Commissioning Brief
15/24 - Assessing service models of community mental health response to urgent care needs
Closing date: 14 May 2015 (two stage – outline to full)

1. Remit of this call: main topic areas identified

The last decade has seen a number of important changes in mental health services and how they are delivered. There has been growing demand (for instance, increased rates of involuntary admissions) with intense pressure on a smaller number of acute beds. Inpatient care is expensive and supporting people in crisis represents the largest part of mental health spend. At the same time, there have been concerns about the appropriateness of hospital stay for people with mental health crises, with reported high levels of patient dissatisfaction with current care. There is also growing recognition in service policy of the need for greater parity between mental and physical health services. Recent years has seen greater use of community alternatives to standard inpatient psychiatric care for people with mental health crises needing urgent attention. Such models include crisis houses and specialist teams providing home support as well as a range of initiatives in the voluntary sector. Not enough is known about these models and their place in the health and care system. High quality primary research is needed to provide commissioners, clinical leaders and patients with better evidence on most cost-effective services and configurations to respond to urgent mental health care needs outside the hospital.

Four areas of research need have been identified for this call, but researchers may wish to tackle more than one area in a single proposal:

- Mapping alternatives and understanding integrated care pathways

A national survey in 2009 showed about one in ten people with urgent mental health problems who would otherwise be admitted to hospital are now managed in the community in alternative facilities such as crisis houses. Anecdotal evidence suggests that this proportion is growing. There are also different initiatives funded by the third sector, including registered host families and other models which have not been well documented. There are also a range of diversionary or preventive services for people with mental health crises which have developed over the last fifteen years. These include crisis resolution teams, early intervention teams and assertive outreach services. Other innovations include peer workers and buddies for people at risk of admission. Some people with mental health crises are also managed in emergency detention centres and other non-health settings. An updated exercise is needed to provide national mapping of different models and a new taxonomy of organisational types. Part of this work would be to understand how models link to existing (non-urgent) services, such as community mental health teams, general practice, social care and other. This descriptive work would also identify staffing models – including use of specialist nurses, navigators, case managers and other roles in community mental health response to urgent care needs.

- Evaluating service models

At present, there is very little robust evidence on the effectiveness and cost-effectiveness of different service models. Published studies to date tend to be small (less than a hundred patients) with only tentative and exploratory findings. More high quality primary research is needed to evaluate the impact of services and to understand the mechanisms of effect.

This should build on earlier research funded by HS&DR and elsewhere, for instance on the effects of early intervention services or in assessing alternatives to inpatient mental care. To measure impact, information will be needed on inputs and resources for different models, costs, staffing levels and skill-mix, use of resources as well as markers of patient outcome and satisfaction. Studies are likely to be mixed methods, using qualitative research to assess staff and patient experience and provide greater understanding of context. Attention should be given to thorough process evaluations to give insights into likely mechanisms and outcomes. Given the complex web of urgent care (and planned services) for people with mental health crises, study designs may need to track particular patients or patient groups to assess different service use and pathways using linked and other data methods. A key marker will be whether these new models reduce emergency admissions to acute mental health trusts. Care will be needed to design studies which account for the heterogeneity of models and range of provision in each locality, while generating robust evidence for those planning and commissioning future services.

- Appropriateness for particular population groups

Some patient groups are high users of emergency mental health services and current services may not best suit their needs. This includes different minority ethnic groups, migrants and those in contact with the criminal justice system. More research is needed to consider the impact of tailored initiatives for target populations. Although some interventions are targeted at particular populations, others have specialist teams for a variety of hard to reach groups. Considering the generalisability of service models – and features which are particular – is an important aspect of this work. Note that HS&DR recently funded two major projects evaluating integrated care for homeless people (including some tracers around mental health problems) so studies looking only at this population will not be high priority for funding.

- Review of evidence from other countries

There is much learning from comparative health systems on different models of community provision for crisis mental health services. This reflects interesting differences between countries – for instance, many other European countries appear to have shorter length of stay for crisis conditions and different services and workforce models outside the hospital to support patients. An international scoping review would need to take into account the complexities of comparisons across systems and settings and consider evidence against plausible mechanisms of effect. Literature is likely to be drawn largely from European and other health systems with comparable systems of primary care and mental health services and some descriptive case studies or vignettes would be useful, in addition to a review of published evidence.

2. Purpose of call

This topic emerged as a priority for service managers, clinical leaders and patients considering key knowledge gaps for the HS&DR programme. There are a growing number of people with serious mental health crises and pressures on inpatient care. Recent alternatives have emerged, from crisis houses to specialist treatment teams. But not enough is known about the appropriateness, use or cost-effectiveness of new models or how they interface with other parts of the health and care system. Evaluation is also needed of more targeted initiatives for particular patient groups to identify any useful lessons from other comparable health systems. Research is needed to address uncertainties around current services and to inform the planning and delivery of future care.

Further information on the background to this call, including knowledge gaps and relevant research is given in supporting information.

3. Notes to Applicants

The NIHR Health Services and Delivery Research (HS&DR) programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services, including costs and outcomes in order to improve health and health services. It is focused on research to support decisions by frontline managers and clinical leaders on the appropriateness, quality and cost-effectiveness of care.

The NIHR HS&DR programme is funded by the NIHR, with contributions from NISCHR in Wales, the HSC R&D Division, Public Health Agency in Northern Ireland, and case by case contributions from the CSO in Scotland.

The programme operates two funding streams; researcher-led and commissioned. Researchers in England, Wales and Northern Ireland are eligible to apply for funding from either workstream under this programme. Researchers in Scotland may apply to the researcher-led workstream but are not eligible to respond to the commissioned workstream and should contact the CSO to discuss funding opportunities for healthcare delivery-type research

4. Application process and timetable

This call for proposals should be read alongside further supporting information and general guidance from the HS&DR programme on applications.

Should you have any questions or require any further clarification please refer to the NETSCC FAQs at HS&DR programme - FAQs, if the answer to your question cannot be found please email your query to hsdrinfo@soton.ac.uk with the title for the call for proposals as the email header. Applicants should be aware that while every effort will be made to respond to enquiries in a timely fashion, **these should be received at least two weeks before the call closing date.**

The process of commissioning will be in **two stages** and applicants should submit **outline proposals** via the HS&DR website by **1pm** on **14 May 2015**. All proposals will initially be checked for remit and competitiveness[1]. No late proposals will be considered. No paper-based only submissions will be considered.

Applicants will be notified of the outcome of their outline application in Jul 2015.

Shortlisted applicants will be invited to submit a full proposal via the HS&DR website (a link will be sent to shortlisted applicants). Applicants will be notified of the outcome of their full proposal application in Dec 2015. Please note that these dates may be subject to change.

5. Transparency agenda

In line with the government's transparency agenda, any contract resulting from this tender may be published in its entirety to the general public. Further information on the transparency agenda is at:
http://transparency.number10.gov.uk/
http://www.contractsfinder.businesslink.gov.uk/

[1] '***Non-Competitive***' means that a proposal is not of a *sufficiently high* standard to be taken forward for further assessment in comparison with other proposals received and funded by the HS&DR programme because it has little or no realistic prospect of funding. This may be because of scientific quality, cost, scale/duration, or the makeup of the project team