King's Fund College

ASSESSMENT, RESETTLEMENT AND REHABILITATION:

Designing the arrangements for moving people from psychiatric hospitals into local services

TOM McAUSLAND, DAVID TOWELL
~~AND~~ SUSAN KINGSLEY

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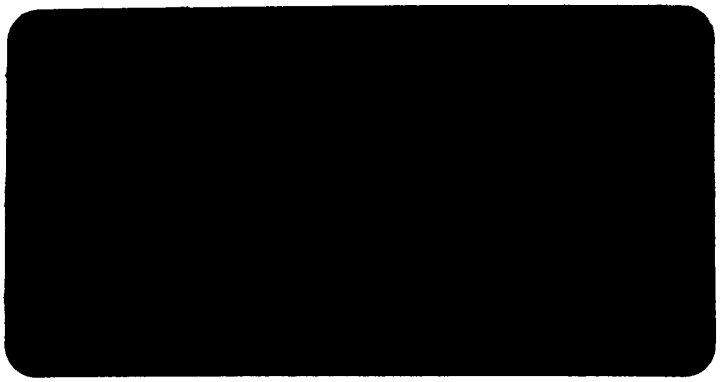

PSYCHIATRIC SERVICES IN TRANSITION
PAPER NO 2

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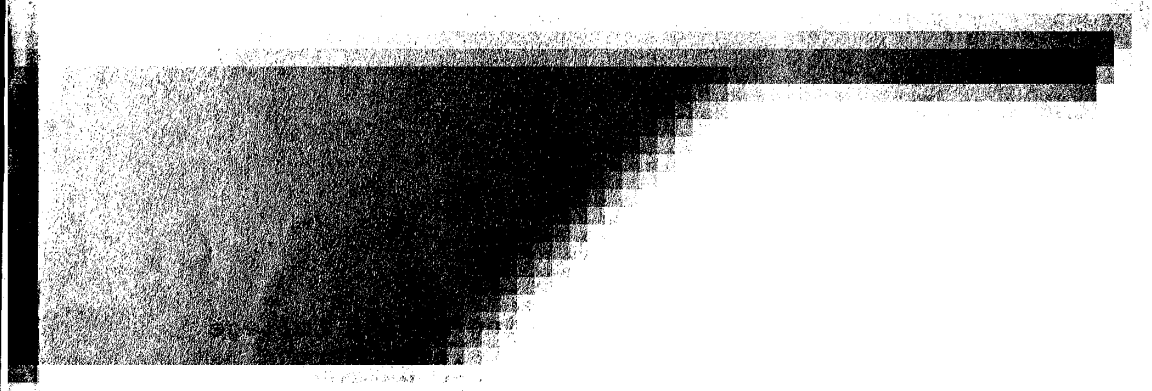


INTRODUCTION

In an earlier paper(`Managing psychiatric services in transition' Health and Social Service Journal Centre 8, 25 October 1984), we provided an overview of key issues in managing the relocation of psychiatric services from large institutions to new patterns of local provision. Another paper (`Moving out from the large hospitals' in Care in the Community - Keeping it Local MIND, 1984) discussed ways of involving staff and patients in this process of transition.

The notes which follow deal with another aspect of managing transition in more detail and offer a summary of our current thinking about the characteristics of an assessment and resettlement model which would be compatible with the wider planning issues set out in the earlier papers.

We will be particularly concerned with two questions:

i) How can senior managers and planners make use of information about the needs and capabilities of people currently living in large hospitals to improve service planning?

ii) How can the overall task of moving large numbers of people out to local services be broken down into manageable stages so that the resources for rehabilitation are used efficiently and the interests of individual patients are safeguarded?

Our starting point was consideration of appropriate techniques for in-patient assessment. It soon became clear however from discussion with people in the field that what is appropriate depends very much on the stage that has been reached in developing local services and the type of planning activity that is involved.

On a strategic level, `receiving' districts and local authorities trying to establish broad parameters for planning local services need information on the approximate number of hospital in-patients who will require local services (taking into account likely deaths over the expected transition period) and basic data on age, sex and estimated functional capacity. `Providing' districts with responsibility for the management of the hospital during the transition require the same sort of data for their co-ordination and monitoring tasks. These planning groups do not need, and do not have the capacity to cope with, highly detailed information from profiles of named individual

patients. For broad brush planning activities (e.g. deciding the relative allocation of resources to user districts; giving a picture of numbers of people each district is planning for) general statistical data which can be obtained from existing hospital records supplemented by information from staff on the wards is probably adequate.

This sort of information is not sufficient for real service planning such as producing operational policies for community dementia teams or deciding the form of local residential provision. These tasks depend on more sophisticated information about patients capabilities and needs, substantial input of professional time and expertise, and opportunities for patients themselves to contribute their experience and preferences as part of the service design process.

The first requirement of an effective assessment and resettlement model therefore is that it clearly differentiates strategic planning tasks from service component/project planning and recognises the need for two distinct stages of information gathering and 'assessment'. In some of the current planning there seems to be a sense of confusion and compromise between these two levels of information, resulting in assessment exercises which fall between two stools - too complex and time consuming to guide broad strategic decisions but too superficial for individual care planning and imaginative service design.

In our experience detailed profiles of individual long term patients are not routinely available through professional records and immediate care staff may not have some of the necessary information. Our work on assessment has, for example, shown the importance of careful exploration of patients social networks (the set of meaningful relationships patients have with other people inside and outside the hospital) to ensure that as far as possible relocation decisions maintain existing supportive contacts. Real social networks often do not conform to professional expectations and groupings. Only one or two contacts may be important out of twenty or more people living on a ward. There may be stronger links with people living outside the hospital in one of the user districts. Identifying such networks is in itself a task requiring considerable professional investment - perhaps a minimum of 3 to 4 hours additional skilled time for each patient.

The importance of this type of individual centred information and the need to commit skilled staff to collect it and to act on it has major implications. It

means that in most situations it will only be realistic to focus the limited assessment and rehabilitation resources available on relatively small numbers of patients at any one time. An effective resettlement model therefore has to have the capacity to identify patients who will have priority in the relocation process before detailed individual assessment and care planning are carried out.

An appropriate model for relocation also has to reflect four other considerations. Firstly, there is the importance of maintaining the viability of the large hospital as an effective organisation during the period of contraction. A transition strategy which 'creams off' the majority of younger patients with lesser disabilities in the first 3 years or transfers professionally prestigious services - acute admission, academic research and teaching, psychotherapy - ahead of services for the more disabled or elderly patients seems likely to risk creating an unmanageable and unstaffable institution in a short time.

Secondly, there is the need to maximise revenue savings at the hospital through relocation in order to transfer resources to the new local services. Some double running costs are unavoidable until the transition process is completed but if closure and transfer of resources can be achieved at ward level this may bring greater savings than if individual 'beds' are removed from a large number of wards.

Thirdly, it seems likely that this large scale operation will generate a great many new ideas about community based services particularly for people with long term and severe disabilities, where our current experience is limited. Service models planned in the early years of the transition are likely to be superseded fairly quickly in the light of the experience of running them in practice. It may therefore be appropriate to aim for a relocation model which from the outset generates successive 'waves' of patient and staff transfers, each with the capacity for experimentation, appraisal and change.

Finally it may also be safe to predict an element of unpredictability in the overall process. However thorough the preparation, some delays in the completion of scheduled projects are likely and unexpected new service development opportunities are liable to emerge which could not be anticipated in advance. Viable resettlement processes require robustness to cope with delays or mistakes and flexibility to capitalise on unexpected opportunities when they are presented.

DESIGNING RELOCATION: BASIC PRINCIPLES

The complexity of the task and the need for pragmatism in the face of limited resources and time make it all the more important that those involved in planning the relocation process have a very clear set of standards by which to judge their performance.

We suggest that similar principles should guide the design of arrangements for both relocating patients and redeploying staff. These are set out in Figure 1. The principles can be understood as aspirations, departures from which need to be rigorously justified. In some areas there will be trade-offs between one aspiration and another, requiring careful examination of how patients' best interests can be served within the constraints enforced by limited resources.

A MODEL FOR RELOCATION AND REHABILITATION

These considerations have led us to formulate a step wise model for managing the relocation of patients and staff. This model is an attempt to reconcile the practical realities and challenges of service development activity with the key principles. It is not intended as a blue-print for service planning. It deals only with some of the assessment and patient transfer processes, and many of the other prerequisites for a successful transition strategy - appropriate personnel and financial policies, staff training arrangements, local and strategic leadership and so on - are not referred to. A description of the process is set out below and summarised later.

Step 1: Establishing a communication and information system

A precondition for any assessment and data collection activity is the establishment of an effective communication system across the hospital and the user districts. Around the country some of the work on this has included:

newsletters, leaflets, and videos; presentations and seminars held in the hospital and the user districts involved; information rooms and travelling displays giving up to the minute details on policy and practical arrangements for transition, proposals for local services and so on.

Figure 1: Basic principles in the design of relocation arrangements

FOR PATIENTS	FOR STAFF
1. Patients should move to a better service:	1. Staff should move to a better service:
2. ... in a locality where they have meaningful links.	2. ... in a district for which they have expressed a preference.
3. ... in ways which sustain existing social relationships wherever possible.	3. ... in ways which sustain existing relationships wherever possible.
4. New services should be designed around the strengths and needs of individuals and small groups.	4. Relevant staff should be involved in the design of new services around the strengths and needs of patients they know.
5. Patients should be involved in decisions about 1, 2, 3 and 4.	5. Staff should be involved in decisions about 1, 2, 3 and 4.
6. Patients should be offered skilled support in contributing to these decisions.	6. Staff should be offered skilled support in making decisions about their own future job.
7. Careful efforts should be made to prepare patients for moving into new situations.	7. High quality development opportunities should be available to prepare staff for relocation and equip them for the practice of new roles and skills.
8. This preparation should seek to minimise 'interim' disruption to patients' lives not directly relevant to relocation.	8. Any staff movement within the hospital should be carefully planned with the preceding principles in mind.

Alongside these ad hoc channels the existing management and staff meetings have been used with varying degrees of success to update everyone on developments. However the process is organised it should include health and local authority staff at all levels inside and outside the hospital and include the patients. From the outset this will have a general role in dispelling myth and rumour about the relocation arrangements. Once hard information is available, this system should get it to the people who need it promptly and without misunderstanding.

Step 2: Who is planning for what?

Hospital managers and staff in the districts currently using the hospital need fairly quick answers to a number of questions:

- How many districts will receive patients and resources?
- What are the geographical areas that each authority takes responsibility for?
- What are the rules for allocating `non catchment' patients from outside all of these districts?
- How are the people from different districts of origin currently located across the hospital wards?

Hospital managers may have to do some work using existing record systems

a) To create a map of all the hospital wards showing distribution of patients from different districts of origin

b) To provide each `user' district with information on the numbers of people who are allocated to them, broken down in fairly rough and ready terms. For example:

- by age, e.g. over/under 65
- by assessment of dependency, e.g. in 3 levels
- by sex
- other categories relevant locally

At this stage most districts do not need a great deal of detail and it is too early to make firm decisions about named individual patients. This is essentially a paper exercise and though some collation of information from records at ward level may be helpful, it need not involve `real assessments' of large numbers of people living in the hospital. It is not a sectorisation process. Patients are not moved from the wards they are living in on the basis of this district of origin, dependency, sex or age data

Step 3: Investigating physical retrenchment options for the hospital

This is mainly a technical exercise looking at options for the phased withdrawal from the site. It should take into account things such as the capabilities of the heating and catering systems, the possibilities of selling sections of land, physical conditions of different ward blocks and so on.

Step 4: Guestimates about the first wave of local provision

In an ideal world, district planning groups and project subgroups would have organised themselves, used the data from step 2, consulted at length with hospital staff and patients, clarified their individual vision of a local service and set out some priority projects based firmly on a detailed understanding of the needs and wishes of a number of hospital patients. In reality the process is likely to have been rather different. One or two proposals may have been imaginatively tailored to the needs of individual patients and small groups, others will be the byproduct of political and professional compromise in district planning groups, off the peg models left over from a previous plan or ideas borrowed from a neighbouring authority. Some districts will be more efficient in putting forward proposals than others so there is likely to be imbalance here in the early stages. As with most planning processes it is useful to be clear about the fact that what appears in the first or second district plan may be very different from the final services which come into operation. Typically these early proposals change a great deal in response to consultation, input from staff, pressure groups and so on. They are best thought of and presented as a `first guess' which must be modified and improved in the light of more detailed knowledge of the patients and their wishes.

Despite their limitations the proposals that do emerge represent an agenda for discussion between district

planners and professionals and the patients and staff in the hospital. They can be a focus for meetings, educational events and visits. It is important that there is a recognised channel for collecting and keeping an up to date overview of the details of these individual schemes. One purpose of this is to be clear about which schemes are due to open in the next 12 - 18 months, how many people they are intended to serve - age, sex, dependency characteristics - and which user district is involved. As far as anyone can judge, it is to these schemes that the first wave of existing hospital patients will move and the timescale is such that selecting and preparing patients is an appropriate task. It may be valuable to establish a group of senior staff from the hospital and the user districts who have a mandate to act as a clearing house and information resource for all of these schemes. A group such as this can keep track of developments and help resolve problems in the practical arrangements for relocation.

Step 5: Consultation with hospital staff on relocation preferences

Step 4 will give some sense of the character of different user districts and an indication of the direction their services are taking. By this stage hospital staff should have had the support of appropriate personnel and training policies and for some the time may have arrived to decide whether to transfer along with their patients to particular districts. Hospital managers will be concerned that enough challenging projects are developing within the contracting hospital to ensure that a fair proportion of well qualified, talented staff opt to stay on rather than move out in the first wave of local provision.

Step 6: Identifying priority relocation wards

Steps 1 - 5 have been basically preparation and information gathering tasks. It is from this point that detailed assessment and resettlement activity begins. It is at this point too that the major difference between this relocation model and the traditional rehabilitation system occurs. The task here is for managers, in consultation with hospital staff and district colleagues, to identify a small number (2, 3 or 4) wards which will be the priority for closure and transfer in the next 12 - 18 months. By the end of that time all (or almost all) of the patients and all the staff and resources associated with these wards will have been transferred to the user districts. 'Priority wards' are intended to accomplish two things:

- to focus relocation work on a manageable number (60 - 80) of patients at any one time so that real individual assessment and consultation can take place.

- to create a focus for resettlement activity in a small part of the hospital and to minimise general disruption in the hospital.

Selecting the wards to have priority will involve consideration of a number of factors (illustrated in Figure 2) but it is aimed at achieving the best possible match between the first wave of user district proposals and the general characteristics - age, sex, district of origin, rough dependency levels - of the people living on the wards selected.

Two points may be worth stressing:

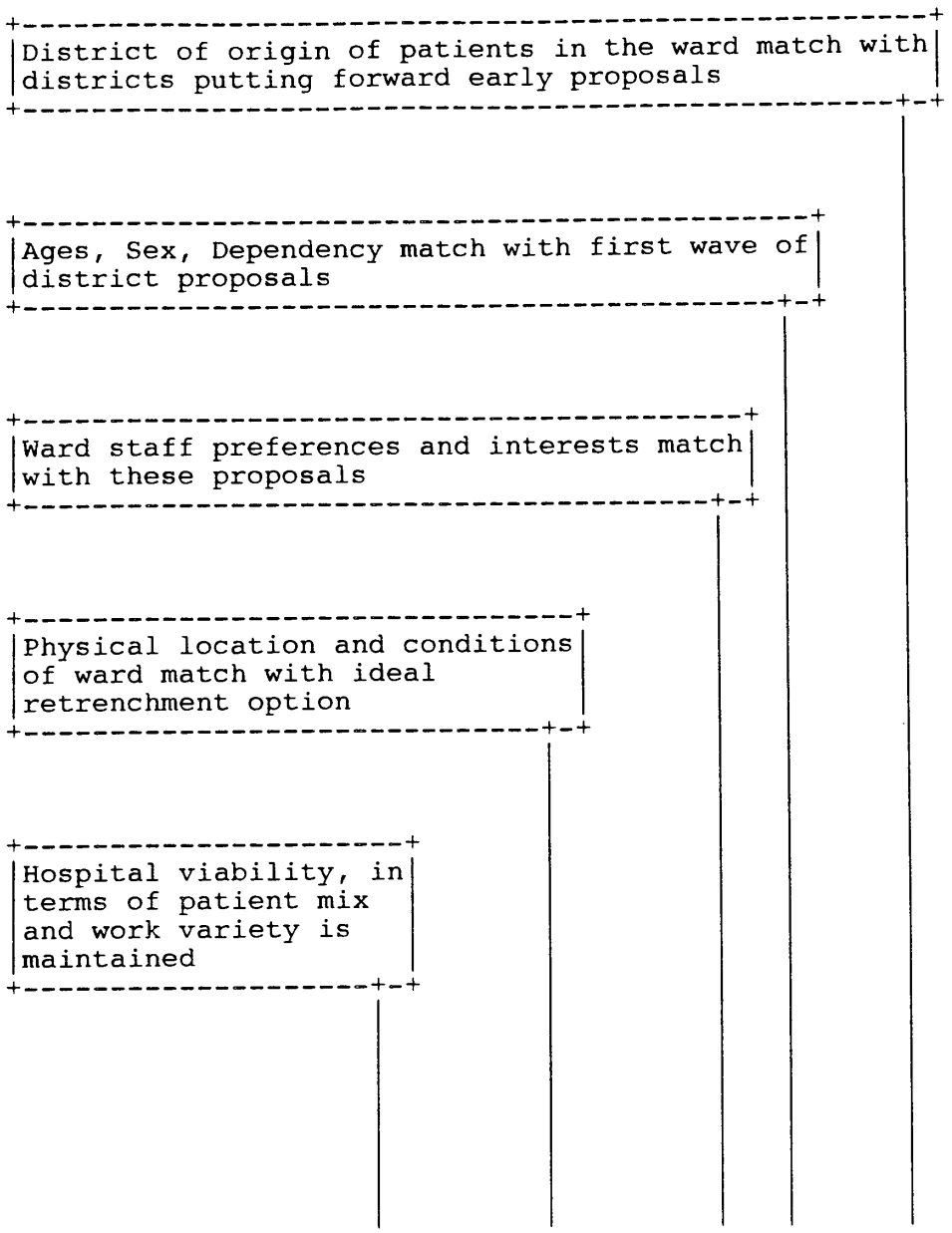
i) It will be fairly easy to correct any mismatch in `district of origin' at this early stage by `paper' adjustment of `out of catchment' allocations and by agreed `swaps' between districts of the named patients for whom they will take responsibility.

ii) The match between the first wave of proposals and the wards is not intended to be exact. It is a first guess which may suit a large number of patients but which will also point to a number of patients living on the wards for whom there is no current service on offer. It is one of the principles of the `priority wards' model that hospital, district, regional and local authority agencies involved agree to give a high priority to the task of creating suitable alternatives for these individuals. It is through this that hospital-based staff will be given incentives to initiate project planning around the needs of very small groups of patients.

Step 7: Exploration of social networks

Before detailed individual assessment and preparation on the priority wards, work is required simply to gain an understanding of the pattern of friendships and social support among the people living on these wards. This will require the allocation of additional specialist resettlement/rehabilitation staff to the ward to help the current ward staff in building up a picture of whether there are some important small groupings which should not be broken up in the relocation process. The

Figure 2: Criteria for selecting priority wards



size of these important networks is likely to be small - 2, 3, 4 people. For some, individual contact will be with people living on other wards and decisions have to be made about whether the `outsider' is to be planned for as part of the priority group. This is a period when staff and patients on the priority wards should be able to take time and space to discuss with each other their general feelings about the transfer and their hopes and fears for the future. Within the wards the task would be to match the individuals and clusters of friends as far as possible to the alternative provision being offered by the user districts.

Step 8: Individual assessment and preparation for resettlement

At this stage - with a relatively small number of patients in mind, with a well informed picture of provision that will be on offer from user districts in the not too distant future and with resettlement and rehabilitation resources from inside and outside the hospital concentrated on the task - it becomes feasible to begin detailed assessments and planning for individuals and small groups of patients. It is now that the introduction of a key worker system, use of techniques such as `getting to know you', nursing process and more general skills training becomes appropriate.

Now staff and patients on the wards should be in a position to discuss, evaluate and adapt the proposed designs and operational policies of the first wave of user district services. There will be opportunities for visits to the proposed provision and close joint working between the local staff and those currently living and working in the hospital.

The recruitment of independent advocates to act on behalf of individual patients on the priority wards is one mechanism for making sure that the interests and views of patients are represented alongside those of hospital staff and professionals in the user district. These advocates may have a particularly important role in monitoring the match between the new professional services being offered and the wishes and needs of individual patients.

If user district planning groups have done their job well, with adequate early consultation and in line with the principles set out above, the proposed services will represent a reasonable match with the needs and wishes of individuals and small networks of patients and there will be flexibility for the necessary changes and

tailoring to improve this match. The lead time of 12 - 18 months will be long enough for the preparation and redesign tasks but not so long that it becomes a meaningless abstract activity for hospital staff and patients.

There will also be a large or small amount of 'mismatch' between the first wave of proposed services and the identified needs of the people living in the hospital. This may be because the proposed provision is too institutional in character and scale or because the proposed level and variety of staff input is wrong and so on. When it is felt that a proposed local service does require substantial rethinking or when the overall amount of provision on offer is not enough to meet the needs of all of the patients living on the priority wards, project design groups involving ward and local staff, patients and advocates and members of the resettlement and rehabilitation team can be charged with the task of developing new proposals for small groups of patients. A 12 - 18 month lead time makes this feasible provided that these groups receive the appropriate priority and backing from senior district, local authority, hospital and regional officers.

Step 9: Patients and staff move to new local services

If there has been good overall coordination across the local project development groups and the priority wards, it should be possible to aim for synchronised dispersals from any one ward within a short period. Now individuals and small subgroups of patients break up from the ward block and move out to the new services scattered within and across user districts. Some staff who have been working with them on the priority wards will have chosen to apply for the jobs in the user district services and they will move along with subgroups of patients they have known as key workers. For other staff this will be a time for transfer to other long term wards in the hospital or to other jobs.

Resettlement staff who have been working with the patients and ward staff on the priority wards over the preceding months will continue to work on a peripatetic basis with the 'priority ward' patients outside the hospital in the new district provision. Though a certain amount of assessment and preparation work will have been carried out before the transfer, the bulk of the intensive rehabilitation and training effort will take place after the transfer to the long term housing and social settings in the user districts. This period after relocation will be when both patients and staff require the most intensive additional support.

This will be the time when practical day to day experience will indicate further adjustment to the operation and staffing of local projects and changes in the care plans for individual patients. In the new setting some patients will be seen to be less dependent than had been anticipated and some will require more help or different forms of help than was predicted from knowledge of the person on the ward. Patient advocates will remain involved during and after the relocation and staff remaining in the large hospital will also have an important role in monitoring the operation of the new services and ensuring that the quality of life of patients is better than it was before the move. As patients and staff in the first wave of reprovision settle down resettlement/rehabilitation staff input can be withdrawn from the new services and made available for redeployment on the next priority wards.

Step 10: The Cycle repeats

Informed by a systematic review of the experience of arrangements for the first wave of reprovision and successes and failures of individual projects steps 2-9 will be carried out again. Results from the previous wave of relocation may encourage earlier and fuller coordination between user district planning groups and the front line staff and the patients on the hospital wards. Short cuts, alternatives and better coordination systems may suggest themselves. If the results are encouraging the process will continue until the final wave of reprovision completes the task of creating imaginative user district services and leaves an empty large hospital site. This 10-step model for relocation and rehabilitation is summarised below.

A model for relocation and rehabilitation: Summary

Steps	Some implications for Managers	Some implications for Staff
1 Establishing an information/ communication system in hospital and across districts	* Making available time, staff and space to do this	* Access to reliable up-to-date information on plans and progress
2 'Paper allocation' of present in-patients to districts including both 'district of origin and 'non catchment' patients	* Agreeing rules for allocation	* Informed of purpose and outcome
- This would be an administrative list for planning and monitoring purposes, not a decision about named individuals		* Informed/consulted on future admissions
- A basis for providing user districts with rough information on numbers/ages/sex/'dependency' levels	* Arranging a simple survey or census if needed, and making information available	
3 Investigating physical retrenchment options for the hospital	* Mainly technical exercise	
4 Taking stock of provisional district proposals for local services - making a guesstimate of first wave of provision to open	* Identify named liaison staff in districts * Arrangements for district visits, handouts, presentations	* Access to a district staff contact and information on proposals
5 Consultation with staff about preferences on relocation. Not a change in job or contract, a chance to express and take note of interests and constraints	* Arranged in consultation with unions and managers * Time and staff needed to do this	* Access to advice, representation and support by unions and managers

Steps 1 - 5 are information gathering and preparation activities. Only from this point on does any change take place in the day-to-day lives of (a minority of) staff and patients.

6	Identification of 2/3 wards to be a priority for transfer in the next 12/18 months	Managers have to juggle 4 or 5 factors in selecting these priority wards (see figure 2) * Involvement of liaison staff from the districts involved * Opportunities to recruit new staff if needed	* All staff informed * Detailed discussion with staff on the 2/3 wards involved * Opportunities to swap wards if requested * Time and space for staff and patients on 2/3 wards to talk
7	Exploration of social networks and friendships on the priority wards and links to localities	* Allocation of additional specialist resettlement input to the wards * Opportunities for patients to swap to match their network of friends * Adjust step 2 paper allocation	* Ward staff actively involved
8	Individual and group preparation to move - More detailed individual assessments and plans	* Input by resettlement and district staff on wards * Recruitment of independent advocates for patients * Assessment of 'match' of patients needs to districts proposals, and where there is 'mismatch' - a) districts have access to other wards b) high priority given at all levels to produce alternatives	* More detailed work getting to know individual patients * Staff discuss, evaluate, adapt proposed operational policies, visit districts * Active involvement by ward staff
9	Patients and staff move to new services	* Co-ordinated to achieve ward 'closure' * Resettlement staff temporarily move with staff and patients to districts	* Priority ward staff move with patients, transfer to other wards or into resettlement team * Long term monitoring of outcome by remaining hospital staff
10	Cycle repeats	* Review of next wave of district proposals in light of experience	* Early active participation by hospital staff in planning

ORGANISATIONAL IMPLICATIONS

There are two further organisational implications arising from this approach which require explicit attention.

i) Sectorisation

Our development of this model has emerged in a programme of work with staff at an `unsectorised' hospital serving a large number of user districts which undoubtedly adds to the complexities.

On balance, however, for hospitals not already sectorised we do not think that the upheaval in major internal reorganisation can be justified if contraction and closure can be envisaged over the next decade. The relocation model outlined above allows a form of `paper sectorisation' at step 2, giving each user district an accurate picture of numbers, important general characteristics and current location within the hospital of people who will be their responsibility. The `priority wards' model does not require that all patients on wards originate from one district or that they all move out to the same district. The evidence we have suggests that widespread `rationalisation' of existing hospitals using `district of origin' or `dependency' information obtained from records and general surveys is likely to cut across and damage important relationships among patients and between patients and staff members. The amount of work required to carry out these internal transfers and their disruptive effects on staff and patients seem on the whole likely to distract attention from the real task of moving patients and staff out from hospital to local district alternatives.

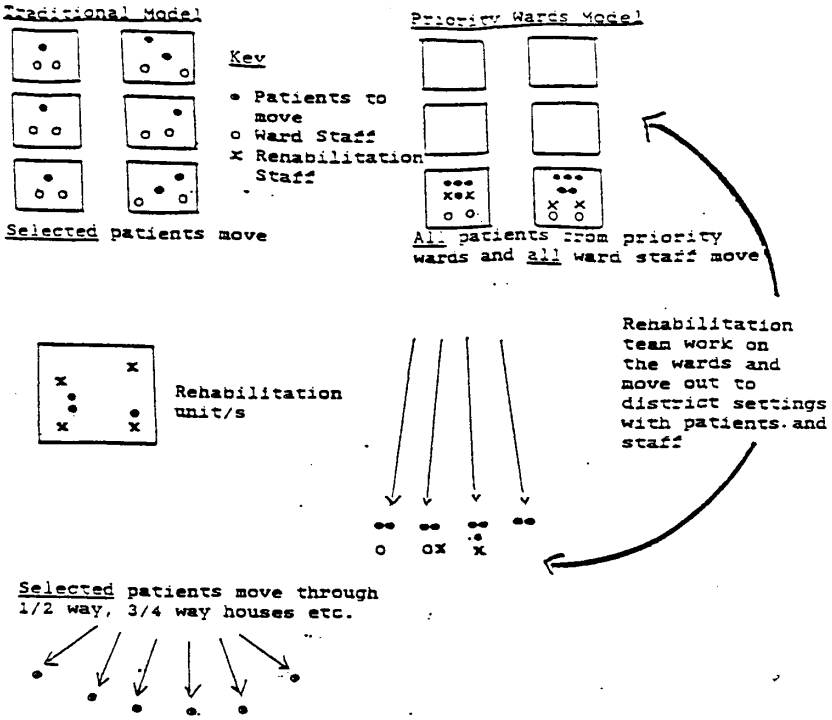
ii) Rehabilitation Services

The model outlined above presents a set of tasks for staff with expertise in assessment, resettlement and rehabilitation which are different from those carried out in the static large hospital. Here the task is to work on a small number of existing wards. The location of the work will not on the whole be in rehabilitation units, half way houses or similar specialist sites and indeed the majority of the rehabilitaion effort will be focused outside the hospital itself in the new services where patients and staff live and work in the long term. Specialists in resettlement/rehabilitation will operate as a group of teams working on a peripatetic basis inside and outside the hospital: allocating large numbers of staff to specific wards or projects at times

of intensive support and withdrawing staff as need lessens. This pattern of work will not be entirely unfamiliar to existing consultants with an interest in rehabilitation or to occupational therapists, nurses, psychologists and social workers. What would be different is the scale of the operation and the dramatic increase in the proportion of time spent away from the hospital. The other major change will be in working with patients who are on the whole older with higher levels of psychiatric disability than those commonly found living in `rehabilitation wards' in most hospitals.

The resettlement/rehabilitation teams will have a major professional role in the transition process and will require an appropriate level of staffing and resources. As the process goes on, individual team members may decide to remain on a permanent basis with a user district where they have been providing short term support. Equally, hospital based staff may be interested in taking up a peripatetic role with this team rather than transferring out directly to one fixed user district service or to other wards within the hospital. There is clearly scope for several phases to evolve in the form any relocation system would adopt. There is also scope for local variation in the detail of this basic rehabilitation team model and for changes in different phases of its operation. Figure 3 presents some key features of this rehabilitation system.

Figure 3: Implications for rehabilitation services



There are a few key differences between a rehabilitation service in the 'priority wards' model and the traditional service for a hospital which is not closing.

1. Traditionally, staff stay where they are while patients move through the system to live and work in different settings with different staff as the relocation progresses. Here, both patients and ward staff move out (in some cases remaining together).

2. Traditionally, rehabilitation is focused on specialist units - halfway houses, intensive training wards etc - with the major input before movement out. Here, rehabilitation input takes place in the existing ward and day time settings and in the new district settings, with some input before but probably with the majority of input after patients move out.

3. Traditionally, patients are selected to move out on the basis of assessments of 'low dependency', successful recovery, cure etc. Here, all patients will move out from the priority wards which may have been selected as representing high levels of 'dependency' or ' illness'. The task is to decide

how services are to be set up to allow these people to live locally with continuing support, not to decide who is ready to be discharged.

4. Traditionally, rehabilitation has drawn individuals out of their existing social networks on wards to recreate networks within the rehabilitation system. Here, the emphasis is on maintaining existing networks before, during and after transition, even when this may mean cutting across 'district of origin' or 'dependency' categories.

Psychiatric Services in Transition

This paper is one of a series of publications which report the experience and conclusions of the King's Fund 'Psychiatric Services in Transition' workshops and associated field development activities. These have been designed to address the varied needs of health service and local authority personnel charged with designing and implementing the development of community-based psychiatric services. The programme has covered creating new services where none existed before; relocating resources from institutional services; and the policy framework required to support change. Further details are available from the King's Fund College.

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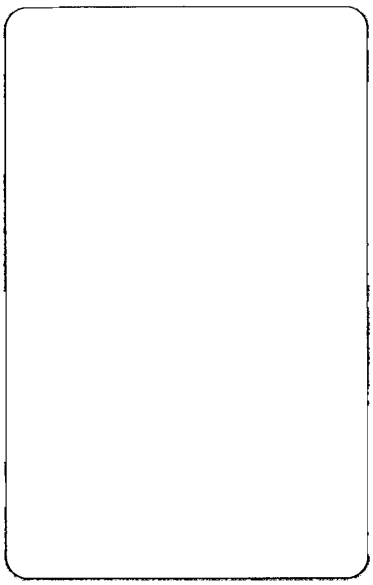

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