Community mental health teams for older people in England: Variations in ways of working

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RESEARCH ARTICLE

Community mental health teams for older people in England: Variations in ways of working

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Objective: Integrated community mental health teams (CMHTs) are a key component of specialist old age psychiatry services internationally. However, in England, significant shifts in policy, including a focus on dementia and age inclusive services, have influenced provision. This study portrays teams in 2009 against which subsequent service provision may be compared.

Methods: A bespoke national postal survey of CMHT managers collected data on teams' structure, composition, organisation, working practices, case management, and liaison activities.

Results: A total of 376 CMHTs (88%) responded. Teams comprised a widespread of disciplines. However, just 28% contained the full complement of professionals recommended by government policy. Over 93% of teams had a single point of access, but some GPs bypassed this, and 40% of teams did not accept direct referrals from care homes. Initial assessments were undertaken by multiple disciplines, and 71% of teams used common assessment documentation. Nevertheless, many social workers maintained both NHS and local authority records. In 92% of teams, nominated care coordinators oversaw the support provided by other team members. However, inter-agency care coordination was less prevalent. Few teams offered the range of outreach/liaison activities anticipated in the national dementia strategy.

Conclusions: Compared with previous studies, teams had grown and changed, with a clear increase in non-medical practitioners, particularly support workers. Measures to facilitate integrated care within CMHTs (eg, common access and documentation) were widespread, but integration across health and social care/primary and secondary services was less developed. Consideration of barriers to further integration, and the impact of current reforms is potentially fruitful.

KEYWORDS

community mental health teams, consultant psychiatrists, integration, older people

1 | INTRODUCTION

Community mental health teams (CMHTs) for older adults are internationally regarded as the exemplar first-tier specialist service for psychiatric support in later life.[1-3] In England, the development of specialist community teams dates from the 1940s,[4] yet the more recent history of service design is characterised by variability and constantly shifting policy priorities. Two national analyses at the turn of the century found much divergence in provision; CMHTs were fully available in less than half of areas, and there was a widespread need for more day and respite care.[5,6] Moreover, this client group were not included in the national mental health strategy[7] and received scant attention (and no dedicated resources) in the older people's strategy.[8] The publication of *Everybody's Business*, a service development guide, in 2005, was thus widely welcomed.[9] This identified multidisciplinary (ideally multiagency) CMHTs with streamlined referral systems and common assessment and care planning processes as the "backbone" of comprehensive services for older adults with mental health problems. However, once again, there were no new monies.

It was not until 2009, with the launch of the National Dementia Strategy,[10] that real momentum for change was gained, and the last few years have seen a steady stream of initiatives designed to improve care for this client group.[11-14] Initially, this new focus on dementia prompted many services to separate support for people with organic

and functional disorders, with treatment for the latter amalgamated within CMHTs for working age adults to create "ageless" or "age inclusive" services. Indeed, by 2012, 1 in 5 Trusts had moved to ageless services or planned to do so imminently.[15] A concerted effort by old age psychiatrists and other interested organisations, however, supported by new evidence that ageless services were less effective in meeting needs than specialist old age services challenged these moves.[16] Age inclusiveness was pronounced counterproductive by the Mental Health Taskforce,[17] and older adult CMHTs were reinstated as the preferred model.

This renewed attention has brought some important challenges into sharper focus. Not least of these are the rising number of older people with mental health problems, and the continuing policy drive to treat ever more people in the community via integrated services.[18] However, the content of the latter is not clear. Definitions of integration vary (covering different disciplines, services, and agencies), and concerns have been expressed that staff in integrated teams may become deskilled, with a potential loss of specialist expertise and medical leadership.[19,20] Further, there is a lack of routinely collected good quality data with which to compare services at a point in, or over, time.[21]

Against this background, the paper summarises the core features of variation in the structure and organisation of CMHTs in England in 2009—the beginning of this period of change—providing a baseline against which subsequent developments in practice and emphasis can be evaluated.

2 | METHOD

A postal questionnaire was sent to the managers of all 429 CMHTs for older people in England identified in the 2008 Combined Mapping Framework[22] in November 2008. Data collection closed in March 2009. The schedule was developed by the research team in collaboration with a steering group of experts in old age mental health services and was piloted with 6 teams from 3 mental health trusts (organisations delivering specialist mental health services). The content was informed by previous surveys of CMHTs and consultants in old age psychiatry[23-25] and a review of the literature,[26] and covered 3 main domains. Information was sought on teams' structure and composition (eg, location and staff mix); organisation and working practice, including several indicators of joint working (eg, access, assessment and care planning arrangements); and liaison and support activities.[27-29] Precoded response sets were provided for most items, but free text boxes encouraged respondents to expand/clarify their answers to particular questions. As not all items were applicable to all respondents, the following figures are given as a percentage of those participants who answered each individual question.

3 | FINDINGS

Three hundred and seventy six teams returned data—an 88% response rate. This included at least 1 team from 93% of trusts. Whilst most teams saw a mixture of patients with functional and organic mental health problems, 4 teams saw only patients with dementia, and 2 saw only patients with functional disorders. Comparison of respondents with the full sampling frame indicated no significant response bias with respect to geographical spread or selected team characteristics.

Key points

- Care coordinators usually oversaw care provided by team members, but inter-agency care coordination was less prevalent
- Compared with previous work, there was a clear increase in non-medical practitioners and unqualified support workers in teams
- Relatively few teams offered the range of outreach/liaison activities outlined in England's national dementia strategy
- Despite systems to coordinate care within teams, integrated work between health and social care and between primary and secondary care was less common

3.1 | Team structure and composition

The majority of teams had been in operation for more than 5 years (72%); covered an urban or mixed urban and rural catchment area (85%); and were based in community mental health centres or alongside old age psychiatry inpatient wards (70%). Approaching three-quarters (71%) worked with 1 local authority (units of local government responsible for the provision of social care); 17% worked with 2; and the remainder worked with 3 or more.

Questions about team composition differentiated between "core" team members (who devoted most, if not necessarily all, of their time to the CMHT and/or had greater responsibility for its operation) and "sessional" members (who had regular but more limited input). Almost all teams had a team manager or coordinator (97%), who was typically a nurse by profession (73%). However, there was considerable variation in team size, with a mean of 18.1 members (standard deviation 8.8), and a range of 1 to 47 (excluding administrative staff). Of these, the vast majority were core staff (mean 16.5, standard deviation 8.0). Nevertheless, just 28.5% of teams could be seen as comprehensive containing a full complement of consultant psychiatrists, community mental health nurses, occupational therapists, psychologists, social workers, and support workers (a generic term for unregistered, assistant-grade practitioners), whilst almost a tenth (9.6%) were unable to access *any* psychology input and around 1 in 20 (4.3%) lacked occupational therapy input.

Community mental health nurses were the most frequently reported (and numerous) profession (see Table 1), while consultant psychiatrists, occupational therapists, and support workers were core members of more than four-fifths of teams. Consultant psychiatrists were also amongst the 3 disciplines most likely to provide sessional input (along with other doctors and psychologists). However, it

TABLE 1 Core team membership

Member	Percentage of teams that contained different practitioners	Mean number of staff (range)	
Team manager	93.9	1.2	(0-6)
Community mental health nurse	98.9	5.5	(0-19)
Consultant psychiatrist	82.7	1.3	(0-9)
Other doctor	64.6	1.1	(0-6)
Occupational therapist	84.0	1.2	(0-4)
Psychologist	50.3	0.6	(0-3)
Social worker	66.8	1.8	(0-10)
Support worker[a]	87.0	2.5	(0-15)
Other[b]	40.0	1.1	(0 to 30)

[a]A generic term for unregistered, assistant-grade practitioners.

[b]Including dieticians, speech and language therapists, and physiotherapists.

appeared that teams were both growing in size and changing. Almost two-thirds of respondents (63%) identified that there had been major changes to the way their team was organised in the previous 12 months (eg, in staff numbers, management structure, or team organisation).

3.2 | Organisation and working practice

3.2.1 | Referrals

Teams accepted an average (mean) of 43.4 referrals in the previous calendar month, ranging from 10 to 250 (median = 36), dependent, at least in part, on team size (r = 0.47). As would be expected, almost all teams (96%) received a large proportion of their referrals from General Practitioners (GPs). Over and above this, practice varied widely. Whereas approximately an eighth of teams (12.8%) received a large proportion of referrals from care homes, more than a third (40.4%) did not accept referrals from this source. Likewise, less than half of teams accepted referrals from voluntary organisations and a similar proportion did not accept self-referrals.

In nearly all teams, referrals were received via a single point of access (93.3%, Table 2), whilst day-to-day decisions about the eligibility of referrals and the allocation of cases to different team members were generally made by the team as a whole (51.5% and 46.1%, respectively) or the team manager (29.2% and 42.6%, respectively). Although four-fifths of teams (80.4%) used formal referral eligibility criteria, around an eighth of teams lacked such criteria and a further 7% had them, but did not use them (Table 2).

3.3 | Assessments

Approximately a sixth of referrals were seen with a week of receipt of referral (16.6%), and approaching two-thirds of referrals within 2 weeks (63.3%, Table 2). Almost all referrals were seen within 1 month (94.3%). Community mental health nurses and consultant psychiatrists were most likely to conduct initial assessments (see the first 2 columns of Table 3), and consultant psychiatrists were said to see all or most of the team's caseload at some point in over half of teams (57.6%). However, other doctors and occupational therapists also conducted initial assessments in approximately three-quarters of teams, and where psychologists or social workers were core team members, the probability that they would undertake initial assessments increased to 61.6% and 78.6%, respectively.

TABLE 2 Care process (% teams reporting different activities)

Activity	%
Referral and assessment	
Single access point to referral	93.3
Referral or eligibility criteria	
Used regularly	80.4
Not used regularly	7
Use same structured assessment documentation	70.7
Time from referral to first visit	
<1 week	16.6
<2 weeks	46.7
<1 month	31.1
>1 month	5.6
Team using electronic service user records?	70
Team and the local services team able to access each other's service user records	31.6
Medical input	
All or most of team's caseload seen by consultant psychiatrist	57.6
Care plan	
Service users having a single care plan with details of each team member's input?	86.8
Staff group authorising services funded by local authority	
Community mental health nurses	14.4
Consultant psychiatrists	1.6
Other doctors	0.8
Clinical psychologists	0.8
Occupational therapists	8.8
Social workers	43.5
Support workers	3.5
Service users routinely receiving copies of:	
Care plan	85.8
Clinical letters	53.3
Case management	
Care coordinator who coordinates care provided by the team	92.5
Care coordinator who coordinates care provided by both team and other services	59.7

TABLE 3 Staff roles (% teams reporting different staff)

Staff group	Conducts initial assessments (% of teams[a])	Acts as key worker/care coordinator (% of teams[a])
Community mental health nurses	99.2	98.7
Consultant psychiatrists	92.0	68.0
Other doctors	76.3	43.2
Occupational therapist	73.9	78.1
Psychologists	47.5	44.3
Social workers	59.7	61.3
Support workers	3.5	9.9
Other	6.7	5.3

[a]Figures relate to all teams. Note, as above, some teams will not have contained particular professions.

Nearly all assessments (93.3%) were conducted in patients' homes. However, 187 teams indicated that practice varied by professional group. Of these, the majority (88.7%) said that nurses were particularly likely to conduct assessments in patients' homes, whilst just 8% said psychologists were particularly likely to do so. All staff groups used the same structured assessment documentation in just over two-thirds of teams (70.7%).

3.4 | Case management, care planning, and case closure.

In the vast majority of teams (92.5%), all or most patients had a named care coordinator who oversaw the care provided by the team, whilst a similarly high percentage (86.8%) said that all patients had a single care plan which contained the details of each member's input as well as support from other services, such as day or home care. By contrast, considerably fewer teams (59.7%) said a named care coordinator oversaw the input provided by both the CMHT and other services/agencies for all or most patients, and only a third of teams (31.6%) were able to access local social services team records for their patients (Table 2).

Community mental health nurses were most likely to act as care coordinators, followed by occupational therapists, consultant psychiatrists, and social workers (see the right-hand column of Table 3). However, in teams where social workers were core team members, the likelihood that they would take on a care coordinator role increased to 81.1%. Not surprisingly, within teams, social workers were most likely to authorise services funded by the local authority (43.5% of teams), although in a significant minority of teams (14.4%), community mental health nurses also had this authority. Lead responsibility for closing cases was taken by individual team members in 33.1% of teams; the team as a whole in 37.1%; and the team manager in 15.2%.

3.5 | Liaison and support activity

Nearly all teams (96%) provided support for staff in mainstream settings over and above their response to case-by-case referrals (Table 4). Much of this appeared to be informal (eg, the provision of telephone advice). However, 92% undertook some type of formal outreach activity in at least 1 mainstream setting, with nearly three-quarters of these (73.4%) having formal arrangements with care homes, and approaching half (47.1%) providing support for day centres.

Education and training were the most common form of support (provided by 75.9% of teams), whilst approaching two-thirds of teams (63.2%) had dedicated link workers (individual team members nominated to liaise with and act as a first point of contact for staff) in particular settings. By contrast, far fewer teams ran case finding or screening programmes, or open clinics (regular scheduled visits to see/discuss people causing concern).

Community mental health nurses (CMHNs) undertook outreach work in 96.3% of teams. However, occupational therapist and consultant psychiatrists also had outreach roles in 64.2% and 60.1% of teams, respectively.[25]

4 | DISCUSSION

This paper provides a unique picture of the configuration of CMHTs for older people in England at the start of a period of intense interest in the needs of older people with mental health problems, with a focus

TABLE 4 Liaison and support (% teams reporting different activities)[a]

	Form of support				
Setting	Open clinic	Link worker	Case finding and/or screening	Education or training	Other general liaison work
GP surgeries/primary care	3.1	23.8	5.3	17.5	40.4
Care homes	6.4	34.1	11.6	60.9	50.1
Day centres	4.4	21.6	7.5	35.7	51.3
Social service teams	1.1	16.3	12.5	25.8	57.1
General hospitals	3.3	21.6	11.9	18	49
Home care providers	1.7	8.6	4.2	31.6	45.2

[a]Figures refer to the 96% of teams that said they undertook liaison work.

on team structure and composition, organisation and working practice, and liaison and support activities. As such, it provides an important benchmark against which subsequent service provision (or provision in other countries) can be compared and gives some indication of the challenges they faced. The discussion explores some of the key issues raised by the findings, with particular consideration of the implications for the drive towards greater integration, and the role of consultant psychiatrists.

4.1 | Team structure and composition

Compared with a previous survey of old age psychiatrists in 2004,[25] this study suggests that the profile of CMHTs was becoming more multidisciplinary, with an increase in the representation of all 6 key disciplines advocated by policy guidance[8,9,18] and a trend towards core as opposed to sessional team membership, in which staff may have divided loyalties between services and roles. Particular growth was seen in the proportion of teams that contained occupational therapists and psychologists as core staff (up from just under two-thirds to 84.0% and a third to 50.3%, respectively). The staff mix and roles appear not dissimilar to those described in service statements in Australia.[30] However, the most striking change was in the number of teams containing assistant-grade support workers (87.0%), considering that just 4 years previously, a quarter of teams had no access to them at all. Recent qualitative work has shed light on the wide variety of tasks that support workers undertake in CMHTs, and the supervisory and training challenges this brings.[31] Nevertheless, still less than a third of CMHTs had all 6 key disciplines as core team members; almost a third had no core team social workers; and a tenth could not access any psychology input. Further, the findings reflect a global trend in healthcare provision towards an increase in the proportion of unqualified as opposed to qualified staff,[32-34] and a relative increase in the presence of non-medical as opposed to medically trained personnel. For comparison, it is noteworthy that Old Age Psychiatry as a specialty has been described as largely an Anglo-Saxon phenomenon and in Europe services are highly variable.[35,36] One report suggested that only the Netherlands, Switzerland, and the UK possessed a significant level of specialist provision.[37]

4.2 | Organisation and working practice

The study found that almost all CMHTs had a single point of access (a measure expected to facilitate integrated care). However, free text comments suggested that practice was more "messy" than this suggested. For example, some respondents stated that particular GPs "deliberately" sent referrals to preferred consultants with a view to bypassing the system, whilst others said that primary care practitioners lacked knowledge and understanding of the referral process. The finding that around an eighth of teams lacked formal referral criteria may not have helped in this respect, albeit the development of such criteria per se is not of course sufficient to ensure their regular use.

The large proportion of referrals that came via primary care was not a surprise, whilst compared with a study in 2000,[23] the proportion of teams that accepted referrals from friends, relatives and neighbours appeared to have risen considerably (from approximately a quarter to half). The proportion of teams that accepted referrals from care homes had also increased. Nevertheless, despite the high number of care home residents with complex mental health problems,[9,38] 40% of teams still did not accept direct referrals from this source. In many cases, this was because respondents required GPs or other physicians to rule out any physical explanation for residents' presenting symptoms prior to their referral. Whether the benefits of such screening outweigh the potential delay in mental health assessment is not known. Moreover, ease of access to health services is itself an indicator of care quality,[39] and past research found fears that open access might release a flood of inappropriate referrals were not substantiated.[40-42]

Writing about a series of visits to high profile old age psychiatry services in the UK over 20 years ago, Dening[43] found the most contentious issue concerned who should undertake initial assessments. The majority of services he visited argued that all referrals should initially be seen by medical staff, but opponents of this view felt that with training assessments could be undertaken all CMHT members and that this was more efficient and cost-effective. Further, a series of contemporary studies appeared to suggest that not all initial assessment needed to be performed by a doctor in terms of the accuracy of diagnosis.[44-46] The current study suggests that by 2008 it was common practice for multiple professionals to undertake such assessments, perhaps at least partly in response to the relative increase in the availability of non-medical as opposed to medical time. However, little is known about the relative outcomes of patients assessed (or managed) by non-medical as opposed to medical personnel, or indeed of teams in which all or most patients are seen by a consultant, as opposed to only some, and the finding that over half of teams said all or most patients were still seen by a consultant at some point is notable, not least for its resource implications.

Whilst common assessment and care planning processes are seen to facilitate effective information sharing and integrated care,[9,18] this survey found that in almost a third of teams, staff used different assessment documents. Free text comments suggested that doctors, in particular, often maintained separate records, whilst many respondents reported that social workers were required to complete *both* the team's paperwork *and* separate local authority reports, duplicating rather than streamlining work. Similarly, although there had been a considerable increase in the proportion of teams in which all or most patients had a single care coordinator since 2004 (from 84.5%[25] to 99.7%), still more than 1 in 8 teams did not allocate a care coordinator to oversee the inter-agency care of *any* of its patients, suggesting case management was by no means fully implemented. Cross agency informing sharing was similarly at best, limited.

Despite the introduction of certain structures to deliver integrated care *within* teams, therefore, less progress appeared to have been made on measures that required a higher degree of trust and cooperation at an agency level. This begs the question as to whether this matters for patient care. An observational study comparing patients supported by integrated and non-integrated CMHTs identified that integration was associated with the delivery of more intensive and wide-ranging community support, but no evidence could be found that patient outcomes were otherwise improved.[47] A robust evidence base

to support efforts towards integrated care remains elusive. Nevertheless, it is cited as a policy goal and activity across jurisdictions.[48,49]

4.3 | Liaison and support activities

Given the very high number of older people with mental health problems in England with more than 680 000 people with dementia alone in 2013,[50] it clearly is not possible for specialist mental health services to see them all. Moreover, this should not be necessary, for with support from specialist personnel, primary care and general hospital staff appear able to diagnose and manage the majority of clients.[8,51,52] The National Dementia Strategy[10] advised an extension of the CMHT role to support care homes, and the present study suggests this is needed, for whilst the majority of teams provided support to such staff, relatively few offered the full range of formal structures arguably expected, including link workers and case finding activities. Furthermore, the overall pattern of support provided to staff in mainstream settings (including primary care) was patchy, and many teams said they lacked the time and resources to provide the assistance required. Other jurisdictions have similarly demonstrated and advised the development of such links.[35,48,49,53]

4.4 | Methodological issues

Whilst the survey's high response rate (>85%) gives confidence in the representativeness of the findings, the results express the views of just 1 stakeholder group (team managers) and other team members may have had different perspectives. Further, although the paper details how teams worked, no attempt was made to assess the sufficiency or quality of services. In addition, particularly in larger units, it appeared there was some variation in what exactly constituted "a team". Thus, although the vast majority of respondents described their CMHT as a single, discrete entity, a small number of teams (<5%) appeared to have a broader remit than would be expected (including staff usually employed in separate memory or home treatment services). However, it is possible that these responses were from service (as opposed to team) managers and related to multiple teams.

5 | CONCLUSIONS

This survey indicates that although many CMHTs had put in place many of the measures designed to facilitate more integrated care *within* teams, less progress had been made in the integration of care *between* agencies (health and social care) or *between* primary and secondary services, despite the obvious importance of joint working across these interfaces. Some features of traditional "silo working" appear still present in some teams, such as a lack of standardised assessment documentation across all professions. Notable in comparison to earlier work was the growth in number of unqualified support-grade staff. This survey acts as a baseline against which to examine developments, as teams continue to be subject to varied policy and resource pressures.[54] There remains an urgent need to continue to monitor the way in which services develop and the impact of these changes.

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