ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
MEMBER VISIT TO THE COMMUNITY MENTAL HEALTH TEAM
THURSDAY 24 SEPTEMBER 2009
(2:00 pm to 4:00 pm)

Present: Councillors Turrell and Blatchford

In Attendance: Zoë Johnstone, Chief Officer: Adults and Commissioning
Tony Dwyer, Adult Services, On-going Care
Community Mental Health Team Members
Andrea Carr, Policy Officer (Overview and Scrutiny)

1. VISIT TO THE COMMUNITY MENTAL HEALTH TEAM AND GLENFIELD HOUSE

As part of the Adult Social Care Overview and Scrutiny Panel's programme of visits to Adult Social Care facilities, Members met representatives of the Community Mental Health Team (CMHT) at Church Hill House prior to a tour of Glenfield House and discussion with its Manager. CMHT was an integrated team comprising Health and Social Services staff. The Team provided services to people living in Bracknell Forest with severe and enduring mental illness through care co-ordination.

Memory Clinic and Referrals

Members met the CMHT (Older Adults) Manager and Dementia Nurse to explore Dementia services which featured the Memory Clinic. All referrals to the Clinic, which could vary from 1-2 up to 15-16 per day in number, were out patients who were treated at Church Hill House or Woodlands Day Hospital on the site of Heatherwood Hospital. Treatment consisted of an assessment of the patient's condition, a CTC scan, investigation of patient history, diagnosis of Dementia and prescription of one of three types of inhibitor drugs. Assessment included a memory test and when low test results were evident the consultant psychiatrist, who offered weekly clinical supervision, would decide whether medication should be withdrawn or restored in the case of those whose condition had significantly worsened following withdrawal. Patients remained in contact with the Clinic for the duration of their drug prescription which could vary from a few weeks to five or six years. Although the majority of Dementia patients were elderly and in excess of eighty years of age, an increasing number in their 50's and 60's were being referred. Dementia was a progressive condition and once diagnosed would remain with patients for the remainder of their life with a probable timespan of 15-16 years.

All Dementia services in Berkshire operated within the National Institute for Clinical Excellence guidelines which stipulated that people with mild Dementia should not be treated until their condition had worsened to a specified level. Funding had been secured to appoint to a new Dementia Advisor post and the postholder would support people in the latter situation by undertaking continuous monitoring of their condition and signposting them towards assistance. The Council's award winning Dementia Home Support Service (DHSS) actioned patients' care plans which were formally reviewed at least once per annum according to statute.

Future service delivery options, reflecting the ambitions of the transforming adult social care agenda, the needs of carers and increased home support, were being considered as current services required development to meet the demographic pressure of an ageing population, exacerbated by the characteristics of a new town.

Officers identified an expanded DHSS, increased access to resources such as the Re-ablement Team, re-ablement training for the DHSS and an improved system to support Dementia patients discharged from hospital as desired service developments.

Duty / Access and Perinatal Services

The Working Group met the Community Services Manager and team members to learn about the range of specialist services within the CMHT. These were:

- Duty and Access – this team operated a single point of referral for all mental health services within Bracknell Forest for adults aged 16-75 and was able to offer crisis and short-term management. People over 75 and presenting symptoms of Dementia would be referred to the CMHT for older people.
- Assertive Outreach Team – the three team members of this service provided intensive support to clients with severe and enduring mental illness supported in the community who traditionally had not engaged with mental health services.
- The On-going Care Team of two operated the Bipolar Education Group and undertook family work.
- Early Interventions Psychosis - this service offered intensive assessment and support to people aged 16-35 with first presentation psychosis.
- Home Treatment Team - this team offered alternatives to admission to hospital where this was not seen to be the best option and provided short-term intervention of up to 8 weeks.

The main sources of referrals to the Duty and Access Team were telephone, letter, GPs, health visitors and school nurses. Once referrals had been processed and logged onto information systems a decision would be made as to which Team was best placed to assist the client. Some referrees required multi-agency support whilst in-patient hospital treatment was necessary for others. Immediate action was taken in the event that any risk to the client or others was identified. The Team received 90-100 referrals per month for initial assessment and had 35 contacts per day by telephone or personal visit. Clinical services for blood tests etc were available.

Perinatal referrals were currently high at 30-40 in number. Referrees typically suffered from anti and postnatal depression and there were some cases of depression following stillbirth and instances of complex needs possibly resulting in self harm. One in six mothers suffered from a degree of postnatal depression within a year of their child's birth. The Surestart and Parents & Children Together initiatives were involved in referrals and liaison. Although only one unitary authority area in Berkshire was currently providing pre-conception counselling, this service was being rolled out across the remaining five localities in the county.

One team member was predominantly a mental health professional with a varied and heavy caseload of both secure clients and those supported in the community. Her work involved courts and tribunals etc.

The Mental Health Act 1983 legislated the work of the Team which was recovery focused and sought alternatives to admission to care. A recovery focused environment encouraged clients to progress and there were several successful support groups including the Bipolar Education, Wellbeing, Link and Carers Groups. Although there were some clients who would remain in need of mental health services, the object was to support clients to progress from the mental health arena to access provision in the community. It was necessary for some clients to be detained under the Act and the length of applications for admission varied. Those retained for

a long term remained under constant review and monitoring. Re-Think, a mental health charity, sought to aid recovery and support people to access mainstream activities such as employment and leisure.

The Team liaised with employers and the local College with a view to assisting mental health sufferers to sustain their employment or studies and early intervention was key. Underperformance at work or College could be stressful and lead to mental health relapses. A contact at the job centre also assisted. People suffering from mental health problems were often stigmatised in society.

Proposed future developments included robust plans to support clients, such as those suffering from an Autistic Syndrome condition who may not fall into traditional service models, to facilitate early prognosis and treatment and to ensure that the appropriate agency took the lead. Educating GPs, counsellors and schools staff etc to detect early signs of psychosis would be beneficial.

Glenfield House

Members completed the session with a visit to Glenfield House where they met the Supported Living Manager and toured the facilities. A supported living project funded by the Supporting People programme operated at Glenfield House where service users could be supported to gain the necessary skills for independent living. There were 17 tenancies at the premises, the majority of which were of a two year temporary nature supporting residents to equip them to move on to independent living. Other tenancies were long term and Glenfield House was home to such tenants. The CMHT were able to make direct referrals. The accommodation included one dedicated bed for a homeless person and four respite care beds which were available at times of crisis or could be booked for carers' respite breaks. Some office accommodation was being converted to a respite unit to improve provision and create separate facilities for men and women.

Glenfield House was resourced with nine Supported Living Advisors and an administrator and there was limited staff turnover leading to stability and continuity for tenants. The reason for and duration of tenancy was made clear to clients and staff offered emotional support and worked with tenants to build trust and rapport. Although clients were encouraged to take responsibility for their lives, many would have on going related support needs to sustain a tenancy and quality of life. Those moving on to independent living in the community were offered out reach support whilst they settled into their new surroundings from the staff member who had supported them at Glenfield House in the interests of consistency.

Following the transfer of the property from the Council to Bracknell Forest Homes, respite care and office accommodation were now leased back by the Council whilst clients were the tenants of Bracknell Forest Homes. Lease arrangements and responsibilities were currently being clarified. Repairs and a deep clean were taking place and a need for some redecoration had been identified.