.

According to *The National Service Framework for Older People* (NSFOP), integrated commissioning and delivery arrangements are fundamental to the provision of person-centred care, a goal to which all agencies commit (DoH, 2001a). The starting point for such joint planning is the availability of good quality data about local demographics, activity levels and resources (Audit Commission 2000, 2002). However, a common complaint in previous years has been that local agencies lacked accurate information about the number of older people with mental health problems receiving, or needing, community services and the money spent on these. It is this need that the current study has sought to address. Other concerns voiced in the past were that the independent and voluntary sectors were not sufficiently involved in service planning and development, but were rather expected to respond to demand as signalled in published strategies, and that users and carers also lacked influence in shaping local services. It would seem self-evident that if the agencies in North Cumbria truly wish to effect a change in the balance of care, then these issues too will need to be addressed.

This chapter starts with a brief summary of the potential for the agencies in North Cumbria to shift the balance of care for older people with mental health problems in the direction of the community, i.e. to reduce the number of older people placed in residential and nursing homes and admitted to acute mental health inpatient beds and to enable them to remain within their own homes. In order to achieve such a change, the study suggests that a number of 'building blocks' will first need to be in place. The majority of this chapter is therefore dedicated to exploring a range of options within each of six discrete areas which have been derived from a combination of the evidence presented within the literature review, the local data collection and the survey of key stakeholders' opinion. It is suggested that this material provides a firm basis on which to undertake evidence based commissioning and to create an agenda for action.

THE BALANCE OF CARE

Balance of care studies seek to identify groups of people whose care needs could be met in more appropriate settings and to determine the resource implications of providing such care. The findings presented in Chapter 5 of this study suggest that it would be possible for the social services department in North Cumbria to care for a significant proportion of those older people with mental health problems who currently enter residential care with enhanced community care packages in their own home at a cost that is no greater than that they are currently meeting. It would similarly appear that the mental health trust could meet the needs of a proportion of those people they are presently caring for in hospital in their own homes without incurring any additional expense. Indeed the suggestion is that such shifts in the balance of care would be likely to release resources which could be invested in developing community services.

A number of observations elsewhere within the study support this conclusion. With regard to the care home entrants for example, one of the most striking findings in Chapter 4 was how little formal support this population received prior to their institutionalisation. Nearly half of the cohort had had no assistance with their personal care and only one in two had been assessed by a consultant psychiatrist. As will be discussed at more length below, Chapters 3 - 7 furthermore suggested that there was considerable potential for social services and mental health staff to work more collaboratively in the provision of integrated care for older people with mental health problems and to utilise a wider range of services, drawing on each others' professional knowledge and expertise. There was also general support for the provision of more community care, with the majority of people in each of the four key stakeholder groups surveyed in favour of weighting the balance of care in this direction. This is not to say that all local users, carers and practitioners believed that the current supply of residential and mental health beds was adequate. Indeed, a number of people prioritised such services for development in any future reconfiguration. What this exercise has highlighted however, is the importance of using these resources <u>only</u> for those people for whom they are <u>the most</u> appropriate option. It is suggested that this is a smaller number than that currently so accommodated, whilst, more widely, the importance of specifying who services are for, and what they are designed to achieve, is a crucial issue for the whole care economy. That there will need to be changes in the nature of the institutional accommodation available is not, however, disputed. Access to nursing home beds varies greatly across North Cumbria, there is a clear lack of specialist residential care for older people with mental health problems in proportion to the number of people requiring such care, and not all of the inpatient facilities for this population meet NHS standards or reflect good practice. Commissioners are already aware of these important issues however, as demonstrated in local planning strategies.

As has already been noted, in order to achieve the potential shift in the balance of care described in Chapter 5, a number of building blocks will first need to be put into place within the agencies' developing infrastructure. These include:

- The creation of integrated community mental health teams (CMHTs) for older people
- The development of intensive care management arrangements
- The growth of a range of community services necessary to enable vulnerable older people to remain in their own homes
- The development of a strategy to support carers
- The provision of specialist mental health support for primary, community, residential and general hospital inpatient services and
- The development of an information network, which can support both front line staff and service planning.

Each of these will be discussed in more detail below.

No paradigm shift is being proposed here. The approach taken throughout this study has been deliberately conservative and the hypothesised changes in the balance of care are modest. It is a low risk, lost cost strategy. Indeed the data clearly show the potential for local agencies to go further if so desired, as exemplified in Chapter 5 by the four care home entrant case types whose community care was considered to be viable if provided in combination with more supportive accommodation, these forming an obvious target group should the local agencies wish to make more radical changes. It may also be the case that the proposals below will be viewed as modest. They are not in the main concerned with new or novel ideas, but rather concentrate on doing the important things well, on increasing efficiency and on strengthening existing arrangements. Their achievement is however considered core to the success of any changes in the balance of care.

THE CREATION OF INTEGRATED COMMMUNITY MENTAL HEALTH TEAMS FOR OLDER PEOPLE

The provision of CMHTs specialising in the care of older people is perceived to be fundamental to the community care of this client group. These teams will need a mixture of specialist staff including consultant psychiatrists, community mental health nurses, social workers, occupational therapists and clinical psychologists, and, as explored in Chapter 1, will have a wide-ranging remit that includes the four following elements:

- The provision and monitoring of antidementia medication for people in the early-moderate stages of dementia, this necessarily accompanied by wider diagnostic, educational and support roles.

- The specialist care of people suffering from behavioural and psychological symptoms of dementia and of people with severe or complex functional mental health problems, employing psychological, social, physical and pharmacological therapies.

- The delivery of intensive care management arrangements.

- The provision of outreach and advice to primary, residential, domiciliary, general hospital and day care services.

As was seen in Chapter 6, the local development of CMHTs was given widespread backing by the GPs, users and carers surveyed in this study, and it is also a priority for the mental health service itself. Indeed, as described in Chapter 5, the packages of care practitioners felt would be necessary to prevent the admission of a proportion of those clients currently admitted to hospital relied heavily on the ability of CMHTs to support these people at home. It is believed that the successful fulfillment of the above functions will necessarily depend upon the integration of specialist social work staff within CMHTs, this being something that the community mental health staff in this study supported enthusiastically, but was viewed more reticently by staff in the social services department.

A recurrent theme throughout this study has been the scope for mental health and social services staff to work together more collaboratively in caring for vulnerable older people with mental health problems in their own homes, as was seen most clearly in Chapters 5 and 6. It is apparent that the different professional groups are not always fully aware of the resources available outside of their own sector, whilst in the care planning exercise, each agency displayed a tendency to draw on its own services for ways of meeting clients' needs, and at times failed to consider the wider range of options available. Obstacles to accessing resources held by other agencies were also described to the study team, and it was clear that there was room to improve inter-professional communication about the care of individual clients.

Although the specific configuration of individual CMHTs may vary across the region according to the demographic and geographic characteristics of different localities, the literature offers a number of pointers to the creation of effective teams. It is thus considered important that these are adequately resourced in terms of staff, money and accommodation and that they have clear and realistic aims. As was noted in Chapter 1, unclear team objectives are said to be the biggest contributor to the poor functioning of teams and it is suggested that the role of the CMHT be clearly defined and agreed with a range of key stakeholders including social services and primary care. This would also provide an ideal opportunity to reinforce criteria for referral to the team and the route of access.

Clarity is also required about the role of each team member, their tasks and place within the team. Thus the unique roles which each professional group will take are separated from the shared core tasks. The assumption is that the team members will have an appropriate breadth of skills and knowledge to meet the needs of their clients. The evidence suggests that the most effective psychological treatments for depression in older people are cognitive behaviour therapy, interpersonal therapy or brief, focused analytic therapy (DoH, 2001a), whilst as seen in Chapter 1, those interventions which have proved most successful in supporting carers of people with dementia require staff to have a range of behaviour management and problem-solving skills. Where these skills are not widely available a strategy for their development will be needed, and whilst it may not be realistic to rely solely on psychologists for the provision of such therapies, they may take the lead in their development at the outset. The social work staff might similarly be expected to take the lead in the introduction of effective intensive care management arrangements, the high level of psychiatric morbidity within their current caseloads described in Chapter 4 showing that this is a group with whom they have much experience. There will, furthermore, need to be a strong commitment to quality within the service as a whole. Such a model of practice has been described in Chapter 1.

THE DEVELOPMENT OF INTENSIVE CARE MANAGEMENT ARRANGEMENTS

The provision of intensive care management by members of the specialist multidisciplinary mental health team is seen as a prerequisite for the delivery of the complex packages of care needed if older people are to be diverted away from institution-based care. Drawing on the discussion in Chapter 1, six factors are considered to be particularly salient to those wishing to implement such arrangements, and each of these will be discussed below. Not all older people with mental health problems will require such arrangements however, and the need for other social care responses including effective organisational procedures for assessments, care planning and reviews should not be overlooked.

Assessment

Government policy indicates that the vast majority of older people with mental health problems should now be subject to the assessment aspects of the Single Assessment Process (SAP). This requires that older people receive a level of assessment that is matched to their individual circumstances. Thus whilst many elderly people with mental health problems will benefit from a wide assessment across a number of domains, those people considered appropriate for the provision of intensive care management by the CMHT are likely to require a comprehensive multidisciplinary assessment. Multidisciplinary assessment should also be the norm for those older people with severe mental illness whose particular circumstances make it more appropriate for the Care Programme Approach to be applied, whilst the old age mental health service will also have a role in advising on the proven assessment scales the SAP guidance requires be incorporated within the local assessment process. These are seen as necessary to ensure that individual needs are properly assessed. The challenge for local agencies therefore is to incorporate the SAP guidance into the CMHTs' organisational policy and to ensure that there is a common, standardised health and social services assessment framework in place that will deliver good quality assessment of a breadth and depth appropriate to meet clients' needs (DoH 2001a, 2002b).

Targeting

The effective targeting of resources is necessary to the achievement of positive outcomes from intensive care management and occurs at two points in the care management process: on entry to the service and within the initial assessment. The development of greater reliability and validity in eligibility criteria is critical to ensuring that those people with more severe and complex needs receive services which differ in content and intensity from those whose needs are of a lesser degree as required by the Department of Health's guidance on *Fair Access to Care Services* (DoH, 2002a). It is then the level of clients' need, rather than particular tasks regardless of level of need, which must be prioritised. A widower with severe depression may be managing to wash and dress himself for example, but lack the motivation to undertake routine domestic chores or go to the shops. As plans to reduce institution-based care are effected, it will also be necessary to examine the criteria for entry to such care in order to ensure that these expensive resources are only used for those people for whom they are the most appropriate option and that practice is consistent across the area.

Monitoring and review

As discussed in Chapter 3, the changing nature of the needs presented by many older people with mental health problems dictates that the care received by those clients in receipt of care management, including intensive care management, is regularly monitored and reviewed, as prescribed in the *Fair Access to Care Services* guidance (DoH, 2002a). Such reviews are necessary to facilitate the timely and appropriate adjustment of care plans in response to changing circumstances and continuity of staff involvement will clearly be important here.

Financial management

The literature reviewed in Chapter 1 suggests that three aspects of practice contribute to effective financial arrangements within intensive care management: the devolution of budgets to care managers, the setting of clear expenditure limits and the availability of explicit unit costs for purchased services. The latter are essential if care managers are to make informed choices about the likely costs and benefits of alternative packages of care, whilst it is suggested that there is some flexibility in any expenditure limits, for there will be instances in which substantial short-term packages can prevent the need for hospital or care home admission, improving longer-term client outcomes and unit costs.

Protected caseloads

The demands of intensive care management require that these practitioners work with a protected number of clients. Only if caseloads are small can practitioners provide the careful and continuing assessment and monitoring of needs, effective liaison with other agencies, and close and regular contact with the elderly person and their network that are needed to effect positive outcomes. This aspect of the CMHTs' work must also be balanced with the other roles of the team, including the support of generic services, the provision of therapeutic interventions and the support of people at home by means of less complex care packages.

Appropriate care managers

As was discussed in Chapter 1, the community care reforms of the late 1980s gave key responsibility for the undertaking of care management to local authority social services departments. The guidance stated that whilst, for any one individual service user, the various core tasks of care management could be undertaken by different professionals, people with high level needs would require a designated care manager who could offer continuity of care (SSI/SWSG, 1991a). Health staff were not prohibited from fulfilling the latter role, but the guidance was permissive as opposed to directive, and in practice it has been relatively unusual for non-social services staff to act as care managers for older people (Weiner et al., 2003).

More recent government policy has contained a clear expectation that health staff will become increasingly involved with assessment and care management tasks (DoH, 2001a; Weiner et al., 2003). Indeed, the SAP guidance referred to above (DoH, 2002b) instructs that joint-agency staff development programmes will cover both assessment and care management skills. As was seen in Chapter 7, social services staff in North Cumbria currently spend a significant proportion of their working week in such activities and, as noted above, it is expected that, at least initially, they would take the lead in implementing any new intensive arrangements. Although their focus might be somewhat different, Chapter 7 also demonstrates that such activities are not unfamiliar to mental health staff, and in the longer term what is most important is that, regardless of the agency they are employed by, the professional who has the most appropriate level of experience, qualifications and training to match the needs of the client acts as their care manager. Formal arrangements will thus be needed to enable all care managers within these integrated teams to access social care resources, such as domiciliary, respite and residential care, from budgets currently held by the social services department, and to provide appropriate training.

THE GROWTH OF COMMUNITY SERVICES

The findings presented in Chapters 3, 4 and 6 suggest that the community services available to support older people with mental health problems in North Cumbria are patchy and inconsistent, and that they often fail to link together into a coherent service network. Furthermore, there would appear to be few services which are specifically tailored to meet the needs of older people with mental health problems and real concern about the quality of some of those services that are currently used to support this population. As was noted in Chapter 4, the most frequently cited reason for the admission of older people with mental health problems to a care home was their inability to undertake daily activities of living. Although this was never the sole reason precipitating their move to institutional care, it does suggest that if there were an adequate and appropriate supply of support services to help these people at home, it would not be necessary for some of them to move. The breakdown of community care was similarly highlighted as a common reason for admission to an acute mental health bed.

As was seen in Chapter 5, when asked to consider what mix of services would be most appropriate to enable those people currently entering institution-based care to remain within their own homes, local practitioners drew heavily on the availability of home care, specialist day care and the input of the CMHT, highlighting the roles of community mental health nurses, occupational therapists and support workers. The care packages they compiled did not then demand the development of new or groundbreaking services, but rather the provision of what might be considered the core or basic services necessary to support these older people in the community. Nevertheless, as detailed in Chapter 6, significant proportions of general practitioners, social services staff, mental health practitioners, users and carers perceived there to be gaps in the current provision of these services. As the need for, and organisation of, CMHTs has already been discussed, the remainder of this section will concentrate on exploring the possibilities for the development of home and day care services prior to more briefly considering two of the other service elements that the study has suggested might be needed in the longer-term growth of community care in North Cumbria: respite and extra care housing. The policy imperatives to promote joint working between health and social care, and to develop services which reflect the priorities of service users and carers, are important here (DoH 1998, 2000, 2004c) as is the fact that local authorities have been asked to give a higher priority to the provision of services for older people with mental health needs (SSI et al., 2004).

Home Care Services

As was seen in Chapter 1, the literature would suggest that whilst home care services are generally well received, many of those older people who might benefit from them do not use them, or use them only in relatively small, inadequate amounts, this an observation already made of the situation in North Cumbria in Chapter 4. The conclusions of the literature review were that a number of factors may contribute to this, including limited availability, the charges made for help, the refusal of assistance and dissatisfaction with the services available, criticisms often centring on issues of consistency and flexibility.

The message from the users and carers met in the course of this study was that the home care support they have received has not always taken account of their needs. In essence, these would seem to be that the input arranged for any one person be consistently provided by a small number of personnel who are skilled and comfortable in working with older people with mental health problems and who have sufficient time to allow the older person to do what they can for themselves, rather than ‘taking over’. In these users’ and carers’ experience it had been particularly difficult to access care at weekends or at night, whilst many described the ‘take it or leave it’ nature of current services when what was desired was a response more flexibly adapted to their individual circumstances.

What would seem to be required is a discrete service tailored to the specific needs of older people with mental health problems. The challenge for local agencies in such a large and predominantly rural area is how to provide this to an often dispersed population. The Audit Commission suggest that in areas where the development of specialist home care services are not viable, perhaps, as here, due to the lack of a critical mass, agencies should consider developing the skills of existing home care staff who express an interest in working with this client group (Audit Commission, 2002). Certainly there would seem to be a need for a new multi-skilled support worker, perhaps along the lines of the triple-duty nurses employed in certain, very sparsely populated areas of the UK. Here, where there is not enough work for whole time nurse teams, multi-qualified nurses, trained as district nurses, midwives and health visitors are employed, these personnel able to carry out multiple assessments/ interventions in one visit (Wood, 2004). Such a generic support worker role proved very successful in the Darlington intensive care management scheme for the frail elderly described in Chapter 1 (Challis, 1993; Challis et al., 1995) where flexibly deployed multi-skilled carers undertook the role of home help, nursing assistant and therapy aide. There would seem to be no reason why such a model would not be equally appropriate in the care of older people with mental health problems, particularly given the problems all local services report in recruiting staff.

It is evident that there are a number of possible answers as to who might employ such staff and where they might be based. One option might be to develop the number and role of the much praised community support workers currently employed by the mental health trust, although given the high proportion of time these staff spend travelling reported in Chapter 7 (23%), they may need to be more widely based than the existing mental health teams. Another possibility would be to develop a joint funded mental health support service, but whatever form the organisation of such a service might take, the same issues will be important i.e. the provision of mental health training, supervision and support, and opportunities for personal development, all of which will necessarily have implications for funding.

Day Care Services

The research reported in the literature review in Chapter 1 suggested that day care is a liked and valued service, which, if provided in adequate amounts, can benefit both users’ and carers’ health. Indeed the most common complaint heard about day care in this study was that there was not enough of it, many current resources operating waiting lists. This concern is recognised by local planners who note that there is currently no logical pattern to the provision of day care for older people with mental health problems across the area, whilst, as seen in Chapter 6, the development of more day care services was prioritised by both GPs and social work staff. The message from the carers met in this study was that day care services should not only provide caregivers with respite, but should simultaneously address the needs and wishes of the users themselves. There was a perception that new developments/

pilot schemes were always in the same (urban) areas and that other places were always neglected, and that the difficulties of travel in such a large rural area precluded many people having access to such services. One carer spoke of the stress of getting her husband up in time for the day care transport for example, whilst another carer would have preferred her husband to attend the day care centre only in the morning, but felt that in view of the significant time it took to get there, this was not a practical option.

The existence of a critical mass of service users is perhaps the real issue here and there would seem to be no one simple solution. As described in Chapter 1, the services developed to address such problems in other rural areas have taken a number of forms, and any one or number of these might be considered in North Cumbria. Thus whilst ‘traditional’ models of specialist day care may well be considered to be the best way of meeting the needs of people living in the more populated areas of the region, some combination of travelling day care or home-from-home services might be more appropriate in the country, whilst another option is to attach small specialist day care units to larger generic day care centres. Whatever the way forward chosen however, there will undoubtedly be a need for specialist mental health staff to provide ongoing support to such facilities, and for the development of funding arrangements that are able to support more flexible services.

Respite and Extra Care Housing

Two other services that might be considered for development in any future re-configuration are the provision of respite and the supply of supported accommodation. As was reported in Chapter 6, the expansion of current respite provision was prioritised by GPs, social services staff and users and carers, whilst the potential benefits of a greater supply of very sheltered housing were highlighted in Chapter 5 where such support was viewed as critical if is hoped to maintain a greater number of the care home case types within the community than was considered in the core analysis.

Although the literature would suggest that evidence for the effectiveness and cost-effectiveness of short-term breaks for older people with mental health problems is limited, a recently published report by Arksey et al. (2004) has cautioned against taking the lack of evidence of effectiveness as evidence of ineffectiveness and this is certainly a particularly complex area to research. Whilst we similarly know very little about the outcomes or costs of living in the various models of extra care housing, it is clear that the critical components of such services are liked by both providers and residents, and that such schemes would appear to offer an alternative for some residential care. The development of such models of housing with care is championed in the recent Green Paper *Independence, Wellbeing and Choice* (DoH, 2005).

THE DEVELOPMENT OF A STRATEGY TO SUPPORT CARERS

Another striking finding within this report was the very high proportion of older people entering institution-based care, particularly care home accommodation, where carer stress was said to be a contributing factor. As was noted in Chapter 4, whether or not they lived alone, the vast majority of the people in both the care home and inpatient cohorts had a significant informal carer. Indeed, all but one of the 17 most prevalent case types of people admitted to care homes had such support, as did 11 of the 13 most prevalent case types of people admitted to hospital. This was most typically one of their children in the case of the care home entrants, and their spouse in the case of the inpatient sample. The presence of informal carers was also a feature of the case types on which the balance of care estimates were based, with three of the four care home case types and two of the three inpatient ones noted to have significant informal carers. This would suggest that within any future arrangements attention must be paid to the development of effective strategies to provide more support for carers, something they themselves saw as a priority.

As observed in Chapter 2, the views of the users, carers and their advocates met in the course of this study cannot be taken to be representative of the experience of all people caring for older people with mental health problems in North Cumbria, but they do offer a feel for the issues which are perceived as salient. Their reflections on the way in which future home and day care services might be configured were thus seen as an important part of the discussion above. It is however suggested that if their views are to carry proportionate weight in future local planning exercises, more information will be needed about what a representative sample of this population want.

In the meantime, there are a number of bodies in both the public and voluntary sectors which are well placed to offer carers more support. As was discussed in Chapter 1, since the implementation of The Carers' (Recognition and Services) Act (1995) local authorities have been required to offer carers an assessment of their needs separate from those of the service users they assist. The focus of such assessments should be the carer's situation and the sustainability of their caring role, and it is again important that any assessment prioritise the level of carers' need rather than particular tasks regardless of level of need. Thus the elderly carer of a person with dementia may be willing to help them with their personal care, but need assistance with the garden. That helping carers was one of the best ways of helping the people they care for was subsequently emphasised in the *National Carers Strategy* (DoH, 1999), whilst the guidance accompanying the later Carers and Disabled Children Act (2000) noted that care managers can legitimately offer carers any council resources that will support them in their caring role or help maintain their health and wellbeing (DoH, 2003). The value of focusing on the specific problems experienced by carers was also highlighted within the literature review in Chapter 1. The two key messages here were that the best evidence of effectiveness, at least for the carers of people with dementia, is provided by individually tailored (as opposed to group) interventions that include problem-solving and/or behaviour management techniques and that the longer problems are left unaddressed, the more intractable they become. The timing of any support is thus critical.

THE PROVISION OF SPECIALIST MENTAL HEALTH SUPPORT FOR GENERIC SERVICES

Whilst much of the above discussion has focused on the needs of those service users who have more severe or complex needs, the vast majority of older people with mental health problems are cared for by their general practitioner and do not come into contact with the specialist mental health services. In the same way, many older people with mental health problems successfully utilise generic community services, live in non-specialist care homes or are cared for in general hospitals.

The importance of the role played by universal or generic services is a key theme of the recent social care Green Paper which sees such support as enabling people to remain integrated within their own communities, preventing isolation and maintaining independence whilst simultaneously enabling specialist services to focus on those people whose specific needs cannot be met in this way (DoH, 2005). It is however recognised that the professionals and staff whose responsibilities include providing care and treatment for older people with mental health problems in such settings will need support from the specialist mental health services (DoH, 2001a). This will include staff in primary care and general hospitals as well as all those formal carers whose work regularly places them in contact with older people.

Support for Primary Care

Although the vast majority of GPs surveyed in this study were positive about the specialist mental health services' response to their referral of individual clients, only a relatively small proportion said that the same services provided general support and training for primary care, a situation acknowledged by staff within the mental health trust as seen in Chapter 6. There was also some ambiguity about who should take the lead in caring for certain types of older people with mental health problems, including those with early signs of dementia.

The expectation of the NSFOP (DoH, 2001a) was that by April 2004 all GP practices would have agreed local protocols for the diagnosis, treatment and care of patients with depression or dementia, and that over time such protocols should be extended to cover all mental health problems in older people. In the light of the comments above, it is suggested that these protocols need to pay special attention to arrangements for the identification and management of older people with dementia in North Cumbria, the relatively recent introduction of antidementia drugs and the development of psychosocial interventions for people in the early stages of this illness making it particularly important that these groups receive specialist input at an early opportunity. However, whilst the formulation of such protocols is seen as a necessary step towards the integrated delivery of services for older people, it is a more difficult task to ensure their regular use in practice. If, as advocated by the Department of Health (2001a), the mental health service also provide training for primary care staff in the use of standardised screening tools, the assessment of suicide risk and the more general care of older people with mental health problems, there should be regular opportunity to reinforce the use of such protocols, but it is likely that the trust will need to make special efforts with those GPs who make few referrals. The identification of these practices will require that the mental health service monitor its referral patterns across the patch (Audit Commission, 2000).

Support for Social Services

Although the NSFOP (DoH, 2001a) places particular emphasis on the support that general practitioners need to manage older people with mental health problems in primary care, it is suggested that the social service department's need for such support is just as great. As was detailed in Chapter 4, it is estimated that approximately 45 per cent of the older people on the caseloads of the social services older people's teams who live in their own homes have mental health problems, and it is important that staff are able to recognise these, to provide appropriate care for those clients whose needs do not warrant the input of the specialist mental heath service and to seek specialist help when indicated. Less than one in four of the social services staff surveyed felt that the specialist mental health service currently provided them with the education and training that would be necessary to make this happen however, and such input will be needed by staff across the local authority.

Attention should also be paid to fostering the broader links between the specialist mental health service and the local authority social services department. This will be essential to the development of the integrated service provision needed by older people with mental health problems, the majority of whom will continue to be cared for by generic services. It might, for example, be considered appropriate to develop a shared operational policy incorporating some explicit standards relating to key areas of practice such as referral response times, such standards providing a framework to monitor and review the interface between the two services. There should also be the opportunity for staff from the specialist mental health service to make joint visits with social services staff to assess clients, whilst, in terms of service development, it will be important that there is a continuing dialogue concerning the growth of services which will support older people at home and prevent inappropriate care home admissions.

Support for Residential Services

As was seen in Chapter 4, the majority of older people with mental health problems admitted to care homes in North Cumbria enter a non-specialist facility. Indeed, nationwide, there is good evidence to suggest that an increasing proportion of the residents of non-specialist residential and nursing homes have mental illness. In recognition of this, the NSFOP (DoH, 2001a) states that specialist mental health services will need to provide advice and support for the staff working in such facilities and the North Cumbria Mental Health and Learning Disabilities Trust have developed a very successful Care Home Education and Support Service (CHESS). At the time this study was undertaken, this was not available throughout the whole trust. However, it is understood that there are plans to commission this as an integral part of the CMHT service. The literature would suggest that such input has a greater and more lasting impact when more staff time is made available for this purpose, and that training programmes have more effect when accompanied by ongoing staff support and the provision of resident specific advice/interventions.

Support for General Hospital Inpatient Services

As detailed in Chapter 1, the prevalence of mental health problems in older people admitted to general hospital beds is also high and staff in general hospitals detect only a small proportion of this disorder. Even when mental health problems are identified, patients do not necessarily get appropriate care and treatment and studies have found that older people with psychiatric co-morbidity have a greater length of stay in hospital, use more resources and have a higher mortality rate than those without. It is thus not surprising that there is much demand for specialist mental health input to general hospital patients, and that, as noted in Chapter 4, approaching one in five of the mental health inpatients in this study were transferred from elsewhere in the hospital system. However, although there is a small and growing body of evidence to suggest that specialist mental health support can improve the psychiatric outcomes of general hospital patients, very little is known about the relative effectiveness of different service models.

It is understood that the proposal in North Cumbria is that there should be a shared care unit within each of the two acute general hospitals in the region, these primarily managed by physicians, but with dedicated input from the mental health service. It might be anticipated that the majority of patients cared for in such a unit would have some combination of dementia/delirium. However, given the make-up of those care home entrants discharged from general hospitals considered in the balance of care analysis in Chapter 5, this study would suggest that attention should also be given to how those hospital inpatients with low mood will be identified and cared for. These case types were not usually cognitively impaired, but rather presented with a combination of characteristics suggestive of depression, including disturbed sleep and agitation.

The lesson for care managers and other professional colleagues here is the importance of making major decisions about people’s futures only when it is clear that the person’s health and functioning is at its optimum and suggests that placement in residential care should ideally occur only after the full potential for mental health treatment has been explored. Furthermore, where care home placement is effected, it should not be a once and for all decision, but should enable a process of review and reassessment.

INFORMATION REQUIREMENTS

The last of the six building blocks needed to support any changes in the balance of care is the development of an information network which can support both service planning and front line staff. The essence of this study was the provision of data to assist local commissioners determine the mix of community and institution-based resources needed to care for older people with mental health problems in North Cumbria. The information required encompassed data about local demographics, activity levels, costs and resources, the study asking who gets what, at what cost and with what outcome? Most of this information is not currently routinely generated, hence the need for a special study, and, as noted in Chapter 2, its collection was a complex and often time-consuming process. That the social services department make no clear organisational separation between older people with mental health problems and other older people added greatly to the difficulties. This situation needs to be redressed, and in order to plan and evaluate changes in the balance of care, systematic information about activity levels, expenditure and any service gaps will need to be produced on a regular basis. More detailed information about the quality of service provision would also help strategic planners, this necessarily involving regular consultation with users and carers, whilst other useful indicators include GPs' views of services (Audit Commission, 2000).

There is also a need to improve the amount and quality of the clinical and cost information available to front line staff. The current existence of multiple case notes and the lack of a formal strategy for information sharing between agencies means that staff frequently lack access to all the information they need, a problem exacerbated by the large rural area and instances of poor quality notes. However, effective information sharing between health and social care practitioners is a prerequisite to successful co-ordination and joint working and the single assessment process will be weakened without it (Audit Commission, 2002). The intention of local agencies to invest in a range of electronic information systems, and to use existing systems more effectively is thus supported, such measures also having the potential to reduce the currently considerable amount of time that front line practitioners spend on paperwork and administration as documented in Chapter 7. These systems will need to be consistently available throughout the area and any initiative will need to take account of the National Programme for Information Technology.

END NOTE

This has been an interesting study with which to be involved. It is one of the few pieces of work known to the study team which takes an evidence-based, whole-systems approach to explore the balance of care needed by older people with mental health problems within a defined geographical area. It is hoped that local commissioners, in consultation with key local stakeholders, will be able to use the data presented to inform decisions about the mix of services needed by older people with mental health problems in North Cumbria. However, we are certain that the findings will also have a wider resonance for the provision of health and social services nationwide.

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APPENDICES

APPENDIX A1
MENTAL HEALTH INPATIENTS: DATA COLLECTION PROFORMA

For any queries / further information please contact Sue Tucker
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SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS: THE BALANCE OF CARE IN CUMBRIA

CLIENTS ENTERING SPECIALIST MENTAL HEALTH IN-PATIENT CARE

This strand of the study is concerned with identifying the characteristics of people who are felt to need admission to acute in-patient care. As far as is possible, please complete the form to reflect the situation / abilities of the client at the point at which hospital admission was arranged.

Hospital Ward:
Windermere ☐1
Oakwood ☐2
Pennine Unit ☐3

Date of admission [*dd/mm/yyyy*]**:** ☐☐ / ☐☐ / ☐☐☐☐

Please indicate if any of the following sources were consulted in completing this form:
Nursing notes ☐1
Medical notes ☐2
Other ward based staff ☐3
Medical staff ☐4
Community mental health team ☐5
Social Services staff ☐6
General hospital staff ☐7
Residential / nursing home staff ☐8

Study case number: ☐☐☐☐
PSSRU use only

Client D.o.B. *[dd/mm/yyyy]* ☐☐ / ☐☐ / ☐☐☐☐

Gender male ☐1 female ☐2

Ethnic Origin European-caucasian ☐1 other *please specify:* …..………………………. ☐8

Marital Status
single ☐1
married ☐2
widowed ☐3
divorced or separated ☐4

Usual Place of Residence		**Residence Immediately Prior to Admission**	
home alone	☐1	home alone	☐1
home with other adult[s]	☐2	home with other adult[s]	☐2
residential/nursing home	☐3	residential/nursing home	☐3
NHS mental health ward	☐4	NHS mental health ward	☐4
other NHS ward	☐5	other NHS ward	☐5
other	☐8	other	☐8

Community Support Package Usually Received

• help with personal care	N/A in care home ☐9	yes ☐1	*number days/week:* ☐	no ☐0
• help with meals/m.o.w.	N/A in care home ☐9	yes ☐1	*number days/week*: ☐	no ☐0
• domestic help/ shopping	N/A in care home ☐9	yes ☐1	*number days/week:* ☐	no ☐0
• Crossroads / carer relief	N/A in care home ☐9	yes ☐1	*number days/week:* ☐	no ☐0
• total no. of hours home care per week [personal care, help with meals, domestic help, carer relief etc]: ☐☐				
• day care	N/A in care home ☐9	yes ☐1	*number days/week:* ☐	no ☐0
• respite [including voucher scheme]	N/A in care home ☐9	yes ☐1		no ☐0
• district nurse input		yes ☐1	*number days/week:* ☐	no ☐0

Specialist Community Mental Health Service Input Received

- attendance at day hospital yes ☐1 *please specify number of days per week:* ……..…….. no ☐0
- contact with CPN weekly ☐1 fortnightly ☐2 monthly ☐3 less than monthly ☐4 no ☐0
- other *please specify:* ………..…………………………………………………………………..
- and within the **past year**, assessment/review by consultant/medical staff yes ☐1 no ☐0

NHS In-Patient Care Received in the Past 12 Months

- specialist mental health in-patient admission yes ☐1 no ☐0
- other NHS in-patient admission yes ☐1 no ☐0

Presence of Significant Informal Carer yes ☐1 no ☐0

<u>If yes</u>: Relationship of Informal Carer to Client:
spouse ☐1
sibling ☐2
child ☐3
other *please specify:*…..…………………..………. ☐8

<u>If yes</u>: Usual Residence of Informal Carer: with client ☐1 separate from client ☐0

DAILY FUNCTIONING *For **each item 1-14**, please tick the level that **most closely** describes the client's level of functioning **in the last month***

1. Feeding
☐0 unable / totally dependent
☐1 needs extensive practical help
☐2 needs limited practical assistance
☐3 needs supervision [prompting or infrequent practical help]
☐4 independent

2. Bathing/Showering
☐0 needs help
☐1 independent [including in and out]

3. Grooming
☐0 needs help with personal care: face, hair, teeth, shaving
☐1 independent [implements provided]

4. Dressing
☐0 dependent
☐1 needs help, but can do about half
☐2 independent, including shoes, zips etc

5. Bed/chair transfer
☐0 unable – no sitting balance or needs lifting
☐1 major help – 1 or 2 people, can sit
☐2 minor help [verbal or physical]
☐3 independent

6. Mobility on level surfaces
☐0 immobile
☐1 wheelchair independent
☐2 walks with help of 1 person [verbal or physical]
☐3 independent

7. Stairs
☐0 unable
☐1 needs help [physical/verbal/carrying aid]
☐2 independent up and down

8. Bowels
☐0 incontinent or needs to be given enemas
☐1 occasional accidents [≤once a week]
☐2 continent

9. Bladder
☐0 incontinent or needs help with catheter
☐1 occasional accidents [≤ once daily]
☐2 continent or manages catheter alone

10. Use of Toilet
☐0 dependent
☐1 needs some, but not total, help
☐2 independent [on & off, wiping, dressing]

11. Short-term memory
☐0 impaired
☐1 not impaired [recall after 5 mins okay]

12. Decision making
☐0 severely impaired [rarely makes decisions]
☐1 moderately impaired [cues/supervision needed]
☐2 some problems [difficulty in new situations]
☐3 independent [decisions reasonable/ consistent]

13. Communication
☐0 rarely or never understood
☐1 sometimes understood [limited ability but can express basic needs]
☐2 usually understood [occasional word finding difficulties or need for prompts]
☐3 understood

14. Mood
☐0 often appears sad or depressed
☐1 doesn't usually appear sad or depressed

15. Behaviour *Please indicate how often the client has displayed **each** of the following behaviours **in the last month**:*

	not at all	less than weekly	more than weekly but not daily	at least daily
wandering				
aggression				
agitation				
delusions/ hallucinations/ paranoia				
disturbed sleep				

ADMISSION TO CARE

Reasons for admission: *please note **all** that apply*

at unacceptable risk of deliberate self-harm in usual/ previous environment ☐ 1
at unacceptable risk of accidental self-harm [including falls] in usual/ previous environment ☐ 2
at unacceptable risk of harming others in usual/previous environment ☐ 3
at unacceptable risk of self-neglect in usual/previous environment ☐ 4
for management of behavioural disturbance ☐ 5
for general diagnostic assessment ☐ 6
for treatment ☐ 7
for planned respite ☐ 8
carer stress ☐ 9
other breakdown of home situation / care arrangements ☐ 10
concerns about current medication ☐ 11
for assessment of future care needs ☐ 12

Broad diagnostic category:

organic illness ☐ 1
functional illness [non-psychotic] ☐ 2
functional illness [psychotic] ☐ 3

Formal Psychiatric Diagnosis [if applicable / known]: **……………………………………………...**

MANY THANKS FOR YOUR ASSISTANCE

APPENDIX A2
CARE HOME ADMISSIONS: DATA COLLECTION PROFORMA

For any queries / further information please contact Sue Tucker
Telephone: 0161 275 5938 or e-mail sue.tucker@man.ac.uk

SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS: THE BALANCE OF CARE IN CUMBRIA

CLIENTS ENTERING RESIDENTIAL OR NURSING HOME CARE

Agency of Care Co-ordinator:
Health ☐1
Social Services ☐2

Base of Care Co-ordinator :
Carlisle ☐1
Penrith ☐2
Whitehaven ☐3
Workington ☐4

Client CRMS Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Study case number: ☐☐☐☐
PSSRU use only

Client D.o.B. *[dd/mm/yyyy]* ☐☐ / ☐☐ / ☐☐☐☐

Gender male ☐1 female ☐2

Ethnic Origin European-caucasian ☐1 other *please specify:* ……… ……….. ☐8

Marital Status
single ☐1
married ☐2
widowed ☐3
divorced or separated ☐4

Usual Place of Residence	**Residence Immediately Prior to Admission**
home alone ☐1	home alone ☐1
home with other adult[s] ☐2	home with other adult[s] ☐2
residential home ☐3	residential home ☐3
nursing home ☐4	nursing home ☐4
NHS hospital care ☐5	NHS hospital care ☐5
other ☐8	other ☐8

Community Support Package Usually Received

- help with personal care N/A in care home ☐9 yes ☐1 *number days/week:* ☐ no ☐0
- help with meals/m.o.w. N/A in care home ☐9 yes ☐1 *number days/week*: ☐ no ☐0
- domestic help/ shopping N/A in care home ☐9 yes ☐1 *number days/week:* ☐ no ☐0
- Crossroads / carer relief N/A in care home ☐9 yes ☐1 *number days/week:* ☐ no ☐0
- total no. of hours home care per week [personal care, help with meals, domestic help, carer relief etc]: ☐☐
- day care N/A in care home ☐9 yes ☐1 *number days/week:* ☐ no ☐0
- respite [including voucher scheme] N/A in care home ☐9 yes ☐1 no ☐0
- district nurse input yes ☐1 *number days/week:* ☐ no ☐0

Specialist Community Mental Health Service Input Currently Received

- attendance at day hospital yes ☐1 *please specify number of days per week:* ☐ no ☐0
- contact with CPN weekly ☐1 fortnightly ☐2 monthly ☐3 less than monthly ☐4 no ☐0
- other *please specify:* ……………………………………………………………………………………
- and within the **past year**, assessment/review by consultant/medical staff yes ☐1 no ☐0

NHS In-Patient Care Received in the Past 12 Months

- specialist mental health in-patient admission yes ☐1 no ☐0
- other NHS in-patient admission yes ☐1 no ☐0

Presence of Significant Informal Carer yes ☐1 no ☐0

<u>If yes</u>: Relationship of Informal Carer to Client:
spouse ☐1
sibling ☐2
child ☐3
other *please specify:*…………………………………… ☐8

<u>If yes</u>: Usual Residence of Informal Carer: with client ☐1 separate from client ☐0

DAILY FUNCTIONING

*For **each** item 1-14, please tick the level that **most closely** describes the client's level of functioning*

1. **Feeding**
   ☐0 unable / totally dependent
   ☐1 needs extensive practical help
   ☐2 needs limited practical assistance
   ☐3 needs supervision [prompting or infrequent practical help]
   ☐4 independent

2. **Bathing/Showering**
   ☐0 needs help
   ☐1 independent [including in and out]

3. **Grooming**
   ☐0 needs help with personal care: face, hair, teeth, shaving
   ☐1 independent [implements provided]

4. **Dressing**
   ☐0 dependent
   ☐1 needs help, but can do about half
   ☐2 independent, including shoes, zips etc

5. **Bed/chair transfer**
   ☐0 unable – no sitting balance / needs lifting
   ☐1 major help – 1 or 2 people, can sit
   ☐2 minor help [verbal or physical]
   ☐3 independent

6. **Mobility on level surfaces**
   ☐0 immobile
   ☐1 wheelchair independent
   ☐2 walks with help of 1 person [verbal or physical]
   ☐3 independent

7. **Stairs**
   ☐0 unable
   ☐1 needs help [physical/verbal/carrying aid]
   ☐2 independent up and down

8. **Bowels**
   ☐0 incontinent / needs to be given enemas
   ☐1 occasional accidents [≤once a week]
   ☐2 continent

9. **Bladder**
   ☐0 incontinent / needs help with catheter
   ☐1 occasional accidents [≤ once daily]
   ☐2 continent / manages catheter alone

10. **Use of Toilet**
    ☐0 dependent
    ☐1 needs some, but not total, help
    ☐2 independent [on & off, wiping, dressing]

11. **Short-term memory**
    ☐0 impaired
    ☐1 not impaired [recall after 5 mins okay]

12. **Decision making**
    ☐0 severely impaired [rarely makes decisions]
    ☐1 moderately impaired [cues/supervision needed]
    ☐2 some problems [difficulty in new situations]
    ☐3 independent [decisions reasonable/ consistent]

13. **Communication**
    ☐0 rarely/never understood
    ☐1 sometimes understood [limited ability but can express basic needs]
    ☐2 usually understood [occasional word finding difficulties or need for prompts]
    ☐3 understood

14. **Mood**
    ☐0 often appears sad or depressed
    ☐1 doesn't usually appear sad or depressed

15. **Behaviour** *Please indicate how often the client has displayed **each** of the following behaviours **in the last month**:*

	not at all	less than weekly	more than weekly but not daily	at least daily
wandering				
aggression				
agitation				
delusions/ hallucinations/ paranoia				
disturbed sleep				

ADMISSION TO CARE

Type of home admitted to:

specialist mental health nursing home ☐ 1
other nursing home ☐ 2
specialist mental health residential home / unit ☐ 3
other residential home ☐ 4

Reasons for admission:
Please note ***all*** *that apply*

physical health problems ☐ 1
mental health problems ☐ 2
inability to perform activities of living ☐ 3
need for rehabilitation ☐ 4
at unacceptable risk of deliberate self-harm in usual place of residence ☐ 5
at unacceptable risk of accidental self-harm in usual place of residence ☐ 6
at unacceptable risk of falls in usual place of residence ☐ 7
at unacceptable risk of harming others in usual place of residence ☐ 8
at unacceptable risk of self-neglect in usual place of residence ☐ 9
at unacceptable risk of abuse/exploitation in usual place of residence ☐ 10
presenting with disruptive behaviours unmanageable in the usual place of residence ☐ 11
carer stress ☐ 12
other breakdown of care in usual place of residence ☐ 13
lack of motivation to care for self in usual place of residence ☐ 14
client's desire to move into chosen accommodation ☐ 15
usual place of residence physically unsuitable ☐ 16
homelessness ☐ 17
loneliness/isolation ☐ 18
anxiety/fear e.g. of falls/ a break in ☐ 19
joining spouse or partner ☐ 20
a recent catastrophic event e.g an acute illness / bereavement / burglary ☐ 21
other *please specify:*.. ☐ 88

Formal Psychiatric Diagnosis [if applicable / known]: ....

MANY THANKS FOR YOUR ASSISTANCE

APPENDIX A3
SOCIAL SERVICES COMMUNITY CLIENTS: DATA COLLECTION PROFORMA

For any queries/further information please contact Sue Tucker tel. 0161 275 5938; e-mail sue.tucker@man.ac.uk

Services for Older People with Mental Health Problems – Community Survey

*Please describe how the client has presented **in the last month** by ticking the appropriate box[es]*

Team: ……………………………………………..

Job Title: ………………………………………

Client Case No.: ☐☐☐☐☐☐☐☐☐☐☐☐

Client Gender: ☐1 male ☐2 female
Client D.o.B: ☐☐ / ☐☐ / ☐☐☐☐
Ethnicity: ☐1 European-Caucasian ☐8 other

Marital Status
☐1 single ☐2 married
☐3 widowed ☐4 divorced/separated

Usual Place of Residence
☐1 home alone ☐2 home with other adult[s]
☐8 other *please specify:* ………………………

Presence of Significant Informal Carer
☐1 yes ☐2 no

Community Support *Please note all that apply*
☐1 personal care [number of days/week: ☐]
☐2 meals/m.o.w. [number of days/week: ☐]
☐3 help with domestic tasks / shopping
☐4 Crossroads / carer relief

Total number of hours care per week from items 1-4 immediately above ☐☐

☐5 day care [number of days/week: ☐]
☐6 respite care [including voucher scheme]
☐7 district nurse input [number days/week: ☐]
☐8 social worker / review officer input

Specialist Mental Health Input
Please note all that apply
☐1 assessment/review by consultant in last year
☐2 day hospital [number of days/week ☐]
☐3 contact with CPN [frequency: ……………...]
☐4 contact with support worker [freq: …………..]
☐5 contact with community OT in last 6/12
☐6 in-patient mental health care in last year

Mood
☐0 often appears sad or depressed
☐1 doesn't usually appear sad or depressed

Short-term Memory
☐0 impaired
☐1 not impaired [recall after 5 mins okay]

Daily Functioning *Please indicate **the degree of help** the client needs with **each** of the following activities*

	none	limited	major	total
feeding				
bathing/showering				
hair/teeth/shave				
dressing				
bed/chair transfer				
mobility on the level				
stairs				
use of toilet				

Continence [bladder]
☐0 incontinent
☐1 some incontinence
☐2 continent

Continence [bowels]
☐0 incontinent
☐1 some incontinence
☐2 continent

Communication
☐0 rarely/never understood
☐1 sometimes understood [limited ability but can express basic needs]
☐2 usually understood [occasional word finding difficulties or need for prompts]
☐3 understood

Decision Making
☐0 severely impaired [rarely makes decisions]
☐1 moderately impaired [cues/supervision needed]
☐2 some problems [difficulty in new situations]
☐3 independent [decisions reasonable/consistent]

Behaviour *Please indicate **how often** the client has displayed **each** of the following behaviours*

	not at all	less than weekly	more than weekly but not daily	at least daily
wandering				
aggression				
agitation				
delusions/hallucinations/ paranoia				
disturbed sleep				

Formal Psychiatric Diagnosis *[if applicable]*
……………………………………………………..

APPENDIX A4
COMMMUNITY MENTAL HEALTH TEAM CLIENTS: DATA COLLECTION PROFORMA

For any queries/further information please contact Sue Tucker tel. 0161 275 5938; e-mail sue.tucker@man.ac.uk

Services for Older People with Mental Health Problems – Community Survey

Please describe how the client has presented ***in the last month*** *by ticking the appropriate box[es]*

Team: ……………………………………………..

Job Title: ……………………………………….

Client Case No.: ☐☐☐☐☐☐☐☐☐☐☐☐

Client Gender: ☐1 male ☐2 female
Client D.o.B: ☐☐ / ☐☐ / ☐☐☐☐
Ethnicity: ☐1 European-Caucasian ☐8 other

Marital Status

☐1 single ☐2 married
☐3 widowed ☐4 divorced/separated

Usual Place of Residence

☐1 home alone ☐2 home with other adult[s]
☐3 residential/nursing home ☐8 other

Presence of Significant Informal Carer

☐1 yes ☐2 no

Community Support *Please note all that apply*

☐1 personal care [number of days/week: ☐]
☐2 meals/m.o.w. [number of days/week: ☐]
☐3 help with domestic tasks / shopping
☐4 Crossroads / carer relief

Total number of hours care per week from items 1-4 immediately above ☐☐

☐5 day care [number of days/week: ☐]
☐6 respite care [including voucher scheme]
☐7 district nurse input [number days/week: ☐]
☐8 social worker / review officer input

Specialist Mental Health Input

Please note all that apply

☐1 assessment/review by consultant in last year
☐2 day hospital [number of days/week ☐]
☐3 contact with CPN [frequency: ……………...]
☐4 contact with support worker [freq: ………….]
☐5 contact with community OT in last 6/12
☐6 in-patient mental health care in last year

Mood

☐0 often appears sad or depressed
☐1 doesn't usually appear sad or depressed

Short-term Memory

☐0 impaired
☐1 not impaired [recall after 5 mins okay]

Daily Functioning *Please indicate* ***the degree of help*** *the client needs with* ***each*** *of the following activities*

	none	limited	major	total
feeding				
bathing/showering				
hair/teeth/shave				
dressing				
bed/chair transfer				
mobility on the level				
stairs				
use of toilet				

Continence [bladder]

☐0 incontinent
☐1 some incontinence
☐2 continent

Continence [bowels]

☐0 incontinent
☐1 some incontinence
☐2 continent

Communication

☐0 rarely/never understood
☐1 sometimes understood [limited ability but can express basic needs]
☐2 usually understood [occasional word finding difficulties or need for prompts]
☐3 understood

Decision Making

☐0 severely impaired [rarely makes decisions]
☐1 moderately impaired [cues/supervision needed]
☐2 some problems [difficulty in new situations]
☐3 independent [decisions reasonable/consistent]

Behaviour *Please indicate* ***how often*** *the client has displayed* ***each*** *of the following behaviours*

	not at all	less than weekly	more than weekly but not daily	at least daily
wandering				
aggression				
agitation				
delusions/hallucinations/ paranoia				
disturbed sleep				

Formal Psychiatric Diagnosis *[if applicable]*

……………………………………………………..

APPENDIX A5

THE KEY ACTIVITIES OF CARING FOR OLDER PEOPLE: DATA COLLECTION PROFORMA

OP

PSSRU
Personal Social Services Research Unit

30 August 2005

Dear Colleague

SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS: THE BALANCE OF CARE IN CUMBRIA

Thank you for agreeing to participate in this study which is designed to inform the long-term re-configuration of services for older people with mental health problems in North Cumbria. The diary study is an integral part of the fieldwork phase and we anticipate that it will provide valuable information about the key activities associated with caring for this client population.

The format for the diary study has been developed by the PSSRU and has been used in previous studies of social services departments across the country. A similar format has also been used in a community mental health team for older people and by nursing staff working in a mental health day hospital. To date the feedback has been very encouraging, with agencies able to use the information collected to support the case for positive changes in working practice / increased resources and individual practitioners finding the process of categorising their daily activities a useful reflective exercise.

Your completion of the diary for a week would thus be much appreciated and a stamped addressed envelope is provided for its direct return to the PSSRU. All responses will of course be treated confidentially, and no individual will be identified in either feedback to the participants or in the final report.

General guidance notes will be found on the back of this document, whilst the diary record sheet and details of the activity types are on the inside pages. If you would like any further information however then please do not hesitate to contact Sue Tucker tel: 0161 275 5938 or e-mail sue.tucker@man.ac.uk.

With many thanks

Yours faithfully

Sue Tucker.

David Challis
Professor of Community Care

Sue Tucker
Research Fellow

ACTIVITY TYPES:

For each half hour block on the diary record sheet, please select the activity which best describes how you occupied your time and insert its code in the relevant slot.
If the activity was related to a care home resident, please also enter an asterisk e.g. 6*
If undertaking ASW duties please use only code 44.

Activities undertaken directly with the client, face to face:

1. Assessment interview [excluding specific financial assessment]
2. Financial assessment
3. Completion of forms [non-financial]
4. Completion of forms [financial, including benefits]
5. Discussion of care plan options
6. Review of needs and/or care plan
7. Providing counselling or support
8. Providing information or education
9. Providing psychological therapies
10. Monitoring mental health and/or the effects of medication
11. Assisting/overseeing the completion of activities of daily living
12. Accompanying the client [or client and carer] for appointments e.g hospital, day care

Activities undertaken directly with an informal carer, face to face:

13. Gathering information about client as part of the assessment process
14. Assessment of the carer's own needs and completion of relevant forms
15. Providing counselling or support
16. Providing information or education
17. Accompanying the carer for appointments e.g. viewing care homes

Activities undertaken directly with the client and/or informal carer by telephone:

18. Pre-assessment arrangements / information gathering
19. Assessment
20. Review of needs and/or care plan
21. Provision of support or information

Indirect but client / carer related activities:

22. Assessment – gathering information from health services staff
23. Assessment – gathering information from other agencies
24. Assessment – gathering information from records / colleagues
25. Assessment – completing documentation
26. Other client/carer related paperwork
27. Discussing case in supervision / clinical team meetings
28. Discussing case with front line care staff e.g home carers, care home staff
29. Arranging social care e.g. home care, respite, care home placement
30. Arranging health care e.g. nurse, GP or hospital input
31. Monitoring social care provision i.e. to ensure appropriate care
32. Monitoring health care provision i.e. to ensure appropriate care
33. Review of care plan / care provision in conjunction with other agencies / providers

Team / Service Work:

34. Administration and reading of departmental documents
35. Team meetings [non-clinical]
36. Service development
37. Training [as a participant]
38. Dealing with general telephone queries

Travel and Other:

39. Travel – directly client and/or carer related e.g home visits
40. Travel – indirectly client and/or carer related e.g. to meetings about client
41. Travel – other
42. Filing, faxing, photocopying etc
43. Lunch / breaks
44. ASW duties
45. Other, please write in

DIARY RECORD SHEET

Are you full-time ☐0 or part-time ☐1 ? Contracted number of hours per week: ………..…

Are you community-based ☐0 or hospital-based ☐1 ?

Are you employed by the NHS ☐0 or by Social Services ☐1 ?

Please state your job title: …….………………………………………………………..……

Which team[s] do you work in? Allerdale ☐1 Carlisle ☐2 Copeland ☐3 Eden ☐4

Week commencing Monday **……………………………………………………….………..**

Please see back page for general instructions on completion.

Time	**Mon**	**Tues**	**Wed**	**Thurs**	Fri	Sat	**Sun**
8.00							
8.30							
9.00							
9.30							
10.00							
10.30							
11.00							
11.30							
12.00							
12.30							
1.00							
1.30							
2.00							
2.30							
3.00							
3.30							
4.00							
4.30							
5.00							
5.30							
6.00							
6.30							
7.00							

DIARY STUDY – GUIDANCE FOR COMPLETION

1 Please complete this diary sheet anonymously.

2 Prior to the first day please familiarise yourself with the categorisation.

3 Select a task code number and insert it into the relevant time slot. For example, if completing attendance allowance claim forms with a client please insert code 4 into the corresponding half hour in which you did this.

4 Tasks relating to the care of a residential or nursing home resident should also be marked with an * e.g. the code for undertaking a face to face review with a client in a residential home would be 6*.

5 We do appreciate that life does not fit into neat half hour slots, so indicate the task which occupied most of each time period. If this is not possible please indicate the two tasks which most occupied you during this period.

6 For staff away from work during the week of the diary study, please complete it for the second week after your return. If you are away for part of the week please complete for those days the following week.

7 Complete the diary each day and if possible do this through the day [to leave it until later increases the likelihood of inaccurate information].

8 When you have completed it, please return the diary sheet in the envelope provided.

9 If you have any queries please telephone Sue Tucker 0161 275 5938

Please return this form in the stamped addressed envelope provided to:

Sue Tucker
Personal Social Services Research Unit / North West Dementia Centre
Dover Street Building
University of Manchester
Oxford Road
Manchester M13 9PL

Many thanks for your assistance

APPENDIX A6
STAKEHOLDER QUESTIONNAIRE: VERSION FOR GPS

PERSONAL SOCIAL SERVICES RESEARCH UNIT
NORTH WEST DEMENTIA CENTRE

SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS: THE BALANCE OF CARE IN CUMBRIA

This survey forms an important part of the evaluation of services for older people with mental health problems in North Cumbria currently being undertaken by the PSSRU at the University of Manchester. It has been designed to seek GPs' views on the present mix of services provided for older people with mental health problems and on their priorities for change and development. The information gathered will contribute to the long-term strategic planning of future services for this client group and this questionnaire thus offers a real opportunity for GPs to participate in an evidence-based whole systems approach to service development.

Please complete and return the questionnaire in the stamped-addressed envelope provided as soon as possible to:

Personal Social Services Research Unit / North West Dementia Centre
Dover Street Building
The University of Manchester
Oxford Road
Manchester
M13 9PL

Your assistance is much appreciated

1. Demographic Information

Please fill in the following details in the space provided.

Name of practice: ………………………………………………………………………………

Area covered: predominantly urban ☐0
predominantly rural ☐1
mixed rural / urban ☐2

Number of partners in practice: single handed ☐0
two or more partners ☐1

Number of patients on your practice list: ……………

Number of patients 65+ on your practice list: ……….

Estimated number of patients aged 65+ you personally refer to the mental health services each year: …………….

2. Mental Health Services for Older People - Content

Please indicate the extent to which each of the following services are available to older people with mental health problems registered with your practice by ticking the appropriate boxes:

	Fully available	Mostly available	Partly available	Not available
1. NHS in-patient beds for assessment/treatment				
2. NHS in-patient beds for rehabilitation				
3. NHS in-patient beds for continuing care				
4. NHS in-patient beds for respite				
5. NHS day hospital places for people with dementia				
6. NHS day hospital places for people with other mental illness				
7. Routine assessments by consultant psychiatrists				
8. Urgent assessments by consultant psychiatrists				
9. Community mental health team input for people at home				
10. Community mental health team input for care home residents				
11. Psychological therapies for older people with mental illness				
12. A memory clinic for people with potential dementia				
13. Anti-Alzheimer drugs for older people with dementia				
14. Specialist services for younger people with dementia				
15. Nursing home beds for older people with mental illness				
16. Residential home beds for older people with mental illness				
17. Non-NHS respite care for older people with mental illness				
18. Day care places for people with dementia				
19. Day care places for people with other mental illness				
20. Homecare services for older people				
21. Carer support services				

Of the services 1-21 listed above, which three do you feel would be the priority for development in any long-term service reconfiguration?

Priority 1: …………………………………………………………………………………………………..

Priority 2: …………………………………………………………………………………………………..

Priority 3: …………………………………………………………………………………………………..

3. Mental Health Services for Older People - Process

Please indicate the extent to which you agree with each of the following statements:

	Completely agree	Tend to agree	Tend to disagree	Completely disagree
The mental health service for older people responds promptly to routine referrals				
The mental health service for older people responds promptly to urgent referrals				
The mental health service for older people provides prompt feedback following assessments				
The mental health service for older people provides ongoing feedback about patients' care and treatment				
The mental health service for older people provides support and training for primary care staff				
The mental health service for older people has offered GPs guidance in the use of assessment scales				
The mental health service has agreed protocols with primary care for the identification and management of older people with mental illness				

4. Mental Health Services for Older People - Clients

Please indicate who you feel would usually be most appropriate to take the lead in caring for the following patients:

	GP/primary care	Specialist mental health service	'Shared care'
People with early signs of Alzheimer's disease			
People with early signs of vascular dementia			
People with moderate dementia where the carer is experiencing stress			
People with dementia who are experiencing delusions/hallucinations			
People with dementia who present with challenging behaviors			
People with recurrent mild depression			
People with symptoms of moderate depression post bereavement			
People with moderate depression who have not responded to first line treatment			
People with severe depression including loss of appetite, disturbed sleep and suicidal ideation			
People with a severe but stable mental illness such as schizophrenia			
People with a severe and unstable mental illness such as schizophrenia			

5. Mental Health Services for Older People - The Future

The following paired statements set out a number of options for the future delivery of mental health services. For each pair, please indicate your preference by ticking one of each pair of boxes.

- Consultant psychiatrists undertake most new assessments in people's homes ☐
- Consultant psychiatrists undertake most new assessments in out-patient clinics ☐

- Consultant psychiatrists undertake most follow-up assessments in people's homes ☐
- Consultant psychiatrists undertake most follow-up assessments in out-patient clinics ☐

- Community mental health staff are based in primary care ☐
- Community mental health staff are based in separate community teams ☐

- GPs refer directly to consultants and/or other staff ☐
- GPs refer to the mental health team who decide on the most appropriate person to undertake any assessment ☐

- More assessments and treatments are carried out at day hospitals ☐
- More assessments and treatments are undertaken within peoples' homes ☐

- The staffing for community mental health teams Mondays-Fridays 9am-5pm is increased ☐
- The community mental health team hours are developed to cover evenings and weekends ☐

- Specialist social workers become core members of community mental health teams ☐
- Community mental health nurses develop stronger links with existing social work teams ☐

- Residential home places for people with mental illness are increased ☐
- Specialist home care services for people with mental illness are developed ☐

- Community mental health teams develop the service they provide to care homes ☐
- In-patient services for people with challenging behaviors are expanded ☐

- The balance of care between hospital and community services remains largely unchanged ☐
- The balance of care between hospital and community services is weighted in favour of the community ☐

<u>Please use the space below for any additional comments you would like to make</u>

……...

……..

……

……..

……..

……..

……

……...

……..

……

THANK YOU AGAIN FOR YOUR ASSISTANCE

As above, please return this questionnaire in the stamped addressed envelope provided to:

Personal Social Services Research Unit / North West Dementia Centre
Dover Street Building
The University of Manchester
Oxford Road
Manchester
M13 9PL

APPENDIX A7

STAKEHOLDER QUESTIONNAIRE: VERSION FOR CONSULTANT PSYCHIATRISTS, COMMUNITY MENTAL HEALTH NURSES AND MENTAL HEALTH TRUST MANAGERS

SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS: THE BALANCE OF CARE IN CUMBRIA

STAKEHOLDER PERSPECTIVES

CONSULTANT PSYCHIATRISTS
COMMUNITY MENTAL HEALTH NURSES
MENTAL HEALTH TRUST MANAGERS

1. Mental Health Services for Older People - Content

Please indicate the extent to which you feel each of the following services are available to older people with mental health problems within your catchment area:

	Fully available	Mostly available	Partly available	Not available
1. NHS in-patient beds for assessment/treatment				
2. NHS in-patient beds for rehabilitation				
3. NHS in-patient beds for continuing care				
4. NHS in-patient beds for respite				
5. NHS day hospital places for people with dementia				
6. NHS day hospital places for people with other mental illness				
7. Routine assessments by consultant psychiatrists				
8. Urgent assessments by consultant psychiatrists				
9. Community mental health team input for people at home				
10. Community mental health team input for care home residents				
11. Psychological therapies for older people with mental illness				
12. A memory clinic for people with potential dementia				
13. Anti-Alzheimer drugs for older people with dementia				
14. Specialist services for younger people with dementia				
15. Nursing home beds for older people with mental illness				
16. Residential home beds for older people with mental illness				
17. Non-NHS respite care for older people with mental illness				
18. Day care places for people with dementia				
19. Day care places for people with other mental illness				
20. Homecare services for older people				
21. Carer support services				

**Of the services 1-21 listed above, which <u>three</u> do you feel would be the priority for development in any
long-term service reconfiguration?**

Priority 1: …………………

Priority 2: …………………

Priority 3: …………………

2. Mental Health Services for Older People - Process

Please indicate the extent to which you agree with each of the following statements:

	Completely agree	Tend to agree	Tend to disagree	Completely disagree
The mental health service for older people responds promptly to routine referrals				
The mental health service for older people responds promptly to urgent referrals				
The mental health service for older people provides prompt feedback following assessments				
The mental health service for older people provides ongoing feedback about patients' care and treatment				
The mental health service for older people provides support and training for primary care staff				
The mental health service for older people has offered GPs guidance in the use of assessment scales				
The mental health service has agreed protocols with primary care for the identification and management of older people with mental illness				

3. Mental Health Services for Older People - Clients

Please indicate who you feel would usually be most appropriate to take the lead in caring for the following patients:

	GP/primary care	Specialist mental health service	'Shared care'
People with early signs of Alzheimer's disease			
People with early signs of vascular dementia			
People with moderate dementia where the carer is experiencing stress			
People with dementia who are experiencing delusions/hallucinations			
People with dementia who present with challenging behaviours			
People with recurrent mild depression			
People with symptoms of moderate depression post bereavement			
People with moderate depression who have not responded to first line treatment			
People with severe depression including loss of appetite, disturbed sleep and suicidal ideation			
People with a severe but stable mental illness such as schizophrenia			
People with a severe and unstable mental illness such as schizophrenia			

4. Mental Health Services for Older People - The Future

The following paired statements set out a number of options for the future delivery of mental health services. For each pair, please indicate your preference by ticking one of each pair of boxes.

- Consultant psychiatrists undertake most new assessments in people's homes ☐
- Consultant psychiatrists undertake most new assessments in out-patient clinics ☐

- Consultant psychiatrists undertake most follow-up assessments in people's homes ☐
- Consultant psychiatrists undertake most follow-up assessments in out-patient clinics ☐

- Community mental health staff are based in primary care ☐
- Community mental health staff are based in separate community teams ☐
- GPs refer directly to consultants and/or other staff ☐
- GPs refer to the mental health team who decide on the most appropriate person to undertake any assessment ☐

- More assessments and treatments are carried out at day hospitals ☐
- More assessments and treatments are undertaken within peoples' homes ☐

- The staffing for community mental health teams Mondays-Fridays 9am-5pm is increased ☐
- The community mental health team hours are developed to cover evenings and weekends ☐

- Specialist social workers become core members of community mental health teams ☐
- Community mental health nurses develop stronger links with existing social work teams ☐

- Residential home places for people with mental illness are increased ☐
- Specialist home care services for people with mental illness are developed ☐

- Community mental health teams develop the service they provide to care homes ☐
- In-patient services for people with challenging behaviours are expanded ☐

- The balance of care between hospital and community services remains largely unchanged ☐
- The balance of care between hospital and community services is weighted in favour of the community ☐

APPENDIX A8
STAKEHOLDER QUESTIONNAIRE: VERSION FOR MENTAL HEALTH INPATIENT STAFF

SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS: THE BALANCE OF CARE IN CUMBRIA

STAKEHOLDER PERSPECTIVES
INPATIENT STAFF

1. Mental Health Services for Older People - Content

Please indicate the extent to which you feel each of the following services are available to older people with mental health problems within your locality:

	Fully available	Mostly available	Partly available	Not available
1. NHS in-patient beds for assessment/treatment				
2. NHS in-patient beds for rehabilitation				
3. NHS in-patient beds for continuing care				
4. NHS in-patient beds for respite				
5. NHS day hospital places for people with dementia				
6. NHS day hospital places for people with other mental illness				
7. Routine assessments by consultant psychiatrists				
8. Urgent assessments by consultant psychiatrists				
9. Community mental health team input for people at home				
10. Community mental health team input for care home residents				
11. Psychological therapies for older people with mental illness				
12. A memory clinic for people with potential dementia				
13. Anti-Alzheimer drugs for older people with dementia				
14. Specialist services for younger people with dementia				
15. Nursing home beds for older people with mental illness				
16. Residential home beds for older people with mental illness				
17. Non-NHS respite care for older people with mental illness				
18. Day care places for people with dementia				
19. Day care places for people with other mental illness				
20. Homecare services for older people				
21. Carer support services				

Of the services 1-21 listed above, which three do you feel would be the priority for development in any
long-term service reconfiguration?

Priority 1: ……………………

Priority 2: ……………………

Priority 3: …………………….

2. Mental Health Services for Older People - Clients

Please indicate who you feel would usually be most appropriate to take the lead in caring for the following patients:

	GP / primary care	Specialist mental health service	'Shared care'
People with early signs of Alzheimer's disease			
People with early signs of vascular dementia			
People with moderate dementia where the carer is experiencing stress			
People with dementia who are experiencing delusions/hallucinations			
People with dementia who present with challenging behaviours			
People with recurrent mild depression			
People with symptoms of moderate depression post bereavement			
People with moderate depression who have not responded to first line treatment			
People with severe depression including loss of appetite, disturbed sleep and suicidal ideation			
People with a severe but stable mental illness such as schizophrenia			
People with a severe and unstable mental illness such as schizophrenia			

3. Mental Health Services for Older People - The Future

The following paired statements set out a number of options for the future delivery of mental health services. For each pair, please indicate your preference by ticking one of each pair of boxes.

- Consultant psychiatrists undertake most new assessments in people's homes ☐
- Consultant psychiatrists undertake most new assessments in out-patient clinics ☐

- Consultant psychiatrists undertake most follow-up assessments in people's homes ☐
- Consultant psychiatrists undertake most follow-up assessments in out-patient clinics ☐

- Community mental health staff are based in primary care ☐
- Community mental health staff are based in separate community teams ☐
- GPs refer directly to consultants and/or other staff ☐
- GPs refer to the mental health team who decide on the most appropriate person to undertake any assessment ☐

- More assessments and treatments are carried out at day hospitals ☐
- More assessments and treatments are undertaken within peoples' homes ☐

- The staffing for community mental health teams Mondays-Fridays 9am-5pm is increased ☐
- The community mental health team hours are developed to cover evenings and weekends ☐

- Specialist social workers become core members of community mental health teams ☐
- Community mental health nurses develop stronger links with existing social work teams ☐

- Residential home places for people with mental illness are increased ☐
- Specialist home care services for people with mental illness are developed ☐

- Community mental health teams develop the service they provide to care homes ☐
- In-patient services for people with challenging behaviours are expanded ☐

- The balance of care between hospital and community services remains largely unchanged ☐
- The balance of care between hospital and community services is weighted in favour of the community ☐

APPENDIX A9
STAKEHOLDER QUESTIONNAIRE: VERSION FOR SOCIAL SERVICES STAFF

SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS: THE BALANCE OF CARE IN CUMBRIA

STAKEHOLDER PERSPECTIVES
SOCIAL WORKERS

1. Mental Health Services for Older People - Content

Please indicate the extent to which you feel each of the following services are available to older people with mental health problems within your locality:

	Fully available	Mostly available	Partly available	Not available
1. NHS in-patient beds for assessment/treatment				
2. NHS in-patient beds for rehabilitation				
3. NHS in-patient beds for continuing care				
4. NHS in-patient beds for respite				
5. NHS day hospital places for people with dementia				
6. NHS day hospital places for people with other mental illness				
7. Routine assessments by consultant psychiatrists				
8. Urgent assessments by consultant psychiatrists				
9. Community mental health team input for people at home				
10. Community mental health team input for care home residents				
11. Psychological therapies for older people with mental illness				
12. A memory clinic for people with potential dementia				
13. Anti-Alzheimer drugs for older people with dementia				
14. Specialist services for younger people with dementia				
15. Nursing home beds for older people with mental illness				
16. Residential home beds for older people with mental illness				
17. Non-NHS respite care for older people with mental illness				
18. Day care places for people with dementia				
19. Day care places for people with other mental illness				
20. Homecare services for older people				
21. Carer support services				

Of the services 1-21 listed above, which three do you feel would be the priority for development in any long-term service reconfiguration?

Priority 1: …………………

Priority 2: …………………

Priority 3: …………………

2. Mental Health Services for Older People - Process

Please indicate the extent to which you agree with each of the following statements:

	Completely agree	Tend to agree	Tend to disagree	Completely disagree
The mental health service for older people responds promptly to routine referrals				
The mental health service for older people responds promptly to urgent referrals				
The mental health service for older people provides prompt feedback following assessments				
The mental health service for older people provides ongoing feedback about patients' care and treatment				
The mental health service for older people provides support and training for social services staff				
The mental health service for older people has offered social services staff guidance in the use of assessment scales				
The mental health service have agreed protocols with social services for the identification and management of older people with mental illness				

3. Mental Health Services for Older People - The Future

The following paired statements set out a number of options for the future delivery of mental health services. For each pair, please indicate your preference by ticking one of each pair of boxes.

- Consultant psychiatrists undertake most new assessments in people's homes ☐
- Consultant psychiatrists undertake most new assessments in out-patient clinics ☐

- Consultant psychiatrists undertake most follow-up assessments in people's homes ☐
- Consultant psychiatrists undertake most follow-up assessments in out-patient clinics ☐

- Community mental health staff are based in primary care ☐
- Community mental health staff are based in separate community teams ☐

- GPs refer directly to consultants and/or other staff ☐
- GPs refer to the mental health team who decide on the most appropriate person to undertake any assessment ☐

- More assessments and treatments are carried out at day hospitals ☐
- More assessments and treatments are undertaken within peoples' homes ☐

- The staffing for community mental health teams Mondays-Fridays 9am-5pm is increased ☐
- The community mental health team hours are developed to cover evenings and weekends ☐

- Specialist social workers become core members of community mental health teams ☐
- Community mental health nurses develop stronger links with existing social work teams ☐

- Residential home places for people with mental illness are increased ☐
- Specialist home care services for people with mental illness are developed ☐

- Community mental health teams develop the service they provide to care homes ☐
- In-patient services for people with challenging behaviours are expanded ☐

- The balance of care between hospital and community services remains largely unchanged ☐
- The balance of care between hospital and community services is weighted in favour of the community ☐

APPENDIX A10

STAKEHOLDER QUESTIONNAIRE: VERSION FOR USERS, CARERS AND THEIR REPRESENTATIVES

SERVICES FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS: THE BALANCE OF CARE IN CUMBRIA

STAKEHOLDER PERSPECTIVES

USERS, CARERS AND THEIR REPRESENTATIVES

Mental Health Services for Older People - Services

Of the services 1-21 listed below, which three do you feel are the priority for any future development?

Priority 1: …………………

Priority 2: …………………

Priority 3: …………………

1. NHS in-patient beds for assessment/treatment
2. NHS in-patient beds for rehabilitation
3. NHS in-patient beds for continuing care
4. NHS in-patient beds for respite
5. NHS day hospital places for people with dementia
6. NHS day hospital places for people with other mental illness
7. Routine assessments by consultant psychiatrists
8. Urgent assessments by consultant psychiatrists
9. Community mental health team input for people at home
10. Community mental health team input for care home residents
11. Psychological therapies for older people with mental illness
12. A memory clinic for people with potential dementia
13. Anti-Alzheimer drugs for older people with dementia
14. Specialist services for younger people with dementia
15. Nursing home beds for older people with mental illness
16. Residential home beds for older people with mental illness
17. Non-NHS respite care for older people with mental illness
18. Day care places for people with dementia
19. Day care places for people with other mental illness
20. Homecare services for older people
21. Carer support services

Mental Health Services for Older People - The Future

The following paired statements set out a number of options for the future delivery of mental health services. For each pair, please indicate your preference by ticking one of each pair of boxes.

- Consultant psychiatrists undertake most new assessments in people's homes ☐
- Consultant psychiatrists undertake most new assessments in out-patient clinics ☐

- Consultant psychiatrists undertake most follow-up assessments in people's homes ☐
- Consultant psychiatrists undertake most follow-up assessments in out-patient clinics ☐

- Community mental health staff are based in GP surgeries ☐
- Community mental health staff are based in separate community teams ☐

- More assessments and treatments are carried out at day hospitals ☐
- More assessments and treatments are undertaken within peoples' homes ☐

- The staffing for community mental health teams Mondays-Fridays 9am-5pm is increased ☐
- The community mental health team hours are developed to cover evenings and weekends ☐

- Specialist social workers become core members of community mental health teams ☐
- Community mental health nurses develop stronger links with existing social work teams ☐

- Residential home places for people with mental illness are increased ☐
- Specialist home care services for people with mental illness are developed ☐

- Community mental health teams develop the service they provide to care homes ☐
- In-patient services for people with challenging behaviours are expanded ☐

- The balance of care between hospital and community services remains largely unchanged ☐
- The balance of care between hospital and community services is weighted in favour of the community ☐

APPENDIX A11

CHARACTERISING THE CARE HOME DATA: POSSIBLE CASE TYPES

Characterising the Care Home Data – Possible Case Types

Group	Source of Admission	Carer	Gender	Behaviours Carers Find Difficult to Cope With	Level of Dependency	No. in Group
1	Community	No	Female	No	Least	1
2	Community	No	Female	No	Medium	0
3	Community	No	Female	No	Most	4
4	Community	No	Female	Yes	Least	1
5	Community	No	Female	Yes	Medium	1
6	Community	No	Female	Yes	Most	3
7	Community	No	Male	No	Least	0
8	Community	No	Male	No	Medium	0
9	Community	No	Male	No	Most	2
10	Community	No	Male	Yes	Least	2
11	Community	No	Male	Yes	Medium	1
12	Community	No	Male	Yes	Most	0
13	Community	Yes	Female	No	Least	5
14	Community	Yes	Female	No	Medium	9
15	Community	Yes	Female	No	Most	5
16	Community	Yes	Female	Yes	Least	10
17	Community	Yes	Female	Yes	Medium	12
18	Community	Yes	Female	Yes	Most	8
19	Community	Yes	Male	No	Least	1
20	Community	Yes	Male	No	Medium	1
21	Community	Yes	Male	No	Most	4
22	Community	Yes	Male	Yes	Least	3
23	Community	Yes	Male	Yes	Medium	5
24	Community	Yes	Male	Yes	Most	3
25	Hospital	No	Female	No	Least	1
26	Hospital	No	Female	No	Medium	0
27	Hospital	No	Female	No	Most	0
28	Hospital	No	Female	Yes	Least	2
29	Hospital	No	Female	Yes	Medium	0
30	Hospital	No	Female	Yes	Most	2
31	Hospital	No	Male	No	Least	0
32	Hospital	No	Male	No	Medium	0
33	Hospital	No	Male	No	Most	1
34	Hospital	No	Male	Yes	Least	1
35	Hospital	No	Male	Yes	Medium	0
36	Hospital	No	Male	Yes	Most	2
37	Hospital	Yes	Female	No	Least	5
38	Hospital	Yes	Female	No	Medium	5
39	Hospital	Yes	Female	No	Most	5
40	Hospital	Yes	Female	Yes	Least	4
41	Hospital	Yes	Female	Yes	Medium	8
42	Hospital	Yes	Female	Yes	Most	5
43	Hospital	Yes	Male	No	Least	1
44	Hospital	Yes	Male	No	Medium	0
45	Hospital	Yes	Male	No	Most	3
46	Hospital	Yes	Male	Yes	Least	4
47	Hospital	Yes	Male	Yes	Medium	3
48	Hospital	Yes	Male	Yes	Most	6

APPENDIX A12

CHARACTERISING THE CARE HOME DATA: EXAMPLES OF CASE VIGNETTES

Group 13: Mrs C

Home situation / Location at time of referral:

Mrs C is an 84 year old widow who lives alone.

Further information relating to the current situation:

1. **Activities of daily living:** Although she is somewhat anxious about falling and cannot manage stairs, Mrs C is fully mobile on level surfaces. She has occasional ‘accidents’, both urinary and faecal, and needs help to wash, shower and dress, but will do what she can. She is not able to prepare a meal but can feed herself and generally sleeps well, there just occasional reports of disturbed nights.

2. **Mental health:** Mrs C has been diagnosed with Alzheimer’s disease, now moderate in degree. Her short-term memory is impaired and she needs cues/supervision to make decisions, but she is able to express herself and can understand what is said to her. She does not appear low in mood and there are no reports of any disturbed behaviour.

3. **Informal care:** Mrs C’s daughter is her main supporter, but she is finding the process of caring for her mother very stressful.

4. **Formal care:** Mrs C attends a day centre 5 days per week and receives 10.5 hours home care per week. This includes daily help with personal care and meals. She is well known to the specialist mental health services and a CPN currently visits weekly.

5. **Attitude to future care:** Mrs C is said to lack motivation to care for herself at home and is described as lonely and anxious. She would like to move into residential accommodation.

Assessment issues:

1. **Contributions to the assessment process:** Mrs C’s daughter, home and day care staff have been able to provide information about Mrs C’s current functioning. Her social worker also has a copy of a recent assessment by the consultant psychiatrist and was able to talk to ward staff at the DGH when Mrs C was an inpatient there last spring.

2. **Risk factors:** Mrs C’s social worker feels that she is at unacceptable risk of self-neglect and accidental self-harm in her current environment and has highlighted the possibility of others exploiting her vulnerability.

Summary:

Mrs C is moderately cognitively impaired and needs some assistance with activities of daily living. She dislikes being at home alone and lacks motivation to care for herself, whilst there is felt to be a certain degree of risk associated with current situation.

Group 18: Mrs H

Home situation / Location at time of referral:

Mrs H is a 92 year old lady who lives with her husband.

Further information relating to the current situation:

1. **Activities of daily living:** Mrs H has had a stroke and is now wheelchair dependent. She needs major help to transfer from bed to chair, and is completely unable to walk. She is mostly continent [having only occasional 'accidents'] but is totally dependent on others to take her to the toilet and to wash, bath and dress her. She sleeps poorly and needs extensive practical help at meal times.

2. **Mental health:** Mrs H has a diagnosis of vascular dementia and her ability to communicate is limited although she can usually express her basic needs. She has obvious short-term memory impairment and it is difficult for her to make decisions. Whilst she is not aggressive as such, she often becomes agitated when receiving personal care, and it is thought that she experiences hallucinations. She is particularly unsettled at night.

3. **Informal care:** Mrs H's next of kin is her husband, but he himself is elderly and is not able to provide the care she needs. He finds this situation very stressful.

4. **Formal care:** Mrs H has a home care package totalling seven hours a week. This includes daily help with personal care and the provision of meals. Crossroads provide some support one day a week and the district nurse also visits weekly. Although Mrs H has no regular input from the CMHT she has been assessed by a consultant psychiatrist.

5. **Attitude to future care:** Mrs H is largely unwilling to accept personal care within her own home and has expressed a positive preference for residential care.

Assessment issues:

1. **Contributions to the assessment process:** Mrs H is well known to her social worker and there is the recent assessment by the consultant psychiatrist. Her husband, home carers and the district nurses have been able to provide further information.

2. **Risk factors:** Mrs H is felt to be at unacceptable risk of self-neglect in her current environment and it is felt that she is a candidate for placement in a specialist mental health residential home.

Summary:

Mrs H needs major help with daily activities of living and is unsettled in the night. She is largely unwilling to accept care at home, but has expressed a positive preference for residential care. Her elderly husband is himself experiencing much stress.

Group 37: Mrs L

Home situation / Location at time of referral:

Mrs L is an 85 year old widow who usually lives at home alone but is currently an inpatient in the district general hospital.

Further information relating to the current situation:

1. **Activities of daily living:** Mrs L is continent and fully mobile but needs some assistance to wash, shower and dress. Ward staff report that she can feed herself and that she is settled at night.

2. **Mental health:** Mrs L has a good memory, is able to make considered decisions and can communicate clearly. She does however appear anxious and depressed and acknowledges feeling isolated and lonely. It is felt that she lacks the motivation to care for herself and there are reports that she has severely neglected her house, it known that she is fearful of burglars and never goes out.

3. **Informal care:** Mrs L's main supporter has been her granddaughter. She would now like to withdraw from this role however.

4. **Formal care:** Mrs L was not known to the social or mental health services prior to her current hospital admission and received no formal care services.

5. **Attitude to future care:** Mrs L is adamant that she can not return to her previous home but would consider residential care.

Assessment issues:

1. **Contributions to the assessment process:** Mrs L's health and abilities have been assessed during her hospital stay and she has had a full occupational therapy assessment. Most of the information about her previous functioning has come from her granddaughter.

2. **Risk factors:** Mrs L's social worker has not highlighted any particular risks associated with her returning home but notes that the situation as it stood has broken down and that Mrs L herself does not want to return home.

Summary: Mrs L is physically quite able, but appears anxious and depressed. She was admitted to hospital when her home situation broke down and now does not want to return.

Group 46: Mr V

Home situation / Location at time of referral:

Mr V is a 70 year old bachelor who usually lives alone but is currently an inpatient on the specialist mental health assessment ward at the district general hospital.

Further information relating to the current situation:

1. **Activities of daily living:** Mr V is continent, fully mobile and able to feed himself but needs some help to wash, bath and dress along with encouragement to eat. His general health is described as poor. Whilst he will sometimes sleep throughout the night, nursing staff report that he often wakes extremely early.

2. **Mental health:** Mr V is cognitively intact and is generally able to communicate clearly although he has some difficulty making decisions in new situations. Although he is not aggressive as such, he often appears agitated and has a diagnosis of depression.

3. **Informal care:** Mr V's main supporter is his brother who is finding this role very stressful.

4. **Formal care:** Mr V does not receive any formal support from social services but is well known to the specialist mental health service. Prior to his admission he was attending the day hospital twice a week and had a further weekly visit from a CPN.

5. **Attitude to future care:** Although Mr V has not expressed any desire to move into residential care it is felt that he lacks the motivation look after himself at home.

Assessment issues:

1. **Contributions to the assessment process:** Mr V's mental health has been fully assessed during his inpatient stay and his brother has been able to provide detailed information about his previous functioning at home

2. **Risk factors:** Mr V is considered to be at unacceptable risk of self-neglect at home, whilst there is also some real concern that he may harm himself.

Summary:

Mr V is in poor physical health and suffers with depression, lacking the motivation to care for himself at home. It is felt that his remaining there leaves him at some risk and that he is a candidate for placement in residential care.

APPENDIX A13
CHARACTERISING THE INPATIENT DATA: POSSIBLE CASE TYPES

Characterising the Inpatient Data – Possible Case Types

Group	Broad diagnosis	Carer	Predominant Risk / Concern	Assessment of future care needs	No. in Group
1	Organic	No	None of list	No	0
2	Organic	No	None of list	Yes	0
3	Organic	No	Risk deliberate self harm	No	0
4	Organic	No	Risk deliberate self harm	Yes	0
5	Organic	No	Disturbed behaviour	No	0
6	Organic	No	Disturbed behaviour	Yes	1
7	Organic	No	Risk accidental harm/neglect	No	2
8	Organic	No	Risk accidental harm/neglect	Yes	3
9	Organic	No	Disturbed sleep & agitation	No	0
10	Organic	No	Disturbed sleep & agitation	Yes	0
11	Organic	Yes	None of list	No	0
12	Organic	Yes	None of list	Yes	3
13	Organic	Yes	Risk deliberate self harm	No	0
14	Organic	Yes	Risk deliberate self harm	Yes	0
15	Organic	Yes	Disturbed behaviour	No	6
16	Organic	Yes	Disturbed behaviour	Yes	7
17	Organic	Yes	Risk accidental harm/neglect	No	3
18	Organic	Yes	Risk accidental harm/neglect	Yes	4
19	Organic	Yes	Disturbed sleep & agitation	No	0
20	Organic	Yes	Disturbed sleep & agitation	Yes	1
21	Functional	No	None of list	No	0
22	Functional	No	None of list	Yes	0
23	Functional	No	Risk deliberate self harm	No	2
24	Functional	No	Risk deliberate self harm	Yes	0
25	Functional	No	Disturbed behaviour	No	1
26	Functional	No	Disturbed behaviour	Yes	0
27	Functional	No	Risk accidental harm/neglect	No	3
28	Functional	No	Risk accidental harm/neglect	Yes	0
29	Functional	No	Disturbed sleep & agitation	No	0
30	Functional	No	Disturbed sleep & agitation	Yes	0
31	Functional	Yes	None of list	No	3
32	Functional	Yes	None of list	Yes	0
33	Functional	Yes	Risk deliberate self harm	No	8
34	Functional	Yes	Risk deliberate self harm	Yes	1
35	Functional	Yes	Disturbed behaviour	No	5
36	Functional	Yes	Disturbed behaviour	Yes	4
37	Functional	Yes	Risk accidental harm/neglect	No	4
38	Functional	Yes	Risk accidental harm/neglect	Yes	1
39	Functional	Yes	Disturbed sleep & agitation	No	5
40	Functional	Yes	Disturbed sleep & agitation	Yes	0

APPENDIX A14

CHARACTERISING THE INPATIENT DATA: EXAMPLES OF CASE VIGNETTES

Group 8: Mrs B

Home Situation: Mrs B is an 85 year old retired bookkeeper. She has been widowed more than 30 years and lives alone in a bungalow on the outskirts of town.

Mental Health: Mrs B first came to the attention of the specialist mental health services about two years ago when her GP queried whether she might have dementia giving a history of increasing forgetfulness. Consultant assessment suggested a diagnosis of Alzheimer's disease, but despite trials of two anti-Alzheimer medications her MMSE decreased from 18 to 10 over the course of a year and this medication was withdrawn. She has since been monitored by the CMHT, a CPN visiting 3-monthly.

In recent weeks Mrs B has become increasingly disorientated to time [the neighbours complaining that she knocks on their doors in the middle of the night] and on one occasion got lost whilst shopping in town. She is however still able to express herself, if experiencing some word-finding difficulties, and generally appears cheerful.

Activities of Daily Living: Mrs B is in good physical health and is continent and fully mobile. There has though been an obvious change in her previously immaculate presentation, she repeatedly wearing the same [soiled] clothes. Although she will tell you otherwise, it does not appear that she has done any cooking for several months, but she has not obviously lost weight and her larder contains multiple packets of biscuits and crisps alongside several bottles of sherry, it thought that she is drinking about three bottles a week.

Mrs B does not have any close relatives and has repeatedly declined to consider the idea of formal support services, resenting any implication that she needs help.

Reasons for Admission: It is felt that Mrs B is at risk of self-neglect and that an in-patient admission would provide the opportunity for a full assessment of her current abilities and future needs.

Group 15: Mr G

Home situation: Mr G is an 80 year old retired teacher who was admitted to a large residential home five months ago when his wife became unable to care for him at home.

Mental Health: Mr G was diagnosed with Lewy Body dementia approximately eighteen months ago. His condition fluctuates, but staff report that he regularly appears to hallucinate and that he often fails to recognise everyday objects. On first moving to the home he appeared fairly settled, but in the last few months he has become increasingly restless/agitated and when distressed has occasionally hit out at staff members. Although he has difficulty expressing himself it is felt that he is particularly sensitive to non-verbal cues and to the emotional atmosphere within the home and he often appears low in mood.

In the last two months Mr G has twice been reviewed by a consultant psychiatrist. It was hoped that medication would improve his mental state, but to date he has not been able to tolerate the preparations prescribed and last week he hit a fellow resident on finding her in his room. Although fortunately she was not hurt, her family have made an official complaint.

Activities of Daily Living: Mr G can mobilise independently although he walks very slowly with a wide based gait. He has difficulty co-ordinating his movements and needs help to wash and dress but he is mostly continent given regular prompts. Staff report that he sleeps poorly and is often awake for prolonged periods in the night.

Reasons for Admission: The manager of Mr G's care home feels that they are not at present able to care for Mr G and that his medication needs reviewing. She is also concerned about the safety of her staff and other residents and notes that Mr G himself may be at risk of harm from fellow residents who do not understand his behaviour. The GP, who has assessed the situation, is also requesting urgent admission.

Group 17: Mr D

Home Situation: Mr D, a 76 year old retired labourer, lives with his wife in a tied cottage several miles from the nearest town. Their only son lives abroad.

Mental Health: Mr D was referred to the CMHT three weeks ago. The GP stated that Mr D had visited the surgery a number of times in recent weeks complaining of difficulty concentrating, headache and constant tiredness but that he had no history of mental health problems. The previous night Mr D had however locked himself in his garden shed, insisting that the police were after him despite his wife's assurance otherwise.

Further to an urgent consultant assessment Mr D was prescribed antipsychotic medication and introduced to a CPN and support worker who have been visiting at least weekly between them. Although he has not expressed any further delusional ideas it has become increasingly apparent that Mr D has some degree of cognitive impairment [he refuses formal testing] and is low in mood with disturbed sleep.

Activities of Daily Living: Mr D suffers with arthritis and is no longer able to get into the bath or manage stairs. He is however able to wash and dress himself and is fully continent. In the last few weeks he has largely lost his appetite, his wife stating that he "toys with his food" and has "lost interest in everything". Mrs D is in good physical health and the couple receive no formal support services.

Reasons for Admission: Mr D's wife is particularly concerned that her husband is not eating whilst the CMHT are finding it difficult to engage with Mr D who tends to withdraw to his bedroom when they visit. It is felt that an admission to hospital would facilitate a more detailed diagnostic assessment and provide the opportunity for further treatment in a safe environment.

Group 31: Mrs M

Home Situation: Mrs M is a 73 year old lady who lives with her husband in a smart bungalow on the outskirts of town. The couple moved to the Lake District upon his retirement from the banking sector and have no family locally.

Mental Health: Although Mrs M says that she has always ‘suffered with her nerves’ she has never previously come to the attention of the specialist mental health services. Since being burgled approximately three months ago she has however become increasingly anxious, experiencing recurrent nightmares and daily panic attacks. Her GP prescribed a course of antidepressants but she only took these for a couple of days, complaining that they made her feel sick and she is adamant that she does not want any further tablets. The GP has thus requested CMHT involvement.

At initial interview with the CPN Mrs M looked tired, drawn and tense. She repeatedly pulled at her skirt and whilst she obviously tried to answer questions her spontaneous speech centred almost exclusively on concerns about her digestion, she complaining of an “unsettled tummy” and “an obstruction” in her throat. According to her husband she has recently eaten no more than a couple of mouthfuls before complaining of nausea and pushing the plate aside and she has lost more than a stone in just a few weeks.

Activities of Daily Living: Mrs M is able to meet all her own personal care needs and has previously been in good physical health, if somewhat underweight. She is a proud and competent housewife and the house appears clean and tidy.

Reasons for Admission: Mrs M believes that there is “something seriously wrong” with her stomach and does not believe that further antidepressant medication would be of any help. Indeed her husband tends to support her in this belief and they are both somewhat sceptical about the use of further visits from the CPN. Their perception is that an admission to hospital would facilitate more detailed investigation/assessment however, whilst the CPN is hopeful that she could then be persuaded to engage in a programme of treatment.

APPENDIX A15
EXPLORING ALTERNATIVE CARE PACKAGES: INPATIENTS SERVICE PROMPT LIST

Inpatient Vignettes

Client: ……………………………………………………………………………………

Looking at the list below, please indicate the combination of services that would be most appropriate to meet this client's needs:

☐ Accommodation: nursing home
☐ Accommodation: residential home
☐ Accommodation: specialist nursing home
☐ Accommodation: specialist residential home
☐ Accommodation: very sheltered housing
☐ Care home support service
☐ Carer support group
☐ Community psychiatric nurse
☐ Community support worker [mental health]
☐ Consultant psychiatrist
☐ Day care
☐ Day care: home from home
☐ Day care: specialist
☐ Day care: specialist, extended hours
☐ Day hospital [mental health]
☐ Dementia café
☐ District nurse
☐ District nursing assistant
☐ General hospital: admission
☐ General / cottage hospital: liaison nurse
☐ GP
☐ Home care: private domiciliary help
☐ Home care: SSD
☐ Home care: specialist
☐ Informal carer
☐ Intensive home support service
☐ Intermediate care
☐ Lifeline
☐ Meals: delivered meals
☐ Memory clinic
☐ Occupational therapist
☐ Paid carer
☐ Palliative care: hospice
☐ Palliative care: Macmillan nurse
☐ Physiotherapist
☐ Psychologist
☐ Respite placements
☐ Respite: nights only
☐ Shopping service
☐ Sitting service
☐ Sitting service: nights
☐ Social worker
☐ Speech therapist
☐ Volunteer

☐ Other, please write in: …………………………………………………………………

Comments:………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

APPENDIX A16

EXPLORING ALTERNATIVE CARE PACKAGES: CARE HOME ENTRANTS SERVICE PROMPT LIST AND CARE PLAN SHEET

The Balance of Care in Cumbria: Services for Older People with Mental Health Problems
Care Home Admission Vignettes : Care Plan Sheet

Group: ……………………… Client: ………………………

Please record length of service input

	Early Morning	Morning	Lunch	Afternoon	Teatime	Evening	Night
Duration*							
Monday							
Duration*							
Tuesday							
Duration*							
Wednesday							
Duration*							
Thursday							
Duration*							
Friday							
Duration*							
Saturday							
Duration*							
Sunday							

Comments: ……

………..

………..

Codes and Prompts: **[Please write in any other services you feel would be appropriate as necessary]**

Accommodation: nursing home **NH**
Accommodation: residential home **RH**
Accommodation: specialist nursing home **SNH**
Accommodation: specialist residential home **SRH**
Accommodation: very sheltered housing **VSH**
Care home support service **CHSS**
Carer support group **CSG**
Community psychiatric nurse **CPN**
Community support worker [mental health] **CSW**
Consultant psychiatrist **CP**
Day care **DC**
Day care: home from home **DC:HFH**
Day care: specialist **DC:S**
Day care: specialist, extended hours **DC:SHE**
Day hospital [mental health] **DH**
Dementia café **DCF**
District nurse **DN**
District nursing assistant **DNA**

General hospital: admission **GHA**
General hospital liaison nurse **GHLN**
General Practitioner **GP**
Home care: private domiciliary help **HCPD**
Home care: SSD **HCSSD**
Home care: specialist **HCSP**
Informal carer **IP**
Intensive home support service **IHSS****
Intermediate care: **IC**
Lifeline **LL**
Meals: delivered meals **ML**
Memory clinic **MC**
Mental health inpatient admission **MHIP**
Occupational therapist **OT**
Paid carer **PC**
Palliative care: hospice **PCH**
Palliative care: Macmillan nurse **PCMN**
Physiotherapist **PHY**

Psychologist **PSY**
Respite placement **RP**
Respite: nights only **RN**
Shopping service **SHS**
Sitting service **SIS**
Sitting service: nights **SISN**
Social worker **SW**
Speech therapist **ST**
Volunteer **VO**

Other – Please write in

**** Please describe in ‘comments

APPENDIX A17
UNIT COSTS SUMMARY

The Balance of Care in Cumbria: Services for Older People with Mental Health Problems Unit Costs Summary

Service	Cost / time frame	Source of costing
Accommodation: nursing home	£355 per week for social care element plus nursing care element of either £40, £77.50 or £125 for bandings low, medium & high respectively	CSSD
Accommodation: specialist nursing home	£389 per week for social care element plus nursing care element of either £40, £77.50 or £125 for bandings low, medium & high respectively	CSSD
Accommodation: residential home – level 1	£283 per week	CSSD
Accommodation: residential home – level 2	£325 per week	CSSD
Accommodation: specialist residential home	£377 per week	CSSD
Accommodation: very sheltered housing	No direct cost to health or social services	
Care home support service	As for CPN	
Community group / bereavement group / luncheon club	Costs of CPN follow up x 2 [expect last twice length average home visit] and support worker [2 hours] divided by 8? i.e. [£101.06 + £36]/8 = £17.13	NCMHLDT
Carer support group	Costs of CPN follow up x 2 [expect last twice length average home visit] and support worker [2 hours] divided by 8? i.e. [£101.06 + £36]/8 = £17.13	NCMHLDT
Church worker	No direct cost to health or social services	
Community psychiatric nurse: initial visit	£91.93 per visit	NCMHLDT

Community psychiatric nurse: follow-up	£50.53 per visit or £23 per hour	NCMHLDT Curtis & Netten (2004, p128)
Community support worker	£18 per hour spent with patient (assumes B grade)	Curtis & Netten (2004, p.131)
Consultant psychiatrist	£148.05 per visit or £95 per patient related hour	NCMHLDT Curtis & Netten (2004, p186)
Day care	£17.32 [mid point of costs of day care currently provided by Age Concern	CSSD
Day care: home from home	£28.50 [Costed as 6 hours home care [6 x £9.50] divided by 2	CSSD
Day care: specialist	£28.13 [The most costly day care currently received by older people in the catchment area]	CSSD
Day care: specialist, extended hours	£56.26 [Double the costs of specialist day care for the traditional day]	CSSD
Day hospital [mental health]	£79.38 per day	NCMHLDT
Dementia café	Costs of CPN follow up x 2 [expect last twice length average home visit] and support worker [2 hours] and social worker [2 hours] divided by 20? i.e. [£101.06 + £36 + £198] / 2 = £16.75	NCMHLD for CPN; Curtis and Netten (2004) for community support workers and social workers
Dietician	£52 per hour home visit	Curtis & Netten (2004, p.166)
District nurse	£18 per home visit	Curtis & Netten (2004, p.127)
District nursing assistant	£7 per home visit	Curtis & Netten (2004, p.131)
Family supporter	£31 per contact hour Based on family support worker working with carers of people with schizophrenia	Curtis & Netten (2004, p.148)

General hospital: admission	£223 per bed day for geriatric admission	Curtis & Netten (2004, p.111)
General hospital: liaison nurse	As for CPN	
General practitioner	£24 per clinic visit £56 per home visit	Curtis & Netten (2004, p.135)
Home care: private domiciliary help e.g. cleaning, shopping, gardening	£5 per 60 mins	CSSD ('word of mouth' in West Cumbria')
Home care: SSD	£6.04 for 30mins £9.50 for 60 mins £7.77 for 45 mins £71.00 for a waking night Night calls = 1.0667 x day cost	The 30 and 60 mins costs are the average of costs given by CSSD for the four districts covered in the study, amalgamating urban and rural rates. The figures are the average of inhouse and independent services. The cost for 45 mins is the mid point between the costs for 30 and 60 mins as suggested by CSSD. It is understood that not all agencies will provide 45 min visits. The waking night costs were provided by CSSD The night call costs were based on the mark up from day call costs for the north of England given in Curtis & Netten (2004, p144) and are close to the ball park figures suggested by CSSD
Home care: specialist	£12 for 60 mins £7.63 for 30 mins £9.81 for 45 mins £89.68 for a waking night 1.0667 x day cost for a night call	Curtis & Netten (2004, p.144) for the 60 mins cost (the cost of independently provided home care where more than 75% of clients have special needs) Other costs marked up/down by the same % as for home care
Incontinence advisor	£42 per hour of client contact – assumes H/I grade Nurse practitioner in primary care costs	Curtis & Netten (2004, p133)

Informal carer	No direct cost to health or social svs	
Intensive home care support service	Consider combination of services needed on a case by case basis	
Intermediate care service	£23.40 per hour, including transport Based on costs of rapid response service with aim of providing alternative to hospital admission / long term care	Curtis & Netten (2004, p.116)
Lifeline	No direct cost to health or social services	
Meals: delivered meals	£3.30	CSSD
Memory clinic	Cost of assessment by consultant plus an average of contact with a CPN or a psychologist i.e £148.05 + [£50.53 + £69 / 2] = £207.82	NCMHLDT for CPN and Consultant costs. Curtis & Netten (2004) for psychologist
Mental health inpatient admission	£196.21 per day	NCMHLDT
Occupational therapist	£44 per home visit	Curtis & Netten (2004, p.120)
Paid carer	No direct cost to health or social services	
Physiotherapist	£44 per home visit	Curtis & Netten (2004, p.119)
Psychologist	£69 per hour of client contact	Curtis & Netten (2004, p.123)
Respite placement	Said to be 1.059 x cost of long term residential care per week or 0.967 x cost of long term nursing home care per week	Curtis & Netten (2004, p.35 & 36 respectively)
Respite: nights only	Costed as for waking nights. No national figures available.	

Sitting service	£12.50 for 60 mins for social input within a 10 mile radius between 8am – 8 pm, Mon-Fri £15.62 for 60 mins after these hours or at weekends / BHs	West Cumbria Crossroads (2004 figures)
Social worker	£99 per hour face to face contact	Curtis & Netten (2004, p.140)
Specialist registrar	£29 per hour worked	Curtis & Netten (2004, p.182)
Speech therapist	£41 per home visit	Curtis & Netten (2004, p.121)
Volunteer	No direct cost to health or social services	

APPENDIX A18
VALIDATING ALTERNATIVE CARE PACKAGES: EXAMPLE OF EXPERT PANEL PROFORMA

Revised 8/2004

INTEGRATED INDIVIDUAL CARE PLAN

Please note - Information you provide may be shared with others involved in your care unless you state otherwise

NAME AND ADDRESS
Mr V
Lives Alone
Currently An Inpatient On A Mental Health Ward

Postcode: GP 46 [1]

Cumbria SSD No:

NHS No:

Date of Birth: 01/01/1935 *(dd/mm/yyyy)*

PART ONE

1 Summary of Assessed need. (As stated on Single Assessment – Contact 2 or Overview).

Activities of daily living: Mr V is continent, fully mobile and able to feed himself but needs some help to wash, bath and dress along with encouragement to eat. His general health is described as poor. Whilst he will sometimes sleep throughout the night, nursing staff report that he often wakes extremely early.

Mental health: Mr V is cognitively intact and is generally able to communicate clearly although he has some difficulty making decisions in new situations. Although he is not aggressive as such, he often appears agitated and has a diagnosis of depression.

Risk factors: Mr V is considered to be at risk of self-neglect at home, whilst there is also some real concern that he may harm himself.

Summary: Mr V is in poor physical health and suffers with depression, lacking the motivation to care for himself at home. It is felt that his current situation leaves him at some risk.

2. Fair Access to Care Eligibility Statement (click relevant box)

Critical ☒ **Substantial** ☐ **Moderate** ☐ **Low** ☐

3. Agreed Outcomes to Plan For:-

Checklist for Assessed Person

Agreed aims and outcomes	x	M = Maintain I = Improve	Agreed aims and outcomes	x	M = Maintain I = Improve
Quality of Life Outcomes:					
Physical health or Wellbeing	☒	*M*	Practical Support	☒	*I*
Emotional Health/Mental Health	☒	*I*	Personal Care	☒	*I*
Peace of Mind	☐		Personal Finances	☐	
Safe & Secure	☐		Control over day to day life	☐	
Social Contact	☒	*I*	Reducing risks	☒	*I*
Recovery or Rehabilitation Outcomes :					
Regaining skills and capabilities	☒	Improving ability to get out	☐		
Improving Confidence and Morale	☒	Reducing Symptoms	☒		

4. How these assessed needs are to be met:

Care package to consist of:

- Twice daily home care input
- Thrice weekly day hospital attendance, to include OT support with meal preparation skills
- Weekly input from a community mental health nurse and support worker
- Twice weekly input from a volunteer
- The provision of a daily hot meal

- Regular review by a consultant psychiatrist
- Installation of lifeline

5. Is planned respite care a feature of the care plan? *(P.I.)* **Yes** ☐ **No** ☒

6. Agreed that services are to be arranged via:-

Care Management ☒ **Direct Payments** ☐ **Mixed Care Management and Direct Payments** ☐

Not Appropriate (e.g case closed, Health provision only) ☐

7. Additional Information or Other Arrangements Agreed:

Informal care: Mr V's main supporter is his brother who is finding this role very stressful.

Attitude to future care: Although Mr V has not expressed any desire to move into residential care it is felt that he lacks the motivation look after himself at home.

Contributions to the assessment process: Mr V's mental health has been fully assessed during his inpatient stay and his brother has been able to provide detailed information about his previous functioning at home.

8. Frequency of Review Required :

None ☐ 6 weekly ☒ 3 Monthly ☐ Annual ☐

Other (please specify)

To be undertaken by : (please specify)

Name: Sue Tucker	**Job Title:**

9. Review Date: 13/05/2005 *(P.I.) (dd/mm/yyyy)*

10. Confirmation Care Plan has been sent to Service User: YES ☐ *(P.I.)* NO ☒

Signature of Person completing care plan: : ______________________

Name (Print): **Sue Tucker** Designation : ____

Address:

Postcode:

Tel No: **Date:** ____ *(dd/mm/yyyy)*

NAME: MR V **CAREFIRST ID:**

SERVICE DELIVERY PLAN MATRIX

1. Services Arranged/Requested (e.g. from Housing)

SERVICE	PROVIDER NAME	CONTACT TEL. NO.	TASKS	START DATE
LIFELINE				**A.S.A.P**

2. Weekly Service Delivery Diary

	MON	TUES	WED	THUR	FRI	SAT	SUN
am	HC 30 MINS	HC 30 MINS	HC 30 MINS	HC 30 MINS	HC 30 MINS	HC 30 MINS	HC 30 MINS
Lunch	DAY HOSPITAL	MEAL	DAY HOSPITAL	MEAL	DAY HOSPITAL	HC 30 MINS	HC 30 MINS
pm	DAY HOSPITAL	CSW	DAY HOSPITAL	CPN	DAY HOSPITAL	VOL	VOL
Tea							
Night	HC 30 MINS	HC 30 MINS	HC 30 MINS	HC 30 MINS	HC 30 MINS	HC 30 MINS	HC 30 MINS

3. Monthly/Annual Diary (for planned/episodic care)

6 WEEKLY HOME VISIT BY CONSULTANT PSYCHIATRIST

COST OF CARE PACKAGE TO SOCIAL SERVICES

NAME: Mr V

Service	No. of units	Cost per week
Home care	16 x 30 mins	£96.64
Meals	2	£ 6.60

Total Cost per Week: £103.24

APPENDIX A19
SOCIAL SERVICES COMMUNITY CASELOAD: ALL USERS BY AREA TEAM

	Allerdale	**Carlisle**	**Copeland**	**Eden**	**Total**
Allocated	616	722	473	336	2147
Deallocated	430	799	425	393	2047
Total	1046	1521	898	729	4194

November 2003
Excludes clients <65 and care home residents

APPENDIX A20
SOCIAL SERVICES COMMUNITY CASELOAD: RESPONSE RATE BY AREA TEAM

	Allerdale	**Carlisle**	**Copeland**	**Eden**
% of total caseload	24.9%	36.3%	21.4%	17.4%
% of total responses	33.3%	31.4%	20.4%	14.9%

November 2003
Excludes clients <65 and care home residents

APPENDIX A21
SOCIAL SERVICES COMMUNITY CASELOAD. CHARACTERISTICS OF CLIENTS WITH MENTAL HEALTH PROBLEMS: A COMPARISON OF ALLOCATED AND DEALLOCATED CASES

	Allocated Number (%)	**Deallocated** Number (%)	**Total** Number (%)
Gender			
Male	35 (31.8)	10 (34.5)	45 (32.4)
Female	75 (68.2)	19 (65.5)	94 (67.6)
Age (years)			
Mean	81.2	81.6	81.3
Standard deviation	6.8	8.3	7.1
Usual place of residence			
Home alone	63 (57.8)	19 (70.4)	82 (60.3)
Home alone with other adult(s)	46 (42.2)	8 (29.6)	54 (39.7)
Presence of informal carer			
Yes	87 (78.4)	18 (64.3)	105 (75.5)
No	24 (21.6)	10 (35.7)	34 (24.5)
Dependency (Barthel Scale)			
Low	63 (58.3)	15 (62.5)	78 (59.1)
Medium	25 (23.1)	8 (33.3)	33 (25.0)
High	20 (18.5)	1 (4.2)	21 (15.9)
Cognitive impairment * (Cognitive Performance Scale)			
No / mild	54 (52.4)	21 (80.8)	75 (58.1)
Significant	49 (47.6)	5 (19.2)	54 (41.9)
Mood			
Not usually sad/depressed	40 (37.4)	6 (22.2)	46 (34.3)
Usually sad/depressed	67 (62.6)	21 (77.8)	88 (65.7)

Allocated cases: max n=111; Deallocated cases: max n=29

* Significance ≤0.05 Pearson's Chi-Square

APPENDIX A22
CARE HOME ADMISSSIONS: ESTIMATED COSTS OF COMMUNITY CARE PACKAGES TO SOCIAL SERVICES AND AGENCY APPROVAL

Case Type	**Cost of Community Care Package to Social Services** £ per week	**Panel Approval Without Reservation**	**Panel Approval With Revised Care Plan**	**Panel Approval With Alternative Accommodation**	**Panel Refusal**
1	138.12	✓			
2	337.23			✓	
3	291.68	✓			
4	310.42				✓
5	840.83			✓	
6	779.85				✓
7	829.83				✓
8	485.90				✓
9	251.13				✓
10	141.56			✓	
11	254.58			✓	
12	419.42				✓
13	539.28		✓		
14	770.46[1]				✓
	268.34[2]	✓			
15	-[3]				
16	103.24	✓			
17	387.44				✓

[1, 2] Practitioners proposed two alternative community care packages for Type 14

[3] Practitioners considered that community care was not a feasible option for Type 15

APPENDIX A23
CARE HOME AND INPATIENT ADMISSIONS: THE VIEWS OF USERS, CARERS AND THEIR REPRESENTATIVES OF THE APPROPRIATENESS OF ADMISSION

Case Type	**Care Proposed**	**Number of Groups Considered by**	**Believed *Would* be Possible to Care For at Home**	**Believed *Might* be Possible to Care For at Home**	**Believed *Would Not* be Possible to Care For at Home**
CH 1	Care home	3	1	1	1
CH 2	Care home	3	-	2	1
CH 3	Care home	3	2	1	-
CH 4	Care home	4	-	1	3
CH 5	Care home	3	1	2	-
CH 6	Care home	3	-	2	1
CH 7	Care home	3	-	1	2
CH 8	Care home	3	-	1	2
CH 9	Care home	3	2	-	1
CH 10	Care home	3	1	1	1
CH 11	Care home	3	-	-	3
CH 12	Care home	3	-	2	1
CH 13	Care home	3	1	1	1
CH 14	Care home	3	-	1	2
CH 15	Care home	4	1	1	2
CH 16	Care home	3	1	1	1
CH 17	Care home	3	1	1	1
IP 1	Inpatient	4	1	2	1
IP 2	Inpatient	4	-	1	3
IP 5	Inpatient	4	2	2	-
IP 7	Inpatient	3	3	-	-
IP 8	Inpatient	4	3	1	-
IP 9	Inpatient	4	2	2	-
IP 13	Inpatient	4	3	1	-

APPENDIX A24
CUMBRIA SOCIAL SERVICES: USUAL PRICES FOR RESIDENTIAL AND NURSING HOME CARE

Residential Care (Older People)		**£ per week**	
		2003/4	*2004/5*
1	To provide for the assessed needs of Older People with **low levels of dependency who do not require a high level of personal care**	*283*	*292*
2	To provide for the assessed needs of Older People **who are very dependent and who require a high level of personal care (includes some people who are elderly mentally infirm)**	*325*	*335*
4 (EMI)	To provide for the assessed needs of Older People **who have significant mental frailty and whose personal care is best met in specialist homes, or in wings or units of a general home, or in designated beds in a general home**	*377*	*389*

Nursing Home Care (Older People)		**£ per week**	
		2003/4	*2004/5*
Social Care Element	**New residents (general nursing homes)**	*345*	*355*
	New residents (EMI registered nursing homes)	*378*	*389*

Nursing Home Care (Older People)		**£ per week** *2004/5*		
		Low	**Medium**	**High**
Nursing Care Element	**New residents (general nursing homes)**	40	77.50	*125*
	New residents (EMI registered nursing homes)			

APPENDIX A25
CARE HOME ADMISSIONS. FOUR CASE TYPES WITH POTENTIAL FOR DIVERSION FROM RESIDENTIAL CARE: ESTIMATED NET COMMUNITY AND RESIDENTIAL COSTS TO SOCIAL SERVICES

Case Type	**12 Month Estimate**	**Residential Cost (gross)** £		**Community Cost (gross)** £	
		Weekly / user	**Annual / all**	**Weekly / user**	**Annual / all**
1	8	205.00	85,280.00	118.12	49,137.92
3	18	257.00	240,552.00	271.68	254,292.48
14 (option 2)	16	205.00	170,560.00	248.34	206,618.88
16	8	163.00	67,808.00	83.24	34,627.84
Total			564,200.00		544,677.12

APPENDIX A26
GPS' PRIORITIES FOR SERVICE DEVELOPMENT

Service	**Number of GPs Prioritising this Service** (n=76)
NHS in-patient beds for assessment/treatment	**27**
NHS in-patient beds for rehabilitation	**9**
NHS in-patient beds for continuing care	**7**
NHS in-patient beds for respite	**15**
NHS day hospital places for people with dementia	**7**
NHS day hospital places for people with other mental illness	**6**
Routine assessments by consultant psychiatrists	**9**
Urgent assessments by consultant psychiatrists	**13**
Community mental health team input for people at home	**25**
Community mental health team input for care home residents	**4**
Psychological therapies for older people with mental illness	**6**
A memory clinic for people with potential dementia	**8**
Anti-Alzheimer drugs for older people with dementia	**-**
Specialist services for younger people with dementia	**9**
Nursing home beds for older people with mental illness	**5**
Residential home beds for older people with mental illness	**10**
Non-NHS respite care for older people with mental illness	**13**
Day care places for people with dementia	**14**
Day care places for people with other mental illness	**3**
Homecare services for older people	**10**
Carer support services	**13**

APPENDIX A27
THE KEY ACTIVITIES ASSOCIATED WITH CARING FOR OLDER PEOPLE: SUMMARY SHEET

The percentage of staff time spent in six broad categories of activity

	Face to face care with clients %	**Face to face care with carers** %	**Telephone contact with clients/carers** %	**Indirect care** %	**Team/service work** %	**Travel** %
Mental health nurses (n=15)	33.7	5.1	4.1	25.8	17.4	13.9
Mental health support workers (n=11)	34.4	2.7	6.2	19.7	13.9	23.1
All mental health staff (n=26)	34.0	4.1	5.0	23.2	15.9	17.9
All social services staff (n=37)	12.0	4.2	7.7	43.2	25.4	7.4
Qualified social services staff (n=30)	13.0	4.5	6.6	42.3	25.8	7.7
Qualified community-based social services staff (n=19)	13.0	5.1	5.4	43.9	24.0	8.7
Qualified hospital-based social services staff (n=11)	13.1	3.5	8.9	39.4	29.1	5.8
Unqualified social services staff (n=7)	7.6	2.8	12.3	47.2	23.8	6.3

Please note that as figures have been rounded to one decimal point, totals may not sum to exactly 100