Professional supporting materials for standards of care in Centres for Mental Health (CMH)

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1. Preamble

This is a well considered plan that correctly identifies the major needs of reforming mental health services and providing effective coordinated care for individuals with severe mental illness in the twenty–first century. I have taken the liberty of suggesting some changes of language and terminology, mainly for increased clarity and the avoidance of any ambiguity. I will comment on specific aspects of the document under its given headings.

My comments are derived from 30 years of leading multidisciplinary mental health teams (20 years generic CMHT and 10 Assertive Outreach team) in London and Oxford, plus 15 years as a clinical director for adult mental health services for 10 years in London and 5 in Oxford for a service to a population of over one million. In addition I have been actively involved in Mental Health Services Research into mobile teams (mainly Assertive Outreach) for over twenty years. I will express my observations simply and make recommendations where I believe both clinical experience and the evidence base are relatively clear rather than present a detailed summary of contradictory evidence with references. I will pay particular attention to areas where I have obtained direct personal experience of research services and believe that the published literature is often misleading (eg crisis care, the provision of 24 hour services, the 'whole team approach').

2. Services provided by the Centre for Mental Health (CMH)

- The SMI target group is well described and appropriate. Between 150 and 200 patients on a stable caseload is manageable. More than this would run the risk of patients not being well enough known by the team members to fully exploit the advantages of multidisciplinary team working. Where local geography poses problems I would advise tending towards smaller teams (towards 150 patients) than larger ones (ie >200).
- I would advise you to specify 'clinical case management' rather than just case management. Your document indicates that this is your intention but any possibility of case management being interpreted as 'brokerage' or 'administrative' should be guarded against. The evidence is that this is a particularly ineffective approach.

- The standards do not specify documentation and I believe this would strengthen the approach. The requirement for each patient to have a documented care plan as for instance in the UK Care Programme Approach has been enormously successful. This is a simple one page document. It outlines the patient's needs and the proposed interventions (usually just 3-4). It identifies the individual responsible for ensuring this is delivered (the case manager) and is signed by him/her and the patient. And lastly it gives a fixed date for a review by the whole team (usually in 12 months). This both engages the whole team and the patient in the process but also acts as a vital focus for coordination and communication.
- I believe the patients in need of **early intervention (target group 2**) should be clarified more. I would indicate that these are patients with an emerging psychiatric problem which carries a significant likelihood of developing into a severe or long-lasting psychosis. Such patients need prompt treatment. As it is written currently it could be confused with some experimental forms of early intervention with 'high risk' groups who are not yet demonstrating any signs of illness.
- **Multidisciplinary team**. '*Professionals…share patients'* In early Assertive Outreach writings it was proposed that all patients were shared between all staff ('the whole team approach'). In practice this makes no sense and never happened – patients have their own case manager who is their main professional carer but who draws on the whole expertise of the team. It is important that you make this distinction as staff may get hold of old influential, but misleading, publications.
- **Emergency services**. I would suggest that you pay particular attention to this section. There is a real discrepancy between what is written about emergency services and what happens in practice. When your mobile services are working well you will have very little need for emergency or crisis services – they will be able to absorb them. Setting up separate emergency services when the general provision is reliable is usually found to be expensive and wasteful. Most services soon abandon them. 24-hour provision is not really feasible within small services – neither an effective use of manpower nor safe. Emergency assessments in the middle of the night will be very rare once decent provision is available and those patients who do need it will need to be seen in a well staffed and safe environment such as a general hospital emergency department. I would strongly advise you not to set up separate 24/7 rotas but to require your CMHs to have a modest availability for emergencies and ensure good integration with general emergency services for out of hours presentations. Similarly you should reconsider carefully the idea of small overnight emergency units. Global experience is that they are unable to cope with your target population – it is not safe to have such patients in 2-4 bedded units. What often happens is that they attract relatively minor problems which

would have resolved spontaneously or if they do admit 'real' crises they have to be rapidly transferred to inpatient wards.

- **Day services**. I am very impressed that you are considering a longer opening of 10 hours. This is particularly valuable where family members work and where early closing of day centres causes them real problems.

3. Personnel criteria

- The staffing proposed appears both appropriate and adequate. This is difficult to judge, of course, from abroad as so much will depend on what is available outside the services.
- The provision of psychiatric staff outlined in the strategy document is broadly in line with what I would expect except for two striking outliers. I am not sure if you meant to provide 1 specialist per 100,000 in sexology – is this a mistake? Also 0.5 specialists per 100,000 in eating disorder seems very high if this refers to psychiatrists. We would have something in the region of 0.2.

4. Material and technical criteria

- My only comments about this are about the crisis centre and are dealt with above. Free standing crisis centres are neither sensible nor sustainable. An admission facility for a few patients is both risky and wasteful of resources. Staff are initially enthusiastic about them but quickly tire of them and this can pose problems for recruitment and retention.

5. Organisational criteria

- Most countries have experienced difficulties with how best to integrate health and social care staff in MDTs. There is no single perfect solution but it is important to think through carefully and document. Will teams have a clear single clinical and administrative lead (health or social)? I would certainly suggest health for the clinical lead. While it is vital to have co-location (social care staff should work in the CMH and take part in the review meetings) how are their responsibilities to the social services to be discharged?
- Some indication needs to be given about the proportion of time spent in review meetings. Your document is excellent in clearly stating that staff should devote 50% of time to face-to-face clinical work. In some European services staff can spend up to one to one and a half days in various review meetings. My own experience suggests that a well functioning team needs half a day a week for formal clinical reviews (which allows for some education and necessary admin) and perhaps an hour on another day for emergency discussions. Many teams want to have daily meetings but these really are

rarely that productive unless they can be successfully kept very short for urgent information (eg 15 minutes at the start of the day).

- Some policy needs to be formalised in mobile teams for safety – eg the easy availability of joint visiting for risky patients and also some system for phoning in at the end of the day. Provision of mobile phones for all staff is generally found to be a very worthwhile investment.

6. Other criteria

- I would suggest that you make a clear provision for regular audit of caseloads, turnover and provision of targeted treatments. Similarly I would encourage some form of mission statement that such teams consider active involvement in national and local research a priority.