Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Secure care services: Medium secure services for men and women at Ardenleigh, Reaside Clinic and Tamarind Centre

Secure care services

Commissioners' information leaflet


Ardenleigh


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Ardenleigh

The women's medium secure service for the West Midlands region is located on the Ardenleigh site.

Our postal address is: Ardenleigh, 385 Kingsbury Road, Erdington, Birmingham, B24 9SA.

Telephone number: 0121 678 4400

The referral co-ordinator's number is
Tel: 0121 678 4526
Fax: 0121 678 4533

Reaside Clinic

The men's medium secure service for the south and west of the West Midlands region is located at Reaside Clinic.

Our postal address is: Reaside Clinic, Reaside Drive, Birmingham Great Park, Rubery Birmingham, B45 9BE.

Telephone number: 0121 678 3000
Fax: 0121 678 3246

Tamarind Centre (Open from December 2012)

The men's medium secure service for north and central Birmingham, for long term medium secure and personality disorder services for the West Midlands region is located at the Tamarind Centre.

Our postal address is: Tamarind Centre, Yardley Green Road, Bordesley Green, Birmingham, B9 5PU.

Telephone number: 0121 301 0500

Inpatient services

The women's service at Ardenleigh is a regionally commissioned, 30-bedded service for adult women. The men's service at Reaside Clinic and Tamarind Centre provides 181 beds in conditions of medium security for men with mental illness, personality disorder, and those who need longer term care. Our services are locally based for the people of the West Midlands.

We provide assessment, treatment and care for men and women who are experiencing complex mental health difficulties and who also pose a significant risk to others either through direct physical violence, sexually harmful behaviour and fire setting, but who may also present a risk to themselves. We provide a safe, quality service for all service users requiring this type of care, managing challenging behaviour while delivering a competitive length of stay.

All service users who come into our care receive comprehensive assessment and treatment. Comprehensive assessment includes opinion on diagnosis, psychological and risk formulation. Assessments include detailed analysis of physical and mental health needs, social care needs, educational and vocational needs and needs with respect to family functioning and peer relationships.

Therapeutic approaches and interventions are needs-driven and implemented by the multidisciplinary team, in order to meet the holistic, gender specific care requirements of men or women. These interventions are informed by best evidence in the field and are implemented on an individualised basis due to the complexity of treatment required by our population.

The vast majority of our service users are detained under either part 2 or part 3 of the Mental Health Act 1983 (updated 2007), and are therefore managed using the care programme approach (CPA) framework.

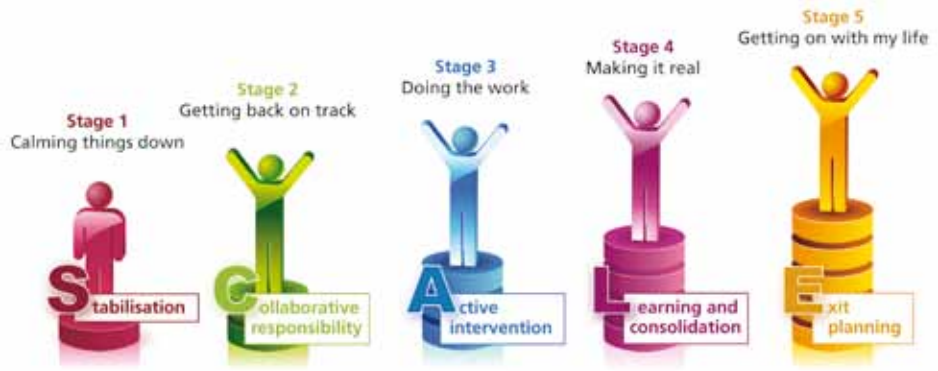
The service offers a wide range of therapeutic interventions at both an individual and group level, using a variety of treatment models and approaches that respect a diversity of needs.

Treatments and interventions offered are based on the needs of our service user group. This means we need to be flexible and adaptable in our approach as our case mix changes. It is also part of our philosophy that we derive strength from the multidisciplinary approach, with many of our interventions being delivered by a number of disciplines, so we can bring a number of skills together in providing care, in order to maximise positive outcomes.

Pharmacological approaches to treatment are also key components of some service users' care. Physical health needs are fully assessed, monitored and managed throughout the care pathway. We also provide interventions for families including assessment, liaison, consultation and specific family work using a variety of approaches. Work with friends and families include support groups, open days, forums and individual meetings.

The service model

The SCALE pathway



Core clinical programmes:

- Mental illness and associated distress,
- psychological wellbeing,
- risk reduction, and
- substance misuse.

Quality of life programmes:

- Home and care environment,
- physical health and wellbeing,
- family and relationships, and
- life skills and community integration.

Community services

A community follow-up service is provided for service users leaving medium secure care where required. A personalised pathway will be developed with the service user. The clinical team will work with the service user to decide the most appropriate pathway, which may include the local community mental health team. We aim to support the service user to identify their own needs, and work with them on risk reduction.

When deciding on the appropriate care pathways, a number of things will be considered:

- The views and opinions of the service user,
- their individual strengths and needs,
- requirements of other agencies eg Ministry of Justice, Multi-Agency Public Protection Agency (MAPPA), National Probation Service, decision of Mental Health Review Tribunal,
- appropriate location,
- where and how identified needs will be met, and
- any specific skills and experience of staff required.

Moving on from secure services will be different for each individual. We strive to develop strong relationships with other services and agencies to support each service user. This may include moving to high or low secure services, community accommodation or in some cases, return to prison.

It may be appropriate for them to be discharged back to the family home or their own home with support the community follow up service where required. This may be delivered in partnership with local mental health services, the probation service or any other agency required to ensure service users can live safely and as independently as possible after discharge.

The clinical teams

There are 16 clinical teams operating a patch based referral model. Referrals are allocated to the teams dependant on the PCT location of the service user.

The teams are comprised of:

- Psychiatrists,
- nursing staff,
- occupational therapists (OT), assistant OTs and technical instructors,
- social workers,
- psychologists,
- physiotherapists,
- activity workers,
- vocational staff,
- administration staff,
- GP services, and
- advocacy and user involvement staff.

Referrals

Referrals need to meet the admission criteria as outlined below and need to be supported by a consultant psychiatrist. Once a referral has been received this will be discussed at the referral meeting and if deemed appropriate, allocated for assessment. The referrers will be kept informed at each stage of the process.

If, following assessment, the service user is deemed suitable for admission, appropriate arrangements will be made for this where applicable. There will be an expectation that the relevant local services will remain involved throughout the person's care and participate in the care programme approach process.

Service users are typically referred from:

- Prison,
- via the criminal justice system,
- high or low secure hospitals in the NHS and independent sector,
- other medium secure hospitals in the NHS or independent sector, or
- local mental health hospitals (non-secure).

Admission criteria

The referral letter can be from any psychiatrist, for example, the NHS responsible psychiatrist, a prison psychiatrist or other relevant psychiatrist.

Men or women will only be considered for clinical assessment by the service if they meet the following criteria:

The person is over 18 years of age at the time of referral

AND

The person could be detained under either part 2 or part 3 of the Mental Health Act 1983 (updated 2007)

AND

The person presents a risk to others of one or more of the following:

- Direct violence liable to result in injury to people,
- sexually aggressive behaviour, or
- destructive and potentially life threatening use of fire.

OR

The person is in custodial care and presents a serious risk of suicide and/or severe self-harm

AND

The referrer can give evidence that serious consideration, and testing where appropriate, of alternatives has already been tried prior to referral, indicating that the case has exceeded the ability of available mental health services to meet the need.

Referrals who meet these criteria will be assessed to see if their needs can be met by the service.

Referrals should be made in writing to one of the consultant psychiatrists in the services.

Referral checklist

Referrers should ensure that they include the following information to ensure timely response to their referral:

- Full referral letter from relevant consultant psychiatrist,
- relevant supporting documentation including as much information as possible on historical and current risk, mental health difficulties, social circumstances, legal status, physical health and previous treatment.

Once your referral has been discussed at the weekly referral meeting and is deemed appropriate an assessment meeting will be arranged. Initially the consultant psychiatrist will visit to assess the person. Following this further assessment may be undertaken by nursing and/or psychology staff, depending on the person's needs and whether they require admission. We aim to assess within two to three weeks of receipt of referral letter but in urgent cases we will come out within two to five days.

If accepted for admission, we will admit at the earliest opportunity. If a bed is not available within a reasonable time frame, dependent on needs, a case will be made to the commissioners to purchase a bed from another provider. You will receive a report detailing the assessment within a month of assessment.

Facilities

Birmingham has a wealth of amenities and enjoys good road and rail links with most of the region due to its central location. Our services have a range of facilities to support our specific treatment plans and enhance recovery and positive outcomes for our service users.

These include:

- Multigym and sports hall,
- indoor swimming pool (based at Ardenleigh but which can be accessed by other services),
- patients library,
- astro turf pitch,
- hairdressers,
- a shop - which is run by the service users,

- multifaith and chaplaincy service,
- GP and primary care suite including dental suites at Reaside and Tamarind Centre,
- occupational therapy workshop,
- horticultural area,
- graphic design studio and vocational training run by First Step Trust (Ardenleigh),
- outdoor spaces
- full range of educational facilities, and
- visiting rooms.

Wards are set up to provide intensive, acute and rehabilitative care. We also have specialist wards in Tamarind Centre to provide care for men who require longer term care and those who have co-morbidity in mental illness and personality disorders.

www.bsmhft.nhs.uk

Main switchboard: 0121 301 0000

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