RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

CR218

Bridges not walls:

Good practice guidance for transition and cooperation between mental health services for older patients

COLLEGE REPORT

College Report CR218

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Approved by: The Policy and Public Affairs Committee

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Introduction

The College is committed to the principle that the needs of patients and carers should be the central driving force of service provision. As the needs of older adults change over time, it is important to have arrangements in place that facilitate cooperation between psychiatric specialties, and ensure a smooth transition for patients to a service that best meets their needs. These arrangements should be kept up to date.

Foreword

However excellent the individual services involved may be, if a patient is not being treated by the most suitable service or if their transfer from one service to another does not go smoothly, it can be detrimental for patients and their carers.

With this in mind, the College has updated the guidance previously contained in College Report CR153 – *Links Not Boundaries: Service Transitions for People Growing Older with Enduring or Relapsing Mental Illness* (Royal College of Psychiatrists, 2009). While the principles remain the same – with a focus on the needs of patients and their carers – this updated guidance provides more detail on issues such as reaching agreement about what needs to happen if patients return to their original service, and record-keeping.

Our thanks to all the contributors who worked so hard on updating the guidance in accord with emerging best practice. We welcome this revised guidance and commend it to our members, with the recommendation that those responsible for service development review their existing transfer protocols in light of this new document.

Dr Amanda Thompsell, Chair of the Faculty of Old Age Psychiatry
Dr Lenny Cornwall, Chair of the Faculty of General Adult Psychiatry
Dr Rajesh Mohan, Chair of the Faculty of Rehabilitation and Social Psychiatry
Professor Pamela Taylor, Chair of the Faculty of Forensic Psychiatry
Dr Ashok Roy, Chair of the Faculty of the Psychiatry of Intellectual Disability
Professor Eileen Joyce, Chair of the Faculty of Neuropsychiatry
Dr Jim Bolton, Chair of the Faculty of Liaison Psychiatry

Purpose of this document

This document updates CR153 (*Links not boundaries: service transitions for people growing older with enduring or relapsing mental illness*), which highlighted the interface transition between three specialist areas of psychiatry: General Psychiatry, Rehabilitation Psychiatry and Old Age Psychiatry.

Since its publication, we have identified the growing needs of patients in specific groups: offenders; older people with alcohol and substance misuse problems; people with neuropsychiatric disorders; and people with intellectual disabilities.

Background

The CR153 made references to the discriminatory aspects of two National Service Frameworks (Department of Health 1999 and 2001). The College has already made it clear that all services should be available to people on the basis of need (not age) and that comprehensive specialist mental health services for older people are essential to meet their needs in later life as appropriate.

There is no justifiable reason for transferring people who are already receiving mental health services to older people's services simply because of their age; this is only appropriate if their needs change and would therefore be better met by those services (Royal College of Psychiatrists, 2009a; 2009b).

It is important to recognise that certain needs arise more commonly as people age, especially those with mental health disorders. This isn't just because of the differences that arise with mental health problems in later life, but also because of an increase in comorbid physical health problems, within the psychosocial context in which the problems developed (Royal College of Psychiatrists, 2011).

Controlled trials and audits indicate that old-age psychiatry services have positive outcomes for acute treatment, particularly with depression (Draper, 2006). A study by Abdul-Hamid *et al*. (2015) showed that the number of unmet needs was twice as high in older patients managed by general adult services than that of older people in the care of old age services.

Revision of CR153

As part of the review of CR153, a survey was conducted in January 2016 to address the use of protocols or local arrangements for transitioning patients between mental health services. It was distributed to faculty psychiatrists, of whom 411 responded.

- The standard triggers they listed included an age cut-off of 65, physical frailty, multiple physical comorbidities, the complexity of care, degree of cognitive impairment, and other age-related needs.
- 54% knew of about the local transition protocol within their Trust.
- 85% said their protocols were needs-based.
- 50% agreed there was a clear focus on the needs of patients and carers.
- 3% said they were aware of monitoring arrangements for the use of the protocol.
- 50% reported issues with resources in transition arrangements.
- Around 66% identified issues about transition arrangements (such as vague criteria that cause frequent disputes and delays in transferring care and result in frustration between teams).
- 20% were aware of relapses in mental health during the transition process (e.g. patients who, after being consulted with and informed about the arrangements, were stressed by delays and uncertainty, especially if they were ambivalent about the transfer in the first place).

A general theme drawn from their responses related to expanding caseloads, absence of day-hospital places and fewer beds, and low numbers of social workers. They also commented on: under-staffing and excessive workloads leading to the absence of proper transition arrangements and Care Programme Approach (CPA) meetings; inadequate transition arrangements leading to delays in care; and the major challenges caused by limited resources. Only a few reported the regular monitoring of protocols.

Service providers and commissioners will have key roles in carrying out the recommendations outlined in the sections on monitoring and commissioning (sections 22–26).

The feedback from the survey was presented to the Executive Committee of the Faculty of Old Age Psychiatry, and the Executive Committee of the Royal College of Psychiatrists Trent Division was

co-opted to provide further input. Revision of the report was carried out by a working group with representation from the following faculties:

- Old Age Psychiatry
- General Adult Psychiatry
- Rehabilitation and Social Psychiatry
- Forensic Psychiatry
- Psychiatry of Intellectual Disability
- Neuropsychiatry.

The patient representative from the Faculty of Old Age Psychiatry also contributed to the review, and additional feedback on the review paper came from a patient and their carer with first-hand experience of transition with respect to in-patient services and older-adult community mental health services.

This Report builds on the recommendations made in CR153, with other changes and additions as considered necessary. The recommendations fall into six key categories:

- availability and use of protocols
- assessment
- transition
- monitoring
- commissioning
- training.

College recommendations

Availability and use of protocols

1 The transition between services is an important aspect of the delivery of mental health services. The services with the greatest expertise in relation to the care needs of individual patients should be involved in providing the mental health care for them.

2 The protocol should offer a clear framework with a focus on the needs of the patients and their carers. While the needs of some patients are best met through consultation and liaison between specialities, others are best served by transferring them from one service to another.

3 All mental health organisations should have a formal transition protocol to govern the process of transition between General Adult Psychiatry, Rehabilitation and Social Psychiatry, Forensic Psychiatry, Psychiatry of Intellectual Disability, Neuropsychiatry, and Old Age Psychiatry services. Transitions must be determined by the needs of the patients (rather than their age).

4 Most transition policies rightly advocate that services should be allocated to patients based on their needs (rather than their age). However, a study by Abdul-Hamid *et al*. (2015) identified a risk of denying the optimum service to some patients in whom age-related needs are missed. To minimise such risk, trusts and health boards should ensure that comprehensive reviews are carried in patients within a locally agreed age range, to establish any changes in their needs that warrant specialist Old Age Psychiatry services.

5 Protocols should be reviewed periodically by representatives from General Adult, Rehabilitation and Social, Forensic Psychiatry, Psychiatry of Intellectual Disability, Neuropsychiatry, and Old Age Psychiatry services. It is important to have representation from patient and carer groups, social workers and mental health leads in primary care.

6 The referring service should continue to be involved until a decision is made by the new service to accept a patient (or otherwise).

7 Protocols should clarify how disagreements will be resolved.

8 Protocols should make allowances for joint working between the referring and receiving services. For example, when cognitive problems change in patients with intellectual disabilities, their challenging clinical presentation may require continuing expert input from both Intellectual Disability and Old Age services. The

same principle applies to other service interfaces – both before and after transfer.

Assessment

9 The transition process should involve a comprehensive assessment of each patient's needs, including those related to their mental and physical health, their social and family circumstances, and their spiritual needs. The assessment should also review the current level of health and social care provision. Any outstanding issues should be highlighted (e.g. treatment adherence and ongoing safeguarding issues).

10 The needs assessments should be sensitive to patients' sexuality, spirituality, and cultural and ethnic background. Older people from black and minority ethnic communities may have particular difficulties in finding and accessing appropriate services.

11 Assessments should reflect why the current services consider that transition as necessary. For example, assessments should identify the risks involved – if transition does not occur – for patients with significant physical health issues that have a lasting impact on their ability to ensure their own safety.

12 Transition to Old Age Psychiatry services from General Adult, Rehabilitation and Social Psychiatry, Forensic Psychiatry, Neuropsychiatry, and Intellectual Disability services may be triggered for patients when changes in their cognitive functioning means that their current provision is inadequate and the care they need will be better provided by Old Age Psychiatry services.

Transition

13 The transition process should incorporate each patient's views, and their informed consent. If they lack capacity, the transfer of care should always be in their best interests, based on consultations with their carers and/or independent advocacy services in a best-interest meeting.

14 At the time of transition, both the current and the new services should provide all relevant information to the patient and their carers to help them make an informed choice. This information should explain why provision of their care is deemed more appropriate within the new service. It should also point out the risk of losing some of elements of their care in the service they are leaving (e.g. provided by health, social care and voluntary sectors) and describe which alternative or similar services they will receive after the transition.

15 A joint case review/care programme approach meeting should be held, whereby the mental health teams from both services discuss and agree future care plans with both patients and their carers. Areas of disagreement should be identified and addressed, as should available resources and treatment options.

16 There should be a local agreement for patients who were discharged by Mental Health Services, and referred back to Mental Health Services within six months, while transfer to Old Age Psychiatry services is being considered. The referral is normally to the service they were under before, especially if the reason for making the referral relates to a pre-existing problem. The clinical decision as to which service is more appropriate should, as always, be driven by the patient's needs.

17 It is best practice to consider to carry out a transfer when the patient's mental health is stable. In some circumstances, transition takes place following an acute episode (if their needs warrant this).

18 The protocol should be available to everyone involved in the transition, and the relevant clinical teams should ensure it is adhered to.

19 Clinical staff from both the current and new services should offer support to patients and their carers before, during and after the transition. They should also address any of their questions and concerns.

20 A written care plan should be shared with all relevant professionals. Copies should be available to patients and (with their informed consent) to their carers.

21 The care plan should identify all the patient's needs and specify which service can best meet them and explain how the referring service (or other) will cooperate with old-age services to maximise the effectiveness of the plan (especially if not all of the relevant resources are available in the new service). Any current needs and resource issues should be noted and solutions sought.

Monitoring

22 Senior management teams in all the services involved in transition should know how the protocol works in practice. Monitoring procedures help to identify problems in the transition process so they can be avoided in future transitions of similar patients; they also highlight positive aspects and areas of good practice, so they can be promoted.

23 An annual review of the number of successfully transitioned patients should be made available to those responsible for local workforce planning, and to governance groups to ensure safe commissioning.

24 As part of the annual review and workforce planning, data should be collected on:

- The annual numbers of over-65s using General Adult, Rehabilitation and Social Psychiatry, Forensic Psychiatry, Neuropsychiatry, and Psychiatry of Intellectual Disability services, with analysis of trends about increasing or decreasing demands on services.

- The number of patients referred to Older Adult services within six months of discharge from General Adult, Rehabilitation and Social Psychiatry, Forensic Psychiatry, Neuropsychiatry, and Psychiatry of Intellectual Disability services.

Commissioning

25 Robust mechanisms should be in place across services to identify issues with resources related to needs-led transitions between different clinical areas.

26 Local commissioners should be made aware of any implications about resources.

Training

27 Trusts and commissioning bodies should recognise the training needs of all health and social care professionals involved in managing patients with long-term mental illnesses and cognitive disorders in light of the rising population of older people.

28 Training with a focus on the assessment and management of long-term mental health conditions should be available for all staff working in Old Age services. Training with a focus on early recognition of changing needs and emerging cognitive problems should be available for all staff working in General Adult, Rehabilitation and Social Psychiatry, Forensic Psychiatry, Neuropsychiatry, and Psychiatry of Intellectual Disability services.

Members of the working group

Faculty of Old Age Psychiatry
Dr Velusamy Sivakumar (lead author)
Dr Rory O'Shea
Dr Stephen Orleans-Foli
Dr David Burke
Dr Edward Dimelow
Dr Swarupa Shinde

Faculty of General Adult Psychiatry
Dr Yennunanda Vishnugopal
Dr Andrew Moore

Faculty of Rehabilitation and Social Psychiatry
Dr Arpan Dutta
Dr Rajesh Mohan

Faculty of Psychiatry of Intellectual Disability
Dr Ezhil Anand

Faculty of Neuropsychiatry
Dr Suresh Komati

Faculty of Forensic Psychiatry
Professor Pamela Taylor

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