Setting up a community support team for the severely mentally ill

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This article describes the process of setting up a community support team for the severely mentally ill, and the challenges this posed. As this method of service delivery has been infrequently described, it is hoped our experience may be instructive to others.

We set up this team when a large mental hospital (Tooting Bec) was near to closure, with only two long-stay wards having patients who required resettlement in the community. Acute services for the district (West Lambeth) are provided by St Thomas' and Southwestern Hospitals. The former long-stay patients who had been accommodated in supported housing throughout the district formed the focus of the team's operation. Melzer *et al*'s study (1991), which was conducted within the same district, showed considerable deficiencies in the delivery and uptake of services among former in-patients who suffered from schizophrenia. This led them to suggest that this group required dedicated provision which would encourage them to use services protected from the demands of the acute service. It was felt that the former long-stay patients were likely to be insufficiently provided for unless a team was devised with the specific remit of addressing their needs.

Considerable rehabilitation efforts were made with this group when moving from institutional care but this input had diminished on resettlement. This was reflected in the gradual redeployment of personnel to other duties, although the level of disability and need among the group remained high. As Shepherd (1991) points out, the identification of continuing care is the key task of services for those with long-term mental illness whether in hospital or the community and the excessive focus on where services should be located has detracted from the importance of what the services actually deliver.

Inadequacies in the training and motivation of staff have received little attention, although it has the greatest significance in delivering high quality care to the severely mentally ill and when lacking is likely to lead to demoralization of staff (Lehman, 1989). Where the proper support of frontline staff is poor there is a risk that mediocre community-based systems will simply transplant institutionalisation structures from the large mental hospitals to the community (Talbott, 1979; Kunze, 1985). There is also evidence that a resident-centred rather than management-centred style leads to better interactions with staff (Shepherd & Richardson, 1979).

Background

From 1986 to 1991 a total of 106 long-stay patients had been resettled in the community, with 57 entering supported housing in the district. When the team was formed the input with these individuals was of a very variable level. Clinical review was provided on a necessarily less frequent basis than was desired as it formed an additional burden on an already overstretched acute service.

Staffing of the houses was headed by a qualified nursing member while other members of staff were mostly untrained apart from a brief induction course. Supervisory management of the houses was concerned mainly with administrative issues, finance, tenancies, staff rotas and suchlike. Almost all houses had a 24-hour staffing presence, usually with two staff present during the day and one sleeping in overnight.

Setting up the team

We began to gather ideas initially on the formation and structure of the team. This included discussion with prominent colleagues interested in this field and visits to model services already in existence.

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Discussions took place with interested senior members of the nursing, psychology, and social work teams. It took little encouragement to form a team, by necessity from existing resources, with a member from each of these disciplines and registrar and senior registrar all devoting time in addition to their other commitments.

The starting premise was that every individual has strengths that can be developed and built upon, and the ethos of the team was built on a strategy of normalisation with encouragement towards the development of independent living skills (Wolfensberger, 1975).

One of the early obstacles to the team's work was the perception by some of the house staff that there would be unrealistic demands on their capabilities. There was also concern that a hidden agenda was to reduce the numbers of staff. In order to overcome these worries a lot of time and effort was invested in the development of relationships and enabling the house staff to appreciate the team as a valuable resource. This required lengthy discussion and exploration of the team's role and the provision of practical support for their work. Staff were encouraged to voice their concerns and to express their needs for support. It was evident the staff group often felt undervalued, with pockets of low morale. It has previously been found that the most powerful predictors of resident-orientated care is the extent that staff feel themselves to be involved in decision making and accordingly it was felt crucial to involve the staff in the planning of the team from the outset (Raynes *et al*, 1979).

Despite the difficulties in caring for this group it was evident that there was a close personal bond between staff and residents. The untrained staff members had an advantage in lacking preconceived concepts of the residents' capabilities and had managed in many cases to foster a sense of independence and confidence which would have been difficult to achieve in the setting of a long-stay ward. The team aimed to support this and to provide personal supervision and practical guidance in rehabilitation skills.

From initial meetings with the staff it was apparent that there was a spread of requirements from the provision of training in basic mental health to the need for a clear response to crises. Early perceptions were that the staff in some cases had inappropriate explanations for residents' behaviour. This occurred particularly with negative symptoms where, for example, withdrawal and apathy was seen as laziness. Another difficulty sometimes encountered was a low level of involvement of residents in the routine running of the houses, and this in turn could lead to the staff giving up trying to engage them. The training needs of the housing staff were seen as a priority, although these varied widely. It was decided intervention initially could be best provided on an individual basis working with the residents and staff members in the houses and providing multidisciplinary input on a weekly review. Each member of the team undertook to complete a detailed assessment of the residents, documenting the lengthy case histories, and performing an assessment of current level of functioning and needs.

The detailed assessment of needs led on to the development of a limited number of goals. At the same time it was acknowledged that these goals would often be prolonged in attainment and in some cases adequate goals would consist of preventing deterioration from the current level of functioning. This method of providing support served to stimulate and sustain personal motivation in staff by the use of clear objectives and ordering of priorities. It also served to strengthen the support team by providing reinforcement of our efforts and ensuring the predominant aim remained the provision of practical support and guidance rather than diffuse objectives.

It was decided to develop a new assessment and care planning document, some elements of which were borrowed from existing instruments. Also it was felt a number of special problem areas needed highlighting in view of their seriousness and the possibility that they could be overlooked as they were buried within the extensive case-notes. These consisted of destructive behaviours, sexually offensive behaviour, self harm, suicide risk, dangerousness to others, acting on abnormal beliefs, disinhibited behaviour, disorientation/wandering, significant mood changes, fire setting, and theft. Daily living activities were also rated on a baseline. Subsequently a number of goal targets was addressed following agreement with the resident and a plan implemented. The practical delineation of this was addressed by the supporting team member and also the weekly team input. In this way skills in behavioural methods could be imparted in addition to addressing educational needs of staff.

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The team sought to increase independence and extend choice in the least restrictive environment possible. It aimed, by improved support and more intense assessment, to prevent crises and to provide acute treatment where this was necessary, although also using the hospital if required. An important element of the team's operation was in forming a liaison with other agencies. This sometimes entailed a brokerage function with day facilities where difficulties arose and often meant involving them directly in the care plan instituted for the individual, where previously the patients may have been requested to stop attending.

As the team developed the house staff gained increased confidence in their role, having seen the positive effects of their interventions. An early example was a resident with marked negative symptoms of schizophrenia who suffered with urinary incontinence. By working with the resident and staff member to draw up a behavioural intervention it became possible to reduce this from a daily to an infrequent occurrence. Similar successful intervention was undertaken with a resident with delusional beliefs who suffered disabling 'agoraphobia' which arose directly out of his psychotic experiences. He was fearful of going out because he felt people persecuted him and used rays on his skin and had been unable to travel alone for many years. His avoidance patterns were indistinguishable from that of any individual with agoraphobia. However, because the fears arose in the context of delusional experiences the staff had not attempted a behavioural exposure programme. By redefining the problem as avoidance due to anxiety, and disregarding the source of the anxiety, a logical intervention involving graded *in vivo* exposure suggested itself. It was implemented and worked. His delusional ideas remained unchanged but he became able to travel alone, a feat which had been impossible for many years. This served to instil in staff a belief in the value of their work and impart a sense of achievement even where, as in many cases, the goals were not of great improvements but simply to maintain the current position and prevent deterioration.

From the first author's (HD) perspective of senior registrar training this experience proved very valuable. The placement offered the opportunity to work with a severely disabled population for long enough to effect change. It was also worthwhile as a teaching experience in the imparting of psychiatric knowledge and behavioural techniques to staff members. At the same time useful skills were acquired from other team members, particularly in the area of daily living skills assessment. The senior registrar also acted as the source of medical knowledge within the team. In addition, the experience of forming a team from the beginning, setting up its objectives and carrying through its implementation enabled the development of not only clinical abilities but also those of team building, planning and service development.

It has been heartening that the benefits of the team have since been acknowledged to the extent that funding has now been provided for a full-time support team across the district.

References

LEHMAN, A. F. (1989) Strategies for improving services for the chronic mentally ill. *Hospital and Community Psychiatry*, **40**, 916–920.

KUNZE, H. (1985) Rehabilitation and institutionalisation in Community care in West Germany. *British Journal of Psychiatry*, **147**, 261–264.

MELZER, D., HALE, A. S., MALIK, S. J. HOGMAN, G. A. & WOOD, S. (1991) Community care for patients with schizophrenia one year after discharge. *British Medical Journal*, **303**, 1023–1026.

RAYNES, N. V., PRATT, M. W. & ROSES, S. (1979) *Organizational Structure and the Care of the Mentally Retarded*. London: Croom Helm.

SHEPHERD, G. (1991) Rehabilitation and the care of the long term mentally ill. *Current Opinion in Psychiatry*, **4**, 288–294.

— & RICHARDSON, A. (1979) Organisation and interaction in psychiatric day centres. *Psychological Medicine*, **9**, 572–579.

TALBOTT, J. A. (1979) Deinstitutionalization: avoiding the disasters of the past. *Hospital and Community Psychiatry*, **30**, 621–624.

WOLFENSBERGER, W. (1975) *The Origin and Nature of Our Institutional Models*. Human Policy Pr.

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