PILOT PROJECT

Proposed New Model of Treatment and Care in Hertfordshire's Secondary Mental Health Care System

Introduction

The purpose of this paper is to initiate a discussion with stakeholders on a proposed new model of care in Hertfordshire's secondary mental health care system. The proposed model is to support people with an enduring mental health problem and/or those with complex needs who have been in mental health services for 10 years or more. The overall aim of the proposed model is to improve the quality of life of the service user (as detailed below) which in turn will improve the health and wellbeing of the carer(s).

The model is primarily based on:

- The Carers in Hertfordshire mental health involvement project which was set-up in 2007.
- The work undertaken over the past eleven years by the mental health involvement workers (Sarah Williams and Deryn Sparrow) who have met many carers at Mental Health Carer Forums, Carer Support groups, Focus groups, one-to-one meetings, etc., and gathered empirical evidence and anthologies of first-person accounts which highlight common themes, particularly around the lack of support provided by Adult Community Mental Health Services.
- Various meetings with both statutory NHS services and the voluntary sector.
- The Triangle of Care, Carers Included: A Guide to Best Practice in Mental Health Care in England
- The study of the Masters MSc Mental Health Recovery and Social Inclusion at the University of Hertfordshire (achieved by the author)
- Mind report entitled 'Life Support', 2015.
- The Hertfordshire Partnership University NHS Foundation Trust Community Services Review, April, 2018.

Background

Whilst legislation (Department of Health, 1995, 2004 and the Care Act 2014) emphasises carers assessments and policies (NSF-MH, 1999), (Closing the Gap, 2014) strive to support carers, carers' concerns still revolve around the support needs of their relative and at the heart of their desires lies better treatment and care for the person experiencing mental illness (Repper et al, 2008).

Many of the carers we come into contact with care for someone with an enduring mental health problem who experience the negative symptoms of schizophrenia (such as poor motivation, not looking after their personal surroundings, unwilling to try new activities or

to make new relationships) and those with complex needs, who have been in mental health services for 10 years or more. These carers express dissatisfaction with the lack of support provided by Adult Community Mental Health Services. It appears the problems carers experience are unresolved leading to them feeling angry, frustrated, stressed and, in some cases, despairing. Many try to seek help by speaking to commissioners, senior NHS staff and professionals, the voluntary sector, and some attend a number of involvement meetings, though we often hear them say "nothing ever changes".

Whilst Carers in Hertfordshire recognises the key role played by the voluntary sector and organisations such as Mind in Mid Herts, Herts Mind Network, Guidepost Trust, Turning Point, etc., we know from the carers we meet that many of the service users do not access these services and, if they do, it is often short-term. Alongside this, some of the service users may have to wait a long time for a service for example being offered a Personal Assistant by Herts Mind Network. Some of the reasons the carers give for this are:

- The service user experiences the negative symptoms of schizophrenia and/or complex needs and has difficulty in accessing community services (local resources and facilities).
- The service user would benefit from one-to-one support and this is not available or is not offered.
- The current Adult Community Mental Health model relies heavily on one member of staff (i.e. a care co-ordinator or a STaR worker) supporting the service user and having local expertise on the patchwork of services delivered by the voluntary sector.
- Reports that NHS mental health staffing issues appear to impact on the service user's mental health and wellbeing particularly the high turnover of care co-ordinators, waiting to be allocated a new care co-ordinator or, in some cases, the service user does not have a care co-ordinator.
- Reports that NHS mental health staff experience high, complex, caseloads which appear to impact on the time they are able to give to each individual service user.
- Reports of issues around Personal Budgets i.e. completing the paperwork and delays in processing the applications.
- Reports that the Triangle of Care model is delivered inconsistently within mental health services across the county.

Proposed Staffing Model

We propose that a new service model is piloted at one Adult Community Mental Health Centre/Wellbeing Centre (if successful it would be rolled out across the county) to offer a recovery-oriented service which recognises that mental health and social problems are inextricably linked. The team would take a joined-up approach and effectively work together to provide a holistic, person-centred, tailored package of care to meet the individual's needs in terms of practical support i.e. with daily living skills, emotional support and social support. The team could consist of unqualified staff who:

- Have a good understanding of mental health/complex needs and the recovery model.
- Are well trained in communication.
- Are trained in the Strengths model.
- Able to provide a mix of practical, emotional and social support together with information and advice.
- Have expertise in local resources and facilities.
- Willing to go the extra mile.

An example of the staffing team model could consist of - keyworkers/primary workers, recovery coaches, peer support workers, volunteers, mentors, befrienders …

The team could be overseen and supervised by a qualified member of staff such as a care co-ordinator, social worker, community psychiatric nurse ...

The Role of the Team

The team will work with the service user as a 'team' with one member of staff designated as a keyworker/primary worker. Embedded in the culture of the service is the establishment of a therapeutic alliance between the service user, the carer, and the mental health care team (The Triangle of Care model), as central to the recovery process. A member of the team would carry out an initial needs assessment with the service user and the carer(s) which would be based on shared-decision making and agree a support plan and a contingency plan for a set period of time.

The plan would clearly state the role of the service user, the carer(s) and the team to enable everyone to be clear who is involved in providing practical, emotional and social support and foster effective joined-up working. It is fundamental that the service user, carer and team effectively work together to monitor progress, set-backs, and identify additional needs such as signposting to other organisations.

One of the main aims of the service will be to provide goal-orientated support on a one-to-one basis to enhance people's quality of life, build their self-confidence, and improve mental wellbeing and aid recovery (Mind, 2015).

Whilst traditional models such as the Recovery Star and Health and Wellbeing Plans are widely used in Hertfordshire, we propose a new model – the Strengths Assessment (Rapp & Gosha, 2012). This is a person-centred support plan which focusses on the service user's needs, aims and ambitions and highlights four domains of life: qualities/attributes, talents/skills, environmental strengths, and aspirations (more information can be provided). A key aspect of the plan would be to keep people connected with each other and the wider community, providing opportunities for social interaction, and support the service user to access community services, voluntary services and employment services.

As an example, the team could offer the service user an initial 12 sessions tailored package of support to meet their individual needs which could be assessed at 3 weeks, 6 weeks and 12 weeks. This allows the service user, carer and the team to monitor progress and identify additional needs such as signposting to other organisations.

Many of the carers we have met over the past 11 years have views and ideas about what services in the community would benefit service users and many of these are reflected in the Mind Report 'Life Support', 2015. The role of the team would be to provide:

Advice and support - information, advice and support on issues like debt, housing, benefits, social welfare and legal problems etc. and practical help with filling out complex forms such as benefit related forms.

Home support and day-to-day living - help with shopping, cooking, managing paperwork like bills and utilities, and keeping the home tidy.

Befriending and social interaction - keep people connected with each other and the wider community, providing opportunities for social interaction. In Hertfordshire, these services are primarily provided by organisations such as Mind in Mid Herts, Herts Mind Network, Guidepost Trust, Turning Point, etc. Alongside this, New Leaf - The Hertfordshire Wellbeing College offers a range of free educational courses to help people take better control of their wellbeing by helping them to increase their knowledge, skills and promoting self-management.
Note: The mental health carers we are in contact with are aware of the range of services provided in Hertfordshire. However, the main issue is that the people they care for need support to access these services and this has not been offered / is not provided.

Information and signposting services - direct people towards other local services that can help them.

Service Criteria

The service user has an enduring mental health problem such as schizophrenia and/or complex needs.

The service user has been with mental health service for 10 years or more.

The service user is willing to fully engage with the proposed team and the service.

If the service user has a carer, they are identified and included in the service user's support plan and ongoing treatment and care.

Key aims of the service

To help service users with everyday tasks associated with living independently by providing practical, emotional and social support together with information and advice.

To improve the health and wellbeing of the carer(s) by providing good treatment and care for the service user.

To enable service users to access a wide range of local resources and facilities (i.e. community services, voluntary services and employment services), and keep people connected with each other and the wider community, providing opportunities for social interaction.

To help the service user to gain a better understanding and manage their mental health problems, improve resilience to problems, cope better and be able to help themselves.

To help the service user to build self-confidence to enable them to exercise choice and control in relationships with services and in their wider lives.

The staff team to build effective partnerships with Hertfordshire's voluntary sector and have robust expertise on what they offer.

Evaluation

Our research should identify whether there is an existing model already working effectively in practice and a robust evaluation tool in place. This would be used to measure and demonstrate the impact of the interventions in terms of outcomes and health impacts. If not, or alternatively, we would suggest we co-produce a framework for measuring and demonstrating the impact of the proposed new service.