

Care management for older people with mental health problems: from evidence to practice

Sue Tucker, Jane Hughes, Caroline Sutcliffe and David Challis

Abstract

Aim: To explore the implications of providing intensive care management in a typical old age mental health service in North West England.

Methods: The time spent by core groups of specialist mental health and social services staff on a range of activities deemed central to the provision of intensive care management was explored by means of a diary exercise. The difference between what is actually being done and what evidence suggests is needed was examined.

Results: More than 1500 hours of activity were appraised. Assessment and care management-related tasks accounted for more than 40% and 30% of social work and nursing staff's time, respectively. However, several fundamental features of intensive care management were lacking, including health staff's adoption of the care manager role, arrangements to facilitate appropriate information sharing and sufficient time for practitioners to provide the necessary careful assessment of needs, liaison with other agencies, and close and regular contact with the elderly person and their care network.

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THE INCREASED BURDEN of chronic disease associated with rising life expectancy presents a considerable challenge to policy makers around the

Sue Tucker, MSc, Research Fellow
Jane Hughes, MSc, Lecturer in Community Care Research
Caroline Sutcliffe, MSc, Research Associate
David Challis, PhD, Professor of Community Care Research
Personal Social Services Research Unit, University of Manchester, Manchester, United Kingdom.

Correspondence: Professor David Challis, Personal Social Services Research Unit, University of Manchester, Dover Street Building, Oxford Road, Manchester, M13 9PL, United Kingdom. d.j.challis@manchester.ac.uk

What is known about the topic?

Intensive care management has the potential to enable many older people with complex mental health problems to remain in their own homes. However, in England, such arrangements have not been widely implemented.

What does this paper add?

This paper presents the findings of one of only a handful of studies that have systematically examined the working patterns of nurse and social work practitioners caring for older people with mental health problems. An examination of these data in the light of the research literature on intensive care management highlights potential areas for development.

What are the implications for practitioners?

There will need to be a number of modifications to the way in which the care for older people with mental health problems is currently organised if services are to deliver recommended models of care. These include changes in the role, caseloads, location and management of health and social services practitioners and in their assessment, care-planning and review processes.

world.¹ Mental health problems, particularly depression and dementia, account for a substantial proportion of this burden.² These disorders are common in older people, can affect every aspect of a person's functioning and are associated with increased resource use.^{3–6} While one might think that there would be a compelling incentive to find the most appropriate, effective and efficient ways of caring for this client group, the evidence base for many common services is, as yet, relatively undeveloped.^{7,8} Moreover, even where studies *do* indicate the effectiveness of a particular approach, this is no guarantee of its adoption in practice.^{9,10} The potential of intensive care management to enable older adults with mental health problems to remain at home, a fundamental aim of many countries' community

I Characteristics of intensive care management

Functions	Coordination and linkage of services
Goals	Provision of continuity; integration of care; increased opportunities for home-based care; promotion of client wellbeing; better use of resources
Core tasks	Case finding and screening; assessment; care planning; monitoring and review; case closure
Characteristics of recipients	Complex and/or severe needs; long-term care needs; multiple service need
Main features	Complex and/or severe needs; long-term care needs; multiple service need

Source: Challis et al, 1995.²⁶

care policy and most people's personal preference, is a case in point.¹¹⁻¹⁵

With origins in concerns about the fragmented delivery of health and social services, case management, implemented as care management in the United Kingdom,¹⁶⁻¹⁸ is in essence a strategy for the organisation and co-ordination of care services at the client level. Primary tasks include case finding and screening, assessment, care planning, arranging services, monitoring and review.¹⁹ Initially a North American concept, a series of pilot studies by the Personal Social Services Research Unit (PSSRU) demonstrated improvements in older people's and carers' wellbeing and reduced admissions to long-term care, providing strong empirical support for the adoption of "intensive care management" with this client group.^{19,20} The key features of this approach include a differentiated response to need, appropriate links with specialist health care expertise, small caseloads and devolved budgets,²¹ and the model appears to have a particular utility for the care of older people with mental health problems.^{12,22-24} Indeed, an important lesson from the demonstration programs was that the efficacy of intensive care management lay in targeting specific groups of older people with multiple/complex needs.²⁵ However, following the 1990 NHS and Community Care Act, which made local authority social services departments responsible for the introduction of care management in the UK, preliminary guidance^{17,18} implied that such arrangements should be applied to *all* service users. It focused attention on the core tasks of the care management process and led local authori-

ties to focus on these as discrete entities that might be undertaken by different members of staff, rather than developing arrangements in keeping with the concept of care management as a model of long-term care as shown in Box 1. It is thus perhaps not surprising that by the end of the 20th century only 5% of local authorities had care management services specifically targeted at older people with complex needs, although there did appear to be some focus on older people with mental health problems, with mental health nurses acting as care managers in about 10% of authorities.^{27,28}

In England, the continuing importance of targeted, intensive care management was reiterated in the National Service Framework for Older People (NSFOP) which indicated that the vast majority of older people with mental health problems would henceforth be subject to the assessment and care management aspects of the new Single Assessment Process (SAP).^{29,30} This aimed to ensure the provision of a standardised framework across health and social care delivering good quality assessment matched to individual circumstances before the formulation, where appropriate, of an inter-agency care plan. The expectation was that community nurses would increasingly become involved with such tasks, and that, regardless of agency, the practitioner with the most appropriate level of experience, qualifications and training to match the client's needs would act as their care manager. For older adults with complex mental health problems, this care was to be provided within the context of a specialist multiprofessional community mental

2 Intensive care management for older people with mental health problems: standards of good practice

- Services for older people with mental health problems require an integrated and informed approach to commissioning that embraces both their health and social care needs
- Care management should be provided by members of a multidisciplinary team specialising in the care of older people with mental health problems
- A differentiated approach to care management is necessary to ensure that older people with mental health problems receive a level of response appropriate to their health and social care needs
- Targeting within care management arrangements is required to ensure that vulnerable older people with complex needs receive the care packages they need to enable them to live at home
- Assessment as a precursor to a care plan must be multidisciplinary and appropriate in terms of content and timing to ensure that older people with mental health problems receive the requisite assistance to maintain their community tenure
- Care plans are needed to support, sustain and enhance the quality of life of older people with mental health problems in their own home and to provide assistance to their carers
- Financial arrangements which facilitate an integrated approach to the provision of health and social care for older people with mental health problems are required
- Monitoring and review in care management is necessary to ensure the timely and appropriate adjustment of the care plan in order to maintain older people with mental health problems at home in response to changing circumstances

Source: Hughes et al, 2005.³³

health team (CMHT),^{29,31,32} and the challenge for mental health services was to develop a model of intensive care management based on the standards in Box 2. Considerable differences existed in the deployment of key professionals within CMHTs, however. While some services had extensive integrated multidisciplinary teams, more than a third of teams had no ring-fenced social work time and several lacked consistent arrangements to co-ordinate the care of even their most needy clients.³⁴

The service in North West England in which the study reported in this paper was undertaken appeared typical of services nationwide. Serving a population of about 56 000 people aged 65 and over, small CMHTs, primarily staffed by qualified nurses and support staff, were based in each of the area's main towns and worked a traditional Monday-Friday, 9am to 5pm pattern, complemented by day hospital provision, outreach services and inpatient beds. There were no arrangements for social services staff to work as part of these teams, and no formal strategy for information sharing. According to locally collected information,³⁵ roughly 65% of the CMHT clients who lived at home had a primarily

organic mental illness, while 35% had a primarily functional mental illness. Most were in their late 70s or their 80s (mean age 78), and women outnumbered men by more than two to one. About 55% lived alone, and all were described as European-Caucasian. Caseloads typically numbered around 40.

Care management for older people with mental health problems was provided by non-specialist social services older people and disability teams that were mainly staffed by qualified social workers (who historically held caseloads of more than 50), unqualified social care workers and occupational therapists. About 60% of their active caseload who lived at home displayed indications of mental health problems and had similar socio-demographic profiles to the CMHT clients, if being rather older, more physically dependent and more likely to be low in mood.³⁵ National indicators suggested that the assessment practice within these teams was similar to that elsewhere, but they undertook considerably fewer reviews than analogous services and, compared with the national average, helped a smaller proportion of the local elderly population to live at home. In particular, a smaller than average proportion of

3 The proportion of staff time spent in six broad areas of activity

Activity	Social workers	Mental health nurses
Face-to-face care with clients	12.6%	33.7%
Face-to-face care with carers	4.6%	5.1%
Telephone contact with clients/carers	6.2%	4.1%
Indirect care	43.8%	25.8%
Team/service work	24.8%	17.4%
Travel	7.9%	13.9%

households received intensive home care (more than 10 contact hours per week and six or more visits per week), a situation attributed, at least in part, to gaps in the availability of services.^{35,36}

While commissioners desired to reconfigure services, they lacked information on which to base decisions, and commissioned a multi-faceted study. This included the collection of data about local people's mental health needs, an examination of the effects of changing the mix of institutional and community services^{37,38} and, as the provision of intensive care management by members of a specialist CMHT was seen as a prerequisite for the delivery of the multi-faceted packages of care needed if older people were to be diverted from institutional care, a study of the key activities undertaken by staff caring for older people with mental health problems. This paper focuses on the latter work, and is particularly interested in:

- the amount of time spent on care management;
- the extent to which the roles of mental health nurses and social work staff overlapped; and
- how patterns of working in a typical service for older people with mental health problems differed from what evidence suggests is needed.

Methods

The principal activities undertaken by core groups of specialist mental health and social

services practitioners caring for older people with mental health problems were explored by means of a time use exercise. All social workers, social care workers, community mental health nurses (CMHNs) and community support workers who primarily worked with older people were asked to complete a specially designed diary schedule adapted from previous research³⁹⁻⁴² to reflect local practice on each working day within a 1-week period in April/May 2004. This involved inserting a code for the activity in which they had been predominantly engaged for each 30-minute period from a list of 45 activities. Staff away from work during the nominated week were asked to fill in the schedule during their second week back at work. Wherever possible, schedules were completed during the course of the day, but failing this, practitioners were asked to fill in the diary at the day's end. To facilitate identification of the most appropriate code, activities were grouped into six broad areas based on previous work:³⁹⁻⁴²

- face-to-face care with clients;
- face-to-face care with carers;
- telephone contact with clients/carers;
- indirect care (activities undertaken away from the client/carer but on their behalf, including liaison and paperwork);
- team/service work (non-client-specific activities, including team meetings and training); and
- travel.

Information about the project was submitted to the local research ethics committee, but the study team was advised that formal ethical approval was not required to undertake this work, which was viewed as a mixture of audit and service development activity. Nevertheless, all staff invited to participate in the study received written information about its design and aims, and the anonymity of participants was guaranteed.

Results

The data reported in this paper relate only to the 27 community-based social workers and 15 CMHNs who completed the diary exercise (an estimated response rate of 50% and 60%, respec-

4 The proportion of staff time spent in direct contact with clients and carers

Item Activity	Mental health	
	Social workers	nurses
Face-to-face care with clients		
1 Assessment interview	3.4%	5.8%
2 Financial assessment	<0.1%	–
3 Completion of forms (non-financial)	1.2%	0.4%
4 Completion of forms (financial)	0.2%	–
5 Discussion of care plan options	2.2%	0.8%
6 Review of needs/care plan	3.9%	6.6%
7 Provision of counselling or support	0.7%	6.9%
8 Provision of information or education	0.4%	0.6%
9 Provision of psychological therapies	–	3.8%
10 Monitoring mental health/medication	<0.1%	7.5%
11 Assistance/supervision with activities of daily living	0.1%	0.8%
12 Accompanying client for appointments	0.5%	0.6%
Face-to-face care with carers		
13 Gathering information about client	2.3%	2.6%
14 Assessing carer's needs/completing forms	0.7%	0.5%
15 Provision of counselling or support	0.8%	1.7%
16 Provision of information or education	0.7%	0.4%
17 Accompanying carer for appointments	0.1%	–
Telephone contact with clients/carers		
18 Pre-assessment information gathering	1.0%	1.1%
19 Assessment	0.5%	0.4%
20 Review of needs/care plan	2.0%	1.1%
21 Provision of support or information	2.8%	1.4%
Total direct care	23.4%	42.9%

tively). The findings represent a total of 1511.5 hours of recorded activity. Hours reported as sick or annual leave were not included in this total, but time recorded as lunch or breaks was retained as part of the working week. Even if this were to be excluded however, practitioners worked an average of at least 2 hours more than the official working week.

The percentage of time each staff group devoted to the six broad categories of activity listed above is shown in Box 3. Overall, the social work practitioners spent about 17% of their time in face-to-face contact with clients and/or carers and a further 6% of their time in telephone contact with them. Thus, almost a quarter of their time at work was spent in “direct care”. If one then adds on the 44% of their time occupied by activities undertaken on behalf of clients and carers, but not in their presence, it can be seen that just over two-thirds of the social workers’ working week was spent in client-related activities. The CMHNs spent more than twice as much of their time in face-to-face contacts with clients and carers (39%), but slightly less on telephone contacts, such that altogether 43% of their working week was spent in direct care. They spent considerably less time on indirect care activities (26%) however, so that, overall, the proportion of their week spent in client-related activities (69%) was not dissimilar to that reported by the social workers.

The specific activities the different professional groups undertook when in direct contact with clients and carers are detailed in Box 4. Assessment and care planning/review activities (items 1, 2, 3, 4, 5, 6, 12, 13, 14 and 17) accounted for the vast majority of the time social workers spent with clients and carers, amounting to more than 14% of their total week. While the CMHNs spent a similar proportion of their week in these activities (17%), the provision of interventions to address people’s emotional and psychological needs, including the monitoring of their health and medication (items 7, 8, 9, 10, 15 and 16), formed a still greater part of their week.

The activities undertaken by staff on behalf of, but not in the presence of, clients and carers are

5 The proportion of staff time spent in activities undertaken on behalf of clients and carers

Item	Activity	Social workers	Mental health nurses
22	Assessment — gathering information from health/social services staff*	2.4%	1.1%
23	Assessment — gathering information from other agencies	1.4%	1.6%
24	Assessment — gathering information from records/colleagues	1.6%	0.6%
25	Assessment — completing documentation	7.5%	3.4%
26	Other client/carer-related paperwork	17.1%	11.2%
27	Discussing case in supervision/clinical team meeting	2.5%	4.6%
28	Discussing case with front line care staff, eg home carers	4.1%	0.8%
29	Arranging social care	3.4%	0.3%
30	Arranging health care	0.7%	0.6%
31	Monitoring social care provision	1.2%	0.2%
32	Monitoring health care provision	0.4%	0.1%
33	Review of care plan/care provision in conjunction with other agencies/providers	1.6%	1.4%
Total indirect care		43.8%	25.8%

* Forms provided to health staff asked about liaison with social services staff; forms provided to social services staff asked about liaison with health staff.

shown in Box 5. From this we can see that the gathering of information about clients and the completion of assessment documentation occupied a further 13% of the social workers' time. Altogether therefore, assessment-related activities (items 1, 2, 3, 4, 13, 14, 18, 19, 22, 23, 24 and 25) accounted for 22% of their working week. In contrast, care planning and arranging services accounted for 11% of their time (items 5, 12, 17, 28, 29 and 30), while review and monitoring activities took up a further 9% of their week (items 6, 20, 31, 32 and 33). The same assessment and care management activities occupied a little over 30% of the CMHNs' working time. As this information was collected at practitioner level, it could not be linked to individual service users. However, further analysis of the previously collected caseload data revealed that about half of the CMHT caseload had input from social work staff and that over a third of the social service users with mental health problems were seen by nurses or support staff from the CMHT. Moreover, the majority of the social workers (70%) reported gathering information from their health

services colleagues in the week in question. Only 40% of the CMHNs recorded gathering information from social work colleagues however, while both groups spent very little time monitoring the provision of care by the other agency.

Discussion

The support of older people with complex mental health needs is one of the greatest tasks faced by welfare services in the Western world.⁴³ However, despite the rising demand for community care, there has been relatively little consideration of how the available workforce can be most efficiently used.^{28,39}

In this paper we present one of only a handful of studies that have systematically examined the working practice of health and social services staff caring for older people with mental health problems. This found that both social work and nursing staff spent about two-thirds of their working week in client-related activities (direct and indirect) of which a substantial proportion was taken up by care management-related tasks.

The reported data thus provide some empirical evidence of what is actually being done. The following discussion considers this information in the light of the wider research literature on the provision of intensive care management and highlights some potential areas for change. The standards set out in Box 2 are used as an organisational framework.

Services for older people with mental health problems require an integrated and informed approach to commissioning that embraces both their health and social care needs

Evidence suggests that the effective commissioning of services for older people with mental health problems is underpinned by robust joint planning mechanisms, good quality information about the use of current services and clear goals.^{29,33,44} However, as noted above, while the work described in this paper was undertaken in an area that substantially operated as a single health economy, with the constituent organisations working together to plan and manage services, planners and commissioners lacked all but the most rudimentary information on which to base decisions. It was in recognition of this situation that the current study was commissioned.

Care management should be provided by members of a multidisciplinary team specialising in the care of older people with mental health problems

This standard suggests that the intensive care management arrangements needed to deliver the complex packages of care required by many older people with mental health problems are best provided by nursing or social work practitioners located within a specialist multidisciplinary CMHT.^{12,21,31,32} However, like many others,³⁴ the area in which this study was undertaken had neither an intensive care management service, nor multi-agency CMHTs. In order to meet the standards in Box 2 therefore, not only would qualified social work practitioners need to be integrated within existing CMHTs, but the com-

munity mental health nurses' remit would need to expand to incorporate the role of care manager in those cases where their specific expertise made them the most appropriate personnel to undertake this function.

The particular knowledge and skills that multidisciplinary CMHTs can offer include an in-depth understanding of the mental health needs, care and treatment of older people and a familiarity with the generic and specialist services in the area.³² Although there has been little evaluation of the interventions provided by such teams, there is some evidence that they can improve outcomes for older people with mental health problems,⁴⁵⁻⁴⁹ and that clients and carers, at least of working age, prefer this form of support to standard service provision.⁵⁰ However, it should not be assumed that simply bringing staff together into multidisciplinary groups will automatically result in the formation of effective teams. Indeed, it is likely that a substantial amount of effort will be required to put the necessary structures and working practices in place.⁵¹ While there have been few appraisals of the organisation or processes of CMHTs for older people,^{52,53} studies of the principles of good teamworking in CMHTs for working age adults suggest such teams need:

- adequate resources (staff, money and accommodation);
- clear, realistic aims/objectives;
- a single team leader with sufficient authority to ensure that all disciplines work to an agreed operational policy;
- clarity about the role of each team member, their tasks and place within the team;
- an appropriate breadth of skills and knowledge to meet clients' needs; and
- explicit models of care supported by joint training and ongoing team development.^{50,54-59}

Although the social work staff who participated in this study held generic rather than specialist mental health caseloads, the high level of psychiatric comorbidity seen in their clients would suggest that this is a group with whom they are very familiar³⁵ and over 40% of their working week was spent in core care management tasks. It

might reasonably be assumed, therefore, that they would take the lead in introducing any more intensive care management arrangements. While their focus may be somewhat different, the mental health nurses in our study also spent almost a third of their working week on these tasks, suggesting a familiarity with such activities. However, formal arrangements, including additional training, would undoubtedly be needed to support their adoption of the care manager role.

A differentiated approach to care management is necessary to ensure that older people with mental health problems receive a level of response appropriate to their health and social care needs

A differentiated approach to assessment and care management distinguishes between service users with severe, complex or fluctuating needs that often require a whole systems response, and those with less complex needs that might be met by a single service/agency.^{31,33} The successful introduction of any new intensive care management arrangements will thus be reliant upon the establishment of effective systems for screening, prioritising and gatekeeping access to this service, including clear eligibility criteria,^{50,60} as well as robust systems for reviews. As not all CMHT clients will require such arrangements however, the need for other social care responses, including effective organisational procedures for assessments, care planning and reviews, should not be overlooked.¹⁷

The provision of sufficient time to implement the model is a further pre-condition of care management's effectiveness, and this raises issues about caseload mix and size, for, in contrast with current practice, intensive care management caseloads must be small for practitioners to provide the careful assessment and monitoring of needs, liaison with other agencies, and close and regular contact with the elderly person and their network that are needed.²¹ Moreover, this aspect of the CMHT's work must be balanced against the other roles of the team, including the support of generic services, the care of people at home by means of less complex packages and the provi-

sion of therapeutic interventions.⁶¹ In our study, for example, the delivery of interventions to address people's emotional and psychological needs accounted for more than a fifth of the CMHNS' working week.

Targeting within care management arrangements is required to ensure that vulnerable older people with complex needs receive the care packages they need to enable them to live at home

The effective targeting of resources necessary to the achievement of positive outcomes from intensive care management occurs at several points: on entry to the service, within the initial assessment and through regular review. The aim is to ensure that those older people with more severe and complex needs receive services that differ in content and intensity from those received by other older people whose needs are of lesser degree.³³ The targeting of services at people on the margins of institutional care will be especially important in the study area, as there were concerns about the CMHTs' ability to manage highly dependent clients in the community.⁶² Furthermore, despite studies having shown that the delivery of care in standard amounts fails to have a marked impact on the probability of an individual being able to stay at home,⁶³ a relatively low proportion of households received intensive home care.³⁶

Assessment as a precursor to a care plan must be multidisciplinary and appropriate in terms of content and timing to ensure that older people with mental health problems receive the requisite assistance to maintain their community tenure

Government policy indicates that the vast majority of older people with mental health problems will now be subject to the SAP.²⁹ This in turn requires that older people receive one of four levels of assessment matched to their individual circumstances, an approach consistent with the differentiated approach to care management discussed above. For most older people for whom the delivery of intensive care manage-

ment is considered appropriate, this is likely to mean comprehensive, multidisciplinary assessment spanning health and social care, an approach that has been found to confer significant benefits for older people with complex needs.⁶⁴ The assessment element of intensive care management is not a one-off event however, but an ongoing process utilising a structured approach.^{29,33}

Although there are no definitive guidelines on how much time staff *should* spend in any particular activity, it is clear that both the nursing and social work practitioners in this study spent a considerable proportion of their working week in assessment activities (17.5% and 22%, respectively). There was, furthermore, some evidence of collaboration, as 3.8% of the social workers' time and 2.7% of the mental health nurses' week was spent gathering assessment material from other agencies. However, while no specific information was collected about the nature or content of the assessments undertaken, a certain amount of duplication seems inevitable, for although many clients were known to both agencies, as noted above, there was no common health and social services assessment documentation or formal strategy for information sharing, and the two agencies employed different computer systems.

The challenge for local services therefore was to integrate a common health and social care assessment framework within the CMHTs' operational policy and planned electronic information system. Any consequent reduction in time spent on documentation would certainly have been appreciated. The completion and transmission of paperwork permeates most working days in occupations of this type (client and carer-related paperwork occupied more practitioner time than any other single activity in this study), but consistently ranks among the least enjoyable aspects of such jobs.^{40,65,66} There are, however, a number of areas that would have required sensitive exploration and support, including the possibility that social work practitioners would perceive an increased emphasis on multidisciplinary assessment as a challenge to their authority and that nursing staff would view any involve-

ment in discussions of charging and finances with concern.⁶⁶⁻⁶⁹

Care plans are needed to support, sustain and enhance the quality of life of older people with mental health problems in their own home and to provide assistance to their carers

The care planning function of care management encompasses the identification of the most appropriate means of meeting the needs/goals identified in the assessment and the securing of the necessary services/resources to meet them.³³ An important feature of intensive care management arrangements for older people with mental health problems is the number and breadth of services required to enable individuals to remain in their own homes.⁴⁰ However, the mental health nurses in this study spent less than 1% of their time arranging care services, while the social workers spent nearly five times more time arranging social, than they did health, care. Furthermore, in an exercise in which staff formulated "ideal" care plans for a number of representative clients, practitioners from each agency relied heavily on their own services to meet client needs and were not always fully aware of the resources available outside of their own sector.³⁵ It would thus be important for future care managers to learn about the services provided by other agencies and for formal arrangements to be put in place enabling them to access them.

One common concern about the introduction of care management is that it could draw staff away from valued direct work into unwelcome administrative tasks.^{28,66,70} Nonetheless, the delivery of effective care management depends upon the establishment of trusting relationships between staff, users and carers that endure over time,^{50,68,71,72} while the provision of supportive information systems and other practical arrangements may attenuate the administrative demands of care management.⁶⁶ Increasing staff's awareness of the benefits to clients of indirect work is also important, since studies have shown that greater time spent on such

activities is associated with better client outcomes and increased service satisfaction.^{73,74}

Financial arrangements which facilitate an integrated approach to the provision of health and social care for older people with mental health problems are required

The financial arrangements consequent upon the introduction of intensive care management find expression at both the macro and the micro level. At the individual level, it is suggested that three aspects of practice contribute to effective financial management: the devolution of budgets to care managers, the availability of explicit unit costs for purchased services and the setting of clear expenditure limits.⁷⁵ These enable practitioners to seek a wider range of responses to identified needs and to make informed choices about the likely costs and benefits of alternative packages of care.^{14,20} At the time this study was undertaken, however, only the third of these was fully in place.³⁵

Monitoring and review in care management is necessary to ensure the timely and appropriate adjustment of the care plan in order to maintain older people with mental health problems at home in response to changing circumstances

The changing nature of the needs presented by many older people with mental health problems dictates that their care is regularly monitored and reviewed. Although there had been concerns about the number of reviews undertaken by social work practitioners, this study found that such activities occupied a substantial proportion (roughly 9%) of both staff groups' time, while, in contrast to areas in which social workers relinquish active involvement with a service user once needs are assessed and services established,⁶⁸ the vast majority of older people with mental health problems known to social services were open, active cases.³⁵ This is significant, for continuity of staff involvement is a top priority for service users.⁷²

Limitations

The effective provision of intensive care management for older people with mental health prob-

lems is undoubtedly about more than a set of activities/tasks and this study does not purport to capture all the complexities and nuances of practitioner–client relationships. Moreover, the quantitative analysis of practitioners' time is itself a complex operation, and there are a number of methodological issues of note.

The chosen diary format employs a transparent process, is convenient to use and produces data that are “close to the ground”. There is however an inevitable element of subjectivity in the selection of the activity that best describes the work undertaken at any one time, while the use of 30 minute time slots is likely to result in the under-reporting of those activities which take only a few minutes and of carer-related tasks, for staff often see service users and families together. Furthermore, although the constituent activities have been refined over a number of years and offer a basis for comparison with other services and time points, the categorisation itself is not viewed as definitive. However, this framework has been used successfully in old age, adult mental health and old age mental health services previously.³⁹⁻⁴²

The diary schedules were distributed to practitioners via team leaders. Although all the CMHNs for older people by definition predominantly worked with older people, there was no precise information on the number of social services staff who did so, and managers therefore left individual practitioners to determine whether their caseloads fulfilled these criteria. While 60% of the targeted mental health nurses participated, it was not possible to calculate an exact response rate for the social work practitioners (although managers estimated that this was somewhere in the region of 50%). It would have been desirable to have captured the characteristics of respondents and non-respondents, but the study team was advised that collecting personal information about respondents would be likely to decrease the response rate. Caution should be exercised in generalising the study's findings therefore, although, interestingly, the results are not greatly different from those reported in other work that has utilised a similar classification,^{39-42,76} while the mix of services for older people with mental

health problems in the study area appeared typical of services nationwide.³⁴

At least some data were recorded retrospectively, as the pressures of work obliged busy practitioners to wait until the day's end before completing schedules. The accuracy of the data is thus subject to recall bias, and no attempt was made to check the veracity of recording. The reporting is further complicated by the fact that the social services department made no clear organisational separation between older people with mental health problems and other older people, such that the information provided by the social services staff relates to mixed caseloads. As noted previously, however, older people with mental health problems constituted at least 60% of the cases open to social services staff, and many of these clients will have had changing presentations and complex needs necessitating a high amount of social work time.

Conclusions

The desire to provide high quality, effective services for older people with mental health problems is universal.⁷⁷ However, services have not always implemented the lessons from the growing evidence base about the needs and care of this population.⁶³ The widespread failure to implement intensive care management arrangements within the context of multidisciplinary CMHTs is a good example. This study explores the implications of introducing such arrangements within a typical old age mental health service in England through the employment of time use data and a set of core standards. Future work could benefit from linking time use data to individual service users so as to link variation in patterns of activity to care outcomes. Despite certain limitations in the methodology, the study offers useful insights, and suggests the need for a number of changes in the organisation and practice of services at ground level.

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Competing interests

The authors declare that they have no competing interests.

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