

Overview and Scrutiny in Southend-on-Sea



Community Services Scrutiny Committee

“OUT-OF-HOURS MENTAL HEALTH SERVICES”

Final Report and Recommendations

**“The onset of becoming unwell can be rapid so the window of awareness of asking for help and treatment and accepting it is small. This is why I believe proper 24/7 services need to be in place.”
(Service User)**

CONTENTS

Foreword

Scope, objectives and methodology

Main Issues for Scrutiny: the national and local context

Evidence/Findings of the Scrutiny

Discussion of the Evidence

- Compliance with NSF Standards
- Related Issues
 - Staffing and resources
 - Sharing of information/ joint working
 - Place of safety/ safe haven
 - Single point of entry
 - Improvements to service provision

Conclusions and Recommendations

Appendix 1: Evidence from Witness Sessions

FOREWORD

During the Municipal Year 2004/5, the Council's Community Services Scrutiny Committee decided to undertake a scrutiny on the subject of "Out of Hours Mental Health Services". This followed some initial pre-scrutiny work carried out by Councillor Mark Flewitt. The over-arching aim of the study was to examine mental health out-of-hours services in Southend in the context of the National Service Framework (NSF).

We started the in-depth scrutiny project in February 2005, and the Committee held evidence-gathering sessions with key stakeholders in April 2005. We explored with them the extent to which services in Southend comply with NSF standards together with a number of related issues such as staffing and resources, sharing of information/ joint working, the need for places of safety/ safe havens for some mental health patients and the need for a single point of entry to services, all of which can contribute to improvements in service provision.

The report makes nine specific recommendations aimed at improving the quality of service provision for mental health patients and their carers.

We would like to thank all those who have been involved in the in-depth scrutiny project, in particular those who took the time to attend meetings to give their evidence, and our colleagues on the Community Services Scrutiny Committee, together with the officer Project Team.



Councillor Julie Cushion
(Chairman, Community Services
Scrutiny Committee)



Councillor Mark Flewitt
(Vice-Chairman, Community Services
Scrutiny Committee)



Councillor Nigel Baker
(Member, Community Services
Scrutiny Committee)



Councillor Teresa Merrison
(Member, Community Services
Scrutiny Committee)

COMMUNITY SERVICES SCRUTINY COMMITTEE

2004/5 Project – “Out of Hours Mental Health Services”

1. SCOPE, OBJECTIVES AND METHODOLOGY

The Scope of the Scrutiny: Objectives and Outcomes

1.1 In the Municipal Year 2004/5, the Council's Community Services Scrutiny Committee decided to undertake a scrutiny on the subject of “Out of Hours Mental Health Services”. The over-arching aim of the study was to examine mental health out of hours services in Southend in the context of the National Service Framework for Mental Health (NSF).

1.2 The objectives agreed by the Committee were:-

- To compare levels and types of provision of mental health out of hours services in Southend against the expectations of the NSF.
- To assess the extent to which the out of hours services meet the specific standards set out in the NSF.
- To examine the reasons for any service shortfall.
- To identify and examine measures which might be taken to improve service provision.

1.3 The outcomes sought from the study were identified as being:-

- To make recommendations to improve service provision.
- To make appropriate recommendations for the future use of resources for mental health out of hours services.

Methodology/Process

1.4 The scrutiny was carried out by the Community Services Scrutiny Committee supported by an Officer Project Team comprising:-

- Geoff Smalley, Principal Committee Officer and Project Co-ordinator
- Phil Stepney, Director of Social Care
- Philip Howe, Director of Adult Mental Health Community Services, South Essex Partnership NHS Trust
- Jane Whalley, Administrative Support Officer

A small Member group comprising the Chairman (Councillor Julie Cushion), Vice Chairman (initially Councillor Ann Robertson and subsequently Councillor Mark Flewitt) and a representative from the other political groups on the Committee at the start of the study (Councillors Nigel Baker and Teresa Merrison) was attached to the project team in order to give guidance and act as a consultative body during the course of the scrutiny. The project plan for the study was drawn up and approved by the Committee. The scrutiny commenced in February 2005 and ended with the formal approval of the final report in June 2005.

1.5 In order to prepare Members to undertake the scrutiny, an initial presentation was given to the Committee by the South Essex Partnership NHS Trust. This provided an explanation of key concepts underpinning the scrutiny as well as an outline of the national agenda for change and a summary of constraints in implementing that agenda locally. A briefing paper summarising out of hour services provided in Southend was also provided for Members.

This briefing material provided background information for two formal public evidence-giving sessions at which the Committee received oral, written and presentational evidence from a number of key stakeholders.

Evidence Gathering

- 1.6 The Committee took oral and written evidence from representatives of service users, carers and advocates operating in the field of mental health services together with clinicians, including GPs, the Police and Ambulance services.
- 1.7 The stakeholders involved in the oral/written evidence process are outlined in para. 1.9 below. Witnesses were advised of the areas of potential questioning prior to the meeting and, a few days before the meeting, a final list of questions was provided to the witnesses to allow them time to prepare their answers. Stakeholders were given the opportunity to make some initial comments on their work and its relationship with the subject matter of the scrutiny and to provide preliminary written answers to the pre-notified questions which would form the basis of a discussion with Members on the issues raised. At the Committee meeting, Officers took a note of the answers and any ensuing discussion. Following each meeting, a copy of the note of evidence was sent to the witnesses for comment on its factual accuracy prior to publication.

Stakeholders

- 1.8 The Committee received evidence from the following individuals representing the organisations indicated, to whom the Council is grateful:-

18 April 2005

Service Users

Tony Armstrong, Mandy Tanner and Kevin Page

(Preliminary arrangements were also made to receive evidence from a young service user but unfortunately this did not materialise.)

Carers

Kay Wright and Annelies Pratt

Southend Advocacy

Steve Young and Lesley Dickenson

South Essex Partnership NHS Trust

Carmel Stevenson, Ann Bateman and Les Hodgson

28 April 2005

Emergency Duty Team – David Stratford

Essex Ambulance Service – Adrian Maasz

General Practitioner – Dr Colin Adey

Essex Police, Southend Division – Sgt Chris Vale

Written answers

Dr Pauline Roberts, Consultant Psychiatrist and Associate Medical Director, South Essex Partnership Trust.

2. MAIN ISSUES FOR SCRUTINY: THE NATIONAL AND LOCAL CONTEXT

2. Introduction

2.1 The initial phase of the scrutiny exercise involved research into what were considered to be the main issues in relation to the subject matter of the scrutiny at both national and local levels. The national agenda for change as set out in the NSF and the opportunities for and constraints on implementing that agenda locally are outlined below.

2.2 There are two types of Out of Hours Services which can be categorised as follows:-

- Extended Hours: services provided by the specialist day services but where work continues into the evening or weekend as a continuation of services for known service users.
- Emergency Services: services provided for both known service users or unknown people in social or health crisis. They can take many forms of service provision such as simple information giving to intensive medical intervention within the hospital setting.

Modernisation: The National Service Framework

2.3 In September 1999 the Government published the National Service Framework for Mental Health. This Framework set out seven Standards to be used as a baseline for commissioners and providers alike. It gave clear statements as to how a fair and equitable service across the country should be provided for people of adult age (18 to 65yrs) who experience or who might be at risk of experiencing mental illness.

2.4 The NHS Plan was then published in July 2000 building upon the earlier publication. It promised new teams including Assertive Outreach (AO), Crisis Resolution and Home Treatment (CRHT) and Early Intervention (EI) Teams across the country as a means toward ending the 'postcode lottery' of health provision for mental health service users.

2.5 The Mental Health Policy Implementation Guide in 2001 produced clear templates for these new teams and services. The setting up of modern teams was no longer dependent on local agreements or initiatives. Targets and specific services were set before the commissioners and providers that had to be achieved. Encompassed within these new services were clearly stated expectations as to what each service would provide out of hours and for whom.

The Guidance

2.6 The National Service Framework outlines the following:

Standard Three.

Individuals with a common mental health problem should:

- be able to make contact around the clock with the local services necessary to meet their needs and receive adequate care.
- be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist help-lines or to local services.

Standard Four.

All Mental Health service users on Care Programme Approach (CPA) should:

- Be able to access services 24 hours a day, 365 days a year.

This standard also notes that: "Timely access to services reducing delays in assessment, treatment and care can also reduce the risk of relapse and potential harm to the service user and others"

Standard Six.

All individuals who provide regular and substantial care for a person on CPA should:

- Have an assessment of their caring, physical and mental health needs.
- Have their own written care plan, which is given to them and implemented in discussion with them.

This standard implies that carers should know what care is being provided to them and to the person they care for and how to access help when needed.

Standard Seven.

Local health and social care communities should prevent suicide by:

- Ensuring that anyone with a mental health problem can contact local services via the primary care team, a help-line or an A&E dept.

Within this standard a milestone is set that by April 2001 all health authorities should ensure that service users on Enhanced CPA should have a written care plan which explains to the them and their carer and their GP how to contact specific mental health services "around the clock".

- 2.7 Department of Health Guidance issued in October 2001 concerning Out of Hours Care focused very much on the primary care gateway into all services. It stated that NHS Direct and NHS Walk-in centres should work closely with other specialist providers to ensure that service users gain quick and accurate advice about accessing the services they need. A further publication concerning Gateway workers stated that by 2004 there would be 500 such workers identified to enable people to access mental health services as appropriate. It was also expected that those not requiring secondary mental health services would be provided with advice and/or redirection to other services where necessary. Gateway workers can be newly appointed staff but the Guidance also recognised that many such staff exist in the form of Approved Social Workers (ASWs) and Qualified Nurses within Community Mental Health Teams (CMHTs), Emergency Duty Teams (EDTs) and Access teams. Dependent on where they are employed they can work extended hours either within, or in liaison with, A&E depts, NHS Walk-in Centres, EDTs, NHS Direct or Help-lines.
- 2.8 Legislation now makes the Social Care agencies and their partners very clear as to their responsibilities toward carers. The Carers and Disabled Children Act 2000 and more recently the Community Care Assessment Direction 2004 [LAC (2004)] make explicit the need to assess carers needs and to provide for them as appropriate regardless of the cared for person's compliance. This implies that, should carers require services out of hours or in a crisis, then those needs should be met.
- 2.9 The Policy Implementation Guides for CRHT, AO, EI and CMH teams make the following references to out of hours services:-

1.

Crisis Resolution Home Treatment teams

- Run 24 hours a day, 7 days a week
- Work in shift patterns
- Evening shift through to the morning will take the form of on-call
- Medical on-call with visits possible 24hrs a day
- Home visits to known service users available 24hrs a day
- Assessment team for acute assessment available 24hrs a day

2.

Assertive Outreach teams

- Runs from 8.00am to 8.00pm 7 days per week
- From 8.00pm to 8.00am (out of hours) on call arrangements for telephone advice
- CRHT to provide emergency cover for out of hours

3.

Early Intervention Services

- Runs from 8.00am to 8.00pm 7 days per week
- From 8.00pm to 8.00am (out of hours) on call arrangements for telephone advice
- CRHT to provide emergency cover for out of hours

4.

Community Mental Health Teams

- Runs from 9.00am to 5.00pm with flexible approach for known service users
- Consideration for extended hours to match PCLTs and GPs i.e. 8.00am to 7.00pm
- Service users known to CMHT out of hours to utilise services of CRHTs, A&Es and Helplines

Provision in Southend-on-Sea

- 2.10 **Southend and Shoeburyness CMH teams** are staffed by Registered Mental Nurses, Approved Social Workers, and Support Time & Recovery Workers. They also have access to other specialist services such as Occupational Therapists and Psychologists and other Therapists. Psychiatrists form an integral part of the team. Each team has a Team Manager who oversees the work and its allocation to team members. The Team provides a comprehensive service to anyone aged 18 to 65yrs in their catchment area who requires social and health care support. This will sometimes take the form of advice and redirection but mostly will be focused on helping the service user to develop their own support networks and to maintain their good mental health through medication and healthy lifestyles. Much of their work will be problem solving so as to enable the service user to remain in their home and/or community. The CMH team has a close liaison role with the primary care team and particularly with the GP. The hours of operation are as described in box 4 above.
- 2.11 The **Assertive Outreach team** works from 8.00am to 5.00pm 7 days per week but will work extended hours as service users needs dictate. Otherwise the service provided matches that as for box 2 above. At weekends the team operates from Rochford Hospital due to constraints on the site on which the Taylor Centre is situated. The Team is comprised of qualified nursing staff and support workers but has a recognised need for approved social workers to join the team. The Team Manager of this team also manages the CRHT team (see below). The AO team works with service users within the Borough who have serious mental illness and are hard to engage in other services provided. The nature of their illness will mean they require complex care packages necessitating the involvement of a number of professional staff and require intensive support and follow-up. The intervention of this team is based on the building of trust and communication between the service user and carer and the team members. Research has shown that the service user may then be able to understand what their condition requires and so will accept help to maintain their continued good mental health.
- 2.12 Southend has one **Crisis Resolution and Home Treatment team**. The team operates slightly differently to that described in box 1 above in that the team works from the Taylor Centre from 8.00am to 9.00pm Monday to Friday. At weekends the team operates from 9.00am to 5.00pm. Given the constraints of the Taylor Centre, at weekends the team is based at Rochford Hospital. During the out-of-hours period there will be approximately two members of staff on duty. The team is made up of qualified Nurses, Support Staff, Occupational Therapists and Cognitive Behavioural Therapists. There are presently no Social Workers in the team. There is a Consultant Psychiatrist available to the team plus input from a junior Doctor and with a Staff Grade Doctor based in the team from Monday to Friday until 5.00pm. The team will assess individuals who present at Southend A&E and will respond to GP requests for people in crisis. The team will also assist people who are known to other mental health teams and where there is a care co-ordinator under CPA. The team provides alternatives to admission to hospital and will work with people in their own homes (with their consent). Work is time limited and strives to move people back into their own networks or into other support teams, e.g. CMHTs, as soon as practicable.

- 2.13 There is one **Early Intervention service** for the whole of south Essex, based at Runwell Hospital. This service provides early intervention for people aged between 14 and 35 years with a first episode of psychosis. They operate as shown in box 3 above. The principle upon which this team is based is somewhat similar to that of the AO team. Research has again shown that, if intensive assistance is given to people who have a first experience of mental health problems in their own homes, then their illness may last for a shorter period, they do not lose contact with family, work, education etc. and their resettlement back into their networks is easier. Close liaison with primary care is necessary in this team and good transitional protocols between CAMHS, CMHTs, CRHTs and the EI service are also helpful.
- 2.14 In addition to the services already highlighted Southend enjoys a good flexible service from the wide-ranging therapists based at the Taylor Centre. Therapies provided here can be 1:1, group or couple in nature and range from Cognitive Behaviour Therapy, Systemic Family Therapy and Psychotherapy to other therapies as needed. Therapy sessions are provided at times to suit the working patterns of service users and therefore therapists are available from 9.00am to 9.00pm Monday to Friday. Therapy could be provided on a Saturday were the facilities of the Taylor Centre more readily available.
- 2.15 **Extended hours** is a principle also applied to day services known as the Queensway Resource Therapy Centre. This resource provides services to people of the Southend Borough on a sessional basis. These sessions may be 1:1, or in groups and will take the form of talking therapy groups, relaxation and art therapy, or practical training sessions such as the European Computer Driving Licence. The team and its manager have a very flexible approach to the services they provide and will run sessions to meet newly identified needs. They have a very good working relationship with local education establishments to the point where the colleges will provide trainers as required. Currently out of hours groups are run on a Monday, Tuesday and Thursday from 6.30pm to 8.00pm.
- 2.16 All the teams in the Taylor Centre take part (i.e provide sessional staff) in the '**Access team**', which takes all new referrals for the purposes of giving advice, and provides the first or initial assessment of need. The result of this assessment will assist the teams in deciding if the person is eligible for a service and who or what service should take them on. This 'team' does not work out of hours but can advise people on what is available to them at the first point of contact.
- 2.17 **Voluntary Organisations** in Southend currently run evening support services in the form of the Balmoral Centre, Salisbury Avenue; Rethink (RISE) Services and; Coast, Victoria Avenue.
- 2.18 The **Emergency Duty Service (EDS)** for the Borough has been commissioned from Essex County Council and is based at Broomfield Hospital, Chelmsford. This service becomes available when the Social Services departments close down, i.e. Monday to Thursday 5.30pm to 9.00am and Friday 4.30pm to Monday 9.00am. This service will not accept issues that have arisen during the day and need resolving. The EDS would expect the day services to continue working with the person to resolve their difficulty. The EDS will take on work that has arisen out of hours and where the situation is critical, e.g. a MHA assessment or someone's care package has broken down such as homecare. Otherwise the EDS will take messages for the day services and then pass them on when they next open for business.
- 2.19 **Carers** needs must be taken into consideration as much as those of the Services User. Carers will have access to the same emergency services as service users. Experience indicates that at these times they require advice and information or assistance for the cared for person who may be in crisis. From an extended hours perspective carers within the South Essex Partnership Trust are offered support in the form of carers forums, individual counselling or therapy according to assessed need and telephone advice.

Emergency Services.

- 2.20 There are three different levels of emergency services.

- Those available to any person who requires immediate medical help, e.g. A&E, GP surgeries and deputising services, ambulance service, NHS Direct. These are general healthcare services.
 - Those available to known service users or previously assessed mentally ill people who need immediate mental health advice, support or admission, e.g. CRHT as above. (During the day CMHTs, AO, and EI teams provide this help.) These are specialist healthcare services.
 - Those available to specialist mental health practitioners who require assistance with specialist mental health assessment e.g. Emergency Duty Teams who provide ASWs. (During the day CMHTs who employ ASWs provide this service). This is a Local Authority service although it is often provided by staff seconded to the Partnership Trust.
- 2.21 Other emergency support can be obtained from voluntary services such as Samaritans, Rape and Incest Crisis Centres, Mental Health Helplines, Childline etc. Although some organisations will cease or change in function others are present and will take up the challenge. Southend enjoys a good number of voluntary organisations and bodies who focus on mental health.

Operational Issues

- 2.22 The success of any out-of-hours service will be dependent on the availability of suitable buildings, administrative support and having the most appropriate professionally trained staff, including medical practitioners, on duty. Anything less than this will hamper sound operational services. Should the staff not be recruited or the buildings not be accessible and the finances to support all this not be available then what is provided will be something short of the best service. The services outlined above strive to provide what are good, sound, supportive services but there are shortcomings particularly around the use of the Queensway building and its versatility out-of-hours. Security is a major worry for staff and management working there.
- 2.23 Access to prescribed drugs out-of-hours will be mostly through the local pharmacies that are open to the general public. Where particular drugs for depot injections are required then these can be obtained by the nurses from the stores available to the CRHT teams.
- 2.24 The quality of the services provided can be measured in a number of ways. Clinical governance provides a useful framework for this to occur. Firstly, all the services provided by South Essex Partnership are recorded on the database known as Totalcare. This system records what is done, when, by whom and in what amounts. The outputs from this information system can be used for internal management reports but also, and very importantly, for external use such as activity reports for the service's commissioners and various central government departments. Some of the activity is also recorded on Social Services systems for their similar purpose. All activity is recorded ultimately for the benefit of the service user and carer and will be retrievable as expected by the Data Protection Act and the Freedom of Information Act.
- 2.25 Quality and performance is also managed through supervision of staff whether they are a Support Worker or Assistant Director. Every person within these services will be provided with supervision at regular intervals to ensure they are performing to their job description and that they are receiving training and development opportunities. Without the necessary practice development they will not meet registration requirements for their professional bodies and may not provide the best service. The services themselves are open to constant scrutiny through the Executive team, Partnership Board, Service Management Boards and various other meetings with Commissioners.
- 2.26 The development of the new mental health services benefited through local initiatives but they have mostly been steered through the national modernisation agenda that has required them to be constantly updated and to move forward. The Southend CRHT team was evaluated in 2004 and lessons learnt from their experience have been fed into further developments for the Southend team and also for other new CRHT teams across the south of Essex. Complaints and compliments from service users, carers and voluntary organisations also provide a useful source of information on service quality.

- 2.27 The services that are provided out-of-hours are limited in the number of people they can assist only by the availability of staff on duty. Services out-of-hours are targeted at the most seriously mentally ill population and those who are in immediate crisis. There have been occasions when the CRHT reached its capacity of 20 service users but this is rare. Given that the service users are mostly known to the mental health services it becomes manageable in that they can be assessed more easily and risks become easier to gauge. However there is no room for complacency and concerns about capacity of services to provide are reported to senior managers at every opportunity. Southend benefits from good networking and co-operation between all agencies. Where difficulties arise there is a willingness for the agencies to work together to make things work for the benefit of the service user and the carers.

3. EVIDENCE/FINDINGS OF THE SCRUTINY

- 3.1 As indicated earlier in this report, whilst background knowledge and understanding of the issues was obtained from publicly available information, evidence of the situation on the ground in Southend was obtained via the formal evidence-taking sessions with key stakeholders. A detailed record of general comments and specific responses to questions posed by Members of the Committee was prepared. This record of evidence was forwarded to a representative of each individual stakeholder group which contributed to the study in order to ensure that the recorded evidence was factually correct. A copy of the evidence from each witness session is attached at [Appendix 1](#).
- 3.2 For the sake of brevity and to avoid unnecessary repetition, it was not considered necessary to further summarise the findings at this stage but rather to move directly to a discussion of the evidence prior to outlining conclusions and recommendations drawn from the study.

4. DISCUSSION OF THE EVIDENCE

- 4.1 The commentary below relates broadly to the main issues of the scrutiny set out in Section 2, which are themselves set out in the context of the objectives and anticipated outcomes of the scrutiny.

Compliance with NSF Standards

- 4.2 Details of NSF standards which impinge on the subject matter of this scrutiny are outlined at para 2.6 above. [Standard 3](#) refers to the use of NHS Direct for first level advice and referral and the provision of facilities for mental health patients around the clock. With regard to the latter, the view of the Southend Advocacy Service is that the Mental Health Trust is starting to make inroads in providing these services via Crisis Resolution Home Treatment teams (CRHT), Assertive Outreach teams and Early Intervention services, which are the principal organisational focus for providing out of hours mental health services in Department of Health Guidance. However, the Advocacy Service contends that some of these are still in their infancy and lack of resources and staffing difficulties are restricting the level at which these services are currently being provided so that "the Trust continues to fail in its objective of providing 24 hour cover through its crisis team service, and this is why service users frequently have to attend the A & E department out of hours." This view is supported by the service users who gave evidence; although the policy implementation guide states that CRHT should operate on a 24/7 basis, the service in Southend operates on a somewhat reduced basis (see para 2.12 above), primarily due to the constraints of the Taylor Centre. Service users themselves confirmed that the full out of hours service is not available at present and that, in their view, this would best be met by a 24 hour crisis resolution team with a published contact number through which all out of hours needs could be met. This would provide a more cost effective means of meeting patients' needs in that it would result in less admissions to acute wards and less distress for service users and their families. Many service users appear to lack information relating to the out of hours services available and how to access them and the approach of North Essex Mental Health Trust in supplying laminated cards to them with emergency phone numbers would be a simple and cost-effective method of improving the provision of information available. Whilst the initial view of the Trust, as expressed by its representatives at the witness session, was that there is not a huge demand for out of hours services, having heard the evidence from service users, there was an acceptance by Trust representatives that the service did need to be made more accessible.

- 4.3 One service user who gave evidence was led to understand that, upon the opening of the Taylor Centre in October 2003, "there would be a 24 hour coverage by the Southend CRHT". However, his Crisis Plan drawn up towards the end of 2004 indicated that his first point of call in an emergency should be A & E at Southend Hospital.
- 4.4 Whilst it is clear that patients do utilise the NHS Direct phone line, the evidence suggests that they are often not able to use it as suggested in the NSF framework for first level advice and referral on to specialist helplines or to local services. It would seem that patients are often unable to access appropriate advice due to the fact that staff with mental health training are unavailable. The procedure is often to take the patient to A & E which is presumably a consequence of difficulties in accessing the crisis resolution team referred to above.
- 4.5 Standard 4 refers to the requirement for patients on a Care Programme Approach (CPA) to be able to access services around the clock. Although a 24 hour on call service is provided in Southend, the experience of patients and their carers is that this is fragmented and difficult to access due to the fact that there is no single point of entry as a result of the limited development of the various mental health teams, in particular the Crisis Resolution and Home Treatment team which does not yet provide what service users refer to as a "proper 24/7 service". The issue to service users and their carers of laminated cards with emergency contact telephone numbers could be of great benefit.
- 4.6 Standard 6 requires the assessment of the needs of carers and the preparation of a care plan so that carers are clear as to what services are being provided both to them and the patient and to enable them to access help when needed. The scrutiny yielded little information one way or the other as to the extent to which this requirement is being complied with.
- 4.7 Standard 7 refers to the prevention of suicide by enabling mental health patients to contact local services via the primary care team, a helpline or an A & E department. In this context, all service users on enhanced CPA should be given a written care plan which explains to them, their carer and their GP how to contact specific mental health services around the clock. Evidence suggests that service users and carers are provided with a care plan but was unclear as to the information given about out of hours services.

Related Issues

- 4.8 The extent of compliance with NSF standards impacts on a number of related cross-cutting issues which are outlined below:-

Staffing and Resources

- 4.8.1 Preliminary information given to the Scrutiny Committee by the South Essex Partnership Trust stated that "the success of any out of hours service will be dependent on the availability of suitable buildings, administrative support and having the most appropriate professionally trained staff, including medical practitioners, on duty. Anything less than this will hamper the provision of sound operational services. Should the staff not be recruited or buildings not be accessible and the finances to support all this not be available then what is provided will be something short of the best service." (see para 2.22 above). Furthermore, "the services that are provided out of hours are limited in the number of people they can assist only by availability of staff on duty. (Consequently) services out of hours are targeted at the most seriously mentally ill population and those who are in immediate crisis." (see para 2.27 above)
- 4.8.2 Evidence presented during scrutiny indicated that the following staffing shortfalls exist:-
- The lack of social workers attached to the Crisis Resolution Home Treatment team, presumably as a result of more general recruitment and retention difficulties are currently being tackled by Southend on Sea Borough Council.
 - The general lack of medical professionals, in particular psychiatrists, community psychiatric nurses and counsellors. Recruitment and retention difficulties in the psychiatric profession impact directly on the patient experience as a high turnover of psychiatrists means that service users are often seen by a psychiatrist who is not conversant with their case and this can cause considerable distress as they have to go through the whole history of their illness

on each occasion. This is a particular problem with referrals to A & E but also applies to contact with psychiatrists during both day time and out of hours.

- 4.8.3 Another staffing issue which was highlighted relates to the need for adequate training for police officers who are likely to encounter mental health patients. Although support and family liaison officers are usually available to help, there are no specifically earmarked staff who can assist people who have a mental health crisis whether during normal working hours or out of hours. However, the Committee was impressed by the willingness of the police to do their best to adapt where necessary.
- 4.8.4 The Taylor Centre is situated in the Queensway building and houses the Crisis Resolution Home Treatment team. However, the Queensway building has a number of constraints including security for staff and management working there, and this impinges on the work of the team which has had to be based at Rochford Hospital at weekends. The efficiency and effectiveness of the Taylor Centre and the services which operate from it are partly dependent on the building being "fit for purpose" and discussions are being held between the South Essex Partnership Trust and the Borough Council with a view to developing the Taylor Centre as a fully operational 24/7 service.

Sharing of information/joint working

- 4.8.5 The preliminary evidence furnished by the South Essex Partnership Trust stated that "Southend benefits from good networking and co-operation between all agencies. Where difficulties arise there is a willingness for the agencies to work together to make things work for the benefit of the service user and the carers." (see para 2.27 above). Whilst not doubting the veracity of this statement, the perception of service users would appear to be somewhat different in that many patients experience what they consider to be insufficient communication between the various services sometimes leading to misunderstanding and misrepresentation. However, other evidence suggested that regular liaison between, for example, the Emergency Duty Service and the crisis team does take place. A protocol which is in preparation for work between the two services should assist in clarifying roles and responsibilities and this may provide a model for more general joint working. Nevertheless, even the best and most all embracing protocol is dependent on individuals in the various agencies making it work.
- 4.8.6 In the view of the Essex Ambulance Service, "the sharing of information between the services has improved greatly." Consequently, for example, "999 and out of hours" are able to "tag" addresses to highlight patients who might require the out of hours service. This gives details such as name, address and type of medication. Other evidence indicated that there is still some way to go in terms of ensuring that health professionals and others have access to medical/patient records in order to save the service users from having to continually go through the whole of their past history with an unknown clinician, social worker etc. and to enable timely and appropriate treatment to be given. Whilst there are important security and confidentiality issues which must be safeguarded, it is nevertheless essential that progress is made towards the goal of improved access to patients' medical records by all the services which need access in order to provide the best out of hours service and shared or complementary I.T. systems are clearly the way forward in this respect.

Place of safety/save haven

- 4.8.7 The representative of GPs expressed the view that more "safe havens" should be provided for mental health patients when they are in crisis. Currently, the "place of safety" under Section 136 of the Mental Health Act is normally a psychiatric hospital facility where a person is taken who has been detained under that legal provision. Where a patient is likely to place either themselves or others at risk, hospital admission may be the only option to ensure that the individual is kept safe and receives appropriate treatment. Admission under the Mental Health Act requires two medical recommendations, one of which must be from a specialist in mental health (Section 12 Approved Doctor) and an application from an approved social worker. All three parties must agree in order for the individual to be detained against their will.
- 4.8.8 However, in reality, other "safe havens" are utilised where necessary, the main ones being the A & E centre and, in certain circumstances, a police cell. Neither of these are appropriate for a number of reasons, the common factor from the perspective of the service user being that both environments would tend to increase rather than diminish their level of anxiety. The Committee

was keen to explore possible alternatives which would be more appropriate but, as ever, additional resources would probably need to be made available in order to provide such places which would need to deal with extremes of behaviour in a sensitive and compassionate manner. Significantly, the South Essex Partnership Trust is at present examining the possible use of the assessment centre at Basildon Hospital as a “model” safe environment as an alternative to either A & E or the police station.

Single point of entry

- 4.8.9 South Essex Partnership Trust is endeavouring to provide a single point of entry for the services, in conjunction with developing the role of the “gateworker” along with GPs and the PCT. From the evidence received from service users, this might well be the single most beneficial change which would create a seamless service for patients and their carers regardless of when they need help. The hope is that if and when the building management problems referred to at 4.8.4 above can be solved, the Taylor Centre could be used as an assessment unit on a 24 hour basis with care co-ordinators available at all times. All the evidence suggests that such a development, allied to the provision of an emergency contact laminated card to all service users, would greatly improve the service and considerably increase the understanding of patients as to what they would need to do in a crisis situation.

Improvements to service provision

- 4.8.10 Evidence from this study indicates that a number of useful improvements can be made to service provision in the following areas:-
- Staffing and resources, including changes to the management of the Taylor Centre / Queensway building
 - Improved sharing of information, including access to patients’ medical records and improved joint working
 - Improved police training in dealing with mental health patients
 - Provision of a single point of entry for access to mental health services.

5. CONCLUSIONS AND RECOMMENDATIONS

- 5.1 The principal outcomes sought from this study were:-
- To make recommendations to improve service provision
 - To make appropriate recommendations for the future use of resources for mental health out of hours services.
- 5.2 Evidence from stakeholders during the scrutiny indicated that efforts are already being undertaken to improve and modernise service provision. In the light of this and of the requirements of the National Service Framework for Mental Health, the NHS plan, the Mental Health Policy Implementation Guide, the Department of Health Guidance on out of hours care, the Carers of Disabled Children Act 2000 and the Community Care Assessment Direction 2004, we make the following recommendations for consideration and adoption by those individuals and bodies indicated:-

Recommendation 1	Action by
That the security and other operational constraints at the Queensway building be addressed as a matter of urgency to make it “fit for purpose” in order to facilitate recommendation 2 below.	South Essex Partnership Trust Southend-on-Sea Borough Council
Recommendation 2	Action by

The Taylor Centre be developed as a fully-operational “24/7” service accessible to all service users	South Essex Partnership Trust Southend-on-Sea Borough Council
--	--

Recommendation 3	Action by
That, in order to facilitate the implementation of recommendation 2, the staffing shortfalls identified during the study, in particular for social workers and medical professionals such as psychiatrists, community psychiatric nurses and counsellors, be addressed as a matter of urgency.	South Essex Partnership Trust Southend-on-Sea Borough Council

Recommendation 4	Action by
That a single point of entry be developed for out-of-hours telephone enquiries relating to mental health services	South Essex Partnership Trust NHS Direct

Recommendation 5	Action by
That all service users and their carers be issued with a laminated card giving essential information including the emergency out-of-hours telephone contact number	South Essex Partnership Trust

Recommendation 6	Action by
That the proposal by the South Essex Partnership Trust to develop the assessment centre at Basildon Hospital as a model safe environment be supported and that further “safe havens” be developed in order to reduce the use of A&E and police cells for this purpose.	South Essex Partnership Trust

Recommendation 7	Action by
That measures be taken to improve the sharing of information by practitioners, particularly by granting access to patients’ medical records utilising shared or complementary I.T. systems in order to enable the best out-of-hours service to be provided.	South Essex Partnership Trust

Recommendation 8	Action by
That the protocol which is being prepared on joint working between the Crisis Team and the Emergency Duty Team be endorsed and that other measures be undertaken to further improve joint working.	South Essex Partnership Trust Southend-on-Sea Borough Council

Recommendation 9	Action by
That improved training be developed for police officers who are likely to encounter mental health patients, possibly involving the designation of police officers who can assist them.	South Essex Partnership Trust Essex Police

**SOUTHEND ON SEA BOROUGH COUNCIL
COMMUNITY SERVICES COMMITTEE –
IN-DEPTH SCRUTINY**

Mental Health Out-of-Hours Services”

**EVIDENCE SESSION NO.1
18th April 2005**

ATTENDEES

Tony Armstrong (Service User)
Kevin Page (Service User)
Mandy Tanner (Service User)
Steve Young, Service Manager (Southend Advocacy Service)
Lesley Dickenson, Field Advocate (Southend Advocacy Service)
Kay Wright (Carer)
Annelies Pratt (Carer)
Carmel Stevenson (South Essex Partnership NHS Trust)
Ann Bateman, Manager Access (South Essex Partnership NHS Trust)
Les Hodgson, Clinical Lead (South Essex Partnership NHS Trust)

1. INTRODUCTION

- 1.1 The Committee received an update on the timetable and project plan for the study, including an outline of the proposed witness sessions.

2. RESPONSES TO QUESTIONS

2.1 QUESTIONS TO SERVICE USERS

- 2.1.1 The Service Users introduced themselves to the Committee. The Committee was informed that Tony Armstrong (TA) would give a short introduction about himself and then he and Mandy Tanner (MT) would respond to the following questions as previously submitted on behalf of the Committee (additional comments are in *italics*):-

TA I have been a service user for the past 30 years. I am a member of the South Essex Users Involvement Network.

The majority of my use of Mental Health Services have been in the Southend Area.

On Wednesday 13th April, 2005, I, together with my two colleagues giving evidence today, put the various questions you pose, to the 19 members attending the Southend Forum of South Essex Users Involvement Network, and their comments and answers are incorporated in my reply.

It will not be necessary for me to mention the full details of the National Service Framework for Mental Health published by the Government in September 1999, as this

has been covered quite adequately by the South Essex Partnership NHS Trust in their written reply to your questions.

Question 1

If you were to require help out of hours how would you obtain it?

Answer

TA Having read the Trust reply, I would say that most users are aware of the steps needed to obtain help out of hours i.e. emergency doctors; NHS Direct; QUIT between the hours of 8 am and 9pm and A &E, Southend General Hospital.

However there is a lack of information relating to the CMHT. There is no advertised telephone number for the CMHT after 5 p.m. (North Essex supply cards to their service users with the telephone number of their CMHT thereon)

MT I have an enhanced CPA (Care Programme Approach) so my priority is high. This is mainly because I was admitted to a psychiatric ward twice within 12 months

I have Bi Polar and have been a service user for 20 years. In all that time despite trying many different medications I have never been stabilized.

I have been admitted to a psychiatric unit at least 10 times and the majority of times via the police, informal and sectioned, a few times via A and E

I am now supported by the Assertive Outreach Team so I have the phone number of the thus Resolution Team, which I have been told has a Duty Team available till 9pm. After that time I am advised to go to A and E and have that phone number also. These phone numbers are part of my 24 hour service access instructions as part of my Care Programme Approach Contingency and Crisis Plan.

However A and E is not a place I like to go as it makes me feel more unwell. In a crisis I would be very unwell and seeing people with physical injuries would really upset me and freak me out. This is what has happened in the past and resulted in my leaving A and E and being picked up on the streets by the police for acting strangely. By that stage I am very unwell and it can take many police to restrain and arrest me. However if it was not for the intervention of the police I do not think I would be alive today as when unwell I am a danger to myself.

In the past I knew when I was becoming unwell and would try to seek the help I needed, however the fact that I could ask would mean that I was not unwell enough to be taken seriously. I still believe this attitude exists still and you have to be very unwell to receive emergency treatment also because the services are overstretched.

I have an Advanced Directive to aid my treatment and to be taken seriously that I know when I am becoming unwell.

However I would often start to feel unwell on the weekend when no services were available.

Now that I am supported by Assertive Outreach Team I feel much safer as I know they are available to me 7 days a week 9 – 5

The Committee was informed that it was possible to phone Runwell Hospital, who will pass information on, but the delay could lead to persons doing harm to themselves.

The Committee was informed by Mandy Tanner that the Assertive Outreach Team were not normally available to service users, and she was asked not to publicise the

telephone number.

The Committee asked whether any identification was carried showing that help could be obtained when an episode took place. Mandy said that in most cases during an episode the service user would not be in position to remember to take it with them.

Question 2

What works well for you out of hours?

Answer

TA From everyone I have spoken to the best treatment available would be from a branch of the Mental Health Teams that is available 24 hours a day, has access to medical details of the client and who is easily accessible.

MT Out of hours I would try and avoid A and E at all costs The main concern I have is that when unwell I am very high and cannot sleep so I have emergency medication that I use to help me to sleep (lorazepam and sleeping tablets). My psychiatric consultant, GP and Assertive Outreach Worker know this is what I will do and have agreed to this.

Also I would leave a message on the answer service machine of Assertive Outreach Team asking for contact the following day as I felt I was becoming unwell.

If I felt I was really in a crisis state I would try to take myself to A and E and would take my CPA and Advanced Directive with me.

The Committee was informed that nothing works well at the moment due to long waiting times and not being able to be diagnosed correctly.

Question 3

Are you aware of the contingency plan and crisis plan that the care co-ordinator would have given you?

Answer

TA Most service users and carers I have spoken to have heard of a care plan but few have heard of a crisis plan. I note that the Trust say that they had been given a deadline of April 2000 to supply users/carers on Enhanced CPA with a written care plan which explains to them and their carer and their GP how to contact specific mental health services "around the clock."

The first Crisis Plan I was asked to sign was in late 2004. Bearing in mind that I was informed "that when the Taylor Centre opened (October, 2003) there would be a 24 hour coverage by the Southend CRHT", this Crisis Plan showed my first point of call in an emergency was A & E Southend General Hospital. It is a good job that I did not require help, out of hours, under these conditions.

MT Yes I am aware of my contingency plan and crisis plan. Having these plans helps me feel much more supported.

Also I have my Advanced Directive that is very important to me as it alerts both professionals and family and friends to the fact that I am very drug sensitive and can have severe side effects to some medications and need other medication to alleviate these symptoms. it also covers a brief history of what has worked for me in the past and what has not, people who I would like contacted or not, and that I have a rabbit that needs looking after if admitted to hospital as I live alone.

An Advance Directive is a document where you can write down what your preferences are if you become so unwell you cannot express yourself.

I have also made a service user personal safety plan which I am presently promoting to

the Trust.

However the onset of becoming unwell can be rapid so the window of awareness of asking for help and treatment and accepting it is small. This is why I believe proper 24/7 hours services need to be in place.

In the long run it would be more cost effective to the Trust, resulting in less admissions to acute wards and more importantly less distressing to service users and their families and friends.

Tony Armstrong informed the Committee that whilst the hospital was his first port of call, it is not accessible as he would have to ask someone to take him, and he does not like the hospital environment.

Question 4

Do you consider that the various services talk together enough in order to help you when you experience a crisis?

Answer

TA Fortunately I have not had to have a multi-team experience when in crisis but I have colleagues who have experienced this. They all have said that there is insufficient communication between the various services with whatever information has been passed being misrepresented, misunderstood and with some services dealing with matters, which greatly affect the service user, without clearly stating the reasons for carrying out these matters, i.e. using an assessment for one particular situation for another.

MT Yes earlier this year I felt I was becoming unwell (high) and my Assertive Outreach worker quickly the same day got my medication changed by consulting with my Psychiatrist and was ready to use the home treatment team as I really prefer not to go onto an acute ward. Also I spoke to my Assertive Outreach worker everyday until I was more stable.

Part of my mental health problem is every month I have severe low periods where I do not talk to anyone so it becomes quite difficult for my worker to keep in contact with me. However the team works together to phone nearly everyday and leaves messages on my answer phone and often calls at my door even though I do not feel able to see anyone.

It also is good to know they are there if I need them.

This month I did not turn up for my Psychiatrist appointment so my worker was very concerned and phoned the same day and the team tried to make contact with me everyday. When I saw my worker she phoned and made a new appointment for me arranging it to be a later time in the morning as when I feel low there is no way I can make a 9.15am appointment

When I see my Psychiatrist someone from the Outreach team always comes in with me so they know there and then what has been agreed.

I feel without the Assertive Outreach Team I would have been admitted to an acute psychiatric ward earlier this year.

When asked if it was not possible to change the appointment time after a restless night, Mandy said she would then stay awake so as not to miss the appointment, as there is a fear that if she asks for a change there would be a delay in the next visit to the Psychiatrist.

The Committee was informed that there was insufficient communication between service providers.

Question 5

Are the right services available to you when you need them? If not, what would you want or need?

Answer

TA Everyone that I have spoken to on this matter states that the right services are not available and that they would much prefer to have a 24 hour Crisis Resolution Team with a published contact number, available for an "all Out of Hours Service."

The reasons are that if, for example, I needed treatment out of hours, I do not feel that I would get the best service from an emergency doctor who has no knowledge of me. I have attended A & E Southend General Hospital and found that the experience made my illness worse, having to wait to see a triage nurse, in the general waiting area, with drunks, screaming children and others waiting for attention.. I felt that I was on display. Having seen the triage nurse I was shown to an area, more suitable and quiet, but had to wait for several hours before a suitable doctor was available. All in all a very disturbing experience.

In their reply, the Trust has commented upon activities within the Queensway Resource Centre, being held "out of hours". It is my understanding that the Queensway Resource Centre, like many other Social Service premises, will cease to operate "out of hours". Their comments on this appear to show that organisations are available when they are not or will not, in the near future, be available.

I have attempted to obtain advice from the NHS Direct services without success, being told "Do what your doctor has advised". This was after being told that there was no-one available with any Mental Health training.

MT I feel very lucky that I have direct access to the Crisis Resolution Team. However, during the night and early hours of the morning are when I am most vulnerable.

As a carer for my daughter who is twenty three and a university student and also has Bipolar, when in crisis getting emergency help is near impossible. Having not been able to sleep for many days getting an appointment with her consultant is of no use as it is often four to six weeks before she can be seen. The advice given by the Taylor Centre is to go to A and E.

Out of desperation my daughter turned to smoking cannabis to help her to sleep even though she had been anti drugs and never even smoked a cigarette in her life.

I think it is very common for people experiencing a mental health problem to turn to self medication with illegal drugs.

I feel an early intervention team is most definitely needed and available 24 - 7, to prevent the onset of a crisis.

While there will always be a need for a Crisis Resolution team it makes sense that for service users that are aware of becoming unwell the system in place at the moment is not working.

The Crisis Resolution Team needs to be available 24 - 7 and available to attend service users at A and E and the Police Station.

There needs to be a free phone service available 24 - 7 that gives real support and the right advice of services available and able to ensure that you will be seen by the right

professionals to meet your individual need within 24 hours.

The suite at A and E should be made to look more comfortable and ensure that you are accessed within an appropriate time frame.

A police cell should not be seen as a place of safety, however if arrested by the police the relevant people should be able to attend and an assessment made as soon as possible. More training is needed for police on mental health.

A dedicated assessment centre that you can be taken to and receive quality treatment over a few days rather than being admitted onto a psychiatric ward.

This could then mean that within 72 hours you could be home and treated at home by the Home Treatment Team.

The Committee was informed that in 2003 South Essex spent money on the Taylor Centre. The Trust notified Service Users that there would be 24 hour contact, but due to Security problems this has not been available after 9.00pm.

It was suggested to the Committee that the Police need more training to deal with people with mental health issues.

2.2 QUESTIONS TO SOUTHEND ADVOCACY SERVICE

- 2.2.1 Steve Young and Lesley Dickenson informed the Committee that they were commissioned by Southend Borough Council Social Services and are based in Weston Road, offering a 9-5 service. The advocacy service is used by adults, including in-patients at Runwell Hospital. They responded as follows to the questions previously submitted on behalf of the Committee:-

Question 1

If your client were to require help out of hours how would you obtain it?

Answer

As the service provided is only offered between 9 and 5, they do not have any personal experience with service users who require out of hours assistance. They are aware that if the service users are in crisis and they can get there, they go to A & E. Unfortunately difficulties do arise from the fact that medical records are currently stored at a variety of venues within South Essex Partnership MHS Trust. However, this is not an exclusive problem when attending A & E department out of hours. Service users complain about the waiting times to be seen at A & E, and the fact that records are dispersed also means that a history has to be taken (time consuming and tedious for service users), that there is no access to records such as 'Advance Directives' held in the medical records, and finally that users do not feel comfortable waiting in this environment.

Question 2

What works well for you/your client out of hours?

Answer

Whilst this is not in their remit, at a 'User Involvement Network Meeting' it was found that a majority of service users did not know how to make contact with the appropriate agencies. As a result they often over medicate themselves to get through the night or end up at A & E.

Question 3

Are you aware of the contingency plan and crisis plan that the care co-ordinator would have given you/your client?

Answer

We do encounter many service users in our work who are either unaware that they should have a care plan, or are maybe aware that they have one but do not have a personal copy. Service users are also often unaware of what their discharge plan contains, as discharge plans are frequently left until the moment/day of discharge. This is particularly the case for in-patients. Our recommendation would be that the CPA processes begin much earlier in the admission process so that all recommended and agreed needs are addressed prior to and well in advance of discharge.

Question 4

Do you consider that the various services talk together enough in order to help you/your client when you experience a crisis?

Answer

This was also difficult to answer as they do not have enough experience with this issue, but the advocacy team also find it difficult to access service providers.

Question 5

Are the right services available to you when you/your client need them? If not, what would you want or need?

Answer

The Mental Health Trust is starting to make in-roads in providing the services stated in the National Service Framework such as Assertive Outreach Teams, Home Treatment Teams, Early Intervention Teams etc. With regard to 'Place of Safety', the Trust has provided this service for some time now and it is much less of an issue than it used to be. However, the other services are only just beginning to come on-line, and lack of resources and staffing are restricting the level to which these additional and essential services are being provided currently. The Trust continues to fail in its objective of providing 24-hour cover through its Crisis Team service, and this is why service users frequently have to attend A & E department out of hours. In the case example explained at the witness hearing, our advocate found accessing appropriate services for support out of hours especially difficult as neither the Crisis Team, Police nor the Social Services Emergency Duty Team were particularly helpful to her, and simply advised going to A & E department. Given that the client was unwilling to attend A & E voluntarily, it resulted in the Police reluctantly agreeing to attend the home address on the condition that the advocate also attend. This action was totally inappropriate for an advocate, given her lack of appropriate training as a mental health professional and in the fact that it was not within her day/day remit to fulfil such a role.

2.3 QUESTIONS TO CARERS

2.3.1 Kay Wright (KW) and Annelies Pratt (AP) responded as follows to the questions previously submitted on behalf of the Committee:-

Question 1

What is your experience in obtaining help and advice for the person you care for at evenings and weekends?

Answer

KW She was never able to obtain help and advice at evenings or weekends from NHS. She did get some advice from a local GP early morning in his chat time. The usual advice would be go to A & E.

Question 2

What would you consider the most frequent difficulty you experience as a carer outside of working hours?

Answer

KW Time spent in recovery by the service user for the past few months.

AP Informed the Committee that she has resorted to calling the police due to lack of an out-of-hours service.

Question 3

Who would you consider the focus of your concern during the evenings and weekends, you, the one you care for or both?

Answer

KW The one I care for, although I frequently feel frustrated, helpless and extremely distressed myself. We have to rely on close friends and family for support although they have no idea of the trauma carers go through.

Question 4

What specific resources in the community would help you continue caring during a crisis in the evenings and at weekend?

Answer

KW I feel the basic problem is the lack of medical professionals. There are not enough psychiatrists, CPNs, Counsellors etc. If service users and carers had access to those more frequently so that medication and well-being were monitored and awareness by all was paramount, many of the problems would not occur. The waiting period for initial appointment with a psychiatrist is far too long and follow up appointments are far too infrequent.

There is a need for a 24 hour helpdesk/drop-in with professionals who are knowledgeable and capable of offering sound advice. "A problem shared is a problem halved."

The CESP programme was most helpful and informative. I only wish I had been able to glean that kind of information at the beginning of the illness.

The carers education and support programme which provides lots of information regarding illnesses and the help available. There are difficulties with obtaining a diagnosis and it is recommended to go privately where psychiatrists are seen within 3 weeks. The NHS takes approximately 4 months and you rarely see the same person twice. The carers feel that there is a need to see the patient more often.

There are courses run through RETHINK funded by Sainsburys. This information was found via a third party and is widely advertised. The course runs for 10 weeks and looks at all issues covering mental health, carers and professionals.

2.4 QUESTIONS TO SOUTH ESSEX PARTNERSHIP NHS TRUST

2.4.1. Karen Bradford responded to the questions previously submitted on behalf of the Committee as follows:-

Question 1

How do you ensure that service users, carers and the public in general know how to access services both in and out of hours?

Answer

General Practitioners are given a copy of 'South Essex Shared Guidelines for GPs' to aid in the diagnosis of mental health conditions.

We attend service user forums to inform of any service developments/changes.

Staff from the Taylor Centre have given presentations at the Primary Care Conference last October (large audience of G.Ps)

A senior manager attends the G.P. Advisory committee on a regular basis in order to provide an update on services.

The recent appointment of a Gatewayworker is making an impact in developing the links between Primary care and the G.Ps

With regards to 'out of hours' demands on the service Sept have found that the demand was not high, this was audited when the Nursing Liaison service was based at A&E.

SEPT/PCT promote themselves in surgeries, colleges and dentists, they are represented at GP Forums on developing primary and secondary care.

The Trust have recently opened a new 8 bed Assessment Unit on the Basildon site. This unit serves both Basildon & Southend A&E departments. Linking into this unit is the support from the Home Treatment/Crisis Resolution Teams (24 hrs)

When a service user presents in A&E a member of the HTT team will attend to assess the service user if requested by the SHO on duty. Following the assessment if the staff member feels that the service user warrants admission to hospital they will then relay the person to the assessment Unit in Basildon.

All service users should have a crisis plan, which contains the number of the Crisis Home Treatment Team.

Service Users/Carers can attend Listen & learn forums which are held on a monthly basis and facilitated usually by both the Chair and the Chief Executive of the Trust. At the last meeting that I chaired on behalf of the C.E. there was approximately 20 service users/carers attended.

Question 2

What steps have you taken to provide service users with feedback on the actions you have taken to improve services?

Answer

Complaints about services are a method of learning and bring about change. The service user publication "Your News" is an ideal medium for feeding back information and well as service user forums.

Every Quarter each area is expected to compile a report on the lessons learned by that service and also outlines action taken to address the issues in order to prevent a re-occurrence.

This information is feed back to the Performance Dept and the data is published in the Trust report.

It is also shared at the PALS meetings of which there are a number of service users and carers who are regular members.

Question 3

How do you see the single point of entry working for 24/7?

Answer

There are difficulties with accessing the Taylor Centre 24/7 at present this is mainly due to risk factors, staff safety, issues connected with the alarm system etc. The Assistant Director and the Facilities manager for the Borough Council are working together to try and resolve these issues. If access was available out of hours it would be possible to see service users who were in need of this service however it would not replace service users attending A&E if they have medical problems or following an overdose etc.

There is an SHO Psychiatrist on duty 24 hrs at the A&E dept.

GPs can refer and often do refer to the Taylor centre to be seen by the Access Team.

Question 4

What efforts are being taken to create a seamless service for service users and their carers regardless of when they need help?

Answer

The development of the Access Team at the Taylor is beginning to create a single point of entry for the service users. All referrals to the mental health services go through this team and are assessed and signposted to the appropriate service either in secondary or on occasions back to Primary care if this is more appropriate. The recruitment of a Gateway worker to lead this team has had a big impact in a short space of time. It is envisaged that this Gateway worker will start to make closer links within primary care (G.Ps & PCTs) and will assist with bridging the gap between Primary care and secondary services. This will help in creating a much more seamless service for service users and their carers when they are trying to access our service.

Question 5

What is the vision of the South Essex Partnership Trust for services that need to be provided at evenings and weekends?

Answer

The Community Mental Health Teams work 9 – 5, but are becoming more flexible in their working practices, many staff now see patients at 8 am before the service users go to work, others have a preference to be seen in the evenings and this is accommodated where possible.

This flexibility need to be further developed to assist service users with their needs and to provide them with choice but also to move away from the original 9 to 5 service we as an organization are aware that mental health needs cannot always be addressed between these core hours.

As new staff are recruited their contracts will be more flexible.

The Queensway Resource Centre is now open until 9.00pm.

Although the evening service that was originally funded by the Mental Health Grant and was withdrawn has now been incorporated into main stream services and there is some provision of evening groups in the Queensway Resource Therapy Centre,

however it does not yet have the element of a walk in support service that was available when it was grant funded. We are working towards expanding on this provision with existing resources.

2.5 **ADDITIONAL POINTS**

2.5.1 **Service Users**

North Essex issue laminated cards with emergency contact telephone numbers to every service user.

It was suggested that a study is done to find out how long it takes to get help to service users, and children's mental health issues also need to be included in any report that is undertaken.

There is a need for a service that everyone understands, as early response is crucial. Contact points must be readily available, and a nationwide study made of how this is done would be useful.

Kevin Page has been a service user for the past 24 years. Whilst he did respond to the questions, he agreed with the comments made by Tony and Mandy. Kevin now tries to help people who are unable to speak for themselves and acts as their spokesperson at various meetings he attends.

2.5.2 **South Essex Partnership NHS Trust**

An audit of response times after the initial referral call indicated that, in a majority of cases, the patient was seen the same day.

Talks are taking place with Southend Borough Council with a view to making the Taylor Centre a 24/7 service.

The assessment centre at Basildon is for both Southend & Basildon residents.

The need to find a solution to accessing patients' medical history for the various agencies concerned is paramount.

The issue of child psychiatry needs to be looked at in greater detail, because at the moment there are no child psychiatrists employed locally.

**SOUTHEND ON SEA BOROUGH COUNCIL
COMMUNITY SERVICES COMMITTEE –
IN-DEPTH SCRUTINY**

Mental Health Out-of-Hours Services”

**EVIDENCE SESSION NO.2
28th April 2005**

ATTENDEES

David Stratford – Emergency Duty Team
Adrian Maasz – Essex Ambulance Service
Dr Colin Adey – General Practitioner
Sergeant Chris Vale – Custody Sergeant and Mental Health Liaison Officer, Southend Police

1. RESPONSES TO QUESTIONS

1.1 QUESTIONS TO EMERGENCY DUTY TEAM

- 1.1.1 Mr Stratford responded to the following questions as previously submitted on behalf of the Committee:-

Question 1

How do you see your service fitting in with modern MH Services?

Answer

The emergency duty service is provided by Essex County Council under contract to Southend as an emergency social work service. Within the service we are required to meet and respond to any formal request for a statutory assessment under the Mental Health Act 1983 or where the case is such that it cannot wait until the next day. Such situations arise in a number of circumstances – a very common situation is where the Police have detained an individual under Section 136 of the MH Act where, if a police officer finds a person in a public place behaving in a strange or odd manner and believes that detention is necessary in order to assess their mental health state they would be taken to a Section 136 suite (Psychiatric Hospital facility) comprising a “place of safety”.

Other circumstances are where a Doctor has seen an individual and is requesting a formal assessment or where a patient is already an in-patient but may be there on a voluntary basis. Such situations happen regularly outside of working hours. Referrals may also come from CRHT/Outreach/CMHT teams and/or others working within mental health services who may have seen or are concerned about a patient/individual outside of normal working hours.

With regard to EDS fitting into ‘Modern MH services’ the most recent developments within MH services are the CRHT and work is currently in hand to develop protocols between the MH Trusts and EDS regarding referrals out of hours. MH Act assessments require an ASW and this is a statutory service that is the responsibility of the local authority. Whilst some CRHT teams may have ASWs as part of the team it is unlikely that there will be sufficient numbers to provide the level of service currently provided by EDS and many teams currently have no ASWs. CRHT teams will also be working out of hours but it is not yet clear how this will fit in with EDS and this will be

the purpose of the protocol. One possibility is for all requests for MH Assessments referred to EDS to be referred to CRHT in the first instance. Over time it is hoped that GPs and other services will become more familiar with the new arrangements and CRHT developments.

At the beginning of 2005 'Home Start' came into being and this has reduced the number of referrals to Runwell Hospital.

Question 2

How do you prioritise calls regarding MH Crises?

Answer

To provide some clarity to this question, it is first necessary to separate out a request for statutory MH Act assessment from other crisis referrals for someone with a MH difficulty.

All calls to EDS are initially taken by a call handler (S/Info advisor) and information will be gathered and a decision made as to whether this needs to be passed to the social work team.

The Duty S/Wk manager will determine the priority of any referrals with vulnerable persons and children at risk as the highest priority – many referrals for an individual with mental health difficulties will be viewed as vulnerable and very urgent and may therefore receive a priority over other less urgent work. The key areas are 'risk' and 'vulnerability'. The performance target involves a maximum response time of two hours.

EDS frequently receive calls directly from service users who are already known to MH services who may be experiencing a crisis or difficulty but do not require a Mental Health Act assessment. In such circumstances they may be referred directly to another agency/team or given advice. Where an individual is threatening suicide or self harm either a referral to the police or ambulance service will be made depending on the perceived level of emergency. Access to patient/client records has recently been improved.

On average it takes 5 minutes to be assessed under the MH Act and within 2 hours it is hoped that the service user has been allocated an approved social worker.

There are a large number of referrals with regard to mental health issues of young persons, and specialist workers are available as and when required to cover their needs.

Question 3

How would you liaise with the Southend Crisis Resolution and Home Treatment Team?

Answer

There is regular liaison between EDS and the Crisis Team and the planned protocol between the services will assist in clarifying roles and responsibilities.

Question 4

What would you describe as the most difficult issue that you have to resolve for MH and how might this be made easier for the service user?

Answer

For individuals suffering from a mental illness/problem the greatest difficulty has been accessing mental health services outside of normal hours and around the clock. For

many people the boundaries between day and night can become blurred and lifestyles can dictate that difficulties and crises do not always occur between 9am and 5.30pm.

The development of CRHT around the country and better access to MH services 24/7 can mean that people can feel supported and kept within their own home without the need for hospital admission, which for many individuals is preferable to constantly being readmitted to hospital - the concept is simple but requires sufficient resources to make it achievable.

For those suffering an acute mental health crisis that is likely to place themselves or others 'at risk', hospital admission may be the only option to ensure the individual is kept 'safe' and receives 'treatment' where appropriate and necessary. An admission under the MH Act requires two medical recommendations (one must be from a specialist in mental health – Section 12 approved doctor) and an application from an ASW. All three parties must agree in order for an individual to be detained against their will.

In these circumstances, a real difficulty can be the length of time taken to transport the individual to hospital and the availability of a hospital bed. The normal mode of transportation is ambulance and often requires assistance of the police. The co-ordination of this is a task for the ASW and it is normally extremely difficult to co-ordinate thus resulting in long delays, with the ASW often being alone with an unwell individual who may be extremely disturbed and a risk to themselves and others.

Although considerable work has taken place between the emergency services to develop protocols, however the responsibility for ensuring the individual actually gets to hospital rests with the ASW and they are dependent on other services who may also have other priorities and resource-based difficulties.

Where a service user needs to be admitted to hospital, it would be easier for the individual service user if there was a quicker and more effective way of transporting them to a hospital and to guarantee availability of a hospital bed. Delay for those in crisis can create additional stress and anxiety for both service users and their carers. ASWs working out of hours within the EDS undertaking assessments in the community late at night are also placed, at times, in an unacceptable position of having to manage an individual's crisis alone until such time as admission can be achieved.

The development of CRHT should result in less hospital admissions and enable MH crisis to be managed in the individual's own home. For this to be effective there will need to be sufficient resources in CRHT and for hospital admissions out of hours to be confined to those whose condition is so serious that it is unsafe for them to remain in the community at that time.

1.2 QUESTIONS TO ESSEX AMBULANCE SERVICE

- 1.2.1 Adrian Maasz responded as follows to the questions previously submitted on behalf of the Committee:-

Question 1

How do you see your service fitting in with current modern trends in MH services?

Answer

Mr Maasz informed the Committee that the out-of-hours service is subcontracted to "Care UK" and is operated out of the fracture clinic at Chelmsford and employs local GPs. The service operates between the hours of 6.30pm and 8.00am, and service users would ring their GP surgeries where the call is diverted to Chelmsford and the details are taken by a clinical assessor. Referrals are made to the hub doctor, who

speaks to the patient and a clinical judgement is made as to whether a home visit is required.

Many calls from MH patients emanate from the NHS Direct/999 network which are co-located with the Ambulance Service and Social Services Out of Hours team. Emergency Care Practitioners are trained paramedics who have worked in GP surgeries and hospitals, and who are therefore able to make the initial visit, diagnose and discharge patients.

Generally the service user is taken to A & E, but this is not always the appropriate action as, with GP referrals, treatment is accessible at home.

Paramedics receive a small amount of training in mental health issues over an 8 to 10 week period. However, the knowledge and experience gained on the job is of great value when making decisions.

Due to procedural difficulties there is often a long delay in diagnosing the condition and treatment of the service user. In particular, to obtain a Section 136 out of hours is very difficult due to the inflexibility of the system.

Question 2

When called to a person's home out of hours and they are expressing suicidal thoughts, are you aware of what services are available to assist you?

Answer

Mr Maasz informed the Committee that the Police, GPs, Community Mental Health and Psychiatric teams are available to assist in an emergency.

Since January 2005 "999 and Out of Hours" are able to tag addresses to highlight patients who might require the 'out of hours' service. The information holds details such as name, address and type of medication. The sharing of information between the services has improved greatly.

The police also prioritise calls, dependant on the likely risk from service users and ambulance crews would not enter a dangerous situation without police attendance.

In the future mental health must get priority treatment, in particular with regard to additional training for paramedics and ECP to give a broader spectrum of expertise.

Question 3

How do you prioritise calls regarding mental health crises?

Answer

When calls are received during the day, they are triaged to ascertain the seriousness of the situation. Response times are category A – 8 minutes, B – 19 minutes and C – 1 hour.

For calls received out-of-hours they are categorised as P1 – serious responded to within 1 hour, and P2 non serious – response time 4 hours.

There is now a closer relationship between the service user, doctor and out-of-hours team, so that fewer MH patients are referred to A & E. Once the situation has been responded to a fax is sent to the patient's GP with treatment information so that the patient's records can be updated.

Response vehicles have been fitted with computers, so that the attending GP can type their notes immediately and these are downloaded to the Chelmsford hub, for direct referral to the appropriate GP.

The Committee was informed that caller identification is now available and this has cut down the response time by 3 seconds.

Question 4

Do you think that you have the capacity to meet the needs of people with a mental illness when they are in crisis?

Answer

Mr Maasz informed the Committee that in a majority of cases they do, but, there are still many service users who go to A & E when it is not appropriate to do so and there needs to be a closer study of the cause rather than the effect.

There is often a struggle to deal with the initial needs of the MH patient, but once their history is logged, their management is better.

1.3 QUESTIONS TO GENERAL PRACTITIONERS

- 1.3.1 Dr Adey responded as follows to the questions previously submitted on behalf of the Committee:-

Question 1

How do you see your role as a general practitioner in responding to people with a mental health crisis out of hours?

Answer

Dr Adey informed the Committee that he does not take part in providing out-of-hours services, but stated that the service provided by GPs should be same 24/7 with no change in role.

He continued by saying that doctors do find it difficult to give sufficient time to patients with MH problems. The general perception is that persons with MH problems cannot deal with their situation, but this is not the case. More safe havens should be provided for MH patients when they are in crisis.

The Committee asked if a service user ran out of medication how would they obtain a further prescription and Dr Adey stated that contact would be made with the out-of-hours team and the patient would be given either a PCC appointment or an emergency prescription.

If a GP believes that medication abuse has taken place, he must use his/her discretion about issuing further supplies.

Question 2

Do you feel you are aware of services and resources available for people who are in MH crisis?

Answer

Dr Adey confirmed that he was fully aware of the services available, but realised that the majority of these services are not available out-of-hours.

Question 3

What is the most common mental health issue raised with you out of hours and what would assist you in dealing with this?

Answer

Dr Adey informed the Committee that MH issues are usually the same day or night, but sometimes all that is required is some tender loving care.

Service provision is variable dependent upon the service user, especially if they are outside of the 18-65 age bracket and this poses additional problems.

Dr Adey continued by saying that mental health issues can be found in the form of post-natal depression in women who have recently given birth. Young persons can present with depression, which could be a result of bullying, abuse or problems at home. This is a specialist field and GPs are strongly urged not to give prescribed medicines. Often self harm is the way a young person deals with depression and in this instance the information is referred to the Child and Family Health Services.

Question 4

From your most recent experience what resources are needed out of hours for people with mental health needs?

Answer

Dr Adey informed the Committee that the resources are dependent upon the service user, so various issues need to be looked at such as:

- **Communication** – to find out what is required
- **Single Assessment Programme** – to enable MH patients to gain swift access and referrals
- **Action Plans** – for all MH patients containing all of their relevant information

He continued by saying that practice nurses are generally not trained in MH issues, so are not available to be utilised in providing a MH back up service. What is needed above all is an easy means of access to services for both health professionals and patients.

Question 5

How do you liaise with other mental health services?

Answer

Dr Adey informed the Committee that there were links with managerial and clinical levels but not in any formal way.

He continued by saying that the PCT does provide a counselling service which MH patients are referred to by GPs as they do not have the resources to deal with these issues.

There is a need to provide the correct expertise, also meetings with appropriate providers to discover what is actually required, so that available resources can be put to the best use.

1.4 QUESTIONS TO SOUTHEND POLICE

- 1.4.1 Sergeant Chris Vale responded to the questions previously submitted on behalf of the Committee as follows:-

Question 1

How do you see your service fitting in with current modern trends in MH services?

Answer

Sergeant Vale informed the Committee that the police work closely with the 'Criminal Justice MH Team' as there is a link between crimes relating to drugs, alcohol and anti-social behaviour and MH problems. The police are co-operating more fully with other services regarding the provision of information.

Question 2

How do you disseminate information to your frontline staff about resources and policies regarding mental health services and their users? (e.g. Section 136 policies, crisis resolution teams).

Answer

Sergeant Vale informed the Committee that the officers have training days within their work duty rota. Divisional trainers make sure that all the necessary tools are available to provide a better service.

Question 3

Do you have identified staff who can assist people in mental health crisis 24/7?

Answer

No, but there are support and family liaison officers available. Victim Support could also be called upon, but unfortunately they are unable to identify the specifics of a MH crisis. Trained negotiators are available, but are not fully able to deal with MH issues, the prime directive being always to deal with the main situation.

Sergeant Vale was unable to confirm if MH issues were discussed at basic training, but officers are very often self aware,

The system in place at the moment is not flexible enough to deal with MH issues, but the services that are provided are usually high, however the time taken to get services to a custody suite is far too long and often the medical condition of the service user can deteriorate, and sometimes results in self harm.

MH service users are given a dedicated officer, who gives constant supervision with the door of the cell left open, until assessments have been made. This places pressure on officer resources, but does help relieve the anxiety of the service user.

Police officers often have a sixth sense about whether to move the patient to Runwell Hospital and will often decide against it if their behaviour is erratic or they are under the influence of drugs/alcohol, as the officer has a 20 minute journey in the back of a patrol car and safety issues have to be considered.

The Committee asked why a place of safety could not be found away from the police station or A & E so to alleviate the anxiety.

Sergeant Vale informed the Committee that over the last 8 years he also felt that these places were not suitable, but resources were a problem. In Southend once a Section 136 has been issued the appropriate place of safety is Runwell Hospital. His opinion has now changed and he feels that police custody is better in the first instance.

The Committee asked was it time for a new place of care?

Sergeant Vale expressed the view that a more appropriate place of safety should be provided but the facility would need to deal with extremes of behaviour as well as patients who are manipulative. The 'place of safety' should enable them to be treated in a compassionate and sensitive manner.

There are issues that relate to the availability of interpreters for MH patients whose first language is not English. The police do have an approved list of interpreters, but they are not readily available and on average it takes 20 minutes to find one.

The police now make use of language line, so that the initial risk assessment can be made.

The legislation states that a police officer, solicitor and court officer must be called within 24 hours so that a MH patient can be put in a place of safety.

Question 4

How do you ensure a consistent approach to your dealing with mental health service users when working within the Mental Health Act?

Answer

Sergeant Vale had nothing further to add to his response at Question 4.

**Southend-on-sea Borough Council
Community Services Scrutiny Committee**

Spring 2005 Scrutiny Study – “Mental Health Out-of Hours Service”

Questions to NON-GP CLINICIANS

***Responses by Dr Pauline Roberts
Consultant Psychiatrist and Associate Medical Director
South Essex Partnership Trust***

1. How do you see your role as a clinician in responding to people with a mental health crisis out of hours?

Participation in Senior On-call Rota

2. What is the most common mental health issue raised with you out of hours and what would assist you in dealing with this?

Deliberate self-harm, increased availability of appropriate support, counselling for patients not moderately or severely ill

3. From your most recent experience what resources are needed out of hours for people with mental health needs?

Greater availability of Approved Social Workers.

4. How do you liaise with other mental health services?

-

5. What would you describe as the most difficult issue that you have to resolve for Mental Health and how might this be made easier for the service user?

- ***Placement of adolescent patients in need of containment in a crisis.***
- ***Availability of dedicated beds for this age group***