Copy 1

CONTENTS

CARING TOGETHER

MENTAL HEALTH

Ageing is associated with health unless there is a sickness or disability. Some ill health and disability can be prevented. When this is not possible, the majority of problems are dealt with through self-care, with support from relatives or friends. When these support systems fail, proper diagnosis and treatment may be required.

The main focus of health promotion in old age rests, therefore, with individuals within their own environment, with health professionals playing a vital role in transferring knowledge and adapting skills so as to enhance the possibility of meaningful, autotomous and satisfying lives for elderly people within their communities.

Taken from the Preface of "Promoting Health among Elderly People"
King Edward's Hospital Fund for London 1988.

INTRODUCTION

Mental Health problems of the elderly are enormously diverse. Not only are the problems extremely varied, but so are the settings in which they occur, the variety of professionals who may help the elderly cope and, finally the kinds of premises that can be provided to respond to these diverse needs. Prevention of mental illness and promotion of mental health in the elderly requires innovative approaches. In contrast to the younger people for whom prevention efforts are initiated before the expression of the disease, prevention and promotional activities for the elderly tend to be directed at persons who already have one or more chronic disease conditions and may be at risk of acute illnesses[1] . Consequently rather than cure, totally reverse or completely prevent diseased conditions prevention and promotion strategies for the elderly persons need to be directed at modifying and delaying further decline. The aim needs to be to increase the elderly persons capacity for improving the quality of life.

Specific problems of later life may be alleviated or reduced through particular interventions and service delivery systems.[2] The Development and implementation of programmes that address specific problems or diseases, e.g. stress, can reduce the individual's risk of poor health, improve mental health and assist in developing more encompassing problems. These programmes and promotional activities attempt to improve the health and well being of individuals and groups by providing people with the information, skill, services and support needed to undertake and increase positive changes in their life-styles. This holistic approach considers the human mind and body and spirit as well as the social, economic, political and environmental networks which affect the life of the individual.

As Unit General Manager for the Mental Health Unit (Mid Staffordshire Health Authority) it is an important concept of my role to plan prevention and promotion programmes for mental health. With the increasing number of elderly persons to care for it is essential that the diverse needs of the elderly are recognised; both in terms of prevention and promotion.

Both as an individual and also in terms of the Mental Health Unit as an entity I recognise that benefits could occur by studying prior efforts/programmes implemented by others working in the field of mental health promotion for the elderly. Although such programmes tend to be relatively new, a number of excellent programmes are operating which can provide useful information and insight into this area of care.

The Travelling Fellowship of the Kings Fund College allowed me the opportunity to visit a number of agencies in the U.S.A. and Canada (SEE APPENDIX 1) that provided health promotion programmes for the elderly.

With this opportunity to analyse, compare, contrast and to a certain degree evaluate such programmes, my knowledge of mental promotion amongst the elderly and in particular amongst the confused or elderly mentally ill was significantly increased. Following the visit there has been the opportunity to modify the Caring Together Scheme (APPENDIX 5) taking into account a number of lessons learned from the programmes seen.

This dissertation describes;

i) work currently being undertaken in Mid Staffordshire to develop services for the elderly at risk

ii) the finding derieved from the tour and

iii) how the lessons learned have been used to modify and improve the Caring Together Scheme.

REFERENCES

1. Health Promotion for the elderly. In A. Somers & D. Fabian (Eds.) The Geriatric imperative (pp187-204) Appleton-Century Crafts. New York

2. Prevention aspects of mental illness in later life. In J. Birren R. B Sloane (Eds) Handbook of mental health and aging. Prentice Hall: Englewood Cliffs. N.J.

CHAPTER 1

THE CURRENT POSITION

Mid Staffordshire Health Authority is a below RAWP target district in a below RAWP target region. The Health District, which is one of 22 health authorities within the West Midlands region, provides health care to a population in excess of 300,000; projected to increase to 330,000 by 1993. Growth is most marked in the 0-4 age group (32%) and in the very elderly, over 85 years old group (67%).(1) The growth in the total numbers of the elderly can be illustrated by the following figures.

There are now 24,000 people over the age of 70 served by St. Chad's. On reducing the age to 65 there will be 35,250 and by 1996 there will be 41,330.(2)

The Authority is one of the largest employers in the area (3500 wte)(3) and consequently contributes significantly to the economy and employment provisions of the community.

	% of total staff (1986)
Nursing	48
Medical, Dental, Scientists	4
Therapists	4
Works Department	8
Ambulance	11
Admin & Clerical	13
Ancillary	16 (4)

The West Midlands Regional Health Authority receives approximately 8% of national funds to divide among its 22 district health authorities. The allocation to Mid Staffordshire is almost 4% of the Regional total. Funds

of approximately £41 million are apportioned amongst the various care groups in the District as follows:

	£ million
Acute Services	14.4
Psychiatric Services	6.05
Direct Services	4.0
Community Services	4.0
Geriatric Services	2.8
Administrative Services	2.0
Mental Handicap Services	.6
Ambulance Services (3 HAs in Staffordshire)	5.1
Joint Finance	1.3
Minor Capital Projects	.5
	40.7

The area covered by the Authority extends over 300 square miles but the major health care facilities are centred in the larger urban conurbations and particularly so in the case of Stafford which has 900 of the 1100 hospital beds in the District. (APPENDIX 2).

Much of the area is rural in nature and consequently was not subject to the same extent of economic decline experienced throughout much of the West Midlands. In fact in a survey based on the 1981 Census, of district health authorities with the highest underprivileged area score (carried out by the Department of General Practice at St. Mary's Medical School) Mid Staffordshire came out as being fourth most privileged out of a total survey of 190 health authorities.

Mid Staffordshire Health Authority is divided up into six units of management (recently revised to 3) each with budgets as follows:

	£ million
District General Hospital	11.4
Stafford General Hospital	4.7
Elderly Unit	3.2
Community & Mental Handicap Unit	4.3
Ambulance	5.1
Mental Health Unit	6.6

The management philosophy of the Health Authority "is to maximise devolution and establish accountability through a task orientated approach".(6) To this end Unit General Managers have been appointed to each of these Units with a direct managerial line relationship to the District General Manager.

The Mental Health Unit

The Mental Health Unit is responsible for the planning, implementation and monitoring of all psychiatric services for the population served.

Therefore the care of the Elderly Mentally Ill is a major objective of the Unit and consumes some 32% of the total budget.(7)

Almost all of the Unit's resources are directed to the provision of in-patient facilities although during the past three years there has been a marked policy change to developing community facilities. Examples include:

i) increasing primary care CPNs from 4 to 14

ii) the commissioning of a mental health centre.

iii) the provision of community day care facilities for addiction services and

iv) the provision of a specialist team of CPN to provide community support for the elderly mentally ill.

St. George's Hospital which provides all in-patient treatment consists of 420 beds and offers a wide range of psychiatric treatments with specialisation in addiction, psychotherapy, personality disorders and forensic psychiatry.

It is generally and widely accepted that the level of care at St. George's Hospital is of a high standard and although the hospital is pre-Victorian, good maintenance of the building stock and estate has ensured that the living conditions for the patients are superior to those one could normally expect from an old psychiatric hospital.

Services for the E.M.I.

During the last three years a number of significant initiatives have been introduced to improve the level of services offered to the elderly mentally ill. These include:

a) Strategy

In May 1987 the Mental Health Unit and the Staffordshire County Council Social Services Department agreed a Joint Strategy which included comprehensive proposals to develop services for the Mentally Ill (including the elderly mentally ill). (APPENDIX 3).

b) Management Arrangements

The revised management structure of the Mental Health Unit (following the appointment of Unit General Managers) divided the work of the Mental Health Unit into four specific areas of care, each with defined objectives to be achieved.

One specific area of care was for the elderly mentally ill. As with the other three sub-units a manager was appointed. The Manager has responsibility for budgetary control, planning and overall management of the services for the elderly mentally ill. This was the first occasion that services for the elderly mentally ill had a designated manager and budget.

c) Developments Commissioned

i) A specialist team of CPNs who work in the community specifically in the care of the elderly mentally ill.

The work of the team includes liaising with and providing advice to nursing homes, part III accommodation, residential homes, etc. as undertaking specific case work in conjunction with the Consultant Psychogeriatrician.

ii) Establishment of a day care facility, in conjunction with the Social Services Department.

iii) Increase in the number of hospital beds for the elderly mentally ill, and

iv) Improved transport facilities to allow both in-patients and day-patients to have greater accessibility to health services and recreational facilities.

However it is clearly recognised that existing facilities provided for the care and treatment of the elderly mentally ill do not meet the needs of this client group and existing provisions do not provide a comprehensive service. With the rising numbers of elderly people who will require help it is accepted by the major service providers that a philosophy of care

substantially based upon the provision of hospital beds will fall far short of providing a truly comprehensive service and will deflect resources away from the provision of services at the point of need.

Therefore a philosophy of care for the elderly mentally has been pursued. This philosophy is based upon one of encouraging, enhancing and supporting culturally valued lifestyles and social relationships.

In putting this philosophy into practice it is essential to develop a comprehensive service for the elderly mentally ill in which the individual's wishes and needs together with those of the individual's family and/or carers are taken into account by those agencies supplying the appropriate service, help, care, support and treatment.

Such a service can only be planned by involving all caring agencies, who provide services for the elderly mentally ill, in discussing both the needs of this group of people and the ways in which these needs can be met.

Consequently a special planning team has been commissioned to study this aspect of care and to make recommendations as to how best the needs of the elderly mentally can be met.

Led by a Consultant Psychogeriatrician the team consists of representatives from Social Services and the voluntary sector and has the opportunity to co-opt from other agencies such as housing and nursing homes.

The recommendations of the group are fed into the formal planning process of the Mental Health Unit and a number of recommendations are planned for implementation.

d) Further developments proposed;

i) The appointment of a second Psychogeriatrician - (1989).

ii) Establishment of a further day centre (25 places) - (1989)

iii) Increasing the number of specialist EMI, CPNs by 4 w.t.e.- (1989)

iv) The development of a charitable trust to provide nursing home places - (1989) (APPENDIX 4)

v) Additional day hospital places (25 places)-- (1992)

In addition to the developments implemented and planned, work has been undertaken in staff training both in terms of attitude and skills. The result is that there is a committed work-force anxious to move towards a comprehensive psychiatric service for the elderly which is integrated with other service providers caring for the elderly.

What else can be done:

If one is to recognise the increasing numbers of elderly people who will require care and if one is to accept the philosophy outlined above then without a doubt a programme of increasing bed numbers (as previously outlined) will not meet the needs of the elderly.

A service to meet the aspirations of the user and their carers needs to recognise.

a) Acceptability - do users of the service think highly of it?

b) Effective - does the service do something in relation to the state of the person's health when the purpose is therapeutic?

c) Access - can all who require service get to it?

d) Economy - when resources are stretched; is the service economic?

e) Equity - are limited resources shared out?

f) Relevance - is the community as a whole assisted?

It is against this background that attempts have been made to design services which will assist in the development of a comprehensive service to the elderly mentally ill.

References

Chapter 1

(1) A Picture of Health - 1986 (Mid Staffordshire Health Authority.)

(2) Development of St. Chad's Unit - draft programme 1988
(St. Chad's Unit provides services for the elderly mentally ill in Mid Staffordshire.]

(3) The First Four Years - 1988 (Mid Staffordshire Health Authority)

(4) The Development of Services for the Mentally Ill - Unpublished dissertation for London Business School Masters Degree 1987.

(5) Chart of district health authorities with the highest under-privileged area score - Dept. of General Practice, St. Mary's Hospital Medical School 1986.

(6) Management Philosophy - Mid Staffordshire Health Authority

(7) Mental Health Unit budget 1987/88

(8) Revised Management Arrangements - Mental Health Unit 1986

Chapter 2

SETTING THE SCENE

In the previous Chapter it was highlighted that deficiencies exist in the level of service provision for the elderly mentally ill within Mid Staffordshire but the extent of the deficiency has not been "measured" and therefore it is extremely difficult to determine the developments required to meet the needs of the population served.

To identify the "problem(s)" outstanding, discussions took place between the author of this report and representatives of a number of agencies. The purpose of these discussions was to prepare a paper for the District Management Board. The aim of the paper was to serve as a discussion document to enable terms of reference to be set for a working party established to look into ways of meeting the needs of the elderly. Although the paper (APPENDIX 5) was to act as a catalyst for discussing the needs of the elderly in general it also served to identify the deficiency in level(s) of service offered to the elderly mentally ill and their carers.

The discussions referred to above involved representatives from such organisations as the voluntary sector (including carers), social services, the primary care providers, general medical practice and consultant medical staff.

In relation to the elderly mentally ill a number of deficiencies in service provision were identified. These included;

i) the need for education of the general public regarding dementia and mental illness in general.

ii) the lack of assistance when an emergency arose.

iii) lack of knowledge about available facilities, e.g. continence laundry service, respite care beds, etc.

iv) problems in identifying the elderly-at-risk and in bringing them into the area of care provision.

v) the need to carry out assessment, by a specialised team, in the earlier stages of dementia and the need to assess the whole person as opposed to assessing the person in respect of their suitability for specific facilities.

vi) the need to develop community networks to replace the reducing levels of social support from friends and family

vii) the lack of knowledge about those at risk.

viii) the absence of a comprehensive directory of available services.

ix) relative lack of co-ordination between service providers and

x) lack of education of the professionals and care staff working in the area of care.

Therefore it was recognised that there was a need to develop increased facilities that help to meet the requirements of the elderly mentally ill outlined above. However, in moving towards filling this gap it was considered essential that this planning exercise did not take place in isolation from the planning of the Mental Health Unit as a whole.

Furthermore any plans/developments for the elderly mentally ill need to recognise the importance of the Unit's overall strategy as outlined in the joint strategy (see below).

In May 1987 the Mental Health Unit of the Mid Staffordshire Health Authority and the Staffordshire Social Services Department agreed upon a Joint Strategy; a document which committed both agencies "to work even more closely together in order that our joint resources can be fully utilised...and in the best interests of the welfare and health of those people who use the services."

Enclosed in the document is the strategic plan which can "only be addressed within a framework of the philosophy of care and the general provision of services". The Joint Strategy is the basic document which incorporates the philosophy and principles of service delivery upon which future patterns of care are determined. Consequently any discussions regarding the development of services for the elderly mentally ill need to incorporate the concepts of care as incorporated in the Joint Strategy.

1. Philosophy of Care

a) The value of the individual

Primarily emphasizes the value of the individual in that all people, irrespective of their needs, have a fundamental right to self-determination on the basis of informed and realistic choices. Thus the individual's wishes and interests must be taken into account by the agencies supplying the appropriate service.

Three underlying and consistent aims in providing assistance to the individual are promoted:

i) to affirm and enhance the self respect and individuality of people

ii) to increase the opportunity for ordinary living

and

iii) to improve mental functioning and thus reduce the effects of disability

b) Value of the service providers

From the user's perspective services are most effective when they are integrated, consistent and responsive to the needs of the individual concerned.

In providing services three basic values are emphasized.

i) Services need to be established to meet the needs of identified users rather than users fitting their needs into an existing pattern of care.

ii) There must be real dialogue between providers and users of the the service in order that the latter will be sensitive to the opinions of the mentally ill.

iii) It is imperative that professionals working in different areas of care are able to accept each other's roles if shared values are to be meaningful.

2. Philosophy of Service Design

i) Whenever possible services must be localised, well publicised and accessible.

ii) Services must be planned on a comprehensive basis providing all patients with a service according to their needs.

iii) Preventative treatment and supporting services will, whenever possible, be non-institutional and community based.

iv) Since in many situations the family are the carers assistance will be given where it is desired to allow the family or the individual to continue to offer care.

v) The feelings of the mentally ill and their families must be considered in the planning of services.

vi) Services must be designed to meet the particular needs of each individual.

vii) At the level of service planning there is the need for a co-ordinated approach by the main statutory agencies together with the active involvement of the voluntary sector.

viii) Particular attention must be given to the position of elderly patients or relatives caring for dependent family members.

ix) It is important to minimise the dependence of the users on professional resources while at the same time providing the level of support and security that is appropriate.

x) An individual's requirement for services needs to be assessed as early as possible and reviewed at intervals.

Thus in planning to improve the level of service offered, any developments need to incorporate the above at the earliest stage in planning. Furthermore any specific programmes of care will only be established when the above philosophy and principles of service design are fully incorporated.

CHAPTER 3

MENTAL HEALTH PROMOTION - A WAY FORWARD

Chapters 1 and 2 highlighted a number of deficiencies in the type(s) and level(s) of service offered; among these being the need for promotional and preventative strategies.

In Chapter 3 there is the opportunity to discuss what is meant by promotion and prevention and how these concepts can be incorporated into a comprehensive strategy for the elderly mentally ill.

1. THE PROMOTION OF MENTAL HEALTH

i) What do we mean by Mental Health

a) The societal perspective

What makes us healthy - "not health care systems"
If not health care systems then what is important?

- system of medical care organisation
- life-style
- environment
- human biology

Therefore health, including mental health, "is a state of complete physical, mental and social well-being not merely the absence of disease or infirmity" (W.H.O. Constitution)

b) The individual perspective

Psychiatry, more than other medical specialties, has recognised that health problems frequently have a complex background in which biological, psychological and social factors interact. Often it is difficult to measure the relevance of each of these factors separately. The competence required is therefore governed by the need for simultaneous or alternative uses of knowledge and experience in medical, psychological and social branches.

Consequently, one may conclude that modern psychiatry has adopted a holistic and epidemiological approach.

Therefore, there are reasons to believe that those working in mental health more readily appreciate the need for the promotion of mental health. The need is to reach other decision makers at different levels in society so that the knowledge and experience about the background factors to mental health can be incorporated into future plans.

ii) "Causes" of mental illness"

- Social change and lack of social support
- Socio-economic stress, e.g. employment
- Urbanisation and housing
- Working Conditions
- Life-style
- Risk groups

iii) Promotion of Mental Health

Must be based on fundamental pre-requisites;

a) mental health is a vital dimension of health in total

b) the overall view demands consideration of all background factors with living conditions and life-styles to be important factors.

c) promotion of mental health has to consider inequalities in occurrence of mental disorders, living and working conditions and access to health services. Therefore strategies must focus on reducing inequalities as well as increasing opportunities to strengthen help.

d) changing living conditions and life styles must involve strengthening social support.

e) promotion of mental health can conflict with other interests in society. To be successful there must be the priority of mental health.

With certain distinctions of health promotion and disease, prevention measures can be presented as follows:-

Promotion Measures

A. individual development through community

B. employment and quality of working life

C. Leisure

D. Housing, living conditions

E. Social opportunity

Prevention Measures

A. Primary prevention

B. Secondary prevention

2. THE PROMOTION OF MENTAL HEALTH WITHIN MID STAFFORDSHIRE

i) The Mental Health Promotion Team

The Team was commissioned in August 1988 and the model followed is based on services provided by the Sheppard Pratt Hospital in Baltimore, U.S.A.

In order to maximise resources a small core team acts as a catalyst and utilises the expertise, skills and knowledge of those working in the Mental Health Unit.

a) Team Membership

The Team consist of:

i) A Tutor/Organiser
ii) A member with nursing/clinical experience
iii) A manager who provides 5 sessions per week to this function

The Team is supported by secretarial staff and on a monthly basis the Unit General Manager and the Chairman of the Division of Psychiatry meet the Team to agree priorities, resources required, etc.

Both the Unit General Manager and the Chairman of the Division of Psychiatry provides assistance on an on-call basis as required by members of the Team.

b) Base

A centre has been established at St. George's Hospital and within the centre audio visual equipment, a seminar and study room and a management information library has been provided. Facilities to carry out research are also included and research by members of different professions is actively encouraged with the result that a number of projects are currently being undertaken.

c) Functions

The functions of the Mental Health Promotion Team include the following:

i) Forum of Speakers

A forum of speakers has been provided so that groups within the community can call upon "experts" in the field of mental health to talk about any particular topic of concern. Examples of this include recent talks to the National Child Birth Trust and relatives of those suffering from schizophrenia.

ii) Supporting Professionals Working in the Field

This may take a number of forms including the provision of films or other back-up material to assist other professionals, e.g. assisting a CPN to set up and help a tranquillizer group.

iii) Provision of Training Packages

Training packages are provided for professional staff, volunteers and carers. The Mental Health Promotion Team has recently produced a training package for elderly confused people. The package provides a six model training course which covers a number of topics to assist the carer in their role.

iv) Organisation of Courses/Seminars

In a similar manner to the development of training packages the Mental Health Promotion Team is responsible for organising study days, etc. An example of this was a week-long seminar held at St. George's Hospital on the subject of Addiction. The seminar included representatives from the Police, Education Department, Social Services Department and representatives of voluntary groups. This seminar was organised in conjunction with the North East Council of Addiction.

v) Organising Campaigns

An essential role for the Mental Health Promotion Team is assisting with the organisation and promotion of specific campaigns. An example in this area is a drink driving campaign which is currently being planned. This will involve local Licence Victuallers, Driving Schools, Garages, Police and the Press etc. so that a comprehensive message can be communicated.

vi) Staff Counselling Service

Members of staff within the Mental Health Unit had direct access to a number of nursing and professional staff who have agreed to provide a confidential counselling and advice service.

vii) Consultancy Service for Nursing Homes

The Mental Health Unit has been charged with taking a lead role to providing consultancy services for nursing homes throughout the District as a whole.

This has involved the provision of an advisory service as well as the design and implementation of training courses.

viii) Public Relations Strategy

In addition to a video, booklets, press statements, etc. the Mental Health Promotion Team takes part in exhibitions. For example at the Staffordshire County Show the Mental Health Promotion Team will provide a number of topics for display.

ii) Strategies promoted by the Mental Health Unit as a whole

Mental health promotion is an integral part of the role performed by all members of staff within the Mental Health Unit. An illustration of how mental health can be performed by all members of staff can be dealt with by examining the role of the CPN in primary care.

In carrying our their role CPNs attached to general practices have;

a) improved accessibility of service
b) "educated" other members of the primary health care team
c) increased collaboration between professionals and self-help groups
d) assisted more to live within the community by recognising early symptoms and directing the sufferer(s) to appropriate agencies and in conjunction with fellow professionals develop support for those with psychotic illnesses.

Other specific interventions in the field of mental health promotion which do not specifically refer to the Mental Health Promotion Team include:

i) Market Research

An extensive market research was carried out in Cannock which highlighted problems faced by the people of Cannock in relation to mental health services. This survey identified a number of preferred outcomes and has subsequently lead to the establishment of the ARC project and also the development of additional resources into that area.

ii) Specialist EMI CPN Service

In addition to primary care CPNS, the EMI service has appointed a number of nurses specifically to work in this field. As well as developing links with nursing homes and Part III accommodation the EMI CPNs offer specialist advice to these establishments and to the carers of elderly confused people.

iii) Caring Together Scheme

The Caring Together Scheme is a project which is presently being planned with the Social Services Department. Without referring to specifics the scheme is intended to identify "high risk" elderly persons and promoting community developments and educational programmes to assist this group together with their carers.

iv) Patient Database

At the present time the Mental Health Unit is designing a patient database with the intention of identifying such issues as multiple admissions, deficiencies in after-care facilities, etc.

3. A COMPREHENSIVE STRATEGY - INPUT FROM THE MENTAL HEALTH PROMOTION TEAM

There are many factors which contribute to mental illnesses and to the promotion of mental health. Many of these are outside the control of the individual. Furthermore a number of these factors are outside the control of the National Health Service. Therefore there is a need for inter-agency collaboration between those working in the field of mental health.

Recent work within the field of psychiatry has highlighted the mental health needs for the healthy population as well as the need to meet the requirements of the mentally ill. The promotion of mental health is not solely for the purpose of disease prevention. It is to improve the quality of life for the whole population at all stages during their life; particularly at times of transition which are times of high risk.

It is not practitcal that the Mental Health Promotion Team should seek to fulfil all the diverse tasks that the promotion of mental health requires. It is therefore necessary to call upon expertise, skill and talents already present in the Mental Health Unit to provide services which are essential to the promotion of mental health to the population as a whole.

For the Mental Health Unit to be successful it is considered that mental health promotion should be an integral part of individual strategies that are commission to look at specific problems.

An example of the work of the Mental Health Promotion Team can be illustrated by the following example.

a) Rationalization of Addiction Services:

Briefly, addiction services in Mid Stafordshire previously consisted of 34 in-patient beds; 18 beds for those with an alcohol related problem and 16 beds in a different location to care for those with a drug related problem.

The present situation is that there are 16 in-patient beds to care for those with an addiction problem and the resultant "freed up" resources has enabled the following to be commissioned:

i) Community addiction team
ii) A day centre which provides a drop-in service; a telephone help-line operating 24 hours per day, 7 days per week; a library and resource centre and day care programmes on an individual appointment basis.

In addition to the above a district-wide strategy has been developed including in-put from those agencies working in the field of addiction. The Mental Health Promotion Team are responsible for the organisation and presentation of training courses to meet the needs of the changing situation, e.g. with an emphasis on developing a community service it is essential that primary care teams receive training to carry out their role effectively. In addition to the training function the Team have been

involved in organisation of campaigns and developing a public relations strategy.

The above example is provided in an effort to give an indication of the philosophy and role of the Mental Health Promotion Team. As a commitment to the overall thrust of improving services and promoting health for the elderly the Team can play a valuable role in providing expertise, skill and knowledge. Any strategy that attempts to provide a comprehensive service need to incorporate such aspects of health promotion as education, support to both professionals and carers and training in all aspects of the care programme. A strategy to assist the elderly mentally ill must incorporate this concept if success is to be achieved.

CHAPTER 4

MENTAL HEALTH & AGING

Interest in prevention and mental health promotion has been expanding rapidly in recent years. In mental health, as in other fields, professionals are eager to identify viable prevention and health promotion models and implement them in a wide range of settings.

The development of such models is an exciting new challenge in the field of mental health. Furthermore these areas of work are now on the threshold of moving from hopeful statements about the possibility of prevention in mental health and the effectiveness of mental health promotion to the less glamorous but ultimately more important task of generating sound evidence about the effectiveness of a wide range of different programmes.

The Fellowship provided the author with the opportunity to visit a number of programmes that are being developed and implemented in various geographical areas of the United States and Canada that address the needs of the elderly for prevention and promotion activities in mental health. Many additional programmes are needed.

One strategy for developing effective programmes is to analyse and learn about the experiences of already established and valuable programmes. By following the case study approach used in organisational management education one can examine a selection of "best practice" models to assist in the planning of similar programmes for the elderly.

Mental Health of the Elderly

Contrary to some of the myths regarding aging, most elderly people, lead useful and active lives in the community.(1) The day to day health of the elderly is adversely affected by the impact of "lifestyle" diseases.

In spite of the significant advances made by modern medicine in the treatment of acute problems, lifestyle diseases(2) such as cancer, stroke accidents, heart diseases and mental illness remain a pressing concern.(3)

These diseases are disruptive to the every day lives of the elderly and are leading causes of death.

Although inextricably linked with health, problems of mental illness are of particular significance because of the high risk situation of the elderly.(4)

In later life the elderly often have to make major adjustments because of changes in role and status, financial difficulties, new leisure lifestyles. changes in relationships, loss of loved ones, experiences of loneliness and isolation and alterations in physical appearance and health.(5) The Committee on Aging, Group for the Advancement of Psychiatry reported

"Mental Illness is more prevalent among the elderly than among younger adults. Seven studies to date show that 18 to 25 per cent of older persons have significant mental health problems: these studies indicate that about 10 per cent of older persons have neurotic disorders."

The Report highlighted other vital facts about mental health.

i) Suicide is more common in the elderly than in any other age group

ii) Psychosis increasessignificantly after age 65

iii) Senile dementia is considered by some authorities to be the fourth leading cause of death.

iv) Many elderly people experience significant psychological reactions caused from stress by loss of health.

v) Many physical illnesses cause and even present mental disturbance

Prevention and the Promotion of Mental Health of the Elderly

Prevention and the promotion of mental health in the elderly require innovative approaches. In contrast to the younger person for whom prevention efforts are initiated before the expression of the disease, prevention and promotion activities for the older person are usually aimed at the elderly who already have one or more chronic disease condition and may well be at risk from an acute illness.(7)

Therefore rather than curing, totally reversing or preventing a disease condition, health promotion and prevention programmes for the elderly need to be directed towards modifying and/or delaying further decline.(8) The need is to increase the capacity of the elderly person to enhance the quality of their life.(9)

Particular interventions and service delivery systems can alleviate or reduce specific problems of the elderly. The design and implementation of programmes that address specific diseases or problems such as stress management can reduce the risk of poor health and mental health for the individual and provide an initial point for the development of a more comprehensive programme. These prevention and promotion programmes can assist in improving the well-being of the elderly person and the community as a whole by providing people with the skills, information, services and support needed to undertake and maintain positive lifestyle changes. It can be appreciated that this approach to prevention and promotion programmes for the elderly supports the concept of the holistic perspective which considers "the human mind, body, and spirit and the social, economic,

political and environmental networks within which the individual lives."(10)

The specific programmes visited on the Fellowship study tour are outlined in Appendix 1.

Chapter 4

References

1. Handbook of aging and the Social Sciences
Brinstock R.H. and Shanas E. (1976)
Van Nostrand Reinhold New York

2. A healthy old age : A source book for health promotion with older adults.
Fallcreeks & Mettler M. (1982)
Seattle Center for Social Welfare Research
School of Social Work. University of Washington

3. Healthy people : Report on health promotion and disease prevention
Report by Surgeon General Office of the Assistant Secretary for Health & Surgeon General, Washington DC (1979)

4. Handbook of geriatric psychiatry
Brusse E.W. & Blazer D.G. (1980)
Van Nostrand Reinhold: New York

5. Mental Well Being of elders. Seeking positive solutions
Davies J. (Spring 1983) Generations 7.

6. Mental health & Aging : Approaches to curriculum developments:
(Vol Xl Pub No.114)

Committee on Aging : Group for Advancement of Psychiatry (April 1983)

Mental Health Materials Center : New York

7. Health promotion for the elderly. Filner B & Williams T. 1981
In A. Somers & D.Fabian (EDS) The geriatric imperative (pp 187-204)
Appleton Century-Crofts: New York

(8) Preventative aspects of mental illness in late life (1980)
In J. Birren & R. Sloan (Eds)
Handbook of mental health and aging
Prentice Hall : Englewood Cliffs N.J.

(9) Primary Prevention : Kessler M. & Abee G. W. (1975)
Annual Review of Psychology

(10) Wellness & health promotion for elders. Dychtwald.K.. (Ed)
Generation 7.(3) (Spring 1983.)

CHAPTER 5

PREPARING FOR THE STUDY TOUR

If maximum use was to be derived from the opportunity of visiting centres in the U.S.A. and Canada it was essential that adequate and detailed preparatory work was needed prior to the tour.

This preparation took two major themes.

a) Writing to various organisations, seeking approval for the visit(s) and arranging a suitable travelling itinerary.

Anyone proposing to undertake such a visit would do well to make preparations as far in advance as possible.

Without wishing to detail the arrangements it is perhaps worthy of note to mention that correspondence between N. America and the United Kingdom can take several weeks for the exchange of one request and to receive an answer. When an intended tour takes a number of visits into the itinerary it will be appreciated that one late postponement can cause dire problems and may lead to very expensive telephone calls.

Needless to say arrangements for the visit took several months to complete and due to a "last minute" cancellation of one visit contingency arrangements had to be made.

[The visit(s) were obviously determined by (b) below.]

(b) Providing a theme or model of care which could be 'tested' on the visit i.e. the Caring Together Scheme.

In earlier chapters discussion took place regarding deficiencies in the types of service(s) offered to the elderly mentally ill and also in regard to the need for mental health promotion for this group.

Prior to the visit the author designed the draft Caring Together Scheme (Appendix 6 details the final proposals drafted after the study tour.)

The scheme proposed four approaches to involve the community at large (especially service providers) to work together to help older adults:

i) The "Gate Keeper" approach which utilises those people working within the community, e.g. postal workers, police, etc. to identify the elderly person(s) at risk and notify the professional co-ordinating team.

ii) An Assessment/Evaluation Unit to provide recommendations regarding appropriate services to meet the needs of elderly persons.

iii) Working towards co-ordinated Community Network Workers and compile an "at-risk" register.

iv) By educating the population and promoting initiatives that will allow the elderly to cope better with the problems of later life.

Therefore in attempting to test out the basis or themes contained in the scheme it was felt to be extremely helpful to examine programmes that:

a) <u>Examine Myths on Ageing</u>

Effective programme design for health promotion with older adults requires that all staff and participants examine critically the prevalent negative stereotypes of ageing which suggest a limited capacity for personal change and community contribution.

b) Define Service Area

"More successful programmes seem to be ones which effectively limit their area of involvement. By concentrating on smaller population areas, this gives a group with limited resources the opportunity to be more involved with a particular community."(1)

c) Design Effective Recruitment Tools

Effective recruitment tools including planning, personal contact, publicity, presentation and personal commitment are essential in building credibility, relationships, interest and personal investment on the part of new participants to the programme.

d) Develop Outreach Strategies

By identifying key participants such as social services agencies, hospitals, social groups, civic associations and other groups, in which older adults participate.

Key participants can be informed by distributing of brochures and project posters, use of media, presentation to community groups and professional associations.(2)

e) Employ Experienced and Knowledgeable Staff

"Employ staff with knowledge and skills related to the elderly and the community and its services. This is important for efficiency and credibility. The educational background of workers can vary but previous experience working in the community is crucial.(3)

Skills needed by staff are

i) commitment
ii) tolerance for complex organisational interfacing
iii) communication skills

iv) flexibility, patience and perseverance
v) organisational assessment skills
vi) familiarity with service delivery and research perspective
vii) experience with management, budget and evaluation
viii) experience in a liaison-boundary role between hierarchical and non-traditional organisational structures

f) Utilise Programme Facilitators

The facilitator's understanding and application of health promotion philosophy, knowledge and group leadership skills assists prevention and promotion programmes to function.

g) Build Organisational and Community Relationships

By making initial contacts with other agencies and organisations at the highest possible level and negotiating written agreements to facilitate implementation of the relationships, successful networking between agencies can be developed.

h) Foster Volunteer Participation

Volunteer agencies are a valuable and efficient source of help if their services meet the needs of clients. "Working with both volunteer agencies and direct volunteers is recommended.(4)

i) Establish Board Financial Support

It is important that a programme faces its financial responsibilities from the outset. Having to attract resources from a large number of people can help to justify the organisation's efforts to be in the public eye.

In was extremely helpful to carry out a literature survey and two books in particular proved to be extremely help.

i) Planning Prevention Programs for Older persons
Sharon Simpson and Laura B. Wilson. With the assistance of Stephanie Fallcreek, Ray Raschko, Ruth Leowinsohm and Nancy Wilson.

ii) Prevention Planning in Mental Health
Edited by Jared Hermalin & Jonathan A. Morell
Sage Publications.

From the above books the author was able to make arrangements with a number of agencies in the USA and Canada to carry out visits and "evaluate" the work being carried out.

After finalising the itinerary (and in doing so "weighting" the time to be spent at each facility the next step was to try to ensure that at each facility it was possible to analyse the feature of the programmes.

In this respect the work of Sharon Simpson and Laura B. Wilson proved to be extremely valuable in that when they reviewed programmes of care for the elderly data was collected in the format of:

1) Background - What are the origins of the programme? Why was it established? When? By whom?

2) Objectives - What are the goals, objectives and purposes of the programme?

3) Programme - What services and activities are offered to clients?

4) Staff - What type of staff are needed? How many are necessary?

5) Clients - What population does this programme serve? How many people are affected? What are the characteristics and needs of clients? Are there eligibility requirements?

6) Organisational Relationships - What linkage does the programme have with other organisations?

7) Finances - What is the budget for the programme? What are the sources of funding?

8) Contact - Who can be contacted for further information about the programme?

Having prepared for the visit the next step in the programme was to prepare for the work to be carried out after returning from N. America. [Although one may gain experience and personal development from such a tour it is of greater benefit if others can derive benefit.] -

Therefore if the Caring Together Scheme, with suitable modifications, was to be implemented following the tour early preparatory work was received.

The Caring Together Scheme clearly identifies the need for the health service and the social services department to work in close conjunction with the voluntary sector to develop services for the benefit of the elderly.

Consequently discussion took place with senior health service managers, with representatives from the social services department and with specific groups in the voluntary sector. In addition health authority members were kept up-to-date about the work to be undertaken, provisional agreement was reached with a local University to assist in the research of the Caring Together Scheme when implemented and provision was made for resources to finance the scheme in the Mental Health Unit Annual Programme 1989/90. In this way a level of anticipation and expectancy was encouraged. Within the Mental Health Unit a substantial degree of discussion took place upon the merits or otherwise of the scheme; the former attracting more attention. Furthermore in the Mental Health Unit newspaper members of staff were encouraged to submit questions they may wish to ask about mental health promotion amongst the elderly if they had the opportunity to visit the agencies in the USA and Canada.

The result was that a great deal of interest arose and a number of members of staff wanted to become involved in the Caring Together Scheme when it was commissioned.

With this preparatory work undertaken it was exciting to be in the position that the study tour could provide a meaningful guide to the development of services for the elderly mentally ill. The tour presented an almost unique opportunity to test one's ideas without risk. It was an opportunity to learn from others in the field and appreciate how similar plans, policies and systems had developed, undergone change and been refined to meet needs. It was an opportunity to perhaps overcome a number of stages in the learning curve before the Caring Together Scheme was commissioned.

MID STAFFORDSHIRE HEALTH AUTHORITY

St. George's Hospital, Stafford ST16 3AG
Telephone: Stafford (0785) 57888

MCM/AC
26th April, 1989

Mr. R. Brazil,
Deputy Director (External Co-ordinator)
King's Fund College
2 Palace Court,
London,
w2 4HS.

Dear Mr. Brazil,

NHS Travelling Fellowship

I enclose the project regarding my study tour to the USA and Canada and look forward to discussing the same with yourself on Thursday, 4th May 1989 at 11.00 a.m.

Should the format, binding, etc. be required to meet specific criteria, I would be pleased to be advised accordingly. Furthermore any comments you wish to make about the contents of the project will be most welcomed.

I have not included a comprehensive set of expense receipts as you will appreciate from our earlier conversation that the cost of my tour was in excess of £1000.

However, if may be helpful to your colleagues to have an indication of some of the costs involved.

	£
Air Fares to North America	418
Air Fares within North America:	273
Toronto to Philadelphia Philadelphia to Detroit Detroit to Seattle Spokane to Calgary	
Internal travel	102
Accommodation	250
	£1043

In addition to the above there were expenses for meals, insurance and other incidentals.

I appreciate that you will not be responsible for reimbursing my expenses but in view of the time span since my tour it would be helpful if you could forward my claim at your earliest convenience.

I look forward to seeing you on the 4th May.

Yours sincerely,

M. C. Murray
Unit General Manager

References

Chapter 5

1. Evaluation of the AAARP Widowed Pensions Service:
   Prisata R.H. (1984)
   American Association of Retired Persons - Washington D.C.

2. Interagency co-operation in Service delivery
   Baldwin E.F.(1983) Paper presented at the 111th Annual Scientific Meeting of the American Public Health Association - Dallas

3. A healthy old age - a source-book for health promotion with older adults

   Fallcreek S. and Mettler M. (1982)
   Seattle Centre for Social Work Research
   University of Washington

4. Working with informal supporters
   Paper presented at the 111th Annual Scientific Meeting of the American Public Health Association - Dallas
   Corrine J. (1983)

CHAPTER 6

--

THE FELLOWSHIP TOUR

The tour to the U.S.A. and Canada provided the opportunity to visit a number of programmes (Appendix 1), investigate the opportunity(s) of mental health promotion amongst the elderly and also "test out" the concepts set out in the Caring Together Scheme.

Each particular programme/visit was initially planned to examine a specific aspect of care. However, it quickly became apparent that individual programmes of care were inter-dependent upon other schemes and visa versa.

The visits are set out in chronological order while Chapter 8 is used to draw together the different aspects of care programmes visited.

VISIT 1 - Philadelphia Geriatric Centre - Philadelphia

The Centre which is situated some 4 to 5 miles from the city of Philadelphia is an example of a comprehensive 'institutional' complex run by a Jewish not-for-profit organisation.

The complex consists of;

i) flats for older adults
ii) an assessment/evaluation clinic
iii) day care facilities
iv) nursing home beds and
v) hospital beds

In total there are over 1000 places/beds and the idea behind the scheme is to enable older adults to live as normal a life style as possible with support provided as and when required.

As far as developments into the community were involved this was restricted primarily to providing advice to those elderly persons who had been to the assessment clinic, e.g. how to get home helps or nursing care and also in the field of research regarding specific community programmes.

The staff of the Centre have been extremely successful in obtaining grants through the National Institute of Mental Health and also through sponsorship. In the field of research the Centre has developed a prestigious reputation for work undertaken and consequently been successful in building up extensive research facilities. It was extremely interesting to discover how wide a field of research had been undertaken by staff of the Centre. Examples include;

a) The design of nursing homes
b) Colour schemes for wards for the elderly confused
c) Institutionalization of the aged
d) Women's changing roles and help to the elderly
e) Parent care as a normative family stress

In addition to seeing the care of the elderly and learning more about the types of research undertaken there was the opportunity to discuss management issues and financial budgeting with the Executive Vice President and Chief of Operations.

Points Noted

a) Early evaluation (and on a continuing basis) is essential if the needs of the elderly are to be identified and an effective programme of care implemented.

b) The research carried out not only assisted in developing new ideas but helped the organisation to continuously question its own role, methods of operation, planning process, etc.

c) Although the Philadelphia Geriatric Centre provided extremely high levels of care for a specific group of people, those served represented a minority selected on religious and financial grounds. [In streets around the Centre there were many elderly people unaffected by the work carried out.]

d) The Centre was devoted to providing institutional care and there was limited effort in attempting to provide a comprehensive service in conjunction with other agencies.

e) Because there is a large captive market the Philadelphia Geriatric Centre is able to determine the services to be offered even if these services do not represent the most effective form of care for the people served. The service is not consumer led.

Visit 2 - Pennsylvania Hospital and Mental Health Centre

The Pennsylvania Hospital is one of the oldest hospitals in the U.S.A. (containing the operating theatre used to treat British soldiers in the War of Independence). The hospital which operates on a not-for-profit basis is a general hospital attached to the University. A small number of mental illness beds are provided within the main city centre complex but the majority are located on a second more modern site. Within the same city centre vicinity as the hospital is a mental health centre administered by the hospital managers.

The visit marked an almost complete contrast to that experienced at the Philadelphia Geriatric Centre.

The Pennsylvania Hospital attempts to provide care for the less affluent members of society and relies to a large extent upon Medicare, Medicaid and City grants to provide services.

Within the hospital there is a recently commissioned day hospital for the elderly. Unlike many day hospitals in the United Kingdom different patient groups, e.,g. elderly physically ill are treated together; with the elderly confused. This obviously presents serious difficulties and when the elderly become extremely confused the day hospital is no longer able to provide appropriate facilities and discharge takes place.

Limited, though it is in resources, it is the only such day hospital in Philadelphia and is considered to be a 'leader in the field.'

The second part of the visit included time spent at a Mental Health Centre attached to the hospital which attempts to provide and develop services for a population living in a neighbourhood of the City of Philadelphia.

Although limited assessment and treatment was provided for the elderly there was little or no promotional activity undertaken. It appeared that the Mental Health Centre was under severe strain; attempting to cope with presenting problems. Outside the Centre was an armed guard and there was a notable police presence around the Mental Health Centre itself; both indicative of both the clients served and presenting problems.

On the question of developing community care staff of the Hospital reported that they had been successful in obtaining grants to design specific programmes. However, it was evident (and agreed by the staff) that there was no co-ordinating agency to develop services for the elderly throughout the city of Philadelphia. Hospitals and mental health centres considered to be operating effectively (as above) were encouraged by grant-aid to develop programmes of care to meet defined areas of need. Consequently, the service is planned on an incremental rather than a comprehensive basis.

Points Noted

a) The most vulnerable groups, e.g. elderly and mentally ill suffered most in a health care system based on market forces.

b) Comprehensive systems of care need to be planned by all agencies concerned. Piecemeal developments lead to duplication and gaps in the service.

c) It appears extremely difficult to maintain the enthusiasm and initiative of staff who are continuously working in an under resourced service which also presents little opportunity for development and improvements.

Visit 3 - Thomas Jefferson University

Situated very close to the Pennsylvania Hospital the Jefferson Medical College is also a general hospital providing both out-patient and in-patient care. There is no mental health centre attached to the hospital. Acute psychiatric care is provided on an in-patient basis with no beds for continuing care.

The Geropsychiatry Assessment Unit offered superficially what appeared to be an effective method of assessment for a given price at a specific time.

Elderly confused clients by appointment attended the clinic and underwent a number of tests and interviews.

Following the processing of the results the elderly person and/or their careers were then offered a treatment plan which they themselves would arrange. For example the plan may recommend 20 hours per week of nursing care and thus the carers would contact a nursing agency to make suitable provision. Although the example is simplified it illustrates the procedure.

However such an assessment does highlight a number of concerns. For example it is difficult to appreciate how a one-off assessment carried out away from the home setting of the elderly confused person can be said to analyse the problem areas. Furthermore without any follow-up assessment and evaluation the monitoring of the elderly person's progress or otherwise could not be undertaken.

Points Noted

a) The process of evaluation, although helpful in conjunction with other programmes of care, is somewhat lacking when used in isolation.

b) Unless there is a network of services to offer after evaluation then the evaluation process can become an academic exercise.

c) Since evaluation needs to be reviewed after treatment(s) there is a need for continuous monitoring.

d) The service evaluation/assessment services was provided on the basis of ability to pay and this facility was not linked to other care programmes offered to elderly persons.

Visit 4 - Child and Family Services of Michigan - Howell, Michigan

The Child and Family Services of Michigan Inc. Livingston County Office, is a private non-profit United Way Agency which has been providing a broad range of human services since 1973.

Services for older adults include;

a) Counselling - at home or at the centre
b) Homemaking - light housekeeping cooking ...
c) Personal care - assistance in bathing, dressing ...
d) In-home respite care - to assist primary care-givers and to prevent premature institutionalization
e) Legal assistance - general consulation in matters of civil law
f) Support groups - assisting support groups, e.g. Alzeheimers Disease, Family Support Group.

The services are made available through grants from Area Agency on Ageing, funds from the 'local authority' and donations.

A major purpose of my visit was to see the "As Parents Grow Older" (APGO) programme in action and to talk to professionals who administered the training manual.

The background to the APGO programme is as follows. The University of Michigan Institute of Gerontology obtained a 30 month Administration of Ageing Model Project grant to develop and evaluate a family intervention programme. A primary aim was to develop a facilitators manual directed to improving the caretaking roles of family kinship systems and to strengthen the link between caretakers and community service agencies.

Consequently the manual is meant as a practical step-by-step guide to enable professionals and social agencies to assist adult children who assume the role of caretaker for the elderly, assuming their rights as individuals, their entitlement to comfort and the opportunity to live out their lives with dignity.

Each APGO group meets for six two-hour sessions with the overall objective of helping the participants.:

1. Increase their understanding and knowledge of the ageing process.

2. Better understand the emotional reaction and needs of older people.

3. Develop a greater awareness of their responses to their aged relatives and thus their own ageing process.

4. Learn to deal more effectively with their own as well as their aged relatives' needs through group problem solving; thus facilitating the development of support systems within the group.

5. Acquire greater access to community supports.

6 Be better able to express and explore alternatives to assist themselves and their aged relatives in maintaining an active and productive lifestyle.

Mental impairment of the elderly and/or stress to the care-giver often are disruptive to the family's giving care to their older family members. A premise of the programme is that such problems can be alleviated when there is a partnership between family and the professional service worker. A second premise is that family care giving or support of the elderly by younger family members can be a viable resource for the older generation.

The family, as the natural support system, is enhanced and strengthened when the professional teams joins forces with the family network.

Points Noted

a) The APGO programme is a comprehensive training manual which can be modified and used within the United Kingdom.

b) Such a programme would offer assistance to many care givers responsible for aiding the elderly and particularly the elderly mentally ill.

c) The programme can act as a catalyst in bringing a number of agencies together.

d) Once designed the programme is inexpensive to administer both in terms of trained staff required and administrative costs.

e) Although the Child & Family Services Department had no access to hospital or nursing home beds a number of services for the elderly had been developed.

f) If a comprehensive system was to be provided there was a need for beds for assessment, respite care and long-term nursing care.

g) There was an obvious and readily recognised need for specialist input, e.g. from a psychogeriatrician to determine degree(s) of disability and 'lead' the service.

Visit 5 - Turner Geriatric Services, The Turner Clinic, University of Michigan Medical Centre, Ann Arbour

In addition to offering an evaluation/assessment service on a multi-disciplinary basis the Turner Clinic has promoted a number of initiatives to assist the elderly.

i) Turner Groups

The number of groups has continued to increase; certain groups operating on a continuing basis while others provide assistance on a short-term basis. Examples of current groups include:

a) Alzheimers' Disease Family Group - providing information and help to families caring for sufferers.

b) Caring for Ageing Relatives Support group - an on-going group for adult children.

c) Intergenerational Womens' Group - women of all ages, sharing insights and experiences. Outside speakers come to about half the meetings.

d) Marriage after 60 - A group for couples to discuss changes in marriage after retirement.

e) Shaking the Blues II - A 10 session group meeting weekly for older people dealing with depression.

Turner learning programmes are supported by the University of Michigan Hospitals, Area Agency on Ageing and the W.K. Kellogg Foundation.

ii) Peer Counsellors

Are a group of retired people who volunteer to provide one-to-one counselling to other older adults. The Peer Councillors are trained and experienced and all matters referred to the Counsellors are confidential.

This voluntary service operates on the philosophy that many elderly people relate well to discussing problems with others of their own age group.

The Peer Counsellors are also active in monitoring a case load of elderly clients who may be at risk and also in offering advice support and experience to other elderly adults who maintain a 'watching" brief over elderly friends and family.

The impetus of the Turner Groups and Peer Counselling Services has help to promote other activities and schemes for the older adults in the Ann Arbour area. Examples include the arrangement of training courses on specific topics, organising regular activities such as the Lunch Bunch (meets once per month for socializing and meeting new friends at local restaurants) and promoting community involvement. An example of the latter is that a scheme has been provided whereby any elderly person can secure a taxi ride to any destination within the city limits for $1.

The involvement of the elderly in caring for the elderly has two important aspects; the elderly are an important resource and assisting others is rewarding and beneficial to the provider of the service.

Points Noted

a) Professionals can act as a catalyst to enable self-help groups to be formed and operate successfully.

b) Different sections of society can provide alternative services.

c) Development of social activities can help the older adult to remain active and assist in their general well-being.

d) The Peer Counselling felt needed and pleased to help others - their own purpose in life was maintained.

e) The older service providers were extremely well placed to understand problems of their older adults.

Visit 6 - Geriatric and Family Services (GFS), University Hospital, University of Washington, Seattle

The GFS is situated within the large general University Hospital located on the University Campus 3 or 4 miles from downtown Seattle. Established in 1978 GFS is a multi-disciplinary service which evaluates some 200 plus new patients annually. Although operating as a not-for-profit clinic there was a clear need for the centre to provide sufficient funds to maintain and develop programmes.

The aim of the GFS is to provide a comprehensive evaluation and treatment programme for impaired elderly persons. The programmes includes the patient's family in the evaluation and treatment.

Underpinning the programme is the philosophy that frail elderly people do not tend to seek assistance themselves especially when physical difficulties are compounded by confusion, suspicion, memory loss or depression. Concerned families who want to do everything possible to preserve independent living for elderly members need information about what exactly the patients difficulties are, what problems to expect and how to help. In order to assist patients and their families GFS provides treatment for patients and also counselling and advice for families.

Patients are evaluated through a services of physical and mental assessments that help determine the complexity or kind of impairment. Most patients seen at GFS have depression, Alzheimers's Disease or a combination of physical and mental problems.

The evaluation includes a psychiatric assessment, complete physical examination, psychological testing, a home visit and a conference to discuss findings and treatment recommendations. While the evaluation usually takes three to four weeks the process can be shortened to three days to accommodate families who travel a long distance.

Once the clinical evaluation is completed patients may be eligible to participate in research projects.

Points Noted

a) Evaluations appeared to be extremely thorough in clinical procedures, tests, etc. However as at Jefferson Hospital the evaluation was a process independent of continuing treatment.

b) The programme is restrictive in that costs involved would be prohibitive to many elderly. Even if the initial evaluation costs of $750 to $1000 could be met, treatment costs are additional.

c) There was little co-ordination with other agencies providing services for the elderly and the GFS was instrumental in attracting patients to the University Hospital

d) As at the Philadelphia Geriatric Centre research was considered an important area of work and had enhanced the reputation of GFS.

Visit No.7 - Spokane Community Mental Health Center Elderly Services

The programme was selected as one of the best practice models of planning preventing programmes for older people described in Prevention Planning in Mental Health (Vol.9, Sage Studies in Community Mental Health) and as such was to form a major part of the visit.

Prior to the visit Ray Raschko the programme director had supplied further information about the work of his team including the information that the programme had been presented with a number of awards. Thus the visit was approached with a high degree of expectancy which proved to be justified.

1. Purpose

The programme has four major aims :

a) Working with the Eastern Area Agency on Ageing, build a community-based comprehensive, long-term care system in Spokane.

b) Prevent premature institutional placement of the elderly.

c) Maintain older persons in their homes and

d) Create a core community agency to take

i) responsibility for on-going care for the elderly living in the community

ii) short-term living in the community for the higher functioning elderly.

2. Target Population

a) The higher functioning older person who requires short-term assistance (Information and Assistance Component).

b) Those elderly persons who are multiply disabled and at risk of institutional placement (Case Management Component)

3. The Elements of the Programme

i) Information and Assistance Component

The telephone Information and Assistance component is staffed by screeners and serves those higher functioning older adults who only require short-term less intensive assistance. Home visits can be provided through this component.

ii) Multi-disciplinary in-home assessment, treatment and case management component.

a) Locate and identify at risk population

This element includes the "gate keeper" approach in which postal workers, policemen, meter readers, etc. are trained to identify the elderly at risk.

b) Multi-disciplinary In-house Assessment

Includes 1 programme director, 1 clinical co-ordinator, 15 case managers, 5 team leaders, 2/3 time psychiatrist and a consulting physician.

An attempt is made to fully evaluate the interrelated physical, cognitive, emotional, social, economic and support system components of the elderly person's functioning. Primary care physicians are worked with very closely as well as any family and support system members.

4. Treatment/Services Plan

A comprehensive care plan is developed which includes all or several of the following: medical care, environmental manipulation, social and economic measures, drugs, family and work supportive counselling.

5. Implementation of Plan/Case Management

Elderly Services of the Spokane Community Mental Health Center has a close relationship with the Eastern Washington Area Agency on Ageing and written arrangements with 13 community agencies funded by them. These and other agencies are utilized to implement the treatment/service plan. Those other services most often utilized include home health, chore/homemaker services, day health and home delivered meals.

In addition to other formal networks many informal networks in the neighbourhoods and community are used to assist in delivering comprehensive in-home services.

Support groups for families caring for a member with a dementing illness have been established.

Weekly formal staffings are held and all agencies involved in the treatment/service plan attend.

6. Crisis Intervention

The programme phone number diverts to the Community Mental Health Centre Crisis Services after hours, weekends and holidays. Elderly Services staff are thus available to cover, by phone or in person, any crisis situation which may occur to an existing client or any other older person in the community.

7. Supportive Counselling

The positive relationship between case manager and older person is viewed as the conduit for the assessment, service plan and continuity of case. Staff have become highly skilled in establishing positive, therapeutic relationships with the elderly and overcoming the initial resistance expected from many older persons who are fearful, anxious, suspicious, hostile, etc.

8. Community Care

Elderly Services maintains primary on-going care responsibility for all persons admitted to the programme.

When active clients are admitted to any area hospital, the social services department is contacted and informed but the programme staff expect to be involved in discharge planning.

When an active client is admitted to a nursing home the client's progress is followed to assess whether or not discharge back home or to a less restrictive alternative is possible.

The programme offered what appeared to be a major initiative in working towards a comprehensive system of care for the elderly and in particular the elderly mentally ill.

Unlike a number of the other programmes visited the initiative in Spokane had been funded out of public funds and sponsorship formed little part of resource generation. The whole emphasis of the programme was to involve the community in working together to address a common problem; how too meet the needs of a vulnerable group. The 300,000 population served was spread over a very large area; with the exception of Spokane extremely rural in nature. Consequently it was essential to involve the community if the elderly-at-risk were to be identified and assisted. Again in contrast to other programmes described, the service in Spokane was designed specifically to meet the needs of those who were least able to cope.

Evidence of community involvement was clearly highlighted by the number of representatives, "gatekeepers" from different organisations who came forward to be identified with the work of the Elderly Services Team. Representatives from the police, local utility company, pharmaceutical profession and the banks all wished to express their support for the programme. It was stated by the representatives of the groups that their own staff, who regularly came across the elderly-at-risk, would be unable to cope without the support of the Elderly Services staff. Examples of assistance received from the programme were readily quoted;

i) The old lady whose bank balance drifted dramatically - received a medical and social assessment and with the co-operation of the family received medical treatment and social support.

ii) The elderly man, found by the police, who insisted on filling his house with old papers and magazines - after visits from the programme

staff the elderly man was persuaded to clear out his house and accept care and assistance for his social and welfare needs.

iii) The elderly lady who was found by a pharmacist to be taking a mixture of tablets that had been prescribed at different times by her doctor - a simple system was implemented which enabled the lady in question to understand which tablet to take at the appropriate time of the day. The system also allowed team members to check the tablets taken.

The above examples illustrate the type of interventions that take place. Perhaps just as important to the gatekeepers was the fact that they could contact the Elderly Services Team about any problem they themselves perceived. The collaboration between the Elderly Services Team and the gatekeepers had developed to such an extent that first name terms were the usual form of address and although links were very professional there was an air of informality and friendly banter. Furthermore the gatekeepers from different organisations mixed well together and appeared to have a common purpose or vision of the way forward for the community.

When questioning the gatekeepers about the benefits to organisations involved in the scheme it was again easily discernable that the organisations themselves saw a number of benefits. First of all there was the public relations benefit -"we are community minded". However this appeared secondary to the fact that involvement in the programme gave a great deal of satisfaction to those involved. As well as increasing the scope of the job(s) staff gained a great deal of satisfaction in knowing their efforts to help others were meaningful.

Although it may not be possible for everyone to personally assist the elderly person one telephone call brought the person at risk into contact with the Elderly Services programme. A third benefit relates to problem briefly touched upon previously. What does the average citizen or worker do when they come across a confused elderly person? Often people do not know what to do or they are afraid of becoming too involved. Perhaps they themselves feel vulnerable? Whatever the situation the elderly person often receives little or no help while others feel ashamed, embarrassed or

worried. The Elderly Services programme in a very simple manner overcomes these problems.

Perhaps because of the simplicity of making contact, perhaps due to the effective service provided or more probably a combination of the above the Elderly Services Programme has succeeded in providing a focal point for the development of services for the elderly.

On a formal basis there have been 14 written co-ordination and referral agreements negotiated with other agencies, most of which are funded by the Eastern Washington Area Agency on Aging. These agreements delinate each agency's role, referral mechanisms, methods of problem resolution;. As a care agency in the network of biophysical services, Elderly Services is highly dependent upon other community agencies for the implementation of much of its treatment/service plan. Among the type of services provided by these agencies are chore services, home health services, day treatment, minor home repair, telephone reassurance, nutrition and home-delivered meals, crime prevention, legal services, transportation and health screening.

On an informal basis Elderly Services provided help to a number of support groups such as the Alzheimers Carers Association and also helped to set up support groups in other areas. Elderly services is an integral part of the community network and provides assistance to other agencies in the field of mental health who do not specifically provide services for the elderly population. Within the centre of Spokane are two large 'hotels' which provide a minimal degree of support to "travellers" and in many cases discharge patients from large psychiatric hospitals. Although the owners of these establishments are well-meaning they receive little or no support except from staff of the Elderly Services who offer advice and assistance. Again it was quickly noted in the first visit to 'hotels' that the Elderly Services staff were both well known and welcomed visitors.

With regard to the type of clients served it may be interesting to note that nearly 55,00 people or 16% of the total population of Spokane are 60 years of age or over and therefore are serviced by the programme. 32% of

the elderly are aged 75 and over. Although 90% of those served live in their own homes nearly 16% live near or below the official poverty level. In 1983, 744 persons were admitted to the Elderly Services in-home case management programme. Problems presented included the following:

chronic physical illness	- 68%
social isolation/lack of social support	- 66%
personal care/activities of daily living	- 64%
emotional depression	- 60%
environmental/social stress	- 57%
denial of illness/problems	- 55%
memory impairment	- 43%

The above data illustrates both the multiple and inter-related nature of the problems experienced by the at-risk elderly and the many facets of care delivered by the Elderly Services programme.

In summary the Elderly Services programme can be said to perform seven essential functions in caring for the older adult(s).

1. Outreach to identify and attract the target population
2 Screening to determine if the elderly person is at-risk
3. Assessment of need to determine, needs and resources available
4. Care planning to specify the types and levels of care to be provided
5. Service agreements to implement the care plan through both informal and formal carers
6. Monitoring to assure that services are provided as planned and modified as necessary
7. Reassessment to adjust care plans to changing needs.

In previous visits, previously described, it was apparent that the population served tend to be restricted either by the lack of facilities available or by the financial resources of the recipient of the service(s). If the Elderly Services programme in Spokane was to meet the stated aims and goals then clients must come from a wide spectrum of social standing and in particular one would expect a high proportion of clients for whom

other service had failed to provide the necessary care and treatment. From statistical evidence available (see above) it was evident that the programme was in fact reaching the elderly at-risk who exhibited multiple problems of dependency. The visit provided the opportunity to see and meet a number of the older adults receiving assistance. Although it was only possible to meet a minority of cases the following examples illustrate different types of programmes provided.

a) <u>The 86 Year Old Lady</u>

This lady lived alone in a rural community. She was suffering from a degree of dementia and had no family support. When first notified to the Elderly Services programme this lady had her house full of old papers and rubbish and was afraid of 'people who lived under the bed.'

After initial anxiety the lady accepted the Elderly Services team (many elderly people were very afraid of going to a nursing home) who arranged for the house to be tidied up, regular visits to take place from the team and social support to be provided. Contact was also made with relatives living in California who visited when possible but kept in touch with the Elderly Services team.

In this very simple way premature institutionalisation was prevented and the elderly lady in question was able to live a much happier lifestyle in the house she was born in.

b) <u>The Family Couple</u>

The husband had the extremely difficult task of caring for an extremely demented and very active wife. The situation of this family differed from many others in that they were relatively affluent. The husband, perhaps because of being afraid of having to pay for services, was initially extremely resentful to the team and attempted to care for his wife alone. The result was that the house was uncared for, the wife was constantly

wandering and also because of the lady's incontinence both the elderly lady and the house smelled quite badly.

By what was said to be an extremely slow progress the husband began accepting advice and assistance, the children of the family were brought into contact and the genuine feeling was that substantial progress could be made.

Even if continuous progress was not made with the couple the Elderly Services team would be in regular contact and thus able to intervene in a crisis.

c) <u>The elderly lady and her grand-daughter</u>

The lady in question was confined to a wheelchair but was otherwise extremely mentally alert and quite a forceful personality. Because she had no close relatives living in the area it would have been necessary for this lady to be looked after in a nursing home.

After making contact with the family arrangements were made for a grand-daughter to provide support by living-in with her grandmother. A benefits allowance was paid to the grand-daughter which covered essential expenses.

During the time both ladies were learning to live together the Elderly Services Team provided much needed support. This took the form of assisting the grand-daughter who was becoming dominated and counselling the grandmother who was quite abrasive and domineering. In addition day care was arranged. This provided both a therapeutic environment and the opportunity for both parties to have some time alone and seeking alternative company. The visit to the home of the grandmother illustrated how successful the programme had been.

d) The couple who lived in a car

Not all interventions are totally successful interventions. Perhaps due to the civil liberties ideology of the USA and the fact that many isolated elderly persons were afraid of "authority" progress could be extremely slow and unsuccessful.

An extremely difficult case for the team was the situation where two elderly people literally lived in a car. The lady weighed in excess of 20 stones and could not get out of the car whereas her husband had difficulty in walking very far. Although the situation is extremely difficult to appreciate the elderly lady could not even get out of the car to wash or to go to the toilet.

The couple had been known to the Elderly Services team for some two years but periodically left the district for periods of time before returning. At the time of the visit the wife had recently discharged herself from a nursing home some few weeks previously with the assistance of her husband. Reaction to the Elderly team member was polite yet distant. The couple maintained that they were coping and wanted no assistance.

It was agreed by the team members that a regular review would be kept on the couple and that offers of help would be repeated. As winter was about to set in it was anticipated that the couple would find the situation unbearable and ask for help; if enough trust between the couple and the Elderly Services team could be developed. [It was not considered appropriate to use powers of detention whereas such action would probably have been taken by professionals working in the United Kingdom].

The above examples illustrate how intervention programmes had been implemented but obviously they are illustrative rather than exhaustive. When one considers that perhaps 750-1000 people are admitted to Elderly Services in-home case-management programme each year it is understandable that many variations in programme design must inevitable take place.

Points noted

a) The Elderly Services programme had been successful in securing involvement of many agencies within the community.

b) The scheme had been successful in co-ordinating a number of agencies to work towards the common goal of helping older adults.

c) In addition to offering intervention programmes the Elderly Services scheme was successful in developing and assisting support groups.

d) Although the team were able to assist many elderly people there was a scarcity of medical resources. This was acknowledged by the team to be an area of great need.

e) A further area of need was the lack of respite care beds to enable families to care for their elderly relatives.

f) Involvement of local medical practitioners (G.Ps.) was relatively limited. Although this involvement was being developed it was apparent that much more work was required.

g) Although almost exclusively "community based" the Elderly Services programme was extremely successful in allowing many people to live a rewarding lifestyle at home.

h) The team had been successful in drawing together private, public and voluntary sectors in developing the programme of care.

i) A great deal of the success of the Team was undoubtedly due to the personal leadership and charisma of the Programme Director. In addition to conceiving the idea of the programme the Director was leader, manager and facilitator.

Undoubtedly the programme was extremely effective but in the time spent on the visit it was difficult to guage how much the success of

the programme was due to this personal leadership of the director of the programme. Although this in itself presented no difficulties in Spokane any attempt to reproduce the programme would need to take into account the need for strong leadership etc. especially in the early stages of development.

j) The programme is based on a very personalised approach, gaining confidence and trust and maintaining a high reputation for helping with almost any problem. Providing these roles were undertaken the programme could be developed within the United Kingdom.

h) The resources available to the Elderly Services team would normally be available within districts in this country and usually with less agencies to co-ordinate. In addition many areas within this country would have access to long term beds and a greater degree of medical input. Given these factors it appears a workable proposition to implement a system of care that sees the elderly at-risk as a target population to receive priority care and treatment.

Visit 8 - The University of Calgary

At the 1984 World Conference on Mental Health held in Brighton a paper was presented on the subject of helping family care givers to support relatives suffering from dementia. The visit enabled discussions to take place with the author; Carole-Lynne Lavenec Assistant Professor, Psychiatric-Mental Health Nursing, University of Calgary, on this subject and also provided the opportunity to learn about the development of services for the elderly mentally ill in Alberta.

"The Care Process with Dementia Patients" is a practical handbook for Nursing Home staff and family care givers. Topics covered in the handbook include

i) a general introduction regarding the nature of dementia, numbers of suffers etc.
ii) a definition of dementia

iii) the diagnosis and testing procedures together with causes

iv) developing effective interventions for patient care including assisting with such aspects of functional behaviour as judgement, orientation, communication and comprehension, attention span, abstract reasoning, affect, aprascias, agnosias, memory and movement.

v) counselling strategies for families.

The handbook had been produced following research carried out by the author (Carole-Lynne Lavenec) in working with families of those suffering from dementia. The study involving 39 families form different areas within the region identified six different 'management' styles by which the caring process took place. The research also covered such questions as;

how does the family get involved?
how does the family stay involved?
and how does the family cope?

From the research the need for a family policy to be developed by all the agencies involved was identified. Other identified resources required included the need for assessment centres , day centres and training for professionals and carers.

Although the information contained in the handbook is expressed in a relatively simplified form (enabling it to be used by those who had little or no caring experience) the profession wishing to explore issues in a greater depth could use the extensive list of references contained.

In addition to discussions regarding research undertaken and the use(s) of the handbook, outlined above, there was the opportunity to gain insight into,

"A new vision for long-term care - meeting the need," which is a discussion document issued by the Legislative Assembly of Alberta on providing for the needs of the elderly.

This new vision aims to foster and promote a continuum of appropriate long term care for the ageing population, emphasising independence and quality of life in a community and family-based environment, commensurate with the resources of the Province and individual." In order to implement the vision six components of service are seen to be needed.

1. Health promotion and illness prevention aimed at keeping older persons healthy and thus avoiding the need for long-term institutional care. The rational behind this is the fact senior citizens have a positive contribution to make to society if they remain independent in later years.

2. Single point entry component to all long-term care services to ensure services are used appropriately; assessments made on the person rather than assessing the person in term of suitability for the facilities offered by a particular agency.

3. Volunteer component to maximize public awareness of and support for the elderly and to develop a positive attitude towards ageing.

4. Community services component which includes a variety of family and community based services for the elderly. The aim of this component is to enable elderly to remain at home as an alternative to institutional placement.

5. Special housing support component to enable the elderly to delay entry into the institutional system.

6. Institutional service component which should only be considered as a final choice, when community alternatives are no longer available or appropriate.

In addition to the above the following directions for change are proposed to be adopted to bring about the vision:

a) implement single point of entry
b) promote well being of the elderly

c) increase volunteer input and promote public support
d) expand community services through planned growth
e) support independence
f) promote development of social housing support service
g) develop a single long-term care institutional system
h) enhance geriatric and gerontological training of care providers
i) improve co-ordination.

The consultation document describes in greater detail how each of the above can be achieved and in all the "New vision" some 43 far reaching recommendations covering a wide spectrum of care programmes.

Points Noted

a) The Care Process with Demential patients is a practical aid that has been developed following academic research. The manual can be used as both a guide for the families of sufferers or as a teaching aid. Furthermore the manual itself is quite adaptable and can be used in a variety of settings, e.g. could be used with little modification in the United Kingdom.

b) The "New Vision" is an exciting document which the Government of Alberta can be commended for attempting to grapple with the long-range issues attending the provision of an adequate social and health system for an ageing population.

In particular a number of positive steps are proposed:

a) emphasis on co-ordination including the rational allocation of resources.

b) recognition of the need to shift the focus in care provision from long-term institutional resources to at-home and ambulatory resources whenever possible, while ensuring appropriate institutional resources for those requiring them and

c) recognition of the need for a maximum level of education and training for all persons working with the elderly in any setting.

Visit 9 - Carewest - Locations in Calgary

Carewest, is a multi-centre non-profit health care organisation, servicing the needs of the elderly, the disabled and the elderly mentally ill in Calgary and the surrounding area. With four auxiliary hospitals and two nursing homes comprising 1000 beds, three day hospital programmes and outreach programmes, Carewest is the largest single provider of long-term care in the city of Calgary.

Within auxiliary hospitals about five per cent of residents are under 35 years of age while the majority 52 per cent are between the ages of 65 and 84 years of age. Most residents are admitted with more than one diagnosis, the most frequent being organic brain failures.

In nursing homes 60 percent of the population are aged between 65 and 84 with only four per cent under 55 years.

Carewest has developed a number of programmes in an attempt to provide a comprehensive service. In respect of the elderly mentally ill programmes include;

i) The Psychogeriatric Day Hospital (30 places) is situated within a 294 bedded hospital and seeks to maintain the independence of the mentally impaired elderly in the community by providing short-term psychotherapeutic services.

The multi-disciplinary team consists of one psychiatrist (the clinical director) two nurses, three occupational therapists, two psychologists, one recreational therapy aid, a volunteer pastor and a secretary.

In essence the day hospital offers assessments and treatment through therapeutic activities. Following the initial assessment, the team meets again in a major patient review conference to share information. Based on

the findings, the patients diagnosis is confirmed and a specific treatment plan is developed. Patients' progress is then regularly reviewed.

ii) Assessment and Placement Pilot Project

In concert with two other organisations Carewest is piloting the single-assessment programme (referred to in Visit No.9).

iii) In-Service Resource Centre

Carewest supports the resource centre which provides training and education materials for staff working in long-term care centres in southern Alberta.

iv) Psychogeriatric Consulting Services

A psychogeriatric consulting service is provided by Carewest to all nursing homes and auxiliary hospitals in Calgary.. The full team consists of a Programme Manager, 2 Psychiatrists, 3 Psychogeriatric Consultants and support staff.

In addition to providing assessment and evaluation of individuals the team provides advice to organisations caring for the elderly.

v) Carewest Research

An increasing emphasis is placed upon research and projects currently being researched include

-Incontinence and the elderly
-Dignity in the care of the elderly and
-Alternative Housing (in conjunction with Social Services Community Health)

In total Carewest has 1400 staff who work in multi-disciplinary teams to provide a holistic approach to care. Teams are composed of a variety of professional staff while the cornerstone of the organisations philosophy is

"that each client is treated as a unique person deserving respect, privacy and companionship."

Although Carewest provides a range of services it is by no means in a position to provide for the needs of the elderly mentally ill on a comprehensive basis. A number of reasons were put forward for the lack of a comprehensive service and it was of great interest to discuss some of the problems faced in Calgary itself. These included:

- lack of assessment facilities
- lack of expertise in the field of psychogeriatric care
- deficiencies in day hospital places
- limited recognition of the needs of the elderly mentally ill by hospitals
- lack of a co-ordinated approach to address the specific problems and service needs of the elderly mentally ill
- little or no availability of respite care beds for this group of patients
- a need to develop educational programmes for professions in the field of psychogeriatrics.

Points Noted

a) Carewest had developed to provide services dictated by the organisation itself; not to meet identified needs. In this way the specific and perhaps unique needs of the elderly mentally ill were not provided for on a segregated basis.

b) Carewest was able to provide care to the less dependent elderly mentally ill in a nursing home type environment but found great difficulty in meeting the needs of the more disabled because of the lack of medical expertise and trained nursing staff.

c) Access to nursing home care is an extremely straightforward exercise but those requiring 'hospital' care faced significant waiting periods.

d) The ease of securing nursing home care, which attracted social benefits, had led to a proliferation of nursing homes in Calgary at the expense of the community developments and hospital treatment.

e) Carewest provided a range of institutionalized services but limited community developments.

f) As within the U.S.A. system, Carewest had to ensure financial viability. A similar pattern of isolated planning by individual organisations was apparent in Calgary. [At the time of the visit efforts were being made to develop a comprehensive and co-ordinated service for the elderly. This issue was a focal point of the news during the time spent in Calgary.]

CHAPTER 7

SOME LESSONS TO BE LEARNED

After the visit it was important to attempt to draw together a number of themes that are essential in designing a programme to meet the needs of the elderly mentally ill.

The following illustrate features considered to be essential in designing services that meet the needs of this group of people and/or their carers.

1. The Service must be accessible to all - restrictions based on location, finance, transportation, etc. are not acceptable.

2. There is an essential need to provide multi-disciplinary assessment and evaluation with the input of a psychogeriatrician - unless the problem is identified it is impossible to develop an appropriate programme of care.

3. The general public need to have a central point of contact - everyone needing help should be able to contact one telephone number, with the person receiving the call trained to co-ordinate appropriate services.

4. Services need to be co-ordinated - the elderly mentally ill often present multiple problems. Unless those caring for the elderly mentally ill work together then there will inevitably be duplication of service and deficiencies in facilities provided.

6. The planning of services needs the involvement and commitment of all caring agencies - as in No. 5 planning is likely to be a wasteful use of resosurces.

7. Services need to be known - those needing the service must be aware of the facilities offered.

Although in both the USA and Canada the visits undertaken illustrated a number of services that were unco-ordinated and planned in a somewhat piecemeal fashion this is perhaps understandable; the need to meet market forces, the competitive nature of health care and the mixture of public and private involvement in service provision.

Within the United Kingdom there is the opportunity to negate many of the problems outlined and thereby work towards a service which is co-ordinated and comprehensive. Consequently a planned development , e.g. the Caring Together Scheme, needs to involve the health service, Social Services and the community (represented by voluntary agencies).

Following the visit to the USA and Canada this philosophy was very much appreciated and consequently the following process has been undertaken.

a) Redesign the Caring Together Scheme

Following the Fellowship Tour the Caring Together Scheme was modified and redesigned (to the format in Appendix 6) after taking into account experiences and lessons gained from the findings of the tour.

[In addition to the above a number of other initiatives have been developed using lessons learned from visits undertaken. These include:

i) the design of a training manual to assist the carers of the elderly mentally ill

ii) an extension to the range of training packages provided by the Mental Health Promotion Team and

iii) the development of a consultancy service to assist nursing homes.]

b) Secure approval from the health service:

Although support had been gained from senior officers (within Mid Staffordshire Health authority), prior to the tour it was important to re-inforce this support to the modified scheme.

A meeting of the three UGMs, responsible for providing services to the elderly, with the District General Manager endorsed previous support while further discussions with representatives from the general practitioner service gained overall approval to the aims and objectives of the Caring Together Scheme.

c) Involvement of Voluntary Groups

Lessons learned in North America emphasized the need to involve the voluntary sector and utilise the expertise of specialised skills to be found in support network and caring agencies. In meetings with the co-ordinators of numerous voluntary groups there was again a great deal of commitment from the voluntary sector to work towards improving services for the elderly and particularly for those elderly who were confused or mentally ill.

There was the strong commitment from the voluntary sector that when the Caring Together Scheme should be implemented the various groups working to provide voluntary support wished to be involved and play an important role in developing the scheme itself.

d) Working with the Social Services Department

If any community service is to be successful then it is important to work in close liaison with the appropriate social services department. This is particularly the case when services for the elderly and mentally ill are concerned. However it must be appreciated that any scheme that identifies more people who require social support will lead to increased demands on the limited resources of the social services department. Such a scenario was described as opening Pandora's box.

Consequently in discussions with Social Services department it was important to recognise and appreciate the difficulties faced by social services staff in agreeing to the objectives of the Caring Together Scheme.

However, after long and sometimes difficult discussions overall agreement was reached and certain minor modifications will be made to the scheme itself. The success of the talks owe much to previous close co-operation between officers of the health service and the social services department and also to a mutual trust based upon shared ideals which recognises the need for and the desirability of transferring funds between agencies when appropriate.

e) Evaluation

In order to learn from the work of the Caring Together scheme arrangements have been made to research and evaluate various aspects of the scheme. Assistance to provide independent evaluation has been sought from a local university and other medical institutions and discussions are continuing on this aspect of the Caring Together Scheme.

f) Other Visits

Although the Caring Together Scheme does highlight a number of innovative approaches for services in Mid Staffordshire it would be inappropriate to try to suggest that the concepts of care in the scheme are unique.

Consequently since the return from North America the opportunity has been taken to study schemes within the United Kingdom; including work in Cambridge and Lewisham. Assistance from professionals working in the field has proved invaluable in re-assessing the Caring Together Scheme; after all the scheme is not about the words written in the document but rather about the way in which services can be designed and further developed to meet the needs of the elderly mentally ill.

Present Position (February 1989)

With agreement reached with all major agencies involved work is now being undertaken to launch the scheme itself with a proposed commissioning date of mid-summer.

Arrangements to be made include:

i) setting up formal meetings with all agencies working with the elderly

ii) drawing up the operational policy

iii) determining what services these agencies will agree to provide

iv) design a directory of services available

v) appoint staff

vii) arrange publicity, etc.

viii) commission scheme

On a personal basis the study tour offered a number of rewards. Obviously the chance to visit programmes of care for the elderly in North America was both exciting and interesting and a great deal of enjoyment was provided. Furthermore there was the opportunity to meet others working in the field of care and develop professional links and friendship.

The tour also provided the opportunity to test out a series of ideas and to learn from others who face similar problems in meeting the needs of a growing number of older adults.

One perhaps less obvious lesson learned was a personal conclusion that North America has much to learn from the National Health Service in the way care is provided to the vulnerable in society. Although there was much to learn from the programmes visited, those providing these programmes could perhaps learn equally from the care systems operating within the United Kingdom. A great deal was learnt from studying management initiatives, research work and different programmes visited it was evident that many gaps existed in services for the elderly mentally ill. This was not due to a simple explanation of the lack of resources, since many elderly patients were over provided for, but rather to the almost universal problem of lack of co-ordination in the planning and delivery of service. Although these problems were readily acknowledged there appeared to be no mechanism for rectifying the situation.

In Spokane, however, great strides had been made to work towards improving services for the elderly-at-risk. As outlined in early chapters much of this was due to the individual skills, hard work and endeavour to the Programme Director. Working against great difficulties an effective service had been developed. Certainly the respect and admiration for the Programme Director has been something to consider during the difficult periods of negotiation whilst attempting to gain support for the Caring Together Scheme.

In conclusion the study tour gave me:

- the impetus to develop new ideas
- an opportunity to learn from others
- added confidence to work through new ideas
- the resolve to make the Caring Together Scheme work
- a greater awareness of the needs of both service users and providers
- the chance to make new contacts in the field of caring for the elderly mentally ill.

The Caring Together Scheme now forms part of a package of programmes for the care of the elderly mentally ill; a package which has been developed to both improve quality and quantity of care.

Within Mid Staffordshire there is now a more comprehensive range of health services to meet the needs of the elderly mentally ill:

Primary Community Psychiatric Nurses (CPNs)
Specialist E.M.I. CPNs
In-patient beds
Respite care beds
Day Hospitals
Nursing home beds and

the range of services included in the Caring Together Scheme.

The Kings Fund Travelling Fellowship has provided the opportunity and support to assist in increasing the range of services offered.

APPENDIX 1

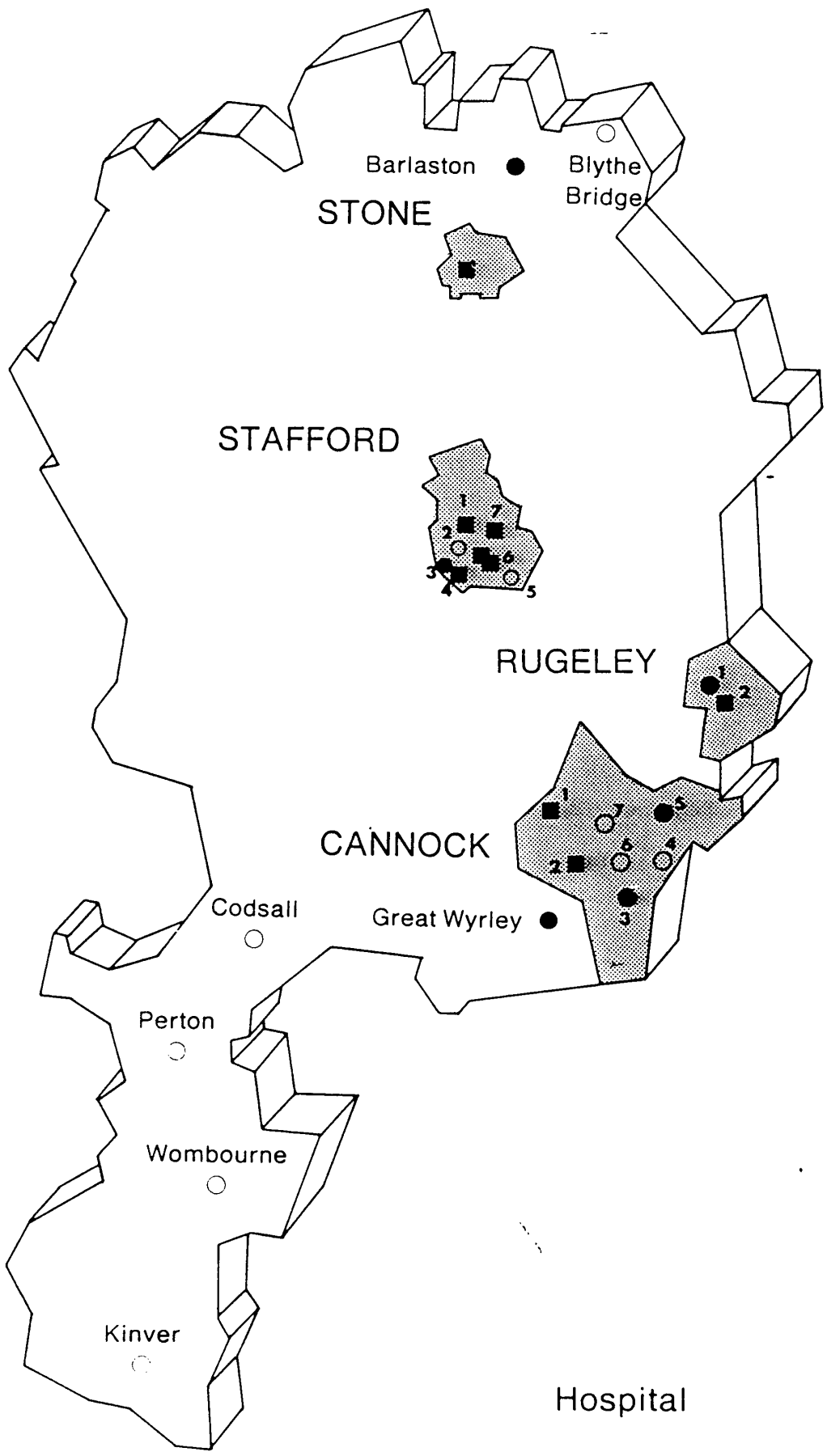
THE STUDY TOUR PROGRAMME

October 3rd	Philadelphia Geriatric Center
October 4th a.m. 4th p.m.	Pennsylvania Hospital & Mental Health Centre Thomas Jefferson University
October 6th	Child & Family Services, Howell, Michigan
October 7th	Turner Gariatric Services, Ann Arbour, Michigan
October 10th	Geriatric & Family Services, University of Washington, Seattle.
October 11th to 14th	Spokane Community Mental Health Center, Elderly Services.
October 17th	sUniversity of Calgary
Octcober 19th	Carewest - Sarcee Auxillary Hospital, Fanning Centre, Carewest Centre.

LOCATION OF

APPENDIX 2

Hospitals, Health Centres & Clinics IN MID STAFFORDSHIRE



STONE

Trent Hospital

STAFFORD

1. Stafford District General Hospital
2. Stafford Central Clinic
3. Rising Brook Health Centre
4. Burton House
5. Weeping Cross Clinic
6. St. George's & Kingsmead Hospitals
7. Staffordshire General Infirmary

RUGELEY

1. Rugeley Health Centre
2. Rugeley Hospital

CANNOCK

1. White Lodge
2. Chase Hospital
3. Heath Hayes Health Centre
4. Chadsmoor Clinic
5. Hednesford Health Centre
6. Beecroft Road Clinic
7. West Chadsmoor Clinic

Hospital ■

Health Centres ●

Clinics ○

APPENDIX 3

STAFFORDSHIRE COUNTY COUNCIL
SOCIAL SERVICES DEPARTMENT

MID STAFFORDSHIRE HEALTH AUTHORITY
MENTAL HEALTH UNIT

A Joint Strategy For the Development of Mental Health Services

May 1987

FOREWORD

We are pleased to present this joint strategy for the development of mental health services in Mid Staffordshire to the Joint Consultative Committee for their consideration.

The strategy document is the basis for enabling our two agencies to work even more closely together in order that our joint resources can be fully utilised without duplication and in the best interests of the welfare and health of those people who use the services.

The involvement of the voluntary sector, other agencies and most importantly the users of the services, make it essential that this is seen as a flexible document providing a base from which better services can be developed in a spirit of co-operation between all agencies.

Director of Social Services,
Staffordshire County Council

District General Manager,
Mid Staffs. Health Authority

INDEX

1 INTRODUCTION

1.1 Care of mentally ill people has undergone radical changes over the years and this process of change is continuing with new concepts of community care.

1.2 The Mental Health Act 1983 and the Care in the Community initiative has brought the need for improved services for mentally ill people into prominence.

1.3 Health Authorities, Social Services Department and Voluntary agencies will have a major part to play in the provision of services for the mentally ill. These services should include primary provision and early identification as well as helping people who are suffering from episodical mental illness or who are long term chronic sufferers.

1.4 This document incorporates the health service and social services approach to mentally ill people, their responsibility and the range of services they can provide.

1.5 Enclosed is a strategic plan which includes implications for the future provision of care for the mentally ill. These issues can only be addressed within a framework of the philosophy of care and the general provision of services for the whole spectrum of people who are mentally ill.

1.6 There needs to be overall guidance on the approach to the development of services for mentally ill people but this guidance should not be prescriptive. The emphasis will be on meeting the needs of the whole community. Within the overall strategy there will be individual initiatives and projects, some of which will be innovatory.

1.7 The existing pattern of services within communities will differ and as such communities will have different needs. The existence of community resources whether they be health services, social services or voluntary can affect the shape of the service in a community and may have an impact on the range of facilities which are required. An open flexible approach by all the agencies concerned is therefore required to meet the needs of each community.

1.8 Joint collaboration between the above agencies offers the opportunity to build upon existing skills and resources and develop new programmes of care within the community of Mid Staffordshire.

2 THE PHILOSOPHY OF CARE

2.1 The Value of the Individual

All people, irrespective of their needs, have a fundamental right to self-determination on the basis of informed and realistic choices. The right to choose from a range of services offered will be only over-rided when it is statutorily necessary to do so in the interest of the individual's own health or safety or with a view to the protection of others. The exercise of self-determination is fundamental to the health and well being of the individual and will be encouraged whenever possible. In putting this philosophy into practice an individual's wishes and interests must be taken fully into account by the agencies supplying the appropriate service.

2.1.2 There are three underlying and consistent aims in providing assistance, at whatever level, from the various elements of the health service and social services. They are:-

i) to affirm and enhance the dignity, self respect and individuality of people regardless of disability or position.

ii) to improve mental functioning and thus reduce the effects of disability.

iii) to promote opportunities for ordinary living.

2.2 Values of the Social Services and Health Service

2.2.1 From the view of the users, services are most effective when they are integrated, consistent and responsive to the needs of the user. In order to achieve this, service needs will be based upon values which are shared between providers and recipients.

2.2.2 Three basic values are however suggested:-

i) Services should be established in a way which meet the identified needs of the users rather than the users of the service fitting their needs into an existing pattern of care. Consequently, structures should not inhibit the delivery of service to the individual.

ii) All services must be sensitive to the opinions of mentally ill people and consequently there needs to be a real dialogue between providers and users of the services. For users of the service to be effectively and usefully involved in determining the type(s) of service provided they need training and advice how to participate.

iii) Shared values can only be based upon mutual respect between the various providers of the services. This requires that professionals working in different areas of care are able to agree and accept the roles of each other as they are defined.

2.3 The Philosophy of Service Design

2.3.1 Services will be localised and readily accessible to people. Potential users must have information available about the services that are provided.

2.3.2 Delivery of care will be on a comprehensive basis providing all categories of patients with a service according to their needs. In order to achieve this, service must be planned comprehensively. Services which are developed on a piecemeal basis tend not to be balanced and undervalue certain groups in a society.

2.3.3 The application of this philosophy requires that preventative treatment and supporting services should, where possible, be non-institutional and be community based. Careful thought will be given to ways of organising the health service input to achieve this and in particular the role to be played by the primary health care team.

2.3.4 In the majority of situations the family are the carers and every assistance should be given where it is desired to allow the family or individual to continue to offer care. A framework of services to care for mentally ill members already exists. This will need to be developed more comprehensively to sustain family well-being as well as to regain or encourage family support where ties have been damaged or broken. In making efforts to assist families to continue to look after mentally ill members at home, attention should be given to providing respite care in forms which match the varying needs of people.

2.3.5 As far as possible the wishes and feelings of mentally ill people as well as their families should be taken into consideration in planning or providing individual services for them. The people of the Mid Staffordshire Area of the County have an important role to play in developing and improving services and consequently the community as a whole is an important resource to be utilised. Communications and liaison between the community and the service providers need to be carefully planned.

2.3.6 The service will be designed to meet the range and needs of individual users and the particular needs of each individual should be identified in drawing up a support and treatment plan. The importance of enabling the individual to retain as much control over his/her life as possible will be incorporated in the plan.

2.3.7 At the level of service planning there should be a co-ordinated approach by the main statutory agencies and with the active involvement of the voluntary sector. Resources must be marshalled, skills shared and combined to achieve good quality modern services to meet the needs of mentally ill people in ways they will find acceptable and which encourage rather than prevent normal living.

2.3.8 Services will endeavour to minimise the dependence of the users on professional resources while at the same time ensuring the level of support and security to the individual that is required. It should be recognised that recommended levels will change over time and therefore skilled assessment of the changing situation and regular consultation between all concerned should take place.

2.3.9 Particular attention needs to be paid to the position of elderly parents or relatives caring for dependent family members. Assurance must be given to them about the form of care which will be provided when they are no longer able to provide care themselves. Opportunities for introduction to appropriate forms of care should be arranged to minimise difficulties in adjustment.

2.3.10 An individual's requirements for services should be assessed at the earliest stage and a plan of action agreed between all the professionals involved. It should be reviewed at intervals subsequently.

3 PROVISION OF SERVICE - PRINCIPLES OF SERVICE DESIGN

3.1 Needs of the Community

3.1.1 A programme will be devised to educate and inform and which will facilitate the understanding of the range of human conditions which are at the present time grouped under the heading of "mental illness".

3.1.2 Education should start from an early age in order to encourage the pursuance of a life programme which promotes mental health.

3.1.3 Information should be widely disseminated throughout the community in order that individuals and families can seek help at an early stage.

3.1.4 Each locality should develop its resources to respond to individual or family problems.

3.1.5 The understanding and help of the wider community will be actively encouraged so that the presence of mentally ill people in the community is fully accepted.

3.2 Seeking Help - Primary Care and Local Service Filter

3.2.1 Service provision will be designed to follow the needs of the person requiring help and wherever possible reflect the pattern of primary care provided by the primary health care team.

3.2.2 Support will be given to primary care and local service providers by the deployment of psychiatrists, community psychiatric nurses, social workers and psychologists. These and other specialists will provide skilled advice and services to the person requiring assistance.

3.2.3 Primary care services will assist in providing a full assessment with an emphasis on prevention.

3.3. Treatment Needs - Active Support from Specialists & Services

3.3.1 Emphasis will be placed on minimal disruption of the individual's usual pattern of life. Therefore in most situations treatment should be provided in the locality of the individual concerned and preferably in the individual's own home.

3.3.2 In some areas there may be a need for specialist resources to allow for local treatment where this cannot be provided by the primary health care or health centre service.

3.3.3 With improved community services the demands of hospital services should diminish. This should result in fewer out-patient attendances and fewer day patient attendances. It is noted in the H.A.S. Annual Report 1984/5 that it is becoming clear that general psychiatric wards are not suitable for "new long-stay" patients or for those with protracted behavioural disturbance.

3.3.4 Treatment aims should be consistent with the ethos of the 1983 Mental Health Act in terms of the "least restrictive alternative" form of treatment.

3.3.5 Assessment and treatment will take account of the social and environmental factors that may affect a person's disability. Appropriate referral to other agencies, including voluntary organisations, will serve to reduce external environmental pressures and form part of an overall treatment plan.

3.4 Resettlement Needs - Rehabilitation

3.4.1 People continuing to live in their own homes within their own community and who need treatment, support and care will require a different programme of rehabilitation from those individuals who have been resettled from long-stay institutions.

3.4.2 When people are no longer able to live at home they should still receive support and training in independent skills within their substitute home.

3.4.3 Residential care should provide a small scale homely substitute for those who are not able to live with their families and give opportunities to take part in ordinary life. Over protection should be avoided and exercise of choice in matters of money, possessions, entertainment, encouraged.

3.4.4 The Social Services Department provides an extensive range of domiciliary support services. These, together with the active co-operation and support of other professional support services and voluntary agencies will play an important part in the rehabilitation of mentally ill persons.

3.5 Continuing/Long Term Care Requirements

3.5.1 Many people will continue to live in their own family home when appropriate support services are provided. However, in some cases family and social networks will have broken and the needs of the individual become isolated. Services therefore will offer the range of care for such individuals including:-

i. Respite services

ii. Home care services including input from primary health care teams and a range of social services domiciliary support services.

iii. A range of different care options, e.g. sheltered living arrangements.

iv. Appropriate use of local day care facilities including local clubs and amenities.

3.5.2 For the more severely disabled person who require a high level of support and security, facilities must be provided which are sympathetic to the needs of these individuals. There will be small scale units situated in or near to the locality of the individual concerned and every effort must be made to ensure a non-institutional environment.

3.6 Day Activity - Sheltered Placement and Employment Programmes

3.6.1 People will receive help in the use of general services for leisure and occupational programmes and to use job finding service.

3.6.2 Wherever possible day care facilities will be local and flexible in their approach to the differing needs of people.

3.6.3 There is a need for more multi-purpose day centres. Social interaction between mentally ill persons and other groups can be of therapeutic value in itself.

3.6.4 A variety of day care provision is needed including drop-in centres, voluntary clubs and groups and recreational and leisure organisations. The different forms of day care will be used appropriate to the changing needs of the individual and progression or transfer from one form to another will take place as part of a continuing support programme for each individual. Hospital day care is intended for those who require treatment or care of a more specialised nature.

3.6.5 There is a need to open day hospitals seven days per week and to provide facilities in the evenings for the periods when people are most isolated. This also applies to multi-purpose day centres.

3.6.6 Relatives also require support and help and it is accepted that this should also be available throughout the week. This help will include counselling and advice.

3.6.7 Mental illness can damage or break family ties. Wherever possible both the nuclear and extended family will need to be focused or in order to regain or encourage the family's co-operation and support for any treatment plan.

3.7 Income Needs

3.7.1 Low or interrupted income can cause many social difficulties and it will be necessary to ensure co-operation with officers of the Department of Health and Social Security.

4 HEALTH & SOCIAL SERVICES - DELIVERY MODEL INCORPORATING VOLUNTARY AGENCIES

4.1 A service delivery model which is based on the needs of the people receiving the service will mean that the health service, social services and voluntary agencies, will have to review their structures and accordingly delegation of responsibilities to staff.

4.2 An efficient and satisfying service for the consumer can only be provided where there is good collaboration at all levels in the organisation and the agencies.

4.3 Collaboration in Service Delivery Between Social Services, the Health Service and Voluntary Agencies

4.3.1 The importance of multi-disciplinary work at grass-roots level cannot be over-estimated. Contribution from a range of disciplines to assessment, rehabilitation plans, treatment, care and maintenance of people is critical to positive ideas.

4.3.2 It is essential to define the boundaries between professional workers and between auxiliaries to prevent unnecessary overlap and to make use of all resources. (See Appendix Management Arrangements of Services).

4.3.3 An operational policy will be drawn up in respect of Social Services and Health Service staff jointly working in day centres or day hospitals.

4.3.4 An agreed guide to the respective roles of the Community Psychiatric Nurse and the Social Worker will be used in joint working projects.

5 THE PART PLAYED BY VOLUNTARY ORGANISATIONS

5.1 There is a growing operational contribution which is being made by the voluntary organisations and this will be reinforced. There should be a recognised partnership between the statutory and voluntary organisations and the delivery of care to mentally ill people.

5.2 Voluntary organisations have a tradition of experimentation and piloting schemes. They operate between different parameters to the statutory agencies and are generally more autonomous. There are, therefore, activities in which they may be effective in delivering some forms of care.

5.3 In particular voluntary organisations can be pressure groups but can also provide services which are a valuable role to the care of the mentally ill. The voluntary sector plays an important role in complementing the work of the health and local authorities.

6 THE NEEDS OF STAFF - TRAINING, EVALUATION & RESEARCH

6.1 The need of staff development and the related elements of training, evaluation and research cannot be divorced from the general provision of services.

6.2 The aim of staff development and training will be to raise the level of work with the mentally ill person beyond that of basis competence, to a level of excellence.

6.3 This implies a commitment to the development of a professional ethos which can only be achieved from a sound theoretical/practical basis. Consequently, the principles of normalisation must be clearly explicit in providing this basis.

6.4 Strategies for providing staff development will prepare for the eventual run down of long-stay wards thus staff in all settings require knowledge and skill about the nature of psychiatric disorders and about the interventions of care which such disorders require.

6.5 The understanding of problems which individuals face is not the sole prerogative of one discipline. Life situations, including clinical conditions of individuals cannot be fully accounted for in one generally accepted model. A variety of perspectives need to be brought to bear on the problem in order to provide thorough assessment and appropriate treatment. Bringing together a range of services to achieve this aim is a complex task. A greater appreciation and acceptance of the respective contribution of the participants is required.

6.6 One important way in which this can be achieved is through participating in the direct care of the clients as a member of a multi-disciplinary team. All major disciplines must play an established role in such teams. Staff need direct experience with mentally ill people who suffer from a range of different disorders.

6.7 The Social Services Department places great emphasis on the training of Approved Social Workers under the 1983 Mental Health Act. The Department aims to ensure that a rolling programme of staff training will result in the large majority of social workers being approved for the purposes of the Act.

6.8 There is a need for more in-service training for social services staff working in day centres and residential homes.

6.9 Closer working relationships between Social Services and Health Service staff will lead to some joint staff training schemes.

7 RESEARCH

7.1 A co-ordinated approach to research is as important as a co-ordinated approach to service planning. Research requires a partnership between providers and users which reflects the needs of the latter and which produce findings of use to all concerned.

7.2 Steps will be taken to make research available to practitioners, managers and others in a forum which they can use. One way to contribute is to educate all service providers to be better consumers of research.

8 MONITOR

8.1 Adequate monitoring arrangements should exist so that the amount and type of work undertaken for mentally ill people can be assessed and regularly reviewed.

8.2 The monitoring arrangements will make use of agreed definitions of mental illness and rely on standard procedures for data collection.

9 EVALUATE

9.1 A service contribution to the well being of mentally ill people must have prominence in service delivery. New service developments will include a mechanism for evaluation before and not after they are established.

10 THE STRATEGIC PLAN

10.1 The service will be designed to meet the range of needs of individual users and the particular needs of each individual will be identified in drawing up a support and treatment plan. The importance of the individual retaining as much control over his/her life as possible will be incorporated into the planning process. The need to maintain and support whatever friendship and caring relatives input the individual has will be paramount in designing future developments to the service.

10.2 This strategic plan sets out future developments for improving the level and types of service that will be provided for the mentally ill.

10.3 It is acknowledged that St. George's Hospital will continue to provide the expertise and service for those patients who will require hospitalisation but the main emphasis on future developments will be directed toward providing additional facilities for the mentally ill within the community. In this respect joint projects will be established between the Health Authority and Social Services.

10.4 Mental Health Centres:

10.4.1 The service will be divided into "natural" areas which are subjectively defined in order that people can be identified with that area.

10.4.2 Within each "natural" area/sector the Health Service will set up a research team which it is proposed will be sent to the identified location in order to:

i. Identify the problem in that area(s).

ii. Identify resources available and build up links with voluntary and statutory agencies.

10.4.3 The research team will liaise closely with the staff who will subsequently provide the service for the Mental Health Centre. The staff will consist of:

1.0 w.t.e. Clinical Psychologist
1.0 w.t.e. Community Psychiatric Nurse
1.0 w.t.e. Social Worker
1.0 w.t.e. Community Liaison Officer

10.4.4 This team will be led by a specialist in research procedures. However, the specialist will only be employed until the Mental Health Centre is commissioned.

10.4.5 The staff of the Health Service Mental Health Centre will also be supported by secretarial staff and each Centre will be under the influence of a designated consultant.

10.4.6 The hours of opening of the Mental Health Centre should be specifically designed to meet the needs of the local community and consequently it is essential that access to the Centre is available both at week-ends and in the evenings.

10.4.7 Referrals to the Centre will not be restricted to any professional or group and it is intended that in addition to referrals from general practitioners, social workers, community nurses etc., there will be a high proportion of self-referrals.

10.4.8 The Centre will in the main offer advice and practical assistance and further referrals rather than offer specific treatment sessions. However, it is acknowledged that team members may on occasions find it effective to offer one-off counselling sessions to meet specific needs and until further facilities are provided in the locality day facilities will be offered.

10.4.9 It is the staff of the Mental Health Centre who must develop close working relationships with statutory and voluntary agencies in order to promote the concept of "mental health" and to ensure that an updated register is maintained of facilities available for those in need.

10.4.10 Although instances of "serious mental illness" will not reduce with the development of Mental Health Centres it is acknowledged that early intervention and treatment has a marked effect on the intervention at an early stage in preventing people under stress from becoming ill. It is an essential function of the Centre to ensure that individuals, families and/or groups under stress are supported within their own setting wherever possible.

10.4.11 Use of volunteers as required will provide support for those in need. It is intended to use community resources whenever possible but the Centre itself will also be made available to groups who may wish to initiate their own activities and projects.

10.4.12 There is also a need to promote "community awareness" in respect of its contribution to health promotion. Also to encourage the community to assume responsibility for the resolution of these problems. This will be an important task of the Centre. Participation in educational talks, seminars and health promotion talks is also recognised as an integral part of the Centre.

10.4.13 The Centre itself will provide support to other health and related workers in the area and also to those members of the community working in a voluntary capacity in this field.

10.4.14 The Centre will be available and accessible to those in the area who are in need of support and the staff of the Centre must accept a responsibility to respond to the needs of those at risk.

10.4.15 It is intended that the research team will carry out a survey within Cannock area during the financial year 1987/88 and following this period of research the first Mental Health Centre will be established.

10.4.16 It is proposed that a second Mental Health Centre will be commissioned at Great Wyrley, Social Services, Day Centre using the facilities.

10.4.17 By establishing two different approaches to the concept of Mental Health Centres a process of evaluation can and will be undertaken after both centres have functioned for 12 months.

10.4.18 A Mental Health Centre is also planned to be commissioned for the Rugeley area by the end of the financial year 1988/9.

10.4.19 By the end of the financial year 1990/1 a further Mental Health Centre will be established within the Stafford area.

10.4.20 Although Mental Health Centres can be effectively utilised throughout the week in areas where there is a catchment population of sufficient size to use the facilities offered it is recognised that many areas within Mid Staffordshire are of a rural nature.

10.4.21 The process of research and evaluation outlined above will be repeated in rural areas and a team will be established to provide services in Health Centres throughout Mid Staffordshire. This team will be made up of psychologists, community psychiatric nurses, social workers and a community liaison officer, and will operate throughout the area to provide a service to Health Centres and Day Centres on different days throughout the week. In this way it is felt that the professional expertise and experience can be more effectively utilised. It is planned to establish this team by the end of the financial year 1990/91.

10.4.22 By the process of research and improved communications with the community at large the planning process can utilise the increased awareness of the community needs with regard to further developments in specific areas.

10.5 Services for the Elderly Mentally Ill

10.5.1 The projected increase in the number of elderly people, including elderly mentally ill in Mid Staffordshire will require the current wide range of health and social services provision to be increased.

10.5.2 Continued emphasis will be placed on care in the community. The type and extent of provision will depend on the individual needs of elderly mentally ill people and in addition to hospital facilities will include such services as home help, social services aide, day care, lunch clubs, meals on wheels, social work support and advice, aids and adaptations, night sitter, respite care, periodic care, and permanent care.

10.5.3 Social Services day care for the elderly is intended to provide social and recreational stimulation, to provide for physical welfare, to monitor the well-being of vulnerable elderly people who may be living alone, and to offer a break to relatives from unremitting care responsibilities. For some elderly mentally ill persons day care is more likely to be of benefit in a smaller and quieter unit rather than a large, busy, multi-purpose day centre. A proposed unit of this type in the north of the county is seen as a first step in this direction.

10.5.4 Within the area covered by Mid Staffordshire Health Authority 607 people are currently resident in homes for the elderly. 319 elderly people attend day care at residential homes and 205 elderly people attend multi-purpose day centres. Some 506 attend lunch clubs and voluntary day centres. 3730 people in the area covered receives home help and 717 people receive meals-on-wheels.

10.5.5 Care in residential homes will continue to have a firm place in the spectrum of community care services, providing residential assessment of needs, short stay, respite and period care as well as long term care. Social Services provision for elderly mentally ill people will involve care of the type afforded by a caring, competent relative but with a good knowledge base, and where necessary the support and guidance of the general practitioner or community nurse. The person should not be in need of any hospital admission or professional nursing, and residential homes should not be seen as nursing homes or an extension of hospital facilities.

10.5.6 Elderly mentally ill men and women reside in social services residential homes. With some elderly mentally ill persons who have specific problems of a behavioural nature this can cause acute distress to other vulnerable residents, and health service provision will be utilised for persons with severe behavioural problems or acute illness.

10.5.7 Wherever possible because of the difference in routine and the pace of life, short stay care will be provided separately from long term care. Short stay units adjacent to day centres have the advantage of providing closely complementary resources. One such unit is proposed to be built in 1987/88 on land adjacent to the proposed Great Wyrley Day Centre. It will be a useful resource for those elderly mentally ill persons who will be attending the day centre and who require short stay care. It will also be used by other client groups including younger mentally ill persons attending the centre.

10.5.8 At the present time the number of beds for the elderly mentally ill that are provided at St. George's Hospital does correspond to those considered appropriate by the Regional Health Authority. However, as outlined above the elderly population within Mid Staffordshire will dramatically increase during the remainder of this century and consequently additional hospital beds will be provided to meet this increased need.

10.5.9 The Cannock Community Hospital which is due to open in January 1990 will provide two 24 bedded wards and a 40 places day hospital for the elderly mentally ill. Included in the above bed numbers will be facilities for joint psycho-geriatric assessment.

10.5.10 In addition to this development it is acknowledged that there is a need for an additional 35 places day hospital for the elderly mentally ill. Although the specific location as to where the day hospital should be situated has not been finalised, it is appropriate that serious consideration should be given to establish a day hospital in the Uttoxeter area.

10.5.11 The planned commissioning of this day hospital is for the period 1989/90 and although it is not intended to build a new hospital it is considered that by the use of existing buildings the development can be fully operational by the end of the financial year 1990/91.

10.5.12 There is an undoubted need to offer respite care beds for the elderly mentally ill in a setting other than St. George's Hospital. At the present time discussions are taking place with a Housing Association to provide a 10 bedded EMI respite care unit in the Stafford area by the end of the financial year 1987/88. Referrals to the unit will be through the Community Psychiatric Nurse who will work in close liaison with general practitioners, social workers and voluntary agencies and with the consultant psycho-geriatrician who will provide the necessary medical input.

10.5.13 A second similar EMI unit will be provided in Cannock by the end of the financial year 1989/90.

10.5.14 A further concept of care presently being developed is for a 10 bedded EMI unit to be established in conjunction with the respite care scheme in Stafford. The unit will provide facilities for both the health and social services to assess:

i. If selected EMI patients can be successfully discharged from St. George's Hospital and

ii. Additionally, if patients referred from social services can be adequately cared for in the community without referral to the hospital.

This development will be commissioned with the 10 bedded EMI Respite Care Unit in Stafford, i.e. 1987/88.

10.5.15 Although a joint psycho-geriatric facility will be commissioned in the Cannock Community Hospital, there already exists the need for such a unit. Therefore, a 10 bedded joint psycho-geriatric assessment ward will be established at St. George's Hospital in the financial year 1987/88.

10.5.16 Both the Health Authority and th Social Services Department hold the view that preventative and supporting services will wherever possible be community based and is accepted and actively promoted. Therefore, a number of programmes are presently being developed to allow the elderly mentally ill to live a fulfilling lifestyle within their own home environment as long as possible.

10.6 Day Facilities

10.6.1 At the present time day hospital facilities are centered in the Michael Flanagan Day Hospital and there is a clear need for further development of this facility.

10.6.2 Day hospital facilities provide a service that enables the individuals to live a more normal lifestyle within the community than they would be able to achieve as in-patients within the hospital. In addition day hospitals will provide facilities for those in-patients who have been discharged.

10.6.3 In order to meet this pressing need it is intended to open an additional 30 places psychotherapy day hospital in the community and this development will be commissioned by the end of the financial year 1987/88.

10.6.4 In addition to the day hospitals at St. George's Hospital serious consideration and effort will be made to establish increased day facilities within the community. In this respect health centres and other voluntary agencies accommodation will be utilised. This will be a continuation of the present trend that has progressed over the last few years. An example of this type of development is the work presently being undertaken at the Methodist Hall in Gnosall. The Cannock Community will also provide 40 day places.

10.6.5 Day Centres for the mentally ill and multi-purpose day centres are an excellent resource for those with mental illness problems and the social interaction of different groups of people is of therapeutic value in itself especially in the development or relearning of social skills.

10.6.6 In Stafford the Marston Road Day Centre provides 20 places for people suffering from or recovering from mental illness. Most of the people attending the Day Centre have had at some stage received in-patient treatment and this is active Community Psychiatric Nursing input to provide support as necessary.

10.6.7 At Northfields Day Centre 50 places are provided including provision for the mentally ill.

10.6.8 There is a need in outlying communities for group activities to be arranged at local centres and one such group meets in Stone on a weekly basis.

However, it is recognised that there is a need to provide additional day facilities in the Stone area and it is intended to provide a multi-purpose day centre with medical and nursing input. The centre would also serve as a base for other day care services and also for Community Psychiatric Nurses.

10.6.9 In Cannock, the Social Services group organiser runs a group for the mentally ill and physically handicapped at a local church hall. Although there is a large unmet need for additional day car provision the commissioning of the Great Wyrley Day Centre will provide additional facilities both for the above group and also to cater for the day care needs of the mentally ill who will reside in accommodation provided by the 25 place Normid Housing Association Scheme in Cannock.

10.6.10 The development of multi-purpose day centres and the use made of them by mentally ill people provides a valuable and cost effective service. Such centres can make use of existing premises, normally vacated schools, and obviate the need to build costly purpose built accommodation. The direct benefit of such centres to the Health Service is that they bring together groups of people who may also be in need of medical or paramedical help; they can also be used as a base of operations for practitioners, in particular for Community Psychiatric Nurses and other health workers.

10.6.11 Multi-purpose day centres are a resource complementary to day hospital provision. A full assessment of the needs of mentally ill people will be made in order to establish the most appropriate form of day care, to be seen as a flexible arrangement based on the changing needs or condition of the individual person.

10.7 Drug and Alcohol Abuse

10.7.1 The problems related to alcohol, drug and substance abuse affect a considerable number of clients dealt with by the Social Services Department. Thus a multi-disciplinary approach to the problem, including close liaison with the Health Authority and the voluntary agencies working in this field will be developed.

10.7.2 Social Services will adopt a broad approach to individual problems and are bound by statutory duties, particularly in respect of child care matters, which needs to be understood when a joint approach is developed. In other words persons dealt with in relation to problems of drug, alcohol or substance abuse will be looked at in the wider context of their family. A move towards community based treatment is an acceptance that people with specific abuse problems usually have other personal or social problems that are causal or consequential in nature. There will be social work involvement in community based treatment plans and in the interests of inter-agency co-operation there should be a nominated contact point in each Principal Area Office, in addition to the duty social worker, who would have a special interest in this field and develop knowledge and expertise.

10.7.3 At the present time individuals with alcohol abuse problems receive treatment at St. George's Hospital and in the main little support from the health service exist within the community. This increase problem will require development of facilities to meet the undoubted growth in demand over the next few years.

10.7.4 It is intended to continue providing in-patient facilities at St. George's Hospital and in addition a day hospital for the care of those individuals suffering from alcohol related problems will be commissioned by the end of the financial year 1987/88. At the present time it is intended that this day hospital will initially utilise the facilities available at St. George's Hospital but the strategic plan aims for the development of this facility in the community by the early 1990s.

10.7.5 The number of in-patient beds in Weston Villa will reduce from 18 to 8 in March 1987 (additional beds will be available if required on Walton Ward) and this will facilitate the use of Weston Villa as the day hospital.

10.7.6 In addition to a day hospital there is a need for a "dry" house/hostel(s) within the community. It is felt that close co-operation between health and social services and voluntary agencies will enable this facility to be developed by the early 1990s.

10.7.7 In order to assist in the promotion of health education it is proposed that, with regard to alcohol abuse problems, additional community psychiatric nurses and/or social workers should be appointed:

i. to promote health education

ii. to provide support to those individuals who have received treatment and who have returned to their last home within the community.

10.7.8 At the present time facilities for the care and treatment of people suffering with a drug related problem are centred on Milford Ward at St. George's Hospital. Milford Ward is a 16 bedded unit catering for those with a personality disorder often related to a drug abuse problem.

10.7.9 Two Community Psychiatric Nurses have recently been appointed:

i. to provide after-care facilities for discharged patients

and

ii. to promote an educational policy which highlights the dangers associated with drug abuse.

10.7.10 Under a joint financing arrangement between the Health Authority and the Social Services Department a scheme to promote the treatment and care of the drug abusers has been established and will be administered under the direction of Turning Point.

10.8 <u>Mental Health Promotion Team</u>

10.8.1 There is a growing awareness of the need to educate the community at large to the problems of mental illness and the dangers of alcohol/drug abuse. It is considered essential that if a comprehensive mental health service is provided then the community at large should be made aware of ways of promoting mental health and also in appreciating how facilities provided by the health service can reduce the problems of those who are mentally ill.

10.8.2 By the end of the financial year 1988/89 a Mental Health Promotion Team will be established to provide support to educational and industrial establishments and also to voluntary agencies and local groups. The Mental Health Promotion Team could ultimately be self-financing but this is not seen as a major constraint to its establishment and development. The joint strategy consequently advocates a priority to this service and adequate finance will be made available to ensure the project work is developed.

10.9 Rehabilitation of long-stay patients

10.9.1 Within St. George's Hospital there is a high proportion of elderly patients amongst the "old long-stay" population. It is considered that a substantial proportion of these patients will not be able to return to life in the community and still enjoy the quality of life that is provided at St. George's Hospital. However, it is acknowledged that such a decision can be finalised only after intensive rehabilitation had been received by this group of patients.

10.9.2 Therefore efforts will be made to rehabilitate all patients whose quality of life can be improved if they undergo intensive rehabilitation and ultimately return to life in the community.

10.9.3 At the present time a substantial amount of work has been carried out in this area and the League of Friends in conjunction with the local authority have provided an important input into this work. The League of Friends "manage" a number of group homes in the community in which discharged patients can live and still enjoy a measure of security with support from the hospital staff.

10.9.4 It is intended to further develop this facility and additional properties are already being negotiated for use in this way. During the next financial year it is planned to increase the number of places for these patients from a present total of 39 to a total of 51. In the next financial year the number of group homes will again increase.

10.9.5 There are a substantial number of patients within the hospital who suffer from chronic mental illnesses. By a process of careful rehabilitation and training it is intended to utilise one of the blocks of flats presently situated on the St. George's Hospital site presently used for hospital accommodation as a "group home" for such patients as a preparation for a future more culturally valued lifestyle.

10.9.6 It is planned that this development will take place by the end of the financial year 1988/89 and will consist of accommodation for 17 discharged patients who will be supported by members of the hospital staff who will "live in" the flats. In addition to the support from the staff who "live in", the individuals in question will still have recourse to hospital facilities located on the same site.

10. 9.7 In Stafford the Vicarage Housing Project - self contained flats for those recovering from mental illness - receives input from the social work field staff and non-residential domiciliary support.

10. 9.8 The Normid Housing Association Scheme in Cannock will provide 25 places for persons with mental illness problems.

10. 9.9 Proposed short stay units adjacent to the Great Wyrley Day Centre will also provide excellent preventative resources for the mentally ill.

10.10 Child/Adolescent

10.10.1 Children and families with problems of a psychological, psychiatric emotional or behavioural nature are in addition to Social Services input, currently dealt with by referral to the school psychological service or, in the absence of a Child Psychiatrist, to other consultants at St. George's Hospital.

10.10.2 There is a need to review areas of need throughout the district and to examine the role of the health service in relation to this need. At present two social workers are attached to the School Clinic in Lichfield Road, Stafford, working in conjunction with educational psychologists. There appears to be a need for a clinical psychiatric input to augment this service. The appointment of a Child Psychiatrist will enable a better co-ordination of psychiatric and psychological services, in particular in the area of assessment.

10.11 Facilities for the new long stay

10.11.1 It is acknowledged that even with the development of community facilities there are a number of patients in St. George's Hospital who will require a more secure and supervised form of care which up to the present has normally been found within a hospital setting.

10.11.2 Within Mid Staffordshire the number of such patients will be relatively small but nevertheless there is a commitment to ensure that a more suitable type of facility is provided in order to ensure that these patients have the highest level of care possible and are not expected to spend excessively long periods of time in hospital.

10.11.3 Although the plans for the provision of such accommodation have not been finalised it is expected that two hostels each with a small number of beds will be provided within Mid Staffordshire Health Authority by the year 1991/92.

10.12 Services for the mentally handicapped patient who additionally suffers from mental illness

10.12.1 It is recognised that at the present time we have not developed facilities for the mentally handicapped patients who also suffer from mental illness and consequently there is a need to identify the extent of services required and develop a strategy to make sure the all patients receive appropriate treatment.

10.12.2 It will be a priority of the Unit General Manager for the Mental Health Unit, in consultation with the Unit General Manager responsible for the mental handicap services, to work towards developing a strategy for the required service(s) in order that appropriate resources will be devoted to this area of care. Discussions on this subject are still at an early stage and consequently are not yet available for inclusion in the strategic plan.

10.13 Industrial Therapy Unit

10.13.1 The Industrial Therapy Unit provides support and treatment to both in-patients and day patients who attend St. George's Hospital. The existing facilities are in need of modernisation and consequently it is felt appropriate that the unit should be moved into the community in order to develop the facilities that are available and allow a less institutional type of care.

10.13.2 The management of the Mental Health Unit are presently engaged in securing alternative premises but in view of the special needs of this facility it is not anticipated that a fully commissioned industrial therapy unit within the community will be established before the end of the 1980's.

10.14 Mother and Baby Unit

10.14.1 It has been identified for a considerable period of time now that there are certain mothers who, following childbirth, are in need of treatment, care, help and support from a psychiatric view point. Consequently, discussions have now taken place between the Midwifery Unit of the District General Hospital and the Mental Health Unit with a view to developing a programme which will be beneficial to mothers who require care in this particular area.

10.14.2 This particular interaction will necessitate co-ordination between hospital based nurses and midwives, community psychiatric nurses and health visitors and community midwives. It may be necessary to bring to bear on particular situations the help and support of other groups of professionals, e.g. social workers, housing agencies, etc. It will also be necessary to develop new techniques of care on behalf of the patient to meet the needs of the mother who presents problems following childbirth.

10.14.3 It is anticipated that facilities for a Mother and Baby Unit will be established at the Stafford District General Hospital during 1987 and in addition to this unit a team of professional staff will provide follow-up care in the community.

11 INCREMENTAL CHANGES

11.1 Although the Joint Strategy outlines specific developments that will take place within the planning period it is acknowledged that incremental developments will take place on a frequent basis both within the hospital and within the community. Examples of these changes will need to include the possibility of increasing the establishment of community psychiatric nurses and social workers.

12 STAFF TRAINING AND DEVELOPMENT

12.1 In order to provide the type of service that is required by the people of Mid Staffordshire it is again stressed that the planners of the service need to be aware of individuals and their wishes. It is accepted and endorsed that the people of Mid Staffordshire have an important part to play in developing and improving services.

12.2 It is considered that improvements in the level of care can only be achieved when members of staff have the opportunity to play the fullest role possible in which to utilise their skills. It is only by the continuing support of the staff that the challenges of the future can be met. The plan outlined in this document is based upon a criteria of job security for Health Service staff in which different opportunities of care can be developed by the retraining and redevelopment of experienced and loyal members of staff.

12.3 Therefore, training and redeployment of staff will be an important ingredient of the Plan. Increased training facilities will be made available in order that the potential of staff will be fully utilised. This development of staff resources can best be achieved by establishing training on a joint basis for staff from the health service and social services.

13 MANPOWER PLANNING

13.1 In addition to the training and development of staff it will be essential that a manpower planning system is implemented as an immediate course of action. With the changes in the types and provision of care offered it will be necessary to plan the service well in advance of developments being commissioned.

Mid Staffordshire Health Authority

Mental Health Unit

ESTABLISHMENT OF A CHARITABLE TRUST TO PROVIDE NURSING CARE

1. INTRODUCTION

Colleagues will appreciate that for sometime there has been a deficiency in the level of service offered to a number of highly dependent people. Although hospital care has not been required for this group other suitable facilities have not been available. Consequently either hospital beds have been ineffectively used, i.e. "blocked" or an even more regrettable situation has arisen where little or no service has been provided.

Within the spectrum of care for the elderly population this deficiency has been to a large extend recognised. Services have been developed to meet this need mainly in the private sector in the form of nursing homes.

However in the case of the more highly dependent person and in the cases of those who require specialist nursing it is often the situation that referrals to nursing homes for these people are not accepted or that for a high proportion of these dependent persons no nursing home within Mid Staffordshire has the facilities particularly in terms of trained staff to meet their needs.

Examples of such types of dependent persons include:

1) the more severely disturbed Elderly Mentally Ill

2) those who have had multiple admissions to St. George's Hospital

3) those although not mentally ill, as defined under the Mental Health Act 1983, cannot expect to live a reasonable normal life-style without specialist support.

2. PRESENT SITUATION

Although as outlined above there have been numerous people who require nursing care rather than medical intervention the District Health Authority has been forbidden from establishing nursing homes whereby residents are charged through personal finances or by using funds in the form of social security payments from the DHSS.

The situation has now changed in that it has been agreed that this is quite permissible (and infact encouraged by the RHA) for District Health Authorities to support and "guarantee" charitable trusts to provide nursing care to the more dependent patients.

At the present time there are a number of patients who could enjoy a more fulfilling, satisfying and rewarding life-style if a charitable trust was established and these were discharged from the hospital to a more suitable environment of care. Furthermore the provision of such a trust would lead to substantial revenue savings to the Authority and more importantly improve the level of care offered.

3. **PROPOSALS**

Outlined below is a simple concept which meets financial and legal considerations. Rather than describe in detail how the scheme would work colleagues are provided with a synopsis of the scheme for information.

1) The Charitable Trust - The Caring Together Foundation - will be established as a Company without shared capital and limited by Guarantee.

2) The Members of the Board would consist of the Unit General Manager, the Consultant Psychogeriatrician,Director of Nursing Services, The Unit Works Officer, the District Finance Officer and a member(s) of the District Health Authority and and representatives of the local community.

   In the latter case approaches have already been made for appointments to be made from those already working in the care of the mentally ill from the voluntary sector.

3) The Trust will set up a series of individual schemes and before any scheme is established agreement will be reached with the District Health Authority regarding guarantees on the individual scheme.

4) Any surplus from the Charitable Trust will be used to benefit the mentally ill in Mid Staffordshire.

Example 1 : The Elms

It is proposed the Trust will be responsible for the operation of the Elms from November 1st:

a) Patients will be discharged to the care of a general medical practitioner.

b) Services to the Trust will be contracted out from the Health Authority (including nursing services).

c) The Board of the Trust will monitor levels of quality of service and report any deficiencies back to the District Health Authority. The revenue savings to the Authority will be approximately £135,000 per year (this figure has been agreed with the District Finance Officer).

It will be of interest to colleagues to know that legal and financial requirements of this scheme have been thoroughly investigated and furthermore the DHSS is in full agreement that patients discharged will qualify for benefits.

Example 2

It is proposed that the second scheme to be undertaken by the Trust will be to provide an 8 bedded residential unit for patients who in the past have had numerous admissions to the hospital. A suitable property has been located and it is proposed that planning application for change of use will be made immediately the scheme has been given approval or DHA.

Example 3

To use Weston Villa to provide a nursing home for highly dependent Elderly Mentally Ill patients. The proposal is that following the upgrading of Michael Flanagan Day Hospital Weston Villa will be converted for use as a nursing home.

4. **DISCUSSIONS/OBSERVATIONS IN THIS PROCESS**

Discussions have taken place with a range of disciplines,staff members and voluntary groups on the proposals to establish the Caring Together Foundation.

All parties have expressed support and keenness to develop this concept as quickly as practicable since there are numerous advantages to all parties concerned.

For example such a scheme will:

1) Allow the more dependent patient to have a more satisfying and rewarding life-style

2) The Trust will allow better use to be made of existing resources and within the same limited resources will provide care for considerably more people throughout Mid Staffordshire.

3) By directing contracting services from the Health Authority continuation of employment for the staff will be guaranteed and opportunities for job creation increased.

4) Due to the fact that the Trust will be a non-profit making public body it alleviates any worries or concerns that a number of agencies have in dealing with the private sector.

5. **SUMMARY**

Members are asked to note the progress made and the fact that a paper will be submitted to the District Health Authority in September of this year.

Financial and legal considerations have been discussed with the District Finance Officer and a local firm of solicitors and hurdles in establishing the Trust have been overcome.

MCM/AC

Mid Staffordshire Health Authority

SERVICES FOR THE ELDERLY

1. INTRODUCTION

Colleagues will recall that previous discussions by the Board have highlighted a corporate concern that existing service provision for the elderly is both inadequate and unco-ordinated.

The potential problem(s) in meeting the needs of the elderly in the future can be illustrated by the fact that the number of people aged 65 years of age and over will increase by approximately % by the year 1995 with a corresponding figure of 60 % for those aged 85 years and over; the latter group displaying high levels of dependency in terms of health and social need.

This paper highlights both areas of need and existing service provision(s) that require further analysis and investigation. The intention of the paper is to stimulate discussion rather than to attempt to provide solutions; the subject matter being too complex and important not to warrant further detailed consideration.

2. DISCUSSIONS UNDERTAKEN

In highlighting areas requiring study, discussions have taken place with representative(s) from the following:

Social Services Department
General Medical Practitioner Service
Community Unit
Mental Health Unit
Acute Unit
Voluntary Groups and
Senior Officers of the Health Authority

3. GENERAL CONSIDERATIONS TO BE NOTED

Before considering the specific needs of the elderly it will be helpful to ponder over the following observations;

a) What do we mean by the elderly? Are we discussing all those over aged 65 years and over or those who depend on existing services? It must be appreciated that those aged between 65 and 74 years of age present a significantly lower demand on services, particularly on social needs, than do their elderly compatriots. The former group are often a source of help rather that the source of a need.

b) Vast numbers of elderly people do not make regular demands on statutory agencies. Although there is strong evidence to suggest 'need' exists relatives of sufferers often act as the major carer; again often without support. It may well be that access to statutory services is discouraged because of the lack of information about resources and about the fact that existing services are already stretched.

If we are to meet the increasing demands of the elderly, and existing services are already facing difficulties in coping, then there is an obvious need to increase service provision and/or better co-ordination between service providers.

c) The needs of the elderly can be met by a number of different agencies; the health service, social services departments, voluntary groups, families and friends and access to the private sector.

Any effective mechanism to provide services for the elderly must incorporate the resources of all these groups into a comprehensive and integrated plan. Isolationists policies lead to duplication and a consequent waste of resources. A unified approach which recognises the value of the above groups and offers support between these groups will do much to ensure that "the whole is greater than the sum of the parts."

d) Service needs for the elderly cannot be fitted into managerial and organisational structures; the structures must adapt to the needs of those served. For example although a relatively high number of people aged 85 years and over will suffer from problems of dementia the same group will also require relatively high levels of medical and surgical resources as well as social support.

e) There is no joint strategy agreed between the Mid Staffordshire Health Authority and the Social Services Department and as yet there is no definite directory of services for the elderly.

This scenario is set against a background of growing problem which will dramatically increase the call on available resources.

Furthermore, within the Health Authority itself there appears to be a need for clarification in approach to a number of important issues:

i) policy regarding long term/continuing care

ii) functional or "generic" approach to managing facilities for the elderly.

iii) role of Cannock Community Hospital

iv) policy on how best to encourage "early" assessments

It is perhaps appropriate to note that in certain respects these conflicts are present in the management of social care.

4. CONCEPTS IN SERVICE DESIGN

Before considering the present level of service it may be helpful to try to establish a criteria against which to evaluate these services.

i) Acceptability

Do users of the service think highly of it?

ii) Effectiveness

Do the service do something in relation to the state of health of the persons who use it when the purpose is therapeutic?.

iii) Access

Can all who require services get to it?

iv) Economy

How cost effective is the service; analysis of costs must form part of the quality where health care resources are stretched

v) Equity

Do all groups of people get an "equal" share of resources

vi) Relevance

Is the community as a whole assisted - relevance in terms of other needs and resources.

Practical use of the above is that;

i) it helps to clarify thinking, observations and concerns

ii) Trade-offs may be important in that moving forward in one direction may lead to other areas of care not receiving "appropriate share of resources". There is a need to consider the service as a whole.

5. OBSERVATIONS REGARDING PRESENT LEVEL(S) OF SERVICE

Outlined below are a number of observations made by representatives of the various organisations involved in discussions.

i) Co-ordination

There are many services that are provided for the elderly but as yet there does not appear to be any central organisation carrying out this co-ordination function, e.g. there is no one at the end of a telephone or any one centre where there is the expertise and skill to make sure assistance is available. Such a facility could help to ensure services are provided when needed. In particular caring relatives and friends can find themselves

in an extremely difficult situation when the condition of an elderly confused person deteriorates - who do they turn to for assistance?.

ii) Use of acute medical beds

There appears to be an obvious need for more acute beds for the elderly unless we modify our existing systems and procedures. (It has been suggested that 60% of acute medical beds are used by the elderly).

Furthermore there appears to be a need for a defined policy for the RMO that allows the doctor to have a up-to-date knowledge about bed vacancies on all the wards. If this was available then the RMO would be able to refer patients to the most appropriate ward and the necessity to ask the general medical practitioner to care for patients in the community, if at all possible, would be reduced.

iii) Out Patients Department

With regard to non-life threatening cases there appears to be a problem when elderly patients need to go to an out-patient department. First of all transport difficulties are apparent and secondly there are long waiting times in the clinics themselves. In certain cases domiciliary visits are used to overcome the above problems. It was suggested that it would be beneficial to examine the reason(s) why certain specialties appear to have such high levels of domiciliary visits.

It may be also worthy of investigation as to why general medical practitioners do not carry out a certain range of tests before a patient goes to the out patients department. If the results of such tests were available prior to the out-patient appointment this would lead to less duplication in carrying out these tests and may well save the time of the consultant.

iv) Investigation Unit

It was felt worthy of consideration to establish an "investigation" unit similar to the one that is provided at Manchester Royal Infirmary. In this way beds may be "freed" up on other wards.

v) Continuing Care

At the present time a programme of continuing care for elderly persons may well be unduly influenced by the agency in which they first come into contact with. For example if the elderly person is assessed by the staff of the Mental Health Unit it may well be the assessment is carried out on the basis of what that Unit can offer rather than what the person needs. This problem is repeated within other agencies.

It would be helpful if consideration was given to the establishment of a single entry assessment model which would help to ensure that a holistic approach was taken in assessing the elderly person. There is also the need to define the Authority's policy in respect of the provision or otherwise of beds for continuing care.

vi) Social Needs

Elderly people often find themselves having to make major adjustments in later life due to changes in role and status, financial difficulties, changes in relationships, loss of loved ones, experiences of loneliness and isolation.

When there is a lack of service provision for this group it is quite usual for the elderly person to seek help from the general medical practitioner. However, the G.P. is then unable to provide the help required because he does not have the knowledge/resources to overcome the social and associated problems.

vii) Centralisation of facilities within the hospital(s)

It is undoubtedly the case that despite problems of transportation and long waiting times treatments such as physiotherapy, occupational therapy, etc. are still provided almost exclusively within the hospital setting.

With initiative and political will it does appear appear extremely practicable to provide such a service in the "community" and in turn provide an effective and extremely convenient service.

Services to be provided outside the hospital setting, for the elderly, also need to include social support. For many elderly people luncheon clubs, community groups etc. provide a role and a meaningful level of support. Statutory agencies have both a role and a duty to provide much needed expertise and skill to assist those administering these groups.

viii) Planning

Despite the fact that the demand on resources that are provided for services for the elderly will be increased dramatically over the next few years there is no coherent and comprehensive policy agreed with the Health Authority.

In addition to this the obvious needs for a joint strategy with the Social Services Department has not been fully explored. Any delays in this area will obviously lead to the possibility that services will not be planned in time to meet increasing demands.

ix) Collaboration between various agencies (incl.private nursing homes)

Although a number of agencies are involved in providing services for the elderly, as yet the level of co-ordination between these agencies appears to be somewhat fragmented. For example there needs to be a defined policy regarding the input of health service provision into nursing homes and although efforts have been made to introduce additional training into the private sector much work is still required in this area.

x) Problems of the Elderly Mentally Ill

Although inextricably linked with health, mental health problems are a particular concern because of the high-risk situation of the elderly. Research in the U.S.A. has highlighted that:

a) mental health is more prevalent among the elderly than among younger adults.

b) 18 to 25 per cent of older persons have significant mental health problems.

c) 10 per cent have neurotic disorders.

d) suicide is more common in the elderly than in any other group.

Without extending the list it is essential that all professionals caring for the elderly are adequately trained to identify problems of mental health and furthermore know where help is available.

As yet this work is in very early stages within the Authority and there is an obvious need to educate both service providers and voluntary organisations.

6. A WAY FORWARD - AREAS TO BE CONSIDERED

i) A Comprehensive Strategy

As in the fields of mental health and mental handicap there is a need to agree a joint strategy with the Social Services Department; this strategy clearly highlighting the ways forward to develop the service.

Without such a strategy it is contended that the problems outlined above, in providing services for the elderly, will remain.

Specific courses of action which commit resources are required in the immediate future. To wait will almost certainly lead to a situation whereby existing services, which are unable to cope adequately, will become stretched further.

ii) Managerial Arrangements

Services for the elderly are provided by a number of agencies. Even within these agencies services may be provided by a number of different departments. This in itself may not lead to a problem but unless there is a clear philosophy regarding care of the elderly and clear lines of communication and managerial lines of responsibility, confusion, fragmentation and unco-operation will occur.

The question of management responsibility for particular services in conjunction with the elderly needs to be addressed so that there will be clear and concise policies which addresses who has responsibility for the provision of services.

iii) Health Promotion

Specific problems of later life may be alleviated or reduced through particular intervention and delivery systems. The design and implementation of programmes that address specific diseases or problems such as stress can reduce an individual's risk of poor health and mental health and provide a starting point for developing more encompassing programmes. These prevention and mental health promotion programmes attempt to improve the health and well being of individuals and communities by providing people with information, skill, services, and support needed to undertake and maintain positive lifestyle changes. This approach to prevention and promotion programmes for the elderly is in keeping with a holistic perspective which considers the human mind, body, and spirit and the social, economic, political, and environmental networks within which the individual lives.

7. CONCLUSION

The above observations are intended to stimulate discussions on the provision of services for the elderly. It would be inappropriate for a paper of this type to suggest overall solutions to the problems raised. However, it is important that those problems are addressed and consequently the DMB is asked to consider how best to progress this matter.

A number of suggestions have been highlighted in discussions and these suggestions can be defined into two broad areas:

i) Planning & Co-ordination by the Elderly Care Team:

It has been suggested that because of the complex nature of problems facing the elderly it is essential that a planning team, which consists of a wide body of service providers for the elderly, should meet to plan and co-ordinate these services. In this way officers from a number of units of management can bring together their ideas and suggestions.

However, it must be appreciated that health care planning teams are advisory and dependent upon co-operation, agreement and more essentially commitment of resources if they are to be successful.

The "whole will only be greater than the sum of the parts" if senior, budget-holding officers, are able to act in accordance with the above criteria. Furthermore it becomes increasingly more difficult to determine personal accountability when a diverse task is not directed in specific terms of reference.

ii) A Project Co-ordinator:

A second approach suggests that the future provision of services for the elderly is too important an agenda item not to be discussed in greater detail by the Board.

This approach suggests that initially small working groups consisting of members of the Board should meet to discuss specific agenda items and in turn design a comprehensive strategy.

To ensure the strategy is implemented then it has been proposed that a 'Project Co-ordinator' reporting directly to the District General Manager would be appointed. The post-holder would have no executive powers but would work closely with Unit General Managers to monitor that each Unit did implement their appropriate strategies.

In this way a co-ordinated approach would be implemented and the District General Manager would be kept informed of progress made or delayed.

This approach has found a great deal of interest since it leads to an approach whereby specified officers are responsible for defined tasks.

However a degree of criticism of the approach has been put forward on the basis of additional bureaucracy.

MCM/AC

SYNOPSIS OF THE CARING TOGETHER SCHEME

The main focus of the Caring Together scheme is to help the elderly at-risk to make better use of existing resources. There is no doubt that many resources do exist to provide help for the elderly throughout the community as a whole. If these resources can be put to better use then benefits to the elderly must occur.

When one considers there are 35,250 people over the age of 65 residing in the area covered by the Mid Staffordshire Health Authority and that this figure will grow to 41,300 by 1996, then it is essential that existing services are fully utilised.

Consequently the Caring Together Scheme proposes that by getting all those who provide services to work together to help the elderly much can be achieved.

The Caring Together scheme encourages this concept by appointing two experienced professionals to help others to maximise their potential into a common goal for the community.

Four approaches are envisaged:

i) The Gate Keepers approach which utilises those people working within the community, e.g. postal workers, police, to identify an elderly person at risk to the professional team.

ii) An Assessment/Evaluation Unit to provide recommendations regarding appropriate services to meet the needs of the elderly person. *

iii) Working towards co-ordinated Community Network workers and compile an "at-risk" register.

iv) By educating the population and promoting initiatives that will allow the elderly to cope better with the problems of later life.

In conclusion the additional resources that will be required for the scheme are extremely limited when one considers the potential benefits to be achieved.

*[Such an approach would provide the basis for a proposed Single Entry Assessment model - Appendix 1)

C A R I N G T O G E T H E R

THE PREVENTION OF MENTAL ILLNESS AND PROMOTION OF MENTAL HEALTH IN THE ELDERLY

1. INTRODUCTION

The fact that the elderly under-utilise mental health services is well established in terms of statistics and clinical experience. The need of the elderly for such services is generally acknowledged to be as great as other adult age groups. Furthermore the fact that therapeutic interventions are useful for the elderly is well established clinically, if not widely accepted.

Taking the above three statements as a concept of the "Caring Together" scheme seeks to ensure that the elderly have:

i) knowledge of existing services

ii) adequate services to meet their needs and

iii) access to service(s) appropriate to their needs.

The philosophy underpining the concept of the "Caring Together" scheme can best be illustrated by:

> "The older among us certainly have a right to enjoy the best possible health and hence the highest quality of life for all the years that they live. Further, older people in optimum health, living and working, participating in all aspects of community life constitute a national resource that we can ill afford to waste. Programs and policies which operate to enhance the health and well-being of older persons enhance the health of the nation." (FallCreek & Stam, 1982, p.4)

The increasing numbers, longevity and health care needs of older people call for new and innovative approaches to meet the needs. Although many facilities now exist for the care of the elderly it is without question that in many cases the older persons have little knowledge of and/or make little use of these facilities. Many schemes are in operation including those provided by statutory and voluntary agencies but perhaps these services are not fully co-ordinated. The result is that a number of elderly people remain "at risk" and eventually older persons may require to undergo institutional care when earlier intervention and support could allow many to live at home for even longer periods of their life.

This project is intended to test the philosophy and cost effectiveness of alternative community bases service delivery systems that would integrate health and social services intervention together with those of the voluntary sector as a means of preventing inappropriate institutionalisation of the elderly at risk and also as a means to improving the quality of life for this group of people.

v) Service arrangements to implement the care plan through both formal and informal providers

vi) Monitoring to ensure that services are provided as planned and modified as necessary

vii) Reassessment of care plans to changing needs

Specific schemes will include:

A) the Gate Keepers approach
B) the assessment/Evaluation Unit
C) the Community Network and
D) Mental Health Promotion

A. The Gate Keepers approach is based upon the simple consideration that the best people to locate the elderly at risk are those who go into elderly peoples' homes, e.g. gas meter readers, insurance collectors, police, etc. However, although those at risk may be identified, notification to appropriate agencies is often not forthcoming because the identifier may not be aware of who is best to help and/or they may fear that action taken by themselves could lead to a deeper commitment.

The Gate Keepers approach seeks to avoid the above problems by the following procedures:

1) Two experienced and trained personnel, i.e. Liaison Officers will be appointed. One Liaison Officer will have experience from a medical background and in particular dealing with elderly people with dementia. The second Liaison Officer will have a professional background in social services.

In additional to the above professional staff, secretarial support will be provided.

The task to be carried out by the liaison officers will include:

i) The establishment of a centre from which they themselves could work and operate a telephone help-line. Furthermore the centre will provide advice and resource material for use by carers, voluntary groups, etc.
ii) Identify gate keepers by liaison with such groups as the Gas Board, Police, etc.

iii) Arrange training of gate keepers

iv) Publicise the service

v) Develop and maintain a directory of available services. [This will involve contacting all services who work towards improving the quality of life of the elderly.]

2) The programme will operate by allowing any gate keeper who feel that an elderly person is at risk to contact a Liaison Officer. The involvement of the gate keeper will then cease although they may wish to be kept informed of the outcome and in certain cases become involve in the care of the elderly person.

3) Liaison officer swill visit the elderly person and after assessing the situation contact the appropriate agencies.

It is essential that the liaison officers have the experience and training which will allow them to communicate and with with elderly persons who may be resentful or frighten of other people entering their homes.

[In all cases the general medical practitioner of the elderly person at risk will be informed. This will ensure that appropriate medical assessment and treatment becomes available.]

4) After onward referral to the most appropriate agencies the liaison officer will review the care programme of the individual elderly person concerned and the liaison officer will maintain an "at risk" register.

In addition to the above the liaison officer will be intimately concerned with a Community Network.

B. The Assessment/Evaluation Unit will consist of the following; Psycho-geriatrician, Community Psychiatric Nurse and a Social Worker.

Referrals will be made on an open basis but it will be the responsibility of the Assessment Team to contact the appropriate general practitioner to ensure the general practitioner institutes the required referral and medical history, etc.

Whenever possible the assessment will be carried out in the home of the elderly person concerned but it will be necessary on occasions for the elderly person to attend hospital where there is in-patient and out-patient facilities so that further medical examination/tests can be performed.

It will be the responsibility of the assessment team to arrange further treatment programmes, certain support, etc. and to ensure that the necessary monitoring and follow-up of the treatment/care programme is carried out.

C. The idea behind the community network is to make use of existing services for the elderly. However, these services may not be well known or co-ordinated and in certain localities elderly persons may not be aware of the services that can be used. Therefore on a neighbourhood or village basis the Liaison Officers will contact a particular "group leader". This may be a local minister or doctor or leader of a voluntary service. Working through the neighbourhood leader, the liaison officer will identify all existing services for the elderly in that neighbourhood and arrange

for "group leaders" of these agencies to meet on a regular basis. In this way a community network of services can be promoted, organised publicised and co-ordinated with support provided by the Liaison Officers.

An example of a promotional programme would be to organise a neighbourhood care scheme whereby a neighbour would agree to keep a watchful eye on an elderly person living nearby and act as a befriender.

In addition the Liaison Officer will maintain a point of contact with the particular neighbourhood so that if any problems occur then those within the neighbourhood can have immediate access to the Liaison Officers.

The value of the scheme is that the Liaison Officer(s) can act as a facilitator in bringing together local groups who use existing local facilities for the benefit of the elderly population in that area. Often all that is needed within a community is an initial catalyst to help undoubtedly willing volunteers to pull their resources towards a common goal.

A further important feature of the neighbourhood Community Network will be to compile at "at risk" register outlined above for the elderly and this list will be maintained on a central data storage system held on a confidential basis by the Liaison Officers. In winter for example the elderly at risk will already be identified.

D. Mental Health Promotion. Although inextricably linked with health, mental health problems are a particular concern because of the high risk situation of the elderly (Busse and Blazer 1980). Older persons find themselves having to make major decisions in later life as a result of changes in role status, financial difficulties, new leisure life-styles, changes in relationships, loss of loved ones, experiences of loneliness and isolation and alterations in health and physical appearance. (Davis 1983).

However, specific problems of later life may be alleviated or reduced through particular intervention and service delivery service systems. (Gaitz and Varmer 1980). The design and implementation of programmes that address specific diseases or problems can reduce an individual's risk of poor mental health and provide a starting point for developing more comprehensive programmes. Mental health promotion programmes can be used to "improve the health and well being of individuals and communities by providing people with the information, skill, services and support needed to undertake and maintain positive life-style changes." (Fallcreek & Mettler 1982).

With the above in mind the Liaison Officer(s) will work in conjunction with the Mental Health Promotion Team to develop and present programmes for the elderly in keeping with a holistic perspective which considers "the human mind, body and spiritual and the social, economic, political and environmental networks within which the individual lives." (Dychtwald 1983).

2. OBJECTIVES

i) Co-ordinate (a) a community based care system and (b) a long-term care system for the enderly.

ii) Prevent premature institutional placement of the elderly

iii) Maintain older persons in their own homes when this meets the wishes/needs of the elderly person and the carers of the elderly person.

3. STRATEGIC AIMS

i) To marshall and direct long-term care resources in the community

ii) To increase access to a wider range of services that is currently available.

iii) To match service use to the identified needs of the elderly persons

iv) To stimulate the development of needed in-home and community services

v) To reduce the need for costly medical and institutional long-term care services.

vi) To promote efficiency and quality in community long-term care delivery services.

vii) To promote reasonable division of labour among informal support systems (including families, neighbours and friends) privately financed services and publicly financed care

ix) To maintain or enhance outcomes for the elderly person including physical and mental functioning and quality of life.

x) To co-ordinate services and promote quality standards in institutions responsible for the provision of long-term care.

4. PROGRAMMES

Interventions used in this project to arrange and co-ordinate services will include the following:

i) Outreach to identify and attract the target population

ii) Screening to determine whether the older person is part of the targeted population

iii) Comprehensive assessment to determine individual problems, resources, available and service needs.

iv) Care planning to specify the types of care to meet the need of the individual elderly person

Although the schemes outlined above are individually described, it must be appreciated that each development or programme is but a part of the whole in providing facilities to help the elderly live a fuller and more rewarding life-style.

5. FINANCIAL IMPLICATIONS

The fundamental principle underpinning the Caring Together scheme is that existing resources can be better used by providing a facilitatory and co-ordinating support team.

Thus only two additional trained members of staff (plus one secretary) would be required to work with those agencies already providing services for the elderly. Furthermore facilities such as office base, telephone etc. will be provided by the existing statutory agencies.

The cost of implementing the scheme would include the following:

		£	
2	Liaison Officers	25,000	
1	Secretary	7,500	
		32,500	
	Travelling	3,000	(approx)
	TOTAL	35,500	per annum

In addition to the above there would need to be a sum set aside to purchase a computer on which to keep the at risk register. Such a computer together with word processing facilities would cost between £500 and £1000.

MCM/AC

APPENDIX 1

SINGLE ENTRY ASSESSMENT MODEL

The proposed Single Assessment model responds i) to recommendations for the need for greater co-ordination in order to provide comprehensive and integrated programmes to the recipients of long-term care and ii) to the problem that the multiplicity organisations involved in the assessment and placement for long term care services.

a) Currently each long term care agency has its own assessment criteria to determine eligibility. As there is often little sharing of information among the different agencies there is a real concern that duplication of effort can take place and this in turn may well result in confusion for the receivers of service. For example within Mid Staffordshire there is the health service, the social services department and private nursing homes who all provide long term care and in addition there is the input from the voluntary sector.

b) Sometimes the service to which the person first goes (because he knows of it or is recommended by his doctor) is the service he receives whether or not it is the most appropriate service. The current assessment and caring processes are not developed and integrated to the extent that all placement options are considered when arranging long term care for a particular person or when transferring that person from one setting to another. Furthermore the lack of consideration given to non-institutional programmes by a number of referral resources is particularly significant in this respect. A Single Entry Assessment provides for an initial comprehensive assessment of the service receiver and the service receiver situation.

c) Currently, different assessment criteria and processes are used by the different agencies with the result that there could be inconsistency in the way that services are arranged for and used by service users in need. Furthermore the various long term care agencies often assess not so much for client need as for client eligibility. On this basis the impartiality of the assessment can also be questioned, since the assessment tools are developed by and used from a service perspective.

d) Currently, the case of "case management" in long term care services has not been carefully considered. Therefore if a client is seen not to be eligible for a particular service is not necessarily assisted to find the appropriate one(s); a difficult process for a client who is frail or handicapped and limited in functional capacity.

e) Because there may be a lack of comprehensive care planning involving the client and the client's family, a number of persons receive more services than they need while others go without the necessary care and attention. Appropriate use of services is a very costly feature of our current system.

f) The present delivery of long term care services can result in fragmented assessment; the process used generally depends on one professional or a number of professionals e.g. a doctor or or a nurse. This may be difficult to assess the multiple health and social problems faced by those in long term care.

In summary one assessment and placement process used by all long term care services within Mid Staffordshire would lead to a reduction in the costly duplication of assessment services. It would provide a focal point which would enable long term care services to work together to combine their efforts and most importantly to help to ensure that appropriate services are delivered to the person in need.