

**MENTAL HEALTH SERVICES FOR OLDER PEOPLE  
Strategy Group Briefing on National Report**

**“Integrating OPMHS: CMHTs for Older People”**

Lingard J & Milne A (2004), Department Of Health, London

*This document summarises an extensive national ‘Commentary and Resource Document’, which our services have contributed to. Anyone interested in OPMH community service development, the integration agenda and National Service Framework implementation will find it useful. The full national report includes extensive references to support OPMH service development and is available from the website: [http://www.nimhe.org.uk/downloads/CMHT\\_OPs\\_June%20042004JL.pdf](http://www.nimhe.org.uk/downloads/CMHT_OPs_June%20042004JL.pdf)*

**SECTION 1: INTRODUCTION**

**Aims:**

- Guides Implementation of NSFOP Standard 7 (see Section 2)
- Resource for services to achieve integration
- Considers whole systems approach for CMHTs: functions, structures, processes and evaluation
- Distils lessons from evidence and practice

**Method:**

- Review of current research and policy
- 32 responses across England to CMHT integration questionnaire (detailed in doc)

**Rationale:**

- Integration at heart of successful NSFOP implementation
- Older people with mental health needs also have physical health and social care needs which are barriers to independent living
- Separation of health and social care functions carries duplication of effort and costs as well as unnecessary confusion and stress for service users and carers
- DOH NSFOP Policy Implementation Team consultation revealed that CMHT integration was seen as key indicator of service quality
- CMHT development and Integration definitions varied and need shared understanding

**Defining Integration:**

**It is not just** – multi-disciplinary, inter-agency (services running alongside each other)

**It is** – health & social care elements have no apparent joins to service users and staff

There is single system for planning, delivering and reviewing care/treatment

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**SECTION 2: POLICY – CONTEXT AND FOCUS**

- Although controversy existed with OPMH placed in NSFOP rather than NSFMH, the policy aim was to ensure integration and co-ordination with generic OP services
- Drivers are increased life expectancy, growing knowledge of late onset MH disorders and reduction of long stay hospital beds.
- Integration assumed to improve: promotion of independence, care at home, service access, increased consistency, dignity and quality of life (research sited)
- Most ‘imaginative and innovative’ ways of meeting OPMH needs are achieved by specialist services focusing on complex/challenging needs (dementia & depression)
- No blueprint for service development - historically specialist services have developed pragmatically to secure funding rather than as whole systems approach in evaluated service model.

**Royal College of Psychiatrists** have issued broad principles. Collaboration and integration are identified as key elements of effective community-based services

### **Partnership Frameworks :**

**NHS & Community Care Act 1990** – flexible care packages support independent living  
- promoting seamless care for vulnerable adults

**Partnership in Action DOH 1998** – discussed improved outcomes via integration

**NHS Plan 2000** – NHS to develop partnerships for patient-centred seamless service  
- concept of Care Trust and other mechanisms for integrated care

**Health Act 1999** – Introduced **HEALTH ACT FLEXIBILITIES** to address legal barriers  
Three new 'permissive structures':

> **Lead Commissioning** = Partners agree to delegate lead commissioning of a service to one lead organisation

> **Pooled Funds** = Partners contribute agreed designated funds to single budget

> **Integrated Provision** = Partners can join staff & resources to integrate services  
From front line to management

**The Carers & Disabled Children Act 2000** – carers' assessment rights extended  
- direct payment rights extended

### **The National Service Framework for Older People (NSFOP)**

All standards applicable to improving quality in OPMH services

Key themes of MH St7 :

- People with complex needs be treated and supported where possible at home by
- Early detection and comprehensive assessments
- Health promotion and prevention
- Access to specialist services, advice & skills, treatment and rehabilitation
- Integrated care management, including CPA for OP with severe/enduring MH needs
- Organisation of specialist services to emphasize home provision and carer support
- Continuous development from sharing good practice
- Access to integrated MH services, provided by NHS & councils

While the NSFOP has not specifically mentioned CMHT(OP)s, specialist MH services to be community orientated with robust links to primary care/social services.

NSFOP St7 milestones relevant to integrated CMHT(OP)s :

- Multi-agency development forums to develop integrated OPMHS, including health promotion
- Health & social care systems agreed protocols for dementia & depression

### **Intermediate Care (IC) & OPMH**

- "The ability of CMHT(OP)s to work with people in their own home distinguishes them from 'traditional' psychiatric services and makes their service meaningful for many service users and carers"
- CMHT model of service shift aligns with policy of promoting independence
- '**Intermediate Care: Moving Forward**' (DOH 2002) addresses misconception that OPMH needs cannot benefit from rehabilitation and IC services
- Dementia sufferers can improve health outcomes with generic IC services for their physical health needs, resulting in fewer admissions to residential care
- Psychologists have demonstrated that active rehabilitation can improve wellbeing for people with dementia
- IC teams developing closer links with specialist MH services can improve under-detection of depression in older people and there are examples of joint working
- Dementia Voice (!! And Devon services) have developed a template for IC with dementia

### **National Service Framework for Mental Health (NSFMH)**

The NSFOP states that, where there are severe mental health needs in older people other than dementia and depression, the NSFMH ought to apply – implying that a CMHT(OP) will be required to meet those needs.

The policy and service devt agenda for Adult Mental Health (16-64yrs) has benefited from early introduction of the NSFMH which specified clear functions of CMHTs and this guidance could be applied to CMHT(OP) development:

- Giving advice on management of mental health problems to other professionals, in particularly advice to primary care and a triage function
- Providing treatment and care for those with time-limited disorders who can benefit from specialist interventions
- Providing treatment and care for those with more complex and enduring needs

## **SECTION 3: COMMISSIONING OPMHS**

### **Audit Commission ‘Forget Me Not: MHSOP’ (2000)**

Cited as most comprehensive overview of current challenges and opportunities with key recommendation for development of OPMH comprehensive strategic planning. Two principal areas of concern were levels of variation in :

- Availability, accessibility and outcomes of OPMH services, particularly in the prevention and management of dementia and depression, and
- Organisational arrangements at strategic and operational level for delivering services, where services sit, and the level and quality of joint working

The following 2yr nationwide audit programme showed good correlation between good co-ordination and strategic planning and good services.

The national priority was identified to improve commissioners’ understanding and expertise about OPMHS and how to deliver them to achieve best outcomes

Agencies were advised to develop joint plans for commissioning and delivering integrated services, based on good information and involving key partners

**The separate publications of NSFMH and NSFOP has led to establishment of separate Local Implementation Teams/Groups and appointment of commissioners.**

***“This has created risk of a lack of focus on the OPMH agenda as it was not firmly located in either area. The OPMH Sub-Group of the National Mental Health Partnership has commented on the difficulty of OPMHS sitting across two commissioning and providing agendas” (see pages 17/18)***

### **Local Mental Health OPMH Strategies**

In England older people (OP) with dementia cost £6.1bn and OP with depression (6.6bn – half of this sum borne by carers.

**Table of Service Planning Demographic Data (compiled from page 18)**

<b>Service Planning Population</b>	<b>Numbers 65+ yrs</b>	<b>Incidences Dementia</b>	<b>Incidences Depression</b>	<b>Incidences other MH conditions</b>
250,000	37,500	2000	5600 (750 severe)	1500 (incl 750 psychoses)
10,000 (GP list size)	1500	75	225 (30 severe)	30

Questionnaire responses (32) showed 50% had developed strategies, however few of these were jointly developed between health and social services.

### **Service Mapping – to assist commissioners understand gaps & duplications**

- **Dr Susan Bedford** (was East NIMHE Regional Lead) has undertaken research on availability of CMHT(OP) services to inform local commissioning, including:  
 Maps of service provision, populations, staffing, levels of integration and local challenges  
 Method semi-structured interviews with team leaders  
 Outcomes to identify gaps, unmet needs and good practice

Durham University have developed comprehensive range of service definitions and have website (<http://www.dur.ac.uk/service.mapping/opmh/>) building up to collate detailed information

- about all services designated as available for OP with MH needs. In pilot stage, integration criteria options are :  
 Inter-agency multi-disciplinary health and social care staff  
 Integrated assessment, care planning and care co-ordination

Joint recording and IT systems supporting CPA and SAP  
Single point of entry/access to specialist mental health assessment

### **Service Specification**

Audit Commission report 'Developing Productive Partnerships' (2002) identifies critical factors for effective partnerships :

- **Shared purpose** – including unambiguous mission statements and terms of reference
- **Resources** – clarity about partnership resources, control, allocation, avoiding over-commitment
- **Clear success indicators** - baseline indicators, milestones, targets and performance monitoring that are all specific and relevant to work of partnership

Integrated teams need clear team service specifications, for operational efficiency, clarity of purpose within team, service evaluation and review

### **Partnership as a Continuum** – A staged model to assist analysis

**Communication** – recognition of benefit of learning from and working together

**Co-operation** – parties agree to take action round mutually defined problem/opportunity

**Co-ordination** – parties work together in systematic way on shared objectives and pool resources, while maintaining boundaries and own internal structures

**Federation** – organisations retain organisational distinction but pool resources and operate to some shared policies

**Merger** – values, priorities & objectives are common, resources wholly collective and working together is entirely systematic from beginning to end

### **Lead Commissioning**

Example learning from SSI Report 2004 on AMH, where lead is often taken by one PCT on behalf of local authorities and other PCTs in SDPs to mutual benefit and full sharing.

### **Sought Outcomes from Integration** - NIMHE & ADSS Joint Briefing (2003) "Positive Approaches to the Integration of Health & Social Care in Mental Health Services"

- Identified outcomes to maximise participation and partnership
- Service users & carers at heart of service
- Service models focus on whole person/whole systems approach in context of where people live
- Organisation has all staff and partner agencies working to common values and goals
- Recognition of valuing diversity
- Sound governance arrangements valuing openness, learning and innovation
- Workforce with right skill mix to achieve objectives, supported, developed and empowered
- Combining service effectiveness with cost effectiveness
- Proper attention to dual diagnoses, including learning disabilities and substance misuse
- Integration of Mental Health and Public Health to preclude emphasis on 'mental illness'

Suggested local outcomes to consider = improved access to specialist services, less complicated care journeys, improved service user experience, reduced carer pressure, reduced number of professionals involved, reduced risk of duplication and reduced risk of oversight.

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## **SECTION 4: CARE PATHWAYS - INTEGRATING HEALTH & SOCIAL CARE**

*" services need to be shaped around the needs , wishes, and aspirations of the people using them not the organisation providing them" - Feb 2004 Stephen Ladyman, Social Care Minister*

CMHTS are the "cornerstone" of comprehensive local community- based services and are a means of assuring the co-ordination of provision the spans health & social care.

### **The Service User**

No national data is currently collected about service users of CMHT's

### **Age**

MH Services should be operating to locally developed transition protocols

Community MH Services for older people can provide services for people who have experienced long lasting serious MH illness that started when they were much younger although their needs may be quite different from older people who develop MH problems later in life.

### **Gender**

The number of the very old is set to rise leading to an increase in widowhood.

Rates of depression in women are double those for men

Men aged 80+ appear to be at particular risk of suicide.

### **Ethnicity**

Older people from black and ethnic minorities do not use MH services to the extent that they should given the prevalence of dementia and other MH problems in these ageing populations.

“Forget me not” highlighted a dearth of services for ethnic minorities.

No evidence of development of culturally appropriate services in CMHT's

### **Living Alone**

Between 1991-2011 the percentage of people with dementia living alone is estimated to increase by 59% from one quarter to one third the total number of those with dementia in the UK. Special attention needs to be paid to identifying and supporting older people with dementia or depression living alone, to their safety and to the co-ordination of services

### **People reliant on carers**

$\frac{3}{4}$  of people with long term MH needs living in the community receive support from carers. Most are older & the majority have spouses.

Older carers are at considerable risk of developing mental ill health themselves.

Considerable investment over the last 10 years to support carers

Eg, Admiral Nurses, Early intervention services, Memory Clinics, Befriending schemes, Carers support groups

Innovative sitting & home based support services are in development through the Carers Grant

Services for carers vary in availability, eligibility and quality

### **People living in care homes**

NSF for older people alerts to the under diagnosis of depression in non specialist care home residents

CMHT's well placed to provide treatment & support for this group as well as those with enduring MH problems to include specific issues around medication.

### **Whole system thinking**

CMHT's do not operate in isolation, commitment to establishing systems & structures that support and facilitate integration on a wider basis is essential.

Objectives of CMHT in relation to wider health & social care system, development of team policies/procedures, clarifying organisational parameters are core elements of defining the team's role & purpose.

A CMHT needs to have a range of formal & informal liaison arrangements within all health & social care services and its position identified within the user & carer pathway.

### **Promoting access in a whole system**

Clear access to the CMHT needs to be understood across all health & social care systems & a clear criteria and referral mechanisms available.

In some areas referrals are received & filtered through a single access point in others referrals were received at several points & required health & social care practitioners to refer on as necessary which led to duplication of effort /assessment & was not a reliable mechanism to ensure prompt access to specialist services.

*“ A Whole System values the contribution of all organisations/agencies/partners to the provision of the service. Services are planned and integrated across organisations and the impact the impact of the contribution of each on the others is essential if there is to be successful planning across organisational boundaries. Whole System Working is not just about working across professions within organisations, so that services are not constrained by professional barriers and demarcations”*

*Health & Social Care Change Agent Team*

## **SECTION 5: PURPOSE AND FUNCTION OF THE INTEGRATED CMHT(OP)**

- The section starts by summarizing the NSF for Older People's Mental Health section: this describes specialist mental health services treating and supporting older people with more severe levels of mental ill-health, predominantly dementia and/or depression, people with complex needs (e.g. physical health problems coinciding with mental health problems, and those at risk of suicide), where first line treatments have been unsuccessful and/or when psychotic symptoms might be present. It describes specific situations that might be particularly relevant to specialist services including patients who wander or at risk of abuse or self-harm, have challenging behavioural and/or psychological symptoms, may be suitable for acetylcholinesterase inhibitors, and have complex or multiple needs.
- CMHT (OP) is a new development, described in 1997 by the World Health Organization as 'the multi-disciplinary specialist service .... can include a range of professionals ... who should meet regularly to co-ordinate and discuss new referrals and current case-load'. On page 30 there is a model of an Integrated CMHT which has a Team Leader and core members (psychiatric nurses, occupational therapist, support workers, and specialist mental health social worker), more peripheral members (Consultant Psychiatrist and other medics, Psychology) and links to other services and professionals (e.g. physiotherapy, speech therapy, dietician, pharmacy advice). The CMHT leader also links directly with in-patient assessment wards, generic social care services, special mental health services such as home care and care homes, and any day facilities. There is no link shown to physical medicine unless 'other medics' refers to this.
- The WHO report regards the team as needing an 'identified leader' and emphasizes that initial assessment should take place in the patient's own home and include other family members and/primary care team wherever possible.
- The paper further defines a number of key functions for the CMHT noting that there is 'broad agreement' that the team's role is to assess, treat and support older adults with complex and/or long-term mental health problems and their carers in the community. Specific functions might include acting as a focus for referrals, conducting home based multi-disciplinary specialist assessments, monitoring and reviewing care and care packages, providing ongoing care and support, providing outreach support, ensuring access to a range of services, and providing support and training to staff in other agencies. On page 32, drawing on a review by Challis et al (2002), there is emphasis on support to Residential and Nursing Homes noting that this may prevent or reduce admissions to hospital or transfers to other Nursing Homes and help provide better care to residents.
- The section further notes a shortage of trained home care workers, specialist day care places, flexible respite care beds, and support for carers of people with dementia.

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## **SECTION 6: THE STRUCTURES OF THE INTEGRATED CMHT(OP)**

It is recognised that organisational culture and values are deep-rooted and cannot be changed quickly. When developing integrated CMHT's, senior management within the NHS and Local Authorities need to ensure that the cultures of their organisations recognise and reward behaviour that promotes integration by staff at all levels of the organisation. Strong leadership is seen as an essential factor when developing integrated CMHT structures. Joint working, and commitment to this ideology is positively supported within CMHT's if the following is in place:-

- shared management by health and Social Services
- a co-ordinator/manager who is skilled in developing joint agency working methods
- pooled budgets with dedicated resources for CMHG activities
- a dedicated/shared office/base
- shared case records
- regular team meetings
- being able to access health/social services resources regardless of discipline
- routine and shared training of health and social care professionals
- team policies and procedures
- user/carer involvement in service planning and delivery

- The organisational context for a CMHT (OP) can be determined according to the best fit within existing local arrangements.
- It is recognised that a move to pooled budgets can be a difficult objective to achieve, and some organisations are setting up parallel accounts on a transparent basis to develop trust, to enable moves, at a future date to a pooled budget position.
- There are many challenges evident when marrying professional and organisation cultures. The table below illustrates these:

Ambiguity over CMHT role and responsibilities      Concerns over perceived 'take overs' and feeling of being externalised      Harder to marry cultures the higher up the organisation you get

Defining and understanding of professional roles and responsibilities essential Time Intensive	HR and Operational issues problematic Needs training and support, for example review meetings and reflective practice	Improve information exchange Co-location increases joint working and mutual respect.
How change is managed is crucial, should have a 'bottom up' approach ensuring staff feel ownership of the process.	Recognising professional differences and acknowledging overlap of skills essential	Reluctant to embrace change

### **Composition of a CMHT(OP)**

The multi-disciplinary nature of the team means that it is important that both the distinct contribution of each discipline is spelled out, as well as the roles that might be shared. Any team needs to be planned according to the locally agreed service model – with set numbers of staff with specified hours.

There are a variety of configurations of team working. These include:

1. Dedicated health practitioners and specialist social workers, integrated meetings and joint documentation
2. Specialist social workers with variable degrees of integration with health colleagues
3. Generic social workers drawn from adult care teams with variable degrees of integration
4. Health practitioners and social workers from integrated adult community mental health teams
5. Specialist health practitioners from adult mental health team, generic social workers from adult social care teams.

Whatever the configuration, formal structures are needed to embed joint working within daily practice and longer term operations of the Team.

### **Team Structures**

It is widely recognised that there is no 'model' team. It is, however, important to develop team work, particularly multi-disciplinary team work. A good description of such a team is 'a group of individuals, with varying back grounds, perspectives, skills, and training, who work together towards the common goal of delivering a health and social care service, and where team members value each others' different contributions'.

While there is no set model for which disciplines should be included in the structure of a CMHT (OP), these might be categorised as:-

- **Core members:** workload is fully in the CMHT, including the Team Manager
- **Part-time members:** total workload is partly generated by the CMHT and partly in other areas of the health/care system
- **Associate members:** work closely with the CMHT but whose workload is generated from a variety of sources.

### **The Team Leader/Manager**

- has an important role in co-ordinating the work of the team members and ensuring the necessary systems and communications are in place.
- The role can be provided by a worker with leadership skills, experience of working in mental health services for older people and a good understanding of the roles and responsibilities of all staff.
- This role could be open to any profession.

- It is essential to establish both line management and professional support systems for team members which in turn supports the Team Leader/Manager role, enabling the team to 'stick to its brief' and to perform the essential role they were set up to perform.

### **The Social Worker/Care Manager**

- brings a social care perspective to the care treatment, and management of the older person and their carers.
- Under the NHS and Community Care Act 1990, social workers have a statutory duty to assess the needs of 'any person in need' of care or support.
- Under the Carers Recognition of Services Act, 2001, it is their specific responsibility to assess the needs of carers.
- Use of the Health Act flexibilities can broaden out these duties in order for them to be shared by the whole team, avoiding the need for duplication of caseloads, breach of the therapeutic relationship and the increased intrusion into the life of the service user or their carer.

### **Approved Social Worker**

- is a social worker who is 'approved' under the Mental Health Act (1983). This act gives social workers a central function in the care and protection of mentally disordered people.
- The status and relationship of the ASW in CMHT (OP)s needs to be carefully considered. to fulfil the spirit of the current ASW role, the social worker needs to have some degree of independence. However, the impact on the quality of the service to the older person by the ASW sitting outside of an integrated team needs to be considered.
- scarcity of ASWs often means that for Local Authorities to provide sufficient cover, ASWs often need to participate in a non-specialist ASW rota. Requests for assessment and follow up takes them away from their base team potentially causing imbalance in a well-managed Team approach. Specialist ASW rotas would therefore seem to be an ideal to work towards.
- At present, the local authority has a duty to appoint ASWs, based on a history of social workers only working as the employees of Local Authorities. With the advent of Partnership and Care Trusts and the integration agenda, social workers may become the employee of an NHS organisation. Interpreting the 'duty to appoint' as meaning social workers cannot be employed by the integrated service provider has the potential to undermine the integrated nature of the CMHT (OP). Legal advice may be helpful in resolving this, although this stands to be clarified by the publication of the new Mental Health Act, where in the current draft of the bill, references are made not to the 'approved social worker' but social worker/mental health professional.

### **The Community Psychiatric Nurse**

- brings experience from working on in-patient wards with older people in both an assessment and continuing care environment. Useful skills will have been acquired for planning and implementing care in a person's home or a care setting.
- They will have developed skills of communicating with people who are experiencing mental health problems, and have knowledge about medication regimes which give them the ability to plan and deliver care for people whose behaviour has been severely compromised by their mental illness. Such knowledge can strengthen the team's ability to treat and support people in the community.
- In an integrated team setting, there is an opportunity for CPNs to take on what were roles previously performed by social care staff in support of the consequent improvement in service and care to service users, their carers and families.

### **The Occupational Therapist**

- can promote a team focus on rehabilitation for the older person with mental health problems, enabling individuals to retain or recover skills they need to live as independently as possible.
- The College of Occupational Therapists reports an increased demand for occupational therapists, recognising the contribution they can make in developing services that promote independence. The move to integration fits with the profession's holistic philosophy and is seen as an opportunity for occupational therapists to modernise their contribution to health and social care services.

### **The Psychiatrist**

- the role played by this professional varies, with some psychiatrists regarding the team as a support service to draw from, whilst others regard themselves as a core member of the CMHT.
- Some GPs prefer the convention of referring directly to a consultant psychiatrist. Investing in liaison time with GP practices by other members of the CMHT (OP) can lead to a greater use of team-based referrals.

- One belief is that all referrals should be assessed by medical staff; the counter argument is that all members of the multi-disciplinary team can conduct an initial assessment resulting in quicker, more flexible and more cost effective services and better use of available skills.
- Funding arrangements for payments to consultants for house visits requested by GPs, and the non-payment for visits from team members, have had potential to influence who receives the initial referral request. A variety of funding arrangements have been built into the new consultant contract to address the payment of fees regarding home visits.

### **The Support Worker**

- has originated as either healthcare/nursing assistant posts within the NHS, or as senior care assistants within the Local Authorities. They can therefore be subject to different salaries, hours and travel expenses.
- In NSF implementation, a post called 'support, time and recovery' (STR) workers, was created. Such workers were described as being able to 'help service users have an ordinary life assisting them with their everyday, practical needs in whatever setting they find themselves to facilitate recovery'. STR workers are now being introduced into CMHTs for adults of working age across England.
- In the past, the support worker role has had little or no consistency in expectation of their role. They have not always been fully integrated into teams to deliver care in a holistic way, training and supervision has been inconsistent, their status has been low with post holders often not highly valued.

### **Care Brokers**

- They have developed a role in some CMHT (OP)s.
- In addition to taking care of much of the paperwork involved in setting up care packages, these staff are well-trained and experienced in negotiating the financial aspects of care provision with local providers. The aim is to reduce the time spent by mental health professionals in the non-specialist practical arrangements of care packages, without the service user having to interface with another professional.

## **SECTION 7: THE PROCESSES OF THE INTEGRATED CMHT(OP)**

A key component of the delivery of high quality care is integrated multi-disciplinary assessment and care management. Most CMHT(OP) users have complex, multi-faceted needs and require support from both health and social care services.

### **Integrated Care Management and the Care Programme Approach**

Both care management and CPA for people with mental health problems were designed to provide co-ordinated care to vulnerable adults. Although not primarily associated with older people, CPA is of relevance given the criteria for inclusion includes a history of self neglect, often a feature of older people with mental health problems.

A recent study of CPA/CM arrangements shows CPA not being applied in a uniform way, and where it is applied, there is often a duplication of approach with care management. The study concluded that there is considerable scope for greater integration of care management and CPA for older people with mental health problems.

### **CPA and Older People**

Principles relevant to the need to integrate CPA and care management for people of working age are as relevant to older people with mental health problems:

- assessing the range of need
- treatment and care at home
- support for carers of people with significant risks
- in-patient care-planning for admission, expediting discharge.

Only 50% of integrated teams report that older people are routinely included in CPA.

### **Integrated Assessment and the Single Assessment Process**

The key operational responsibility for CMHT (OP)s is that they 'ensure that where it is appropriate for older people to move from CPA to SAP (or vice versa), such transitions are managed with minimum or no disruption to the services that are provided'.

**Guidance** in the Single Assessment Process clarifies the relationship between CPA and SAP

- “The care Programme Approach (CPA) should be applied to older people with severe mental illness due to schizophrenia or other psychoses. The assessment of their needs should be based on the Single Assessment Process (SAP) for older people
- SAP, plus critical aspects of CPA, should be applied to other older people with severe functional or organic mental health problems, who were they younger would be provided for under CPA
- When individuals subject to CPA reach old age, switches to SAP are not inevitable, and should only be made in the best interests of individuals and the continuity of their care”

The guidance goes on to say

*“For older people with severe mental illness, such as schizophrenia, localities should apply CPA. When doing so, the assessment and care management aspects of SAP should be applied to all other older people with mental health problems including depression and dementia. If, because of their needs, such older people would have been placed under CPA had they been younger, localities should consider applying critical aspects of CPA to their care.....”*

### **Integrated Assessment**

Accurate and balanced risk management is at the heart of the assessment role of the CMHT. Safety and security need to be balanced against autonomy, opportunity and choice.

Given the different approaches and policy guidance between health and social care agencies, a risk management policy that is acceptable to all, is required to promote effective integrated working. CMHT(OP)s need to provide members with a framework for sharing risk management and a decision making process – with leadership clearly accepted by a nominated senior clinician or the team manager. Risk management protocols need to be in place.

### **Access to Health and Social Care Services**

Better care for OPMH has been associated with:

- Working across traditional health & social care boundaries, having prompt, flexible access to services
- ‘Forget me not’ audits resulted in the Commission concluding that ‘community based professionals need to have ready access to a range of flexible services including the practical and therapeutic resources of both health and social care agencies in order to help users and carers appropriately’.
- The Audit Commission recommends a single point for all referrals into the Team to ensure a co-ordinated and prompt multi-disciplinary response.

### **Designing Effective Care Management Systems**

Effective care management depends on the following elements being in place:-

- an assessment and care management procedure which is agreed and ‘signed-up’ to by all team members
- breaking down territorial boundaries between health and social services agencies and between health and social care professionals
- devolution of decision-making to CMHTs, including devolved budgets
- conducting joint multi-disciplinary assessments and maintaining shared records
- a single point of entry for referrals

### **Joint Recording Systems and IT Systems supporting both CPA and SAP**

Advances in information and computer technology offer the potential to improve information exchange and managers to review and monitor performance. There appears to be no evidence of fully compatible IT systems between health and social services.

The use of single multi-agency files is limited, but can improve the management and co-ordination of care.

### **Charging for Care**

- Despite inter-agency working resulting in shared commitment to CMHT goals, this can be put at risk because of external pressures to determine the cost of health and social care. The advent of pooled budgets may relieve this pressure.
- Even where there are pooled budgets, it remains necessary to charge for some social care services. Councils have had the power to charge for social services within the 1948 National Assistance Act, which recognised the principal that while health services should be delivered free, charges for social services were acceptable.
- Local Authorities can now delegate specified charging functions for care services to NHS Trusts, but Councils need to ensure that NHS based staff are fully trained to advise in all aspects of charging, including assessment of a person’s ability to pay charges, and their entitlement to state benefits.

- Guidance stresses that 'it is of the utmost importance that service users understand which services are provided free by the NHS. It is important to be clear what elements of need are healthcare and which are social care'.

### **Continuing Care**

An important responsibility of local commissioners is the application of an effective continuing care policy to support the CMHT(OP), in arranging for the care of service users.

Strategic Health Authorities have a responsibility to take 'such steps as it considers reasonable to obtain the agreement to the proposed criteria of each Primary Care Trust situated in the Authority's area, and each Local Authority, within its area.

## **SECTION 8: THE INTEGRATED CMHT(OP)**

### **Integration of Two Agencies**

Five stakeholder conferences held in 2003 concluded the 'joint appointments between health and social care have made a real difference to effectively delivering services'.

The potential benefits identified as flowing from the integrated CMHT (OP) are illustrated below.

Positive Aspects of Integration, rated by the number of times mentioned :

<b>Community-Based Care</b>	Enhances the opportunity to maintain people at home for as long as possible and minimizes hospital admissions
<b>One-Stop Shop</b>	Provision of specialist and comprehensive assessment, intervention and care for users and carers at a "one-stop show"
<b>Networking</b>	Advantages of a multi-disciplinary team, including sharing of skills, resources and knowledge and opportunity for networking
<b>Inter-Agency Working</b>	Established good links within disciplines and with other organisations/sectors
<b>Speed of Service</b>	Ensures a quick response for users/carers
<b>Value-for-Money</b>	Financially beneficial as increases economies of scale and is more cost-effective compared to wards
<b>Co-ordinated Care</b>	Ensures continuity of care between the home and hospital
<b>Efficient</b>	Reduces duplication through joint assessment, documentation and identification of health needs
<b>Normalising</b>	Provides a less institutionalised form of care thereby reducing the associated stigma and prejudices
<b>Galvanising</b>	Leads to a shared vision of the future direction of mental health services for older people

To date there are only limited degrees of integrated CMHT(OP)s. There is a view that the low priority of older people's mental health has led to a lack of resources, training time, and development of such teams. A lack of commitment at senior level was a common issue said to be standing in the way of integration.

The most commonly cited issues standing in the way of integration were:-

- no compatibility between all systems of CPA & SAP
- terms and conditions of employment
- budget management
- electronic and paper information keeping

Where integration had taken place, only limited use had been made of Health Act flexibilities to create interagency working arrangements. Both health and social care professionals commission social care services in a very small proportion of integrated CMHT(OP)s.

### **Integration Consolidated by Health Act Flexibilities**

**The integrated CMHT in the Royal Borough of Kingston**, set up nine years ago, was highlighted as an example of good practice by Shard and Cox in 1998. There is now a section 31 partnership agreement between the local authority and the mental health trust for management of mental health services. There is a joint strategy for older people between the acute trust, primary care trust, local authority and the mental health trust. The borough is home to 20,000 older people and is served by 30 GP practices.

The core functions of the team are

- assessment, identification of the individuals health and social care needs

- implementation of the combined health and social care plan to meet those identified needs
- commissioning of services required, both in terms of health and social care
- implementation of the plan, monitoring
- reviewing the health and social care plan

**Croydon Integrated Mental Health of Older Adults** is another example of good practice. They describe their experience as follows.

“Our experience has enabled us to begin to:

- offer a continuity and continuum of care to clients and carers
- reduce duplication and be more seamless for clients and carers
- improving communication and understanding
- breakdown professional boundaries and silos
- work with others more closely, i.e. primary care, voluntary sector and community

Crucial to being able to do this and making it work are:

- all team members being co-located together
- a single management and reporting structure
- clear professional supervision structure
- commitment and buy-in from senior management and commissioners
- clear communication and consultation
- motivation and commitment of front-line staff and managers
- good relationships locally
- involvement of users, carers, voluntary and community organisations

What would help us to develop this further is:

- an integrated performance management framework
- pooled budgets
- specific key performance indicators/targets
- ring fenced grants/development/growth funding from the centre
- joint commissioning with a single lead commissioner
- clarity on health commissioning i.e. either mental health or older people

## **SECTION 9: THE OUTCOMES OF THE INTEGRATED CMHT(OP)**

- This section emphasizes that a crucial element of developing a new service is evaluating its outcome. There is a paucity of good outcome studies on the concept of community mental health teams and the section is rich in offering some suggestions as to how this might usefully be accomplished.
- Evaluation of services: this form of outcome measurement involves bringing together elements of performance monitoring, audit and research. However, a crucial step is to be clear about what is being evaluated and why. For example, is it an ‘impact evaluation’ where the outcomes and effectiveness of the service is determined for individuals or groups of individuals, or is it about a specific aspect of the service such as ‘integration’ which might cover how well professionals work together, difficulties encountered, achievements, and how they jointly achieve the team’s aims? There are also questions about who the evaluation is for.
- There is a brief but useful discussion about the design and methodology used in such studies (page 58 – 59).
- The section emphasizes that the ‘real test’ of whether or not integrated care is working is whether outcomes for users and carers are improved. This raises important issues about collating the views of users who are ‘dis-empowered’ or traditionally thought to be ‘unreliable’ sources of information (such as people with a dementia). Evidence about what service users and carers want from CMHTs (OP) is limited, but having such a viewpoint would obviously be important in establishing whether an integrated service is meeting those needs or not and would be one aspect of the service’s evaluation. This does emphasize that the whole process of obtaining carer and user views is complex, time-consuming and requires very specific effort.
- Evaluating service outcomes has 3 aspects:

- ❖ **Performance assessment** – the collection of information generated through record keeping or management information systems that monitor the functioning and costs of running a particular service (relevant performance indicators are listed in Appendix 8 and include areas such as missed out- patient appointments, psychiatric re-admissions, trend analysis, suicide rate, transition of care, the number of patients with copies of their own care plan). There are also a number of indicators provided by Social Services (Appendix 9).
- ❖ **Service Evaluation** – covering processes, outputs and outcomes. An example of a service evaluation is that provided by the Audit Commission's 'Forget-Me-Not'.
- ❖ **Research** – this aims to evaluate the overall function of a particular aspect of the service using validated measures or research tools. Examples are given of research studies evaluating the outcomes and/or effectiveness of psychogeriatric teams. In reviewing these, a number of methodological weaknesses are identified including non-representative samples, incomplete data sets, lack of comparison data, and limited confidence about outcomes being linked to the intervention of the team.
- On the whole, this section provides very important ideas about the evaluation of CMHT (OP), drawing on the work (and mistakes) of other mental health teams. I think it emphasizes that the area is relatively poor in terms of the standard of evaluations carried out so far, and that perhaps mental health teams are based on an assumption of good practice that has not yet been clearly evaluated or accurately compared with other ways of working. Evaluation of such services demands time and resources.

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