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M. L. WESSON AND P. WALMSLEY

Service innovations: Sherbrook partial hospitalisation unit

AIMS AND METHOD

Nationally, a variety of community care projects are being developed to replace institution-based care. We describe an innovative system of providing mental health care in Southport, combining an extended day service with short-term hospital admission – the partial hospitalisation philosophy.

RESULTS

During the first year of operation 438 assessments took place with 27% of patients being admitted to a crisis bed and a further 25% supported via attendance at the unit. Twelve per cent needed in-patient admission and 10% were deemed not to require any involvement of the mental health service.

CLINICAL IMPLICATIONS

The use of short-stay admission coupled with extended day care and crisis line support can provide a viable alternative to admission to the acute ward.

The closure of large psychiatric institutions and the move to community care has brought a pressing need to develop services that are acceptable to patients, effective and safe. Current acute psychiatric in-patient provision has been criticised as being poorly organised (Muijen, 1999), lacking therapeutic activity and unsafe (Sainsbury Centre for Mental Health, 1998), while the proportion of admissions under the Mental Health Act 1983 has increased from 7% to 12% in the past decade (Wall *et al*, 1999).

There is little evidence to demonstrate the effectiveness of hospital care and few variables shown to predict better outcome, including length of stay. A recent review (Johnstone & Zolese, 1999) suggests short hospital admissions were no less effective on a number of measures than long-term or standard hospital stay. In the USA a controlled trial showed day hospital care combined with crisis respite community residence was as effective as acute hospital care for those with severe mental illness (SMI) (Sledge *et al*, 1996). In the UK extending the role of the day hospital has been shown to be an effective alternative to admission (Harrison *et al*, 1999).

Following closure of the asylum Greaves Hall Hospital, Southport, in 1994, the psychiatric service for the population of 120 000 was re-provided via an acute in-patient ward (Park unit) of 22 beds, a longer stay ward (Patterson unit) of eight beds and associated day unit, out-patient department and community psychiatric nurse (CPN) service. In an effort to promote better integration across all elements of the service and taking into account service users' wishes for out of hours access, the notion of partial hospitalisation was developed, which led to the creation of an innovative new unit – the Sherbrook unit. The reconfigured service resulted in closure of the Patterson unit, creation of two additional acute beds and formation of two crisis beds. Overall, the number of beds available was reduced from 30 to 26.

Sherbrook unit

Partial hospitalisation can be described as a total care package delivered part of the time in hospital (Walmsley, 1998). The Sherbrook unit, Southport, is a 24-hour assessment and treatment unit for patients with mental health problems. It has two beds with additional day places extended from the old style 9 a.m. – 5 p.m. to 8 a.m. – 9 p.m. The unit has a maximum 72-hour duration of stay.

The unit is located in accommodation on two floors forming part of the Hesketh Centre. It has its own entrance on the ground floor and a link door through to the Park unit on the first floor. During the first year it was staffed by a clinical team leader (P.W.), eight registered mental nurses (RMNs) (day staff), five nursing assistants and two part-time night staff (8.45 p.m. – 7.30 a.m.). Bank staff also provided night cover. The close proximity to the acute ward enabled some cross cover in case of emergency and staff transfer if the crisis beds were unoccupied.

Referrals to the unit come from local general practitioners (GPs), members of the community mental health team (CMHT) or by self-referral. The patient may be new to the service or an existing user requiring additional support and monitoring. Patients can be referred for assessment or with specific treatment aims in mind. The assessments are carried out by trained RMNs in conjunction with psychiatric trainees, depending on patient need. This process involves a comprehensive risk assessment and HoNOS score (Wing *et al*, 1996). The outcome of the assessment may be short-term admission, day attendance, support via the CMHT or not accepted into the service. For those patients unlikely to be safely managed on the unit then admission to the acute ward remains an option.

There are close working links with staff of the CMHT, in-patient unit, social services and the voluntary sector. This provides flexibility and offers each patient a unique package of care driven by their needs rather than fitting in with traditional service delivery. Patients can attend daily, including weekends, and have access to a 24-hour crisis telephone line. Medical cover is provided by the responsible medical officer's psychiatric trainee, or if not available, by the trainee on call for that day.

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Multi-disciplinary reviews are held weekly by each of the three consultants responsible for patients attending the unit.

The RMNs on the unit are trained via Childline, who are experts in telephone counselling. The crisis line is kept clear of other calls and is a freephone number. Calls are catalogued and important information passed to the relevant CMHT.

Patients admitted to one of the two crisis beds are reviewed on a daily basis and discharged to day care or transferred after a maximum of 72 hours. The unit accepts patients with both SMI and those with less severe mental health problems. It functions as a transitional step for those patients leaving the in-patient unit who still require a high degree of support, allows assessment of those with first episode psychosis and provides a safe environment to commence treatments with lithium or clozapine, for example. For those with less SMI, treatments are provided according to patient need.

Findings

During the first year 438 assessments took place. Forty-three per cent of the patients were male. All were aged 16–64 years. The majority of the referrals came from GPs (28%), followed by CPNs (20%) and consultants (19%). Six per cent were referred from the in-patient unit and 6% from social workers. Thirteen per cent were self-referrals.

Following assessment 130 (27%) were admitted to a crisis bed, while 120 (25%) were given a day place. Twelve per cent were admitted to the in-patient unit, 10% were not accepted into the service and 11% were referred to out-patients.

The average crisis bed occupancy rate over the 12-month period was 41% or 10.8 patients per month. The average length of stay in the crisis bed during the first year was 2.9 days. Patients attending the day unit generally remained for 6–8 weeks, during which time attendance was gradually reduced prior to discharge. The number of admissions to the acute unit fell by 15% despite the fact monthly admissions, percentage bed occupancy and mean duration of stay had remained relatively constant in the preceding 3 years. The reduction in acute admissions has continued although the length of stay has increased (see Table 1).

The crisis line received an average of 20 calls per month, the majority (70%) outside of the 9 a.m.–5 p.m. period.

The number of domiciliary visits by the consultants at the request of local GPs has dropped by over 60% since the unit opened. The number of referrals to the unit has continued to rise and for July 1999 was 52. Initially all assessments on the unit involved psychiatric trainees. However, the increasing number of referrals has necessitated the introduction of a triage system. All patients are now seen by an RMN, who decides on initial management following the unit's protocol. An experienced specialist registrar attached to one of the consultant teams provides supervision for this process. The triage system is currently underway and early reports are encouraging. Initial anxieties among nursing staff were dealt with by acknowledgement of such concerns, attendance for all staff on a 2-day training course and support from the consultants.

Table 1. Pattern of admissions to the Park unit 1995–1999 (Sherbrook Unit opened June 1997)

Year	1995	1996	1997	1998	1999
Monthly admissions (mean)	20.4	20.4	19.4	19.8	15.1
Monthly percentage occupancy (mean)	80.6	89.2	92.1	91.1	95.4
Duration of stay (mean days)	29.6	31.6	34.5	30.9	40.4
Total admissions	245	245	233	237	181

The unit also has one session per week of psychology input provided by a clinical psychologist. This allows for psychometric assessments and time limited therapies where appropriate. A representative from the local Citizens' Advice Bureau attends the unit twice weekly to offer help and advice with a range of problems.

Discussion

The Sherbrook unit provides an acceptable form of help for those with mental health problems. It allows contact with a mental health worker 24 hours a day.

The flexible approach adopted by the unit, in conjunction with short-term admission policy, seems to provide a genuine alternative to traditional in-patient admission. The unit also bridges the gap between in-patient status and return to the community by providing a useful transitional stage between the two.

The unit has proved viable with just two beds because of its close geographical and functional links with the acute unit and also other elements of the mental health service. The extended day support available has maintained patients who would otherwise have previously been admitted to the Park unit.

The modest reduction in acute admissions could be related to any number of variables for which it is impossible to control. However, it appears to be a sustained finding since the changes to the mental health service in the area, including the opening of the Sherbrook unit in mid 1997. The increased duration of sdtay for fewer admissions in 1999 likely reflects the clinical impression that those with the more severe, treatment-resistant illnesses are being admitted.

The psychiatric trainees in Southport are able to assess patients in crisis and have exposure to those experiencing a wide range of mental health problems. They can assess patients in conjunction with experienced RMNs and receive supervision from the specialist registrar or consultant.

Disadvantages include the unit accepting patients experiencing SMI, enduring mental illness and non-SMI because this causes some logistic difficulties (currently being addressed). The number of referrals is increasing, as

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is the number not felt to be appropriate for the unit. During the first year 21% were identified (10% not accepted into service and 11% referred to attend out-patients).

The impact on domiciliary visit rate suggests the majority of such requests for visits by GPs are for expediency rather than inability or unwillingness on the part of the patient to attend the local mental health unit.

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Residential care homes for the mentally ill

Implications for a catchment area service

AIMS AND METHOD

This study describes residents in seven care homes, reviews their usage of mental health services and evaluates cost implications of psychiatric health care provision.

RESULTS

The patients are predominantly male with multiple diagnoses who are receiving psychiatric health care, but in general lack structured rehabilitation services. Forty-seven per cent of the residents moved into the trust catchment area in order to occupy the placement. The cost associated with the provision of differing models of out-patients care varies considerably.

CLINICAL IMPLICATIONS

These vulnerable residents are costing the mental health service relatively little, although the total cost to society is higher. This study points to the necessity of multi-agency planning for 'new long-stay' patients.

The provision of residential care homes for the severely mentally ill in the community is an important issue for psychiatry, and mental health teams regularly search for that will maximise a patient's skills and quality of life. Closure of institutions and current Government policies on community care have led to a rapid expansion of residential care homes in the private sector. Thirty-two per cent of residential places for the mentally ill are now managed by the private sector, and Lelliott *et al* (1996) found an almost threefold variation between districts in the total number of residential places available per unit of populations. Generous provision of residential care can be advantageous, as it can provide much needed transitional or permanent placement for new long-stay patients. However, it can also be disadvantageous, especially if the facilities fail to provide adequate rehabilitative care, which may result in the development of 'new institutions' in the community akin to the asylums of the past. Furthermore, a localised excessive provision of such care homes can transfer morbidity into the catchment area in which they are located.

NHS reforms have also focused on quality management, providing the highest quality of service at the lowest possible price. The pace of private residential care expansion may suggest that such provision is cost-effective and benefits patients. However, there is little or no evidence to support or refute this. Thus, accurate information on costs, service provision and outcomes of placements is required so that informed, strategic development can take place.

The aims of this study were to describe the characteristics and referral agents of residents in seven mid-staffed care homes (as defined by Lelliott *et al*, 1996), to identify the mental health services currently used by the residents, including admissions to hospital, and to evaluate the cost and cost variations of their psychiatric health care.

The study

The population of the study live in care homes in the borough of Lambeth, within a South London catchment area in what was then the Lambeth Health Care Trust. This now forms part of the South London and Maudsley NHS Trust. Of the boroughs in England and Wales, Lambeth has the sixth poorest Jarman index (Jarman *et al*, 1992). The care homes were selected because they are owned by the private sector and provide for people with

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