Meeting the Needs of People with Complex and Severe Mental Ill Health in Birmingham to Reduce Health Inequalities

1. Purpose

The report was requested by the Birmingham Health and Wellbeing Board to support discussion around the theme of 'Making Every Adult Matter'. The aim of the discussion is to explore how services currently providing homelessness, mental health and any additional care and support to every adult in Birmingham can work together to reduce the health inequalities faced by the adult population in our city.

This paper focuses on provision to support people with complex and/or severe mental health conditions, including people with a diagnosis of personality disorder. The paper provides contextual information, a summary of existing provision and planned developments and indicates areas which present opportunities for further improvement with a particular focus on partnership and integration.

2. Population eligibility

Across the Birmingham and Solihull Commissioning footprint there are c14,000 adults recorded on the GP register as having a severe mental illness (SMI). The relationship between mental health and social disadvantage is complex.

There is a strong correlation between social injustice and the impact of poor Mental Health and Wellbeing. Research by the Mental Health Foundation (2007)[1] identified that there were notable differences of reported mental illness in relation to household income. The research identified that in the UK, 75% people living in the lowest income bracket reported having experienced a Mental Health problem, compared with 60% in the highest income bracket.

A recent study of the health needs of members of the homeless population in Birmingham found higher levels of mental illness and substance and alcohol dependency than in the general population. Further to this Public Health data shows that of people receiving a Care Programme Approach (CPA) to meet their mental health needs, those who have the highest level of need, only 55% were recorded as being in stable housing. Whilst this is similar to the national average it attests the significant interplay between mental health and social factors and presents a key area of focus for our strategic approach to the health and happiness of the population.

3. Strategic approach

Our vision is driven by a fundamental belief that mental ill health should not define the individual nor limit their potential to thrive physically, socially, educationally or economically.

We all want to prevent poor mental health and provide support for people who are suffering from mental health problems which actively promotes their recovery. We seek to increase independence, self-agency and hope, enabling people to live the life they want

[1] https://www.mentalhealth.org.uk/sites/default/files/fundamental_facts_2007.pdf

The approach looks to address the improved outcomes that we have all agreed to work to deliver across health, social care, local authority, police and criminal justice services.

There is a strong alignment between the principles of Making Every Adult Matter and the strategic priorities for the CCG which are to:

- Tackle and reduce health inequalities
- Rebalance investment in health care from crisis management to prevention and early action
- Achieve closer integration between health and social care

Our strategic aims for mental health are set out in the Birmingham Statement of Purpose for Improvement Mental Health.

The approach is intended to achieve the following strategic outcomes:

4. Service Provision and Current Accomplishments

The following section briefly describes a number current services and approaches intended to holistically support people with complex mental health needs. This is not intended as an exhaustive list of provision but rather highlights particular aspects of the pathway pertinent to this group. The

offers described form part of a full pathway of provision spanning primary, secondary and acute care:

4.1. System of Care for People with a Diagnosis of Personality Disorder

For a number of years there has been a recognition that people with this diagnosis often receive a comparably poor service when it comes to accessing health and social care support. In some cases people with this diagnosis may present challenges to services in terms of engagement and the development of trusting relationships. As such people have often been supported at the margins through A&E and at other points of crisis.

Evidence suggests that services sometimes lack the specialist skills to work with this group. The higher prevalence of substance misuse and alcohol dependency within the cohort, alongside challenges in sustaining housing and employment means that a skilled multi-disciplinary and trauma informed approach offers the best chance of supporting recovery.

This issue has been recognised in Birmingham. A system simulation exercise undertaken in 2017 found that admissions to psychiatric beds for this group were higher than in other areas operating more specialist services. In response commissioners have worked with providers of adult mental health services to develop a Personality Disorder Strategy which works with people in ways that are better suited to people's needs and patterns of engagement. A Personality Disorder Lead has been employed by Birmingham and Solihull Mental Health Foundation Trust to help ensure that the approach is not confined to a single service but informs support for people wherever they have contact with mental health services. Forward Thinking Birmingham, who provide mental health support for people aged 0-25 have developed their own service, ICON. In both cases admissions to inpatient beds have reduced and a number of people receiving are in hospitals outside the City have been brought back to their own community.

4.2. Assertive Outreach Teams (AOTs)

Assertive Outreach Teams have formed a key part of the mental health pathway for a number of years. They are based on a national model and carry small caseloads of mental health patients with complex needs. Very often this cohort of patients present challenges in terms of low levels of engagement and the interaction of a range of social factors including issues around housing, offending and broader issues of social exclusion.

AOTs are by design multi-disciplinary. In Birmingham investment via the Better Care Fund supports the inclusion of social workers in this service. Key facets of the Social Work input is to:

- Work as integrated member of the Assertive Outreach Team MDT
- Provide an AMHP service to this function
- Assess and plan around individuals care and support needs
- Promote service user and carer involvement
- Provider expertise in relation to Social Systems Support

Although AOTs continue to experience high levels of demand they remain highly effective in reducing risk to self and others; helping to prevent relapse and admission; maintaining people in a

stable housing environment; improving social functions and increasing stability in the lives of people's family and carers.

4.3. Crisis and Urgent Care

Where possible crisis should be prevented through collaborative treatment and management between the individual, the MDT supporting them and their family and support network. However, on occasions people's mental health will deteriorate to a point where a timely assessment of their needs is required. In some cases this may result in an admission to a psychiatric inpatient bed for further assessment and treatment. Currently, crisis support is provided through Crisis Resolution Home Treatment Teams and Psychiatric Liaison Services provided at general acute hospital sites with A&E units. Psychiatric Liaison is available 24 hours a day, 7 days a week.

In recent years the number of commissioned inpatient beds in Birmingham has increased. However, concurrently the demand for admissions has increased resulting in some patients being placed in units outside the local area. The CCG are working closely with providers and NHS England on a detailed plan to reduce to zero the number of such placements by march 2021.

4.4. Rehabilitation and Recovery Pathway

Discharge from an acute setting should be a catalyst for recovery and independence. The CCG commissions a range of rehabilitation support including 102 'Steps to Recovery' beds which are inpatient rehabilitation services provided by BSMHFT. In addition, individual packages of care are commissioned under Section 117 of the Mental Health Act. In many cases packages are commissioned jointly by the CCG and Local Authority where people's needs span health and social care.

Rookery Gardens is a rehabilitation unit located in North Birmingham which offers an innovative model of care for women with complex mental health needs. The workforce on the unit includes a majority of staff from Birmingham Mind who ensure a holistic recovery focused service is provided. The service is an example of the increasing recognition of the value of partnership and collaboration across statutory and non-statutory providers.

Locally the CCG has worked with providers to a scheme to deliver Personalised Care Plans in partnership with a voluntary sector organisation with resultant PHB's for community patients living isolated and impoverished lives. This approach is central to the above aim of stepping down rehabilitation patients giving them choice and co-production in the care plans to be delivered when back in the community, promoting security of tenure, citizenship and recovery.

4.5. Recovery and Employment

In 2018 Birmingham redesigned mental health day services and learning and work services. There are now 3 'Recovery Centres' offering a wide range of support for people with severe mental ill health. The services take a proactive approach to recovery encouraging individuals to set meaningful goals for themselves. Recovery is measured through the use of a validated client rated monitoring tool. Where a person wants to work, bespoke support is offered through an Individual Placement Support Service (IPS). IPS has a strong evidence base and provides both employee and employer with support for as long as is needed to achieve sustained employment. Workers are based in Community Mental Health Team and will be co-locating with Early Intervention Teams this year.

4.6. Supporting Carers

CCG commissioners worked in partnership with Birmingham City Council retender support for carers of people with mental illness. The service, which will continue to be provided by Home Group, will expand in remit to support carers of children with mental health issues. The service offers advice and information, one to one support and peer support for children and adult carers. The service offer is now aligned with the local authority commissioned offers for carers.

5. Challenges and Gaps

5.1. Demand

More people than ever are wanting to access mental health services. This is particularly the case amongst younger people where the evidence suggests that prevalence of poor mental health is growing.

5.2. Workforce

Nationally, mental health systems are challenged by under-supply of medics, nurses, allied health professionals and psychological therapists. Our local system is no exception to this and is grappling with both recruitment and retention of staff.

5.3. Balancing investment

A significant proportion of the money we spend on mental health funds hospital beds and specialist care. Shifting the balance so that more money is directed towards prevention and community-based services presents a challenge. Currently the system is spending in excess of £4m pa on Out of Area Admissions whilst support in primary care to assist GPs in managing patients with complex needs is limited.

5.4. Social Determinants

Increases in social causes of poor mental health, like homelessness and substance misuse, alongside reductions in local authority funding in these areas places additional demand on mental health services

5.5. Supporting Positive Risk Taking

Sometimes people with mental health problems pose a risk to themselves and occasionally to those around them. Striking the right balance between managing this risk whilst promoting recovery and independence will require a shift in culture.

5.6. Sharing Information

Putting in place information systems that talk to one another and enable staff to work more collaboratively across organisations.

5.7. Increasing use of Section 136

The use of s136 has doubled since 2017-18 increasing pressure for rapid assessment and short term admission

6. Recommendations and Next Steps

The following section sets out key recommendations for collaborative work across the system to ensure a more joined up and effective approach to supporting people with complex and severe mental health needs.

6.1. Develop Joint Commissioning Practice

Commissioners across Health, Social Care and LA Commissioning have begun working more closely together to align our work. Areas of focus include drug and alcohol services, vulnerable people support, homelessness and rough sleeping, personalisation, carer support and coproduction. A new Section 75 Agreement provides a framework for the ongoing development of our practice in this area.

6.2. Maximise potential funding streams

A number of funding opportunities have been made available to the local system to support ongoing transformation and improvement. CCG commissioners are working with Birmingham City Council submit a bid for c£500k from NHS England to improve our mental health offer to people who sleep rough. In addition, the CCG has submitted bids to enhance psychiatric liaison across our acute sites and develop a range of alternatives to admission for people in mental health crisis.

6.3. Improve Community Pathways

BSMHFT and FTB are both developing transformative plans to improve access and flow through their services. This will benefit those with the most acute needs by helping to ensure that capacity is freed up to work preventatively with people who have a greater risk of relapse.

6.4. Develop Crisis Alternatives

The CCG is working with mental health providers and local VCS organisations to develop alternatives to admission for people in acute need. These will include crisis cafes and crisis houses which offer people a place to go and, on occasion stay, when their mental health is compromised. These less-medicalised settings reduce the likelihood of admission, keep people closer to home and in closer contact with their family and local community.

6.5. Transform Rehabilitation

Person-centred planning should become the norm enabling people to shape the support they need to live the life they want. Personal Health Budgets (PHBs) offer a mechanism to hand more control to individuals and their families. Our aim is that everyone eligible for after-care under Section 117 should be enabled to have a PHB.

As post-acute support is increasingly provided in response to people's expressed preferences and goals a market will be shaped to meet these demands. Commissioners will work proactively in the space between the individual, statutory services and the market to facilitate the growth of provision that transforms the opportunities for recovery for people following hospitalisation. We want to expand the successes of approaches delivered by provision like Rookery Gardens empowering service users to move through recovery and rehabilitation pathways to independence.

Health and Local Authority commissioners, BSMHFT and FTB have committed to the principles of a rehabilitation, recovery and reablement system which will be characterised by:

- Support and treatment close to home
- Personalised support planning
- The goal of each person having their own front-door with the right support
- The opportunity for employment
- Support to be an active and engaged citizen

Our intention is to start by focusing on the needs of people in out of area rehabilitation settings with the aim of supporting them to achieve greater levels of independence in the local community.

We anticipate the establishment of Community Recovery Teams working with people with severe mental illness both pre and post admission. An approach of this type is being developed in Solihull. Teams will work closely with agencies providing care and support around a single recovery plan that pulls together housing, employment and social activity alongside care and treatment.

6.6. Improve our ability to share information

We know that all too often people are asked to tell their story on multiple occasions. This is unhelpful and potentially traumatic, not to mention inefficient. Commissioners and providers are exploring a range of approaches to use technology to enable staff to access key information about individuals and to empower citizens themselves to make decisions about who to share information with. As part of our Personalisation Programme we are trialling the use of a wiki system that gives children and their families the chance to tell their story once and then share it with professionals when the time is right. In addition, the CCG has worked with colleagues in Public Health to bid for funding via Public Health England to build on the tool developed through the Changing Futures Programme to enable professionals to view shared support plans of people with multiple complex needs.