Locality Services in Mental Health

Developing Home Treatment & Assertive Outreach

THE NORTHERN BIRMINGHAM EXPERIENCE

Booklet 2

The Sainsbury Centre for Mental Health

Northern Birmingham Mental Health NHS Trust

This is a time of enormous change and great opportunity for mental health care. The message has at last hit home that we need to develop mental health services that offer comprehensive and well integrated care, 24 hours a day, 7 days a week, balancing high quality care for service users with the wider needs of society. The Government's mental health policy emphasises the importance of access, engagement and treatment adherence for people with severe mental health problems. Essential services to achieve these aims are crisis and assertive outreach teams, backed up by a range of support services including 24-hour places of care.

This approach makes intuitive sense and is evidence based. Research has shown that users, carers and staff prefer this style of working, and that safety is not compromised. Nevertheless, only very few services in the UK have introduced this style of care. This means that dissemination of good practice is a priority.

An influential example of good practice is Northern Birmingham, where well-integrated community services have been run now for some 5 years, following the closure of the local asylum. Many lessons have been learnt, both positive and negative. All these have great relevance for others, whether they address how to configure services or how to achieve a competent workforce.

The importance of this publication is that it gives an honest account of how services were set up, run and sustained, as told by the people who did it. This should help managers and clinicians elsewhere to replicate the successes, but avoid the pitfalls.

I very much hope that it will achieve its aim: supporting people anywhere to improve care in a practical and accessible manner. Good luck!

Matt Muijen
Director, The Sainsbury Centre for Mental Health

The Sainsbury Mental Health Initiative

In 1994, the Sainsbury Centre invited mental health services across the UK to bid for a share of £3 million, to establish innovative new services for people with severe and long-term mental health problems. The eight sites, selected from over 300 applications, were awarded a three-year grant as pump priming to get their services up and running. Each of the projects has undergone an evaluation by the Sainsbury Centre.

The range of services developed include assertive outreach, home treatment and intensive community support teams, joint health and social service initiatives, a carers' support team, an advocacy project and a rural out of hours intensive support service.

Many vital service development and evaluation lessons have been learnt from each of the sites. These will be published in a series of journal articles, resource manuals and reports. This is the first in a series of service development manuals providing practical guidance on setting up these services.

The Initiative was funded by the Gatsby Charitable Foundation, the Sainsbury Centre for Mental Health, the Department of Health in England and Wales and overseen by a Steering Group of national experts and leaders in the mental health field.

Acknowledgements

Northern Birmingham Mental Health NHS Trust would like to acknowledge the contributions of all those staff within the Trust who participated in the development of its services. In particular, it would like to make the following special note.

'Without the dedication, determination and co-operation of all the staff within theservices in the Yardley and Hodge Hill Locality, the re-modelling and maintenance of the service could not have happened.

The pioneering work of Dr John Hoult – his passion and energy to make the changes happen was crucial.'

Edited by Helen Wood & Sarah Carr
The Sainsbury Centre for Mental Health

Designing the Locality System

Mary Bath

THIS BOOKLET IS Nº **2**
OF A SERIES OF **5**

2

Service Configuration and Strategic Plan

Northern Birmingham Mental Health Trust profile

(All figures from the **West Birmingham Psychiatric Epidemiology Research Project 1993/94**, unless stated otherwise.)

The Northern Birmingham Mental Health Trust (NBMHT) catchment area has a population of 563,000 people, living in both highly deprived inner-city areas and the more affluent outer-city suburbs. The racial mix is as follows:

- 423,000 White (75.2%)
- 91,000 Asian (16.2%)
- 41,000 African-Caribbean (7.2%)
- 8,000 Other (1.4%).

However, in areas of the Trust ethnic minority populations comprise over 40% of the total local population.

In 1994 NBMHT were managing the following mental health services:

- 2 Victorian institutions (All Saints & Highcroft)
- 2 local adult in-patient units
- 500 beds
- 11 adult mental health team bases
- 1200 staff in total.

In the same year, a mental health service locality profile was carried out in West Birmingham. 3,175 people out of a total population of 176,000 were in contact with the mental health services and had the following diagnoses:

- 38% seriously mentally ill (1,190)
- 33% neurosis and depression (1,050)
- 15% did not have a psychiatric diagnosis (485)
- 14% drug or alcohol dependence (450).

Of the 1,050 people diagnosed as having neurosis or depression, 600 had mild to moderate problems, and 60% of the whole group were discharged or not in contact with the mental health service after one week.

For comparison, the chart below illustrates the prevalence of mental health problems in England, showing that only those with the most serious problems need specialised care or admission to hospital.

Annual incidence per 1,000 population in England

In-patients	5·71
Mental health service users	23.5
Problems identified by GP	101.5
GP attenders	230
Problems in the community	260–315

Source: Goldberg & Huxley, 1992

Again, in 1994, acute psychiatric admissions to All Saints Hospital were monitored and it was discovered that two-thirds of those admitted came in more than once:

Number of admissions	*Number of clients admitted*
1	220
2	191
3 or more	229
	Total 640

In addition, 53% of patients admitted during 1994 were Mental Health Act detainees, compared with a national average of 11%. At All Saints Hospital 43% of patients were detained under the Mental Health Act (1993), of which 80% were African-Caribbean.

The community mental health teams in the locality had the following difficulties:

- overloading, with a 250% increase in 3 years from 1992 to 1994
- poor client focus
- commitments too numerous and diverse
- administrative fatigue
- little supervision or training.

Restructuring the NBMHT provision

The Northern Birmingham Mental Health Trust was formed in April 1994 as the result of a merger between three mental health units that were formally part of three separate district health authorities. The services, as previously stated, included two Victorian institutions. Community services were provided by community mental health teams, with one area having a home treatment service, and another, a continuing care team.

The district health authority, in collaboration with the King's College Centre for Mental Health and the Northern Birmingham Mental Health Trust, held an extensive series of stakeholder conferences throughout 1994. These stakeholder conferences involved some 500 people, including GPs, service users, voluntary organisations, the private sector and Trust staff. The main concerns were as follows:

- virtually everyone said that they could not get help when they needed it
- the main reason people disengaged with the mental health services was the style of service being offered
- GPs wanted more knowledge about effective interventions, better communication and help in the surgery
- carers wanted improved and increased assertive follow-up, particularly those with severely mentally ill relatives
- service users complained about a lack of things to do, poor housing and a lack of money. Many people on the in-patient ward reported that they found it boring, or, more disturbingly, traumatising.

The key outcomes of this process were identified, and the resulting purchasing strategy for adult mental health services included:

- user participation culture
- support for carers
- sensitivity towards the needs of individuals, including cultural, religious and communication needs arising from ethnic origin
- 24 hour access to services and crisis resolution as the highest priority for service development
- availability of consistent up to date information about services
- proactive crisis service offering preventative support
- address service issues relating to women, particularly Muslim women
- develop relationships with other emergency services such as the police and A&E departments.

(from: Birmingham City Council and Social Services Department/North Birmingham Health Authority (1995) *Mental Health Purchasing Strategy 1995–1997: A Consultation Document*)

A mental health service to meet some of the recognised needs needed to include these elements:

- crisis response
- continuing care
- assertive outreach
- psychological therapies.

A development for the whole of Birmingham for homeless people funded by the health authority and supported by the local authority was implemented at this time. It remains as an important core service, reducing inappropriate hospital admissions and improving the continuity of care for this group.

Funding provided by The Sainsbury Centre for Mental Health pump-primed a 24 hour pilot service, which was initially called the 'psychiatric emergency team' (PET) and later renamed the '**home treatment team**'. The service was piloted in the Yardley/Hodge Hill locality in the NBMHT. A key driving force was Dr John Hoult who brought his valuable experience of operating a similar model in Sydney, Australia (Hoult, 1986).

Service plans for Yardley/Hodge Hill had included an additional in-patient unit to replace one of the existing 23-bed wards in one of the institutions. It was agreed that this development should be delayed pending the introduction and evaluation of the emergency home treatment team.

Given the experience in Sydney, it was felt that the adult in-patient requirement for the locality population of 150,000 could be feasibly met by the already existing 20 beds. The monies released from the closure of the 23-bed ward could then cover the costs of the emergency home treatment team, with excess funds contributing to the development of the assertive outreach service. Following the success of the pilot, it was planned to implement emergency home treatment across the Trust.

Mental health staff seemed sceptical that a reduction in bed usage could be achieved and sustained. Therefore, it was very important for the strategy that the Yardley/Hodge Hill pilot succeeded. It needed to operate as a core service provision within the locality and to integrate with minimum disruption. Service functions and admission criteria had to be clear and consistent if the service was to be sustained.

Three years on from the start of the implementation, one of the comments from the local user forum, Libra, says perhaps more than any report can:

> *"Before the home treatment team service was available, people were not willing to come forward and seek help because they knew it meant hospital, or sometimes the police station, in the first instance. Now people are willing to be put in touch with services".*

Proposed locality system

Home treatment team

The principal characteristics of this team are:

- mobility
- 24 hour 7 day availability
- an immediate response
- ability to carry out long visits and remain involved until problem is resolved
- good patient referral system
- gate-keeping function to hospital
- enable earlier discharge from hospital
- less stigmatising for clients.

These principles changed the focus of service provision for people with serious mental illness approaching or in crisis. It maximised the opportunity to treat at home, with these marked advantages and outcomes:

- significantly increased compliance
- reduction in compulsory admissions
- more acceptable to people from minority ethnic groups
- shorter episodes of acute care at home
- avoidance of hospitalisation
- needs based assessment and shared care plans

- stronger links with other community facilities
- 50% reduction in acute admissions.

Operational policies set down the criteria for entry to this service, and the team is comprised of health and social services staff.

Continuing needs service

The service provided by these teams is for people with long-term needs. The **assertive outreach** service provides for people who require a high level of input and who may also be difficult to engage. Most will have experienced many episodes of relapse in the past. The maximum caseload is ten for each worker. The assertive outreach team maintain daily contact, if necessary, for seven days a week. The team meet every morning to review every client.

The **continuing care team** is for people who have severe and enduring mental health problems, but who have been stabilised for some considerable time. It provides the required continuing support and encouragement towards recovery.

Each team will:

- ensure medication collaboration
- assist in daily living tasks
- provide individual and family counselling
- link with general community activities
- secure good housing
- support 'place and support' work programmes.

Primary care mental health teams

The primary care mental health teams replaced community mental health teams, with the services described above taking some defined work out of their remit. The name was changed to reflect the change in team function and the need to work closely with the general primary care services. It created the opportunity to provide a better understanding of each other's roles and responsibilities and encourage support and education.

The teams would be the access point for all non-emergency referrals not requiring home treatment or admission.

To recognise and reflect the closer working relationship with GPs, the services were changed to respond to practice populations, replacing the previous electoral ward boundaries. This had been requested by the majority of GPs over a long period of time.

There is an on-going move to establish sessions in larger practices for co-working with primary care team staff, assessment and short-term intervention.

However, resource investment to primary care mental health teams is still to be completed within the Trust, and we are therefore, as yet, not setting the standards we would wish for all referrals.

The Trust recognises the importance of counselling services at primary care level, and wishes to develop this service by working with professionals who have the skills in psychological therapies and who are clinically supervised and managed through the Trust. This remains a resource issue and one still to be resolved.

The Trust has taken a clear lead in respect of severe, complex, recurrent or otherwise difficult cases of emotional, mood, behavioural or personality disorder. Such cases can entail marked personal distress, can be associated with considerable disability, handicap and cost.

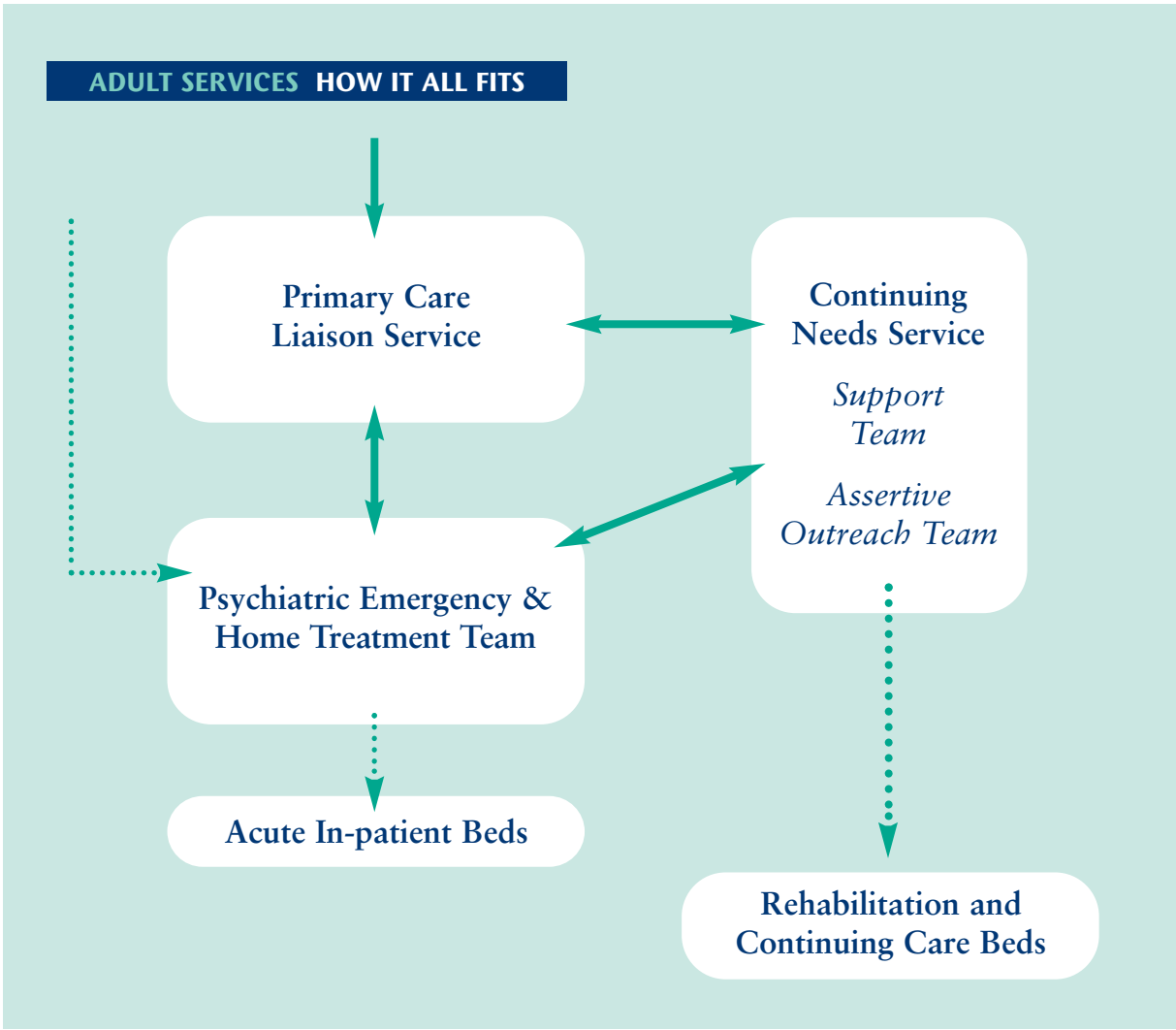
People with these problems are often unresponsive to or cannot be effectively managed in an ordinary primary care setting, with non-specialist intervention and support and so need skilled, co-ordinated, intensive and sometimes medium term intervention. Such problems might include:

- anorexia and other complex eating disorders
- problems associated with sexual abuse
- complex psycho-sexual problems
- severe neurotic depression, often with recurrent self-harm
- marked obsessive-compulsive disorders
- chronic panic disorders and severe agoraphobia
- severe and disabling persistent anxiety

- severe post-traumatic stress disorder
- severe personality disorder
- entrenched habit disorders
- complex relationship problems
- 'thick file' and 'heart-sink' cases.

Each primary care mental health team will:

- operate 9am–5pm, Monday to Friday, with an emergency duty rota and will be the first point of contact for non-emergency referrals
- take a lead role in the organisation and delivery of services
- have social workers as part of the team
- work closely with other statutory and non-statutory agencies to provide a co-ordinated system of mental health care
- offer interventions in community-based settings, particularly in peoples' homes
- accept referrals from health and social care professionals. All non-urgent self- or carer referrals will be asked to consult their GP first. Walk-in referrals are not encouraged, but urgent telephone referrals will be accepted
- keywork complex and simple CPA
- work with other teams in the transfer of patients between the service functions as required.



Implementation Plan

Pre-pilot mental health service profile

The newly formed Trust had implemented the first stages of its restructuring with the appointment of executive officers and locality managers. The implementation of the pilot was assisted by the appointment of Dr John Hoult as consultant psychiatrist, Patrick McGlynn as team leader and Mary Bath as locality manager.

- Before the pilot scheme, the plans for further development of services in Yardley/Hodge Hill included a 14-bed in-patient unit with space for one of the existing CMHTs, the other one already being accommodated in Newbridge House with 20 beds (new unit).
- The revenue for the facility was to be transferred from the closure of the 23-bed ward on the Highcroft site.
- The new strategy was to focus on treatment and services provided to the client in their own home, wherever possible. Therefore, plans for the 14-bed unit development were suspended, and an application was submitted to the Sainsbury Centre for Mental Health for funds to pump-prime a home treatment team and an assertive outreach team.

Pilot site: locality profile

Yardley/Hodge Hill Locality

- *Population 150,000*
- *6 electoral wards*
- *20–30% (total pop) unemployment*
- *38% non-white in some areas*

Pre-existing mental health services

- *2 CMHTs for clients 16–64yrs*
- *(1 Yardley/1 Hodge Hill)*
- *2 CMHTs for clients 65+yrs*
- *(1 Yardley/1 Hodge Hill)*
- *1 Child and family team (0–15 yrs)*
- *4 continuing care health and social services staff (16–64yrs)*
- *20-bed ward for clients 16–64yrs, 5 beds used as ICU on Yardley Green site (Newbridge house is a new building)*
- *23-bed ward for clients 16–64yrs on Highcroft Hospital site (outside locality)*
- *1 day hospital for clients 16–64yrs (20 places)*
- *32 admission assessment beds for clients 65+yrs*
- *24 continuing care beds for clients 65+yrs*
- *2 adult day hospitals for clients 65+yrs (50 places).*

During the 2 years of the pilot, the adult day hospital services went through a review period. The service has been remodelled to better meet the needs of a functionalised service approach, although with the resources currently available, this is limited. The new day hospital service provides:

- identified priority group work
- clinical services such as depot clinics and phlebotomy sessions
- day respite for home treatment team patients
- one to one therapy.

In 1997, a house in the community was purchased to provide emergency respite services to the locality. Unfortunately, due to public opposition at the time, we were unable to use the facility for this purpose. As an interim arrangement, it is being used by the voluntary sector for people with less severe mental health problems and a longer residency is allowed. However, we will attempt to restore it to its original purpose as soon as possible, as the need has been established.

We have discovered that inappropriate hospital admissions can occur due to the lack of out of hours respite facilities. When there is a family or accommodation crisis it is difficult to resolve quickly out of office hours, therefore people often come into hospital.

Home treatment team implementation

Working with social services, the Locality formed two groups:

Group 1: Operational group

- met every two weeks
- agreed policies and procedures
- identified issues and tasks
- co-ordinated services
- monitored process.

Group 2: Steering group

- met monthly and then quarterly
- included user group and voluntary organisation representatives and community health council (CHC)
- shared information
- acted as a means of consultation.

Key management issues for the success of the Home Treatment Service were:

- training
- service criteria
- top of agenda for management
- team building
- ownership by locality.

Assertive outreach implementation

The development of this service was imbedded within the strategy and its value was well acknowledged with the experiences of Madison in the United States (Stein & Test, 1980) and Sydney in Australia (Hoult, 1986), therefore there was less work to be done on ownership and consultation.

Local social services were not, at the time, able to commit to input into the team as funding issues were still to be agreed between the local and health authorities. However, the staffing requirements, service criteria and operational policies were jointly agreed.

The key issues were, and continue to be:

- service criteria
- management of workload
- team support
- worker role from user perspective
- worker role from NHS perspective.

Medical Staffing

Within the locality, we agreed that for the first 6 months of the home treatment team pilot, Dr John Hoult would act as Consultant RMO for all people referred in that service.

After the pilot period, each locality consultant took on the responsibility for their own patients in the home treatment team and maintained their responsibility for primary care mental health, in-patients and day hospital. It was felt that this would provide improved continuity of care for the patient.

Assertive outreach clients have a single consultant and part time SCMO. Continuing care also have a single consultant.

Finances

The figures below demonstrate how, in terms of relative cost, the home treatment and assertive outreach services compare with acute in-patient services.

Home treatment team service costs 1997/98

Manpower Resources = £330,624		
1.0	Manager	
4.0	G-Grade CPN	
3.0	F-Grade CPN	
1.0	E-Grade CPN	
2.0	B-Grade CPN	
3.0	ASW	
1.08	A&C Grade 3	
14.08		
Non-pay		£33,401
		*£394,025

*plus an additional 0.4 sessions of psychology

Assertive outreach service costs 1997/98

Manpower Resources = £187,953		
0.5	Manager	
2.0	G-Grade CPN	
2.0	E-Grade CPN	
2.0	ASW	
1.0	Senior 1 OT	
0.5	A&C Grade 3	
8.00		
Non-pay		£9,000
		£196,953

Estate costs are covered in the overheads of the locality. The non-pay is recognised as inadequate to cover all non-pay items.

Recurring revenue

Following the success of the home treatment team pilot, the 23-bed ward closure was agreed. This would provide the recurring revenue pick-up of the service.

Excluding fixed overheads and capital charges, the ward closure released £604,500.

*Analysis of the adult acute ward costs for 1996/97 p&p**

Items	*Figures (in £1,000s)*
Nursing – Direct	342.7
Nights	5.0
Bank	7.6
Nurses total	**355.3**
Pharmacy	2.5
Drugs	7.8
Physiotherapy	17.1
Occupational Therapy	7.8
Medical	17.1
Medical Records/Secretaries	6.2
Patients Benefit	11.1
SLAs	13.4
Catering	45.8
Hotel Services	31.9
Porters	9.3
Laundry	2.8
Nurse Admin.	7.8
Estates and Grounds	42.9
Other	8.1
Subtotal (1)	**586.9**
Overheads	60.0
Subtotal (2)	**646.9**
Capital Charges	34.3
Total Gross Cost @ 96/97 p&p	***£681.2k***

nb: Total Cost = £681.2k + 3% = £701.6k

* p&p = pay & prices

Summary of implementation issues

1 *What went well?*

- service proposal was valid
- planning and implementation time allowed
- 1 month protected training time
- ownership within locality
- clear policies

2 *What were the obstacles?*

- health authority and local authority funding agreements
- changing attitudes
- maintaining agreed focus
- catchment area of Trust vs. social services
- communication
- community perspective of people with mental health problems
- availability of qualified staff with skills, language and cultural knowledge suitable for Asian communities.

Research and evaluation: an operational approach

The Trust recognises the need for monitoring, evaluation and research for creating a healthy environment for service delivery. The Yardley/Hodge Hill locality will be implementing evaluation and facilitating data collection through the agreed use of minimum data sets. These have already been piloted for the home treatment team and the in-patient service. The minimum data sets are comprised of the following elements:

1. socio-demographic profile
2. current and previous psychiatric involvement
3. referral details
4. assessment details
5. diagnosis – using ICD-10 (WHO, 1992) R&D criteria
6. morbidity – using BPRS (Brief Psychiatric Rating Scale); GAF (Global Assessment of Functioning); HoNOS (Health of the Nation Outcome Scale, Department of Health, 1994)
7. needs profile – using the FACE, core assessment of adult mental health, psychological, physical and social functioning (QDU, 1996).

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