The Mental Health Network

The Mental Health Network at the NHS Confederation is a membership organisation which provides a voice for mental health and learning disability service providers. We currently have 76 members which include mental health trusts, independent sector members and PCTs which deliver mental health services.

The majority of our members are from mental health trusts throughout England although membership is open to any provider of NHS mental health services provided they are already a member of the NHS Confederation. We are the only network to bring together organisations from across the statutory, private and voluntary sectors.

Our submission

The Mental Health Network submission to MIND’s independent inquiry into acute mental health services highlights the key initiatives, both national and local, to improve service users and carers experience of crisis services. This includes best practice which demonstrates evidence of:

- Patient/service user satisfaction
- Improved person centred care planning
- Reduced stigma and social exclusion
- Improved recovery outcomes
- Reduced unwanted hospital admissions
- Closer working with pharmacy to improve inpatient and community medicine management
- Improved investment in the physical, social and therapeutic environment of inpatient services.

The submission highlights the national policy initiatives including the National Service Framework for Mental Health\(^1\) and the NHS Plan\(^2\) which saw the development of specialist community teams. The subsequent momentum to maintain the focus to improve services which support people in crisis is also identified. The submission additionally indentifies best practice to highlight the safety improvements including medicine management.

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Mental health acute and crisis care
To achieve the best possible outcomes for people in mental health crisis, acute services have made significant changes in both the community and hospital in order to be more responsive to peoples needs and more attentive to the physical environments in which care is received.

Timely care and treatment is increasingly offered in the least restrictive environment and includes the provision of alternatives to psychiatric admission. Implementation of the National Service framework and the NHS Plan has resulted in the over 300 crisis home resolution teams (CRHTs). These teams have radically changed the experience of people in mental health crisis by providing intensive home support and avoiding admission to hospital wherever clinically appropriate. For a person in crisis, being maintained in the community can lead to new and helpful ways of coping, reduce stigma and protect the integrity of family, friend and community relationships.

New specialist teams and new working environments have also required more staff training and a skilled efficient workforce.

Significant investment in inpatient environments, with over £2 billion invested in new and refurbished mental health facilities since 2001 means that where a hospital admission is considered the most appropriate intervention, people in crisis now have access to services which offer safe, clean comfortable and welcoming physical inpatient environments.

Crisis care in the community
For a person in crisis, being cared for and supported in the community can lead to new and helpful ways of coping, reduce stigma and protect the integrity of family, friend and community relationships. Key functions of CRHTs include:

- A 24 hour a day service 365 days a year
- Care at home with a mobile responsive workforce
- Offer an alternative to hospital admission
- Gate keep inpatient beds
- Provide intensive support, visiting 2-3 times a day in the acute phase of crisis.
- CHRT remain involved until the crisis is resolved
- Work as a multi disciplinary team.

The evidence suggests that when used appropriately and safely CRHTs brings clinical benefits and increased patient satisfaction\(^3\) it can also reduce the stigma and social exclusion frequently faced by people experiencing acute mental illness. CRHTs also support the earlier discharge of people from inpatient treatment.

\(^3\) The National Audit Office (2007) The role of crisis resolution and home treatment services.
Improving safety

Risks of deterioration and harm to self and others can be reduced by intensive support and this period is an ideal time to develop positive resolutions to distress. CRHT will work alongside the service user / carer to develop a care plan to meet individual needs.

This may include medication management, education, support, assistance to develop positive coping strategies and a relapse prevention plan to address any deterioration in mental health in the future.

The good work of Dorset HealthCare University NHS Foundation Trust's Crisis and Home Treatment Team has been recognised at NHS South West's recent Health & Social Care Awards (held on 7 October). The team won the ‘Mental Health and Wellbeing’ category for its ‘zoning policy’ which focuses on the level of intervention required to safely care for mental health service users in the community.

Dorset HealthCare University NHS Foundation Trust

CHRT – award winning zoning policy prioritises safety and prevents unwanted hospital admissions

The CRHT’s role is to help people at home, as quickly as possible, in order to avoid admissions to mental health hospitals or to facilitate early discharge for those who absolutely required admission.

Initially service users must be seen face to face every day and then this is reassessed as they recover. The zoning policy is a crucial tool which helps our team communicate quickly with each other about each service user’s overall need for care, to ensure their safety.

The system described as simple and unambiguous, has proved very effective at helping staff to accurately manage their rapidly changing case loads. Although service users are not aware of its use, the zoning policy allows a member of staff who may only have basic knowledge of a service user to make fast and accurate decisions, speeding the progress of the service user’s care and ensuring a rapid and appropriate reaction to changing clinical circumstances.

The zoning policy has become central to enabling the crisis team carry out its primary function of avoiding unwanted hospital admissions.

The Chairman of the South West Strategic Health Authority, Charles Howeson, who presented the awards, and Sir David Nicholson CBE, NHS Chief Executive, attending the ceremony congratulated the winners and commended the passion, the dedication, the expertise and the professionalism of the people across health and social care who are committed to providing excellent care.
Earlier this year *Getting the Medicines Right 2*[^4] was published and acknowledged the important role medicine management has in supporting positive outcomes in community mental health care. The document, launched by Northumberland Tyne and Wear NHS Foundation Trust in conjunction with The National Mental Health Development Unit in October 2010, detailed the varied circumstances where medicine management is a critical aspect of CRHT. For example, for people experiencing distress and agitation, delayed access to supportive medication can exacerbate a crisis and result in a hospital admission. Also one of the major risks for admission and re-admission includes poor adherence to medication for a variety of reasons (forgetting to take medicine, difficulty in opening medicine, too many medicines, and unpleasant side effects). The risk of suicide and self harm is constantly assessed during a mental health crisis, and a decision is made whether it is safe to leave medication with a patient, and whether to restrict the amount supplied (limit to a few days supply).

The development of CRHTs means that the teams are often managing people in the community with complex problems who may require intensive pharmacological treatment with changing and complex medication needs. Therefore CHRTs are now supported more closely by clinical pharmacy. Pharmacy services are now seen as part of care co-ordination, sharing information and expertise and working towards matching the pharmacy support levels experienced in inpatient units.

The document highlights important areas of best practice, for example:

- At triage, rapid access to a medicine summary including information on the medicine list and allergy status, involving a pharmacy technician and pharmacist who can review the medicines and respond to queries, helps reduce medication errors at a critical time.
- A number of CRHTs have direct access to a psychiatrist offering prescribing support which has reduced prescribing errors.
- In house staff training on the use of PGDs[^5] including side effect profiles, pharmacology treatment options and medico-legal aspects.
- Some CRHTs have developed local protocols to administer small amounts of supportive medicines until a pharmacy opens.
- Adopting a staged process of returning medication to service users in the community where there are concerns of risk.

**Case studies**

Cheshire and Wirral Partnership NHS Trust’s CRHT has reduced hospital admissions, currently having one of the lowest bed use per population in the country. The multidisciplinary team approach adopts a holistic care pathway approach across inpatient to community crisis services, proactively promoting and planning for early discharge from inpatient services. They have also adopted best practice around medicine management.

[^4]: National Mental Health Development Unit (2010) Getting the Medicines Right 2
[^5]: PGD’s are
Cheshire and Wirral Partnership NHS Partnership Trust

CRHT – a real alternative to admission

The CRHT in Wirral prioritises attendance at all community multi-disciplinary team meetings which ensure effective and good network communication. They have built up close good working relationships with all of the teams which then in turn ensure good practice and outcomes for the service users and carers. At the Acute care (CRHT and Inpatient) meeting all potential early discharges are identified and meetings are prioritised and planned, this enables the team to be proactive and ensure that they free up beds on a regular basis. This is borne out in the beds that the trust have available (In the recent Audit Commission paper – Maximising Resources in Mental Health) which indicated they had one of the lowest bed use / numbers per population in the country.

The Wirral team are part of an acute care pathway that sees clinical leadership (Acute Care consultants and other senior clinical staff) spanning the acute care pathway of inpatient and crisis team. The team has had a major impact on mental health act assessments in that it offers a real alternative to admission.

Clozaril titration in the community has been positive and successful for the team; feedback obtained is that both carers and clients have appreciated the fact that their treatment has been facilitated in this way.

They are an integrated team which promotes a holistic approach with support staff providing both practical and emotional support to both service users and carers which is invaluable. They fully utilise the concepts inherent in the recent NMHDU publication – Triangle of Care⁶.

The Acute care consultants spend more time proactively with service users in their home environment and this really makes a difference in terms of medicines management (in line with Getting the Medicines Right 2 NMHDU) and having the availability of advice and support of the consultant where it is needed most.

Custom built crisis management plans have seen CRHT staff in Bristol change their working practice to better support people who frequently present in a crisis. This required greater closer working with service users, their care co-ordinators and other members of the care team to achieve a detailed analysis of the problems leading to crisis and leading to new solutions to manage the difficulties.

Avon & Wiltshire Partnership Mental Health Partnership Trust

Bristol’s CRHT – Custom built crisis management plans: Making ‘a difference that makes a difference’

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⁶ National Mental Health Development Unit, The Princes Trust For Carers, Acute Care Declaration (2010) Triangle of Care: Carers Included A Guide to Best Practice in Mental Health Care
Analysis of the data base identified 20 people who had in the previous year used CRHT and/or acute wards the most. This led to an analysis of who this group were and whether the existing crisis services where not being as effective for this group as they could be and whether staff needed to employ a different approach. The consultant nurse worked with a female Service User Development Worker who was part of the team and had a diagnosis of Borderline Personality Disorder, this was extremely helpful because at the beginning of this project nearly all of the people identified as frequently using services were women with the same diagnosis. Ward staff, psychiatrists, psychiatric liaison staff, carers and other staff where individuals turned up in crisis were all engaged.

The care co-ordinator, service user and carer all worked together to identify what the common features of a crisis were for them (e.g. turning up at a general hospital), and at what points things go wrong. Personalised crisis management plans were then written detailing a clear intent for receiving home treatment and where hospital admission was required there was a focus for facilitated early transfer back to CRHT. Some service users agreed for their relatives to override their own views when in a crisis.

One of the challenges for the CRHT was a cultural one, they were used to working with a high threshold for acute admission but for some people it was considered that there might need to be a lower threshold for hospital admission if required. Therefore there was agreement noted in the crisis plans that a short admission might be more beneficial, with facilitated early transfer back home. There was also work to challenge some stigma around the BPD with the CRHT which helpfully facilitated new ways of working with people with this diagnosis.

The plans although negotiated and agreed with the service user were largely written for staff. The custom built plans succinctly and clearly detailed what to do and what not to do for the individual in a crisis presentation. A brief description of the person’s usual level of functioning was noted so that an assessor could have more of an overall picture of the person and especially if the person has communication difficulties when in a crisis.

Service user’s have responded very positively to the approach and reported feeling really heard, demonstrating the value of the care co-ordinator being involved in the process rather than separate from it. There has been a significant drop in contact and use of services from this group. For both service user and staff, the analysis of the problems leading to crisis led to solutions which in hindsight were described as obvious but there was real value in stepping outside of the system and looking afresh at what these problems were to fully understand individual service user needs and to adapt the service where needed to better meet them. Paradoxically there has been less demand for hospital since this been a more explicit option at an earlier point of their presentation to use these services.

This is not a static process; all individual plans are reviewed and changed as required, especially following several or long admissions or many self referrals. Also the ‘top 20’ are always changing so there is a constant need to review and work with individual client needs.
Involving carers

There has been greater recognition of the essential role that carers play in caring and supporting people with mental health problems and of the expert knowledge they have of the ‘well person’. It is acknowledged that carers need to be kept informed and be seen as part of the treatment team, with information sharing at all stages of acute care. The Triangle of Care document details the six key elements to achieve better collaboration and partnership with carers in the service user and carers journey through a typical acute episode. These six elements were identified as:

1. Acknowledging the essential role that carers play and for them to be contacted as first contact or as soon as possible thereafter.
2. Staff being ‘carer aware’ and trained in carer engagement strategies
3. Policy and practice protocols on confidentiality and information sharing being in place.
4. Having defined role(s) responsible for carers in place
5. A carer introduction to the service and staff being in place, with a relevant range of information being available across the care pathway.
6. A range of carer support services being available.

The document details numerous best practice examples from our members including Avon and Wiltshire Mental Health Partnership Trust, Northumberland, Tyne and Wear NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust and Humber Mental Health Foundation Trust.

Cheshire and Wirral Partnership NHS Foundation Trust are hosting a North West launch of Triangle of Care on the 1st February 2011 in partnership with the Princess Royal Trust for Carers.

Northumberland Tyne and Wear NHS Foundation Trust

Considering Carers in a Crisis

The development of CRHT in Newcastle and Tyneside has resulted in reduced admission rates and seen a reduction in bed occupancy by approximately 40% and received positive feedback from service user’s and carers. The team have made significant efforts to progress carer support and includes:

- CRHT referrals from service user’s and request for assessment by relatives and carers
- Relatives, friends and carers being routinely invited to participate during the assessment process in A & E or at the home address
- Carers not present at the initial assessment will be encouraged to utilise the 24 hour carer helpline where their views are validated and documented.
- The Trusts Carers’ charter underpins the philosophy and ethical stance of the organisation and also includes information about support services etc.
- The Mental Health Carers Development Worker provides session time to the CRHT and can participate in joint visits with CRHT clinicians to maximise opportunities to address carer needs and issues.
• A Carer Centre which provides access to holistic support and advice.

A further benefit of working in partnership with the Carer Support Development Worker has enabled the team to strengthen and offer a wider range of support to families. This has resulted in positive outcomes of the service including:

• Carers being able to continue in their caring role.
• Carers being able to continue in work/training or employment.
• Carers being able to sustain their overall well being (mental and physical health) whilst caring.
• Carers being less isolated.

In order to minimise escalation of risks in the community setting, contingency planning with services users and carers/relatives are included in the treatment plans, with information regarding out of hours contact points, self help literature, mental health organisation and statutory service pathways. Alongside the range of service contact points operates the trusts own 24 hour Carers Helpline.

As part of Home Based Treatment, if there are critical risks identified regarding the carer/relative ability to continue supporting the service user, then hospital admission is considered/facilitated. The CRHT use critical indicators to determine the clinical rationale for admission, in some cases carer exhaustion may be the sole reason Home Based Treatment is reconsidered.

It is recognised that maintaining people’s integrity within the community is of critical importance, with identification of significant risks which undermine this, being addressed seriously and transparently, in partnership with service users and carers and the whole multidisciplinary team.

**Early intervention in psychosis**

Adolescence and emerging adulthood are a high risk time for developing mental disorders and in England each year 7,500 young people develop an emerging psychosis. The early phase of psychosis is a critical period affecting long term outcome. A systematic appraisal of evidence suggests that the longer the duration of untreated psychosis the worse the outcomes⁷. The literature suggests that it is essential that young people with a first episode of psychosis are assertively followed up in low stigma settings to ensure consistent engagement in treatment. This is a key premise of early intervention services.

Early intervention in psychosis services are an integral part of comprehensive community mental health services. These teams work with 14 to 35 year olds during the first three years of psychotic illness. They aim to reduce the duration of untreated psychosis to less than 3 months, and employ specialist staff to provide specific evidence based interventions. The approach is based on active engagement of young people, being a youth friendly service, supportive of families, therapeutic optimism and expectations of young people with first episode of psychosis. Services include:

Comprehensive, multi-disciplinary assessment;
Comprehensive and individually tailored care and crisis plans;
Concerted efforts to engage young people;
Monitoring medication;
On going one to one support
Psychosocial interventions including Psycho-education, Cognitive Behavioural Therapy (CBT), and family work;
Supporting service user’s in education or employment.
Liaison with other organisations (e.g. youth justice, housing, etc).

An early psychosis approach has been shown in randomized controlled studies to reduce the severity of symptoms, improve relapse rates, and decrease the use of inpatient care, in comparison to standard care, at 18 months follow up. These studies also clearly show greater levels of user satisfaction with the service. The result from two large scale randomized controlled trials are below.

- In the UK, Lambeth Early Onset (LEO) study evaluated the effectiveness of an EIP service compliant with the Policy Implementation guidelines (2001) recommendations. They discovered that an EIP service delivering specialist care for patients with early psychosis was superior to standard care for maintaining contact with services and reducing hospital readmissions.  
- In Denmark, the OPUS study found significant advantages in terms of lower admission rates; symptoms and improved quality of life for an EIP service delivering integrated, sustained treatment compared to standard CMHT based care.

Key aims of many early intervention services are to maintain people in education, training or employment or to enable recovery in these areas. Clearly there are individual economic gains to be attained in terms of increased income as well as improved quality of life associated with financial stability. There are also societal gains in terms of increased production.

Inpatient care

For some home treatment alone may not be the safest or most therapeutic environment. Home factors may be the precipitating trigger for anxiety, stress or depression and a break may be the most realistic option. There may be a need for crisis house/ respite facilities, acute day hospital treatment or a full admission to hospital.

Significant investment in inpatient environments, with over £2 billion invested in new and refurbished mental health facilities since 2001 means that where a hospital admission is considered the most appropriate intervention, people in crisis now have access to services which offer safe, clean comfortable and welcoming physical inpatient environments.

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8 Jones, P, Shiers, D and Smith J (2010) Early intervention in Psychosis Why a specialised EIP service model is preferable to a CMHT model.
9 Ibid
Starwards\textsuperscript{10} is a website which highlights excellence in mental health inpatient care. The website supports, appreciate, and publicises, the excellent work that staff across the country, despite extraordinary challenges. Best practice examples demonstrate how many of the Mental Health Network’s members are creating healing, imaginative and fun opportunities for thousands of patients. Please click here \url{www.starwards.org.uk} for more information.

\textbf{An example from the independent sector}

\textbf{Investing in physical environments and Active Care}

Cambian Healthcare\textsuperscript{11} provide single gender care in locked intensive rehabilitation hospital environments for people assessed as requiring care and treatment that is required after acute inpatient admission or for others who are unable progress their rehabilitation needs in their current care environment (often PICUs, low or medium secure services). The ‘crisis’ for this group is often that they have remained ‘stuck’ in a care pathway and progression to recovery has been inhibited.

There is great investment in bringing service user’s into a very high quality clinical and physical environment. All service user’s are welcomed to a newly decorated room, new mattress and bedding. They also receive a welcome pack including personal luggage, and MP3 player, toiletries and a dressing gown.

Cambian Healthcare adopt an ‘Active Care’ approach, characterised by a multi professional care and treatment model with high qualified staffing levels and the service user ‘actively’ engaged with treatment and intervention. The four main disciplines of nursing, psychiatry, occupational therapy and psychology, in partnership with the service user, their family and local services work in synergy towards a range of evidence based outcomes. These include over 200 measures of progress towards rehabilitation.

Prior to admission the service user will already have received a robust assessment and a full individualised care plan is available for implementation on day one of admission. A key premise is keeping Service User’s busy and engaged in their treatment plan, focusing on need and re-skilling. There is access to onsite gym facilities, an internet cafe and a health and beauty saloon (in the female hospitals). All of the Cambian Rehabilitation Hospitals have been awarded the prestigious ‘Full Monty’ Star Awards award.

It is evident that it is not only the physical environments of inpatient wards which are changing but the philosophy of care. A number of inpatient facilities have made significant improvements to the daily experiences of service user’s while they receive hospital care, including increased choice of therapeutic and leisure activities and implementation of the recovery principles.

\textsuperscript{10} \url{http://starwards.org.uk}

\textsuperscript{11} Cambian Healthcare is part of the wider Cambian Group an independent sector organisation delivering specialist psychiatric rehabilitation, education and LD services across England and Wales.
Birmingham and Solihull Mental Health NHS Foundation Trust

Improving the range and choice of activities improves service user experiences of care and recovery outcomes

User Voice workers hold forums with patients to gather their views on services. A recent forum concentrated on how patients felt the facilities in our new Oleaster Unit had impacted on their care:

“I have more opportunities to do activities based on and off the wards for example massage, exercises, going to the gym and games outside. These didn’t all occur before because the wards only had a tarmac yard.”

“The activity workers help you find things to do. Some days I do artwork but I can just play scrabble with them or get a coffee whilst watching TV.”

“Before we used to have tea served at set times but now I can go to the activity area and use the café. This means I can have a cup of tea or coffee anytime.”

“The staff seem happier on the wards and can spend a bit more time with you.”

“I had a very good experience at Oleaster Unit - it changed my life.”

“This time when I came into hospital they gave me complementary therapies like massage, nearly every day. This relaxed me more. When I left hospital I went back to work much quicker.”

The organisation also supports SUs to achieve their recovery outcomes and have links with First Step Trust (a charity working with the trust to improve service users’ recovery outcomes). This enables service users to improve their work, training and employment opportunities.

Central and North West London NHS Foundation Trust have been working to improve the experiences of service user’s on their inpatient wards and particularly to involve service user’s in influencing and improving services and to have their opinions heard and acted upon.

Central and North West London NHS Foundation Trust

Improving Service User’s experiences

As well as extensive refurbishment of the Mental Health Unit at Northwick Park Hospital, the Trust has set up projects to facilitate service user involvement and
engagement on two of their wards and a Service User newsletter has been introduced as a part of this work. The trust also employs Associate Mental Health Practitioners on some of their inpatient wards. These practitioners come from backgrounds such as Psychology Graduates and return to work mothers. They bring life experience and a new perspective to an inpatient group. Feedback received regarding these posts has been extremely positive, both from a service user and staff point of view.

A SOS (Strategy of Sharing) Project has also helped to facilitate increased sharing and openness to improve service user’s experiences.

Lengthy inpatient admissions have sometimes compromised service user’s existing accommodation, causing worry and also delayed discharges while a new home is found. Some organisations are working to strengthen their relationships with housing organisations to provide continuity and stability accommodation during stressful periods of Service User’s lives.

**Humber NHS Foundation Trust**

**Acute Mental Health links with MIND Housing**

In May 2010 the Trust met with local MIND Housing representatives to look at how services could work more closely together to help people suffering from mental health problems with accommodation needs. While the two organisations had a history of working together both were finding that the service they could offer to clients were often characterised by urgent and often inappropriate referral to MIND resulting in a frustrating often negative response.

It was agreed that in order to work more closely the following principles needed to be followed:

- Early identification of accommodation needs
- Early referral to MIND for accommodation and support
- Early involvement (while the client is still in hospital) of the MIND Housing workers with clients who may benefit from their support while they are discharged from hospital
- Closer links between the two organisation at a staff nurse/housing worker level
- Good discharge and contingency planning
- Generally raising the profile of MIND within the units

In order to achieve this it was agreed that:

- MIND Housing will do a housing “surgery” once a month on each unit
- MIND were offered and took up two seats on the Trust’s Acute Care Forum
- MIND to identify a named housing worker for each inpatient unit
- MIND to be invited into individual unit team meetings on a regular basis to enhance partnership working
An example of good practice around this was when an existing resident of MIND Housing became unexpectedly pregnant which de-stabilised her mental health and required admission to hospital. Throughout the pregnancy and birth the Trust and MIND Housing worked closely together to support the woman. MIND visited her on the unit and attended clinical reviews and Trust staff escorted her to visit her MIND accommodation and MIND staff accompanied her to her pre-natal appointments.

The woman eventually returned to her MIND accommodation (without the baby) but the seamless working between the two organisations meant that her accommodation needs never became an additional worry to her throughout a traumatic period in her life.

**Acute Care Declaration**

In recognition of the need to maintain improving acute care as a national priority, mental health patient groups, NHS service providers and staff groups came together to launch the first national declaration for people with a mental health crisis in November 2009.

The declaration sets out that people who are acutely ill should receive safe high quality care in a comfortable environment. The organisations work together to achieve this by focusing on integrating people back into their everyday lives while also setting out the need to promote a more positive image of mental illness.

The declaration is supported by Mind, the National Patient Safety Agency, Star Wards, Rethink, the Royal College of Nursing, Royal College of Psychiatrists, Royal College of GPs, and The Centre for Mental Health, The British Psychological Society, College of Occupational Therapists, the National Mental Health Development Unit and the Mental Health Network.

The declaration covers five areas

- Tackling stigma
- Promote recovery and inclusion
- Commissioning and providing better care
- Support the development of specialist workforce
- Promote research and development


**The Mental Health Network’s role in acute care**

Since 2005, the national acute programme has been operating as a formal partnership with the Department of Health and the NHS Confederation Mental Health Network to provide a more focused and coherent multi-agency approach to service improvement in acute care. The core components of the acute programme include: Crisis resolution/home treatment teams, respite / crisis house provision, inpatient beds, acute day treatment services, PICU, places of safety and step-down / supported housing provision.

If you would like more information on any of the information detailed in our submission or you would like us to arrange a visit to the services mentioned please contact: