SOCIAL SERVICES

Shirveishyn Y Theay

Mental Health Service

July 2009

Caring for the Nation ~ Jeeaghyn mysh yn Ashoon

Modernisation of Clinical Practice and Service Delivery

A consultative document

Isle of Man Government

Reiltys Ellan Vannin

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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Dear Colleague

Welcome to this consultative document that sets out our vision for developing the Mental Health Service.

I use the word 'vision' advisedly as in compiling this document contributors have been mindful to balance aspiration against what can be realistically achieved within the resources – human and financial – we may have at our disposal.

Recovery is at the heart of all that we in the Mental Health Service seek to achieve and it has also been the driver for this document.

But this is only the beginning. What you have before you is a living document that will be updated; one that can adapt to change as indeed all of us in the Mental Health Service must do if we are to achieve what we have set out in our mission statement:

'To provide a recovery-focused, effective and efficient mental health service for the population of the Isle of Man'.

Thank you for your support.

Steve Chell
Assistant Director of Social Services (Mental Health)

INVESTOR IN PEOPLE
Fir-Tashtee Pobble

CONTENT

PREFACE

This document outlines the vision for the Mental Health Service, identifies possibilities for developing existing services and should be seen as the start of a modernisation and improvement process involving service users, carers, partner agencies and staff.

In drafting this document contributors have been mindful to reflect on:

- (Why) Do we need to change?
- Who and what can change?
- How can we make change happen?
- Is the right range of interventions being provided to manage risk and meet expressed and assessed need?
- Can we deliver the service more efficiently?
- Are the right numbers and type of staff in place?
- Are services delivered in a timely and acceptable manner?
- Are there barriers to access/success?
- What role should the service play in supporting other agencies in a more skilled and responsive way?

Isle of Man Government Statement Strategic Plan

'To maintain and build on the high quality of life enjoyed by the Island's community'.

Social Services Vision Statement

'Putting people first – promoting independence, opportunity, protection and inclusion. To provide the high quality public services the people of the Isle of Man should expect and to do so effectively, fairly and sensitively.'

Mental Health Service Vision Statement

'To provide a recovery-focused, effective and efficient mental health service for the population of the Isle of Man'.

The Mental Health Service will:

- Provide a service in the right place, at the right time, with the right results;
- Clarify distinctions between primary and secondary care services;
    - Development of primary care mental health services in conjunction with primary care colleagues;
    - Review eligibility criteria for all secondary care services;
- Nurture a culture of positive risk taking and innovative practice;
- Ensure service delivery outcomes are defined then measured;
- Emphasise integrated, multi-disciplinary working - with reference to core capabilities and engagement; ensure provision of clear evidence-based high quality services;
- Support, recognise, reward and invest in our people, ensuring the service seeks to recruit and retain a motivated, skilled and committed workforce;
- Enhance collaboration with partner agencies to maximise service provision and minimise duplication;
- Encourage involvement of service users and carers;
- Embrace financial governance, devolving (as far as reasonably practicable) responsibility and accountability for cost effectiveness and value for money;
- Develop the leadership capacity and capability of its workforce, recognising effective leadership is fundamental in motivating people and achieving success;
- Embrace a holistic approach to wellness – focusing on cultural needs, social inclusion, social responsibility and individual creativity.

The modernisation process will present a number of advantages, including:

- More appropriate access to mental health services;
- Treatment at home as an alternative to hospitalisation;
- Earlier discharge from the inpatient areas;
- Increased choice of treatment options;
- Increased support for carers and families;
- More opportunities for greater family/carer involvement in treatment plans;
- Reduction of repeated admission;
- Reducing the perceived stigma of admission;
- Encouraging family and social networks;
- Improved continuity of care;
- Cost efficiency.

1 INTRODUCTION

1.1 Mental illness is life-changing. At any one time in the UK one in four people will have a mental health issue, and one in six a diagnosable mental health problem (MIND: www.mentalhealth.org.uk /DoH cited in www.mentality.org.uk).

1.2 Contemporary literature indicates that to be truly effective, mental health services must intervene as early in the onset of a condition as possible, seek to mitigate the negative impact as much as possible and be accessible to and aligned with the overarching aim of recovery.

For the purposes of this document recovery will be defined as:

> "...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."
>
> *(Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. Psychosocial Rehabilitation Journal, 16(4), 11-23.)*

2 PRINCIPLES AND VALUES

2.1 This document, whilst encompassing the whole spectrum of mental health service delivery, provides a broad-brush outline of activities and makes recommendations for development.

2.2 Strategic intent is based on the values and principles of the recovery model - i.e. the Mental Health Service should be: service user-centred, carer focused, non-stigmatising, inclusive, accessible, seamless, safe, high quality, evidence-based and cost-effective.

2.3 The Service must ensure people are treated in the right place, at the right time, with the right results. This will require a shared understanding of eligibility criteria, consistent care pathways and clear key performance indicators to help drive service development and contribute to health improvement in the Isle of Man.

In so doing:

- 'The service will engage with and include service users and carers at every opportunity;
- A policy of social inclusion will improve service users' lives;

- The Mental Health Service will aim to deliver targeted services with clear eligibility criteria;
- Services will be delivered at a local level wherever possible;
- The Mental Health Service will work in partnership to ensure its services are part of, not separate from the community;
- The Mental Health Service will be sensitive to cultural needs;
- Services will follow best practice and up to date research, at the same time seeking to encourage positive risk taking in the interests of its users;
- The Mental Health Service will support, recognise, reward and invest in its people and seek to recruit and retain a motivated, skilled and committed workforce;
- The Mental Health Service will encourage and provide opportunities for professional development and progression;
- The Mental Health Service will encourage recovery and individual creativity, embracing an holistic approach to wellness;
- The Mental Health Service will promote a wider understanding of mental illness;
- Treatments offered will be evidence-based;
- Outcomes will be audited;

2.5 **Financial Perspective** - For the service to be viable we must focus on:

- Cost-effective care – within budgetary constraints;
- Supporting our people to improve service delivery;
- Expanding revenue opportunities where appropriate/feasible;
- Developing and monitoring partnerships;
- Ensuring financial probity, sustainability and productivity in accordance with Standing Orders and audit systems.

2.6 **Service User Perspective** - To achieve our vision we must:

- Demonstrate continued clinical and operational excellence;

- Review customer values;
- Maximise health and wellbeing through high quality safe services;
- Model services around the user's journey based on their individual needs.

2.7 **Internal Perspective** - To satisfy our service users we must ensure:

- The right numbers of people are treated, in the right place, at the right time, with the right results.

2.8 **Learning and Growth** To sustain our ability to change and improve we must:

- Clearly communicate expectations and accountabilities;
- Create an environment to support service user/carer/employee engagement;
- Develop leadership/management talent;
- Recruit/retain high calibre people;
- Develop an IT network that supports service improvement;
- Engage clinicians in the leadership and development of our services.

2.9 **Corporate Governance Issues –** We will:

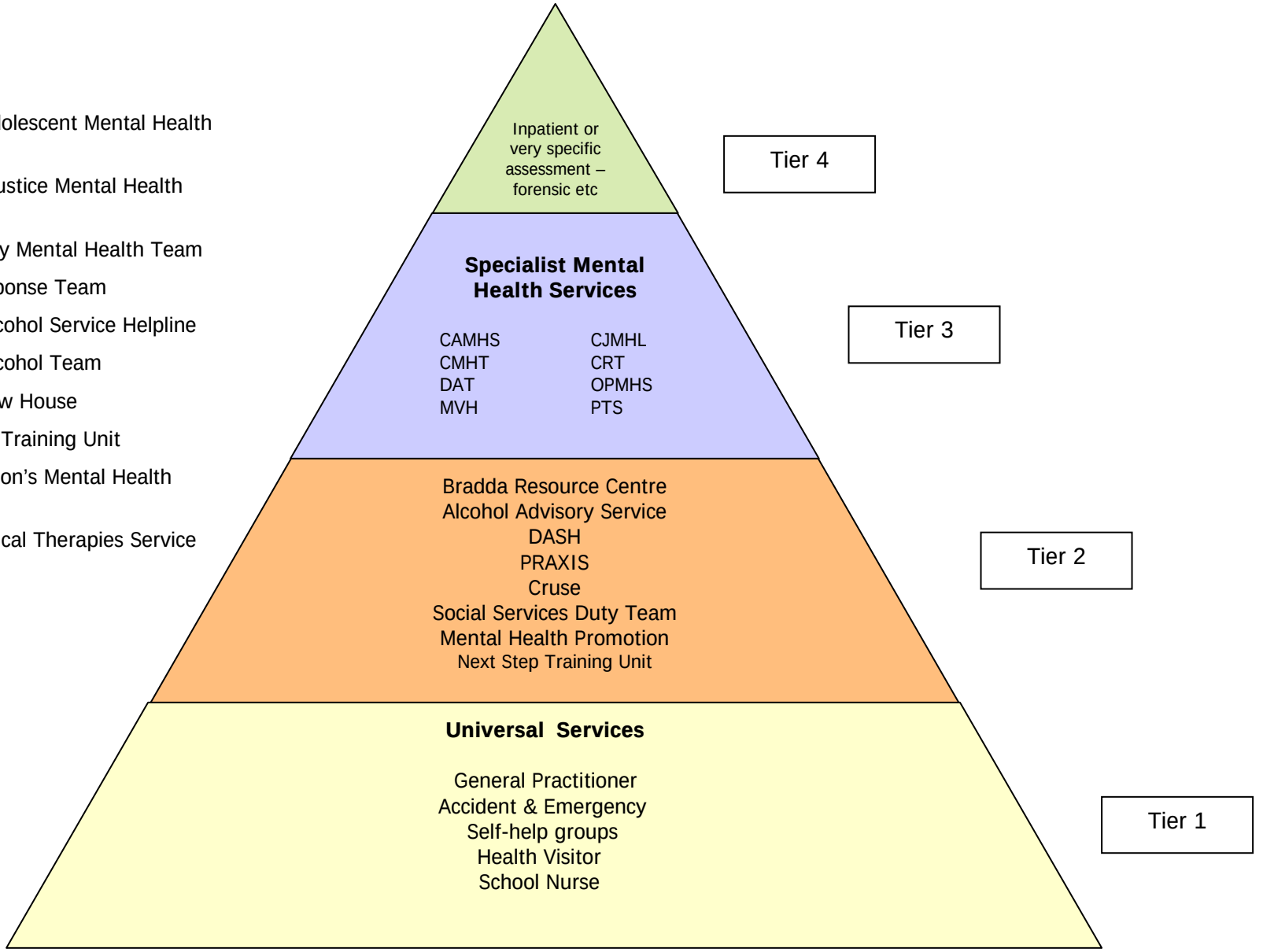
- Implement robust systems - supporting accountability via risk, financial and performance management processes;
- Establish a leadership style with vision to clarify strategy, objectives, roles and responsibilities;
- Develop the leadership capacity and capability of our workforce to motivate our people to contribute towards the success of the service;
- Develop a culture of open and transparent communications within a clear framework of accountability;
- Apply an external focus on service users' and the wider community's needs and work with all partners to reduce health inequalities and improve the health of our community;
- Meet all standards and compliances for health and social care.

2.10 To facilitate such intent, care must be tiered, ensuring people are managed optimally by those with the appropriate level of competence and guided by clear care pathways and eligibility criteria.

2.11 **Tiered Model of Service Delivery**

Abbreviations

CAMHS	-	Child & Adolescent Mental Health Service
CJMHL	-	Criminal Justice Mental Health Liaison
CMHT	-	Community Mental Health Team
CRT	-	Crisis Response Team
DASH	-	Drug & Alcohol Service Helpline
DAT	-	Drug & Alcohol Team
MVH	-	Mount View House
NSTU	-	Next Step Training Unit
OPMHS	-	Older Person's Mental Health Service
PTS		Psychological Therapies Service



3 THE WIDER CONTEXT

3.1 As in similar strategies in the United Kingdom. [See Appendix 2] core documents have informed the development of this strategy.

4 RECOVERY

In order for the Service to move forward and be in a position to respond to a changing health/social care environment it needs to embrace the development of a recovery model of practice.

4.1 Mental illness is often associated with diminished social standing and a changing relationship between the individual and the community. The recovery model seeks to strengthen that relationship. Recovery is not only about social functioning or clinical symptoms, but also about social integration. The Service should support individuals to develop strong personal identities not defined by illness. Such a practice model results from skillful use of effective treatments and nurtures the restoration of hope and ambition for living purposeful lives.

4.2 Interventions must be provided in a manner responsive to characteristics such as race, gender, age, culture and disability. They must also take account of social, spiritual and practical needs, recognising that diversity demands an eclectic range of services. There is a need to foster a shift from entanglement or passive dependency on services to an active stance positively encouraging/supporting independence and self-management.

5 SERVICE PROVISION

5.1 Grianagh Court Admission Unit

i) Provision must be underpinned by a clear definition of 'admission criteria' and acknowledgement that all alternative clinical options have been excluded;

ii) There must be service-wide agreement on admission, and discharge planning must begin before or at the point of admission;

iii) Care is delivered in the least restrictive environment consistent with clinical and safety needs. Clear protocols and procedures are developed in relation to intensive care as the preferred alternative to seclusion;

iv) The physical environment of the in-patient area will need to be reviewed. As far as reasonably practicable, there must be less emphasis on the division of staff/service user areas, with a greater availability of space and facilities to stimulate engagement, interaction and recreation;

v) The staff of the in-patient unit are key to ensuring that each in-patient becomes engaged with the service and has all their needs met. The named nurse system

ensures that each in-patient is assigned an identified nurse available to them on each shift. There is an expectation that every in-patient has dedicated nursing time on a one-to-one basis for each nursing shift. It is vital all in-patients' information be in one case file with contemporaneous note keeping, ensuring patients' details are fully documented, the ward team advised of developments, care planning meetings co-ordinated and information shared with community care co-ordinators. In addition, carers should have a clear point of contact with a named nurse and doctor;

vi) A ward-based therapeutic activities programme is available every day including evenings and weekends, delivered by ward-based occupational therapists in conjunction with registered nursing staff;

vii) Regular means/forums for augmenting service user/carer involvement will be actively pursued. Ward-based meetings for those (currently) in receipt of in-patient care will be encouraged**;**

viii) Clinical psychology input into in-patient areas will be increased with defined and dedicated sessional commitment. The psychology role includes assessment and therapy, with input to staff training and supervision to enable development of therapeutic skills. This will assist the provision of high quality in-patient care, with active therapeutic engagement led by competent and motivated staff;

ix) Consultant psychiatrists are ultimately responsible for the care of in-patients and must conduct multi-disciplinary meetings for each in-patient every week. These meetings will review current progress, plan future therapeutic input and examine discharge arrangements. Every meeting will address the question of whether the service user still requires in-patient care and explore the possibility of discharge. The meeting will be attended by the service user (and the carer where appropriate and possible), consultant psychiatrist and multi-disciplinary team, named nurse or team representative, community care co-ordinator, and other professionals involved in the service user's care. Decisions made at the meeting will be clearly documented;

x) While a service user is in receipt of in-patient care, community care co-ordinators will maintain consistent and continuing contact;

xi) The interface between the Crisis Resolution Team (previously Central Referral Team) and Grianagh Court will be improved with one manager responsible for the two areas

5.2 Central Referral/Crisis Response Team (CRT)

i) The National Service Framework for Mental Health outlines the need for the development of Crisis Resolution Teams. The aim is to offer an alternative to admission for those individuals experiencing acute crisis in their mental health, with emphasis on treatment within the home environment wherever practicable. In order to enable the Service to meet need more effectively, the current Central Referral Team will change focus to become a Crisis Resolution Team while maintaining its current central referral function;

ii) The Crisis Response Team (CRT) will have the gate-keeping function for adult inpatient beds while Older Persons Mental Health Service (OPMHS - formerly OPAS) will retain the gate-keeping function for older adults. Patients will only be admitted after an assessment by CRT or OPMHS if home treatment is deemed an unsafe option;

iii) In order to avoid the more restrictive option of in-patient treatment, comprehensive packages of care will be developed in conjunction with care co-ordinators, service users, carers and consultant psychiatrists. Similar provision will also be jointly developed with Day Treatment. (As Day Treatment is currently provided in the acute inpatient area it is strongly influenced by "an inpatient philosophy" and is often referred to as "an inpatient stay without a bed");

iv) In the UK, Crisis Response Teams and community-based Day Treatment Services offer options other than hospital admissions. It is therefore proposed that Day Treatment and CRT be combined;

v) Consideration will be given to developing more localised Day Treatment provision to allow for a more therapeutic environment and comprehensive packages of care to be implemented outside the inpatient arena;

vi) More robust packages of care and the possibility of home treatment will offer an alternative to compulsory admission under the Isle of Man Mental Health Act 1998.

5.3 Rehabilitation and Recovery Service

5.3.1 Tynwald Terrace – New build (Geddyn Reesht)

i) A facility for up to 14 people offering treatment and rehabilitation for those with complex needs. The service could be accessed directly for relapse prevention work, short re-admission for stabilisation, dual-diagnosis, relapse prevention and rehabilitation programmes of varying intensity;

ii) It is important that accommodation be appropriate for service users off-Island, detained under the Mental Health Act and experiencing intractable psychosis and/or personality disorder. They are initially transferred to the UK because of their need for secure accommodation and, after time, are transferred to open rehabilitation wards. Geddyn Reesht will have the facility to provide care to service users who require a degree of security while offering an environment conducive to rehabilitation. This will enable some service users off-Island to return, with subsequent cost savings.

5.3.2 Staffing of Rehabilitation Service

i) Quality rehabilitation should be provided with a dedicated Consultant Psychiatrist trained and accredited in rehabilitation psychiatry. This consultant post will be responsible for rehabilitation of those outpatients who fulfill assertive outreach criteria and have augmented community outreach care, also possibly for service users in the criminal justice system.

ii) Provision of appropriate secure and open rehabilitation would require additional skill development. There must be a full multi-disciplinary team with the inclusion of psychology (with appropriate training in cognitive behavioural therapy and forensic psychology for the seriously mentally ill) and occupational therapy.

iii) The Rehabilitation and Recovery Service requires a Clinical Nurse Specialist. Such a post would be instrumental in developing clinical practice, enhancing multi-disciplinary collaboration and fostering closer links with partner agencies. Emphasis would also be on developing the learning environment. The Clinical Nurse Specialist will develop/co-ordinate assessment, placement and review of UK placements with the exception of Child and Adolescent MHS and the Drug and Alcohol Team.

5.3.3 Respite

i) Traditionally, respite has been seen as a benefit to the carer but increasingly has also been viewed as beneficial for the person with mental illness. In the past, service users have accessed respite beds within the hospital environment. This is now deemed inappropriate, the service user risking loss of independence, autonomy and responsibility. It is proposed that a respite function be maintained but as a component of the service level agreement with partner agencies.

5.3.4 Accommodation

i) Service users must be supported within their own home as far as practicable. It may be possible to extend the Ballamona Association for Mental Health property portfolio but this could only be viable if the Association were to adopt a more "hands on" approach in relation to property management, maintenance and rental arrangements. There are many examples in the UK of charitable organisations (and private landlords) developing supported rental property for people with mental illness.

ii) Partner agencies' roles in providing accommodation will be reviewed, to consider extending their function and exploring the viability of other agencies coming to the Island, e.g. Re-think, Mind etc.

5.4 Community Mental Health Team (CMHT)

i) Living on an Island with a small population, economy of scale dictates that local teams need to be flexible and remits may not be as defined or specific as they are in the UK. It is suggested that the Community Mental Health Team (CMHT) approach should continue to be eclectic and based on a holistic assessment of need.;

ii) It is important to acknowledge that the CMHT has experienced a period of significant change, having evolved from two separately managed teams to adopt an operational model incorporating one senior manager plus two deputy managers (in half-time managerial/clinical posts) and maintaining a north/south geographical divide. A move is planned during 2009, when the team will relocate to the Central Community Health facility in Douglas, which will involve the integration of the whole multi-disciplinary team;

iii) It is anticipated the move will facilitate the recently introduced Care Programme Approach (CPA) and introduction of integrated case records, both of which will put an increased emphasis on the care co-ordinator responsibilities of Community Mental Health Professionals (CMHPs);

iv) The CMHT in its current guise represents a core area of service delivery, providing a link between primary, community and acute care. It is accepted that it has an important integral role to play in supporting a diverse range of people who use services and family members with multiple needs;

v) In line with the UK DoH (2002), Policy Implementation Guide, the CMHT performs functions for those service users needing specialist care for:

- Severe and enduring mental disorders associated with significant disability (predominantly psychoses such as schizophrenia and bipolar disorder but also unipolar depressive disorders);
- Longer-term disorders of lesser severity;
- Disorders where there is significant risk of self harm or harm to others or where the longer-term nature exceeds the acute intervention Crisis Resolution Home Treatment Teams could offer;
- Complex problems of management and engagement such as presented by service users requiring interventions under the Mental Health Act;
- Personality disorder;
- Dual diagnosis.

vi) An assertive outreach function will be developed within the CMHT. This 'sub-team' will focus on those with severe mental illness, with emphasis on:

- Social disability;
- Engagement problems;
- Poor compliance;
- Dual diagnosis/forensic presentation.

vii) The recovery approach recognises that individuals employ diverse strategies to achieve social inclusion after experiencing serious mental health problems or illness. In addition to a focus on treatment outcomes, increasing emphasis would need to be on outcomes that relate more widely to achieving a good quality of life. Team functioning would continue to hinge on a holistic assessment of need and easing social inclusion through the integration of biological, psychological and social interventions.

viii) The focus would be on supporting the individual's journey of recovery. Team resources/establishment should allow for flexible and wide ranging approaches which, in turn, would also necessitate a defined and shared understanding of concepts such as safety and positive risk taking;

ix) The Consultant Psychiatrist and Associate Specialist for the north and south areas will be fully integrated into the CMHT, sharing the same team base and able to review

service users with care co-ordinators when necessary. There will be less emphasis on routine follow-up in outpatient clinics and consultants would be available for more complex cases;

x) In the interests of meeting changing need more fully, the multi-disciplinary nature of the team needs to be developed, incorporating psychology and occupational therapy and the team's hours of operation extended;

xi) Whilst acknowledging that core function is fundamentally linked to secondary care and predominantly focused on severe and persistent mental disorders, it is proposed that 'link' practitioners be identified for primary care liaison and dual diagnosis. In addition, the consultant psychiatrist must be able to advise and liaise with primary care regarding assessment of new referrals to the service as and when necessary.

xii) In view of associated benefits [see Appendix 3] it is felt that assertive outreach may be undertaken by CMHT as a result of less complex needs being met by contracted service providers. This will be progressed via the service level agreement;

xiii) The CHMT see a number of service users who, in addition to their enduring mental illness, are diagnosed with a significant substance misuse problem. Continued emphasis will be on effective co-working with DAT within the CPA framework;

xiv) Case workers for the assertive outreach component would have smaller caseloads than generic CMHPs and would participate in a multi-disciplinary approach to the care planning;

5.5 Drug and Alcohol Team (DAT)

5.5.1 Background

i) A recent consultative exercise as part of the Island's Drug and Alcohol Strategy review indicated that the Isle of Man has a marked problem in relation to cannabis and volatile substance misuse. Evidence also suggests that heavy drinking, both episodic and chronic, is a marked cultural factor (Isle of Man Government 2005). Current high profile need also includes service provision for younger people;

ii) A consultative process related specifically to substance misuse has indicated strong support for:

- The central position of treatment and support provision for blood borne disease;
- Increased multi-agency collaboration and wider social welfare provision (Isle of Man Government 2005).

5.5.2 Recommended Drug and Alcohol Team development areas

i) A crucial prerequisite for developing drug and alcohol service provision is an immediate review of the grant status of tier 2 partner agencies (currently Alcohol Advisory Service and Drug Advice Service Helpline). In the interests of effectiveness and efficiency

there will be a more formal contractual relationship with clearer service level agreement/specification;

ii) Service level agreements will clarify the roles of each agency, provide clear lines of accountability and remove barriers to service improvement. Agreed contracts will focus upon each agency's core functions.

5.5.3 Drug and Alcohol Inpatient Unit

i) In the Isle of Man DHSS Business Plan 2004-2007, reference is made to a medium-term operational objective of developing a Drug and Alcohol detoxification unit and service within a refurbished Ard Aalin (Reayrt Noa).

ii) There is increasing evidence supporting the provision of a range of services for drug users and indicating that these services are effective in reducing harm to users and the community. Although the major part of service users' treatment may well be delivered by the Community Drug and Alcohol Team, there will always be service users whose presenting need indicates inpatient management. Service users with substance use problems may have difficulty in achieving abstinence or stability in the community. Inpatient programmes are therefore necessary for those whose needs require supervision in a controlled medically orientated environment;

iii) In essence, the overall policy of care would be to provide facilities for treatment and support in a safe, comfortable and familiar environment. As Reayrt Noa would also accommodate the Community Team, some outpatient and inpatient treatment programmes might be combined in order to optimise resources;

iv) The proposed inpatient element of drug and alcohol treatment will augment existing provision and strengthen the service's capacity to respond as flexibly as possible to substance misuse;

v) Following the budget announcement in March 2009 giving approval for the inpatient unit, the Mental Health Service will initiate a commissioning process and begin to draft an implementation plan.

5.5.4 Shared Care

i) Some DAT work is already based in primary care and the general hospital setting. It is recognised that this practice must be reviewed to optimise the efficiency of secondary care delivery. It is recommended that shared care be developed as a matter of priority.

5.5.5 Health Screening/Hepatitis Vaccinations

i) The majority of strategic planning for health screening services within the DAT has been completed but funding has still not been forthcoming for the provision of vaccination for all drug-using service users who are, by the nature of their behaviours, a high-risk priority group. This issue requires further dialogue with the drug and

alcohol co-ordinator, primary care and public health.

5.5.6 Service Users with Dual Diagnosis

i) The DAT see a number of service users who, in addition to their substance misuse, are diagnosed with an enduring mental illness. Continued emphasis will be on partnership working with other services in the CPA framework.

5.6 Older Person's Assessment Service (OPAS)

i) OPAS will be known as the Older Persons Mental Health Service (OPMHS) as this more appropriately reflects its function;

ii) In line with guidance from the Audit Commission (2002), DoH (2001/2004) CSIP/DoH (2005) the function of the OPMHS will be to offer a specialist, centrally based and fully integrated service. This service will operate from a common, geographically accessible central base (Central Community Health facility) and be multi-disciplinary in nature - including medical, nursing, social work, psychology and occupational therapy staff. In order to achieve integrated, collaborative care all the multi-disciplinary team members must be managed in the OPMHS. Additional dialogue will be required with regard to the integration of social work, occupational therapy and psychology;

iii) A central, common base will facilitate a co-ordinated referral and communication system including integrated health care records and preserve the established all-Island seven days a week service;

iv) In order to develop OPMHS' status as a specialist element of service provision, its core business will be examined and clear eligibility criteria/referral pathways established to ensure roles/competencies reflect service user needs. Service remit will be clearly defined and conveyed to all local agencies. Provision will be based on assessed need and not chronological age alone;

v) In order to promote integrated working, the team must continue to improve and formalise links with Noble's Hospital and primary care teams and seek to enhance the level of collaboration with wider service providers to facilitate seamless transition of care from the service user's perspective;

vi) Consideration and further guidance are required on how the CPA and single assessment process inter-relate, and whether two separate management systems may be required;

vii) A Clinical Nurse Specialist is required to develop clinical practice, enhance multi-disciplinary collaboration and foster closer links with partner agencies. Emphasis would also be on developing the learning environment;

viii) When the central Elderly Mentally Ill (EMI) facility becomes operational, the day centre function will transfer there from Cronk Coar and line management to Adult Social Services. As agreed in the 2003-2008 Mental Health strategy, 3.0 wte will transfer to central EMI facility.

5.7 Child and Adolescent Mental Health Service (CAMHS)

i) 'Every Child Matters' (2003) and 'The National Service Framework for Children, Young People and Maternity Services' (DoH, 2004) indicate that all children and young people, from birth to their 18th birthday, who have mental health problems and disorders, should have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support for them and their families;

ii) With the above best practice in mind, over the next three years the service will aim to extend the age range for CAMHS from 16 to 18. It is acknowledged this change will have significant implications for this element of the Service.

These include:

- Behavioural disorders that have already been identified will need continued treatment;
- Psychotic disorders under treatment will rise;
- The numbers of deliberate self-harm assessments will increase;
- There will be a need to include treatment options for drug and alcohol misuse and clear care pathways drawn up in collaboration with the Drug and Alcohol Team;
- Possible additional pressure on the need to access inpatient beds both on-Island and in specialist facilities in the UK.

iii) Serious consideration must be given to enhancing the contribution of those in primary health care, education and Social Services whose remit includes working with children with mental health problems to a 'Comprehensive Child and Adolescent Mental Health Service' mode of practice. At the moment, it is thought that a lack of training and organisation impedes the effective deployment of this potentially huge resource for children with mental health problems. This could be addressed by tailored training courses, combined with managerial work on systems and remits;

5.7.1 The Mental Health Service supports the creation of a CAMHS Co-ordinator in primary care/health promotion;

i) This would be linked to the Integrated Children's Service initiative, line management and funding sitting outside of Mental Health;

ii) Dialogue with primary health care, public health, education and wider Social Services colleagues needs to take place to explore this post;

iii) Responsibilities would include safeguarding and risk management of all vulnerable groups in CAMHS including looked after children, children and young people with learning disabilities, those with multiple behavioural problems and those on the 'at risk' register. It is acknowledged that in these instances, treatment is delivered as close to the young person as possible and an integral component would include parenting, educating and co-ordinating the professional network. It is suggested both primary and secondary prevention be achieved with these vulnerable groups who are not normally able to access services.

5.7.2 'Therapist/Practitioner' Post (1.0 wte)

i) Initially consideration will be given to the development of a 'therapist/practitioner' post - working to a flexible, assertive outreach model/delivering home treatment/support to children's ward when needed - and which will also have a Tier 2 and early intervention role. This provision will be reviewed annually in accordance with the business planning process.

5.8 Psychology and Counselling Service

i) Following consultation regarding challenges faced and adopting best practice, it is proposed there be a centralised Psychological Therapies Service (PTS). It is envisaged that such provision will ensure:

- Professional standards are monitored, maintained and upheld;
- Clinical governance of psychological work will be professionally operated;
- High calibre people will be attracted to work for the organisation and equally importantly, be retained;
- Continuing professional development of staff will be maintained to deliver and respond to future service requirement and succession planning;
- Appraisal, career development and supervision of staff is professionally undertaken;
- Service planning and development of psychological services are facilitated;
- Delivery of stepped-care provision to clients of the most appropriate therapy;
- Access to a wide range of psychological therapies (including Psychology, Counselling, Art Therapy and Cognitive Behavioural Therapy (CBT));

ii) Psychological therapies are an integral component of any modern mental health system. Ideally, a range of such service provision should be available across both primary and secondary care;

iii) There is an expressed need from psychiatrists, nursing staff, service users and community mental health professionals for increased input from the psychology service to all areas of service;

iv) There is a strong argument to suggest that counselling would be more appropriately placed in primary care. It is planned that as individual counsellors leave they will be replaced with alternative practitioners (e.g. possible link with Cognitive Behavioural Therapy (CBT) development/Psychotherapy Psychodynamic therapist):

v) Psychology and counselling referrals generated within the Mental Health arena and currently open to existing practitioners will be given primacy and dedicated sessional commitment on a weekly basis.

vi) In the interests of improving access, collaborative care, staff supervision and diversifying staff skills, the Psychological Therapies Service will seek to integrate its work within wider Mental Health Service teams. Greater emphasis will be given to

training and developing the skills and competencies of wider colleagues.

vii) As it is recognised that psychological therapies are an integral component of any modern mental health system, the Psychological Therapies Service will focus on the following:

- Maintaining the current psychology provision of 0.5 wte to the Drug and Alcohol Team;
- Allocating 0.5 wte psychology input to each of the north and south components of the Community Mental Health Team (Within this allocated time commitment, psychologists would accept referrals from the CMHT/Psychiatry Service only, providing a combined 10 clinical psychology sessions per week);
- Exploring the opportunity to enhance service development within Rehabilitation Services by employing a consultant clinical psychologist for Rehabilitation/Forensic Services, within existing resources;
- 2.0 wte available for referrals from:-
    - in-patient
    - day treatment
    - GPs
    - partner agencies
    - self referrals
- Prioritising both inpatient and day-treatment referrals, offering initially one session per week;
- Exploring the possibility of providing sessional input to OPMHS through the appointment of a part-time or fixed-term clinical psychologist.

viii) The Art Therapist will be based and line-managed within the Psychological Therapies Service providing art therapy across the whole of the Mental Health Service. Consideration will be given to incorporating other therapists under the remit of the PTS manager.

5.9 Next Step Training Unit and Brunswick Gardens

i) Vocational or occupational services for mental health service users are principally delivered through the Next Step Training Unit/Brunswick Gardens and the Disability Employment Service. These services aim to work closely with CPA care co-ordinators and are considered when indicated by needs assessment;

ii) In recent years several documents have described the good work done by Next Step Training Unit/Brunswick Gardens and it is acknowledged that these units constitute an important part of the social inclusion and recovery agendas;

iii) This service will be maintained and developed but its profile needs raising. Line management arrangements will remain unchanged at present.

5.10 Occupational Therapy

i) The majority of Trusts in the UK have placed occupational therapists in mental health multi-disciplinary teams (e.g. crisis teams, outreach teams, CMHTs etc.) and abolished occupational therapy departments in mental health settings. This practice will be progressed here through urgent negotiation with health services senior management;

ii) It is acknowledged that if occupational therapists were devolved into the wider teams they would not be perceived as generic community mental health practitioners but as serving a distinct and specialist role, with any job description reflecting this and identifying professional governance arrangements.

5.11 Clinical Governance

5.11.1 Clinical Governance

i) The Service must raise the profile of clinical governance, given that it is at the crucial interface between 'management' and the wider workforce and pivotal to the service user/professional partnership;

ii) Acknowledging clinical, risk management, communication, resource, strategic and learning effectiveness, together with service user experience to be fundamental components of the clinical governance framework, it would seem pragmatic they should be integral to the 'governance' post. The clinical governance manager/lead nurse will be responsible for taking the lead on clinical governance issues and will have line management responsibility for the following posts:

- Specialist in Mental Health Promotion;
- Risk/clinical development;
- Mental Health Act/Care Programme Approach;
- Audit/projects.

iii) Clinical governance is central to the provision of responsive, consistent, high-quality and safe patient care. It should be about creating a positive service ethos and an environment where excellence in clinical care will flourish;

iv) The governance role will continue to incorporate the professional lead for nursing. It would be impractical for one individual to take this on without support/assistance, therefore, it is suggested the role be more tangibly linked to lead practitioners throughout the service. This 'governance/senior practitioner forum' would oversee (in conjunction with medical staff) the development/monitoring of clinical practice. It is possible that this forum would seek periodic involvement from the DHSS Education and Training Centre and Human Resources Directorate (in relation to evolving workforce development/planning needs).

5.11.2 Specialist in Mental Health Promotion

i) Including a mental health promotion standard in the National Service Framework

represented an important milestone;

ii) The DoH (2001) suggests that a strategic approach to mental health promotion should aim to include: developing coping/life skills, promoting social support and networks and addressing structural barriers to mental health (in areas such as education, employment and housing);

iii) Demographic change would suggest a requirement to increase preventative/health promotion activity. A dedicated mental health promotion post will be retained, become a closer fit with the rest of the service and implement key practice themes of the recovery model;

iv) The post will utilise a community development model, which would function at individual, social and structural levels.

5.11.3 Risk/clinical development

i) The management of risk is vital in a modern mental health service. It is felt that the development of safe, effective clinical service goes 'hand in hand' with the management of risk. Therefore, it is proposed there be a post dedicated to addressing risk/clinical development;

ii) It is acknowledged that careful consideration must be given to ensuring the Mental Health Service continues to have a voice on learning/educational forums. The post is additionally important given the re-introduction of mental health nurse training. Accordingly Mental Health should maintain its current educational systems and procedures until such time as a range of mechanisms/processes are in place.

5.11.4 Audit/projects

i) Acknowledging the challenging health and social care environment a dedicated 0.5 wte (whole time equivalent) audit/projects role is proposed. This will be directed by priorities set by MHMT and reflect the ethos of 'making money work – focusing on achieving results'.

5.11.5 CPA/Mental Health Act administration

i) Once CPA is implemented, it is envisaged the CPA and Mental Health administration functions will be combined and developed through a CPA lead officer role.

5.12 Modernisation of Medical Staffing

Over the past 10 years there have been profound developments within the Isle of Man Mental Health Service. In particular, a number of specialist community-based multidisciplinary teams have evolved. Doctors are members of each of these teams and their duties and workloads have increased appreciably over this time. It is acknowledged that an increase in medical staff numbers is required in order that the various medical functions can be carried out adequately and safely;

i) To make the most efficient use of time, some doctors already work predominately within a particular team; for example the Drug and Alcohol Team, Child and Adolescent Mental Health Service and the Older Persons Mental Health Service;

ii) The Community Mental Health Team, the Rehabilitation and Recovery Service and the Adult Inpatient and Crisis Resolution Team will also have their own dedicated medical staff. This will allow for greater efficiency and availability of medical staff, who will no longer spend as much time travelling between work locations, in addition to which there will be greater consistency of medical care within the teams. This change may mean that patients will be cared for by different doctors if they need to be managed by a different clinical team and procedures will be put in place to ensure smooth and efficient transfer of care when required.

iii) The Crisis Resolution and Adult Inpatient Team, located in Grianagh Court have two dedicated doctors. A consultant and a specialist doctor will see those people referred to the Crisis Resolution Team who need medical assessment and will be able to admit them to inpatient beds as required. They will also provide a medical liaison service to Noble's Hospital for people who are thought to have mental health disorders but who are not already being cared for by one of the other specialist teams.

iv) There will be one Consultant Psychiatrist and one specialist doctor working with the Adult Community Mental Team, based in the Central Community Health facility at Westmoreland Road, Douglas.

v) One Consultant Psychiatrist will work with the Rehabilitation and Recovery Service, currently based at Tynwald Terrace, but shortly will relocate to Westmoreland Road.

vi) A specialist doctor will join the Consultant Psychiatrist at the Child and Adolescent Mental Health Service to deal with the workload generated by the increased number of referrals, particularly of children suffering from ADHD and Autistic Spectrum Disorders.

vii) The Drug and Alcohol Team and the Older Persons' Mental Health Service will continue to work with one consultant and one specialist doctor for each team.

viii) The Clinical Director, who will also be a member of Mental Health Management Team, will manage medical staff and work with the Crisis Response Team to provide medical assessments for adults with complex needs, including those with learning disabilities and those needing forensic assessments. The clinical director will be responsible for the allocation of cases referred to the Crisis Response Team who need medical assessment and treatment.

ix) The Clinical Director and other doctors will work with other agencies, outside the Mental Health Service, such as Disabilities Services and the Prison, to provide comprehensive care for those people with complex mental health needs.

x) The changes in the organisation of medical staffing reflect developments in the United Kingdom, in particular "New Ways of Working".

xi) To implement these changes it will be necessary to employ one new Consultant Psychiatrist and one new specialist doctor.

xii) It is acknowledged that cost efficiencies will need to be made to accommodate this increase in substantive staff. At the present time, locum doctors are employed through agencies to cover for periods of doctors' leave of more than one week. Consultant psychiatrist and specialist doctors have been identified, who will be directly contracted to provide locum cover as required, thus avoiding the cost of agency charges. It is planned that with the new substantive posts, it will be possible to provide some degree of cross cover when consultant psychiatrists and associate specialist doctors are on leave and this will save on the need for locum doctors.

In summary, Mental Health Service medical staff will be reorganised and expanded to provide an up-to-date service, compatible with new ways of working with multidisciplinary teams to provide a comprehensive and efficient service to deal with the mental health needs of the community in the Isle of Man.

5.13 Administrative Support

i) As access to the Mental Health Service becomes easier and its associated stigma diminishes, the administrative workload has increased. While recognising that new IT and data handling systems will have a positive impact, evolving clinical governance, audit and data gathering responsibility will impact on the nature and scale of administrative support;

ii) Potential changes in staffing levels and relocation of services will necessitate a review of administrative support.

5.14 Housekeeping Support

The high standard of housekeeping services is acknowledged.

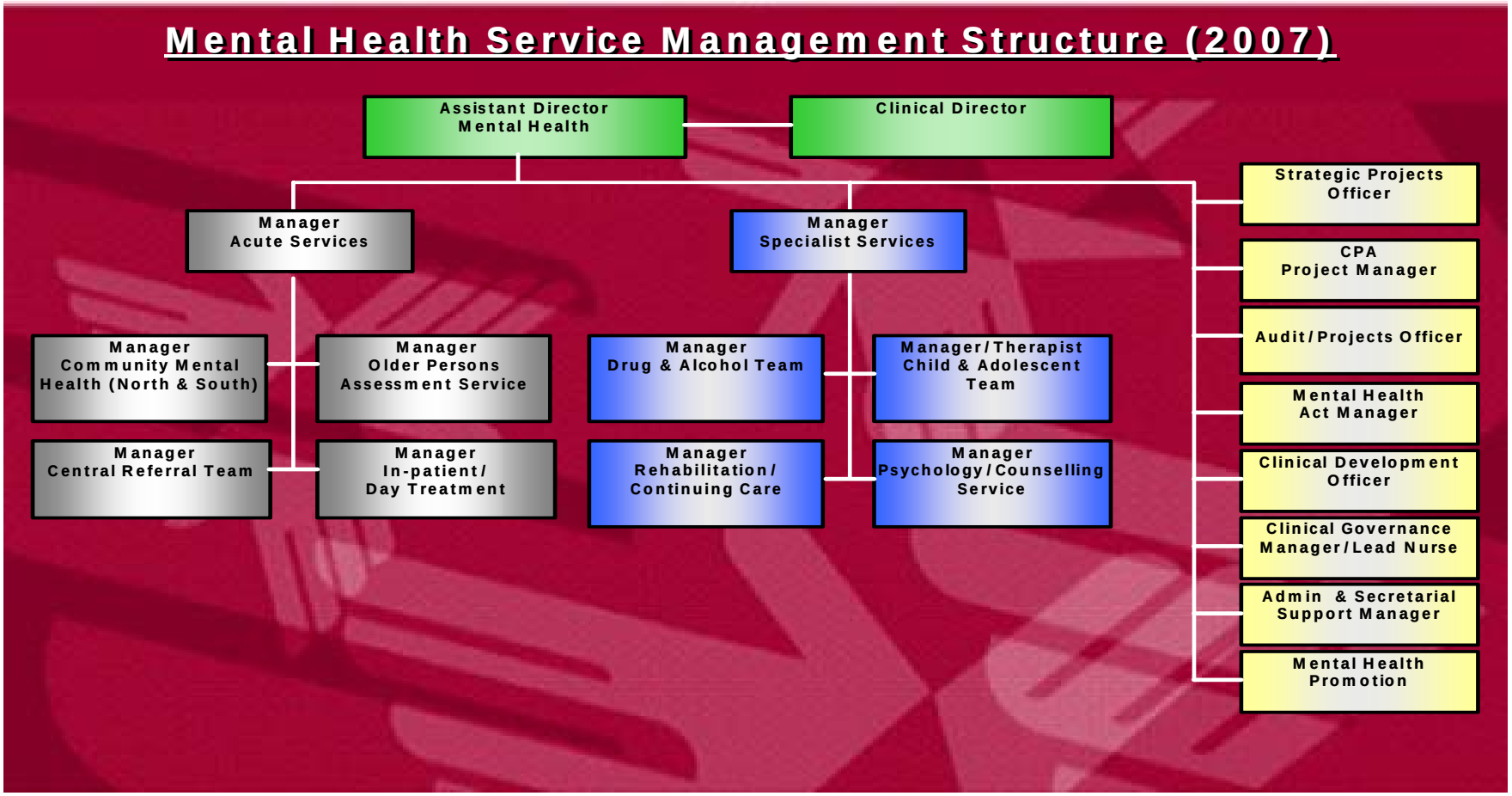
i) Potential changes in service provision and relocation of services will necessitate a review of housekeeping support

6 Mental Health Management Structure

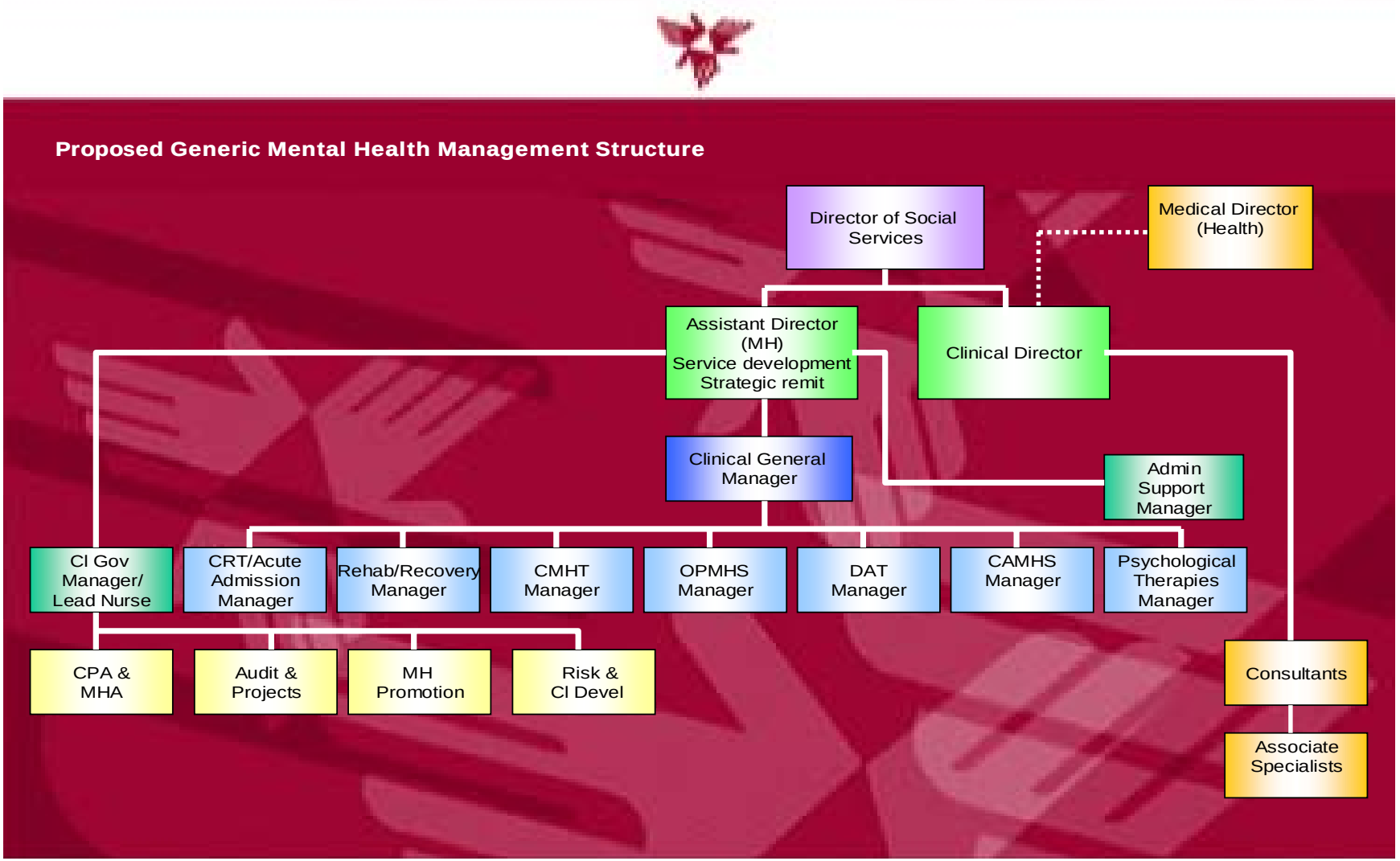
6.1 Management re-organisation

The Service will retain the 'Mental Health Management Team' arrangement. This will now consist of an assistant director, a clinical director, clinical governance manager and clinical general manager. (Following considerable discussion at both Service and divisional levels, it is decided to combine the roles of specialist and acute manager rather than adopt the 'operational manager' model favoured by the Division. It is also decided that the exigencies of the Service necessitate a clinical general manager role).

6.2 Mental Health Management Structure 2007



6.3 Proposed Generic Mental Health Management Structure



6.3.1 The implementation of the revised structure means the reduction of management positions as follows:-

- 1.0 wte operational manager (reduced by 1.0 wte);
- 1.0 wte CRT/acute admission manager (reduced by 1.0 wte);
- 1.0 wte CPA/MHA manager (reduced by 1.0 wte);
- Strategic projects officer 1.0 wte transferred to ICT.

As a result, 3.0 wte posts would be available for clinical practice.

6.3.2 Senior management/leadership

The Assistant Director for Mental Health and Clinical Director will continue to foster a key management partnership dedicated to strategic development and leadership.

6.3.3 Medical management structure

The clinical director will report to the Director of Social Services regarding managerial issues; clinical/professional matters will be addressed via the medical director.

Consultant Psychiatrists will report to the Clinical Director; Associate Specialists report to their service area Consultant Psychiatrist.

6.3.4 Clinical General Manager role

The Clinical General Manager will have senior management responsibility for all seven service areas, with each specialist area having a dedicated manager.

- CRT/Acute Admission;
- Rehabilitation and Recovery Service;
- CMHT;
- OPMHS;
- DAT;
- CAMHS;
- Psychological Therapies Service.

6.3.5 Clinical Governance

Systems which underpin the safe, effective delivery of services will be incorporated within the governance framework, i.e:

- Mental health promotion;
- Audit and projects;
- Risk and clinical development;
- CPA and MHA.

7 WIDER SERVICE DEVELOPMENTS

7.1 Partner Agencies

i) Emphasis will be placed on changing the grant status of partner agencies to formal contracts with defined service level agreements;

ii) Service level agreements will clarify the roles of each agency, provide clear lines of accountability and remove barriers to service improvement. Agreed contracts would focus upon each agency's core business, data collection processes, protocols for collaborative working, management of complaints, best use of funding and required skills for staff members.

7.2 Primary Care Mental Health

i) It is important that tier 3 and 4 mental health functions should not be seen as isolated from primary care (tier 1 and 2) and service eligibility criteria must reflect a continuum of support and treatment options. With this in mind and acknowledging the UK Government's encouraging increased community co-ordination of healthcare, discussion will take place with primary care regarding meeting the needs of those in the community with less complex disorders and stable long-term mental health issues.

7.3 Criminal Justice Liaison

i) 'Offender Mental Health – A Case for Change' (DoH, 2005) states that although prisoners represent a very small proportion of the total population, approximately 0.1%, they are likely to be extensive consumers of a wide range of services. This text indicates that prisoners are a socially excluded group who experience many health and social inequalities. The document also highlights research suggesting:

- As many as 90% of prisoners have some kind of mental disorder;
- The prison population is at greater risk of developing mental health problems compared with people of a similar age and gender in the community;
- Prisoners' mental health needs are less likely to be recognised; they are less likely to receive psychiatric help or treatment and are at an increased risk of suicide.

ii) The document 'Changing the Outlook' (HMPS/DoH, 2001) recognises the need to plan more effective locally commissioned mental health services for prisoners, based on the assessment of health need and which acknowledge the needs of particular groups, e.g, young people;

iii) The Mental Health Service, in conjunction with the Department of Home Affairs, will seek to develop and expand current functions. This may include the provision of assessment and therapy, which is beyond the remit of the Prison Healthcare Department, and facilitating access to the wider Mental Health Service via Court diversion, prison in-reach and probation liaison. Consideration will be given to developing a prison/Court liaison role.

7.4 User-led Support Services

i) A key factor for independence is the ability to maintain wellness and coping outside of the statutory services. The assumption that people must at all times be provided for is both erroneous and counterproductive. Letting go and giving responsibility are essential components of effective rehabilitation and recovery;

ii) The development of the Service User's Network (SUN) must be encouraged to work towards empowering individuals to move out of services and into independent living;

iii) Increasing emphasis will be placed on service user input. This might be developed via training of SUN members or seen as a component of partner agency delivery. The feasibility of employing SUN members on a part-time basis to explore addressing such issues as advocacy, peer support and inclusion will be considered.

7.5 Carers

i) People who provide informal (unpaid) care are often a vital source of support to service users. Many performing this role experience hardship, social isolation and ill health as a result and it is vital that the Mental Health Service considers what support it can offer and involve them in care programmes.

ii) The Mental Health Service will continue to acknowledge the input of carers' representatives in working parties and groups. Consideration must be given to covering carers' costs when attending such meetings.

7.6 Personality Disorder

i) The inclusion of personality disorder in the mental health arena has been controversial. However, DoH guidance makes it clear that people with personality disorder are no longer to be excluded from mental health services. The document 'Personality Disorder: No Longer a Diagnosis of Exclusion' (NIMHE, 2003), recommends that service provision for Personality Disorder can most appropriately be provided by means of specialist multi-disciplinary personality disorder teams and /or specialist day treatment services.

ii) Evidence indicates there will always be significant numbers of people with personality disorder in the mental health service receiving interventions focusing on secondary issues instead of the core issue. It may be argued that this is extremely expensive, unproductive, and poor practice. In the absence of separate/distinct PD provision, there is a need for a personality disorder focus in local services to complement existing specialisms and ensure clinical and social intervention;

iii) The Mental Health Service along with Department of Home Affairs will establish a multi-agency forum to consider how best to meet the needs of people with personality disorders.

7.7 Data Gathering and Performance Monitoring

'Modern, integrated services need modern integrated information and systems to deliver this' (The Mental Health Policy Implementation Guide, DoH, 2001, p108).

i) The Mental Health Service needs to generate (or be provided with) intelligent information, both qualitative and quantitative, to allow an accurate and up-to-date understanding of need, performance and operation. Such data should be used to identify trends and 'bottlenecks', promote discussion and analysis and contribute to local thinking about service improvement. Potential action on this issue might be guided by the values of the Mental Health Information Strategy (DoH, 2001);

ii) Future planning of the Service needs to be increasingly guided by both departmental and government strategy; with a clearer indication of the Service's role in relation to the Island's public health agenda.

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APPENDIX 1

A MODEL FOR THE 21st CENTURY – THE 10 HIGH IMPACT CHANGES

Guidance highlights the need for Mental Health Services to continue to move away from in-patient, reactive, and socially excluding traditions.

The '10 High Impact Changes' produced by the National Institute for Mental Health in England underpins the concepts within this modernisation document and may be used as a tool to measure service performance.

- Treat home-based care and support as the norm for delivery of mental health services;
- Improve flow of service user and carers across Health and Social Care by improving access to screening and assessment;
- Manage variation in service user discharge process;
- Manage variation in access to all mental health services;
- Avoid unnecessary contact for service users and provide necessary contact in the right care setting.
- Increase the reliability of interventions by designing care based on what is known to work and what the service users want.
- Apply a systematic approach to enable the recovery of people with long-term conditions.
- Improve service user flow by removing queues.
- Optimise service user and carer flow through the service bottlenecks using 'process templates'.
- Re-design and extend roles in line with efficient service user/carer pathways to attract and retain an effective workforce.

APPENDIX 2

BIBLIOGRAPHY - CORE DOCUMENTS

The National Service Framework for Mental Health (1999)

Setting out seven standards in five areas:

(1) Mental health promotion and discrimination exclusion
(2, 3) Primary care and access to services
(4, 5) Services for people with severe mental illness
(6) Services for carers
(7) Actions necessary to reduce suicides

National Service Framework Five Year Review (2004) – priorities for five years:

Inpatient care
Dual diagnosis
Social exclusion
Ethnic minorities
Care of long-term mental disorders
Availability of psychological therapies
Better information/information systems
Workforce redesign/new roles

The National Health Service Plan (2000) - Chapter 14 - Clinical priorities for Mental Health

Primary care
Early intervention
Crisis resolution
Assertive outreach
Services for women
Support for carers
High secure hospitals
Prisons

Mental Health Policy Implementation Guide (2001)

Service specifications for:

Crisis resolution/home treatment
Assertive outreach
Early intervention
Primary care
Mental health promotion
Cultural/gender sensitivity
Involving service users/carers

Health and Social Care White Paper (2006) – 'Our Health, Our Care, Our Say:

A New Direction for Community Services'

Four main goals:

Better prevention services with earlier intervention
More choice
Increased emphasis on tackling inequalities and improving access to community services
More support for people with long-term needs

Plus:

Better joining up of services and encouraging innovation

APPENDIX 3

ASSOCIATED BENEFITS OF ASSERTIVE OUTREACH

- Increasing capacity within primary care through collaboration;
- Building alliances with community organisations;
- Reducing the stigma associated with mental health care;
- Working with communities to provide positive opportunities for people with mental health problems;
- Ensuring care is delivered in the least restrictive and disruptive manner;
- Stabilising social functioning and protecting community tenure;
- Establishing a detailed understanding of all local resources relevant to support of individuals with mental health problems and promoting effective interagency working;
- Initiating joint working with employment, education, housing, voluntary and leisure providers;
- Assisting service users and carers in accessing such support, both to reduce distress but also to maximise personal development and fulfillment;
- Providing 1:1 advice and support to service users, families and carers.

With emphasis on:

- Increasing service users' self-determination including, self-understanding of their experience, their identity and their lives. Including information regarding successful coping strategies and the triggers that bring about episodes of crisis;

- Building support systems, including friends, family, peers and others. Developing coping, monitoring and responding strategies and learning about and deciding on preferred professional supports and treatments;

- Developing advocacy skills and strategies to ensure people get what they need from the services and from the community;

- Promoting the development of lifestyles that support wellness, including having valued roles, being able to relax, companionship, pleasurable and meaningful activities and opportunities for closer community involvement.

SOCIAL SERVICES

Shirveishyn Y Theay

The information in this booklet can be provided in large print or on audio tape on request

Caring for the Nation ~ Jeeaghyn mysh yn Ashoon

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