CHAPTER 4

SECONDARY MENTAL HEALTH SERVICES – PART I

INTRODUCTION

4.1 The Framework provides a service blueprint for adults with more severe mental health problems and needs* requiring the specialist skills and facilities of mental health services. This includes:

- a range of services for people with acute needs or in crisis
- enhanced support for primary care services
- the management and prevention of relapse
- support and interventions to promote recovery and address the residual effects of illness which can significantly impact on personal, domestic, relationship and occupational functioning
- the psychological, educational and training needs of service users
- the need for psychoeducational support and therapy for family members and carers.

4.2 The Framework envisages a major shift in the centre of gravity of secondary mental health services being achieved over the next 10-15 years. With appropriate development of the full range of community based services it is anticipated that the need for admission to hospital will be much reduced and the duration of admissions much shorter. The magnitude of community based services, the skills and capabilities of Community Mental Health Teams and the range of available service options should enable the great majority of service users to be treated and cared for entirely within community settings.

* More severe health problems and needs arise principally from such mental illnesses as schizophrenia, bipolar affective disorders, severe depression

A PERSON-CENTRED APPROACH

4.3 A person centred approach to service planning and provision is fundamental. Mental health services must reflect the multi-dimensional nature of service user and carer need embracing:

Health Needs	Education/Training
Occupation	Income
Accommodation	Personal Life, Family Life and Culture
Carer and Family Needs	Advocacy

The Whole System of Care

4.4 While the sections which follow review each of these issues and associated service requirements, beginning with health needs, consideration must also be given to the whole system of service organisation and delivery. Central to effectiveness is the integration of services – the relationships between different service elements and functions require careful planning, including sequencing, appropriate for local arrangements. The optimal shape of local community mental health services should therefore be the subject of careful planning and consultation including the involvement of representative service users and carers. Non-statutory providers must be engaged as appropriate in planning, development and delivery. Services must be needs driven considering both service users and their carers.

4.5 The service reforms and developments envisaged for Mental Health Services are considerable. The changes and the process of change will present formidable challenges for professional staff, administrative staff and management at all levels. These challenges must be adequately prepared for. Robust Service organisation, information management, team working and communication will all be pivotal in realising and maintaining these reforms.[1]

4.6 It is essential that the needs of those within the current model of provision, service users, carers and staff, are addressed as part of the change process. Particular attention must be given to the small number of people still resident in mental hospital settings, many now elderly and frail. The sequencing of planned changes will be most important. In general, investment and development in community based

services will be an essential first step to service development, including any restructuring of inpatient services (see 4.9).

4.7 Adult Mental Health Services cannot be considered in isolation. There are many interfaces between adult services and other services. A key interface is between primary and secondary care (see Chapter 3). Consideration must be given to the transitional needs of younger people, older people and those with less severe learning disability, in consultation respectively with child and adolescent services, services for older people and learning disability services. There are also important interfaces with substance misuse and forensic services. The needs of people requiring Specialist Services (see Chapter 6) must be reviewed by each local service provider in consultation with the Department. While all Trusts should assume responsibility for tier 2 services (see Chapter 6) some must assume responsibility for tier 3 and 4 services.

4.8 **Service configuration and organisation**. Organisational structures play a key role in effective and efficient delivery of services. Service configuration should be considered for all of mental health and learning disability as a whole. The principles that must inform service configuration are that:

- delivery of services are focused on the community and not dealt with separately from other community health and social services;
- service delivery bodies cover a population of sufficient size to allow for delivery of an appropriate range of services;
- resources are equitably allocated according to need;
- transparent accountability for resources exists within each programme of care;
- commissioning of services are based on population groups co-terminous with one or more providers;
- a regional mechanism is used for commissioning and delivering highly specialised services;
- a regional body has responsibility for strategic planning and for monitoring of strategy implementation, service development and delivery;
- administrative boundaries for HPSS Services are aligned with other public services (for example, education, housing);

- the role of the voluntary sector in delivering services is recognised and supported;
- partnership arrangements which integrate the voluntary and statutory sector are supported.

A smaller number of delivery bodies than currently exist, covering larger populations, would give each of them more leverage in terms of budget and a better capacity to deliver smaller sub-specialities. Based on consultations, the Review recommends a population size of 250,000-350,000. A regional mechanism is required for a small number of highly specialist services.

4.9 Inpatient services are an important element in the whole system of care and must be considered in that context, not in isolation. While Northern Ireland still has its six large psychiatric hospital sites, the direction of change throughout the UK, Western Europe and beyond is away from such isolated exclusive forms of provision. This change has been achieved through development of community service and alternatives to hospital for both acute and longer term care.

4.10 While there has been some movement in this direction in Northern Ireland, the Review's vision for service development includes a marked acceleration of this process for the people of Northern Ireland. Acute inpatient services should be located within the community they serve and closely integrated with the other elements of crisis services (see 4.20). For people requiring longer term residential care this should, as far as possible, be community based. Some service users with persistent and severely challenging behaviour may require prolonged periods of hospital provision (see 4.38, 4.63) For each of the groups with special needs (see Chapter 6) there is a small requirement for hospital or highly supported provision, including voluntary sector provision where appropriate. The needs of adults requiring treatment in conditions of security are considered in the reports by the Forensic Services Committee and Learning Disability Committee.

Recommendations

20	The optimal size and configuration of organisations involved in the provision of mental health services should be the subject of review by the Department. This should reflect the Review's consideration of the issues and principles, in relation to service configuration.

21. Each Trust should adopt a planned approach, including sequencing, to the whole system of mental health service provision and organisation in their area, involving all statutory and independent providers.
22. Service vision, plans and strategy should be needs driven based on local assessment.
23. Representative service users and carers must be involved in service planning, development, delivery and monitoring.
24. Agreed protocols appropriate for the transitional needs of younger people and older people must be established.
25. The needs of current long stay residents in mental hospital settings must be considered throughout the change process of the Framework strategy.
26. The needs of people requiring specialist services (Chapter 6) and the interface with Forensic, Alcohol and Substance Misuse Services, Services for Younger People and Older People must be included within service plans for Adult Mental Health.
27. Services must be underpinned by good managerial cohesion, information management, team working and communication.

MENTAL HEALTH NEEDS

4.11 From a user perspective the various elements of services required to meet individual mental health needs must be available and accessible. In the planning and delivery of services a user perspective on the pathways into, through and out of services is essential. Such a perspective emphasises the importance of the connectedness of services, patient and carer information appropriate to their situation, and the maintenance of hope for recovery and restitution through the provision of appropriate services and supports.

4.12 A modern mental health service consists of a complex set of activities and functions designed to meet the needs of individual service users. From a person-centered and needs perspective, the complement of mental health services can be considered in three domains:

- living in the community;
- times of crisis, including acute episodes of illness and difficulty;
- promotion of recovery of health, personal functioning and fulfilment.

Each of these is considered in detail below, followed by a review of the needs of people with specific service requirements, treatments and interventions and physical health needs. However their interdependencies must be stressed, particularly in the context of the anticipated development and changes of existing services.

Living in the Community

4.13 For people whose mental health needs cannot be met within primary care ready access to mental health services is essential. The Community Mental Health Team (CMHT) with its close links to primary care forms the cornerstone of secondary care.

4.14 **Community Mental Health Teams.** Throughout most of Great Britain generic CMHT have become the basic building block of community mental health services.[2] CMHTs are central to supporting service users and their families within community settings and for supporting the mental health work of Primary Care Teams.[3, 4] The National Service Framework (NSF) Implementation Guide for England considers them as the core around which newer service elements can be developed.[5] Within this Framework CMHTs are considered central to the care of the majority of people with mental health problems in the community requiring secondary services including tier 2 services for people requiring specialist services (Chapter 6). Although less well developed in Northern Ireland at the present time, the evidence for the potential benefits of CMHTs in the provision of high quality community based treatment, support and care commends them as an essential element of future service provision.

4.15 Person-centred services. A central advantage of generic CMHTs is their ability to provide a wide range of services and continuity and flexibility of care. Service users may, at times, require intensive contact, for example during a relapse, and at other times require relatively low levels of support. People with severe and enduring mental health needs arising from their illness should be provided with a yearly multidisciplinary review including review of treatment plans and risk assessment.[6]

4.16 In many places CMHTs are undergoing a process of change but their core functions remain. The wide spectrum of service user needs has led to a differentiation of functions within or between established CMHTs with a focus on either primary care

liaison/crisis services or community support/rehabilitation/assertive outreach services. These services are considered in detail in subsequent sections.

4.17 The effectiveness of CMHTs is dependent on a number of factors:

- Resources. Teams must be adequately staffed by a range of health and social care professionals, including Social Work, Nursing, Occupational Therapy, Support Workers, Clinical Psychology and Medicine. There should also be ready access to specialist Psychological therapy Services. One advantage of larger catchment based services (50,000) is a corresponding enlargement of CMHTs to provide a greater range of skills, competencies and increasing patient choice. Based on the services mapping data for 846 services in England in 2002 the mean CMHT size was 19, with a mean of 49 care staff/100,000 adult population.[7]
- Skills. Staff must be appropriately skilled and competent to respond to the range of health and social needs of service users embracing a wide spectrum of treatments, support, care, health promotion and relapse prevention. There should be a facility for continuing professional development and mechanisms for supporting staff.
- Information. CMHTs must have access to a detailed knowledge of the number and needs of individuals with severe mental health illness in their area.
- Effective Team Working. Staff require effective team working skills. There must be also be effective team leadership and team management. The integrity of the team – issues such as professional accountability, agreed policies on confidentiality and information sharing, need to be agreed.
- Access. The boundaries for teams need to be agreed with local stakeholders. Access arrangements need to be clear and transparent to service users and carers. Primary care's relationship with its local CMHT is fundamental to effective working. In addition the team's relationship with the local A&E Department should be clear, with appropriate consultation facilities.

4.18 Although a key building block, CMHTs cannot work in isolation. Access to a range of day-time facilities and accommodation is essential. Effective working relationships with primary care, day care, day hospital and inpatient services are fundamental. Within a given service sector General Practitioners must have ready access to a CMHT (See Chapter 3). This may be achieved by a CMHT being based

in a primary care setting or a mental health professional working in primary care supported by or part of a CMHT (see Chapter 3). Primary care provision for people with more severe mental health needs must be determined locally and requires the development of shared care protocols.[8] Access to a range of non-healthcare services, including employment agencies (see 5.8) and housing agencies (see 5.20), voluntary and user led facilities are essential. Co-locating services complementary to the workbase of CMHT can provide a One Stop Shop for services and improve access and efficiency.

4.19 CMHT must develop appropriate relationships with other mental health services including forensic services. Appropriate services must be provided for people involved with the criminal justice system, including those on bail, in court, on probation or discharged from prison. Some prisons also arrange for CMHT to provide in-reach services. CMHT must also liaise with forensic services to ensure appropriate care for people discharged from secure inpatient settings.

Recommendations

28. Community Mental Health Teams should be established for all sectors to provide an essential element of future mental health service provision.
29. People with severe and enduring mental health needs should be provided with yearly multidisciplinary review including review of treatment plans and risk assessment.
30. Where CMHT are providing input to Primary Care then the seamlessness of provision must be addressed including the identification of a named individual on the CMHT for Primary Care staff. In addition to service support such input has an important has an important educational role (see Chapter 3).
31. The relationship between each CMHT and local primary care and A&E services should be clearly defined and agreed by both provider and referring services.
32. CMHT must be adequately staffed with a range of health and social care professionals. The Review recommends a minimum provision of 50 care staff/100,000 adult population, including community rehabilitation.
33. Staff must be appropriately trained and skilled, embracing leadership, team working and therapeutic skills.
34. CMHT must be provided with detailed information on the numbers and needs of individuals with mental health problems in their area.

35.	CMHT must have access to a range of community facilities and services including day hospitals, day activities, special accommodation, vocational and leisure services, voluntary and user led facilities.
36.	Where other community teams, for example, Crisis Resolution Teams, are separate from CMHT, then good interface arrangements including the involvement of key workers of known service users is essential. Arrangements for dealing with crisis must be agreed with each service user and their key carer.

In times of Crisis

4.20 People with severe mental illness often experience crises which may arise through illness relapse or through problems in coping with the demands of their social and personal situation. Present evidence suggests that the majority of inpatients are admitted to psychiatric hospitals as emergencies. In many situations admissions are likely to have an underlying social, rather than a medical cause, the likelihood of being admitted being more strongly correlated with social than clinical factors. At present the most common service response to people in crisis and in need of immediate and high levels of treatment, care and support, is admission to hospital. The majority of inpatients are admitted to psychiatric hospitals as emergencies with many admissions having an underlying social cause.

4.21 A number of problems are associated with this pattern of crisis response:

- average occupancy of available places in hospital frequently exceeds 100%
- readmission rates are high
- "overspill" admissions are often required at some distance from a person's home
- a significant proportion of inpatients in acute psychiatric hospital require high levels of support but are not acutely unwell
- acute inpatient units may represent both untherapeutic environments and inefficient use of resources.

Present evidence suggests that conventional community services, including CMHTs working within normal working day arrangements are unable to respond adequately to the needs of people with severe mental health problems when in crisis. Research

also suggests that up to one third of inpatients could have been provided treatment and care in more appropriate settings. [9, 10, 11, 12]

4.22 **Crisis Resolution/Home Treatment.** Crisis Resolution (CR) has been introduced in a number of western countries as a community alternative to inpatient hospital care. The purpose of modern CR services is to provide for flexible assessment and home-based treatment, care and support as an alternative to inpatient care on a 24 hours a day 7 days a week basis. This requires the skills of a multi-disciplinary team of appropriately trained staff who can provide easy access to early assessment of need together with appropriate interventions and support for service users, their carers and families. The introduction of CR is greatly appreciated by service users and families and can make a significant impact on the requirements for inpatient admission.[11, 13, 14] CR teams typically have a time-limited role (weeks) but nevertheless assume responsibility for the period of crisis. Referrals are accepted from General Practitioners, A&E Departments. Arrangements may also be made for CR teams to respond to the needs of mentally disordered people in police stations.

4.23 A second function of CR is to provide a gatekeeper function for hospital admission which can make an impact on the requirement for hospital admission. [11, 13, 14, 15] Teams can also facilitate the early discharge to home of patients admitted to hospital.[16] Together these impact on inpatient service requirements. The presence of CR including the provision of out-of-hours services, can enhance and complement the functioning of CMHTs. CR services may be a stand alone team or a sub-function within a CMHT.

4.24 More research is required on the various elements that may optimise the functioning of CR and on their relationship with CMHTs. Nevertheless key elements found to be central to effectiveness include:

- Policy. Services must be targeted – specifically the needs of those who would otherwise require admission to hospital. Typically people with acute psychosis, people with relapsing chronic mental illness, severe depression or acute reaction to severe stress.

- Philosophy. The crisis service is premised on the view that the management of a person's problems can be achieved within a community setting.
- Assessment – a comprehensive initial assessment is fundamental with access to multiple sources of information. This should embrace clinical, social and risk assessment.
- Planning. Flexible plans prepared in collaboration with the service user and, where appropriate, their key carer is essential. All participants in the situation must understand the plan.
- Management. Action plans must address practical problems, for example accommodation, financial issues. Treatment must be at the point of need. Follow-up frequency must be appropriate to the needs of the situation. Crisis team members must aim to build a trusting relationship with the user and carers. The crisis team remains involved until the crisis is settled. For people with enduring mental health needs involvement of the key worker from the CMHT facilitates continuity of care.
- Gatekeeping. CR teams must interface efficiently with Primary Care and A&E services on the one hand and be given a clear gate-keeping function for hospital admission on the other.
- Skills. Staff require appropriate skills to deal with a range of healthcare and social situations.
- Resources. CR teams must be appropriately resourced and supported including the availability of crisis houses.

4.25 The Review strongly recommends early consideration of CR services. Adequately resourced CR teams with clear gate-keeping functions can significantly reduce the pressures on inpatient services and CMHTs while providing users with increased choice of provision at times of crisis.

Good Practice Examples

Homefirst Crisis Response Service*. This Trust-wide service was established in April 2003 for people experiencing a mental health crisis that could have the potential to result in an admission to hospital. The CR team comprises nursing, social work, medical professionals and support workers. The C R team offers a multi-disciplinary approach to care and a single point of access for referral agents.*

The objectives are to:

- *Offer a rapid, 24 hour response and assessment service for patients referred with mental health difficulties who present to the service in crisis*
- *Provide a flexible, accessible service which will work alongside existing to enhance the care and treatment of people with a mental health crisis*
- *Support carers and families of those with mental illness in crisis*
- *Work alongside primary and secondary care to provide a more seamless service for users*
- *Support General Hospital facilities in providing assessment and advice for those who present with mental health problems.*

In its first year, the team accepted 2903 appropriate referrals. The team was able to maintain approximately 90% of those who presented in the community, and achieved a reduction in hospital admissions of 39% compared with the year before the service was introduced. (Contact: 028 9040 2038)

The Newcastle Crisis and Treatment (CAT) Service *is based on a Crisis Response and Home Treatment model with high fidelity to five key components:*

- *Provision of 24/7 access – in this team, the night shift is only two people but they are on-site, not on-call (demand for home treatment beyond 10.00 pm is described as very low).*
- *Involvement until resolution of the crisis – this can range from a few days to several weeks.*
- *Multi-disciplinary care – the key components are seen as medicine, nursing, social work and OT.*
- *Team mobility – they must be able to assess in a variety of locations at any time and usually within two hours or sooner*
- *Gate keeping of admission to places in psychiatric acute hospital – to ensure achievement of the overall goal, the home treatment of psychiatric crises.*

A crucial part of the operation of the team is a triage arrangement with all referral agents. Once someone is identified as being in need of an urgent assessment (at risk of significant harm to self or others or at risk of hospital admission), they are seen by a team member, assessed and a decision made on the management of their care and treatment. The aim is to offer home based treatment if at all possible, based on a partnership with carers and the imaginative use of whatever resources can be brought to bear on the situation. The CAT team currently consists of 34 staff serving a catchment population of 460,000. Operating now for three years they have had a significant impact on inpatient requirements with a fall from 30 adult places/100,000 to a planned requirement next year of 20/100,000. (Contact 0191 370 7760)
Useful information on crisis resolution/home treatment can be obtained from the Department of Health's NSF Policy Implementation Guide (www.doh.gov.uk/NSF/mentalhealth.htm).

4.26 If a person cannot be maintained in their own home an effective alternative to hospital is community step-up housing[17] or residential crisis care.[18]

Good Practice Example
Anam Cara, Birmingham *offers stays of up to three weeks for people referred by home treatment teams or for former guests who self-refer. This is a user-led initiative providing an alternative crisis service to hospital admission. In an evaluation by the Sainsbury Centre most residents had a diagnosis of Schizophrenia. All those interviewed felt the service had met all their needs (Contact: 01213841344).*

4.27 **Day Hospital Services**. Acute day hospitals should be considered as a cost-effective option for the provision of acute care both as an alternative to acute admission to hospital and to facilitate early discharge from inpatient care.[19] A recent systematic review identifying 9 randomised controlled trials found that day hospital treatment was a feasible alternative to inpatient admission in between 23% and 38% of instances. There is also evidence of greater satisfaction among patients and no evidence of increased burden on carers. The cost-effectiveness of this model of provision over home treatment is an important consideration.[20] Within a modern community focused service Day Hospitals provide a valuable step down function and a base for Community Teams serving crisis outreach and rehabilitation services. Day

hospitals can also provide an import base for specialist services for example Eating Disorder services, Personality Disorder services.

Good Practice Example
Ards Mental Health Day Hospital. *The Ulster Community and Hospitals Trust Mental Health Day Hospital, a purpose-built unit opened in 1989 adjacent to the Inpatient and Outpatient Units, was recently awarded the Charter Mark for its work.*
Staffing: Nurses – four full-time and one part-time
Occupational Therapists – two full-time, two part-time and one OT technician
Complementary Therapist – one part-time.
The Day Hospital, which has 40 places, receives 10-15 referrals each week. It functions both as an alternative to admission for patients in the Community, as well as facilitating early discharge from inpatient care. Each service user has an individual plan of care co-ordinated by a named health professional. Each user is assessed prior to admission and treatment is regularly reviewed by the multi-disciplinary team.
The Unit is open Monday – Friday and facilitates many individual and group activities outside working hours. In addition to individual programmes of care and therapy there are a number of group activities: Patient advocacy service, Job Clinic, Carers' Group.
Future plans include extending the opening hours from 9.00 am – 9.00 pm seven days a week and providing a base for the Crisis Intervention Team. (Contact: 02891 510115)

4.28 **Acute Inpatient Provision.** Acute inpatient care is an integral part of mental health services. Improving the quality of inpatient care and its integration with the other key elements of the whole system of service provision form an essential part of this Framework.

4.29 A range of reports on inpatient services has consistently demonstrated significant shortcomings and dissatisfaction with current provision.[11, 21, 22, 23] Service users, and a recent report from the Northern Ireland Association for Mental Health[24] highlight a number of concerns including:

- a poor care environment, both physical and psychological;

- inadequate arrangements for privacy, dignity and comfort;
- often poor safety arrangements;
- lack of contact with staff;
- lack of meaningful activity;
- lack of information including information on their condition and treatments being received; and
- lack of involvement in the planning of their own care.

4.30 From a service user perspective if a period of inpatient care is necessary this must be of high quality and provide an appropriate range of treatments and services including where necessary intensive nursing services (see 4.66). In the context of well developed community services inpatient admission should only be required for people with most severe episodes of illness, typically psychosis and severe depression. While there is a need for a better evidence base on inpatient services several reviews and surveys provide strategic pointers for addressing present shortcomings.[11, 22, 23, 25]

4.31 **System of Care**. A single system of co-ordinated acute and crisis care is fundamental for service effectiveness. In particular there must be joint working between inpatient and Crisis Resolution Services. Inpatient services work best when they are close to the service user's local community maximising their connections and integration with community mental health services and supports.[15, 17B] Such connectedness can be facilitated by the formation of Acute Care Forums involving users, carers and service providers with clear accountable links to Trust management.[21] While the Royal College of Psychiatrists recommends inpatient units are best located on district general hospital sites,[23] Boards and Trusts should explore the full range of choices for providing care.

4.32 Within the context of a well-developed and appropriately resourced community service, including staffed community residential facilities, the need for inpatient services should be significantly less than at present. Nevertheless it is likely that a small number of people with severe and enduring mental health problems will require the safety and security of hospital provision for lengthy periods of time, for example

people recovering from severe brain injury, people suffering from psychosis with ongoing high risks to themselves or others (see 4.59).

4.33 **Environment**. Service user centred care is a fundamental principle which should underpin inpatient services. Service users require individual care plans specific for their needs. A range of therapeutic resources must be available appropriate for need. The hospital environment must be designed to deliver a relaxed, secure and non-stigmatising atmosphere. Provision must be appropriate for gender and cultural needs.

4.34 **Leadership and Staffing**. Clinical and professional leadership is essential for ensuring co-ordination across the Acute Care system. Staff must also be provided with support and supervision. Staff levels and skill mix must be appropriate for patient needs and staff must be provided with opportunities for education, training and professional development.

Recommendations

Crisis Resolution Services

37. CR services must be available and accessible to each Trust's catchment area.
38. CR services should be accessible to General Practitioners, A&E Departments, CMHTs, Social Services, and Police.
39. CR services should be available on a 24 hour basis subject to demand.
40. CR services must be the gatekeeper for hospital admissions.
41. CR teams must be appropriately resourced and skilled to deal with the range of healthcare and social situations for people in mental health crisis, their carers and families, including risk management.
42. There should be a single system of co-ordinated acute and crisis care, including crisis houses and inpatient provision.

Day Hospitals

43. Within each Trust consideration should be given to providing day hospital provision as an alternative to acute admission and complementing CR teams

Acute Inpatient Services

44. Acute inpatient services should be based on well designed facilities and close to the community they serve such as General Hospitals sites.
45. The quality of inpatient services should be the subject of both regional and local review.
46. Acute inpatient services must be of high quality and provide an appropriate

range of assessments, treatments and services including intensive nursing services.

47. Acute inpatient services must deliver a therapeutic and safe atmosphere and be sensitive to gender and cultural needs.
48. Appropriate training and supervision should be provided for all inpatient staff.
49. Each provider must designate a lead clinician or manager to take overall responsibility for inpatient services.

Promoting Recovery

4.35 Central to recovery from mental illness is regaining control of ones life. Individuals who have experienced recovery highlight the importance of hope, self esteem, empowerment and social connectedness.

> "A person with mental illness can recover even though the illness is not "cured"….[Recovery] is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in ones life and as one grows beyond the catastrophic effects of mental illness." Anthony WA (1993) Psychosoc Rehab J 16, 11-23

4.36 For people with more severe and enduring mental health needs arising from their illness a diverse range of services is required to promote recovery, tailored to individual circumstances. They have, by definition, greatest need and should be afforded the highest priority. Services are also required to give carers the information, skills and support necessary to assist them in their caring role and to minimise the stress associated with that role.[27] In this section detailed consideration is given to the needs of people with more severe and enduring needs and the services necessary to meet these, including Rehabilitation Services and Assertive Outreach Services. Some people have special needs including needs arising from challenging behaviour, co-morbid substance misuse, growing older. These issues are dealt with in subsequent sections.

4.37 Many people who have suffered a psychotic illness (schizophrenia, bipolar affective disorder) have enduring needs, as a result of their illness. These may include problems with continuing symptoms, difficulties with social functioning, including personal care, interpersonal skills, or need for vocational skills or leisure skills. They

may also have secondary problems related to income (see 5.32) and accommodation (see 5.16).

4.38 Research, including local research, has shown that service provision for people with severe and enduring needs is generally of good quality so far as specific medical treatments are concerned. The gaps are mainly in the areas of psychological and social provision.[28, 29] From a service perspective therefore unmet needs occur particularly in the areas of emotional wellbeing and social functioning including education needs, work related activity, domestic functioning and socialisation and also emotional needs[28]. The needs of this group of people often cannot be met fully by generic CMHTs and require specialist community services for example by sub-specialisation of or within CMHTs.[30] People with complex needs require Care Plans, a consideration of their individual Care Pathways based on both a multi-disciplinary approach and the involvement of users and where appropriate carers in the planning arrangements.

4.39 When people with severe and enduring needs no longer require the intensive provision of acute services they may still, for a time, require a range of supportive services within an appropriate residential environment. Such "step-down" facilities need not be within a hospital setting and may often be more appropriately provided in the community and nearer to home. Nevertheless their functional integration with acute services is essential.[31] The duration of such "step down" provision should be determined by need alone, including risk of harm to self or others, and may be for many months. Recent research has demonstrated the effectiveness of medium term community based facilities which enable people with severe psychotic symptoms to move successfully from hospital to community living.[32] The continuum of provision includes services led by service users.

4.40 A range of services is required to address psychosocial needs. The aim is to optimising functioning throughout an individual's personal and social domains, embracing educational, training and vocational needs (see 5.2). Given the aim of full community integration every effort should be made to destigmatise and normalise aids to recovery, making maximum appropriate use of ordinary facilities and resources.

4.41 Essential professional skills to promote social integration for service users include:[30]

- prescription and supervision of complex medication regimens;
- evidence based psychosocial interventions;
- training/support for independent living skills;
- training for vocational skills;
- evidence based psychological treatments, including family work;
- social skills training; and
- financial management.

4.42 In the context of community-based recovery and longer term support the role of carers is often pivotal. In addition to their own health needs they require and can greatly benefit from formal education, training and support for their caring role (see 5.61).

Good Practice Examples

Slievegrane Centre, Downpatrick. *The Centre, recently awarded Charter Mark and Environmental awards, aims to provide a service for people with severe and enduring mental illness. It consists of a six bed residential unit with four supported flats, staffed 24 hours. There are also 7 supported group homes and outreach is provided to individuals who have moved on from the service to independent living. The philosophy of the service is empowerment and normalisation. Residents are encouraged to see the unit as a home and to live as independently as possible, whilst engaged in a structured, tailored rehabilitation programme. The staff team consist of two psychiatrists (one consultant, one staff grade), a unit manager, 8 residential workers, 2 care assistants, 1 consultant clinical psychologist, 1 social worker and 1 occupational therapist. Very positive results have been achieved since opening of the unit in 2000, with many residents moving on to independent living (contact: 028 4483 9959).*

The Cavan Monaghan Rehabilitation/Recovery Team. *This team, established in 1998, takes referrals only from the mental health service. The core philosophy is to provide individualised care for service users and carers based on identified needs and implemented as much as possible in a non-institutional setting. Referrals are made through the team co-ordinator and discussed at weekly team meetings. The*

protocol for patient care includes: referral, assessment, programme implementation, programme review. Care plans are drawn up by relevant team members once assessments are completed, involving, where possible, the service user. The multi-disciplinary rehabilitation/recovery team takes referrals only from within the mental health service and are made through the team co-ordinator and discussed at weekly team meetings. (http://www.monaghanmodel.com/implications.htm).

4.43 **Assertive Outreach.** A small number of people with severe mental health problems and complex needs have difficulty maintaining involvement with the services they require. As a result they are at high risk of relapse which would require readmission to hospital. Present evidence suggests that Assertive Community Treatment (ACT) is a successful alternative to inpatient hospital treatment, enabling service users with the highest levels of disability and greatest vulnerability to be maintained more successfully in community settings. Although earlier research [33,34] suggested that ACT was a more general alternative to inpatient hospital treatment more recent evaluations, including UK based studies, have found the magnitude of the benefits is smaller when compared with modern community based services.[35-38] Effectiveness depends on small caseload and on staff having the necessary skills.[39,40]

4.44 ACT sits best within the spectrum of services promoting recovery enabling the most vulnerable and severely mentally ill to move more easily from inpatient settings to community settings and reducing the need for lengthy inpatient stays. However by selectively focusing on the most disabled and providing the sustained support of ACT over months and years service users can be enabled to cope more effectively with independent living, again reducing their need for hospital based provision.[41, 42] Present evidence[43,44,45] demonstrates that Assertive Outreach[*] can:

- improve engagement
- reduce hospital admissions
- reduce length of stay when hospitalisation is required
- increase stability in the lives of service users and their carers/family
- improve social functioning

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[*] The term Assertive Outreach is used in this context to refer to the availability of an Assertive Community Team.

- be cost-effective

4.45 The goal of Assertive Outreach is to increase stability within the lives of service users, to facilitate personal growth and provide opportunities for personal fulfilment. Fundamental to the effectiveness is the establishment of meaningful engagement with service users. The aim is to provide a service that is sensitive and responsive to users' needs and supportive to service users and their families over sustained periods of time. This must include effective risk assessment and risk management. ACT Services must also ensure effective liaison with community forensic services. While treatment support and care for this group of people will usually be required on a long term basis, this need not necessarily be provided by ACT.

4.46 Assertive Outreach cannot work effectively in isolation. The generic needs of this group of users are similar to all people with mental illness. These include the need for adequate income, accommodation, meaningful day-time activity, support with daily living, in addition to both primary care and specialist mental health interventions.[46] This in turn depends on a readily available range of services including suitable supported accommodation, a range of daytime activities including employment opportunities, clear arrangements for accessing safe 24 hour care.

4.47 While more research is required on the specific elements of Assertive Outreach which contribute to service effectiveness, present evidence suggests two key features. First, staff must be appropriately skilled [36, 46, 47] in:

(i) assessment – embracing mental state, general functioning, needs and risks;

(ii) planning – including care planning and management;

(iii) interventions with service user and families including medicine management and concordance, problem solving and goal setting, issues surrounding dual diagnosis, information and education, family interventions;

(iv) social support with housing, education, work and welfare benefits; and

(v) multidisciplinary teamworking

Second, ACT must be adequately resourced. The Royal College of Psychiatrists recommends an optimal team size of between 8-10 FTEs with social work, nursing, occupational therapy, clinical psychology and medicine as essential disciplines.[30] An optimal caseload for individual care co-ordinators is about 12.[36, 5] The relationships

between Services Promoting Recovery, CMHTs and ACT teams need to be carefully planned appropriate for local needs.

Good Practice Example

Cavan/Monaghan Project. *The Assertive Outreach Team is a component part of the community rehabilitation/recovery team and consists of 11 Assertive Outreach nurses. They takes responsibility for all new referrals to the Community Recovery Team. The locus of care for Assertive Outreach is primarily in the patient's home* (http://www.monaghanmodel.com/implications.htm).

Recommendations

50. The service requirements of people with severe and enduring mental health needs should be given the highest priority.
51. The requirements of those with severe and enduring mental health should be clearly defined for each Trust's catchment area.
52. Identifiable services promoting recovery should be established within each Trust for people with complex needs and providing comprehensive coverage of the Trust area.
53. Care plans embracing risk assessment should be provided for all people with complex needs, based on a multi-disciplinary approach and when required a multi-programme approach. Risk assessment should include accommodation needs. Users and where appropriate, carers, must be involved in care planning.
54. The introduction of step-down facilities should be considered to facilitate discharge from inpatient care.
55. A range of community support services must be available required to facilitate recovery of people with complex needs.
56. Every effort must be made to destigmatise and normalise, making maximum appropriate use of ordinary facilities and resources.
57. Staff must be provided with appropriate training in services promoting recovery, including risk assessment and its management.
58. ACT should be provided for service users with highest levels of disability and greatest vulnerability, particularly those who have difficulty maintaining links with existing services.
59. Staff involved with ACT must be provided with the appropriate training including assessment and planning, direct service provision and teamworking.
60. ACT teams must be adequately resourced – an optimal individual caseload for

delivering care is 10-12.

People with Specific Service Needs

(i) Younger People Entering Adult Life

4.48 The Review envisages a substantial development in young people's services. Nevertheless there is a need for flexibility and, where appropriate, joint working appropriate for the needs of individuals. It is essential that there are seamless transitional arrangements for people whose mental health problems arise in childhood and extend into adult life. These should include specific plans for:

- young people with psychotic illness that may require lifelong care;
- adults with developmental disorders such as autistic spectrum disorders, learning disability and attention deficit hyperactivity disorder;
- adults with mental health problems arising from adverse childhood experiences including people who are survivors of abusive experiences.

4.49 While a comprehensive adolescent service must include appropriate inpatient facilities, the reality at the present time is a deficiency of such places. It is wholly unsatisfactory that older adolescents are admitted to adult inpatient units. Nevertheless until additional adolescent inpatient facilities are established it is essential that there are agreed flexible arrangements at local level to allow, where necessary, young people to be admitted to adult inpatient facilities.

4.50 Further consideration on the interface between Child and Adult Services is given in the Review of Child and Adolescent Mental Health Services.

4.51 **People with a first episode of psychosis.** There have been growing concerns regarding the shortcomings of service provision for young people with severe mental illness. These arise from the evidence that delays in first treatment may lead to poor outcomes both the short term and long term.[48, 49] Surveys of services by Rethink have highlighted delays on average of twelve months between onset of psychotic symptoms and initiation of treatment. They also report services to be insensitive to the needs of young people including their training and employment needs.

4.52 Emerging evidence suggests that early intervention, embracing assessment, medical and psychological treatment and appropriate assistance with training and educational needs, can improve recovery and social functioning.[50-53] General practitioners are key pathway players. Based on current evidence the NSF Implementation Guidelines[5] suggest the following principles for service provision:

- separate, age appropriate facilities for young people
- emphasis on service users' needs including support, education and employment
- family orientated services
- age, gender and culture sensitivity
- treatment provided in the least restrictive and stigmatising setting
- emphasis on managing symptoms rather than diagnosis

4.53 The aims of early intervention are:

- to encourage liaison between primary/secondary care in the early detection and management of the first psychotic episode to reduce duration of untreated psychosis;
- early effective interventions to accelerate remission and prevent relapse including pharmacotherapy and adjunctive psychosocial interventions;
- normalising experiences and reducing adverse consequences of trauma, depression and suicide; and
- maximising social, educational and work functioning.[54]

Good Practice Examples

Windsor First Episode Service. *This service, based at Belfast City Hospital, was established in 2000 for young people (18-30 years) living within the South Belfast*

catchment, experiencing a first episode of psychosis. The service consists of a multi-disciplinary, multi-agency team from the Belfast City Hospital Trust, South & East Belfast Community Trust, School of Nursing Queen's University, voluntary and independent sectors including care and user participation. The aim is to provide an up-to-date evidence based range of services including family intervention, social skills development, medication management, cognitive behavioural therapy and family intervention. (Contact: 028 90 32 9241 ext 2518)

***West Midlands IRIS Group** have produced guidelines and a 'tool-kit' for the development of Early Intervention Services (www.iris-initiative.org.uk).*

Recommendations

61. Separate age-appropriate services for younger people with a first episode of psychosis should be established.
62. Services should be gender and culture sensitive.

(ii) Adults with Mild Learning Disability

4.54 The majority of people who have a mild learning disability live in society without formal additional support and may be well integrated into their communities. While not disabled by their intellectual impairment they are at increased risk of mental illness[1]. Mental illness in addition to pre-existing intellectual impairment may be disabling. Adults with mild learning disability and their carers wish to access health services as other adults including where appropriate Adult Mental Health Services.

4.55 The Royal College of Psychiatrists[56] endorsed example of good practice in Northern Ireland where adult mental health services and learning disability services co-operate in a planned way to provide treatment and care for people with various degrees of learning disability. Community based models of treatment in both programmes are broadly similar.

4.56 Services should be based on individual context and a comprehensive assessment of need. Continuity of care is of great importance for people with a learning disability.

Recommendations

63.	Adults with mild learning disability should be facilitated in accessing adult mental health services as a first preference. The preferences of people already within either adult mental health services or learning disability services should be respected.
64.	Adult Mental Health services should be resourced to include people with mild learning disabilities. Additional time is required for assessment and for consultation between professionals within and across programmes of care.
65.	Co-operative working, sharing of facilities and expertise between adult mental health services and learning disability services must be established in each Trust area.
66.	Training opportunities must be provided for local health professionals providing services for people with mild learning difficulties.

(iii) People Becoming Older with Enduring or Relapsing Mental Illness

4.57 With increased life expectations generally more people with major psychiatric disorders such as schizophrenia, bipolar affective disorder, organic brain disease, severe depression, are living into later life. Given the separate development of health and social service services for older people it is essential that there are locally agreed arrangements for service provision for people within adult mental health services who reach 65 years of age. As noted by the Royal College of Psychiatrists,[57] graduation from one age group to the next offers an important opportunity to review treatment and care needs including any comorbid physical illness. Such a review by the lead service providers should include social needs including accommodation, support, and the needs of carers.

4.58 Further consideration on the interface between Adult Services and Services for Older People is given in the Review of Mental Health Issues of Older People.

Recommendations

67.	Local arrangements for meeting the needs of people who enter old age with enduring or relapsing mental illness must be agreed.
68.	Local population needs of people entering older age and their carers should be assessed.

69.	The treatment and care needs of individuals graduating from adult mental health services to services for older people should be the subject of review.

(iv) People with Challenging Behaviour

4.59 Within adult mental health, the term 'challenging behaviour' refers to people who are suffering from a serious mental illness, for example schizophrenia or sequelae of head injury and who, in addition to severe and often persistent symptomatology, show a range of behavioural problems, such as aggression, violence, repeated self-harm, extreme self-neglect, fire-setting or inappropriate sexual behaviour.[58] In the past, many people with these problems would have been cared for in the continuing care wards of mental hospitals. Nowadays, they remain in acute wards for long periods of time or are caught in the revolving door of recurrent acute hospital admissions. The term has also been used in connection with 'new' long-stay patients,[59] to refer to patients who have been in hospital continuously for more than 1 but less than 5 years. The cycle of repeated admissions, together with behavioural problems, leads to deterioration in social networks and a reliance on mental health professionals or other service users,[60] thus creating a pattern of repeated admissions and further weakening of social networks.

4.60 A consistent picture has emerged of the type of person whose behaviour is likely to lead to great difficulties in community placement. The majority is a group of young, predominantly male patients, most of whom have a diagnosis of schizophrenia, whose illness is poorly controlled and who have co-morbid drug and/or alcohol misuse. Young male patients are at high risk of substance misuse, which is associated with higher use of inpatient services.[61] Second, there is an older group, often with treatment resistant bipolar disorder, which is likely to account for a further 20%. Third, is a group with significant cognitive impairment due to acquired brain damage, alcohol misuse, pre-senile dementia or psychosis associated with severe cognitive decline. Estimating the numbers in each category is difficult. Wing[62] suggests that, for specialist residential care for this group, between 10 and 30 places per 100,000 might be needed.

4.61 **Treatment And Management Options.** Specialist Supported Living. Residential provision for this group of patients attempts to combine the best features of hospital care (high staffing levels, intensive professional input, individualised programmes of care) with a setting that is both homely and domestic in scale and operation. The emphasis must be on improving and maintaining functioning rather than simply symptomatic improvement.

4.62 Intensive community support. Present evidence favours the use of Assertive Outreach for psychotic patients who relapse frequently, requiring hospital admission and with established patterns of poor engagement with services and concordance with treatment.[63] People targeted for Assertive Outreach services have complex needs, including challenging behaviour.

4.63 Hospital treatment and care. The following definitions were developed by a multidisciplinary practice development network as part of their work in developing national minimum standards for Psychiatric Intensive Care Units (PICU) and low secure units, and published by the Department of Health.[64]

4.64 'Psychiatric intensive care is for patients compulsorily detained usually in secure conditions who are in an acutely disturbed phase of a serious mental disorder. There is a loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open acute ward…. Length of stay is appropriate to clinical need and assessment of risk, but would not ordinarily exceed 8 weeks in duration'.

4.65 'Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of a serious mental disorder who require the provision of security…. Patients will be detained under the Mental Health Act …. needing rehabilitation for a period of up to 2 years' (see 4.40).

4.66 PICUs must be seen as part of a core acute inpatient service, with good links between acute inpatient services and well defined admission and discharge criteria. It is essential that they have a comprehensive range of multidisciplinary activities and an

intensive therapeutic intervention programme, underpinned by a core philosophy of risk assessment, management and intensive engagement.

4.67 Secure locally-based NHS facilities are also part of a seamless forensic service. The Reed Report[65] into services for mentally disordered offenders and others requiring similar services, proposed that, in addition to medium secure facilities, ' access to local intensive care and locked wards should be available more widely' and that 'secure provision …should include provision… for those who require long-term treatment and/or care'.

4.68 The Cavan/Monaghan project[66] recommends that patients who have enduring disturbed and challenging behaviour in the context of mental illness require care in a specialist unit, possibly provided on a regional basis in view of the very small numbers of people requiring such facilities. A policy statement from Rethink[67] stated that sufficient secure facilities should be available for those who need them, that they should be locally based and used for the shortest possible time.

4.69 Further consideration on the interface with Forensic Services is given in the Review of Forensic Services.

Recommendations

70. Trusts must plan for the needs of people with challenging behaviour.

71. Community mental health services should have the capacity to provide intensive support and treatment in the community for people with challenging behaviour. This should include where appropriate multiprogramme networking.

72. Specialist accommodation in the community should be developed with appropriate levels of skilled staff to provide treatment and care for people with challenging behaviour. (see recommendations 138 and 141).

73. Services must include the provision of local intensive care and low secure inpatient services.

74. Low secure units should develop an ethos of rehabilitation within a secure setting, and have close links with rehabilitation and Assertive Outreach services.

75. Low secure units can function as 'step-down' services from the Regional Secure Unit.

76. Staff employed in settings where there may be people with challenging behaviour,

including CMHTs, ACTs and low secure units, should have appropriate training that focuses on the needs of people with chronic severe mental illness, including training in forensic mental health, risk assessment and risk management.

77. Longer term high quality hospital provision is likely to prove necessary for a small group of people whose behavioural problems are often chronic and severe.

78. The level of need for low secure provision should be the subject of needs assessment.

79. Further research is required on the particular therapeutic interventions that have the potential to ameliorate behavioural problems in the context of severe mental illness.

(v) People with Severe Mental Disorder and Substance Misuse (Dual Diagnosis)

4.70 While the term "dual diagnosis" is unsatisfactory as personality disorders and serious medical problems are also frequently present in those with a history of substance misuse and mental health problems, it is retained here as other alternatives are less succinct. Providing high quality care to those with a dual diagnosis of a concurrent mental health illness and substance misuse problems- alcohol and/or drugs – has been identified as a major challenge for mental health services.

4.71 People with dual diagnosis have, compared to patients with similar mental health problems alone, significantly poorer outcomes. It is also clear that some people with mental health problems may deteriorate even after relatively low levels of alcohol or drug use.

4.72 Concerns have been raised that people with a dual diagnosis have fallen between the two stools of mental health and addictions services with neither service accepting responsibility for their treatment needs. Mental health services have lacked skills in substance misuse, whereas addictions services have been poor in the recognition and treatment of mental health problems.[68]

4.73 The Safer Services report[69] published in 1999 by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, recommended that people with concurrent severe mental illness and substance misuse should be managed within mainstream mental health services but this guidance does not appear to have been universally accepted or implemented.

4.74 **Prevalence of co-existing mental disorder and substance misuse.** Much of the research in this area has been carried out in the US where almost 50% of service users with mental illness may have substance misuse problems. The commonest co-morbid disorders are anxiety states, affective disorders and personality disorders.[70]

4.75 Drug use in inpatient psychiatric units is an increasing cause of concern in the UK. Some patients with dual diagnosis may continue to use alcohol or drugs in acute psychiatric units.[71] There is also evidence that the routine assessment of alcohol or drug use at the time of admission to acute psychiatric units markedly underestimates substance misuse problems.[72]

4.76 A consultation document on guidance for service providers on substance misuse in mental health settings has been circulated by the DHSSPS in December 2002 and this will eventually replace previous Departmental guidance issued in 1995.

4.77 **Substance misuse, suicide and homicide.** Substance misuse is an important risk factor of suicide and homicide. In Northern Ireland the estimated risk of suicide in the presence of current alcohol misuse or dependence was found to be 8 times the suicide rate of the general population not drinking alcohol.[73] The National Suicide Prevention Strategy for England (2002) identified the need for mental health services to implement local strategies for dual diagnosis covering training on the management of substance misuse, and joint working with substance misuse services. The role of substance misuse in homicide or serious assaults has also been emphasised in a succession of confidential enquiries.[74]

4.78 **Substance misuse and co-existing physical disorders.** The health problems associated with alcohol and drug misuse are widespread. People with a history of injecting drug misuse are particularly at risk from overdose, infections and blood borne viruses such as hepatitis C and to a lesser extent hepatitis B and HIV. The highest risks of premature death from natural and unnatural death for common mental disorders are for substance misuse and eating disorders. Opioid dependence and abuse had a mortality risk for suicide of 10 times that expected, for violent deaths 13 times that expected and for natural deaths 4 times that expected.[75]

4.79 **Management and Services Models.** Guidance on good practice in relation to dual diagnosis patients reflect the complex interactions between substance misuse and mental health problems.[76-81] Three main models of service delivery have been proposed for people with dual diagnosis; serial, parallel and integrated.

4.80 The serial treatment model proposes mental health and substance misuse disorders are treated consecutively For example, patients presenting to mental health services with a substance-induced mood disorder which subsequently quickly resolves following a brief period of abstinence would then be appropriately referred on to addictions services. In the parallel treatment model concurrent input is proposed by substance misuse services and mental health services. However this may create tensions in treatment delivery between the two services. In the integrated treatment model treatments for both psychiatric and substance misuse are provided within one clinical team. Specialist integrated services have been established in both the USA and UK for people with dual diagnosis.

4.81 While there is a lack of sound evidence on the relative effectiveness of these models[82] current UK guidance strongly supports an integrated treatment model delivered within mainstream services by mental health staff who are appropriately trained in substance misuse. The National Treatment Agency for substance misuse have been developing modules of care for the treatment of drug misusers, including care pathways, which will incorporate issues pertinent to dual diagnosis workers.[83]

4.82 Further consideration on Dual Diagnosis services is given in the Review of Alcohol and Substance Misuse Services.

Recommendations

80. Trusts should make provision for people with mental health problems and co-existing alcohol or drug misuse.
81. Local prevalence and needs of people with dual diagnosis should be assessed.
82. For people with dual diagnosis, a single service should provide for their needs:
    - The needs of those with severe, enduring and relapsing mental illness should be met by adult mental health services

- The needs of those with less severe need but requiring secondary care services, should be met by adult mental health services, unless their substance misuse is their more dominant need. For those with less severe mental health needs whose dominant problems are substance misuse, their needs can best be met by substance misuse services
- For people with personality disorder and substance misuse agreed arrangements need to be established between specialist services for people with personality disorder and substance misuse services.

83. Comprehensive assessment of mental health problems with substance misuse and relevant physical health problems is essential.
84. Adequate numbers of staff must be provided with appropriate training in the assessment and management of the needs of people with dual diagnosis.
85. Staff working in Adult Mental Health Services should have competence in the identification, assessment and appropriate specific evidence based interventions for substance misuse.
86. Staff working in substance abuse service require training and regular updates on the recognition of mental disorders, risk assessment, and be competent in evidence based treatment of mental health problems.
87. The needs of offenders and ex-offenders with mental health problems and co-existing alcohol or drug- related problems should be addressed.

(vi) People in General Hospital Settings

Introduction

4.83 Mental health services are required to address the needs of people with mental health problems presenting in general hospital settings. There is increasing recognition of the high prevalence of mental health problems in general hospital settings, both inpatient and outpatient. The following are the most common.

4.84 **Deliberate Self-Harm**. The frequency of deliberate self-harm (DSH) has risen steadily since the 1960s and currently there are 140,000 such presentations per year at general hospitals in England and Wales with this behaviour.[84] The individual intent in DSH varies. Underlying the act of self-harm there are a variety of situational, addictive and mental health disorders that require accurate assessments. Between 5-

20% of people who present with an act of deliberate self-harm require urgent psychiatric admission for their own safety.[85] In the year following an attempt of self-harm about 1% commit suicide. There is a significantly higher rate of suicide after self-harm in those who are not adequately assessed.[86]

4.85 **Alcohol and Drug Misuse.** Alcohol misuse contributes to 20-25% of all general hospital admissions.[87, 88] Alcohol misuse is a risk factor for many serious health problems including cancers, heart disease, stoke, accidents and suicide. Screening for alcohol misuse in a general hospital setting is simple and effective. There is also clear evidence of the efficacy of brief interventions to reduce alcohol misuse in those identified and appropriately counselled.[89]

4.86 **Organic Brain Syndromes**. Dementia is common in general hospital populations reflecting the age profile of patients today. Prevalence rates as high as 35% have been reported, increasing with age. Delirium is also common with prevalence rates in general hospital patients of up to 60%. This is particularly common after cardiac and hip fracture surgery and again with increasing age. Both dementia and delirium are important indicators of physical illness and are associated with increased mortality and increased length of stay in hospital.

4.87 **Medically Unexplained Symptoms**. Some people present with physical symptoms for which there is no obvious underlying physical cause, or where symptoms are disproportionate to any underlying medical disorder. In many but not all, the presentation is associated with underlying mental health problems. While such conditions are known by a variety of different terms, "medically unexplained symptoms" is to be preferred, as this does not imply any specific cause. Medically unexplained symptoms account for 40-50% of service users in hospital outpatient clinics. The more physical symptoms that people report, the greater the likelihood of associated mental illness regardless of the nature of their symptoms. Appropriate psychological intervention can reduce such functional somatic symptoms, generally best tried initially by the treating physician with mental health specialists involved where problems are more intractable.[89]

4.88 **Behaviours and Emotional Reactions Impacting on/or associated with Medical Care.** Lifestyle issues account for a significant proportion of physical illness. Smoking for example, despite education regarding its negative consequences, risk taking behaviours, which negatively affect physical morbidity or mortality, may be helped by specific psychological interventions. The emotional needs of people with physical health problems may require specific psychological interventions in addition to general support.

4.89 **People with Physical and Mental ill-health.** Given that mental health problems are common, many people admitted to general hospitals may have unconnected mental disorders, which may require advice or adjustment of treatment because of the associated physical difficulties.

4.90 **Perinatal Mental Health Problems.** For women childbirth is the time of greatest vulnerability for becoming severely mentally ill. About 10% of all recently delivered women have a major depressive illness. The incidence of admission to hospital for puerperal psychosis is 2 per 1000 women delivered and about 2 per 1000 women delivered in the UK are admitted to hospital suffering from non-psychotic conditions.

4.91 The antenatal period and the contact it brings with obstetricians and other antenatal staff offers a unique opportunity to identify and screen women at risk. The risk of relapse or recurrence of psychotic mental illness is well established and factors that increase the risk of a non-psychotic postpartum mental illness can also be identified. Liaison between psychiatrists and obstetricians offers the opportunity for improving the medical management of psychiatric disturbance in pregnancy and the puerperium and for ensuring close co-operation and communication between all health professionals involved in the care of the mother with mental health problems and her child.

Service Model

4.92 It is important that medical specialists should have access to Liaison Mental Health services to allow input where necessary[87] particularly to the above groups of people.

4.93 A multidisciplinary Liaison Mental Health Service (LMHS) provides the best means of ensuring effective methods of dealing with the mental health needs of service users in a general hospital setting including those in Accident & Emergency Departments.

4.94 Liaison Teams are also suitably placed to provide education and to improve the knowledge and skills required to treat people with mental health problems and learning difficulties in general hospital settings, regardless of whether or not they need to be referred to specialist services.

4.95 **Identification and Assessment of Needs.** It is generally acknowledged that the identification of mental health problems in general hospital settings is poor. Identification is based on clinical assessment, history taking and mental state assessments, supplemented by other sources of information. Whilst it may sometimes be difficult, staff should endeavour to identify admitted patients who have a mental health problem, learning disability or dementia and any special needs they may have arising from this. Where appropriate and with the person's consent additional information should be sought from key informants. Appropriate information and education should be provided to general hospital staff to enable them to undertake psychosocial assessments. Ward staff should liaise with professionals in the community.

4.96 **Stigma.** People with mental health problems, learning disability or dementia have the same fundamental rights as any other person including rights to the same standards of health and social care. General hospital staff should be trained in mental health awareness to prevent medical patients with mental health problems feeling stigmatised or prejudiced. They also should have access to an advocate should they wish to avail of this.

4.97 **Care Environment.** General hospital staff should consider the immediate environment of patients in terms of physical needs, safety and where appropriate potential risk of deliberate self-harm. Staff undertaking such duties should have adequate training in the care of patients with mental health needs. It may be

advisable that specific wards or units are allocated such patients because of familiarity and experience in dealing with the above difficulties.

4.98 **Referral to Liaison Services.** On occasion referral to a mental health specialist is appropriate for assessment, advice and management of a service users' mental health problem. Referral should be to a LMHS, a multi-disciplinary team that may typically consist of a liaison nurse, social worker, clinical psychologist, psychiatric trainee and consultant psychiatrist. The LMHS should provide prompt and ideally same day assessment to assess risk, identify mental illness, and advise on physical and appropriate psychological treatments and follow-up. The LMHS team can also give specialist advice regarding the use of the Mental Health Order and offer training and education to hospital staff or identification and management of mental health problems in the general hospital setting.

4.99 Because of potential dangers in certain presentations, it is important that the LMHS team can respond quickly (usually within one hour) if requested. There is a need for clear referral protocols from the general hospital ward. It is also important that the LMHS team have effective patterns of communications with General Practitioners and other mental health professions, allowing clear aftercare plans to be made prior to the service user leaving the general hospital.

4.100 In view of the sensitivity of many of the issues surrounding mental health in the general hospital setting, it is important that consultation arrangements ensure comfort, privacy and security for service users and for the mental health professionals involved. In view of the unpredictability of crises, it is important that appropriate services are available 24 hours per day 7 days per week.

4.101 **Accident and Emergency Services.** The range of presentations noted above can present to A&E Accident & Emergency departments and often in a more acute state than on a general hospital ward.[90] It is important therefore that departments have appropriate access to Mental Health Services 24 hours per day 7 days per week. The speed of response is imperative because of the potential dangers of severe untreated mental health emergencies but also to alleviate distress to waiting service users and

their carers. Agreement will be required between LMHS teams and CR services regarding nature and configuration of services.

4.102 Deliberate self-harm is a very common reason for presentation to departments and as noted above there is a wide range of mental health problems associated with this presentation. It is important that as many users are offered psychosocial assessment and where necessary support. Misuse of alcohol and drugs is common within the deliberate self-harm group and while brief counselling can be undertaken in an A&E setting, it is important that there is ready access to addiction services.

4.103 It is again important that comfortable, confidential and safe accommodation is provided for interviewing in the A&E environment. In view of the potential for aggression there should be clear policies including support procedures by security staff.

4.104 Young people attending A&E with mental health problems should be seen by those with appropriate expertise. Clear protocols authorising responsibility (based on relevant expertise) should be in place between Liaison Teams and CAMHS teams.

4.105 **Perinatal Services.** Mental health problems following childbirth is common and can be serious with long term adverse effects on the woman's mental health and on infant development. Perinatal mental health problems need to be addressed with a clear Regional Strategy focused on the different levels of services required and ensuring that all staff involved receive adequate training and support. The above can be managed within general liaison services.

4.106 **Commissioning and Audit of Service.** The above services should be developed in all general hospitals throughout Northern Ireland, the extent depending upon the size of the hospital and particular patient mix. Specialist hospitals may require emergency liaison mental health assessments and local arrangements should be established for each hospital. This should be part of the commissioning process although LMHS teams may not be required at these hospitals.

Recommendations

General Hospital Services

88. Appropriate education should be provided to general hospital staff to allow them to undertake psychosocial assessments.
89. General hospital staff should be trained in mental health awareness to prevent people with mental health needs feeling stigmatised or prejudiced
90. General ward staff should where necessary have access to appropriately trained and experienced mental health professionals.
91. Acute hospitals should ensure that appropriate liaison services are identified.
92. Clear referral protocols should be in place.
93. Liaison Services should provide prompt same day assessment to assess risk, identify mental illness, and advise on physical and appropriate psychological treatments and follow-up.
94. In view of the unpredictability of crises, it is important that appropriate services are available 24 hours per day 7 days per week including A&E departments.
95. Liaison Services must be able to access addiction services quickly for patients who are willing to avail of them.
96. Comfortable, confidential and safe accommodation must be provided to interview service users in A&E environments and general hospital settings.
97. Policies outlining the support procedures from security staff should be established.
98. All people with deliberate self-harm should be offered psychosocial assessment and appropriate after care plans.
99. People with problems relating to addiction attending A&E should be able to avail of prompt access to community addiction services.
100. Young people attending A&E with mental health problems should be seen by those with appropriate expertise. Clear protocols authorizing responsibility (based on relevant expertise) should be in place between Liaison Teams and CAMHS teams.

Perinatal Services

101.	Comprehensive Assessment of Maternal Health must include Mental Health.
102.	Protocols for the management of women who are at risk of a relapse or recurrence of a serious mental illness during the perinatal period must be in place in every Trust providing maternity services.
103.	Women who have a past history of serious non-postpartum psychiatric illness, should be offered assessment by a psychiatrist in the antenatal period and a management plan instituted regarding the high risk of recurrence following delivery.
104.	Substance misuse services should be accessible throughout antenatal care.

Treatments and Interventions

(i) **General**

4.107 From a health perspective services, their configuration and organisation, are but vehicles to enable the optimal delivery of specific treatments, interventions, care and support. During acute phases of illness, including illness relapses the primary focus is treating the illness, alleviating symptoms and providing support and care for sufferers and their families. In the nature of severe mental illness there are often enduring problems including residual symptoms and functional impairments. Therefore in addition to symptom relief, therapeutic and caring effort must also be directed towards the consequences of such impairments – disabilities or handicaps affecting an individual's role and functions within their family, work and wider social situation.

4.108 Such a range of interventions implies a range of skills and understanding grounded in evidence-based health and social care. This in turn assumes the availability of an appropriately trained and adequately staffed workforce (see Chapter 7). In addition to specific intervention skills, health and social care professionals require a range of general skills and abilities including interpersonal skills, team-working and communication skills. Optimal holistic treatment and care also depends fundamentally on collaborative working between the person with mental health problems, their family, carers and the professionals and organisations involved.

4.109 **Psychological Therapies**. Throughout the Adult Mental Health paper it has been recognised that there needs to be improved access to psychological therapies, from appropriately trained, qualified and supervised staff.

However, one of the consistent observations received by the Review is the relatively poor development of psychological therapies in Northern Ireland, resulting in limited access and unacceptability long waiting lists for assessment and treatment.

4.110 A number of service examples for the delivery of psychological therapy are in operation within the NHS, for example the Northumberland Tiered Approach.[91] Their aim is to increase access to a broad spectrum of psychological therapies for a range of problem severity and complexity. Services place emphasis on training and supervision as well as the provision of intensive and dedicated therapy services. These can probably be best provided through a Trust-wide multi-professional department.

> *Good Practice Example*
> ***Foyle Health and Social Services Trust*** *have proposed a new psychological therapies service model within their strategic review of adult mental services (2003). They propose a 21 person Psychological Therapy Team, composed of a number of different professional groups, whose members have expertise in the range of psychological assessment, formulation and intervention skills. The team will be brought together from existing and newly appointed staff (Contact: 028 71314201).*

(ii) **Specific Treatments and Interventions**

4.111 In the remainder of this section three groups of disorders are considered, schizophrenia, major depressive disorder and bipolar affective disorder. These are severe, disabling, at times life threatening and often enduring illnesses for which effective biological treatments remain the foundation on which a holistic approach rests. The complexities of severe mental illness and their sequalae therefore require a variety of approaches – medication, psychological therapy, psychosocial

interventions and specific social and occupational programmes such as vocational training. Recent developments in models of service delivery, psychological and social interventions suggest that the range of treatment options is likely to expand significantly.

a. Use of Medication

4.112 The Review recognises that medication is an important aspect of treatment for specific mental health disorders . It recommends that the most up to date evidence based guidelines such as those of the British Association of Psychopharmacology and the National Institute for Clinical Excellence are employed and that in general the prescription of medication should be within the recommended dose ranges as stated in the British National Formulary. It recognises that medication can be an important part of a comprehensive care package which addresses the individual's clinical, emotional and social needs.

4.113 **Schizophrenia.** Antipsychotic medication form the cornerstone of both acute treatment and relapse prevention in schizophrenia.[92] The first generation anti-psychotics are generally effective in producing remission from positive symptoms but have little impact on, or may even worsen the negative symptoms and cognitive deficits associated with the disorder.[93] Evidence suggests that the second generation or so called atypical antipsychotics are as efficacious in overall response rates, but may have a more beneficial effect on reducing the negative symptoms and cognitive deficits.[94] While all antipsychotic drugs are associated with side effects the atypical antipsychotics are less likely to produce neuromuscular side effects in the short to medium term.[95] The more favourable side-effect profile of the second generation antipsychotics can increase treatment concordance which will in turn lower the risk of relapse.[96]

4.114 The choice of antipsychotic should be made jointly by the individual and the clinician responsible for treatment, and where appropriate the individual'[94] carer or advocate[97]. All antipsychotic drugs may take several weeks to control symptoms. In general the minimum effective dose must be used and doses should not normally be used above the therapeutic recommendations as the likelihood of side effects is increased. Where

the response is inadequate or unacceptable side effects occur a different antipsychotics should be prescribed. An atypical antipsychotic should be used as to treat those individuals with a first psychotic episode.[98] Antipsychotic drugs, atypical or conventional should not be prescribed concurrently, except for short periods to cover the changeover from one medication to an other.

4.115 In individuals whose illness has failed to respond satisfactorily to at least two antipsychotics given in therapeutic doses for a minimum period of 6-8 weeks, (one of which must have been an atypical antipsychotic drug) the use of clozapine is recommended.[99] (It is currently the only atypical licensed for use in Treatment Resistant Schizophrenia).

4.116 **Major Depressive Disorder.** The goal of treatment with antidepressant medications in the acute phase is the remission of symptoms. Approximately 70% of people will respond to antidepressants provided an adequate dose is given for an adequate period. All antidepressants have similar efficacy for the majority of patients with major depressive disorder.[100] The newer antidepressants are generally better tolerated and are safer in overdose than the older tricyclic antidepressants.[101]

4.117 When antidepressants are prescribed the individual must be made aware of the delay in onset of action, the time course of treatment, potential side effects and the need to take the medication as prescribed. In addition individuals should be informed of the risk of discontinuation symptoms.

4.118 There is strong evidence to recommend the continuation of antidepressants for at least 6 months following remission in order to reduce the risk of relapse.[102] In addition where an individual has had 2 or more depressive episodes in the past and who experienced functional impairment during the episodes antidepressants should be continued for 2 years.[103]

4.119 Approximately 20-30% of patients with depression fail to respond to the first antidepressant prescribed, in spite of taking an adequate dose for an adequate period of time. Consideration should then be given to switching antidepressants. Evidence shows that approximately 50% of patients will benefit from this.[104] Where there is

still a lack of response and social or other stresses have been addressed the use of additional pharmacological strategies including augmentation and combination treatments may be appropriate.

4.120 Bipolar Affective Disorder. The Review recommends the use of evidence-based guidelines for treating bipolar disorder,[105] recognising the importance of accurate diagnosis, and user engagement in the management of the disorder. The needs of carers and families of individuals with bipolar disorder must also be considered. Education about the illness should emphasise the need for medication long-term.[106] Information about possible side effects should be given, and their possible emergence monitored, making their reduction a priority in order to improve compliance.

4.121 Treatment will be dependent on the phase of the illness, (acute manic or mixed episode, acute depressive episode) and longer term treatment. Prophylaxis should always be considered after a second episode of illness.[107] Service users taking mood stabilisers must have appropriate monitoring carried out in accordance to the recommendations for that particular medication.

4.122 Where monotherapy has failed to prevent relapses/long-term treatment may involve the use of combinations of agents. In general discontinuation of long-term treatment is not recommended when there is a good clinical control of the illness.[108]

4.123 Electroconvulsive Therapy. Electroconvulsive therapy (ECT) is only recommended[109] to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with:

- severe depressive illness
- catatonia
- a prolonged or severe manic episode.

4.124 A comprehensive assessment of the risks and potential benefits to the individual will inform the decision as to whether ECT is indicated or not. Valid consent should be obtained where the individual has the ability to grant or refuse this. The

administration of ECT must comply with the most recent best practice recommendations of the Royal College of Psychiatrists.[110]

b. Psychological Interventions

4.125 Major advances in psychological treatments have taken place in the last few decades, both in terms of their sophistication and proliferation. In parallel, a more rigorous approach to researching clinical effectiveness has resulted in a number of reports advising which psychological therapies may be helpful for particular conditions.[111,112,113] The evidence is now strong in relation to the effectiveness of specific psychological therapies for anxiety disorders with marked symptomatic anxiety (panic disorder, social phobia, obsessional compulsive disorder and generalised anxiety disorder).[113] Likewise, rigorous protocols have been developed for post traumatic stress disorder and moderate levels of depression.[113] A forthcoming report from the National Institute for Clinical Excellence (NICE) will clarify the state of the evidence in relation to psychological approaches to the treatment of eating disorders.

4.126 Evidence about the efficacy of psychological approaches with people who have severe and enduring mental illness is relatively recent and it may suffer from a bias that affects all research on such treatments. Certain treatments, because they can be protocol driven (such as cognitive behaviour therapy (CBT) lend themselves to investigation through randomised controlled trials, whilst others such as the psychodynamic therapies do not. This may result in some treatments being assigned an artificially low grade of evidence.

4.127 **Schizophrenia. Theoretical Models**. One of the main driving forces behind the application of psychological and social interventions for severe mental illness is the increased understanding of the interaction of biological, psychological and social factors involved in psychosis. Such ideas have been described within the “stress-vulnerability” model.[114] This provides a multi-factorial account of risk and relapse within psychosis and thus, accommodates a range of aetiological theories and treatment options. It suggests that everybody has a different level of vulnerability to the development of psychotic experience. The vulnerability may be the result of biological factors (e.g. genetic, or birth trauma) or psychosocial ones (e.g. resilience

to stress or history of childhood abuse or neglect). This model underpins and provides a rationale for psychological and social interventions. For example, it hypothesises that if we provide an individual with increased resources for coping with stress, or reduce the stress in the environment, significant advances in outcome could be made.

4.128 Family Interventions. The most established and best-evaluated psychosocial intervention aimed at reducing stress in the environment has been family intervention. Research has consistently demonstrated that family interactions have a significant role in precipitating relapses in vulnerable individuals. People diagnosed with schizophrenia from families that express high levels of criticism, hostility, or over-involvement, have more frequent relapses than people with similar problems from families that tend to be less expressive with their emotions.[115] There is consistent evidence that family intervention dramatically reduces relapse rates, the need for rehospitalisation and reduces costs to services. It may also improve general social impairment.[116] Recent National Institute for Clinical Excellence guidelines suggest a standard of 100% of families should be offered family intervention.[117]

4.129 The main purpose of family intervention is to reduce the levels of distress within the family and to improve the quality of family relationships. While components of family work depend upon the needs of a particular family, intervention usually involves education about schizophrenia, problem solving, stress management and communication training.

4.130 Not all people who have psychotic experience live with their families. It is likely that relationships with staff have similar effects in terms of relapse. This suggests that mental health team members need to train, supervise and support staff carers to reduce the potentially negative effects of unhelpful relationships.[118]

4.131 Cognitive Behaviour Therapy. Cognitive behaviour therapy is the name given to a broad range of therapeutic approaches to psychological distress. The main assumption in CBT is that emotional problems depend on how people think and behave. Change in distress is brought about by changing thinking patterns and by changing behaviour. Recent applications of CBT in psychotic disorders have been directed at:

- coping strategies for psychotic symptoms;
- changing delusional beliefs and beliefs about other symptoms such as hallucinations; and
- changing dysfunctional beliefs about the self and others.

4.132 CBT is a tried and tested intervention for a range of mood disorders. Within severe mental illness several randomised controlled trials now exist.[119,120] Overall results are positive; for example, one study reported a 25% reduction in symptom severity[119] while approximately 50% of people involved in the trial benefited. Recent research suggests that effects persist at 5-year follow-up.[121] Doubts about the strength of the evidence base have been expressed,[122] but recent NICE guidelines (2002) suggest a standard of 100% of clients who are experiencing persistent psychotic symptoms, be offered CBT.[118]

4.133 Psychodynamic Therapies. In a recent review[123] no randomised trials of psychoanalytic approaches in the treatment of schizophrenia were found. The authors concluded that there was no data to support the use of psychodynamic psychotherapy for hospitalised people with schizophrenia. However there is evidence that therapeutic communities run along psychodynamic principles produce benefits for specific client groups, such as those with severe personality disorders, and produce improvements in mental health and functioning of other, more severe disorders.[124]

4.134 Motivational Interviewing. Lack of compliance with medication regimes is regarded as one contributing factor to relapse rates in schizophrenia. Motivational interviewing has been used with individuals with severe and enduring mental illness and has been

shown to achieve greater adherence to medication and a better overall clinical outcome.[125]

4.135 Preventative Treatments. A number of centres are developing services aimed at the prevention of psychotic disorder by targeting risk group through the delivery of psychological interventions (Salford, England), or psychological interventions and pharmacological intervention (Personal Assessment and Crisis Evaluation (PACE) - part of the Early Psychosis Prevention and Intervention Centre in Melbourne). No published outcome data is yet available but both represent considerable innovation in practice.

4.136 **Bipolar Affective Disorder.** There has been an increasing interest in applying and evaluating psychological interventions to bipolar disorder, but as yet there is limited published evidence of its effectiveness. The National Institute of Mental Health in the US consensus conference on bipolar disorders concluded that adjunctive psychosocial therapies should be more widely used in the treatment of bipolar disorder.[126]

4.137 There is some evidence for the efficacy of cognitive therapy for people with bipolar disorders. One study showed an increased compliance with medication[127] whilst another[128] found a significant reduction in symptoms, which had not fully responded to medication. In a small-scale study cognitive therapy appeared to reduce relapse rates.[129] The most recent review of psychosocial treatments in bipolar disorder is largely positive.[130] Group therapies employing a psychoeducational approach revealed greater improvements in global measures of well being, but not in objective clinical measures, over controls. Most of the six controlled trials of family psychotherapy showed treatment groups as better in global status, symptoms, psychosocial functioning and compliance. A recent study in which family psychoeducational sessions were integrated with interpersonal therapy showed the treatment group had less depressive symptoms and relapses.[131] Although more research in the area of psychosocial interventions is needed,[130] the evidence for the efficacy of family psychoeducational approaches is developing.

4.138 **Major Depressive Disorder.** There is considerable supporting evidence for the clinical and cost effectiveness of psychological approaches to depression. A review

of several studies[132] found that psychological intervention (especially CBT) could produce comparable or superior outcomes to medication in the treatment of depression. In addition pharmacotherapy has substantially larger drop out rates than does psychological intervention. Relapse rates appear to be lower in groups treated with CBT.[133]

4.139 Another study has shown cognitive therapy to be as effective as anti-depressant medication in the treatment of major depressive disorder and its effects were more durable than those provided by pharmacotherapy.[134] The costs of psychotherapy were comparable to those of medication in the short term, and less than those of medication over longer follow-up. A review of the effects of cognitive therapy compared with other treatments[135] suggested it was superior to antidepressants (17 comparisons), psychodynamic therapies (7 comparisons) and interpersonal therapies (4 comparisons). The patients in these studies had major as opposed to psychotic depression.

4.140 Two more recent reviews have compared various psychological therapies for depression.[136,137] An analysis of six controlled studies concluded that short-term psychodynamic psychotherapy, cognitive behaviour therapy and behavioural therapy were equally effective in the treatment of depression.[136] The conclusion of the larger review[137] was that some forms of psychological therapies, particularly those derived from cognitive/behavioural models, are beneficial in the treatment of people with depression being managed outside hospital settings. Using these therapies in individual formats appeared more effective than in groups. There was also some evidence to support the efficacy of psychodynamic therapy and interpersonal therapy(IPT).

4.141 These conclusions were reflected in the Department of Health's Clinical Practice Guideline[113] in which cognitive therapy and interpersonal therapy were recommended for depression and psychodynamic therapy was also regarded to be of benefit.

4.142 **Access to Psychological Interventions for people with Severe Mental Illness.** Accessibility to psychological interventions remains extremely poor within Northern

Ireland. Increasing accessibility to evidence-based interventions for psychosis is a major challenge involving a number of elements. These include:

4.143 **Staff Training.** There is a requirement for training across all mental health professional groups in developing skills of therapeutic relationship building and the use of evidenced based psychosocial therapies.[117]

Good Practice Examples

THORN. *A notable educational initiative in recent years has been the creation of THORN courses at Queen's University and the University of Ulster. These courses provide training for a range of professionals in psychosocial interventions for people with severe mental illness. (Contact:QUB 028 90335742 and UU 028 90522067)*

The Meriden Project in the West Midlands Region *provides in-service, multi-disciplinary training aimed at increasing access to evidence-based psychosocial interventions. It is funded by the West Midlands NHS executive and involves training across 17 Trusts within the region in family intervention. A cascade model of training was implemented with trainers being trained in each Trust to run courses and act as supervisors. To date more than 1500 therapists from all disciplines have been trained and carers' experience of the mental health service in the region has been transformed.*[138] *(Contact: 0121 6235500)*

4.144 **Specialist Teams.** The implementation of evidence-based psychological interventions depends not only on training but also on the creation of service structures compatible with their delivery.[139] One solution is the formation of teams that focus exclusively on the management of psychosis or serious mental illness.[140] Examples of such teams include traditional rehabilitation teams and newer examples in the NHS of Early Intervention and Assertive Community Treatment Teams. Some argue that they provide improved access to psychological interventions and give professionals with specialist training an opportunity to apply those skills. [141,142] Others argue against the creation of specialist teams, both on the grounds of their cost and the creation of over-complex service structures.[143] However, generic teams have been criticised for their tendency to neglect people with severe and enduring mental health problems.[144] Others have noted the difficulty that staff, with specialist THORN

training, encounter when attempting to utilise their skills against a background of high caseloads and lack of organisational support.[145]

Recommendations

General

105. A workforce strategy developing psychological therapy services must be addressed as a matter of urgency.
106. A Northern Ireland-wide training strategy to improve access to psychological therapies and psychosocial interventions must be developed as a matter of priority.
107. Psychological therapy services must be organised in ways that promote the use of psychological interventions in routine practice.
108. Those responsible for prescribing physical treatments in mental illness must be encouraged within a multi-disciplinary framework, to develop protocols for the prescribing, monitoring and review of treatment regimens according to evidence-based guidelines.

Schizophrenia

109. Medication, psychological and social interventions must be integrated within a complete package of treatment, care and support.
110. The choice of antipsychotic should be made jointly by the individual and the clinician responsible for treatment.
111. Motivational interviewing should be available in order to enhance concordance.
112. The prescription of antipsychotic medication should conform to best practice based on the most up to date evidence based guidelines.
113. Antipsychotic drugs, atypical or traditional should not be prescribed concurrently except for short periods when one medication is being discontinued and a different antipsychotic drug being introduced.
114. If a patient has had two anti-psychotics (including one atypical) each for 6-8 weeks without improvement, clozapine should be considered.
115. All families who have a member diagnosed with schizophrenia should be offered family intervention.
116. People with schizophrenia, especially those with residual symptoms should be assessed for CBT suitability.

Major Depressive Disorder

117. In severe illness, treatment with antidepressants is recommended and newer drugs have advantages both in side effect profile and safety in overdose.
118. A variety of adjunctive treatments are recommended for refractory illness.
119. ECT should be available for the treatment of severe depression and may be first line treatment in life threatening situations.
120. CBT and IPT should be available as treatment options in major depressive disorder.
121. Psychodynamic psychotherapies should be considered as treatment options in major depressive disorder
122. The use of ECT must comply with current Best Practice Guidelines of the Royal College of Psychiatrists.

Bipolar Affective Disorder

123. Prevention of new episodes is advocated from as early in the illness course as is acceptable to the individual and their family and on a long term basis, because of the high risk of relapse and progression to more frequent episodes.
124. Service users taking mood stabilisers must have appropriate monitoring.
125. The needs of carers and families of individuals with bipolar disorder must also be considered.
126. Family psychoeducational approaches should be considered for bipolar disorder.

PHYSICAL HEALTH

4.145 People with mental health problems are at increased risk of having physical health problems. Many of the excess deaths of people with severe mental disorder are potentially preventable by better medical treatment and attention to lifestyle, including diet and smoking. Smoking as substance use is part of the specific Review of Alcohol and Substance Misuse. Assessment therefore should cover physical health needs. One approach to identifying and targeting people with more severe and enduring mental health needs is the establishment of case registers at primary care level.[146] Primary and secondary care services, in conjunction with the service user, should jointly identify which service will take responsibility for monitoring physical health. General Practitioners should consider the health promotion of people with severe mental health problems within their practice and regularly monitor their physical health. The NICE Guidelines for Schizophrenia recommend paying

particular attention to endocrine disorders such as diabetes and hyperprolactanaemia, cardiovascular risk factors, side-effects of medication and lifestyle factors such as smoking.[19]

Recommendations

127. The assessment of people with more severe mental health needs must include assessment of physical health needs.
128. Registers should be established of people with severe mental health needs at primary care level.
129. Local providers of services should agree which service (primary or secondary) will take responsibility for monitoring physical health.