Community Caseloads Review of Working Age Adults and Older People's Mental Health Services in the London Borough of Redbridge

Final Report

Graham Durcan
The Sainsbury Centre for Mental Health

July 2005

Contents

Introduction

Redbridge Primary Care Trust (R-PCT) in collaboration with the Local Authority for the London Borough of Redbridge (LA) and the North East London Mental Health Trust (NELMHT) commissioned the Sainsbury Centre for Mental Health (SCMH) to conduct a review of community caseloads for mental health services provided to both adults and older people.

Information and data for the review was collected between October 2004 and January 2005, some of this being presented at a Stakeholder Day in January. The Stakeholder Day sought views on changes and developments of provision that would inform the recommendations.

The Brief

The review was asked to use a variety of methods to inform the project commissioners on:

(a)   The size of team caseloads as well as that of individuals within the teams
(b)   The profile of each team caseload (including complexity)
(c)   The nature of contact with team clients
(d)   The experience of service users and carers and how they were supported by services.
(e)   The practices and procedures that teams employ for dealing with referrals allocation and transfer

Methodology

The SCMH team adopted a multi-method approach to the review, gathering existing and prospective data and utilising quantitative and qualitative methods.

Steering Group

SCMH worked with a small steering group that consisted of representatives from each of the commissioning organisations.

Review of documentation

SCMH reviewed a number of documents concerning strategy, policy and previous reviews. With regards the latter the most recent review was a needs assessment conducted across the four Boroughs served by NELMHT (including Redbridge) by Dr Pratibha Datta (reference). This review was conducted shortly before the SCMH review and so is of relevance here. The SCMH projected aimed to build on the findings of this review.

The aim of the documentary review was to inform other elements of the review (e.g. the formation of interview questions), but also to: explore gaps in documentation (e.g. the absence of a protocol where one is indicated), consistency between different documents and a comparison of what is written as policy or procedure with findings of practice 'on the ground' (derived from interviews).

A bottom-up needs assessment exercise (NAE)

A key element to the development of any service is a thorough understanding of the need for that service and the population that it serves. Essentially there are two broad approaches to measuring need; these can be labelled 'top-down' and 'bottom up' (measuring expressed need).

Top down approaches typically use population data, understanding of deprivation and previous large scales surveys/research of mental health (e.g. Singleton et al, 2001), to make predictions of need. Such methods are reasonable in providing estimates of people suffering from different illnesses (e.g. 'caseness' for psychosis, depression), but have greater difficulty in forming service development plans, as they lack precision. (Cooper & Singh, 2000). 'Caseness' does not necessarily equate with a service need (Bebbington, 1990).

As stated previously a top-down needs assessment had already been conducted across Redbridge, therefore SCMH agreed to compliment this with a 'bottom-up' approach.

SCMH conducted a detailed needs assessment exercise (NAE) on a random sample of clients drawn from all Community Mental Health Team (CMHT) caseloads.

The NAE was conducted in two stages, firstly clinicians from CMHTs provided some basic (anonymised) data on their entire caseload, and this consisted of a neutral identifier (as opposed to a real identifier), age, sex, diagnosis, ethnicity, CPA status and date of referral. The North CMHT opted to provide data on its caseload in a different way, providing a single anonymised list of its clients, though not all the required information was supplied for each of its clients.

This basic data on all clients on all caseloads was essentially a snapshot of all open cases to the teams as of November 10th 2004. The second stage, selecting the random sample, was based on this data and SCMH asked that more detailed information be supplied on this sample for each team.

The second stage involved the completion of five simple-to-complete data collection tools by the care coordinator responsible for each randomly selected client. The aim of the random selection was to achieve a 20% - 30% sample of the overall caseload. This range, based on previous evaluations

represents a balance between a robust sample size and a manageable data collection for busy clinicians.

The data collection instruments used for working age adult CMHT clients were:

The Needs Assessment Schedule (NAS)[1] –
A tool developed for previous evaluations by the author and colleagues and adapted to meet local circumstances[2]. This tool collects basic factual data on socio demographic characteristics, housing, employment, legal status, service use, service history, diagnosis, symptoms / problems, carer needs, unmet needs of the client, proxies for engagement and ability to self-care.

The Substance Abuse Treatment Scale (SATS - McHugo et al, 1995)
This is a standardised instrument that gauges the stage of treatment for a substance misuse problem.

The Drug Use Scale (DUS – Drake et al, 1990)
This is a standardised instrument that gauges the severity of a drug misuse problem.

The Alcohol Use Scale (AUS – Drake et al 1990)
This is a standardised instrument that gauges the severity of an alcohol misuse problem.

The Threshold of Assessment Grid (Slade et al 2002 & Slade et al 2000)
This is a standardised instrument that provides a rating of severity across seven broad domains (unintentional self-harm, intentional self-harm, risk from others, risk to others, survival skills, psychological functioning and social functioning). The TAG provides data on risk, severity and functioning in some key areas.

A variant of the NAS was used for older people's mental health services, as well as different supplementary tool:

The Health of the Nation Outcome Scale for Elderly People (HoNOS65+ - Burn et al 1999)
This is one of several variants of the original Health of the Nation Outcome Scale (HoNOS). The original HoNOS was designed for working age adults; the HoNOS65+ has slight modifications to item descriptions and guidance to better reflect the needs of the older person. It remains a 12 item scale and is

---

[1] The Needs Assessment Schedule originates from research into serious mental illness caseloads undertaken at the University of Manchester (Huxley et al. 2000).

[2] Using the steering / reference group and local clinicians

broadly similar to the TAG (above) in purpose and scoring, in that the person using the scale is asked to rate severity across 12 broad domains.

Additionally there were modifications to the NAS for the Older Peoples Mental Health (OPMH) CMHT and the SATs, DUS and AUS were not used (there were questions within the modified NAS that provided some coverage of substance misuse etc).

It was agreed that the following teams would be included in this exercise.

Adult CMHTs:
    North
    South
    West
The Assertive Outreach Team (AOT)
The OPMH CMHT

The Home Treatment Team was excluded as this was a newly launched service.

At a later stage it was decided that psychiatrist outpatients be sampled also and this is described later.

All the teams were provided with training session and full written guidelines to support rater reliability and a telephone helpline was provided during data collection.

Semi-structured interviews.

SCMH met with over 70 people (original sample size agreed n=40), mostly in the form of one to one semi structured interviews, though some small focus groups took place.

The interviews collected factual data (e.g. further service descriptions), experience of CMHTs and the wider mental health system from the various stakeholder perspectives, issues of fidelity to the PIG, issues concerning integration of different service elements, staff skills and competencies as well views on changes to service structure / provision required as well as ideas on realising these.

Range of stakeholders

- User representatives
- Carers support agency workers
- A carer
- Staff working CMHTs (including psychiatrists)
- Managers CMHTs
- Representatives from other mental health services/teams

- Managers in the provider NHS Trust
- Local authority managers
- PCT commissioners
- Key voluntary sector provider representatives

Primary care was not successfully engaged in this exercise, as practitioners in primary care were not identified locally for the interview sample.

Benchmarking, review of resources and activity

The steering group originally agreed some comparator areas:
- Barnet
- Enfield
- Hillingdon
- Bexley
- Greenwich
- Hounslow
- Sutton
- Croydon
- Harrow
- Kingston-upon-Thames
- Waltham Forest
- Ealing
- Havering
- Merton
- Wandsworth

However not all the above were felt to be good comparators, for example, Greenwich is significantly more deprived (deprivation in that borough ranging from 34% to 78% above the national average, and the average being 58% more).

Therefore it was agreed that the following areas be compared:
- Croydon
- Barking and Dagenham
- Enfield
- Hounslow
- Ealing

A full rationale is provided in the resources section of this report.

These areas were compared with Redbridge for the following:
- Spend on Mental Health
- Community staffing

Each area compared was weighted to account for differences in deprivation and likely need for mental health services.

A questionnaire for service users

During the progress of the review, RUN-UP a user organisation, offered to distribute questionnaires to its mailing list of 80 service users. SCMH designed a questionnaire for this purpose. A returned questionnaire was received from 34 service users. This is described in a later section.

Assessing Mental Health Needs

Top-Down Assessment

Dr Pratibha Datta conducted a 'top-down' needs assessment across the four Boroughs served by NELMHT, including Redbridge, and this was reported in the autumn of 2004.

The needs assessment made some estimates / predictions as to the numbers of people affected by mental illness, using the MINI deprivation index to weight the population. A more recent version of the MINI, the MINI2k, was developed by the Centre for Public Mental Health. This programme is available from the Durham University Centre for Public Mental Health website and provides a number of a summary measure of mental health need (www.dur.ac.uk/mental.health).

The programme assesses mental health need in two steps. First it divides boroughs (and wards) by the Office of National Statistics Area Classification and then it uses elements of the DETR index to generate the MINI 2K predictions of the number of admissions to acute mental health wards for 3 diagnostic categories: schizophrenia and other psychoses; affective disorders and other disorders. It also gives a prediction of total admissions. A score is generated that shows how much higher or lower than the National average is the local predicted admission rate for total admissions and for each of the diagnostic categories compared to the predicted admission rates for England.

The MINI2K total score explained 42% of the variation in admission rates between London Mental Health trusts in 2003 (McCrone, Jacobson 2004). In practice, the MINI2K psychosis estimates correlate better with known estimates of socio-economic variation and is intuitively a better measure of need for services for people with severe mental illness than the estimates for all admissions or admissions for affective disorders. Therefore, to assess mental health need for CMHTs, whose principal workload comes from people with severe mental health problems, the MINI2K score for psychosis was used.

Dr Datta reported that Redbridge has the largest working age adult population of the boroughs served by NELMHT and that by 2016 this group will experience a 12% growth indicating a likely need for an increase in mental health resources to serve this predicted increase.

Dr Datta's report made predictions on the likely prevalence of different mental health problems. This was done by using the findings on national prevalence figures (based on the ONS Psychiatric Morbidity Survey – Singleton et al 2000) and weighting these with the for local deprivation. The following predictions were made:

- 760 adults with a psychotic illness,
- 24,000 with any form of neurosis
- 12,000 with alcohol dependence
- 6,380 with drug dependence
- 220 with dementia

SCMH found that by using the MINI2k Psychosis Score the number of people with psychosis rises to somewhere in the region of 930.

Another factor that should be taken into account is that, with the exception of psychosis, many of the above mental health problems will not be recognised by primary care or will not attend primary care, perhaps somewhere in the region of 50% and it is expected that around 9% (*SCMH 2002*) of the total figure for any illness (excluding psychosis) will be seen by secondary care.

Whilst the bulk of mental health care occurs within primary care (*see SCMH 2002*) much goes unrecognised and there is therefore potentially a role for mental health services in supporting primary care in recognising more, as well as effective treatment.

Dr Datta also reports that refugee populations are likely to have higher need for mental health services. The London Asylum Consortium reported in the week ending 5th March 2004, that there were 886 refugees in Redbridge.

Using the MINI2K overall score, not the psychosis score, (as the latter is not thought to be accurate in predicting the morbidity of non-psychotic mental illness) of 0.96 (national average being 1) the following estimates of morbidity are produced. They are broadly similar to the findings of Dr Datta's needs assessment, the most marked need being for all neurosis.

Derived Weekly Prevalence from OPCS 2000, aged 16-64

Psychotic Illness	799
Mixed anxiety and depression	14,708
Generalised Anxiety	7,514
Depressive Episode	4,476
All Phobias	3,037
OCD	1,918
Panic Disorder	1,119
All Neuroses	27,657
Drug Dependence	6,714
Alcohol Dependence	12,949

Estimates of numbers of people with mental illness seen in primary care and numbers seen in secondary care

	Based on 50% identified and / or presenting in primary	Based on 9% being referred on to secondary care
	Primary Care	Secondary care
Psychosis	799 (assumption all identified)	799 (assumption all identified and referred)
Mixed anxiety and depression	6,424	635
Generalised Anxiety	3,282	325
Depressive Episode	1,955	193
All Phobias	1,327	131
OCD	838	83
Panic Disorder	489	48
All Neuroses	12,080	1,195
Drug Dependence	2,933	290
Alcohol Dependence	5,656	559
All mental illness (excludes drug and alcohol)		1994

The above table makes some estimates as to the potential demand on mental health services at any point in time. But for the reasons discussed earlier (see top-down assessments and 'caseness' discussion) it is difficult to translate the above into service provision, it is not clear for example how many non-psychotic people with mental illness would have complex needs and therefore how many would be on enhanced CPA; nor should it be assumed that all people with psychosis will be on enhanced care.

Bottom-Up Needs Assessment: the NAE

Working Age Adults

The three CMHTs were asked to supply basic information (in an anonymised form) on all clients on their caseload with the exception of clients exclusively seen by psychiatrists in outpatients. West and South CMHTs were able to supply this data, with team members completing forms on each of their cases; however, North CMHT opted to supply this basic data from its information system. The North CMHTs information system had inaccuracies, which became apparent later, as a proportion of clients chosen as part of the random sample were either closed or unallocated.

Total clients on whom some basic form data was provided on

CMHT West	216
CMHT North	241 (modified to 227 at a later stage)
CMHT South	293
AOT	48

The above table is based on data supplied on cases open to the teams and allocated on November 10th 2004. The data on caseload supplied for the annual National Service Mapping Exercise suggests somewhat bigger caseloads for all but the Assertive Outreach Team (AOT). This might be explained by the fact that the data was supplied for a different month (September 2004 for the NSF-Mapping data), that some staff did not supply data on their caseloads to SCMH and that the information systems on which the NSF-Mapping data may have contained inaccuracies.

However, the first stage of the NAE appeared to capture the bulk of clients worked with by CMHTs and therefore was a sound base for forming the random sample.

The second stage of the NAE involved the care co-ordinator randomly sampling the caseload for South, West & OPMH CMHTs and the AOT, and from the total caseload data supplied by North CMHT. The desirable sample size was between 20-30%.

Some psychiatrist outpatients were included in the exercise, these were sampled differently[3]. The target was to once again achieve a 20 – 30% random sample of clients attending outpatients during a week in mid-November who were not care coordinated by other members of the CMHT. The reason for this was to avoid any possibility of double counting in the overall sample. Also, the total number of people who receive outpatients only is likely to be quite large and 20 - 30% of these would be a significant

---

[3] It did not prove possible to include older people's outpatients in the exercise.

number in itself and perhaps demand too much of those supplying the data. Additionally most outpatient only clients are not seen frequently (perhaps 3 to 6 monthly) and so providing data on a sample which includes clients not seen for quite some time may not reflect an accurate picture of their needs. There were a total of 64 people who met the inclusion criteria.

Response rates

Number of clients on who data was supplied

	Sample data supplied on	Total caseload	Total caseload corrected[4]	Random sample target range 20-30%	Actual achieved response rate
AOT	15	48	48	10 – 14	31.3%
NORTH	28	241	227	45 - 68	12.3%
SOUTH	74	293	293	59 - 88	25.3%
WEST	53	216	216	43 - 65	24.5%
OUTPATIENTS	9	*64*[5]	64	13 - 19	14.1%
OPMH	53	220	220	44 - 66	24.1%

The response rate for most CMHTs was satisfactory; the key exceptions are for North CMHT and Outpatients. This is perhaps more crucial for the North CMHT as the data on outpatients, given its method of sampling, is only intended to give a flavour of the 'need' amongst this group. When low response rates are received then it is possible that the group on whom data is supplied will not be representative of the overall caseload. Attempts were made to test for this using some of the variables that were supplied with the total dataset (i.e. mean age, proportion of males and females and psychosis for the total caseload and random sample).

The mean age and proportion of males/females was not significantly different for either the total North Caseload or the North random sample. However, there was a difference between the total caseload and random sample for the proportion of clients with a diagnosis of psychosis, the random sample

---

[4] At the point of stage two of data collection it became that there had been some inaccuracies in data supplied in stage one.

[5] There were 64 clients meeting the criteria seen at outpatients during a single week. The Outpatient sample was based on single week's attendance (see explanation of sampling elsewhere in the text).

appearing to have a significantly greater proportion. However, 100% data on diagnosis was supplied on the random sample, whereas over 50% was missing for the total caseload data. Therefore for two 'markers' (mean age, proportion males/females) the two groups are similar and for the third (proportion of clients with psychosis) no conclusion can be drawn. It is possible, but not certain, that there is some bias towards clients with psychosis in the North CMHT random sample.

The other random samples did not differ significantly from the total caseloads which they were drawn from.

Profile of the adult random samples

	AOT	North	South	West
Mean age	35.8	43.3	40.4	42.1
Male%	73.3%	53.6/%	58.2%	35.8%
White UK	46.7%	64.3%	34.2%	71.9%
Live alone	66.7%	25.0%	22.8%	31.6%
Unemployed /registered sick	73.3%	67.9%	74.7%	72.0%
employed	6.7%	14.3%	5.1%	12.3%
Enhanced CPA	100%	75.0%	50.6%	55.1%
Section 117	66.7%	25.0%	32.9%	17.5%

The mean age for the four adult teams falls within the range which previous SCMH evaluations indicates is typical for team type, AOT clients tending to be on average a younger group.

Very few clients were in full or part time work and the vast majority were registered sick / unable to work or unemployed; again the proportions are fairly typical.

Substantial proportions of the caseloads were for clients from black and minority ethnic (BME) communities and this was marked in CMHTs South and North and the AOT.

The table below gives more detail on the BME make-up of the caseload.

	AOT	North	South	West
Other White	6.7%	7.2%	10.1%	12.4%
South Asian	6.7%	10.7%	29.1%	5.3%
African-Caribbean	40.0%	10.7%	20.3%	3.6%
Mixed	0.0%	0.0%	3.9%	2.8%
Other	0.0%	0.0%	1.3%	0.0%
missing	0.0%	7.1%	1.3%	1.3%

There is some further discussion of ethnicity and service use, which makes reference to findings of the NAS, in the Interview Findings section.

There were marked differences between clients in the CMHTs on enhanced CPA in that at least 25% more clients from the North team were enhanced, this could be evidence of a bias in the sample, though the majority of clients in the total caseload data supplied were on enhanced care.

Admission history

	AOT	North	South	West
In bed on day data was collected	6.7%	7.1%	3.8%%	10.5%
In past 12mths	60.0%	28.6%	22.8%	24.6%
Multiple admitted in past 12 months	20.0%	3.6%	7.6%	7.0%
MHA admission in past	80.0%	60.7%	53.2%	21.1%
Admission in past lasting 3 months or more	60.0%	42.9%	36.7%	24.6%

Relatively few clients were in an inpatient bed on the day data collection was based. Most clients from AOT had experienced an admission in the past 12 months, which is perhaps not surprising given this is a relatively new team and early engagement with clients with quite severe and largely untreated problems may necessitate admission. It is therefore too early to make a judgment on this admission rate. Most other findings in the above table are quite typical, though the proportion of North Team clients with a history of a previous admission under the mental health act is quite high and that for the West team lower than usually found.

Diagnosis

	AOT	North	South	West
Psychosis	100%	78.6%	81.1%	54.4%
Depression, Anxiety etc (exclude clients with psychosis)	0.0%	21.4%	12.7%	35.1%
Depression, Anxiety etc (all)	6.7%	32.1%	24.1%	42.1%
Psychotic symptoms	66.7%	25.0%	31.6%	17.6%
Psychosis diag' and symptoms	100%	78.6%%	84.8%	59.6%
Multiple diagnosis	53.3%	35.7%	31.6%	49.1%
Multiple symptoms	80.0%	67.9%	70.9%	57.9%

The majority of all caseloads had clients with either a diagnosis of psychosis and/or symptoms of psychosis. But there are significant differences between the proportions of West CMHT clients with psychosis and that of the other two adult CMHTs. Clients in the West sample appeared more likely to have two or more diagnoses, adding to the complexity (though not always the severity) of their problems. Data was also collected on symptoms / problems that were current / recent regardless of diagnosis. The majority of clients had three or more current / recent symptoms / problems (see 'Multiple symptoms' above). The next table details problems where at least one team sample had 20% of clients with a particular symptom problem.

Symptoms / problems where at least one teams sample has 20% plus clients with a particular problem

symptoms problems	AOT	North	South	West
depressed mood	33.3%	32.1%	62.0%	57.9%
anxiety / stress / tension	60.0%	46.4%	57.0%	56.2%
panic attacks	20.0%	25.0%	15.2%	17.5%
somatoform	20.0%	7.1%%	5.1%	5.3%
aggression	33.3%	25%	27.8%	10.5%
sleep	46.7%	14.3%	34.2%	42.1%
relationship (s)	60.0%	25.0%	43.0%	24.6%
eating	20.0%	7.1%	13.9%	12.3%
use of substances	66.7%	14.3%	17.7%	12.3%
literacy and numeracy	26.7%	7.1%	6.3%	7.0%
personality	26.7%	3.6%	8.9%	8.8%
OTHER * not always described	26.7%	17.9%	7.6%	3.5%

A client's diagnosis will not always be indicative of the day to day mental health or other problems that they face. The above picture is not untypical, in that most clients have a range of problems, not necessarily related to their diagnosis and some which mental health professionals alone may not be skilled to help with. The AOT caseload clearly has considerable disability and social disadvantage (over a quarter of clients have problems with literacy and numeracy). Such data is useful in pointing teams in the direction of interventions their clients may need to support their daily living and improve the overall quality of life.

Clients with marked physical health care problems

AOT	North	South	West
26.7%	17.9%	24.1%	26.3%

Previous evaluations have tended to fall around the 15% mark, the AOT, South and West sample all fall around a quarter.

Accommodation

Living alone

	AOT	North	South	West
	66.7%	*25.0/%*	*22.8%*	*31.6%*

Living in supported / sheltered accommodation

	AOT	North	South	West
	0.0%	17.8/%	10.4%	12.3%

Most clients lived in owned or rented accommodation. Most AOT clients live alone, but all CMHTs have significant proportions of their caseloads living alone. North CMHT has the greatest proportion of clients who live in supported accommodation.

Carers

	AOT	North	South	West
Clients with informal carers	40.0%	53.6%	68.4%	43.9%
Clients with carer offered assessment	33.3%	46.7%	51.9%	80.0%

The NAS, the tool used to collect data on carers, was not completed for whether an assessment had taken place and if not why not, for most clients who had been offered and assessment. The above table may indicate quite different practices between CMHTs in terms of offering assessments to carers, but the NAE cannot indicate the reasons for this other than that they may occur.

Severity of problems

The Threshold of Assessment Grid (TAG) was completed on all clients in the sample as part of this exercise.

The TAG is used to rate the severity of problems across seven broad domains and these are:
- (i)   Unintentional Self-Harm
- (ii)   Intentional Self-Harm
- (iii)   Risked posed by Others
- (iv)   Risk posed to Others
- (v)   Survival
- (vi)   Psychological
- (vii)   Social

The ratings are: "None", "Mild", "Moderate" and "Severe" (4-point scale) for domains (ii), (iii), (vi) and (vii), with an extra "Very severe" domain for the remaining 3 domains (which may require immediate action).

The TAG total score is calculated by summing the domain scores (0 for None, 1 for Mild, 2 for Moderate, 3 for Severe and 4 for Very Severe), with a possible score ranging from 0 to 24.

The TAG is often used to rate the suitability of referrals. However, it has been used in this case to provide a proxy severity rating across the entire sample, regardless of when referred.

Previous research work on the TAG (Slade et al, 2002, 2000) has established an expected mean score for threshold of referral to a CMHT of 5.6. As this score is usually rated at the time of referral, one would expect the score of a client who has been in contact with a team for some time to be lower (as in the case of the most of sample used in this review).

Other expected scores for CMHTs are 22% of clients with at least one severe problem; and at least 60% of clients at least two moderate problems. As stated, these norms have been established with client groups at their most acute phase (i.e. at time of referral), and therefore it would not be expected with the team samples (given most have been case-worked for some time) that the above mean score and proportions would be matched.

	AOT	North	South	West
Mean TAG	8.9	5.6	6.7	4.2
At least one severe problem	46.7%	17.9%	22.8%	15.8%
At least two moderate problem	86.7%	50.0%	48.1%	28.1%
No problems	0.0%	7.1%	1.3%	10.5%

The mean TAG for AOT falls within the expected range; SCMH has used this measure with a small number of AOTs and all have scored between 7 and 12. Additionally this score fits with the profile that has been emerging from other tables. The score for the South is also quite high and well above what might be expected, as indeed is that of the North sample. Therefore the caseloads for both of these teams have clients with marked apparent severity of problem (see also last sentence in this paragraph) The West score is perhaps more typical of a CMHT. South also matches the 'benchmark' for the proportion of clients with at least one severe problem.

Clients in CMHT caseloads who might benefit from an assertive approach

SCMH combined several variables to build a picture of the proportion of clients who might benefit from transfer to the AOT. These variables were combined in different ways, but included: proxy ratings for engagement with care, severity of problems, psychosis as a diagnosis or as a symptom, admission history and level of support required.

Many clients will have problems with engagement and require support, but only a minority of these clients will meet the criteria for the AOT. The following tables indicate that whilst quite significant numbers of clients may require support in engaging and in their day to day support needs relatively few will meet more stringent criteria.

Proxy for engagement

	AOT	North	South	West
Contact	60.0%	17.8/%	34.2%	22.8%
Medication	46.6%	39.3%	45.6%	26.6%
Both	20.0%	10.7%	8.9%	10.5%

Level of support

Requires support with:	AOT	North	South	West
Self care	73.3%	39.3%	40.5%	26.4%
Maintaining tenancy	80.0%	53.6%	58.1%	35.8%
Managing finances	80.0%	46.4%	56.0%	35.8%

It is hard to form a firm picture of the actual number of clients who may benefit from transfer to AOT; the following figures are estimates and health warnings should be applied, for example SCMH are not sure how representative the data for the North Sector is.

Actual number in the sample

	North	South	West
Actual number in sample	3	4	0
Estimate across caseload	12?	14-16	?

None of the small Outpatients sample met the criteria, but this does not exclude the possibility that a small number may be found. There were a small number of clients with quite marked need; likewise for West team and it is possible the NAE was not sensitive enough to detect such 'need' in the West sample.

Older People Mental Health needs assessment

The NAE conducted for OPMH was conducted in a similar way to that of the working age adult service. The NAE collected data from one team, the OPMH CMHT. The late decision to include outpatients in the NAS did not allow sufficient time to negotiate the inclusion of OPMH outpatients.

Profile of sample

Mean age	*76.1(min= 27/ Max 96)*
Females	*77.4%*
Ethnicity	• *White UK = 30.2%* • *White Irish = 43.4%* • *Jewish = 11.3%* • *South Asian = 5.7%* • *African and* • *Caribbean = 3.8%*
Organic diagnoses (includes dementia)	*35.8%*
Functional ➢ Psychosis ➢ Depression /anxiety	*64.2%* *22.6%* *40.0%*
Live alone	*43.4%*

The bulk of OPMH CMHT clients (almost two thirds) suffer from functional mental health problems and a significant proportion of all clients live alone. Not surprisingly given the shorter life span of men approximately three quarters of the sample were women.

Accommodation

Accommodation type	N =	%
Owned home	32	60.4%
Rented	5	9.4%
Supported accommodation	2	3.8%
Sheltered housing	7	13.2%
Residential home	2	3.8%
Nursing home	2	3.8%
Hospital awaiting placement	1	1.9%

Most of the OPMH CMHT sample were living in their own home, but around 25% were living in some form of supported accommodation (including residential and nursing homes). Only one client was admitted to a mental health bed on the day of data collection

Admission History

Only two clients in the sample had experienced a compulsory admission since being in contact with OPMH. Four of the sample had experienced an inpatient stay of 6 months or more. Just under 20% (n=10) had experienced an admission in the past 12 months. Only one client had experienced two or more admissions in the past 12 months.

Engagement with care

Keeping contact	9.8%
Cooperating with medication regime	14.0%

Most clients were cooperative with the care provided and only a small proportions had issues concerning their engagement.

Requires support

Support with self-care	41.5%
Support with tenancy	39.6%
Support with finance	47.2%

The proportions requiring support with self-care were high which is not surprising in a group of older people, where one might expect a higher degree of frailty and therefore a reduced capacity for self-care. What perhaps is more interesting are the proportions of people requiring support with maintaining their tenancy and in managing finances. This is likely to add considerably to the symptomology amongst this group, in particular anxiety and depression.

The NAS was modified for the OPMH CMHT sample and included an extended problem / symptom list, which also asked the rater to decide on the level of problem/ symptom ('no problem', 'some problems' and 'marked problems'). Additionally the NAS was supplemented with the HoNOS65+. These are reported below.

Just over half the sample had 'some problems' with anxiety and just over a quarter of the sample had severe problems with depressed mood as measured by the HoNOS65+.

The table below has bolded symptoms / problems that at least 20% of the sample suffered at the 'some problem' and 'marked problem' levels. Mobility was the only problem that over 20% of the sample suffered at the 'marked problem' level, though there were some 11 other problem / symptom areas that 20% or more of the sample suffered at the 'some problems' level.

The tables that follow all indicate the degree of complexity of problems suffered by the OPMH CMHT sample.

Problems / Symptoms checklist from the NAS

Problems with:	No Problem	Some problems	Marked Problems
Maintaining safe environment	39.6%	**37.7%**	17.0%
Communication	58.5%	**24.5%**	11.3%
Mobility	34.0%	**37.7%**	**20.8%**
Orientation	50.9%	**26.4%**	15.1%
Eating / Drinking	45.3%	**39.6%**	9.4%
Dressing	43.4%	**34.0%**	17.0%
Hygiene	47.2%	**30.2%**	15.1%
Sexual dysfunction	64.2%	3.8%	7.5%
Inappropriate sexual behaviour	88.7%	0.0%	0.0%
Anxiety / Stress / Tension	28.3%	**52.8%**	11.3%
Obsessive-compulsive	75.5%	7.5%	0.0%
Phobic type problem	77.4%	5.7%	0.0%
Panic attacks	58.5%	**26.4%**	0.0%
Post traumatic stress	83.0%	0.0%	0.0%
Dissociative	79.25	0.0%	3.8%
Somatoform	71.7%	13.2%	1.9%
Problems with Sleep	34.0%	**47.0%**	3.8%
Problems with relationship(s)	62.3%	**22.6%**	0.0%
Problems related to victimisation	83.0%	1.9%	0.0%
Learning difficulty	75.5%	3.8%	0.0%
problem in autistic spectrum	43.0%	0.0%	0.0%
Problem with personality	79.2%	5.7%	0.0%
Problems with elimination	56.6%	17.0%	11.3%
Problems with continence	56.6%	18.9%	11.3%
Problems with self neglect	50.9%	18.9%	17.0%
Problems with wandering	64.2%	7.5%	13.2%

The HoNOS65+ uses what is known as a Likert type rating scale to measure the severity of problems at a point in time and as an 'outcome' measure it is designed to be used at repeated intervals. Its use in the NAE was as a one off proxy rating of severity and as such no assumptions can be made as to causality (i.e. why a problem has a particular level of severity).

The total score that any individual can be given is 48; this would indicate the most serious level of severity. The actual highest score was 28 and only a handful of clients had total scores over 20. Total score is only one way with the HoNOS65+ to review severity.

The mean total score for the whole sample is given in the table below. Also given in this table are the mean scores for two distinct groups within the sample, those with organic problems (such as dementia) and those with psychosis. The mean scores suggest a tendency towards greater severity within this sample.

Mean total HoNOS65+ scores

Whole sample mean HoNOS total score	10.6 (standard deviation = 6.6)
Organic mean HoNOS total score	12.6 (standard deviation = 6.3)
Psychosis mean HoNOS total score	12.3 (standard deviation = 6.8)

As stated previously, total scores are only one means of assessing severity and indeed not a particularly sensitive means at that, as clients with identical scores can have markedly different levels of severity (one severe problem has the same score as four mild problems). The two tables below look at severity differently.

Proportion of sample with severe problems as measured by the HoNOS65+

Number of moderately severe and severe	%
No severe problems	39.6%
One severe problem	28.3%
Two severe problems	5.7%
Three severe problems	13.2%
Four severe problems	7.5%
Five severe problems	1.9%
Seven severe problems	3.8%
At least one severe problem	60.4%

Perhaps the most significant findings from the above table are that most of the sample has at least one severe problem and over a quarter have 3 or more severe problems.

The final table presents severity via item on the HoNOS65+. There was only one item that no client within the sample had a severe problem with and that was 'problems – drinking or drug taking'. There were three items that at least 20% of the sample had a severe problem with. These were:

  ➢ Physical illness of disability
  ➢ Depressed mood
  ➢ Activities of daily living

Percentage of sample with moderately severe or severe problems by HoNOS=65+ item

HoNOS-65+ items	%
1Overactive, aggressive, disruptive behaviour	7.5%
2 Non-accidental self-injury	3.8%
3 Problem-drinking or drug-taking	0.0%
4 Cognitive problems	13.2%
5 Physical illness or disability problems	**32.1%**
6 Problems associated with hallucinations and delusions	9.3%
7 Problems with depressed mood	**24.5%**
8 Other mental and behavioural problems	11.3%
9 Problems with relationships	1.9%
10 Problems with activities of daily living	**20.8%**
11 Problems with living conditions	3.8%
12 Problems with occupation and activities	15.1%

Resources

Population figures for Redbridge and the comparator group were taken from Primary Care Organisation (PCO) population data published on Department of Health (DH) website. It is based on the latest census data projections for 2003 and does not include "Special Populations" i.e.:
- armed forces
- dependents of foreign armed force
- convicted prisoners who have been inmates for 6 months or more

For more information on the data and how it has been collated please visit the below website.

http://www.publications.doh.gov.uk/stats/population/

To make like for like comparisons between the PCOs, the level of deprivation in the various areas needs to be taken into account. In order to do this we have used the 'Mental Illness Needs Index Psychosis predominance rate' (MINI2K Schiz pred rate) as it gives scores that are consistent with other measures of deprivation.

The overall MINI 2K rate is based on all admissions to psychiatric hospitals and includes admissions for neurotic conditions. Admission rates for these conditions vary considerably from area to area, depending on local policies and availability of beds and therefore are not so tightly related to need. On the other hand admissions for psychosis are more related to need (though this is changing fast with the development of home treatment teams).

Data on MINI2K can be found on the below website.

*http://www.dur.ac.uk/mental.health/index.php?l1=1&l2=27&s=27*

Analysis of Spend on Mental Health Services

Financial data used for the below analysis was taken from the Primary Care Trust (PCT) spend on mental health services incurred during the year 2002/03.

In order to compare Redbridge with other similar PCTs in the greater London area, a comparator group was chosen based on those PCTs where deprivation scores (MINI 2K) were within 20 points of Redbridge. It was felt that choosing comparators in this way would select areas which were most similar to Redbridge. The areas included Croydon, Barking and Dagenham, Enfield, Hounslow and Ealing.

PCTs	Mini 2K Schz pred rate	Total Adult Pop. (16-64yrs)	Weighted Adult Pop.
Croydon	95.37	226,105	215,636
Barking and Dagenham	100.99	107,272	108,334
Redbridge	**112.01**	**162,566**	**182,090**
Enfield	114.79	189,558	217,594
Hounslow	120.1	151,476	181,923
Ealing	126.09	218,763	275,838

PCT	Total Spend (£ '000's)	Spend on High Dependency, Secure and MDO Services (£'000's)	Total Spend per head weighted adult pop	Spend on High Dependency, Secure and MDO Services per head weighted adult pop
Comparator PCT	1670	1608	£15.42	£14.84
Comparator PCT	32844	2129	£150.94	£9.78
Comparator PCT	52032	2398	£188.63	£8.69
Comparator PCT	38623	1381	£212.30	£7.59
Redbridge	**39042**	**5373**	**£214.41**	**£29.51**
Comparator PCT	64278	5135	£298.09	£23.81

Total Spend on mental health services per head weighted adult pop
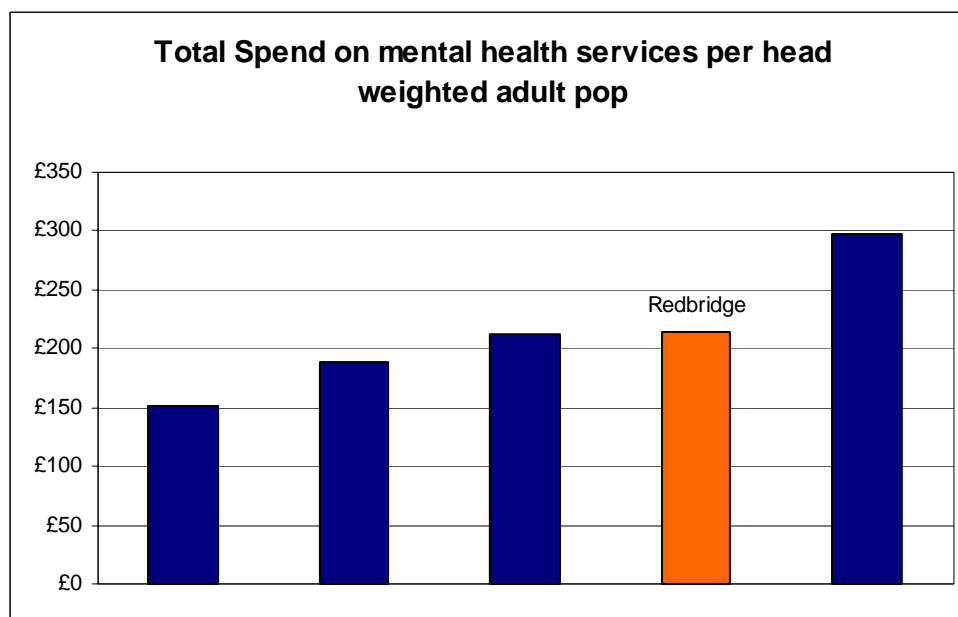
The above tables and graphs suggest that when compared to these localities spending on mental health by Redbridge is at the higher end and particularly so for 'high dependency, secure and mentally disordered offenders'. The spend data is for 2002/03 and not for the most recent period 2003/04 as the latter is not in the public domain and therefore not available for the comparators localities. Therefore recent changes in spending are not represented.
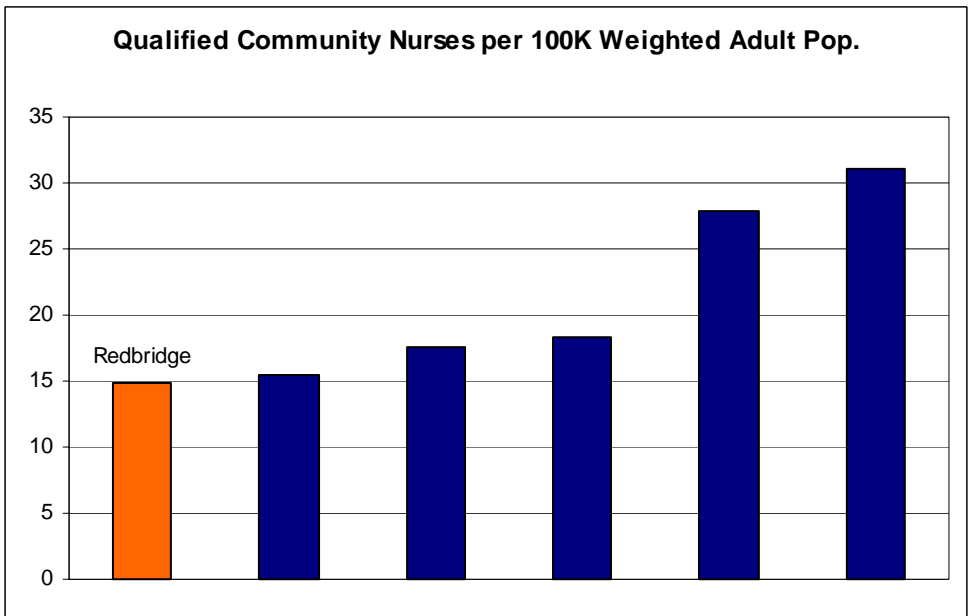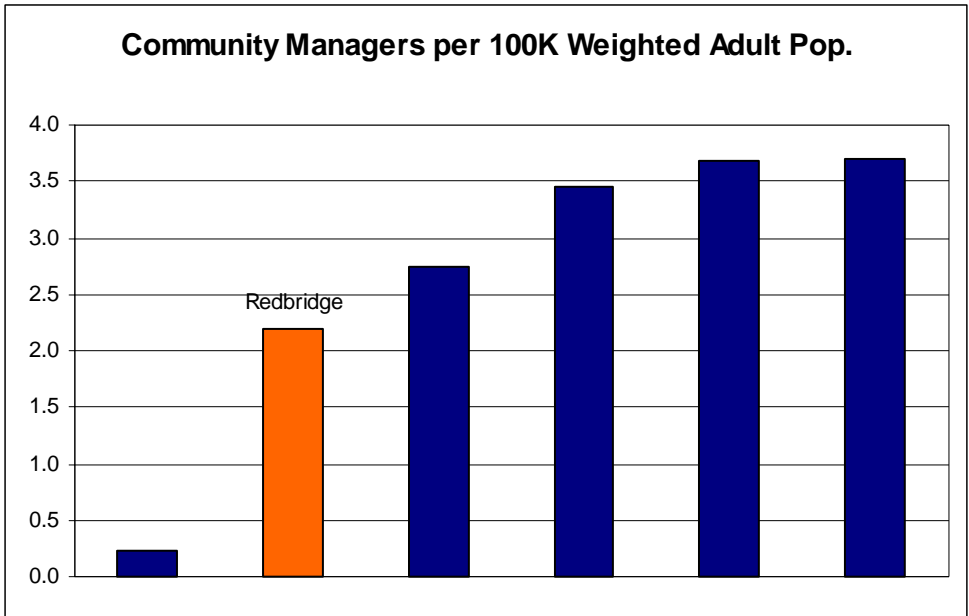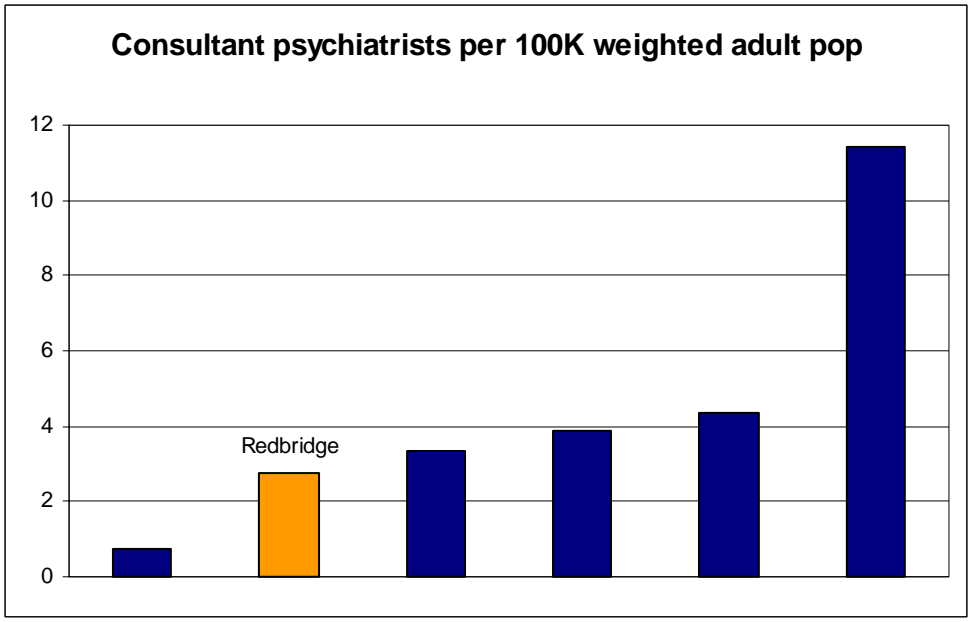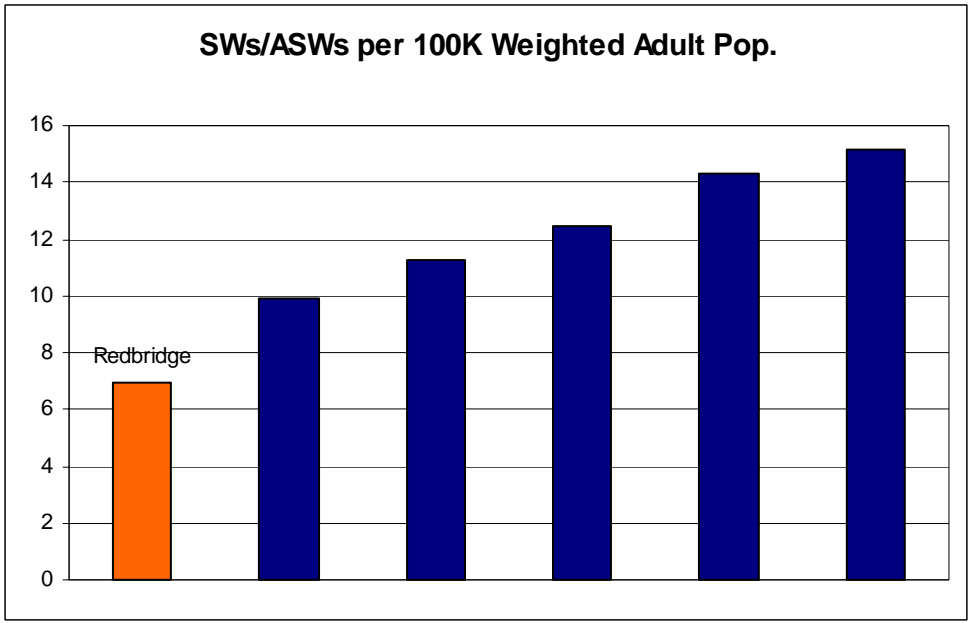
Mental Health Community and Inpatient Staffing

Staffing data for the PCT areas was taken from the Durham Service Mapping website. Numbers are based on the September 2004 returns, which is the most recent data on the website. Community staffing includes staff in community mental health teams (CMHTs), assertive outreach/ home treatment teams (AO/HTTs), crisis resolution teams (CRTs) and early intervention teams (EITs).
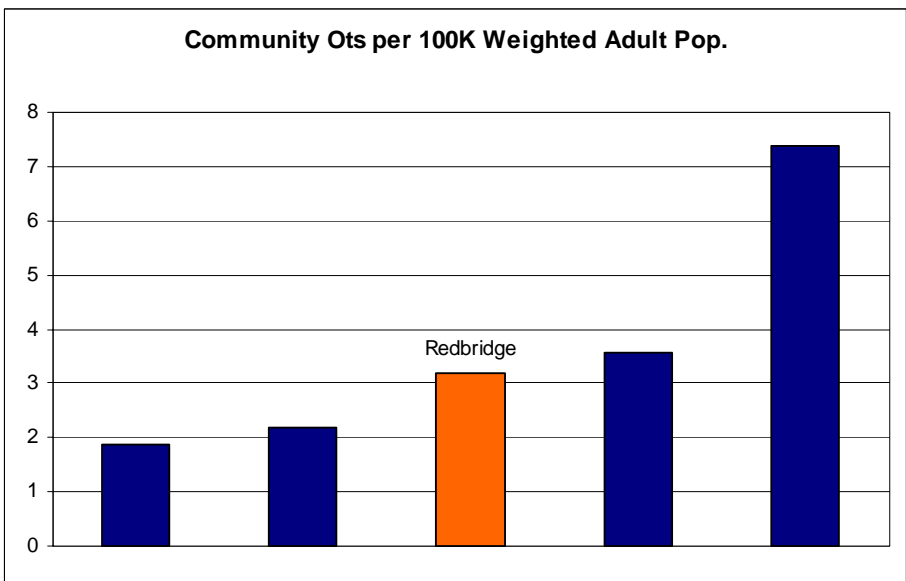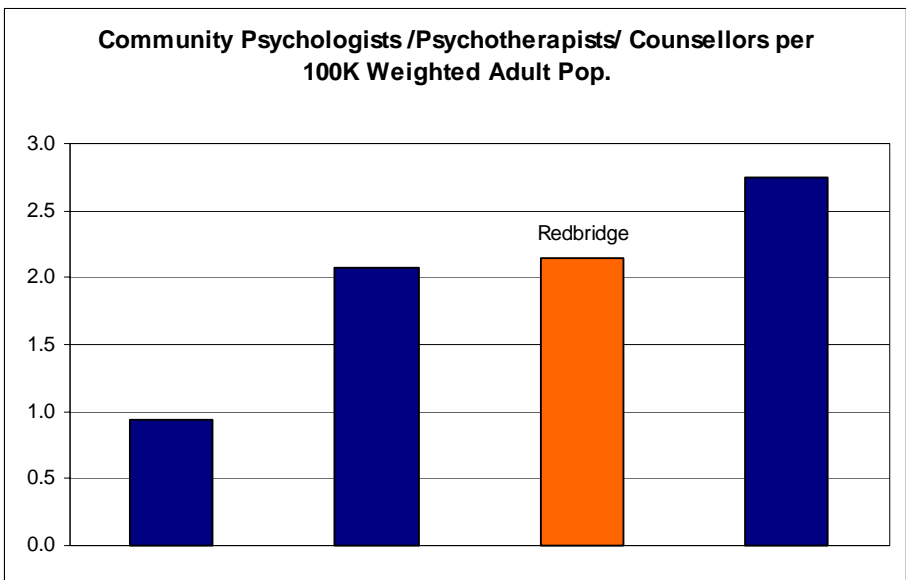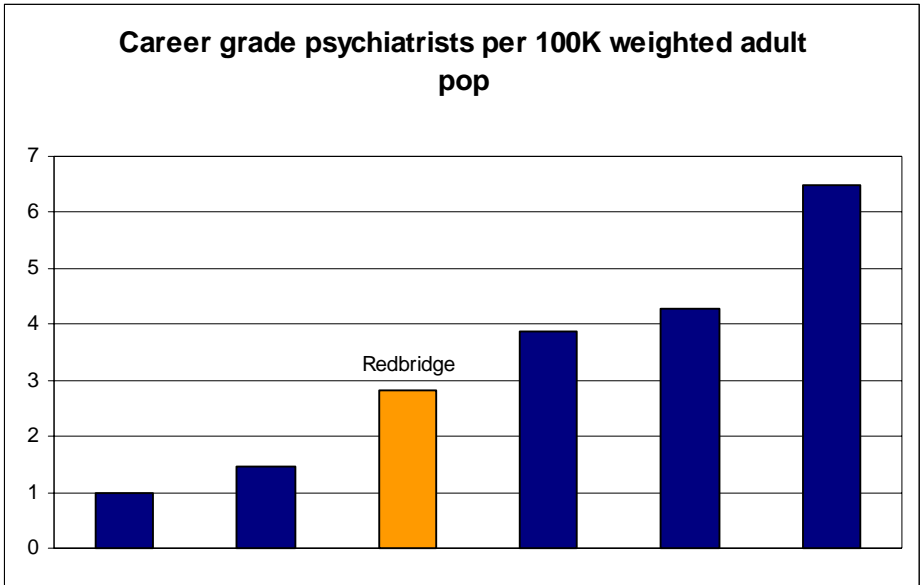
Community Staffing per 100K weighted adult population[6]								
PCO	Managers	Healthcare Assistants	Qualified nurses	SWs/ ASWs	Psychologists/ Psychotherapists/ Counsellors	OTs	Support/ care workers	Admin. Staff
Redbridge	2.2	0.0	14.9	6.9	2.1	3.2	0.5	4.2
Comparator PCT	3.7	0.0	27.9	15.1	0.0	7.4	4.4	8.8
Comparator PCT	0.2	0.0	31.1	9.9	0.0	0.0	6.1	9.7
Comparator PCT	3.4	2.2	18.4	12.4	0.9	2.2	1.8	9.1
Comparator PCT	3.7	0.0	15.4	11.3	2.1	1.9	1.6	5.2
Comparator PCT	2.7	1.9	17.6	14.3	2.7	3.6	1.1	6.6

Medical staffing per 100k weighted adult population			
consultants		Career grade	
Barking and Dagenham	0.8	Hounslow	1.0
Redbridge	2.7	Barking and Dagenham	1.5
Hounslow	3.4	Redbridge	2.8
Enfield	3.9	Enfield	3.9
Ealing	4.4	Ealing	4.3
Croydon	11.4	Croydon	6.5

---

[6] Definitional issues may explain some of the differences in this table, however, it is not possible to explain what if any impact definitional differences have made.

Community Managers per 100K Weighted Adult Pop.

Qualified Community Nurses per 100K Weighted Adult Pop.

SWs/ASWs per 100K Weighted Adult Pop.

Consultant psychiatrists per 100K weighted adult pop

Career grade psychiatrists per 100K weighted adult pop

Community Psychologists /Psychotherapists/ Counsellors per 100K Weighted Adult Pop.

Community Ots per 100K Weighted Adult Pop.

Community Support/care workers per 100K Weighted Adult Pop.

Community Admin.Staff per 100K Weighted Adult Pop.

The findings of this section of the review suggest that based on comparisons made with these agreed comparators Redbridge falls to the lower end of provision for certain key staff groupings:
- Nurses
- SWs
- Consultant Psychiatrists
- Support workers

Other staff groups appear to be reasonably well provided for, for example psychology and occupational therapy. However, in the case of both these disciplines, there are national shortages and it could be the case that the comparison is really between very poorly provided areas and only slightly better provided areas.

It is important to note that the Durham data sets only records staff in post and not establishments.

The OPMH CMHT

There are currently no available datasets allowing for comparisons of resources for OPMH. Datasets are available for adults and to some more limited degree for Child and Adolescent Mental Health Services (CAMHS). These are held by the University of Durham.

Caseloads

Adult Services

Durham Data

Team	Staff (WTE's)	Caseload	Average Caseload
North	12.40	433*	34.9
South	14.85	328	22.1
West	13.80	261	18.9

*See footnote one – below (which explains differences between this data and that in the next table)

The above data was drawn from the website at the University of Durham and represents a snapshot of staffing and caseloads (September 2004) for the National Service Framework Service Mapping statistics. The caseload data varies for South and West when compared to other data collected for this review for the same month (see table two – for North see footnote one)

Caseload data

Team	Staff (WTE's)	Caseload	Average Caseload	Caseload Range
North	12.40	226[7]	18.2	?[8]
South	14.85	310[9]	22.5	1 - 26
West	13.80	240[10]	16.2	3 - 27

The above table uses statistics gathered for the Needs Assessment Exercise (NAE) collected for the Caseload Review or for a separate Team Activity Statistics exercise also conducted as part of the review, whichever is deemed to be more accurate. The staffing data is still taken from the Durham data. The *Caseload Range* is taken from the Needs Assessment Exercise; some of the staff who supplied data on the clients they were care coordinator for had

---

[7] NORTH: This data is based on the *Needs Assessment Exercise* as North *Team Activity Statistics* do distinguish between allocated and unallocated cases. It should noted that the staffing data is based on September and the caseload data is based on December and therefore is out of sync. If there were significant differences is staffing between the two periods then the average caseload should be recalculated. A total of 192 clients were unallocated and are excluded from the above, the total allocated and unallocated caseload = 418. Unallocated cases tend to managed through the duty system and include new referrals, accepted for treatment cases and unre-allocated cases for staff who are on long-tem sick.

[8] NORTH: North CMHT opted to supply the data as a total team caseload, other teams supplied data by individual worker caseload, allowing the caseload range to be calculated

[9] SOUTH: This data is based on *Team Activity Statistics* for September 2004

[10] WEST: This data is based on *Team Activity Statistics* for September 2004

specialist roles (e.g. senior practitioners or most their work being specialist inputs to clients care coordinated by other members of the team), worked part-time or were new and hence caseloads were smaller.

There are some differences in caseload by discipline in that Nurses tend to have larger caseloads, followed by Social Workers and then OTs and Psychologists.

Average caseloads for staff groups with greatest responsibility for care coordination

	Nurses	SWs
North	Not available	Not available
South	21.0 (max 27)	15.6 (max 18)
West	16.1 (max 26)	14.6 (max 16)

The caseload data lends some support to the conclusion drawn by Dr Datta NELMHT needs assessment, namely that there appears to be some 'spare' capacity with CMHTs. However, Dr Datta's review did no consider the severity of problems of clients serviced by the CMHTs. SCMH would not recommend working to the CMHT PIG limit, 35 cases maximum for care coordinators. Given the fairly high mean severity ratings (see the NAE) it would probably better to work towards a lower target, perhaps around 25 clients per care coordinator. Currently South come closest to this figure though falling a little short.

Older People's Mental Health

For the needs assessment data was collected from 14 staff members on a total of 220 allocated cases. However, data collected for the *Team Activity Statistics* gave much higher caseload figures (September =400[11], October 450 and November 510, all excluding outpatients – also average monthly new referrals = 122[12] and average monthly new allocated cases = 119). The 220 figure is allocated cases, the larger monthly figures (given in brackets above) includes allocated cases, new referrals, cases awaiting allocation, and cases at the assessment phase (i.e. undergoing assessment process to inform decision on allocation) who are not on CPA but whom will have two face to face contacts during this phase (some of these clients will not be allocated/accepted by the service).

---

[11] Other figures for the same period put this figure at 426 and that all these cases are allocated?

[12] The annual referrals for OPMH for April 2003 to March 2004 was 1449 (average a 120.75 per month)

Team	Staff (WTE's)	Caseload	Average Caseload	Caseload Range
OPMH	13.80[13]	220	15.9	5 - 27
Averages for staff groups with greatest responsibility for care coordination				
Nurses			22	
SWs			22	

Health Warning on data
- All teams do considerable other face to face (client) work, in the form of assessments via duty and indirect work (e.g. liaison).
- OPMH do considerable follow-up, liaison/service brokerage for unallocated cases post assessment (i.e. more than sign-posting to other services).
- Data on team caseload complexity is not yet available and this is a crucial factor in understanding caseloads.
- Psychiatrists and support workers are excluded from the data above.

---

[13] the total staff group is 24.86, however, if non care coordinating staff are excluded this leaves 16.87 WTE staff, therefore the table above is missing 3.07 WTE staff. If the 220 caseload figure is divided between the 16.87 WTE staff the Caseload per care coordinator is 13.04. If the greater figure (426) given in the note above is accurate then the caseload per care coordinator is 25.25.

Interviews

The results of the interviews (and some small focus groups) are summarised here. The interviews were semi-structured and the data they produce is qualitative, concerning the participants' perspectives, experiences and desires. Not all participants shared the same view, and some of the views reported here may not match those of the reader. On the whole this section reports where there was agreement between participants, or the views of individuals or small numbers of participants where one would expect such individuals or groupings to particular or unique knowledge on a particular issue.

The 'Burden' of CPA

Though not all practitioners find the CPA process burdensome, most of those in the CMHT did. The 'burden' was largely administrative, some of those using electronic CPA found the system slow and there was concern that the different information systems (social care and health) did not tie up and that this created duplication. Those that had less problems with the electronic system tended to report being IT competent.

There are differences, reported earlier and in the interviews, in terms of the degree to which different disciplines took on responsibility for care coordination. There were some differences between Nurses and Social Workers and on the whole Nurses who tended to carry greater responsibility understood the some Social workers (Approved Social Workers) carried out emergency duty assessments and therefore differences were reasonable. This was not universal amongst Nurses; more contentious for some Nurses and Social Workers were the care coordination caseloads of Psychologists and Occupational Therapists.

Though all teams are multi-disciplinary some teams felt quite divided between disciplines, having separate supervisions and separate allocation processes.

Perhaps the most significant findings from the interviews on CPA concerned its practice, rather than its administrative processes. Both CMHT and inpatient participants reported communication problems over clients they shared, each tending to see fault in the other parties communication. Typically CMHT staff criticised the lack of sufficient notice of reviews and discharge planning and inpatient staff felt that care coordinators abdicated their responsibility when a client was admitted. This tended to be less of an issue for the West CMHT and of course there were some excellent examples of practice across all teams.

Most informants acknowledged that some key groups were difficult to allocate; these included new to service inpatients ready for discharge but deemed to require ongoing care and clients with long-term mental health marked needs (what were termed in several interviews 'rehabilitation clients', or 'former long-stay' and 'new long-stay') particularly those under the care of

the rehabilitation consultant and those using the limited rehabilitation inpatient facility. <u>There is no community rehabilitation team and therefore this role currently falls to the CMHT.</u>

Care coordination was a less controversial issue for the OPMH CMHT. The relationships between different parts of the **OPMH** service were reported to be good and there were no real concerns over communication between inpatient and community services. The issues of real concern to OPMH services fell **outside the remit of this review**, but were consistently reported by OPMH participants; essentially a shortage of specialised residential and respite placements for older people. This primarily relates to older people with functional mental health problems or drink related dementia. This shortage had an impact both on the wards, as there were reportedly delayed discharges on wards[14] and consequential difficulties in finding beds for admission for new patients on these wards.

There is a strategy for increasing the number of places for older people with dementia through the provision of training for staff so that they are better able to manage people with dementia enabling homes to be reregistered for this client group. This is linked to the training partnership managed through the Resource Centre for people with dementia. However problems can be experienced where people have challenging behaviour.

The recovery focus of work with clients

Most interview participants from adult CMHTs stated that the 'recovery model' was being discussed in teams. In most teams there were identified as being individuals who had more expertise, for example, Occupational Therapists or Nurses who had undergone Thorn training. It was acknowledged that, though there was desire to adopt a recovery philosophy across all teams, this was yet to happen and that activity towards supporting recovery was limited. Most CMHT participants felt much of their activity with clients was about 'maintenance' or preventing crisis.

The understanding of the term 'recovery' was also key, some participants saw this as largely concerning returning people to work and felt that this wouldn't apply to many of their clients because they were "chronic". This is a very narrow definition of 'recovery' and perhaps a very pessimistic view of clients' potential. It suggests that whilst the adoption of a recovery philosophy is seen as a desirable outcome (see Workshop Section) there is a lot more discussion and possibly training to make it a reality.

---

[14] SCMH was supplied other evidence (via PCT) suggesting that there were no delayed discharges during the course of the review, but other localities supported by NELMHT did have such problems.

Access to mental health

There was almost universal agreement that there were "problems" with access to mental health services, a few participants felt unable to comment, but no participant challenged the notion of problematic access.

Each team runs a duty system involving team members taking turns to be the duty worker on any given day. It is the duty workers job to review referrals and attempt to gather further information if what has been received is limited. The primary route into the CMHTs is via referral from the client's general practitioner (GP). Teams on the whole did not accept self-referral, though several participants gave examples of exceptions to this 'rule'.

Cases classed as routine or at least non-urgent were allocated differently in the different teams; at least one team allocated new cases at least three times a week, another team allocated on a weekly basis. Urgent cases were also responded to differently, though all teams had problems in responding at times. One team felt more often than not they would be able to provide a same day assessment, using staff from different disciplines. Other participants stated that people referred would be asked to go to the Accident and Emergency department (A&E). Both staff and service users (and others) felt this was less than satisfactory.

When a referral was felt to be inappropriate then most participants from teams reported making attempts to 'signpost' else where and depending on the team this would be to the referrer or to the person referred, in most cases this would happen without an assessment taking place (i.e. no face to face contact), though on occasions some referrals thought to be 'appropriate' were found not to be after an initial assessment.

It seemed to SCMH interviewers that there was little to distinguish criteria for access to the CMHTs (for assessment) and CMHT eligibility criteria (for a service from CMHT) and that in practice all teams applied an eligibility criteria when considering referrals. In other words if it was thought that there was any likelihood of an initial contact resulting in signposting elsewhere then an assessment would not be offered.

Related to this was a view stated that by most CMHT participants that the mental health service was not geared to **intervene early** or to be preventative and that often people did not get a response from the service until they had reached a crisis.

There was a general view that work needed to be done on helping people from **BME communities'** access services. Some communities were felt to be over represented in parts of the service and under represented in others. This is supported by the NAE. African and Caribbean clients (also including 'Black British) on adult CMHT caseloads appeared to have been more likely to have been admitted in the 12 months preceding data collection (43%) compared to

other groups (White UK = 24% South Asian/Asian British = 10%). The NAE also demonstrated apparent differences in history of compulsory admissions:

- White UK CMHT clients   = 36%
- Asian CMHT clients   = 55%
- African / Caribbean CMHT clients   = 71%

These proportions should not be taken too literally, but are likely to be indicative of different patterns of service use for different ethnic groups. Additionally African and Caribbean clients accounted for 40% of the AOT sample.

Participants felt that greater efforts needed to be made in engaging with BME communities and the parts of the non-statutory sector that serves them in order that Redbridge mental health service learn how to address any imbalance in service provision and to shape services for different communities.

The interviews with non statutory sector participants suggested that African – Caribbean and also Bengali speaking people required more to support them in accessing services early. One of the main specialist providers, Redbridge BME Befriending & Support Project, provides a number of services and groups, particularly for South Asian communities, but felt they did not have staff with the right language skills to support Bengali speakers.

Quite a number of the interview participants felt that mental health services were not particularly "geared" towards engaging with **young people**. Some attributed this, in part at least, to the professional referral criteria of adult CMHTs. Some young people don't visit GPs and as this is the primary referral route could be a barrier. The SCMH team was also told that younger people were "even more" sensitive to the stigma surrounding mental health services and therefore may be less likely to attend an appointment at a 'mental health' venue. Several participants thought certain groups of young people were at greater risk of mental health problems (one example given being care leavers) and that perhaps some form of outreach service should be established to support access to services where needed. NELMHT has a strategy for implementing Early Intervention in Psychosis across its four boroughs which is discussed later.

Access to the OPMH CMHT appeared to be much less of an issue as the service offers an open access service for clients with functional problems. Clients with suspected dementia are expected to be screened by the GP first to exclude other potential explanations. CMHT participants felt that on the whole new referrals were seen quickly.

Clients with **learning difficulties** also had access problems. In particular these concerned existing mental health clients who were deemed by the mental health service to require some specialist support. When clients who

are deemed to have 'borderline' learning difficulties it was the general experience of interview participants that support for this was not forthcoming.

Specialist community teams

Participants from **OPMH services** reported that the range of services available was limited. Most questioned that, if working age adults were felt to need a home treatment team (HTT) and were provided such a service, older people were not. Some described this as "ageist". Most participants felt that OPMH services should be supplemented with such a team and that it should be a specialist (in OPMH) rather than the existing adult HTT. Participants external to the OPMH services (senior managers, including those in the Adult services) did not necessarily agree with this view; though did agree that a HTT should be available to OPMH services, feeling that the existing HTT should be skilled and / or resourced to do this.

In addition, there is a specialist community support team for people with Dementia (local authority) which works in partnership with the Resource Centre and the CMHT enabling people with dementia to be supported in their own homes. This team has also enabled some people in residential care to return home. The team is managed by the council as part of the home care service.

The **Adult HTT** was launched during this review and therefore it is not appropriate to comment on its performance. Participants from the CMHTs reported both that the team had been supportive already and on those occasions when they reported not receiving the desired response this was attributed to the team not being fully staffed and not always able to cope with the demand. Managers report that it is planned to increase resources available to the HTT. The service which preceded it, 24/7, was viewed negatively by many participants. However, some participants felt that 24/7 had a wider remit and that there was a gap in the adult mental health services crisis response capacity as a result of its closure. Most, but not all, participant understood the difference between HTT and 24/7.

Some views expressed on the **AOT**, particularly from CMHT participants, were fairly typical of those expressed most recent SCMH evaluations. The views included:

- The threshold for the team was too high
- The assessment/transfer process took to long

However, there was far less negativity surrounding the AOT in Redbridge than SCMH has recorded in other areas and indeed many participants were very positive and supportive of the team and its model. AOT has developed link workers with each of the CMHTs and this has influenced more positive relationships. Some consultants interviewed thought the use of acute beds was high and that there could be differences in views between generic

consultants and the AOT over clients the service wanted to admit. The AOT has no dedicated beds and there were mixed views both within and without the team on whether this was desirable.

AOT participants reported that they adopted a team approach and felt that there was high fidelity to the policy implementation guidance (PIG - insert reference), these views were not challenged as such, but there was some concern both within and without the team that pressure to achieve the caseload size target agreed by the Strategic Health Authority and Primary Care Trust, might result in "diluting" the entry criteria and reducing fidelity and effectiveness.

Lack of supported accommodation (specialist) provision for OPMH

This 'finding' has already been reported in this section but is highlighted again as it was raised by virtually all OPMH participants. It was reported that there are no specialised mental health placements for older clients within the borough.

Adult participants also identified supported accommodation as a gap in service provision.

Employment

The non-statutory sector is quite "vibrant" in Redbridge but there is a gap in services supporting people with mental health problems in training for, and in returning to, work. Starfish Employment was the single non-statutory sector service identified. SCMH were not able to establish how many clients it was serving but were informed that it had a waiting list of 68 clients. Most clients were on CPA, but the service also took direct referrals from GPs. Starfish has a very limited staffing resource (1.5 WTE). It was apparent from the interviews that there were quite weak links between Starfish and the mental health teams.

NELMHT provides the Vocational Rehabilitation Service (VRS). VRS participants reported that it was serving 70 service users at the time of the interviews[15]. The VRS is currently being 'redesigned' and it was reported to the SCMH team that the likely outcome of this was a re-commissioned service, in the non-statutory sector (possibly more than one service) serving about half the current caseload. It was unclear what was to happen to the remaining half. There is considerable resentment in the VRS amongst staff and service users over the 'redesign' and the consultation over the change does not appear to have as thought out as clearly as it could have been (this is the view of a considerable number of interview participants). The initial communication on the change to the VRS suggested that the service was to close; indeed this was what was initially reported to the SCMH team.

---

[15] This figure has been challenged by the PCT who suggest that there are doubts that 70 was a valid number for people actually using the service, as many of these did not attend. The Service currently has 30 service users. This reduction has been achieved within 2 months.

It was not clear from the interviews if there was any significant resource within the Local Authority, Trust or non-statutory sector concerned with developing relationships with local employers and ultimately work placements for people recovering from mental health problems and wishing to gain real work experiences; nor did there appear to be any significant initiatives with further education services, though some small initiatives were mentioned.

Day centres / meaningful daytime activities

Though not within the remit of this review quite a number of participants commented on "other community resources" and in particular Mellmead House; the only NHS day resource. The local authority provides a resource centre at Ley Street which was originally a drop in service. Following a recent review it has become more activities-based but provides services for people with serious and enduring mental health problems. Ley Street reports that its attendances have increased since the change.

Both CMHT staff and Ley St feel that more could be done to build relationships between them. Ley Street felt that CMHT staff weren't aware of the services they were able to provide and conversations between SCMH and CMHT seemed to confirm this view point.

There are a number of other day and drop in services provided by the non-statutory sector, however, few specific comments were made about these services. There was a general perception that for adult mental health services, and for much of the borough there were very limited facilities to occupy people with mental health problems in a meaningful way.

Mellmead is located within the West sector and was regarded as inaccessible to clients from the North and South by most participants. Mellmead was originally designed as part of the Claybury closure, but now is serving a different purpose. Participants from the West CMHT had mixed views on Mellmead, some were quite positive, commenting on good relationships between the CMHT and Mellmead and that their clients were well served.

Others felt that range of group therapies offered were limited. It was the view of some participants that Mellmead did not provide enough services for clients with psychosis. Mellmead sees itself serving acutely ill clients rather than clients with "chronic" problems, the assumption appearing to be that the latter group were less likely to benefit from shorter term therapeutic interventions. SCMH have had access to the recent internal review of Mellmead, which presented it in a rather poor light. Mellmead feel the review was flawed, its report unfair and that it was misrepresented.

OPMH day's services generally viewed positively. The Grovelands Day Hospital, the NHS resource, served clients with both functional and organic problems. In addition the Memory Clinic was also run from the Grovelands. This was felt to be a good service but also, by most participants, to be under

resourced. It can be subject to lengthy waiting lists and this is related to the availability of senior psychiatrist trainees. Grovelands itself was highly valued but was much in demand and therefore was usually offered on a weekly basis. The facilities were felt by Grovelands staff to require updating, to cater for a frailer clientele than perhaps it had originally catered for.

There is also a Resource Centre provided by the local authority[16] for people with dementia, as the location is not ideal for disabled access, this is largely an outreach service. The Centre provides some service for people with early onset dementia.

Additionally Age Concern manages an early intervention service, the Alzheimers Society provides day care, carers support, advice and information and the Respite Care Association provides day centre.

Group therapy
The North CMHT does have facilities for running some activities and groups and dependent on available resources, groups are run using these facilities. Currently there is a dual diagnosis group that is open to clients from all three localities, the group is reported as well attended and that there is considerable user involvement in the group's running and activity. The group is co-facilitated by staff from Redbridge Drug and Alcohol Service, North and West CMHTs. No client using the group was interviewed, but several clinicians did comment on it and these were very positive and the group is seen as a good initiative.

Managing workloads

Only one adult CMHT (West) was experiencing any period of stability in terms of management during the review. The North CMHT had a locum manager who left during the review and South CMHTs Manager returned to post after a period of extended absence about midway during the review. The consequence of this for both of those teams had been Senior Practitioners taking on more management responsibility, at the cost of time given clinical leadership and supervision.

Interview participants such as adult CMHT practitioners, senior practitioners, team managers and other clinicians' were of the view that there were a number of clients on all caseloads that no longer required or were benefiting from being on the CMHT caseload. Different reasons were given for this and included, that clients required a lesser degree of input (e.g. befriending) but this was not available, difficulties in accessing teams made some clinicians reluctant to close cases in case the client relapsed, clients had developed

---

[16] The Resource Centre for people with dementia although managed by the council is a partnership involving Age Concern, the Alzheimer's Society and Redbridge Respite Care Association. Age Concern manages an early intervention service.

some dependency and were hard to move on, and related to these points there were some gaps and weaknesses in clinical supervision and caseload management.

Some participants questioned how well the CMHTs knew their caseloads, suggesting that there were clients who met AOT entry criteria but had not been referred.

Most teams had attempted different link arrangements with primary care, but with a few exceptions these had largely fallen by the wayside. The most common reason given being caseload pressures.

Overall the SCMH team felt that workload and caseload management had been weak in recent times and this needed to be resolved. NELMHT has previously experimented with caseload management systems but does not appear to have adopted one. Quite a number of participants felt adopting a method of caseload or rather workload management would be beneficial. This might employ some quantitative and qualitative tools[17].

Lack of appropriate home based care for OPMH

Most practical support given to OPMH service clients is reported to be conducted by agency staff, though some is provided by staff directly employed by the local authority. The local authority community team provides some of this service (see section of '*Specialist Mental Health Teams*') The quality of the provision (by agency staff) was questioned by several OPMH participants and a particular concern was that for clients with dementia still coping within the home environment, there was a tendency for these home-based care services to complete tasks for the clients rather than support the clients in completing tasks for themselves and thereby maintaining their independence[18].

No out of hours support

With the closure of 24/7[19] quite a number of clinicians were concerned that there was not an out of hours crisis response apart from A&E. HTT of course will offer support to a limited group of clients who otherwise might experience admission.

---

[17] It is also possible that there are some issues around the quality of supervision and this should be explored.

[18] The PCT report that some agencies providing home-based care are part of the Training Partnership and their staff have been appropriately trained for the task.

[19] 24/7 was a service that was established to provide a crisis response, this service had been closed shortly before the review commenced.

Perceived shortages in staff

The North team reported during the time of the interviews (December 2004 to early January 2005) that they were running on approximately two thirds of their establishment. Prior to this a number of staff were agency workers. The agency team managers left post around Christmas time and a new team manager is now in post.

Another staffing issue discussed concerned teams with considerable numbers of part-time staff and the complexity involved in attempting to coordinate efforts in these teams, South CMHT was cited as an example.

Lack of organisational vision for mental health

There did not appear to be a clear and defined (and agreed) vision for mental health service in Redbridge shared between NELMHT and its partners. Several participants felt that this needed to be addressed and that it "didn't make sense" to develop strategies with some guiding vision behind them.

Management at senior levels in Trust

There was much comment during the interviews on changes in management at board level at that time. These changes created uncertainty and some participants felt the management lead from the top of the Trust had been weak for some time.

Intensive support over period of crisis

SCMH staff asked both service users and clinicians about their capacity to work with clients intensively, particularly over a period of a crisis. There was variation within teams but overall both North and South found it difficult to offer support that required more than weekly appointments. West team practitioners felt more able to offer more frequent contacts, but acknowledged this would become difficult to sustain if for more than a couple of weeks.

AOT felt able to offer an intense service, the issue being the degree to which the client was engaged rather than a capacity issue for the team.

The OPMH CMHT felt on the whole they were able to support clients in crisis, but that there was limited choice and resource in all mental health services for older people.

Choice and services

The OPMH CMHT felt they were expected to be "all singing, all dancing". As stated above they felt there was very little resource put into OPMH and that over the years the team had had to be creative about how it used that resource and most recently had introduced Admiral Nurses to support carers. The OPMH was a highly regarded service, the only negative comment coming from another service provider, who felt they were "too medical model" and

were weak on dementia support. However, what was universal amongst all OPMH participants is the limited range and choice in services.

Some adult mental health participant had similar feelings, stating that for most clients it was either limited support from a CMHT or even more limited support from outpatients.

The non-statutory sector

It was not within the remit of the review to map all non-statutory services within the borough, nevertheless it became apparent during the review that there was quite a vibrant non-statutory sector. In spite of this, the most striking finding was the limited knowledge amongst many clinicians about "what is out there" and certainly very few practitioners were up to date on the capacity of these organisations.

Many CMHT practitioners talked about referring people on to non statutory sector organisations, however, a couple of these organisations felt some CMHT referrals were simply about moving people on rather than there being a specific issue which their organisation could help a client address. They expressed a desire for closer working, indeed this was a general desire in non-statutory services (and some other statutory services).

The issues concerning the OPMH non-statutory sector were somewhat different. Relationships with the "limited" number of specialist organisations were good, but more it was the view of OPMH participants that the more generic non-statutory sector tended to stigmatise mental health and dementia and were harder to engage to provide a service.

Interventions

There were skilled individual practitioners in all the adult CMHTs, but there was a general view that the capacity of CMHT practitioners to do interventions that went beyond CPA administration and maintenance visits was often very limited. It was something that practitioners from all teams were dissatisfied with. A number of practitioners reported having attended training courses, but only having limited opportunities to practice skills.

Still other participants reported types of clients they worked with but struggled to help, attributing this to a lack of specific skills. Clients with a dual diagnosis (mental health and marked substance misuse problems combined) were commonly cited by staff, some also cited clients with personality disorder (or borderline personality disorder). These difficulties largely concerned those staff groups with the greatest responsibility for care coordination (i.e. Nurses and Social Workers).

Liaison / communication

There was no input in this review from primary care practitioners and so the perspective reported on here is that of secondary care. Whilst there are some examples of good practice in liaising with primary care, most consultants,

team managers, and practitioners, felt there was little in the way of meaningful liaison with primary care currently.

Knowledge of the non-statutory sector was generally limited within the adult CMHTs, those that knew were sometimes newer staff and this knowledge had been acquired during an induction programme (which is commendable). There did not seem to be much in the way of sustainable efforts to build relationships with potential partners in the non statutory sector.

Internal liaison communication tended to be more positive. The AOT had developed within its team's link workers for the CMHTs. As reported earlier communication between inpatients and CMHTs still needed to be improved on, but most participants were able to cite a time when it was "worse". The relationship with the HTT was at an early stage.

There is little if any liaison with medicine and no dedicated nursing or consultant resource for this. It is highly likely therefore, that there is unmet need in this area. A&E liaison was on a pilot footing during the review, but is now on a more permanent footing.

Dual diagnosis?

It was reported in a considerable number of interviews that substance misuse was a "growing" problem for people with mental health problems. There were reports of drug use and indeed trading on the Goodmayes site. Several members of staff have dual diagnosis experience in the teams, but most teams feel under resourced in this area and lacking in confidence. The AOT has one specialist dual diagnosis worker, but may benefit from some increase in this provision given that two thirds of the AOT sample for this exercise was deemed to have substance misuse issues.

It was not apparent how NELMHT and Redbridge mental health services were addressing the PIG concerning dual diagnosis. It is reported by both mental health and substance misuse participants that there is very little co-working. The group run from the North CMHT (see before) was cited as one "island" of good practice. Substance misuse participant reported being keen to do more joint working with CMHTs. The South CMHT was seen as the major mental health referrer to substance misuse and therefore a likely place to pilot and develop some joint working initiatives.

User involvement

Redbridge has a number of small user groups, most in early stages of their development. RUN-UP has a number of user consultants which it is trying to develop and is based on the Goodmayes site. The group provided considerable support to the review and helped provide access to service user views.

It is probably fair to say that user involvement is in it infancy and there is some room for think creatively about how to get service users views on service provision.

The OPMH service, specifically the CMHT has its own user forum which has been running for the past 18months.

Carer support

Many adult CMHT practitioners felt that it was difficult to "take on the carer agenda" as work demands with the client were high. Consequently many practitioners felt that they did not provide a very good service to carers. SCMH only spoke to one 'carer', though it is debatable that this rather elderly woman would meet the service definition of a carer. She was clearly caring for someone with profound mental health problems, but was not in contact with services. She had sought advice from mental health professionals on how to cope, but felt she was not taken seriously and "dismissed" because her son was not a current service user.

Non-statutory sector carer support agencies also reported some frustration in dealings with mental health services and this wasn't just concerning adult mental health services but those supporting older people too.

OPMH have made recent investments in developing it carer support work and particularly for carers with the introduction of two Admiral Nurses and a carer support worker. Whilst the OPMH service was not free of criticism in this respect, it certainly attracted less than adult services as well as some positive comments.

For older people with dementia the Resource Centre partnership provides considerable support for carers. It has developed a number of carer support groups for older people with dementia from the Asian communities. Building on the pilot funded by the Kings Fund. This involved staff with appropriate cultural and religious backgrounds and who could speak various languages with religious and community groups to identify people with dementia who were not known to specialist services.[20]

The financial climate

Several interviews were with participants of sufficient seniority to report the PCTs and Trusts ability to invest in development. NELMHT and the PCT are in deficit and there will be an expectation that Redbridge will have to identify significant savings. It is therefore unlikely that there will be any new monies

---

[20] Additionally the PCT reports that non-statutory agencies that are part of the partnership provide day respite care and respite care at home, and that TLC which is our main provider of respite care at home has a significant number/percentage of service users who have dementia or another mental health problem.

for development and that any required development must come from redesign.

Unmet need groups

The SCMH team sought participant's views on groups they felt they did not serve well or that Redbridge mental health services did not provide for. These included:

- Asylum seekers
- People from BME communities
- People with eating disorders (during early stages in particular)
- People labelled with personality disorder
- Clients with substance misuse and mental health problems
- Young people with serious mental health problems
- Older people from BME communities

Integration

Integration with social services and mental health appears to have worked well at the senior level, but there is evidence of some 'division' in some teams and these may well be 'maintained' by quite separate management and supervision arrangements between disciplines that were described in the interviews.

This did not appear to be an issue for the OPMH CMHT.

Different practices/operational styles in different adult teams

The three CMHTs appear to work quite differently and to some extent this has been reported earlier in this section. Though it was hard to establish each teams access and eligibility criteria through the interviews (there appeared to be a lack of clarity for practitioners on these) there were quite different ideas about this between the teams. For one team virtually all access in crisis would be via A&E, whereas another team would at least attempt to avoid the necessity for this by offering an assessment. To some extent there appeared to be both differences in provision (e.g. access to day centre in West) as well as access dependent on where clients lived in the borough.

Inclusion criteria(who do CMHTs take on)

As reported above there is very little clarity within the teams on this. The SCMH were given one example where the CMHT in question did not feel a referral was appropriate, but because the clients GP "made a fuss" the client was offered a service.

There were also some differences between some CMHTs and some (but not all) psychiatrists as to which clients should be on the CMHT caseload. Examples were given by both CMHT participants (CPNs, SWs & OTs) and psychiatrists of these differences.

Respite provision

The essential finding in this area from the interviews for both OPMH and Adult services is that there is a perceived shortage of respite, this view was shared by both statutory and non-statutory participants.

Early onset dementia

The general view was that OPMH were most likely to have the skills to work with this group. The only specific service in the borough is provided by the resource centre. However, it was acknowledged in the interviews that this was a very small group of people and this in itself made them difficult to provide for. OPMH were not considered appropriate for this group. People with early onset dementia can pose problems for all service environments. Inpatient participants described some of the difficulties they faced, stating that they required considerably greater staffing resource often to cope.

Cultural awareness training for staff

Participants from several OPMH services stated that was a growth within the population of older people from BME communities. OPMH generally felt that they did know how to help these groups access services or how to provide a service once accessed. A first step was seen as a training initiative developing culturally sensitive and appropriate services and non racist practice for OPMH staff. Such training is likely to be relevant to staff from all mental health services.

Follow-up work for non allocated cases in OPMH

It was apparent from the OPMH interviews that referrals that were not accepted by the OPMH CMHT and which were perhaps signposted elsewhere were allocated considerable resource to allow 'follow-up' or support in attaining service provision elsewhere. CMHT staff will put time in to liaison on behalf of these cases. It did not appear to be the case that adult CMHTs provide an equivalent service.

Information for management

Although not unique to Redbridge, it is still worthy of note, namely that information systems are poor and provide little of use for the effective management of the service. This was a consistent finding in the interviews and what little information was supplied from information systems for the review had considerable inaccuracies. Whilst some staff complaints were from people who did not have IT competence, most complaints were about the system(s) itself. Participants felt that the integration of Health and Social Services needs to be followed up by the integration of their information systems.

Service user questionnaires

Though not part of the original brief, SCMH agreed to take up an offer by RUN-UP to survey its members via a questionnaire, designed for this review and agreed by the two organisations. The questionnaire was circulated to a mailing list of 80 people and 34 were returned (43%).

Profile of services users returning questionnaires

Gender

Males	62%
Females	32%
Missing	6%

Age

Under 35yrs	9%
36 – 55yrs	47%
56 and older	24%,
Missing	20%

Ethnicity

White UK	62%
Other white	12%
African and Caribbean	6%
Asian	9%
Missing	11%

Currently using a service	91%

Using three or more mental health services	44%

The questionnaire asked service users about their satisfaction with different elements of use.

	Mostly satisfied	Mostly dissatisfied
How would you rate the quality of service you receive now or most recently received?	82%	6%

	Mostly	Sometimes	Not often
Do you get (or did you get)the kind of service you want?	12	14	4

	Mostly	Sometimes	Not often
To what extent does the service meet your needs?	19	10	2

	Yes =
If a friend were in need of similar help, would you recommend the service to them?	23

	Mostly	Not really
How satisfied are you with the amount of help you receive?	25	7

	Mostly	Not really
Have the services you have received helped you to deal better with your problems?	23	6

The vast majority of these self-selected service users were at least mostly satisfied with the services received, which is a positive message for mental health services.

Some of the respondents mentioned the teams they had contact with

AOT	= 3% (n=1)
North	= 23%
South	= 23%
Not recognised /not given	= 51%

However, when asked to provide detailed of any negative experience, 50% of the sample, regardless of overall satisfaction were able to cite examples. These ranged from not feeling services listened to what they had to say to failing to respond to several requests for help (CMHT, 24/7 and psychiatrist cited) leading to an admission to Goodmayes under section 136 and Police involvement.

Improvements in services were also suggested and several of the following were suggested more than once:

- More help for socially isolated service users (support in social engagement)
- Provision of a crisis alternative to A&E
- Sustaining the Vocational Rehabilitation unit
- Fewer temporary staff (e.g. locum psychiatrist)
- Provision of free counselling
- More service user support groups
- Improve communication between services
- Rapid crisis service for people with psychosis

The Workshop

A workshop was run for both working adult and older people's community services on the January 13th 2005. The work shop was attended by 50 people.

The purpose of the workshop was to present available findings to a broad group of stakeholders and seek their views on solutions.

The workshop audience was divided in to four groups, three adult mental health groups and one older people's mental health group. Each group worked together on different themes during the day and later presented their ideas with the other groups.

The themes the groups were asked to consider over the day were:

- Developing a vision for our service
- Accessing our service – who are our services for?
- What happens when in a service (introducing recovery)?
- Communication, linking, partnerships

The groups went into considerable detail and the main findings are summarised here.

Main findings

Adult CMHTs

There was considerable consensus across the three groups with similar ideas emerging from them.

Open and accessible services

The vast majority of participants wanted to allow self referrals, but also to create mechanisms that allow access for harder to reach groups (e.g. outreach for younger people and BME communities). There was concern that both access and service provision should be available in non stigmatising environments where possible.

There was a prevailing view that the existing CMHT service could not provide these services as currently structured, and that a new structure would need to be developed to support access. This was either one or more access teams for the borough, described by some participants as intake teams.
An intake team was envisaged as the single point of access by some participants, but there was a general view that wherever in the "system" a person arrived, it should be their responsibility to support them in accessing services.

Some participants saw the intake team as being able to provide short-term interventions with some service users.

All participants saw the intake service as being open and willing to see people and being knowledgeable and connected to other services to signpost to other more appropriate services.

The was also clear support that considerable expertise be invested in this team (or teams) and that if it assessed a need for a secondary care service then the service user/client accessed that service and was not subject to further filtering assessments. Speed of access to services was also seen as vital.

Additionally the workshop emphasised the need to provide a **client centred service.**

A recovery focussed service

There were a variety of different definitions provided on recovery, but each emphasised a service led journey to achieving an optimum level of recovery and quality of life.

CMHTs would need to lead in promoting recovery and would need to develop specialist services and skills for different groups of clients with enduring mental health problems.

Relationships with non-statutory services and mainstream services (education, leisure etc) would need to be developed.

Participants thought that adopting recovery and supporting social inclusion of clients would involve a massive cultural shift.

CMHTs would be seen as the centre of care coordination and many participants wanted the notion and the role of care coordination to be revisited in order to make it effective.

A comprehensive service with diverse service provision allowing choice for service users and skilled practitioners

There were many ideas shared on different types of services that mental health services "should" provide and a general desire to see much service provision being located in the non-statutory sector. There was recognition that there was not one way of providing services and choice where possible was desirable.

There was a great desire to develop patterns of working which moved beyond "maintenance" type contact and which instead allowed practitioners to use evidence based interventions to help their clients. A number of key skills were identified as being crucial to providing mental health care.

A service that intervenes early

There was a desire for services to move towards intervening at the earliest possible moment and move away from crisis only responses. The development of easy access to mental health services (via an intake team was seen as crucial to this). Developing new partnerships with other mental health and non mental health organisations and with the communities served was also seen as crucial to this.

A service that is well targeted

There was considerable consensus on unmet need and on particular groups with greater potential risk of mental health problems. Numerous examples were given, and three examples cited on the day were asylum seekers/ refugees, young African and Caribbean men and care-leavers. There was a desire for services to outreach to such groups and where possible to help them avoid coming into mainstream mental health services.

A service that works in partnership

The definition of mental health services used by participants during the day was a broad one and included all services, regardless of sector that had a role in providing for people with mental health problems.

It was seen as vital to support partnership working for organisations to think strategically about relationships with its partners. It was also seen as vital to develop fora where different partners sharing and interest can meet to promote joint working.

A service that promotes mental health

Additional ideas and principles
- User & carer centred
    - Identify need
    - Outcome measures
- Accessible and easy to navigate
    - Sense of flexibility
- Clear and uniform criteria
- Clear clinical priority
- Culture to contain and care for staff
- Quality and choice of treatment
- Shared understanding/philosophy
    - Local ownership of services
- Working as a whole system
- Acknowledging a place for differences

- Making easy links between teams / professionals

- Acknowledging principles of recovery framework

- Strong / clear management and leadership

- Communicating with partners and understand their experience of mental health services

- Access to services out of hours

- Reducing dependency on services

OPMH

The older people's mental health participants on the day felt they shared much of the vision of adult services and to some extent were providing some of the service (the CMHT is thought to be very accessible).

Vision

- Timely accessible service for older people with mental health problem
- Treatment / clinical interventions (not everything to everyone)
- Service that is well regarded and that meets the need of older people in the Borough effectively
- Empowering uses, carers and other stakeholders
- Seamless service
  - Within health & Local Authority
  - Across boundaries to other statutory services
  - With voluntary sector services
- Advocacy
- Access to specialist services (AOT, HTT, Translation, Drug & Alcohol, Community Rehabilitation, Early Intervention)
- No age discrimination or diagnosis discrimination
- Separate properly resourced memory clinic

Move away from Cinderella service
Promotion and profile of service

User-friendly services

seamless service/ effective liaison
- Across boundaries within Health (prim'/second'
care), Also with Social Services and Vol' sector

Effective cultural awareness &
delivery

Clinical practice
- Effectiveness
- Timely
- Accessible

Financial investment in our service
staffing / IT systems

Separate well resourced
Memory clinic /day service

Specialist and effective

Effective liaison

Rooting out age/diagnosis discrimination
i.e. access to other specialist services or develop our own

User and carer involvement
(properly resourced)

Well resourced from
- Health
- Social Services
- PCT

Recognition of work done & protected time to carry it out

Access

- ➢ Open Referral System
    - o Except new organic cases – which need primary care screening
      to rule out physical illness
- ➢ Will accept
    - o Self referral
    - o Professional agency / referral
    - o Family and carer referral
    - o Voluntary sector service referral

- ➢ Early intervention into Dementia and Depression
- ➢ All other functional mental heath (SMI)
  - o 2 tier system
- ➢ CMHT access is not a big issue, most people are able to access an assessment. Following initial assessment, service will only accept those with most complex needs. This sometimes causes confusion for other services, as a result the CMHTOP have occasional difficulty in passing cases on which are not complex.

- ➢ High risk referrals – seen within 4 hours
- ➢ Non urgent – seen within 10 days

- ➢ Robust duty system (in place currently) – OPMH has no access to other services, so they developed the system out of necessity.

- ➢ Holistic assessment – conducted by two different professionals in persons own home.

Action
- ➢ Be proud of access / response to referrals
- ➢ Need to liaise more, to make other services aware of criteria, how it works and how to apply it
- ➢ Share practice and reduce fragmentation

What happens when in a service

- ➢ Allocation
  - o Generic allocations
  - o Discipline specific
  - o Joint working
- ➢ Issues for / services provided by OPMH
  - o All singing all dancing (expectation of the service)
  - o Medication monitoring
  - o Medication administration
  - o Counselling
  - o Anxiety management
  - o Care management
  - o Psychometric testing
  - o Mental health monitoring
  - o Benefits advice
  - o Housing
  - o Groups
    - ▪ Creative
    - ▪ User forum
    - ▪ Mindfulness
    - ▪ CBT
    - ▪ Loss and bereavement

- Social and leisure
  - CPA functions
  - Education – information
  - Admission avoidance
  - Carers intervention / support
  - Risk assessment
  - Functional assessment
  - Physiotherapy
  - Continuing care arrangements
  - Health promotion
  - Administration
  - Joint working
  - Crisis intervention
  - AOT
  - HTT
  - Physical health screening
  - Access to specialist investigations

*note: shaded areas chosen by group as particularly problematic

Care management
- ➤ Complex process
  - Time consuming

Communication – who do we contact engage

- ➤ Cinderella Service – Split between Adult Mental Health and Generic Older Peoples Services – Never sure where we fit. Not just a Redbridge issue
  - A national problem
  - DoH pledge to make OPMH a priority area and to invest in services

- ➤ Good relationships exist in OPMHS

- ➤ Address fragmentation between OPMH and generic OP services
  - Statutory and non statutory and other specialist services

- ➤ Functional unit difficulties
  - Never meet with other managers
  - Spread self so thin – need to network with other managers
  - Time to network
  - Recognition of the capacity issue should be higher to achieve this
  - Time to look at other services and meet other stat H?
  - Identify links to do this

- ➤ Recognition of difficulties faced by OPMH
  - o Links to
    - ▪ LITs
    - ▪ PCT
    - ▪ Social Services
    - ▪ Voluntary Sector

- ➤ Lone voice sometimes, we grin and bear it and carry on

- ➤ No recognition of being a speciality

- ➤ Rides on the back of adult Mental Health and generic older people services

- ➤ No critical mass

- ➤ Poor resources and funding

Despite all this we continue to shout the need of OPMH as we are passionate about our work

We need to network more effectively and make time to do this
- ➤ Develop more links to PCT
- ➤ Primary care
- ➤ SSD – especially older peoples services
- ➤ Voluntary sector
- ➤ Private sector
- ➤ Users and carers

Allow more time for clinicians and practitioners to do this and not just managers
Cascade more information
Encourage more involvement from others

Discussion

Adult Mental Health Services

There are a number of key issues that have emerged from the review and these will be discussed in turn and the recommendations will follow this discussion.

There is some evidence from this review suggesting that there is some existing 'spare' capacity within the CMHTs, however, two of the CMHTs have mean severity scores which are quite high and this will impact on any available capacity. In SCMH's view, accessing this capacity can only come through some restructuring.

The evidence gathered for this review suggests that existing services are not accessible enough. There is a desire to open up access to services (to assessments) and indeed there may be some requirements both legal and policy guidance that requires this.

There is no likelihood of additional investment in mental health services to make them more accessible, therefore creating more accessible services requires redesign (working within existing resources). SCMH believes that accessible services can be achieved within the existing resources framework, allowing teams with sufficient critical mass to have impact, if there are changes made to the existing team structure.

Structure

Borrill et al (2000) reported to the Department of Health on a detailed study they had conducted on health care teams (both primary and secondary) on what are the characteristics of effective teams. These are summarised below:

> ➤ "Team composition and organisational factors have a strong influence upon innovation and effectiveness".
> ➤ Members in "...teams characterised by clear leadership, high levels of integration, good communication and effective team processes have... low stress levels. In secondary health care settings the retention rates of staff are higher in those teams characterised by good processes".
> ➤ Greater levels of team working are associated with lower patient mortality
> ➤ Teams comprising a mix of professional groups are linked to higher innovation than teams of one group.
> ➤ "Teams cease to exist above around 12 to 14 members. Teams that extend beyond this are deemed more to be mini-organisations rather than teams.

Additionally it is SCMH's experience that small teams are more impacted on by staff sickness, training and leave and it is likely such teams are experienced as more stressful and more difficult to recruit to.

According to the University of Durham NSF Service mapping website there were a total of approximately 55 WTE staff in the existing three CMHTs (approximately 18 staff each) including all types of staff[21] (e.g. medical and admin). This would suggest that following the findings of Borrill et al that there is capacity for four teams. Ideally any new structure should allow the potential for the development of specialist functions , including intake/assessment (see next section) and community rehabilitation), and these may be best supported within a sub-team structure, so that on the one hand they are clearly defined but on the other have more ready access to cover (e.g. for leave & sickness) from the 'greater' team. This suggests that the existing resource be divided into three teams (two locality teams and an intake team – see *Access* section for discussion of 'intake') or two teams (two locality based teams with specialist intake service within each).

It would seem to make sense to revisit the team structure in Redbridge to enable mental health services to achieve more accessibility and greater support of specialist need.

Access

There was considerable support in the workshop for the development of more accessible adult mental health service that includes both self-referral and some element of outreach for 'special need' groups who do not currently access service or access early enough. It was recognised that more mental health care could be provided by primary care practitioners, but that this would require support. There was also a recognition that some clients who can't be helped by primary care, fall short of the threshold for entry into secondary care and that many of these could be helped by short term interventions. Many in the workshop believed that all of the above functions could be supported by a new type of dedicated intake service. Such a service would need to have critical mass to cope with both demand and the fluctuations in staffing and to provide adequate support (including supervision). The NSF service mapping data suggests that there is something short of a 1000 referrals a year to the CMHTs, however, other data supplied suggests that the figure may be greater than this. Data supplied to SCMH on three months over the autumn of 2004 suggested a total number of 1500-1800 referrals over a year if the referral rate was sustained (probably including outpatient referrals).

---

[21] IT should be noted that Care Coordinating staff account for approximately 40 WTE equivalent staff.

A team of around 14 WTE could likely support such volume of referrals and have some capacity to work with a short-term caseload. There would also be some ability to outreach but this may require additional resources. Liaison would also take up significant time and this would need to be planned for and resourced.

The intake service as stated could be a stand alone service or could be developed as a specialism within a broader, locality based mental health team. The latter option may ease transition between the intake service and that providing more extended care.

Recovery, intervening and developing specialisms

There is a strong desire within the service to adopt the notion of recovery and to develop a recovery orientated philosophy.

An SCMH press release at the time of the publication of the Social Exclusion Units report (Office of the Deputy Prime Minister 2004) on Mental Health stated: *"The journey to exclusion often begins in the very services that are supposed to help people. The role and purpose of mental health services must be rethought with much more emphasis put on preventing people losing their jobs, their relationships and their place in society."*

During the workshops the participants worked on defining what recovery meant and several different definitions were achieved, but all had at their core: a service user focused and defined approach that helped people achieve their optimum level of functioning and addressed social exclusion.

A small proportion of clients require long-term care of quite some intensity in spite of their engagement with service. These clients could form the basis of a community rehabilitation service and would probably benefit from being on small caseloads (1:15?) and provided expert care. Currently these clients are the responsibility of a rehabilitation consultant, but there is no designated community team resource. The existing CMHTs provide some service, but there have been problems in allocating some of these clients and as things stand the service offered to those on caseloads can be quite limited. In addition to developing 'intake' as a specialism of mental health teams, community rehabilitation should also be developed as a specialism. This could sit within a broader team (as a sub-team) or be a stand alone service. The former would benefit the service through some management savings (and possibly accommodation costs) and would allow staff cover during periods of absence from the greater team.

Currently, few mental health services seriously address the issue of their client's social exclusion, and this is also true to some extent of Redbridge, though most teams were discussing social inclusion and recovery and how

they might address these issues. Workers in the mental health teams often feel unable to do much more than risk-manage and review mental health status. During the workshop, participants recognised that developing a greater sense of partnership with non-statutory sector services is necessary to begin addressing recovery and the exclusion their clients experience.
Social exclusion is not easy to address and of course is not just the responsibility of mental health services, but these can play their part and make a start by forming closer links with voluntary sector services. This type of work might be best served by some locality oriented provision, such provision also allows for the development of knowledge, more readily at least, about particular locality based communities (BME groups etc).

The bulk of clients likely to be supported by the new locality teams will be serious and or enduring mental health problems, who require care of some duration but fall short of requiring community rehabilitation input. 'Recovery' should feature in the care plans of all clients, recognising that each starts from a different place.

There is a desire within the clinical/professional workforce to increase the amount of time that they have available to do interventions. Skills in groups work, dual diagnosis working and in psycho-social interventions are all seen as important. The ability to provide more in the way of skilled interventions suggests a team structure of sufficient critical mass to allow the sharing of skills, the planning and organisation that group work takes and also to provide readily opportunities for support and supervision.

As need varies across the Borough, so too will the skills requirements for the locality teams. So there may be some variance of what is offered within different localities, but this variance should be based on a sound understanding of local need.

It is also important for the credibility of any service development to actively engage with service users in the planning, through existing local forums such as RUN-UP.

Psychiatry

There is a move within the UK to reconsider the role of the psychiatrist and several pilot sites will test out new working arrangements, which focus psychiatry towards clients with complex need and away from the traditional outpatient service, which has always involved considerable wastage (through non attendance). Redbridge is probably best advised to wait for the results of these pilots. However, careful consideration needs to be given to how psychiatrists currently work and how they will relate to any new team structure. Adopting a two team/locality structure does not preclude some practitioners (including psychiatrists) have designated responsibility for sub-

localities with each given locality. NELMHT and the PCT have identified these sub-localities, each based around GP clusters.

Care coordination

Whilst there are many examples of good communication and practice around care coordination, most those commenting in the interviews and at the workshop felt, overall, care coordination work is not sufficiently robust. The essential role of the care coordinator is to support the client's journey through the service, whatever its duration, supporting and negotiating access to resources that aid the client's recovery, and monitoring progress. Problems were identified when clients were using inpatients and to a lesser degree the new HTT (though this was a very new service at the time of the review). It was the view of those wanting to see change in this that the care coordinator needs to be more than just a "key worker" and that when a client is receiving inputs , for example from inpatient care or the HTT, then this should be seen as being provided on behalf of the care coordinator with a commitment by all parties to communicate.

SCMH would see the locality based teams being the hub of care coordination, being responsible for all enhanced clients bar those of the AOT.

Caseloads

The maximum care caseload recommended in the PIG (DoH 2002a) is 35. SCMH feels this is probably too large for Redbridge and that 25 is probably a more realistic maximum of clients care coordinated by any single practitioner. However, severity also needs to be taken into the equation; as if a client has greater severity of problem then they are likely to require greater input, reducing the capacity for working with other clients.

Other factors also need to be accounted for. Currently nurses and social workers care coordinate more clients that other disciplines (e.g. occupational therapists and psychologists). If all team members are expected to have a similar care coordination burden then this may reduce access to specialist skills for some clients.

Direct client work is only part of the work of a practitioner and may only account for 60% of their workload; travel, admin, liaison, supervision and meetings accounting for remainder of their time. Assuming a full-time practitioner works a 37.5 hour week then this leaves 22.5 hours available client time. The degree to which this can be spread across a caseload will vary according to need and severity for example, but carer support, joint working with colleagues clients, training requirements etc will also impact.

Developing or adopting a workload management system will support decisions about caseload, as long as such a system takes account of both client and non client work and accounts for need / severity and changes in all of these.

Outreach

Redbridge needs to consider how people access services and where possible provide a variety of ways of allowing this. Basing some services in primary care may be part of the solution and could, if negotiated with each GP practice, support primary care. Additionally some groups may not access service through 'traditional' routes and may require more of an outreach approach; these groups include some young people and some members of BME communities.

Early intervention

NELMHT has developed a Trust-wide draft strategy on the development of an **early intervention in psychosis** service. It is difficult to see this service being developed without additional resources. The needs assessment conducted by NELMHT suggests that the number of people with a first episode of psychosis in Redbridge could be as many as 38 per year[22] and that the maximum caseload could be as high as 115 clients after a period of three years. This suggests a team with 7 – 8 care coordinators (based on caseload size of 1:15). The strategy suggests 8 and the following structure:

- 8 care coordinators
- 0.4 Consultant

- 0.8 career grade
- 3.5 hours per week of CAMHs psychiatrist
- 1.5 days psychology

The NELMHT 'model' is one of a central hub within the Trust and spokes within the boroughs (borough based teams), jointly managed between adult services and CAMHS.

A significant proportion (20 – 30%) of young people experiencing the first onset of psychosis pose a risk to themselves or others. Many will have made several unsuccessful attempts to seek help before the problem is recognised and this may not happen before crisis admission and negative first contact with mental health services. There is also mounting evidence that the greater the delay in treating the psychosis, the greater the likelihood of long-term problems.

---

[22] It is not certain to what degree these predictions take account of apparent different levels of morbidity in different ethnic groups.

These may include:
- Serious physical injury
- Unemployment
- Impoverished social networks
- Decreased ability for complete remission
- Resistance to treatments
- Compulsory admissions

It is argued that there is a window of opportunity for intervening with this group, often known as the 'critical period', hypothesised to have a duration of 2 – 3 years. Evidence to support this view indicates that effective intervention during this period can:
- Decrease likelihood of relapse
- Reduce social disability
- Reduce psychological problems
- Limit development of treatment resistant symptoms
- Improve service engagement
- Reduce 'longer-term' health care costs

Providing the capability to intervene with this group is no simple matter requiring interventions at three levels:

- primary intervention require community engagement through health promotion and education helping people to recognise the early signs and symptoms
- secondary level intervention requires using a variety of engagement techniques with young people in the early stages and specific intervention to manage the psychosis and prevent admission
- tertiary intervention involves supporting the client from the point of remission and reducing the likelihood of relapse.

Considerable detail on the development of early intervention service is provided in a recent SCMH report (SCMH 2003).

Most early intervention services have adopted assertive approaches to care to provide the intensity of contact during the 'critical period', with low client to care co-ordinator ratios when compared to local CMHTs.

The ETHOS service, based at St George's (serving Merton, Sutton and Wandsworth) has a ratio of 12:1, though other teams have set higher maximum ratios (e.g. 15:1). Models of service provision appear to vary considerably. The SCMH report cited above describes three very different services. The SCMH team involved in this review have recently evaluated another service, with yet again a very different model of provision. The Insight Team in Plymouth, is based in and managed by a voluntary sector youth service, as part of a 'one-stop-shop', and, whilst having the full range of health and social care disciplines represented, also includes youth workers.

Regardless of model of provision adopted, developing an early intervention service will require significant resources. It is not clear from the strategy document how wide the consultation has been at this stage and therefore to what extent it reflects local desires and need, whether there is any flexibility for variation in the model between boroughs and to what extent alternative models of provision and management to those proposed have been considered.

Dual diagnosis

Many practitioners do not feel confidence in working with people who have concurrent substance misuse with their mental health problems. There are some excellent examples of joint working with substance misuse services, including the group work described in the interview section; however, the general consensus was that there was still a risk of people with 'dual diagnosis' falling between services and that a strategy ought to be developed. Obviously this requires collaboration of the DAT.

The guidance around dual diagnosis (DoH 2002b) is less prescriptive than Model 4 is seen as what approximates to the current service model nationally, according to the PIG, and appears to best describe existing provision within Redbridge. This type of service model involves the least joint working and the greatest possibility for those people with a dual diagnosis to fall between services.

The findings from the interviews indicate that most mental health practitioners regard dual diagnosis as part of mainstream mental health work, but many feel they lack the skills and confidence to work effectively with these clients.

Models 1 and 3 are less resource-intensive when compared with model 2. Given the current financial climate it is unlikely that model 2 is achievable. Any consultation needs to acknowledge this reality.

The consultation needs to be conducted jointly with the DAT.

See next page for models -

Modes of service delivery for dual diagnosis

Model 1 - Parallel service

Referrer

(primary care, A&E, therapies, housing providers, criminal justice agencies)

CMHT/ Enhanced Team

Liaison/ support

Substance Misuse Team

Service user

Case responsibility

?
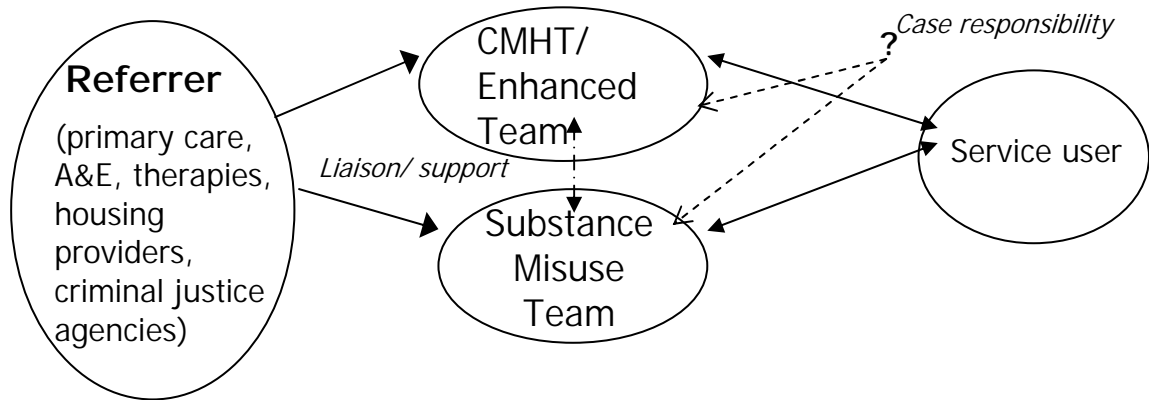
Model 2 - Integrated/ dedicated service

Referrer

CMHT/ Enhanced Team

Specialist Dual Diagnosis Team

Substance Misuse Team

Service user
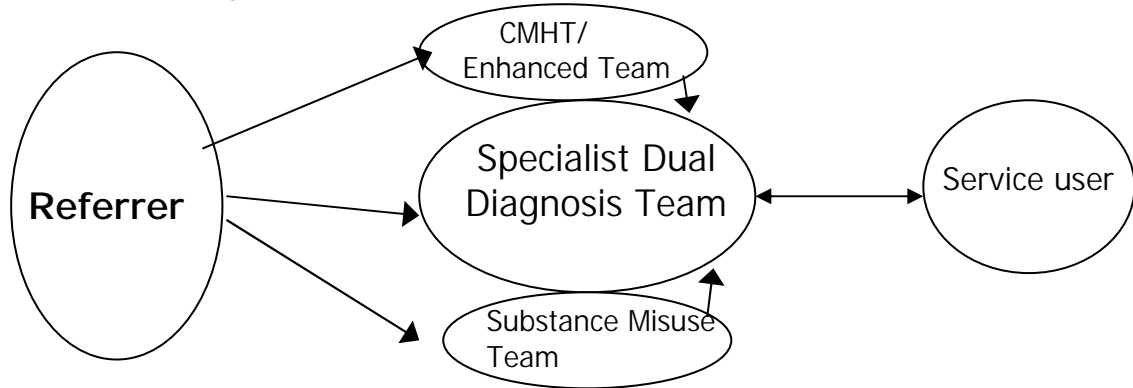
Model 3 - Specialist support in CMHTs

Specialist dual diagnosis worker(s)

Referrer

CMHT/ Enhanced Team

Substance Misuse Team

Liaison/ support

Service user

Model 4 - Serial service

Referrer

CMHT/ Enhanced Team

Service user

Substance Misuse Team

Service user
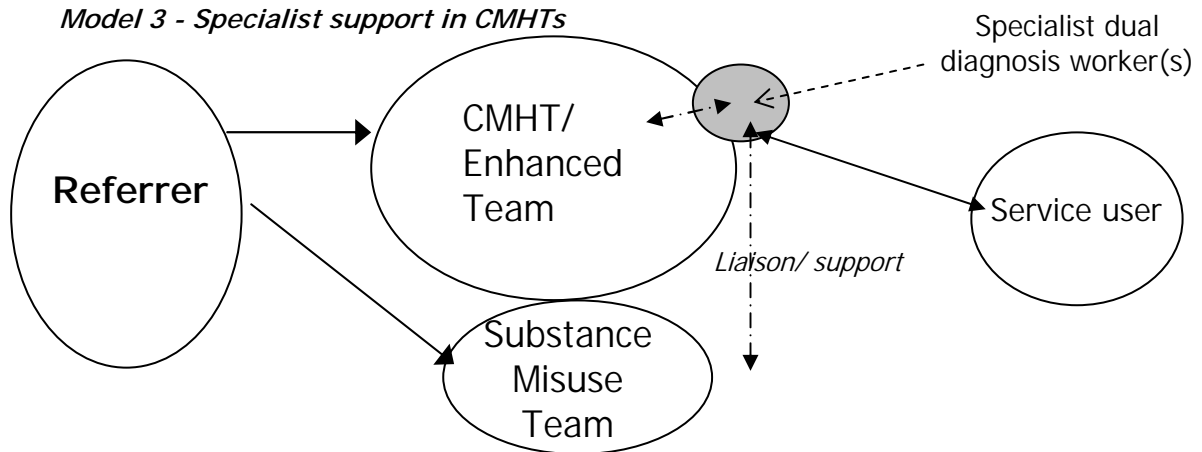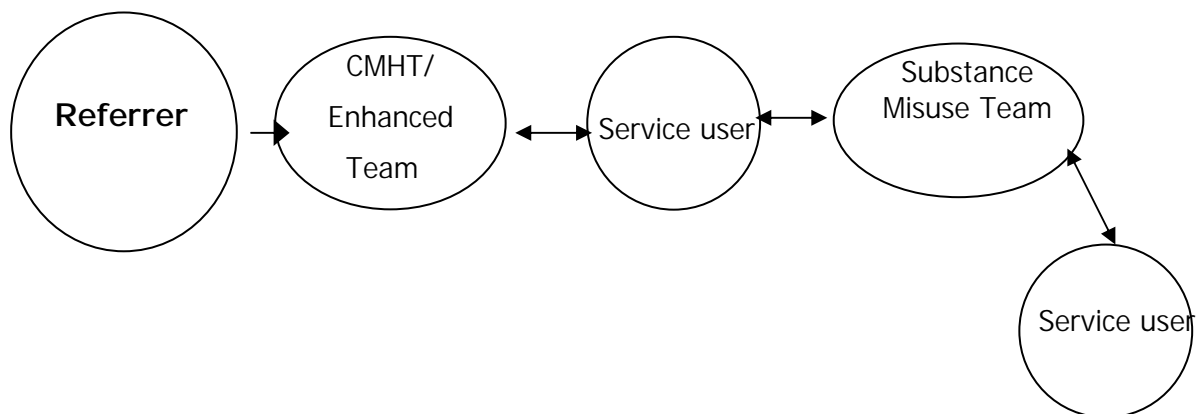
Monitoring performance, measuring outcomes

Another essential requirement is the monitoring of performance and robust performance management. Mental health services need to demonstrate that they are achieving what they set out to achieve. Both statutory and non-statutory services should have formal agreements outlining in concrete terms the expectations of these services. Robust monitoring can also identify problems in delivery and develop solutions at the earliest stage.

Monitoring progress should occur at all levels of the service including at the clinical level. Care planning and measuring progress towards client goals supports clinical work and can help focus it. Measuring outcomes can be done in a variety of ways, for example:
- ➢ recording critical events
- ➢ using standardised measures
- ➢ assessing user satisfaction

Information

Practitioners and there managers require information to conduct their work and to monitor their performance. SCMH encountered several difficulties in accessing reliable and valid information when using existing systems with mental health services in Redbridge. This is not a problem unique to Redbridge, but rather a national problem. Nevertheless this requires attention.

Older Peoples Mental Health

The OPMH CMHT appeared to be an accessible and responsive service, which had invested recently in carer support (Admiral Nurses and support post). Adult mental health services nationally have had a more robust reform experience following the NSF and NHS Plan and the subsequent funding that followed it; leading to the development of specialist services. This, with some exceptions, is a largely absent feature from OPMHs. This is also true of Redbridge.

Specialist mental health services

The apparent 'cut-off' of Redbridge's current CRT/HTT service at 65yrs was perceived almost universally in the interviews and workshop to be illogical. The review did not establish the level of need for such a service, but SCMH would predict that there is a need that could be met by a modest resource. OPMH are very much in favour of their own specialist service CRT type service. This is possible whilst also making use of some of the existing HTT

resource, such as sharing a base, administration and possibly even management.

Redbridge does have a memory clinic within the OPMH service, but this can have quite long waits and is dependent on having a specialist trainee psychiatrist in post. Alternative arrangements should be considered to ensure a year round service with limited waits for assessment.

Fragmentation

There are large numbers of agencies, statutory and non statutory, specialist mental health and non mental health specialist, which form part of the network that the OPMH CMHT need to relate to. Some participants reported that understandably there was considerable fragmentation in the 'sector' and there was a desire to reduce this through the development of multi- agency groups and meetings. There is at least one strategic group in existence, but this may not be the most appropriate meeting for all forms of liaison. The issue of reducing fragmentation and increasing liaison opportunities needs to be considered at different levels. The strategic level being one, but operational management and practitioner levels also need to be addressed. In the case of the latter, this may happen to some degree on a client by client basis, but in SCMH's experience may benefit from providing meeting and liaison opportunities even at times when clients are not shared.

BME and OPMH

There is recognition that the population within the Borough and the aging population is changing, but that is not yet reflected in the service user population.

OPMH service believe that their services are geared towards a largely white and western population, and indeed most the clients who were not 'white UK' clients in the needs assessment sample were still white and European (e.g. 'white Irish').

OPMH were less clear on how to address this and on how to provide culturally appropriate services for BME communities. It was felt that something in the way of day services should be provided. Training in cultural awareness and anti racist practice and related issues would doubtless play a part in supporting the service in addressing what is an apparent gap. It may also be worthwhile seeking some expert consultancy on this issue.

Other issues

There were concerns raised about the quality of home-based care provided by some agency staff, but most the remaining issues were ones shared with

adult services, such as the need for information for both clinical and management purposes and the need to monitor performance.

Recommendations and rationale

Working age adult services

1. SCMH recommends that an intake service be developed
   a. This could be a whole borough access team (stand alone)
   b. or a service divided between locality teams.

The service would need to have capacity to deal with:
- between 100 – 150 referrals per month across the borough(based on estimates of current referral rates)
- liaison with a range of services including primary care
- a small short term intervention caseload
- some limited outreach capacity for special need groups

This would probably be achievable with a multi-disciplinary dedicated team of 14 WTE clinicians (excluding any psychiatry input), but limited additional resource would ensure outreach and liaison goals are achievable (possibly an additional 2 WTE).

2. SCMH also recommends that Redbridge mental health service accept self-referrals and that the intake service becomes the **single gateway to all secondary care services**. This does not mean that the intake team does not have **multiple points where it can be accessed**; indeed it is recommended that it does have multiple points of access and these might include:
- a single well publicised telephone number
- single postal address
- several venues across the borough where assessments take place
- availability through non mental health specific venues
- access through outreach to specific need groups

3. SCMH also recommends that the intake team have some virtual elements supporting access; this might include a shared outreach resource with any new early intervention in psychosis service to help provide access to younger people in need. Another possible virtual element would out of hours access provided by HTT (which may require some additional resource for HTT), however, the extent of this cover could be limited to holding arrangements until the intake service proper is on duty. The A&E liaison service could also be managed from within the intake team.

4. SCMH recommends that Redbridge move from the three locality division of community mental health teams to a two locality division, i.e. that there be two locality community mental health teams. These two teams would be CMHTs primarily with a role in **supporting recovery and promoting rehabilitation** with clients with enduring mental health problems. Each team would serve a newly defined locality. It's envisaged that these teams would

have a similar resource base to the intake team (three teams of 14 - 16WTE which is similar total resource available to the 3 current CMHTs – though the team sizes should be based on a consideration of locality need). Each locality team may divide into some sub-teams, based around GP clusters, but also with some specialist sub teams. The intake service can be one such speciality.

The new CMHTs would prioritise clients with marked need such as

- clients with serious and enduring mental health problems
- clients whose mental health problems are associated with marked disability
- clients having experienced admission and deemed to require ongoing support
- clients with longer term rehabilitation needs
- clients from vulnerable groups

Two CMHTs with 16 WTE care coordinators would have a maximum capacity to manage a caseload of 800 service users and if 14 WTE's then the capacity would be 700 (caseload ratio 1:25). The number of cases managed will have an impact on the degree to which a service can perform other duties (see 'liaison' below).

Careful consideration will need to be given to how psychiatrists relate to the new teams. Psychiatrists and some other team members may relate to particular GP clusters.

5. SCMH recommends that development of a community rehabilitation service and there are three options for this service:

a. A stand alone team

b. A single team hosted by one of the locality mental health teams

c. A rehabilitation service divided between the two teams

6. SCMH recommends that **care coordination be reviewed** and that care coordinators carry more authority than is currently the case. For example HTT inputs to CMHT clients must be seen as being conducted on behalf of the care coordinator, with regular updates to the care coordinator. Inpatient care in a similar way would be conducted in full consultation with the care coordinator.

7. SCMH recommends that a **consultation process be launched on implementing guidance for clients with dual diagnosis**. The various models of provision described within the PIG (see discussion).

8. SCMH recommends that **dedicated liaison roles be developed** in the two new CMHTs and the intake service. Some liaison can be conducted by

individuals in one team but on behalf of the whole service (i.e. liaison with certain non-statutory sectors; e.g. BME services). Other liaison will require activity from all teams. An example of the latter is liaison with primary care. It is recommended that the intake service liaises with all practices to support access to mental health services; however, practitioners with the two locality CMHTs would also have a liaison role and this could be focussed on:

➢ shared care
➢ advice to GPs etc on interventions in primary care.

There are a large number of organisations that liaison relationships ought to be developed with, but a crucial factor in successful liaison is providing time for that liaison to take place. This can be supported by effective workload management.

9. **SCMH recommends that NELMHT launch a project in Redbridge to develop a workload management system** that incorporates caseload management. Any system adopted needs have both qualitative and quantitative elements and be pragmatic. The system would provide guidance to clinicians, supervisors and team managers as to individual's capacity to be allocated new cases and conduct other important duties. There are a number of examples of such systems that NELMHT could review.

10. SCMH recommends that some review be conducted of how the proposed early intervention service can be adapted to meet the needs of Redbridge.

11. SCMH recommends that the PCT, London Borough of Redbridge and NELMHT consider **developing capacity within in non-statutory sector to support the development of services that promote recovery** and that some of this provision be **targeted towards BME groups** currently not well served. This provision should include vocational rehabilitation services and other services providing meaningful daytime activity.

12. **Consideration should be given to using the current resource in Mellmead to providing a borough wide service**. This might suggest a service that is mobile rather than purely centre based, providing outreach to the two new recommended CMHTs and adding to their capacity to run collaborative specialist group programmes.

13. SCMH recommends that **access to psychological and other evidence based interventions is increased** by the development of a training programme that all CMHT and Intake staff requiring it can access. The training programme would cover:

• Psychological interventions (CBT)
• Psychosocial interventions
• Skills in dual diagnosis

14. Additionally **training which combines aspects of anti-racist practice, cultural sensitivity and cultural awareness should be made available to all staff**.

Consideration should be given to opening any training to other mental health services providers.

15. SCMH recommends that the **measuring of outcomes be integrated with practice**. Outcomes can be measured though:
- Recording critical events
- Using specific outcome measurement scales
- Through qualitative methods (e.g. user satisfaction surveys and 'exit' interviews)

16. SCMH recommends that the **new teams be supported by rigorous performance managemen**t.

Performance management can include the monitoring of **team development plans** (see below).

17. We would recommend that each new team dedicate time to considering its function, goals and objectives, and that this be done formally in an agreement with the adult mental health service manager, planning 12-month development activities that are evaluated at the end of this period (as part of performance managing teams). These development plans could include the development of liaison roles, increasing the capacity of each team to provide evidence based interventions, agreed targets around developing partnerships with other provider organisations and the steps the teams have taken to integrate measuring outcome with practice.

19. It is also important for the credibility of any service development to actively engage with service users in the planning, through existing local forums such as RUN-UP, and the PCT/Council need to demonstrate that this has been done.

Older Peoples mental health

19. SCMH recommends that **OPMH have access to a Crisis Resolution Home Treatment** type service and that this be based on a review of the capacity of the existing HTT and the likely need for this service. In order for the existing HTT to provide this service (the most likely option given the resource situation) then OPMH would need to provide training and supervision to HTT. Ideally and finances allowing, additional resources managed by the OPMH would provide this service, but could share the HTT base and some other resources.

20. The PCT and Borough of Redbridge should **support services for older people in reducing fragmentation** in this sector, by the development of joint fora attended by all. Such fora would be developed around specific shared interests[23].

21. **Capacity needs to be developed within the OPMH CMHT to support liaison** with other key services. SCMH recommends the adoption of a workload management system (see working age adult recommendation on this) and that the OPMH CMHT take part in the review of such systems.

22. SCMH does not recommend any changes to the way the service is currently accessed as this appears to be robust, both for clients with functional and organic problems.

23. SCMH recommends that **training which combines aspects of anti-racist practice, cultural sensitivity and cultural awareness should be made available to all staff across OPMH.**

24. SCMH recommends that a **consultation on providing services for older people from BME communities be launched**. The outcome of this might be the adaptation of existing services to meet need and / or the development of new specialist services within the non-statutory sector. The limited evidence from this review indicates that **day care for these groups** is the most likely area requiring development.

25. As with the adult service it is recommended that **rigorous performance management and adoption of development plans** be adopted by OPMH.

26. **Home based care requires review to ensure that such services are provided in a sensitive way**, supporting the independence of service users. SCMH recommends that **agreement with providers cover this specifically** and that mechanisms be developed enabling **care coordinators to input into performance management of these agreements**, further to this such input are sufficiently 'weighted'.

27. Unfortunately many of the gaps in service or service shortcomings did not directly concern the OPMH CMHT and fell outside the remit of this review, but clearly requires attention and SCMH recommend that specialist residential/nursing home provision be reviewed and the development of such resources within borough be considered.

---

[23] The PCT reports that there is already a forum for discussing issues. The Older Peoples Mental Health Sub Group   provides a link between the Partnership Planning Group for Older People and the Mental Health LIT. It meets every 6 weeks and is due to have an away day at the end of April to discuss future priorities. It is possible that the issue of joint for a could be addressed through adapting this group and reviewing its role and membership.

28. Additionally respite care needs for older people and their carers are reportedly thin on the ground and should be developed.

29. The Council should meet with local housing providers with a view to developing housing support options.

Recommendation for working age adult and older peoples mental health services

30. **Mental health services need to prioritise developing effective information for management**. Existing information for management is weak and commitment to provide information within the service is variable. SCMH recommends that some consultations to identify current barriers and current needs. Practitioners and managers are unlikely to have anymore commitment to providing information if it is not used ultimately to support their work.

Where more than one information system is employed (e.g. more than one health system or a health system and a local authority system) then a timetable needs to be agreed on the streamlining and merger of those systems.

The PCT should consider what additional work-based support should be available to support staff with IT.

References

Bebbington, P. (1990) Population Surveys of Psychiatric Disorder and the Need for Treatment. *Social Psychiatry and Psychiatric Epidemiology.* 25: 33-40

Borrill, C.S., Carletta J., Carter, A.J., Dawson, J.F., Garrod, S., Rees, R., Richards, A., Shapiro, D., & West, M.A (2000).*The effectiveness Of Health Care Teams in The National Health Service Department of Health.* London. HMSO

Burns, A, Beevor A, Lelliott P, Wing J, Blakey A, Orrell M, Mulinga J & Hadden S (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS65+). *The British Journal of Psychiatry May* 174: 424-427

Cooper, B. & Singh, B. (2000) Population Research and Mental Health Policy: Bridging the Gap. *British Journal of Psychiatry.*176: 407-411

Department of Health (2003). *Establishing the responsible commissioner : guidance for PCTs.* London. HMSO

Department of Health (2002a) *Mental Health Policy Implementation Guide, Community Mental Health Teams*. London. HMSO

Department of Health (2002b) *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*. London. HMSO

Department of Health (2001) *The Mental Health Policy Implementation Guide*. London. HMSO.

Department of Health (2000) *The National Plan*. London. HMSO.

Department of Health. (1999) *A National Service Framework for Mental Health* London HMSO

Drake, R., Osher, F., Noordsy, D., Hurlbut, S., Teague, G. & Beaudett, M. (1990) Diagnosis of Alcohol Use Disorders in Schizophrenia. *Schizophrenia Bulletin*. 16, 57-67

Huxley P, Reilly S, Gater R, Robinshaw E, Harrison J, Mohamad H, et al. Matching Resources to Care: the Acceptability, Validity and Inter-rater Reliability of a New Instrument to Assess Severe Mental Illness (MARC-1). *Social Psychiatry and Psychiatric Epidemiology,* 2000; 35: 312-317.

McCrone P, Jacobsen B, (2004). Indicators of mental health activity in London: *Adjusting for socio-demographic need*. London Health Observatory, Institute of Psychiatry, London Development Centre for mental health

McHugo, G., Drake, R., Burton, H. & Akerson, T. (1995) A Scale for Assessing the Stage of Substance Abuse Treatment in Persons with Mental Illness. *The Journal of Nervous and Mental Disease*. 183 (12), 762 –767

Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion: The Social Exclusion Unit* .. London. HMSO.

SCMH (2003) *A Window of Opportunity: A practical guide for developing early intervention in psychosis services.* London. The Sainsbury Centre for Mental Health.

SCMH (2002) *Primary Solutions: An independent policy review on the development of primary care mental health services*. London. The Sainsbury Centre for Mental Health.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A, & Meltzer, H. (2001) *Psychiatric Morbidity among Adults Living in Private Households, 2000: Summary Report*. London. Office of statistics

Slade M, Cahill S, Kelsey W, Powell R, Strathdee G (2002) Threshold 2: The reliability, validity and sensitivity to change of the Threshold Assessment Grid (TAG), *Acta Psychiatrica Scandinavica*, 106, 453-460.

Slade M, Powell R, Rosen A, & Strathdee G (2000) Threshold Assessment Grid (TAG): the Development of a Valid and Brief Scale to Assess the Severity of Mental Illness, *Social Psychiatry and Psychiatric Epidemiology*, 35, 78-85.

Appendices

Appendix 1: Needs Assessment Schedule Adult Team version

The Sainsbury Centre for Mental Health

Please answer all questions and return this form to your Clinical Service Manager by close of day at the latest December 14th 2004.

Data collected in this document is based on things as they stood for this client on or before Wednesday November 10th 2004

Review of working age adult and older peoples mental health services in Redbridge

NEEDS ASSESSMENT SCHEDULE (adapted – TAG)

Unique 4 digit Client ID (see guidelines)	☐☐☐☐

Your Name	Sector / Team

Location of Team

Your Occupation (Please tick one)

CPN ☐   SW ☐   Psychiatrist ☐   OT ☐   Psychologist ☐

Other ☐ …….(and please specify) _____

Helpline

If you need help in completing this NAS or have another question about the Census then contact:

Graham Durcan

The Analysis Team
The Sainsbury Centre for Mental Health

On

88

1. Postcode? ☐☐☐☐ ☐ **1a.** *or if of **No Fixed Abode** please enter '88' in the boxes*

2. Age of Client? ☐☐

3. Gender? ☐
1 = Male
2 = Female

4. Ethnic group	
01 British White (English, Scottish, Welsh)	16 Pakistani or British Pakistani (except Kashmiri) ☐☐
02 Irish	17 Bangladeshi or British Bangladeshi
03 Greek (including Greek Cypriot)	18 Other Asian, British Asian, Asian Unspecified
04 Turkish (including Turkish Cypriot)	19 Caribbean
05 Eastern European (incl ex-Yugoslavia & USSR)	20 Somali
06 Other White European	21 African (except Somali)
07 Orthodox Jewish	22 Black British
08 Jewish	23 Other Black, Black Unspecified
09 Other White, Mixed White, White Unspecified	24 Chinese
10 White and Black Caribbean	25 Arab or Middle East
11 White and Black African	26 Kurdish
12 White and Asian	27 Vietnamese
13 Other Mixed, Mixed Unspecified	28 Traveller
14 Indian or British Indian	29 Any Other Group
15 Kashmiri or British Kashmiri	30 Not known

4a Please describe the religious affiliation of this client (see guidelines).

5a. Refugee or Asylum Seeker?   **5b Please indicate whether a refugee or asylum seeker**
1 = Yes, ☐   Refugee ☐   Asylum seeker ☐
0 = No

6. Marital Status? ☐
1 = Single   2 = Married/Cohabiting   3 = Divorced/separated   4 = Widowed

7. Current living Arrangements?
1 = Yes, 0 = No
Live alone ☐   Parent(s) ☐
Single parent ☐   Other family ☐
Spouse/partner ☐   Non-family ☐

8. **Number of children under 16 years** (*excluding client where applicable*) **living in household?**

enter number in the box ☐

9. Accommodation type? (*Please select only **one** category*) ☐☐☐

01 = House or flat (owned)   06 = Hostel
02 = House or flat (rented)   07 = Sheltered housing
02a= Bedsit (rented)   08 = Residential home
03 = Boarding out (incl. B&B)   09 = Nursing home
04 = Mobile home   10 = Hospital ward
05 = supported/group home   10b= Hosp' awaiting placement
                               11 = Homeless

10. Is this client currently occupying an acute psychiatric bed? (answer "Yes" even if the client is on leave 'on leave' from acute ward on the census date)
1 = Yes
0 = No ☐

11. Current employment status?
1 = In paid work
2 = In sheltered employment
3 = Other return to work type employment/ work placement
4 = In training/education
5 = In voluntary employment

6 = Not working – short/long term illness or disability
7 = Not working – looking after the home
8 = Unemployed
9 = Retired   1st ☐
10 = Other   2nd ☐

12. Care Programme Approach?   (if not known enter a "+")

0 = Not assigned
1 = Standard   ☐
2 = Enhanced

---

13 Details of referral

a Date of referral to your team ☐☐ ☐☐ ☐☐   (day-month-year)

b. If Specialist within team (i.e. Psychologist) give date of referral to you ☐☐ ☐☐ ☐☐

c. Date of Assessment ☐☐ ☐☐ ☐☐   d. Date of 1st contact post assessment ☐☐ ☐☐ ☐☐

e. Was this a first episode of care? (enter '1' for Yes or '0' for No) ☐   f. Number of Years in contact with MH services? ☐

---

14. Which of these currently apply?

1 = Yes, 0 = No   (*enter for all that apply*)

Section 117 after-care ☐
Supervised discharge (Section 25a) ☐
Other court order (include S. 37/41) ☐
Guardianship ☐

Section of Mental Health Act ☐
(and which section applies – complete box below)

☐

On sexual offender register ☐
Children on Child Protection Register ☐
Contact with (LA)Child and Family Services ☐
Children in LA care / 'Looked/after' ☐

15a Is the Client registered with a G.P.? ☐
1 = Yes, 0 = No

15b If no to 15a then please say why?

16a. Client co-operation with help given/offered?

1 = Complete refusal/partial refusal
2 = Reluctant acceptance/occasional reluctance
3 = Passive acceptance/ moderate participation/active participation
4 = Not applicable

Keeping appointments / face to face contacts ☐

Medication ☐
enter score for each of the above

16b Are there any other issues / difficulties with regards engagement with this client (please give brief description)?

---

17. How much contact does this client have with other services?

1 = Some (unknown amount)	5 = Twice a month
2 = Six monthly	6 = Once a week
3 = Three monthly	7 = More than once a week
4 = Once a month	8 = Once daily or more

Please include all services, statutory and voluntary

Name of service   Contacts

Service 1 ☐
Service 2 ☐
Service 3 ☐
Service 4 ☐
Service 5 ☐

Name of Service   Contacts

Service 6 ☐
Service 7 ☐
Service 8 ☐
Service 9 ☐
Service 10 ☐

Continue on blank sheet of paper if necessary.

18a. How much contact does this client have with you?
a. How many times has this client been <u>seen</u> by you in the past 3 months? ☐

18b. How may unsuccessful contacts in the last 3 months? ☐

19. Any compulsory admissions to hospital?
1 = Yes
0 = No ☐

20. Any psychiatric inpatient episodes of more than 3 months?
1 = Yes
0 = No ☐

21a. Any admission to psychaitric hospital in the last

   12 months?
   1 = Yes
    0 = No ☐

21b Length of stay of most recent admission in

   last 12 months?
   ☐☐☐(days)

22. More than one admission in the last 12 months?

1 = Yes

0 = No ☐

23. Number of visits by CMHT care coordinator during most recent admission in last 12 months? ☐☐☐
(see Guidelines)

24. Has this client had treatment for detoxification during an admission in the last year?
1 = Yes   If yes (1) state if for 1 = Alcohol detoxification
0 = No   2 = Drugs / other substance detoxification
         ☐   3 = Both of the above ☐

25. Has the client been treated by the 24/7 or home treatment team in the last 12 months?
1 = Yes ☐
0 = No

91

26. Has this client ever been an inpatient in a secure facility?
1 = Yes ☐
0 = No

If yes ('1') then indicate the type of facility ?
Enter 1 = Yes   or   0 = No for each and then name the facilities (include NHS and Independent sector)

Intensive Care Unit ☐   **Low Secure Unit** ☐

☐   ☐

Medium Secure) ☐   **High Secure / Special Hospital** ☐

☐   ☐

27a. Has this client ever been remanded to or served a sentence in Prison ?
1 = Yes ☐
0 = No

27b. Is this client currently in Prison?
1 = Yes ☐
0 = No

27c and if Yes ('1') to 27b is this client currently in receipt of Psychiatric in-reach?
1 = Yes ☐
0 = No

27d Is there current contact with Probation Services (or youth offending/justice services)?
1 = Yes ☐
0 = No

---

28. Is this client currently exhibiting psychotic symptoms?
1 = Yes ☐
0 = No

29. What is the Primary Diagnosis?   Enter number here ☐☐

01 = Schizophrenia   11 = Alcohol misuse related
02 = Other Schizoaffective and Bipolar Disorders 12 = Drug misuse related
03 = Other Psychosis   13 = Personality Disorder
04 = Depression   14 = Organic/Dementia
05 = Post Traumatic Stress   15 = Learning difficulties
06 = Phobias
07 = Panic disorder   16= None available
08 = Generalised Anxiety Disorder   17 = Not known
09 = Obsessive Compulsive Disorder   18 = **Other**
10 = Mixed Anxiety and Depressive Disorder   and please specify ☐

30. What, if any, is the secondary diagnosis? (enter number from list above) ☐☐ secondary

List other diagnosis that apply below secondary diagnosis   ☐☐ 3rd
                                                                  ☐☐ 4th

31. Does this client have a marked current physical illness or disability?
1 = Yes ☐
0 = No

32. Independent living skills? Please their skills (either without OR with support):

- **Able to undertake all self-care tasks <u>without</u> support** ☐ **OR** **With support** ☐
- **Able to maintain a tenancy <u>without</u> support** ☐ **OR** **With support,** ☐
- **Able to manage their financial affairs <u>without</u> support** ☐ **OR** **With support,** ☐

33. Does the service have a problem communicating with this client? 1 = Yes; 0 = No

If 'yes' to a language problem what is the problem (e.g. what is client's first language or write literacy / cognitive / learning difficulty as appropriate)

With regards to language? ☐

With regards to sensory impairment? ☐

34. Does this client have: 0 = No; 1 = Yes; **?** = Don't know

At least one close friend ☐   Regular contact with a relative ☐

Someone to turn to for needed help ☐   A mental health advocacy worker ☐

35a. Is there an identified carer?

☐

1 = Yes
0 = No

35.b If yes to Informal Carer has the carer been offered an assessment?

1 = Yes
0 = No ☐

35c Has the client agreed to an assessment?

1 = Yes
0 = No ☐

35d If yes, have the carer's needs been assessed?

35e If yes to 35c but assessment has not taken place then why not

36. Are the client's carer arrangements currently at risk of breaking down?

1 = Yes
0 = No ☐

37 Is the client a carer for someone else?

1 = Yes
0 = No ☐

38. Does this client have mental health or related assessed needs which are NOT currently being met?

1 = Yes

0 = No ☐   If Yes (1) then please list or describe in the space below and continue on reverse of
     this

Problem / Symptom Checklist
What type of problems does your client have?

Please tick all that apply

• Psychotic symptoms	
• Problems with depressed mood	
• Anxiety / Stress / Tension	
• Obsessive-compulsive	
• Phobic type problem	
• Panic attacks	
• Post traumatic stress	
• Dissociative type problem	
• Somatoform (physical manifestation of psychological problem)	
• Self-harm / suicide attempts	
• Problems with aggression	
• Cognitive problems (include any person suffering or suspected of suffering dementia)	
• Problems with Sleep	
• Problems with relationship(s)	
• Problems related to victimisation (includes victim of previous abuse)	
• Sexual (aggressive / inappropriate)	
• Sexual dysfunction	
• Problems with eating	
• Problems with use of substances/ drugs/ and/or alcohol	
• Learning difficulty	
• Problems with literacy and numeracy	
• Autism / or problem in autistic spectrum (e.g. Aspergers Disorder)	
• Problem with personality (possible Personality Disorder)	
• Other (*please specify in box below*)	

Rating

<!-- empty box -->

Substance Abuse Treatment Scale

Instructions: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last **six months**. If the person is in an institution, the reporting interval is the time period prior to institutionalization

0 enter zero if there is no problem

1. **Pre-engagement** The person (*not client*) does not have contact with a case manager, mental health counsellor, or substance abuse counsellor, and meets criteria for substance abuse or dependence.

2. **Engagement** The client has had only irregular contact with an assigned case manager or counsellor, and meets criteria for substance abuse or dependence.

3. **Early Persuasion** The client has regular contacts with a case manager or counsellor, continues to use the same amount of substances or has reduced substance use for less than 2 weeks, and meets criteria for substance abuse or dependence.

4. **Late Persuasion** The client has regular contacts with a case manager or counsellor, shows evidence of reduction in use for the past 2-4 weeks (fewer substances, smaller quantities, or both), but still meets criteria for substance abuse or dependence.

5. **Early Active Treatment** The client is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse of dependence during this period of reduction.

6. **Late Active Treatment** The person is engaged in treatment and has not met criteria for substance abuse or dependence for the past 1-5 months.

7. **Relapse Prevention** The client is engaged in treatment and has not met criteria for substance abuse or dependence for the past 6-12 months.

8. **In Remission or Recovery** The client has not met criteria for substance abuse or dependence for more than the past year.

CLINICIAN RATING OF DRUG USE DISORDER

Please rate your client's use of drugs over the past six months according to the following scale. Rate the worst period over the last six months. If the person is in an institution, the reporting interval is the time period prior to institutionalization. You should weigh evidence from self-report, interviews, behavioural observations, and collateral reports (family, day center, community, etc.) in making this rating.

Rating

0 = NO PROBLEM

1= ABSTINENCE - Client has not used drugs during this time interval.

2= USE WITHOUT IMPAIRMENT - Client has used drugs during this time interval, but there is no evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use and no evidence of recurrent dangerous use.

3= ABUSE - Client has used drugs during this time interval and there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use or evidence of recurrent dangerous use. For example, recurrent drug use leads to disruptive behavior and housing problems. Problems have persisted for at least one month.

4= DEPENDENCE - Meets criteria for 'abuse' plus at least three of the following: greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of drug use, continued use despite knowledge of substance-related problems, marked tolerance, characteristic withdrawal symptoms, drugs taken to relieve or avoid withdrawal symptoms. For example, binges and preoccupation with drugs have caused client to drop out of job training and non-drinking social activities.

5= SEVERE DEPENDENCE - Meets criteria for 'dependence' plus related problems are so severe that they make non-institutional living difficult. For example, constant drug use leads to disruptive behaviour and inability to pay rent so that client is frequently reported to police and seeking hospitalisation.

Mark drugs used: Cannabis/ Cocaine/ Hallucinogens/ Opiates/ PCP/ Stimulants/ Sedatives/ Hypnotics/ Anxiolytics/ Over-the-counter /Other

Rating ☐

CLINICIAN RATING OF ALCOHOL USE DISORDER

Please rate your client's use of alcohol over the past six months according to the following scale. Rate the worst period over the last six months. If the person is in an institution, the reporting interval is the time period prior to institutionalization. You should weigh evidence from self-report, interviews, behavioral observations, and collateral reports (family, day center, community, etc.) in making this rating.

0 = NO PROBLEM

1= ABSTINENCE - Client has not used alcohol during this time interval.

2= USE WITHOUT IMPAIRMENT - Client has used alcohol during this time interval, but there is no evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use and no evidence of recurrent dangerous use.

3= ABUSE - Client has used alcohol during this time interval and there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use or evidence of recurrent dangerous use. For example, recurrent alcohol use leads to disruptive behavior and housing problems. Problems have persisted for at least one month.

4= DEPENDENCE - Meets criteria for 'abuse' plus at least three of the following: greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of alcohol use, continued use despite knowledge of substance related problems, marked tolerance, characteristic withdrawal symptoms, alcohol taken to relieve or avoid withdrawal symptoms. For example, drinking binges and preoccupation with drinking have caused client to drop out of job training and non-drinking social activities.

5= SEVERE DEPENDENCE - Meets criteria for 'dependence' plus related problems are so severe that they make non-institutional living difficult. For example, constant drinking leads to disruptive behaviour and inability to pay rent so that client is frequently reported to police and seeking hospitalization.

THRESHOLD ASSESSMENT GRID (TAG)

SCORE SHEET

TAG ASSESSES THE SEVERITY OF A PERSON'S MENTAL HEALTH PROBLEMS

For each domain (numbered 1 to 7), tick ONE statement that best applies to the person being assessed. There should be a total of 7 ticks on the completed grid (one for each domain). Then for each level of severity (e.g. 'None', 'Very Severe') add the number of ticks and record in the box at the bottom of the column. 'Very Severe' is only available for domains where life-saving emergency action by specialist mental health teams may be required. The checklists overleaf provide some guidance on the issues to consider when assessing each domain - they are not intended to be prescriptive. Further information on the TAG is available from www.iop.kcl.ac.uk/prism/tag.

		NONE	MILD	MODERATE	SEVERE	VERY SEVERE
SAFETY	**Domain 1** Intentional self harm	No concerns about risk of deliberate self-harm or suicide attempt ◯	Minor concerns about risk of deliberate self-harm or suicide attempt ◯	Definite indicators of risk of deliberate self-harm or suicide attempt ◯	High risk to physical safety as a result of deliberate self-harm or suicide attempt ◯	Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt ◯
	Domain 2 Unintentional self harm	No concerns about unintentional risk to physical safety ◯	Minor concerns about unintentional risk to physical safety ◯	Definite indicators of unintentional risk to physical safety ◯	High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment ◯	
RISK	**Domain 3** Risk from others	No concerns about risk of abuse or exploitation from other individuals or society ◯	Minor concerns about risk of abuse or exploitation from other individuals or society ◯	Definite risk of abuse or exploitation from other individuals or society ◯	Positive evidence of abuse or exploitation from other individuals or society ◯	
	Domain 4 Risk to others	No concerns about risk to physical safety or property of others ◯	Antisocial behaviour ◯	Risk to property and/or minor risk to physical safety of others ◯	High risk to physical safety of others as a result of dangerous behaviour ◯	Immediate risk to physical safety of others as a result of dangerous behaviour ◯
NEEDS AND DISABILITIES	**Domain 5** Survival	No concerns about basic amenities, resources or living skills ◯	Minor concerns about basic amenities, resources or living skills ◯	Marked lack of basic amenities, resources or living skills ◯	Serious lack of basic amenities, resources or living skills ◯	Life-threatening lack of basic amenities, resources or living skills ◯
	Domain 6 Psychological	No disabling or distressing problems with thinking, feeling or behaviour ◯	Minor disabling or distressing problems with thinking, feeling or behaviour ◯	Disabling or distressing problems with thinking, feeling or behaviour ◯	Very disabling or distressing problems with thinking, feeling or behaviour ◯	
	Domain 7 Social	No disabling problems with activities or in relationships with other people ◯	Minor disabling problems with activities or in relationships with other people ◯	Disabling problems with activities or in relationships with other people ◯	Very disabling problems with activities or in relationships with other people ◯	

The Sainsbury Centre for Mental Health

Appendix 2: Need Assessment Schedule. Older Peoples Version

Please answer all questions and return this form to your Clinical Service Manager by close of day on December 14th at the latest.

Data collected in this document is based on things as they stood for this client on or before Wednesday November 10th 2004

Review of working age adult and older peoples mental health services in Redbridge

NEEDS ASSESSMENT SCHEDULE (adapted for older peoples mental health – includes HoNOS 65+)

Client ID (see guidelines)	☐☐☐☐☐☐☐

Your Name	Sector / Team

Location of Team

Your Occupation (Please tick one)

CPN/Nurse ☐ SW ☐ Psychiatrist ☐ OT ☐ Psychologist ☐

Other ☐ …...(and please specify)

Helpline
If you need help in completing this NAS or have another question about the Census then contact:

Graham Durcan

The Analysis Team
The Sainsbury Centre for Mental Health

On

1. Postcode? ☐☐☐☐   **1a.**   *or if of* **No Fixed Abode** *please enter '88' in the boxes*

2. Age of Client? ☐☐

3. Gender?   1 = Male 2 = Female   ☐

4. Ethnic group

01 British White (Welsh)
02 Other British White (English, Scottish)
03 Irish
04 Greek (including Greek Cypriot)
05 Turkish (including Turkish Cypriot)
06 Eastern European (incl ex-Yugoslavia & USSR)
07 Other White European
08 Orthodox Jewish
09 Jewish
10 Other White, Mixed White, White Unspecified
11 White and Black Caribbean
12 White and Black African
13 White and Asian
14 Other Mixed, Mixed Unspecified
15 Indian or British Indian
16 Kashmiri or British Kashmiri

☐☐

17 Pakistani or British Pakistani (except Kashmiri)
18 Bangladeshi or British Bangladeshi
19 Other Asian, British Asian, Asian Unspecified
20 Caribbean
21 Somali
22 African (except Somali)
23 Black British
24 Other Black, Black Unspecified
25 Chinese
26 Arab or Middle East
27 Kurdish
28 Vietnamese
29 Traveller
30 Any Other Group
31 Not known

5. Marital Status?   ☐
1 = Single
2 = Married/Cohabiting
3 = Divorced/separated
4 = Widowed

6. Current living Arrangements?
1 = Yes, 0 = No   ☐
Live alone   ☐
Spouse/partner

Other Family   ☐
Non-family   ☐

7a. Accommodation type? (*Please select only **one** category*)

01 = House or flat (owned)   07 = Sheltered housing
02 = House or flat (rented)   08 = Residential home
03 = Boarding out (incl. B&B) 09 = Nursing home
04 = Mobile home   10 = Hospital ward
05 = supported/group home   11 = Hospital awaiting placement
06 = Hostel   12= Homeless

☐☐

7b If Accommodation is '11' 'awaiting placement, then please give date when declared ready for discharge

day   month   year
☐☐ ☐☐ ☐☐

8. Is this client currently occupying an psychiatric bed? (answer "Yes" even if the client is on leave 'on leave' from acute ward on the census date) 1 = Yes 0 = No   ☐

9. Current employment status?
1 = In paid work
2 = In sheltered employment
3 = Other return to work type employment/ work placement
4 = In training/education
5 = In voluntary employment

6 = Not working – short/long term illness or disability
7 = Not working – looking after the home
8 = Unemployed
9 = Retired
10 = Other

☐

10. Former employment status?
1 = In paid work
2 = In sheltered employment
3 = Other return to work type employment/ work placement
4 = In training/education
5 = In voluntary employment

6 = Not working – short/long term illness or disability
7 = Not working – looking after the home
8 = Unemployed
9 = Retired
10 = Other

☐

11. CPA status (enter 1, 2, or 3 in the box) ☐
1 = not assigned   2 = Standards 3 = Enhanced

12. Which of these currently apply?
1 = Yes, 0 = No   (enter for all that apply)

Section of Mental Health Act ☐
(and which section applies – complete box below)

Section 117 after-care ☐
Supervised discharge (Section 25a) ☐
Other court order (include S. 37/41) ☐
Guardianship ☐

Subject to Vulnerable Adults procedures ☐

13a. Client co-operation with help given/offered?
1 = Complete refusal/partial refusal
2 = Reluctant acceptance/occasional reluctance
3 = Passive acceptance/ moderate participation/active participation
4 = Not applicable

Keeping appointments ☐

Medication ☐
enter score for each of the above

13b. Are there other issues in engaging with this client? Please give some detail?

14. How much contact does this client have with other services?

0 = None	5 = Twice a month
1 = Some (unknown amount)	6 = Once a week
2 = Six monthly	7 = More than once a week
3 = Three monthly	8 = Once daily or more
4 = Once a month	+ = Not known

Please include all services, statutory and voluntary
Name of service   Contacts

Name of Service   Contacts

Service 1 ☐

Service 6 ☐

Service 2 ☐

Service 7 ☐

Service 3 ☐

Service 8 ☐

Service 4 ☐

Service 9 ☐

Service 10 ☐

Service 5 ☐

Continue on blank sheet of paper if necessary.

15. How much face to face contact does this client have with YOU? [inpatient staff do not need to complete]

a. How many times has this client been <u>seen</u> by you in the past 3 months? ☐

b. How may unsuccessful contacts in the last 3 months?
[inpatient staff do not need to complete] ☐

16 Details of referral
a Date of referral to your team ☐☐☐☐☐☐   (day-month-year)
b. If Specialist within team (i.e. Psychologist/OT) give date of referral to you ☐☐☐☐☐☐

c. Date of Assessment ☐☐☐☐☐☐   d. Date of 1st contact post assessment ☐☐☐☐☐☐
e. Was this a first episode of care? (enter '1' for Yes or '0' for No)   f. Number of Years in contact with MH services?
☐   ☐

17. Any compulsory admissions to hospital since client has been in contact with older peoples services?

1 = Yes   ☐
0 = No

18. Any psychiatric inpatient episodes of more than 6 months since client has been in contact with older peoples services?   ☐
1 = Yes
0 = No

19. Any psychiatric admission in the last 12 months? ☐   **19b Length of stay of last admission**
1 = Yes   ☐☐☐
0 = No

20. More than one admission in the last 12 months?

1 = Yes   ☐
0 = No

21. Number of visits where contact was made with service user by CMHT staff during most recent admission (see Guidelines)   ☐☐

22. What is the Primary Diagnosis?

Enter number here ☐☐

1 = Schizophrenia
2 = Other Schizoaffective and Bipolar Disorders
3 = Other Psychosis
4 = Depression
5 = Post Traumatic Stress
6 = Phobias
7 = Panic disorder
8 = Generalised Anxiety Disorder
9 = Obsessive Compulsive Disorder
10 = Mixed Anxiety and Depressive Disorder

11 = Alcohol misuse related
12 = Drug misuse related
13 = Personality Disorder
14 = Organic/Dementia
15 = Learning difficulties

16 = None available
17 = Not known
18 = **Other**
and please specify   [   ]

23. What, if any, is the secondary diagnosis? (enter number from list above ☐☐   secondary

List other diagnosis that apply below secondary diagnosis   ☐☐   3rd
☐☐   4th

24. Independent living skills? Please enter a 1 for Yes and O for No :

- **Able to undertake all self-care tasks without support** ☐   OR   With support   ☐
- **Able to maintain a tenancy without support** ☐   OR   With support,   ☐
- **Able to manage their financial affairs without support** ☐   OR   With support,   ☐

25. Does the service have a problem communicating with this client? 1 = Yes; 0 = No

If 'yes' to a language problem what is the problem (e.g. what is client's first language or write literacy / cognitive / learning difficulty as appropriate)

With regards to language?   ☐ If 'yes' please state nature of this   [   ]

With regards to sensory impairment?   ☐

 please state nature of impairment   [   ]

26. Does this client have: 0 = No; 1 = Yes; ? = Don't know

At least one close friend ☐   Regular contact with a relative ☐

Someone to turn to for needed help ☐   A advocacy worker ☐

Contact with Spouse/ Partner ☐

27a. Is there an identified carer?

1 = Yes   ☐
0 = No

27b. If YES for Q27a *("is there a carer?")*, **for ALL of the items listed, please indicate in each column whether the   personal needs of the <u>carer</u> have been assessed, identified and met**

1 = Yes 0 = No

	Need assessed	Need identified	Need met
Information	☐	☐	☐
Support	☐	☐	☐
Health	☐	☐	☐
Needs for Respite/short break	☐	☐	☐
Other *(please specify)*	☐	☐	☐

☐

28. Are the client's carer arrangements currently at risk of breaking down?

1 = Yes
0 = No   ☐
88 = Not applicable

29 Is the clients a carer for another person ?

1 = Yes
0 = No   ☐

30. Does this client have mental health or related assessed needs which are NOT currently being met?

1 = Yes   ☐

1 = No   If Yes (1) then please list or describe in the space below and continue on reverse of
this

☐

Problems/ Symptoms checklist and scales

Problems with:	No Problem	Some problems	Marked Problems
Maintaining safe environment			
Communication			
Mobility			
Orientation			
Eating / Drinking			
Dressing			
Hygiene			
Sexual dysfunction			
Inappropriate sexual behaviour			
Anxiety / Stress / Tension			
Obsessive-Compulsive			
Phobic type problem			
Panic attacks			
Post traumatic stress			
Dissociative			
Somatoform (physical manifestation of psychological problem)			
Problems with Sleep			
Problems with relationship(s)			
Problems related to victimisation (includes victim of previous abuse)			
Learning difficulty			
Autism / or problem in autistic spectrum (e.g. Aspergers Disorder			
Problem with personality (possible Personality Disorder)			
Problems with elimination			
Problems with continence			
Problems with self neglect			
Problems with wandering			

HoNOS 65+

1. Rate each item (1 to 12) in order, from 0 to 4
2. Do not include information rated in an earlier item
3. Rate the most severe problem that has occurred during the last __two weeks__
4. All scales should be rated using the following format:
   - 0 = No problem
   - 1 = Minor problem requiring no action
   - 2 = Mild problem which is definitely present
   - 3 = Moderately severe problem
   - 4 = Severe to very severe problem

   If you are unable to rate an item, please give a score of **9** for that item.

Item	9	0	1	2	3	4
1 Overactive, aggressive, disruptive behaviour						
2 Non-accidental self-injury						
3 Problem-drinking or drug-taking						
4 Cognitive problems						
5 Physical illness or disability problems						
6 Problems associated with hallucinations and delusions						
7 Problems with depressed mood						
8 Other mental and behavioural problems - specify A to J * in the box provided						
9 Problems with relationships						
10 Problems with activities of daily living						
11 Problems with living conditions						
12 Problems with occupation and activities						

Re item 8. choose the worst problem in last two weeks from this list:
*__A__ phobic; __B__ anxiety; __C__ obsessive-compulsive; __D__ stress; __E__ dissociative; __F__ somatoform; __G__ eating; __H__ sleep; __I__ sexual
__J__ problems not specified elsewhere