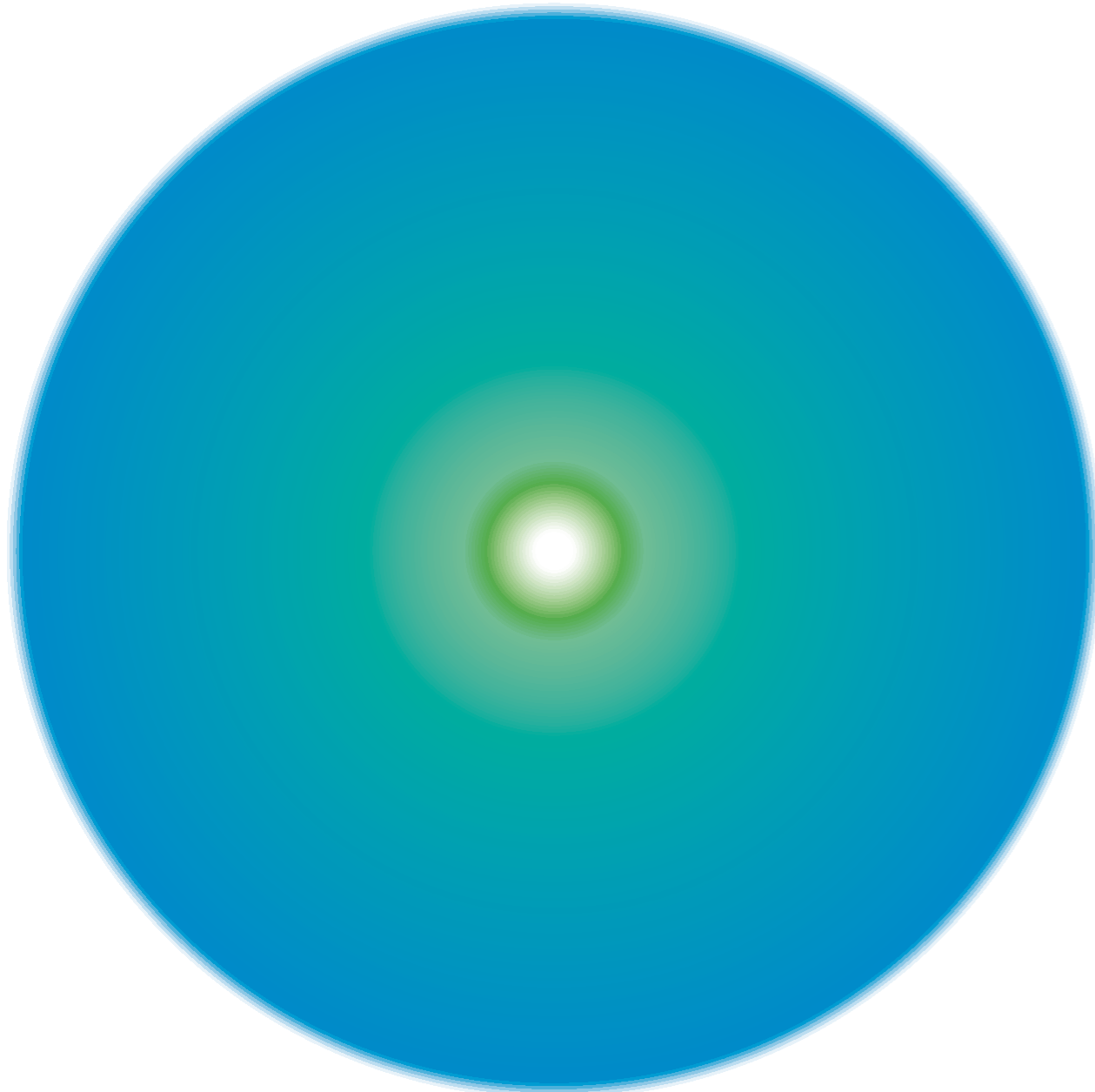




The Mental Health Pathway



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Wellbeing for all

1
This chapter (based on the work of the Mental Health CPG – full report available at www.yorksandhumber.nhs.uk) sets out what we need to do to make sure we provide the best possible mental health services.

The Case for Change

2
In England mental health problems result in greater loss of economic potential than any other condition – with lost output and high benefit payments. 13% of NHS spend is on MH services. Although 1 in 6 of us will have a mental health problem, mental health conditions remain some of the least understood in the community at large resulting in high stigma and isolation for some sufferers.

3
In Yorkshire & the Humber there is a higher than the national average suicide rate of 8.61 per 100,000 population as opposed to 8.25 nationally; the national rate is reducing but in this region it rose between 2003 and 2006.

4
Rates of self reported stress, depression and anxiety caused or made worse by work is one of the highest rates in the country.

5
Across Y&H there is considerable variation in the services provided in localities and the speed in which services have been modernised as illustrated by the following:

- Community mental health teams remain the building block of services for most people needing specialist care, but staff numbers do not reflect need in communities and resources do not reflect variation in demand.
- Despite the efforts of staff, Primary Care MH Teams are poorly developed and their role is poorly defined with few localities having planned and implemented services which are integrated with specialist services.
- Referral routes are overly complex with an onus on the referrer, (often a generalist practitioner) to be experts in service identification and placement. Services are organised into 'discrete building blocks' with artificial barriers between them that do not allow for easy flow through the care system. Referral processes are overly complex and unnecessary, with some GPs having to handle up to 29 different protocols for referral into mental health services



6

Psychological therapy and talking therapy approaches to care remain unavailable to people with severe mental health problems. People with LTCs and carers do not have easy access to psychological interventions despite evidence to suggest that this would be beneficial. It is estimated that 50% of 'unexplained' medical conditions could be resolved by psychological interventions.

7

Y&H spends the fourth lowest amount on crisis response/home treatment according to the National Audit Office and only two PCT areas are achieving their targets for home treatment episodes. Recent investigation into why performance is so poor suggests that teams are focusing on assessment of people experiencing a mental health crisis at the expense of home treatment. Teams do not play the central role in gate-keeping access to beds that evidence indicates is necessary.

8

The establishment of Early Intervention in Psychosis teams across the region has been slow with only two PCT areas treating their expected number of new cases. This is an area of concern as evidence clearly demonstrates that early intervention offers the best outcomes for a young person with realistic opportunities for a full recovery from a first episode of psychosis.

9

The transition from children's mental health services to adult services is poorly developed across the region. CAMHS on-call systems are sparse leading to inappropriate care in adult units and poor levels of 'Tier 4 provision'.

10

The implementation of integrated health and social care teams is not yet complete across the region.

11

The government have commissioned the development of a national strategy for dementia which will be available early in 2008. The CPG support the emerging themes but signalled that variation in implementation will occur without coordinated strategic leadership.

12

The CPG identified lack of quality control and standards as an area for development. People who use the service and their carers report having many assessments which are repetitive. The current mental health system is perceived as being complex for both people who use the services and people who refer or signpost people into the service.

"All living in Y&H to be able to get the maximum out of life, free from discrimination, disability, and poverty – wellbeing for all is our aim."

Key Recommendations

13

Clinicians have advised us of the key recommendations we should be taking forward to improve mental health services.

14

Of critical importance is the implementation of generic mental health pathways which the CPG describe in the models below. The key features of these pathways are:

- Integrated primary/secondary and health and social care.
- Care planning supported by 'advocate' challenged care navigation.
- Single point of access.
- Open access to a range of supportive interventions provided by a range of providers.
- NICE guidelines/good practice/evidence underpins the care packages.
- Care elements/packages can be allocated a cost so that individuals can have their own budget.
- Personal advisors or advocates are available to support people in accessing the appropriate support.
- National standards for services which enable benchmarking to take place.

15

The CPG support the same aspiration for mental health outcomes as described in the report of the London review – "Framework for Action" – 'all living in Y&H to be able to get the maximum out of life, free from discrimination, disability, and poverty – wellbeing for all is our aim'.

16

This aspiration should feature in Local Strategic Partnerships and Local Area Agreements.

17

The term 'Crisis Resolution' should be dropped completely as it causes significant confusion to referrers and commissioners alike.



The Mental Health Pathway

18

The CPG have devised a model which we think will lead to more integrated and accessible care giving easy access to the right care at the right time (see figure 35 and 36).

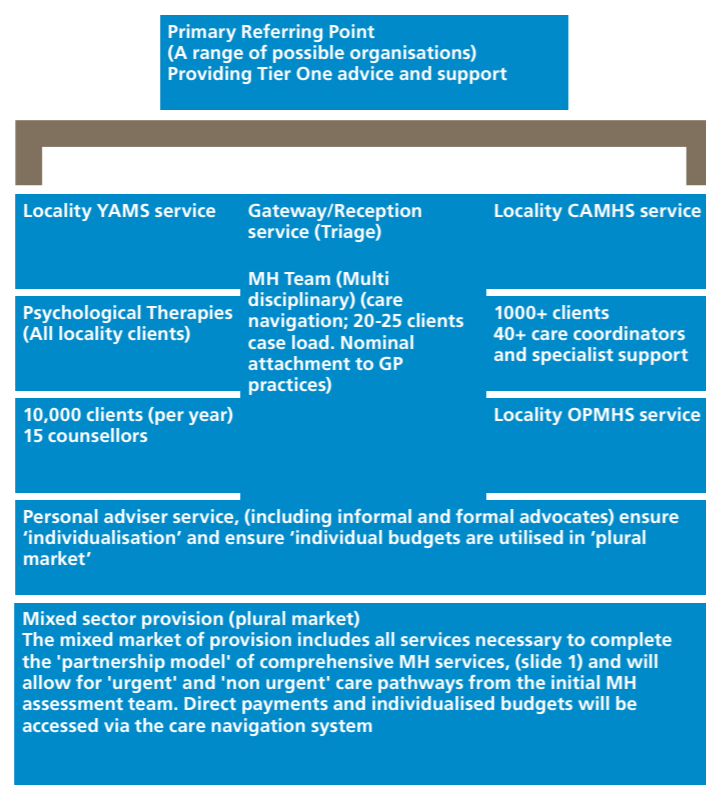
The non urgent care Pathway in Practice

19

People who need mental health services are identified and seek access to help from a variety of points from GP practices, to schools, work places, police, and social services, etc. These areas need to be able to provide basic 'Tier' 1 care to ensure they spot, assess and deal with those issues presented to them. They need the skills to identify those that need referral to non generic services, i.e. into Tier 2 and 3 specialist services.

Figure 35. The Non-urgent Care Pathway / Source: Y&H MHCPG

Pbc sized locality community - Average 75,000 population

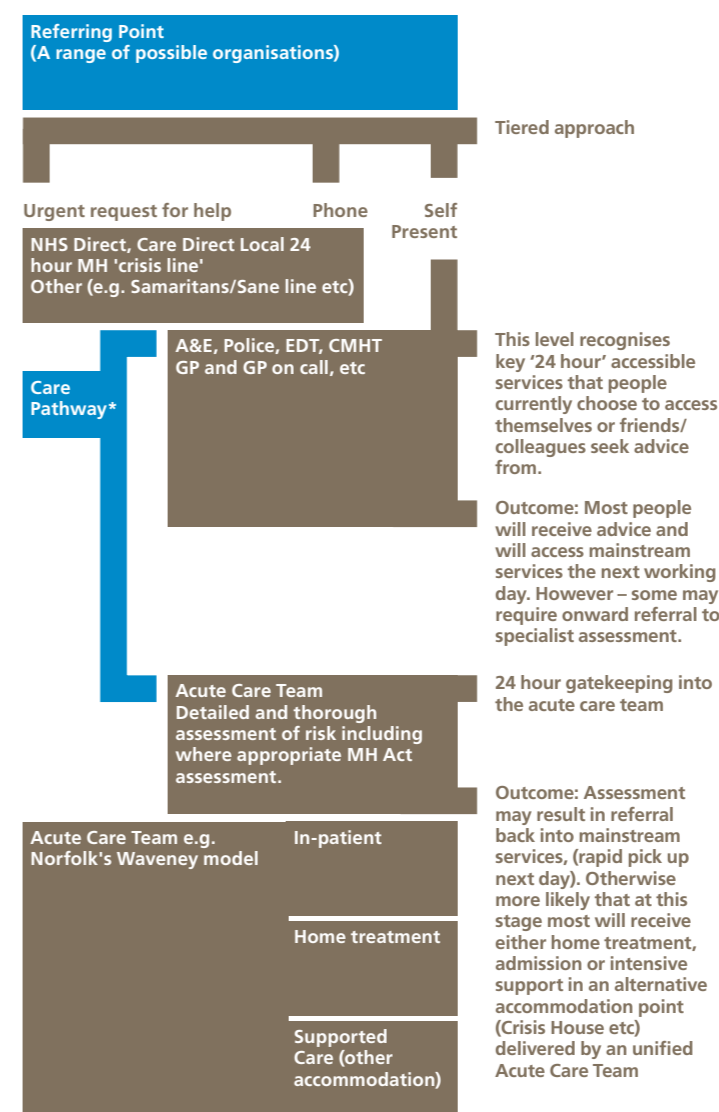


An all age 'generic' specialist assessment service is provided by a locality MHT structure. Gateway staff available on site to direct phone enquiries and self presentation to the 'resource unit'. Unit offers team base but staff work in community settings and are attached to primary care practices.

Note: Attachment to GP practice is based on fact that most of the population are registered with a practice therefore it becomes the logical 'building block' to build services around. A joint health/social and personal care module is used to ensure holistic care planning (see diagram and note on primary care development).

The GP attachment module works as defined in the above diagram. Staff are assigned in sufficient resources, (w.t.e.) to meet demographic need. They will assist in development of QOF registers. Counselling (CBT) and specialist MH staff will work from the practices. Service users entering the 'gateway' will be assigned to attached staff for initial assessment. Choose and book will operate using diary entry, operated by gateway staff.

Figure 36. The Urgent Care Pathway / Source: Y&H MHCPG



This Care Pathway* is for people in high level intense crisis where 'intensive staff' support is required with the option of a bed in a ward or other crisis house facility. Evidence suggests it should not be open access. '24 hour crisis and emergency 24 hour services' are available for general access. This means the 'Acute Care Team' can be accessed by the specified referrers identified.

20

Such Tier 1 services could include:

- GP based health visiting and practice nurse services, (peri-natal tier 1 support – Edinburgh post natal depression inventory).
- A&E and acute hospital services.
- A&E and acute mental health liaison teams need to be commissioned to provide Tier 2/3 advice support to the high numbers of people in acute settings with MH problems).
- social care area offices with generic assessment.
- work place occupational health services.
- school/college based school nurse services.
- university based GP services and counselling services.

21

The 'Tier' 1 access points are 'all age' therefore they need to be able to 'sign-post' into appropriate services and not be worried too much about bureaucratic multi-referral protocols or cumbersome paper systems.

22

Psychological therapy services and what are often referred to as primary care mental health services should be integrated with 'traditional' CMHT type staff into a local, integrated multi-disciplinary locality MH resource team. The team would provide an all age service, (18 – elderly service with specialist workers located within the team).

23
The locality MH team could be based on a practice based commissioning consortium population or equivalent depending upon local circumstances.

The urgent care Pathway in Practice

24
There are occasions where service users are perceived to be in such risk of harm to themselves (or occasionally to others) that urgent assessment for intensive care is required.

25
The pathway to urgent 'acute care' is based on the principles of the Department of Health's MH Policy Guide for Crisis Resolution Teams. However, clinicians have advised us that the term 'Crisis Resolution' should be dropped completely as it causes significant confusion to referrers and commissioners alike.

26
The initial identification that a person is in need of mental health care can take place in a variety of settings, e.g. within a GP practice, police station, A&E department, social service area office, voluntary organisation, education service, work place, (Occupational Health service), etc. The key is allowing access from these entry points into a reliable 'one stop shop and one step' for assessment and on-going care coordination and navigation.

27
Tier 1 MH services, (promotion, advice and support) would need to be available in all the above settings for dealing with the initial identification of a problem/need and hopefully containing the vast majority of people

with 'simple' problems capable of responding to advice, listening, etc. There is potential for mental health first aid to be taken forward in localities.

28
The local MH team would house psychological therapy services to meet the needs of the local population (and could draw on specialists via a district wide service network).

29
Gateway/Reception workers would help provide triage services to people who self refer and an initial assessment for some people referred for an assessment by Tier 1 services. They could also take initial referrals from other agencies and identify the best person in the team to meet the identified need for initial detailed assessment via 'booking' into the psychological therapy service or the specialist care team for more detailed MH assessment.

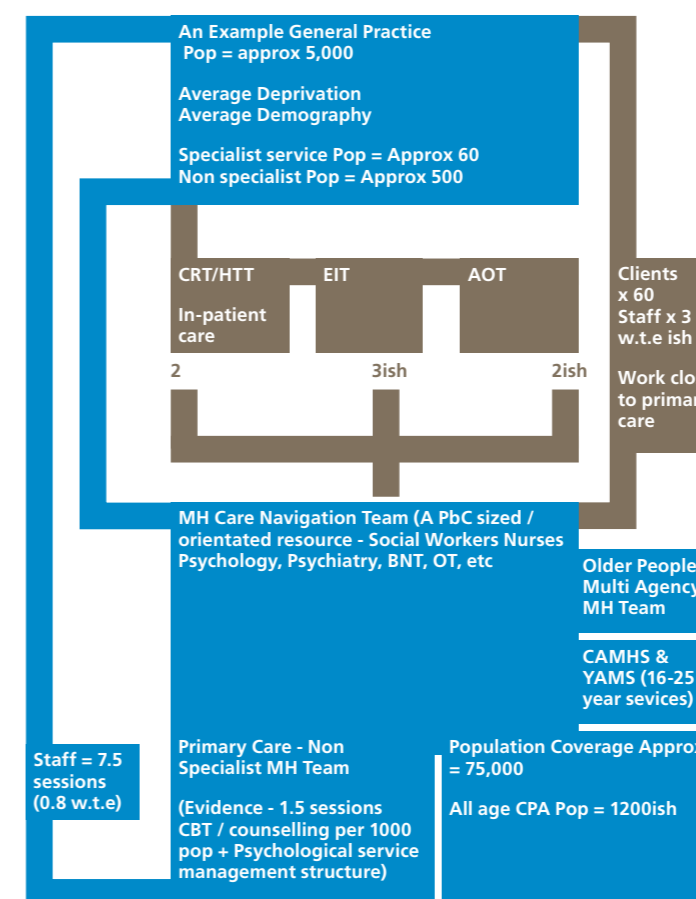
30
Co-ordination of longer term care support, (using care navigation principles) would provide onward referral to a mixed market of services.

31
The team would house sufficient expertise to be able to co-ordinate delivery of expert advice to adult and older people coming into its contact.

32
Because most people are registered with a GP, (and those that are not should get access to homeless/outreach primary care services) a nominal association can be made between all clients in all parts of the system and the GP practice they relate to.



Figure 37. Population-based model / Source: Y&H Mental Health CPG



Note:
MH Team:
Small caseloads mean practice attached staff do 'today's work today' (lean systems). Free slots mean availability for urgent response to situations where necessary (4 hour standard).

1°C teams respond (7 day standard) to initial assessment by keeping free slots to be booked by 'Gateway' team receiving initial referral.

Both teams: Close liaison with 1°C (working from their practices) means a 'relationship' based approach to referral, support and negotiated work.

- MHTs**
- Identify/coordinate the Specialist User group
 - Offer support and advice to Tier 2 primary MH team
 - Liaise with Tier 2 primary MH team
 - Refer to the other providers in a mixed 'plural' market

33
This means that simple systems can be put in place to ensure all clients have a known care-coordinator based on the practice they come from, (with some choice managed within this system) This means new people can be given care coordination support immediately on access. The care coordinator concept was well received by the public and service users.

34
Using choose and book methodologies (and IT) the Gateway person could book a new referral into a 'slot' in the diary of the therapist/MH practitioner to allow rapid access, with no queues.

35
The provider organisation for the locality MH team should be commissioned with clear 'walls' between itself and other provider services. The main locality team should be provided by the NHS/LA in partnership. The 'walls' are a definite requirement to ensure maximum use of 'individual purchased care' arrangements, e.g. Direct Payments with referral into partnership services where appropriate rather than 'retaining the person' in the statutory sector.

36
An example of how staff would be attached to practices, (i.e. how the numbers of staff would be derived from local practice size population demand) is given in the following diagram opposite (figure 37) which is based on an 'adult' care group system.

“Whilst the Mental Health CPG have made specific recommendations for mental health services, it is important that patients’ mental health and well being are considered as NHS organisations take forward the recommendations from all of the pathways featured in this report”

37

The key feature of the locality mental health team will be to:

- Accept and assess new clients and take responsibility for ensuring they receive the care they need by identifying the skills and staff to best meet the needs. This represents a major opportunity and simplification of the referral system for GPs and other referrers. If they identify a person who needs services they can refer into a ‘whole system’ mental health service. The mental health service will take responsibility for navigating the person to the best staff member to meet need. Referrers will not need to remember numerous referral protocols.
- Act as a central point for enquiries and referrals (all age).
- Provide a base for self referral access.
- Act as a Clinical Assessment Service, (Choose and Book) booking people into slots available in CMHT/ counsellor and other workers’ diaries direct.
- Ensure provision of rapid response to more urgent assessment using ‘Lean Thinking’ methodology of ‘do today’s work today’ serviced by an extended hours operation (not Home Treatment).
- The team will provide local psychological therapy services on a stepped care basis to Tier 2 clients but also to people with more complex MH problems who would benefit from increased access to ‘talking therapies’ as an alternative (or more likely addition) to other forms of treatment.
- The team will provide care navigation to those people that require inputs from more than one agency/service and hence provide on going care coordination to these clients under CPA, SAP etc.
- The team will provide assessment services for adults (18 years old to elderly) and have close liaison with CAMHS, Youth Mental health services and older age local MH services.
- They would refer into specialist district wide services such as early intervention teams and assertive outreach services but would ensure they continue to care coordinate the person for eventual return to local service networks.
- Matching teams with primary care practices will ensure good relationships and rapid consultancy support to the primary care teams.
- The development of a locality CAMHS service to work alongside the locality MH service.
- The development of a locality older peoples’ MH service to receive referrals for specialist older peoples’ care, including integrated memory assessment services and evidence based cognitive impairment services.
- Development of a young persons’, (16 – 25) mental health service as currently developed in early intervention teams to meet the mental health needs of all younger people not just those with psychosis.

38

The size of the service would depend on local assessed need, initially based on public health/epidemiological based predictors and would be built up from GP practice registered populations to practice based commissioning consortia to PCT/local authority populations (joint strategic needs assessment).

Barriers to Change

39

The CPG identified a number of barriers and outlined how these could be addressed.

40

One, they identified the need for an electronic health record for people who use mental health services, which they ‘own’ and use to control their care.

41

National standards for mental health services which can be used to benchmark services would help drive improvements.

42

Outcomes which are determined by people who use mental health services and their carers and which are used by commissioners to commission and monitor services would make services more sensitive.

43

Population based needs assessment should be used to allocate resources.

44

There is a significant training and development agenda focussed on on-going training for staff to keep them ‘customer focussed’.

Sources

1

This chapter is based on the work of the Yorkshire and the Humber Mental Health Clinical Pathway Group. Report available at www.yorksandhumber.nhs.uk.

2.

Yorkshire and Humber Focus Group Reports – September and December 2007 and Deliberative Events September 2007 and January 2008

3

Adult and older peoples NSF’s

4

Valuing People White paper

5

National Audit Office report

6

G. Glover (MINI); Wing et al

7

‘New Ways of Working’ in Mental Health, Department of Health

8

125 Camberwell Assessment of Need (CAN)

9

MH Act

10

MH Policy Guide for Crisis Resolution Teams, DH

11

‘Mind the Gap’ Report

Good Practice

A model of ‘Acute Care’ is currently provided at Waveney Hospital – Norfolk. This model merges the Home Treatment team with the in-patient staff team to provide a more fluid and person responsive solution to care. The referral to this service represents very small numbers of the total population. In order for the team to be able to deliver highly intensive packages of care within non-hospital settings they must not be distracted by ‘general crisis calls and assessments’. These can be covered by currently available 24hr services, (A&E, Police, EDT, etc) and extended hours locality MH Teams. Commissioners should ensure the back-up of 24hr ‘crisis telephone lines’ for people in mental distress/panic who can be assured of services available to respond the next day.

Conclusion

45

Whilst the Mental Health CPG have made specific recommendations for mental health services, it is important that patients’ mental health and wellbeing are considered as NHS organisations take forward the recommendations from all of the pathways featured in this report. This will be essential to the ambition of “wellbeing for all” set out in this chapter.

46

Our pledge in taking forward this pathway will be to ensure we have no waits for mental health services.