A rapid response intermediate care service for older people with mental health problems

Exploring the development of a rapid response intermediate care service for older people with mental health problems, to treat and support them at home

INTRODUCTION

Over the past 40 years, there has been a marked reduction in inpatient psychiatric units as a result of strong national and local moves towards treating patients in the community.

In 2000, the North Yorkshire Health Improvement Plan recognised there was a need to develop intermediate care for older people with mental health problems to reduce avoidable or inappropriate admissions to hospital and nursing and residential homes.

In August 2003 in North Yorkshire, 26 older people with mental health needs were occupying NHS beds after consultants had deemed them ready for discharge.

This meant that 50% of the elderly mentally ill (EMI) beds were not available for emergency or urgent patients. Waiting lists rose and some older people had to be admitted inappropriately to the acute psychiatric wing, which is in an area for working-age adults.

Although the evidence to support home treatment for older patients with mental health problems is not as strong as it is for working-age adults, Joy et al (2006) reviewed crisis intervention studies and found that patients’ and relatives’ satisfaction was higher with home care than inpatient care. This Cochrane Review showed that crisis intervention reduced hospital admission or time spent in hospital, repeat admissions and disengagement with mental health services.

Systematic reviews on cost-effectiveness have been inconclusive, but Burns et al (2001) found treatment costs were lower than for standard inpatient care. They also identified six essential components of community-based services:

- Home environment;
- Skill mix;
- Psychiatrist involvement;
- Service management;
- Caseload size;
- Health and social care integration.

There was a consensus that caseloads of less than 25 and flexible working hours over seven days are important, and little support for 24-hour services.

DEVELOPING THE SERVICE

Funding was secured for a multidisciplinary/multi-agency team to assess, treat and support EMI patients in their own home or place of residence.

Recruitment to the rapid response intermediate care elder person’s mental health (RRICE) team, which is based in older people’s community mental health services, began in October 2004. The team became fully operational in April 2005.

One of the first appointments was the community services manager, who had a background in social care. This helped networking and communication with adult and community services, and led to a jointly funded intermediate care budget.

The team includes mental health staff nurses, HCAs, occupational therapists, physiotherapists, social workers, community care officers and psychiatrists. It has access to psychology, speech and language services.

It operates 8am–6pm, seven days a week, 365 days of the year, and has capacity for 18–24 patients.

During evenings and weekends, RRICE can assess, source and implement care packages in the home or a 24-hour respite or rehabilitation environment. An on-call psychiatrist is available for advice and information.

The RRICE team is based in Harrogate and covers the Harrogate and Rural district. The area’s rural nature presents significant transport and communication challenges. Patients may have to travel long distances to clinics and there are capacity difficulties when trying to source home care for outlying areas.

RRICE accepts referrals for:

- Older adults who have a functional mental health issue or a degenerative organic dementia and adults under 65 with dementia;
- Older adults facing a crisis where the primary cause is mental health deterioration.

Patient ages range from 55 to over 100 years, with the majority aged 75–89.

WHAT RRICE DOES

The National Service Framework for Older People (Department of Health, 2002) defined intermediate care as ‘a range of integrated services which will promote faster recovery from illness and prevent unnecessary admission to hospital, to support timely discharge from...’
hospital and maximise independent living’. Intermediate care encompasses a wide range of services, so, to provide focus, RRICE outlined that its objectives were to:

- Provide a single point of contact for urgent mental health assessments (within four hours of referral);
- Prevent inappropriate admission to hospital or 24-hour care facilities;
- Support clients in 24-hour care facilities whose mental health is in crisis and there is a risk of inappropriate admission to hospital or an inappropriate change in status;
- Support timely discharge from psychiatric inpatient units where it is felt the discharge would be vulnerable without a short period of intensive support.

Referrals are accepted from healthcare and associated professionals and referrers must have seen and assessed patients within the previous 72 hours. RRICE carries out a holistic assessment of patients’ needs within 24 hours and a programme of intensive care is agreed. This may include up to four visits a day for a period of up to 12 weeks; the average is 4–6 weeks, with the intensity of visits reducing as the intervention proceeds. In urgent cases, RRICE will respond within four hours.

The initial assessment uses basic tools, such as the Mini Mental State Examination, Barthel’s Index of Activities of Daily Living (BAI), the Geriatric Depression Scale, falls screening and, where appropriate, the Carer Strain Scale. Risk assessment, using the FACE Risk Assessment tool, looks at the home environment, personal, physical, mental and emotional well-being and safety of both patients and carers.

Staff use a range of skills, including cognitive and behavioural approaches, communication skills, medication management and profession-specific interventions.

RRICE also identifies and uses carers’ and families’ strengths, and provides them with an educational intervention.

**IMPACT OF THE SERVICE**

RRICE set itself the following targets:

- To offer a seven-day-a-week service, 365 days of the year;
- To discharge 25% of clients back to primary care services in the first year, 35% in the second year and 50% in the third year;
- To facilitate timely access to services;
- To reduce hospital bed occupancy.

The targets for discharging clients to primary care were met in the first two years but then appeared to reach a plateau, with 37% discharged to GPs in the third year. However, the targets were based on expected outcomes for physical health and did not take into account the enduring nature of some mental illnesses and the need for these to be monitored.

On average, 84% of referrals are seen within agreed time frames.

The service’s effect on bed occupancy has proved difficult to measure. Data shows that 57% of patients referred to RRICE are at risk of hospital admission, and just under half of these referrals are admitted – approximately two-thirds need admission to psychiatric wards, the remainder to general medical wards.

Anecdotal evidence suggests that bed occupancy has reduced. There are no waiting lists for admission to older people’s psychiatric inpatient units and, although older people may at times be admitted to working-age adult inpatient areas, this is an option relevant to patients’ needs and no longer a capacity issue.

**SATISFACTION**

A qualitative questionnaire was sent to all professionals who had referred patients to RRICE over a three-month period. Patients and/or carers were also surveyed, by phone or questionnaire. Most referrers appeared to be satisfied with the service and, in particular, with the outcomes of the episodes of care. Most patients and/or carers expressed satisfaction, and carers were particularly pleased with response times and the support offered. Those surveyed were asked how the service could be improved.

Referrers found the referral process difficult at times. Problems raised included inconsistent advice over appropriateness of referral, no flexibility around referral criteria, and uncertainty over RRICE’s role and when to refer.

Some service users and carers felt the RRICE team should be involved for longer. In some cases, there were gaps between the team finishing and other services taking over, and long-term problems were not resolved. A few users complained there were too many people visiting, which was confusing and intrusive.

Private-sector carers said it was useful to be able to contact the team directly, post discharge, to ask for visits and advice without the need to be referred again.

All respondents said communications could be improved. Referrers felt that both verbal and written communication with them needed to be more consistent and frequent.

Patients and carers did not always feel fully involved in planning care. Some carers said that their concerns were listened to but then dismissed as trivial, and their phone calls were not always responded to at the agreed time.

Carers who did not live at the same address as the patient felt they were not always consulted about changes to care plans.

Improvements have been made, based on the data collected. Time frames and structures for written and verbal communication have been drawn up and patients are referred to other services before discharge from RRICE to try to ensure an overlap/handover. Where possible, choice is offered on the number and gender of staff visiting patients at home.

**CONCLUSION**

Pressures on hospital bed occupancy were reduced following the introduction of RRICE, although other factors, such as social care funding that increased 24-hour care capacity in the community, will have had some impact.

Data collected suggests that intermediate care interventions are effective in reducing symptoms of distress, the effects of social isolation and preventing unnecessary admission to inpatient facilities.

RRICE would not be able to function successfully without the commitment and support of the older people’s mental health inpatient units, day hospitals and community teams.

**REFERENCES**

