Guidance for commissioners of acute care – inpatient and crisis home treatment

Joint Commissioning Panel for Mental Health

www.jcpmh.info
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Ten key messages for commissioners

1 Commissioners should have as their standard that they commission acute care services that they would recommend to family and friends.

2 There should be evidence of service user, patient and carer involvement in the commissioning, strategic direction, and monitoring of acute care standards.

3 Commissioners should commission a range of services in the acute pathway including inpatient beds, psychiatric intensive care unit beds, crisis resolution and home treatment teams and residential alternatives to inpatient admission.

4 Commissioners should ensure that sufficient resources are available within the acute care pathway to ensure patient safety, enable service user and patient choice and for individuals to be treated close to home, and that choice is facilitated through the roll-out of personal health budgets.

5 Facilities of an acute care service should be available 24 hours a day, 7 days a week.

6 Commissioners should expect clear criteria for entry and discharge from acute care.

7 Commissioners should ensure that the service provider collects, analyses and acts upon a range of agreed outcome data.

8 The full range of NICE approved interventions should be available for patients in the acute care pathway.

9 Clear standards for communication with primary care should be set and audited.

10 Commissioners must ensure that acute care pathway providers meet their statutory duties under the Mental Health Act and Mental Capacity Act in accordance with the relevant Codes of Practice, and that all care is underpinned by humanity, dignity and respect.
Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. The JCP-MH brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- people with experience of mental health problems and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities (prior to April 2013)
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning

The JCP-MH has two primary aims:

- to bring together people with experience of mental health problems, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, the experience of people with mental health problems and carers, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published *Practical Mental Health Commissioning*, a briefing on the key values and principles for effective mental health commissioning
- has so far published ten other guides on the commissioning of primary mental health care services, dementia services, liaison mental health services to acute hospitals, transition services, perinatal mental health services, public mental health services, rehabilitation services, forensic services, specialist community mental health services, and drug and alcohol services
- provides practical guidance and a developing framework for mental health.

WHAT IS THIS GUIDE ABOUT?

This guide is about commissioning services for people with acute mental health needs. It explains the purpose, characteristics and components of acute care so that commissioners can commission good quality services that are therapeutic, safe and support recovery.

No part of mental health care works in isolation from other services and this guide should be read alongside other guides in this series, in particular those setting out best practice guidance in primary care mental health services, specialist community services and rehabilitation services.

WHO IS THIS GUIDE FOR?

This guide is for:

- any commissioner wishing to gain an overview of how a high quality acute care pathway can be commissioned
- Clinical Commissioning Groups as the primary commissioners of acute care
- local authorities who commission local Healthwatch, advocacy services and other services that contribute to the acute care pathway
- Health and Wellbeing Boards in their strategic role
- NHS England as it supports and holds to account clinical commissioning groups
- the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions as it works to improve patient care
- acute care service providers, and providers of other services that promote the recovery and social inclusion of people using or moving on from acute care
- Public Health England as reducing mental disorder and promoting wellbeing is an important part of their role and also contributes to a range of other public health priorities.
What are acute care services?

Acute mental health services work with those people who are either (a) experiencing, (b) at risk of, or (c) recovering from a mental health crisis. These services:

- meet the mental health needs of those people who cannot be managed by primary care and specialist community-based services
- include crisis resolution and home treatment services and inpatient services
- include a range of community-based supports that may be commissioned to complement treatment at home or in hospital.

ACUTE CARE: WHAT IS THE AIM?

The aim of an acute care service is to support patients and their families through what is often a frightening and distressing phase of their illness by:

- undertaking a thorough assessment
- ensuring their safety
- identifying goals for their recovery
- and implementing a care plan which starts the person on a trajectory of recovery that enables them to move forward with less intensive services.

Some people in acute care services will be detained in hospital under the Mental Health Act 1983. Others will be informal or voluntary patients. However, the same high quality standards should apply to all.

ACUTE CARE: WHAT TYPES OF SERVICES ARE THERE?

The following service components are key:

- **Crisis Resolution and Home Treatment team (CRHT):** this is a multidisciplinary team that operates on a mobile basis 24 hours a day, 7 days a week. Providing treatment at home for those acutely unwell who would otherwise require hospital admission, the team ‘gate-keeps’ (assesses the appropriateness) of inpatient admissions, and facilitates early supported discharges. Some trusts have reorganised their structures and provide this function as part of a wider community mental health team (CMHT).

- **crisis house and recovery house provision:** these community-based crisis services provide support in a residential setting to people in crisis who (a) cannot be treated at home but who (b) do not need to be admitted to hospital. This provision is often made by, or in partnership with, local voluntary or social care organisations. CRHTs may provide a gate-keeping function. This provision may also be used to support people making the transition from hospital to home.

- **inpatient services:** these aim to provide a high standard of humane treatment and care in a safe and therapeutic setting for patients in the most acute and vulnerable stage of their illness. Admissions are considered where this would play a necessary and purposeful part in a person’s progress to recovery from the acute stage of their illness. There are at least four types of inpatient service:
  - acute inpatient wards – these usually provide inpatient facilities for a broad range of psychiatric diagnoses for people within a local area. In some areas they are separated into acute assessment/triage wards and longer stay/recovery wards.
  - psychiatric intensive care units (PICUs) – these provide high intensity nursing and medical care for patients whose illness means they cannot be safely or easily managed on general acute wards. PICUs usually serve a wider catchment area population than a CRHT or admission ward. They can be sited as a stand-alone unit adjacent to other mental health inpatient facilities or as a ward within a larger unit.
  - rehabilitation units – these units provide care for patients, usually with severe mental illness, who require inpatient admission for longer periods than is usually available on acute wards – separate commissioning guidance is available for rehabilitation services.
  - specialist beds – these include, for example, mother and baby beds and eating disorder beds, and are the subject of separate commissioning guidance and are commissioned nationally.

- **acute day services:** these provide an alternative to admission for people who are acutely unwell and are a means of facilitating early discharge and preventing readmission. Acute day services may be provided as an integral element of an acute hospital unit or as a stand-alone facility.

- **‘place of safety’ provision:** a small suite of rooms for the emergency psychiatric assessment of those detained by the police under S136 of the Mental Health Act. Police custody is sometimes used as a ‘place of safety’ but guidance makes it clear that this should be on an exceptional basis only and that it is preferable for the person to be detained in a hospital or other healthcare setting. This could be adjacent to, or part of, an acute unit.
• step-down and supported housing: housing support can help reduce hospital admissions by signposting to other services and providing housing and support for people leaving hospital16. This may include support to manage a tenancy and live independently, to connect with other services and to rebuild life after a crisis. Integrating housing support into discharge planning helps ensure patients' discharge from acute care is not inappropriately delayed, and services may find it helpful to develop partnership arrangements with voluntary and independent sector providers.

Depending on the local context, other services will link (directly or indirectly) to the acute care pathway including: Accident and Emergency/liaison services; acute medical wards; primary care services; community mental health services; early intervention services; drug and alcohol services; assertive outreach services; and police (particularly in relation to Section 136 of the 1983 Mental Health Act).

ACUTE CARE: THE INTEGRATED PATHWAY

The term ‘acute care pathway’ used throughout the document refers to the journey an individual makes from initial referral to discharge from acute services.

An ‘integrated pathway’ refers to the interlinked services and agencies working together to support patient and carer needs and achieve the desired outcomes.

An effective pathway is one where all those involved in providing the service share aims, priorities and values as well as operational policies. The relationships between the component parts are as important as the properties of the parts themselves. There need to be clear arrangements in place for the cohesive overall management of a locality's acute care services and its workforce.

Why are acute care services important to commissioners?

Patient need
At the point of needing to use acute care, people have high levels of need and are often in crisis, afraid and vulnerable. In many cases people will be at risk of self-harm or suicide. Getting acute care 'right' is critical to health outcomes overall and to the individual's recovery and future engagement with mental health services should the need arise.

Patient safety
As acute care is a particularly high risk area of mental health care it is essential that services are well enough resourced and led to provide a timely response, sufficiently intensive support, safe environments and seamless care.

Configuration of services
Mental health services have led the way in moving from inpatient-based services (which were the norm until the 1970s), to community-based services. Inpatient beds should now be used only for people who cannot be supported in the community, and the number of inpatient beds has subsequently fallen over time.

With this shift, commissioners need to have a focus on prevention, wellbeing and community services. However, even if all of these are of an excellent standard, there will always be a need for acute mental health care services.

Cost
Inpatient services are the mostly costly part of mental health, although acute care is less expensive than secure services. Improvements to the acute care pathway can reduce costs by reducing the need for hospital admission and length of stay. These improvements can include strengthening community-based acute care and targeting groups at higher risk of unnecessary or over-long stays. However, commissioners need to avoid reducing acute service capacity such that providers are unable to assure timely access, choice and appropriate care. This would have harmful consequences for patients, prevent the achievement of NHS outcomes and would be likely to generate costs in other parts of the system.

Legal duties
A high proportion of inpatients are detained under the Mental Health Act, some patients will lack capacity at least for a time, and all patients are owed certain duties. Commissioners will want to ensure that they, and the providers they commission, are fulfilling their legal duties to patients. These include protection from bad practice (Human Rights Act 1998), tailoring services to ensure equal access (Equality Act 2010), upholding the rights of detained patients and those subject to supervised community treatment (Mental Health Act 1983), empowering and protecting people who may lack capacity to make some decisions for themselves (Mental Capacity Act 2005) and giving mental health care equal priority with physical health care (Health and Social Care Act 2012).
What do we know about current acute care services?

RECENT CONCERNS
Recent concerns raised about inpatient psychiatric wards include difficulties in accessing a bed because of overcrowding, inadequate personal safety and the lack of availability of therapeutic interventions.

In a review of NHS acute inpatient mental health services, the Healthcare Commission assessed all NHS Trusts providing mental health acute inpatient services (covering, at that time, acute mental health wards and nearly 10,000 beds).

The review concluded that personalised, safe and good quality acute care was both achievable, and being achieved. However, there were wide differences between Trust performances and, in some places, marked differences between wards within Trusts in relation to the quality of acute inpatient services provided.

Consequently, the report identified four priority areas for improvement:

1. putting a greater focus on the individual and providing care which is personalised
2. ensuring the safety of patients, staff and visitors
3. providing appropriate and safe interventions
4. increasing the effectiveness of the acute care pathway by ensuring that CRHT teams acted as gate-keepers towards, and that there were realistic alternatives to, acute inpatient care.

Important subsequent documents setting out concerns about inpatient care include Listening to Experience and Do the right thing: How to judge a good ward.

KEY ISSUES
Key issues that have been identified in these and other reports include:

- **bed occupancy rate** – the Royal College of Psychiatrists has recommended that bed occupancy rate should be no more than 85%. This is to provide a margin to help manage the inevitable fluctuations in demand for admission and help ensure that those patients who do require admission can be admitted in a timely manner close to home.

- **wards must provide a safe and non threatening environment** – the 2006/2007 National Audit of Violence found that 43% of patients on acute wards for adults of working age had felt upset or distressed. Thirty-one percent had been threatened or made to feel unsafe and 15% reported being physically assaulted. As the Healthcare Commission report, the Pathway to Recovery noted “this is simply not acceptable in a 21st Century service and would not be tolerated in other walks of life”. It is equally unacceptable for staff to be concerned about their safety when working.

- **availability of skilled staff** – patients admitted to inpatient units are those who are the most ill and should clearly have an expectation of regular, planned, individual time with skilled clinicians to plan and review care received.

- **availability of effective interventions** – all inpatients should be able to access the full range of appropriate NICE recommended interventions to facilitate recovery.

- **physical environment of inpatient units** – these should be light, airy and non-stigmatising with single rooms.

- **CRHT teams** – these need to be sufficiently resourced to provide continuity of care and effective interventions alongside advice and support.

PROGRESS AND ACHIEVEMENT
Although there is more work to be done, a significant amount of work has been undertaken over the past five years which has led to an improvement in acute care services. Initiatives include:

- the Royal College of Psychiatrists AIMS Project (an accreditation service for inpatient wards, while an accreditation service for home treatment and crisis resolution teams has just started)
- the Star Wards initiative led by a service user
- the Virtual Ward website promoting positive acute practice
- policy implementation guidelines for PICU and acute care units
- the care service improvement partnership within the former National Institute of Mental Health in England programme
- Triangle of Care – a programme developed by carers and staff to improve carer engagement in acute care services.
The acute care pathway needs to play its part in achieving the strategic objectives set in the English mental health strategy, No Health without Mental Health1 and implementation framework24 with a focus on recovery, good physical health, reducing avoidable harm, stigma and discrimination.

It is also important to recognise that the acute care pathway is dependent on well functioning CMHT and rehabilitation services for those who will not recover within the timeframe of acute care. Furthermore, a strategic approach to commissioning services for people on a wider definition of emotional or mental health crisis should help ensure that people can access timely support whether they need the acute care pathway or a less intensive response.

FUTURE DEVELOPMENTS

CCGs will be rolling out personal health budgets for people with long-term health conditions. The pilot programme25 found that personal health budgets had a “significant positive impact on care-related quality of life, psychological wellbeing and subjective wellbeing” of the people taking part. They were shown to be effective for people with mental health problems. Personal health budgets are therefore a real option for people with long-term mental health problems who may periodically need to use acute mental health services. As personalisation of health care develops, there will be a growing evidence base of what individuals choose to buy to support them through mental health crises, which will also help to inform future commissioning.

It is clear that as more resources are provided to support individuals and their families in the community, hospital admission can be reduced both in number and in length of stay. The NHS Plan26 in 2000 made the provision of CRHT teams a priority. These teams employ dedicated staff to work closely with people in crisis in order to prevent and shorten hospital admissions. A target was set for 335 CRHT Teams to be in place in England by 2005. The National Audit Office reported in 2007 that there were 343 teams in place providing nearly 100,000 home treatment episodes27. However, four out of ten trusts that responded to an FOI from Mind had staffing levels below established benchmarks, and there was a ten-fold difference in rates of access between trusts (from 42 to 430 referrals per 10,000 population)28. In an accompanying Mind poll of people with experience of mental health crisis, only 14 per cent felt they had all the help and support they needed when in crisis29. Therefore there is further work to do in ensuring that teams are resourced to meet the crisis needs of their local communities.

The related challenge faced by mental health services is to (a) identify the number of beds required as part of a comprehensive community-based mental health service which (b) allows appropriate hospital admission to occur as close to home as feasible for those people who require admission, reflecting the severity of their illness and personal choice. Too often there are insufficient beds to meet this standard.
What would a good acute care service look like?

This section addresses five main questions:

1. what should all good acute care services look like?
2. what would a good community acute care service look like?
3. what would a good inpatient acute care service look like?
4. what standards should acute care services aspire to?
5. what outcome measures should acute care services use?

1 WHAT SHOULD ALL GOOD ACUTE CARE SERVICES LOOK LIKE?

Good acute care services, both crisis resolution and home treatment teams and inpatient wards, will have the following:

- a philosophy of care which is holistic, person-centred and which facilitates recovery underpinned by humanity, dignity and respect
- clear admission and discharge criteria
- a protocol to deliver a thorough holistic assessment
- a care pathway used and understood by all professionals and easily explained to service users, patients and carers which delivers a full range of evidence-based social, psychological and physical interventions which focus on the person’s recovery
- sufficient staffing to ensure that the interventions are available when people require them
- access to advocacy and peer support
- good communication within the acute pathway and with other mental healthcare teams and primary care
- a recovery focus which is demonstrated by outcome measurement
- evidenced patient and carer experience data and satisfaction
- information.

Philosophy of care

Individuals should be involved in all aspects of their journey from initial assessment, through treatment to recovery and discharge. All treatment and care should take into account their needs and preferences, and patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.

Doing this may involve jointly developing plans to prevent or respond to future relapse, and discussing medication and other treatments to enable the individual to decide whether the treatment is right for them.

Patients should be asked to provide feedback about their experience of the service, including therapy and activities they would like, and concerns they have through, for example, focus groups, one-to-one interviews and surveys.

Staff are the key to delivering such holistic, person-centred, recovery-focused care. Staff should:

- offer a rationale for care plans suggested
- use a range of methods to suit the different ways people like to plan their care or self-manage, including anticipating a crisis, recognising early warning signs, and learning from mistakes (e.g. negative lifestyle habits or interactions with the team)
- encourage learning and engagement that is active and participatory
- use appropriate methods for the age, cultural and social background of the person with mental health problems
- take a positive approach, with a focus on DO rather than DON’T
- build on patient experiences, for example finding out what they already know, the source of that knowledge and what they want to know
- use practical activities and approaches which are realistic and achievable

Continued overleaf
What would a good acute care service look like? (continued)

- be mindful of equality, diversity and cultural issues (see box 1)
- deliver personalised care which means finding out how the person understands their mental health problem – this includes in terms of their cultural background, finding out what is important to them and tailoring treatment, care and support to the outcomes they want (e.g. around family, work or meaningful activity)
- facilitate advance statements and joint crisis plans to enable people to have a say in their crisis care – in particular, people should be able to choose between hospital, home treatment and other community-based services, taking account of carers' and other family needs.

Admission and discharge criteria
The acute care pathway should have clear admission and discharge criteria. The purpose of such criteria is not to put in place artificial boundaries with regard to care, but to clarify the purpose of the intensive input that the acute care pathway provides. Such clarity is helpful both to staff and more importantly to patients and carers.

BOX 1: EQUALITY, DIVERSITY AND CULTURE

Acute mental health care needs to be accessible and appropriate to all those who may need it. Specifically, services must promote equality for those protected by the Equality Act 2010. Issues to consider include:

- accessibility of mental health services – for example there may be difficulties for black and minority ethnic groups due to stigma in the community; adjustments may be needed to enable a disabled person to stay in an acute unit, access psychological therapies or participate in therapeutic activities; language barriers and other communication issues may need to be addressed
- cultural awareness in constructing care plans and providing services, including for example:
  - the person may live with family members, or may need to have support from family and friends both inside and outside the acute unit to reduce fear and isolation
  - food requirements, dress requirements, a place and time to pray if needed, should all be discussed with the person and considered throughout inpatient care
  - in organising therapeutic activities staff should be mindful that individuals may wish not to drink, mix with the opposite gender in close proximity, or may have certain beliefs or values which would be contradicted if they were forced to carry out specific activities such as some sports.

Actions that promote equality and cultural awareness include:

- employing interpreters or staff with various language skills
- providing information in various languages and formats, including for example how the service is organised, processes involved in hospital admission, medication requirements, and the right to advocacy
- training staff in different groups’ needs and requirements
- displaying policies and accredited standards in wards and other premises to confirm that discrimination, abuse or violence will not be tolerated towards any group
- openly recruiting staff from all sections of society
- working with external agencies and charities such as BME charities, lesbian and gay charities, disability groups and religious and spiritual organisations, to ensure the needs of people with mental health problems are being met in the best way possible
- recording and measuring objectives and outcomes of services, including service user/patient satisfaction, and by protected characteristics under the Equality Act, so that inequalities can be addressed
- ensuring access to advocacy and support to make complaints, for example through organisations such as local Healthwatch, Patient Advice and Liaison Services (PALS), Independent Health Complaints Advocacy (ICAS), local mental health charities, and Citizens Advice Bureaux
- considering patients’ needs holistically, including the impact of race or religion on where people live, their community, places they go to, people they see, and what they discuss with others in regards to their mental health
- taking account of the cultural environment to which people return when discharged, and the impact on them and their family after being in an acute unit.
Assessment protocol

A thorough holistic assessment should ensure that a full social and psychological history is undertaken. Individuals should not repeatedly be asked the same questions by a series of professionals. Instead, different professionals should pull together a thorough and detailed assessment, focusing on different aspects of the assessment and allowing, in a specified time, a full holistic assessment to be completed.

An acute care admission provides an opportunity for a detailed assessment to be undertaken which can then sensibly guide further care planning. The assessment should consider:

- an individual’s symptoms and the severity of their illness
- risks posed to the individual or others
- personal and family history, previous life trauma and social functioning
- the views of people with mental health problems and their carers and networks (including any advance statements and/or decisions)
- a history of previous care focusing on past history of illness, interventions which have worked and those which have not, and the strengths of the person
- full assessment of alcohol and drug misuse
- full assessment of social circumstances
- safeguarding issues concerning children and vulnerable adults
- physical health needs as well as mental health needs.

Care pathway

A care pathway should be available for both CRHT services and inpatient services. This should include the following:

- **key professional** – a named key professional who has a thorough understanding of the reasons for admission, the assessment, and the goals set. This individual is not expected to deliver all the interventions but will have a coordination role to ensure that the interventions are delivered. It would be expected that, as a minimum, patients should expect to see this individual twice a week. Underpinning this role is good team working and communication to ensure continuity of care.

- **psychological interventions** – all patients should have access to a range of appropriate psychological interventions. These include:
  - A problem-solving tailored to individual recovery/discharge goals
  - B specific NICE defined psychological interventions for a range of psychiatric disorders
  - C the availability of both group and individual work.

The use of specific psychological therapies within crisis settings has been gaining ground (brief therapy, solution-focused therapy, psychotherapy, mindfulness and cognitive behavioural therapy) with studies from New Zealand indicating that crisis clinicians use a wide range of psychological interventions drawn from a broad theoretical base. There is emerging interest among experts in the value of adopting cognitive behavioural strategies and family-focused approaches in crisis intervention with some focus on the management of suicide risk with reduced maladaptive cognitions and as a result decreased suicidal ideation being indicated.

There should be a range of therapeutic social activities available in mental healthcare and community settings. Individuals within the acute care pathway may benefit from community resources accessed through the local community.
Third sector organisations can provide a range of information, advocacy and support to help prevent crises and to act as a bridge between acute care and the wider community both during and after a period of acute care.

- **meeting physical health needs** – mental health units should be equipped to do basic physical health tests such as blood tests and ECGs. Protocols need to be in place between mental health and physical health services so that patients can access appropriate primary and specialist care pathways to meet their physical health needs, while receiving mental health care. Crisis teams need an awareness of physical health needs that could be better treated in hospital.

- **meeting spiritual needs** – spiritual care can play an important part in recovery and individuals should have the opportunity to identify their spiritual needs and have them met. This may be, for example, exploring a spiritual aspect of their crisis, receiving support from their faith community, having space to follow religious practices, or the opportunity to do spirit-nurturing activities such as meditation, arts appreciation, making friends or spending time in nature. A mental health chaplaincy or department of spiritual care can support this care in both inpatient and community settings.

### Staffing

All parts of the acute care pathway should have a staffing complement which ensures that individuals have access to the required skills to ensure that they get as well as possible, as quickly as possible, and are enabled to attain their goals. In practice this is likely to mean that individuals will have access to psychiatrists, psychologists, occupational therapists, pharmacists, dietitians and physiotherapists as well as nursing staff with a range of expertise.

Peer support is well established in advocacy, and there are a number of peer-run services. Some trusts are now employing peer support workers in acute mental health care, to bring a different focus and quality than that of the professional staff they work alongside (www.skillsforhealth.org.uk). Cambridge and Peterborough NHS Foundation Trust has implemented a programme for training and using trained peer support workers in their inpatient units (see box 5).

Staff should be recruited according to the values of recovery, person centeredness and empowerment of patients and carers.

All staff should receive an annual appraisal, personal development planning and receive clinical supervision at a minimum of every eight weeks, or more frequently, as per professional body guidance. Staff should have clear clinical supervision guidelines which include a system of monitoring and auditing supervision.

Staff should have access to training to cover all aspects of their work including care planning, therapeutic interventions, use of the Mental Health Act and engagement with individuals and their families.

### Advocacy

All individuals should have access to advocacy in order that they can be helped to discuss any issues that they might have, free from concerns about discrimination. The individual should be informed of how they can make a complaint whether formally or informally if they are not happy with any treatment or service they have received, whether through local advocacy groups, or through nationally recognised organisations such as Independent Complaints and Advocacy Services. People who are detained under the Mental Health Act or on supervised community treatment are entitled to access Independent Mental Health Advocacy (IMHA) services. Local authorities need to commission IMHA services to meet the needs of their local communities. Commissioners of acute care should ensure that providers inform eligible individuals about IMHA and enable advocates to meet with them. Peer support has a key role to play in the provision of advocacy.

### Good communication

It is essential that there is clear communication between acute care teams and others involved in the care of people in both primary and secondary care, specifically:

- close liaison between inpatient and crisis teams
- GPs/practices to be contacted within 24 hours when someone is admitted acutely/seen by a crisis team and that they are again informed within 24 hours when someone is discharged with a current diagnosis and list of their current medication (more detailed discharge summaries can follow later)
- close, proactive communication with community mental health services/ care co-ordinators to ensure better care continuity and to facilitate move on through the care pathway.

On leaving acute care, individuals should have a discharge care plan that will enable them to continue to recover in a less intensive setting. At a minimum this will include:

- how to access future help
- relapse indicators
- self-help measures
- advice to families/carers.
Recovery focus
All care pathways should collect outcome measures with a focus on recovery. Measures could include the attainment of individual goals, maintaining housing, employment and relationships.

Patient and carer experience
All pathways should collect patient and carer experience using a range of techniques including questionnaires, focus groups and individualised feedback. There should be evidence of patient and carer involvement in service design.

Information
The individual should be informed of which services to use (for example when they should go into A&E) and given a number for the out-of-hours emergency team. They could also be informed about local mental health charities and peer support groups. The individual needs to know who their key worker is, who their doctors are, and how to contact them. The individual should also be made aware of their rights under the Mental Capacity Act, such as making advance decisions, and rights when being sectioned under the Mental Health Act. Information and ways of working should be grounded in legal and good practice frameworks.

2 WHAT WOULD A GOOD COMMUNITY ACUTE CARE SERVICE LOOK LIKE?

The general principles set out in the previous section equally apply to community-based acute care, including CRHT teams (and other community-based resources accessed by them).

In some areas, crisis services are provided by CMHTs during working hours and only by specialised crisis teams out-of-hours. In other areas, crisis teams have a broader remit and look after all crises 24 hours a day. Home treatment can only be provided by specialist teams. In all areas, crisis teams should be the gateway to inpatient beds, and patients should not be admitted except through the CRHT.

The following are characteristics of good CRHT services.

Access
• clear acceptance criteria which are widely disseminated – these generally include that hospitalisation will be needed without an intensive community intervention, and that assessment is needed within 24 hours. Criteria regarding diagnosis, age group, inclusion or exclusion of people with learning disabilities, and catchment area also need to be stated.

• clear criteria as to who can refer, that are widely disseminated – this will normally include other local inpatient and CMHTs, and self-referrals are normally accepted from patients and carers already known to the team. Whether other key agencies such as GPs, social services, third sector providers and the police should be able to refer directly to the CRHT is still debated. If they are not given such access, it is essential that effective provision is made for rapid access to assessment for people whom they refer, for example by a liaison team and/or specific assessment service.

• a single point of entry to the team – if the referral is not suitable, telephone triage should be available with a suitably trained clinician with signposting or advice if the referral is not suitable for the service.

Assessment
• an agreed response time – around four hours may be appropriate, but account needs to be taken of travelling distances within the service. Multidisciplinary assessment with access to senior medical advice should be available 24 hours per day – assessment including the nature of the crisis, psychiatric history, mental state examination, assessment of physical health problems, assessment of risk, and assessment of social circumstances.

• feedback to the referrer (if appropriate) within 24 hours of acceptance of referral.

Capacity
• an appropriately trained multidisciplinary team, including doctors, nurses, support workers, psychologists, social workers and occupational therapists

• capacity to visit those receiving home-based treatment at least twice per day, but as often as necessary to keep out of hospital

• capacity to answer telephone triage (and patient and carers’ line 24 hours per day)

• 24 hours telephone line for those receiving home-based treatment (patient and carers’ line)

• capacity to gate-keep inpatient beds – that is being involved with all decisions to admit, including under the Mental Health Act, to ensure the least restrictive environment is considered.
What would a good acute care service look like? (continued)

Interventions
Home-based treatment is a clear alternative to hospital admission (i.e. without the service the individual will be admitted). The following are needed:

- a named worker to coordinate care
- daily team meetings where senior team members including medical staff present to discuss progress and risk, and to provide supervision
- medical review as part of initial assessment
- a range of evidence-based interventions, including psychoeducation for patients and carers and training for staff in problem solving, supporting families and social networks during crises and simple crisis intervention principles – brief interventions (including brief cognitive therapy, brief focused therapy, brief interpersonal therapy, brief interventions for alcohol misuse, medication adherence interventions and relapse prevention) should either be delivered by the team or readily available from partner services on referral from the team
- carer support and assessment when necessary
- prescription of medication as necessary – access to prescribers 24 hours per day
- 24 hour access to a consultant psychiatrist
- discharge planning and seamless transfer to ongoing intervention, including face-to-face handover meetings at the point of discharge
- audit and research processes embedded, including monitoring of response times, time spent with individuals, patient and carer satisfaction and simple outcomes.

BOX 2: CRISIS-FOCUSED DAY SERVICES AND THERAPEUTIC PROGRAMMES

Programmes of psychosocial interventions provided in the community, or more traditionally as day hospital services, form part of wider acute provision. They can be delivered by health or third sector organisations.

Some therapeutic programmes are provided by CRHT teams and aim to act as a bridge between ward and community, and prevent admission and promote earlier discharge from hospital, on an outpatient basis. These programmes are separate from the ward-based therapeutic programme and consist of a package of care/treatment with the following characteristics:

- a clear model of intervention, (e.g. cognitive behaviour therapy)
- short-term, fixed time frame (e.g. six weeks)
- multidisciplinary input, including psychiatric input
- evidence-based psychosocial group interventions for people in crisis, including relapse prevention, emotional regulation, social inclusion and recovery oriented interventions
- a key-working system
- social inclusion assessments and ‘bridge-building’
- intentional peer support.

These programmes are provided by a number of CRHT teams across the country to some of the people on their caseload. There are currently no standards or official guidelines but they seem to be an effective way of offering intensive psychosocial interventions where appropriate.

Commissioners may consider commissioning crisis-focused day services and therapeutic programmes, crisis houses and other kinds of crisis support (see boxes 2 and 3).

An integrated model – Camden acute recovery service

This innovative inner city service was launched in 2008 and delivers comprehensive care for mental health crises. It is provided and managed within the NHS, deriving funding from both NHS and local authority sources and it maintains service user/inpatient input at its heart. There are three components to the service, all housed within the same building, and all embedded in the acute service line:

1 the CRHT providing rapid emergency assessment and recovery-focused home treatment
2 the six-bedded crisis house with rapid turnover and average stay of six days
3 the 30 place acute day service with an average length of stay of less than 10 weeks, offered to people in an acute crisis. The usual admission pathway is via the wards or crisis team. Care involves a multidisciplinary recovery-based assessment and management for people in crisis, including occupational therapy, nursing, therapeutic, pharmacy and psychiatric input.
In the Camden acute recovery service, people can flow seamlessly between each element of the service according to their current needs and the course of their mental health crisis. Evaluation and feedback has been central to the unit’s philosophy, and findings demonstrate it is delivering care to those with high levels of need, particularly the unemployed, those with previous admissions to acute mental health services, histories of severe mental illnesses and/or risk to themselves. Local acute bed usage decreased after the service opened and levels of patient satisfaction are consistently high.

Staff and patients rate strong therapeutic relationships and co-location of the services as key to its success. Individuals feel safe and respected, often remarking on the calm atmosphere and wide-ranging group activity programme. The unit is approximately three miles from the nearest inpatient wards, which delineates it as separate from standard psychiatric wards, but the distance is sometimes a barrier to attendance for some patients. Sites nearer to acute wards might overcome this, and the relevant local authority has recently funded a sister service nearer to the wards, partly based on the high levels of care and the satisfaction observed in the original unit.

### BOX 3: CRISIS HOUSES

Crisis houses and similar approaches to providing respite or sanctuary outside of hospital have been developing alongside CRHT and hospital approaches. They have strong support from service user and patient groups. These are community-based crisis services that offer residential support and include:

- **clinical crisis houses** – these services are similar in many features to hospital-based services although located within community settings. They provide residential services with staff onsite through the night and have a high level of clinical staff involved in providing onsite care.
- **specialist crisis houses** – these services share similar features to clinical crisis houses but are aimed at specific groups such as women and people with early psychosis.
- **crisis team beds** – these services provide a small number of beds aimed at short stays and are fully integrated with CRHT teams.
- **non-clinical alternatives** – mainly managed by the voluntary sector with few clinical staff but many have also forged strong links with CRHT teams.

Crisis houses, however, will be relevant for a relatively restricted population and may have modest benefits if home treatment is properly equipped and fully functional. Where crisis houses have been unsuccessful, this is where staffing is low and remote from inpatient units. Inevitably difficulties have arisen in coping with disturbed behaviour or they have ended up providing residential care to a group of patients who would not usually have been admitted. Peer support crisis initiatives are a good idea but will be constrained by what levels of crisis it is appropriate for peers to manage and the support peers need.

Nevertheless, a recent service evaluation of a community-based mental health crisis house in inner-city Liverpool showed significant improvements in symptoms, social functioning, mood and activities of daily living and a reduction in risk issues.

### BOX 4: OTHER APPROACHES TO CRISIS CARE

- **Survivor led sanctuary and support** – Leeds Survivor Led Crisis Service was set up in 1999 to provide services which are an alternative to hospital admission and statutory provision for people in acute mental health crisis. Dial House provides sanctuary – one-to-one emotional support and ‘time out’ – during weekend evenings until late, when most other services are closed. The service also provides a nightly helpline and peer-led group work.
- **Host families** – Hertfordshire Partnership NHS Foundation Trust set up the first UK host family scheme in 2010 as one alternative to hospital. The host family provides a caring, family environment and is supported by the Trust’s specialist mental health team who also provide any ongoing treatment or therapy. Someone from the team visits every day and staff are available 24 hours a day to provide additional support to the individual and host family if needed.
- **Sanctuary for people in suicidal despair** – the Maytree Respite Centre in London provides a sanctuary for people in suicidal despair – short residential stays in a calm, safe, homely environment in which to talk, reflect and rest.
3 WHAT WOULD A GOOD INPATIENT ACUTE CARE SERVICE LOOK LIKE?

Admission and discharge criteria

Inpatient wards have an important place within the acute care pathway and should have a focus on enabling patients to get as well as possible, as quickly as possible. Admission to the inpatient ward should not be a last resort when all else fails. Admission criteria need to include:

- the needs of the patient and family
- risks posed to the individual and others
- local availability of alternative interventions
- goal and purpose of admission.

Just as important as admission criteria are discharge criteria. If staff, patients and carers have a clear understanding of the purpose of admission, once this has been met, there should be a clear understanding of when discharge should occur. Early, proactive discharge planning, in conjunction with community services, should be an essential part of inpatient care.

Environment

All inpatient units should provide an environment which meets best practice standards in terms of safety. There must be access to safe outdoor space and where possible individuals should have a single room. The ward should be an environment that commissioners, staff and patients would recommend to family and friends. Wards should be welcoming to patients and their families.

Assessment

The inpatient assessment should be done within 72 hours of the admission. It may be done by different members of the multidisciplinary team, but these will need to work together to avoid repeating the same questions, and to undertake a comprehensive assessment.

Once completed the assessment should result in a discussion with patients and where possible their carers to determine:

- individuals’ recovery goals for admission
- interventions necessary to deliver those goals together with a plan of care setting out an agreed timetable of therapeutic interventions.

Care pathway

All individuals admitted to an inpatient unit should have a detailed and comprehensive holistic assessment. The outcome of the assessment should result in a discussion with the patient and their carers where possible about the interventions required to promote discharge and ongoing recovery. There should be clearly defined and well understood processes that are standardised and monitored via a control system that delivers reliable and consistent performance regardless of where a person is admitted.

The standard tasks that are required for all patients during the assessment phase of admission should be identified and achieved within (a) agreed time frames by (b) agreed disciplines and (c) based on a system that asks ‘what task?’, ‘whose job?’, and ‘by when?’.

The operation of agreed standard tasks needs a control and monitoring system to ensure adherence to the timely delivery of services. A recovery-focused care plan should then be drawn up for each patient setting out:

- what therapies and activities will be delivered
- what further assessments are needed and when they will occur
- what needs to happen within the community to support discharge
- how carers, supporters and families will be involved. The care plan should include the person centred goals for recovery and discharge from inpatient care.

A range of NICE approved psychological, social and physical interventions should be available to all inpatients. Clear links need to be established with community-based teams in order to facilitate discharge once inpatient goals have been met.

An example of a care pathway is provided in Figure 1 on page 18.

Staffing

It is difficult to be precise as to the number of staff required as this will reflect local circumstances (e.g. the quality of the ward environment, the duration of admission and the availability of activities). A key factor of inpatient care is to ensure that all patients feel safe at all times. Inpatient wards should be undertaking regular reviews of patients to test this out and address any issues raised. It is unacceptable for individuals to feel unsafe on wards unless this is an aspect of their illness and commissioners should not commission wards which do not provide an environment in which individuals feel safe. Staff should be trained to a standard where they can work flexibly and without resorting to force.

Inpatient services should be running on a continual process basis (i.e. decision making taken by all the multidisciplinary team should be available at a minimum of a daily basis across the working week and ideally 24/7). Specifically weekly decision-making meetings such as ward rounds are not ideal practice given the pressure on bed usage. Investment should be made to ensure that there are enough clinical staff to be able to make daily decisions and reviews of patients’ care. This demonstrably improves quality of care and shortens length of stay by putting expert skills and knowledge at the patient’s disposal, reducing waiting times and accelerating recovery.
Number of beds

There isn’t any national normative guidance on the number of inpatient beds that need to be commissioned. This means that each CCG needs to come to a decision locally about the level to purchase, in conjunction with patients, carers and other stakeholders. In coming to this decision, commissioners will need to take a number of factors into consideration.

We know that across England there is considerable variation in the level of beds available and how they are used. So a first step for commissioners must be to bring together all the available data for an initial assessment.

Part of the variation will be associated with population need. We know that there is a strong correlation between the use of acute inpatient mental health facilities and certain population characteristics (e.g. aspects of deprivation and co-morbidity including drug misuse).

No one indicator will answer whether a service is effective overall but commissioners will need to consider a range of benchmarked indicators including:

- what kind of beds it is purchasing (at least against the four categories identified on page 5)?
- how beds are being used? – commissioners can assess this by obtaining data on the comparative case mix either expressed by diagnosis or by PbR care cluster and by comparing the level of patients who have been admitted under the Mental Health Act
- what NICE-compliant interventions are taking place in those beds? – each Trust should audit clinical practice against NICE guidance
- what are the outcomes of care and what is the patient experience of inpatient care?

BOX 5: GOOD PRACTICE

The training for peer support workers at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) takes place over four to five weeks involving 166 hours including four days of work experience. A commitment is made by CPFT to locate posts for peers to apply for, following successful completion of the training. For the people who undertake the training, this is a life-changing experience as most of them have not been used to thinking positively about themselves or about their illness. One peer support worker at CPFT said: “The Peer Support Training took me on a massive journey of discovery about myself and gave me an appreciation for my strengths. Through it I came to realise that all those scary places I had been during my time of being unwell, were going to allow me to hold up a torch for others during their dark times and help them on their road to recovery – it wasn’t wasted time”. CPFT currently employs 34 peer support workers, including two peer educators who work in many of its adult inpatient and crisis teams. This will shortly be expanded to 43 as the Trust is intending to extend their work into the prison environment. Their integration within the Trust has been modelled on that practiced at Recovery Innovations in Phoenix, USA.

The aims of peer support workers in the inpatient wards include being available for people so they have more one-to-one time, listening to people’s stories and experiences and share elements of their own journey, accompanying people out on leave for social and leisure pursuits and more importantly focusing on people’s strengths, hopes and dreams.

There has been much positive reaction to the peers. Patients have realised that they can relate to peer support workers who understand completely the trauma that they are going through as they have had that lived experience. Staff attitudes began to change, and more clinical staff may now be more open and honest about their own lived experience of mental ill-health.

Within this context, commissioners can consider a rounded view of service operational performance/efficiency including:

- occupancy levels
- lengths of stay
- the level of out-of-area treatments (OATS)
- the level of emergency readmissions
- provider costs and how they relate to commissioner spend.

Even these indicators will need careful interpretation. A high level of planned readmissions may be appropriate if this is part of a coherent service model which uses inpatient care as a proactive choice; long lengths of stay may be appropriate if the local service model focuses on providing inpatient care only to those people with the most severe illness.

So the decision about bed numbers must be a local one which matches performance against the local objectives agreed for services; the approach to risk and choice and the relative importance given to the acute care pathway as reflected by the level of spend.
What would a good acute care service look like? (continued)

FIGURE 1

The involvement of the Crisis Team in the admission process to consider alternatives to admission is mandatory.

The date and time of the 72hr CPA Review/Formulation Meeting is set at the initial 24hr Report Out. If patient has a care coordinator, or if Crisis Team are to have this role, ward admin contact relevant team, inform them of date and time of CPA Review/Formulation Meeting and request attendance. If patient is not known to services and inpatient MDT request care coordinator to be allocated, ward admin staff to contact relevant community team to hand over request and invite to 72hr CPA Review/Formulation Meeting.

The 24hr Report Out is chaired by the nurse in charge or consultant. The Report Out has a task time of 30 mins. Each new admission is allocated no more than 10 mins. A personalised assessment plan and professional involvement in this is defined and traffic light status.

- **Green**: aim of admission/discharge criteria has been met. Regular reviews by medic not required. Ready for discharge, no need for medic review.
- **Amber**: aim of admission/discharge criteria has been defined. Action plan in place and progressing. Regular review by medic required. Review by a medic required before discharge.
- **Red**: further assessment needed. Aim of admission/discharge criteria to be defined. Regular review by consultant required. Not suitable for discharge.
- **Blue**: a ‘Blue Star’ is used to signal (a) ‘Fast track’ discharge, involve Crisis Team to agree discharge plan – 48hr timescale or (b) priority for MDT attention (i.e. due to complexity, risk etc.)

**DISCHARGE PLANNING MEETING/ DISCHARGE CPA**

- **Chair**: care coordinator
- **Time allocated**: 30 mins max
- **Documents**: Agenda, Formulation/CPA meeting doc, outcome plan and discharge compact
- **Present**: care coordinator, ward nurse, specialist nurse practitioner, psychologist, Crisis Team, SHO and consultant
- **Standard operations**: All present

- **Review the current and agree the new action plan**

**72HR CPA REVIEW/ FORMULATION MEETING**

- **Chair**: care coordinator
- **Time allocated**: 30 mins max
- **Documents**: Agenda, Formulation/CPA meeting doc, outcome plan and discharge compact
- **Present**: care coordinator, ward nurse, specialist nurse practitioner, psychologist, Crisis Team, SHO and consultant
- **Standard operations**: All present

**24HR REPORT OUT**

- **Chair**: ward nurse in charge/consultant
- **Time allocated**: 10 mins new patient(s), 30 mins total
- **Use**: Control Board

**ASSIST PATIENT PRIOR TO DECISION TO ADMIT TO INPATIENT WARD**

- **Assess patient prior to decision to admit to inpatient ward**
- **Consider alternatives**
- **Complete crisis assessment, face risk profile and Mental Health Clustering Tool**

**NO ALTERNATIVES TO ADMISSION**

- **Admission to inpatient ward**

**ADMITTING NURSE TO CONTACT COMMUNITY TEAM TO INFORM OF ADMISSION AND CONFIRM CARE COORDINATOR**

**REVIEW THE CURRENT AND AGREE THE NEW ACTION PLAN**

**DISCHARGE**
4 STANDARDS

The Royal College of Psychiatrists has an accreditation service for inpatient units and CRHT teams. The standards have been drawn up by a multidisciplinary group of staff in conjunction with service users, patients and carers. The standards reflect and expand on the issues set out in this guidance. The process of accreditation involves self and external assessment. Commissioners involvement in this process reflects a desire by acute care providers to implement high standards of care and to allow benchmarking to determine whether aspirations are achieved.

For further information on the Accreditation for Inpatient Mental Health Services (AIMS) programme, please visit www.rcpsych.ac.uk/aims

5 OUTCOME MEASURES

There are a range of outcome measures that can be used to determine the quality of inpatient care. Consideration should be given to commission a generic, global, Patient Rated Outcome Measure (PROM) and Clinician Outcome Measure (CLOM) in addition to other outcomes outlined below.

Generic PROM

• Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) – this is a generic wellbeing scale for mental health, referenced by the No Health Without Mental Health strategy as a well evidenced and validated measure for wellbeing.
• quality of life measures (e.g. the Short Form Health Survey (SF-12) or the EuroQol EQ-5D health questionnaire). These are simple, patient-reported measures in routine use in the NHS for some physical conditions.
• individual patient/service user identified goals.

Generic CLOM

• these can range from functional to symptom rating (e.g. the Global Assessment of Functions (GAF), Health of the Nation Outcome Scale (HONOS), Brief Psychiatric Rating Scale (BPRS)). The most widely accepted generic CLOM is the HONOS. Consideration should be given to the addition of symptom ratings as well (e.g. the BPRS is a generic symptom rating scale that can be used to show reduction in symptom severity).
• a suite of patient safety measures – these measures are controversial as they do not directly measure quality of care. However statistical outliers for measures such as the number of absconsions for people detained under the Mental Health Act, the number of violent incidents on the ward involving patients and staff, and number of falls on the unit should signal potential concern. Adverse events, however, are probably still significantly under-reported and providers should be encouraged to increase their rates of patient safety incident reporting.
• performance measures, median length of stay by month together with variance reporting – it should be noted that short lengths of stay are not necessarily an indicator of good quality and may reflect inappropriate admissions. A long length of stay (LOS) may reflect inefficiencies within the service and a lack of alternatives to treatment and placement in the community. Ideally a unit performing to standard work practice would have a narrow variance of LOS.
• mental health clustering in conjunction with diagnosis coding identifies which patient cohorts are being admitted to the inpatient units, and therefore interventions need to be available to best meet their needs. HoNOS scores on admission and discharge can be subject to factor analysis and then associated to cluster and diagnosis demonstrating the benefit of inpatient care and allocation of resource.
• patient satisfaction surveys to be agreed between commissioners and providers.
Supporting the delivery of the mental health strategy

The Joint Commissioning Panel for Mental Health believes that commissioning which leads to the effective planning and management of acute mental health care services, including the involvement of patients and their carers in the development of these services, will support the delivery of the mental health strategy by contributing to the following shared objectives:

**Shared objective 1:**
More people will have good mental health.
Commissioning high quality acute care will support the lasting recovery of people in mental health crisis. It will also improve the wellbeing of people who experience mental health crises by providing confidence in the availability and quality of support when needed.

**Shared objective 2:**
More people with mental health problems will recover.
Commissioning high quality acute care will help achieve this objective by supporting recovery and connecting people with community resources.

**Shared objective 3:**
More people with mental health problems will have good physical health.
Commissioning high quality acute care will help prevent deaths by suicide, mitigate the adverse effects of medication, and facilitate access to physical health care where appropriate.

**Shared objective 4:**
More people will have a positive experience of care and support.
High quality acute care is central to meeting this objective as it is in acute mental health crisis that people are least likely to have choice and control and are most likely to be subject to restrictions.

**Shared objective 5:**
Fewer people will suffer avoidable harm.
The philosophy and standards of high quality acute care and the use of quality outcome measures will help achieve this objective.

**Shared objective 6:**
Fewer people will experience stigma and discrimination.
A high quality acute service that is valued and effective is likely to contribute to public understanding and attitudes.
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**Development process**

This guide has been written by a group of mental health service experts. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts. Final revisions to the guide were made by the Chair of the Expert Reference Group in collaboration with the JCP’s Editorial Board (comprised of the two co-chairs of the JCP-MH, one user representative, one carer representative, and technical and project management support staff).
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