



THE 8 PILLAR MODEL OF COMMUNITY SUPPORT

A report in association with Alzheimer Scotland

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SUMMARY

Scotland's Government, NHS Boards, Local Authorities and third sector bodies are uniting to drive forward improvements to standards of care and support provided within our communities for all who are faced with the challenges that dementia brings. With the launch of Scotland's 2nd National Dementia Strategy 2013-2016 (Scottish Government, 2013) comes the 8 Pillar Model of Community Support (Alzheimer Scotland, 2012). But are the 8 pillars strong enough to support the predicted heavy load? Each pillar provides part of the support required but all 8 pillars together provide a solid structure that would appear capable of achieving its aims.

Delivering integrated dementia care is a key focus for Scotland (Scottish Government, 2013). Alzheimer Scotland (2012) has presented The 8 Pillar Model of Community Support, to support integrated health and social care. The aim of this model is to enable health and social care to work together closely in providing a continuous service of seamless care, for both the individual with a diagnosis of dementia and their family/carers within the community, during the moderate to severe stages of their illness.

The following discussion will explore the relevance of this model within dementia care in Scotland, highlighting some of the facilitators and barriers within each pillar. With the use of a case study it will show how two of the 8 pillars have been implemented within practice and the result they had on the care intervention for the individual with dementia and their family/carer.

The conclusion will argue that by employing the 8 Pillar Model of Community Support, Scotland will facilitate the integration of health and social care required to meet the needs of the individuals with dementia and their family/carers.

INTRODUCTION

The 8 Pillar Model of Community Support has been developed to assist in the restructuring of dementia care for the individual with dementia living at home in the moderate to severe stages of their illness (Alzheimer Scotland, 2012). Its key focus is to provide holistic support that is integrated and comprehensive, with an evidence-based approach, delivered by health, social care and the third sector services to support the individual, their family and carers (Alzheimer Scotland, 2012).

Early intervention, support and management of dementia has been a focus within policy and research for a long time (Department of Health, 2001; Pitkeathley, 1999) but funding has focused on crisis and acute care with little focus on early intervention for preventative measures to sustain wellbeing within dementia (House of Commons All-Party Parliamentary Group on Dementia, 2011; Page et al, 2006). There has also been an increased focus at the other end of the scale, on early diagnosis and post diagnostic support for dementia (Department of Health, 2009, Scottish Government, 2010)

The 8 Pillar Model of Community Support is designed to fill the gap between the post diagnostic stage and acute/crisis stage services, see Figure 1. This gap has been increasing in size since the closure of institutional/ asylum care, reduction of hospital beds, and the increasing numbers in dementia diagnosis, all of which are being absorbed within the community, according to the *Griffiths Report* (Department of Health, 1988). Griffiths said of community care that it was ‘Everyone’s distant relative but nobody’s baby.’ This appears to have remained the case for some time with evidence suggesting that individuals with dementia, their families and carers, are still disadvantaged by a lack of appropriate services and coordinated care within the community (Page et al, 2006, House of Commons, 2011; Innes et al, 2012). The Dementia Strategy for Scotland (Scottish Government, 2010), Promoting Excellence Framework (Scottish Government, 2011) and the Standards of Care for Dementia in Scotland (Scottish Government, 2011) have already provided solid foundations and knowledgeable professionals to facilitate the implementation of The 8 Pillar Model.

The 8 Pillar Model of Community Support will be a key priority within the next Dementia Strategy for Scotland due to be published June 2013 (Alzheimer Scotland, 2012). The implementation of the 8 Pillar Model into practice is relying on local authorities, and NHS boards, to take it forward in the agenda for change and Integration of Adult Health and Social Care in Scotland (Department of Health, 2004, Scottish Government,

2012). However, there are many barriers to be overcome in the process of developing an Integrated Health and Social Care Service in Scotland such as (Stewart et al, 2003, Weatherly et al, 2010, Williams and Sullivan, 2010, Watt et al, 2010):

- lack of understanding of other professional's role,
- separate IT systems that do not 'speak' to each other,
- separate budgets, management structures and leadership,
- wage structure and pensions,
- organisational cultures, training, status, identity and professional boundaries are just the tip of the iceberg

The evidence in terms of its success for the patient's wellbeing is weak, although the evidence for reduction in hospital admissions and the increase of community services are positive (Cook et al, 2007, Stewart et al, 2003, Weatherly et al, 2010). Work is on-going in these areas, the introduction of a Bill to the Scottish Parliament is forecast to be before the summer of 2013 and plans for implementation of an integrated service by 2016 (Scottish Government, 2013).

Recommendations from Alzheimer Scotland state that the Scottish Government should ensure the implementation of the 8 Pillar Model by making it a key target within the Integration of Adult Health and Social Care in Scotland (Alzheimer Scotland, 2012). One of the drivers for quality improvement, within integrated health and social care for people with dementia, are quality standards set out by NICE guidelines which have recently been piloted and are due to be published April 2013 (NICE, 2012). Petch (2007) suggests that collaborative working requires collaborative care pathways and guidelines for Integration of Health and Social Services to be successful; this will provide clarity in the form of the service provision, shared goals and outcomes.



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Figure 1. 8 Pillar Model of Community Support

Dementia Practice Coordinator

A key strength of this model is The Dementia Practice Coordinator. These coordinators will be the main facilitators for delivering the 8 Pillar Model, in the community, and will coordinate the care, treatment and support delivered by the multi-disciplinary services including all pillars of the model (Alzheimer Scotland, 2012). Having a single point of contact that deals with a complete care package was something that people with dementia, their families and carers said they wanted rather than being shunted from pillar to post, receiving parts of information, but never the full story, or, sometimes, conflicting advice (Alzheimer’s Society, 2010, Mental Welfare Commission & Care Commission, 2009). A single assigned coordinator allows for a therapeutic relationship (Reynolds, 2009) between the coordinator and the individual with dementia, their family/carers, and provides a more holistic approach to their care, throughout their journey from diagnosis

to end of life. This can influence the support and adaptations to their care package when required. The coordinator will be able to assess change and deterioration promptly, and provide timely and suitable intervention; as they will have a good sound knowledge of the individual, their abilities and needs. However, this could also lead to dependency upon the coordinator and therefore boundaries must be established at the onset of the working relationship (Reynolds, 2009). The Dementia Practice Coordinator will have to overcome inter-professional barriers to Integrated Health and Social Services, which occur when different professional bodies integrate (Coxon et al, 2005; Maslin-Prothero and Bennion, 2010). However, evidence suggests that inter-profession educational training, such as the Promoting Excellence Framework (Scottish Government, 2011), reduces variation in knowledge and promotes effective collaborative working (Howarth et al, 2006).

Support for Carers

The support for carers pillar is extremely significant as the hours of care provided by informal carers across Scotland accounts for 55% of all care provided in the community, which amounts to an estimated saving of £12.4 billion per year (Alzheimer Scotland, 2010). The cost to those who provide this care can be significant as research suggests that adopting this role results in increased stress, psychological morbidity, diminished social life, reduced or loss of employment, financial difficulties, exhaustion and ill-health (The Princess Royal Trust for Carers, 2011; Moise, Schwarzingler and Um, 2004; Page et al, 2007).

Furthermore, appropriate support for carers has been found to have a positive impact on the wellbeing of the person with dementia and can delay the need for residential/acute care (Alzheimer's Society, 2007, Page et al, 2007). The quality of care provided by family members can be enhanced by providing dementia education, learning new skills and coping strategies, empowering the carer to work as a partner in the care provision to be able to deliver a better quality of care enhancing quality of life for both the person with dementia and the carer (Scottish Government, 2011).

There is a range of support available for carers, including the Carers Trust, Alzheimer Scotland, Carers net, Peer Support Groups, Respite Care and many others, but if sign posting is poor or offered, too early or, too late it can have a negative impact (Page et al, 2007). Offering support too early can be seen as an insult to the carer's ability to cope, which can jeopardise the therapeutic relationship, referring too late becomes damage limitation rather than supportive preventative measures.

Personalised Support

The Personalised Support Pillar is unique for each individual with dementia, and their family/carer, but also essential to provide this support to promote independence and a feeling of belonging and worthiness (Alzheimer Scotland, 2012). It requires insight of the individual, such as their likes and dislikes, in order to provide support which is both personalised and meaningful. Too often people are inappropriately placed within services or services are provided which do not meet their needs but are often used, as these are deemed to be the only services available (Alzheimer's Society, 2012). Although tailored dementia day care facilities are a valuable service they are not always the most appropriate choice (Page et al, 2006).

For example, tailored personalised care can be as simple as supporting the individual with activities of daily life such as; getting washed and dressed, a walk in the park with their pet dog, polishing the brass, using other community supports can often be more beneficial, cheaper and purposeful (Alzheimer Scotland, 2012). In the current financial climate in Scotland, dementia services are stretched, waiting lists are immense and charity funded services, that were valuable resources, have been lost due to lack of funding (Alzheimer's Society, 2012). Hence, being resourceful with what is available within the local community and not restricting the individual with dementia and their family/carer to dementia-specialist services is creating a far more personalised and flexible service and inclusion within their community.

Community Connections

The Community Connections Pillar is closely linked with the Personalised Support Pillar, but should not be confused with it. Personalised support will often incorporate community connections, but for some, isolation is not a choice but a consequence of their illness (Mental Welfare Commission & Care Commission, 2009) and although in receipt of personalised support they have lost contact with community life.

For the individual with dementia, this may be due to low self-esteem, lack of confidence, declining physical ability, stigma and/or withdrawal of friends (Batsch and Mittelman, 2012; Page et al, 2006; Alzheimer Scotland, 2012; SIGN, 2006). For the family/carers, research has shown that lack of knowledge and support for carers' impacts on their health and wellbeing, additionally impacting on their own social connections and therefore becoming victims of isolation as a consequence (Alzheimer Scotland, 2013; Bruce and Paterson, 2000; Page et al, 2006; The Princess Royal Trust for

Carers, 2011). Batsch and Mittelman (2012, p 10) state that “the resulting isolation and lack of stimulation causes disability beyond that caused by the illness itself,” concluding that community connections are essential in providing a good quality of life.

Environment

Another key priority is the Environment Pillar. The environment may require adaptations or assistive technology to enable the individual with dementia to remain in the community and in their own home for as long as possible and assist the family/carers in providing support (Alzheimer Scotland, 2012). Forth Valley have access to good resources. The Iris Murdoch Dementia Centre provides training and tours of their Design and Technology suite to show how different techniques and adaptations to the environment can improve the quality of life for people with dementia and their family/carers, such as improving their; ability to function, orientation, independence, mobility, wellbeing and has a therapeutic effect (DSDC, 2011; NHS Forth Valley, 2011; Chaplin, 2011), although the suite is aimed more towards care homes, adaptations can be made in other environments.

The Forth Valley Sensory Centre assists with technology for any sensory impairment, aiding communication and stimulation to improve quality of life (Dubuc and Blackwell, 2005; SIGN, 2006; Chaplin, 2011). There is little evidence or research to suggest that environmental issues within the community are being met and this is an area that needs more research. My own practical experience as a Community Mental Health Nurse suggests that this is an area where existing services are meeting needs.

Therapeutic Interventions to Tackle Symptoms of the Illness

Therapeutic Interventions to Tackle Symptoms of the Illness is a relevant Pillar within this model, although policy and guidelines recommend therapeutic interventions as treatment for dementia (NICE, 2006; SIGN, 2006; NES, 2008; NHS forth valley, 2011; Scottish Government, 2011) there is little evidence to show this is being achieved (Alzheimer Scotland, 2012). Research suggests that therapeutic intervention improves quality of life such as; better communication, improved self-esteem, a sense of identity, productivity, improvement of functional impairments and decreases anxiety, behavioural issues, depression and sleep disturbance (NHS Forth Valley, 2011).

Therapeutic Interventions can be delivered by a range of professionals, some require more specialized training than others and due to this, the availability of trained staff is poor (Scottish Government, 2008). There are many types of therapeutic interventions such as; music therapy, art therapy, dance therapy, singing therapy, Reminiscence, Validation Therapy, Cognitive Stimulation Therapy, Cognitive Rehabilitation/Cognitive Training, Recreational Activities, Reality Orientation Therapy, Physical Activities and Purposeful Activities all of which could improve quality of life for the person with dementia and their family/carers if the delivery of them is improved with the introduction of the 8 Pillar Model of Community Support (Alzheimer Scotland, 2012).

Mental Health Care and Treatment is provided by Psychiatrists and the Community Mental Health Team. Their roll is imperative to support the individual with dementia and family/carers (Alzheimer Scotland, 2012), the community mental health nurse plays an active role from diagnosis to end of life care, providing knowledge, education, skills and support to enhance quality of life (Page, 2006; SIGN, 2006, Department of Health, 2009/2011; Scottish Government, 2009). The Mental Health Care and Treatment Pillar will be looked at in greater depth in the following case study.

The general health and wellbeing of the individual with dementia and their family/carers is a priority, illness can exacerbate symptoms of dementia, cause carer distress and if unaddressed result in crisis/acute care (Alzheimer Scotland, 2012; SIGN, 2006; NICE, 2010; NHS, 2011). The General Health Care and Treatment Pillar will be considered in greater depth in the following case study.

Case study

For confidentiality reasons and consistent with the Nursing and Midwifery Code of Conduct (NMC, 2008), the individual is referred to as Mrs M throughout the text.

Mrs M is an 84 year old lady, who has been living on her own for the past 12 years following the death of her husband. Her daughter lives locally and visits daily. Mrs M was diagnosed with Alzheimer type dementia 2 years ago. Following post diagnostic support for her and her family Mrs M was prescribed a cognitive enhancer, Aricept 10mg once daily. She was able to cope independently with everyday life and felt she had no need for any service intervention or support at that time.

The Community Mental Health Nurse provided Mrs M with the relevant contact numbers should she feel that her situation changed or if she needed any more information and then referred Mrs M to the Dementia Link Service for follow up. She has been visited by the Dementia Link Nurse every 6 months to monitor the effects of her medication and cognitive testing to measure any decline.

Recently, Mrs M had a urinary infection and delirium; this has caused Mrs M to be confused, agitated and disorientated, experiencing auditory and visual hallucinations; she is extremely distressed, not sleeping and her diet and fluid intake is poor. Mrs M's daughter called the dementia link nurse to ask for advice and her case has been referred back to the Community Mental Health Nurse (CMHN) for further assessment.

Due to Mrs M's current situation and her complex needs, the Mental Health Care and Treatment pillar and the General Health Care and Treatment pillar are essential to support her and her family at this time. Mrs M was treated by her GP with one week's course of antibiotics at home, as both Mrs M and her daughter were reluctant for her to be admitted to hospital. The daughter moved in with her mother in order to provide 24 hour care, however her symptoms were persistent.

Assessment was carried out by the CMHN and in consultation with the Consultant Psychiatrist the decision was made to contact Mrs M's GP, due to the fact that in this instance a multi-disciplinary approach was required. Further urine and blood tests were carried out by the GP and an additional week's course of antibiotics was commenced. Observations of symptoms were monitored by the CMHN and communications between both services were maintained.

Mrs M's sleep pattern remained unsettled, sleeping for only short periods of time and this was causing her daughter to become distressed due to her own lack of sleep. Further medication was commenced by the GP to alleviate symptoms, Mrs M's physical health improved but her mental health did not. The CMHN referred Mrs M to the Day Therapy Unit; this is a day facility which is part of the CMHT, to monitor Mrs M over a longer period of time. However, Mrs M attended once and refused to return.

The CMHN continued to support both Mrs M and her daughter with home visits and telephone contact, providing illness education, coping strategies and distraction techniques to improve communication, functioning and wellbeing. Working closely, the two services provided Mrs M with medical treatments and interventions to improve her physical and mental health. Information and support for her daughter was also provided by the two services.

Mental Health Care and Treatment

The Mental Health Care and Treatment pillar is essential to the 8 Pillar Model. An individual with a diagnosis of dementia requires continuous review of care and treatment due to the fact that dementia is a progressive illness (WHO, 1993). Dementia impairs cognitive functioning, deterioration is inevitable subsequently this will affect a person's emotional control and their behaviour (NHS Forth Valley, 2011), and therefore intervention from the CMHT is on-going through the person's journey with dementia.

In the case study, the mental health care was continuous as cognitive enhancing medication had been prescribed and was being monitored. Due to the continuous involvement of the CMHT it was quick and easy to facilitate a CMHN to reassess Mrs M's needs. If Mrs M had not been on this medication she would have been discharged from the CMHT as no further input was required at that time. A referral from the GP would have been necessary to re-engage Mrs M with the service, due to the increase demands on the service (Alzheimer Scotland, 2013) waiting lists can delay prompt allocation.

This then can be seen as weakness within the service and a barrier to continuous care. It would have been appropriate for Mrs M to have been admitted to hospital with a delirium caused by infection, which is best treated with intravenous antibiotics and monitored closely (NICE, 2010).

However, it was clear that Mrs M and her daughter did not want this and wished to remain at home. With support and expertise from both the mental and general health care services appropriate care and treatment were delivered within the home in their familiar surroundings. This respected their decision, provided dignified care, also ensuring that their rights were upheld (MWC, 2011).

General Health Care and Treatment

The General Health Care and Treatment pillar is critical to this model. The GP is the primary care giver within the community and the first point of contact when illness or health problems occur (Alzheimer Scotland, 2012). In the case study communication was a strong facilitator to the care and treatment provided however, research suggests that the lack of communication among multi-disciplinary professions is poor and acts as a barrier to consistent continuous care (RCN, 2007; Scottish Executive, 2005).

The GP was the first point of contact in this case study and provided prompt medication and further investigation into type of infection and cause of the delirium, however it was Mrs M's daughter that sought further

advice from the CMHT and not the GP. Mrs M's GP has known her in a professional capacity since before her diagnosis and has provided regular check-ups in regards to her general health (NHS Forth Valley, 2006), so it was easy to establish a diagnosis of delirium and not regard her current state as a possible decline in her dementia.

This has had a positive dignified quality care outcome for Mrs M and her family in regards of preventing acute admission and avoiding crisis. Having their care needs met in an environment that was familiar and comfortable for them provided dignified and person centred care (Scottish Government, 2011).

CONCLUSION

The 8 Pillar Model of Community Support sets out solid foundations for integrated health and social care, with a holistic and person centred approach that meets the needs of the individual with dementia and their family/carers. Each pillar is designed to incorporate the support required to cope with the difficulties and challenges that the individual and their family/carers are faced with within dementia.

Scotland has made good progress in tackling the huge task of dementia awareness and education, and yet there is still a long way to go to provide a service that will be considered as a “transformational change to deliver world-class dementia care and treatment” (Scottish Government, 2010). However, the 8 Pillar Model will provide another stepping stone towards this goal.

There are many barriers to overcome before integration of health and social care can be implemented, but multidisciplinary working is evidenced to have better outcomes for quality of life for the individual with dementia and their family/carers. Employing the 8 Pillar Model will assist in facilitating integrate care, achieving this through close partnership working and joining resources. Fewer institutional resources means greater reliance on community facilities, so improving joint effective working within the community is required and this model provides the opportunity to redesign an affective, comprehensive and evidenced-based framework.

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ABOUT

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Figure 1 © Alzheimer Scotland 2012

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