

Richmond borough: Mental health and wellbeing need assessment

Evidence based frameworks

Executive Summary

1. The paper covers
 - Models of care and care pathways in guiding effective practice (section 2)
 - Measurement of quality and outcomes (section 3)
 - Integrated responses to mental health and physical health (section 4)
 - Reconfiguration of specialist community mental health services, including evidence informing redesign of teams (section 5).
2. The new Outcomes Frameworks and NICE quality standards are important elements of the mental health commissioning system. Commissioners are expected to demonstrate to the NHS Commissioning Board whether and how the quality standards for mental health are being met.
3. Evidence shows that specialist community mental health teams can achieve clinical and economic benefits. Patient satisfaction with care by teams has been shown to be greater than standard CMHTs. Crisis resolution and home treatment teams can reduce hospital admission rates and length of stay. Research on assertive outreach shows AOTs can increase engagement and satisfaction but not reduce bed use. Community mental health teams are providing as good as care as the AOT model.
4. NICE clinical guidelines relating to psychosis and schizophrenia and bipolar disorders make recommendations on use of early intervention, crisis resolution and home treatment and assertive outreach teams.
5. However the evidence also shows that potential benefits of specialist teams are not always realised as the original specification of teams (set out in policy implementation guidance) have not been effectively implemented locally. Survey work has shown substantial variation across the country in how different teams operate with respect to core features. For example a NAO report stated CRHT teams were not achieving their potential due to inappropriate skill mix, ineffective management arrangements, limited access to psychiatric expertise and inadequate capacity to provide 24/7 coverage.
6. Overall, the model of interventions underpinning the teams' care and the role of evidence based practice are often unclear. Many areas are redesigning teams, recognising inefficiencies and overlaps. While adopting more integrated approaches it is important not to lose the benefits of specialisms.

7. In addition, different types of 'crisis houses' are now an important element in acute care, providing alternatives to hospital admission. An evaluation suggests that these provide shorter length of stay and higher patient and carer satisfaction rates and are associated with clinical improvement, but not to the same extent as traditional care.
8. There is little evidence on the most effective way of redesign and integration, although local examples provide useful points.
9. There is a move to establish 'integrated acute care teams', working to a common pathway. Crisis resolution and home teams are part of a coherent acute care service, working with inpatients, day hospital and respite and other alternatives within a common management structure. Camden and Islington (appendix 4), and Norfolk and Waverley are examples of this approach to service delivery.
10. Overall the overview of evidence identifies the need to:
 - Consider how NICE health and social care quality standards for mental health can be fully incorporated within commissioning processes. What indicators should be used to assess whether the quality standards are being met?
 - Consider how the measurement and use of outcomes can be strengthened within assessment, care planning and case management, and within the commissioning processes. How can information management systems support this?
 - Consider how more integrated approaches to management of mental health and physical health can be further strengthened within assessment, care planning and case management and through commissioning processes.
 - Review the care pathway for acute care services as a whole, and the potential for greater integration of the crisis resolution/home treatment team and inpatient care and related services including day hospital/care and respite.
 - Consider the potential for integrating the AOT specialist function within the community mental health. (Assertive outreach is likely to only provide additional benefits if those who frequently use inpatient services are targeted).
 - Review the early intervention team against the evidence-based audit criteria, including the measurement of 'duration of untreated psychosis'.
 - Consider ways of strengthening alternatives to hospital admission in terms of links to the integrated community health and social care teams, psychiatric liaison in acute and other settings, and RAID, and continued assessment of the pilot CRHT.

Mental health and wellbeing needs assessment Evidence based frameworks: DRAFT FOR DISCUSSION

1. Purpose

This section covers:

- The role of models of care and care pathways in guiding effective practice and integrating health, social care and related services.
- The measurement of quality and outcomes (health and social)
- Integrated responses to mental health and physical health.
- The reconfiguration of the mental health system to strengthen prevention and recovery approaches.

This overview of evidence is intended to inform the implementation of the Richmond Borough mental health joint commissioning strategies (2011).

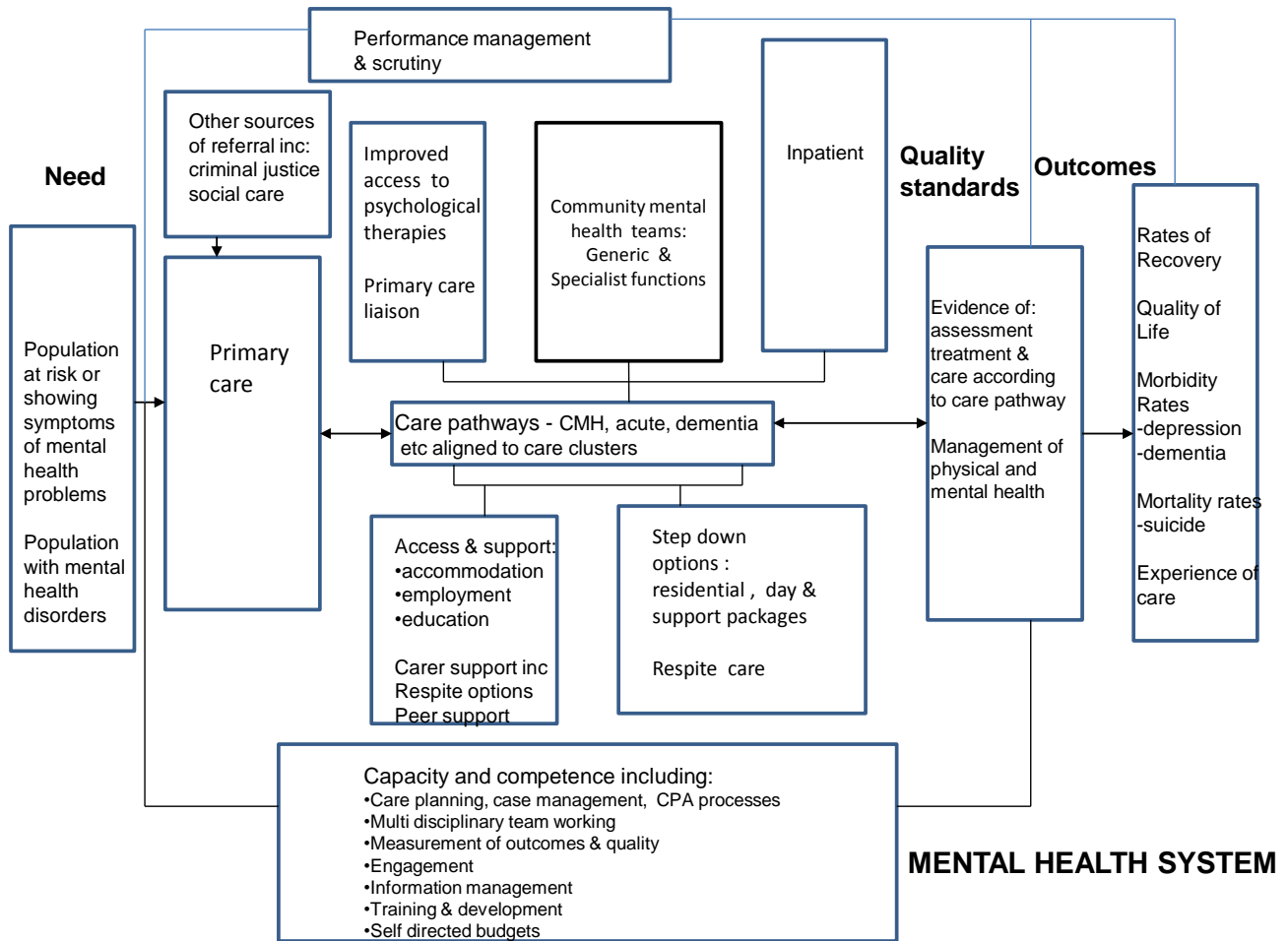
2. Models of care and care pathways for mental health and wellbeing

The diagram below shows a 'schematic' overview of links between the main elements in the mental health system.

It shows the main components of a comprehensive mental health programme that are required to improve mental health outcomes. Quality standards for health and social care provide the markers of progress towards achieving improved outcomes (DH 2010)

These components span prevention, early intervention, treatment, care and support services. These services are delivered at the individual level according to defined care pathways.

The recovery approach is central to the mental health programme (DH 2011). Recovery is concerned with promoting independence and social inclusion of those experiencing mental health problems. The approach encourages the individual to take responsibility for their own wellbeing, recognises the role of carers in facilitating recovery and promotes partnership working between the individual and practitioners.



Improved outcomes are dependent on the effective delivery of models and care and care pathways that are evidence based. These are set out in NICE guidelines and health and social care quality standards (existing and in development).

Commissioners and providers are expected to ensure that the appropriate range and balance of components are in place to quality standards and improved outcomes for service users.

The balance and mix of services and investment is based on the assessed needs of the population within the available resources.

3. Definition and measurement of outcomes and quality in mental health

Outcomes frameworks and quality standards are part of the new mental health commissioning system. The aim is to strengthen measurement and use of outcomes and quality standards as a focus of professional practice, as well as overall service development and performance management.

Traditionally in mental health services the measurement and use of outcome measures has been weak. Routine data collection and information systems have given emphasis to process (NHS London 2010).

The national strategy for mental health *No health without mental health* defines a set of strategic objectives and outcome indicators (DH 2011). These indicators are part of the national outcomes frameworks for the NHS, Social Care and Public Health. Appendix 2 sets out these objectives and examples of outcome indicators.

NICE quality standards have been published for the following areas of mental health:

- Depression
- Experience of mental health services
- Dementia

The depression quality standards are presented in Appendix 3.

These quality standards are a set of specific, concise statements and associated measures. They set out 'aspiration but achievable' markers of high-quality, cost-effective patient care, covering the treatment, care and prevention of different diseases and conditions.

Also a number of important improvements are taking place.

- Health of the Nation Outcome Scale (HoNOS) is now incorporated in the Mental Health Minimum Data Set as a means to demonstrate the clinical impact of services.
- The method of care clusters is now being implemented as the basis of Payment by Results from April 2013 (DH guide 2010). This method of clustering is based care pathways for people grouped into needs-based clusters incorporating diagnostic groups but not based entirely on diagnosis. Each cluster defines a group of service users who are relatively similar in their care needs and therefore their resource requirements.
- Incentive mechanisms can strengthen the focus of providers and professionals on outcome and quality measurement (QOF and the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) Payment Framework.
- The Improved access to psychological therapies service requires sessional outcome monitoring for all service users using standard outcome measures. These are a measure of depressions, a measure of anxiety and measurement of functional impairment (work and social adjustment scale).
- The mental health recovery star enables users of services to guide and record their recovery progress and enables providers to identify individual outcomes and benchmark across services.

4. Integrated approach to mental and physical health needs

Evidence shows that improving the response to co-morbid physical and mental health problems can significantly improve patient experiences and outcomes (Naylor et al 2012).

There is a strong association between mental and physical ill health. For example depression has been associated with a four-fold increase in the risk of heart disease, (after taking account of other factors)(Osborn et al 2007).

Co-morbid mental health problems have a significant impact on the costs related to the management of long term-conditions. For example the total cost to the health service of each person with diabetes and co-morbid depression is 4.5 times greater than the cost for a person with diabetes alone (Egede et al 2002).

There are a range of service developments that can enable a more integrated response to co-morbid physical and mental health problems (Imison et al 2011, Naylor et al 2012).

- Expanding screening for mental health needs among people with long term conditions
- Implementing collaborative care models as recommended by NICE for people with depression and a long term condition (see depression quality standard above). The model emphasises case management, systematic follow up and close collaboration between primary and secondary care.
- Working with Improving Access to Psychological Therapy services in its role in providing mental health support for people with a long term condition. For example development explicit care pathways for peoples with diabetes and comordid depression or anxiety
- Strengthening liaison psychiatry services in acute hospitals, care homes and other settings.

5. Reconfiguring mental health services

5.1 . Adult specialist community mental health services

Crisis resolution and home treatment

Crisis resolution and home treatment teams are intended to provide intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inpatient admissions (National Audit Office 2007). Teams are also intended to reduce out of area treatments and support earlier discharge.

According to the original policy criteria (DH 2002), a fully functioning CRHT should:

- Be multidisciplinary (ie including nursing, psychiatry, psychology, social care and occupational therapy)
- Be available to respond to 24 hours a day 7 days a week
- Have frequent contact with service users, often seeing them at least once on each shift
- Provide intensive contact over a short period of time

- Stay involved with the service uses until the problem is resolved
- Have the capacity to offer intensive support at service users' homes.

Evidence from ten clinical trials (including three in the UK) other evaluation studies and secondary analyses show overall positive outcomes in terms of high patient satisfaction and effects in preventing hospital admissions, particularly voluntary ones (Glover et al 2006, Johnson et al 2005, McCrone et al 2009, Nolan 2012). For example north Islington study showed patients in the care of the crisis resolution team were less likely to be admitted to hospital in the eight weeks following crisis, compared to the controlled group. Patients also tended to be more satisfied with their care (Johnson et al 2005).

Based on review of the evidence, NICE clinical guidelines for psychosis and schizophrenia recommend that crisis resolution and home treatment teams should:

- be used to support people with schizophrenia during an acute episode in the community
- pay particular attention of risk monitoring as a high priority routine activity
- be considered for people with schizophrenia who may benefit from early hospital discharge

Acute day hospitals should be considered alongside crisis resolution and home treatment teams instead of admissions to inpatient care to help early discharge from inpatient care.

The National Audit Office review on crisis resolution and home treatment teams (2007) clearly showed however that the model of CRHT teams was not being fully implemented and consequently benefits for clients as well as potential cost savings were not being realised (NAO 2007, Morgan 2007). This review included an audit of 25 local areas. The findings showed:

- Many teams lacked dedicated input from key health and social care professionals, particularly consult psychiatrists
- Having a CRHT member at the assessment makes it more likely the CRHT to be considered as an appropriate alternative to admission. But only half of the admissions had been assessed by CRHT
- Around one in five of admissions were considered by ward managers to be appropriate candidates for CHRT
- Cost savings could be made by full use of CRHT services as appropriate cases costs appropriately £600 less per crisis episode than one in which CRHT is not available
- Crisis and respite alternatives and acute day-hospital facilities could be used to strengthen Acute Care Service, providing other midway options that might be sufficient to contain the crisis
- 24/7 staffing could potentially be better utilised where CRHT staff and ward staff work together as an integrated Acute Care Service, so the wards would benefit from CRHT staff on duty overnight.

A recent national survey investigated **residential alternatives** (crisis 'houses') to standard acute psychiatric wards in England (Lloyd-Evans et al 2010). It estimated that these units now provide around 10% of acute provision. The survey identified six main 'types' of alternative. The effectiveness of these was evaluated based on case study analysis of each type compared to six local acute wards. A summary of the case study types are shown in the box below.

The findings showed:

- Patients improved less (staff-rated clinical outcome measures) during the admissions to alternative than standard services but admission was typically briefer and cheaper. There was no difference in inpatient or community service over the following year, suggesting no lasting adverse consequences from the briefer initial admission.
- Patient and carer satisfaction were greater with community alternatives. The quality of relationships with staff and perception of coercion and safety were key to patients' experiences.

Assertive outreach

Assertive outreach teams (AOT) aim to keep people with serious mental health problems in contact with services. Mental health problems are often combined with additional needs relating to drug or alcohol misuse, offending and social relationships. AOTs have the following features:

- A multi-disciplinary team-based approach to care (involving a psychiatrist with dedicated sessions)
- Care provided for those with serious mental illness
- Team members shared responsibility for clients
- Provide all the psychiatric and social care for each client rather than referring on to other agencies (ie intensive case management)
- Care is provided at home or in the work place as far as this is possible
- Treatment and care is offered assertively to uncooperative or reluctant service users
- Medication concordance is emphasised.

There is good evidence for their clinical effectiveness in the USA and Australia in terms of reducing the need for in-patient care and associated costs. However, however trials in the UK have not replicated these benefits. For example in the UK REACT (Randomized Evaluation of Assertive Community Treatment) study in North London found no advantage over usual care from community mental health teams in reducing the need for in-patient care and in other clinical outcomes, but participants found AOT more acceptable and engaged better with it (Killaspy 2006,2009). The lack of additional benefits was attributed in part to the fact that both teams used intensive case management (primary clinical responsibility, based in the community, team leader doing clinical work, time-unlimited service) (Killaspy 2010).

A systematic review of a number of evaluation trials concluded that the advantages of AOT were most evident where there was high local use of in-patient care and where the comparison intervention did not replicate key aspects of AOT (Burns et al 2007). It showed that AOTs were not likely to lead to substantial reductions in hospital use if average hospital use is already low. However teams can have impact on hospital use by focusing on patients with a history of high hospital use.

The NICE guidance clinical guideline for schizophrenia recommends that assertive outreach teams should be provided for people for people with schizophrenia who:

- Frequently use inpatient services, and
- Have a history of poor engagement with services leading to frequent relapse or social breakdown (homelessness or inadequate accommodation).

Early intervention services

Early intervention services are expected to provide care for people between 14 and 35 years with first presentation of psychotic symptoms and those during their first 3 years of psychotic illness. The service may be provided by a team or specialised element of a team which has responsibility for early identification and therapeutic

engagement of people showing psychotic symptoms and provision of specialised treatment interventions during or immediately following a first episode of psychosis.

There is good evidence on the effectiveness of the effectiveness of early intervention services from a number of trials. For example In London the Lambeth Early Onset (LEO) study found that a team delivering specialised care for patients with early psychosis was superior to standard care for maintaining contact with services and reducing readmissions to hospital (Craig et al 2004).

A study of early intervention in psychosis services in England in 2005 was based on an audit of services against ten criteria (elements in the policy implementation guide). It found that very few teams met all the 10 audited early intervention requirements and there was variation in service models (Pinfold et al 2007). The following particular criteria were commonly not met: out of hours support, designated acute beds and input, full coverage of the age range, input from CAMHS. Half of teams were not concerned with early detection and fewer teams measured the duration of untreated psychosis and there are inconsistencies in standardised measurement. The study concluded that the teams needed to address these areas. While variations in model were not necessarily an indication of poor services, teams should document the impact of their practices on patient and family outcomes. A review of early intervention services in West Midlands also demonstrates variation in models adopted and operational issues, including funding (Birchwood et al 2006).

In summary the overview of evidence on specialist community mental health teams shows a range of benefits (both clinical and economic) can be achieved. However survey work has shown substantial variation across the country in how different teams operate locally and the potential benefits are not always realised. The model of interventions underpinning the teams' care, and the role of evidence based practice are often unclear. This means that patient care pathways can be disjointed and relevant interventions may not be considered. Some areas are now moving to more integrated teams. However it is important to ensure that the strengths of specialist functions are not lost.

5.2. Reconfiguring older people's mental health services

Inpatient care

The Royal College of Psychiatrists (Faculty of Psychiatry of old age) more recent guidance (2011) on inpatient care for older people within mental health services states:

- The purpose of inpatient care is to provide specialist expertise with intensive levels of assessment monitoring and treatment unable to be provided in other settings.
- There should be clear and robust arrangements for urgent medical interventions and regular expertise available from geriatric medicine services.
- Community services should provide alternatives to inpatient admission. This should include crisis intervention and home treatment that is focused on the needs of the elderly.

The guidance also states that the number of beds for acute care originally identified by the Faculty (1-2 beds per 1000 elderly persons) will need to be adjusted according to local resources and demands (eg availability of home treatment, day hospital, local authority provision, service age cut off). Consequently some areas have reduced acute beds to 0.8 -0.67 per 1000 elderly population. Optimal bed occupancy for safe and efficient inpatient bed management is 85%.

Crisis resolution and home treatment

The provision of specialist older people crisis response and home treatment teams nationally is much more limited in comparison to services for working age population (Cooper et al 2010, Anderson et al 2009).

There are few evaluation studies focusing on specialist Older People's Teams, however the limited evidence that is available suggests CRHT teams can have an impact on admissions of older people to hospital. For example Andersen and colleagues mapping review indicated that hospital admissions rate can be reduced by up to 31% along with reduced length of stay and admissions to care homes (Anderson et al 2009). However the small scale evaluations in this area are less than robust so findings need to be treated with caution (Dibben 2008, 2009; Sadig et al 2009, Richman et al 2003).

Nevertheless the potential benefits demonstrated by CRHTTs for the working age population are applicable to older people's services. The slow development of CRHT services for older people is viewed as age discrimination within mental health services (Commission of Health Care inspection and audit 2006, Andersen et al 2009).

National mapping of services shows there is no single model for older people crisis resolution and home treatment services: general adult CRHT team extended to older people, specialist older people CRHTTs and intermediate care (Cooper et al 2010). Local service configurations appear to be the main factor to how pathways have been established and function.

A recent review undertaken as part of a Kingston & Richmond Project provides a useful reference of service development (and ongoing assessment of the pilot CHRT for older people recently established in Richmond) (Turner 2011). This review suggested using the cluster methodology to assess demand for HTT show in Appendix 5.

The review recommended the following features for a local service:

- Extended hours, 7 days a week, backed up by Generic HTT at night.
- Being part of a whole system where there is effective gate-keeping to consider alternatives to admission and to use the HTT fully.
- Having close links with CMHTs and wards.
- Establishing clear pathways for different clusters
- Having clear protocols for communication, risk management and assessment to be used in high risk situations and when admission is being considered to ensure that best practice is followed and that alternatives to admission are fully explored.
- Putting in place discharge planning & relapse prevention from time of admission.
- Training staff to provide short-term focused interventions.
- Promoting links with Generic HTT to enhance skills for management of out of hours incidents and to ensure effective gate-keeping with clear protocols for client management, using crisis plans for existing clients & guidelines for new clients.

Psychiatric liaison services

Evidence shows that rates of co-morbidity are particularly high among elderly people in general hospitals, accounting for about two-thirds of occupied beds. Up to 60% of these patients have or will develop a mental disorder during their admission, the most common conditions being dementia, depression and delirium (NAO 2007).

Regarding dementia, a survey carried out in Lincolnshire by the National Audit Office found that patients with dementia were particularly likely to experience delays in discharge and overall more than two-thirds of those with dementia were assessed as no longer needing to be in hospital. Potential savings from quicker discharge were estimated at £6.5 million in the local area, equating to more than £300 million if extrapolated over the whole of England (NAO, 2007).

A recent systematic review concluded that findings suggest liaison mental health services in general hospitals have the potential to be effective in improving outcomes such as length of hospital stay, discharge disposition and hospital costs. From UK evidence it has been difficult to establish the most effective models for psychiatric liaison (Holmes et al 2010).

The RAID (Rapid Assessment Interface and Discharge) model is one option (currently being piloted in SW Thames) that has a sound evidence base (Tadros et al 2011). The service aims to meet the mental health needs of all adult patients in the hospital, including those who self-harm, have substance misuse issues or have mental health difficulties commonly associated with old age, including dementia.

An economic evaluation of the RAID service demonstrated cost savings to the acute hospital from the reduced use of in-patient beds, whether because of shorter lengths of stay or reduced numbers of admissions and re-admissions (Parsonage & Fossey 2011). There were increased contacts with specialist mental health services, as RAID directed patients to the most appropriate care pathway. In addition the study identified cost savings to social care as fewer patients were discharged to institutional care and to their own homes.

Other options being developed as alternatives to hospital admissions include the provision of specialist mental health input within 'generic' integrated community based teams and /or intermediate care.

6. Summary of possible implications for future developments

The evidence-based frameworks have a number of implications for the development of mental health services for the population of Richmond borough.

- Consider how NICE health and social care quality standards for mental health can be fully incorporated within commissioning processes. What indicators should be used to assess whether the quality standards are being met?
- Consider how the measurement and use of outcomes can be strengthened within assessment, care planning and case management, and within the commissioning processes. How can information management systems support this?

- Consider how more integrated approaches to management of mental health and physical health can be further strengthened within assessment, care planning and case management and through commissioning processes.
- Review the care pathway for acute care services as a whole, and the potential for greater integration of the crisis resolution/home treatment team and inpatient care and related services including day hospital/care and respite.
- Consider the potential for integrating the AOT specialist function within the community mental health. (Assertive outreach is likely only to provide additional benefits if those who frequently use inpatient services are targeted).
- Review the early intervention team against the evidence-based audit criteria, including the measurement of 'duration of untreated psychosis'.
- Consider ways of strengthening alternatives to hospital admission in terms of links to the integrated community health and social care teams, psychiatric liaison in acute and other settings, and RAID, and continued assessment of the pilot CRHT.

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Appendix 2: National mental health strategy: No health without mental health objectives and selected outcome indicators

Mental health strategy objectives and outcomes		
		Examples of outcomes
1	More people will have good mental health	<ul style="list-style-type: none"> school readiness: foundation stage profile attainment for children starting key stage 1 childhood poverty self-reported wellbeing Health-related quality of life for older people access and utilisation of green space older people's perception of community safety social connectedness
2	More people with mental health problems will recover	<ul style="list-style-type: none"> proportion of older people (65 and over) who were still at home after 91 days following discharge from hospital into reablement/rehabilitation services. delayed transfers of care emergency readmissions to hospitals within 28 days of discharge proportion of adults in contact with secondary mental health services in employment. the proportion of adults in contact with secondary mental health services in settled accommodation
3	More people with mental health problems will have physical health	<ul style="list-style-type: none"> suicide rate mortality rate of people with mental illness rate of hospital admissions as a result of self-harm rate of hospital admissions per 100,000 for alcohol-related harm number leaving drug treatment free of drug(s) of dependence work sickness absence rate smoking rate of people with serious mental illness
4	More people will have a positive experience of care & support	<ul style="list-style-type: none"> health-related quality of life for carers (Eq-5d) patient experience of community mental health services. proportion of people using social care who receive self-directed support.
5	Fewer people will suffer avoidable harm	<ul style="list-style-type: none"> proportion of people using social care who feel safe and secure. patient safety incident reporting severity of harm number of similar incidents.
6	Fewer people will experience stigma & discrimination	

Appendix 3: NICE Mental health quality standards

NICE quality standards for depression	
1	People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode.
2	Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression receive regular supervision that ensures they are competent in delivering interventions of appropriate content and duration in accordance with NICE guidance.
3	Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust delivery of interventions.
4	People with persistent subthreshold depressive symptoms or mild to moderate depression receive appropriate low-intensity psychosocial interventions.
5	People with persistent sub threshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific clinical criteria in accordance with NICE guidance
6	People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy.
7	People with moderate depression and a chronic physical health problem receive an appropriate high-intensity psychological intervention.
8	People with severe depression and a chronic physical health problem receive a combination of antidepressant medication and individual cognitive behavioural therapy.
9	People with moderate to severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care.

Appendix 4: Example: Camden and Islington Acute Mental Health Service

Extract of document: Changing Mental Health Hospital Services in Camden and Islington 2010

The description of the acute model for mental health

The acute model for mental health is based on alternatives to inpatient care delivered with gate-keeping of beds, establishing whether there are 'least restrictive' alternatives appropriately based on risk and clinical need. The principle of always taking a least restrictive alternative follows the ethos of the Mental Health Act 1983. Inpatient care will become more specialised with functional teams (i.e. teams which only work in the hospital setting) offering focussed, evidence-based treatment.

The alternatives include home treatment crisis resolution services, which gatekeep all admissions to acute beds and crisis beds for short non hospital base stays. These often do not require medical or nursing intervention but provide a safe space for review, 'timeout', assessment of alternatives, respite for carers, re-establishment of medication, medical review and assessment of risk.

The recent model of linking daytime interventions at recovery centres (which are focussed day hospitals providing short term interventions) has provided a flexible alternative of around 12 weeks of daytime intervention linked with either a few weeks of evening/ morning visits and administration of medication or a short 1-4 week intervention of crisis beds without needing to access hospital based care. This is a model established in Camden at Daleham House, which was supported by commissioners and service users alike and has received public recognition.

More recent early data (unpublished) by DPJ Osborn et al shows one year admissions to 6 beds at Daleham House in Camden, with a turnover higher than that of an acute ward, length of stays of one week average, over 70% previously been to hospital and half previously detained. These initial findings appear to indicate that this provides an alternative to hospital beds with a consequent reduction in acute bed usage. The data for acute bed usage may be compounded by other improvements in pathway, gate-keeping and assessment wards in the acute setting. These crisis beds are linked to a daytime recovery centre and crisis team within the same building.

Assessment wards focussing on assessment and diagnosis, a short intervention, with daily ward input from a Consultant, crisis teams focussing on alternatives and early discharge when safe, appear to be having an impact on length of stay. Intensive models provide an increase in trimmed average length of stay (ALOS) of 10 days. However ALOS locally has 2 peaks one at less than 10 days and one at over 100 days. This would suggest there are broadly two groups in the population using inpatient beds. It would seem that the crisis interventions, crisis houses and recovery centre might have an impact on the 10 day peak but not on the 100 day peak. Further development in the rehabilitation pathway with service line management and care pathway approach could have some effects on this group but this is as yet untested.

Appendix 5: Types of residential alternatives to hospital admission (Lloyd-Evans et al 2010)

Residential alternatives to hospital admissions		
Type	Local case study	
Clinical Crisis House	8-bedded residential unit within a Community Mental Health Resource Centre in Staffordshire	Staffed similarly to a standard acute ward, i.e. mainly by nursing staff with input from psychiatrists from the CMHT. A daily structured programme of activity provided within the unit. CMHT gatekeep access to the beds: only known clients admitted directly from the community, precluding admissions unknown to services via the police or accident and emergency units. Detained patients can be admitted directly from the community.
Crisis Team Beds	4 beds run by the local Crisis and Home Treatment Team, within a larger social services rehabilitation hostel. Situated in a housing estate near Central Middlesbrough	Patients' basic daily care is provided by the hostel's social care staff with additional daily input from Crisis Team clinical staff, including regular scheduled time from psychiatrists and psychologists. Typical length of stay is about one week. Home treatment support is often planned and provided by Crisis Team staff for patients following an admission to the crisis beds. Detained patients are not accepted directly from the community, but patients can be admitted from hospital under section 17 leave.
Non-clinical alternative (Black focus)	9-bedded crisis house in a residential street in Hackney, run by a voluntary sector Housing Association. Accepts patients from black minority ethnic communities,	Aims to provide a culturally sensitive alternative to hospital admission and will admit patients only from the community not transferred from acute wards. Detained patients not admitted. Staff is non-clinical, social care workers but a counsellor and alternative therapists also provide input. Any required medical care is provided to patients by their general practitioners or through the local crisis and home treatment team. Aftercare is provided by the voluntary sector service provider, but liaison with statutory mental health services is also common. An initial two week limit is set for admissions
Non-clinical alternative	9 -bedded crisis service situated in a large property in a residential street in Islington, North London	Staffed by social care staff, many of whom have an interest or background in counselling. Run a voluntary sector provider but funded by and closely linked to statutory services. Local crisis teams can provide additional support and medical input to residents and gatekeep two of the beds. Admissions typically no longer than a month
Tidal Model Ward (General therapeutic cluster)	single twenty-bedded inpatient ward with attached outpatient unit in inner-city Birmingham	The Tidal Model of nursing care provides an expectation that daily written care plans will be agreed with patients and agendas set by patients will guide weekly ward rounds with medical staff. Admits male and female patients: most staff are nurses or healthcare assistants but one occupational therapist is also employed on the ward.
Short-stay ward	Situated within Basildon General Hospital close to the Accident and Emergency Department, the local mental health day hospital, crisis team offices and standard acute wards	It is a 25-bedded inpatient ward with a 72-hour maximum stay. All non-detained patients in the locality are initially admitted to the Assessment ward. A multi-disciplinary assessment is carried out involving inpatient nursing and medical staff and the crisis team, with the aim of diverting as many patients as possible from admission to a standard acute ward.

Appendix 6. Use of care clusters for CRHT for older people (Turner 2011)

Cluster (Cluster numbers in brackets)		Risks and situations which may lead to admission or need for HTT	Likelihood of needing HTT
Non-psychotic – with and without physical co-morbidity	Low-moderate severity (1-4)	Low risk , unlikely to need admission or HTT	LOW
	Moderate to high severity (5-8) Includes severe depression, anxiety and personality disorders	Moderate to high risk : Risk of suicide or self harm	MOD - HIGH
Psychotic – with and without physical co-morbidity	First onset and ongoing/recurrent psychoses (10-13) First episode cluster 10 unlikely to be used in older people	Moderate risk : Some vulnerability to relapse	MODERATE
	Moderate to high severity (14-17) Includes severe depression, schizophrenia and bi-polar disorders	High risk : Risk of suicide or self harm; risk of harm to others; Need to rule out physical causes of symptoms.	HIGH
Organic/dementia	Cognitive Impairment - Low Need (18)	Low or no risk . Unlikely to need admission.	LOW
	Dementia, complicated – Moderate need (19)	Moderate risk : Risk of self neglect, harm to self or others. May lack awareness of problems. May have co-morbid depression or anxiety.	MODERATE
	Dementia, complicated – High Need (20)	High risk of self-neglect or harm to self or others. Risk of breakdown of care. Includes Challenging Behaviour in dementia both in residential / nursing homes and in the community	HIGH
	Dementia – High physical or engagement issues (21)	High risk of self-neglect. Risk of breakdown of care. Intersection between OPMH & OP services is important. Not likely to need HTT .	LOW TO MODERATE