



Northern Health & Social Services Board

COMMISSIONING A MODERN MENTAL HEALTH SERVICE

A vision for the commissioning and development of services for people with mental health problems in the Northern Health and Social Services Board area

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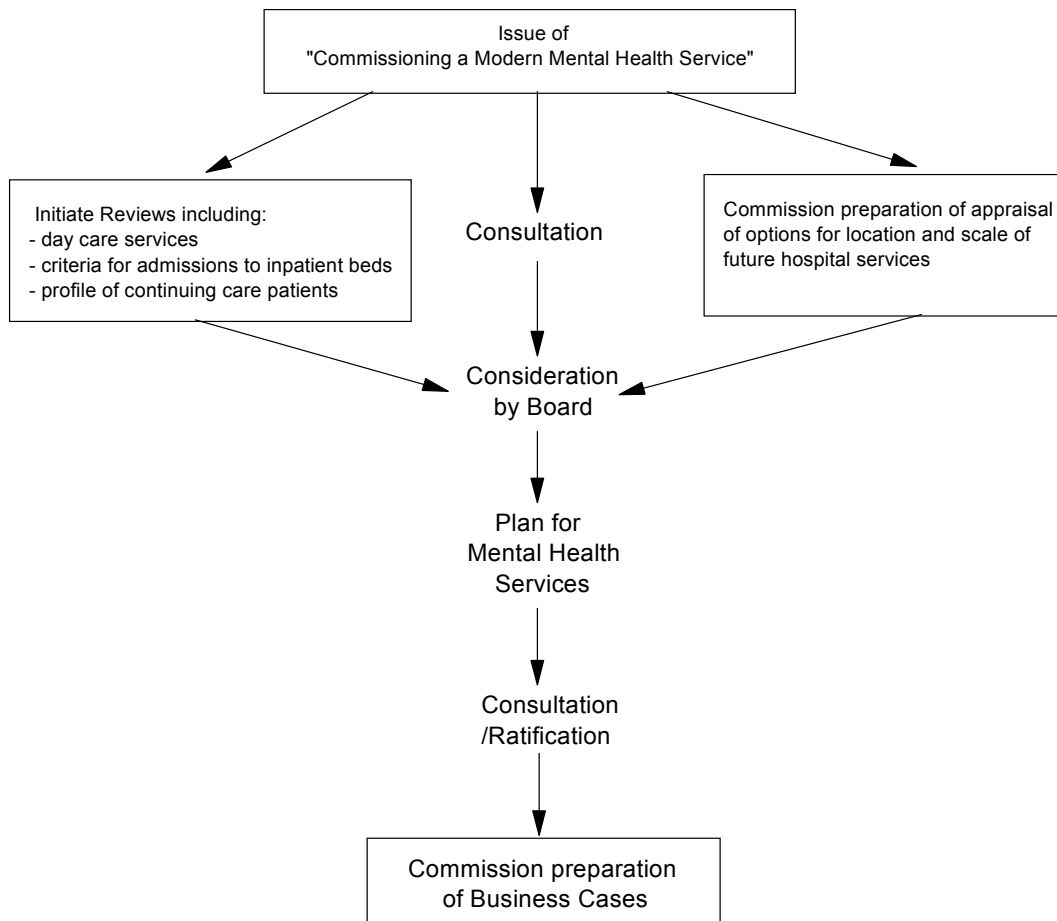
1.0 DEVELOPING THE VISION

- 1.1 This document is about how we should commission and develop services for people suffering from mental health problems within the Northern Health and Social Services Board area.
- 1.2 Over the last two years, the Board has been developing its vision for the commissioning and development of services for people with mental illness in its area. In March 1997, a mental health workshop was held which brought together a wide range of interests including GPs, Psychiatrists, Psychologists, Nurses, Social Workers, together with representation from mental health voluntary organisations. The purpose of the workshop was to identify the key issues, challenges and opportunities facing mental health services in the future and to shape the process for developing a mental health strategy.
- 1.3 An important key element in the process of developing the strategy was obtaining the views of people involved in mental health services. A series of focus groups involving users, carers and voluntary organisations and mental health professional staff and GPs were organised across the Board's area in order to obtain views on the principles which should apply to mental health services, the needs of people with mental illness, how well current services meet those needs and how services could be improved.
- 1.4 The outcome of this, together with an extensive literature review, research into best practice and analysis of information on current services, enabled the production of various theme papers under the headings of:
 - users and carers;
 - mental health promotion;
 - primary care;
 - acute care;
 - continuing care; and,
 - community care.
- 1.5 These theme papers formed the basis for further discussion with individuals, organisations and agencies involved in the field of mental health with a wide range of views being received. In addition, a separate but similar approach was used to develop a theme paper for addictions services.
- 1.6 Drawing on the theme papers and the views expressed, this vision statement sets out the key priorities for the development of mental health services within the Board's area. In developing this vision into a realisable, relevant and affordable plan, the Board will progress along three inter-related paths. These are:
 - the issue of this document to obtain views from users, carers, professionals, providers, and many others who may wish to comment on the analyses and vision proposed. Submissions will be considered by the Board and taken into account in carrying forward the following areas of work;

- progressing a number of reviews on key issues relevant to the current operation and future development of care services, in particular reviewing the shape and form of day care services, establishing criteria for admission to inpatient beds, and producing a profile of the needs of continuing care patients at Holywell Hospital;
- in parallel, the Board will commission the preparation of an appraisal of the options regarding the location and scale of future mental health hospital services across the Board's area.

1.7 The combined outcome of these three strands will inform the development of a major detailed plan for mental health services. The Board will also consult formally on this plan prior to implementing any of its proposed service changes.

1.8 These steps are summarised diagrammatically below:



- 1.9 Anyone who wishes to comment on any of the proposals outlined in this vision document, should do so, in writing, to:

Director of Strategic Planning and Commissioning
Northern Health and Social Services Board
County Hall
182 Galgorm Road
BALLYMENA
BT42 1QB

Comments should be received by Friday, 5 February 1999.

2.0 INTRODUCTION

- 2.1 Mental health problems are very common. These problems range from relatively minor conditions such as mild anxiety to very severe and long lasting forms of mental illness such as major depression and schizophrenia. As many as one in three adults - 100,000 people in the Northern Health and Social services Board area - will experience some form of mental health problem each year. It is, therefore, something that should concern us all.
- 2.2 For most people, these problems will be relatively minor, involving emotional or psychological distress. Depending on severity, many people will deal with the problem themselves or within their families. Many more will seek the advice or intervention of their General Practitioner or other members of the primary care team. In more severe cases people will need to have access to community mental health care specialists, and some will need to have their treatment in hospital.
- 2.3 This document begins by looking at the advances in medical treatment, policy changes, and other pressures which are driving change in the delivery of mental health services. The document also considers the principles which underpin the vision. It then describes how these principles can be upheld in three major settings:
- Primary Care - the management of all mental health problems by members of the Primary Care Team.
 - Community Care - the management of severe mental illness by specialist mental health workers outside the hospital environment.
 - Hospital - which includes acute admission and intensive care in-patient and continuing care (long stay) facilities.
- 2.4 The document focuses on adult and old age psychiatric services (excluding dementia). Subspecialties within the mental health services such as Community Addictions, Rehabilitation, Liaison Psychiatry and Eating Disorders are included within this. Although child and adolescent mental health services are not considered here, a parallel review, facilitated by the Board's mental health and children's services specialist staff, is in progress. The conclusions of this work will also be important in determining the overall mental health service development.
- 2.5 In developing this vision the Board wishes to determine the broad picture of the direction of service development. Agreement on this will allow better future co-operation regarding the most effective delivery of care for people with mental health problems.
- 2.6 Accordingly, this document should not be considered as a comprehensive examination of all aspects of how mental health services are currently delivered in the NHSSB area. Neither does it attempt to give a detailed specification of how proposed changes will occur, although areas where such work is needed are clearly outlined.

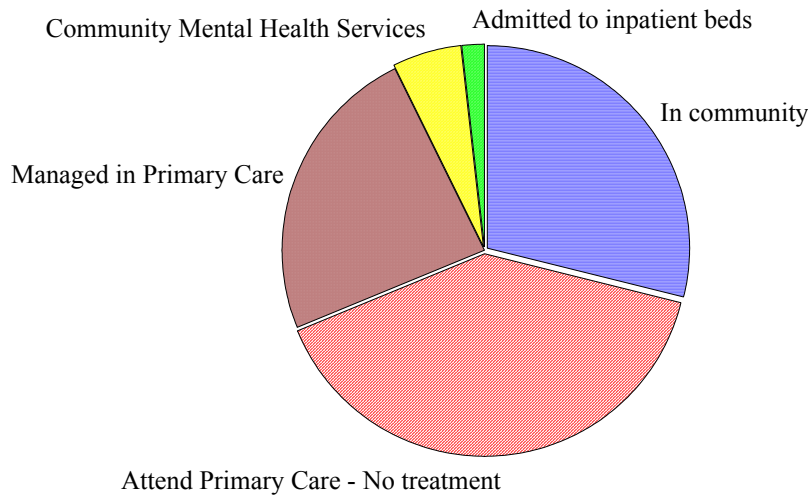
- 2.7 This document is therefore a further step in the development of comprehensive mental health services for our population.
- 2.8 The Board has identified many areas for change , development and modernisation. Some may be achieved without any additional cost and steps towards their implementation can be taken almost immediately. Moving ahead on some of these may depend on redeployment of current resources. In this respect, the Board will wish to work collaboratively with service providers to quantify the degree of change necessary.
- 2.9 Most changes will require additional resources and we will only be able to make progress as these resources become available.
- 2.10 Given that major change in any area is potentially costly, we should not underestimate the difficulties in funding the strategic direction of the service as set out in this document. Analysis of expenditure using 1996/97 data shows that, in comparison with other Boards in the province, the Northern Health and Social Services Board is already spending more on mental health services than it receives. In this climate, the redirection of further resources towards mental health services could disadvantage other client groups. The Board is determined however to make strong representations to the Department of Health and Social Services for additional resources in this area. In doing so, it will be necessary to demonstrate that the resources currently at its disposal are used to best effect in providing a balanced range of mental health services.

3.0 MEETING NEEDS

- 3.1 Most people with mental health problems will be in contact with primary care professionals, usually their General Practitioners during the course of the year. Some will consult as a direct result of their mental health problem, but many more will visit because of a related or unrelated physical condition. A large number of people will receive treatment for their mental health problem within primary care and a smaller proportion will be referred to the secondary mental health services receiving treatment within the community or in psychiatric in patient facilities.
- 3.2 Perhaps the most visible aspect of mental ill health is the suicide rate. Each year, in the Northern Health and Social Services Board area, between 30 and 40 people take their own lives. This is around the same number of deaths as those caused by road traffic accidents. Like road traffic accidents, suicides are largely unnecessary and preventable. Of particular concern in recent years is the apparent increase in the number of suicides in young men.
- 3.3 At the other end of the scale, most of us will suffer from a mental health problem at some stage in our lives. For the majority, this may be a stress-related condition which is short lasting and tends to resolve without the need for outside help. However, all these problems have the potential to develop into more serious conditions requiring the involvement of professionals at the primary or even secondary level.
- 3.4 Therefore, there is a need for everyone to be aware of the importance of good mental health. This applies to the population at large as much as those known to be at risk of developing more serious mental health problems. These positive attitudes will assist earlier intervention which is effective in preventing some mental health problems and is vital for the management of many more.
- 3.5 Good mental health depends on factors often outside the control of the health and personal social services, such as family life, housing conditions, employment, level of income and education.
- 3.6 Staff at primary and secondary care level are already engaged in general population awareness work and individual programmes with service users and their families. It is important that this work should be further developed and that services listen to and include the views of users and carers.

3.7 The diagram and table below gives an estimate of the number of people at the different levels of management of mental health problems in any one year. These estimates are based on the work of Goldberg and Huxley, which is derived from practice in England in the 1980s. The need for hospital admission will tend to be overestimated in the absence of effective community-based support. Other factors, not taken into account when applying these rates to a local population include the acknowledged greater need for mental health services in urban areas and areas of high socio-economic deprivation. The numbers in the table refer to the total number of people in the population with mental health problems during a given period of time (prevalence) rather than the number of people experiencing a mental health problem for the first time (incidence).

Mental Health Problems in the Population



3.0

Level □		Number of People	% of People with Mental Health Problems □	% of Population
1	In community, managed outside primary care □	29,000	29	9.5
2	Attend primary care - no treatment □	40,000	39	12.8
3	Managed in primary care □	24,000	24	7.8
4	Managed in community mental health services □	5,500	6	1.8
5	Admitted to in patient beds □	1,800	2	0.6

4.0 DRIVERS FOR CHANGE

4.1 Every service must respond to changing circumstances in order to deliver the best possible care to its population. This section considers the issues which are currently driving change within the mental health services. In summary these are:

- Care within the community;
- New drug treatments;
- Increasing public expectations;
- User and carer consultation;
- Increasing specialisation;
- Primary care commissioning;
- Focus on serious mental illness;
- Increasing demand for acute hospital beds;
- Equity;
- Interagency work.

4.2 It is apparent that there are potential conflicts between many of these factors. For instance, the cost of providing extra inpatient beds could limit developments in the community. The future development of mental health services will depend on our ability to recognise these tensions and address them.

Care within the Community

4.3 The policy of delivering care wherever possible in the community is reflected in the Regional Strategy *Health and well-being: into the next Millennium* where the strategic goal is that “long-term institutional care should no longer be provided in traditional psychiatric hospital environments”, recognising the right of people with serious mental health problems to lead as full and independent a life as possible.

4.4 These considerations must be balanced with the need to protect vulnerable people with serious mental health problems from the hazards encountered in the community and the need for the community itself to be protected from the small number of seriously mentally ill people who are considered dangerous by virtue of their mental state.

New Drug Treatments

4.5 In recent years new drug treatments in psychiatry have led to rising drug costs for mental health services. It must be recognised, that their use may lead to a better overall quality of life for many people with serious mental illness and indeed enable them to be cared for within the community.

Increasing Public Expectations

- 4.6 Factors such as the pressures of modern life, the breakdown of the extended family and, particularly within Northern Ireland, the effect of the “Troubles” has resulted in a greater number of people seeking help for psychological problems. Together with the publication of Patients’ Charters, this has led to an increasing public awareness of mental health services. This has increased expectations of the service in terms of access, speed of referral and availability of a comprehensive range of treatments.

User and Carer Consultation

- 4.7 The active participation of users and carers is essential in planning modern mental health services. This stems from the recognition that people in receipt of a mental health service have fundamental rights in shaping that service.

Increasing Specialisation

- 4.8 As mental health services become more sophisticated and respond to new demands, so there has been increasing specialisation, particularly within the hospital sector, for example Psychiatric Intensive Care and the need for specialised addiction services. While specialisation helps to improve the quality of the service, it is also costly.

Primary Care Commissioning

- 4.9 The concept of a primary care centred national health service is Government policy. Within Northern Ireland this has most recently been highlighted in the consultation paper *Fit for the Future*. It is clear that, whatever the future shape of the service, primary care will have much greater involvement in and control of the commissioning process.

Focus on Serious Mental Illness

- 4.10 Where demand is high and resources limited, services must prioritise towards those in greatest need and it is right that there should be a focus on serious mental illness as the appropriate domain of secondary mental health care services. This will always involve the exercise of individual and collective clinical judgement and will not be to the exclusion of complex social problems or those with severe personality disorder.

Increasing Demand for Acute Hospital Beds

- 4.11 There is increased demand for admission to acute mental health beds across the UK generally and this is also true in Northern Ireland. The reasons for this are complex and resources will require careful management to meet growing demand.

Equity

- 4.12 All individuals in need of mental health care should have equal access to that care and mental health services generally should receive a fair share of the total resources. The Commissioner must respond positively to both of these pressures.

Interagency Work

- 4.13 There is increasing recognition that good health and social care planning and practice will be based on co-operation with those agencies responsible for matters such as housing, levels of income, education and employment. Northern Ireland also has a large and growing voluntary sector and the many highly successful examples of successful partnership between statutory and voluntary organisations demand that we build on that success.

5.0 PRINCIPLES OF THE VISION

5.1 The aims of a mental health service are:

to improve the mental health of the population and maintain that improvement by:

- assessing, treating and caring for people with mental health problems;
- supporting their relatives and carers;
- actively engaging users and carers in the development of treatment and support programmes;
- where possible, reducing distress, disability and death;
- enabling the greater fulfilment of potential in all areas of life;
- promoting positive mental health for all;
- assessing the risk of community placement of individuals with serious mental illness, both to the individuals themselves and to the whole community.

5.2 Issues relating to the mental health of the population are wider than the scope of the health care services. If an improvement in the mental health of the population is to be achieved and maintained, all relevant agencies working within the community must be involved. It is therefore vital that our objectives are broad enough to allow all participants to identify with them rather than feel they are “health care” oriented.

5.3 In this respect, we must take account of the broad direction of national and local guidance both in mental health and other aspects of the development of the health and personal social services, e.g. the NHSSB’s strategy for the development of Acute Services, the Regional Strategy for Health and Social Well-being - *Into the Next Millenium, Well into 2000* and the recently-published consultation paper *Fit for the Future* on the structure of Northern Ireland’s Health and Personal Social Services. It is also vital that the results of the best and most recent research into hospital and community care of people with mental health problems are disseminated and applied where appropriate to the development of our services.

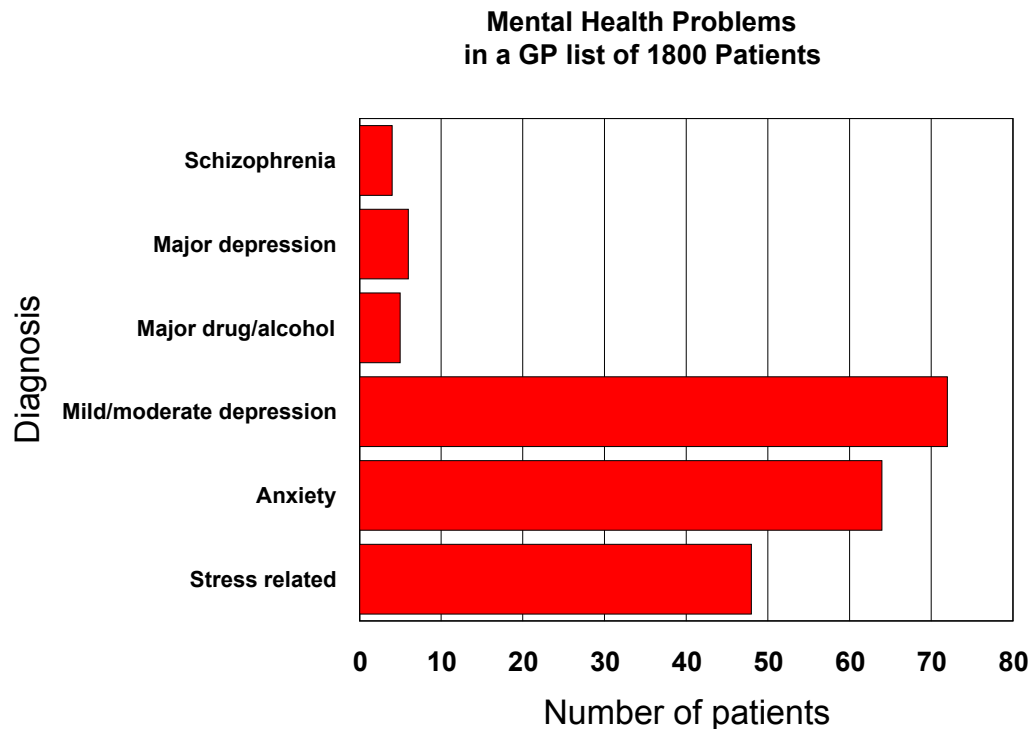
5.4 Our overall objective must be to focus on the incidence of severe mental illness and to reduce the distress and suffering associated with such conditions by ensuring that an appropriate and effective service is in place. Mental health services are complex and it is important that clear principles are stated upon which these services may be shaped to address the mental health needs of our population.

5.5 Therefore, the following general principles apply:

- Services must achieve the highest possible quality of care;
- Services, whilst working to improve the mental health of all, must afford the highest priority to those with the greatest need;
- Services must ensure that all Northern Board residents receive equal treatment for equal need;
- Services must provide a comprehensive range of interventions that respond to individual mental health needs;
- Services, wherever appropriate, must aim to conduct the caring process within the community;
- Services must be provided on a multidisciplinary and multi-agency basis and the commissioning process must involve key agencies on a collective basis;
- Services, where possible, must use interventions which are evidence based and clinical care which represents recognised good practice;
- Services must take account of the views of users and their carers, managing the possible tension with professional advice.

6.0 PRIMARY CARE

- 6.1 Most people with mental health problems are assessed and treated within the primary care setting and without referral to secondary care services.
- 6.2 Primary care teams vary in their composition but usually include General Practitioners, Nurses, and a range of other professionals. All members of the primary care team have an important role to play in the care of people with mental health problems.
- 6.3 All primary care professionals tend to have a long-standing knowledge of the families in their care. This continuity of care has the potential to prevent relapse, promote effective treatments and avoid unnecessary hospital admissions. This is particularly relevant in vulnerable groups such as young mothers with post natal depression and the isolated elderly. Primary care professionals will often be the first to recognise the impact of a developing mental health problem on individual sufferers or those close to them.
- 6.4 The figure below gives an estimate of the number of patients with different types of mental health problems on a typical General Practitioner's list of 1,800 patients.



- 6.5 It is apparent that the experience of mental health problems in primary care is heavily weighted towards the less severe types of mental ill health.
- 6.6 The Primary Care team plays a vital role as the “Gatekeeper” to the secondary mental health service. With the secondary services charged with the management of serious mental health problems, it follows that most, if not all, other presenting mental health problems should be managed within primary care either through treatment at primary care level or appropriate redirection to other agencies.
- 6.7 The Primary Care setting is also the most appropriate for mental health promotion in terms both of patient education and early recognition of mental health problems. This important role has long been recognised by workers in primary care whose training encourages them to consider the psychological and social, as well as the physical determinants of presenting problems. Studies estimate between 20% and 60% of all activity in primary care has a major psychological component.
- 6.8 In recent years, perhaps as a consequence of increasing patient expectation, there has been a noticeable increase in the workload in primary care. This is a particular problem for the assessment and management of mental health problems within primary care as they tend to be more time consuming than physical problems.

There is thus the potential for:

- Failure to identify emerging mental health problems;
 - Somatisation - attributing a physical cause to the problem, resulting in unnecessary physical investigation and medication;
 - Inappropriate referral to the secondary mental health service leading to an increased workload in that area and ultimately to an increased demand for acute inpatient admissions.
- 6.9 As primary care workers are trained as generalists their knowledge and experience of mental health problems will vary greatly.
- 6.10 Primary Care Teams should be equipped with the skills and confidence required to carry out their role as first point of contact in the management of all forms of mental health problems.
- 6.11 This will be facilitated by:
- Participation in the development of and commitment to appropriate criteria for admission to mental health in-patient beds and referral to the Community Mental Health Team;

- Engagement with the Community Mental Health Team to determine the appropriate level of advice and support required in managing mental health problems within the primary care setting;
- Identification and provision of appropriate specialised training programmes for all members of the Primary Care Team.

Primary Care Mental Health Workers

- 6.12 All referrals to the secondary team should be through primary care. This approach would be aided greatly by the establishment of specialist Primary Care Mental Health workers within the team. These would ideally include people with a nursing, psychology and social work background with either a specialised interest in mental health as part of their generic role or previous experience of working with people with mental health problems. The Primary Care Mental Health workers would ideally be able to undertake some functions currently the responsibility of secondary team members such as anxiety management groups and other “talking treatments” and self-referrals to social services.
- 6.13 There is also scope for the appointment of workers whose primary brief is to provide practical support. In the case of both the Primary Care Mental Health Worker and the Support Worker, it is likely that their responsibilities would be to a number of Primary Care Teams. The support of and liaison with the appropriate CMHT would be vital to the success of this initiative as would be the establishment of a formal support network of all Primary Care Mental Health workers.

Counselling in Primary Care

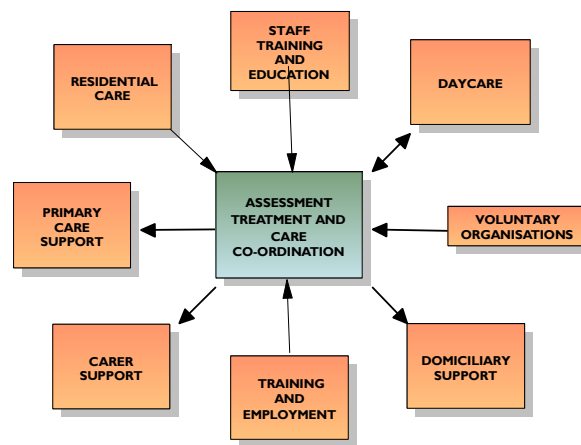
- 6.14 The establishment of a counselling service in primary care has been proposed as an option in tackling the volume of less severe mental health problems in this setting. However, the evidence, particularly when applied to non-directive counselling, that this is an effective option is equivocal. Neither is there much support for the belief that it will reduce the General Practitioner’s work load, rather there is a suggestion that a new client group would be created, thus increasing the overall burden on the Primary Care Team.
- 6.15 The Board has therefore determined that any proposed scheme for the introduction of counselling in primary care will be on a pilot basis only. Furthermore such a pilot scheme should clearly establish the categories of service users likely to benefit from its services and the specific types of interventions to be used. Activity would therefore be restricted to these service users and interventions. Continuation of the scheme beyond the pilot phase would be conditional on confirmation of predetermined outcomes, including a reduction in the workload of other members of the Primary Care Team and/or a reduction in referrals to the secondary sector

7.0 MENTAL HEALTH CARE IN THE COMMUNITY

- 7.1 In a community-centred mental health service the vast majority of care of people with severe mental health problems and contact with mental health professionals takes place in a community setting. Within the Northern Health and Social Services Board Area, the care which is initially provided by a GP or other primary care professional is supported by a Community Mental Health Team (CMHT) which usually includes the services of a range of professional and supporting staff, principally a Consultant Psychiatrist, Mental Health Social Worker, Psychologist, Occupational Therapist and Community Psychiatric Nurse.
- 7.2 The care of people with mental health problems in the community carries with it a level of risk for the sufferer, carer, the wider community and those who work in the mental health field. It is important to recognise these risks and to do everything possible to minimise them. It is also important to acknowledge that risk is often unpredictable and cannot be completely eliminated.
- 7.3 Nevertheless, modern mental health care has enabled most people with severe mental illnesses such as schizophrenia or major mood disorders to live within the community rather than in institutions. This is reflected by the workload of mental health professionals in the community. For instance, in 1997/98 there were over 15,000 mental health outpatient attendances in the Northern Health and Social Services Board area. Psychiatric outpatient clinics run by Consultant Psychiatrists, are just one aspect of a wide range of community based mental health services provided within the Northern Board area by Homefirst and Causeway Trusts and several independent organisations. These include:
- community mental health nursing;
 - community mental health social work;
 - psychology;
 - psychotherapy;
 - occupational therapy and other Professions Allied to Medicine (PAMs);
 - assessment and treatment of addiction problems;
 - statutory and independent sector specialist residential care;
 - respite care;
 - non-specialist residential and nursing home care;
 - day-care and social care;
 - training and employment schemes;
 - home - based care and support;
 - befriending;
 - carer support.

7.4 The provision of community mental health services is therefore a complex undertaking, involving a wide range of professional disciplines and services. It focuses not only on the care and treatment of each patient's formally diagnosed psychiatric illness but also on a range of social and relationship problems which, if not addressed, can contribute to the development or recurrence of mental ill-health. This complicated and interdependent set of organisational relationships is outlined in the diagram below.

THE COMMUNITY MENTAL HEALTH TEAM



7.5 In 1996/7 year, community mental health services cost approximately £9 million, representing 38% of the Board's total spend on mental health services.

Community Mental Health Teams

- 7.6 CMHTs operate in all localities throughout the Board. They are an important link between community and hospital services and are well placed to access and co-ordinate a range of therapeutic services in the community for people with mental health problems. They also directly provide a wide variety of services and have statutory responsibilities under a range of legislation including the Mental Health (NI) Order (1986) and the Children (NI) Order 1995. They are responsible for the management of serious mental illness in a community setting. In this context, they assess, treat and monitor individual mental state and general well-being. Considering their client group, they have significant responsibilities in the protection of vulnerable adults and children and are tasked with responding to individual and family health and social needs including housing, finance, relationships, training and employment, and leisure and the needs of children and their families.
- 7.7 As a secondary care service, the work of CMHTs should focus on those presenting with severe and enduring mental health problems. However, as indicated above, community mental health teams are experiencing an unprecedented level of demand for their services. Through the policy of community care, more and more patients who were previously treated in hospital are being treated at home and/or followed up by the community teams. At the same time, greater numbers of people with less severe problems are being referred to the teams.
- 7.8 The Board believes that, for the majority of serious mental health problems, CMHTs are most appropriately located within or as close as possible to the communities they serve. If serious mental health problems are to be dealt with in this way the caseloads of community mental health professionals will need to be reviewed in order to release professional time to deal with serious problems in an effective way. This will inevitably mean that the less severe mental health problems will have to be managed within primary care. To facilitate this CMHTs should develop the consultative role in order to provide support and advice to primary care workers. The differing needs and abilities of Primary Care Teams should be recognised, with CMHTs providing an appropriate package of support for each Primary Care team within its sector. Every primary care team and/or GP practice within the Board's area should have an identified and named professional from the community mental health team to act as their contact and liaison point, to advise on individual referrals or to co-ordinate access to training if necessary.
- 7.9 In addition, if the role of the CMHTs is to become more specialist, dealing with a patient/client profile with a higher degree of dependency, it is important that appropriate training programmes are put in place and adequately resourced.
- 7.10 For certain mental health subspecialties the most effective delivery of care is on a Board wide basis. This may be either on the basis of a dedicated community team, as in the case of addictions or as an additional part of the work of an existing CMHT - for example, the development of a community-based eating disorders service.

- 7.11 During consultation on the development of this vision statement, it became clear that a consensus exists between users, carers and professionals that community services are underdeveloped and that this is one of the major contributory factors to the current pressure on acute beds.
- 7.12 It is also recognised that there are differing demographic characteristics within the Board's area, for example the growing problem in the use of illicit drugs. The Board wishes to ensure that there will be an appropriate community service response to this growing problem and various models of provision have been discussed between representatives of the Northern Drugs Co-ordination Team and Board Officers. The Board will monitor developments associated with this and respond appropriately.
- 7.13 The future development of community based services must be sufficiently flexible to respond to the particular mental health problems of each locality. Additionally, any significant differences in the level of service provision across the Board's area which is not readily explained, either in terms of population size, deprivation or unmet need must be addressed.
- 7.14 In order to support the strategy outlined for acute and continuing care hospital services, it is clear that community services will require:
- additional new investment;
 - a redefinition of their role and associated refocusing of their activities;
 - an ability to accommodate new ways of working.
- 7.15 In summary, the following measures are required in order to ensure the continued effective functioning of CMHTs:
- refocused caseloads for Community Mental Health professionals;
 - the development of appropriate advice and support arrangements between CMHTs and Primary Care Teams;
 - additional and continuing specialised training for Community Mental Health professionals.

Alternatives to Hospital Admission

- 7.16 No-one wants to have to go into hospital but this sometimes seems to happen because there is no available community alternative. The apparent lack of appropriate community alternatives to hospital admission can also be responsible for delayed discharge from hospital. The Board is therefore convinced that the development of community based facilities for the assessment and treatment of serious mental health problems is a priority.

- 7.17 If community mental health teams are to focus on severe mental illness, it is essential that the range of services available in the community is as wide as possible in order to deal effectively with most presenting problems. Their ability to do so at present is inhibited by the relatively restrictive range of facilities available.
- 7.18 Despite innovative approaches, and the high level of commitment of the professional staff, it is quite clear that more could be done within the community. Best practice elsewhere suggests that the development of a range of community based alternatives to full hospital admission for the assessment and treatment of some mental health problems significantly enhances the effectiveness of community health teams, relieves pressure on mental health hospitals and ensures that people only have to go to hospital when it is really required. Over the next five years the Board will wish to see developments in this direction.
- 7.19 The type of developments the Board would wish to see in place (in addition to the enhancement of the day-hospital option) are defined, for the purposes of this document, as short-stay assessment and treatment houses with close involvement and support from CMHT members but established in residential accommodation within the community. Such establishments would not differ greatly from some existing hostels. However, they would clearly be able to manage a range of acute psychiatric conditions, thereby dealing with patients for whom hospital would have previously been the only available alternative.
- 7.20 The Board attaches a high priority to the development of such an approach. It has no fixed preference as to the location of such a project and wishes, subject to resources being available to begin an early dialogue with potential providers, users and carers as to the best way of securing this service.
- 7.21 The ability of the service to deal flexibly and effectively with serious mental health problems in the community would be greatly enhanced if, as elsewhere, the type of approach outlined above could be supported by the development of “drop-in centre” schemes. There are a number of different models which can be adopted ranging from a ‘clubhouse’ to a ‘crisis support centre’, which will be based in the major centres of population within the Board’s area. It may be possible to move this forward through identifying voluntary sector partners.
- 7.22 As many alcohol and drug problems continue to be treated in hospital, the Board will wish to develop over time the capacity of the Community Addictions Service to receive and treat such problems in a community context. As a first step, the Board is promoting a small piece of research into home detoxification as an alternative to hospital admission for those people for whom this is appropriate.

The Provision of an Out-of-Hours Mental Health Crisis Response Service

- 7.23 Mental Health problems and crises can and do occur at any time of the day or night, weekday or weekend. The need to provide care on a seven-day-a week, 24 hours per day basis has been recognised by the Board for some time. Elsewhere, the development of a 24 hour Crisis Response Team has been suggested as an alternative to immediate hospital admission. The Board believes, however that the establishment of such a team, given its area's relatively small population and large geographical area, would not be a cost effective option. As an alternative, a proportion of mental health "crises" occurring out of hours may be resolved, at least in the short term, by 24 hour telephone access to appropriate professional expertise. Such a service was given a high priority by user and carer groups in discussions on the development of mental health services.
- 7.24 The existing 'out-of-hours' Social Services 'Standby' system is currently being reviewed and its further development, including the possibility of closer links to the 'out-of-hours' Dalriada Doctor on Call service, will be examined with particular reference to mental health problems. The strategic aim will be that patients or clients who are experiencing a crisis will receive a high quality specialist response.

Day Care

- 7.25 The current range of day care for people with mental health problems continues to play an important role in the delivery of a community-based service, not only in terms of providing a therapeutic and health - maintenance function but also in terms of it's provision of prevocational assessment, training and respite care. For many people, attendance at their local day-centre is a vital and invigorating part of their weekly experience and day care staff are to be commended for their efforts to provide individually tailored programmes of care.
- 7.26 For others, however, traditional forms of day care are insufficiently dynamic, particularly for younger people. It is no longer acceptable to them to have their needs addressed alongside the needs all client groups or to sublimate their individual requirements within the framework of existing provision.
- 7.27 There have also been significant conceptual advances in day-care planning with a variety of new models in evidence around Northern Ireland. Recent policy changes mean that individual clients can now secure alternative forms of day care if it is available through the Direct Payments legislation. They may in the future be liable to contribute toward the cost of their day care if the DHSS proceeds to introduce plans for charging for certain services. All of these changes have occurred against the background of an increasing drive for efficiency and effectiveness, not least in terms of cost.

7.28 With the above in mind, the Board wishes to review the range of day care provision in both the statutory and independent sectors, engaging with all providers to examine the current profile of day-care, to canvass the views of day care users and work towards the provision of the optimum range and level of service. This review will be based on partnership throughout and will include:

- an assessment of the different models in use and the available conceptual models;
- the efficiency and effectiveness of different models with particular reference to the costs of various alternatives;
- the impact of change on other programmes of care;
- the availability of training and employment opportunities to all those who may benefit;
- the location of these services in line with the need to ensure equal access for equal need within the Board's area.

8.0 HOSPITAL SERVICES

- 8.1 Hospital services, particularly inpatient beds, have traditionally been considered the centre of a mental health service. Broadly there are two types of inpatient beds: acute beds where patients are admitted, assessed and treated for relatively short periods of time and continuing care beds where patients with severe and enduring mental illness have been cared for in a hospital environment for considerably longer periods of several years. Regarding the latter, it is established Government policy that the future provision of care should not take place within a hospital environment.
- 8.2 During the last forty years and more, there has been a planned shift away from large psychiatric hospitals. In the past decade this has largely been as a result of implementing Government policy on “care in the community”. However a number of highly publicised incidents in Great Britain has recently cast some doubt on the wisdom of this approach.
- 8.3 It is clear that a balanced view is required. In this respect, it is perhaps fortunate that an extensive programme of psychiatric hospital closures did not proceed in Northern Ireland as elsewhere. However, there have been significant net bed reductions within the Northern Board area over the past number of years, although these have largely been replaced by the commissioning of other services, including beds, in the community. The total number of hospital inpatient beds has decreased from 414 in 1992/93 to 346 in 1997/98. This planned reduction has been facilitated by the integrated nature of health and social services within Northern Ireland and the availability of considerable bridging funding over the period to enable the shift from hospital to a range of appropriate community settings.
- 8.4 As well as national initiatives, the pattern of mental health services in the Board’s area and in the province generally have changed as a result of more local policy developments. For example, the implementation in the late 1980’s and early 1990’s of what became known as the Donaldson 2 Review saw responsibility for mental health services for the Magherafelt, Cookstown and Coleraine areas transfer from the Western Board to the Northern Board. Implementation included the development of Ross Thomson Unit, Route Hospital, Ballymoney and a number of community based initiatives in the Magherafelt and Cookstown areas.

Acute Inpatient Care

- 8.5 Within the Northern Health and Social Services Board area acute inpatient facilities for the assessment, care and treatment of people with a mental illness are situated in 3 locations: Holywell Hospital, Antrim; the Ross Thomson Unit, Ballymoney; and Ward 8, Whiteabbey Hospital. A relatively small number of patients make use of facilities located in the Western Health and Social Services Board area. Other patients may be referred, through the extra-contractual referral process to facilities within or outside Northern Ireland.

- 8.6 The services commissioned by the Board at Holywell includes three wards providing an acute admission service for adults with a mental illness living in Larne/Carrickfergus, Antrim/Ballymena, and Magherafelt/Cookstown areas.
- 8.7 A number of Board-wide specialist services including psychiatric intensive care, rehabilitation and continuing care beds are also located on the Holywell site.
- 8.8 The site at Ross Thomson provides a 24 hour acute admission service for adults and old age mental health problems for the population of Ballymoney, Coleraine and Moyle.
- 8.9 Ward 8, Whiteabbey provides an acute admission service for the Newtownabbey area and differs from the Ross Thomson Unit in that it offers admission on a five day week basis (Monday - Friday, 9am - 5 pm). People requiring admission outside this time are admitted to Holywell. Hospital.
- 8.10 There can be no doubt that inpatient hospital treatment is the only practical option for specific groups of patients at specific stages of their illnesses. Therefore the provision of an appropriate number of inpatient beds will always be a key component of any plan for the development of mental health services.
- 8.11 However, as stated above, a key principle is the provision of mental health care within the community wherever possible. This acknowledges the need for a further move away from the centrality of the inpatient provision. A modern mental health service must be community centred. Admission to hospital, for the majority of conditions, should be seen as the last resort. This position will be greatly facilitated by the existence within the community of effective alternatives to hospital care.
- 8.12 Having agreed that inpatient bed provision is necessary, further important considerations are the purpose, location and scale of in patient beds in the required facilities.

Purpose

- 8.13 It will be necessary to continue to commission locally based acute psychiatric hospital bed provision within the Board area. These services will continue to focus on the assessment and treatment of adult and old age mental health problems, with the addition of full day-care provision on all sites.
- 8.14 The main area-wide services which will be required include forensic psychiatry, an eating disorders service and an in-patient addictions/detoxification service. As a first step, the Board wishes to see the establishment of a Detoxification Unit as an area-wide service. The Board will also consider positively options to improve current intensive care facilities.

- 8.15 Some highly specialised services will need to be provided on a region wide basis. In some instances, this will involve patients travelling outside the Board's area to access the services. These may include some forensic services (Medium Secure Unit and psychosexual disorders), residential treatment of eating disorders, and brain injury services.

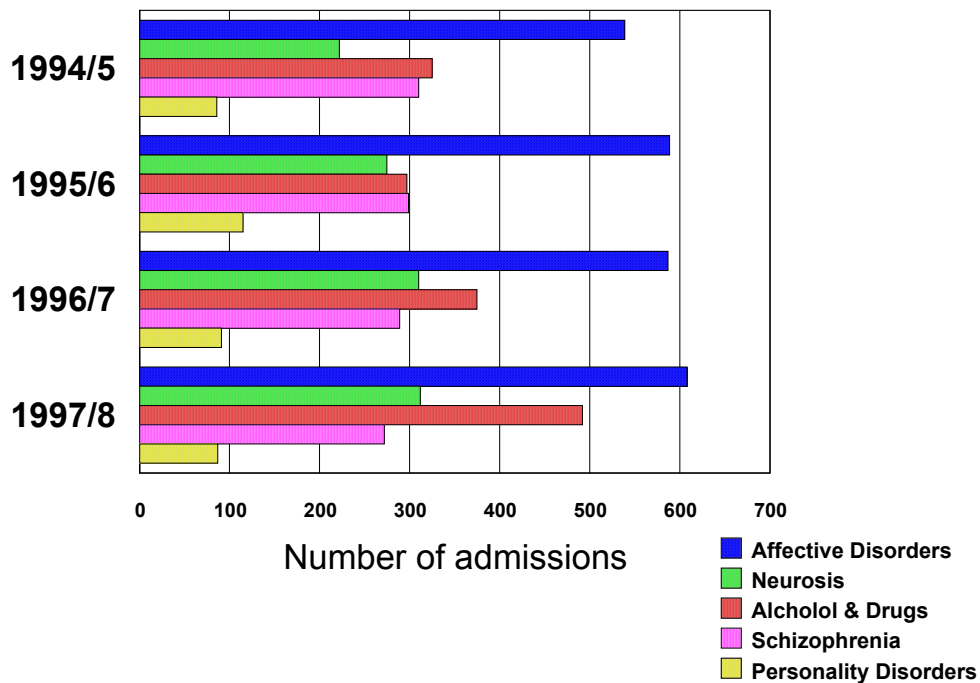
Location

- 8.16 Acute admission in-patient beds for the Causeway area are due to move from the Ross Thompson Unit in Ballymoney to the new Causeway Hospital in Coleraine. The opportunity may also exist to relocate the current Whiteabbey service into alternative accommodation within the Whiteabbey Hospital site and to strengthen its capacity to provide 24 hour, seven-day cover. Acute admission sites will therefore be located at Antrim, Whiteabbey and Coleraine for their respective sectors.
- 8.17 As stated above, the role of inpatient mental health services is changing, as reflected in the greater specialisation of area-wide services and increasing patient and public expectations. Central to much of this is the need for specialised mental health services to be located in close proximity to acute medical and surgical facilities. The facilities currently sited at Holywell are more reflective of the care delivered in previous eras. Amongst the problems are its inappropriate scale and its age which are both leading to increasing maintenance costs. Planning for a new build may ultimately be more cost-effective than piecemeal change of existing building stock. This will need to involve the appraisal of a number of strategic options including the development of new stand-alone facilities on the Holywell site and the possibility of relocating some services currently provided from Holywell Hospital to the Antrim Area Hospital site.
- 8.18 In relation to all the above elements, the Board will wish to examine these concepts and test their feasibility. Clearly, any relocation of acute facilities off the Holywell site has implications for the location of the new Psychiatric Intensive Care Unit.

Scale

- 8.19 For several years there has been an increasing demand for acute mental health in-patient beds. For example in 1997/8 there were over 1,900 direct admissions to acute and psychiatric intensive care beds in the Northern Board area compared with 1,600 admissions in 1994/5. This is not limited to our area but is a recognised national problem.
- 8.20 It is likely that the problem is due to a combination of factors rather than a single source. Furthermore, the types of patients admitted to mental health beds and the duration of their stay is closely linked to the availability of alternative care provision in the community. All admissions to inpatient beds will clearly be 'appropriate' in the absence of community alternatives. An understanding of the broad diagnostic groups of patients currently admitted to in-patient care will be helpful in the development of community-based alternatives. The figure below highlights the changes in the number of admissions in five such diagnostic groups over a three year period.

Diagnosis of people admitted to inpatient beds 1994/7



8.21 The ‘logical’ response to the increased demand would be an increased provision of in-patient beds. However this response would be at the expense of the development of viable community alternatives to hospital admission. The Board also recognises the legitimate concerns that a reduction in in-patient beds prior to community developments would exacerbate the problem.

8.22 Considering the above the Board wishes to make the following undertakings:

- The Board does not plan any permanent increase in the current in-patient mental health provision.
- The existing acute bed provision will be maintained pending the development of effective community alternatives to in-patient care. If the pilot schemes detailed above are successful, it is likely that the future bed requirement will be less than that currently commissioned.

- 8.23 In order to address the problems and achieve the changes outlined above, it will be necessary for providers:
- in consultation with General Practitioners within their catchment area, to develop admission and discharge criteria which reflect efficient and appropriate use of in-patient beds. Separate, but complementary criteria should be developed for subspecialty beds such as intensive care and detoxification.
 - to adopt a rigorous approach to the application of these criteria.
 - to participate in the development of pilot schemes in the community which are designed to act as alternatives to hospital admission.

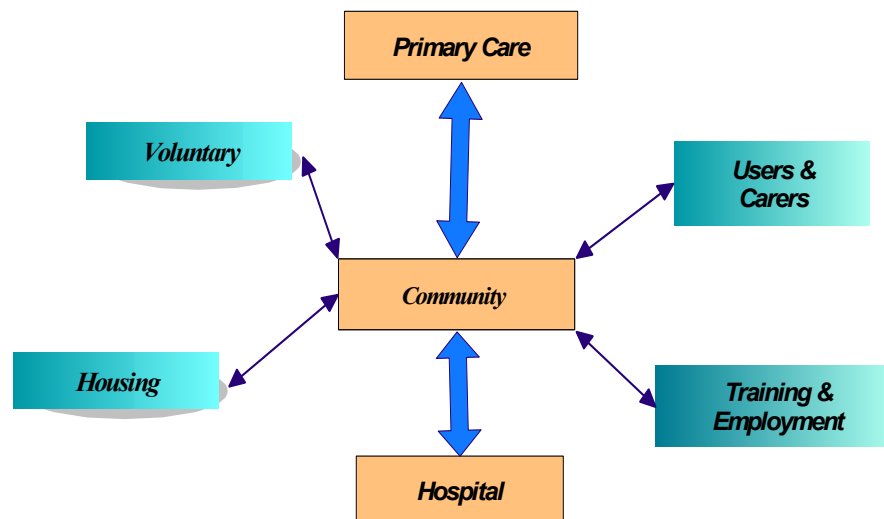
Continuing Care in Hospital

- 8.24 Everyone working within the mental health service wants to ensure that we avoid creating a new group of institutionalised patients. This is yet another instance of the principle of mental health care based within the community. It is also a requirement of the Regional Strategy ‘that long-term, institutional care should no longer be provided in traditional psychiatric hospital environments’. There are however two groups of patients for whom the community approach may not be possible:
- those patients who have been in hospital for many years, who have either attempted to move into a community placement and have found that for whatever reason, this has been unsustainable or who have expressed a wish to remain in a hospital setting;.
 - those patients who fall into the “new long-stay” category (in hospital for more than six months) for whom a community placement has not yet proved possible.
- 8.25 The Board is aware of its duty to minimise risk to the individual patient and the wider public and believes that no patient should be discharged into the community if that is unsafe for that person or for the community, or if the individual is so institutionalised that they cannot successfully leave the hospital. At the same time, the Board is determined to ensure that the quality of the life experience for those patients who remain in hospital is as high as possible within the constraints which are imposed by living within a segregated hospital site. Furthermore, the development of community alternatives for the majority of continuing care patients must not be at the expense of a deteriorating quality of life for those remaining in hospital-based continuing care.
- 8.26 A detailed and comprehensive profile of the individual patients who constitute the continuing care population is required to determine the number of hospital beds needed both in the short and medium term for these patient groups.
- 8.27 All efforts should be made to facilitate patients who wish to attempt an alternative placement outside a hospital ward and who are able to do so safely.

- 8.28 For those for whom this is not possible, the Board wishes to reprovide their existing accommodation in order to improve quality of life, maximise individual independence and provide opportunities for movement within this new system. A possible model would be the replacement of existing facilities with purpose-built units. Support within these units could be ‘tiered’ to reflect the varying levels of independence of groups of patients within them.
- 8.29 So that progress can be made quickly, and not delayed until the wider question of the location of acute facilities is worked out, it may be possible to enter discussions with service providers relatively soon with regard to the development of stand alone continuing care facilities on the Holywell site, with the vacated space in the interim being used for the provision of intensive care facilities.
- 8.30 The existence of a group of patients - typically younger people with a dual diagnosis of psychosis and drug or alcohol abuse and “challenging behaviour” is placing increasing demands on in-patient services. Their need for assessment and treatment, often in excess of six months, would technically categorise them as “new long-stay”. However, it is recognised that their needs differ from those of the groups described above and may be met within the “challenging behaviour” remit of the proposed new Psychiatric Intensive Care Unit.
- 8.31 The main steps required are therefore:
- to profile the current continuing care population through individual assessments;
 - to initiate a planned programme of resettlement and reprovider based on the assessments;
 - to visit and learn about existing best practice in facilities designed for patients who continue to require long-term care in a hospital setting;
 - to consider the development of stand alone continuing care facilities on the Holywell site.

9.0 CONCLUSIONS

- 9.1 If we ourselves do not experience mental ill-health at some point in our lives, it is likely that someone very close to us will.
- 9.2 Modern care of people with mental illness and mental health problems is not confined to the activities taking place within hospitals and other institutions. Our task has been to attempt to build on the high levels of skill, experience, enthusiasm and dedication which mental health and primary care professionals demonstrate on a daily basis. The basis of everything in this document is to improve the quality of care - this includes not only the way in which care is delivered and the outcome that is achieved but also the organisational arrangements, the mind set of those engaged in the process of helping others and the need to promote positive attitudes towards mental health in the population. All activity must be geared toward this goal of improvement.
- 9.3 Taking this approach will inevitably present us all with the challenge of reconsidering many assumptions and previously taken-for-granted aspects of our thinking and it will undoubtedly raise difficult questions about resources. The one thing we can be sure of is the need for change. Affirming this need will enable us to reach forward to a new and better way of providing care.
- 9.4 Throughout the document a number of innovative and often radical developments have been proposed for the delivery of mental health care within its three major settings of hospital, the community and primary care. The figure shows the concept in diagrammatic form with the community based team at the centre, supporting and drawing support from a wider network including primary care and hospital services.



- 9.5 It is clear that change in any one area is intimately dependant on a reciprocal change in the others. All proposed changes are in line with the major principles outlined above and have been shaped by consultation with service providers, users of the service and their carers.
- 9.6 The vision outlined in this document is about this change for the better - a change that will not be secured overnight. However early progress may be made on a number of key areas such as:
- establishment of criteria for admission to multidisciplinary inpatient beds;
 - assessment of out of hours services; and,
 - examination of the location and scale of future hospital services.
- 9.7 It is not possible to identify more precise timescales at this stage, which, in certain key areas, will be influenced by the availability of resources. Implementation of other areas which are not resource dependent can also proceed on a phased basis, for example, reviewing and refocusing of day care.
- 9.8 Progress will be reviewed annually as part of the Board's roll forward of service agreements. This will also be informed by further work on the Board's ongoing review of the equity of its investment across programmes of care.
- 9.9 Commissioners and providers now require the courage and trust to work in co-operation to make this vision a reality and develop the mental health services that our population needs and deserves.