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# New service models in mental health: emerging lessons

This digest highlights recent research around the organisation and delivery of mental health services and new ways of working. It can help managers with evidence of what works and evaluations of service initiatives that could have wider benefits across the NHS.

## Overview

Around one in four people experience some form of mental health problem, including an estimated 15 per cent of adults experiencing clinical depression and 4 per cent generalised anxiety disorder, alongside a smaller proportion with severe mental illness needing specialist help.[1] One in seven pounds of NHS funding is spent on mental health services, but the wider costs to society include an estimated £30 billion in lost economic output.[2] Mental health services are a key part of NHS activity, with latest figures showing 12.5 million patient contacts outside hospital for 2009/10 and more than 1.25 million people using specialist mental health services.[3]

The last decade has seen a number of important changes in mental health services and how they are delivered. This includes the introduction of specialist teams, such as early intervention and assertive outreach, as well as rises in funding and staffing. Service activity data over the last six years suggests changes in how services are used – since 2004, the number of people in contact with services has risen, with a decreasing proportion spending time in hospital (although, for the first time, the most recent data indicates a small rise in the last year).[4] Overall, there has also been a general trend for shorter stays in hospital. However, data shows marked variation in different parts of the country. Having adjusted for population differences, the Audit Commission found as much as twenty-fold variation in total bed days; fifteen-fold variation in length of stay; and six-fold variation in admission rates.[5]

**Read more to find out:**

- What the evidence says on making best use of new specialist services, like crisis resolution teams
- How much care is now provided by alternatives to hospital and the potential for savings
- How services are engaging users – from peer workers to online support groups

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The National Audit Office (NAO) has also calculated that one in five mental health admissions could be avoided.[6]

Managers of mental health services need to know what works in managing costs of services, while meeting the needs of patients. The NIHR Service Delivery and Organisation (SDO) programme commissions research to help managers improve service effectiveness, efficiency and productivity. Over the last five years, it has funded a number of projects that have evaluated new ways of working in mental health. This digest summarises the findings of these studies in the context of other evidence to identify key messages for the service.

## At a glance

- Specialist services, such as crisis resolution and home treatment, appear to be well received and may help managers to reduce rates of hospital admissions, but they are not always used to best effect and need to be integrated with existing services.
- Alternatives to traditional inpatient mental healthcare, such as 'crisis houses', now make up 10 per cent of all provision and can provide a useful part of local acute care systems, possibly leading to cost savings.
- New technologies and initiatives, such as peer workers, can help in supporting self-care and keeping people out of hospital.
- Localities have organised stepped care for mental health in different ways, but the principal driver of patient flow through stepped care systems was allocation to initial treatment.

## Impact of new specialist services

A number of studies have tried to evaluate the impact of active measures to reduce avoidable stays in hospital for people with mental health problems. These include crisis resolution and home treatment teams, as well as early interventions for people with conditions such as early-onset psychosis. There is limited evidence, but an early randomised controlled study of crisis resolution teams showed high patient satisfaction and effects in preventing hospital admissions, particularly voluntary ones.[7] Broader assessment seemed to confirm positive effects of early intervention services[8] and of crisis resolution and home teams on admissions[9], with other studies suggesting that these interventions were likely to be cost effective.[10] However, a more recent review, which included re-analysis of existing secondary data, showed no definite impact of crisis resolution and home teams on psychiatric admissions, although the authors cautioned that they were not looking at wider measures of quality or impact on other parts of the service.[11]

There appears to be agreement, however, that crisis resolution and home intervention teams are not always used to best effect, with some undoubted benefits not fully exploited.[12] The NAO found examples of inappropriate skill mix, ineffective management arrangements, inadequate capacity to provide 24/7 coverage and limited awareness of these services among referrers.[13] An early SDO-funded study[14] looked at partnership working between the statutory and voluntary sector in one of the pilot early intervention services. Although positively rated by users of the service, this evaluation showed challenges of integration between the new specialist team and established community mental health services. Some services are now developing integrated inpatient, community and specialist mental health teams to a common pathway. In one service, this involves integrated teams across a locality led by a consultant psychiatrist (see case study one on page 3).

## What does this mean for me?

"This is a time of great change in mental health services. Although there are no simple messages, reading these accounts of different studies made me think again about what we do here and what could be done differently."
Dr Nick Land, Medical Director, Tees Esk & Wear Valleys NHS Foundation Trust.

## Alternatives to hospital

Other studies have looked at alternatives to hospital admission. New approaches have ranged from general acute wards applying innovative therapeutic models, through clinical crisis houses that are highly integrated with local health systems to more radical voluntary sector alternatives. These have been poorly mapped and understood. A recent NIHR SDO-funded study (Slade 2010, see page 7) provided important new evidence of the extent of these services – giving an estimate for the first time that 10 per cent of acute provision is now delivered in alternative modes or settings. The study also provides tentative findings about impact, although full economic evaluation was not possible. Initial findings suggested that alternatives provided shorter length of stays and higher patient and carer satisfaction rates than standard care and are associated with clinical improvement, but not to the same extent as traditional care. Costs are less and there was little difference between the groups in use of services a year after discharge (i.e. no greater rate of readmissions by alternatives). Further work is now being funded by the SDO (see page 14) to understand why patients seem to prefer alternatives, comparing the nature of therapeutic relationships in crisis houses and inpatient wards.

Another SDO-funded study (Shepperd 2008, see page 8) looked particularly at alternatives to inpatient mental healthcare for children and young people. This provided useful mapping of alternatives, ranging from home treatment, intensive outpatient, assertive outreach and day services. However, the systematic review proved difficult given limited robust evidence (and very little from the UK). The authors concluded that, although some health gains were reported for alternative provision, this was not consistent and current evidence provided very little guidance for the development of services. For instance, we do not know if residential inpatients for young people with eating disorders (one of the most common areas of activity) are more effective than alternatives.

## Using new technologies

Some studies have explored using new technologies to support self-care and modernised services. One SDO-funded study (Pinfold 2010, see page 9) provided insights and solutions to better communication between staff and patients or carers. From qualitative research on why staff find it hard to give information to patients,

## Case study one: Integrated care pathway for acute mental health services in Norfolk and Waveney

An innovative model for adult acute services has been introduced in Norfolk and Waveney to provide a seamless service for mental health users. Each locality has an integrated team led by a consultant psychiatrist. The service has a single point of entry and assessment, which determines how best an individual may be supported through the acute phase of their illness and enabled to remain as independent as possible. By integrating the acute services into one team, the care, support, treatment and staff remain constant whatever the setting. The multi-disciplinary care team reviews plans daily, with the patients and any carers, and a range of options (or combinations of options) are available. These include home treatment, crisis beds, inpatient care, psychiatric intensive care unit and day or shared treatment.

This service structure helped the trust reduce its use of inpatient beds by almost one-third between 2005 and 2008, by reducing both admission rates and length of stay, and generating an estimated saving of around £1 million per year.[15] Staff motivation levels are also reported to have improved within the new structure.

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an online tool using scenario-based learning was developed and evaluated. This was targeted at staff on inpatient wards with the aim of better supporting discharge and community rehabilitation. Another SDO study (see page 15) is evaluating a new health and risk dataset for mentally disordered offenders that can be directly accessed by police officers and others. Although small scale, this pilot project shows the potential for new technologies in sharing information and decision-making across agencies for particularly high-risk patients. A key theme in mental health is the need for better partnership working across a range of agencies and providers.

## Engaging patients

Many mental health problems can be seen as chronic conditions[16], where the focus needs to be on the best way of supporting people over their lifetime. Importance has also been placed on a personalisation agenda[17], where services are designed as much as possible around the needs of individual patients. Shaping services around the needs of patients requires good levels of user and carer engagement – although an SDO review noted that improvement initiatives showed disappointing levels of input (Worrall 2008, see page 10).

More encouraging news came from an SDO-funded study (Gillard 2010, see page 11) looking at contrasting case studies on self-care initiatives in mental health trusts. These ranged from training initiatives for personal planning to peer support groups for people with personality disorders. Although relatively small scale, findings from these few sites showed positive impact in confidence and empowerment among patients and reduced levels of emergency admissions. The same research team is now being funded by the SDO (see page 14) to evaluate innovative peer worker initiatives in mental health services, where patients with mental health problems are employed

## Case study two: Internet-based peer support network in Cumbria

This initiative forms part of a coherent programme of care for people with personality disorders and related complex mental health disorders in Cumbria. A need was identified for informal support between 'face-to-face' sessions as part of a therapeutic community. The rural nature of north Cumbria posed further challenges. The idea was developed of an internet-based service user network focused on out-of-hours care, as part of the wider therapeutic programme.

This features a number of service user-only support boards that are password protected, including a real time chatroom. The latter is for use in a crisis or if particularly difficult problems can be anticipated. The site is operated and moderated by elected service users who employ a sophisticated system of feedback in order that online exchanges which raise significant concerns are communicated to staff members. Service users provide training in use of the site for new members of the community as part of their induction and a low-cost scheme of equipment leasing has been introduced by the trust for those service users who do not have personal access to the internet. This initiative is now being evaluated, as part of the wider therapeutic service.

The service pioneered the employment of consultant service users – five are now employed by the trust. Their activities range from working in the therapeutic community as generic therapists, teaching staff, engaging in research and acting as service user governors for the trust.

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by statutory agencies to carry out key services. Another SDO-funded study in progress looks at a range of service user initiatives, from traditional to more radical forms of engagement to consider what impact these have on patient care (see page 13).

## Organising services

Many studies have looked at particular services and their effectiveness. However, research is also needed for those planning and commissioning mental health services across a whole system. A recent SDO study (Richards 2010, see page 12) noted the lack of specific guidance on how to organise services in national guidelines on stepped care in depression. Stepped care is used for many common chronic conditions covering a spectrum of severity (such as depression), where the least resource-intensive treatment is delivered first and escalated when necessary, to allow for more efficient use of resources. In field work for this SDO study, it was noted that different sites had developed very different pathways, although all were implementing the same national guidelines. This study used operational research methods to help four NHS services design effective stepped care systems for psychological therapies adapted to local needs and service patterns. Detailed throughput and modelling data also provided useful insights for managers – such as a rough 'benchmark' that at least 10 per cent of patients would be stepped up over time from low to high-intensity treatment. A key finding was that the principal driver of patient flow through stepped care systems was allocation to initial treatments. In other words, where people start in the system determines the overall numbers in each of the steps. This study also showed the benefits of applying operational research and modelling techniques to mental health services, which could be used more widely.

Mental health services are very important for older people and new research is being commissioned on a range of topics relating to dementia services. Service developments include initiatives such as specialist mental health liaison teams, although access may be variable. An SDO-funded project nearing completion is considering new ways of working, including specialist medical/mental health units in hospitals (see page 13).

## What does this mean for managers?

This digest highlights a mixed portfolio of recent research around service innovations in mental health. This is a particularly dynamic area, with many interesting local developments that have not all been subject to rigorous evaluation. There have not always been realistic assessments of impact and potential benefits and it is sometimes difficult for managers and commissioners to make sense of this complex evidence. This digest considers a range of studies related to new service models in mental health. In this rapidly developing area, some emerging points include the growing importance of a range of alternative provision to crisis services; the need to integrate specialist services with other forms of care to form coherent pathways; and new ways of engaging and working with users. In some of these areas, such as partnerships with the third sector and use of peer workers, mental health services have shown more imaginative ways of working which could be transferable to other long-term conditions. Although there are many unanswered questions, emerging research highlights some interesting points for service users, providers and commissioners.

### Five questions to ask at your trust:

- How does your acute bed use compare with other trusts?
- What use do you make of alternatives to inpatient mental health services?
- Are you making best use of crisis resolution and home treatment teams?
- How well integrated are your services, including specialist teams (such as early intervention), inpatient services and community mental health teams? Are there common pathways and protocols?
- What technologies and initiatives, such as peer workers, are you using to support self-care and shape services around user needs?

## References

1 Layard R. 2006: 'The case for psychological treatment centres', *BMJ*, 332, pp1030-1032.

2 Naylor C and Bell A. 2010: *Mental health and the productivity challenge*. The King's Fund

3 *Mental health bulletin: fourth report from mental health minimum dataset (MHMDS) annual returns 2010*, NHS Information Centre, 2011

4 ibid

5 *Maximising resources in adult mental health*, Audit Commission, 2010

6 *Helping people through mental health crises: the role of crisis resolution and home treatment teams*, National Audit Office, 2007

7 Johnson S et al. 2005: 'Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study', *BMJ*, 331, p599.

8 Bird V et al. 2010: 'Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: systematic review', *BJPsych*, 197, pp350-356.

9 Glover G, Arts G, Babu KS. 2006: 'Crisis resolution/home treatment teams and psychiatric admission rates in England', *BJPsych*, 189, pp441-445.

10 McCrone P et al. 2009: 'Economic evaluation of a crisis resolution service: a randomised controlled trial', *Epidemiol Psichiatr Soc*, 18, pp54-58.

11 Jacobs R and Barrenho E. 2011: 'Impact of crisis resolution and home treatment teams on psychiatric admissions in England', *BJPsych*, 199, pp71-76.

12 Kingdon D. 2011: 'Transforming mental health services', *BJPsych*, 199, pp1-2.

13 National Audit Office, op. cit.

14 Lester H et al. 2009: 'Development and implementation of early intervention services for young people with psychosis: case study', *BJPsych*, 194, pp446-450.

15 Audit Commission, op. cit.

16 Scott J. 2006: 'Depression should be managed like a chronic disease', *BMJ*, 332, pp985-986.

17 *Personalisation in mental health: a review of the evidence*, MIND, 2009

# Summaries of recent research

These research summaries highlight findings from six recent SDO-funded studies on innovations in mental health. They indicate growing evidence on what works and gaps in what we know from research.

## Study one: Alternatives to inpatient mental healthcare

Little is known about what constitutes effective inpatient care. Acute mental health inpatient wards are costly and widespread service user dissatisfaction has been reported. A range of inpatient and non-hospital residential alternatives has been developed but their prevalence within the UK acute care system or their effectiveness and acceptability compared to standard wards have not been extensively researched.

### Method

The study carried out a national survey of provision – the first of its kind. It also used multiple methods to evaluate six alternatives and six comparison local acute wards. Information was collected for 35 consecutively admitted service users at each service regarding socio-demographic characteristics, health status at admission and discharge and one-year service use. Up to 40 service users at each service provided quantitative data about satisfaction with services. The experience of service users and carers and the views regarding alternatives of key clinicians and managers in the local acute care system were explored through semi-structured interviews. The content of care at services was assessed through observation, staff-report and patient-report measures.

### Findings

The national survey indicates a range of alternatives to standard acute psychiatric wards in England, including 41 community-based residential crisis services. Assuming similar numbers of beds for non-responders to the survey as for responders, it is estimated that there are just under 1,300 beds in these alternative units, of which around 250 are outside hospital. This compares with a national tally of around 12,400 acute beds for adults of working age, suggesting that around 10 per cent of acute provision is now in alternatives.

More detailed work found:

- There was considerable overlap in the characteristics of populations using standard acute wards and community alternatives.
- Patients improved less during admission to alternatives than standard services but admission was typically briefer and cheaper. There was no difference in inpatient or community service use over one-year follow up, suggesting no lasting 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.
- Staff-patient contact was no greater at alternatives than standard wards.

### Lessons and implications

It is difficult to make definite conclusions about the clinical effectiveness and cost-effectiveness of alternative services. Patients typically improved less on staff-rated clinical outcome measures at alternatives than at standard services and have briefer, cheaper admissions. Length of stay for acute psychiatric admissions is longer in the UK than some other European countries, indicating that UK services offering briefer admissions may be appropriate for some patients. No difference was found in follow-up use of services over one year. If service use is viewed as a proxy measure of patient outcome, there was no indication that being discharged earlier with less improvement had an adverse impact on patients at alternatives.

### Source

*Inpatient alternatives to traditional mental health inpatient care (the alternatives study)*, January 2010.
**www.sdo.nihr.ac.uk/project.php**

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# Study two: Children and young people – alternatives to inpatient mental healthcare

Current policy in the UK and elsewhere places emphasis on the provision of mental health services in the least restrictive setting, while also recognising that some children will require inpatient care. As a result there is a range of mental health services to manage young people with serious mental health problems in community or outpatient settings who are at risk of being admitted to an inpatient unit.

## Method

This study was formed of two parts. The first was a systematic review of different organisational structures and therapeutic approaches described in the literature as alternatives to inpatient mental health services for children and young people, and assess the evidence of effectiveness, acceptability and cost of these alternatives. Due to differences in interventions and outcomes, there was no attempt to pool data.

The second part of this study was a national postal survey to identify the range and prevalence of different models of service that seek to avoid inpatient care for children and young people in the UK. This included secure services and independent providers.

## Findings

### Systematic review

58 studies were included, which covered eight types of services. There was not evidence against all eight service types, but what evidence there was indicated:

### Multi-systemic therapy (MST) in the home

Young people receiving home-based MST experienced some improved functioning in terms of externalising symptoms, they spent fewer days out of school and in out-of-home placement. At short-term follow up the control group had a greater improvement in their adaptability and cohesion; this was not sustained at four months follow up.

### Family preservation services

The results from these studies were mixed, with small significant patient improvements being reported in both the intervention and control groups. Non-randomised studies reported fewer out-of-home placements for those receiving family preservation services.

### Intensive home treatment

No differences at follow up were reported between inpatient and home-treated children from two randomised controlled trials (RCTs). One non-randomised study reported a greater improvement in symptoms.

### Intensive outpatient services

No differences were reported at follow up for those receiving intensive outpatient services compared with inpatient care for behavioural or psychological outcomes.

### Survey

Analysis of survey responses found that the predominant models of care in the UK are early intervention in psychosis services, intensive day services, intensive outpatient treatment and intensive home treatment, with day hospitals being the longest running service.

> 'The evidence base is currently limited and provides little guidance for the development of services. Monitoring services through prospective audit could improve the evidence base'

## Lessons and implications

The evidence base is currently limited in terms of quality and quantity of studies. In its current form, it provides very little guidance for the development of services. Prospective comparative systems of audit, conducted across several centres, which include baseline measurement at admission along with demographic data, and outcomes using a few standardised measures could improve the current evidence base.

## Source

*Systematic review and mapping study of alternatives to inpatient care for children and adolescents with complex mental health needs,* July 2008.
**www.sdo.nihr.ac.uk/project.php**

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# Study three: Sharing information with mental health carers – why is this such a challenge?

Mental health is a complex area for people living with mental illness, their families, friends, practitioners and managers. A particular issue is the difficulties for carers in accessing information to support their caring role. Previous research by Rethink Mental Illness in collaboration with the University of Swansea and King's College London had identified a number of barriers to information sharing.

Among staff, these included lack of time, concerns about confidentiality issues and lack of confidence. Few trusts had policies in place guiding staff on what or how to share information with carers. Service users were anxious about what might be shared without them. There were also concerns from carers about confidentiality – a third had been told information could not be shared with patients without fully understanding the reasons for this. A key theme was variability of people's experiences – so much depends upon the quality of relationships between practitioner, service user and carer.

"This is an area of practice that causes a lot of dilemmas for professionals and support staff within their roles. It is also highlighted in serious untoward incidents/complaints where information was not shared and should have been." (Business manager LD and MH services)

"Carers have got a role to play – we know a service user best of all." (Carer)

## Method

Building on findings from earlier research, the team proposed to develop and test an online learning resource package for mental health professionals. The principle was using real-world scenarios to guide best practice, bringing to life the guidance from professional code of practice handbooks. This was developed using action research principles and recruiting a number of purposively selected sites to carry out usability testing of a pilot tool and to explore issues of acceptability.

## Findings

Feedback from piloting and usability testing showed positive responses, with two-thirds of users stating that they 'learned a lot'. Consultation with stakeholders led to development of self-paced learning rather than face-to-face training. Feedback from this stage also led to modifications of the pilot and pointers on best implementation.

"It highlights the things you know but just don't do." (Occupational therapist)

## Lessons and implications

This project indicates that it is possible to produce a practical evidence-based tool to support mental health practitioners to work more effectively with family/friend carers. Several NHS trusts have now purchased the online resource under licence. Further research is needed to evaluate impact, in terms of the confidence of mental health professional before and after the use of the tool and its impact on carers. It would also be useful to experiment with other forms of media to deliver key messages.

'Professionals are provided with little clarity on how to deal with information sharing dilemmas in practice within legal and ethical frameworks'

(The web resource is available at **www.carersandconfidentiality.org.uk** but the interactive e-learning element is only available with a licence.)

## Source

*The development of an online training resource for mental health professionals to involve carers in information sharing*. June 2010
**www.sdo.nihr.ac.uk/project.php**

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# Study four: Evaluation of a centrally-driven improvement initiative for mental health services

In 2004, a two-year national pilot scheme of improvement initiatives targeted at mental health services was initiated. These were adapted from general improvement programmes for hospitals, and included components of training staff in project management and process-mapping techniques.

## Method

Four pilot sites were selected pragmatically from across England and a realistic evaluation was carried out from 2006 to 2008 to measure impact. This included detailed examination of activity at the four sites, focusing on context, mechanism and outcomes as well as comparison with other non-pilot sites.

## Findings

Overall, only two out of the 15 workstreams across the four sites showed medium impact – the rest had little or no effect on service quality. One area of success was optimising the capacity of clinical teams, with a focus on caseload and waiting lists and times. The other was around understanding unplanned and emergency access to secondary mental health services to inform the development of an improved service model.

Pilot sites were insufficiently ready for change. This was neither recognised nor addressed by the initiative. It lacked a scientific approach and had no clear theory. A limited range of service improvement techniques was used. PRINCE 2 (a project management tool) was often felt to be excessive, but provided structure and durability.

## Lessons and implications

True partnership working was extremely difficult and the degree of service user or carer involvement was disappointing. Locally, the initiative was focused on too few personnel. Consequently, there was insufficient capacity to deal with issues that arose.

Resourcing, including project management support from the centre, had been less than expected which, together with structural changes during the lifetime of the pilots, added to the challenges. Better use could have been made by pilot initiatives of existing quality improvement structures, such as clinical audit teams.

Implications for service managers include:

- successful improvement initiatives need to be based on interventions of proven effectiveness, tailored to that service setting
- these interventions should be applied using a scientific approach, for example with good measurement of baselines and progress and with learning shared during the course of the work
- substantial work is needed to build and sustain relationships (including with service users and carers) to realise improvements
- project management skills can be useful for frontline staff in a number of ways, including resource management and team working.

> 'Many of the planned changes did not materialise, due to limited capacity and contextual distractions'

## Source

*Evaluation of the mental health improvement partnerships programme*, September 2008.
**www.sdo.nihr.ac.uk/project.php**

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# Study five: New organisational technologies for supporting self-care in mental health

The shift to a culture of supporting self-care at the centre of improved service delivery for long-term conditions, including mental health, has been reaffirmed by recent mental health strategy (*No health without mental health*). The existing evidence base focuses on individual cognitive behaviour therapy-based self-help packages. Understanding of the processes and outcomes of psychosocial modes of supporting self-care for people with long-term mental health conditions is underdeveloped.

## Method

A mixed method study aimed to identify the barriers and facilitators of supporting self-care in mental health trusts. Contrasting case studies included training for personal planning in community mental health services; community arts programmes; and peer support groups for people with personality disorders. All initiatives employed service users to co-deliver support. 120 new patient referrals to these interventions completed standardised psychosocial measures (along with questionnaires) about service use at referral and nine months later. This included measures of engagement. Interviews were also carried out with patients, staff and NHS managers about experiences and expectations. Service user researchers were involved in designing the research, carrying out interviews and leading on analysis of interview data.

## Findings

Key findings included:

- significant reduction in use of A&E for psychiatric emergency care for users of interventions
- significantly increased levels of empowerment and mental health confidence over the nine months of the study
- association between highly-rated service user-staff collaboration and remaining engaged with initiatives
- no association between level of engagement and outcomes.

Qualitative interview data shed light on these findings and suggested that support for self-care in mental health cannot be prescribed or 'dosed'. Service users strongly indicated that having control over when and how they used self-care support – 'timing it right' – was key to feeling empowered. This included genuine self-referral processes and the absence of punitive discharge for non-attendance. Service users and staff valued a change in staff role from 'provider' to 'enabler'.

## Lessons and implications

Overall, this study suggests that providing support for self-care has the potential to underpin delivery of the wider recovery, well-being and personalisation agendas in mental health, especially where those strategies are purposively aligned within and across organisations. In particular, the study found:

'Self-care involves a degree of 'positive' risk for service users and service provider'

- the specific interventions of peer support groups, personal planning initiatives and employing service users to provide support are highly valued components of supporting self-care in mental health
- the core qualities of supporting self-care – relaxed, enabling service user-staff relationships and giving people control over how they use support – are more important than simply prescribing components of self-care support in the delivery of services for long-term mental health conditions.

## Source

*The barriers and facilitators of supporting self-care in mental health NHS trusts*, April 2010.
**www.sdo.nihr.ac.uk/project.php**

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# Study six: Implementation of stepped care for depression

NICE has recommended 'stepped care' to organise treatment for common mental health problems. There is little evidence available as yet to support service delivery, such as optimal staffing profiles, competences, treatment protocols and patient pathways. The ideal balance between systems which are predominantly 'stepped' (where patients receive low-intensity treatments first) and 'stratified' (where patients are allocated to different treatment intensities) is unclear.

## Method

The study used a consensus development approach to help four NHS health services sites develop stepped care systems. The team analysed patient pathways through these systems to develop a standalone decision and modelling aid and accompanying user manual. Interviews with participants at the four pilot sites, and with additional sites after further dissemination, shone light on experience in using it and identified likely barriers to stepped care reconfiguration in the NHS.

## Findings

- All four sites moved successfully to new stepped care structures. The service models developed were extremely diverse and included elements of stepped and stratified systems.
- The principal driver of patient flow through stepped care systems was allocation to initial treatments. Service performance was additionally influenced by triage, resource constraints, access points and staff role.
- Rates of stepping patients up from low to high-intensity treatment were around 10 per cent when balanced high and low-intensity staff resources were available.
- Barriers to change included: staff resistance to the prescriptive nature of stepped care and the degree of professional clinical scrutiny required in stepped care systems; uncertainties about the exact format of the low-intensity clinical methods; the requirement for adequate resources to be present in all steps; and managing the change process of introducing a new workforce and reassigning traditionally qualified professional workers.
- Additional sites experienced great difficulty using the decision and modelling aid in a standalone manner. This was partially due to a rapidly changing context, principally the national *Improving access to psychological therapies* initiative.

## Lessons and implications

Stepped care as implemented by different NHS sites will vary greatly in structure and design according to different site contexts. While the design of the systems as 'stepped' or 'stratified' is a key dimension that influences the performance of stepped care systems, staff availability and professional referral behaviour can subvert initial plans in important ways. Reconfiguring to a stepped care system requires close management attention to referral pathways and to professional, clinical independence and specific clinical competences.

'The optimal configuration of system elements (for stepped care) is unknown'

NHS managers and clinical leaders do not find it easy to utilise standalone operational research modelling tools to aid decision-making and require training and support. In contrast, a fully supported consensus development method can be used to design locally appropriate service configurations. National initiatives should incorporate local modelling to reflect local contexts. Clinical trials of stepped care comparing stepped, stratified and traditional models of treatment delivery are required to improve decision models.

## Source

*Developing evidence based and acceptable stepped care systems in mental health care: an operational research project*, August 2010.
**www.sdo.nihr.ac.uk/project.php**

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# Research underway

These brief summaries describe relevant NIHR SDO-funded research in progress on a range of issues relating to innovations in mental health. Some of these have been commissioned as follow-on studies, to address particular gaps identified in previous research.

## Better mental healthcare for older people in general hospitals

Two-thirds of NHS general hospital beds are occupied by people over 65 years. Up to 60 per cent of these will have mental health problems including dementia, delirium and depression. This group does not fit easily into general hospital services and staff may lack training, confidence or time to care for them adequately. Some trusts provide links with specialist mental health liaison teams, but access is limited. This multi-method study considers the needs of this complex patient group, with a view to further work to test the effectiveness of specialist medical/mental health units.

This study combines a literature review; a series of case studies of patients in general hospital (who also have mental health problems), their carers and advocates, and the staff looking after them; and a parallel workforce investigation into expectation, training and support needs of staff. Understanding the extent and precise nature of their healthcare needs, and the impact that combined physical and mental health problems have on both outcomes and costs, should inform best practice, and support the business case for developing and commissioning better services. This study is at final publication stage and should be available in early 2012.

### Contact

John Gladman, University of Nottingham
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**Will be helpful to managers:**
in considering new ways of managing older patients with mental health problems in general medical settings.

## How managers respond to service user involvement in mental health

There is strong policy and service commitment to greater user involvement in mental health services, but it is not known how best to do this. Mental health differs from other medical specialities or social care groups because people with mental health problems can be deprived of their liberty. This has consequences for the relationship between patients and staff. People with mental illness are also typically younger than other groups of people with disabling conditions and so require a range of different services to live independently in the community. This study considers the deployment of service users in mental health in the context of other organisational research on 'new social movements'. It looks at particular user involvement initiatives, including recent projects to address the personalisation agenda and engagement of service users in the governance of foundation trusts.

The research project will cover five to six user groups in three mental health trusts, across a spectrum of traditional to more radical forms of engagement. It will use surveys, interviews, observation, stakeholder workshops and document analysis to investigate the impacts of user involvement and study how managers and leaders in the NHS respond to user involvement, in both its existing and emergent forms and what they can do to facilitate this. The research team will include service user input and is due to report before the end of 2013.

### Contact

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**Will be helpful to managers:**
in understanding what works in engaging service users.

## Employing peer workers in mental health organisations

Mental health NHS trusts and voluntary sector mental health organisations are increasingly employing people who have used mental health services themselves to work in or alongside existing mental health teams. These people are often known as peer workers. While some evidence suggests that peer workers are effective in supporting recovery, other research indicates challenges in the adoption of this new role, including acceptance by existing professional groups.

This project explores the introduction of the role of peer workers through 12 comparative organisational case studies – six in mental health trusts and six in the voluntary sector. Case studies in trusts will include services where peer workers will replace mental health professionals on existing clinical teams; where they have a specific and limited role (for example, training service users to develop recovery plans); and partnership working with other organisations. The voluntary sector projects will include service user-led projects (for example, providing crisis support, peer support and training) and projects targeted at black and minority ethnic (BME) communities. A range of interview and documentary data will be analysed while outputs will include handbooks and online training resources for managers in statutory and voluntary organisations. The research team includes peer workers and experienced service user researchers as well as mental health service and organisational researchers. The study is expected to report in 2013.

### Contact

Steve Gillard, St George's, University of London
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**Will be helpful to managers:**
in understanding how best to introduce and support new peer worker roles in service provider organisations.

## Comparing therapeutic relationships and patient satisfaction in acute inpatient and alternative crisis services

This study builds on previous SDO-funded research to investigate what influences staff-patient relationships, patient satisfaction and whether therapeutic relationships are stronger in crisis houses than in hospital. Data will be collected from four non-hospital crisis houses and four acute inpatient wards in London. This will include questionnaires with about 100 crisis house residents and inpatients to measure their therapeutic alliance (the quality of their relationship) with key staff, and satisfaction with services, including their perceptions of recovery and experiences of negative events during admission. Components of the study are a quantitative comparison of therapeutic alliance between crisis houses and inpatient wards, modelling of the factors associated with patient satisfaction with acute care and a qualitative exploration of contextual factors which promote or impede strong therapeutic alliances. This study is due to report in mid 2013.

### Contact

Sonia Johnson, University College London
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**Will be helpful to managers:**
in understanding why patients seem to prefer crisis houses and to inform commissioning decisions.

## Sharing clinical information on mentally disordered offenders across agencies

Ensuring continuity of care for mentally disordered offenders is a major challenge for community mental health services. Inquiry reports following homicides by people with mental illness commonly highlight critical failings in the sharing of risk information, both within and across criminal and health agencies.

This project is piloting a health and risk dataset, populated with data from NHS clinical systems, which could be directly accessed by police officers through a web-based multi-agency information sharing network, rather than through an NHS clinical system. It will be tested and evaluated at a prison health site and surrounding community health and criminal justice systems. Key data items will be agreed by a panel of health and criminal justice staff. This includes such issues as substance misuse issues and risk of self-harm as well as mental and physical health data. The method of access will also be tested, including a system to filter information using secure passwords according to role (summary data for police officers and more detailed clinical and diagnostic data for clinical staff). The main aims are to ensure that vital health and risk data is available immediately at the point of entry into police custody, independent of the presence of a clinician. This study is at final publication stage and should be available in early 2012.

### Contact

Jane Senior, University of Manchester
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**Will be helpful to managers:** in considering how best to share health and risk information with non-clinicians.

## The Service Delivery and Organisation (SDO) Network

The SDO Network supports NHS managers to use research to improve and develop the services they manage. The network is funded by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme.

For more information visit **www.nhsconfed.org/SDONetwork** or contact **SDONetwork@nhsconfed.org**

## Department of Health disclaimer

The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR SDO programme or the Department of Health.

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