



# Community mental health teams for older people: variations in case mix and service receipt (II)

DOI:

[10.1002/gps.4190](https://doi.org/10.1002/gps.4190)

## Document Version

Final published version

[Link to publication record in Manchester Research Explorer](#)

## Citation for published version (APA):

Wilberforce, M., Tucker, S., Brand, C., Abendstern, M., Jasper, R., Stewart, K., & Challis, D. (2015). Community mental health teams for older people: variations in case mix and service receipt (II). *International journal of geriatric psychiatry*, 30(6), 605-613. <https://doi.org/10.1002/gps.4190>

## Published in:

International journal of geriatric psychiatry

## Citing this paper

Please note that where the full-text provided on Manchester Research Explorer is the Author Accepted Manuscript or Proof version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version.

## General rights

Copyright and moral rights for the publications made accessible in the Research Explorer are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

## Takedown policy

If you believe that this document breaches copyright please refer to the University of Manchester's Takedown Procedures [<http://man.ac.uk/04Y6Bo>] or contact [uml.scholarlycommunications@manchester.ac.uk](mailto:uml.scholarlycommunications@manchester.ac.uk) providing relevant details, so we can investigate your claim.



# Community mental health teams for older people: variations in case mix and service receipt (II)

Mark Wilberforce<sup>1</sup>, Sue Tucker<sup>1</sup>, Christian Brand<sup>1</sup>, Michele Abendstern<sup>1</sup>, Rowan Jasper<sup>1</sup>, Karen Stewart<sup>1</sup> and David Challis<sup>1</sup>

Personal Social Services Research Unit, University of Manchester, Manchester, UK

Correspondence to: M. Wilberforce, E-mail: mark.wilberforce@manchester.ac.uk

**Objectives:** To determine the extent to which services provided to older people via community mental health teams (CMHTs) vary in duration, composition and intensity. In particular, to identify the degree to which differences between teams are due to casemix.

**Methods:** Data were collected about the services provided to a random sample of patients from 15 CMHT caseloads, including contact with CMHT staff, other specialist mental health and social care services. The relationship between patients' needs and service receipt was explored.

**Results:** Information was obtained for 1396 patients. Average time on CMHT caseloads was 11.6 months, but there were marked between-team differences. The proportion of re-referrals also varied from under a tenth to over half. People with functional mental health problems and complex needs were most likely to be long-term CMHT clients. The proportion of patients seen by a consultant in the previous 6 months ranged from approximately a fifth to almost all. Differences with respect to contact with other qualified practitioners were less marked. Older people with functional disorders, challenging behaviour and at least one medium risk had the most regular contact with CMHT staff. Risk of self-harm, delusions and paranoia increased the likelihood of consultant involvement. Support workers were more likely to see people at risk of self-neglect. The receipt of other services, including day hospitals and inpatient care varied greatly.

**Conclusions:** Considerable diversity was found in the length, nature and frequency of services provided to patients with different needs. Differences between teams were not wholly explained by case mix. Copyright © 2014 John Wiley & Sons, Ltd.

**Key words:** community mental health teams; older people; caseloads; service provision

**History:** Received 12 May 2014; Accepted 24 July 2014; Published online 9 September 2014 in Wiley Online Library (wileyonlinelibrary.com)

DOI: 10.1002/gps.4190

## Introduction

Older people with mental health problems can expect to have a broad range of services available to them, depending on their particular needs. However, international consensus suggests the first tier of specialist provision should consist of community-based services that bring together the skills and expertise of consultant psychiatrists, mental health nurses, social workers, occupational therapists and psychologists (WHO and WPA, 1997). In England today, the cornerstone of such support is formed by multidisciplinary community mental health teams (CMHTs), which take a central role in assessment, diagnosis, treatment and care coordination across

disparate health and social care services (DH and CSIP, 2005). Two linked papers in this issue explore the extent of variation in CMHT models through data collected from 15 teams. Whereas the first paper focused on CMHTs' caseloads (Tucker *et al.*, 2014), this paper examines the services they deliver.

### Sources of variation in service provision

As part of an emerging 'localism' agenda, a degree of diversity has recently been encouraged in the National Health Service (NHS), with individual organisations urged to tailor services to community preferences

and priorities (Allen, 2006). Local commissioning consortia, whereby general practitioners and community representatives establish the specification for secondary provision, are perhaps the most visible manifestation of this agenda (DH, 2010). However, other sources of variation may be less purposive, including a limited evidence base regarding optimal service structures, a lack of clear direction from government agencies, inconsistent policy implementation and the strong influence of historical patterns of local delivery (Macdonald, 2005; McCrae and Banerjee, 2011).

Sources of variation in CMHT provision can be found at both service structure and practitioner levels. At the macro level, the *National Service Framework for Older People* and accompanying guidance (DH, 2001; Lingard and Milne, 2004) established the importance of CMHTs but provided only limited direction on their role. Furthermore, as outlined in the first paper (Tucker *et al.*, 2014), in recent years, a range of new specialist services have evolved, including memory clinics, outreach and liaison teams. Additionally, some areas now have separate dementia-specific CMHTs (Challis *et al.*, forthcoming). This has created a diverse network of provision, and although more recent national clinical guidance provides care pathways for common psychiatric conditions (e.g. NICE, 2006, 2011), it does not specify which services should be responsible for which aspects of care.

At the practitioner level, the promotion of multidisciplinary working across the NHS and local authorities (responsible for long-term social care) has given considerable latitude for variation in professionals' roles, including the extent to which staff from different disciplines undertake generic rather than profession-specific tasks (Brown *et al.*, 2000). Another relatively recent issue concerns the growing number of support workers, employed under a broad range of job titles, with correspondingly diverse responsibilities (Wilberforce *et al.*, 2013). Finally, although *New Ways of Working* aspired to make better use of consultants' skills within multidisciplinary teams, focusing their input on complex, high-risk patients (DH, 2005), the evidence to date (albeit sparse) demonstrates disagreement and inconsistency in its delivery (Dale and Milner, 2009).

The resulting diversity in CMHT models has significant ramifications for the productive and allocative efficiency of the healthcare system. To the extent that any differences in provision reflect patients' needs, this would appear consistent with efforts to ensure that public resources are targeted at those with the greatest clinical need. However, where case mix fails to explain variation, there is the potential for resource misallocation and a need to understand why differences exist. Against this background, this paper explores the degree

to which services delivered through individual CMHTs vary in their duration, composition and intensity and to what extent between-team differences are due to caseload variation.

## Methods

Caseload and service provision data were collected from 15 CMHTs from two separate, but related, studies of old-age psychiatric services in England. Nine geographically spread teams (A–I) in separate NHS Mental Health Trusts participated in the first (CMHT) study. Six teams (J–O) from two trusts in north-west England participated in the second (balance of care) study. Teams ranged in size from nine to almost 40 members. All included at least one team manager, consultant, nurse, occupational therapist and support worker, whilst social workers and psychologists were present in nine and eight teams, respectively. Of 11 teams for which information was available, eight worked alongside separate memory clinics (the other three had no such services available locally). Data collection for the study was achieved via bespoke paper-based tools for a random selection of community-dwelling patients, excluding individuals under 65 years and those not yet assessed. Further details of the teams included within the study, the data collection and development of 'case types' are provided in the first of these linked papers (Tucker *et al.*, 2014).

Box 1 summarises the content of the service receipt data collection, which included information on referrals, CMHT contacts, input from other specialist mental health services and social care. The classification of the latter requires elaboration. Detailed information was collected on receipt of personal care, domestic support, sitting services, meals, day care, respite care and contacts with local authority social workers. These were summarised in a single variable with four categories: 'no or minor support' (no services or only social worker input), 'intermittent support' (less than daily support; most care provided outside the home, e.g. day or respite services), 'limited care package' (1–9 h/week personal care/domestic help/sitting service or seven or more meals per week) and 'intensive care package' (10+ h per week personal care/domestic help/sitting service). Analysis was conducted in STATA (release 12, StataCorp, College Station, TX) and took the form of simple descriptive statistics, complemented by logistic regressions using binary forms of the number of consultant visits (0 vs 1+) and the frequency of support worker contact (fortnightly or more vs monthly or less).

## Box 1. Summary of service receipt data collection

**Referral data:**

- Date of referral to CMHT (current episode)
- Whether an individual was previously known to CMHT (Teams A–I only)

**Contacts with CMHT members:**

- Number of consultant contacts in the previous 6 months
- Frequency of regular contacts with other qualified practitioners (four categories)<sup>1</sup>
- Frequency of regular contacts with support workers (four categories)<sup>1</sup>

**Other service receipts from allied services:**

- Number of day hospital visits (days per week)
- Number of mental health inpatient episodes in the last 6 months
- Frequency and composition of social care support (four categories)<sup>2</sup>

<sup>1</sup>Less than monthly/monthly/fortnightly/weekly or more often<sup>2</sup>No or minor support/intermittent support/limited care package/intensive care package**Findings**

Data were collected on 1396 patients. Referral dates were provided for 1360 (Table 1). At the point of data collection, the average (median) time on teams' caseloads was just under a year (11.6 months). More than a quarter had been seen for less than 6 months, and a similar proportion for 2+ years. However, a long tail was evident in the distribution, with 5% referred more than 6 years previously. Much of the variance reflected between-team differences. For example, the median time on Team M's caseload was 7.4 months, compared with 23.0 months in Team A. The proportion of recent referrals (within the previous 6 months) similarly varied from a tenth (Team N) to four-tenths (Team F). Further differences were found in the proportion of patients known to teams before their current care episode (data available for Teams A–I only). Hence, although a third of the full sample was re-referrals, this ranged from just 7% in Team D to more than half in Team G.

Table 2 details the frequency of contact with CMHT practitioners. Over two-thirds of patients had seen a consultant psychiatrist in the previous 6 months, but this proportion varied greatly between

Table 1 Time since referral and prior team contact

		Full sample (%)	Min–max % across teams	Full sample (n)
Time since referral	<6 months	27.1	10.0–40.5	397
	6 < 12 months	21.5	13.4–35.3	297
	12 < 24 months	21.1	11.6–29.5	300
	24+ months	29.9	18.3–57.5	366
Whether known to team before current episode <sup>a</sup>	Yes	33.8	7.0–54.5	304
	No	66.2	45.5–93.0	596

Weighted percentages to adjust for different sampling ratios applied to functional and organic cases.

<sup>a</sup>Only available for Teams A–I.

Table 2 Frequency of contact with community mental health team practitioners

		Full sample (%)	Min–max % across teams	Full sample (n)
Consultant (contacts in previous 6 months)	None	30.3	2.8–80.0	465
	One	44.7	15.0–68.4	576
	Two or more	25.0	5.0–47.3	322
Nurse, occupational therapist, social worker, psychologist (frequency of contact)	Less than monthly	19.9	0.0–43.6	282
	Monthly	36.1	13.7–55.2	479
	Fortnightly	28.9	12.9–47.4	411
	Weekly/ more often	15.0	6.8–40.9	191
Support worker (frequency of contact)	Less than monthly	78.2	59.3–96.5	1088
	Monthly	5.2	0.0–14.4	75
	Fortnightly	6.4	0.0–15.4	97
	Weekly/ more often	10.1	0.9–21.1	119

Weighted percentages to adjust for different sampling ratios applied to functional and organic cases.

teams, from a fifth in Team F to four-fifths or more in Teams A and K–O. Indeed, all but three individuals in Team L (97.2%) had had consultant contact. Such variation was less marked with respect to contact from other qualified staff (nurses, occupational therapists, social workers and psychologists). Hence, 43.9% of the full sample received regular contact (at least fortnightly), and the figures for six CMHTs were within 10 percentage points of this. Nevertheless, the range spread from under a third (29.2%) in Team F to more

than three-quarters (77.4%) in Team O. Support workers visited a narrower range of individuals than consultants or qualified practitioners. Overall, just a sixth of patients received regular support worker contact, ranging from 3.5% in Team E to over a quarter in Teams J, L and H, with the availability of such staff varying greatly (Tucker *et al.*, 2014).

In terms of other support services received by the full sample, less than a tenth regularly attended a day hospital (Table 3), although there were no such facilities available to Teams A, B, C and F. However, day hospitals were a prominent feature of the support provided in Teams J and O, where 40.5% and 30.6%, respectively, were regular attendees. Similarly, although approximately a tenth of the full sample had been admitted to a psychiatric bed in the previous 6 months, this ranged from fewer than five individuals (a negligible proportion) in Teams A, F, H and M to approaching a quarter in Teams L and N (22.1% and 24.1%, respectively).

A narrow majority of individuals received no social care beyond (at most) input from a social worker, whereas over a third (37.1%) received regular support (combining the limited and intensive care options in Table 3). Some variation was evident across teams, with more than half the sample from Teams J, M and O receiving regular care packages (51.6%, 51.1% and 50.2%, respectively), but less than a quarter from Teams A and F (24.6% and 21.3%, respectively).

Taken together, these findings paint a patchy, inconsistent pattern of service provision across teams. Patients seen by Team F appeared to receive the least intensive support, being least likely to have seen a consultant in the previous 6 months or to have received regular contact with other qualified practitioners.

Table 3 Receipt of support from other services

	Full sample (%)	Min–max % across teams	Full sample (n)
Other specialist mental health input			
Proportion attending day hospital on a regular basis	8.3	0.0–40.5	89
Proportion admitted to a mental health ward in the last 6 months	10.1	1.4–24.1	115
Social care support <sup>a</sup>			
No/minor support	55.2	37.0–72.3	701
Intermittent support	7.7	3.1–13.8	106
Limited care package	25.5	12.8–37.7	327
Intensive care package	11.6	4.6–18.2	158

Weighted percentages to adjust for different sampling ratios applied to functional and organic cases.

<sup>a</sup>Based on categorisation described in the methods.

The proportion receiving regular support worker input was also below average, although few had had recent inpatient care and there was no day hospital service. Individuals from Team F were also least likely to have regular social services support. No team stood out as providing consistently high input across all service types, but people from Teams L and O were considerably more likely than average to have seen a consultant and to have received regular visits from qualified practitioners and support workers.

#### Explaining variation in service receipt: case types

Two different approaches were taken to explore whether certain client groups received more support than others and the extent to which this explained the aforementioned picture of service variation. First, using the classification detailed in the previous paper (Tucker *et al.*, 2014), Table 4 presents a summary of the services received by 12 common case types (groups of people with similar needs for care, as determined by their diagnoses, need for help with activities of daily living (ADLs), level of challenging behaviour and risk).

With respect to time on caseload, patients with functional mental health problems were consistently more likely to be long-term CMHT clients, particularly if they exhibited challenging behaviour. Indeed, regardless of diagnosis, the tendency was for people with more complex clinical profiles to stay longer on teams' caseloads. Nevertheless, around a third and a fifth of the lowest-level needs groups (Case Types 1 and 6, respectively) had been seen for over 2 years. For teams A–I, it was also possible to investigate the proportion of each case type known to the team before the current care episode (not shown). Thus, a third (33.8%) had been seen before, representing 50.9% of people captured by functional case types and 20.4% captured by organic ones, the latter largely concentrated in case types with challenging behaviour.

Consultants were more likely than not to have seen the people represented by all 12 case types in the previous 6 months. However, this likelihood peaked for those with functional mental health problems, challenging behaviour and at least one medium risk (Case Types 4 and 5). Other qualified practitioners were also most likely to see these case types and least likely to be in regular contact with those who were ADL independent and displayed no/low levels of challenging behaviour or risks (Case Types 1 and 6).

Support workers were similarly more likely to support people with functional mental health problems, particularly where they displayed challenging behaviours or risks. Thus, support workers were in regular contact with



Table 4 Specialist mental health service provision by case type

Case type	Diagnosis	Physical dependency	Challenging behaviours	At least medium risk	Time since referral			Consultant contacts (last 6 months)		Qualified practitioner contacts (frequency)		Support worker contacts (frequency)		Other mental health inputs		Max sample size
					Less than 6 months	6–24 months	More than 24 months	None	At least one	Monthly or less often	Fortnightly or more often	Monthly or less often	Fortnightly or more often	Day Hospital	Inpatient admission	
1	F	No	No	No	27.1	37.9	35.0	29.4	70.6	64.0	36.0	87.8	12.2	6.9	9.6	163
2	F	No	No	Yes	23.2	42.0	34.8	27.4	72.6	50.9	49.1	77.6	22.4	11.7	9.0	122
3	F	No	Yes	No	20.0	35.3	44.7	33.3	66.7	51.4	48.6	76.2	23.8	7.2	9.7	72
4	F	No	Yes	Yes	16.9	37.8	45.3	22.2	77.8	44.4	55.6	74.8	25.2	13.9	19.5	132
5	F	Yes	Yes	Yes	13.4	42.2	44.4	16.2	83.8	34.8	65.2	80.7	19.3	10.1	13.9	54
6	O	No	No	No	39.6	41.6	18.8	30.7	69.3	73.8	26.2	87.5	12.5	0.0	1.0	101
7	O	No	No	Yes	31.4	53.5	15.1	32.6	67.4	60.5	39.5	90.7	9.3	5.1	4.9	88
8	O	No	Yes	No	38.1	42.9	19.0	21.6	78.4	55.1	44.9	78.7	21.3	9.7	4.5	74
9	O	No	Yes	Yes	29.3	54.5	16.1	25.1	74.9	55.6	44.4	80.9	19.1	7.1	5.9	144
10	O	Yes	No	Yes	12.8	56.4	30.8	42.9	57.1	58.5	41.5	82.9	17.1	2.9	0.0	38
11	O	Yes	Yes	No	18.6	34.9	46.5	40.5	59.5	65.9	34.1	86	14	8.6	5.1	41
12	O	Yes	Yes	Yes	31.8	45.8	22.4	31.2	68.8	49.6	50.4	88.4	11.6	13.4	15.1	178

Weighted percentages to adjust for different sampling ratios applied to functional and organic cases.

22.4% of patients with functional diagnoses who were ADL independent and displayed some level of risk but no/low challenging behaviour (Case Type 2), but just 9.3% of those with the same ADL, risk and behaviour profile but organic/mixed diagnoses (Case Type 7). With respect to other specialist mental health input, Case Types 4, 11 and 12 (representing individuals with functional and organic disorders who exhibited challenging behaviour and risks) were amongst the most likely to attend day hospital and to have been admitted to inpatient care.

#### Explaining variation in service receipt: regression analyses

Logistic regression analyses were used to explore the likelihood of having seen a consultant in the previous 6 months and receiving regular support worker contact. These were the two inputs the preceding analysis suggested varied most between teams, and this approach enabled any team effects to be observed whilst holding the range of clinical characteristics used in the case type constant. Instead of broad diagnostic groups, dependence, risks and behavioural difficulties, individual variables denoting specific clinical characteristics, were entered into the models.

With respect to consultant contact, the model presented in Table 5 suggests that although clinical and team-related characteristics were important in determining whether people saw a consultant, many unobserved factors were also influential. Individuals with symptoms of depression and/or organic/mixed diagnoses were more likely to see a consultant than people without a diagnosis (although this may be an artefact, as diagnosis is often provided on the basis of consultant assessment). The risk of self-harm and delusional/paranoid behaviours also increased the likelihood of seeing a consultant, whereas the risk of self-neglect reduced it. Perhaps not surprisingly, people with a recent inpatient admission were five times more likely than those without to have seen a consultant. Even controlling for clinical characteristics, however, team variance was stark, with patients in Teams L and O considerably more likely to see a consultant than patients in Teams F and H.

Table 6 presents the equivalent analyses for support worker contacts. As can be seen, these confirmed that people with functional mental health problems, including symptoms of depression and a diagnosis of schizophrenia, were more likely to be seen by a support worker than those needing significant help with ADLs or with organic/mixed diagnoses. Patients at risk of self-neglect also had a greater than average

Table 5 Likelihood of having seen a consultant in the previous 6 months (logistic regression)

	Odds ratio	Standard error	p-value
Socio-demographic characteristics			
Age	0.977	0.010	0.022
Receiving informal care	1.305	0.209	0.097
Clinical profile and diagnosis			
High functional dependence	0.290	0.103	<0.001
Positive depression screen (Patient Health Questionnaire 2)	1.496	0.223	0.007
Organic/mixed diagnosis	1.526	0.272	0.018
No diagnosis	0.583	0.157	0.045
Risks and challenging behaviours			
At risk of self-neglect	0.620	0.099	0.003
At risk of self-harm (deliberate)	1.899	0.599	0.042
Displays delusions, hallucinations or paranoia	1.580	0.262	0.006
Other service receipt			
Inpatient admission in the last 6 months	5.059	1.915	<0.001
Team dummies			
Team A	1.838	0.649	0.085
Team F	0.081	0.025	<0.001
Team H	0.395	0.094	<0.001
Team L	10.681	7.893	0.001
Team M	3.330	1.274	0.002
Team O	12.667	13.260	0.015
Constant	8.360	6.669	0.008

Model fit: pseudo- $R^2 = 0.186$ ; likelihood ratio  $\chi^2(16) = 271.56$ ,  $p < 0.000$ ; Hosmer–Lemeshow  $\chi^2 = 9.40$ ;  $p = 0.310$ .  
Diagnostics:  $n = 1169$ ; link test coefficient ( $y\text{-hat}^2$ )  $p = 0.690$ .

Table 6 Likelihood of regularly seeing a support worker (logistic regression)

	Odds ratio	Standard error	p-value
<b>Socio-demographic characteristics</b>			
Age	1.022	0.011	0.045
Lives alone	2.026	0.312	<0.001
<b>Clinical profile and diagnosis</b>			
Functionally independent	1.493	0.283	0.034
Positive depression screen (Patient Health Questionnaire 2)	1.350	0.207	0.050
Diagnosis of schizophrenia	1.815	0.560	0.053
<b>Risks and challenging behaviours</b>			
At risk of self-neglect	1.413	0.228	0.032
At risk of self-harm (deliberate)	1.715	0.482	0.055
Wanders away from home/carer	1.536	0.330	0.046
<b>Team dummies</b>			
Team D	0.422	0.143	0.011
Team E	0.117	0.061	<0.001
Team I	2.649	0.665	<0.001
Team K	0.478	0.134	0.008
Constant	0.018	0.160	<0.001

Model fit: pseudo- $R^2 = 0.0898$ ; likelihood ratio  $\chi^2(113.30)$ ,  $p < 0.001$ ; Hosmer–Lemeshow  $\chi^2(8) = 3.05$ ;  $p = 0.931$ . Diagnostics:  $n = 1263$ ; link test coefficient ( $\hat{y}$ -hat<sup>2</sup>)  $p = 0.849$ .

likelihood of seeing a support worker. Once caseload characteristics were controlled for, team variations were largely muted, with the reduced proportion of variance explained by the model (pseudo- $R^2 = 0.090$ ), suggesting other unobserved variables were more important in determining who saw a support worker. That said, the chances of seeing a support worker were slightly higher in Team I and a little less in Teams D, E and K regardless of clinical profile.

## Discussion

Although the first paper identified a limited literature on the caseloads held by CMHTs (Tucker *et al.*, 2014), contemporary information about the input required by patients with different needs profiles and the services they receive is similarly sparse (Hunter *et al.*, 2002). In addressing this gap, this paper offers an account of the support provided to a large cross section of older people seen by 15 CMHTs in England and suggests that what people receive is (at least in part) dependent on the particular team they see. Thus, considerable diversity was found in the length, nature and frequency of input provided, which could not be wholly attributed to clinical profiles.

### Methodological considerations

In addition to the issues raised in the previous paper, it should be acknowledged that the description of the support patients received refers only to face-to-face

contacts. Telephone contacts were not included. Moreover, the data tell us nothing about the content and/or quality of this input.

### Variations in service receipt between patients

In keeping with past studies of CMHTs for older and working-age adults (Brown *et al.*, 1996; Macdonald *et al.*, 2007; Hunter *et al.*, 2002), this analysis found that the duration of CMHT support varied considerably according to the types of people concerned. Thus, individuals with functional mental health problems or more complex needs tended to have longer care episodes than people with organic diagnoses or less complex needs. This relationship with care needs is not surprising and suggests a targeted response to acuity. The link with diagnosis, however, is worthy of further exploration, for organic illnesses are, by definition, generally chronic and progressive (Ballard and Bannister, 2010), and the proportion of people with dementia on CMHT caseloads may itself be declining (Tucker *et al.*, 2014).

One obvious explanation relates to age, as patients with organic disorders were generally older than those with functional disorders, increasing the probability of institutionalisation and mortality. Reflecting the discussion by Tucker *et al.*, 2014, another possibility is that further to assessment and the resolution of acute problems, people with dementia were more often referred onto other services, including social services. This is particularly likely where teams lacked social work staff, as it is considerably harder to access



social care resources in such circumstances (Challis *et al.*, forthcoming). Indeed, there were no social workers in either of the teams providing the lowest social care packages in this study.

In view of the level of re-referrals, however, it seems likely that at least some people were simply discharged between acute care episodes. In light of increasing numbers of CMHT referrals (Banerjee and Chan, 2008), this may be a necessity. Nevertheless, it cannot be desirable, as not only do older people and their carers value continuity of care, re-referrals also often present in a less well-managed state (Macdonald *et al.*, 2007). The finding that people with dementia also had less regular contact with CMHT staff (particularly consultants) is also potentially concerning, and more research is needed to ascertain the reasons for this.

#### Variations in service receipt between community mental health teams

If only modest variation was seen in the proportion of patients seen by other team members, individuals in some teams were considerably more likely to see a consultant or support worker than those in others, regardless of clinical profile. What might this suggest? Clearly, one possibility is that CMHTs are not configured to match patient needs but simply use whatever resource they have. Certainly, the teams in this study were configured differently, although workforce planning in the UK has sometimes been criticised (Evans *et al.*, 2012). Alternatively, it may be that the precise professional discipline of team members is less important than their particular skills and knowledge in determining their roles (Macdonald, 1991; Dening, 1992), although a third explanation might relate to a lack of consensus on professional boundaries. Whichever of these theories prevails, however, such variation is surely at least partly sustained by the lack of research in this area, with very little known about the different patient groups different professionals help most and where such specialist input should be focused (Philpot and Banerjee, 1997; Banerjee and Chan, 2008).

#### Implications for service managers and commissioners

Although multidisciplinary CMHTs are widely seen as the vehicle of choice for delivering community care to adults of all ages (WHO and WPA, 1997; Lingard and Milne, 2004; Molodynski and Burns, 2008), Evans *et al.* (2012) note that the rationale for team composition has

never been clearly articulated, nor the relative contribution of particular disciplines explained and documented. In seeking to determine optimal CMHT staffing, we would contend that planners first need to define who teams are serving and then to specify the input required. Only then can staffing reflect local needs and appropriate training be identified (Evans *et al.*, 2012).

The study also raises questions about the balance of input provided to people with organic and functional disorders and whether this is appropriate. It suggests the need for further research that seeks to identify how and by whom different people's needs are best met and a mental health workforce strategy that ensures the availability of the requisite number of appropriately skilled personnel. Although differing local needs might at least in part justify the identified variation in teams' composition and caseloads, it is surely harder to make a case for the differences in input provided to similar people in different localities.

## Conclusions

The enhancement of community-based care and the provision of mental health services that are comprehensive and accessible are long-standing and universal aims (Challis, 1996; WHO and WPA, 1997; Marshall, 1999). Service providers are thus challenged to deliver a service to the full range of people that might benefit from them (horizontal comprehensiveness) and to ensure that the necessary range of specialist services are available to those people with the most complex needs (vertical comprehensiveness; Thornicroft and Tansella, 1999). Writing about CMHTs for working-age adults almost two decades ago, Peck (1995) noted that many teams had interpreted 'comprehensive' to mean delivering a limited range of services to a broad range of people and did not always provide a comprehensive service to people with complex needs. Our data suggest that at least some CMHTs for older people similarly fail to meet this challenge today, for such teams' caseloads varied greatly, and although services were targeted at people with particular needs, similar people seen by different CMHTs received clearly different levels of input.

## Conflict of interest

None declared.

### Key points

- The delivery of multidisciplinary community support is widely advocated as the first tier of secondary mental health provision. However, little is known about the length, nature and frequency of such input.
- This study found marked differences in the duration of input provided by CMHTs for older people in England. Individuals with functional mental health problems or more complex needs tended to have longer care episodes than people with organic diagnoses or less complex needs.
- The proportion of patients seen by consultants varied greatly between teams. Risk of self-harm, delusions and paranoia increased the likelihood of seeing a consultant; risk of self-neglect increased the likelihood of seeing a support worker.
- Between-team differences in service receipt could not be wholly attributed to differences in caseloads.

### Ethics statement

Ethical approval for the two studies from which these data were drawn was granted by Cambridgeshire 3 Research Ethics Committee (reference numbers 10/H0306/43 and 10/H0306/51), and research governance procedures in each participating organisation were fulfilled.

### Acknowledgements

We are very grateful to the CMHT staff who participated in this research. This paper presents independent research funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research scheme (RP-PG-0606-1109). The views expressed in this publication are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

### References

- Allen P. 2006. New localism in the English National Health Service: what is it for? *Health Policy* 79(2): 244–252.
- Ballard B, Bannister C. 2010. Criteria for the diagnosis of dementia. In *Dementia*, Ames D, Burns A, O'Brien J (eds). Hodder Arnold: London.
- Banerjee S, Chan J. 2008. Organization of old age psychiatric services. *Psychiatry* 72(2): 49–54.
- Brown P, Challis D, Von Abendorff R. 1996. The work of a community mental health team for the elderly: referrals, caseloads, contact history and outcomes. *Int J Geriatr Psychiatry* 11(1): 29–39.
- Brown B, Crawford P, Darongkamas J. 2000. Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health Soc Care Community* 8(6): 425–435.
- Challis D. 1996. Community care. In *Epidemiology in Old Age*, Ebrahim S, Kalache A (eds). BMJ Publications: London.
- Challis D, Tucker S, Wilberforce M, et al. Forthcoming. National trends and local delivery in old age mental health services: towards an evidence base. A mixed methodology study of the balance of care approach, community mental health teams and specialist mental health outreach to care homes. *Programme Grants Appl Res*.
- Dale J, Milner G. 2009. New ways not working? Psychiatrists' attitudes. *Psychiatr Bull* 33(6): 204–207.
- Dening T. 1992. Community psychiatry of old age: a UK perspective. *Int J Geriatr Psychiatry* 7(10): 757–766.
- Department of Health. 2001. National Service Framework for Older People. Department of Health: London.
- Department of Health. 2005. New Ways of Working for Psychiatrists: Enhancing Effective, Person-centred Services through New Ways of Working in Multidisciplinary, Multiagency Contexts. Department of Health: London.
- Department of Health. 2010. Equity and Excellence: Liberating the NHS. The Stationary Office: London.
- Department of Health, Care Services Improvement Partnership. 2005. Everybody's Business. Integrated Mental Health Services for Older Adults. A Service Development Guide. Department of Health: London.
- Evans S, Huxley P, Baker C, et al. 2012. The social care component of multidisciplinary mental health teams: a review and national survey. *J Health Serv Res Policy* 17(Suppl 2): 23–29.
- Hunter MD, Jadresic D, The Audit Working Group. 2002. Two weeks in the life of a community mental health team: a survey of case-mix and clinical activity in the north-west of Sheffield. *Psychiatr Bull* 26(1): 9–11.
- Lingard J, Milne A. 2004. Integrating Older People's Mental Health Services: Community Mental Health Teams for Older People. A Commentary and Resource Document. Department of Health: London.
- Macdonald A. 1991. Running a team. In *Working Out: Setting Up and Running Community Psychogeriatric Teams*, Lindsay J (ed.). RDP: London.
- Macdonald A. 2005. Evaluation of service delivery. In *Psychogeriatric Service Delivery: An International Perspective*, Draper BM (ed.). Oxford University Press: Oxford.
- Macdonald A, Ball C, Burton S, et al. 2007. The birth of a speciality: the first ten thousand patients of an old age psychiatry service. *Int Psychogeriatr* 19(1): 53–63.
- Marshall M. 1999. What do service planners and policy-makers need from research? *Int J Geriatr Psychiatry* 14(2): 86–96.
- McCrae N, Banerjee S. 2011. The challenge of evaluating mental health services for older people. *Int J Geriatr Psychiatry* 26(6): 551–557.
- Molodynski A, Burns T. 2008. The organization of psychiatric services. *Medicine* 36(8): 388–390.
- National Institute for Health and Clinical Excellence. 2006. *Dementia: Supporting People with Dementia and Their Carers in Health and Social Care*. NICE: London.
- National Institute for Health and Clinical Excellence. 2011. *Depression in Adults Quality Standards*. NICE: London.
- Peck E. 1995. On the team. *HSJ*, 6 April: 28–29.
- Philpot M, Banerjee S. 1997. Mental health services for older people in London. In *London's Mental Health, The Report to the King's Fund London Commission*, Johnson S, Ramsay R, Thornicroft G, et al. (eds). King's Fund Publishing: London.
- Thornicroft G, Tansella M. 1999. Translating ethical principles into outcome measures for mental health service research. *Psychol Med* 29(4): 761–767.
- Tucker S, Wilberforce M, Brand C, et al. 2014. Community mental health teams for older people: variations in case mix and service receipt (I). *International Journal of Geriatric Psychiatry*. DOI: 10.1002/gps.4191
- Wilberforce M, Tucker S, Abendstern M, et al. 2013. Membership and management: structures of inter-professional working in community mental health teams for older people in England. *Int Psychogeriatr* 25(9): 1485–1492.
- World Health Organisation, World Psychiatric Association. 1997. *Organisation of Care in Psychiatry of the Elderly: A Technical Consensus Statement*. WHO and WPA: Geneva.