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might have been due to the enthusiasm of the teams, but the new assessment processes encouraged this enthusiasm.

Whether such quick assessments of more patients has an impact on other parts of the service is not known, and requires further research and evaluation.

## Declaration of interest

None.

## References

DEPARTMENT OF HEALTH (2001) *National Service Framework for Older People*. London: Department of Health.

— (2002) *Mental Health Policy Implementation Guide: Community Mental Health Teams*. London: Department of Health.

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# Service innovations

## An outreach support team for older people with mental illness – crisis intervention

**AIMS AND METHOD**

We describe activity and outcome concerning a consecutive series of older community patients referred to an outreach support team while waiting for acute psychiatric admission.

**RESULTS**

Forty patients on an admissions waiting list who were referred to the outreach support team were followed up. Each patient was reassessed for admission by the responsible medical officer when an in-patient bed became available. Thirty patients who would have been admitted (if a bed had been available at the time of the first assessment) remained at home and did not need hospitalisation.

**CLINICAL IMPLICATIONS**

This study suggests that intensive domiciliary support might offer an acceptable form of crisis intervention for older people with mental illness. Further research is needed before generalisation of these findings can be recommended.

The Cheshire and Wirral Partnership NHS Trust has approximately 57 000 Wirral residents aged 65 and over. The population is serviced by three-and-a-half whole-time equivalent consultants and three community mental health teams. Each team is led by a senior registered mental nurse and has a case coordinator. There are 15 community mental health nurses, three occupational therapists (and two assistants), two physiotherapists and four nursing auxiliaries/support workers. A functional day hospital supports the community teams. It is staffed by a nurse manager, a staff-grade doctor, three primary nurses, two associate nurses and two support workers. There are 24 acute functional beds and 30 acute organic beds servicing the population.

The outreach support team was established in November 1999 because of winter bed pressures within the acute geriatric wards at the local District General Hospital. These pressures led to the closure of 20 acute psychiatric beds for older patients. The team has three aims: to provide additional support to community mental health teams (CMHTs) for older, community patients experiencing crisis – irrespective of the nature of their mental illness; to reduce acute admissions and to facilitate early discharge from psychiatric in-patient care. The team is based within a day hospital facility and is staffed by six support workers with clinical work coordinated by a registered mental nurse.

The team provides services over a 12-hour day and operates 7 days a week. The activities of the team vary according to individual patient needs. They include monitoring the mental states of patients, monitoring fluid and dietary intake and compliance with medication assisting with physical care, supporting carers, helping patients with basic target setting and assisting patients in developing new coping skills. The patient is usually visited once or twice per day, but visits may take place more frequently if necessary. Most visits involve just one member of the team, but occasionally two or three staff are needed on a visit. Care is taken to try to prevent patients becoming dependent on the service. Referrals are accepted from consultants, CMHTs and in-patient units. Patients may have functional or organic disorders, and the service is available for any patient in crisis. The day hospital provides additional respite (daytime) support for functional patients and the in-patient units provide occasional day respite services for organic cases.

During its first 5 months, the outreach support team witnessed the referral of 59 patients, receiving 668 visits/units of activity. It must be emphasised that the team was establishing itself over this period, and was busy developing protocols and referral criteria while also engaged in clinical work. Of the 59 patients handled, a sub-group was referred for transient home support while on a waiting list for in-patient treatment. It was noted



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that admission was subsequently avoided in a number of cases. A prospective descriptive study was therefore undertaken in order to quantify the activity of the team and establish the outcome of a subsequent, consecutive series of patients referred to the waiting list for acute psychiatric in-patient care, to inform future audit and service development. During the period of the study, the team continued to provide support for patients in crisis who were not on the waiting list and those being discharged from in-patient care.

## Method

### The sample

The sample consisted of a consecutive series of Wirral residents (Table 1) who were placed on the waiting list for in-patient psychiatric assessment and treatment (no in-patient bed being available at that time). The study was conducted between May and December 2001. The sample excluded patients detained under the Mental Health Act 1983 and those patients considered at high risk of self-harm or harm to others because of their mental illness. In these situations, outreach support team involvement is not appropriate and if no bed is available locally, these patients are admitted to units outside the locality. The responsible consultants controlled entry to the waiting list, either directly or through liaison with the keyworker. All patients lived in their own homes (including one in sheltered accommodation and one in a nursing home). All patients entered onto the waiting list were automatically referred to the team to provide immediate additional support until a bed became available. When an in-patient bed became available, the individual was reassessed by the registered mental nurse with regard to the suitability of admission. If the patient's circumstances had changed to the extent that admission was not indicated, the team would remain engaged until appropriate care plans were in place.

**Table 1. Summary of patient characteristics and outcome**

| Patient characteristics (*n*=40) | Outcome: Admitted to hospital | Outcome: Remained at home |
|---|---|---|
| Female (*n*=31) | 7 | 24 |
| Male (*n*=9) | 3 | 6 |
| Aged 75 and under (*n*=19) | 4 | 15 |
| Aged over 75 (*n*=21) | 6 | 15 |
| Living alone (*n*=20) | 4 | 16 |
| Not living alone (*n*=20) | 6 | 14 |
| Affective disorder (*n*=28) | 7 | 21 |
| Schizophrenia/delusional disorder (*n*=5) | 2 | 3 |
| Organic disorder (*n*=7) | 1 | 6 |
| Concomitant physical disorder (*n*=14) | 4 | 10 |
| Evidence of harm through self-neglect, behavioural or cognitive disturbance (*n*=28) | 8 | 20 |
| Mild to moderate risk of suicide/self-harm (*n*=7) | 0 | 7 |
| History of previous suicide attempts (*n*=3) | 0 | 3 |
| Previous episode of psychiatric illness (*n*=26) | 7 | 19 |
| **Total (*n*=40)** | **10** | **30** |

### Data collection and analysis

Data regarding the use of services was prospectively collected through clinical information systems designed to record activity. Patients were divided into those who required admission when a bed became available and those who were maintained in the community. Routinely collected clinical, demographic and service use information is described, but no attempt is made to draw a causal relationship between the activities of the outreach support team and subsequent maintenance in the community.

## Findings

### Admissions and referrals

There were 189 admissions to the organic and functional old age wards on the Wirral over the time of the study and 40 patients on the waiting list for admission were referred for outreach support team involvement.

### Demography

Nine males and 31 females (*n*=40) were included in the analyses. The mean age of the sample was 76 years. One person, suffering from organic illness, was under the age of 65. Twenty-eight subjects were diagnosed with affective disorder, five had schizophrenia or related paranoid states and seven had organic disorders. Fourteen of the patients (35%) had significant concomitant physical disorders. There was evidence of harm through self-neglect, behavioural and cognitive disturbance in 28 of the referred patients. Seven patients were described as a mild-to-moderate risk of deliberate self-harm/suicide. Three patients had a history of suicide attempts. Twenty-six (65%) had a previous episode of psychiatric illness.

### Service use prior to outreach support team referral

Ten patients had been referred to the community mental health team prior to placement on the waiting list for admission and outreach support team involvement. Two patients were already involved with the day hospital. Four patients had been referred, through a consultant, following discharge home from acute medical care. The remaining 20 were referred as a direct consequence of reviews conducted by a consultant. Thirteen patients were in receipt of social service care input. Fifteen (38%) had a previous psychiatric admission and nine (23%) were new referrals to the service.



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## Service use during outreach support team involvement

Twenty-nine patients were subsequently maintained in their own homes by the team until a full care plan was in place. One patient was maintained in a nursing home and 10 patients were admitted to acute psychiatric in-patient beds. The mean duration of engagement of the team was 26 days (maintained at home: 30 days, requiring admission: 12 days), and the number of interventions ranged from 1 to 105 for patients maintained at home, and 2–29 for patients requiring admission.

Visits varied in time, usually lasting 1–2 hours. During outreach support team engagement, community services were developed: seven patients received day hospital support, eight had CMHT involvement and five had medical reviews. Eleven were involved with social services, of whom two attended day centres. Where a community nurse was already involved in a patient's care, the outreach support team would contact them daily to update them on the patient's mental state and the care package. Home visits over this time were usually maintained by the team alone, with the community psychiatric nurse visiting again when its involvement ended.

## Service use on withdrawal of the team

Out-patient follow-up ($n$=19), day hospital attendance ($n$=9), CMHT involvement ($n$=21), and voluntary and social service input ($n$=9) provided the main components of subsequent care plans for the 29 patients remaining in the community (excluding the one person living in a nursing home). Patients living alone appeared to be more likely to remain at home (80% living alone compared with 70% not living alone). Of the ten patients requiring in-patient care at reassessment, two suffered from bipolar affective disorder, two had schizophrenia with significant paranoid features, five had moderate-to-severe depressive disorder and one had an organic disorder. Review of the case notes suggests that the admitted group might have suffered from more severe degrees of mental illness than those remaining in the community. However, these observations are speculative. None of the patients maintained in the community were subsequently admitted over a follow-up period of 3 months (Table 1).

## Service costs

We did not undertake a prospective cost analysis of the outreach support team. However, we captured information regarding actual staff costs. Actual staff cost was approximately £11 110 per month over a 4-month period. During this period, the team managed 13.5 patients who would have otherwise been admitted to hospital. This implies that the actual cost per patient per month was £823. As the team concurrently managed a significant number of community patients not included in the survey, this figure is a substantial over-estimation of costs incurred by patients on waiting lists held in the community. These correspond to actual staff costs of approximately £1814 per in-patient bed per month, should a patient be admitted. We acknowledge that these are rough estimations based on staff costs, and that they do not reflect the total cost of the services or enable reliable comparisons to be made. Their main purpose is to inform future development of the service, enabling a more detailed cost analysis to be performed.

# Discussion

Crisis intervention services for younger people with mental illness have been designed to reduce hospital admissions and time in hospital (Weisman, 1989). Despite wide acceptance, there is relatively little empirical evidence showing its efficacy. However, home crisis intervention, supported with a comprehensive and continuing home care package, is likely to be an effective intervention (Joy *et al*, 2002). No studies have examined these issues in older patients with mental illnesses.

A recent Cochrane review has examined the role of domiciliary services in promoting early discharge of older people with physical illnesses. The reviewers suggest that such services may contribute towards early discharge, but do not support the development of such services as an alternative to in-patient care (Shepperd & Iliffe, 2002). The evidence supporting the development of crisis services designed to reduce hospital usage for older people with mental illness is virtually non-existent.

This service was developed in the context of substantial bed reduction and based on what little evidence there was available at the time. It was developed as a service specifically for patients in crisis, supporting the three community teams covering the geographical area. The centralised management of the outreach support team enabled a high level of coordination and optimised continuity of care, which would not have been available if staff of the team had been devolved down to the community team level of management.

This is a naturalistic study that was designed to generate descriptive data for service planners concerning the additional support required by older community residents with mental illnesses facing crisis and warranting in-patient care as determined by a consultant psychiatrist. We have examined the outcome of outreach support team intervention in terms of hospital admission. The data suggest that intervention of this nature might reduce the likelihood of admission in individuals who are entered onto a waiting list for in-patient management. The generalisability of these findings is limited as this is not a randomised controlled trial. There is an obvious sampling bias in that subjects requiring admission (in the absence of an available bed), under the Mental Health Act 1983 or through unacceptable levels of clinical risk, were admitted to facilities outside the catchment area. 'Entry criteria' in terms of going on to the waiting list were poorly defined,



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and determined by the clinical decision of the consulting psychiatrist and the availability of beds at that point in time. Other uncontrolled variables include the character of the supporting community services and potential pressure from carers.

Despite these problems, the data suggest that ready access to generic psychosocial domiciliary crisis support (as described above), combined with comprehensive community services, may offer a temporary alternative to acute hospital admission in this population. In the absence of the team, all of the 40 patients in the study would have been admitted to in-patient units as soon as a bed became available.

Intensive domiciliary services providing support for older people with chronic mental health problems (over and above services provided by CMHTs) might prevent institutionalisation (Wilson & Cunningham, 1994). Few studies have examined the potential role of crisis intervention in this population. This naturalistic study highlights some interesting possibilities regarding the potential effectiveness of this service. A considerable amount of developmental work remains to be carried out. In particular, it is important to note that prevention of admission might be associated with increased risk to the patient and increased stress to the carer, and may only delay admission by up to 3 months. Systematic surveys, audits and further research are required before this service is accepted as a generalisable and viable alternative to crisis admission.

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## Declaration of interest

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## References

JOY, C. B., ADAMS, C. E. & RICE, K. (2002) Crisis intervention for people with severe mental illness. The Cochrane Library issue 1 pubs: Update Software.

SHEPPERD, S. & ILIFFE, S. (2002) Hospital at home versus in-patient hospital care. The Cochrane Library issue 1 pubs: Update Software.

WEISMAN, G. K. (1989) Crisis intervention. In *A Critical Guide for the Treatment of Schizophrenia* (ed. A. S. Bellack), pp. 101–134. New York: Plenum Press.

WILSON, K. C. M. & CUNNINGHAM, S. (1994) Community care: experimental developments. In *Principles and Practice of Geriatric Psychiatry* (eds J. R. M. Copeland, M. T. Abou-Saleh & D. G. Blazer), pp. 898–903. London: John Wiley & Sons.

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