ABC of mental health

Community mental health services

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Every person with a mental illness shall have the right to live and work, as far as is possible, in the community
United Nations (1990)

Community mental health centres should be located in the locality that they serve and provide the base from which multidisciplinary teams deliver the bulk of mental health services for a particular community. A multidisciplinary team may include psychiatrists, nurses, occupational therapists, psychologists, social workers, and counsellors supported by an administrative team. The psychiatrist is the bridge between inpatient and community teams and maintains close links with general practitioners, social services, and voluntary organisations.

Who to refer?

When a referral is considered it is important to remember that mental health services are required to focus on the needs of those with serious mental health problems.

Those in distress in the absence of a mental disorder may be helped in one of several other ways: consultation with their general practitioner is all that is necessary for many people with distressing but brief emotional upsets. Assessment and treatment of mild to moderate depressive disorder should also be undertaken by general practitioners. Other patients may be given advice on self help techniques (such as commercially available relaxation tapes) or referred to a counsellor based in the general practice or to a voluntary counselling organisation.

All patients suspected of suffering from a psychotic illness should be referred for assessment. Similarly, anxiety states, phobias, and obsessive-compulsive disorders can be disabling and will often require specialist intervention.

Organisation of community mental health services

Assessment and short term treatment

All patients referred to a community mental health team will receive a comprehensive mental health assessment. The initial assessment may be performed by any member of the team, since all should be skilled in history taking and mental state examination. Standardised interviews should be used to ensure that important details (such as physical illness, medication, or alcohol consumption) are not forgotten.

Patients with difficulties not needing specialised mental health services will be directed elsewhere, while others may require further investigation (such as by the psychiatrist, the occupational therapist, or psychologist). Treatments offered may include behaviour therapy, cognitive therapy, medication, time limited counselling, and anxiety management.

Crisis intervention

Many situations in community mental health work require an urgent intervention: from an acute psychotic episode to a suicide attempt after bereavement. Community mental health teams should aim to respond rapidly to anyone believed to be

Community mental health centre in a suburban street (Lewin Road, Streatham)

Differing characteristics of minor and severe mental disorders

Minor mental health problems

- Brief, time limited, event related
- Sufferers seek help and advice
- May improve with time
- Best dealt with in person's home and family
- Specialist treatment rarely necessary
- Medication usually contraindicated

Severe mental disorders

- Chronic (may be life long) and disabling
- Sufferers often avoid medical contact
- Deteriorate with time if not treated
- Specialist supervision and treatment required
- Medication usually necessary

These represent the extreme poles of a continuum: in the middle are disorders that may be managed by a combination of available resources. When this involves several agencies, the responsibilities of each agency should drawn up clearly in the care plan.

Advantages of multidisciplinary assessment

- Reduces waiting time for initial assessment
- Ensures attention paid to non-medical aspects of the presenting complaint
 - Patients with mental disorders often require psychological or social interventions
 - The referring general practitioner will commonly have attended to medical problems or started medication
 - Use of standardised assessment interviews by all team members minimises chances of overlooking concurrent physical illness
- Range of treatment options available from early in assessment process
 - "One stop" entry to all mental health services
 - "Seamless" transfer from one discipline to another

The success of community services depends on patients' participation. "Client led" services include patients acting as carers and therapists and being on management committees and appointment panels, and developing advocacy services and employment schemes

in need of urgent assessment, either at their home or at the mental health centre. For reasons of safety, home assessments of new patients should be performed by two members of the team, and this can prove expensive.

After an assessment of a person's situation and mental state, the team may plan a crisis intervention at the patient's home, admission to hospital (using the Mental Health Act if necessary), or placement in a crisis house if this is available.

At a time of crisis people can be helped to bring about positive changes in their coping strategies—so crisis intervention is appropriate for many psychiatric emergencies. Crisis teams must have immediate support from psychiatrists for prescribing drugs and arranging compulsory admission to hospital.

Other agencies

Successful community mental health care depends on the availability of a wide range of services. Patients need good general medical care and housing appropriate to their level of skill in self care and budgeting.

Social services departments offer advice and social support to those with mental health problems in cooperation with health services. Voluntary agencies may provide day care drop-in centres or counselling and befriending services; others give financial aid or run second hand clothes shops. Self help groups of various kinds provide a remarkable degree of support for many sufferers and their carers. Local liaison and cooperation between all these service providers will make the difference between an ordinary system of care and an excellent one.

Key terms in community mental health

Assertive outreach

- Active process in which repeated attempts are made to maintain contact with patients regardless of
 - Their location (at home, in a hostel, homeless)
 - Their reluctance to receive care
 - Their disorganised lifestyle
- Includes actively involving a patient's family and other carers (drop-in centres, day centres)
 - To monitor mental state
 - To promote compliance with medication
 - To improve self care and daily living skills

Key worker

- Mental health worker (such as nurse or social worker)
- First point of contact in a crisis
- Reviews a patient's care plan at regular meetings of patient, carers, and all agencies involved
- Liaises with primary care services, specialist mental health services, and local authority housing and social services

Essential elements in a community mental health service

Community mental health centre

- Located in the community to be served
- Easily accessible to patients and their carers
- Services appropriate to needs of local ethnic minority groups
- Multidisciplinary teams which provide
 - Crisis intervention
 - Non-urgent assessment
 - Range of short term treatments
 - Long term support of severely mentally ill patients in their own homes
 - Long term support of group homes and hostels

Primary care services

- Management of minor mental health problems
- General medical care of those with severe mental illness

User participation

- Patients actively participate in directing development of services

Support from

- Specialist psychiatric (inpatient) service
- Local authority social services
- Local authority housing department
- Voluntary organisations

Cooperation between all agencies facilitated by

- Care programme approach
 - Care plans
 - Coordination by key worker
 - Communication
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Purchaser

- Usually the local health authority or commissioning agency responsible for implementing public health policy

Provider

- The organisation commissioned by the purchasing authority to provide care to a community (such as an NHS trust)
- The mental health worker who provides care for individual patients

Broker (care manager)

- Health or social services worker who manages a local budget to purchase care for an individual patient
- Under current legislation, such budgets are usually held by local authority social services departments (which then act as care managers)
- Mental health workers may have limited access to these funds, in which case they may act as both broker and provider

Severe mental disorder

Services for people with the most severe mental disorders need to be easily accessible to patients and their carers. Traditional care based in large mental hospitals distant from local communities promoted institutionalisation of staff and patients and made no provision for the "assertive outreach" needed to prevent those with the most severe problems from "falling through the net of care."

Closure of many large institutions has significantly reduced the availability of inpatient beds, but there is evidence that their former residents have been well served by schemes such as supported housing in the community. However, the needs of large numbers of people with severe mental disorders who have never been mental hospital patients, or those who have lost touch with services, must not be overlooked.

Site of the former Tooting Bec mental hospital, South London

Case management

The role of the community psychiatric nurse has become increasingly specialised to meet the needs of severely mentally ill patients. Many are case managers who provide long term intensive follow up to patients with the most severe mental health problems—these are patients who are vulnerable to repeated relapses of psychotic mental illness, have had several admissions to hospital, and often show poor compliance with treatment.

Case managers give practical help with social security benefits, housing, and family support as well as administering drugs and advising on other means of coping with psychotic symptoms. Case management services use an assertive outreach approach to prevent patients from defaulting from contact with services—they may offer extended hours of working, including evenings, weekends, and bank holidays.

Community outreach

Outreach teams offer less intensive follow up to those patients suffering psychotic illness who are more likely to cooperate with follow up and to need less support in dealing with social security benefits and housing issues. Often contact will centre on administration of depot antipsychotic drugs at the patient's home or at a special depot clinic.

Shifting the focus to severe mental disorders

The NHS and Community Care Act 1991 separated the roles of purchasers and providers of health and social care. The responsibility for developing community care plans for people with complex needs rests with the local authority. With mental health, purchasers are required to ensure that providers focus on the needs of those with severe mental health problems, and this is reinforced by implementation of the care programme approach.

This complements and extends the provisions of section 117 of the Mental Health Act 1983, which sets out the responsibilities of health and social services in providing aftercare to patients detained under certain sections of the act. The final tiers of provision are the supervision register and supervised discharge, introduced in 1994 and 1996 respectively, which apply to a relatively small group of severely mentally ill patients who require supervision to ensure that they receive the care they need.

Care programme approach

Everyone accepted by specialist mental health services, including all inpatients, must have a comprehensive assessment of their health and social care needs. Then a care plan should be devised and a key worker appointed to arrange its implementation. For most patients, the care plan will be a course of treatment and the key worker will be the person providing it (for example, a psychiatrist, psychologist, nurse therapist, or psychotherapist). The patient will be discharged from secondary care on satisfactory completion of the care plan (or treatment).

Those with more complex needs require a multidisciplinary approach: the key worker should coordinate care and review the care plan regularly with the patient and other members of the multidisciplinary team. This process includes discharge planning for hospital inpatients and involves general practitioners and social workers. Although not mandatory, a case register of those patients with complex needs helps to ensure that they receive regular multidisciplinary reviews.

Changing role of community psychiatric nurses

Case manager

- Intensive, assertive follow up of small number of most severely mentally ill patients living in the community
- Coordinating all aspects of community care (from social security benefits to medication)

Community outreach nurse

- Less intensive follow up of larger number of mentally ill patients
- Regular contacts centred on administering depot medication
- Referring more complex needs to other agencies

Nurse therapist

- Specialised treatments (usually cognitive or behavioural) delivered in defined programme over relatively short time
- May see patients with wide range of mental disorders

Flow chart for developing a community care plan

Levels of community care planning

Criteria for planning a complex care programme approach

- Patients who, as a consequence of their mental disorder,
 - Require involvement and coordination of several agencies
 - Have severe social disability or major housing difficulties
- Patients who have suffered repeated relapse of their illness
- Patients who are subject to the aftercare provisions (section 117) of the Mental Health Act
- Patients who are at risk
 - Of self harm or suicide
 - Of self neglect
- Patients who represent a danger to others

Supervision register and supervised discharge

All health districts are required to maintain a register of patients considered to pose a substantial risk to themselves or others—that is, risk of suicide, severe self neglect, or serious violence to others. The Department of Health estimates that 3000 patients may be included. A care plan should be devised as for the complex (multi-agency) care programme approach, but including a higher level of contact with the key worker and other mental health services. In addition to the provisions of the care plan, these patients should have a risk assessment, which may require input from specialist forensic staff. The decision to place a patient on the register rests with the responsible consultant psychiatrist after discussion with the multidisciplinary team.

Supervised discharge is intended for “revolving door” patients—those who may fail to comply with treatment after discharge from hospital and, as a result, pose a serious risk to themselves or others. They will usually be included in the supervision register and receive a similar assessment and services.

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Further reading

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Aids to assessing risk

Assessing risk is always a multidisciplinary process. It must take account of

- Patient's history—medical and psychiatric case notes; nursing notes; court reports, witness statements, and other forensic material
- Self reporting by patient at interview
- Examination of patient's mental state and observation of behaviour
- Discrepancies between what is reported and what is observed
- Psychological and, if appropriate, other special investigations

Factors increasing risk of self harm, suicide, or self neglect

Self harm or suicide

- Recent discharge from hospital
- Substance misuse
- Previous self harm or attempted suicide
- Stated intent
- Social isolation
- Recent major life event

Severe self neglect

- Social isolation
- Deterioration after refusing treatment or defaulting from aftercare
- Previous “falling through the net”

Factors increasing the risk to others

Mental state

- Paranoid delusions
- Depressive delusions with ideas of killing others
- Morbid jealousy

Dangerousness

- Threats to repeat violence
- Unwillingness to accept treatment
- Sadistic fantasies

Current episode of violence

- Lack of provocation
- Bizarre violence
- Lack of remorse
- Continuing denial

Circumstances

- Persistence of known provoking events
- Alcohol or drug misuse
- Social difficulties and lack of support

History

- Previous episodes of violence
- Repeated impulsive behaviour
- Inability to cope with stress
- Inability to tolerate frustration
- Diminished self restraint
- Sadistic or paranoid personality traits

A lesson learnt

My brother's keeper?

It was a pleasant afternoon in June. I was strolling on Fifth Avenue in New York with my elder brother, an airline pilot. I had arrived recently in America in hunt of a residency and these were lonely days when I looked forward to my brother's incoming flights. His youthful liveliness used to cheer me up.

On this occasion he was not at his best—looking tired and exhausted due to untimely flights and unrecovered jetlags. He mentioned a worsening of the back and neck pain that he had suffered since starting long distance flights. He attributed this to his poor sitting posture and protracted periods of immobility. However this pain was slightly higher in the neck and sounded more severe. Considering the strong family history and his smoking habits I was concerned though not alarmed. He tried to calm me down; he had recently been given a clean bill of health during his routine medical checkup.

I spent the next couple of days with him during which he intermittently complained of the pain. During one of these

episodes I noticed him sweating as well. I now wonder how I overlooked the obvious, but intuition was not strong enough to make me shout for help.

He—a robust, fit person—and I—a novice—decided to call it arthritis.

The next day I saw him off with the rest of his airline crew for a transatlantic flight. It was only six hours later that I heard the sombre news of his sudden death following severe chest, neck, and back pain. I was later told that the pain got worse and involved his shoulders and chest as well. He sustained a sudden cardiac arrest and died within minutes despite efforts to resuscitate him by on board doctors.

This has left me with endless remorse. I had learnt the most precious lesson of my life not from a strange patient but my own brother. Perhaps I should have been more receptive to my intuition and not listened to his unprofessional reassurances.

Mansoor Ahmed, *geriatric registrar, Birmingham*