A Thematic Analysis of Responses to the Re-Engineered Community Mental Health Services Discussion Paper - April 2005

30 August 2005

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Background

1. Manchester Mental Health and Social Care Trust (MMHSCT), Manchester City Council and North, Central and South Manchester Primary Care trust are undertaking a major project on the re-design of Manchester's secondary mental health services. As part of this process a discussion document entitled 'Re-Engineered Community Mental Health Services[1]' was circulated for comment to a wide range of stakeholders. People were asked to frame their responses under three headings:

    a. Are services likely to meet the needs of people with mental health problems in Manchester?
    b. Will the ways in which community health services are planned to work together, as described in the document, be successful from the point of view of users and staff?
    c. Will the services proposed in the document, if implemented, improve Manchester's mental health?

2. Once the responses to the document had been received the Health and Community Care Research Unit, at the University of Liverpool, were commissioned, to produce a thematic analysis of the responses. This thematic analysis was undertaken in July 2005.

Methods

3. Themes are defined as units derived from patterns such as "conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs" (Taylor & Bogdan, 1989). The identification of themes in this study followed the pragmatic approach outlined by Aronson (1994) which focuses on identifying themes and patterns of living and/or behaviour. Related patterns are combined and catalogued into sub-themes. The "coherence of ideas rests with the analyst who has rigorously studied how different ideas or components fit together in a meaningful way when linked together" (Leininger, 1985).

4. Each response received by the Leadership Group to the discussion document will be analysed thematically using the techniques described above.

5. The 'Re-engineered Community Mental Health Services' document is structured according to the following headings:

- Title
- Purpose of the paper

[1] The Re-Engineered Community Health Services discussion paper is referred to in the text for ease as 'the document', or 'the discussion document'.

- Background
- The Emerging Community Services proposal
- Navigation through Mental Health Services in Manchester
- Community Mental Health Teams (Adults of Working Age)
- Community Living Services
- Community Mental Health Teams (Older People)
- Early Onset in Dementia
- Early intervention in Psychosis Service
- Assertive Outreach Teams
- Crisis Resolution and Home Treatment Teams
- Homeless Team
- Memory Clinic
- Day Alcohol Services
- Eating Disorder Team
- Prison In-reach/Psychiatric Assessment Service

6. It was decided that analysis of the responses would be undertaken according to these headings. In the analysis we have tried to separate out the need for clarification of the proposed changes from views and comments about the impact of a proposed change in service delivery.

Structure of findings

7. The analysis of the themes is presented under each of the section headings as they appeared in the discussion document. Where there are no specific comments the section has been left blank. The themes which run across all the services are raised at the end of this report. In presenting the themes we have tried to reflect the range of views received. Although this process is by definition selective we have avoided any judgement of the validity of the views presented.

Findings

8 A total of 92 responses were received. Respondents included individual users and user groups as well as individual health and social care staff and teams of professionals working in all sectors. Some of the responses had been elicited through a series of open meetings in the community while the majority were written comments of varying length. The responses to the consultation can be categorised in a number of different ways. Surprisingly few of the respondents chose to address the three questions posed by the MMHSCT. The majority of respondents commented on specific sections of the document, usually those sections which related to the specialty in which they worked or the types of service they received. A very few respondents used the opportunity of the consultation exercise to articulate personal views on current service provision. These could not be directly mapped on to the discussion document.

9. In addition to the different ways in which respondents had framed their comments there was huge variation in the content of the responses. In the majority of cases responses were restricted to the nature and re-configuration of community mental health services. However, a significant number of respondents criticised the language of the document, particularly the use of jargon and its inaccessibility to the layperson. It was felt that at the very least a glossary of terms could have been provided. While some people liked the diagrams at the end of the document others felt that they were inaccurate and difficult to interpret. This was particularly the case where the document had been photocopied and the diagrams appeared in black and white.

10. There were also a substantial number of comments on the process of consultation. While it was recognised that the Trust would not provide all the services outlined in the document it was felt that little attempt had been made to engage with those providers who would be providing the services as partners. There was a feeling that the current process was being driven by managers who wanted to reconfigure all the services in one go, rather than creating and facilitating a culture of gradual change. This level of upheaval was felt to be very threatening, particularly to staff.

11. While the discussion events that had been organised were welcomed there was a sense in which users and professionals felt that they were being engaged in a process of service planning for the first time. Had the process adopted a more community development approach from the start and involved users of services and health and social care staff more closely in the creation of the discussion document more positive comment might have been received. It was also felt that inadequate time had been allowed for the consultation exercise, which put patient and user groups wanting to provide a collective response at a considerable disadvantage.

12. The notes of all the open day discussion groups raise issues which underline the need for much more consideration to be given to how to conduct public consultation exercises, as well as how to involve service users and carers on an ongoing basis.

Section 3. The Emerging Community Services Proposal

13. Many of the comments expressed about this section of the document re-surface elsewhere in the particular client based sections (particularly sections 5 and 7). However, there were a number of issues raised in response to this section which do not.

14. There was no recognition of the valuable role played by existing services often within extremely limited resources, thus while there were some positive views expressed about the work that had gone into re-designing the services there was a strong sense of implied criticism. Clear signals were received from this section of the document that new teams were to be developed from existing

ones, and yet there was no human resource strategy outlining how this would happen.

15. While the relationship with primary care was mentioned in this section there were some strongly held views from a few people about the importance of mental health services to primary care and general practitioners (GPs) in particular. It was stated that GPs needed more, not less support in dealing with patients with mental health problems. Any re-organisation of services that reduced the capacity of Community Mental Health Teams (CMHTs) was seen as having a detrimental impact on primary care. There was a feeling that the interface between the CMHT and the local Primary Care Trust (PCT) mental health teams needed to be developed further and some GPs would have liked just one point of contact for all mental health referrals. Questions were raised about the outcome of the 'primary care consultations' which had apparently taken place in 2004 but from which no feedback had yet been received.

16. There was concern that in the new service configuration a number of services had been omitted. These included; respite care; liaison psychiatry; services for people considered to be personality disordered and for people with complex adjustment disorders; perinatal services and post natal depression services. A number of psychological services such as, psychosexual therapy, psychotherapy and neuropsychology were also identified by psychologists as being absent. It was felt that greater recognition should have been paid to the rich and diverse nature of Manchester's mental health services and that a starting point for the discussion document might have been a list of all the services currently involved in providing community mental health services. In general, respondents were unclear whether the omission of a service should be regarded as oversight or whether there some hidden message was being imparted.

17. It was also noted that throughout the document there was insufficient information on access to services and particularly on eligibility criteria. It was stated that in the past MMHSCT have not had clear operational eligibility criteria which has led to decisions that have been inconsistent, arbitrary and inexplicable.

Section 4. Navigation through MH services in Manchester

18. There was a general feeling that there was a lack of clarity and detail in the discussion document about routes into services. For instance, who are the Gateway workers and where will they sit exactly? It was suggested that consideration be given to navigation models used elsewhere in the country, in particular that used by Lancashire Care Trust and 5 Boroughs Partnerships. One respondent raised a particular concern about the implication contained in the proposals that self-referral would be a route into services for older people. They felt that because of the co-existence of physical and mental health problems in older people it was essential that primary care were involved in all referrals originating in the community.

Section 5. Community Mental Health Teams (Adults of Working Age)

19. A total of 38 respondents commented on the content of this section of the discussion document. Respondents reflected the broad range of respondents to the document – users and user groups and health and social care providers along with voluntary sector providers of care.

20. There was general support for the idea that an integrated CPA/care management system is the best organisational framework for community mental health services for this group of people. There was also a sense that the current arrangements for the CMHTs, in which team members undertake rehabilitation, crisis and assertive outreach work, were unsatisfactory. However, despite the general overall support for the proposals, this section of the document gave rise to some highly charged statements.

21. There was a feeling that the document failed to reflect the true nature of the work currently undertaken by CMHTs. Some respondents felt that there were implied criticisms of the service they currently provided from the way in which the discussion document talked about the new service configuration. There was a general feeling that the effect of the proposals, if implemented as set out in the document, would be to lower morale even further amongst CMHTs.

22. The most common theme to emerge from the plans for the service for working age adults related to the interface between services. The proposals were seen as reflecting a trend towards specialisation which was perceived critically as leading to fragmentation of the service. The problems raised by this increasing fragmentation of services were multiple but largely centred on the problems associated with communication within and between teams.

23. Several respondents raised concerns about the effect of this increased specialisation/fragmentation on service users. A number of suggestions were made for simplifying access to services. These included:
    - Establishing a single point of access to all services through a single assessment process in order to eliminate multiple assessments
    - Combining services for all adults and older adults
    - Increasing the responsiveness of all services to the range of needs that were identified within this section of the document.

24. Numerous examples of interface problems were given. The two most common examples were the CMHT with the Community Living Services and the CMHT with the Crisis Resolution and Home Treatment Services. In the past there had been an assumption that rehabilitation was the province of the Community Living Services and consequently that the role of the CMHT was to support Community Living Services. In this document the relationship indicates a *volte face* with the Community Living Services supporting the CMHT. Questions were raised about how this would work in practice and whether it would affect the dynamics between the two services.

25. In terms of the interface between the CMHTs and the Crisis Resolution and Home Treatment service, concern was expressed about the effect on the therapeutic relationship of transferring clients in crisis temporarily to the crisis resolution team. The placing of the Crisis Resolution and Home Treatment services as gatekeepers to in-patient services was also viewed as problematic. It was felt that this would create a barrier between staff in the CMHTs and ward staff resulting in poor cooperation across the hospital community divide. In addition, there was some concern that the effective management of beds was being seen purely in terms of gate keeping. It was pointed out that important lessons could be learned from the Gateway project in Manchester.

26. As has been mentioned elsewhere, there were suggestions that the service configuration described in this section of the document was heavily medically driven without enough cognizance paid to the social model of care. While social inclusion was mentioned in the document it was felt that there was little reference in the document to the services which would enable this to happen. In fact it was felt that the proposed staffing levels would undermine the likelihood of this happening.

27. The document places the Rehabilitation and Recovery model of care at the heart of the CMHT work with this group of people, and this was generally supported in the responses. However, some respondents felt that references to the model in the document lacked clarity, with an absence of detail about the service philosophy, nature of intervention and anticipated outcomes. At the same time it was felt that there was insufficient recognition of the highly specialised skills and knowledge underpinning rehabilitation and recovery and no recognition of the training that might be required in order to equip CMHTs to undertake this as a central part of their role. It was also suggested that having to carry out emergency assessments would have a detrimental effect on the ability of the CMHTs to undertake long-term rehabilitation and recovery work.

28. The issue of referrals received considerable attention in the responses to this section of the document. It was noted that the range of agencies referring into CMHTs needs to be broadened to include active case managers, nurse practitioners, voluntary sector providers and in-patient referrals. In addition, although it is planned that CMHTs will be the main point of access for specialist mental health services, it is known that some people get referred to in-patient services who are not known to the CMHT. ie through A & E). Patients then have difficulty getting assessed and some are discharged home without an assessment or follow up visit from the CMHT.

29. In terms of reconfiguring community mental health teams for this group of people it was felt that there were very good models of practice elsewhere, such as Camden and Islington and that these models should be studied before decisions are made about services in Manchester.

Clarification of roles

30. A number of respondents wanted clarification of the clinical and professional background of the Team Leader and the role of CMHT team leader. In particular, there were questions about the relationship between the Team Leader and the staff delivering assertive outreach and the home treatment services.

Omissions

31. A number of respondents identified key omissions from this section of the document. They are:

- There was no mention of Research and Development;
- There was no mention of Personality Disorder;
- There was no mention of preventative work;
- While the document details structures and manpower it does not explore the sort of therapies that will be offered. This is particularly true of the clinical psychology input;
- There was no mention of the relationship between CMHTs and the physical health services for instance neurorehabilitation and other physical rehabilitation;
- There was no mention of the need for CMHTs to provide a culturally appropriate service. It was suggested that the CMHTs should work with those voluntary organisations who work with Black and Minority Ethnic (BME) users.

Human resource issues

32. The human resource implications of the new services were discussed at length by the majority of the respondents. One respondent argued that in order to know whether the resources identified would be sufficient to meet the service outlined they would need a clearer definition of standard and enhanced CPA.

33. It was noted that Social Workers were referred to as ASWs but it was not clear whether all of the Social Workers needed to be Approved to work within the CMHTs. It was also suggested that the current role of social workers in the CMHTs was problematic, and that this was not discussed in the document.

34. The majority of respondents suggested that there were not adequate staff to deliver the service outlined. One consultant psychiatrist per team was not thought to be sufficient and at least one of the Clinical Psychologists in each CMHT needed to be a Grade B. The role of Occupational Therapists was underplayed throughout the document but in the CMHTs for this group of people, it was felt that there would be consequences for service users of downgrading the OT posts to Senior II. Why are there no Senior I Occupational therapists included? What will happen to Senior I posts? What arrangements would be made to manage the Senior II OT staff? What redundancy or retirement opportunities would be available? Where are the technical Instructor posts? These were common questions posed throughout the responses to the document. It was generally felt that these proposals would have a definite impact (negatively) on morale and upon the quality of service provided to users. As well as the inadequacies in the clinical staffing

proposals, it was also felt that the level of administration proposed was inadequate.

35. Cover for holidays, sickness, training, vacant positions and emergencies were all mentioned as problematic within the new service configuration outlined in the document. Hours of work and the precise nature of the duty rota were significant but not outlined in the document.

36. There was a strong sense from the responses that the proposed CMH teams would work best if co-located in suitable buildings and locations. However, this had not been mentioned in the discussion document. The existing geographical spread of CMHTs was mentioned as being problematic, but again, the proposals did not address this issue.

37. As discussed elsewhere there was a feeling that the diagrams do not accurately reflect the patient care pathways. In this section it was noted that the arrows for in-patients suggests a flow into the service but not outwards again.

Section 6. Community Living Service

38. Sixteen respondents commented specifically upon the proposals relating to the Community Living Service, most of whom were staff working either in or closely with the Community Living service or were users or user groups. There was widespread acknowledgement that there needed to be fresh thinking in relation to the development of Community Living Services which it was hoped would result in an expansion of services.

39. There was a general view that the document was extremely vague about Community Living Services and placed insufficient emphasis on the existing range and importance of Community Living Services. The majority of the responses reflected strong feelings of dissatisfaction about the way in which Community Living Services appear to be perceived by the Trust. There was a feeling that the document devalued the role and work of Community Living services. The majority of respondents felt that the document reflected a lack of awareness of the role of Community Living Services which translated into a very limited vision of how the services might be developed in the future.

40. Several respondents commented that no reference had been made to the 'Proposals for Modernising Community Living Services'. While there were mixed views about the success of the consultation process leading up to the development of these proposals considered by the trust Board in October 2003, the lack of reference to these proposals was remarked upon by a number of respondents.

41. A view strongly expressed by the majority of respondents was that the document as a whole adopted an overly medicalised view of community mental health services, with a lack of emphasis on and attention to the social dimension of mental health care. The references to social inclusion were thought to have little substance behind them. In relation to Community Living

Services, particular concerns were expressed about the effect on Community Support Teams (CSTs) of having to work within a medical model. These teams currently work within the local authority's social inclusion agenda, where a medical model of care does not dominate.

42. There were a number of different views on the proposed change to the management arrangements of the service. Some respondents felt that a move towards locality management of services would be beneficial for service users, but there was some concern that this might result in a focus on clients with enhanced CPA as opposed to those on standard or on no CPA.

43. Several respondents expressed specific concerns about the effect on Community Support Teams of transferring management of the teams to the Review Team. The document was unclear on how much of the existing management structure would remain, and there was a fear that existing expertise and healthy management/staff relationships would be jeopardised. Concern was also expressed about the wider implications for the service of the loss of its 'gatekeeping' role.

44. It was argued that Community Living Services currently rely on the services of organisations such as START, Moving On and the day centres to provide access to activities, employment and training and yet it was not clear whether these activities would continue to be valued within a new management setting.

45. Particular concern was expressed about accessing the Supporting People Fund should the management of Community Support Teams be transferred to the Review Team. Currently, the Community Support Teams are required to submit monthly occupancy reports and quarterly activity reports as a precondition of their funding. Questions were raised about whether the CMHT would claim the fund and if so how this would affect the employment of people currently paid from it. Concern was also expressed about the impact on the shape and direction of future service delivery should the allocation of these funds be controlled by the CMHT.

46. One respondent also raised concerns about the potential effects of the transfer of management arrangements on training for care staff.

47. Referring specifically to a comment in section 5, a number of respondents were critical of the idea that Community Living staff should be seen as having a support role in relation to the CMHTs. Criticism was also made of the repeated references in the document to the need to **develop** a 'recovery and rehabilitation' model when according to the respondents working in the field of community Living Services this was already a central activity. It would be more natural therefore for the Community Living services to take on a lead role in the pursuit of this model rather than giving it to the CMHTs for whom it might be seen as a relatively new way of working.

Omissions

48. Network Support Teams were not mentioned in the document. There was no clarity about what time period was covered by short term and medium term.

Section 7. Community Mental Health Teams (Older People)

49. A total of 19 responses related to the section on the Community Mental Health Teams for older people. All types of respondent (staff and users) provided comments on this section. The majority of these responses comprised questions or points requiring clarification.

50. There was a general feeling that this section suffered from the absence of underlying principles governing the development of services for older people and that there was a lack of aspiration for the commissioning of services for this group of people. Interestingly, these points were also raised in relation to the services described for people of working age. It was also noted that there remained considerable confusion around the implementation of the Single Assessment Process (SAP).

51. The majority of responses to the document highlighted the difference in number, type and range of services between people of working age and older adults. There was a feeling that the more specialised services were concentrated in the working age group. Questions were therefore raised about the interface between working age and older people services – Are older adults denied services at 65 that they could access at 64? How well do agencies deal with the transition of people across services when they move from being 64 to 65? Given the problems created by the existence of an age boundary two respondents suggested that the services for all age groups should be combined.

52. There were a number of questions about the interfaces between specific services and access to these services. These included:

- Assertive outreach
- Outreach into nursing homes
- Crisis resolution services
- Homeless services
- Services for people who are known to the service but who are in crisis
- The memory clinic
- Young onset dementia service
- The Admiral service

53. The discussion document referred to the integration of older people's mental health services. This raised questions about the nature of health and social care integration; how teams will work, how will they be managed, what are the national definitions for integrated teams, what will be the performance targets for the teams?

54. The proposal to develop six co-located teams throughout the city seemed to indicate that the EDIT team would be replaced. This was viewed with some concern since they were deemed to be providing a service well above the levels described in the NSF for older people.

55. Questions were also raised about the role of the day hospital and of primary care within the referral process and the importance of priority setting.

Human resources

56. There were a few responses which addressed the human resource implications of the plans outlined in the discussion document. The following issues were raised:

- Is the level of Clerical and Administrative support to the older age teams adequate? Strong feelings were expressed by a number of respondents about the low levels of administrative support proposed for the older people's teams. These were noted as being significantly lower than current levels, and also lower than the levels proposed for the adult teams.
- Are there any plans for the development of Nurse Consultant and advanced practitioner roles in the field of older age mental health?
- Will staff be allowed to choose their future location and place of work?
- How will the skill base be enhanced to introduce the ASW input?
- The local authority contact centre is difficult to access – not always 24 hr service and difficult at the weekends.

57. The point was made by several respondents that while the equitable allocation of resources might be a worthy goal, the service configuration for older adults needed to take account of the disparate provision of residential, nursing home and EMI provision across the city.

Omissions

58. A number of key omissions were noted. There was a feeling that older adults should be fully engaged in the process of service development but there were no plans outlined in the document to do this. It was also felt that throughout the country there were many different models of CMHT working with this client group and that lessons could be learned from these. Occupational Health and Speech and Language Therapy have a regular input with Older Age Psychiatry Services but their role was not fully acknowledged in the document. Similarly, the different professional roles and boundaries within the CMHTs were not fully described.

59. Black and Minority Ethnic issues were not addressed in this section or anywhere else in the document. The role of prevention and health promotion were not discussed.

60. The flow charts for older age services were not seen as accurate; PEARL and SAFIRE were identified as being absent.

Section 8. Early Onset in Dementia

61. There were only a handful of explicit references to this service. Although reference was made in the background of the discussion document (page 3) to the development of a model for this service, the model was not described in this document.

62. While these respondents were encouraged to see that the input of the psychologist was recognised for this client group, it was felt that 0.2 wte across the city would be extremely unlikely to meet the needs of the population.

Section 9. Early Intervention in Psychosis

63. Ten respondents made comments relating specifically to the section on the Early Intervention in Psychosis (EIP) service. Most of these were from psychiatrists, with one response from the union and one from an administrator.

64. While welcoming the development of this service, it was felt that there should be some recognition in the document of the organisations and staff who were currently playing a role in supporting this client group.

65. There was a general question about the evidence on which the information in this section was based. Two respondents noted that the document did not seem to take account of the "extensive work" of the EIP Steering Group which has been meeting for the last 18 months. Another respondent referred to a locally commissioned study not mentioned in the document which contains detailed information on rates, characteristics and needs of young people with first episode psychosis.

66. From the latter study this respondent listed the range of skills needed for case managers in an EIP service as being:

- Engagement and rapport building
- Assessment and formulation
- Therapeutic skills including cognitive behaviour therapy
- Family intervention
- Substance misuse management skills

67. One of the main questions raised in relation to this section was about the predicted caseload of the EIP team. An estimate of 120-150 users at any time was made on the basis of Mental Health National Service Framework Policy Implementation Guidance (MHNSFPIG or PIG for short). One respondent noted that this represents a misreading of the PIG, which actually states that an EIP service will have 150 **new** patients per year. They argued that local needs data suggests 90-127 new cases per year in Manchester. With an average stay of 3 years, this would produce a caseload of 270-381. On this basis the respondent noted that the EIP Steering Group estimated that 3 or 4 teams would be needed, rather than the 1 suggested in the document. Another respondent referred to EIP services elsewhere, such as Birmingham with 4 teams for a population of 1.2 million and Central Lancashire with 3 teams for 1.3 million.

68. Concern was raised about the assumption that the service would be open access. It was noted that the question of whether an EIP service should be open access or a tertiary service has been the subject of considerable debate on

the EIP Steering Group. It was argued that making the service open access would considerably increase the staffing requirement.

69. The interface between the EIP and inpatient services was raised as an issue. Although the document stated that the EIP service would only have access to inpatient beds through the crisis resolution and home treatment teams, it was argued on the basis of the MHPIG that the EIP team should be involved in crisis resolution and thus should interface directly with inpatient services. The EIP Steering Group has discussed interfacing with specific wards.

70. Another question raised was about the facilities required to enable the EIP team to function effectively. Even if the team were to operate on an outreach basis adequate on-site clinical facilities would still be needed. It was suggested that in the interests of communication and morale the service might be best based in a multi-purpose community facility.

71. A couple of respondents were concerned that the EIP service should be treated as an additional service, not as part of the reconfiguration of existing services.

Omission

72. It was noted that the proposed EIP staff team did not include any administrative support.

Section 10. Assertive Outreach Teams

73. Eight respondents commented upon the section on Assertive Outreach Teams. In general it was felt that there was insufficient detail about the model for this service.

74. There was a view that section 10 suffered from a lack of knowledge of the nature of the service already provided and that as a consequence the text read 'like a purely theoretical, policy-driven exercise'. The role of the Policy Implementation Guide (PIG) in driving forward the service outlined in this section of the document was recognised by all respondents. It was recognised that this had both advantages and disadvantages. In relation to Manchester's population it was felt that the model required the additional input of vocational, housing and welfare rights workers. In general, it was felt that the evidence presented in the PIG for assertive outreach emanated from outside the UK, and that an evaluation of the existing service in Manchester might provide a more useful guide to how the service might be developed and expanded locally.

75. While the partnership between Manchester Mental Health and Social Care Trust and HARP was recognised in the document, it was not clear what role this partnership would play in the expansion of service described. Some respondents suggested that any expansion of the outreach service provided by N'Gage would have to be accompanied by satisfactory arrangements for the 'governance' and management of the service.

76. Some concerns were expressed about the estimated caseloads of the proposed teams. One respondent observed that these are based on PIG guidelines, with no reference made to local data. Others felt that the number of teams proposed (3) and the estimated city-wide caseload was about right. It was noted that the proposals took account of the higher than average level of need in Manchester, with an adjustment made to the staffing numbers in order to accommodate the greater than average likely caseloads. However, despite this adjustment the view was expressed that Manchester is still likely to be disadvantaged in comparison with average localities. It was also noted that no adjustment has been made in the proposals for medical staffing numbers.

77. Another caseload-related observation made was that patients appropriate for such a service are unevenly distributed across the city, and that for the teams to have an impact on inpatient admissions special attention needs to be paid to where they should be located.

78. Clarification of the role of an employment specialist nurse was sought along with the absence of support workers in the proposed staffing structure (despite an acknowledgement of their importance in the text). A ratio of 4 support workers per 100 clients was suggested.

79. Half time posts were not seen as the most efficient way of running the assertive outreach model and there was a general question about the future of existing staff members who did not fit into the model described.

80. The impact of the proposals on the Community Living service was again raised. One respondent expressed concern about the effect on their existing Supporting People contracts of Community Living staff supporting assertive outreach and substance misuse teams.

81. One respondent pointed out that the diagram on page 19 did not incorporate an arrow out of the assertive outreach. They felt that a protocol for the referral of clients back to CMHTs needed to be drawn up.

Section 11. Crisis Resolution and Home Treatment Teams

82. Seven respondents commented specifically on the section on Crisis Resolution and Home Treatment teams. Whilst some respondents were generally happy with the proposals outlined in the document, others viewed them as a more contentious model of working. It was clear from the responses that current provision in this area varies considerably across the city, and the different emphases of respondents reflected this.

83. A key issue raised was that of equity of service provision across the city. It was noted by several respondents that proposals for the distribution of teams across the city is weighted in favour of the north, with only one team proposed for South Manchester. It was argued that this does not adequately reflect the level of need in the south and it was suggested that if this proposal was implemented then the staffing level for this team needed to be increased. It

was also noted that no reference is made in the document to the considerable work already undertaken in planning a home treatment service in South Manchester.

84. Attitudes towards the proposed remodelling of existing services were polarised. One view was that current services in Central and North Manchester need reviewing and adapting, whilst another view was that the existing model used in North Manchester provided clients with a seamless transition into crisis care. Questions were raised as to whether users or staff had been consulted about the proposed changes, and whether any evaluation of existing models had been conducted.

85. Questions were also raised about the caseload projections made in the document. It was suggested that the level of need in Manchester was underestimated and that this, coupled with the fact that Manchester's crisis teams tend to run at full capacity, may mean that the staffing levels were set too low. It was suggested that these might need to be increased by 20%. Another factor not accounted for in the caseload calculations was the proposal that the crisis resolution and home treatment teams would accept self-referrals. It was also noted that in the caseload projections patients with the home treatment teams are excluded from the caseloads of the CMHTs even though the document states that CMHTs should continue to work with patients being seen by the home treatment teams.

86. A key issue raised by several respondents was the need for adequate accommodation for the teams. The document suggested that only a limited amount of face-to-face work would be carried out at the teams' office bases. This was disputed by respondents who argued that simple office accommodation would be inadequate for the needs of these teams and the type of work to be undertaken. A number of factors are identified as needing to be considered in any building design:

- Access to clinical facilities for carrying out full health assessments (including physical health assessments)
- Access to a safe interview venue away from the patient's own home (where necessary)
- Access to a venue for team reviews with patients

87. It was noted that this issue had been discussed at length in the Crisis Resolution/Home Treatment Steering Group. In the absence of appropriate accommodation it was argued that most consultants saw hospital admission as an inevitability. It was also argued that many patients valued having access to a safe place away from home and other difficult environments. In addition to an appropriate building, access to day hospital facilities for clients treated by these teams was also seen as being essential.

88. A number of issues were raised relating to the interface between the crisis team and other services. One specific area concerned the relationship between the Crisis team, PEARL and SAFIRE. It was noted that the flow chart presented at the back of the document suggested that some patients might have

to be seen by all three teams before being able to access in-patient care. This would seem to increase the complexity of navigation around services for patients and for professionals.

89. The proposal that crisis resolution and home treatment teams would gatekeep admissions to in-patient beds was raised in a number of different contexts by many respondents to the consultation. It was suggested that there will remain a need for some non-crisis admissions and that clarification is needed about when and by whom such admissions should be managed. The proposal that CPA care co-ordinator responsibilities would remain with CMHTs throughout an individual's use of the crisis service was also queried, particularly since any patient being admitted would in theory continue to be the CMHT's responsibility. However, it was argued that the intention of the MHPIG had been to ensure that CMHT staff continue to be in contact with the patient, not that they continue Care Co-ordinator responsibility. It was argued that this would result in the involvement of too many people in an individual's care, and thereby a breakdown of ACT principles.

Section 12. Homeless Team

90. No specific comments were received on this section.

Section 13. Memory Clinic

91. There needs to be some acknowledgement that the memory clinic provides out patient services outside Manchester as well as across the city. More detail is needed on staffing. Where will the clinic be held if Laureate House closes? Will there be multiple sites across the city?

Section 14. Day Alcohol Services

92. The rationale for maintaining the current management arrangements for alcohol services was questioned. It was suggested that consideration be given to the idea of managing the Brian Hore Unit and Community Alcohol Team services under one structure, either under the PCT or the Trust.

Section 15. Eating Disorders

93. Only one specific comment was received about this service and that was that consideration needs to be given to the eating needs of older people.

Section 16. Prison In-reach / Psychiatric Assessment Service

94. One respondent was extremely surprised to find that there was no reference to the psychological service input to prison in-reach.

Summary and general themes to emerge

95. Many of the responses to this consultation document recognised the time and effort expended by the Trust in considering the way forward for community mental health services. The willingness of the Trust to re-deploy resources in new and cost-effective ways was viewed as both a challenge and an opportunity. Many of the respondents to this consultation exercise expressed a desire and a willingness to be a part of this process of change. Indeed members of the team responsible for compiling the document were invited to spend some time with those working in the field to understand the complexities of the work they were undertaking. However, the document circulated lacked a lot of the detail that respondents would have liked and the document was therefore considered by the majority of respondents to raise more questions than it answered.

96. It was felt that there was a lack of clarity about the principles or philosophies underpinning the services described. It was not clear therefore what was trying to be achieved by the proposed service configurations. While there was a stated relationship between this discussion document and the earlier 'Visioning document' few respondents found it easy to make the link. The view of these respondents was that some key principles for community mental health services had been agreed and set out in the visioning document but that these had not been carried through into this document. It was, however, recognised that there was a very strong policy steer in the form of the Mental Health National Service Framework Policy Implementation Guidance (MHNSFPIG or PIG for short). This was often considered to lack the sensitivity to local need. The high levels of deprivation experienced in certain parts of Manchester were referred to as producing a very particular local climate requiring locally driven services. There was a fear that in trying to create equity across Manchester, local initiatives and responses to local need might get lost.

97. One of the most important general themes to emerge from the responses to the document was an over-emphasis on the medical approach to mental health care. This criticism took various forms, which in part reflected a wider critique of mental health services rather than simply a critique of the proposals contained in the document. However, there was a clear general feeling that if implemented the proposals would represent a strengthening of the medical dominance of mental health services to the neglect of more holistic, socially oriented approaches. A number of specific points were made.

- There is a lack of emphasis placed on the importance of social care services in tackling mental ill health. It was argued by a number of respondents that more social support services needed to be available than at present.

- Several respondents argued that a more holistic approach was needed to mental health, one which promoted 'wellness' and (by implication) placed more emphasis on preventive services. A number of respondents made the case for more alternative therapies to be made available.

- The document was criticised by several respondents for its absence of attention paid to tackling social exclusion, despite its references to the promotion of social inclusion. For some people the highly medicalised approach reflected in the document simply does not fit with an approach which is orientated towards promoting social inclusion. The point was also made that social inclusion should mean inclusion within the general community, not just within a mental health service user community.

98. The document was seen as representing a shift from a broadly generic approach to community mental health services to a more specialised approach, with the consolidation of CMHTs as the focus of long term 'rehabilitation and recovery' work and the more specialised functions of crisis resolution, assertive outreach etc allocated to separate teams. Several respondents commented upon this fundamental shift, some broadly positive about it, some ambivalent and some strongly opposed to it.

99. While categorisation, compartmentalisation and specialisation characterise the proposed reconfiguration of community mental health services there was a feeling that this would fragment services and create new difficulties in communication and the co-ordination of services. In addition, it was felt that there might be an impact on the ability of services to meet patient need if the boundaries between services and the eligibility criteria for entrance to services were too rigidly applied. However, it was noted that the document fails to identify any clear operational policies which would promote the seamless provision of services.

100. Even those who were broadly positive about the shift towards specialisation saw the proposals as outlined holding the potential for fragmenting services, with some users being excluded from receiving any service. Rather than increasing specialisation it was thought that efforts should be made to improve the responsiveness of existing services. It was , however, acknowledged that the current (generic) basis on which CMHTs work is not sustainable, with team members having to switch between assertive outreach, crisis resolution and rehabilitation. However, caution was expressed about a wholesale switch towards specialisation, the point being made that there is currently insufficient research evidence to support the move. The suggestion was made that specialist functions should be incorporated within the existing CMHT model, with certain staff 'ring fenced' and trained to undertake these specialised roles.

101. Finally, concerns were expressed in the majority of responses about the human resource implications of this document. Individuals were concerned about the deployment, re-deployment and relocation of staff, the management of staff, the training needs of staff, the funding of posts and the impact of change on the morale of staff.

102. Whilst the analysis of the responses presented here seems to be predominantly negative in tone it is important to recognise the energy and enthusiasm that is represented in these responses. A great many people put considerable time and effort into reflecting on the proposals contained in the document and into

how these proposals might be improved. This includes people working within different paradigms of mental health who in some cases feel themselves to have been marginalised in the document. There is clearly a great deal of commitment in Manchester across a wide range of agencies to people with mental health problems. If properly harnessed this should enable the development of culturally appropriate services that meet the needs of people with mental health problems in the community.

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