Locality Services in Mental Health

Developing Home Treatment & Assertive Outreach

THE NORTHERN BIRMINGHAM EXPERIENCE

Booklet 5

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

Service Development Strategies & Tools

Helen Wood

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

5

Managing the Process of Change and Implementation

"Management of change is about good management but more of it."

Effects of change

Many of the difficulties related to implementing a new style of service provision are associated with the impact that change has on those within the system. Often, people's response to change is a feeling of loss. This may include loss of:

- perceived status
- types of work
- valued colleagues
- job or career prospects.

(Upton & Brooks, 1995)

This sense or fear of loss can also be felt by those receiving services. In some instances people may fear they will no longer get the help and support they need, or will not know how to obtain the new service when they do need it.

Factors that influence the response to change:

- *ownership*
- *the degree to which people feel able to influence the change*
- *the significance of the change on their lives*
- *previous experiences of change*
- *support available during the process.*

(Upton & Brooks, 1995)

These elements will influence the degree of resistance to be faced during the process of implementation and management of the transition to the new service system.

Key elements

Beckhard and Harris (1987) provide a useful framework for the change management process. They identify four key elements when implementing new developments:

1 Degree of dissatisfaction with current situation

What are the incentives for change? These may include:

- met vs. unmet need
- awareness of changes in expectation (service users, purchasers)
- exposure to advances in practice.

As a manager or leader of change, the ability to successfully communicate, and facilitate the recognition of, the need for change is essential for successful implementation.

2 Belief that proposed changes will improve the situation

To achieve positive change, a tangible vision of a desired alternative is needed, therefore:

- people need to have the opportunity to participate in defining alternative options once the need for change has been identified

- the benefits and outcomes of the proposed change need to be widely understood and the impact on different parts of the system recognised.

3 Steps to change: implementation plan

A well conceived plan of how to achieve the desired future state is essential. Project management techniques can assist with defining this process (examples of these techniques are outlined later).

4 Managing resistance

To achieve effective change, all of the above must outweigh any resistance that might occur.

Critical success factors for managing change

- *direction and ownership: clearly understood aims and objectives based on the reasons for change*
- *time scales: need to be realistic*
- *communication: clear and repeated to avoid rumour*
- *consultation: people involved in shaping the process and involved at the right time*
- *resources: investment of time, energy, money, skills, resources to assess need; securing deployment*
- *making change real: 'walking the talk', behaving in ways consistent with change to make it visible*
- *job security: early identification of new structures and posts to help people feel secure.*

(Upton & Brooks, 1995)

Many of the difficulties associated with implementing change are often a result of:

- lack of ownership and commitment
- poor leadership and lack of direction
- poor understanding of the to need to change and/or incorrect diagnosis of the problems
- lack of awareness of alternatives
- short sighted planning with quick fix solutions and unclear objectives
- lack of continuity of change managers/ leaders
- poor awareness of the knock on effects of change to other parts of the system
- loss of priority to other issues and changes within the organisation
- Inadequate investment in training and practice development in preparation for new work patterns.

Project management strategies

Change is a consistent feature of mental health services. Practitioners and managers now need to perceive change as positive and learn how to use it to their best advantage, rather than resist it. They need to develop the skills and techniques required to manage change successfully.

Project management is a proactive structured response to managing and directing change. In essence, it delivers the management of change.

The key features of this process are:

- clear objectives
- change orientated
- multi-disciplined – needs a wide range of skills
- practical – an action based process
- opportunistic
- performance orientated
- control orientated – to achieve results in tight time scales
- avoids being trapped by vertical thinking.

(Industrial Society,1998)

It is essential that enough time be dedicated to planning as a key task at the beginning of the process.

Consequences of short–sighted planning

- *wild enthusiasm*
- *disillusionment*
- *chaos*
- *search for the guilty*
- *punishment of the innocent*
- *promotion of the non-participants.*

(Young, 1993)

The key stages to project management are:

- defining the project
- planning
- carrying out the project
- closure.

What is necessary to define a project?

1 A stakeholder list

Those affected positively or adversely, the people whose participation is essential and those whose support is necessary, either directly or indirectly.

2 A statement of objectives

A written brief outlining desired outcomes.

3 Scope of work statement

An extension of the above, but also including:

- data to support rationale for the process
- resources
- training and human resource implications
- potential impact on rest of the organisation
- limitations and standards.

4 Risk assessment

An analysis of potential threats to the integrity of the project at any stage and what might prevent success. This is an opportunity to identify critical success factors. Contingency plans can then be developed for high-risk areas.

(Industrial Society, 1998)

Project planning tools

A number of techniques have been established to help identify:

- what needs to be done
- order of tasks
- their impact on each other
- feasibility
- required time scales
- resource implications.

The key techniques used are as follows:

- *layering the plan*
- *task boarding*
- *critical path method*
- *Gant charts*
- *resource loading diagrams.*

(Young, 1993)

Implementing the plan

Maintaining involvement and enthusiasm of staff, keeping the project on track and monitoring progress are vital for successful change management.

This will involve:

- attending to motivational factors for those involved
- recognition of achievement
- regular communication and feedback of project progress (e.g. visual charts)
- keeping records (i.e. project log)
- providing support
- maintaining a positive work environment
- changing the organisational culture.

Steering or project groups can be useful for monitoring implementation. They can provide the opportunity to regularly review progress, identify blocks and problems, discuss and agree solutions.

Closure and review

Once the desired change has been achieved and the alternative service implemented, a proper hand over of responsibility and information must take place. This also provides an opportunity to evaluate the process and ask questions, such as:

- what problems occurred?
- how were these identified?
- which procedures worked well?
- what improvements can be made now?
- what improvements have been made?

The future

It is essential that full thought be given to sustaining momentum once the service becomes fully operational. The ability of the service to sustain effectiveness over time can be influenced by the continuity of:

- **staff:** their levels of motivation, job satisfaction and skill development
- **funding:** cost improvement pressures
- **surrounding services:** e.g. effectiveness of services the team may rely on (i.e. in-patient services)
- **focus:** on desired client group.

Many people thrive on the excitement of new developments, losing some of the enthusiasm once it becomes established practice and loses the focus of attention.

Key strategies here may include:

- continual development of staff skills
- on-going service development plans
- support systems built in to the service
- opportunities for project staff to be involved in other projects
- involvement in training and networking outside of the organisation
- in-built evaluation of service by those involved, ensuring that constant review and development is built into the culture of service.

Critical success factors for successful change management

- *dedicated, skilled project leader*
- *clear objectives and project definition based on a comprehensive assessment of need*
- *detailed planing*
- *involvement of key people*
- *realistic time scales*
- *broad based ownership*
- *clear, phased implementation*
- *communication as priority*
- *dedicated time and resources for tasks involved in implementation*
- *avoidance of duplication of effort*
- *steering and management groups with clear remit and right people*
- *investment in training and team building to equip people to do the new job*
- *building an organisational culture that supports, facilitates and rewards innovation*
- *constant attention to sustaining service effectiveness.*

References

Beckhard R & Harris R (1987) Or*ganisational Transitions* London: Addison-Wesley

Industrial Society (1998) *Project Management Training Manual* London: The Industrial Society

Upton J & Brooks B (1995) *Managing Change in the NHS* NAHAT London: Kogan Page

Young T (1993) *Planning Projects* London: Industrial Society

Young T (1993) *Implementing Projects* London: Industrial Society

Service Development

Work Sheet 1

Defining the need for change

WHAT ARE THE KEY FACTORS INFLUENCING CHANGE IN YOUR SERVICE?

Political

-
-
-

Ideological

-
-
-

Technological

-
-
-

Local

-
-
-

WHAT INFORMATION DO YOU HAVE ABOUT LOCAL NEED?

1 Prevalence of mental illness. ☐

2 Use of existing services:

- in-patient bed use and readmission rates ☐
- CMHT case load ☐
- out-patient case load ☐
- use of day services ☐
- Mental Health Act ☐
- extra contractual referrals (ECRs) ☐
- A&E referrals ☐
- other services ☐
- number of supported accommodation places ☐

3 Number of people on CPA (Levels) and Care Management. ☐

4 Levels of met and unmet need. ☐

5 Satisfaction with current services and views on potential developments: service users, carers, PHCT, local authority, other providers. ☐

Work Sheet 1 *continued...*

WHAT INFORMATION DO YOU HAVE ABOUT EXISTING RESOURCES/SERVICES (health, social service and independent/voluntarty sector provision)?

Service Component	Provider	Hours
Hospital and community beds		
Case management, rehabilitation and assertive outreach		
Response to crisis		
Assessment and consultation services		
Help with 'something meaningful' to do (e.g. day, education and employment services)		
Support to carers		
Practical support at home and help with benefits		
Advocacy and user-led services		
Out of hours support (evenings and weekends)		
Help with physical and dental care		

HOW DO THESE SERVICES MEET EXISTING NEED AND WHERE ARE THE GAPS?

Service Development

Work Sheet 2

Developing a strategy for change: Checklist

- [ ] What does the information tell you about local services and need?
- [ ] What are the key areas of need for service development?
- [ ] What needs to change and/or what is the most effective way of organising services to achieve this?
- [ ] What are the desired options/service models? What evidence do you have to support these options?
- [ ] What are the potential benefits? How will this change things?
- [ ] Does the organisation have the capacity to undertake this development? What partnerships can/need to be made?
- [ ] What impact will this have on other parts of the system? Will other services need to operate differently as a result of this service change?
- [ ] Who needs to support this project (directly and indirectly, both within the organisation and externally)?
- [ ] How will service users and carers be involved?
- [ ] What are the potential difficulties/blocks for implementation?
- [ ] What are the resource implications?
- [ ] Who is it most likely to affect?
- [ ] Will there be any resistance to these proposals? Who from and why?
- [ ] How will you manage it?

Service Development

Work Sheet 3

Developing a strategy for change

Stakeholder list

-
-
-
-
-

Objectives statement

Scope of work statement

- rationale and data to support change
- resources required
- training and human resource implications
- potential impact on rest of the organisation
- limitations
- standards

Risk assessment

- potential threats and blocks
- critical success factors (what needs to be in place to make it happen)

(Industrial Society, 1998)

Service Development

Work Sheet 4

Implementation plan: Checklist

- Who is going to lead the development and implementation of the project (project manager)? ☐
- What will their key tasks be and how much protected time will they have to undertake them? ☐
- Who will they report to? ☐
- What consultation, planning and or advisory forums need to be established? ☐
- Who, external to the organisation, do you need to consult, inform, and involve? ☐
- What is your time scale for implementation? ☐
- Do you have a checklist of tasks to be undertaken (e.g. operational policy checklist)? ☐
- In what order do planning tasks need to be done? ☐
- Have you established your critical path of tasks and or Gant planning chart? ☐
- Do you need to establish smaller project groups involving clinicians to work on specific service components, such as:
  - training and induction ☐
  - referral criteria and pathways ☐
  - documentation ☐
  - in-patient/primary care liaison ☐
  - risk assessment etc? ☐
- How will you keep people informed and up dated on the development of the new service (e.g. newsletters, away days, attending existing service meetings etc)? ☐
- What are the specific skill mix and training requirements? ☐
- Have you completed a skills and experience audit? ☐
- Will you recruit internally or externally? ☐
- If you are recruiting internally or re-organising existing staff, what impact will this have on existing services? ☐
- What resources will the proposed service/team need in order to undertake its work effectively and safely, such as:
  - mobile phones/Bleeps ☐
  - IT systems ☐
  - transport/parking permits ☐
  - accommodation ☐
  - administration ☐
  - access to medication ☐
  - petty cash float for client related activities etc? ☐
- What are the capital and revenue implications (in the short, medium and long term)? ☐
- What are the key sustainability issues to be addressed during planning? ☐
- What indicators will you use to measure whether the development achieves the intended outcomes? ☐
- How will these information requirements be built into routine data collection for the service? ☐
- Are they simple and quick to collect? ☐
- How will they routinely be fed back to the service to inform practice and development? ☐

Service Development

Work Sheet 5

'Going Live': Checklist

Case load

- Do you have an agreed definition of your target group? ☐
- Have you identified your potential caseload from known service users? Are these referrals prioritised according to need, risk and urgency? ☐
- Have you agreed transfer of care procedures? How will you incorporate CPA reviews into this process? ☐
- Do you have an agreed timetable for the transfer of cases to the new service with names of key individuals? ☐
- How will you inform relevant others of the transfer of care? ☐
- Have caseload monitoring and management mechanisms been agreed and established? ☐
- Have the team agreed how they will manage the work? Will there be individual caseloads or co-working and joint working arrangements? ☐

Referral and assessment pathways

- Have you informed all relevant agencies of any new procedures for referral including:
  - contact numbers and hours of operation ☐
  - required information ☐
  - location of service ☐
  - new referral criteria ☐
  - response times ☐
  - assessment procedures ☐
  - procedures for feedback to referrer? ☐
- Have you established a system for assessing all new referrals? ☐
- Do you have a system for prioritising referrals and an allocation procedure, such as:
  - single point of entry ☐
  - priority ratings based on risk, need and urgency ☐
  - duty rota for referral assessments? ☐
- When allocated for assessment, do you have a common comprehensive assessment tool? ☐
- How will this information then be fed back to the team? ☐
- Will this process meet the requirements for CPA and Care Management protocols? ☐
- If after assessment, a referral does not need team involvement, how will this be dealt with? What links have you established with other services/agencies for referring on? ☐

Team operation

- Have all the staff been fully inducted into the new procedures? ☐

Work Sheet 5 *continued...*

- Does the service/team have a weekly timetable established for:
  - handovers ☐
  - reviews ☐
  - shifts ☐
  - other communication and team events? ☐
- Have all relevant documentation and record keeping systems been agreed and made available? ☐
- Will there be a common client record held by the team? ☐
- Have protocols and systems been established for team safety and responding to risk? ☐
- How will the team facilitate joint working:
  - Within the team? ☐
  - With other services such as community teams, in-patient services and specialist teams like addiction, forensic and day services? ☐
  - With other agencies such as PHCT, housing, DSS, social services (if not integrated), employment, education, community groups and cultural groups? ☐
- How will the service operate at evenings and weekends? ☐
- Have lines of accountability and responsibility been clarified? ☐
- What support and supervision systems will be in place? ☐

Training and team building

- Have the team had team building sessions prior to operation? ☐
- Are staff in the team fully aware of other services and agencies around them? ☐
- Have all staff familiarised themselves with the locality? ☐
- Have all team members undergone a comprehensive induction programme. (See Worksheet 6) ☐

Core services

- Are you clear about the service components the team offers and how they will be provided? ☐
- What evidence-based interventions will the team provide? ☐
- Have key protocols been agreed (e.g. safe carrying and administration of medication in the community)? ☐
- How will the service/team audit its clinical effectiveness? ☐
- What mechanisms will exist to ensure service users (and carers) are proactively involved in determining their own care, and in the service as a whole? ☐
- How will the team work to specifically support carers? ☐

Marketing and information

- Does the service/team possess an up to date and comprehensive resource directory? ☐

Work Sheet 5 *continued...*

- Has the service/team developed simple, accessible and informative information leaflets about its services for service users, carers, and other agencies? ☐
- How has the team been promoted to other agencies and services? ☐
- Do all relevant agencies have contact numbers for key people such as the team manager and the lead clinician? ☐

Service Development

Work Sheet 6

Core Training and Induction Guidelines

Home Treatment

Model of care

- discussion and analysis ☐
- dissemination of research ☐
- development of operational policy ☐

Skills

- strategies for working with psychosis in the community ☐
- a range of social, psychological and medical home interventions ☐
- situational role play ☐
- family work & potential effects of home treatment on children in a family setting ☐
- team responsibilities ☐
- CPA/Care Management ☐

Role definition

- community psychiatric nurses ☐
- approved social workers ☐
- support workers ☐
- medical staff ☐
- psychologists ☐

Risk and crisis

- good practice in assessing and managing risk ☐
- working with crisis ☐
- links with in-patient services ☐
- individual concerns ☐
- out of hours work ☐
- communication ☐
- supervision ☐

Team building

- development of common aims ☐
- team work ☐
- effective use of team meetings and communication ☐

Work Sheet 6 *continued...*

Assertive Outreach

Fidelity to the model for successful engagement

- critical service elements ☐
- good outcomes linked to close adherence to a model ☐
- dissemination of research ☐
- development of operational policy ☐

Team approach

- clear identification of shared and specialist skills ☐
- effective use of daily team meetings ☐
- operational issues for team and out of hours work ☐

Role definition

- clarity of clinical leadership ☐
- team leader's role ☐
- core team member's roles ☐
- clarity shared and specialist skills ☐
- importance of team within service integration ☐

Skills

- negotiation skills with individuals, carer and across agencies ☐
- comprehensive assessment (strengths) ☐
- evidence based interventions ☐
- substance misuse and serious mental illness ☐
- ethical issues ☐
- community resources ☐
- CPA & Mental Health Act ☐
- Risk and crisis ☐
- good practice in assessing and managing risk ☐
- working with crisis ☐
- relapse prevention ☐
- close links with crisis services ☐

Individual concerns

- support and supervision ☐
- identified needs within method of working and client group focus ☐
- formal and informal lines ☐
- out of hours work ☐

Fact sheet 1

Locality Needs Assessment

Edana Minghella & Helen Wood

What is the difference between benchmarking and needs assessment?

Benchmarking usually refers to a way of comparing service components, such as service provision (e.g. no. of CMHNs); service activity (e.g. no. of people assessed each month); targeting (e.g. casemix) across teams, localities or districts.

Needs assessment can be a confusing term, as it may refer to 3 main areas:

- assessing an individual's needs, often as part of a clinical or social services assessment process
- assessing the needs of a population of users
- assessing the needs of a local population as a whole.

Why carry out benchmarking or a needs assessment?

Benchmarking and/or needs assessments can be used to:

- identify levels of service need
- identify gaps and overlaps in service provision
- examine whether resources are used effectively
- provide data for service planning and development
- provide data to influence purchasers.

What should be benchmarked?

A range of indicators could be included, as the list illustrates.

Local area data

- socio-demographic and population trends
- housing
- levels of morbidity.

Health and social service provision

- what is provided across the spectrum of care and for whom
- specialist services available
- existing out of hours services.

Other provision

- non-statutory sector e.g. housing associations
- non-mental health services e.g. primary care services, housing, etc.

Individual client care

- Care Management and CPA implementation
- risk assessments & supervision register
- structures for user/carer involvement.

Costs

- How much spent per head of population?
- How much spent on different components of the service?

Benchmarking often means quantifying service provision per head of the population e.g.

- How many acute beds per head of the population are provided in a given locality?
- How does this compare with other localities in the district?
- How does this compare with figures from similar areas around the country?

What should a needs assessment address?

The fundamental question which a needs assessment should address is *whether relevant services are being delivered to the people who need them.* For example, if groups of users are identified as having higher levels of need, like people diagnosed with schizophrenia or those who have frequent hospital admissions, needs assessment questions could include:

- Are users getting the community services suitable for their needs, or are teams having to work with a large number of people with less complex needs so that they are unable to allocate time for the more needy group?
- Are resource levels appropriate for the population served?
- Are the resources distributed according to need? (e.g. are resources disproportionately used on in-patient services?)
- Are there alternative ways of delivering services?
- How does the mental health care system function as a whole?

How do you do a needs assessment?

Identifying the needs of a user population first requires identification of all users in contact with services. This can be problematic; if someone is in contact for a short term assessment, should s/he be included as part of the user population?

MEASURING NEED

Individual Needs	• HoNOS scales • CPA Level • Age • Previous hospital use • Diagnosis • Social factors
Population Needs *(can be used for small areas e.g. electoral wards)*	• Jarman indices • Socio-demographic data • Mental Illness Needs Index (MINI) • York Psychiatric Resource Allocation Index

A needs assessment also requires an assessment of resources, e.g. what services are available to meet different needs?

What are some of the common pitfalls?

The common pitfalls to avoid include:

- failing to compare 'like with like', e.g. using national figures to compare your local, rural service with services in a different environment, e.g. the inner-city
- failing to consider other contextual issues, e.g. has your service recently closed a large hospital?
- using only one variable, such as diagnosis, to measure need.

A needs assessment checklist for community mental health teams

Do you know how many users in contact with the team need to have:

- individual, flexible home-based support, e.g. out of hours support workers
- access to respite accommodation, as an alternative to admission
- specialist supported accommodation
- help with financial and welfare matters
- access to employment and further education opportunities
- day time support and social opportunities, including befriending schemes
- spiritual, cultural and religious support
- specialist interventions, e.g. cognitive behaviour therapy, psychotherapy, marital/relationship therapy, alternative therapies
- a comprehensive medication review, including previous and current medication, side effects and positive/negative outcomes
- a complete physical and dental check, which includes lifestyle health education and family planning advice
- carer support and education?

Does your team have a case register, which contains an accurate, comprehensive picture of the group serviced, e.g.

- numbers and levels of people on the CPA
- socio demographic details
- key agencies involved, by individual
- a summary of assessed met and unmet needs, by individual?

Have you recently undertaken a bed audit to review use of hospital in-patient beds, to identify:

- service usage patterns
- key people with frequent readmissions
- ECRs (extra contractual referrals) and delayed discharge?

Useful reading

Audit Commission (1994) *Finding a place* London: HMSO

Department of Health (1994) *The Health of the Nation Key Area Handbook: Mental Illness* (2nd ed.) London: HMSO

Peacock S & Smith P (1995) *The Resource Allocation Consequences of the New NHS Needs Formula* York: University of York

Jarman B (1983) Identification of underprivileged areas. *British Medical Journal* **286**

Fact sheet 2

Auditing Hospital and Community Beds

Geraldine Strathdee

Extract from *Mental Health Service Development Skills Workbook* (1997) The Sainsbury Centre for Mental Health

There are a number of tested methods for auditing bed usage in mental health services. Most studies show consistent findings about the types of individuals who occupy acute beds, the reasons preventing discharge and the factors which lead to bed blocking.

What factors influence bed use?

Research indicates that there any many factors which influence bed use, including:

- individual-related factors
- available bed service components
- use of bed management strategies
- staffing levels
- treatments offered
- organisation of mental health services
- local inter-agency provision.

What factors relating to individuals can influence bed use?

The following table highlights what research indicates are the individual-related factors which can influence bed usage.

Socio–demographic

- *young*
- *male*
- *lower socio-economic class*
- *black*
- *living alone or in unsupported accommodation*
- *no carer.*

Clinical

- *SMI including schizophrenia, manic depressive psychosis and other psychoses*
- *vulnerable to suicidal or forensic behaviours*
- *concomitant physical morbidity*
- *dual diagnosis, e.g. concurrent alcohol or drug abuse.*

Previous pattern of service use

- *recently discharged from psychiatric hospital*
- *multiple previous admissions*
- *minimal insight or control over illness*
- *poor collaboration with medication and other treatment strategies*
- *no trusting relationship with carer or professional*
- *previous detention under the MHA.*

How can bed use be audited?

There are a number of research-based bed audit methods which can be used, including:

- Bebbington *et al* One Day Bed Audit
- Lelliott *et al* MILMIS Bed Audit
- North & South Thames Bed Audit
- The Sainsbury Centre for Mental Health ACIS Bed Audit.

What should be audited in a Bed Use Audit?

In general, the following factors are measured by most of the bed audit methods described above:

- socio-demographic characteristics of those using beds
- reason for admission, e.g. prevention of harm or relapse
- treatment, management and supervision received
- lack of alternative provision, i.e. if alternative services, such as a crisis team, a respite house or assertive outreach services had been available, admission would be prevented/ discharge would be expedited.

Data can be collected from interviews with users & keyworkers, and by examining and analysing case notes and centrally-held computer records of service usage.

What do bed audit studies show?

There are consistent results in most studies; a summary of the most significant can be found in the following table.

Bebbington *et al's* (1994) study in inner London in which case-rates were examined and key workers interviewed, found that:

- admissions related to a relapse of psychosis
- one-third of subjects had been in-patients in last month
- 57% of subjects lived alone
- only 7% of admissions were planned
- 25% of admissions were compulsory
- 65% of subjects would have been more appropriately managed in a high support 'home'.

Lelliott's inner London clinician group (1994) reported the following MILMIS findings:

- true bed occupancy was ›120%
- 30% of patient stays were ›3 months; 12% were ›6 months
- there were 100 ECRs (at any one time), equalling a total of £5 million pa
- conditions on acute wards were poor/?dangerous
- 40% of new long stay patients' discharges were delayed
- many new long stay patients were young, with history of violence
- high staffed hostels excluded those with a history of violence
- ‹20 of staff in high support hostels have qualifications.

An audit of North and South Thames Region bed occupancy (Fulop *et al*, 1994) concluded that:

- 42% of subjects had schizophrenia
- 15–30% were black (4·3% population)
- 10% were homeless

Continued...

- ›25% were in for ›3 months
- 50% had ›1–2 admissions in the last year
- ›50% were waiting for Local Authority Care Management input
- there was a significant lack of supported accommodation.

The Sainsbury Centre for Mental Health Acute Care In-patient Study (ACIS) (Shepherd *et al*, 1996) used three methods to gain information from a number of sites throughout the UK:

- a cross-sectional survey
- a one-day census
- interviews with staff & keyworker ratings methods.

The main outcomes were that 2236 patients were admitted on the census day, of whom:

- 52% were female (mean age 41)
- 88% were white
- 30% were detained under the Mental Health Act
- 74% had a diagnosis of schizophrenia/mood disorder.

The medium length of stay was 28·5 days; ›7% had been in the bed for more than six months.

The key conclusions were that:

- bed use in acute psychiatric units is related to:
  - social deprivation
  - bed availability
  - presence/absence of safe alternatives to admission
- 28% of patients acute units are inappropriately placed
- 61% of new-long-stay patients remained in hospital for more than six months

References

Bebbington P *et al* (1994) Inner London collaborative audit of admissions in two health districts *British Journal of Psychiatry*, **165** p743–749

Fulop N *et al* (1994) *One-day census of adult acute, low-level secure and elderly mentally ill acute and assessment psychiatric patients across North and South Thames Regions* London: Kensington & Chelsea and Westminster Health Commissioning Agency

Lelliott P & Wing J (1994) National Audit of new long-stay psychiatric patients 2: impact on services *British Journal of Psychiatry* **165** p160–169

Shepherd G *et al* (1996) *Acute Care In-patient Study: Stage One* London: The Sainsbury Centre for Mental Health (unpublished)

Strathdee G *et al* (1996) Commissioning and Managing Hospital and Community Beds In *Commissioning Mental Health Services* Thornicroft G & Strathdee G (eds.) London: HMSO

Fact sheet 3

Developing Team Operational Policies

Helen Wood

Extract from *Mental Health Service Development Skills Workbook* (1997) The Sainsbury Centre for Mental Health

The development of a good team operational policy is increasingly important, particularly when inter-agency work and user involvement are imperative. The policy can provide a core reference point for staff, users and external agencies which illustrates the aims, intentions and roles of the service as well as providing an effective organisational tool.

What are the components of a good operational policy?

A good operational policy should include the following sections:

- team definition, 'raison d'être' and service configuration
- service components
- promoting clinical effectiveness and effective team functioning
- service development, evaluation and marketing.

The following sections list some suggested topics for inclusion in the operational policy.

Section One. Defining the team 'raison d'être' and service configuration

- Statement of the team's aims and philosophy and a description of short and long term aims.
- Description of local demography and needs assessment.
- Client group to be served, e.g. agreed definition of target group, links with other agencies for those not included in target group.
- Relationship with other local services, e.g. in-patient services, primary care, local authority, police, day and employment services, specialist psychiatric services e.g. forensic, addiction, children & family services.
- Service contract information.

Section Two: Service components

- How the service provides the full range of the Health of the Nation service components:
  - assessment services
  - crisis response
  - assertive outreach, case management and rehabilitation
  - primary care liaison
  - Care Management
  - user involvement and advocacy
  - development of housing and a range of beds
  - support to carers
  - access to day care and employment.
- Who provides them, and when they are available, e.g. 9–5 or 24-hour; weekend, bank holiday cover?
- How they are to be accessed, e.g. referral criteria and procedures?
- Target emergency, crisis and non-urgent response times?

Section Three: Promoting clinical effectiveness

- range of effective interventions provided
- what outcomes the team is trying to achieve
- process of individual needs assessment and review, e.g. CPA and Care Management
- how the service promotes user choice
- clinical information systems and confidentiality
- procedures for team and individual case mix profiles, size and monitoring
- systems for auditing team clinical effectiveness
- complaints procedure.

Section Four: Promoting effective team functioning

- team management, including lines of accountability and responsibility
- team skill mix, including membership, roles and responsibilities, review procedures
- supervision, training and role of professional advisory structures
- strategies for team building and developing a team approach
- balancing generic and professional specific work
- procedures for safe working practices, e.g. on-call, home visits
- standards for documentation and recording team activity
- personnel procedures and policies, e.g. recruitment, leave, shift work, personal development plans.

Section Five: Service development, evaluation and marketing

- standards for service provision
- procedures for service evaluation and audit
- service development plan
- marketing strategy
- provision of written information
- liaison worker roles
- team activity information.

Who should be involved in developing the operational policy?

In order for an operational policy to be successful, all involved in its implementation should be involved in its development; the consultation process can be achieved through a project group. Ideally, the group should include:

- representatives from all disciplines of the team
- service users and carers
- representatives from other key stakeholders, e.g. primary care, contracts department, local providers.

How should the operational policy be used?

The operational policy can be used:

- as a project management tool for service development
- as a guide for service provision
- as a contracting tool
- for marketing and publicising the service
- to inform recruitment and induction of staff
- as a baseline of service objectives for service review and evaluation.

Useful reading

Onyett S & Ford R (1996) Multi-disciplinary Community Teams: where is the wreckage? *Journal of Mental Health* **5** p47–55

Onyett S (1995) Responsibility and Accountability in Community Mental Health Teams *Psychiatric Bulletin* **19** p281–285

Onyett S, Heppleston T & Bushnell D (1994) *The Organisation and Operation of Community Mental Health Teams in England* London: The Sainsbury Centre for Mental Health

Ovreveit J (1993) *Coordinating Community Care: Multi-disciplinary Teams and Care Management* Buckingham: Open University Press

Wood H (Ed) (1995/6) *CMHT Manager* **1–8** London: Mental Health Foundation

Checklist

Addressing the Mental Health Needs of Minority Ethnic Groups

Dr Kamaldeep Bhui

Summary of chapter in: *Commissioning Mental Health Services* (1996) HMSO (reprinted from *Mental Health Service Development Skills Workbook*, 1997)

Service information

Public information campaigns

- Does your service run Public Health Education Campaigns?
- Does it cover information useful to users, e.g.:
  - personal responsibilities/legal rights/ appeals/complaints
  - medication
  - diagnoses: what they mean and do not mean
  - treatments of major illnesses
  - an explanation of the roles of the hospital and community team members
  - advocacy and support agencies
  - minorities and mental health
  - services in the locality
  - getting help with social problems
  - family therapy and treatment sessions
  - resources centres?
- Is this information available in an accessible medium, such as:
  - video
  - television
  - radio
  - cinema advertisements
  - local community and religious centres
  - festivals
  - concerts
  - seminars and open evenings
  - displays in shopping precincts?

Information/advice facilities

Are you aware of:

- local black mental health organisations operating in your area
- their opening times
- the availability of a 24-hour crisis service
- the range of languages available
- the cultures (not skin colour or language) represented
- the extent to which the services reflect the profile of the local population
- which religious groups are catered for
- the links between black organisations and the local health and social services, e.g. case conferences, educational meetings, service planning meetings, joint training meetings, business meetings?

Interpreting services

- Do you know if there are interpreting services in your area?
- Which languages are represented?
- Have the interpreting staff received any training in mental health?
- Have they received training in interpreting for the mentally ill?
- Can patient requests concerning the sex or religion of an interpreter be met?

- Do you know the disorders or problems for which it is necessary to involve an interpreter, e.g. sexual problems, marital problems, major mental illnesses and family meetings?
- Do you know the interpreting threshold, e.g. what constitutes a communication problem warranting an interpreter?
- Can interpreters be obtained out of hours?
- Do you know the policy for the use of interpreters? Do you know if guidelines exist for working with interpreters in the realm of mental illness?

Multi-professional fora

- Do you know:
  - the arrangements for meeting with local minority groups
  - how often meetings are held
  - who attends the meetings
  - who chairs the meetings and sets the agenda
  - the level of input from local agencies
  - whether local views are minuted, considered and influential on local policy
  - if attempts are made to deal with specific grievances where local services continuously fail to meet the needs of particular individuals
  - what attempts are made to elicit local consumer views
  - whether these initiatives are time limited or contribute to the continued development of services, e.g. a pool of patients and carers representative of the local population socio-demographics could be regularly polled about local health service decisions?
- Is this information published for local users and providers?

Directories of mental health agencies for minority groups

- Do you know:
  - the black agencies that are available locally
  - which specialist black agencies are available, e.g. support for black mentally disordered offenders and black homeless projects
  - which minority groups are in the local region
  - what the racial, religious and linguistic breakdown of the local population is
  - how closely local black organisations represent the local population
  - which groups are not accounted for in any way
  - if and how the neglected groups are represented
  - whether directories of local black organisations are available
  - are these directories accessible to users as well as staff
  - do they give a breakdown of the specific skills available in any one organisation and include a contact name and telephone number?

Range of health care services

Mechanisms to define local minority groups and their needs

- What mechanisms are used to monitor changes in the composition of the local population?
- How often is this monitoring done?
- How are local needs measured?
- How valid are these as measures of need amongst the user groups?
- Are needs met equally amongst the different ethnic groups?
- Which approaches can effectively assess the needs of different ethnic groups at a general population and individual level?

- Does the local mechanism of needs assessment and service provision meet otherwise unmet needs? How is this monitored and how often?
- Who are the 'hard to help'?
- How do services meet the needs of this group?

Range of locally available and flexible treatment packages

- Does each user and their carer receive a brochure outlining:
  - illness to be treated in hospital and illness to be treated as at out-patients
  - when home treatment for major mental illnesses will be implemented
  - who is involved in home treatment and how frequently reviews can be expected
  - what alternative treatments are on offer individually and as part of a package for any particular disorder
  - the choices a patient has regarding medication and psychotherapy treatments
  - the choices a patient has about the ethnic origin of their key worker, primary nurse or psychiatrist?
- What information is given about available therapies and what therapy involves, e.g. is cognitive management of hallucinations/ delusions available for individuals who persistently refuse medication or tolerate low doses only?
- Do you know the alternative treatment practices users would like to have provided?
- Are there investigations or local research into flexible treatment packages to avoid hospital admission?
- When can individuals exert choice over their preferred drug, therapy or method of treatment?
- Is there a local consultant developing specialist alternative treatment packages?

Addressing the needs of minority groups: specialist services

- Is there a list of all local statutory services provided for users as well as other professionals, which includes:
  - all the inclusion or exclusion criteria for patient referral
  - the range of services offered by each agency?
- Do specific agencies within local services ensure a flexible approach to users' demands?

Addressing the needs of minority groups: religious and cultural imperatives

- Do you know the resources available to clinical teams, as team needs may differ according to local population characteristics?
- Do you know the voluntary agencies working with particular wards, consultants and day hospitals?
- Do users have access to facilities for religious worship while in hospital, sheltered accommodation or other community resources?
- Are there sufficient opportunities for users to take part in their preferred cultural activities?
- To what extent are local religious leaders regularly involved in visits to wards, health service planning, etc?

Addressing the needs of minority groups: psychotherapy services

- Do you know :
  - the psychotherapy skills on offer
  - which of these are offered to minority groups
  - which minority groups can access multilingual therapists
  - the groups having difficulties accessing a specific mode of therapy

  - how well training therapists are equipped to work with patients from minority groups
  - how many therapists are trained in intercultural therapies
  - the results of consumer satisfaction polls from previous minority group patients using the therapy services
  - what other evaluative measures are used to assess outcomes
  - how culturally appropriate these outcome measures are?
- If patients cannot be accommodated:
  - are therapists with necessary skills 'bought' in
  - does work continue with an interpreter
  - what extra sessions are contracted to provide an equitable level of work if an interpreter is used
  - which groups and how many people cannot be afforded therapy and why?

Family meetings through in-patient admission and out-patient contact

- Do you know:
  - the percentage of patients having family therapy
  - what the ethnic breakdown is
  - if patients are routinely involved in at least one family meeting on first contact
  - if regular family meetings form part of the treatment package
  - what arrangements there are for inter-cultural family therapy
  - how many trained family therapists there are
  - how many of these are trained or experienced in multi-cultural work
  - the level of local evaluation of family therapy amongst ethnic minorities
  - who is not offered family therapy and why?

Valuing and encouraging cultural and religious identification in rehabilitation

- How are minority groups and cultural events, e.g. dietary requirements, celebration of religious and other festivals, incorporated into long term care plans for those with chronic disorders?
- Which agencies are specifically involved? What are the range of skills?
- What culturally positive events occur regularly?
- What employment/retraining opportunities are available to cater for minorities?
- Is there a local matrix of services to provide a complete package of long-term care?
- Are there clear communication channels?

Service policies

- What are the ideologies of local mental health organisations?
- How are the problems of minority groups addressed?
- Where does this conflict with the interests of minority groups?
- What procedures are in place to allow users personal choice and risk-taking as part of exercising greater autonomy and control over their future?
- How are these procedures implemented?

New services: evaluation amongst minority groups

Monitoring take-up and success rates across cultural groups

- What locally innovative schemes are there?
- Are these being evaluated specifically amongst minority groups?
- Are these evaluations carried out from inception?

- What means exist to measure the accessibility of these schemes for minority groups?
- Are the views of users routinely solicited?
- Were black organisations consulted prior to the establishment of such schemes?

Black mental health teams

- Is there a local black mental health team to:
  - raise the profile of the needs of local black people
  - act as a resource for other agencies
  - contribute to the training of health care workers?
- How many meetings are there with black organisations, where are they held and what is their purpose?
- What contribution do black agencies make to the day-to-day care of patients, e.g.
  - as advocates, communicating wants and wishes of patients
  - providing explanations
  - providing/suggesting alternatives to medication
  - housing and family care?

Social care: application of policy to minority groups

Ensuring quick and effective access to services

- Are there workers specifically allocated to facilitate applications by minority groups?
- How do community care procedures differ for minority groups?
- Are all contacts with social care agencies monitored for outcome data?
- Which schemes operate locally to ensure patient satisfaction and prompt resolution of problems?

Staff and institutions

Training in cross cultural health care delivery

- Do all organisations have explicit Racism and Harassment policies?
- Are these policies actively operated?
- How frequently are they implemented, e.g. how many cases and the outcomes?
- Are there cross-cultural attachments and training schemes for mental health staff?
- What local courses are regularly run?
- Do local audit initiatives address cross-cultural psychiatry and black people's experience of services?
- How do black organisations contribute to mental health professional training?

'Black-Led' research pertinent to consumer views

- What local funding is there for black-led research?
- Which successful schemes have been funded by such grants?
- What training is available to black organisations wishing to conduct research?

Useful reading

Belliapa (1991) *Illness or Distress? Alternative models of mental health care* Confederation of Indian Organisations

Bhugra, D (1993) Setting up services for ethnic minorities In *Dimensions in Community Mental Health Care* M Weller & M Muijen (eds.) London: Saunders

Bhui K & Christie Y (1996) Purchasing mental health services for black communities: practical considerations In *Commissioning Mental Health Services* G Thornicroft & G Strathdee (eds.) London: HMSO

Fernando (1988) *Race & Culture in Psychiatry*. Tavistock/Routledge

Wilson M (1994) *Black Mental Health: a dialogue for change* NHS Management Executive: Mental Health Task Force