# In-patient Alternatives to Traditional Mental Health Acute In-Patient Care

***Report for the National Institute for Health Research Service Delivery and Organisation programme***

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prepared by

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# *The Report*

# 1 Introduction

## *1.1 Background*

The proportion of mental health budgets devoted to in-patient care remains high and there is a wide consensus that such care is required for effective management of some emergencies (Szmukler and Holloway, 2001). A recent national audit reported around 12,400 NHS acute mental health beds for adults of working age in England and Wales (Department of Health 2006). The kind of service provided by acute mental health wards has been described in a qualitative study using semi-structured intervews with inpatient staff (Bowers et al. 2005). Bowers and colleagues reported the main functions andactivities of acute wards as being containment (risk assessment, de-escalation, restraint), presence (being with patients, mental state assessments, assessment of living skills), ''presence plus'' (building up trust, support, empowerment), treatment (medication, sedation, different types of therapy) and management (admission, discharge, bed finding, care coordination). Acute hospital care has recently been identified as a problematic and poorly understood component in the UK mental health care system (Muijen, 1999, Quirk and Lelliott, 2001; Department of Health, 2002). Three main aspects contribute to this view: its unpopularity among service users, lack of clarity about its functions, and lack of evidence about its outcomes.

There is considerable evidence that being a psychiatric in-patient is an unpleasant experience for many (Rose 2001; Quirk and Lelliott, 2001; Muijen; 1999; Department of Health, 2002). Criticisms have included that the physical environment is often poor and freedom greatly restricted, especially for the many who are compulsorily treated, opportunities for activity and exercise are limited, food is often unappetising and nutritionally unsatisfactory, and many in-patients feel unsafe, especially from the threat of violence by other patients. The stigma associated with in-patient care further exacerbates this unpopularity: even where they think the environment and care received have been reasonable, patients often feel that the stigma associated with having been admitted to a psychiatric hospital is even greater than that associated with receiving a psychiatric diagnosis (Johnson et al. 2003).

A clear consensus also seems to be lacking regarding appropriate aims, functions and treatment processes for acute wards. Whereas in the past, the asylum functioned as a 'total institution' delivering a wide range of forms of clinical and social care, most admissions are now unplanned responses to emergencies (Quirk and Lelliott, 2001), with risk of violence, self harm and serious self neglect the most frequently identified reasons for admission (Flannigan et al. 1994). Little detailed attention has recently been paid to the processes involved in hospital treatment, the strategies used to contain risk and manage crises, and the content and philosophy of in-patient care (Szmukler and Holloway, 2001, Quirk and Lelliott, 2001). Recent surveys of in-patients suggest they find their interactions with staff and the structured treatment and activity available on wards too limited (Higgins et al. 1999). Bray (1999) found that many nurses wanted to do more active therapeutic work with in-patients, but felt uncertain about which treatment models were appropriate and overwhelmed by patients' high levels of disturbance.

Outcomes of in-patient care have been a neglected research area. Jepson et al. (2001) identified only one systematic review on a theme related to acute in-patient care: this found no differences in outcomes between routine admissions and planned short hospital stays (Johnstone and Zolese, 1997). Trials of innovative community treatments often use hospitalization as an indicator of a poor outcome, but the extent to which admission eventually results in reductions in risk or in any clinical and social benefits to the patient is largely unknown.

Some descriptive information is available regarding characteristics of in-patient populations in the UK, for example from the studies of Fulop et al. (1996), and Shepherd et al. (1997). This evidence suggests that a substantial proportion of acute in-patient stays could be shortened or avoided if suitable alternatives were available. Crisis resolution teams, which work mainly in service users' homes, are advocated in current NHS policy as the main alternative to admission (Department of Health, 2000). However, home treatment may be unsafe or undesirable for some people who are functioning very poorly, are at high risk, or have a home environment which exacerbates their difficulties. In-patient alternatives to traditional in-patient care which have potential to resolve some of the problems in current services are of considerable interest for the care of this group. Studies investigating the views of service users and carers indicate that they favour alternatives to traditional in-patient settings (Rose, 2001).

Despite this enthusiasm for residential alternatives to in-patient care and the development of a range of pioneering services in various countries over the past 40 years, the evidence base relating to them remains very limited. Several forms of residential alternative have been described. Some take the form of innovative programmes based in units on hospital premises, while

others are community-based. Residential units in the community offering short-term emergency admission, sometimes known as crisis houses, are probably the form of residential alternative to admission which has received most attention in the UK (Davies et al., 1994). A few descriptions and evaluations of such services have been published in the US, though without very widespread adoption of this model. These studies have usually been small and have sometimes had substantial methodological difficulties, but results have suggested clinical and social outcomes at least as good as for standard in-patient care (Bond et al., 1989, Fenton et al., 1998). In the UK, investigation of the Drayton Park Crisis House in Islington, a 24 hour staffed crisis house for women (Killaspy et al., 2000; Johnson et al., 2003) suggests that it is highly valued by service users. They think that their recovery is promoted by a home-like environment, absence of disturbed male patients, ready availability of staff for talking through current and past difficulties and good support from other residents. Admission to the house is often experienced as less stigmatising than hospital. Women using the house had comparable clinical and social problems to those accepted by the local crisis resolution team. In South London, data from the Croydon women's crisis house indicate that women admitted are at least as severely disabled and symptomatic and have similar levels of unmet need to women admitted to acute in-patient wards. In Staffordshire, introduction of a crisis house open only at weekends when community services are unavailable has been associated with reduced use of local in-patient services (Hodgson et al., 2002). Some crisis houses have adopted a user-led rather than professionally led model of care, and a high level of user involvement in developing and providing these services appears to be frequent, as in the residential crisis facilities supported and described by the Mental Health Foundation and the Sainsbury Centre for Mental Health (Mental Health Foundation, 2002).

Another strategy for providing residential alternatives to in-patient care in the community is to establish hybrid facilities offering crisis admission alongside one or more other types of community care. Perhaps the most prominent example is in Trieste, Italy, where 24 hour community mental health centres include crisis beds alongside day programmes and drop in facilities (Mezzina and Vidoni, 1995), and similar services have been described elsewhere in Italy and in France (Katschnig et al. 1993). In the UK, Boardman et al. (1999a, 1999b) investigated beds integrated into community mental health centres in North Staffordshire with results suggesting greater client satisfaction and better outcomes on some measures for the group managed in the community mental health centres than for hospital in-patients. Wesson and Walmsley (2001) have described a community-based unit in Southport which combines day care and crisis admission beds.

Emergency placement with suitable foster families was pioneered as an alternative to hospital by Paul Polak in Denver, Colorado in the 1960s (Polak

et al., 1979), where families in the scheme received specific training and 24 hour support from mental health professionals. Stroul (1988) surveyed community-based residential crisis facilities in the United States and reported that short-term housing and support at the homes of carefully selected families appeared to be the most frequently available of these types of care. The Accredited Accommodation Scheme in Powys offers care of this form to a selected sub-group of community mental health team users, though Readhead et al. (2002) comment that while the scheme was developed for crisis care, in practice it is often used for planned periods of respite and rehabilitative social care.

Other alternatives to traditional in-patient care take the form of hospital-based units, either offering innovative programmes to a broad range of those needing acute admission or specialising in a sub-group. Brief treatment beds, designated for intensive multidisciplinary treatment, usually with discharge planned within one week, have been investigated by a number of North American groups (Guido and Payne, 1967; Herz et al.,1977), with findings suggesting swifter return to normal roles and no increase in family burden or reduction in treatment adherence. In-patient units offering brief programmes based on crisis intervention theory rather than on a traditional medical model have been described in various European countries, though some such units have closed following difficulties applying this model to the long-term and complex difficulties of many of those presenting to emergency services (Katschnig et al., 1993). Regarding units specialising in acute care for sub-groups, the international literature yields descriptions of in-patient units focusing on particular ethnic groups (Matthews et al., 2002) and segregating patients by diagnosis (Bonsack et al., 2001). In the UK, acute wards have tended to operate on a sectorised basis rather than specialising in this way, but Mother and Baby Units (MBUs) are an example of acute units tailored to the needs of a particular sub-group of service users. These have been developed in the UK in response to growing evidence of problems with infant attachment to the mother when mothers and children were separated in children's hospitals. The Royal College of Psychiatrists now recommends admission to a specialist mother and baby unit whenever a mother requires acute admission to a psychiatric unit following childbirth, although fewer than half the health authorities in the UK provide such units. A further UK example of a specialist ward is the early psychosis ward of the Lambeth Early Onset (LEO) service.

Thus a variety of residential alternatives to acute admission have been described, and most seem to be represented within the NHS at least to a limited extent. However, knowledge remains very limited regarding the degree to which they are disseminated across the country, the nature of the clinical populations they serve and the interventions they provide and the costs and outcomes associated with them.

## 1.2 Aims

The overall study aims are to investigate the development, availability and organisational characteristics of statutory and voluntary sector in-patient alternatives to traditional NHS acute general adult psychiatric in-patient care in England (excluding intensive care units), and to evaluate their effectiveness, cost and cost-effectiveness and acceptability to service users and their carers. We have prioritised the objectives shown below in order to focus on the key questions to be addressed by the study, to offer value for money, to ensure feasibility of the work, and to strike a balance between broad coverage of the question across the whole of England and more detailed quantitative and qualitative investigation of key questions. We have chosen to place the experience of users and carers at the centre of this study. In addition, we have used a deliberately multi-disciplinary and multi-method approach, including within the study team representatives of the views and interests of users and carers as well as contributions from the fields of nursing, health economics, organisational psychology, statistics, clinical psychology, social care and psychiatry (Fulop et al, 2001). The study took place under the auspices of the Mental Health Research Network of the National Institute for Mental Health for England (NIMHE), whose local hubs provided help with recruitment and data collection.

## 1.3 Objectives

1. To identify all in-patient alternatives to traditional acute psychiatric in-patient care for adults of working age in England.

2. To describe their organisational structures, operational methods and relationships with other elements in local service systems.

3. To produce a typology of in-patient alternatives to traditional in-patient care based on these data.

4. To compare social, demographic and clinical characteristics of consecutive series of service users admitted to a purposive sample of each type of alternative facility with a series admitted to traditional in-patient facilities in the same catchment areas.

5. To investigate the views of service users about the acceptability and helpfulness of these alternative facilities and how they compare with traditional in-patient care.

6. To assess the acceptability to carers of traditional settings and each type of alternative facility.

7. To compare users admitted to each type of alternative facility with those admitted to traditional in-patient settings in terms of (a) the initial outcome of admission in terms of severity of social and clinical problems, disability and risk, and (b) longer term outcome over the year following admission in terms of readmission and in-patient bed use.

8. To compare the costs and cost-effectiveness of index admissions to traditional in-patient settings and alternative forms of in-patient care, and to compare costs associated with psychiatric service use over the year following the index admission.

9. To investigate clinical service managers' accounts of the organisational development of the alternative facilities, the success factors and impediments encountered, and the models of care on which they are based.

10. To understand the role of the alternative services within the local mental health service system

An overview of the design of the study, illustrating how the above aims were addressed, is provided in Table 1.1.



 

Table 1.1 Overview of The Alternatives Study

| | Module | Methods | Measures | Sample |
|---|---|---|---|---|
| **1** | National survey of alternatives | Telephone survey of managers of potential alternative services | Questionnaire (Appendix 1) | 131 alternatives identified<br>109 interviews completed |
| **2** | Characteristics of service users at alternatives and standard services | Socio-demographic information and health ratings provided by staff for cohorts of service users at admission | Questionnaire, including ratings using HoNOS, GAF and TAG<br>(Appendix 2) | 12 services<br>433 patients |
| **3** | Users' experience of alternatives | Semi-structured interview with patients at alternatives who had also experienced standard inpatient services | Interview topic guide<br>(Appendix 4) | 6 services<br>40 patients |
| **4** | Carers' experience of alternatives | Semi-structured interview with carers of patients at alternatives who had also experienced standard inpatient services | Interview topic guide<br>(Appendix 5) | 6 services<br>25 carers |
| **5** | User's short and medium term health outcomes | Service use and health ratings provided by staff for patients from Module 2 at discharge. 1 year service use data collected from electronic records | Questionnaire including HoNOS, GAF and TAG (Appendix 3)<br>Service use data collection form (Appendix 6) | 12 services<br>433 patients |
| **6** | Costs and cost-effectiveness of alternatives and standard services | Service use and costs per bed-day collected from routine data | n/a | 12 services<br>433 patients |

| | Module | Methods | Measures | Sample |
|---|---|---|---|---|
| **7** | Alternatives manager interviews | Semi structured interview with alternative service managers | Interview tropic guide (Appendix 7) | 6 services<br>6 managers |
| **8** | Alternatives stakeholder interviews | Semi structured interview with alternative service stakeholders (managers and clinicians from other acute services and commissioners) | Interview topic guide (Appendix 8) | 6 services<br>30 interviewees |
| **9** | Content of care at alternatives and standard services | Data collected regarding intensity and nature of care from direct observation, staff and patient-report | CaSPAR, CaRICE and CCCQ-P<br>(Appendices 9-11) | 8 services<br>CaSPAR: 228 observations<br>CaRICE: 1 week recording per service<br>CCCQ-P: 314 patients |
| **10** | Users' satisfaction with alternatives and standard services | Questionnaire completed with patients close to the point of discharge | Questionnaire including CSQ, AES, SSS-RES, WAS<br>(Appendix 12) | 8 services<br>314 patients |

# 2. Methods

The study was conducted in two phases. Phase 1 was the national survey of alternatives (Module 1 in Table 1.1). Phase 2 was the evaluation of six alternative services and comparison standard inpatient services (Modules 2-10 in Table 1.1).

## *2.1 Phase 1: National survey of in-patient alternatives to standard in-patient care in England and development of typology of these alternatives (Module 1)*

### 2.1.1 Identification of Services

#### *Inclusion criteria*

A national cross-sectional survey was conducted of alternatives to standard acute in-patient care. A set of inclusion criteria were created to identify units (wards or services) providing a residential alternative to traditional acute inpatient settings. Units were defined as alternatives if they met the following criteria:

Located in England

Residential

For adults 16-65

For people with acute mental health problems of a severity to warrant admission to a traditional acute admission ward

Is an alternative from a traditional ward in at least one of the following:

a) Is disorder specific

b) Caters for a specific socio-demographic population

c) Provides a specific therapeutic orientation

d) Maximum length of stay of two weeks or less for all clients

e) Is located in the community and not on a hospital site

#### *Identification of the alternative units*

As no single method was likely to allow us to find all the services which met these criteria, multiple methods were used. These included examination of the Mental Health Service Mapping for Adults of Working Age in England, telephone calls to all mental health acute wards in England, Google internet searches and consultation with a variety of expert sources, including the national mental health

voluntary organisations MIND and Rethink, and snowball sampling with identified participants.

i) Literature searching

A search of the literature was performed using Medline for the years 1996 to March 2005 inclusive. The search strategy used is shown in Figure 2.1.1.

An internet search was performed using the search engine 'Google'. The search strategy is outlined in Figure 2.1.2.

The Durham mapping project is a self-reporting database updated by Primary Care Trusts with details of mental health services for adults of working age across the UK. The service is accessible online at:

http://alison.dur.ac.uk/service.mapping/amh/index.php

Reports for the Durham Mapping Service were generated from information provided up to March 2004 by local implementation teams, primary care trusts, and provider trust for emergency accommodation and acute in-patient services. Each location was contacted by phone and the email address of a suitable contact as defined earlier.

ii) Contacting key mental health organisations

A number of organisations, which had a key role in the provision and documentation of acute services in England, were contacted. A contact with knowledge of adult acute care was identified in each organisation and the inclusion criteria were circulated. Each organisation was asked if it could identify any units that fit the inclusion criteria.

The National Institute for Mental Health in England (NIMHE) is a NHS initiative, which works to improve the quality of life for people experiencing mental distress. The national acute lead was contacted and the inclusion criteria communicated for further dissemination to regional acute leads.

Rethink and Mind and Turning Point are all mental health charities, which provide acute inpatient services. A contact in each of the charities and the inclusion criteria were circulated. They were each able to identify both units that they provide and units that they were aware of meeting the criteria of an alternative to traditional inpatient admission units. In addition, mapping of early intervention services conducted by Rethink and the National Institute for Mental Health in England provided further units which met the inclusion criteria.

The Sainsbury Centre for Mental Health (SCMH) is a charity working to influence policy and practice in mental health across the United Kingdom. Researchers at SCMH have been involved in mapping acute mental health services across the UK. This database enabled us to identify further alternative units.

The Service User Research Enterprise (SURE) is a user focused research unit based at the Institute of Psychiatry. Members of the SURE team both work with users of mental health services and have service use experience themselves.

The Service User Research Group Enterprise is a service user–led research group with a wide knowledge of mental health services obtained both through personal and professional experience.

The Marcé Society is an international organisation for the understanding, prevention and treatment of mental illness related to childbearing. The Marcé Society maintains a detailed database of mother and baby services across the country which was used to identify mother and baby services. All mother and baby units meet the inclusion criteria of an alternative by providing a service for a particular socio-demographically defined group of people.

iii) Contacting acute wards

NHS Trusts providing inpatient services for people with mental health problems were identified using the NHS website:

http://www.nhs.uk/england/authoritiesTrusts/mentalhealth/default.aspx

A total of 81 Trusts were identified. Each Trust was contacted by telephone or email for a list of their adult inpatient services. The Modern Matron, Clinical Nurse manager, Ward manager or Charge nurse for each service was contacted by telephone.

Private providers of mental health services across the country were identified using the Private Providers UK website.

http://www.privatehealth.co.uk/psychiatric

The websites of each company were used to identify adult acute inpatient services.

When contact was established with acute wards and other potential alternative units, a suitable person, i.e. a service manager, modern matron, ward manager, deputy ward manager or clinical nurse was identified at each service. Each was asked a series of questions based on the inclusion criteria and formulated into a screening questionnaire (Figure 2.1.3). The screening questionnaire comprised additional questions which aimed at identifying any further alternative residential units in both their locality and the local Trust. Alternative services positively identified through the screening questionnaire were circulated to the NIMHE regional acute leads and mother and baby units to the Marcé Society for verification

**Figure2.1.1 Search strategy for Medline literature search**

| Search term | Meaning |
|---|---|
| 1. psychiatr$.tw | Any publication with psychiatry or psychiatric in the title, abstract or text. |
| 2. acute service | |
| 3. 1 and 2 | Only acute psychiatric services… |
| 4. inpatient or residential | |
| 5. 3 and 4 | …with beds |
| 6. (alternative or crisis).tw | At least one of these should feature |
| 7. 5 and 6 | Alternative acute psychiatric services or crisis accommodation… |
| 8. UK.mp | …in the UK |

**Figure2.1.2: Search terms for Google internet search**

| Search term |
|---|
| 1. Crisis house |
| 2. Crisis accommodation |
| 3. Emergency accommodation |
| 4. Crisis beds |
| 5. In-patient alternative mental health |
| 6. Mental health acute care |
| 7. Mental health crisis house |
| 8. Mental health emergency accommodation |
| 9. Adult mental health |
| 10. Residential crisis bed |
| 11. Residential crisis care |
| 12. Acute mental health treatment |
| 13. Short-stay mental health |
| 14. Short-stay crisis accommodation |
| 15. Mental health acute services |
| 16. Mental health crisis service |
| 17. Innovative mental health treatment in-patient |
| 18. Innovative mental health treatment acute |
| 19. Innovative mental health treatment crisis |
| 20. Alternative treatment mental health hospital |
| 21. In-patient mental health treatment |

**Figure 2.1.3: Inclusion screening questionnaire**

My name is _____ and I am a researcher at the Institute of Psychiatry/University College London. I am doing a national survey of alternatives to traditional inpatient care across England. I have been funded by the NHS Service Delivery and Organisation programme. To start with we are trying to identify services that should be included in a more detailed survey.

Are you the best person to ask about the acute inpatient care for adults of working age provided at your unit/hospital?

Would you mind answering a few short questions about your unit/wards within your hospital. It should only take 5 minutes.

1) Is your unit/are your wards for adults of working age between the ages of 16 and 65?
2) Do they offer beds to people with acute mental health problems of a severity that they would warrant inpatient admission?
3) Is your unit/any of your wards disorder specific?
4) Is your unit/are any of your wards specifically for ethnic minorities?
5) Does your unit use have a specific therapeutic orientation or philosophy intended as an alternative to traditional services. Some examples of this are where the mix of workers are not primarily nursing staff or a particular model is used that offers an alternative way of working with clients to traditional psychosocial, individual/person-centred models of care.
6) Are clients admitted for a fixed length of time or for as long as needs meet?
7) Is your unit based in the community or on a hospital site?
8) Do you know about any services that would meet these criteria in your area? These might be run by your Trust or the private or voluntary sector.
9) Do you know of any crisis houses in your area?

Thankyou very much for your time, this has been very helpful.

## 2.1.2 Data collection

All services identified in this way as alternatives were contacted and invited to participate in an interview with a researcher using a questionnaire designed to cover the main clinical and organisational characteristics of services. The Alternatives Study steering group, which comprised 19 experts with backgrounds including psychologists, psychiatrists, service users and representatives of key voluntary organisations, identified the key topics to be covered and the questionnaire was refined following pilot interviews with 7 service managers.

A questionnaire package was developed. The questionnaire package comprised an introductory letter, information sheet and questionnaire. In order to test the questionnaire package, questionnaire questions, format and the best way to maximise responses, the package was piloted. Seven units were chosen which

included units representative of the public, private and voluntary sector, and units representative of at least one of each of the inclusion criteria. The units chosen and their fit to the inclusion criteria are shown in Table 2.1.1.

**Table 2.1.1 The units chosen for piloting the questionnaire and how they each represent the inclusion criteria.**

| Name of unit | Type of unit | | | Inclusion criteria | | | | |
|---|---|---|---|---|---|---|---|---|
| | Public | Voluntary | Private | Socio-demographic | Disorder specific | Therapeutic orientation | Fixed stay | Community based |
| Department of Psychiatry, Eastbourne Hospital | √ | | | | | √ | | |
| Harrogate Clinic Cygnet Hospital | | | √ | | | √ | √ | |
| Alexandra Crisis House | √ | | | | | | √ | √ |
| Andover Crisis and Support | | √ | | | | | √ | √ |
| Scrogg Road Mental Health Resource Centre | √ | | | | | | √ | |
| Ward 35, Tameside General Hospital | √ | | | | √ | | | |
| MBU Hinchingbrooke Hospital, | √ | | | √ | | | | |

It was ensured that at least one unit was chosen with a dual role, with some beds used for a service qualifying as an alternative and some beds used as part of a traditional service.

The ward manager or service manager for each unit was contacted by telephone and their consent sought for participation in the study as a pilot site. Each contact was asked whether they would like to receive the questionnaire package by post or by email. All units agreed to partake in a telephone interview within one week of receiving the questionnaire. The questionnaire package (excluding the introductory sheet) was sent to each unit within 10 days of initial contact. Three sites received the package by post and 2 sites by email. In addition to the questionnaire package, a number of pilot questions were included as a separate document. The pilot questions aimed to assess the information letter, ease of use of the questionnaire, areas of difficulty, areas requiring considerable input and additional time in an effort to assess how the questionnaire could be adapted to maximise the number of responses (Figure 2.1.4).

**Figure 2.1.4: Letter sent out with pilot questions sent out to six pilot sites**

**The Alternatives Study**
**Module 1: Pilot Questionnaire**
**Questions for Prespondents on Process**

1. We would like to try and ensure a high completion rate for this questionnaire without causing people too much inconvenience. What do you think is the best way to approach people with the questionnaire?

2a) Which method of completing the questionnaire is most convenient for you to respond with?

- By telephone interview
- Electronically
- By post

2b) Could the process of completing the questionnaire have been made more convenient for you: if so, how?

2c) Does phoning as well as posting the questionnaire make it more likely to be completed?

3) Do you feel the questionnaire took too long to complete? If so, what made it take too long?

4) Was all the information sought in the question naire readily available to you? If not, what did you have to look for?

5) How do you think completing the questionnaire could be made less time-consuming?

6a) Were there any questions you did not feel happy to answer? If so, please explain why.

6b) Were any question so problematic they made you less likely to return the whole questionnaire?

7a) Did you feel the questionnaire allowed you to describe the most important aspects of the service you provide?

7b) Did you feel that it allowed you to explain the main ways in which your service is different from a conventionals hospital service?

8) Any other comments…

The final version of the questionnaire is provided in Appendix 1. Topics covered included location and facilities, types of care provided, referral criteria and pathways, funding and management, links with other services and staffing.

Respondents were also asked for anonymised socio-demographic and clinical details of all residents in their service on the preceding night (see Appendix 1). Interviews were usually conducted over the telephone with the manager of the service, who received and had the opportunity to prepare answers to the questions in advance. As a check on how comprehensive identification of alternatives had been, respondents were asked to name any other alternatives of which they were aware in the surrounding area: this yielded only two previously unidentified services, confirming our impression that our initial strategy identified most services nationally.

In addition to data collected through the questionnaire, local social deprivation data were gathered for each unit. The postcode of each unit was used to determine its local authority, and Government Office Region and Indices of Multiple Deprivation were obtained for each local authority to indicate deprivation. The Indices of Multiple Deprivation (Jordan et al 2000) are based on the 2001 Census (Office of National Statistics 2001) and are derived from weighted information about seven domains, including income deprivation, employment deprivation, health deprivation, crime, living environment deprivation, barriers to housing and services, education, skills and training deprivation. Six different summary measures make up the overall Index of Multiple Deprivation, and no single measure is favoured above the others, since there is no single best way of comparing area-level deprivation. They include 1) the average ranks and 2) average scores which depict the average level of deprivation across the whole local authority, 3) a "concentration" measure, which describes the severity of multiple deprivation in each authority (measuring "hotspots" of deprivation) 4) an "extent" measure which describes the proportion of a LAD population which lives in the most deprived areas (similar to wards) of England, and 5) income and 6) employment scales. We also recorded whether each alternative was situated in the city centre of one of the ten most populous English cities according to the 2001 Census.

### 2.1.3 Analysis

SPSS for Windows (Version 12) was used to conduct initial descriptive analyses. A typology of services was derived using the Two Step Cluster Analysis procedure. This allows inclusion of both binary and quantitative variables, using a preclustering module followed by a hierarchical likelihood-based method in which continuous variables are assumed to have a multivariate normal distribution and categorical variables a multinomial distribution. The decrease in log-likelihood on merging clusters is used as the clustering criterion (SPSS Technical Report 'Twostep Cluster', available from support@spss.com). Variables for the cluster analysis were initially selected from the questionnaire by the Alternatives Study steering group. They were asked to rate the importance of each candidate variable for inclusion in the analysis. This resulted in identification of 13 variables that were rated overall as at least moderately important, of which the 10 most highly rated were given priority in subsequent analyses. To obtain a final model from cluster analysis, effects were explored of allowing between 5 and 9 clusters

to emerge from the analysis and of adding to the 10 variables given highest priority for the cluster analysis each of the other 3 identified as potential candidates for inclusion. Criteria for selecting a final model were clinical plausibility, stability of the model when small changes were made in the list of included variables, and avoidance of clusters containing a very small or very large proportion of the sample. The variables used in the cluster analyses are shown in Figure 2.1.5.

**Figure 2.1.5: Variables used to identify service clusters**

**1 Number of beds**

**2. Voluntary sector management**

**3. Typical length of stay, reported by manager**

**4. Proportion of staff who are nurses**

**5. Whether outside hospital**

**6. Whether Care Programme Approach meetings (care planning meetings which are a statutory requirement within the National Health Service) are organised within the service**

**7. Whether any programme of structured activity is available to residents**

**8. Whether service dedicated to people with a specific diagnosis**

**9. Whether service dedicated to a specific socio-demographic group**

**10. Implementation of a specific therapeutic model**

**11. Score for degree of integration with crisis resolution team –measured by a scale consisting of binary items regarding extent of joint management and joint working arrangements (Cronbach's α for scale =0.69)**

**12. Score for extent of hospital-like interventions, measured by scale with binary items on interventions characteristically provided in hospitals e.g. blood tests, physical examinations, medication review by medical staff, one-to-one supervision (α=0.91)**

**13. Score for severity of target group, measured by scale including items on referral pathways and criteria e.g. whether specialist mental health services main referrer to service, whether compulsorily detained patients accepted, whether history of violence an exclusion criterion (α=0.73)**

## *2.2 Phase 2: Identification of services*

Phase 2 (Modules 2 -10) of the study focuses on a sub-sample of alternatives representing the service types identified through the national survey and, for each alternative, a local comparison standard general acute admission ward.

Six alternative services were identified for inclusion in Phase 2 of the study. The location of these services and the type which each represents, are listed in Table 2.2.1.

**Table 2.2.1 Alternative services participating in Phase 2**

| **Service** | **Location** |
|---|---|
| Clinical Crisis House | North Staffordshire |
| Crisis Team Beds | Middlesbrough |
| Non-clinical alternative 2 (Black focus) | Hackney, London |
| Non-clinical alternative 1 | Islington, London |
| Tidal Model Ward (General therapeutic cluster) | Birmingham |
| Short-stay ward | Basildon, Essex |

Services were identified on the basis of clustering and of other criteria including service user turnover, availability of local controls, willingness to participate, whether a good exemplar of the particular cluster and to represent a mix of city, town and rural services. A comparison standard acute ward for each service was identified which accepted patients from a similar catchment area and was served by the same community mental health services as the chosen alternative services. Priority was also given to services in Mental Health Research Network Hubs, as the study has been adopted by the Mental Health Research Network, who can facilitate the processes of engaging services, obtaining research governance approval and collecting data at services within their hubs.

Three clusters from the typology did not provide alternatives to participate in Phase 2 of the study: specialist crisis houses, wards for specific diagnostic groups and wards for specific socio-demographic groups. This was because it was not possible to identify comparison local standard wards admitting sufficient similar patients. Two services were included from the non-clinical alternatives cluster. This allowed inclusion of a dedicated black minority ethnic service and a more generic non-clinical alternative in the study. Brief descriptions of the alternatives included in Phase 2 of the study and their comparison standard wards are provided below.

**The Clinical Crisis House** is an eight-bedded residential unit within a Community Mental Health Resource Centre in Staffordshire. It was established ten years ago and is one of five similar units within the local mental health trust designed to avert admissions to the local psychiatric hospital where possible and facilitate early discharge by transferring patients from the acute wards. The Ashcombe Centre is situated in a rural village about fifteen miles from Stoke-on-Trent in a very mono-ethnic white British area. It is 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 is provided within the unit, including an extensive gardening project. The CMHT gatekeep access to the beds: only known clients are admitted directly from the community, precluding the admission of people unknown to services via the police or accident and emergency units. Detained patients can be admitted directly from the community. Admissions are typically longer than for the other alternatives in the study: the service's records indicate a typical length of stay of about one month.

**The Crisis Team Beds** are four beds run by the local Crisis and Home Treatment Team, within a larger social services rehabilitation hostel. The service is situated on a residential street on a housing estate about a mile from Central Middlesbrough. It has been running for four years. 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 2 (Black focus)** is a nine-bedded crisis house in a residential street in Hackney, run by a voluntary sector Housing Association. It accepts patients from black minority ethnic communities, who are widely represented in the local community. The service has been running for ten years. It explicitly 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 cannot be admitted. Staff are non-clinical, social care workers but a counsellor and alternative therapists such as a reflexologist also provide sessional 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, but two additional weeks can be agreed if considered necessary by the patient and staff.

**Non-clinical alternative 1** is a nine-bedded crisis service situated in a large property in a residential street in Islington, North London. It is staffed by social care staff, many of whom have an interest or background in counselling. It is run

by 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 are typically no longer than a month. The service has been established for 11 years,

**The Tidal Model Ward** is a single twenty-bedded inpatient ward with attached outpatient unit in inner-city Birmingham. The Tidal Model (Barker 2000) of nursing care has been implemented in the ward for about a year. As implemented at Newbridge House, the Tidal Model 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. Newbridge House admits male and female patients: most staff are nurses or healthcare assistants but one occupational therapist is also employed on the ward.

**The Short-Stay Ward** is situated within Basildon General Hospital and is in close proximity 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.

The six comparison standard services are all general acute admission inpatient services, all but one within the same mental health trusts as the alternatives. **The clinical crisis house comparison service** is situated in a suburban area of Stoke-on-Trent, Staffordshire and has three acute wards, two 18-bed single sex wards for lower dependency patients and one 15-bed mixed ward for acute admission patients. All three wards were included in the study; all patients requiring general acute admission are admitted to one of the three. **The crisis team beds comparison service** in Middlesbrough comprises two 25-bed wards, one male one female, within a larger psychiatric hospital. It is situated within walking distance of the Middlesbrough Crisis Team Beds about a mile from central Middlesbrough. **The non-clinical alternative 2 (Black focus) comparison service** is two 20-bed mixed-sex acute wards in the mental health unit of a general hospital in Hackney, London. **The non-clinical alternative 1 comparison service** constituted four mixed-sex general acute wards in two Hospitals in Camden, the neighbouring borough to Islington where the non-clinical alternative 1 is situated and part of the same mental health trust catchment area. **The Tidal Model ward comparison service** was (it has subsequently closed), a 22-bed mixed sex acute psychiatric admission ward within a general hospital in Solihull, a suburban area in the south of the region covered by Birmingham and Solihull mental health trust. **The Short-Stay ward comparison service** includes two acute wards in the mental health unit of a general hospital in North Kent. Neighbouring across the Thames Estuary and not demographically dissimilar from South Essex, where Basildon Assessment Unit is

situated, it was chosen as a comparison service because none was available in South Essex, as all voluntarily admitted patients there use Basildon Assessment Unit. All six standard services employed a staff mix typical of acute wards,, i.e. predominantly nursing staff and health care assistants with psychiatrists and occupational therapists also represented. All were considered one of the mainstream acute inpatient services within the local service system.

In advance of data collection, each participating facility was visited by research staff, who presented the study to clinical staff and provided training in use of the study measures. Key members of staff (typically ward or service managers) with whom researchers can keep in touch were identified.

## *2.3 Comparison of service user characteristics in alternative and standard services (Module 2)*

### Aim

This part of the study sought to compare the socio-demographic and clinical characteristics of patients admitted to alternative and standard services. It addresses a key question of the extent to which alternatives cater for a population with difficulties of a similar severity and nature to those admitted to standard acute wards.

### Measures

Information was sought from service staff about the characteristics and health status of series of patients admitted to alternative and traditional services. The study Admission Form used to collect these data is provided in Appendix 2. In addition to basic socio-demographic, clinical and referral pathway data regarding each patient, the Admission Form includes three ratings of severity of symptoms and disability at admission using the Global Assessment of Functioning (GAF), Health of the Nation Outcome Scale (HoNOS) and Threshold Assessment Grid (TAG). These are all brief instruments with established reliability, validity and suitability for use in this setting. References to all study measures are provided in section 5.

### Sample

Information was sought for a series of 35 consecutively admitted patients at 6 alternative and 6 standard services, yielding a total sample size of 420. Exclusion criteria from the study sample were:

- patients who opted out of inclusion in the study
- patients whose admission was identified by staff as being for purposes other than the management of a crisis (e.g. planned respite care)

- patients transferred from another acute ward for non-clinical reasons (e.g. bed management)

The research team obtained data regarding any such exclusions and reasons given for them and presented any doubtful cases to the research panel, consisting of the study applicants and collaborators.

**Recruitment and consent**

35 consecutively admitted patients at each participating service were sought. Participants were recruited to the study in the following way:

(i) Once a site had agreed to participate, an information sheet was given to all staff. A link member of staff at the service was identified with the service manager. They identified a series of consecutively admitted patients and informed an appropriate member of staff (primary nurse or key worker) for each that this patient was included in the study.

(ii) Involved patients were informed about the study in three ways. First, the link person displayed posters about the study prominently around the unit. Second, an information sheet about the research was given to each involved patient immediately after they were admitted. Third, the same information sheet was given to them at discharge. Service users were invited to object to the use of data about them in the study by telling a member of the clinical team or a researcher that they did not wish data about them to be used, or by completing a reply slip on the information sheet and handing or sending it to staff. A note was made on clinical records of all patients who opted out and the link person informed. Data about patients who object to use of data about them in this way was not included in the study.

(iii) If patients had not objected to use of information about them, then clinical staff recorded data about patients as soon as possible after admission. These data were passed to the research team. Throughout the study, the research team maintained close contact with the clinical team, especially the link person, and monitored data collection and assisted clinical staff with any difficulties they had in making ratings.

Careful consideration was given as to how to reconcile recruitment of such a representative sample with ethical and data collection principles. Obtaining individual consent from each service user for clinicians to make and give to the research team ratings regarding them was not likely to be feasible. At the time of admission, some patients will not have the necessarily decision-making capacity to consider participation, and their distress and more immediate needs will often be too great for staff or patients to consider research participation a priority. Many of the units admit patients only for brief stays, so that researchers will have only limited opportunities to get access to them. These considerations and previous experience of recruiting patients at the time of a mental health crisis (e.g. Johnson et al. 2005) suggest that attempting to obtain individual consent from each service user for staff to make research ratings about them was likely to

result in a highly unrepresentative sample, as well as being beyond the study resources. A variety of sources regarding ethical procedures in situations where obtaining individual consent is not feasible was therefore consulted. In particular, valuable guidance on this was provided by the Medical Research Council's ethical guidance on "Personal Information in Medical Research" (MRC, 2000, updated 2003). This suggests that research use of information about service users without their informed consent may be valid where obtaining such consent is not feasible, where the study has no effect on care received by the patients and does not in any way directly involve them, and where an ethics committee has given its approval to such use of information. However, this guidance also requires that, if information is to be used without their explicit consent, patients must be informed of this use of their data and given the opportunity to object to it. In this component of the study, no direct participation of patients of any kind was required, nor were there be any changes in the care they receive. Given this and the likely unfeasibility of recruiting a representative series in each setting of attempting to obtain individual consent from all, it was decided instead to inform all patients of the planned research use of information about it and to invite them to inform clinicians or the research team if they object to this use. Ethical approval was obtained for this procedure.

### Data management

All completed forms were returned to the researchers by the link workers. Researchers entered the data onto an electronic database using SPSS software. This database is held in password protected files on secure networks at University College London and the Institute of Psychiatry and accessed by members of the research team only. Each patient was assigned a unique identifying study number. A list of which patient has which number was kept separately by the research workers; patient names were not included on the database. Written material will be stored in a locked filing cabinet in a private office at UCL or IoP and archived as soon as follow-up is completed.

### Analysis

Our aim was to conduct an exploratory analysis regarding differences between the cohort admitted to alternatives and that admitted to standard services. Little previous literature has investigated this topic, so we drew on a paper that reported a review of variables associated with admission to hospital rather than management by an intensive home treatment service and an investigation of variables associated with management by a crisis team rather than an inpatient ward (Cotton et al. 2007). This allowed identification of a set of candidate variables that we anticipated might be associated with being admitted to an alternative rather than a standard inpatient ward. Variables for psychosis and depresion were derived from HoNOS items 6 and 7 respectively based on an item score of 3 or more. The distributions of data were assessed graphically prior to analysis. The first step in the exploratory analysis was to conduct univariate tests testing whether each of these variables was associated with being admitted to an

alternative rather than an acute ward. As a second step, a logistic regression analysis with admission to an alternative rather than to hospital as the dependent variable was carried out. The dependent variables in this regression were those variables associated with admission to an alternative at $p<0.1$ level of significance on initial univariate tests. As a secondary analysis, we also explored differences on a pair by pair basis, comparing each alternative with its local standard comparison service.

Adjustment was made for lack of independence of observations within each service by using the cluster command in Stata Version 10 to compute robust standard errors. Less than 10% of the data were missing, but exclusion of all cases with missing data would nonetheless have resulted in substantial loss of data. To avoid this, we used multiple imputation, which fills in the missing values based on values of other variables and a missing at random assumption (Little and Rubin 2002). Unlike other methods of imputation, multiple imputation acknowledges uncertainty about the missing values by creating several imputed datasets. Each imputed dataset is analysed separately and the results are combined in a way that correctly allows for uncertainty about the missing values (Schafer 1997). In this instance, we generated five imputed data sets using the ice command in Stata (Royston 2004), and conducted a regression analysis on the imputed data using the micombine command.

## *2.4 Service users' experience of alternatives (Module 3)*

### Aim

This part of the study sought to understand patients' qualitative experience of admission to alternative services and, where possible, how this compares to previous experience of admission to a standard inpatient ward. It uses a User Focused Monitoring method (Rose 2001) in which former psychiatric patients have led the design of the research.

### Measures

An in-depth interview of up to two hours' duration was conducted. A semi-structured interview was developed, using a topic guide which covered areas identified by service users as important in defining their experience of hospital admission (Gilburt et al., 2008). The topic guide is provided in Appendix 4. The focus of the interview was on exploring views about the helpfulness of alternative facilities and any problems associated with them, differences from traditional in-patient care, and experiences of stigma associated with alternative and traditional care.

### Sample

8 patients were sought from each alternative service, yielding a total sample of 48 participants. A purposive sample of patients was recruited with experience in the previous three years of admission to a standard inpatient ward.

### Recruitment and consent

Patients were recruited to the study in the following way:

1) An identified link staff member at each service identified patients who were well enough to be approached. Service staff initially approached patients to ask about their willingness to participate in this study. Staff provided interested patients with an information sheet about the study but did not seek consent to participate at this point.

2) Staff informed researchers and introduced them to patients who had expressed an interest in participating in the study. A researcher met each patient to explain what the study involves, referring back to the information sheet, and answering any questions. At this point, patients' written consent to participate in the study was sought.

3) A researcher conducted a semi-structured interview lasting about 45 minutes with each patient. This interview was recorded. Patients were reminded they can withdraw from the study or take a break at any point.

All interviews were conducted at the residential alternative service by one researcher (HG).

### Data management

Interviews were taped using a digital recorder and transcribed by the research assistants. Each patient was assigned a unique identifying study number. A list of which patient has which number was kept separately by the research workers. Patient names were not included on written interview transcripts. Interview transcripts were uploaded to the qualitative software programme Nvivo7 for analysis. Recordings of interviews were then deleted and written transcripts archived.

### Analysis

The in-depth interviews were audio-taped and transcribed. Manuscripts were imported into QSR NVivo 7. We analysed the material using a thematic analysis (Boyatzis, 1998; Flick, 2002). Initially four interviews were independently coded and an open coding session between four researchers was used to confer on and list themes. These themes were used as a basis to code the rest of the transcripts with new themes being added as they emerged. Findings and emerging themes were tested for validity through discussion – in both one-to-one and group meetings – by an interdisciplinary team comprising researchers with psychiatric, psychological and social work backgrounds, both with and without clinical experience. Furthermore efforts were made to explore the respondents underlying reasoning and elements within the data that appeared to contradict the emerging themes ('deviant case analysis').

## *2.5 Carers' experience of alternatives (Module 4)*

### Aim

This part of the study sought to understand carers' qualitative experience of the admission of their partner, relative or friend to alternative services and, where possible, how this compares to previous experience of admissions to standard inpatient wards.

### Measures

A semi-structured interview was developed. The topic guide is provided in Appendix 5. The focus of the interview was on exploring carers' views about the helpfulness of alternative facilities and any problems associated with them, the support provided to carers, the acknowledgement by services of their role and any differences from traditional in-patient care.

### Sample Size

8 carers were sought from each alternative service, yielding a total sample sought of 48 participants. Where possible, carers of people who have also experienced admission to a standard inpatient ward were recruited.

### Recruitment and consent

Carers were recruited to the study in the following way:

i) Patient participants in the qualitative interviews described in section 2.4 and the quantitative user experience study described in section 2.11 were asked if they would nominate a carer whom researchers may contact about participation in the study. A researcher then contacted nominated carers by phone or letter and asked about interest in the study. An information sheet posted or e-mailed to interested carers and a time to meet arranged.

ii) Staff at alternative services and local carers' organisations were contacted and asked to identify potential participants, provide them with an information sheet and ask them to contact researchers if interested in participating in the study. Researchers then answered any questions and arranged to meet interested carers.

A researcher met each carer to explain what the study involves, referring back to the information sheet, and answering any questions. At this point, carers' written consent to participate in the study was sought. Telephone interviews were offered as an alternative to potential participants where face-to-face meetings were not convenient for participants. In these circumstances, consent forms were posted to carers and returned in advance of the interview being conducted.

A researcher conducted a semi-structured interview lasting about 45 minutes with each carer. This interview was recorded. Participants were reminded they could withdraw from the study or take a break at any point.

**Data management**

Interviews were taped using a digital recorder and transcribed by the research assistants. Each patient was assigned a unique identifying study number. A list of which patient has which number was kept separately by the research workers. Patient names were not included on written interview transcripts. Interview transcripts were uploaded to the qualitative software programme Nvivo7 for analysis. Recordings of interviews were then deleted and written transcripts archived.

**Analysis**

Thematic analysis was conducted on transcribed data from interviews using Nvivo7 software and key themes identified.

## *2.6 Comparison of short and medium-term outcomes at alternative and standard services (Module 5)*

### Aim

This part of the study sought to compare the health status at discharge of patients admitted to alternative and standard services and their service use over a one-year follow-up period following admission.

### Measures

Information was sought from service staff about the health status at discharge and aftercare of series of patients admitted to alternative and standard services. The study Discharge Form used to collect these data is provided in Appendix 3. Information is collected about length of stay, referral pathways and contact with other services. The three health ratings completed by staff for patients at admission are repeated at discharge: the Global Assessment of Functioning (GAF), Health of the Nation Outcome Scale (HoNOS) and Threshold Assessment Grid (TAG).

Service staff were asked to collect information from service records and electronic administration systems about the service use of patients admitted to alternative and standard services over one year following admission. The study One-Year Follow-Up Form used to collect this information is provided in Appendix 6. Psychiatric in-patient bed use were recorded for the year after and also previous to admission. Contacts with community mental health teams (CMHTs), out-patient clinics, crisis resolution teams and accident and emergency departments were included.

### Sample Size

Information was sought about the 420 patients included in the comparison of service user characteristics described in section 2.3.

### Recruitment and consent

35 patients were recruited from each participating service. Identification of participants and consent procedures were described in section 2.3.

A member of staff was asked by the identified link worker to complete the study Discharge Form for each participant as soon after their discharge as possible. Wherever possible, the same member of staff who completed the study Admission Form for the patient also completed the Discharge Form. Completed forms were passed to the research team. Throughout the study, the research team maintained close contact with the clinical team, especially the link person,

and monitored data collection and assisted clinical staff with any difficulties they had in making ratings.

At one year after the admission of the last study participant, researchers made contact with the identified link worker at each service. The link worker facilitated collection of data for the One-Year Follow-Up Form from the Patient Administration System (PAS) or other service records. Completed forms were passed to the research team, who liaised with the link worker to assist with any difficulties in data collection.

### Data management

All completed forms were returned to the researchers by the link workers. Researchers entered the data onto an electronic database using SPSS software. This database is held in password protected files on secure networks at University College London and the Institute of Psychiatry and accessed by members of the research team only. Each patient was assigned a unique identifying study number. A list of which patient has which number was kept separately by the research workers; patient names were not included on the database. Written material will be stored in a locked filing cabinet in a private office at UCL or IoP. and archived as soon as follow-up is completed.

### Analysis

**Short-term outcomes:** Baseline values and changes for each of the outcomes were calculated and presented for each service, and t tests used to compare lengths of stay and costs. Mean differences between the standard and alternative admissions at follow up, adjusted for area and baseline level only and also for possible confounding factors, were estimated from linear regression models, one for each outcome of interest. Choice of possible confounders was informed by results regarding the characteristics of users of alternative services (Section 3.2), which identified predictors of being admitted to an alternative rather than a standard service. Service was included as a clustering variable and robust standard errors computed. Area was included as a fixed effect, and analyses were repeated excluding the single non paired site as a sensitivity analysis. A logistic regression was also performed with the binary dependent variable a clinically significant change in HoNOS score, and proportions improving in the two types of service were estimated from this model (adjusting for area and baseline level). Multiple imputation was used for missing values (these were mainly for the predictor variables, about 13% of the total).

**Medium term outcomes:** Psychiatric admissions and use of other hospital and community mental health services over the 12-months from date of index admission are described and compared between the two groups. An evaluation of other outcomes was not possible over this period as repetition after a year of outcome measures other than service use was not feasible.

## *2.7 Comparison of costs and cost-effectiveness of alternative and standard services (Module 6)*

### Aims

This part of the study sought to compare the short-term cost and cost-effectiveness and the medium-term cost of alternative and standard services. An evaluation of cost-effectiveness was not possible over the medium-term as outcome measures were not repeated at the 12-month follow-up.

### Procedures

Data on psychiatric admissions and use of all other hospital and community mental health services were collected from computerized patient activity systems at each service, as described in Section 2.6. All unit costs were calculated for the financial year 2006/2007. The manager of each alternative service provided budget data for the service to calculate cost per bed day. National average unit costs were applied to all other services (Curtis, 2007; DoH 2007).

### Analysis

**Short-term:** The total cost of the index admission was calculated and differences in the cost of standard and alternative admissions compared using standard parametric tests, despite skewed cost distributions. The validity and robustness of the results were confirmed using non-parametric bootstrap techniques (Efron and Tibshirani 1993), as recommended by Barber & Thompson (2000). Analyses were adjusted for area (six areas associated with the six paired comparison sites) and for possible confounding factors identified as predictors of being admitted to an alternative rather than a standard service (Section 3.2). These included age, gender, ethnic group (white/black/other), born in the UK (yes/no), patient initiated help seeking (yes/no), previously known to services (yes/no), baseline behaviour problems as determined by the HoNOS (yes/no), baseline risk of harm to others as determined by the TAG (yes/no), baseline GAF symptoms score and the cost of psychiatric admissions in the 12-months prior to study entry. Costs were linked to outcomes using an incremental cost-effectiveness analysis to explore the relationship between cost and HoNOS score. The uncertainty surrounding the estimates of cost-effectiveness were then explored through the construction of a cost-effectiveness acceptability curve (CEAC). The CEAC demonstrates graphically the probability that admission to an alternative service is more cost-effective than admission to a standard ward given different values that a decision-maker may be willing to pay for improvements in the HoNOS outcome (Fenwick and Byford 2005).

### Medium term:

Service use data are reported descriptively. Differences in costs were analysed in the same way as described above for short-term costs. Multiple imputation was used for missing items. Univariate associations between baseline characteristics and total costs over the 12-month follow-up period were investigated. Results for continuous variables are presented in two groups split at the median value, but analyses were carried out on the continuous data. Multiple regression was used to reduce the variable list to those independently associated with follow-up costs using a process outlined in previous research (Byford et al. 2001). This involved, in the first instance, fitting a multiple regression model which included all variables that had important univariate associations with costs and discarding from this model all variables that ceased to be important. Secondly, each variable that did not have a univariate association with costs was added, one at a time, and retained if it added significantly to the model or otherwise discarded. The model finally arrived at was checked to ensure that none of the terms currently excluded would add significantly to it. In carrying out this procedure a significance level of 10% was used.

## *2.8 Alternative services - development and models: manager interviews (Module 7)*

### Aim

This part of the study sought to understand service managers' understanding of the organisational development of alternatives, the success factors and impediments encountered, the model of care being implemented and the distinct differences between alternatives and standard inpatient care. Descriptive data previously collected for the study about patient characteristics, outcomes and referral pathways were used to inform questions about services' role and model of care.

### Measures

A topic guide for a semi-structured interview with service managers was developed. This is provided in Appendix 7. The views of service managers about the development and model of care at the service were sought. Respondents were also asked to comment on descriptive data from the study comparing the characteristics of admitted patients and their short-term health outcomes (see sections 2.3 and 2.6). Participating managers were provided with data about patients from their service and the local comparison standard service, concerning patients demographic characteristics, length of stay, referral pathways and health ratings at admission and discharge.

### Sample

One service manager was identified at each alternative service, generating six interviews in total.

### Recruitment and consent

Service managers were contacted and provided with an information sheet, the interview topic guide and the study data which they would asked about. An opportunity to discuss the study with a researcher before the interview was provided. Managers were asked to sign a consent form before the interview started. It was conducted by a researcher using the topic guide.

### Data management

Interviews were taped using a digital recorder and transcribed by the research assistants. Interview transcripts were uploaded to the qualitative software programme Nvivo7 for analysis. Recordings of interviews were then deleted and written transcripts archived.

### Analysis

Preliminary data indicated that the role of the service in the overall system was typically complex and not always understood in the same way by different stake-holders. To capture this complexity and maximise the ecological validity of the emergent understanding of the service in context, we focussed on understanding the role of the service through interviews with multiple stake-holders. This approach ensured consistency between Modules 7 and 8, and proved the best approach to locating the service in its wider context. Data from the manager and other key stake-holder interviews were synthesised to produce an ecologically valid overall understanding of the role of the service. A thematic analysis was conducted of transcripts of interviews with service managers and stakeholders using Nvivo7 software and key themes were identified.

## *2.9 The role of alternatives in the mental health care system: stakeholder interviews (Module 8)*

### Aims

This part of the study sought to explore the views of key stakeholders of alternative services about the role of alternatives in the local acute care system. Through triangulation from multiple data sources, areas of consistent agreement between stakeholders about the role and function of the alternative services could be identified. Descriptive data previously collected for the study about patient characteristics, outcomes and referral pathways were used to inform investigation of services' roles.

### Measures

A topic guide for a semi-structured interview with stakeholders was developed. This is provided in Appendix 8. The views of stakeholders about the role of the service in the local mental health system were sought. Respondents were also asked to comment on descriptive data from the study, as in the interviews with service managers described in section 2.8.

### Sample

Interviews were sought with up to 10 key stakeholders of each alternative service. Following discussion by the study group, stakeholders were defined to include the following at each service:

- a representative of the local standard inpatient service
- the manager of the local crisis and home treatment team

- a representative of a referring service. The referring service was identified as the most common referral source for patients in the study admitted to the alternative. A consultant psychiatrist was used as the representative of the referring service where possible.
- A representative of the management of the local mental health trust.
- A representative of the agency funding/commissioning the alternative service

Appropriate interviewees meeting these criteria were identified by discussion with the managers of relevant services. Where there were multiple potentially suitable candidates for these interviews, purposive sampling was used to give priority to:

i) staff who had occupied their current or similar roles for longest. In particular, we aimed to recruit interview participants who had been familiar with the local service system since before the introduction of the alternative

ii) staff who worked most closely with the alternative – this applied especially when deciding which senior trust manager and which representative of the local commissioners to approach

iii) staff from a range of professional backgrounds

A total sample of at least 30 interviews was generated.

### Recruitment and consent

Stakeholders were contacted and provided with an information sheet, the interview topic guide and the study data which they would asked about. An opportunity to discuss the study with a researcher before the interview was provided. Participants were asked to sign a consent form before the interview started. It was conducted by a researcher using the topic guide.

### Data management

Interviews were taped using a digital recorder and transcribed by the research assistants. Interview transcripts were uploaded to the qualitative software programme Nvivo7 for analysis. Recordings of interviews were then deleted and written transcripts archived.

### Analysis

Preliminary data indicated that the role of the service in the overall system was typically complex and not always understood in the same way by different stake-holders. To capture this complexity and maximise the ecological validity of the emergent understanding of the service in context, we focussed on understanding the role of the service through interviews with multiple stake-holders. This approach ensured consistency between Modules 7 and 8, and proved the best approach to locating the service in its wider context. Data from the manager and

other key stake-holder interviews were synthesised to produce an ecologically valid overall understanding of the role of the service. A thematic analysis was conducted of transcripts of interviews with service managers and stakeholders using Nvivo7 software and key themes were identified.

## *2.10 Content of care in alternatives and standard services (Module 9)*

### Aims

This part of the study sought to compare the content of care in alternative and standard services. A multi-method approach, incorporating the perspectives of staff and patients, assessed the amount of contact between staff and patients and the types of care provided at services. The influence of care provided at alternative and standard services on patient satisfaction was explored.

### Measures

Three measures were developed and piloted for the study.

Camden Record of Inpatient Care Events CaRICE: a contemporaneous staff-completed record of all direct patient contacts. It provides a measure of the minutes' contact per patient per day, and the minutes' per patient per day spent providing social, psychological and physical/pharmacological interventions and general care organisation.

Camden Staff-patient Activity Record CaSPAR: a measure of the proportion of patients in contact with staff, using momentary time recording based on researcher-observation or staff report.

Camden Content of Care Questionnaire CCCQ(P): a patient-completed retrospective questionnaire providing a measure of the intensity of overall care and of social, psychological and physical/pharmacological care and general care organisation provided during an admission.

Measures are provided in Appendices 9-11.

One outcome measure was used in each service for exploratory investigations of associations between care received and patient satisfaction:

Client Satisfaction Questionnaire (CSQ) (Attkisson and Zwick 1982); a patient-completed questionnaire providing a measure of a patient's satisfaction with a mental health service. This measure is provided in Appendix 12.

### Sampling

**Services:** Due to the resource implications of data collection and in accordance with the study proposal, 8 services (4 alternatives and their local comparison standard services) were included in this part of the study and the investigation of patient satisfaction reported in section 2.11. The participating services (described in section 2.2) were:

Alternatives: The Ashcombe Centre, The Nile Centre, Middlesbrough Crisis Beds, Newbridge House Inpatient Unit

Standard Services: Wards 1,2&3 Harplands Hospital, Brett and Conolly Wards Homerton Hospital, Teesbay Unit St. Luke's Hospital and Ward 21 Solihull Hospital.

**Sample size:** The following data were collected for the study

1) CaSPAR: 28 momentary time recordings were carried out at each services, recording whether all patients were in or out of the unit and in contact with staff or not. This generated 224 recordings in total.

2) CaRICE: Recording forms were completed by all staff at eight services over a five day (Monday – Friday) recording period at each service.

3) CCCQ(P): 40 participants were sought from each service (n = 320).

4) CSQ: 40 participants were sought from each service (n = 320).

**Recruitment procedures**

CaSPAR: Guidance regarding the times and frequency of CaSPAR recordings and criteria for recording patients as with staff or not are provided with the measure, presented in Appendix 10. For each recording, a researcher walked through the communal areas of the service observing how many patients were in contact with staff. He then approached a member of staff and asked:

i) whether any staff were with patients in inaccessible areas of the service (e.g. in a patient's room)

ii) how many patients were out of the unit, either in another part of the service or away from the service

iii) whether any of these patients were with staff

Whenever possible, the researcher would check staff report information (e.g. going to the occupational therapy room or the garden to observe whether patients were in contact with staff). Whenever possible, observation was used to provide data; when this wasn't possible, staff report was used.

CaRICE: During the data collection period, a researcher was present at all times when staff were expected to start or finish work at the service (every shift handover and constantly between 9am-5pm as a minimum). Researchers distributed and collected recording forms individually from staff at the beginning and end of their shifts. Researchers helped explain how to use the form whenever required. Researchers kept a record of every inpatient staff member at work each

day and whether they had completed a CaRICE form. When a researcher left the ward, forms were left prominently in the staff office in the service. On returning to the unit, researchers checked with staff whether any other staff had been to the unit (e.g. an on call doctor) and whether a form had been completed.

No individual consent was obtained for collection of CaRICE data, which involved no direct patient contact or information about identifiable individual patients.

CCCQ(P) and CSQ: An identified link staff member at each service identified patients who were well enough to be approached. Service staff initially approached patients to ask about their willingness to participate in this study. Staff provided interested patients with an information sheet about the study but did not seek consent to participate at this point. A researcher met each initially consenting patient to explain what the study involves, referring back to the information sheet, and answering any questions. At this point, patients' written consent to participate in the study was sought. Researchers sought to ask all patients close to the point of their discharge about participating in the study unless service staff indicated the person was too unwell to be approached. Numbers of patients participating and declining to participate were noted by researchers. Data collection continued until 40 participants had been recruited from the service. Participants were paid £15 each in cash upon completion of study measures.

**Data management**

Researchers entered the data from completed forms onto electronic databases using SPSS software. SPSS databases were subsequently converted into Stata databases for data analysis. All these databases are held in password protected files on secure networks at University College London and the Institute of Psychiatry and accessed by members of the research team only. Each patient was assigned a unique identifying study number. A list of which patient has which number was kept separately by the research workers; patient names were not included on the database. Staff-completed CaRICE forms were also assigned an identifying number: staff names were not included on the database. Written material was stored in a locked filing cabinet in a private office at UCL or IoP. and archived as soon as follow-up was completed.

**Analysis**

The three community-based crisis houses were grouped in analyses and compared to their three local comparison standard services. Descriptive data were provided for the fourth alternative in this part of the study, Newbridge House Inpatient Unit, and its local comparison standard service.

CaSPAR data: The proportion of patients in contact with staff at each CaSPAR observation was calculated. Two linear regression analyses were carried out using Stata software to determine:

i) the relationship between proportion of patients in contact with staff and service type (community alternative or traditional), adjusting for clustering by individual service.

ii) the relationship between proportion of patients in contact with staff and service type (alternative or traditional), adjusting for clustering by individual service and recording variables (day and time of recording).

R-squared value, regression coefficients and t-test,p values and confidence intervals for difference in CaSPAR mean scores were reported. A p value of $<0.05$ from regression analysis adjusting for recording variables was considered to indicate a significant difference between community alternative and standard services.

CaRICE data: CaRICE data was not sufficiently powered for statistical analysis. Descriptive data for individual services were presented for CaRICE total score and social, psychological and physical and pharmacological subcale scores. An effect size for community alternatives compared to standard services was estimated for each CaRICE variable. A mean difference greater than 0.5 of the standard deviation of all data was considered to indicate a medium effect size, as proposed by Cohen (1988).

CCCQ(P) data: CCCQ(P) total score and social, psychological and physical and pharmacological subcale scores were calculated for each participant. Two linear regression analyses were conducted for each CCCQ(P) variable to determine:

i) the relationship between CCCQ(P) scores and service type (community alternative or traditional), adjusting for clustering by individual service

ii) the relationship between CCCQ(P) scores and service type (community alternative or traditional), adjusting for clustering by individual service and patient characteristics (age, gender, ethnicity and mental health act status)

R-squared value, regression coefficients and t-test, p values and confidence intervals for difference in CCCQ(P) mean scores were reported. A p value of $>0.05$ from regression analysis adjusting for patient characteristics was considered to indicate a significant difference between community alternative and standard services.

Content of care and satisfaction data: The relationship between participants' CSQ score and service type was explored by the following linear regression analyses using Stata software:

i) the relationship between CSQ scores and service type (community alternative or traditional), adjusting for clustering by individual service

ii) the relationship between CSQ scores and service type (community alternative or traditional), adjusting for clustering by individual service and patient characteristics (age, gender, ethnicity and mental health act status)

iii) the relationship between CSQ scores and service type, adjusting for clustering by service, patient characteristics and CCCQ(P) variables (CCCQ(P) total score, social, psychological and physical and pharmacological interventions subscale scores – each adjusted for in separate analyses).

R-squared value, regression coefficients and t-test, p values and confidence intervals for difference in CSQ mean scores were reported for each analysis. The explanatory power of CCCQ(P) variables in a model of patient satisfaction and to understand differences between community alternatives and standard services in patient satisfaction were considered.

## *2.11 Users' satisfaction with alternatives and standard services (Module 10)*

### Aim

This part of the study sought to complement the qualitative exploration of patients' views of alternative services by providing a quantitative comparison of patient satisfaction at alternative and standard services. Patients' perception of coercion at admission and perception of the style of the service were also compared at alternative and standard services.

### Measures

Four patient questionnaire measures were used. All are published and have established psychometric properties.

- Client Satisfaction Questionnaire (CSQ) (Attkisson and Zwick 1982); an 8-item questionnaire providing a measure of patient satisfaction with a mental health service.
- Service Satisfaction Scale – Residential Form (SSS-RES) (Attkisson et al undated); a 33 item scale measuring aspects of patient satisfaction with residential and inpatient mental health services, derived from the 30 item scale developed by Attkisson and Greenfield (1995)
- Admission Experience Survey (AES) – (Gardner et al 1993); a 16 item measure of perceived coercion with admission to hospital or residential acute care, developed for the MacArthur Coercion Study
- Ward Atmosphere Scale – Short Form (WAS) Moos (1996); a 40 item measure of service style, comprised of ten subscales

Measures are provided in Appendix 12.

### Sample

Measures were completed at the four alternative services and their four comparison standard services identified in section 2.10. Questionnaires were completed as a battery of measures, together with CCCQ(P) content of care measure with 40 patients at each participating service (n = 320).

### Recruitment and consent

An identified link staff member at each service identified patients who were well enough to be approached. Service staff initially approached patients to ask about their willingness to participate in this study. Staff provided interested patients with an information sheet about the study but did not seek consent to participate at this point. A researcher met each initially consenting patient to explain what

the study involves, referring back to the information sheet, and answering any questions. At this point, patients' written consent to participate in the study was sought. Researchers sought to ask all patients close to the point of their discharge about participating in the study unless service staff indicated the person was too unwell to be approached. Numbers of patients participating and declining to participate were noted by researchers. Data collection continued until 40 participants had been recruited from the service. Participants were paid £15 each in cash upon completion of study measures.

### Data management

Researchers entered the data onto an electronic database using SPSS software. This database is held in password protected files on secure networks at University College London and the Institute of Psychiatry and accessed by members of the research team only. Each patient was assigned a unique identifying study number. A list of which patient has which number was kept separately by the research workers; patient names were not included on the database. Written material will be stored in a locked filing cabinet in a private office at UCL or IoP. and archived as soon as follow-up is completed.

### Analysis

Data were entered using SPSS (version 14) (SPSS 2006) and then converted to Stata version 10 for further analysis (StataCorp 2007). Satisfaction and experience outcomes were initially compared between each local pair of services and then aggregated according to alternative or traditional service. Data were inspected for normality of distribution and compared using t tests and chi square tests. Where distributions deviated from normal non-parametric tests were employed. Potential confounding variables were also explored with univariate tests. Multivariate linear regression was then employed to explore any association between alternatives and satisfaction/ experience outcomes. All regression models were adjusted for clustering by service, using Stata cluster commands. The amount of variance in outcomes explained by each multivariate model was noted according to the $R^2$ statistic. When outcome variables were not normally distributed, a sensitivity analysis was performed, using ordinal logistic regression to explore whether significant associations were stable irrespective of method of regression analysis.

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# 3 Results

## *3.1 National survey of in-patient alternatives and development of typology (Module 1)*

A total of 358 units providing residential care to adults with acute mental health problems were identified using the methods described. Following verification a further 6 units were identified with a final total of 364 units. Of the locations, five were not contactable or refused to answer questions on their unit. Information was successfully obtained from a total of 359 units. The composition of this group is shown in Table 3.1.1.

**Table 3.1.1 Number of units surveyed displayed by provider**

| **Provider** | **No of units meeting criteria** |
|---|---|
| NHS/statutory sector | 314 |
| Voluntary sector | 17 |
| Private sector | 28 |
| ***Total*** | 359 |

228 units did not meet the criteria of offering an alternative to traditional inpatient acute admission. Reasons for not meeting the alternative criteria are shown in Table 3.1.2.

**Table 3.1.2. Number of units not meeting the inclusion criteria**

| *Reason for exclusion* | *Number of units* |
|---|---|
| **a) Service now closed** | 10 |
| **b) Service not residential** | 3 |
| **c) Service not for adults age 16-65** | |
| Over 65 | 8 |
| **d) Service not for people with acute mental health problems requiring admission to a general acute ward** | |
| Specialist Forensic/secure service | 4 |
| Psychiatric Intensive Care Unit | 3 |
| Non-acute service (e.g. rehabilitation services) | 19 |
| Service not for people with mental health problems | 2 |
| **e) A standard service: an acute residential mental health service which met none of the criteria for alternative services** | 179 |
| **Total** | 228 |

A total of 131 units were identified as offering an alternative to traditional psychiatric acute inpatient care. Table 3.1.3 reports the providers of these services. Table 3.1.4 presents which inclusion criterion was met by services to classify as an alternative.

**Table 3.1.3: Units meeting the inclusion criteria as alternatives displayed by provider:**

| **Provider** | **Total No. of Units identified as Alternatives** |
|---|---|
| NHS/Statutory Sector | 94 |
| Voluntary Sector | 16 |
| Private Sector | 21 |
| Total | 131 |

**Table 3.1.4 Units meeting the inclusion criteria as offering an alternative to traditional acute inpatient admission**

| **Inclusion criterion met** | **No. of alternative units meeting a criterion based on algorithm** |
|---|---|
| Disorder specific | 7 |
| Socio-demographic specific | 28 |
| Specific therapeutic orientation | 50 |
| Time-limited admission | 5 |
| Community-based | 41 |
| ***Total*** | 131 |

The managers of 130 units agreed to receive and complete the questionnaire following phone contact by researchers. One manager was sent the questionnaire by e-mail without initial phone contact.

Completed questionnaires were obtained for **109** out of **131** services. This is a completion rate of **83.2%.**

Of the 22 non-responders, 14 were statutory sector, 5 private sector and 3 voluntary sector. The non-responders met the inclusion criteria as alternatives as follows:

| | |
|---|---|
| Disorder-Specific | 2 |
| Socio-demographic-specific | 6 |
| Therapeutic orientation | 8 |
| Time-limited admission | 0 |
| Community-based | 6 |

Table 3.1.5 shows the characteristics of the 109 services identified as alternatives, from whom a completed questionnaire was received and whose

data was included in the cluster analysis used to develop a typology of alternatives.

**Table 3.1.5: Units from which completed questionnaires were received**

| **Inclusion Criterion** | **No. of units** |
|---|---|
| Disorder specific | 5 |
| Socio-demographic specific | 22 |
| Specific therapeutic orientation | 42 |
| Time-limited admission | 5 |
| Community-based | 33 |
| **Total** | **109** |
| **Provider** | **No. of units** |
| NHS/Statutory | 80 |
| Voluntary Sector | 13 |
| Private sector | 16 |
| **Total** | **109** |

Cluster analysis of data from completed questionnaires produced **8** types of alternative service. This typology, with the number of services of each type identified, is shown in Table 3.1.6 below.

**Table 3.1.6: Typology of Alternatives**

| Type of service | No. of services |
|---|---|
| Therapeutic wards for specific diagnostic groups | 4 |
| General wards with a distinct therapeutic programme | 35 |
| Short-stay wards and generic wards for specific groups | 9 |
| Wards for specific socio-demographic groups | 19 |
| Specialist Crisis Houses | 5 |
| Non-clinical Crisis Houses | 11 |
| Short-stay CRT-linked Crisis Beds | 13 |
| Clinical community houses | 13 |
| **Total** | **109** |

**Inpatient Alternatives**

**1. Therapeutic wards for specific groups (n=4):** This small group consisted of hospital services implementing a specific therapeutic model that targeted a particular diagnostic group, such as people with early psychosis or borderline personality disorder. Three of the four were in the voluntary or private sector.

**2. General therapeutic wards (n=35):** Services in this cluster were hospital-based, served a range of diagnostic and demographic groups, and had implemented a specific therapeutic model. The most frequently reported model was the Tidal Model20, which focuses on exploring patients' individual narratives.

**3. Short-stay wards and general wards for specific groups (n=9):** A final residual cluster comprised hospital wards with a fixed brief length of stay (in some cases as short as 48 hours) and others which targeted a particular diagnostic group, but without implementation of a specific therapeutic model.

**4. Wards for specific demographic groups (n= 19**): These were hospital services dedicated to specific demographic groups, all but one Mother and Baby Units.

**Community-based alternatives**

**5. Specialist crisis houses (n=5):** This small group consisted of community services for specific groups, such as women or people with early psychosis.

**6. Non-clinical alternatives (n=11):** Services in this group tended to be voluntary sector-managed, with limited use of nursing staff or of hospital-like interventions.

**7. Crisis team beds (n=13):** This group was characterised by small bed numbers, short length of stay and a high level of integration with crisis resolution and home treatment teams21.

**8. Clinical crisis houses (n=13**): These were community-based services that tended to use more hospital-like interventions and had more nursing staff than other community clusters.

The typology produced a complete separation between hospital and community services, with no cluster containing both. The clinical and specialist crisis houses were intermediate in their characteristics between the hospital services and less clinical community alternatives. Table 3.1.7 summarises the characteristics of services in each cluster of the typology. Community services were characterised overall by lower severity of target group, fewer medical and nursing staff, and fewer services with waking night staff than hospital services. However, even among the less clinically oriented types of community service, there were indications of considerable collaboration with NHS secondary mental health services. Every service accepted referrals from NHS professionals and most named an NHS mental health service as their most prolific referrer. The exceptions being two clinical crisis houses and two non-clinical alternatives, 38 of 42 community-based services reported that, in a situation of high risk, they would make a referral to NHS services (for example for a Mental Health Act assessment) even for a client who had not consented to this. Only five of the services described as situated in a community rather than hospital setting reported that they accepted admissions of compulsorily detained patients directly from the community. These five services had all in fact acquired the legal status of hospitals, but were described by their managers as not being hospital services: they were typified by having small numbers of beds, not sharing premises with other inpatient services, being unlocked and not being recognisable as inpatient units from outside. Their legal status as hospitals suggests some blurring of boundaries between community and hospital services.

Not surprisingly, 'medical' interventions such as physical examinations, review of medication and blood tests were more likely to be available in hospital-based services, but this also applied to most other types of intervention included in the study, including individual psychological treatment, groups, complementary and alternative treatments, and occupational therapy or other organised activity. Again the community and specialist crisis houses were intermediate between the hospital services and the non-clinical community alternatives and crisis team beds, offering a programme of organised activity in every case, medication review and investigations in the majority, and cognitive behavioural therapy in around a third of the services.

**Table 3.1.7 Characteristics of alternatives to standard acute hospital care, classified into clusters defined by service features**

| | General therapeutic wards | Wards for specific demographic groups | Therapeutic wards for specific groups | Short stay wards and general wards for specific groups | Clinical crisis houses | Crisis team beds | Non-clinical alternatives | Specialist crisis houses |
|---|---|---|---|---|---|---|---|---|
| Number in group | 35 | 19 | 4 | 9 | 13 | 13 | 11 | 5 |
| Mean number of beds | 20.9 | 7.1 | 13.0 | 10.9 | 8.8 | 4.5 | 7.0 | 6.4 |
| Typical length of stay (days) | 35.8 | 54.9 | 151.5 | 30.8 | 33.0 | 9.5 | 36.0 | 52.2 |
| Involuntary admissions accepted direct from community | 35 (100%) | 18 (97%) | 4 (100%) | 7 (78%) | 3 (23%) | 0 | 0 | 2 (40%) |
| Any compulsorily detained patients accepted, including those on leave | 35 (100%) | 19 (100%) | 4 (100%) | 7 (78%) | 11 (85%) | 5 (39%) | 8 (73%) | 4 (80%) |
| Proportion of staff (Full time equivalents) who are nurses | 58% | 53% | 70% | 61% | 42% | 11% | 3% | 32% |
| Hospital interventions scale: mean score (maximum 6) | 5.8 | 5.8 | 5.4 | 5.4 | 3.0 | 0.8 | 1.3 | 3.4 |
| Crisis team integration scale: mean score (maximum 5) | 2.6 | 1.2 | 0.5 | 1.6 | 2.5 | 3.5 | 2.4 | 1.0 |
| Severity of target group: mean score (maximum 7) | 6.2 | 5.7 | 5.8 | 5.3 | 4.0 | 2.7 | 3.0 | 3.6 |
| Psychological treatment or psychotherapy sessions with recognised model available | 22 (63%) | 12 (63%) | 4 (100%) | 5 (56%) | 4 (31%) | 3 (23%) | 2 (18%) | 3 (60%) |
| Structured activity programme available | 35 (100%) | 19 (100%) | 4 (100%) | 5 (56%) | 13 (100%) | 2 (15%) | 4 (36%) | 5 (100%) |
| Service users involved in group making management decisions about operation of service | 19 (54%) | 7 (37%) | 1 (25%) | 7 (78%) | 7 (54%) | 6 (46%) | 6 (55%) | 1 (20%) |
| Managed by voluntary sector organisation | 0 | 0 | 2 (50%) | 0 | 0 | 0 | 11 (85%) | 2 (5%) |
| Managed by private company | 11 (31%) | 1 (5%) | 1 (25%) | 0 | 0 | 0 | 0 | 0 |

Table 3.1.8 shows the characteristics of the service users resident in the included services on the census night. Gender and ethnic mixture were examined as indicators of equity of access to these alternatives. On the census night, women were in the majority in all models except the clinical crisis houses and specialist crisis houses. 76% of the residents of the alternatives were White British compared while 9% came from Black Caribbean and African groups. Two of the community service types, the non-clinical alternatives and the specialist crisis houses, had especially high representation of ethnic minorities. Except in the non-clinical alternatives, a majority of residents in every service type had a previous history of hospital admission.

Table 3.1.9 shows the geographical distribution of the alternatives, especially in relation to area social deprivation and region. Most alternative units were not situated within the centres of the ten most populous cities. Regional distribution was highly uneven, with few units in the South West, the North West and East of England. Far more alternatives are available in local authorities falling in the highest quartile for social deprivation (i.e. most severe deprivation) than in those falling in the lower quartiles, whichever index of multiple deprivation was applied (Table 3.1.9). At least 70% of alternative units we identified were located in the most deprived half of the country.

**Table 3.1.8 Characteristics of patients in residence at one night census**

| | Male residents (%) | White British (%) | Black Caribbean, British or African (%) | History of previous admission (%) | On section (including on leave from ward) (%) | Diagnosis of psychosis (%) |
|---|---|---|---|---|---|---|
| Specific therapeutic wards | 259/571 (45%) | 445 (78%) | 26 (10%) | 395 (70%) | 207 (36%) | 285 (50%) |
| Therapeutic wards for specific groups | 10/44 (23%) | 30 (68%) | 10 (23%) | 24 (54%) | 25 (57%) | 20 (45%) |
| Wards for specific demographic groups | 4/92 (4%) | 65 (71%) | 10 (11%) | 59 (64%) | 14 (15%) | 38 (41%) |
| Short stay wards and general wards for specific groups | 37/84 (44%) | 71 (85%) | 5 (6%) | 68 (81%) | 33 (39%) | 44 (52%) |
| Clinical crisis houses | 48/93 (51%) | 80 (86%) | 6 (6%) | 80 (86%) | 9 (10%) | 52 (56%) |
| Crisis team beds | 13/48 (27%) | 38 (79%) | 7 (15%) | 33 (69%) | 0 (0%) | 14 (29%) |
| Non-clinical alternatives | 21/61 (34%) | 37 (61%) | 14 (23%) | 24 (39%) | 1 (2%) | 13 (21%) |
| Specialist crisis houses | 17/29 (59%) | 10 (34%) | 9 (31%) | 24 (83%) | 11 (38%) | 21 (72%) |
| Total | 409/1022 (40%) | 776 (76%) | 87 (9%) | 648 (63%) | 300 (29%) | 487 (48%) |

**Table 3.1.9 Distribution of alternatives according to indices of multiple deprivation, region and location within largest cities in England**

| | Total | General therapeutic wards | Wards for specific demographic groups | Therapeutic wards for specific groups | Short stay wards and general wards for specific groups | Clinical crisis houses | Crisis team beds | Non-clinical alternatives | Specialist crisis houses |
|---|---|---|---|---|---|---|---|---|---|
| Government office region | | | | | | | | | |
| North West | 8 (7%) | 0 | 2 (10%) | 0 | 3 (38%) | 2 (15%) | 0 | 1 (9%) | 0 |
| North East & Yorkshire | 35 (32%) | 17 (49%) | 4 (20%) | 2 (5%) | 2 (25%) | 5 (39%) | 3 (23%) | 1 (9%) | 1 (20%) |
| South West | 3 (3%)) | 0 | 3 (15%) | 0 | 0 | 0 | 0 | 0 | 0 |
| South East and London | 37 (34%)) | 11 (31%) | 6 (30%) | 2 (5%) | 2 (25%) | 2 (15%) | 7 (54%) | 6 (55%) | 1 (20%) |
| Midlands (E&W) | 19 (17%) | 6 (17%) | 3 (15%) | 0 | 0 | 3 (23%) | 2 (15%) | 2 (18%) | 3 (60%) |
| East | 7 (6%) | 1 (3%) | 2 (10%) | 0 | 1 (13%) | 1 (8%) | 1 (8%) | 1 (9%) | 0 |
| Inner city (10 most populous cities ) No | 75 (69%) | 23 (66%) | 13 (65%) | 2 (50%) | 6 (75%) | 12 (92%) | 11 (85%) | 7 (64%) | 1 (20%) |
| Yes | 34 (31%) | 12 (34%) | 7 (35%) | 2 (50%) | 2 (25%) | 1 (8%) | 2 (15%) | 4 (36%) | 4 (80%) |
| Index of Multiple deprivation[1] Average rank of borough scores (overall score) | | | | | | | | | |
| Quartile 1 (Highest) | 57 (52%) | 17 (49%) | 7 (35%) | 2 (50%) | 5 (63%) | 7 (54%) | 6 (46%) | 8 (73%) | 5 (100%) |
| Quartile 2 | 20 (18%) | 9 (26%) | 3 (15%) | 0 | 2 (25%) | 2 (15%) | 4 (31%) | 0 | 0 |
| Quartile 3 | 20 (11%) | 6 (17%) | 7 (35%) | 2 (50%) | 0 | 3 (23%) | 1 (8%) | 1 (9%) | 0 |
| Quartile 4 (Lowest) | 12 (11%) | 3 (9%) | 3 (15%) | 0 | 1 (13%) | 1 (8%) | 2 (15%) | 2 (18%) | 0 |
| Index of Multiple deprivation Rank of Income scale | | | | | | | | | |
| Quartile 1 (Highest) | 68 (62%) | 21 (60%) | 9 (45%) | 2 (50%) | 7 (88%) | 9 (69%) | 7 (54%) | 8 (73%) | 5 (100%) |
| Quartile 2 | 20 (18%) | 8 (23%) | 6 (30%) | 2 (50%) | 0 | 2 (15%) | 2 (15%) | 0 | 0 |
| Quartile 3 | 16 (15%) | 5 (14%) | 4 (20%) | 0 | 0 | 2 (15%) | 4 (31%) | 1 (9%) | 0 |
| Quartile 4 (Lowest) | 5 (5%) | 1 (3%) | 1 (5%) | 0 | 1 (13%) | 0 | 0 | 2 (18%) | 0 |
| Index of Multiple deprivation Rank of Employment scale | | | | | | | | | |
| Quartile 1 (Highest) | 69 (63%) | 22 (63%) | 11 (55%) | 2 (50%) | 6 (75%) | 9 (69%) | 7 (54%) | 7 (64%) | 5 (100%) |
| Quartile 2 | 20 (18%) | 6 (17%) | 4 (20%) | 2 (50%) | 1 (13%) | 3 (23%) | 2 (15%) | 2 (18%) | 0 |
| Quartile 3 | 14 (13%) | 6 (17%) | 4 (20%) | 0 | 0 | 1 (8%) | 3 (23%) | 0 | 0 |
| Quartile 4 (Lowest) | 6 (6%) | 1 (3%) | 1 (5%) | 0 | 1 (13%) | 0 | 1 (8%) | 2 (18%) | 0 |

[1] For simplicity, only 3 of the 6 indices of multiple deprivation are shown in this table, but the remaining 3 were also calculated and showed a very similar pattern to those shown.

## *3.2 The characteristics of users of alternatives and standard services (Module 2)*

### Sample numbers

The Tidal Model ward differed from the others in being the only form of residential acute care available to adults of working age in its catchment area: this and doubts about the extent to which the model had been implemented (see manager and stakeholder interviews, Section 3.7) led to the decision to exclude this ward from the following comparison between alternative and standard services. Univariate comparisons between the Tidal Model and its local comparison indicated very similar service user cohorts, confirming this decision.

Data were collected regarding 35 admissions to the Tidal Model ward and 39 admissions to the Tidal model comparison service. Data for a cohort of 176 admissions to the other 5 alternatives were collected, and were compared with 183 admissions to the local standard comparison wards. These admissions were a consecutive series, except for 23 patients for whom data were not obtained and 8 who refused permission for their data to be included in the study. The target number of 35 per service was reached in all the services except the clinical crisis house, where a slower than anticipated admission rate meant that these number could not be achieved during the study data collection period, even though this was extended.

### Characteristics of residents in the alternatives and the standard services

Table 3.2.1 describes the characteristics of cohorts using the alternatives and the standard services (excluding the Tidal Model ward and its comparison service), reporting results from univariate tests comparing these.

**Table 3.2.1 Differences between service users in 5 alternatives and 5 local comparison services**

| Characteristics at the time of admission<br>*Data Source from Admission Questionnaire (Appendix 2)noted* | Traditional services<br>N (%)<br>*Or*<br>Mean (SD)<br>*Or*<br>Median (IQR)<br>N=183 | Alternative services<br>N (%)<br>*Or*<br>Mean (SD)<br>*Or*<br>Median (IQR)<br>N=176 | Test | P= |
|---|---|---|---|---|
| Age (B01) | 39.5 (SD 12.8) | 42.2 (SD: 13.3) | t = -1.89 | 0.060 |
| Male gender (B02) | 101 (55.2%) | 86 (48.9%) | $\chi^2$ = 1.44 | 0.23 |
| Ethnic group (B05)<br>-White British<br>- White Other<br>- Black or Black British - Caribbean<br>- Black or Black British - African<br>- Asian groups<br>- Other or mixed<br>*(16 categories from B05 combined for data reduction purposes)* | <br>132 (72.1%)<br>15 (8.2%)<br>11 (6.0%)<br>9 (4.4%)<br>11 (6.0%)<br>6 (3.3%) | <br>123 (69.9%)<br>5 (2.9%)<br>27 (15.3%)<br>14 (8.0%)<br>2 (1.1%)<br>5 (2.8%) | $\chi^2$ =19.9 | 0.001 |
| Born in UK (B06) | 134 (77.5%) | 149 (86.6%) | $\chi^2$ =4.92 | 0.027 |
| Living alone (B04) | 76 (42.0%) | 90 (50.9%) | $\chi^2$ =2.81 | 0.093 |
| In open market employment (B10) | 23 (13.4%) | 20 (11.8%) | $\chi^2$ =0.20 | 0.65 |
| Currently known to mental health services (contact in previous 3 months) (C02) | 102 (55.7%) | 125 (71.0%) | $\chi^2$ =9.02 | 0.003 |
| Previous hospital admission (B14) | 107 (68.6%) | 92 (73.0%) | $\chi^2$ =0.66 | 0.42 |
| Service user initiated helpseeking in current crisis (A03) | 29 (16.7%) | 53 (30.8%) | $\chi^2$ =9.22 | 0.002 |
| Pathway to admission via A and E department (A04) | 22 (12.6%) | 7 (4.0%) | $\chi^2$ =8.37 | 0.004 |
| Pathway to admission via police/criminal justice system (A04) | 25 (14.5%) | 6 (3.5%) | $\chi^2$ =12.80 | <0.0005 |
| Compulsory admission (A06) | 51 (28.2%) | 13 (7.5%) | $\chi^2$ =25.75 | 0.0005 |

| | | | | |
|---|---|---|---|---|
| Deliberate self harm in 2 weeks before admission (B17) | 39 (21.1%) | 26 (14.8%) | $\chi^2$ =2.59 | 0.11 |
| Harm to others in 2 weeks before admission (B17) | 24 (13.1%) | 13 (7.4%) | $\chi^2$ =3.18 | 0.074 |
| Psychotic symptoms present (score 3 or above HoNOS item 6) | 86 (47.0%) | 53 (30.1%) | $\chi^2$ =10.77 | 0.001 |
| Depressive symptoms present (score 3 or above HoNOS item 7) | 52 (28.4%) | 71 (40.3%) | $\chi^2$ =5.66 | 0.017 |
| Not adhering to prescribed medication (C07) | 52 (32.5%) | 34 (20.9%) | $\chi^2$ =5.60 | 0.018 |
| Cooperative with staff when arranging the assessment that led to admission (D02) | 133 (75.1%) | 154 (92.2%) | $\chi^2$ =18.12 | <0.0005 |
| GAF symptom score | 46.4 (20.6) | 55.1 (17.4) | t=4.32 | <0.0005 |
| GAF disability score | 59.1 (19.3) | 59.9 (17.7) | t=0.40 | 0.69 |
| TAG score – self harm (TAG item 1) | 1 (IQR: 0-2) | 1 (IQR: 0-2) | Kruskal-Wallis $\chi^2$ =0.86 | 0.35 |
| TAG score – unintentional self harm (TAG item 2) | 0 (IQR: 0-1) | 1 (IQR: 0-1) | Kruskal-Wallis $\chi^2$ =0.35 | 0.55 |
| TAG score – harm to others (TAG item 3) | 1 (IQR: 0-2) | 0 (IQR: 0-0) | Kruskal-Wallis $\chi^2$ =27.0 | 0.0001 |
| *Converted into binary score with > or equal to 2 as indicating significant risk for multivariate analysis* | 64 (35.0%) | 26 (14.8%) | $\chi^2$ =19.49 | |
| HoNOS subscale total – behaviour problems (HoNOS items 1-3) | 3 (IQR: 2-5) | 2 (IQR: 1-4) | Kruskal-Wallis $\chi^2$ =20.18 | <0.0005 0.0001 |
| *Converted into binary score with > or equal to 5 as indicating significant problems for multivariate analysis* | 61 (33.5%) | 28 (15.9%) | $\chi^2$ =14.85 | |
| HoNOS subscale total – impairment (HoNOS items 4-5) | 1 (IQR 0-2) | 1 (IQR 0-2) | Kruskal-Wallis $\chi^2$ =3.86 | <0.0005 0.050 |
| HoNOS subscale total – symptoms (HoNOS items 6-8) | 4 (IQR 3-6) | 4 (IQR 2.7-6) | Kruskal-Wallis $\chi^2$ =0.66 | 0.41 |
| HoNOS subscale total – social problems (HoNOS items 9-12) | 4 (IQR 1-6) | 3 (IQR 2-5) | Kruskal-Wallis $\chi^2$ =0.01 | 0.90 |



 

Similarities were substantial on many measures: in both groups, the majority of people admitted were unemployed, known to mental health services already, and had a previous history of hospital admission. No significant differences were found in risk of intentional or unintentional self harm, social functioning (GAF-Disability score) and social problems or recent self harm. However, users of the alternatives were more likely to be suffering from depressive and less likely to be suffering from psychotic symptoms, and they were less likely to be perceived as a risk to others. They were more likely to have referred themselves for help in the current crisis and less likely to have been admitted via the general hospital casualty department or the police and criminal justice system. The significant association with ethnic group is likely to be largely a result of the inclusion among the alternatives of a service dedicated to people from Black African and Black Caribbean backgrounds.

For those indicators where admissions to the alternative and standard ward differed at a $p<0.1$ level, we explored pair by pair differences between each alternative and its standard comparison. Lack of power needs to be acknowledged as a limitation for all these analyses. Table 3.2.2 shows the complex pattern that emerges, with the extent and nature of differences between alternative and standard services varying considerably between areas.

**Table 3.2.2 Differences between alternatives and their local comparison services** ***(differences at least the p<0.1 level between standard and alternative service highlighted)***

| Variables (threshold for inclusion: p<0.1 on overall trad vs. alt comparison) | CRT beds | CRT beds comparison | Clinical crisis house | Clinical Crisis house comparison | Non-clinical alternative 1 | Non-clinical alternative comparison 1 |
|---|---|---|---|---|---|---|
| **Age** | 42.8 (13.3) | 40.5 (13.9) | **48.8[1] (13.6)** | **39.0[1] (14.3)** | 40.7 (9.6) | 39.2 (12.8) |
| **Ethnic group** | | | | | | |
| White Brit | 32 (91%) | 28 (80%) | 31 (100%) | 33 (89%) | 23 (66%) | 24 (62%) |
| White oth | 1 (3%) | 0 | 0 | 1 (3%) | 4 (11%) | 7 (18%) |
| Black Car | 0 | 0 | 0 | 2 (5%) | 3 (9%) | 1 (3%) |
| Black Af | 0 | 0 | 0 | 0 | 2 (6%) | 3 (8%) |
| Asian | 1 (3%) | 6 (17%) | 0 | 0 | 0 | 2 (5%) |
| Other | 1 (3%) | 1 (3%) | 0 | 1 (3%) | 3 (9%) | 2 (5%) |
| **Born in UK** | 33 (94%) | 25 (86%) | 31 (100%) | 34 (94%) | **28 (82%)[1]** | **23 (61%)** |
| **Lives alone** | 17 (49%) | 15 (43%) | 10 (32%) | 12 (32%) | **30 (86%)[1]** | **23 (61%)** |
| **Known to mental health services** | 28 (80%) | 22 (63%) | 24 (77%) | 25 (68%) | **29 (83%)[1]** | **19 (49%)** |
| **Helpseeking initiated by service user** | 9 (26%) | 8 (26%) | 3 (10%) | 2 (6%) | **11 (32%)[1]** | **5 (13%)** |
| **Casualty dept. approach for help** | 1 (3%) | 4 (13%) | 0 | 1 (3%) | **0** | **8 (21%)** |
| **Police/criminal justice system referred** | 2 (6%) | 2 (6%) | 1 (3%) | 5 (14%) | **0** | **9 (23%)** |
| **Committed physical assault in past 2 weeks** | 2 (6%) | 2 (6%) | 5 (16%) | 2 (5%) | 2 (7%) | 8 (21%) |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Psychotic symptoms** | **8 (23%)** | **15 (43%)** | **13 (42%)** | **7 (19%)_** | **11 (31%)[1]** | **25 (64%)** |
| **Depressive symptoms** | 17 (49%) | 11 (31%) | 7 (23%) | 5 (14%) | 16 (46%) | 11 (28%) |
| **Non compliant with medication** | 9 (28%) | 8 (30%) | 6 (21%) | 6 (18%) | 7 (21%) | 15 (43%) |
| **Cooperative with assessment** | 28 (93%) | 26 (79%) | 25 (89%) | 29 (81%) | **34 (97%)[1]** | **27 (71%)** |
| **GAF symptom score** | 45.9 (19.6) | 50.3 (13.5) | 57.2 (20.1) | 57.5 (21.1) | **57.1 [1] (14.8)** | **45.6 (17.8)** |
| **TAG risk of harm to others (binary)** | 5 (14%) | 8 (23%) | 5 (16%) | 7 (19%) | **3 (9%)[1]** | **16 (41%)** |
| **HoNOS behaviour problems** | 9 (26%) | 9 (26%) | 3 (10%) | 9 (24%) | **2 (6%)[1]** | **15 (38%)** |
| | | | | | | |
| Variables (threshold for inclusion: p<0.1 on overall trad vs. alt comparison) | Non-clinical alternative 2 (Black focus) | Non-clinical alternative comparison 2 | Short stay ward | Short stay ward comparison | | |
| **Age** | 36.0 (12.7) | 40.4 (10.1) | 43.2 (11.5) | 38.6 (16.1) | | |
| **Ethnic group** | | | | | | |
| White Brit | **0[1]** | **15 (43%)** | 32 (93%) | 32 (86%) | | |
| White oth | **0** | **6 (17%)** | 0 | 1 (3%) | | |
| Black Car | **24 (69%)** | **7 (20%)** | 0 | 1 (3%) | | |
| Black Af | **11 (31%)** | **4 (11%)** | 1 (3%) | 2 (5%) | | |
| Asian | **0** | **1 (3%)** | 1 (3%) | 0 | | |
| Other | **0** | **2 (6%)** | 1 (3%) | | | |
| **Born in UK** | 22 (69%) | 19 (56%) | 35 (88%) | 33 (92%) | | |
| **Lives alone** | 20 (57%) | 12 (35%) | 12 (31%) | 14 (38%) | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Known to mental health services** | 20 (57%) | 12 (34%) | 24 (60%) | 24 (65%) | | |
| **Helpseeking initiated by service user** | **15 (43%)** | **4 (13%)** | 15 (38%) | 10 (27%) | | |
| **Casualty dept. approach for help** | **0** | **4 (12%)** | 6 (16%) | 5 (15%) | | |
| **Police/criminal justice system referred** | 0 | 2(7%) | 3 (8%) | 7 (19%) | | |
| **Committed physical assault in past 2 weeks** | **1 (3%)** | **6 (17%)** | 3 (8%) | 6 (18%) | | |
| **Psychotic symptoms** | 13 (37%) | 18 (51%) | **8 (20%)** | **21 (57%)** | | |
| **Depressive symptoms** | 12 (34%) | 10 (29%) | 19 (48%) | 15 (41%) | | |
| **Non compliant with medication** | 7 (22%) | 12 (41%) | 5 (14%) | 11 (31%) | | |
| **Cooperative with assessment** | **33 (94%)** | **24 (71%)** | 34 (87%) | 27 (75%) | | |
| **GAF symptom score** | 56.9 (18.0) | 47.2 (24.5) | **35.8 (14.1)** | **54.2 (19.1)** | | |
| **TAG risk of harm to others (binary)** | **5 (14%)** | **14 (40%)** | **8 (20%)** | **19 (51%)** | | |
| **HoNOS behaviour problems** | 4 (11%) | 10 (29% | 10 (25%) | 18 (49%) | | |

The cohorts admitted to the clinical crisis house, crisis team beds and short stay wards appear to resemble their local comparison services on most indicators, whereas the two non-clinical alternatives show prominent differences on more variables. There are however also substantial variations among standard comparison services on indicators such as risk of harm to others, suggesting that the threshold for admission may well differ between areas. A regression analysis, exploring who is admitted to an alternative rather than a standard ward, is presented in Table 3.2.3.

**Table 3.2.3: Variables associated with being admitted to an alternative rather than to hospital on logistic regression (multiple imputation for missing values and adjustment for clustering by service)**

| Characteristic | Odds ratio | 95% confidence intervals | P= |
|---|---|---|---|
| Age | 1.013 (per year) | 0.997-1.030 | 0.11 |
| Gender | 0.97 | 0.48-1.97 | 0.93 |
| **Ethnic group (white UK as reference group)** | | | |
| White Other | 0.92 | 0.16-5.33 | 0.93 |
| Black Caribbean | 3.26 | 0.30-35.6 | 0.33 |
| Black African | 4.44 | 0.79-24.8 | 0.09 |
| Asian | 0.35 | 0.06-1.89 | 0.22 |
| Other/mixed | 1.78 | 0.52-6.12 | 0.36 |
| **Born in UK** | 1.80 | 0.91-3.57 | 0.091 |
| **Known to mental health services in past 3 months** | **2.60** | **1.31-5.19** | **0.007** |
| **Patient initiated helpseeking him/herself in current crisis** | **2.25** | **1.18-4.30** | **0.014** |
| **A and E on pathway to care** | 0.33 | 0.07-1.63 | 0.17 |
| **Police/criminal justice system initiated referral** | 0.44 | 1.14-1.39 | 0.16 |
| **Psychotic symptoms** | 0.63 | 0.28-1.42 | 0.27 |
| **Depressive symptoms** | 1.21 | 0.47-3.08 | 0.69 |
| **Not thought compliant with medication** | 1.03 | 0.48-2.21 | 0.95 |
| **Cooperative with assessment** | 1.56 | 0.80-3.04 | 0.20 |
| **GAF symptoms score** | 1.014(per point on scale) | 0.999-1.030 | 0.07 |
| **TAG risk of harm to others (binary)** | **0.49** | **0.31-0.78** | **0.002** |
| **HoNOS behaviour problems (binary)** | 0.58 | 0.33-1.02 | 0.06 |

Table 3.2.3 shows the results of a regression analysis exploring which characteristics are independently associated with being admitted to an alternative rather than a standard ward. Variables where admissions to the alternative and standard ward differed at least the p=0.1 level were included in the analysis. Adjustment is made for clustering by service, which means that variables that are strongly associated with this outcome in only one or two services rather than across most of the areas tend not to emerge as significant. Three variables emerge as independently associated with admission to an alternative after adjustment for all the other candidate variables: these are already being known to mental health services, service users having initiated help seeking themselves in the current crisis, and lower risk of harm to others. Symptom severity and level of behavioural disturbance are also very close to statistical significance, and the increased odds of admission to an alternative for UK-born service users also approach it.

## *3.3 Users' experience of alternative services (Module 3)*

48 patient interviews were conducted, and the results of analysis of 40 of these interviews are presented here.

Ten main themes emerged from the analysis of the patients' accounts of their experiences of admission which highlighted perceived differences and similarities between alternative and traditional inpatient services. In addition a further theme was drawn out where patients noted opinions and preferences for different types of services. These themes are summarised in this section. Verbatim quotes from interviewees, illustrating each theme are provided in Appendix 13.

It emerged that during the process of the research the hospital-based service using the tidal model had poor implementation of the specific model of care and this was reflected in interview transcripts with patients and stakeholders (Lloyd-Evans et al., 2009). It functioned on the same premise as a traditional hospital and will be considered as such for the discussion of patients experiences.

*See Appendix 13 Quote 1*

### Opinions about services

Twenty five patients expressed an overall opinion about one type of service. Seventeen patients reported that their overall experience of an alternative service had been positive, while 2 had negative experiences of alternative services. Of those that expressed an opinion about hospital, 8 labelled their experience overall as negative and one patient had a positive experience of hospital.

*Quote 2, 3, 4, 5*

### Relationships

Relationships was the most frequently reported theme in the experiences of patients featuring in all of the transcripts. In addition the majority of the other themes were reported within the context of relationships experienced while in hospital. Relationships focused on were those formed between staff and patients, patients amongst themselves and with family and friends outside of hospital. Between staff and patients effective communication was identified as a key factor in building successful relationships. Staff characteristics also identified as important with qualities such as being nice, caring, friendly, polite, genuine being valued by over half of the patients interviewed. Relationships had a powerful impact on patients both in alternative and traditional services but there were no discernable differences in terms of the number and type of interaction between types of services. Indeed, within individual services patients highlight staff with particularly good communication skills and valued qualities and those that lacked them.

*Quote 6, 7, 8*

Continuity of care was noted by ¾ of patients. Not only was this identified as important but also influenced patient's experiences of services. Many patients had used services several times. They described having established relationships with staff and with such services, which positively affected patient's experiences of the service. It was particularly noted in some alternative services where community agencies continue to provide care despite the patient being in an inpatient unit.

*Quote 9, 10*

Continuity of care also extended to patients family and friends. A third of patients placed particular importance on staying in contact whether in terms of telephone, or visitors. In alternative services patients identified that family and friends also had some impact on their care such as being able to refer directly into the service, influencing length of stay and providing information for the service, not noted in traditional hospital services.

*Quote 11, 12*

**Patients**

Over half of patients identified that those hospital based inpatient services displayed more acute illness and disturbed behaviour. This included the hospital-based alternatives services. Such patients were seen to contribute negatively to patients' experience of hospital through fears for safety and increased demand for staff time and input. Patients identified the importance of being able to relate to other patients in both a social and therapeutic role, a role which often more acute patients did not fulfil or negatively affected.

*Quote 13, 14, 15, 16, 17, 18*

**Coercion**

Reports of coercion were greater in hospital services. Instances of hard coercion, such as control and restraint, and forced medication were limited to hospital-based services, including both hospital-based alternative services. Soft coercion in the form of threats, perceived force and perceived punishment were experienced in both services but predominated in traditional hospital services. The nature of soft coercion also varied between different types of service. Patients in alternative services reported feeling coerced regarding issues of wellbeing such as eating and washing and punishment took the form of a verbal reprimand whereas patients in hospital more often report punishment as in terms of actions such as loss of freedom or increased observations.

*Quote 19, 20, 21, 22*

**Freedom**

Patients reported greater amounts of freedom in alternative services. Both detained and voluntary patients reported less freedom in traditional hospital services. Freedom incorporated being able to 'come and go' but also being able to go out and smoke a cigarette. Not being able to go out was experienced predominately by patients in traditional hospital services. Exceptions included restrictions for patients detained under the Mental Health Act and at the first few days of admission at alternative services.

*Quote, 23, 24, 25, 26*

**Paternalism**

Paternalism by staff was identified by almost half of patients in both alternative and traditional hospital services. Negatively perceived paternalism was reported most frequently in traditional hospital services. Paternalism was experienced negatively when patients were treated as if they were children in terms of punitive measures e.g. had phone taken away, or in terms of practical measures involved in running a service such as being told when to go to bed. Patients describe feeling anger and expressing aggression towards such forms of paternalism. The form of paternalism that patients experienced positively was that in which they felt cared for e.g. fed, supervised through the night.

*Quote 27, 28, 29*

**Safety**

Safety was a dominant theme with over half of interviewees reporting fearing for their safety during an admission to a hospital-based service and four people during an admission to a crisis house service. The most commonly reported negative influence on safety was being around people who were acutely unwell.

*Quote 30*

Incidents of sexual, physical and verbal assault were directly linked to patients' perceived safety in inpatient services. While a number of patients experienced such incidents, witnessing them also had profound negative effects on patients' perceived safety. With one exception, all instances of assault were limited to traditional hospital services. Most commonly physical assault was reported by over ¼ of patients experiencing or witnessing attacks by patients on other patients or instances of restraint undertaken by staff.

*Quote 31, 32*

Over ¼ of patients reported feeling threatened or being threatened and these accounts were specific to hospital-based alternative and traditional services. The most commonly experienced threat was that of other patients. Poor communication characterised threatening relationships with staff. Staff that were

experienced as not listening or caring were perceived as oppressive and threatening. A small minority of patients report feeling directly intimidated by staff and threatened with violence.

*Quote 33, 34, 35*

Over half of patients reported feeling safe while an inpatient, the majority of these being in alternatives services. Both staff and environment were key factors in patients' perceptions of safety. Staff being around and providing a sense of control through maintaining rules and boundaries was highlighted of importance in installing a sense of safety in addition to developing relationships with patients through talking to and providing help for them. Homely environments which enabled patients to have a sense of privacy while still having people around were perceived as particularly safe.

*Quote 36, 37*

A strong emphasis was placed on feeling safe among those people who identified themselves as high risk in terms of suicide or risk to others. They placed particular value in containing environments such as locked doors and having people around who were able to handle high levels of distress.

*Quote 38*

**Activities**

In terms of day to day activities, patients reported no substantial differences between alternative and traditional inpatient services. Both were characterised by a relative lack of activities with media orientated activities such as watching television most prominent in both types of services. Access to Occupational Therapy was sparse in traditional services and in alternative services similar types of activities were initiated by care staff.

*Quote 39, 40*

**Treatment**

Two thirds of patients identified medication as the primary form of treatment in both alternative and traditional inpatient services. While hospital-based services provided structured episodes of medication provision, alternative services were typically more flexible with self medication and provision by community based agencies different options utilised however there were a range of preferences expressed by patients for different approaches. All traditional services and all but one alternative had access to medical provision, however where limited some patients expressed concerns and such input was identified as important.

*Quote 41, 42, 43, 44*

Social problems were identified by patients as key stressors both in admission to hospital and also while an inpatient. Over half of all patients highlighted help with social factors to be important in receiving inpatient care. Clients of both alternative and traditional hospital services reported positive experiences of social care provision and areas that were lacking.

*Quote 45*

Physical health problems were also raised by ¼ of patients. The most commonly reported problem was that of substance misuse. Positive action for physical health problems is described by both alternative and traditional service settings. However where problems were reported with services these were specific to hospital-based services and related to the patients role as a mental health patient but also a lack of skills and experience by psychiatrically trained staff.

*Quote 46, 47*

**Environment**

Individual's preferences for physical environments varied there was no clear divide between alternative services and hospital settings. There was a general appreciation of places which were 'a bit more like home' however almost a half of patients referred rather to 'people make a place'. Staff and patients, their relationships and impact on the environment providing somewhere both peaceful in terms of atmosphere and noise yet still having people around to socialise with held meaning for many across services rather than the validation of the physical environment of either type of service. Characteristics of physical environments which were valued included having your own decent sized room, having access to outside space, some access to privacy and overall cleanliness of the setting.

*Quote 48, 49*

**Findings for ethnic minority patients**

Ethnic minority patients did not mention qualitatively different views to other patients. Particular issues arose around safety and discrimination with some young African-Caribbean men reporting that they could be perceived as aggressive and threatening when ill, while a number of men and women reported expectations of discrimination in inpatient services. Services specifically for the African and Caribbean community were valued as places where these expectations could be put aside, although respondents also noted the range of heritages within the black community, not all of which could be specifically catered for.

*Quote 50, 51*

## *3.4 Carers' experiences of alternative services (Module 4)*

Not all service users interviewed identified carers whom researchers could contact. Not all identified carers were available or willing to participate. Both these factors limited recruitment, resulting in a smaller sample than anticipated. Individual qualitative interviews were conducted with twenty five carers.

In this summary the predominant themes of the interviews are grouped into three sections: Carers' experiences of both inpatient and alternative services; Differences between carers experiences of inpatient and alternative services; and Themes specific to individual services, which describes observations made specifically about individual units.

### Carers experiences of both inpatient and alternative services

#### Patient Confidentiality

While many carers reported an understanding of the need for patient confidentiality, a recurring theme across interviews was that this was often used by busy clinicians as an excuse for failing to inform carers of changes to service users' diagnoses or treatment plans:

*'Whether they can't be bothered, whether they haven't got the time or whether they are just hiding behind the confidentiality thing, I don't know'.*

*Carer: Non-clinical alternative 1*

and:

*'Whenever I asked any pertinent questions I was told 'confidentiality' which was being used as a smokescreen for me not finding out what really went on'.*

*Carer: Crisis Team Beds*

Many carers felt that the level of patient confidentiality was unacceptable when it was often they who suffered the consequences of being unaware of changes to medication or discharge dates. Carers reported that they felt unable to ask simple questions of the clinical staff in case this encroached the rights of the service user.

**Accessing mental health services at times of crisis**

Carers appeared particularly unclear as to how mental health services could be accessed if the service user relapsed. Few reported receiving clear instructions. There was confusion as to whether Accident and Emergency or appointed crisis teams should be contacted. Some carers reported reliance on either the process taking care of itself or reliance on a mental health contact to provide information. One elderly carer commented that simply having a card with emergency contact details would be helpful. A further concern among many carers interviewed was a lack of crisis services outside standard working hours:

*'My experience is people don't get to crisis point at 10.30 in the morning on a Tuesday, they get to their crisis point at midnight on Tuesday'.*

*Carer: Short-stay ward*

and:

*'Weekends for mentally ill people and their families are hellish...because all of a sudden there's no back-up'.*

*Carer: Crisis Team beds*

**Smoking arrangements**

Carers of non-smoking service users described how there was no outdoor space for them to use as any available outdoor space was used for smoking residents. Some carers suggested that non-smokers would often be excluded from social gatherings within units due to the majority of residents being smokers and thus occupying designated smoking areas:

*'There's a smoking garden, but if you don't smoke that's no good for you really'.*

*Carer: Clinical Crisis House*

and:

*'The staff tended to ignore the smoking rooms so there were people in there smoking drugs'.*

*Carer: Clinical crisis house (talking about the standard service)*

**Medication**

The perceived bureaucracy surrounding medication was a common complaint among the carers interviewed. Some described situations in which the service user had been admitted as an emergency and was then without medication for several days because the service did not hold their prescribed medication. Carers reported frustration at staff informing them that they were unable to provide the service user with the needed medication brought from home:

*'I found out that they didn't have one of these medications on the ward, so she didn't have it that night'.*

*Carer: Crisis Team Beds*

A number of carers cited situations in which GP's and crisis team members had informed service users that they were not obliged to take their prescribed medication. Carers felt that such advice was particularly misguided as they knew little of the service users' history which indicated that their mental health deteriorated when medication ceased. Similarly, many carers also expressed concern over changes in medication:

*'I couldn't understand at the time why they took her off it in the first place because she'd been taking it for four years, so I thought that wasn't very good, especially when she relapsed after she was discharged'.*

*Carer: Tidal Model Ward*

## Differences between carers' experiences of inpatient and alternative services

### Clinical staff

Whether a carer reported a positive or negative experience at either inpatient services or alternatives was dependent on their assessment of the behaviour of clinical staff. Although there were some complaints about staff members at alternative services, more often clinical staff were regarded favourably at these services. It was commented on that carers in alternatives could be very flexible. Examples included allowing carers to visit outside visiting hours if they were shift workers or had work commitments, talking to psychiatrists if the service user had problems with a medication and generally being happy to work with the carers and service users until a happy compromise had been reached by all. Staff were described as being straight talking and with a no-nonsense approach, yet carers reported the service users feeling they could trust and talk confidentially to them. One carer commented that he would always choose to send his wife to an alternative, because she would be willing to go there resulting in less conflict and a greater likelihood of her condition improving. Carers appeared to believe these

staff were experienced and well trained and had confidence in their ability to help service users. A number of carers, when discussing staff in alternatives, described how they were always interested in what the carer had to say, that they would question them about the service users' progress and that they always made time to talk to both carers and service users regardless of how busy they were.

*I was more settled at home because I knew that she was in good care basically and I knew that I could just pop down and anything. But also when I was concerned about A there was never a problem. I found I telephoned the hostel and they would afford me courtesy and understanding at all times and I was asked several times how I was and I was kept well informed of what was going on whereas before I wasn't informed of what was going on*

*(Carer: Clinical crisis house)*

In contrast staff at inpatient services were poorly perceived:

*'It was very much 'us' and 'them''.*

*Carer: Short-stay ward (talking about standard service)*

Some carers reported that they were rarely listened to by inpatient clinical teams and that they sometimes resorted to confrontational behaviour to gain staff's attention:

'*There is a certain amount of medical arrogance that goes on and it's only if you get bolshy that they actually start responding*'.

*Carer: Tidal Model Ward (talking about standard service)*

However, some carers reported a reluctance to address problems directly with staff due to fear of indirect consequences for the service user:

*'You don't want to rock the boat, you are afraid that when you walk out there will be repercussions and they will come back on the sick person'.*

*Carer: Crisis Team Beds (talking about standard service)*

Accusations levied at inpatient staff included sitting in their offices and a failure to interact with service users. Concerns were also raised regarding the high number of bank staff, with some carers describing that this led to high staff turnover and fewer staff members knowing the history and character of regular inpatients. Additionally, some carers accused inpatient staff of being young and

inexperienced which they felt had led to inappropriate comments to service-users.

The lack of contact or exchange of information with inpatient staff was a complaint made by the majority of carers interviewed. Many carers reported incidences where they had repeatedly contacted members of the clinical team and had received inadequate responses:

*'I've tried to ring the consultant of the ward a few times and left messages but she's never got back to me....I ring the ward and sometimes they'll tell me and sometimes they won't...it's a bit hit and miss really'.*

*Carer: Clinical Crisis House (talking about the standard service)*

Carers described how they felt they should be included in the care plan of service users and be kept informed as they felt that only they were able to offer information on the service users progress at home:

*'I would have thought someone who has known her and lived with her for 40 years ought to be listened to'.*

*Carer: Clinical Crisis House*

However, within alternatives, where adequate contact was generally reported (e.g., by an email or telephone call once a week), carers reported being content with the level of contact and the care of the service user and involved with the treatment plan.

Carers also reported that clinical staff were more approachable in alternatives and that they were prepared to discuss problems. Similarly, there were fewer complaints of staff being too busy in these settings compared to inpatient facilities and it was suggested this might be due to a higher staff to patient ratio within alternatives units:

*'I think every time we came up a carer came to speak to us...you could go into the office and no matter how busy they were, they would stop and tell you everything'.*

*Carer: Tidal Model Ward*

**Other service users**

Many of the carers interviewed suggested that service users in standard hospital facilities were less well and more disruptive than those in alternatives accommodation. In addition, carers expressed concern for the safety of those they cared for while admitted and also reported feeling unsafe when visiting themselves:

*'The people inside the hospital are shouting, hollering, getting quite aggressive and if I'm visiting someone in that environment, I don't feel safe'.*

*Carer: Non clinical alternative 1 (talking about standard service)*

and:

*'She* (service user) *was attacked in there. She had things thrown at her '.*

*Carer: Clinical Crisis House (talking about standard service)*

In contrast, carers suggested that service users in alternatives were friendlier and prepared to help other residents. However, bullying was reported in both types of services, the most common being aggressive and repeated requests for cigarettes.

A small number of carers reported being distressed at other service users receiving no visitors at both services. It was suggested that community projects involving the general public in visitor schemes would benefit these service users. Some carers hoped that such schemes would reduce the stigma of mental illness within society and would assist the integration of service users back into the local community:

*'I just think that you talk about care in the community, but as soon as you take them out of the community, we don't let the community in'.*

*Carer: Tidal Model Ward*

**Activities**

Many carers interviewed reported a dearth of activities offered to service users in both inpatient and alternatives:

*'If she didn't watch television there was nothing else to do'.*

*Carer: Crisis Team beds*

However, of the two types of services, it was generally reported that alternatives offered a greater range of activities and holistic therapies and also gave service users more opportunity to listen to music and take short trips away from the unit:

*'Every room, there was a CD player...so everyone had the option to play their own music which I thought was really good'.*

*Carer: Clinical Crisis House*

It was further suggested that books should be available at both inpatient and alternatives services, as the only form of regular entertainment presently available was television.

Some carers also described how some staff pressurised residents to take part in activities on acute wards taking little notice of how keen the service user was to participate. In contrast, alternatives services were reported to take a more relaxed approach allowing service users greater flexibility which carers reported more favourably.

**Living environment**

The physical environment of inpatient facilities was considered by most carers to be poor. Concerns included old buildings that appeared dilapidated with damp and broken windows and the use of old linen and poor quality furniture. The use of dormitory style wards with little curtain coverage for privacy was also described as being below an acceptable standard in acute wards:

*'I mean why do mentally ill people have to live in second class conditions...why should mentally ill people have to come into scruffy bedding and scruffy walls and tatty furniture just because they are mentally ill. No other member of society would put up with it really'.*

*Carer: Crisis Team Beds (talking about standard service)*

and:

*'There was urine all over the floor. It wasn't swept up'.*

*Carer: Tidal Model service (talking about standard service)*

A general lack of cleanliness in standard wards was also reported by carers, whereas the living environment within alternatives was (with the exception of one service) well reported.

A further difference reported by carers at alternatives and inpatient services was the privacy they were afforded. Many carers felt that they were given no privacy on wards and that they were unable to talk alone to service users:

*'The worst thing about mental hospitals is there is no privacy at all, none'.*

*Carer: Short-stay ward*

This was in contrast to alternatives units where most carers reported rooms being made available for them to talk privately and service users having been provided with their own bedroom with en suite facilities.

A further difference in the living environment between the two types of service was the suggestion that service users in alternatives settings were allowed to consume alcohol that had been acquired during periods of unescorted leave. It was claimed that this led to both a deterioration in the service user and a pungent smell in the unit.

**Care for service users with a physical disability**

Among the carers interviewed, some looked after service users with both mental health and physical difficulties. These carers raised concerns of both inpatient and alternatives units failing to be suitable for a resident with a physical disability:

*'The ward is totally incapable of looking after somebody who is in mental health crisis who has got a physical disability'.*

*Carer: Crisis Team beds (talking about standard service)*

Carers described how there were no handrails on walls, arm rests on chairs or alarms or handles in bathroom facilities in either type of service. However, some carers described that in hospital units staff were able to assist a resident with physical disability whereas staff in alternatives units were not. One carer described how he visited his wife with Parkinson's Disease to find her lying on the floor:

*'I had to get her off the floor cos apparently the nurses aren't allowed to lift them'*

*Carer: Clinical Crisis House*

Experiences such as this led many carers of service users with both mental health problems and physical disabilities to state that although they theoretically preferred alternatives settings, practically they felt these services were not suitable for such service users and as such preferred a hospital environment describing it as safer for someone with a physical disability.

## Themes specific to individual services

### Clinical crisis house - Dignity

Carers of service users staying at the clinical crisis house consistently reported that it was able to preserve the dignity of its residents. Carers suggested this was made possible by the centre providing a home-from-home environment which included private bedrooms with en suite bathrooms, kitchen facilities where service users could make snacks and private spaces in which to talk with visitors:

*'They are encouraged to do things for themselves....like the ladies did a bit of baking...it was as much as it could be home from home'.*

*Carer: Clinical Crisis House*

Carers also discussed the benefits of staff not forcing unwanted activities on residents and asking residents whether they wanted to receive visitors before a visitor could be admitted. However, the overwhelming view of the clinical crisis house was that staff were amiable and frequently informed carers of the progress of their residents:

*'I was asked several times how I was and I was kept well informed of what was going on whereas before I wasn't informed of what was going on'.*

*Carer: Clinical Crisis House*

The clinical crisis house was described fondly by all carers of service users that had resided there:

*'The country needs filling with these places'.*

*Carer; Clinical Crisis House*

**Black minority Ethnic (BME) non-clinical crisis house- Culture**

The BME non-clinical crisis house is a service that specifically provides respite for Black Caribbean and African service users. Here, carers discussed the role of culture in a service with mixed views. One carer felt that such an environment was helpful as staff understood cultural differences more pertinently helping service users recover more rapidly:

*'I see it as a culturally sensitive service which helps particularly young African and Caribbean males to find out a little bit more about themselves in a safe environment.'*

*Carer: Non-clinical alternative 2*

However, another view held was that it isolated these ethnic groups and that there should be greater integration with service users that are reflective of the general community:

*'I don't like this stereotype Afro-Caribbean kind of thing. I think it should be for everyone. I don't think it should just be for one type of culture. I think it should be a mixed culture'.*

*Carer: Non-clinical alternative 2*

## *3.5 Users' short and medium term outcomes and costs at alternatives and standard services (Modules 5 and 6)*

Results regarding users' outcomes, services' effectiveness and cost-effectiveness are derived from the same cohort of admissions to alternatives and standard services described in Section 3.2. Clinical effectiveness and cost effectiveness comparisons of alternatives and standard services are therefore reported together in this section.

### Short-term outcomes

Outcomes data were collected for 433 participants, ranging from 34 to 40 per service. The characteristics of participants are shown in Table 3.5.1. Initial analysis indicated that the profile of patients admitted to the Tidal Model ward, and their length of stay and subsequent outcomes (as well as content of care provided), were similar to the profiles for standard in-patient services. Therefore they are presented separately in Table 3.5.1, and the remainder of the Results uses data from the five other alternatives and the six standard services only. The mean admission and discharge ratings for the Tidal Model ward (n=35) were: GAF symptoms 45.2 (s.d. 20.7) improving to 62.3 (s.d. 23.2); GAF functioning 60.6 (s.d. 18.2) improving to 71.7 (s.d. 19.6), TAG 6.8 (s.d. 3.7) improving to 3.7 (s.d. 2.9); and HoNOS 12.0 (s.d. 4.4) improving to 8.5 (s.d. 6.6).

**Table 3.5.1 Socio-demographic and clinical characteristics (n = 433)**

| | Alternatives minus Tidal Model ward | Tidal Model ward | Standard services | Whole sample |
|---|---|---|---|---|
| *Number of services* | *5* | *1* | *6* | *12* |
| *Number of patients* | *176* | *35* | *222* | *433* |
| Male (%) | 86 (49) | 11 (31) | 120 (54) | 217 (50) |
| Age in years (s.d.) | 42.2 (13.3) | 42.5 (11.9) | 39.4 (12.9) | 40.1 (13.0) |
| Marital status (%) | | | | |
| *Unmarried* | 101 (57) | 15 (43) | 113 (54) | 229 (55) |
| *Married / co-habiting* | 27 (21) | 9 (26) | 64 (31) | 110 (26) |
| *Separated / divorced* | 36 (21) | 9 (26) | 26 (12) | 71 (17) |
| Ethnicity (%) | | | | |
| *White British* | 120 (68) | 24 (71) | 159 (72) | 303 (70) |
| *Caribbean* | 23 (13) | 3 (9) | 8 (4) | 34 (8) |
| *African* | 12 (7) | 1 (3) | 8 (4) | 21 (5) |
| Born in UK (%) | 149 (85) | 23 (85) | 170 (81) | 342 (83) |
| Years since first contact with mental health services (%) | | | | |
| *Less than 2* | 54 (31) | 13 (41) | 86 (41) | 151 (37) |
| *2-5* | 30 (18) | 5 (16) | 37 (18) | 72 (18) |
| *More than 5* | 84 (51) | 14 (44) | 83 (40) | 181 (45) |
| Contact with mental health services in 3 months preceding admission (%) | 125 (71) | 26 (74) | 128 (58) | 279 (64) |
| Symptoms / diagnosis (%) | | | | |
| *Psychosis symptoms / diagnosis* | 54 (31) | 11 (31) | 103 (46) | 168 (39) |
| *Depression symptoms / diagnosis* | 71 (40) | 11 (31) | 63 (28) | 145 (34) |
| Patient initiated help-seeking (%) | 53 (30) | 4 (11) | 36 (17) | 93 (22) |
| Co-operative in admissions procedure (%) | 154 (92) | 25 (71) | 166 (77) | 345 (83) |
| Length of stay (days, s.d.) | 17.5 (27.6) | 32.0 (31.2) | 38.2 (47.7) | 29.2 (40.6) |

The length and costs of the admission are shown in Table 3.5.2.

**Table 3.5.2: Length and cost of admission for each service (n=397)**

| Alt.=alternative<br>Comp.=comparison standard ward | **Crisis Team Beds** | **Crisis team Beds comp.** | **Short-stay ward** | **Short-stay ward comp.** | **Clinical crisis house** | **Clinical crisis house comp.** | **Non-clinical alt. 1** | **Non-clinical alt. 1 comp.** | **Non-clinical alt. 2 (Black focus)** | **Non-clinical alt. 2 comp.** | **Tidal Model ward comp.** | **All 5 alt. services** | **All 6 comp. svcs** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| n | *35* | *34* | *40* | *37* | *31* | *37* | *35* | *39* | *35* | *35* | *39* | *176* | *221* |
| **Length of stay** | 7.1 | 50.4 | 1.2 | 23.6 | 53.9 | 36.4 | 16.4 | 44.3 | 15.6 (8.1) | 43.1 | 32.5 | 17.6 | 38.2 |
| (mean days, s.d.) | (5.3) | (68.4) | (0.5) | (32.4) | (49.1) | (43.3) | (6.5) | (48.2) | | (55.5) | (27.8) | (27.5) | (47.7) |
| Mean cost of admission per service user | 657 | 13,011 | 292 | 6,080 | 13,633 | 9,379 | 3,466 | 11,422 | 2,737 | 11,131 | 8,395 | 3,832 | 9,850 |
| (mean £, s.d.) | (489) | (17,645) | (126) | (8,352) | (12,400) | (11,180) | (1,374) | (12,443) | (1,412) | (14,330) | (7,167) | (7,023) | (12,316) |

Admissions to alternative services were shorter on average: mean 17.6 compared to 38.2 days, with a difference of 20.6 days (95% CI 12.6 to 28.6, $p<0.001$). Consequently the costs of admission to the alternative services were significantly lower than the costs of admission to the standard services (£3,832 vs. £9,850; $p=0.025$).

Admission scores on the four staff-rated outcome measures are shown in Table 3.5.3.

**Table 3.5.3: Clinical outcomes at admission to each service (n=397)**

| Alt.=alternative<br>Comp.=comparison on standard ward | **Crisis Team Beds** | **Crisis Team Beds comp.** | **Short-stay ward** | **Short-stay ward comp.** | **Clinical crisis house** | **Clinical crisis house comp.** | **Non-clinical alt. 1** | **Non-clinical alt. 1 comp.** | **Non-clinical alt. 2 (Black focus)** | **Non-clinical alt. 2 comp.** | **Tidal Model ward comp.** | **All 5 alt. services** | **All 6 comp. svcs** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| n | *35* | *34* | *40* | *37* | *31* | *37* | *35* | *39* | *35* | *35* | *39* | *176* | *221* |
| GAF symptoms | 50.3 | 45.9 | 54.2 | 35.8 | 57.1 | 57.5 | 57.1 | 45.6 | 56.9 | 47.2 | 56.1 | 55.1 | 48.1 |
| | (13.6) | (19.6) | (19.1) | (14.1) | (20.7) | (21.1) | (14.8) | (17.8) | (18.0) | (24.5) | (16.4) | (17.4) | (20.3) |
| GAF functioning | 55.2 | 60.1 | 63.1 | 51.8 | 58.0 | 66.3 | 58.6 | 57.7 | 63.8 | 59.5 | 63.6 | 59.9 | 60.0 |
| | (18.9) | (19.8) | (16.5) | (18.2) | (21.8) | (13.9) | (14.8) | (20.9) | (16.2) | (21.1) | (16.7) | (17.7) | (19.0) |
| TAG | 7.2 | 7.3 | 5.8 | 10.2 | 4.7 | 5.0 | 7.2 | 7.6 | 6.9 | 6.0 | 5.6 | 6.4 | 6.9 |
| | (3.4) | (3.4) | (2.7) | (3.1) | (2.9) | (2.8) | (3.2) | (2.9) | (3.3) | (3.1) | (3.8) | (3.2) | (3.6) |
| HoNOS | 12.8 | 13.0 | 11.2 | 16.1 | 9.2 | 10.0 | 13.1 | 13.1 | 11.8 | 12.2 | 11.4 | 11.7 | 12.6 |
| | (5.8) | (6.4) | (5.3) | (4.5) | (4.0) | (4.7) | (5.5) | (4.4) | (5.3) | (6.1) | (5.6) | (5.4) | (5.6) |

At discharge, outcomes were in the direction of improvement on every measure. Change in outcomes at the point of discharge are shown in Table 3.5.4.

**Table 3.5.4 Change in outcome at discharge from each service (n=397)**

| Alt.=alternative<br>Comp.=comparison standard ward | **Crisis Team Beds** | **Crisis Team Beds comp.** | **Short-stay ward** | **Short-stay ward comp.** | **Clinical crisis house** | **Clinical crisis house comp.** | **Non-clinical alt. 1** | **Non-clinical alt. 1 comp.** | **Non-clinical alt. 2 (Black focus)** | **Non-clinical alt. 2 comp.** | **Tidal Model ward comp.** | **All 5 alt. services** | **All 6 comp. svcs** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| n | *35* | *34* | *40* | *37* | *31* | *37* | *35* | *39* | *35* | *35* | *39* | *176* | *221* |
| GAF symptoms[1] | 9.1 | 22.7 | 12.5 | 23.3 | 10.4 | 14.5 | 6.1 | 18.4 | 9.2 | 26.4 | 20.5 | 9.5 | 20.9 |
| | (12.7) | (23.3) | (15.9) | (18.3) | (23.6) | (23.9) | (16.2) | (19.2) | (18.4) | (27.6) | (16.9) | (17.5) | (21.8) |
| GAF functioning[1] | 6.6 | 12.2 | 7.3 | 8.9 | 3.4 | 6.3 | 7.1 | 11.3 | 4.3 | 14.7 | 11.8 | 5.9 | 10.8 |
| | (19.5) | (13.6) | (16.3) | (16.6) | (15.0) | (18.4) | (21.2) | (15.7) | (11.8) | (19.5) | (18.0) | (17.0) | (17.1) |
| TAG[2] | -1.9 | -3.1 | -1.5 | -3.5 | -0.4 | -2.2 | -1.5 | -3.7 | -0.9 | -3.2 | -2.8 | -1.3 | -3.1 |
| | (3.5) | (3.4) | (2.1) | (2.7) | (3.7) | (3.5) | (3.8) | (3.5) | (3.2) | (2.6) | (3.7) | (3.3) | (3.3) |
| HoNOS[2] | -2.3 | -5.8 | -0.9 | -6.6 | 0.1 | -2.3 | -2.9 | -5.1 | -2.8 | -6.5 | -4.6 | -2.2 | -5.1 |
| | (5.3) | (6.0) | (4.2) | (4.2) | (6.4) | (7.3) | (6.2) | (4.6) | (4.0) | (6.2) | (6.8) | (5.3) | (6.1) |

[1] Increase shows improvement. [2] Reduction shows improvement

Using a 7-point change in HoNOS rating as indicating reliable and clinically significant change (Parabiaghi et al. 2005), 38 (22%) of 176 patients in alternative services improved, as did 92 (41%) of 221 in standard services (difference 19%, 95% CI 11% to 29%, $p<0.001$), with an odds ratio of 1.56 (95% CI 1.10 to 2.21, $p=0.012$) after adjustment for area and individual characteristics.

There were significant differences at the aggregated level, comparing all alternatives versus all standard services, in favour of standard services.

Results are presented in Table 3.5.5.

**Table 3.5.5 Estimated differences between standard and alternative services at follow up controlling for baseline, area and personal characteristics**

| | Controlling for baseline and area only (max n=340) | | | Controlling for baseline, area and individual characteristics[3] (max n=339) | | | Controlling for baseline, area and individual characteristics[3], after imputation of missing values (n=398) | | |
|---|---|---|---|---|---|---|---|---|---|
| Outcome | Coefficient | 95% CI | P | Diff. | 95% CI | P | Diff. | 95% CI | P |
| GAF symptoms[1] | 5.588 | 2.107 to 9.069 | 0.005 | 3.142 | -0.651 to 6.934 | 0.095 | 4.327 | 0.722 to 7.932 | 0.023 |
| GAF functioning[1] | 4.579 | 0.797 to 8.361 | 0.022 | 4.150 | 1.080 to 7.219 | 0.013 | 4.183 | 0.522 to 7.843 | 0.029 |
| TAG[2] | -1.375 | -2.165 to -0.586 | 0.003 | -1.403 | -2.511 to -0.295 | 0.018 | -1.356 | -2.574 to -0.139 | 0.032 |
| HoNOS[2] | -1.657 | -3.184 to -1.657 | <0.001 | -1.993 | -2.859 to -1.126 | <0.001 | -2.196 | -3.176 to -1.216 | 0.001 |

[1] Positive difference: standard better than alternative. [2] Negative difference: standard better than alternative

[3] Age, gender, ethnic group, born in UK, self-referred, known to services, behaviour problems (HoNOS), risk of harm to others (TAG),GAF symptoms at baseline

Some (although not all) of the relative improvement in the standard services could be attributed to baseline predictors, since the effect sizes reduced when these were controlled for. For TAG and HoNOS, these differences remained statistically significant even after controlling for predictors. For GAF symptoms the evidence was less clear, since the difference for this outcome only remained significant at the 0.05 level in the imputed data after adjustment. Overall, the standard services were more costly than the alternative services, but were associated with better outcomes.

Incremental cost-effectiveness analysis indicated that the standard services cost an additional £2,939 per unit improvement in HoNOS score. To inform decision-making about the trade-off between the additional cost of admission to standard services and the improvements in outcome, a cost-effectiveness acceptability curve was calculated to assess the probability that admission to the standard services is cost-effective for different values that a decision-maker may be willing to pay for improvements in outcome. If there is no willingness to pay anything for an improvement in HoNOS score, the probability that admission to standard services is more cost-effective than admission to standard services is zero. In other words, society would not be willing to pay the additional cost of the standard services in order to generate the additional benefits observed. As the value placed on the willingness to pay for improvements in HoNOS score rises, the probability that admission to standard services is cost-effective also rises to a maximum of just under 100%. Standard services have a greater probability of being the more cost-effective option at levels of willingness to pay of around £3000 per unit improvement in HoNOS and above.

## Medium term outcomes

After exclusion of the Tidal Model ward, 398 participants were available for inclusion in the assessment of medium term use of resources and costs. Data were available for all 398 participants from 6 standard services (n=222) and 5 alternative services (n=176).

*Mental health service use and cost*

Contacts with mental health services in the twelve months before and after the date of index admission are reported in Table 3.5.6. In the year before index admission, those admitted to standard services spent 22 days on average in hospital for psychiatric reasons, compared to 27 days in those admitted to an alternative services (mean difference=5). In the twelve months following the date of index admission, the mean number of psychiatric inpatient days was much greater (mean 70 standard, 57 alternative; mean difference=13). Observed differences between the alternatives and standard services were more evident for the index admission (mean 44 standard, 29 alternative; mean difference=15) than for subsequent admissions (mean 26 standard, 28 alternative; mean difference=2). Participants admitted to alternative services had more contact with community mental health teams, early intervention services and crisis teams,

whilst participants admitted to standard services had more contact with assertive outreach teams.

**Table 3.5.6: Mental health service use prior to and post date of index admission by group**

| | Standard (n=222) Mean (s.d.) | Alternative (n=176) Mean (s.d.) |
|---|---|---|
| 12-months preceding date of index admission | | |
| Psychiatric inpatient days | 22 (50) | 27 (56) |
| 12-months following date of index admission | | |
| Number of psychiatric admissions including index | 2(1) | 2(1) |
| Index admission days* | 44 (58) | 29 (55) |
| Post index admission psychiatric inpatient days | 26 (52) | 28 (58) |
| Total psychiatric inpatient days | 70 (77) | 57 (79) |
| Psychiatric outpatient attendances | 3 (4) | 2 (2) |
| Psychiatric day hospital attendances | 3 (10) | 5 (16) |
| Community mental health team contacts | 9 (16) | 14 (19) |
| Assertive outreach team contacts | 5 (23) | 3 (11) |
| Early intervention service contacts | 0 (1) | 2 (15) |
| Community rehabilitation team contacts | 1 (5) | 1 (5) |
| Crisis Resolution team contacts | 7 (14) | 9 (17) |
| Accident and emergency/liaison psychiatry contacts | 0 (1) | 0 (1) |

*Index admissions include transfers from the initial admitting service to other facilities, not previously reported in the short-term outcomes in this section

Total costs per participant are reported in Table 3.5.7. There were no significant differences in mean costs between standard and alternative services for psychiatric admissions in the twelve months prior to index admission (mean £5685 standard, £6560 alternative; mean difference £875, p=0.513) or total use of mental health services subsequent to the index admission (mean £8228 standard, £8719 alternative; mean difference £491, p=0.721). However, large differences in the mean cost of the index admission were evident (mean £11060 standard, £6233 alternative) resulting in statistically significant differences in total cost per participant over the full 12-month follow-up period (mean £19288 standard, £14953 alternative; mean difference £4335, p=0.029). Adjustment was

made in analyses for area, age, gender, ethnic group, born in UK, self-referred, known to services, baseline behaviour problems (HONOS), baseline risk of harm to others (TAG), baseline GAF symptoms, and pre-index admission costs (Adj. p in Table 3.5.7). Adjusted analyses did not alter the significance of these findings. Across all services, participants cost just over £17,000 per annum on average, with psychiatric inpatient admissions accounting for 89% of this amount.

**Table 3.5.7: Total cost per participant (s.d.) by group**

| | Standard (n=222) Mean (s.d.) | Alternative (n=176) Mean (s.d.) | Mean difference (95% CI) | p | Adj p* |
|---|---|---|---|---|---|
| 12-months preceding study entry | | | | | |
| Psychiatric admissions | 5685 (12868) | 6560 (13687) | -875 (-3502 to 1751) | 0.513 | |
| 12-months following study entry | | | | | |
| Index admission | 11060 (15033) | 6233 (13267) | 4827 (2034 to7620) | 0.001 | 0.005 |
| Post index admission psychiatric admissions | 6525 (13311) | 6477 (13041) | 47 (-2570 to 2665) | 0.972 | 0.878 |
| Psychiatric outpatient attendances | 382 (494) | 283 (298) | 100 (21 to 178) | 0.013 | 0.002 |
| Psychiatric day hospital attendances | 237 (965) | 471 (1522) | -234 (-493 to 25) | 0.077 | 0.054 |
| Community mental health team contacts | 638 (1148) | 1006 (1349) | -368 (-619 to -117) | 0.004 | 0.017 |
| Assertive outreach team contacts | 185 (924) | 100 (446) | 85 (-64 to 234) | 0.264 | 0.179 |
| Early intervention service contacts | 3 (22) | 65 (424) | -62 (-125 to 1) | 0.053 | 0.027 |
| Community rehabilitation team contacts | 44 (339) | 57 (372) | -12 (-83 to 58) | 0.728 | 0.910 |
| Crisis Resolution team contacts | 186 (354) | 234 (442) | -49 (-127 to 30) | 0.224 | 0.238 |
| A&E/liaison psychiatry contacts | 28 (111) | 26 (68) | 2 (-16 to 21) | 0.815 | 0.949 |
| **Total cost subsequent to index admission** | **8228 (13590)** | **8719 (13603)** | **-491 (-3189 to 2206)** | **0.721** | **0.847** |
| **Total cost including index admission** | **19288 (20044)** | **14952 (19026)** | **4336 (447 to 8225)** | **0.029** | **0.049** |

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Index admissions, including length of stay in the initial admitting service and subsequent moves as part of the index admission, were found to vary considerably in terms of mean length of stay (range 25 to 64 days standard; 16 to 61 days alternative) and index admission cost per participant (range £6311 to £16442 standard; £3293 to £12336 alternative). Non-clinical and crisis team bed alternatives were found to have the shortest index admission lengths on average (mean 17 days), whilst the clinical crisis house had the second longest length of index admission of all services (mean 61 days). Despite having the shortest lengths of stay in the index service (mean 1.2 days index service), the short-stay psychiatric ward fell in between these two extremes (mean 35 days index admission), as a result of having the longest stays in subsequent index admission services. This contrasts with a mean index admission duration of 44 days in the standard services. The pattern for costs was the same, with the non-clinical and crisis team bed alternatives being associated with the lowest index admission and total 12-month costs of all services, the clinical crisis house being the most expensive in terms of total 12-month costs and the third most expensive in terms of index admission costs and the short-stay ward being located between the two.

*Factors associated with costs*

Univariate associations with total 12-month costs are reported in Table 3.5.8. In addition to allocation to standard versus alternative services, higher total costs per participant were significantly associated with older age, being previously known to services, help-seeking not initiated by the patient, risk of harm to others and higher cost of psychiatric admissions in the 12-months prior to index admission.

**Table 3.5.8: Univariate associations with total 12-month cost**

| Variable | n | Mean (s.d.) | p-value |
|---|---|---|---|
| Service | | | |
| Standard | 222 | 19288 (20044) | |
| Alternative | 176 | 14952 (19026) | 0.029 |
| Age* | | | |
| <=40 | 206 | 16532 (19382) | |
| >40 | 187 | 18362 (20181) | 0.030 |
| Gender | | | |
| Male | 206 | 17688 (20044) | |
| Female | 192 | 17031 (19358) | 0.740 |
| Ethnicity | | | |
| White | 310 | 17969 (20170) | |
| Black | 53 | 16258 (18257) | |
| Other | 35 | 13757 (17408) | 0.443 |
| Born in the UK | | | |
| Yes | 319 | 17613 (20067) | |
| No | 64 | 16581 (18493) | 0.704 |
| Known to services | | | |
| Yes | 253 | 20208 (21040) | |
| No | 145 | 12421 (15994) | <0.001 |
| Self-referral | | | |
| Yes | 89 | 11924 (15944) | |
| No | 293 | 18698 (20138) | 0.004 |
| GAF symptom score* | | | |
| <=52 | 202 | 18648 (21104) | |
| >52 | 193 | 16199 (18189) | 0.238 |
| TAG risk of harm to others | | | |
| Yes | 93 | 22181 (23627) | |
| No | 305 | 15904 (18120) | 0.007 |
| HoNOS behaviour problems | | | |
| Yes | 98 | 18657 (23360) | |

| | | | |
|---|---|---|---|
| No | 300 | 16951 (18364) | 0.457 |
| Cost of admissions in previous year* | | | |
| =0 | 220 | 14189 (16461) | |
| >0 | 178 | 21303 (22507) | <0.0001 |
| Area | | | |
| 1 | 70 | 15238 (17268) | |
| 2 | 68 | 23332 (20775) | |
| 3 | 70 | 16769 (22149) | |
| 4 | 39 | 15080 (12281) | |
| 5 | 77 | 16556 (21672) | |
| 6 | 74 | 16535 (18924) | 0.470 |

*Summarised in the table as two groups split at the median, but p-values relate to analysis on a continuous scale

Table 3.5.9 details the final multiple regression model, which found the same associations to be significant as the univariate analyses. Total 12-month follow-up costs were found to increase by £180 for every additional year of age and by £0.45 for every additional £1 spent on psychiatric inpatient services in the 12-months before entry to the study. Participants known to services cost almost £7,000 more than participants not known to services, on average. Participants assessed by the TAG as at risk of harm to others cost almost £5,500 more than participants not at risk of harm to others. Participants who initiated help-seeking, were found to cost £4,000 less on average than participants who did not initiate help-seeking, although this relationship was weak. The model was able to explain around 20% of the variation in total follow-up costs (adjusted $R^2$=0.19).

**Table 3.5.9: Multiple regression for total 12-month follow-up costs**

| Variable | Coefficient (95% CI) | p-value |
|---|---|---|
| Service – standard vs. alternative | 4147 (400 to 7893) | 0.030 |
| Age | 180 (42 to 318) | 0.011 |
| Known to services – yes vs. no | 6844 (3011 to 10677) | 0.001 |
| Patient initiated help seeking – yes vs. no | -3914 (-8211 to 383) | 0.074 |
| Risk of harm to others – yes vs. no | 5456 (1148 to 9764) | 0.013 |
| Pre-index admission cost of admissions | 0.45 (0.31 to 0.58) | 0.000 |

## *3.6 The role of alternatives, their development and models: manager and stakeholder interviews (Modules 7 and 8)*

Analysis was based on 36 interviews with managers and stakeholders at 6 alternatives. Stakeholders included at each service a local Crisis and Home treatment Team manager, a local inpatient service representative, a representative of the commissioning service, a manager of the local mental health trust and a representative of a regular referring service. At two services, the alternative service manager also fulfilled one stakeholder role (one Crisis Team and one inpatient service manager). At the two voluntary sector alternatives, (the two non-clinical alternatives), managers of the voluntary sector provider service were also interviewed. The main themes relate to 5 services. The Tidal Model ward is considered separately.

**1. Role**

4 roles were identified for alternatives:

- **acute crisis**
- **sub-acute crisis**
- **step-down**
- **respite (for patient or carer)**

In reality, all alternatives seem to do some of all of these. There is often a lack of consensus among stakeholders about which are most common roles/priorities. Alternatives can be seen as a genuine alternative to inpatient admission, or a separate tier of care for a less acute client group. Roles can change: e.g. the BME non-clinical crisis house used not to accept step-down care but now will; the clinical crisis house has seen an increasing focus on crisis care in the past decade.

*"I think it is alternative but as I say ag ain its not a ward in the community and it doesn't pretend to be so. I think there is a certain group of service users if you like that need to um.. that can't be worked with in their home but don't necessarily need to be taken out of the community to be worked with and supported. And I think that group of serv ice users is the service users we would work with. And if we weren't here then they would go in hospital, there is nowhere else for them to go."*

*(Manager, Non-clinical crisis house )*

The Brief-stay ward is viewed as designed to prevent admission to an acute ward and was explicitly identified by two stakeholders as serving a similar function to a crisis house.

*"I am thinking to myself why do we need Crisis Houses at all because to all intents and purposes the [Brief-stay ward] is filling that function."*

*(Trust manager, Brief-stay ward)*

**2. Referral pathways**

Important features include:

- **Client self-referral:** Self-referral risks reducing usefulness of alternative to statutory services and generation of non-crisis admissions. However, it may increase the perceived independence and acceptability of service to patients, facilitate prompt help-seeking by patients and increase access. Gatekeeping of access to beds, e.g. by crisis team, has the opposite effect.

*"So the role played here is to intervene early in order to prevent that person from going to deeper crisis that will result in a hospital admission. So we are here and we want people to know about us so that we can help our people out of crisis."*

*( Manager, BME non-clinical crisis house)*

*"So the GPs cannot refer, or self referra l cant be made to a CRHT because we would be inundated and not be able to do any work. So there's filters."*

*(CRT manager, Brief-stay ward)*

- **Time of client presentation:** there were difficulties admitting patients to some alternatives at evenings or weekends, either due to planned refusal to take any out of hours referrals (clinical crisis house), lack of 24 hour crisis team to assess/signpost or lack of skilled, confident staff at alternative to assess and admit.
- **Place of presentation:** Non mental health services (Primary Care, A and E, police) may be less aware of alternative as an option.
- **Referrers' habits:** Clinicians vary in willingness to admit to alternatives and (especially consultants) often have the power to ignore operationalised referral pathways.

*"There is a big difference in the sort of patients that you do get, and the willingness to take on therapeutic risks and take therapeutic risks compared, you know, between different Consultants, betw een different teams, between different practitioners, be them nurses, or social workers or OTs or, yeah massive variance there."*

*(Inpatient representative, Crisis Team Beds)*

- Alternatives can be full, unlike inpatient services which have to find a bed somewhere.

### 3. Who uses alternatives?

Stakeholders did not identify any targeted or preferred diagnostic group for alternatives in theory or practice. Admission was more based on risks, behaviour and cooperation of clients. A few stakeholders expressed doubts that acute wards are helpful for people with personality disorders and that crisis houses may be more appropriate.

*"I cant remember someone being turned down by* [the non-clinical crisis house] *because of symptoms of an illness for example. As I said before the only ones that you might get turned down were significant risk to other people or…and I think in a good way they actually do turn down some people who they don't think need to be in there"*

*(CRT manager, non-clinical crisis house)*

There was acknowledgement and acceptance by many stakeholders that crisis houses are more likely to take known clients, where risks can be accurately assessed and where prompt referral, before crisis is unmanageable, may be more possible.

*It may well be that someone who is new, new to everybody might be felt more appropriate to have an inpatient admission first of all. Whereas someone perhaps presenting similarly but is well known to the service, so they know what their triggers are, they know their behaviours can be predicted to some extent in the course of their relapse and recovery*

*(PCT commissioner, Crisis Team beds)*

### 4. How alternatives are configured

The following factors were identified as affecting the role and functioning of alternatives:

- **Size:** Small services may be more homely and provide a more personal quality of care. Quiet, undemanding patients are less likely to be neglected. A small service may limit admission of risky patients however, as limited additional cover is available to deal with crises. It may also limit the available therapeutic care e.g. there may never be enough patients to run therapeutic groups; it may be harder to cover staff absence, e.g. if the only Occupational Therapist goes off sick.

*"with the best will in the world there are some people in acute admission ward that will demand staff's time for a variety of reasons and will get it. And those resources of staff, resources are not finite you know sometimes people are very*

*quiet and retarded fade into the back ground when there are all these other people."*

*(CRT manager, clinical crisis house)*

*"What you gain in the fact that somebody can be supported close to home is lost in terms of the strength of service they can actually receive whilst they are in that satellite unit. And there is always a danger that we start to re-centralise things to gain that economy of scale and re-create mini institutions that we've tried to move away from over the last 10 or 15 years. But I do think that a hospital setting that is slightly larger can actually offer that critical mass of clinical input, therapeutic programmes that can actually perhaps support people's acute episode in a stronger way"*

*( Inpatient representative, Clinical crisis house)*

- **Geographical location:** Local services may be more convenient for patients and carers and have good liaison with community teams because fewer teams/individuals are involved. However they may be cut off from other services, e.g. general hospital, PICU etc, limiting who can be admitted and cared for. There are particular implications for services in rural areas (e.g. the clinical crisis house). Inpatient services may be more necessary and stays may be longer because other options like day hospital or outpatient appointments are hard for people to access. Difficulties of getting patients from the alternative to A and E etc even greater though.

*"the area is quite a parochial area rea lly. I mean the [hospital] is almost like another planet to a lot of people, its out of the Moorlands, they view the Potteries as you need your Passport to get there."*

*(CRT manager, clinical crisis house)*

*"Whereas if there's an incident up here it really is pretty worrying for staff. And also a long way from the physical care su pport services, so that you know it's a 15 mile trip to the local A & E Department so that's an issue."*

*(Referring consultant, clinical crisis house)*

- **Skills of the staff**: the two non-clinical crisis houses use almost exclusively non-clinically trained staff and have no medical cover. The Crisis Team Beds have no qualified staff at nights; the clinical crisis house has no medical cover at nights. This can limit what interventions can be offered, who can be admitted. It can delay referrals, e.g. if staff wait for the manager to make decisions. Staff may fail to understand psychotic symptoms and therefore mismanage patients, although experience of this was rare. A normalising approach to acceptable and unacceptable behaviour can also sometimes be helpful. "Unqualified" staff can create a homely, non-stigmatising environment. They may bring other skills, such

as interest/background in counselling, psychology graduates etc. Clinical training is not a guarantee of greater skills: the lack of initiative and autonomy of inpatient nursing staff was identified as a problem and compared unfavourably with crisis house by one respondent.

*"And I think if we got better at being clea rer about what the role of [the crisis team beds] was and supported, and to be fair supported [crisis team beds] staff in terms of improving their skills in terms of Risk Assessment and Needs Assessment as well, so that if something happened they were a bit more, perhaps a bit more kind of able to adjust and contact people as and when appropriately."*

*(Trust manager, Crisis Team Beds)*

*"the actual staff as well, very good st aff, don't necessarily come from, aren't professionally qualified and I think that 's actually a bonus sometimes because I think the patients themselves will relate mo re to people if they haven't got this professional hat on."*

*(CRT manager, BME non-clinical crisis house)*

- **Time-limited admission:** The galvanising effect of time-limited admission was identified frequently. Delays in assessments, developing treatment plans and making referrals are minimised. Bed-blocking is avoided, so the service does not become clogged. Community teams report crisis houses enforce time limits with some flexibility: this is perceived as helpful: most respondents did not feel time limits limited alternatives' ability to help acutely ill clients. Basildon Assessment Unit, enforces 72 hour time limit rigidly. Its focus is much more on diagnosis and signposting than treatment.

*"I just think that we are not always very proactive about getting people out sooner rather than later. I think sometimes they are here and referrals are going to other agencies and they would be wait ing for them to come back and there's no urgency I think sometimes for people to respond, because they are here, they are safe, you know." (CRT manager, clinical crisis house)*

*"If you have therapy to go in on the assessment unit, then three days is too short but if the therapy bit is divorced from the assessment, so the assessment is complete, three days is a fair amount. No w what is needed is all clear and then you direct so it only serves as a diagnostic function" ( referring psychiatrist, Brief-stay beds)*

*"But the advantage of the Assessment Unit wa s that it really provided an area of safety for clinicians to be able to make decisions in a joined up robust way and*

*for the initial crisis that created the need for the patient to come to A & E in the first place to be properly addressed."*

*(Trust manager, Brief-stay beds)*

The quality of assessment possible in the assessment unit - multi-disciplinary, in a safe environment, when the patient has sobered up or calmed down, once relatives can have been contacted - was identified as far superior to what is often possible at A and E. Provision of adequate aftercare was identified as crucial to making time-limited admission work. Time-limited alternatives try to find ways to provide this: own follow up support (non-clinical crisis houses), guaranteed crisis team follow up (Crisis Team Beds), Day Hospital acceptance before discharge (Brief-stay beds).

*"Again I suppose when people are di scharged from Crisis Beds into the community we don't just sort of wash ou r hands of them, we follow them up in the community with daily contact and visits, for what a week or two weeks or whatever. So are we throwing them out of Crisis Beds sooner because we've got that level of support, whereas a lot of pe ople admitted to the ward, I mean some will get involved with the Crisis Team at discharge but a lot won't, so do they have to be that much better for discharge from the ward"*

*(referring psychiatrist, crisis team beds)*

- **Embedded services:** (physically situated within bigger centres also housing community teams – Basildon, Middlesbrough, Ashcombe). This facilitates inter-agency communication and allows greater positive risk-taking in accepting referrals, because additional help is at hand. It may reduce how alternative the alternative feels however, affecting its acceptability and impact on stigma.

*"like I said about the stigma and things , the [nam e of service m entioned] could be anything. If someone mentioned to yo u they were in the [service nam e] and you hadn't heard of it be fore, you wouldn't necessar ily think ooh, that saved them from going into hospital, did it? But something attached to the North CMHT crisis house; you'd kind of know what was wrong, wouldn't you?"*

*(Trust Manager, BME non-clinical crisis house)*

- **Built environment:** Crisis houses were generally identified as more comfortable, homely and less stigmatising than hospital wards. However, the layout of a residential house may be unsuitable for high risk patients, e.g. ease of observation, access to sharps or ligatures.

*"the public at large don't necessarily badge it as a place for mental health, a place where m ad people go. So it's a non-stigmatising environment, its more homely, people can come an d go a lot more easily. Its not the institutional environment of a hospital ward."*

*(PCT commissioner, BME non-clinical crisis house)*

- **Culturally-specific service:** the BME non-clinical crisis house was generally valued by stakeholders: possible advantages include acceptability to service users, creation of a more homely, culturally tailored service (food, understanding other languages or patois), reduced chance of misinterpreting behaviour and beliefs, increased sense of collaboration, reduced perceived coercion. A referring consultant has known black clients not keen on a BME service, not perceived as relevant to their black British identity. A BME service inevitably limits access: the BME service is the only crisis house funded by Hackney and can't be used by most Hackney residents. Turkish/Kurdish clients were identified as equally needing culturally specific service in Hackney.

*"Recently, a few days ago one of the service users at the Nile Centre was describing his experience of the Nile. He said I've got an aunty and a cousin here who have just cooked and I've had some and its like home and I can talk to them like home. And that makes me feel good, they've done nothing but make me feel like a human being again."*

*(Voluntary Housing Association Manager, BME non-clinical crisis house)*

- **Detained patients:** many stakeholders were ambivalent about the desirability of alternatives taking detained patients: a trade off between widening who can use the service and diluting its nature. Changes in make up of staff team, client autonomy, built environment would have to be made. The fact that alternatives patients don't see other very disturbed patients, forcible treatment, s.136 police presence etc is seen as beneficial: this might be lost. Varied views were expressed about usefulness of accepting people on s.17 leave to facilitate early discharge: there are possible downsides re continuity of care and extending total length of admission.

*"I think that once somebody is detained if they are on Section 3, treatm ent Section for instance, it would mean that we would have to become the same people that we don't want to be. We will have to give them injections, if they refuse to take oral medication and I th ink that will lead to mistrust, it will undermine our credibility in terms of offering something different"*

*(Voluntary Housing Asociation Manager, BME non-clinical crisis house)*

- **Other parts of the acute care system:** The role and need for alternatives is also affected by what else is available locally. Day Hospital, 24 hour-staffed crisis teams, weekend "safe houses", arrangements with private landlords for short-term crisis lets were all identified as alternatives to alternatives in some circumstances. Several respondents identified dedicated inpatient consultants as very useful in reducing delays in inpatient care, reducing length of stay and potentially the need for alternatives.

**5. The care provided**

Many respondents identified an aim and perception that staff at alternatives spend more time with patients than on acute wards. No specific models of care (other than Tidal Model) were identified. There was a common perception that care aimed to be less medically focused and more holistic at alternatives and that the style of care may be less paternalistic and more empowering. Greater interpersonal skills and warmth at alternatives were identified by some. However, these were also all identified as aims of care on standard acute wards: no fundamental difference in models/philosophy of care was identified. There was some perception that inpatient wards can provide a greater range of expertise and interventions than crisis houses: especially medication (providing information, prescribing and ensuring compliance) but also due to multi-disciplinary team (psychologists, OTs and more). Similarities in care between alternatives and standard services were also emphasised.

*"the input again is based on you know in put from a Care Co-ordinator or perhaps the Crisis Team which is maybe just once a day for half an hour. You compare that to a ward that's staffed by at least two qualified at any one shift, RMNs with the nursing assistants, the Ward Manager, two Ward Sisters, the whole context of being hospital, the Modern Matron, the Consultant Psychiatrist, the SHOs the Occupational Therapy Departm ent, there's an awful lot more services provided here, so I would im agine there's a huge di fference in what happens. People are under continuous assessment, there's st ructured planned care based on an evidence based assessment tool…. You know [the Crisis Team beds] don't have any of those things."*

*(inpatient representative, Crisis Team Beds)*

*"Listen pal" says the [BME non-clinical cr isis house], "you do what you want, we are here to help you make decisions for yourself". Whereas whilst we try to enshrine that in the care of the inpatient philosophy, in the [hospital] we also do "Listen pal, we are here to help you, but if you don't, we are going to carry on giving you Depot until you do" kind of thing."*

*(Referring consultant, BME non-clinical crisis house)*

*"I think that we look at the individual ab ove the diagnosis. We obviously have to follow the medical rule as well if people are prescribed medication then we will*

 

*supervise it being taken here but I think because we do give people the time and space to reflect and talk through their issues and talk through what they feel has put them in crisis and how they feel they can adapt to stop that happening again. It is more of a sort of recovery service user-centred approach."*

*(Alternative Service manager, non-clinical crisis house)*

*"[At the hospital] we've got the pati ent protected time, it gives us the opportunity to be with our patient on a one to one basis and talk with them, and just understand what is happening fo r them and helping them to understand their own experiences. So I think there is a lot that we do in hospital which I am not sure is happening elsewhere. But again it's about the relationship that you develop with the patient, that's very, very important. Because medication is not the, what makes people get better is not only medication but its also the relationship they have with staff. Th at support helps to support them through the difficult periods in their lives. Me dication plays a great role but I think relationship with staff as well also plays an important role."*

*(Inpatient representative, non-clinical crisis house)*

**6. Impact of alternatives**

**a) for patients:** Alternatives were identified as having the following effects:

- Increasing choice and autonomy: patients are self-selecting to an extent and may be given more control/choice during a stay (e.g. choice of what to eat, when to come and go). This may encourage timely help-seeking by patients, promote coping and reduce dependence. There is typically less confrontation/aggression at alternatives: patients may be more willing to respect house rules having agreed to go there and feeling they have made a choice.

*"I think [the non-clinical crisis house], it's a lot more about working together and I suppose making contracts with each othe r, that someone is going to get some use out of their stay there. And I think again that's inherent in their assessment, you know 'why do you want to be in here?' So I suppose people are again invited to articulate what they think they want to get out of the stay. Again that's missing from hospital, obviously the se ctioned patients, but quite often with informal patients as well that's missing. So there's not someone sitting down and saying 'why do you want to be here'. We try and do that because obviously Crisis Team's job is to question people about what they think they would get out of a hospital ward, but quite often you know the people in there don't have an idea of why they are there."*

*(Trust manager, non-clinical crisis house)*

- Reducing trauma: Hospital admission was identified as a big event, potentially very upsetting and frightening. Negative impact can be exacerbated by exposure to other very ill patients. This maybe less the case at alternatives.

- Reducing stigma: Admission to an alternative may have less stigma and fewer negative connotations than a hospital admission. Non-statutory services, especially the non-clinical crisis houses, may not even be obvious as acute mental health services to friends, employer etc.

*"You know to be quite truthful you know , I don't mean, but who wants to be on an inpatient ward. I mean if its your fi rst illness and the first thing you can do is go into an inpatient ward, I think you know definitely, its frightening, its stigmatisation, its not very nice for fam ilies or anything you know, I think its not the place to be"*

*(PCT commissioner, Brief-stay beds)*

- Recovery: a calmer atmosphere and more attention from staff at alternatives was seen as therapeutic; a smaller range of interventions and less guarantee of medication compliance were seen as possible disadvantages. Smaller changes in HoNOS and GAF scores at alternatives were also ascribed to shorter length of stay and a more chronic client group whose symptoms are less amenable to swift change. The possibility that admission to an alternative delays access to necessary inpatient treatment for some patients was identified by one respondent but was not seen as big problem – outweighed by benefits of seeking to treat in least coercive environment.

*"I think the environm ent at the end of it is conducive for Bipolar Disorders, you know. I mean it's a lot calmer environment at the end of it, you know"*

*(Manager, clinical crisis house)*

*"Because in the [hospital], we throw the book at it, we've got much more sophisticated and detailed co nnections to a variety of services, Occupational Therapy, Psychological support, 24 hour qu alified nursing staff on shift working round the clock, highly motivated young Psychiatrists, and Doctors and Nurses and God knows who else coming, pouring in and out 24 hours a day with Ward Rounds too, sometimes three times a week, liaison onto CMHTs etc. etc. etc. Small surprise that coming into hospital by comparison to the [crisis house] leads to a much more intensive bio-psycho-soc ial wash and brush up compared to the punters who come into the [crisis house's] doors"*

*(Inpatient consultant, BME non-clinical crisis house)*

- Adverse events: alternatives identified as less able to cope with high risk clients: the possibility of suicides/harm to others was raised by respondents. This was stated by the trust manager of the brief-stay ward as one reason why they prefer the Brief-stay ward model.

*"Now the advantage of the Crisis House is that its not a psychiatric institution, its not a hospital, its not run by professionals, it's a place of sanctity, a place of sort*

*of um… safety for people with a mental illness. But there are terrible risks involved in all of it as well and the governance arrangements of Crisis Houses, I think will change if and when, or as and when, certain incidents start to take place"*

*(Trust manager, Brief-stay ward)*

Alternatives knowing their limitations stressed as important. 2 suicides at Nile mentioned.

*"I mean the [crisis house] isn't a picnic obviously. But I think the [crisis house] does a commendable job in knowing when to intervene to get people out of there."*

*(Inpatient representative, BME non-clinical crisis house)*

**b) for staff**

- Embedded services help inpatient staff to gain a wider perspective on the whole service system. This may lead to inpatient staff take more interest/responsibility in smooth running of whole service – liaising with community teams, and gatekeeping.

*"nurses can become very tunnel-visioned and it's better to develop people's roles and skills. And it's quite nice for inpatient wards to be aligned with CRHTs [in the Brief-stay ward] because it's, they get the whole picture"*

*(Inpatient representative, Brief-stay ward)*

- Crisis house staff more likely to work with clients out of the unit, e.g. going back home, accessing community services. May help them to get a better sense of client and understand their environment, improving their assessments, making their jobs more interesting and them more interested in their clients.

*"staff in acute areas see the patient at their worst, see them when they are well enough to move somewhere else but don't really see them in their own community at their best. And I think that 's always a tricky scenario for staff to work in. I think that's the negated quite a lot in the Resource Centre"*

*(Trust Manager, clinical crisis house)*

- Crisis house staff may have more autonomy/independence than ward staff: they control admissions to the service, there may be no hierarchies

with doctors. This may increase job satisfaction and their sense of initiative.

*"And I think as well that there's some so rt of, when somebody goes into [the crisis house], the fundamental difference is that the staff on [the crisis house] are more empowered because they actually do the assessment on the client who is coming in, and they make the decision with the client and any other service about whether or not they come in. And again if you are looking at differences, the hospital staff do not do that ….. so they are going to feel less involved, less as though they are using their skills and I think you will find that has a knock on effect."*

*(Trust manager, non-clinical crisis house)*

- Ward staff are exposed to very high levels of distress, threats and actual violence. Crisis house staff are likely to see less of this and may experience less stress and burnout.

**c) Other services**

Alternatives were consistently viewed positively as relieving the pressure on inpatient services and a resource for community services. All negative comments were about wanting them to do more, rather than wanting rid of them. Alternatives were linked to reduction in out of area placements and/or numbers of inpatient beds. The Brief-stay ward in particular was identified by respondents as having solved a problem with out of area placements and making big cost savings for the trust.

**7. Obstacles and facilitating factors**

- Awareness of other services is crucial. The alternative needs to be in the minds of potential referrers. There are particular difficulties achieving this with non-mental health services like GPs, police, A and E. The proliferation of community mental health services also identified as problematic by the BME non-clinical crisis house, which needs to forge links with 10+ community teams. A gatekeeping role by one service like a crisis team to all acute admissions can help mitigate this.

- Swift assessment and admission procedures are crucial. Same day admission and 24 hour acceptance of referrals are not guaranteed in any of the crisis houses. This was identified as one of the major barriers to services functioning as genuine alternatives. Time consuming referral forms and demands for lots of paperwork were also highlighted as disincentives to refer.

*"I feel at times a sort of defensive block, batting away cases at times, which I think is to do with threshold and attitude. But even where it is acceptable at*

*times, I me an some times the re is a de lay of a day, or two or three and the person ends up in hospital because of that."*

*(Referring consultant, non-clinical crisis house)*

- Collaboration with community services is helpful. As well as helping to generate referrals, community services can provide additional care to patients at alternatives, help with aftercare planning, provide advice, support or training to staff at alternatives. Additional interventions from statutory services are particularly used to supplement care by voluntary sector services with unqualified staff: for example, crisis team visiting patients daily to dispense medication, provide medication reviews, clinical assessment and more. The Brief stay ward was also based on close collaboration with crisis team, who visit every morning and do joint assessment of anyone admitted overnight. Crisis teams identified as common and valued partners for alternatives: they are used to providing intensive short-term help out of the office and at short notice.

*"I guess if you've got someone who is being seen by a Crisis Team who have access to a Psychiatrist and a Doctor and a team of social workers and nurses, then you would be able to carry a slight ly higher degree of risk in the Crisis House and slightly more disturbed pati ents because you've actually got the fallback of getting some from the Crisis Team to come and see that person at short notice."*

*(Trust Manager, non-clinical crisis house)*

- Clarity of purpose is perceived as important so referrers, funders and other services know what the service can and can't do and who it's for. Pressures (mainly from statutory services) to extend role beyond the stated aims or sometimes competence of the alternative service are described – e.g. to admit very complex or non-acute patients, to waive time limit of admission for clients with no accommodation, to take overspill from wards without a clear clinical purpose, to cede control over access to beds to statutory services.

*"One of the things that we have had issu es with, teething problem s I guess, is that we weren't always, or the staff weren't quite sure where the boundaries were and then those boundaries could be pushed by the statutory services and then you take on too much or be expect ed to do too much and you then stretch your service too much and too far"*

*(Manager, non-clinical crisis house)*

*"You know, you guys, the [crisis house], like all of us, are sailing through choppy waters in mental illness especially providin g health care in the inner City and its important to keep your eye on that sa me guiding star and sailing a straight course. Try to go and sail off in search of other more spectacular constellations, for example becoming and After Care rehabilitation unit or Step-Down Care, I*

*think is unnecessary, you know to set your barque by that particular light. I think that the [crisis house] should just stick with what its doing otherwise its in danger of being, becoming subsumed as yet another post or pre-discharge storage silo of the people that should be going somewhere else"*

*(Referring consultant, BME non-clinical crisis house)*

- Flexibility also valued by stakeholders from other services however and adaptation of alternatives to changing local needs was described (e.g. re step down care, time-limits, referral procedures). Successful alternatives may combine core integrity of role with flexibility/helpfulness where possible..

*"we may ask, can we have this place in the Nile Centre for a while. Now that won't necessarily mean that that person's in particular crises, but it might be that kind of respite for them. So that's what we've used it for. They have been incredibly flexible with us before, th ings like people that are waiting for accommodation, have nowhere to go, that kind of thing. It's very difficult to think of a specific example, but I think it 's fair to say that they're incredibly flexible with us and they always try to help out, when they can"*

*(Trust manager, BME non-clinical crisis house)*

**8. The Tidal Model Service**

Few of the main themes identified above apply to the Tidal Model ward. It is one of the local main inpatient acute wards, serving the same patient profile with the same referral criteria and pathways as the other local acute wards. Stakeholders identified aims of the Tidal Model as being to provide more contact between nursing staff and patients and understand and take more account of patients' views. The manager and an inpatient consultant both reported that the tidal model was well received by patients and was useful for ensuring important issues were raised in ward rounds. But only when it was implemented properly, which was not consistently by all staff or sustained over time.

*"I mean, the staff make an effort to be compliant with a, with a plan where it was more centred on a client than themselves and that was a good thing. And I personally think that whether or not the Tidal Model should stay or not, something similar…. should be running."*

*(Referring consultant, Tidal Model ward)*

A process of diluting the Tidal Model was described. Paperwork was reduced; language on forms was changed; patients were not allowed to keep their own notes. A number of obstacles to successful implementation were identified:

- The amount of recording and paperwork was too time consuming and demanding
- The service was suffering from initiative overload. Star wards, electronic record keeping, preparing for a CHI inspection were all cited as distracting from implementation of Tidal Model.
- Lack of support or drive from ward or senior management. There were no consequences for staff who did not provide the intervention.
- Lack of engagement of ward staff initially. The Tidal Model was imposed from above as a response to serious incident on the ward and never actively chosen or wanted by the team delivering it.
- The acute ward nursing culture is very reactive and averse to planning a shift in advance or seeking out work/patient contact.
- Some resistance from other services e.g. grumbling about the unfamiliar format of Tidal Model documentation.
- Demoralisation/cynicism among the staff team.

*"Yeah, it is a time consuming kind of process. Because you know it's a busy ward, you have to set time aside, you might not have that in a day. Due to work restraints you might get some of the nurses not doing it as often as they should, kind of putting it on the back burner and doing the m ore kind of, seen as the more kind of nursing activities like me dication, well not just medication but writing up notes or doing this or doing that"*

*(Ward Manager, Tidal Model ward)*

*"There were other nurses that have been qu ite cynical or actually didn't like it at all. Basically it seemed to me throug h cynicism and just seemed 'what's the point to taking to people that are unwell and they're just going to keep com ing back in again' and really having say not a very recovery orientated or a positive view of what was going on. In other wo rds they seem ed to prefer the custodial role that they had, they found it easier and they found it less stressful for them."*

*(Tidal Model Lead, Tidal Model ward)*

Stakeholders describe minimal lasting impact from the Tidal Model and doubts that it was implemented properly. The local champion (Tidal Model Lead Nurse) describes the difficulties of bringing innovation and changing culture and practice on acute wards. He feels the Tidal Model has yet to be properly implemented in the Trust despite several attempts/relaunches at different services over a number of years. Stakeholders suggest local factors, the nature of the Tidal Model and the nature of acute wards generally may contribute to the difficulties of implementation.

## *3.7 The content of care at alternatives and standard services (Module 9)*

28 CaSPAR recordings were made at each service. The status (with staff or not) was identified for 99.0% of patients resident at recording times. 5 days of CaRICE data were collected from each service. Completed forms were obtained from 871/919 staff, a response rate of 94.7%. CCCQ-P and CSQ questionnaires were obtained from 314 patients, a response rate of 70.2%. Missing data from CCCQ-P forms required the exclusion of up to 11 CCCQ-P responses from analyses.

Table 3.7.1 provides descriptive data from CaSPAR, CaRICE and CCCQ-P. Data from 3 community-based alternatives and from their comparison services are aggregated; results from the Tidal Model ward and its comparison service are presented separately. Descriptive data from content of care measures from individual services are provided in Table 3.7.2.

**Table 3.7.1 Content of care measures – descriptive data**

| Domain | Instrument | Community alternatives | Standard services | Tidal Model ward | Tidal Model comparison service |
|---|---|---|---|---|---|
| | | Mean score *(standard deviation)* | | | |
| Total care | CaSPAR *(intensity of contact: 28 recordings per service)* | 12.3% *(20.9)* | 11.8% *(9.4)* | 10.8% *(10.3)* | 8.8% *(8.0)* |
| | CaRICE *(depth of care: 5 days data per service)* | 149.6 *(39.1)* | 135.9 *(23.1)* | 109.6 *(26.2)* | 82.6 *(5.6)* |
| | CCCQ(P) (n=217) *(breadth of care)* | 25.7 *(16.2)* | 30.6 *(15.5)* | 31.9 *(15.3)* | 34.4 *(18.9)* |
| Social interventions | CaRICE | 60.7 *(35.6)* | 43.8 *(17.7)* | 43.3 *(7.0)* | 32.6 *(7.3)* |
| | CCCQ(P) (n = 222) | 7.4 *(6.6)* | 7.9 *(6.4)* | 8.7 *(6.7)* | 7.6 *(7.2)* |
| Psychological interventions | CaRICE | 29.7 *(24.6)* | 19.8 *(5.7)* | 18.4 *(10.5)* | 16.4 *(2.2)* |
| | CCCQ(P) (n = 221) | 5.7 *(6.3)* | 4.7 *(5.8)* | 4.8 *(5.5)* | 6.6 *(6.9)* |
| Physical and pharmacological interventions | CaRICE | 31.9 *(30.0)* | 48.3 *(16.6)* | 28.8 *(15.4)* | 20.4 *(6.4)* |
| | CCCQ(P) (n = 220) | 7.7 *(5.8)* | 12.7 *(5.8)* | 12.5 *(3.9)* | 14.1 *(5.7)* |

**Table 3.7.2 Descriptive data from CaSPAR, CaRICE and CCCQ(P): mean service scores (and rankings)**

| | Total care | | | Social interventions | | Psychological interventions | | Physical/pharmacological ints. | |
|---|---|---|---|---|---|---|---|---|---|
| | CaSPAR | CaRICE | CCCQ-P | CaRICE | CCCQ-P | CaRICE | CCCQ-P | CaRICE | CCCQ-P |
| CRT beds | 4.6% (8) | 160.4 (1) | 29.1 (7) | 24.9 (8) | 6.8 (8) | 36.6 (2) | 6.8 (1) | 64.2 (1) | 3.3 (8) |
| Clinical crisis house | 21.6% (1) | 139.5 (3) | 29.8 (5) | 98.0 (1) | 7.9 (4) | 10.8 (8) | 5.6 (3) | 16.9 (7) | 12.4 (5) |
| Non clinical (BME) crisis house | 8.6% (6) | 133.3 (4) | 20.6 (1) | 59.2 (2) | 7.7 (5) | 41.7 (1) | 4.7 (7) | 14.6 (8) | 3.3 (8) |
| Tidal Model ward | 10.8% (4) | 109.6 (7) | 31.9 (2) | 43.3 (4) | 8.7 (2) | 18.4 (5) | 4.8 (5) | 28.8 (5) | 12.5 (4) |
| Crisis beds comparison | 14.1% (2) | 131.7 (5) | 29.4 (6) | 31.1 (7) | 6.9 (7) | 22.9 (3) | 4.7 (6) | 54.3 (3) | 12.0 (6) |
| Clinical crisis house comparison | 13.5% (3) | 154.5 (2) | 31.8 (3) | 57.0 (3) | 8.8 (1) | 15.6 (7) | 5.2 (4) | 60.4 (2) | 13.1 (2) |
| Non clinical crisis house comparison | 8.0% (7) | 121.7 (6) | 30.6 (4) | 43.2 (5) | 8.0 (3) | 20.9 (4) | 4.3 (8) | 30.3 (4) | 13.0 (3) |
| Tidal model comparison | 8.8% (5) | 82.6 (8) | 34.4 (1) | 32.6 (6) | 7.6 (6) | 16.4 (6) | 6.6 (2) | 20.4 (6) | 14.1 (1) |

Table 3.7.1 shows that scores for the Tidal Model ward were more similar to mean scores for standard inpatient wards than mean scores for community alternatives on total care variables from all three measures and five out of six subscale variables. Results indicate that the intensity of contact and types of care provided at the Tidal Model ward were broadly similar to standard wards.

Table 3.7.2 shows that, despite some divergence of individual service scores across measures, egregious features of services' care provision can be consistently identified. The non-clinical crisis house, which employed no medical or nursing staff, ranks lowest of all services on both CaRICE and CCCQ-P for physical and pharmacological interventions. The crisis team beds score lowest of all services on CaRICE and CCCQ-P for social interventions but highly on both measures for psychological interventions. A lack of emphasis on patients' social problems may be explained by the brief length of stay at the crisis team beds, typically less than one week. The clinical crisis house, which provides a daily structured programme of activities within the residential unit, scored highest on CaSPAR total score and CaRICE and CCCQ-P for the current activity item.

Statistical comparison of CaSPAR and CCCQ-P scores from community alternatives and standard wards is provided in Table 3.8.3, reporting results from regression analyses.

**Table 3.7.3: Comparison of community alternatives and standard services: regression analyses of CaSPAR and CCCQ(P) data**

| Dependent variable | Model | $R^2$ | Regression coefficient* | 95% Confidence Intervals | p |
|---|---|---|---|---|---|
| CaSPAR total score | relationship to service type (community alternatives vs standard services) , adjusting for clustering by service | <0.01 | -0.45 | -12.68, 11.78 | 0.93 |
| | relationship to service type, adjusting for day and time of recording and clustering by service | 0.03 | -0.45 | -12.98, 12.03 | 0.93 |
| CCCQ(P) total score (n = 217) | relationship to service type, adjusting for clustering by service | 0.02 | 4.85 | -2.70, 12.41 | 0.16 |
| | relationship to service type, adjusting for patients' MHA status at admission, age, gender and ethnicity and clustering by service | 0.06 | 3.31 | -2.27, 8.90 | 0.19 |
| CCCQ(P) social interventions subscale score (n = 222) | relationship to service type, adjusting for clustering by service | <0.01 | 0.49 | -1.00, 1.97 | 0.44 |
| | relationship to service type, adjusting for patients' MHA status at admission, age, gender and ethnicity and clustering by service | 0.03 | 0.02 | -2.09, 2.14 | 0.98 |
| CCCQ(P) psychological interventions subscale score (n = 221) | relationship to service type, adjusting for clustering by service | 0.01 | -0.97 | -2.80, 0.85 | 0.23 |
| | relationship to service type, adjusting for patients' MHA status at admission, age, gender and ethnicity and clustering by service | 0.04 | -1.33 | -2.48, -0.18 | **0.03** |
| CCCQ(P) physical and pharmacological interventions subscale score (n = 221) | relationship to service type, adjusting for clustering by service | 0.16 | 5.03 | -1.01, 11.08 | 0.09 |
| | relationship to service type, adjusting for patients' MHA status at admission, age, gender and ethnicity and clustering by service | 0.25 | 4.35 | 0.75, 7.96 | **0.03** |

* negative regression coefficient = higher score at alternatives

Table 3.7.3 shows no significant difference in intensity of staff-patient contact at community alternatives and standard services was identified by CaSPAR or CCCQ-P. Analyses of CCCQ-P subscale data, adjusting for patient characteristics and clustering by service, indicate significantly greater provision of psychological interventions and less provision of physical and pharmacological interventions at community alternatives. No significant difference was found from CCCQ-P data for social interventions. $R^2$ values from analyses indicate that service type has greater power to explain how much physical and pharmacological care patients receive than other types of care or overall intensity of care.

Analyses and estimates of effect size for community alternatives compared to standard services from CaRICE data are presented in Table 3.7.4.

**Table 3.7.4: Comparison of community alternatives and standard services: CaRICE data**

| CaRICE domain | Mean difference: minutes of contact per patient per day<br>*(community alternatives – standard services)* | 95% confidence intervals | t | p | Estimate of effect size<br>*(mean difference / standard deviation)* |
|---|---|---|---|---|---|
| Total care score | 13.7 | -10.6, 38.0 | 1.17 | 0.26 | 0.42 (small) |
| Social care | 17.0 | -4.4, 38.3 | 1.66 | 0.11 | 0.59 (medium) |
| Psychological care | 9.9 | -3.9, 23.7 | 1.52 | 0.15 | 0.54 (medium) |
| Physical and pharmacological care | -16.4 | -34.8, 2.0 | -1.85 | 0.08 | 0.65 (medium) |

Table 3.7.4 shows no significant differences in CaRICE results were found between groups but this may reflect the limited power of CaRICE data. Confidence intervals from t-tests reported in Table 3.7.4 indicate the possibility of clinically important differences in care between alternatives and standard services. Consistent with CCCQ-P results, a medium effect size was found for community alternatives for more psychological care and less physical and pharmacological care. A medium effect size was also found for more social care at alternatives: this indicates the duration of social interventions may be greater at alternatives than standard wards; CCCQ-P data indicated their frequency and range were not. A small effect size was found for community alternatives for CaRICE total care score.

### The impact of care received on patient satisfaction

Results of a model of patient satisfaction using regression analysis including CSQ and CCCQ-P data are presented in Table 3.7.5.

**Table 3.7.5: Relationship of service type, patient characteristics and care to patient satisfaction**

| n = 314 patients from 8 services (3 community-alternatives and 5 standard services)<br>Dependent variable in all analyses = CSQ score | | | | |
|---|---|---|---|---|
| **Model: relationship to patient satisfaction** | **$R^2$** | **Regression coefficient** | **95% confidence intervals** | **p** |
| 1. Service type, adjusting for patient characteristics (Mental Health Act status, gender, age, ethnicity) and clustering by service (n = 314) | 0.13 | | | |
| Service type: standard (reference category = community alternative) | | -1.98 | -3.06, -0.91 | <0.01 |
| 2. Service type, adjusting for CCCQ-P social interventions score, patient characteristics and clustering by service (n = 306) | 0.21 | | | |
| Service type: standard (reference category = community alternative) | | -2.13 | -3.40, -0.85 | 0.01 |
| CCCQ-P social interventions score | | 0.26 | 0.20, 0.32 | <0.01 |
| 3. Service type, adjusting for CCCQ-P psychological interventions score, patient characteristics and clustering by service (n = 306) | 0.23 | | | |
| Service type: standard (reference category = community alternative) | | -2.01 | -3.14, -0.88 | <0.01 |
| CCCQ-P psychological interventions score | | 0.31 | 0.21, 0.40 | <0.01 |
| 4. Service type, adjusting for CCCQ-P physical and pharmacological interventions score, patient characteristics and clustering by service (n = 307) | 0.18 | | | |
| Service type: standard (reference category = community alternative) | | -3.38 | -4.76, -2.00 | <0.01 |

| n = 314 patients from 8 services (3 community-alternatives and 5 standard services)<br>Dependent variable in all analyses = CSQ score | | | | |
|---|---|---|---|---|
| **Model: relationship to patient satisfaction** | **$R^2$** | **Regression coefficient** | **95% confidence intervals** | **p** |
| CCCQ-P physical and pharmacological interventions score | | 0.25 | 0.13, 0.37 | <0.01 |
| 5. Service type, adjusting for CCCQ-P total score, patient characteristics and clustering by service (n = 303) | 0.27 | | | |
| Service type: standard (reference category = community alternative) | | -2.94 | -4.30, -1.58 | <0.01 |
| CCCQ-P total score | | 0.14 | 0.10, 0.18 | <0.01 |

Table 3.7.5 shows all CCCQ-P subscale scores were significantly positively associated with patient satisfaction. $R^2$ values indicate variance in CSQ scores could be explained more by analysis including CCCQ-P total care score than any subscale score. The amount of care received by patients may therefore be more influential to their satisfaction with services than the broad types of care received. Patient satisfaction with community alternatives remained significantly greater than at standard wards after adjustment for all CCCQ-P variables, indicating differences in the amount of care or types of intervention provided may not be primary influences on patients' greater satisfaction with alternatives. $R^2$ values indicate nearly three quarters of the variance in patient satisfaction could not be explained by variables included in this model. The biggest change to the correlation coefficient for service type followed adjustment for CCCQ-P physical and pharmacological interventions: the increase in correlation coefficient following adjustment indicates community alternatives are more acceptable than standard wards despite, not because of, providing less physical and pharmacological care.

## *3.8 Users' satisfaction with alternatives and standard services (Module 10)*

A total of 314/485 eligible service users completed the satisfaction and experience questionnaires (response rate 65.0%). The most common reasons for non-participation (n=171) were leaving the unit before the researcher could approach the service user (96; 19.8% of total eligible); refusal to discuss the study (50; 10.3%), being too unwell (11; 2.3%) and declining to participate after reading the study information (6; 1.2%).

Discussion with ward staff and stakeholders revealed that the tidal Model was not being routinely implemented in the Tidal Model ward for a variety of practical reasons. The univariate satisfaction and experience results also revealed that the Tidal Model ward was more similar to the other traditional units than the other alternative services, including the mean length of stay and number of participants detained under the Mental Health Act (see Table 3.8.1). The results for this Tidal Model ward and its comparison are therefore presented separately in this paper, rather than combining them with true Residential Alternatives.

**Table 3.8.1. Participant characteristics in alternative and traditional units**

| | Alternative Units N=102 | Comparison units N=125 | p | Tidal Model Ward N=40 | Tidal Model Comparison N=47 | p |
|---|---|---|---|---|---|---|
| **Mean Age** years (sd) | 40.2 (12.6) | 38.4 (13.2) | 0.289 | 39.6 (11.7) | 40.4 (13.8) | 0.764 |
| **Gender** | | | | | | |
| Male (%) | 47 (46.1) | 77 (61.6) | 0.019 | 16 (40.0) | 22 (46.8) | 0.523 |
| **Ethnicity** | | | | | | |
| White British | 58 (58.0) | 88 (72.1) | | 20 (51.3) | 33 (87.8) | |
| White Irish | 0 (0) | 1 (0.8) | 0.001 | 0 (0) | 0 (0) | 0.047 |
| White other | 1 (1.0) | 3 (2.5) | | 0 (0) | 2 (5.3) | |
| Black Caribbean | 21 (21.0) | 11 (9.0) | | 5 (12.8) | 1 (2.6) | |
| Black African | 16 (16.0) | 4 (3.3) | | 3 (7.7) | 0 (0) | |
| Black other | 0 (0) | 6 (4.9) | | 1 (2.6) | 0 (0) | |
| Pakistani | 0 (0) | 4 (3.3) | | 5 (12.8) | 0 (0) | |
| Bangladeshi | 0 (0) | 0 (0) | | 1 (2.6) | 0 (0) | |
| Asian other | 0 (0) | 1 (0.8) | | 1 (2.6) | 0 (0) | |
| White Black Caribbean | 2 (2) | 2 (1.6) | | 1 (2.6) | 1 (2.6) | |
| White Black African | 2 (2) | 0 (0) | | 0 (0) | 0 (0) | |
| White Asian | 0 (0) | 0 (0) | | 1 (2.6) | 0 (0) | |
| Chinese | 0 (0) | 1 (0.8) | | 0 (0) | 0 (0) | |
| Other | 0 (0) | 1 (0.8) | | 1 (2.6) | 0 (0) | |
| **Admission status** | | | | | | |
| Involuntary (%) | 5 (4.9) | 46 (36.8) | <0.001 | 21 (53.9) | 6 (13.6) | <0.001 |
| **Numbers in each service** | | | | | | |
| Crisis beds | 41 | 43 | | | | |
| Clinical Crisis house | 20 | 40 | | | | |
| Non-clinical Crisis house | 41 | 42 | | | | |
| Tidal Model Ward | | | | 40 | 47 | |
| **Duration to completion of questionnaire (days)** | 10.7 | 57.3 | 0.027 | 47.6 | 44.8 | 0.854 |

Table 3.8.1 describes the distribution of participants across the different units, including their socio-demographic features and proportions admitted compulsorily. Participants in the residential alternatives were more likely to be female, less likely to define their ethnicity as white and less likely to have been detained involuntarily.

Table 3.8.2 provides descriptive information of mean scores on the main experience outcome measures for individual services.



 

**Table 3.8.2 User experience measures: individual service mean scores**

| | Non-Clinical Alternative 2 (Black focus) | Clinical Crisis House | Crisis Team Beds | Tidal Model Ward | Non-clinical Alternative 2 Comparison | Clinical Crisis House Comparison | Crisis Team Beds Comparison | Tidal Model ward Comparison |
|---|---|---|---|---|---|---|---|---|
| **CSQ total score** | 26.6 | 25.7 | 26.6 | 23.8 | 22.1 | 22.0 | 25.1 | 24.6 |
| **SSS-RES total score** | 125.6 | 125.3 | 126.4 | 117.3 | 106.7 | 116.7 | 120.6 | 119.9 |
| **AES Perception of coercion score** | 0.86 | 1.65 | 1.48 | 3.48 | 2.67 | 2.95 | 2.23 | 2.19 |
| **WAS Involvement** | 3.19 | 2.53 | 2.32 | 2.67 | 2.25 | 2.74 | 2.62 | 2.71 |
| **WAS Support** | 3.08 | 2.93 | 2.21 | 2.12 | 1.68 | 1.95 | 2.13 | 2.05 |
| **WAS Spontaneity** | 2.15 | 2.18 | 1.58 | 1.90 | 1.74 | 1.70 | 1.90 | 2.05 |
| **WAS Autonomy** | 2.54 | 2.49 | 2.33 | 2.09 | 1.97 | 1.94 | 2.33 | 1.88 |

| | Non-Clinical Alternative 2 (Black focus) | Clinical Crisis House | Crisis Team Beds | Tidal Model Ward | Non-clinical Alternative 2 Comparison | Clinical Crisis House Comparison | Crisis Team Beds Comparison | Tidal Model ward Comparison |
|---|---|---|---|---|---|---|---|---|
| **WAS Practical orientation** | 2.71 | 2.06 | 2.18 | 2.05 | 2.00 | 2.12 | 2.40 | 2.30 |
| **WAS Personal problems orientation** | 1.87 | 1.51 | 1.02 | 1.77 | 1.56 | 1.88 | 1.56 | 2.27 |
| **WAS Anger and aggression** | 1.05 | 1.18 | 1.22 | 2.18 | 2.33 | 2.18 | 2.31 | 2.24 |
| **WAS Order and organisation** | 3.51 | 3.42 | 3.07 | 2.83 | 2.47 | 2.93 | 2.84 | 2.89 |
| **WAS Program clarity** | 3.03 | 3.12 | 2.68 | 2.94 | 2.54 | 2.08 | 2.82 | 2.87 |
| **WAS Staff control** | 2.06 | 2.15 | 1.91 | 2.18 | 1.98 | 2.00 | 1.96 | 1.73 |

Table 3.8.2 shows mean satisfaction scores were higher in each of the clinical crisis house, the non-clinical alternative and the crisis team beds, compared with their comparison wards. Their total satisfaction scores were higher on both the CSQ and the SSS-RES. All three alternatives had lower mean coercion scores than their comparison ward on the AES, and on the WAS we found higher mean scores for support and lower mean scores for anger and aggression.

Table 3.8.3 examines the main experience outcomes according to whether the participant was admitted to an alternative or a standard inpatient unit. Results for the Tidal Model Ward and its comparison unit are presented separately.

**Table 3.8.3: Satisfaction and experience outcomes in traditional and alternative units**

| | Alternative mean score N=102 | Comparison mean score N=125 | p | Tidal Model N=40 | Tidal comparison N=47 | p |
|---|---|---|---|---|---|---|
| **Satisfaction:** | | | | | | |
| CSQ score (possible range8-32) | 26.4 | 23.1 | <0.001 | 23.8 | 24.6 | 0.53 |
| Satisfaction: Total SSSRES score (poss. range33-165) | 125.8 | 114.5 | <0.001 | 117.3 | 120.0 | 0.62 |
| Staff Program SSSRES (15-75) | 57.7 | 52.5 | 0.001 | 54.3 | 55.1 | 0.72 |
| Medication and Aftercare SSSRES (poss. range 15-55) | 40.8 | 36.8 | 0.002 | 37.1 | 39.1 | 0.31 |
| Day Night Availability SSSRES (poss. range 3-15) | 11.1 | 10.4 | 0.050 | 11.0 | 11.0 | 0.98 |
| Facilities SSSRES (poss.range 4-20) | 16.5 | 14.6 | <0.001 | 15.0 | 14.8 | 0.72 |
| **Admission Experience** Perception of coercion (poss. range 0-5) | 1.3 | 2.6 | <0.001 | 3.5 | 2.2 | 0.00 |
| Negative Pressures (poss. range 0-6) | 0.65 | 2.5 | <0.001 | 2.6 | 1.8 | 0.09 |
| Voice (poss. range 0-3) | 2.4 | 1.5 | <0.001 | 1.5 | 1.9 | 0.87 |
| **Ward Atmosphere (possible range 0-4 for all WAS scales)** WAS Involvement | 2.7 | 2.5 | 0.255 | 2.7 | 2.7 | 0.85 |

| | Alternative mean score N=102 | Comparison mean score N=125 | p | Tidal Model N=40 | Tidal comparison N=47 | p |
|---|---|---|---|---|---|---|
| WAS Support | 2.7 | 1.9 | <0.001 | 2.1 | 2.1 | 0.81 |
| WAS Spontaneity | 1.9 | 1.8 | 0.354 | 1.9 | 2.1 | 0.49 |
| WAS Autonomy | 2.4 | 2.1 | 0.010 | 2.1 | 1.9 | 0.35 |
| WAS Practical orientation | 2.4 | 2.2 | 0.231 | 2.1 | 2.3 | 0.41 |
| WAS Personal problems orientation | 1.5 | 1.7 | 0.175 | 1.8 | 2.3 | 0.05 |
| WAS Anger & aggression | 1.1 | 2.3 | <0.001 | 2.2 | 2.2 | 0.80 |
| WAS Order &organization | 3.3 | 2.7 | <0.001 | 2.8 | 2.9 | 0.79 |
| WAS Program clarity | 2.9 | 2.5 | 0.021 | 2.9 | 2.9 | 0.77 |
| WAS Staff control | 2.0 | 2.0 | 0.782 | 2.2 | 1.7 | 0.03 |

People admitted to residential alternatives had significantly higher satisfaction scores on both the CSQ and the Total SSS-Res scales. Satisfaction was also significantly higher on each subscale on the SSS-RES. Scores for coercion and negative pressures were significantly lower in alternative units, whilst scores for "voice" were significantly greater in alternatives. The Ward Atmosphere Scale revealed less differences between alternatives and inpatient units. However, levels of anger and aggression were rated as significantly higher on the traditional inpatient units, whilst the alternative units scored significantly more highly for program clarity, autonomy, order and organization and support. The statistical significance of these associations was identical whether parametric or non-parametric univariate analyses were performed on the CSQ, SSS-RES, AES or WAS.

The other variable most strongly associated with total satisfaction on the CSQ was detention under the mental health act ( T test for detained versus not,

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p<0.001) . Gender, age, and duration between completion of the experiences questionnaire were not significantly associated with the total CSQ score.

Table 3.8.4 contains results from the multivariate analyses. For each outcome two models are presented, firstly a model only including type of service (alternative versus traditional) and secondly a model adjusted for age, gender, ethnicity (binary; white versus non-white) and detention under the Mental Health Act. After full adjustment, alternative units were associated with significantly greater levels of satisfaction on the CSQ but the association with greater scores on the total SSS-RES lost significance. Associations between each subscale of the SSS-RES and service type also lost significance (p>0.05) after adjustment and these results are not included in the table. On the AES, residential alternatives were still significantly associated with greater levels of Voice and Autonomy as well as significantly lower levels of coercion and negative pressures (AES). From the Ward Atmosphere Scale, the only subscale which remained significantly associated with type of unit was the anger and aggression scale, with greater levels reported in the traditional units.

**Table 3.8.4 Comparison of satisfaction and experience in traditional and inpatient units. Regression analyses**

| Dependent variable | Model | $R^2$ | Regression Coefficient | 95% Confidence Intervals | p |
|---|---|---|---|---|---|
| Satisfaction. Total CSQ score | Service type (community alternative or standard) | 0.07 | 3.34 | 0.87 – 5.81 | 0.018 |
| | Service type<br>Detention under MHA<br>Age, gender and ethnicity | 0.17 | 2.35 | 0.58 – 4.13 | 0.019 |
| Satisfaction Total SSS-Res score | Service type (community alternative or standard) | 0.05 | 11.4 | 1.14 – 21.6 | 0.036 |
| | Service type<br>Detention under MHA<br>Age, gender and ethnicity | 0.11 | 9.44 | -1.69 – 20.6 | 0.081 |
| Perception of Coercion (AES) | Service type (community alternative or standard) | 0.11 | -1.34 | -2.08 - -0.060 | 0.006 |
| | Service type<br>Detention under MHA<br>Age, gender and ethnicity | 0.27 | -0.77 | -1.45 - -0.08 | 0.035 |
| Negative Pressures (AES) | Service type (community alternative or standard) | 0.19 | -1.84 | -2.82 - -0.85 | 0.005 |
| | Service type<br>Detention under MHA<br>Age, gender and ethnicity | 0.36 | -1.38 | -2.44 - -0.32 | 0.020 |
| Voice (AES) | Service type (community alternative or standard) | 0.14 | 0.91 | 0.43 – 1.39 | 0.004 |
| | Service type<br>Detention under MHA<br>Age, gender and ethnicity | 0.32 | 0.53 | 0.13 – 0.92 | 0.019 |
| Anger and aggression WAS sub-scale | Service type (community alternative or standard) | 0.24 | -1.13 | -1.31 - -0.96 | <0.001 |
| | Service type<br>Detention under MHA<br>Age, gender and ethnicity | 0.28 | -1.18 | -1.35 – -1.01 | <0.001 |

We performed three additional "sensitivity analyses". The statistical significance of each multivariate result in Table 3.8.4 remained stable when ordinal, rather than linear, regression was applied. Similarly, the multivariate results were almost identical after adding geographical area to the model and adding duration of time between admission and completing the questionnaire. This stability included both the amount of variance explained by the models and the statistical level of significance for each association between type of service (alternative versus traditional) and outcomes.

# 4 Discussion

## *4.1 National Survey of Alternatives to standard inpatient admission (Module 1)*

### *Study limitations*

The major methodological limitation is that data were obtained solely from service managers, with no independent check on accuracy. Social desirability effects are especially likely in response to questions about interventions available, severity of patients' needs and service user involvement. Cluster analysis is rarely definitive - other methods might have led to different classifications; however the typology found by the Two-step method led to distinct subgroups which had face value in terms of clinical plausibility and which were robust to changes in variables used to define the clusters.

### *Availability of alternatives*

With regard to the first aim, our findings indicate substantial previously unreported activity in development of alternatives to standard inpatient care. Assuming similar numbers of beds for non-responders to our survey as for responders, we estimate 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 (Department of Health 2006), so that around 10% of acute provision is now in alternatives. Thus these alternatives now represent an important, but so far undocumented, uncoordinated and unevaluated sector of the national mental health economy, largely within the statutory sector.

### *Types of alternative*

A spectrum of alternatives was identified. This ranged from general acute wards that seek to make their content of care more therapeutic through application of a specific model, through hospital services specialising in specific sub-groups and community-based services that retain a substantial resemblance to hospital wards, to more radical community alternatives. New service types with distinctive sets of characteristics, such as short stay community beds that are very closely linked and sometimes directly managed by crisis resolution teams, are emerging in various parts of the country. This is encouraging in terms of service user choice, especially in view of the unpopularity of in-patient care. However, if these new models are to be sustained and disseminated, there is a pressing need for evidence about which groups they are suitable for and whether they are indeed an improvement on standard hospital care. Of the various innovative therapeutic models in use in the study sample, only one (dialectical behaviour therapy), has been subject to a randomised controlled trial. A further caveat regarding the community alternatives is that, even though they probably provide a more

acceptable environment than hospital (Johnson et al 2004), the care they deliver may in some ways be more limited. Few community alternatives offered a distinctive therapeutic model, and psychological treatment and structured activity, as well as conventional hospital interventions such as physical investigations, were less likely to be available than in the hospital services in our sample. Use of community resources outside the units may compensate for some of these gaps and the client groups served may not need a full range of hospital-like interventions, but service planners need to guard against developing community alternatives that provide care that is in certain respects of lesser quality and range than in hospital

### *Clinical populations served*

The third study aim was to describe the clinical population served by the alternatives. Although we cannot compare severity of disturbance and risk between alternatives and standard services, our rough indicators suggest that the alternatives are focusing on groups with severe mental illness, defined by prevalence of psychotic symptoms or by previous history of admission. For the community units, this applies especially to the types of alternatives that are more clinically focused and integrated with statutory services - the clinical and specialist crisis houses. This suggests that the client groups using these alternatives overlap considerably with hospital in-patients and with users of secondary mental health services in general, rather than being a distinct group with lower levels of need and illness severity. The less clinically focused community alternatives - the crisis beds and non-clinical alternatives - reported fewer residents with psychotic diagnoses. This may well be appropriate: acutely ill patients with psychoses may need a range of clinical interventions that resembles that available in hospital, while people with other types of mental health problem, such as depression and personality disorders, may benefit from a markedly different approach. In the community, the major limitation of the alternatives is that they manage mainly voluntary rather than compulsorily detained patients. However, the fact that some such alternatives accept detained patients and the presence even of a small handful of detained patients at the time of the census is of considerable interest, suggesting scope for further development of alternatives which can meet the needs of detained patients. This has potential greatly to increase the range of current in-patients to whom a community alternative could be offered. This would address a current potential ethical concern regarding the provision of alternatives; that they extend choice only to a sub-group of people requiring acute admission, characterised by less severe risks and need for containment.

### *Equity of access*

With regard to our final aim, investigating equity of access, the 2005 Healthcare Commission national census allows comparison with the demographic profile of in-patients nationally (Healthcare Commission 2005). On the census day in this study, 55% of in-patients were male, compared with 40% in our study (44% if

Mother and Baby Units are excluded). There is also evidence that intensive home treatment prevents more female than male admissions (Glover et al 2006), so that a gender inequity may be developing overall in access to alternatives to standard acute admission. With regard to ethnic background, the proportions of residents in the alternatives who were White British (76%) and who belonged to a Black ethnic group (8%) were very similar to those in the national in-patient census (79% and 9% respectively). Caution needs to be exercised in interpreting this as adjustment is not made for the local ethnic mix, but it provides a preliminary indication that the full range of groups represented in in-patient settings are also served by the alternatives. The uneven geographical distribution of alternatives between regions is potentially inequitable and probably reflects their origins in local interest and pressures rather than central policy and planning. A more encouraging finding is their tendency to develop in deprived areas, where demand for in-patient care is likely to be greater (Harrison et al 1995), suggesting that they may be a response to high levels of local need.

***Summary***

In summary, alternatives to in-patient care have been proliferating in some regions of England, probably in response to local pressures and dissatisfaction with standard in-patient care. There is evidence that they serve clinical populations that bear some similarities to current in-patient populations, although men are under-represented and most community alternatives principally serve voluntary patients. Given the substantial investment in them, these alternatives remain remarkably under-investigated. Evaluative research is thus urgently needed to explore whether, as intended, they resolve some of the known problems in acute care system internationally.

## *4.2 Characteristics of users of alternatives and standard services (Module 2)*

**Main findings: the role of alternatives within catchment area mental health systems**

Our study suggest that residential alternatives to acute wards are well integrated into local service networks and serve people with substantial needs and histories of mental health service use. Rather than engaging new populations with less severe mental health problems as critics have sometimes suggested, the alternatives serve populations whose resemblances to those on acute wards substantially outweigh their differences. Indeed they are more likely than people on standard acute wards to be already on mental health service caseloads. This may reflect greater confidence in managing in community residential settings service users who are a known quantity in terms of treatment response and risks.

Despite similarities on many parameters, there are indications of differences in degree of difficulties and disturbance in certain areas. Quantitative data regarding referral pathways suggested that alternative service users were more likely to be help seekers who cooperate with care. This was supported by a clear consensus emerging from the stakeholder interviews that the alternatives place limitations, seen as for the most part appropriate, on the role they serve and the level of disturbance they attempt to manage. Bowers et al. (2009) have discussed the main roles of inpatient care: of these, the alternatives resemble acute wards in that they provide 'presence' (continuous on the spot availability of staff), 'treatment and management', and containment in certain senses. However, they do not to the same degree provide 'legitimate authority and power' and certain aspects of containment, in particular intrusion and regulation. This difference in role may be seen as explaining the lesser role of the alternatives with groups where these roles are very salient: the limited use of the Mental Health Act in the alternatives is of course one important facet of this difference in role.

Corresponding differences in service user characteristics also emerge indicating overlapping rather than identical populations. Risk of self harm and impairment of social functioning are very similar in standard and alternative settings, but risk and history of violence are uncommon in the alternatives, and behaviour problems are less prevalent. As well as characterising acute ward roles, Bowers et al. (2009) have described the admission problems managed by wards. The range of these managed by the alternatives is broadly similar, but with limitations to the degree to which alternatives manage risk, treatment refusal and (possibly) social disagreeableness.

**Methodological issues**

The strengths of this study are in its naturalistic nature, reporting on a sample very closely resembling a routine clinical cohort, and in the triangulation of different methods for investigating the role of alternatives: findings could be combined to form a coherent picture. Most of the limited previous literature on residential alternatives reports only on a single service: a strength of the current study is its multisite nature, although this also introduces considerable heterogeneity among alternatives. Limitations included the use of data recorded by clinical staff and of simple, global measures to distinguish between service

user populations. Important differences may not have been captured: in particular, our study did not include a measure of the 'acuteness' of the crisis, so that we were unable to differentiate clearly between longstanding clinical and social difficulties and risks and those of recent onset. Most significantly, our methods do not yield direct answer to the question "How many service users would have gone to hospital if they had not been admitted to the alternative": it is difficult to envisage a method that would directly address this.

**Implications of findings**

Our findings suggest that residential alternatives are functioning parts of local secondary mental health services, accepting people whose needs are long-term and severe and in general valued by local stakeholders as a useful part of the system (Section 3.6). Thus far the study provides some support for such alternatives. The extent to which they divert people from acute admission cannot be directly gauged from the current study: most were too long established and part of too complex a local service network for it to be possible to gauge directly how far their introduction had resulted in reductions in acute bed use, and the far from fixed nature of thresholds for acute admission impedes judgements about who would have been admitted in the absence of alternatives. The wide variations among the standard services in service user characteristics supports the idea that admission thresholds vary widely even among standard catchment area acute wards, and that service availability is likely to be an important determinant of these (Bowers et al. 2009).

## *4.3 Users' experiences of alternative services (Module 3)*

The development of alternatives to hospital has been seen as a potential approach to the improvement of mental health services both in the United States of America and a number of European countries (Johnson et al. 2007). From offering non-clinical settings, non-clinical staff, shorter admissions and specific models of care, each has sought an improvement in patient experiences and outcomes. The research undertaken here identifies that while the majority of patients prefer such environments, the difference in preferences is more complex and lies both in what is done and where, as well as in how it is done.

Many of the differences between hospital-based services and non-hospital alternatives in terms of what is done may be accounted for by the differences in patients admitted to both types of services. The advent of developments in the provision of community care in the UK has seen hospital inpatient populations growing increasingly acute (Keown et al., 2008) and the strength of the links made here between sharing space with disturbed patients and levels of safety highlight its very real impact on patients. Hospital environments may further exasperate patients' sense of insecurity and create environments of fear and aggression in such circumstances through decreased levels of freedom, characterised both here and in other studies by wards routinely locking their doors (Bowers et al., 2009) and a lack of outside space, and through the use of coercive measures such as control and restraint. Ironically the latter used to contain situations can also create a sense of fear and distrust in both the subject of the action but also in those witnessing. In employing the selective admission of people with chronic mental health problems in crisis with a low risk profile services are able to offer greater levels of safety and freedom while promoting a therapeutic space for recovery. The recommendation that highly-disturbed patients be treated separately from those with less problems has been indicated in the UK (Commission of Healthcare Audit and Inspection, 2008) and services that address this have been long overdue.

The development of inpatient care primarily within the National Health Service (NHS) has sought both to develop specialist services but also to draw on the supporting structures of other health professions and specialities encompassed within its' structures. Yet service users identify that while non-hospital services themselves may not be able to offer such diversity of services, they have been proactive in seeking this input through liaison and partnership with other agencies including the NHS itself. Activities and treatments on offer were seen to differ little between both types of services. In particular alternative services were instrumental in maintaining links with community treatment agencies such as assertive outreach and crisis intervention teams during admissions for the provision of medical intervention but which consequently made for satisfactory discharge planning and transfer of care between agencies in several instances. Such continuity of care was highly valued by service users. The relative clinical inexperience of staff in non-hospital alternatives may have further benefitted

patients with reports of superior physical health in non-hospital based alternatives. The impact of stigma and a lack of wider medical training on psychiatric wards may account for the perceived delays in obtaining treatment for patients with physical health complaints admitted onto psychiatric wards.

One fundamental difference that could be readily observed between the different types of services was their environments. Much has been made of the environment in which patients are treated (Karlin and Zeiss, 2006). Many changes have had a positive impact on patient care such as the removal of ligature points. However patients in this study demonstrate that there are diverse opinions and preferences for different types of services. Modern state of the art hospitals were valued equally with older buildings and those situated in converted buildings within the community. Beyond this environments which fostered positive interaction while maintaining people's need for privacy and space were optimal.

Defining what is done in providing care to people admitted for acute mental health problems is one facet of treatment, the other is understanding how it is done. How an aspect of care is provided can impact on whether it is experienced positively or negatively by a patient. Relationships are an inherent influence in life and can be seen to be essential in understanding the how of providing care. Research has demonstrated that relationships experienced when admitted to hospital are the most important factor in defining the inpatient experience (Gilburt et al., 2008). The majority of themes in this paper were expressed within the context of a relationship. The culturing of relationships on the ward and maintenance of those off the ward play an important role, yet the relationships between staff and patients in inpatient services remains key (Walsh and Boyle, 2009). Gross abuses of trust in terms of sexual and physical abuse were rare but on day to day interactions both positive and negative relationships were described in each type of service and there were no defining differences in the quality of the relationships experienced between services. Positive relationships were most often defined in terms of effective communications identifying itself in terms of caring, compassionate and helpful staff.

Communication and communication style had further consequences in the provision of care. While actual coercion such as forcible medication may serve a useful purpose in some circumstances benefitting the safety of both staff and a majority of patients on a ward, soft coercion such as threats and perceived force were more widely used but described as equally pervasive yet were often counterproductive. More common in hospital-based services, it may be a further consequence of working with an acute patient group. However it was also present within alternative services and may indicate a lack of effective communication skills in working with patients.

In maintaining the safety, and effecting recovery often by maintaining a consideration of the best interests of the patient, staff take on not only a caring role but often a custodial role. As such staff can often be perceived paternalistically. Patients identify positive and negative impacts of paternalistic communication styles: when used effectively in a supportive role, these were experienced positively; when used to restrict and punish patients, they were uniformly experienced negatively. In the move towards deinstitutionalisation service users value paternalistic input moving them closer towards recovery yet those that enforce rules characteristic of old institutions are counterproductive.

With poor experiences and outcomes obtained in psychiatric hospitals, alternative services for the black and ethnic minority population present a new and innovative way of providing acute mental health care. Such services have taken due consideration of cultural needs and the problems experienced by these communities. Our indications are that such considerations are welcome but that the problems of working with marginalised communities may lie not singularly in providing culturally specific services but in working with staff to enhance cultural understanding and further consideration of patient-centred care provision.

### Methodological issues

The study had some methodological limitations. Most importantly patients were interviewed while residing at alternative services. Their preferences and experiences may have been impacted upon by their current perceived need or lack of need for care from the services in which they were admitted. Furthermore, patients' retrospective recollection of their experiences of traditional hospital services may also be party to a number of further influences. However, patients' experiences in the alternative service in which the tidal model was previously implemented were similar to those in thematic content to those of traditional hospital services suggesting that the influence of time on recollection of experiences was minimal. While the sample represented is large, it is unlikely to be representative. Only patients who were prepared to participate in research and conduct an interview with a researcher were included. Moreover the study was conducted with a small number of alternatives services and patients in alternative services elsewhere may have had different experiences. The study placed users' views and testimonies at the centre of the methodological approach. In the vast majority of cases, the researchers believed the participants' accounts to be accurate and pertinent. Mental health care workers may have expressed different views and stated good reasons for the similarities and differences in care that was identified by patients, but their views were not assessed in this study.

### Implications of the study

In targeting a population who require episodes of care over their life but present a low risk during these periods providing care in an alternative setting, optimising freedom, safety and patient interaction and reduced levels of coercion results in

positive outcomes in terms of patient experience and satisfaction. Services with increased links into the community offering a level of continuity and improved patient experiences may instigate early help seeking and early discharge lessening the burden on current hospital acute care provision. Furthermore in enhancing links with the community and social inclusion through giving patients greater levels of freedom and reducing unhelpful paternalism, potential institutionalisation is prevented.

However the implications of this research go beyond the values of alternative services. Hospital-based provision remains the mainstay of acute inpatient provision and arguably an essential component of an effective care system for a small number of people with acute mental illness. Driven by evidence based medicine and on what should be done research such as this highlights that we should increasingly turn our attention in the direction of how it is done. Research in this area is currently woefully lacking and should be directed at enhancing therapeutic relationships, effective communication and supporting staff in providing care while maintaining a safe and therapeutic environment. Measures of patient satisfaction provide vital evidence of the widescale impact of care and innovations yet say little about the value placed on individual factors by patients. Consideration should be given to mixed methods studies which remain an important and arguably vital tool in the development of effective, acceptable and patient-centred care in health settings.



 

## 4.4 Carers' experiences of alternative services (Module 4)

There are two main limitations of this study of carers' experiences. First, difficulties with recruitment meant the sample of carers interviewed is smaller than originally planned. A minority of carers were recruited via local carer organisations rather than directly from service users. The carers in this study may not be wholly representative of carers from alternative services. Second, carers' experience of standard hospital wards was not always recent: their perception of care on standard acute wards may not wholly reflect current reality.

In this study, carers frequently expressed despondency and dissatisfaction with services. This reflects previous reports of carers' experience. Carers have high levels of mental and physical health needs (Rethink 2003). They frequently do not get the services they need to support them (Department of Health 1999) and are not consulted about care plans for service users (Social Services Inspectorate 1998). A UK survey of over 1,000 carers (Rethink 2003) concluded that involvement from mental health professionals can help. Carers who perceived themselves as having enough information and feeling involved and valued by staff reported fewer mental health problems and reduced stress.

Much of what carers said they want is basic: staff who are accessible and return phone calls, information about treatment and care plans, somewhere private to see their relative/partner when they visit, flexibility over visiting times. Carers' markedly positive experience of the clinical crisis house indicates it is possible to meet these needs in acute inpatient services. The generally more positive appraisal by carers of alternatives compared to standard wards is an important favourable finding for alternatives. The more collaborative and holistic nature of care reported by some stakeholders (Section 3.7) and service users (Section 3.3) may influence carers' experience too.

Two themes identified as important in qualitative interviews with service users (Section 3.3) are reinforced by the carer interviews. First, the key importance of relationships with staff was emphasised by carers. The quality of relationship between carer and the staff team impacted on other themes identified in the interviews, such as how treatment or service environment were appraised. Important elements affecting staff-patient relationships include, basic warmth and courtesy of staff, involvement of carers in information gathering and treatment planning and continuity of care –the availability of one or more consistent staff contacts for carers. Service evaluation involving measuring therapeutic alliance between carers and service staff and more focused exploration of factors impeding and enhancing good relationships are promising areas for future research.

Second, he impact of other patients was considerable: carers feared their relative might experience intimidation or violence from disturbed or aggressive patients. An advantage of alternatives appears to be that they offer less exposure to these threats to patients' safety.

The importance of the living environment was emphasised more by carers than service users. All inpatient services should aim to be clean, comfortable and accessible for physically disabled patients.

## *4.5 Users short and medium term outcomes and costs at alternatives and standard services (Modules 5 and 6)*

### Short term

Outcomes consistently improved in a series of admission cohorts admitted to both standard in-patient wards and residential alternatives to in-patient services. The improvement was larger for the cohorts admitted to standard services, especially for HoNOS and TAG. Admissions to alternative services were in general shorter, and therefore cheaper. In other words, both costs and outcome are driven by length of admission. Standard services have a greater probability of being the more cost-effective option at levels of willingness to pay of around £3000 per unit improvement in HoNOS and above.

These results can be understood at the patient and the service level.

### Patient level implications

In relation to patient care, outcomes improved in both classes of service. The improvement was larger in the standard services, and equivalent to reductions from admission (mean 14.3) to discharge (mean 7.2) in the largest HoNOS outcomes database (n=101,820), generated through routine outcome collection in Australia (Australian Mental Health Outcomes and Classification Network 2005).

There are at least three possible reasons for the greater improvement in HoNOS ratings for standard admissions. First, standard services may be more effective than alternative services in addressing the domains of health and social functioning specifically assessed with HoNOS. However, the difference after adjustment was of only marginal clinical importance: 2.0 points on HoNOS and 1.4 points on TAG.

Second, the admission HoNOS score for alternatives was either equal to (Non-clinical alternative 1 only) or lower than the comparison standard service. A similar pattern was evident for TAG (though less so for GAF). A proportionally similar improvement in outcome across both classes of service would therefore lead to a greater absolute improvement in standard services, and exactly this pattern of proportional rather than absolute change has been found in previous studies of HoNOS change in different sub-populations (Trauer et al. 2006).

Finally, the length of stay was longer at standard (mean 38.2 days) than at alternatives (mean 17.6 days). There was a complex relationship between length of stay and outcome improvement across the 4 outcomes and 12 services, but no consistent relationship between length of stay and outcome at the patient level, despite this finding at the aggregate level. Therefore length of stay was not included as a confounder. This leaves open the possibility that the higher improvement in HoNOS is partly or wholly attributable for some patients to the longer length of stay associated with admission to a standard service. Our data cannot directly address this possibility, but the pattern for some patients in alternative services of very short lengths of stay and relatively poor outcomes raises questions about whether: (i) they are discharged prematurely (and longer stays would lead to improved outcome); or (ii) they are rapidly assessed as unsuitable for the service and discharged.

### Service level implications

At the service level, the shorter length of stay in alternatives means that (assuming 100% bed occupancy) they can offer 2.2 times the admissions per bed possible from a standard service. Although it is tempting to link throughput data with the number of HoNOS improvers to arrive at an overall cost effectiveness measure for each class of service, this is not appropriate for two reasons.

First, the study was an observational design, and the choice of where to admit an individual was not random. People admitted to alternatives or standard services differed (section 3.2), and so the two classes of service are working with different, although overlapping, groups.

Finally, it is not possible to know whether standard services would achieve the same gains in outcome using shorter admissions and hence more efficient use of beds. One approach evaluated in Scotland was to close a ward and use the resulting resources to fund a marginal increase in beds available on other wards and increased staff in community services (Melvin et al. 2005). No difference was found in post-closure rates of admission, bed occupancy, number of incidents, number of days the ward doors were locked, observation levels, sickness levels, and number of temporary staff used.

### Medium term

Index admissions to alternative services were on average shorter and thus cheaper than index admissions to standard services. The use and cost of subsequent admissions and other hospital and community mental health services differed little between the two groups, resulting in significantly lower 12-month total costs for patients in the alternative services. These findings suggest that shorter lengths of stay in alternative services are not associated with a greater need for subsequent admissions or for support from other hospital or community mental health services.

The overall service use and cost results mask substantial variation between the services, with non-clinical alternatives and crisis team beds being associated with the lowest lengths of stay and costs, whilst the clinical crisis house was found to be one of the most expensive services. This suggests a trend for clinical services, irrespective of type, to involve longer lengths of stay and greater costs than non-clinical services, with even the short-stay psychiatric ward involving much greater lengths of stay and costs than the cheaper non-clinical alternative services. However, there is also evidence to suggest that participants admitted to clinical alternatives differed very little from their comparison standard service, in contrast to participants admitted to non-clinical alternatives who were significantly more likely to be known to services, to be self-referred and to co-operate with assessment and were significantly less likely to have psychotic symptoms, to be admitted via accident and emergency or the police and criminal justice system, to have behaviour problems and to be perceived as at risk of harm to others. Thus the shorter lengths of stay and lower costs observed in the non-clinical alternatives may be explained to a large extent by the fact that they appear to be admitting a less severe group of patients.

Analysis of factors associated with follow-up costs suggest that those patients not initiating help-seeking, those at risk of harm to others, those with admissions in the recent past and those who are older are likely to be high cost service users and require relatively long admissions on average. Being at risk of harm to others and not initiating help-seeking were found to be significantly associated with admission to a standard service, which is in turn associated with longer lengths of stay and thus higher costs. In contrast, those participants who were previously known to services were found to be significantly associated with admission to an alternative service, which in turn is associated with lower costs on average. In the current analysis, however, this group were in fact found to be more expensive than those not previously known to services. Exploration of the data suggests this is due to longer lengths of index admission on average (mean 32 days known to services, 18 days not known to services).

### Limitations and future research

Alternative services now comprise 10% of the overall in-patient provision (Johnson et al. 2009), but this growth has been unevaluated and unco-ordinated. Our observational study demonstrates that, in relation to short-term clinical outcomes, clinical improvement occurs in both classes of service. Without more experimental designs, it is not possible to make definitive statements about relative and absolute cost-effectiveness. For example, randomisation of the sub-group of patients who are served by both classes of service to either an alternative or standard admission would allow comparative effectiveness to be established. Barriers to a randomised controlled trial include lack of fidelity scales for the identified types of alternative services and for what constitutes a 'standard' in-patient service, lack of consensus in relation to evaluation

strategies, and the likely requirement for substantial resourcing to both run and evaluate several services, which in turn raises questions about generalisability.

A more feasible short-term research strategy would be to identify and amplify the active and positive ingredients of in-patient services. There is no consensus on the ideal in-patient service model, and there is great variation in even the most basic service planning decisions. For example, the most recent survey of in-patient care in England identified that the numbers of beds per ward ranged from 5 to 32 (Royal College of Psychiatrists and Healthcare Commission 2008). A complex relationship between service type and content of care provided was also found in this study (Section 3.7), a finding replicated in relation to service type and satisfaction (Section 3.9) and the experience of services (Section 3.3). Experimental intervention to systematically vary potential active ingredients of care will allow the development of testable models, which can then be investigated using established methodologies for evaluating complex interventions (Campbell et al. 2007). It is plausible that the concept of an alternative service may prove to be a proxy measure for a constellation of features, such as more patient choice and control, less coercion, more motivated staff, less staff-patient social distance, and specific types of intervention. A more detailed understanding of these components and their effectiveness may over time lead to the abandonment of the binary alternative versus standard service distinction, in favour of a more sophisticated understanding of the impact of each feature for individual patients (Pawson and Tilley 1997).

A specific research question relates to the impact of different lengths of stay. Keeping lengths of stay equal in the two classes of service would allow a direct comparison of effectiveness, but for some services (*e.g.* Short stay ward) this would not be possible. A repeated measures design would allow investigation of the extent to which outcomes improve continually during an admission, or whether there is a plateau after a certain length of time. This would inform guidelines about the ideal length of admission.

A final research strategy involves more systematic exploration of trade-offs between different desirable dimensions of evaluation. Service provision is not all about outcome. For example, it is known that rates of detention are higher for people from Black and Minority Ethnic (BME) communities: 38% compared with 19% among people from non-BME communities (Healthcare Commission 2007). The rationale for the BME-focused service investigated in our study was not to generate improved outcome but to offer a more culturally sensitive experience of admission. The relative weighting placed on accessibility, satisfaction, effectiveness, cost-effectiveness and efficiency is a sociopolitical not a clinical decision. The contribution research can make is to inform the debate, and identify the implications of different weightings.

Avoiding the need for hospitalisation is desirable, and crisis resolution teams which provide intensive support leading to reduced admission rates (Johnson et

al. 2005) are now widespread in England (Glover et al. 2006). Where admission is necessary, we found that people are likely to improve in relation to short-term clinical outcomes whether admitted to an alternative or a standard service. It is known that the experience of admission is central. Satisfaction associated with an involuntary admission predicts one-year involuntary readmission rates (Priebe et al. 2009), yet in 2008 the Mental Health Act Commission found that standard wards "*appear to be tougher and scarier places than we saw a decade ago*" (Mental Health Act Commission 2008). Recent calls from professionals (Royal College of Psychiatrists 2008) and consumers (Slade 2009) and emerging policy guidance (Care Services Improvement Partnership 2008) have all emphasised the need for more focus within inpatient services on "*putting a greater focus on the individual and care that is personalised*" (Healthcare Commission 2007). Our empirical finding that there is no substantial difference in short-term staff-rated outcomes provides a further argument for ensuring that the service user's preferences and experiences should strongly inform clinical decision-making.

An important limitation of the medium-term analyses presented is the lack of an assessment of patient outcomes at the 12-month follow-up point. It was not feasible within the study to re-interview participants at this point, so we instead relied on data available from patient activity systems. This had two important implications. First, the cost perspective was necessarily narrow, excluding hospital services for reasons other than mental health, primary health care services, social services, criminal justice system costs and productivity losses as a result of time off work due to illness. However, previous research suggests that hospital and community mental health services contribute the greatest proportion of the total costs of caring for people with severe mental health problems (Byford et al, 2009; McCrone et al, 2009), so a broader perspective is unlikely to have a substantial impact on the reported results.

Second, the lack of outcome results meant it was not possible to undertake a full economic evaluation to explore the relative cost-effectiveness of alternative compared to standard services. A limited cost-effectiveness analysis was undertaken at the point of discharge from the initial admitting alternative and standard services, which suggested a trade-off between the two service types, with standard services demonstrating better staff-rated clinical outcomes but for greater cost, as a result of longer lengths of stay. However, it is possible that greater improvement in outcome for the standard services was partly or wholly due for some patients to the longer length of stay associated with admission to a standard service, so these short-term findings are inconclusive. Using readmissions as a proxy for outcome over the medium-term suggests that whilst the cost advantage of the alternative services remains, the outcome-advantage for standard services is diminished.

## *4.6 The role of alternatives, their development and models: manager and stakeholder interviews (Modules 7 and 8)*

Manager and stakeholder interviews provide some evidence for the success of community alternatives, in that it's clear that these services are a functioning part of local networks, accepting people with severe mental health needs, generally valued by stakeholders. Most participants did not see alternatives' role as identical to the local standard acute wards, but felt that they took pressure off these wards in a variety of ways, including admission diversion for some service users, and early discharge or pre-empting an imminent crisis for others. Each alternative appeared to be valued in this role by local stakeholders; if they took issue with the current role of the alternatives, this tended to be because they wanted them to do more rather than because they felt they were not performing a significant function at present.

More explicit definitions of roles and purposes of admission to alternatives would be useful: there is some consensus in each area on what role these alternatives have within a system, but it doesn't often seem to be very clearly articulated in local service policies or a clear element in coherent and explicit acute care pathways. Many of the issues about the role and usefulness of alternatives discussed by stakeholders reflect wider debates in health services provision: the balance for alternatives and general acute care provision is uncertain, for instance between: small locally responsive services versus large, well resourced services; expert-led versus user-led services; targeted, niche services versus general services.

A tendency for alternatives to be established but not sustained in acute care systems has been identified (Lloyd-Evans et al. in press). This study includes three alternative services which have run for more than a decade (Clinical crisis house, non-clinical alternatives 1 and 2). Interviews with service managers and stakeholders suggest a key to survival for alternatives is to retain a core sense of purpose while exhibiting some flexibility to meeting changing local needs, such as establishing relationships with new services like home treatment teams, responding to local inpatient bed pressures.

Administrative/organisational requirements sometimes set up unnecessary barriers to managing acute admissions at the alternatives, for example where admission procedures prevent same day admissions in crises. It seems desirable for these to be reviewed and addressed in order to make the alternatives accessible to as wide a range of suitable service users as possible.

Stakeholders across a range of alternative service models report high levels of integration with local crisis home treatment teams. Formal arrangements by which integration may be achieved identified by stakeholders include home treatment teams providing regular sessional input at alternatives, gatekeeping beds or managing the residential service directly. Models of collaboration between alternatives and home treatment teams and potential benefits of such

partnerships have been identified (Lloyd-Evans et al. 2008). As well as providing continuity for patients between inpatient and outpatient care, such collaboration can help clarify referral criteria and processes and provide access to formal and informal supervision and training for alternative service staff. Community residential alternatives are not necessarily an alternative to home treatment but can be a tool available to home treatment teams in achieving the goal of averting hospital admission.

The perception of many stakeholders that alternatives may offer a less paternalistic style of care than standard wards, offering greater empowerment and autonomy to service users is consistent with the qualitative interviews conducted for this study (Section 3.3) with current users of alternative services who had also experienced standard inpatient care. The greater emphasis from stakeholders and managers in differences in style of care than in the content of interventions is also consistent with service user report (Section 3.3) and the limited differences found in quantitative content of care measurement (Section 3.6). The nature and style of interventions at alternatives may be a key factor influencing patients' experience and satisfaction with alternatives.

A limitation of this investigation of stakeholder perspectives is the fact that stakeholders are defined exclusively as involved mental health professionals. The views of service users and carers have been explored elsewhere in this study. However, the provision of care in alternatives or standard services may also impact on other sections of society such as family and friends without a direct caring role, the local community or the police. The views of potential non-health service stakeholders like these were not investigated in this study: our understanding of stakeholder perspectives regarding alternatives is therefore not complete.

## *4.7 The content of care at alternatives and standard services (Module 9)*

Multi-method quantitative assessment found no significant difference in the intensity of staff-patient contact at alternatives and standard services. There was greater provision of psychological care at community alternatives and of physical and pharmacological care at standard wards. No evidence was found that care at the Tidal Model ward differed from standard inpatient care. There was preliminary evidence of differences in care provision between different types of community alternatives. All broad types of care were positively experienced by patients. Amount of direct care received may be more important than types of intervention in explaining patient satisfaction; neither has a substantial role in explaining greater patient satisfaction at community alternatives than at acute wards.

### Limitations

This study has three main limitations. First, only a small number of patient characteristics could be adjusted for in comparisons of alternatives and standard services. This limits understanding of how far differences in care reflect different needs and presentation of the patients admitted or represent intrinsic differences in what services provide. Second, the study involves only one exemplar of each type of alternative. Evidence about care provision at different alternative service types is therefore preliminary. Third, limited depth of information is available about care at services. While CaRICE and CCCQ-P measure 21 types of care, information about delivery of specific interventions, or the style or quality of care, is not provided.

The multi-method approach is a strength of the study. Triangulation of data from different measurement methods, information sources and variables describing service content can identify salient differences between services and service types. Qualitative data from patients (Section 3.3), carers (Section 3.4) and stakeholders (Section 3.6) can indicate potentially important aspects of service provision not captured by quantitative investigation.

### Clinical implications

It is not clear that differences in care between community alternatives and standard services are of great clinical importance. CCCQ-P data showed significantly greater provision of (broadly defined) psychological interventions at alternatives; however CaRICE data indicated this amounts to less than 10 minutes more per patient per day. CCCQ-P item scores indicate that at all services except the non-clinical crisis house, patients typically received core medical interventions such as medication prescription and provision. Some reduction in pharmacological interventions or safety measures such as observations may be appropriate for the client group at alternatives, who are less likely to be detained and more likely to be known to services (Section 3.2), with a probable existing treatment plan. Stakeholders identified that shortfalls in

pharmacological interventions at alternatives compared to acute wards may be mitigated by close collaboration with community services such as Crisis Teams. A conclusion that there is much similarity in care provision between alternatives and standard wards is supported by stakeholder interviews and the lack of differences in service interventions identified by patients in qualitative interviews (Section 3.3). Service planners and referrers should not conclude that alternatives offer fundamentally different care to standard wards. They may conclude that alternatives can form part of mainstream acute care provision.

The model of satisfaction presented in this paper does not support wholesale change in the types of care provided by acute residential services, nor a highly critical appraisal of care provision on standard acute wards. All broad types of care were positively received by patients. Reduced provision of medical-type interventions at alternatives was not found to be related to their greater acceptability to patients. This study suggests a focus on increasing the amount of contact and care provided to patients should be a priority for clinicians and managers, above changing the types of interventions available.

Neither the Tidal Model nor community crisis houses were found to address an expressed concern of patients (Baker 2000, Rose 2001, Sainsbury Centre for Mental Health 2006) and expectation of stakeholders, to increase the amount of staff contact available to patients. Interventions with a more specific focus and mechanism for increasing staff-patient contact may be required. Protected Engagement Time (CSIP 2005) - where for set periods of time staff are relieved of administrative duties, the ward is closed to visitors and the office closed to staff - is one, as yet unevaluated, example of an attempt to achieve this. The daily activity programme at the clinical crisis house contributed to its high item scores for current activity and top-ranking CaSPAR score for proportion of patients with staff. Service managers should consider greater use of structured groups and recreational activities at services as a means to increase staff-patient contact.

### Research implications

Nearly three quarters of variance in patient satisfaction was unexplained by the model presented in this paper. Stakeholders indicated that the nature of care may be important at alternatives: more individual, consensual and informal than at acute wards (Section 3.6). Carer and user qualitative interviews (Section 3.3 and 3.4) indicate relationships with staff may be more collaborative in alternatives compared to standard services. Quantitative and qualitative data from service users (Sections 3.3 and 3.8) suggest admission and stays at alternatives may be experienced as less coercive. Service evaluation focusing on the nature of staff-patient relationships or therapeutic alliance at alternatives and standard wards may identify differences in care not measured by this investigation of the care provided.

The lack of impact of the Tidal Model found in this study may be due to its inadequate implementation. Stakeholders from the Tidal Model ward recounted the difficulties in implementing innovation and changing culture on acute wards. A previous launch of the model within the trust had also been discontinued. Evaluations of the Tidal Model (Gordon et al. 2005, Stevenson et al. 2002, Berger et al. 2006, Lafferty and Davidson 2006) have typically been of newly-implemented services, small-scale and over short periods. Research to define and measure fidelity to the Tidal Model, then evaluation of services where it is well established, would be useful.

Differences in care provision between the community alternatives in this study support the typology of alternatives developed from a national UK survey (Johnson et al. 2009). Further investigation could establish whether there are consistent differences in service provision between types of alternative. This could inform the development and subsequent evaluation of models of acute residential care, assisting the goal of providing effective, acceptable services.

## *4.8 Users' satisfaction with alternatives and standard services (Module 10)*

Participants in the three residential alternative services were more satisfied with their care than participants in traditional units. However levels of satisfaction in both types of service were at the higher end of the range for both of the satisfaction scales we used.

People admitted to residential alternative units also reported less coercion and negative pressures during their stay and described greater levels of autonomy and voice. Initial results also suggested that they were more satisfied with facilities, staff programs, day and night availability of services and their medication and aftercare. However there were important differences between participants in the different types of service, particularly the numbers detained under the Mental Health Act during their stay, as well as differences in ethnicity and sex. When these factors were accounted for in the multivariate analysis, satisfaction was still significantly greater in the alternative units on the CSQ, as were levels of autonomy and voice. However Detention under the Mental Health Act attenuated some of the reported differences in descriptions of ward atmosphere, such as greater levels of support, autonomy and order which were no longer significant. Therefore differences in numbers detained in each service explains some but not all of the differences in patient experience.

Some admission experiences did not differ between the services. Compared to traditional units, people in residential alternatives reported similar levels of staff control, focus on personal problems, practical orientation, involvement and spontaneity.

**Strengths**

This is the first national in-depth study of patient experiences within residential alternatives to inpatient psychiatric care. Each service was chosen to represent one of the main types of alternative that had been identified in a previous national survey of all identifiable novel residential mental health services (Johnson et al, 2009).

The greater levels of satisfaction within residential alternatives were generally robust whichever form of analysis was used to explore them, including different statistical methods and adjusting for different possible explanatory variables such as geographical area and length of admission. This satisfaction is an important service user outcome, given that a comparison of clinical outcomes revealed no clear cut clinical or economic advantage for either type of services (Section 3.5).

The variability in our quantitative experience findings is consistent with results from qualitative interviews undertaken with people admitted to the same services. Qualitative user interviews (Section 3.3) suggest that while many people prefer admission to residential alternatives, they also identified a number of similarities between the two types of service, including the type of care that they received during their stay. Furthermore, in a quantitative exploration of the content of care in different service types (Section 3.7) many similarities were found between alternative residential services and traditional units.

Service user satisfaction seems to be one key difference between the services, yet it is not simply explained by the type of care received and our finding suggest this satisfaction may hinge on feeling less coerced and having more influence over the type of care received.

**Limitations**

We were only able to select one service from each type of residential alternative and the generalisability of our results to other services nationally cannot be guaranteed. Our observational study was not randomised and therefore sampling bias and residual confounding are important considerations. It is possible that participants in the two types of services were not fully representative of all those in the services. While we adjusted for demographic variables, including area and length of stay, we did not have further data to explore how differences in clinical presentation in the services, such as severity of illness, might account for the increased satisfaction in alternative services. However, detention under the Mental Health Act is one proxy for severity and whilst it attenuated some results, satisfaction remained greater in alternatives, with less negative experiences and perception of coercion. The comparison of patient characteristics (Section 3.2) indicates that while alternative services do cater for similar groups of patients to traditional inpatient units, they admit fewer psychotic patients and fewer patient who may be a risk of violence to others. We were unable to control for these variables in this part of the study and it is possible they explain some of the differences in admission experiences and satisfaction that we report.

# 5. Conclusion

In this study, we have used multiple methods to carry out a naturalistic evaluation. While each method has distinct strengths and limitations, an advantage of combining them is that a coherent overall picture has emerged that takes a variety of perspectives into account. Evidence is strengthened by triangulation of different types of data.

Alternatives are generally positively perceived by mental health commissioners, managers and clinicians. They are serving a severely mentally ill population. There is considerable overlap between people admitted to acute hospital wards and community alternatives. Alternatives can form a useful part of local acute care systems.

Patient satisfaction is greater with alternatives than standard services. Alternatives can provide a choice for service users at times of mental health crisis and may be more acceptable than hospital admission for many. Alternatives may therefore encourage prompt help-seeking and improve patients' pathways to care.

The amount of contact and the quality of relationships patients have with staff are important. They may influence patients' experience of acute admission more than the physical environment of the service or the types of intervention provided. Service managers should focus attention on increasing the amount of time staff spend with patients and enhancing therapeutic alliance.

Other disturbed, aggressive patients have a substantial negative impact on patient experience of acute admission. Alternatives were valued for having fewer intimidating or potentially violent patients. Providing separate services for acutely admitted patients who are not overtly disturbed or aggressive may improve their experience of admission.

It is difficult to make definite conclusions about the clinical effectiveness and cost-effectiveness of alternative services. Patients typically improve less on staff-rated clinical outcome measures at alternatives than at standard services and have briefer, consequently cheaper admissions. Length of stay for acute psychiatric admissions is longer in the UK than some other European countries (McCrone and Larusso 1999), indicating that UK services offering briefer admissions may be appropriate for some patients. No difference was found in follow-up use of services over 1 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.

Similarities in care provided at alternatives and standard services are greater than differences. Alternatives have a high degree of integration into local acute care systems. If service planners wish for a more distinctly different service from standard acute care, other service models not represented in current UK service provision could be considered, such as low medication use Soteria hostels (Mosher 1999), adult family placements (Polak 1976) or user led services (Faulkner 2002).

The development of crisis and home treatment teams appears to strengthen the case for alternatives. Stakeholders identified that relationships between alternatives and the local crisis team were typically close. Additional input from crisis teams allows alternatives to accept patients with higher risks and needs than would otherwise be possible. Alternatives can constitute a useful tool for home treatment teams to use in averting hospital admissions.

Should planners and commissioners support the development of residential alternatives? If the driver for decision-making is cost-effectiveness, then the study indicates that alternatives are associated with clinical improvement but not to the same extent as standard services, that they cost less, and that post-discharge service use one year later does not differ between people admitted to alternative and to standard services. If the driver for decision-making is the experience of admission, then the study indicates that satisfaction of service users – assessed using both qualitative and quantitative approaches – and of their carers is greater with admission to alternative services.

Clear directions for policy and practice from this study are limited by the complexity of findings. Recommendations which can be provided regarding community-based alternatives and acute inpatient care are presented here.

**Recommendations for practice**

- Increasing the amount of time staff spend with patients and enhancing relationships between staff and patients should be priorities for alternatives and standard services.
- Alternatives should continue to provide brief admissions: we found no evidence that early discharge with less improvement had an adverse impact on patients at alternatives.
- Alternatives should develop strong links with other community services to address limitations in service provision, e.g. regarding physical healthcare or medication review.
- Alternatives should prioritise reducing organisational barriers to access: they should aim to offer same-day admission at any time of day or night.

### Recommendations for policy

- Alternatives can form a useful part of local acute care systems. They have considerable overlap with acute wards in populations served, are associated with greater patient satisfaction and acceptable to carers.
- Service planners should be attentive to evidence of current regional and gender inequity in access to alternatives.
- Integration with local acute care systems and Crisis Resolution Teams in particular can enable alternatives to admit patients with higher risks and needs than otherwise possible.
- Alternatives were valued by patients for feeling safe and having fewer patients exhibiting overtly disturbed behaviour: approaches which reduce the impact of people who are overtly disturbed or aggressive are an important element of improving the experience of admission.

### Recommendations for research

- Greater understanding of staff-patient relationships in inpatient services should be a research priority, including identifying organisational factors which facilitate and inhibit good relationships and developing interventions to enhance therapeutic alliance.
- Investigation is needed of the relationship between length of stay and outcomes, using a repeated measures design.
- The development of models and measures of fidelity is required for types of alternative and standard inpatient care.
- In alternatives and inpatient services, further exploration is desirable of the impact on outcomes of features of service provision including patient choice, staff team make-up and morale, specific interventions provided and staff-patient social distance.
- Firmer evidence for service effectiveness could be provided by a randomised trial involving the sub-group of patients who are served by both alternatives and hospital inpatient services.

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# Appendix 1 National Survey Of In-Patient Alternatives Questionnaire

## THE ALTERNATIVES STUDY

### NATIONAL MAPPING OF IN-PATIENT ALTERNATIVES

**Service name:**

**Study number:**

**Address:**

**Phone** **Email:**

**Interviewer:**

**Interviewee:**

**Interviewee's job title:**

**Date of data collection:**

**Completing the questionnaire:**

This questionnaire covers a wide range of different types of service. Because of this, some questions may not seem very relevant to your service, but we would be really grateful if you could answer all of them as best as you can so that we can carry out a complete national mapping. **Please note that with most questions there are no 'right' answers that mean a service is of good quality.** Much of the questionnaire is about differences in service style not in service quality, and no service is likely to have all the facilities and types of care in the questionnaire.

The Alternatives Study researchers (Bryn Lloyd-Evans and Helen Gilburt) will be in touch to arrange a time when they can go through this questionnaire with you by phone. It will save time on the phone if you can read the questionnaire beforehand and type or write in answers to those questions that ask for a number or tick to be put in a box. Do not worry, however, if you are not able to do this before you speak to Helen or Bryn – they can go through the full questionnaire with you if this is more convenient. They can also discuss any questions that you are unsure how to answer. **If you can't answer any of the questions, please leave them blank.**

**Thank you very much for helping us with this national mapping!**

## Section A PREMISES AND FACILITIES

**1 Where is your service located?** *Write in the box the number of the answer that fits best.*

1 = In a general hospital with a casualty department
2 = In a psychiatric hospital
3 = In a hospital with a mixture of specialities but no casualty department
4 = In the community, in a converted house
5 = In the community, in purpose built premises
6 = Other, please describe:

QUESTIONS 2a AND b ARE FOR COMMUNITY-BASED SERVICES ONLY

**2 a. Do you share your premises with any of the following services?** *Tick any that apply:*

i. Crisis resolution team (also known as home treatment or crisis assessment and treatment teams) .....

ii. NHS day hospital .....

iii. Day centre or drop in centre.....

iv. Community mental health team (CMHT) .....

v. Longer term community residential facility.....

vi. Other, please describe:

**b. If you share with another service, which of these best describes your links with this service?**

1 = Operate as a single unit with shared management
2 = Good links, but operate as separate services
3 = Limited or no links, premises shared mainly for convenience
8 = Not applicable, premises not shared.

QUESTION 3 IS FOR HOSPITAL SERVICES ONLY

**3 Does your service occupy a whole hospital ward or does it share a ward with another service?**

1 = Occupies a whole ward
2 = Shares with another service

**4 How many beds does your service have?**

**5 Do all clients have their own bedrooms?**

0 = No 1 = Yes

**6 Are there facilities for clients to make themselves hot drinks whenever they wish?**

0 = No 1 = Yes

**7 Are there facilities for clients to cook meals for themselves if they wish?**

0 = No 1 = Yes

**8 Are three meals a day provided for clients?** 0 = No 1 = Yes

## SECTION B CARE AND SUPPORT

9 a. **Is your service based on a specific philosophy of care or therapeutic model?**

0 = No 1 = Yes, please state what this is ☐

**IF NO, PLEASE GO TO QUESTION 10.**

b. **In practice, how does this philosophy of care or therapeutic model influence the care that is provided?**

10 THERAPIES AND ACTIVITIES

**We would like to know about the treatment and care that clients can access *because* they are residents at your service.** Please do not include care from other local services that you may refer clients to, but that are also available to people who are not resident at your service.

a. **Is counselling available to clients?**
*By this we mean a series of pre-arranged, structured appointments that is described as counselling and is distinct from the general support and care your staff offer all clients on a daily basis.*

0 = No 1 = Yes ☐

b. **How many hours of counselling per week can be provided to a client?** ☐

c. **Are any of the following types of individual psychological treatment or psychotherapy available to clients?** Please tick any that apply:

i. Cognitive behavioural therapy..... ☐

ii. Cognitive analytic therapy..... ☐

iii. Psychodynamic/psychoanalytic psychotherapy..... ☐

iv. Other, please describe ☐

If relevant, please describe the position within your service and profession of the staff providing psychological treatments and/or psychotherapies:

d. **How many hours per week of psychotherapeutic or psychological treatments can be provided to a client?** ☐

e. **Are any complementary or alternative therapies available?**

0 = No 1 = Yes, please describe type & who provides it ☐

f. **How many hours per week of complementary or alternative therapies can be provided to a client?** ☐

g. **Are any types of occupational therapy or organised recreational activity available at your service?**

0 = No 1= Yes, please list the available activities

h. **Are groups of any of the following types held at your service for clients?**
For each type of group, write 0 in the box if you do not have this type of group.
If you do have it, write the number of times a week it takes place:

**No. of times per week**

i. Support groups, social groups or community groups.....

ii. Educational or skills training groups.....

ii. Therapeutic groups, please describe type and who conducts: .....

i. **For approximately how many hours a week in total can a client at your service be engaged in groups, occupational therapy or organised activity?**

j. **Is any specialist help with drug or alcohol problems available to clients?**

0 = No 1 = Yes, please describe type of help and who provides it:

k. **Are any of the following provided within your service for your clients' carers?**
Please tick any that apply:

i. Care planning or review meetings to which carers are invited.....

ii. Education for carers about mental health problems .....

iii. A carers' support group.....

iv. Family therapy, please describe type and who provides it: .....

## 11 MEDICAL CARE AND MEDICATION

a. **Who are the doctors who mainly provide medical assessment and care in your service?**

0 = Not relevant, our model of care does not involve significant input from doctors
1 = Psychiatrists and/or trainee psychiatrists employed within our service
2 = CMHT psychiatrists
3 = Crisis team psychiatrists
4 = General Practitioners employed to work sessions within the service
5 = Other arrangement, please describe:

b. **Do your staff usually arrange for clients who are taking medication for mental health problems to have a medication review by a doctor?**

0 = No, staff in our service don't usually arrange medication reviews.
1 = Yes, medication reviews are arranged, but only if there are particular problems or issues regarding a client's medication.
2 = Yes, all or most clients who are taking medication are reviewed by a doctor during their stay.

c. **Which of the following best describes your arrangements for clients who are taking prescribed medication for mental health problems?**

1 = Clients keep their own medication, staff do not usually monitor this
2 = Clients keep their own medication but staff sometimes monitor whether they are taking it.
3 = Clients' medication is kept by staff and given to clients when a dose is due.
4 = Mixture of the above depending on clients' needs.
8 = Not applicable, clients are not usually taking medication.

d. **Is physical examination by a doctor a routine part of your admission procedure?**

0 = No 1 = Yes

e. **If clients need blood tests (e.g. because they need a physical health check before starting on new medication), is it usual for them to have their blood taken at your service?**

0 = No 1 = Yes

## 12 RISK ASSESSMENT AND MANAGEMENT

a. **Do you have a procedure assessing and documenting risk?**

0 = No
1 = Yes, risk is assessed and documented using a standard risk assessment form
2 = Yes, risk is assessed and documented, but no standard form in use

b. **Are contracts with service users regularly used as a means of managing risk in your service?**

0 = No 1 = Yes

c. **Can one to one care be provided for clients about whom there are particular concerns?**

0 = No
1 = Yes, but only feasible for a few hours (usually fewer than 12 hours)
2 = Yes, usually feasible for at least 12 hours, but not as much as 48 hours
3 = Yes, for 48 hours or more if needed

d. **If a client seems at very high risk of self harm or harming others despite the support of your service, is it your usual practice to refer them to other local mental health services that are within the NHS** *(for example, crisis teams)*?

0 = No
1 = Yes, but only if the client agrees
2 = Yes, other local services sometimes contacted even without client's agreement if level of concern is high.

## 13 ADVOCACY AND ADVICE

a. **Does an independent advocate provide sessions at your service?**

0 = No 1 = Yes, please describe who this is and how much time is available:

b. **Do staff in your service offer help with social problems e.g. obtaining and helping complete forms for benefits claims or housing applications?**

0 = No 1 = Yes

c. **Does a welfare rights or benefits advisor provide sessional input at your service?** ☐

0 = No 1 = Yes

**14 OTHER TYPES OF CARE**

**Are there any other types of care you provide that you think are important but haven't had the chance to describe? If so, please tell us what they are**

## SECTION C REFERRALS

**15 Do you have a defined catchment area from which you accept referrals?** ☐

0 = No 1 = Yes, please name the areas within this preferably by listing Primary Care Trust areas:

**16. From which of the following do you accept direct referrals?** *Tick any that apply.*
*Do not tick if these referral sources are normally asked to refer to another agency (e.g. crisis team)*

People known to local statutory services (self-referrals)..... ☐

People not known to local statutory services (self-referrals) ..... ☐

Carers..... ☐

GPs..... ☐

Crisis resolution/home treatment team staff..... ☐

Staff in a community team directly linked to your service..... ☐

Other local NHS community mental health staff..... ☐

Mental health workers outside NHS (e.g. day centre, hostel staff)..... ☐

Local in-patient services who wish to refer in-patients for further care..... ☐

A & E department staff..... ☐

General hospital staff..... ☐

Police and criminal justice agencies..... ☐

**17 From which three sources do you get the most referrals?**

a.

b.

c.

18 **If a bed is available and a suitable client is referred in the morning, can you usually admit them the same day?**

0 = No, our assessment and admission procedures usually take longer than this.
1 = Yes , but only if the client is already known to us.
2 = Yes, we can usually admit any client on the day of referral if we have a bed.

19 **Do you have written information about how your service operates and its facilities that you give to all clients on admission?**

0 = No 1 = Yes

## SECTION D ADMISSION AND DISCHARGE

20 **Which of these groups of clients is your service mainly intended for? Please write 1 in the box next to the client group that is your highest priority, 2 next to the second highest and so on. Write 0 next to groups you do not usually accept.**

i. People experiencing a crisis that would otherwise result in admission to a standard general acute ward

ii. People experiencing a crisis, but not of a severity and nature likely to result in admission to a general acute ward.

iii. People who need a period of respite from their usual living situation, or whose carers need respite

iv. People who were initially admitted to a general acute ward and need further residential care before going home.

21 ENTRY AND EXCLUSION CRITERIA

a. **What are the minimum and maximum ages at which you can accept clients?**

**Minimum:** ☐ years **Maximum:** ☐ years

b. **Is your service for men only, women only or both sexes?**

1 = Women only 2 = Men only
3 = Both sexes

c. **Do you have any entry requirements or exclusion criteria related to diagnosis or type of problem being experienced?**

0 = No 1 = Yes, please describe:

d. **Do you have any entry requirements or exclusion criteria related to level of risk?**

0 = No 1 = Yes, please describe:

e. **Please describe any other major entry requirements or exclusion criteria for your service:**

**22 Can you admit sectioned patients to your service?**

0 = No
1 = Yes, they can be admitted directly from the community on section
2 = Yes, but only as transfers from an in-patient unit
3 = Yes, but only if they are on Section 17 Leave

**23 Can clients stay at your service with their children?**

0 = No
1 = Yes, but only one child per service user
2= Yes, maximum no. of children per client is two or more than two.

**In what age range are children accepted?**

**Minimum:** **Maximum:**

**24 Is there a fixed maximum length of stay at your service?**

0 = No 1, Yes, please say what this is:

**Maximum:**

## SECTION E FUNDING AND MANAGEMENT

**25 Which of the following manages your service?**

1= NHS Mental Health or Mental Health & Social Care Trust
2= Voluntary sector organisation, *please state which:*
3= Primary Care Trust
4= Local authority
5= Private company
6= Other or combination, please describe:

**26 From which of the following do you obtain funding?** Tick any that apply.

NHS Mental Health/ Mental Health & Social Care Trust.....

Voluntary sector organisation:.....

Primary Care Trust.....

Local authority.....

Private company.....

Other or combination, please describe:.....

27 **In which year did your service start operating in its current form?**

## SECTION F SERVICE USER INVOLVEMENT

28 a. **When executive decisions are made about how the service should operate, what is the role of current and former service users?**

1 = Executive decisions are mainly taken by service users.
2 = They are included in the group that makes executive decisions
3 = Neither of the above

b. **Is there an advisory group consisting mainly of service users that is consulted regarding the operation of the service?**

0 = No 1 = Yes

c. **Are service users usually included in interview panels when staff are recruited?**

0 = No 1 = Yes

d. **Are service users involved regularly in delivering training to your staff?**

0 = No 1 = Yes

e. **Are service users paid for their involvement in the above tasks?**

0 = No
1 = Always 2 = Usually
3 = Sometimes 4 = Usually not
8 = Not applicable, service users are not involved in the ways described.

29 **Are carers consulted in any of the following ways on the operation of the service?** *(Tick any that apply)*

i. Carers participate in the group that decides how the service should operate.

ii. They are represented on an advisory group that is consulted about service operation.

iii. Regular consultations are held about the service with at least one local carers' organisation.

## SECTION G LINKS WITH OTHER SERVICES

30 a. **Do you have any specific arrangements for joint working with local crisis resolution teams?** *For example, are they the gatekeepers for your service and/or do you often do joint therapeutic work with them?*

0 = No 1 = Yes, please describe:

b. **Has the introduction of crisis resolution teams led to any change in the role or client profile of your service?**

0 = No 1 = Yes, please describe:
8 = Not applicable 9 = Don't know

31 **Do you work closely with any local services other than crisis teams?**

0 = No 1 = Yes, please describe:

32 **Do you usually request copies of NHS documentation regarding clients you admit who are known to statutory services (e.g. discharge summaries, CPA forms)?**

0 = No 1= Yes

33 **Do you organise or ask other professionals to organise Care Programme Approach (CPA) meetings for your clients during their admissions?**

0 = No
1 = Yes for some clients
2 = Yes for most or all clients

34 **Do your staff regularly refer clients to local NHS mental health services if they think follow-up would be helpful?**

0 = No
1 = Yes
8 = Not applicable, clients are usually known to mental health services already.

35 **How good is communication between your service and the CMHTs in your area?**

1 = Very poor
2 = Poor
3 = Fair
4 = Good
5 = Excellent
8 = Not applicable

36 **How good is communication between your service and local GPs?**

1 = Very poor
2 = Poor
3 = Fair
4 = Good
5 = Excellent
8 = Not applicable

## SECTION H STAFF

37 a. **Is your service staffed 24 hours a day, 7 days a week?**

0 = No, please give the hours and days during which staff are present:
1 = Yes

b. **What is the minimum number of staff you normally have present on each daytime shift?**

c. **Which of the following best describes your overnight staffing?**

0 = No staff
1 = Staff on call from elsewhere
2 = Staff on site, may be asleep if not needed
3 = Staff on site, at least one awake throughout

38 a. **How many of your staff do you know to be current or former mental health service users?**

b. **When advertising posts, have you stated in advertisements that you actively encourage applications from current or former service users?**

0 = No
1 = Yes, for some posts
2 = Yes, for all posts

39 **Do new staff in your service receive any training in specialist therapeutic skills that are needed to work in your service?**

0= No
1=Yes, please say what skills staff are trained in and how many hours' training they receive:

**40 Please use the following table to list all the staff involved in providing clinical care to client**

Include the clinical service manager or team leader (i.e. the person responsible for day to day operation the service, usually based within the service). Please include vacant posts, but do not include students trainees. If staff spend some of their time at your service and some at another service, please include th time they spend at your service.

| **Job title** *e.g.service manager, staff nurse, project worker, music therapist* | **Professional Background (if any)** *e.g. nurse, social worker, group analyst* | **Grade (if applicable)** *e.g. D grade if a nurse, Senior 1 if an occupational therapist Senior House Officer if a psychiatrist* | **Status** *Please use these codes: 1= Filled by substantive postholder 2= Vacant or filled by agency/locum staff 3= Sessional worker, paid for sessions rather than as employee.* | **Full time equivalents** *e.g. 1.0 if full-time (35-40 hrs per week), 0.6 if working days a week.* |
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**In an average week, how many hours of agency or bank staff time do you use?**

# SECTION I CLIENT PROFILE

**41 In the most recent year for which you have data, how many admissions lasting at least one night did you have?** ☐

Which one year period does this information relate to?

From ☐ to ☐

Please tick here if this is an estimate: ☐

**42 What was your average percentage bed occupancy over that year?** ☐

Please tick here if this is an estimate: ☐

**43 How many days does an average client stay at your service?** ☐
*If you have a figure for **median** length of stay, please give it: If not, please make an estimate*

Please tick here if this is an estimate: ☐

**44 SERVICE USER CHARACTERISTICS**

**a. How many clients stayed the night in your service last night?** ☐

**b. How many of these clients are male and how many female?**

Male ☐ Female: ☐

**c. How many belong to each of the following ethnic groups?**

White British ☐ Other White ethnic groups: ☐

South Asian ethnic groups: (including Indian, Pakistani Bangladeshi) ☐ Black ethnic groups: (including Black British, Black Caribbean, Black African) ☐

Other or mixed: ☐ Not known: ☐

**d. How many are currently on a section?** ☐

**e. How many were on the caseload of a local NHS mental health service when admitted to your service?** ☐

**f. How many have a previous history of psychiatric hospital admission?** ☐

**g. How many were having problems related to depression, anxiety and/or self harm when admitted?** ☐

**h. How many were experiencing psychotic symptoms (e.g. hallucinations, paranoid beliefs) when admitted?** ☐

45 **In general, what proportion of your clients have a diagnosis of psychosis and/or are experiencing psychotic symptoms when admitted?**

1 = Fewer than 10%
2 = 11% to 25%
3 = 26% to 50%
4 = More than 50%

46 **To what extent do you think your service admits clients who would otherwise go to standard general acute wards?**

1 = Only to a very limited extent, the client group is largely different from local general acute wards
2 = Some of the clients would otherwise be on general acute wards, but fewer than 50%
3 = At least 50% of the clients would otherwise be on general acute wards
8 = Not applicable, service is one of the main local general acute wards.

47 **Do any aspects of your service's operation and resources or of the wider local service system limit your ability to provide an alternative to admission to local general acute wards?** If so, list up to 3.

a.

b.

c.

48 **What aspects of your service are you most proud of?** List up to 3.

a.

b.

c.

49 a. **Has a service user satisfaction survey been carried out at your service in the past 2 years?**

0 = No 1 = Yes

b. **Is any research or audit currently being carried out or has research or audit been carried out in the past?**

0 = No 1 = Yes

If yes, please give details. We would be very grateful if we could see any available reports from your research, audit or user satisfaction surveys.

50 **We would like to check that our mapping includes as many as possible of the available alternatives to standard in-patient care. Please list any others that you know of in your local are**

# Appendix 2: Admission Form

## A Study of Inpatient and Residential Alternatives to Hospital Inpatient Psychiatric Care
## Admission Form

**Service user's name:**
**Service:**
**Form completed by:**

### When to fill in the form

Please complete this form as soon as possible after the admission of the service user to this service.

### A Referral and admission

**A01 Date of admission** *ddmmyy* ☐☐ ☐☐ ☐☐

**A02 Was the service user admitted on the same day as the referral was received?**
☐ 0 No
☐ 1 Yes
☐ -1 Don't know

**A03 Who first identified the need for urgent intervention and sought help in the current crisis?**

☐ 1. The patient sought help

☐ 2. The patients' family, friends or neighbours sought help on his/her behalf

☐ 3. The crisis was identified during a planned contact with the patient by mental health professionals (e.g. by the CMHT)

☐ 4. The police or court officials identified the need for mental health intervention

☐ 5. Health or social care staff outside the NHS mental health services sought help for the patient

☐ 6. Other:

☐ -1. Don't know

**A04 Who was the immediate referrer to this service?**
☐ 1 Patient himself/herself
☐ 2 Patient's family
☐ 3 GP
☐ 4 Other Primary Care worker
☐ 5 Community Mental Health Team (CMHT) or Psychiatric Outpatient Clinic
☐ 6 Crisis Resolution/Home Treatment Team (CRT)
☐ 7. Assertive Outreach Team (AOT)
☐ 8. Early Intervention Team for Psychosis (EIS)
☐ 9. Inpatient psychiatric service (NHS)
☐ 10. Other NHS specialist mental health service
☐ 11. Residential support staff
☐ 12. Accident and Emergency Dept.
☐ 13. General Hospital inpatient service
☐ 14. Police or criminal justice system
☐ 15. Private/voluntary sector mental health service
☐ 16. Other:
☐ -1. Not known

**A05: Was the patient's GP involved in managing the crisis and making the referral at any stage?**
☐ 0 No ☐ 1 Yes ☐ -1 Don't know

**A06 MHA status at admission**
☐ 1 Voluntary
☐ 2 Detained under a section of the Mental Health Act
☐ 3 On a section of the Mental Health Act, but currently on

**B01 Date of Birth***ddmmyy* ☐☐ ☐☐ ☐

**B02 Sex** ☐ 1 Male ☐ 2 Female

**B03 Marital status**
☐ 1 Unmarried
☐ 2 Married
☐ 3 Cohabiting
☐ 4 Widow/widower (not currently cohabiting)
☐ 5 Separated/divorced (not currently cohabiting)
☐ -1 Unknown

**B04 Living arrangements**

☐ 1 Lives alone
☐ 2 Lives with other adult(s)
☐ 3 Lives with other adult(s) and dependent children
☐ 4 Lives with dependent children (no other adults)

**B05 Patient's ethnic background**

White
☐ 1 White British
☐ 2 White Irish
☐ 3 White Other

Black/Black British
☐ 4 Caribbean
☐ 5 African
☐ 6 Black Other

Asian/Asian British
☐ 7 Indian
☐ 8 Pakistani
☐ 9 Bangladeshi
☐ 10 Asian Other

Mixed
☐ 11 White/Black Caribbean
☐ 12 White/Black African
☐ 13 White/Asian
☐ 14 Other mixed

Chinese or other
☐ 15 Chinese
☐ 16 Other ethnic group

**B06 Was patient born in the U.K.?**
☐ 0 No
☐ 1 Yes
☐ -1 Don't know

**B07 Immigration Status**
☐ 1 Permanent UK resident
☐ 2 Time-limited leave to remain in UK
☐ 3 Asylum Seeker (claim or appeal pending)
☐ 4 No legal claim for residence
☐ -1 Not known

**B08 Patient has ___ children under 18 years of age**

**B09 Housing on admission**
☐ 1 Independent permanent accommodation
☐ 2 Independent temporary accommodation
☐ 3 24-hour supported accommodation
☐ 4 Accommodation with staff support at least 5 days a we
☐ 5 Other supported accommodation/tenancy
☐ 6 Prison
☐ 7 Street homeless/direct access hostel
☐ 8 Other:

**B10 Employment Status before Admission**
☐ 1 Employed (open market employment)
☐ 2 Employed (sheltered or voluntary employment)
☐ 3 Not employed (job seeking or sick)
☐ 4 Not employed - other(e.g. student, carer, retired)
☐ -1 Not known

**B11 Educational Attainment**
☐ 1 Difficulties with basic literacy
☐ 2 Basic literacy skills but no school-leaving qualifications
☐ 3 Passed some school-leaving level exams or subsequent equivalent (e.g. NVQs) but no degree level or professional qualification
☐ 4 Degree or equivalent professional qualification

**B12 Years since first contact with mental health services:**
☐ 1 This is the first contact
☐ 2 Less than 2 years
☐ 3 2 -5 years
☐ 4 More than 5 years

**B13 Diagnosis before admission *(Please record below if known)*:**

_____

**B14: Number of previous admissions to psychiatric hospital (in patient's lifetime):**
☐ 0 ☐ 5-10
☐ 1 ☐ More than 10
☐ 2-5 ☐ Not known

**B15: Number of previous admissions to residential alternatives to psychiatric hospital, e.g. a crisis house (in patient's lifetime):**
☐ 0 ☐ 5-10
☐ 1 ☐ More than 10
☐ 2-5 ☐ Not known

**B16 Life events experienced by the patient in three months preceeding this admission:**

1 Bereavement ☐
2 End of relationship with partner ☐
3 Became homeless ☐
4 Loss of job ☐
5 Victim of violence ☐
6 Arrest/or other involvement in criminal justice process ☐
7 Change of country of residence ☐
8 Problems with immigration status (e.g. threat of deportation) ☐
9 other (please state) ☐
0 None known ☐

| **B17 Acts of self injury and violence in two weeks before admission:** | 0 None known | 1 Yes |
|---|---|---|
| 1 Attempted suicide | ☐ | ☐ |
| 2 Self injury | ☐ | ☐ |
| 3 Physical assault on others | ☐ | ☐ |
| 4 Was assaulted by others | ☐ | ☐ |



## C Services received before admission

**C01 Use of statutory secondary mental health services during the last 12 months**

*Mark one box in each column*

| | A Community services | Inp s |
|---|---|---|
| 0 No known contact | ☐ | |
| 1 Contact | ☐ | |

**C02 Follow-up from services in last 3 months before admission. *(Tick any services with which patient has had at least one face to face contact )***

1 GP ☐
2 Other Primary Care Services ☐
3 CMHTor Psychiatric Outpatients Clinic ☐
4 CRT ☐
5. AOT ☐
6. EIS ☐
7 Other specialist NHS mental health service ☐
8 Residential support staff ☐
9 Private/voluntarymental health service ☐
10 Drug/Alcohol Services ☐
11 Other: ☐
0 None known ☐

**C03 Contact/Support in the last 48 hours before admission**

1 GP ☐
2 Other Primary Care Services ☐
3 CMHTor psychiatric outpatient clinic ☐
4 CRT ☐
5 AOT ☐
6 EIS ☐
7 Other secondary mental health service ☐
8 Residential support staff ☐
9 Private/voluntarymental health agency ☐
10 Drug/Alcohol Services ☐
11 Support from family or friends ☐
12 Other ☐
0 None known ☐

**C04 CPA status up to admission**
☐ 1 Not CPA registered
☐ 2 Registered on standard CPA
☐ 3 Registered on enhanced CPA
☐ -1 Not known

**C05 Prescribed medication up to admission**
*(Please record if known. Mark on C07 if the patient did n medication.)*

| Name of medication | mg /day |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

| C06 Depot injection *(up to admission)* | Dose |
|---|---|
| | |

**C07 How did the patient take the medication the last 2 weeks before the admission**

☐ 1 No prescribed medication
☐ 2 Took medication mostly as prescribed
☐ 3 Took medication only partially as prescribed
☐ 4 Did not take / mostly did not take medication as prescribed
☐ -1 Unknown

## D Assessment at admission

**D01 Main reasons for admission as the team sees it**
*Tick between one and three boxes*

☐ 1 Diagnosis and clinical assessment
☐ 2 To treat/alleviate symptoms of acute illness
☐ 3 To reduce/manage risk of harm to self
☐ 4 To reduce/manage risk of harm to others
☐ 5 To reduce/manage risk of severe self neglect
☐ 6 Detoxification from drugs or alcohol
☐ 7 Planned change or start of medication
☐ 8 To address/alleviate psychological and social factors which triggered the crisis
☐ 9 Remove person from a distressing/stressful environment
☐ 10 To provide respite for carers
☐ 11 to facilitate prompt discharge from hospital *(non-hospital services only)*
☐ 12 Other (please state)

**D02 To what extent was the patient willing to co-operate with emergency assessment?**

☐ 1 *Fully co-operative* - willing to do whatever is necessary to get help
☐ 2 *Moderately co-operative* - has not been fully willing to accept all suggestions/plans for carrying out the assessment, or has required some persuasion, but generally appears to wish to be assessed and to get help.
☐ 3 *Moderately uncooperative* - assessment has been carried out only following considerable persuasion or substantial efforts to make contact, on balance subject does not appear to wish to be assessed.
☐ 4 *Very unco-operative* - subject has resisted assessment so actively that significant coercion has been needed e.g. by forcing entry to premises, or a police presence has been required to allow the assessment to take place.
☐ 5 *Difficult to rate* - describe the reasons:

**Please now complete the following three measures about the patient <u>at the point of their admission</u> to this service.**

*This measure is the Health of the Nation Outcome Scale (HoNOS)*

Summary of rating instructions

1 Rate each scale in order from 1 to 12, place the number in the box which applies best to the service user.
2 Do not include information rated in an earlier item except for item 10 which is an overall rating.
3 Rate the MOST SEVERE problem at the point of the service user's admission to this service.
4 All scales follow the same format:
0 = no problem
1 = minor problem requiring no action
2 = mild problem but definitely present
3 = moderately severe problem
4 = severe or very severe problem
*Rate 9 if not known*

**1. Overactive, aggressive, disruptive or agitated behaviour.**

- *Include such behaviour due to any cause (e.g. drugs, alcohol, dementia, psychosis, depression, etc.).*
- *Do not include bizarre behaviour rate at Scale 6*

0 No problem of this kind during the period rated.
1 Irritability, quarrels, restlessness, etc. not requiring action.
2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked overactivity or agitation.
3 Physically aggressive to others or animals (short of rating 4); threatening manner; more serious overactivity or destruction of property.
4 At least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); serious intimidation or obscene behaviour.

**2. Non-accidental self-injury.**

- *Do not include accidental self-injury (e.g. due to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5.*
- *Do not include illness or injury as a direct consequence of drug /alcohol use, rated at Scale 3 (e.g. cirrhosis of the liver or injury resulting from drink driving are rated at Scale 5).*

0 No problem of this kind during the period rated.
1 Fleeting thoughts about ending it all but little risk during period rated; no self-harm.
2 Mild risk during period rated; includes non-hazardous self-harm (e.g. wrist scratching).
3 Moderate to serious risk of deliberate self-harm during period rated; includes preparatory acts (e.g. collecting tablets).
4 Serious suicidal attempt and /or serious deliberate self-injury during period rated.

**3. Problem-drinking or drug taking.**

- *Do not include aggressive / destructive behaviour due to alcohol or drug use, rated at Scale 1.*
- *Do not include physical illness or disability due to alcohol or drug use, rated at Scale 5.*

0 No problem of this kind during the period rated.
1 Some over indulgence but within social norm.
2 Loss of control of drinking or drug taking, but not seriously addicted.
3 Marked cravings or dependence on alcohol or drugs with frequent loss of control, risk taking under the influence.
4 Incapacitated by alcohol / drug problem.

**4. Cognitive problems.**

- *Include problems of memory, orientation and understanding associated with any disorder: learning disability, dementia, schizophrenia etc.*
- *Do not include temporary problems (e.g. hangovers) resulting from drugs / alcohol use, rated at Scale 3.*

0 No problem of this kind during the period rated.
1 Minor problems with memory or understanding (e.g. forgets names occasionally).
2 Mild but definite problems (e.g. has lost the way in a familiar place or failed to recognise a familiar person); sometimes mixed up about simple decisions.
3 Marked disorientation in time, place or person; bewildered by everyday events; speech is sometimes incoherent; mental slowing
4 Severe disorientation (e.g. unable to recognise relatives); at risk of accidents; speech incomprehensible; clouding or stupor.

**5. Physical illness or disability problems.**

- *Include illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning.*
- *Include side-effects from medication; effects of drug/ alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drink-driving, etc.*
- *Do not include mental or behavioural problems rated at Scale 4.*

0 No physical health problem during the period rated.
1 Minor health problems during the period (e.g. cold, non-serious fall).
2 Physical health problem imposes mild restriction on mobility and activity.
3 Moderate degree of restriction on activity due to physical health problem.
4 Severe or complete incapacity due to physical health problem.

**6. Problems associated with hallucinations and delusions.**

- *Include hallucinations and delusions irrespective of diagnosis.*
- *Include odd and bizarre behaviour associated with hallucinations or delusions.*
- *Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions rated at Scale 1.*

0 No evidence of hallucinations or delusions during period rated.
1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.
2 Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour.
3 Marked preoccupation with delusions or hallucinations, causing much distress and/ or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem.
4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient.

**7. Problems with depressed mood.**

- *Do not include overactivity or agitation, rated at Scale 1.*
- *Do not include suicidal ideation of attempts, rated at Scale 2*
- *Do not include delusions or hallucinations, rated at Scale 6*

0 No problem associated with depressed mood during period rated.
1 Gloomy; or minor changes in mood
2 Mild but definite depression and distress (e.g. feelings of guilt; low self-esteem).
3 Depression with inappropriate self-blame; preoccupied with feelings of guilt.
4 Severe or very severe depression, with guilt or self accusation.

**8. Other mental and behavioural problems.**

- *Rate only the most severe clinical problem not considered at items 6 and 7 as follows.*
- *Specify the rate of the problem by entering the appropriate letter: A phobic; B anxiety; C obsessive-compulsive; D mental strain/ tension; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify.*

0 No evidence of any of these problems during period rated.
1 Minor health problems only.
2 A problem is clinically present at a mild level (e.g. patient has a degree of control).
3 Occasional severe attacks of distress, with loss of control (e.g. has to avoid anxiety provoking situations altogether, call in a neighbour to help etc.), i.e. moderately severe level of problem.
4 Severe problem dominates most activities.

**9. Problems with relationships.**

- *Rate the patients most severe problem associated with active or passive withdrawal from social relationships, and or non-supportive, destructive or self-damaging relationships.*

0 No significant problem during the period rated.
1 Minor non-clinical problem.
2 Definite problem in making or sustaining supportive relationships; patient complains and /or problems are evident to others.
3 Persisting major problems due to active or passive withdrawal from social relationships and /or to relationships that provide little or no comfort or support.
4 Severe and distressing social isolation due to inability to communicate socially and /or withdrawal from social relationships.

**10. Problems with activities of daily living.**

- *Rate the overall level of functioning in activities of daily living (ADL's), (e.g. problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, organising where to live. Do not include lack of opportunities for exercising intact abilities and skills, rated at Scales 11-12.*
- *Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.*
- *Do not include lack of opportunities for exercising intact abilities and skills, rate at Scales 11-12.*

0 No problem during period rated; good ability to function in all areas.
1 Minor problems only (e.g. untidy, disorganised).
2 Self-care adequate, but major lack of performance of one or more complex skills (see above).
3 Major problem in one or more area of self-care (see above) as well as major inability to perform several complex skills.
4 Severe disability or incapacity in all or nearly all areas of self-care and complex skills.

**11. Problems with living conditions.**

- *Rate the overall severity of problems with the quality of living conditions and daily domestic routine.*
- *Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones?*
- *Do not rate the level of functional disability itself, rated at Scale 10.*

**NB: Rate patients usual accommodation. If in an acute ward, rate the home accommodation. If information not available, rate 9.**

0 Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.

1 Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal location, not preferred option, doesn't like the food etc.).

2 Significant problem with one or more aspects of the accommodation and /or regime (e.g. restricted choice; staff or household have little understanding of how to limit disability or how to help use or develop new or intact skills).

3 Distressing multiple problems with accommodation (e.g. some basic necessities absent); housing environment has minimal or no facilities to improve patient's independence.

4 Accommodation is unacceptable (e.g. lack of basic necessities, patient at risk of eviction, or roofless, or living conditions are otherwise intolerable, making patient's problems worse.

**12. Problems with occupation and activities.**

- *Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, access to supportive facilities (e.g. staffing and equipment of day centres, workshops, social clubs, etc.).*
- *Do not rate the level of functional disability itself, rated at Scale 10.*

**NB: Rate patient's usual situation. If in acute ward, rate activities during period before admission. If information not available rate 9.**

0 Patient's day-time environment is acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.

1 Minor or temporary problems (e.g. late giro cheques); reasonable facilities available but not always at desired times etc.

2 Limited choice of activities; lack of reasonable tolerance (e.g. unfairly refused entry to public library or baths etc.); handicapped by lack of permanent address; insufficient carer or professional support; helpful day setting available but for very limited hours.

3 Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or add new ones; unskilled care difficult to access

4 Lack of any opportunity for day-time activities makes patients problem worse.

*This form is the Global Assessment of Functioning (GAF) scale*

## Symptoms

Using the scale below, rate symptoms **on admission**. Use intermediate codes when appropriate, e.g. 45, 68, 72.

**Rating:** [ ]

| | CODES |
|---|---|
| **Absent or minimal symptoms** (e.g. mild anxiety before an exam). | 90 \| 81 |
| **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g. difficulty concentrating after family argument). | 80 \| 71 |
| **Some mild symptoms** (e.g. depressive mood and mild insomnia). | 70 \| 61 |
| **Moderate symptoms** (e.g. flat affect and circumstantial speech, occasional panic attacks). | 60 \| 51 |
| **Serious symptoms** (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting). | 50 \| 41 |
| **Some impairment in reality testing or communication** (e.g. speech is at times illogical, obscure, or irrelevant). | 40 \| 31 |
| **Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication of judgement** (e.g.sometimes incoherent, acts grossly inappropriately, suicidal pre-occupation). | 30 \| 21 |
| **Some danger of hurting self or others** (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitment) **OR gross impairment in communication (e.g. largely incoherent or mute**). | 20 \| 11 |
| **Persistent danger of hurting self or others** (e.g. recurrent violence OR serious suicidal act with clear expectation of death). | 10 \| 1 |

## Disability

Using the scale below, rate symptoms **on admission**. Do not include disability due to physical or environmental limitations. Use intermediate codes when appropriate, e.g. 45, 68, 72

**Rating:** [ ]

| | CODES |
|---|---|
| **Good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g. an occasional argument with family members). | 90 \| 81 |
| **No more than slight impairment in social, occupational, or school functioning** (e.g. temporarily falling behind in school work). | 80 \| 71 |
| **Some difficulty in social, occupational, or school functioning** (e.g. occasional truancy or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.** | 70 \| 61 |
| **Moderate difficulty in social, occupational, or school functioning** (e.g. few friends, conflicts with co-workers). | 60 \| 51 |
| **Any serious impairment in social, occupational, or school functioning** (e.g. no friends, unable to keep a job). | 50 \| 41 |
| **Major impairment in several areas, such as work or school, family relations, judgement, thinking or mood** (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school). | 40 \| 31 |
| **Inability of function in almost all areas** (e.g. stays in bed all day; no job, home, or friends). | 30 \| 21 |
| **Occasionally fails to maintain minimal personal hygiene** (e.g. smears faeces). | 20 \| 11 |
| **Persistent inability to maintain minimal personal hygiene.** | 10 \| 1 |

# THRESHOLD ASSESSMENT GRID (TAG)

## SCORE SHEET

TAG ASSESSES THE SEVERITY OF A PERSON'S MENTAL HEALTH PROBLEMS

For each domain (numbered 1 to 7), tick ONE statement that best applies to the person being assessed. There should be a total of 7 ticks on the completed grid (one for each domain). Then for each level of severity (e.g. 'None', 'Very Severe') add the number of ticks and record in the box at the bottom of the column. 'Very Severe' is only available for domains where life-saving emergency action by specialist mental health teams may be required. The checklists overleaf provide some guidance on the issues to consider when assessing each domain - they are not intended to be prescriptive. Further information on the TAG is available from www.iop.kcl.ac.uk/prism/tag.

| | | NONE | MILD | MODERATE | SEVERE | VERY SEVERE |
|---|---|---|---|---|---|---|
| SAFETY | **Domain 1** Intentional self harm | No concerns about risk of deliberate self-harm or suicide attempt ◯ | Minor concerns about risk of deliberate self-harm or suicide attempt ◯ | Definite indicators of risk of deliberate self-harm or suicide attempt ◯ | High risk to physical safety as a result of deliberate self-harm or suicide attempt ◯ | Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt ◯ |
| | **Domain 2** Unintentional self harm | No concerns about unintentional risk to physical safety ◯ | Minor concerns about unintentional risk to physical safety ◯ | Definite indicators of unintentional risk to physical safety ◯ | High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment ◯ | |
| RISK | **Domain 3** Risk from others | No concerns about risk of abuse or exploitation from other individuals or society ◯ | Minor concerns about risk of abuse or exploitation from other individuals or society ◯ | Definite risk of abuse or exploitation from other individuals or society ◯ | Positive evidence of abuse or exploitation from other individuals or society ◯ | |
| | **Domain 4** Risk to others | No concerns about risk to physical safety or property of others ◯ | Antisocial behaviour ◯ | Risk to property and/or minor risk to physical safety of others ◯ | High risk to physical safety of others as a result of dangerous behaviour ◯ | Immediate risk to physical safety of others as a result of dangerous behaviour ◯ |
| NEEDS AND DISABILITIES | **Domain 5** Survival | No concerns about basic amenities, resources or living skills ◯ | Minor concerns about basic amenities, resources or living skills ◯ | Marked lack of basic amenities, resources or living skills ◯ | Serious lack of basic amenities, resources or living skills ◯ | Life-threatening lack of basic amenities, resources or living skills ◯ |
| | **Domain 6** Psychological | No disabling or distressing problems with thinking, feeling or behaviour ◯ | Minor disabling or distressing problems with thinking, feeling or behaviour ◯ | Disabling or distressing problems with thinking, feeling or behaviour ◯ | Very disabling or distressing problems with thinking, feeling or behaviour ◯ | |
| | **Domain 7** Social | No disabling problems with activities or in relationships with other people ◯ | Minor disabling problems with activities or in relationships with other people ◯ | Disabling problems with activities or in relationships with other people ◯ | Very disabling problems with activities or in relationships with other people ◯ | |
| | **No. of ticks** | | | | | |
| | **TAG score** | 0 points for each None rating: **0** | 1 point for each Mild rating: | 2 points for each Moderate: | 3 points for each Severe: | 4 points for each V. Severe: |

TAG score

# Appendix 3: Discharge Form

**A study of in-patient and residential alternatives to hospital in-patient psychiatric care**
**Discharge Form**

**Service user's name:**
**Service:**
**Form completed by:**

**When to fill in the form**
Please complete this form just before or as soon as possible after the service user is discharged from this service.

## E Cooperation and coordination

**E01 Mental Health Act status during admission.** *Please tick any of the following sections the patient has been on at any time during this admission:*

☐ 1 Voluntary patient throughout admission
☐ 2 section 5.4
☐ 3 section 5.2
☐ 4 section 2
☐ 5 section 3
☐ 6 Other section:

---

**E02 Who has the team at this service had contact (face-to-face or phone) with during the patient's stay?**
*(please tick any that apply)*

☐ 1 GP
☐ 2 Other Primary Care Services
☐ 3 Community Mental Health Team (CMHT) or Psychiatric Outpatient Clinic
☐ 4 Crisis Resolution/Home Treatment Team (CRT)
☐ 5 Assertive Outreach Team (AOT)
☐ 6 Early Intervention Team for Psychosis (EIS)
☐ 7 Other NHS specialist mental health service
☐ 8 Residential support staff
☐ 9 Private/voluntary sector mental health service
☐ 10 Drug and alcohol services
☐ 11 Family or friends
☐ 12 Other
☐ 0 None of the above

**E03 CPA meeting held during admission**
☐ 0 No
☐ 1 Yes

## F Assessment at discharge / ending

**F01 Diagnosis at discharge *(if known)*:**

_____

| **F02 Self injury and violence during the stay** | 1: Yes, within the unit | 2: Yes, outside the unit | 0: No |
|---|---|---|---|
| 1 Attempted suicide | ☐ | ☐ | ☐ |
| 2 Self injury | ☐ | ☐ | ☐ |
| 3 Physical assault on others | ☐ | ☐ | ☐ |
| 4 Was assaulted by others | ☐ | ☐ | ☐ |

**F03 Please state whether the patient has experienced the following losses during this admission *(i.e. has lost during the admission and will not be able to resume when discharged)*:**
☐ 1. Housing
☐ 2. Job
☐ 3. Relationship with partner
☐ 4. Child care responsibilities
☐ 0. None of the above

**F04 Could admission to this service or a similar one have been avoided if other services had been available?**
☐ 0 No, admission could not have been avoided
☐ 1 Yes, if the following had been done:

_____
_____
_____

## G Discharge / transfer or ending

**G01 Discharge date** *ddmmyy* ☐☐ ☐☐ ☐☐

**G02 How the discharge was implemented**

☐ 1 Patient self-discharged without consultation/planning
☐ 2 Planned discharge without formal discharge meeting
☐ 3 Planned discharge with formal discharge meeting
☐ 4 Discharge following Managers' hearing or Mental Health Review Tribunal
☐ 5 Patient killed him/herself
☐ 6 Patient died of another cause

**G03 Where the patient is discharged to**

☐ 1 Independent permanent accommodation
☐ 2 Independent temporary accommodation
☐ 3 Crisis House or other community residential alternative to acute inpatient care
☐ 4 Other 24-hour supported accommodation
☐ 5 Other Accommodation with staff support at least 5 days a week
☐ 6 Other supported accommodation
☐ 7 Prison
☐ 8 Street homeless/direct access hostel
☐ 9 (Other)psychiatric hospital inpatient care
☐ 10 Other:

**G04 Who will provide further care to the patient** *(please tick any that apply)*

| | |
|---|---|
| 1 GP | ☐ |
| 2 Other Primary Care Services | ☐ |
| 3 CMHTor psychiatric outpatient clinic | ☐ |
| 4 CRT | ☐ |
| 5 AOT | ☐ |
| 6 EIS | ☐ |
| 7 Other secondary mental health service | ☐ |
| 8 Residential support staff | ☐ |
| 9 Private/voluntarymental health agency | ☐ |
| 10 Drug/Alcohol Services | ☐ |
| 11 Other | ☐ |
| 0 None of the above | ☐ |

**G05 If patient is to be followed up by another service once he/she leaves this service, what contact has been established prior to transfer?**
(Please tick any that apply)

☐ 0 No contact
☐ 1 Referral made, no response
☐ 2 Service has agreed to provide patient with future care
☐ 3 Patient has appointment with worker(s) from service(s) providing ongoing support
☐ 4 Patient has met worker(s) providing ongoing support during this admission

**G06 Medication taken by patient at time of discharge**

| Name of medication | mg /day |
|---|---|
| | |
| | |
| | |
| | |
| | |

| G07 Depot injection | Dose |
|---|---|
| | |

**Please now complete the next measures about the patient at the point of their discharge from this service.**

*This measure is the Health of the Nation Outcome Scale (HoNOS)*

**Summary of rating instructions**

1 Rate each scale in order from 1 to 12, place the number in the box which applies best to the service user.
2 Do not include information rated in an earlier item except for item 10 which is an overall rating.
3 Rate the MOST SEVERE problem that has occurred during the previous 2 weeks [reduce this period if the person the admission has been short, to give an indication of how they are *at discharge*].
4 All scales follow the same format:

0 = no problem
1 = minor problem requiring no action
2 = mild problem but definitely present
3 = moderately severe problem
4 = severe or very severe problem
*Rate 9 if not known*

**1. Overactive, aggressive, disruptive or agitated behaviour.**

- *Include such behaviour due to any cause (e.g. drugs, alcohol, dementia, psychosis, depression, etc.).*
- *Do not include bizarre behaviour rate at Scale 6*

0 No problem of this kind during the period rated.
1 Irritability, quarrels, restlessness, etc. not requiring action.
2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked overactivity or agitation.
3 Physically aggressive to others or animals (short of rating 4); threatening manner; more serious overactivity or destruction of property.
4 At least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); serious intimidation or obscene behaviour.

**2. Non-accidental self-injury.**

- *Do not include accidental self-injury (e.g. due to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5.*
- *Do not include illness or injury as a direct consequence of drug /alcohol use, rated at Scale 3 (e.g. cirrhosis of the liver or injury resulting from drink driving are rated at Scale 5).*

0 No problem of this kind during the period rated.
1 Fleeting thoughts about ending it all but little risk during period rated; no self-harm.
2 Mild risk during period rated; includes non-hazardous self-harm (e.g. wrist scratching).
3 Moderate to serious risk of deliberate self-harm during period rated; includes preparatory acts (e.g. collecting tablets).
4 Serious suicidal attempt and /or serious deliberate self-injury during period rated.

**3. Problem-drinking or drug taking.**

- *Do not include aggressive / destructive behaviour due to alcohol or drug use, rated at Scale 1.*
- *Do not include physical illness or disability due to alcohol or drug use, rated at Scale 5.*

0 No problem of this kind during the period rated.
1 Some over indulgence but within social norm.
2 Loss of control of drinking or drug taking, but not seriously addicted.
3 Marked cravings or dependence on alcohol or drugs with frequent loss of control, risk taking under the influence.
4 Incapacitated by alcohol / drug problem.

**4. Cognitive problems.**

- *Include problems of memory, orientation and understanding associated with any disorder: learning disability, dementia, schizophrenia etc.*
- *Do not include temporary problems (e.g. hangovers) resulting from drugs / alcohol use, rated at Scale 3.*

0 No problem of this kind during the period rated.
1 Minor problems with memory or understanding (e.g. forgets names occasionally).
2 Mild but definite problems (e.g. has lost the way in a familiar place or failed to recognise a familiar person); sometimes mixed up about simple decisions.
3 Marked disorientation in time, place or person; bewildered by everyday events; speech is sometimes incoherent; mental slowing
4 Severe disorientation (e.g. unable to recognise relatives); at risk of accidents; speech incomprehensible; clouding or stupor.

**5. Physical illness or disability problems.**

- *Include illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning.*
- *Include side-effects from medication; effects of drug/ alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drink-driving, etc.*
- *Do not include mental or behavioural problems rated at Scale 4.*

0 No physical health problem during the period rated.
1 Minor health problems during the period (e.g. cold, non-serious fall).
2 Physical health problem imposes mild restriction on mobility and activity.
3 Moderate degree of restriction on activity due to physical health problem.
4 Severe or complete incapacity due to physical health problem.

**6. Problems associated with hallucinations and delusions.**

- *Include hallucinations and delusions irrespective of diagnosis.*
- *Include odd and bizarre behaviour associated with hallucinations or delusions.*
- *Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions rated at Scale 1.*

0 No evidence of hallucinations or delusions during period rated.
1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.
2 Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour.
3 Marked preoccupation with delusions or hallucinations, causing much distress and/ or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem.
4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient.

**7. Problems with depressed mood.**

- *Do not include overactivity or agitation, rated at Scale 1.*
- *Do not include suicidal ideation of attempts, rated at Scale 2*
- *Do not include delusions or hallucinations, rated at Scale 6*

0 No problem associated with depressed mood during period rated.
1 Gloomy; or minor changes in mood
2 Mild but definite depression and distress (e.g. feelings of guilt; low self-esteem).
3 Depression with inappropriate self-blame; preoccupied with feelings of guilt.
4 Severe or very severe depression, with guilt or self accusation.

**8. Other mental and behavioural problems.**

- *Rate only the most severe clinical problem not considered at items 6 and 7 as follows.*
- *Specify the rate of the problem by entering the appropriate letter: A phobic; B anxiety; C obsessive-compulsive; D mental strain/ tension; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify.*

0 No evidence of any of these problems during period rated.
1 Minor health problems only.
2 A problem is clinically present at a mild level (e.g. patient has a degree of control).
3 Occasional severe attacks of distress, with loss of control (e.g. has to avoid anxiety provoking situations altogether, call in a neighbour to help etc.), i.e. moderately severe level of problem.
4 Severe problem dominates most activities.

**9. Problems with relationships.**

- *Rate the patients most severe problem associated with active or passive withdrawal from social relationships, and or non-supportive, destructive or self-damaging relationships.*

0 No significant problem during the period rated.
1 Minor non-clinical problem.
2 Definite problem in making or sustaining supportive relationships; patient complains and /or problems are evident to others.
3 Persisting major problems due to active or passive withdrawal from social relationships and /or to relationships that provide little or no comfort or support.
4 Severe and distressing social isolation due to inability to communicate socially and /or withdrawal from social relationships.

**10. Problems with activities of daily living.**

- *Rate the overall level of functioning in activities of daily living (ADL's), (e.g. problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, organising where to live. Do not include lack of opportunities for exercising intact abilities and skills, rated at Scales 11-12.*
- *Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.*
- *Do not include lack of opportunities for exercising intact abilities and skills, rate at Scales 11-12.*

0 No problem during period rated; good ability to function in all areas.
1 Minor problems only (e.g. untidy, disorganised).
2 Self-care adequate, but major lack of performance of one or more complex skills (see above).
3 Major problem in one or more area of self-care (see above) as well as major inability to perform several complex skills.
4 Severe disability or incapacity in all or nearly all areas of self-care and complex skills.

**11. Problems with living conditions.**

- *Rate the overall severity of problems with the quality of living conditions and daily domestic routine.*
- *Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones?*
- *Do not rate the level of functional disability itself, rated at Scale 10.*

**NB: Rate patients usual accommodation. If in an acute ward, rate the home accommodation. If information not available, rate 9.**

0 Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.

1 Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal location, not preferred option, doesn't like the food etc.).

2 Significant problem with one or more aspects of the accommodation and /or regime (e.g. restricted choice; staff or household have little understanding of how to limit disability or how to help use or develop new or intact skills).

3 Distressing multiple problems with accommodation (e.g. some basic necessities absent); housing environment has minimal or no facilities to improve patient's independence.

4 Accommodation is unacceptable (e.g. lack of basic necessities, patient at risk of eviction, or roofless, or living conditions are otherwise intolerable, making patient's problems worse.

**12. Problems with occupation and activities.**

- *Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, access to supportive facilities (e.g. staffing and equipment of day centres, workshops, social clubs, etc.).*
- *Do not rate the level of functional disability itself, rated at Scale 10.*

**NB: Rate patient's usual situation. If in acute ward, rate activities during period before admission. If information not available rate 9.**

0 Patient's day-time environment is acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.

1 Minor or temporary problems (e.g. late giro cheques); reasonable facilities available but not always at desired times etc.

2 Limited choice of activities; lack of reasonable tolerance (e.g. unfairly refused entry to public library or baths etc.); handicapped by lack of permanent address; insufficient carer or professional support; helpful day setting available but for very limited hours.

3 Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or add new ones; unskilled care difficult to access

4 Lack of any opportunity for day-time activities makes patients problem worse.

*This form is the Global Assessment of Functioning (GAF) scale*

## Symptoms

Using the scale below, rate symptoms **at discharge**. Use intermediate codes when appropriate, e.g. 45, 68, 72.

**Rating:** [ ]

| | CODES |
|---|---|
| **Absent or minimal symptoms** (e.g. mild anxiety before an exam). | 90 \| 81 |
| **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g. difficulty concentrating after family argument). | 80 \| 71 |
| **Some mild symptoms** (e.g. depressive mood and mild insomnia). | 70 \| 61 |
| **Moderate symptoms** (e.g. flat affect and circumstantial speech, occasional panic attacks). | 60 \| 51 |
| **Serious symptoms** (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting). | 50 \| 41 |
| **Some impairment in reality testing or communication** (e.g. speech is at times illogical, obscure, or irrelevant). | 40 \| 31 |
| **Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication of judgement** (e.g.sometimes incoherent, acts grossly inappropriately, suicidal pre-occupation). | 30 \| 21 |
| **Some danger of hurting self or others** (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitment) **OR gross impairment in communication (e.g. largely incoherent or mute**). | 20 \| 11 |
| **Persistent danger of hurting self or others** (e.g. recurrent violence OR serious suicidal act with clear expectation of death). | 10 \| 1 |

## Disability

Using the scale below, rate symptoms **at discharge**. Do not include disability due to physical or environmental limitations. Use intermediate codes when appropriate, e.g. 45, 68, 72

**Rating:** ☐

| | CODES |
|---|---|
| **Good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g. an occasional argument with family members). | 90 \| 81 |
| **No more than slight impairment in social, occupational, or school functioning** (e.g. temporarily falling behind in school work). | 80 \| 71 |
| **Some difficulty in social, occupational, or school functioning** (e.g. occasional truancy or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.** | 70 \| 61 |
| **Moderate difficulty in social, occupational, or school functioning** (e.g. few friends, conflicts with co-workers). | 60 \| 51 |
| **Any serious impairment in social, occupational, or school functioning** (e.g. no friends, unable to keep a job). | 50 \| 41 |
| **Major impairment in several areas, such as work or school, family relations, judgement, thinking or mood** (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school). | 40 \| 31 |
| **Inability of function in almost all areas** (e.g. stays in bed all day; no job, home, or friends). | 30 \| 21 |
| **Occasionally fails to maintain minimal personal hygiene** (e.g. smears faeces). | 20 \| 11 |
| **Persistent inability to maintain minimal personal hygiene.** | 10 \| 1 |

# THRESHOLD ASSESSMENT GRID (TAG)

## SCORE SHEET

TAG ASSESSES THE SEVERITY OF A PERSON'S MENTAL HEALTH PROBLEMS

For each domain (numbered 1 to 7), tick ONE statement that best applies to the person being assessed. There should be a total of 7 ticks on the completed grid (one for each domain). Then for each level of severity (e.g. 'None', 'Very Severe') add the number of ticks and record in the box at the bottom of the column. 'Very Severe' is only available for domains where life-saving emergency action by specialist mental health teams may be required. The checklists overleaf provide some guidance on the issues to consider when assessing each domain - they are not intended to be prescriptive. Further information on the TAG is available from www.iop.kcl.ac.uk/prism/tag.

| | | NONE | MILD | MODERATE | SEVERE | VERY SEVERE |
|---|---|---|---|---|---|---|
| SAFETY | **Domain 1** Intentional self harm | No concerns about risk of deliberate self-harm or suicide attempt ○ | Minor concerns about risk of deliberate self-harm or suicide attempt ○ | Definite indicators of risk of deliberate self-harm or suicide attempt ○ | High risk to physical safety as a result of deliberate self-harm or suicide attempt ○ | Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt ○ |
| | **Domain 2** Unintentional self harm | No concerns about unintentional risk to physical safety ○ | Minor concerns about unintentional risk to physical safety ○ | Definite indicators of unintentional risk to physical safety ○ | High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment ○ | |
| RISK | **Domain 3** Risk from others | No concerns about risk of abuse or exploitation from other individuals or society ○ | Minor concerns about risk of abuse or exploitation from other individuals or society ○ | Definite risk of abuse or exploitation from other individuals or society ○ | Positive evidence of abuse or exploitation from other individuals or society ○ | |
| | **Domain 4** Risk to others | No concerns about risk to physical safety or property of others ○ | Antisocial behaviour ○ | Risk to property and/or minor risk to physical safety of others ○ | High risk to physical safety of others as a result of dangerous behaviour ○ | Immediate risk to physical safety of others as a result of dangerous behaviour ○ |
| NEEDS AND DISABILITIES | **Domain 5** Survival | No concerns about basic amenities, resources or living skills ○ | Minor concerns about basic amenities, resources or living skills ○ | Marked lack of basic amenities, resources or living skills ○ | Serious lack of basic amenities, resources or living skills ○ | Life-threatening lack of basic amenities, resources or living skills ○ |
| | **Domain 6** Psychological | No disabling or distressing problems with thinking, feeling or behaviour ○ | Minor disabling or distressing problems with thinking, feeling or behaviour ○ | Disabling or distressing problems with thinking, feeling or behaviour ○ | Very disabling or distressing problems with thinking, feeling or behaviour ○ | |
| | **Domain 7** Social | No disabling problems with activities or in relationships with other people ○ | Minor disabling problems with activities or in relationships with other people ○ | Disabling problems with activities or in relationships with other people ○ | Very disabling problems with activities or in relationships with other people ○ | |
| | **No. of ticks** | | | | | TAG score |
| | **TAG score** | 0 points for each None rating: **0** | 1 point for each Mild rating: | 2 points for each Moderate: | 3 points for each Severe: | 4 points for each V. Severe: |

# Appendix 4: Topic guide for Service User Qualitative Interviews

## A study of in-patient and residential alternatives to hospital in-patient psychiatric care

## Topic Guide for Module 3 Interviews

The purpose of this interview is to understand more about your experiences of different types of residential services for people with mental health problems. I am going to ask you to talk about your views and experiences of the service you are staying in at the moment and services you have stayed in prior to this.

**Questions**

1. Can you tell me about your views and experiences in this service?

2. Can you tell me about your views and experiences in services you have stayed at previously?

3. How does this service compare to the services you stayed at previously?

**Topic guide for each question**

A. Relationships
   - Support
   - Trust
   - Coercion
     - Threats
     - Punishment
     - Force
     - Restraint
   - Communication
     - Listening
     - Talking
     - Understanding

B. Safety
   - Violence
   - Fear
   - Suicide

C. Treatment
   - Therapies
   - Activity
   - Medication

D. Freedom

E. Race and Religion

F. Environment

## Recording sheet

Date of interview: / /

Interviewer:

Participant ID:

Date of birth: / /

Ethnicity

| | | | |
|---|---|---|---|
| White | ☐ | Pakistani | ☐ |
| Black Caribbean | ☐ | Bangladeshi | ☐ |
| Black African | ☐ | Chinese | ☐ |
| Black Other | ☐ | Other Asian | ☐ |
| Indian | ☐ | Other (specify below)…….. | ☐ |

Gender

Male ☐ Female ☐

Mental Health Act status

Voluntary ☐ Detained ☐ Not sure ☐

**Record details of interview below**

# Appendix 5: Topic guide for Carer Qualitative Interviews

## A study of in-patient and residential alternatives to hospital in-patient psychiatric care

## Carers Experiences form

You have been identified as a carer for <name> staying on a unit in the study. The aim of the study is to understand any differences between traditional and alternatives services, and as part of that we want to try to understand the perspective of carers. The information you give will be recorded, transcribed, anonymised with your name and <name> replaced with initials, analysed and then reported.

I am going to ask you few details about yourself and then some questions about the service <name> is staying in now, or has just been discharged from, and the hospital services they have stayed at in the past. I would like you to think about your relationship to these services and what your views are on each of the services. The questions are deliberately open-ended, because we want to understand your views. There are no right or wrong answers. Your responses will be confidential to the research team, and won't be fed back either to the services or to <name>, so we hope you will be as honest as possible.

**Carer information**

Date of interview / /

Carer ID:

Date of birth: / /

Ethnicity

| | | | |
|---|---|---|---|
| White | ☐ | Pakistani | ☐ |
| Black Caribbean | ☐ | Bangladeshi | ☐ |
| Black African | ☐ | Chinese | ☐ |
| Black Other | ☐ | Other Asian | ☐ |
| Indian | ☐ | Other | ☐ |
| | | (specify below)…….. | |

Gender

Male ☐ Female ☐

Living situation

Living with person ☐ Not living with person ☐

## General Questions

1. Tell me about the current service <name> is staying at now or has just been discharged from.
   *[Prompts for this and subsequent: Can you say a bit more about that? Why do you think that was? How did you feel about that? Did you think that was a good thing?]*

2. *[identify which previous admissions were to traditional acute mental health services, and then identify one of these services to ask about – generally the most recent, or (where relevant) the most frequently used. May be one unit or a group of units,* e.g. *acute wards at the local psychiatric hospital. Clarify that this question is just about the identified service.]*

   Tell me about the previous service <name> stayed at before their last admission.

3. The rest of this interview will involve comparing the current alternative service and the previous traditional service. What were the main differences between the current service and the previous service from your point of view?

4. How were each of the current and the previous services helpful?

## Your views about the care offered to patients

5. What was your impression of the safety of each service? Did you feel safe when you visited? Did you feel safe when arriving at and leaving the service?

6. What are your views on the treatments, therapies and support that were on offer and those that <name> actually received in each of the services?

7. What are your views about the freedom available to patients to spend time as they wished at each service? What was the atmosphere like in each service?

8. What are your views on the physical environment that patients stayed in, for each of the services?

9. In your opinion, were the needs of <name> met at each service?

## Questions about you and the service

10. Can you describe what your relationships were like with the people you met in each service? This can include your relationship with the staff, with other in-patients and with other carers.

11. Did you feel your role as a carer and your knowledge was recognised and valued by each of the services?

12. If you had any needs, were you able to communicate them and were your needs met by each of the services?

13. Did you want and receive any information or education about mental illness from the staff of each of the services?

14. If you had any cultural or religious needs, were these recognised and/or were they dealt with sensitively.

15. If you or <name> needed to access either of the services again, how easy would this be?

16. Which service would you choose to access again, and why?

17. Is there anything else you would like to add, either in relation to what we have covered or anything else that you think is relevant to understanding your views as a carer?

# Appendix 6: 1 Year Follow-up Form

**Participant ID:**

**Date of original admission:**

**Service admitted to:**

**Information recorded by:**

1. Psychiatric inpatient bed days in year preceding admission

i.) In alternative services

ii.) In standard services

2. Psychiatric inpatient bed days during index admission

*Index admission = total duration of stay in any crisis residential or inpatient services from initial admission until discharge: if person was transferred between services during admission, please record days spent in each service separately.*

| Service name | Type;<br>1 = standard<br>2 = study alternative<br>3 = other alternative | Date in | Date out | Inpatient days | Detained under MHA during admission?<br>Yes/No |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

3. Total duration of index inpatient admission (days) ☐

4. Additional psychiatric inpatient bed days in year following index admission:

*Please record each stay in each inpatient service separately*

| Service name | Type;<br>1 = standard<br>2 = study alternative<br>3 = other alternative | Date in | Date out | Inpatient days | Detained under MHA during admission?<br>Yes/No |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

5. Total number of inpatient admi ssions in year following admission *(including index admission)* ☐

*(if patient was transferred between services, count stay at both services as one admission)*

6. Number of days spent in the community following discharge from index admission ☐

*(before readmission or end of 1 year follow up period)*

☐

7. Number of kept psychiatric out-patient contacts in year following admission:

7a. Number of missed psychiatric outpatient contacts in the year following admission:

8. Number of kept CMHT contacts in year following admission:

8a. Number of missed CMHT contacts in year following admission:

9. Number of kept Assertive Outreach Team contacts in year following admission

9a. Number of missed Assertive Outreach Team contacts in year following admission

10. Number of kept Early Intervention Service contacts in year following admission

10a. Number of missed Early Intervention Service contacts in year following admission

11. Number of kept community rehabilitation team contacts in year following admission

11a. Number of missed community rehabilitation team contacts in year following admission

12. Number of days' contact with Crisis Resolution/Home Treatment team in year following admission

12a. Number of kept contacts with Crisis Resolution/Home Treatment team in year following admission

12b. Number of missed contacts with Crisis Resolution/Home Treatment team in year following admission

13. Number of kept psychiatric NHS day-patient attendances in year following admission:

13a. Number of missed psychiatric NHS day-patient attendances in year following admission:

14. Number of attendances at Liaison Psychiatry in year following admission:

# Appendix 7: Alternative Service Manager Interview Topic Guide

## A study of residential alternatives to traditional hospital in-patient psychiatric care

## Alternative Service Manager interview Topic Guide

I am going to ask you a number of questions about the service you work in. Please answer the questions in as much detail as possible. Feel free to ask if there is anything you do not understand or that needs clarifying. I will be taping and recording in writing your responses as we talk.

### 1. Tell me about how the service started

*Prompts*
Where did the original ideas for this particular type of service? What was the original vision?
How were clients to be referred?
Who was the service designed for? Were there any specifically excluded client groups?
What was the process you went through to develop this service? Who decided what the service would do?

### 2. What changes have happened to the service?

*Prompts*
What obstacles / challenges have been encountered? How have you had to adapt the service? How has the service been affected by other changes to local services? Does the service work with the same group as initially envisaged? Has the original vision changed?

### 3. Tell me about how the service works today

*Prompts*

Access – how does the service fit into the local service system? Which relationships work well, and which don't work well?

Content – what types of support or care does the unit provide?

What is the relationship with the in-patient unit? Is the service intended to work with the same group?

What is the relationship with the local crisis team (if applicable)?

Has the service model been effectively implemented? Is there any gap between rhetoric and reality in what your service offers?

Is the service under threat at the moment? Why?

### 4. Here are some data from your service and our comparison site. Can you comment on this?

*Prompts*

Pre-prepared comparison of anonymised Outcomes sub-study data for the 2 sites – Gender, ethnicity, diagnosis, MHA status, length of stay, baseline & discharge ratings

**5. We have been evaluating your service as an alternative to traditional in-patient care. Do you think your service is an alternative? In what ways?**

*Prompts*

Consider: therapeutic model; role in the local service system; funding; staff attitudes and values; building location.

Who leads the development and maintenance of what makes the service alternative?

What are the implications for staff – how is this communicated to staff, how are disagreements resolved, does it impact on the type of staff employed, what skills do staff need, are some staff groups particularly affected, what benefits are there for staff in implementing the model?

# Appendix 8: Stakeholder Interview Topic Guide

## A study of residential alternatives to traditional hospital in-patient psychiatric care

## Stakeholder interviews
## Topic Guide

I am going to ask you a number of questions about the service you work in. Please answer the questions in as much detail as possible. Feel free to ask if there is anything you do not understand or that needs clarifying. I will be taping and recording in writing your responses as we talk.

**1. For people experiencing crises in the local area, what determines whether they are cared for by the alternative service, the (usual) in-patient wards, or (if applicable) the crisis resolution / home treatment service?**

Prompts:
Influence of:

- Patient variables – symptom severity, risk (particularly of violence), MHA status, service users' preferences, type of mental health problem, social functioning, social support, cooperativeness/willingness to accept treatment, dual diagnosis (particularly co-morbid substance misuse), specific diagnosis (e.g. personality disorder, eating disorder)
- Setting in which they present – do pathways from certain referrers tend to run towards certain settings e.g. does A and E presentation tend to result in in-patient admission?
- Clinician variables – preferences of particular individuals/disciplines
- Timing – availability of places in particular services, opening hours, speed of admission

*Interviewer – summarise differences (if any) found in the Alternatives Study between pathways into and out of the alternative and the standard local services. Then ask:*

**2. Do you agree with this description of the different pathways? How do you explain the differences in referral pathways between the alternative and the traditional service?**

*Interviewer – summarise differences (if any) found in the Alternatives Study between characteristics of people using the alternative and the standard local services. Then ask:*

**3. Is this what you expected? How do you explain any differences in who uses the two services?**

**4. Would it be a good thing if the alternative worked with a service user group that is more similar to people admitted to standard local hospital services?**

*Prompts*
If no, why? If yes, what are the barriers and what would need to happen for this to be possible?
(If relevant) Why do you think the service does not accept people who are sectioned under the Mental Health Act at present? Could changes be made to allow it to admit patients on section? What would be the advantages and disadvantages?

**5. In what ways, if any, is the alternative a useful part of the local service system?**

*Prompts*
Do any problems arise in collaborations between the alternative and other local mental health services? Prompt for difficulties around referral, discharge, communication about the patient, views about who the alternatives are suitable for, collaboration with CRTs.
Do you think there are any ways in which the alternative could be made a more useful part of the local acute service system?

**6. What advice would you give staff in another catchment area who were planning to develop a residential alternative to admission?**

# Appendix 9: CaRICE

## CaRICE

### Camden Record of Inpatient Care Events

All staff at this service are being asked to record your direct contact with patients during your working day. This is to measure all the care provided to patients at this service. Please use this form record contact they have with resident service users.

Please record when you have **any** face-to-face contact for five minutes or longer with a patient in your service. You do not need to record which patient(s) you saw. You will need to record:

- Length of contact
- Purpose of the contact (see purpose of contact sheet)

- Please record contacts with more than one service user at the same time as one contact (e.g. if you are running a group)

- If more than one member of staff sees a service user together, please could each member of staff record this as a contact (e.g. at a meeting)

***Purpose of contact***

Please record the main purpose of each contact with a service user as one of the categories of care on the attached list. If your contact involves more than one intervention, please record all the types of care you provided.

**e.g. if you saw a service user at 10.15am for 25 minutes to help them with a housing application and to give them a depot injection, this would be recorded as below:**

| Time of contact | Length of contact (in minutes) | Purpose(s) of contact *(put number(s) for type of contact)* |
|---|---|---|
| *10.15am* | *25* | *1, 16* |

*** Please return your completed recording sheet before you leave work***

Thank you very much for your time and help with this research project.

# Content of Care: Event Recording Sheet

Name _____ Service _____

Job Title _____

Start of shift _____am/pm End of shift _____ am/pm

Date _____ Ref. No. (researcher use only) _____

| Time of contact | Length of contact (in minutes) | Purpose of contact *(put number(s) for type(s) of contact)* |
|---|---|---|
| *e.g. 10.15* | *25* | *1,16* |
| | | |
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**Photocopy this page if further pages are needed**

## Event Recording Sheet: Categories of Care

| Purpose of contact | Description |
|---|---|
| **1** | Help with **housing problems**,<br>(e.g. help finding somewhere to live or making current housing more suitable) |
| **2** | Help with **financial problems**<br>( such as claiming benefits or managing debts) |
| **3** | Help with **legal matters** (e.g. providing a letter or report for the court or his/her solicitor, providing information about his/her legal rights or help to access legal services) |
| **4** | **Current activity:** help to plan or engage in social, leisure, occupational or religious activities while staying at this service |
| **5** | **Future activity:** help to plan or access work, education, social, leisure or religious activities when he/she leaves this service |
| **6** | Help for him/her to practice or improve **skills in every day tasks**<br>(e.g. managing shopping, cooking using a washing machine, self care) |
| **7** | Contact between staff and his/her **family, friends or carers** to help support him/her and them |
| **8** | **Assessment of his/her difficulties**<br>(help focused mainly on asking him/her about the nature or severity of current problems or his/her life history) |
| **9** | Help (other than medication) focused mainly on finding **ways to cope with distressing feelings, thoughts and experiences** (e.g. low mood, panic attacks, intrusive or strange thoughts or hearing voices) |
| **10** | Help focused mainly on resolving or managing difficulties with **current relationships** |
| **11** | Help focused mainly on resolving or managing difficulties with negative or traumatic **past events** |
| **12** | Help focused mainly on problems he/she is experiencing with **drug or alcohol use** |
| **13** | Help focused mainly on **providing him/her with information or explanation** about the nature of his/her mental health or psychological problems or his/her diagnosis |
| **14** | Help with **concerns or questions he/she has about his/her medication**<br>(e.g. providing information about treatment options or side effects, discussing advantages or disadvantages of medication or problems he/she is experiencing) |
| **15** | **A review or change of his/her current medication**<br>*(only include medication for mental health problems or side-effects of mental health medication in this category)* |
| **16** | Practical help with **taking medication**<br>(such as staff dispensing medication or giving an injection, or reminding him/her to take medication) |
| **17** | Help with his/her **physical health**<br>(treatment, investigations, tests or help to access physical health services)<br>*(Don't include prescribed medication for mental health problems or side-effects from mental health medication in this category)* |
| **18** | **A member of staff staying with him/her** continuously or at regular intervals to make sure he/she or others are safe at times when he/she has been distressed or disturbed. |
| **19** | **A member of staff physically restraining him/her** to make sure he/she or others are safe at times when he/she has been distressed or disturbed. |
| **20** | **A meeting** for him/her and everyone involved with his/her care to discuss his/her current needs and concerns |
| **21** | Help to plan or arrange **care from other mental health services once he/she leaves this service** |

# Appendix 10: CaSPAR

## CaSPAR

### Camden Staff-Patient Activity Record

**Name of Unit:** _____

**Please record:** 1) Date and time of the observation

2) Number of service users resident at the unit

3) Number of service users engaged in each of the categories below.

***Please refer to attached guidance for scheduled recording times***

| Day | Date | Time | Total Service users resident | *In the Unit* | | *Out of the unit* | |
|---|---|---|---|---|---|---|---|
| | | | | With staff | Not with staff | With staff | Not with staff |
| ***Monday*** | ***29/02/06*** | ***10.00am*** | ***20*** | ***5*** | ***8*** | ***2*** | ***4*** |
| Monday | | 10.45 | | | | | |
| Monday | | 13.15 | | | | | |
| Monday | | 15.45 | | | | | |
| Monday | | 17.15 | | | | | |
| Tuesday | | 11.15 | | | | | |
| Tuesday | | 13.45 | | | | | |
| Tuesday | | 16.15 | | | | | |

| Day | Date | Time | Total Service users resident | *In the Unit* | | *Out of the unit* | |
|---|---|---|---|---|---|---|---|
| | | | | **With staff** | **Not with staff** | **With staff** | **Not with staff** |
| ***Monday*** | ***29/02/06*** | ***10.00am*** | ***20*** | ***5*** | ***8*** | ***2*** | ***4*** |
| Tuesday | | 18.15 | | | | | |
| Wednesday | | 09.15 | | | | | |
| Wednesday | | 11.45 | | | | | |
| Wednesday | | 14.15 | | | | | |
| Wednesday | | 19.15 | | | | | |
| Thursday | | 09.45 | | | | | |
| Thursday | | 12.15 | | | | | |
| Thursday | | 14.45 | | | | | |
| Thursday | | 20.15 | | | | | |
| Friday | | 08.15 | | | | | |
| Friday | | 10.15 | | | | | |
| Friday | | 12.45 | | | | | |
| Friday | | 15.15 | | | | | |
| Saturday | | 10.15 | | | | | |
| Saturday | | 13.45 | | | | | |
| Saturday | | 16.45 | | | | | |
| Saturday | | 18.45 | | | | | |
| Sunday | | 10.45 | | | | | |

| Day | Date | Time | Total Service users resident | *In the Unit* | | *Out of the unit* | |
|---|---|---|---|---|---|---|---|
| | | | | With staff | Not with staff | With staff | Not with staff |
| ***Monday*** | ***29/02/06*** | ***10.00am*** | ***20*** | ***5*** | ***8*** | ***2*** | ***4*** |
| Sunday | | 13.15 | | | | | |
| Sunday | | 16.15 | | | | | |
| Sunday | | 19.15 | | | | | |

# How to use CaSPAR

**Who is resident?**

- Service users who spent last night on the unit
- Service users who were admitted on day of recording
- **Include** current service users away from the unit except those on extended (overnight) leave

**Who is with staff?**

- Service users actively engaged (interacting) in any way with a member of staff (e.g. talking, playing a game, eating together, going out for a walk, receiving medication)

**Who is not with staff?**

- Service users alone
- Service users with other service users or family/friends
- Service users near staff but where staff are not interacting
  (e.g.) a service user queuing up to see staff or being in the same communal room but not interacting with staff)

**Who is in?**

- Service users in the unit itself
- Service users in another part of the building/hospital (e.g. participating in a group activity)
- Service users currently resident who are known to be in the unit's garden or grounds. *Record service users using periods of day leave or agreed time away from the service as out.*

**Times of recordings**

- 28 recordings will take place at each participating service at the times listed on the form
- A maximum of 2 recordings per day and 10 recordings altogether to be made in any one week

# Appendix 11: CCCQ(P)

**A study of in-patient and residential alternatives to hospital in-patient psychiatric care**

**Content of Care Questionnaire**
**Service user version**

**Participant ID:**

**Participant D.o.B.**

**Service:**

**Date of admission *(if known)*:**

**Date questionnaire completed:**

**Researcher:**

*Please use this form to record the amount and types of care received by the service user from staff at this service during this admission.*

| Question | Type of help | Have you received any help of this sort from staff at this service during your stay?<br><br>0 = No<br>1 = Yes | If yes, how frequently have you received this sort of help from staff at this service?<br>1 = once only<br>2 = less than once a week<br>3 = once a week<br>4 = two or three times a week<br>5 = more than three times a week but less than every day<br>6 = once a day<br>7 = more than once a day |
|---|---|---|---|
| 1 | Help with **housing problems**,<br>(e.g. help finding somewhere to live or making current housing more suitable) | | |
| 2 | Help with **financial problems**<br>( such as claiming benefits or managing debts) | | |
| 3 | Help with **legal matters** (e.g. providing a letter or report for the court or your solicitor, providing information about your legal rights or help to access legal services) | | |
| 4 | **Current activity:** help to plan or engage in social, leisure, occupational or religious activities while staying at this service | | |
| 5 | **Future activity:** help to plan or access work, education, social, leisure or religious activities for when you leaves this service | | |
| 6 | Help for you to practice or improve **skills in every day tasks**<br>(e.g. managing shopping, cooking using a washing machine, self care) | | |
| 7 | Contact between staff and your **family, friends or carers** to help support you and them | | |
| 8 | **Assessment of your difficulties**<br>(help focused mainly on asking you about the nature or severity of current problems or your life history) | | |
| 9 | Help (other than medication) focused mainly on finding **ways to cope with distressing feelings, thoughts and experiences** (e.g. low mood, panic attacks, intrusive or strange thoughts or hearing voices) | | |
| 10 | Help focused mainly on resolving or managing difficulties with **current relationships** | | |
| 11 | Help focused mainly on resolving or managing difficulties with negative or traumatic **past events** | | |
| 12 | Help focused mainly on problems you are experiencing with **drug or alcohol use** | | |
| 13 | Help focused mainly on **providing you with information or explanation** about the nature of your mental health or psychological problems or your diagnosis | | |
| 14 | Help with **concerns or questions you have about your medication**<br>(e.g. providing information about treatment options or side effects, discussing advantages or disadvantages of medication or problems you are experiencing) | | |
| 15 | **A review or change of your current medication**<br>*(only include medication for mental health problems or side effects of mental health medication in this category)* | | |
| 16 | Practical help with **taking medication**<br>(such as staff dispensing medication or giving an injection, or reminding you to take medication) | | |
| 17 | Help with your **physical health** (treatment, investigations, tests or help to access physical health services)<br>*(Don't include prescribed medication for mental health problems or side-effects from mental health medication in this category)* | | |
| 18 | **A member of staff staying with you** continuously or at regular intervals to make sure you or others are safe at times when you have been distressed or disturbed. | | |
| 19 | **A member of staff physically restraining you** to make sure you or others are safe at times when you have been distressed or disturbed. | | |
| 20 | **A meeting** for you and everyone involved with your care to discuss your current needs and concerns | | |
| 21 | Help to plan or arrange **care from other mental health services once you leave this service** | | |

# Appendix 12: Satisfaction Questionnaires

**A study of in-patient and residential alternatives to hospital in-patient psychiatric care**

## Satisfaction Questionnaire

### Introduction

The questions in this questionnaire aim to find out your opinions about the services you have received in this service during your current stay.

Please express your opinion whatever it is. We are especially interested to know your criticisms and about the problems you have with the services.

All your answers will be treated confidentially and no-one treating you will find out the opinions which you have expressed in this questionnaire, including the professionals working in the service and your relatives.

Please feel free to ask the researcher for help if a question is not clear or if you encounter any problem filling in the questionnaire.

Please listen to, or read, the questions very carefully and take your time before answering.

---

Date of interview: / /

Interviewer:

Participant ID:

Date of birth: / /

Ethnicity

White
- ☐ 1 White British
- ☐ 2 White Irish
- ☐ 3 White Other

Black/Black British
- ☐ 4 Caribbean
- ☐ 5 African
- ☐ 6 Black Other

Asian/Asian British
- ☐ 7 Indian
- ☐ 8 Pakistani
- ☐ 9 Bangladeshi
- ☐ 10 Asian Other

Mixed
- ☐ 11 White/Black Caribbean
- ☐ 12 White/Black African
- ☐ 13 White/Asian
- ☐ 14 Other mixed

Chinese or other
- ☐ 15 Chinese
- ☐ 16 Other ethnic group

Gender

Male ☐ Female ☐

Mental Health Act status

Voluntary ☐ Detained ☐ Not sure ☐

# CIRCLE YOUR ANSWER

**1. How would you rate the quality of service you received?**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Poor | Fair | Good | Excellent |

**2. Did you get the kind of service you wanted?**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| No, definitely not | No, not really | Yes, generally | Yes, definitely |

**3. To what extent has this service met your needs?**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| None of my needs have been met | Only a few of my needs have been met | Most of my needs have been met | Almost all of my needs have been met |

**4. If a friend were in need of similar help, would you recommend this service to him or her?**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| No, definitely not | No, not really | Yes, generally | Yes, definitely |

**5. How satisfied are you with the amount of help you have received?**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Quite dissatisfied | Indifferent or mildly satisfied | Mostly satisfied | Very satisfied |

**6. Has the service you received helped you to deal more effectively with your problems?**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| No, they seemed to make things worse | No, they didn't really help | Yes, they helped somewhat | Yes, they helped a great deal |

**7. In an overall general sense, how satisfied are you with the service you have received?**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Quite dissatisfied | Indifferent or mildly satisfied | Mostly satisfied | Very satisfied |

**8. If you were to seek help again, would you come back to this service?**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| No, definitely not | No, not really | Yes, generally | Yes, definitely |

**You are going to read some statements about your coming into the service at this time. Please tick one box, either 'True' or False' or Don't know' for each question. Try to answer each question individually, no matter how similar it may sound to another.**

| | | True | False | Don't know |
|---|---|---|---|---|
| 1. | I felt free to do what I wanted about coming into the service | ☐ | ☐ | ☐ |
| 2. | People tried to force me to come into the service | ☐ | ☐ | ☐ |
| 3. | I had enough of a chance to say whether I wanted to come into the service | ☐ | ☐ | ☐ |
| 4. | I chose to come into the service | ☐ | ☐ | ☐ |
| 5. | I got to say what I wanted about coming into the service | ☐ | ☐ | ☐ |
| 6. | Someone threatened me to get me to come into the service | ☐ | ☐ | ☐ |
| 7. | It was my idea to come into the service | ☐ | ☐ | ☐ |
| 8. | Someone physically tried to make me come into the service | ☐ | ☐ | ☐ |
| 9. | No one seemed to want to know whether I wanted to come into the service | ☐ | ☐ | ☐ |
| 10. | I was threatened with being sectioned | ☐ | ☐ | ☐ |
| 11. | They said they would make me come into the service | ☐ | ☐ | ☐ |
| 12. | No one tried to force me to come into the service | ☐ | ☐ | ☐ |
| 13. | My opinion about coming into the service didn't matter. | ☐ | ☐ | ☐ |
| 14. | I had a lot of control over whether I went into the service | ☐ | ☐ | ☐ |
| 15. | I had more influence than anyone else on whether I came into the service | ☐ | ☐ | ☐ |

| | True | False | Don't know |
|---|---|---|---|
| 16. How did being admitted to the make you feel? | | | |
| a. Angry | ☐ | ☐ | ☐ |
| b. Sad | ☐ | ☐ | ☐ |
| c. Pleased | ☐ | ☐ | ☐ |
| d. Relieved | ☐ | ☐ | ☐ |
| e. Confused | ☐ | ☐ | ☐ |
| a. Frightened | ☐ | ☐ | ☐ |

**Please read each question carefully and circle whether you think the statement is true or false for the service you are staying in at the moment.**

| | | |
|---|---|---|
| 1. Patients put a lot of energy into what they do around here | T | F |
| 2. Doctors have very little time to encourage patients | T | F |
| 3. Patients tend to hide their feelings from one another | T | F |
| 4. The staff act on patients' suggestions | T | F |
| 5. New treatment approaches are often tried on this unit | T | F |
| 6. Patients hardly ever discuss their sex life | T | F |
| 7. Patients often gripe | T | F |
| 8. Patients' activities are carefully planned | T | F |
| 9. The patients know when doctors will be on the unit | T | F |
| 10. The staff rarely punish patients by restricting them | T | F |
| 11. This is a lively unit | T | F |
| 12. The staff know what the patients want | T | F |
| 13. Patients say anything they want to the doctors | T | F |
| 14. Very few patients have responsibility here | T | F |
| 15. There is very little emphasis on teaching patients solutions to practical problems | T | F |
| 16. Patients tell each other about their personal problems | T | F |
| 17. Patients often criticise or joke about the staff | T | F |
| 18. This is well-organised unit | T | F |
| 19. Doctors do not explain what treatment is about to patients | T | F |
| 20. Patients may interrupt when a doctor is talking | T | F |
| 21. The staff are proud of this unit | T | F |
| 22. Staff are interested in following up the patients once they leave the unit | T | F |
| 23. It is hard to tell what the patients are feeling here | T | F |
| 24. Patients are expected to take leadership here | T | F |
| 25. Patients are strongly encouraged to plan for the future | T | F |
| 26. Personal problems are openly talked about | T | F |
| 27. Patients on this unit rarely argue | T | F |
| 28. The staff make sure that the unit is always neat | T | F |
| 29. If a patients' medicine is changed, a nurse or doctor always explains why | T | F |
| 30. Patients who break the rules are punished for it | T | F |
| 31. There is very little group spirit on this unit | T | F |
| 32. Nurses have very little time to encourage patients | T | F |
| 33. Patients are very careful about what they say when staff are around | T | F |
| 34. Patients are encouraged to be independent | T | F |
| 35. There is very little emphasis on what patients will be doing when they leave | T | F |
| 36. Patients are expected to share their personal problems with each other | T | F |
| 37. Staff sometimes argue openly with each other | T | F |
| 38. The unit sometimes gets very messy | T | F |
| 39. The patients clearly understand the unit rules | T | F |
| 40. Patients who argue with other patients will get into trouble with the staff. | T | F |

**Please read each question and circle one answer for each question.**

**What is your overall feeling about the . . .**

1. Opportunity to choose which staff you see

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

2. How much services helped you deal with your problems

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

3. Administration (organising meetings / assessments with you, giving you the right paperwork, *etc.*)

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

4. The kinds of questions asked and how they were asked

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

5. Knowledge and competence of the staff seen

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

6. Location and access to the services (distance, ease of parking, public transportation, etc.)

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

7. Appearance and layout of the facility and grounds

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

8. Ability of staff you worked with to listen to and understand your problems

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

9. Personal manner, involvement, and caring of the staff

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

10. Activities at this service

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

11. Cleanliness and comfort of the residential environment

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

12. How your family, significant others, or other support people were or were not involved

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

13. Help with practical problems (financial, locating suitable housing, or landlord problems, etc.)

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

14. Effect of services in helping you stay well and preventing you becoming an inpatient again

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

15. Confidentiality and respect for your rights as an individual

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

16. Information on how to get the most out of services (the availability and usefulness of such information)

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

17. Helping you get needed prescriptions, or other medical or dental services

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

18. Helping you handle medication side effects, discomfort, and other medication concerns

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

19. Suggestions on what to do on your own after discharge

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

20. Explanations of agency procedures and treatment plans

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

21. Effect of services in helping relieve symptoms

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

22. Response of staff to your urgent needs *during the day*

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

23. Response of staff to your urgent needs *in the evening or at night*

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

24. Safety of the environment (how "at home" you could be)

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

25. Usefulness of referrals to other counsellors, doctors, etc.

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

26. Communication between the residential staff and other service providers

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

27. Willingness to see you as often as you feel is needed

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

28. Handling and accuracy of your records (as best you can tell)

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

29. Quality and quantity of food

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *DELIGHTED* | *MOSTLY SATISFIED* | *MIXED* | *MOSTLY DISSATISFIED* | *TERRIBLE* |

30. Help you received from working on problems with other people staying at this service

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| *TERRIBLE* | *MOSTLY DISSATISFIED* | *MIXED* | *MOSTLY SATISFIED* | *DELIGHTED* |

# Appendix 13
# User experiences of alternative services : Quotes

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 1 | | Hospital-based alternative | *'But it's not employed. You're talking about the tidal model aren't you? You are supposed to sit down each day… yeah and they don't do it.'* |
| 2 | 2108 | Alternative service | *'…it was nice and pleasant and I feel relaxed and refreshed after a two week break.'* |
| 3 | 3126 | Alternative service | *'…this I would recommend to anybody to come, it's nice and peaceful.'* |
| 4 | 3140 | Alternative service | *'I think I would prefer to come here because the environment is a lot more calm, a lot more easygoing…'* |
| 5 | 6122 | Hospital service | *'…it was a total and utter nightmare, I've never experienced anything so extreme with people running up and down corridors, screaming at 3 am in the morning, I was terrified. I would never go there again. Hospital would make me worse.'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 6 | 1164 | Hospital service | *'They* (staff) *were just really friendly and caring and lovely.'* |
| 7 | 2142 | Hospital service | *'They were rude, their job was to, there was, although people were sick right they thought everybody was stupid. They'd talk down to use like we were lower than them.'* |
| 8 | 5144 | Hospital service | *'they won't sit in a room with you and say like, come on tell me your problems, let's get on with it, you know. It's like, are you feeling OK, do you want a cup of tea, can I get you anything, do you want to play a game of cards or something, then you go on and you start a conversation from there and that's how they are skilled in building a conversation , you feel comfortable into telling them something.'* |
| 9 | 3126 | Hospital service | *'When it was Ward X I was so familiar with the staff that I didn't mind going there because I knew the staff.'* |
| 10 | 4111 | Alternative service | *I trust the staff 100% because I've been coming here for the last, well the last 3 ½ years.'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 11 | 4101 | Alternative service | *I usually wait until my mum and dad get here at night so and then go for a walk with them more like which is, it's just nice, it adds to the fact that this is a cosy place.'* |
| 12 | 2108 | Alternative service | *'…my dad has extended it (length of stay) so it will be, I will be here for the rest of today and I don't know how long then but it will do me good, I will benefit from it.'* |
| 13 | 6122 | Hospital service | *'Just the fact that you are in an open ward and just the terror of hearing people, the anguish and pain that they were going through and of course it makes you worse you know.'* |
| 14 | 1161 | Hospital service | *'I would say that every other patient, most of them have been too ill to engage in relationships with.'* |
| 15 | 3101 | Hospital service | *'…there were quite a lot of like ill people on there and being there a long time, there wasn't really anywhere you could get any peace and quiet you know, it was just, I don't know I just felt like somewhere it wasn't like a therapeutic environment.'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 16 | 6105 | Hospital service | *'there were so many people and they had lots of problems of their own and it was hard to get on and maybe talk to staff because there were so many patients in the hospital unwell.'* |
| 17 | 5101 | Alternative service | *'This compares pretty good because I think this is more relaxed, it's chilled out, there's not as many people and the people are not as bad when they come in here as they're not as ill as they are when they're on the ward because it's more serious.'* |
| 18 | 3126 | Alternative service | *'…at one time there were four of us and plus you could help each other, if one was really upset you know you would go and comfort them or try to do what you could…'* |
| 19 | 6106 | Hospital service | *'Yeah forced, the medicine. They say if I don't take the tablet they were going to inject me.'* |
| 20 | 1143 | Hospital service | *'They forced me to the ground, they put my face down on the floor…'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 21 | 3101 | Hospital service | *'…it was a case of you just come over and see what its like (hospital) and then before I knew it I was either staying or I was sectioned so the way I got to go over there was you know, I was quite upset about it really.'* |
| 22 | 1143 | Alternative service | *'Well they force me sometimes as they do with the rest of the patients, to keep cleaner, to have a shower, have a shave and do the laundry, that kind of thing.'* |
| 23 | 2123 | Alternative service | *'You have more freedom here because you can go in and out as you please, do you know what I mean, it's not like in hospital… I don't like to be in hospital, I prefer being here, it's much better because you've got more freedom.'* |
| 24 | 2142 | Alternative service | *'When I've finished watching this (TV) I'll go up the road and buy some sweets and cigarettes, and come back down. I like that freedom you known what I mean.'* |
| 25 | 4102 | Hospital service | *'…you feel like a prisoner, that isn't safe, you have to escape. That's why I did my running (AWOL) because even you are not on a section, but say having a bad day and you got to the nurses and say can I just go have a walk round the grounds the answer would be no.'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 26 | 2121 | Alternative service | *'…for the first few days you really can't go outside. …you can only go and do the groceries and come back.'* |
| 27 | 3108 | Hospital service | *'I just felt as though I was back at school still you know what I mean, having to go there and having to do something with, do pottery or something like that, I didn't want to do it. I felt like an imbecile.'* |
| 28 | 3126 | Alternative service | *'…it's nice that there is no sort of like routine as I say what time you have to go to bed, what time you get up, you can't have a cup of tea or anything before 6 am (in hospital) and here I've got the freedom to do as I please.'* |
| 29 | 1125 | Hospital service | *'They literally treat you like babies in here. They feed you a two hourly basis which is nice. …they watch what you eat and they'll make sure that you are looking after yourself. That's how it should be.'* |
| 30 | 3140 | Hospital service | *'For the first few days I was crying to go home because I was scared….Of what I was seeing like some people were really ill and that was quite scary.'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 31 | 1102 | Hospital service | *'Nurse X broke someone's arm. … Under restraint… before I got here.'*<br>"How does that make you feel?"<br>*'Scared of Nurse X.'* |
| 32 | 1112 | Hospital service | *'He spat in my face (patient) because he wanted me to pay attention to him.'* |
| 33 | 5138 | Hospital service | *'They want your cigarettes all the time, I'm not the only one they do it to other people as well. They say there are people and they are going to beat you up or something.'* |
| 34 | 1161 | Hospital service | *'I felt the whole environment was very very threatening… the nurses refusing to listen or understand…'* |
| 35 | 6102 | Hospital service | *'I would be glad if there were cameras in the hallways and in the rooms due to the amount of threats of violence from staff and intimidation.'* |
| 36 | 2108 | Alternative service | "What makes you feel safe?"<br>*'Well the staff are around, the surroundings are very homely, very relaxing as you would find in your own home…'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 37 | 3108 | Alternative service | *'I think it's the rule and everything you know, they keep conform to rules and things you know, it just, just feels a very safe atmosphere all in all.'* |
| 38 | 3101 | Alternative service | *'I've had times when I probably haven't been safe with myself and with my thoughts and things and its, I mean there's always staff around and people around if you are feeling like that where as like at home and staff there wasn't… and my family find it difficult to cope with really.'* |
| 39 | 4101 | Alternative service | *'I do get bored, it's one of the reasons I go to bed in the afternoons.'* |
| 40 | 2144 | Hospital service | *'Well they had a TV area again like a lounge, obviously a big massive TV where everybody will sit down and talk and watch a TV programme…'* |
| 41 | 4101 | Alternative service | *'I've felt better than I have done for a while, coming down here… I feel like I've sort of achieved more coming to this place.*<br>"What has helped you achieve something while you've been here?"<br>*'It's this new, the clozapine in particular.'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 42 | 2146 | Alternative service | *'You know like home treatment comes around 11 am and they know you take your tablets…'* |
| 43 | 3140 | Hospital service | *'In Hospital X they have the time which the medication is done at, which is good because it keeps your system going and then when you go home you've got the times haven't you…'* |
| 44 | 3140 | Alternative service | *At least in Hospital X they can give you something to calm you down or anything like that because it's written up if you need it but here there's nothing like that. …It's a shame they can't help you when you need something to calm you down because there are no doctors here.'* |
| 45 | 2146 | Alternative service | *'I trust them (staff) enough to tell them about my immigration problems so now they are taking care of it.'* |
| 46 | 1164 | Hospital service | *'and they are not having their lithium checked regularly because they can't take blood.'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 47 | 5143 | Hospital service | *'if you fall on the floor for God sake help somebody to get up, they didn't help me to get up any of them when I fell and it's very difficult for me to manoeuvre.'* |
| 48 | 1125 | Hospital service | *'I've got an en suite bathroom and shower. And my room, I can change it round, put the bed in the middle and on the side and do all that in my own room.'* |
| 49 | 6105 | Alternative service | "What about the environment here?"<br>*'Yeah, it's pretty good. It's quiet most of the time and staff come and sit with you in the sitting room sometimes which you and that and you can have you know just chat and that.'* |
| 50 | 2121 | Hospital service | *'My physique, I am a tall person and well built and I wear a hat sometimes, trainers and they think yeah, he's probably aggressive. It's worse with black people like myself, they get more alarmed by me than say an English person.'* |

| Quote no. | Interviewee | Focus of quote | Quote |
|---|---|---|---|
| 51 | 2144 | Alternative service | *'so this organisation where, obviously that's the whole purpose of it to have people of your culture or nature of whatever to understand so you've got no reason to complain, oh they are not helping me because of your culture or your colour or whatever.'* |

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