6 DELIVERING SERVICES

Services must be responsive, effective and offer high quality, evidence based care in an environment and an atmosphere that provides dignity, privacy and support.

National Service Framework: key action 20

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

There is to be effective communication and liaison between primary and secondary care, including between community mental health and primary care teams. [Key action 20 paragraph 21.5]

How can effective communication and liaison between primary and secondary care be achieved?

See Section 6.7 for information on liaison psychiatry
See also Section 6.4 for further information on communication between community mental health and primary care teams

The *statements* | The *evidence*

6.1 Communication and liaison between primary and secondary care

6.1a Formal **liaison between GPs and specialist services** leaves most physical health outcomes unchanged, but improves functional outcomes in chronically mentally ill patients. It may confer modest long-term health benefits through improvements in patient concordance with treatment programmes and more effective clinical practice. Patient retention rates within treatment programmes improved with GP involvement, as did patient satisfaction. Doctor (GP and specialist) behaviour changed with reports of more rational use of resources and diagnostic tests, improved clinical skills, more frequent use of appropriate treatment strategies, and more frequent clinical behaviours designed to detect disease complications.[i]

Caveat: Key papers may have been missed as unpublished research was not sought and it is unclear if non-English language papers were included.

i. Mitchell GG. Does primary medical practitioner involvement with a specialist team improve patient outcomes?: a systematic review. *British Journal of General Practice* 2002; **52(484)**: 934-939

(Type I evidence – narrative systematic review of 7 randomised controlled trials (involving 963 subjects and 899 controls) to assess the efficacy of formal liaison of GPs with specialist service providers on patient health outcomes. Literature search to 2001.)

The *statements*

6.1b This review does not support the hypothesis that adding **Mental Health Workers** (MHWs) to primary care provider organisations in 'replacement' models causes a significant or enduring change in Primary Care Practitioner (PCP) behaviour. **'Consultation-liaison'** interventions may cause changes in psychotropic prescribing, but these seem short-term and limited to patients under the direct care of the MHW. Longer-term studies are needed to assess the degree to which demonstrated effects endure over time.

There was some evidence that **'replacement' model MHWs** achieved significant short-term reductions in PCP psychotropic prescribing and mental health referral, but the effects were not reliable. Consultation rates were also reduced, but with even less evidence of a consistent effect. There were no indirect effects in prescribing behaviour on the wider population and no consistent pattern to the impact on referrals. 'Indirect' effects on PCP consultation rates were not assessed. There was some evidence that 'consultation-liaison' model MHWs had a direct effect on PCP prescribing behaviour when used as part of complex, multifaceted interventions.[i]

Caveat: Only English language papers were included and unpublished literature was not sought.

The *evidence*

i. Bower P, Sibbald B. Bower P, Sibbald B. On-site mental health workers in primary care: effects on professional practice. *The Cochrane Database of Systematic Reviews* 1999, Issue 4. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000532/frame.html** [accessed 29/07/05]

ii. Bower P, Sibbald B. Systematic review of the effect of on-site mental health professionals on the clinical behaviour of general practitioners. *British Medical Journal* 2000; **320 (7235):** 614–617 **http://bmj.bmjjournals.com/cgi/reprint/320/7235/614** [accessed 29/07/05]

(Type I Evidence – a systematic review of 38 studies (24 RCTs, 14 controlled before-and after studies) involving more than 460 primary care providers and more than 3880 patients. Literature search date June 1998.)

The *statements*

The *evidence*

6.1c This type of facilitated intervention tailored to context has the potential to improve care and interface working. Intervention patients had fewer psychiatric relapses than control patients (mean = 0.39 versus 0.71, respectively, p = 0.02) but there were no differences in documented processes of care. Intervention practitioners were more satisfied and services improved significantly for intervention practices. This could be explained by the intervention working via the improvements in **informal shared care** developed through better **link working**. There were no significant differences in patients' perception of their unmet need, satisfaction or general health. There was an additional mean direct cost of £63 per patient with long-term mental illness for the intervention compared with the control.[i]

Caveat: Of the 145 patients who completed baseline surveys, only 99 patients completed follow-up (68.3%). It is unclear if an intention to treat analysis was used. Patients received £5 voucher for returning the surveys.

i. Byng R, Jones R, Leese M, Hamilton B, McCrone P, Craig T. Exploratory cluster randomised controlled trial of shared care development for long-term mental illness. *British Journal of General Practice*. 2004; **54(501):** 259-266

(Type II evidence – randomised controlled trial of 23 general practices and associated community mental health teams in England allocated to service development as usual or to a Mental Health Link programme (designed to improve communication between the teams and systems of care within general practice). Questionnaires and an audit of notes assessed 335 patients' satisfaction, unmet need, mental health status, processes of care, and general practitioners satisfaction with services. 24 months follow-up.)

6.1d A **collaborative care intervention** was associated with sustained improvement in depressive outcomes without additional health care costs in approximately two thirds of **primary care patients** with **persistent depressive symptoms**. The collaborative care intervention was associated with continued improvement in depressive symptoms at 28 months in patients in the moderate-severity group ($F_{1,87} = 8.65$; $p = 0.004$), but not in patients in the high-severity group ($F_{1,51} = 0.02$; $p = 0.88$). Improvements in the intervention group in antidepressant adherence were found to occur for the first 6 months ($\chi^2(1) = 8.23$; $p < 0.01$) and second 6-month period ($\chi^2(1) = 5.98$; $p < 0.05$) after randomisation in the high-severity group and for 6 months after randomisation in the moderate-severity group ($\chi^2(1) = 6.10$; $p < 0.05$). There were no significant differences in total ambulatory costs between intervention and control patients over the 28-month period ($F_{1,180} = 0.77$; $p = 0.40$).[i]

Caveat: There were significantly more females in the usual care group than the intervention group (81.6% vs 67.5%, p=0.02). The study was based in America, and may have limited generalisability to a UK setting.

i. Katon W, Russo J, Von Korff M, et al. Long-term effects of a collaborative care intervention in persistently depressed primary care patients. *Journal of General Internal Medicine* 2002; **17(10)** :741-748

(Type II evidence – randomised controlled of patients with major depression, stratified into severe and moderate depression groups prior to randomisation. 114 patients in Washington (mean age 47.2 years) received a multifaceted intervention using collaborative management by a psychiatrist and a primary care physician and 114 patients (mean age 46.7 years) to usual care. 187 Group Health Cooperative patients were included in the cost and adherence analyses. Follow-up was at 1, 3, 6 and 28 months.)

The *statements*

The *evidence*

6.1e A **collaborative care intervention** for patients with **panic disorder** was associated with significantly more anxiety-free days (mean of 74.2 more anxiety-free days during the intervention, 95% CI 15.8-122.0), and no significant differences in total outpatient costs. Results also suggested a distribution of the cost-effectiveness ratio based on total outpatient costs that suggests a 70% probability that the intervention was dominant, compared with usual care (e.g. lower costs and greater effectiveness). The incremental mental health cost of the intervention was $205 (95% CI, -$135 to $501), with the additional mental health costs of the intervention explained by expenditures for antidepressant medication and outpatient mental health visits. The incremental cost-effectiveness ratio for total ambulatory cost was -$4 (95% CI, -$23 to $14) per anxiety-free day. [i]
Caveat: It is unclear whether an intention-to-treat analysis was used. Results of this American study may have limited generalisability to a UK setting.

i. Katon WJ, Roy-Byrne P, Russo J, Cowley D. Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. *Archives of General Psychiatry* 2002; **59(12)**: 1098-1104

(Type II evidence – randomised controlled trial of 115 primary care patients with panic disorder assigned to either a collaborative care intervention (mean age 39.6 years, 51% female) that included systematic patient education and approximately 2 visits with an on-site consulting psychiatrist, or usual primary care (mean age 41.9 years, 64% female). Patients were assessed at 3, 6, 9, and 12 months.)

6.1f A stepped **collaborative care programme** for depressed primary care patients led to substantial increases in treatment effectiveness and moderate increases in costs. Improving outcomes of **depression treatment in primary care** requires investment of additional resources, but the return on this investment is comparable to that of many other widely accepted medical interventions. Patients receiving collaborative care experienced a mean of 16.7 additional depression-free days over 6 months. The mean incremental cost of depression treatment in this programme was $357. The additional cost was attributable to greater expenditures for antidepressant prescriptions and outpatient visits. No offsetting decrease in use of other health services was observed. The incremental cost-effectiveness was $21.44 per depression-free day.[i]
Caveat: It is unclear if an intention-to-treat analysis was used. The results of this American study may have limited generalisability to a UK setting.

i. Simon GE, Katon WJ, VonKorff M, *et al*. Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. *American Journal of Psychiatry* 2001; **158(10)**: 1638-1644

(Type II evidence – economic analysis based on a randomised controlled trial of 168 primary care patients (mean age 47 years, 74% female) with persistent major depression assigned to continued usual care or collaborative care. Main outcomes measured depression, health services utilisation and costs. 6 months follow up.)

6 DELIVERING SERVICES

National Service Framework: key action 21

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Inpatient and community services are to be provided in fit for purpose environments. These are to offer dignity, privacy and appropriate space and resources for purposeful activity for users and staff. A therapeutic, supportive environment must be created and properly staffed. All inpatient wards are to offer the choice of single sex environments. People are to be treated in the least restrictive environment possible. [Key action 21 paragraph 22.2]

What evidence is there regarding good ward environments for inpatient and community services?

The *statements* | The *evidence*

6.2 Beneficial ward environments

6.2a As well as investment to improve the **ward environment,** there needs to be a culture change that respects patients and therefore begins by recognising the daily indignities that too many inpatients of acute wards endure. What people value in these services – for example higher staff:patient ratio, access to the kitchen, service user input at design stage – needs to be built into quality assurance measures for the wider NHS.

56% of patients said that ward was an un-therapeutic environment, more than double those who said it was therapeutic (25%). 45% said the ward conditions had a negative effect on their mental health. 30% said they found the atmosphere on wards unsafe and frightening. Just under a third (30%) said illegal drugs were being used on the wards. 64% of patients who needed an interpreter did not get one. More than half (57%) of patients said they didn't have enough contact with staff. The vast majority (82%) of patients, who said they didn't have enough contact with staff, said that they had 15 minutes or less with staff each day. Almost 1 in 6 (16%) of patients said they had experienced sexual harassment on the ward, and 72% of those patients who complained said no action was taken to prevent it happening again. 60% of patients had problems getting a restful night's sleep. Just under half (45%) of patients said they didn't have enough access to food and 31% said they didn't have enough access to drinks. A quarter (26%) of patients said the toilets weren't clean.[i]

Caveat: The survey response rate was very low (9%).

i. Baker S. *Environmentally friendly: patients views of conditions on psychiatric wards*. London: MIND, 2000

(Type IV evidence – questionnaire survey to investigate service users' experiences of inpatient services on psychiatric wards and to identify examples of good practice. 4,500 questionnaires were sent to individual members of MindLink, members and groups on the Diverse Minds network and the 220 Local Mind Associations in England and Wales. 343 people responded.)

The *statements*	The *evidence*
6.2b A review of the psychiatric literature revealed that a **beneficial treatment environment** for people with chronic psychosis should be highly supportive, with an **emphasis on relationships** and an orientation toward **individual needs**. The environment should contain little expression of anger and aggression, a relaxed, non-restrictive regime of care and opportunities for user involvement. Using the concept of the maternal archetype, the author explores why such an environment may prove healing. As severely psychotic individuals may exhibit profound disturbances at the level of the primal relationship, an environment with strong maternal qualities may provide opportunities for growth.[i]	i. Smith J. The healing elements of an environment for those with chronic psychosis. *Therapeutic Communities* 2000; **21(1)**: 37-46 (Type V evidence – narrative literature review with systematic search strategy from 1978-1998. 25 primary and descriptive studies to determine what constitutes a healing environment for people with chronic mental illness were included.)
6.2c A report from the Sainsbury Centre for Mental Health is available which provides information on the **physical ward environment** and the **therapeutic milieu** of inpatient wards. This series of articles looks at many aspects of acute mental health inpatient care, providing an overview of current policy and practice, backed by findings from research and includes information on areas of good practice.[i]	i. Warner L, Bryant M, Dallender J, Lindley P, McCulloch A, Rose D. *Mental Health Topics: Acute Inpatient Care*. The Sainsbury Centre for Mental Health. 2002 (Type V evidence – expert opinion)

Purpose built accommodation

6.2d **Purpose-built accommodation**, with carefully structured care provision for the more disabled and severely mentally ill, may be effective in reducing the frequency of previously chronic problem behaviours for long-stay psychiatric residents. Results indicate that **bungalow residents** showed significantly lower levels of psychiatric difficulty than their **'ward-based'** counterparts. Social Behaviour Schedule mean scores (both the severe behaviour problems score (BSS) and the moderate or severe behaviour problems score (BSM]) for the bungalow group were significantly lower than those obtained from the traditional ward group (BSM 4.5 versus 9.8, BSS 2 versus 5.4).[i]	i. McGonagle IM, Allan S. A comparison of behaviour in two differing psychiatric long-stay rehabilitation environments. *Journal of Psychiatric & Mental Health Nursing* 2002; **9(4)**: 493-499 (Type IV evidence – cross-sectional survey of 18 long-stay residents (mean age 55 years, 61.1% female) residing in bungalow complex set within hospital grounds, 37 long-stay hospital ward residents (mean age 48 years, 62.16% male) and 11 residents (mean age 31.5 years, 54.5% female) living in hostel accommodation and associated flats near a city centre.)

The *statements*

The *evidence*

6.2e Moving to **new purpose-designed psychiatric wards** can result in positive changes in the perceptions and behaviour of **nursing staff**. However, it is clear that a vital component in the success of any environmental manipulation is an appropriate corresponding change in the organisation climate. Increases in burnout and stress appeared to be related to organisational climate and it is possible that the impact of the physical environment may be mediated by stress. Consequently, without appropriate organisational change, the potential benefits of the new environment may be attenuated. For the behaviour interaction with patients there was a significant interaction between environment and type of ward ($F_{1,76}$=15.47, p<0.001) with the new ward resulting in more interaction with patients in the acute ward but less interaction with patients in the long-stay ward. The percentage of interactions that were positive increased in the new wards ($F_{1,76}$=168.18, p<0.001) but this was largely due to the much greater increase in positive interactions in the acute ward ($F_{1,76}$=68.10, p<0.001) [i].

i. Tyson GA. The impact of ward design on the behaviour, occupational satisfaction and well-being of psychiatric nurses. *International Journal of Mental Health Nursing* 2002; **11(2)**: 94-102

(Type IV evidence – qualitative observational study in Australia following nursing staff through the replacement of old acute and long-stay wards with newly built purpose-designed psychiatric wards. Staff behaviour was observed in 40 psychiatric nurses from the old wards 6 months prior to the move, and then 40 psychiatric nurses from the new wards approximately 6 months after the move. In the first stage of measures, 37 staff members also completed questionnaires, and 34 questionnaires were returned at the second stage. Additionally, 16 staff were interviewed.)

National Service Framework: key action 22

Raising the standard - the revised adult mental health national service framework and an action plan for Wales.
Welsh Assembly Government, October 2005

Community mental health teams are to be multidisciplinary and working from a common base. They are to have effective liaison with primary care and specialised services. [Key action 22 paragraph 23.1]

What evidence is there to support the CMHT and MDT models?
How can effective links be developed and maintained with primary care services?

See Section 6.1 for liaison between primary and secondary care
See also Section 6.7 for liaison psychiatry

The *statements* | The *evidence*

6.3 Effectiveness of community mental health teams

6.3a **Community mental health team management** is not inferior to **non-team standard care** in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing **hospital admission** and avoiding death by **suicide**. CMHT management may be associated with fewer deaths by suicide and in suspicious circumstances (OR 0.32 95%CI 0.09-1.12). It causes less people to be dissatisfied with their care (OR 0.34 95%CI 0.2-0.59) and to leave the studies early (OR 0.61 95%CI 0.45-0.83). No clear difference was found in admission rates, overall clinical outcomes and duration of in-patient hospital treatment, although this was partly a consequence of poorly presented data.[i]

i. Tyrer P, Coid J, Simmonds S, Joseph P, Marriott S. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. *The Cochrane Database of Systematic Reviews* 1998, Issue 4.
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000270/frame.html [accessed 29/07/05]
(Type I evidence - systematic review and meta-analysis of five randomised controlled trials comparing the effectiveness of community mental health team management to non-team community management in severe mental illness. Literature search to 1998.)

6.3b Providing additional **intensive community focused care** to a group of heavy users of psychiatric in-patient services in an outer London borough does not lead to any important clinical gains or reduced costs of psychiatric care. Despite a 24 fold increase in community contacts in the study group, there were no significant differences between the two groups in any of the main outcome measures. Small savings on in-patient and day-hospital service costs were counterbalanced by the increased costs of outpatient and community care for the subjects assigned to Enhanced Community Management (ECM). Clinical outcome data derived from interviews in two-thirds of the subjects were similar in both groups.[i]
Caveat: Follow-up at 1 and 2 years was low (65%).

i. Harrison-Read RP, Lucas B, Tyrer P, *et al*. Heavy users of acute psychiatric beds: randomized controlled trial of enhanced community management in an outer London borough. *Psychological Medicine* 2002; **32(3)**: 403-416
(Type II evidence – parallel randomised controlled trial of 193 heavy users of psychiatric in-patient services (mean age 39.2, 52.9% male) allocated to either a dedicated multi-professional team providing enhanced community management (ECM) or locality-based management alone. Main outcome measures were costs of the treatments, use of psychiatric services and clinical outcomes, over the 2-year study period.)

The *statements* | The *evidence*

6.4 Links between community mental health teams and primary care

6.4a Shifting to a **consultation-liaison relationship** should increase rates of referral of patients with serious mental illness, including those who can most benefit from the skills of **CMHTs.** Increasing the provision of primary care-based psychology might improve practice use of mental health services, reducing avoidable outpatient psychiatric referrals. The average annual referral rate to the eleven CMHTs in East London is 10 per 1000 adult population annually. The teams show a sixfold variation in rates of referral from all sources. Where good working relationships (a consultation-liaison style) exist between CMHTs and general practice, there are greater numbers of referrals requiring both long and short-term work by CMHTs. Two-stage multivariate models explained 47% of the referral variation between practices. Where primary care-based psychologists work with practices there are greater numbers of CMHT referrals, but less use of psychiatric services.[i]

i. Hull SA, Jones C, Tissier JM, Eldridge S, Maclaren D. Relationship style between GPs and community mental health teams affects referral rates. *British Journal of General Practice*. 2002; **52 (475)**:101-107.

(Type IV evidence – cross-sectional study with all 161 general practices in East London and the City Health Authority. Questionnaire surveys were used to identify style of relationship and collection of routinely available referral data to all statutory mental health services over a two-year period.)

6.4b Each of the study's **multi-agency groups** implicitly supports a complex range of **model dimensions** regarding the nature of schizophrenia, the appropriateness of specific forms of treatment and care, and their respective rights and obligations towards each other. The influence of these implicit model patterns on processes of **shared decision making** are discussed through evaluating (including informal carers) and between practitioners and patients during clinical encounters.[i]

i. Colombo A, Bendelow G, Fulford B, Williams S. Evaluating the influence of implicit models of mental disorders on processes of shared decision making within community-based multi-disciplinary teams. *Social Science and Medicine*. 2003; **56**: 1557-1570.

(Type IV evidence – qualitative study of 100 participants representing 5 distinct multi-agency groups: psychiatrists, community psychiatric nurses, approved social workers, patients and informal carers operating within Leicestershire, UK.)

The *statements*

The *evidence*

6.4c The findings suggest that the **Shared Care** model is more consistent with supporting personal and organisational continuity of care, whereas the **Specialist Liaison** model is limited to encouraging personal continuity of care but further study is needed. In the Shared Care model, nurses maintain close contact with GPs throughout the episode of acute care. In the Specialist Liaison model, the **community mental health team** assumes overall responsibility for care and treatment throughout the acute episode of illness. Contact with GPs throughout the episode of care by the community mental health team is, at best, intermittent.[i]
Caveat: Only limited data available for independent assessment. The findings may have limited applicability to a UK setting.

i. McCann TV, Baker H. Models of mental health nurse-general practitioner liaison: promoting continuity of care. *Journal of Advanced Nursing* 2003; **41(5)**: 471-479
(Type IV evidence - qualitative study with interviews and observation of 24 community mental health nurses in regional and rural New South Wales, Australia.)

6.4d The overall impression was of **primary care teams** encountering high levels of need for which they felt unprepared, and of a **community psychiatric nurse** (CPN) service torn in two by the opposing demands of **general practitioners** (GPs) and their employing trust. The discussion section of the paper compares the findings of the study with a model for reorganisation put forward in the literature and highlights the obstacles to be overcome in bridging the policy gap.[i]
Caveat: The authors also intended to conduct a questionnaire survey, however, responses to the survey were poor.

i. Secker J, Pidd F, Parham A, Peck E. Mental health in the community: roles, responsibilities and organisation of primary care and specialist services. *Journal of Interprofessional Care*. 2000; **14(1)**: 49 – 58.
(Type IV evidence – qualitative study focus groups with 30 primary care nurses, interviews with 3 general practitioners (GPs) and a group discussion with 7 community psychiatric nurses (CPNs) from two districts in London.)

6.4e Guidance is available for England mental health policy implementation which includes information on the key elements of community health team approach, working with primary care, and liaison with other parts of the health system.[i]

i. Mental Health Policy Implementation Guide. *Community Mental Health Teams*. Department of Health 2002
http://www.dh.gov.uk/assetRoot/04/08/57/60/04085760.pdf [accessed 29/07/05]
(expert consensus guidelines)

National Service Framework: key action 24

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Each LA/LHB is to have a range of alternatives to admission and facilities to support individuals after discharge, including day services. This should include supervised short or medium term accommodation with residential care staff on site and mechanisms to support people in their own accommodation.[Key action 24 paragraph 20.3]

What alternatives to admission can be offered?

What facilities to support individuals after discharge are effective?

What are successful methods of supporting people in their own accommodation?

The *statements* | The *evidence*

6.5 Alternatives to admission and support for individuals after discharge

Advance directives

6.5a **Users' advance instruction** directives had little observable impact on the outcome of care at twelve months. Fifteen patients (19%) in the intervention group and 16 (21%) in the control group were readmitted compulsorily within 1 year of discharge. There was no difference in the numbers of compulsory readmissions, numbers of patients readmitted voluntarily, days spent in hospital or satisfaction with psychiatric services.[i]
Caveat: Only 70.8% participants were followed up.

i. Papageorgiou A, King M, Janmohamed A, Davidson O, Dawson J. Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. *British Journal of Psychiatry* 2002; **181**: 513-519
(Type II evidence – randomised controlled trial in two psychiatric services in inner London. 156 in-patients (mean age 35.9 years, 59.5% male) about to be discharged from compulsory treatment under the Mental Health Act were allocated to either the advance directive intervention or standard. Main outcome measure was rate of compulsory readmission to hospital.12 months follow-up.)

Assertive community treatment

6.5b **Assertive Community Treatment** (ACT) is a clinically effective approach to managing the care of severely mentally ill people in the community. ACT, if correctly targeted on high users of in-patient care, can substantially reduce the costs of hospital care whilst improving outcome and patient satisfaction. Policy makers, clinicians, and consumers should support the setting up of ACT teams.

Continued

The *statements*

The *evidence*

6.5b continued from previous page

Those receiving ACT were more likely to remain in contact with services than people receiving **standard community care** (OR 0.51, 99%CI 0.37-0.70). People allocated to ACT were less likely to be admitted to hospital than those receiving standard community care (OR 0.59, 99%CI 0.41-0.85) and spent less time in hospital. In terms of clinical and social outcome, significant and robust differences between ACT and standard community care were found on accommodation status, employment and patient satisfaction. ACT invariably reduced the cost of hospital care, but did not have a clear cut advantage over standard care when other costs were taken into account.

Those receiving ACT were no more likely to remain in contact with services than those **receiving hospital-based rehabilitation**, but confidence intervals for the odds ratio were wide. People getting ACT were significantly less likely to be admitted to hospital than those receiving hospital-based rehabilitation (OR 0.2, 99%CI 0.09-0.46) and spent less time in hospital.

There were no data on numbers remaining in contact with the psychiatric services or on numbers admitted to hospital for studies comparing ACT and **case management**. People allocated to ACT consistently spent fewer days in hospital than those given case management. There was insufficient data to permit robust comparisons of clinical or social outcome. The cost of hospital care was consistently less for those allocated to ACT, but ACT did not have a clear cut advantage over case management when other costs were taken into account. [i]

Caveat: Studies investigating ACT as an alternative to hospital admissions were not included in this review. It is unclear whether unpublished research was sought.

i. Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. *The Cochrane Database of Systematic Reviews* 1998, Issue 2. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001089/frame.html**

[accessed 29/07/05]

(Type I evidence – systematic review of 20 randomised controlled trials comparing ACT to standard community care, hospital-based rehabilitation, or case management for people with severe mental disorder the aged from 18 to 65. Literature search to May 1997.)

The *statements*

The *evidence*

6.5c Significant differences were found between **Assertive Community Treatment** (ACT) and usual care in time to first arrest, but not hospitalisation, homelessness or emergency room (ER) visits. The paucity of significant main effects may have been due to a prolonged "start-up" phase of the ACT programmes, poor ACT implementation, restricted availability of psychiatric hospital beds, or changes in usual care services delivered over the study period. Shorter time to first hospitalisation was associated with male gender, diagnoses other than **schizophrenia**, high psychiatric symptomatology and lower provider case load. Shorter times to homelessness were predicted by poorer therapeutic alliance between case manager and clients. Shorter time to first arrest was predicted by client minority status and enrollment in usual care.[i]

Caveat: Unclear if intention-to-treat analysis was used. The results of this study may not be generalisable to a UK setting.

i. Clarke GN, Herinckx HA, Kinney RF, et al. Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: findings from a randomized trial of 2 ACT programs vs. usual care. *Mental Health Services Research* 2000; **2(3)**: 155-64.

(Type II evidence – randomised controlled trial of 163 participants in America (mean age 36.5 years; 60.7% male) allocated to one of 2 intervention groups: a) ACT programme staffed by mental health consumers, who had experienced major mental illness, b) ACT programme staffed by non-consumers or usual care from several community mental health providers. 2-years follow-up)

6.5d England adult mental health policy implementation guidance is available, that covers topics of **assertive outreach, crisis resolution**, and **early intervention services**. For each type of service the following details are presented: who the service is for, what it is intended to achieve, what the service does and how it relates to other services, operational procedures and references for further evidence.[i]

i. Department of Health. *The Mental Health Policy Implementation Guide*. Department of Health, March 2001. **http://www.dh.gov.uk/assetRoot/04/05/89/60/04058960.pdf** [accessed 29/07/05]

(Type V evidence – implementation guide to support the delivery of adult mental health policy locally. The document builds on comments received and observations made since the publication of the English NSF and the NHS Plan, and aims to set out clearly the expectations placed on local implementation teams.)

The *statements*

The *evidence*

Community residences

6.5e Drayton Park project appears to be succeeding in providing a safe **alternative to hospital admission** for women with severe and enduring mental health problems. The findings show that service is able to respond quickly to referrals (78% were seen within 48 hours of admission) and appears to be functioning safely. The women admitted have a relatively short length of stay, half suffer from **depressive episodes** and 1/3 have a relapse of **schizophrenia or bipolar disorder**.[i]
Caveat: There is a potential conflict of interest as the principal author is a Specialist Registrar at Drayton Park.

i. Killaspy H, Dalton S, Mcnicholas S et al. Drayton Park, an alternative to hospital admission for women in acute mental health crisis. *Psychiatric Bulletin* 2000; **24:** 101-104

(Type IV evidence - observational study using randomly selected case files from 100 women admitted to Drayton Park, the first women-only residential mental health crisis facility in the UK. Inmate case notes were examined for demographic details, reasons for referral, diagnosis and source of referral.)

6.5f **Community care** has enhanced the quality of life of this group of patients, involved in a well-planned and adequately resourced reprovision programme. Of the 670 discharged patients, there was no change in the patients' clinical state or in their problems of social behaviour. However, they gained domestic skills (baseline:10.2 95% CI 9.3-10.8, 1 year follow-up: 14.6 95% CI 13.6-15.9, and 5 year follow-up: 11.5 95%CI 10.6-12.4) and **community living skills** (baseline: 6.91 95%CI 6.45-7.36, 1 year follow-up: 8.21 95%CI 7.82-8.61, 5 year follow-up: 7.87 95%CI 7.45-8.30). They also acquired friends and confidants. They were living in much freer conditions and the great majority wanted to remain in their current homes.[i]
Caveat: There is a high percentage of missing data, particularly at 5 year follow-up. 126 patients died within 5 years of discharge. In addition, some patients refused to complete certain schedules. For example, only 286 (53% of the 523 patients at follow-up) completed the social network scale.

i. Leff J, Trieman N. Long-stay patients discharged from psychiatric hospitals. Social and clinical outcomes after 5 years in the community. The TAPS Project 46. *British Journal of Psychiatry* 2000; **176:** 217-223

(Type IV evidence - prospective observational study to compare the quality of life of 670 long-stay patients (mean age 54), in 2 north London hospitals scheduled for closure, with that in the community homes to which they were discharged. Measures were analysed for clinical, social and physical health outcomes.)

The *statements*

The *evidence*

6.5g The psychosocial environment profiles for psychiatric settings in different phases of the care process, may vary in terms of subscales of the Community Oriented Program Environmental Scale (COPES). The study showed that the **psychosocial environment** differs between the 2 types of settings. Residents and staff in **small congregate residences** rated higher levels of Autonomy (for example, residents autonomy: 6.15 SD1.7 versus patients: 4.95 SD 1.7, $p<0.05$) and lower levels of Practical Orientation, Anger and Aggression and Order and Organisation than patients and staff in **inpatient settings**.[i]

Caveat: Staff on inpatient settings differed significantly from residence staff on age and qualification. The study was conducted in Sweden and may have limited generalisability to the UK.

i. Brunt D, Hansson L. A comparison of the psychosocial environment of 2 types of residences for persons with severe mental illness: Small congregate community residences and psychiatric inpatient settings. *International Journal of Social Psychiatry* 2002; **48**: 243-252

(Type IV evidence – cross-sectional study conducted in Sweden. Participants were 27 residents (mean age 41 years, 67% male) and 53 staff (mean age 41 years, 77% female) from 8 small congregate community residences; and 24 patients (mean age 35 years, 54% male) and 40 staff (mean age 48 years, 70% female) from 2, 12-bed inpatient rehabilitation wards and 3 community-based therapeutic communities.)

6.5h An economic analysis of expenditure and income data demonstrated overall that hospital care was nearly twice as expensive as **care in the community** setting. The 4 community residences were found to be $190 less expensive per occupied bed-day than the hospital in the year 1995-1996. The factors which may have influenced, although not necessarily altered, the substance of the findings largely related to organisational efficiency. The mental hospital as an older, more rigid system was likely to be less efficient than the newer community service provision which was under intensive scrutiny both clinically and financially by all interested parties.[i]

Caveat: The results of this study may have limited generalisability to a UK setting.

i. Lapsley HM, Tribe K, Tennant C, Rosen A, Hobbs C, Newton L. Deinstitutionalisation for long-term mental illness: cost differences in hospital and community care. *Australian & New Zealand Journal of Psychiatry* 2000; **34(3)**: 491-495

(Type IV evidence – pre-post economic analysis of 47 patients (mean age at final discharge was 41 years; 25 men, 22 women) transferred from a psychiatric hospital in Sydney between May and August 1994 to 4 community residential facilities, each of 10 people, which were specifically established for them. Patients were costed either as a community patient or a hospital patient and not individually followed. Expenditure information was collected for the first 2 years of establishment of these community residences.)

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6.5i Subjects who were eventually **resettled in the community** showed more evidence of improvement over the length of their stay, and had significantly better overall functioning in the period immediately prior to their resettlement. Those subjects who were eventually transferred out of the unit to **traditional psychiatric hospital wards** showed less evidence of improvement and more evidence of deterioration, albeit commonly following some initial improvement. They also showed an increase in violent and aggressive behaviour in the weeks immediately prior to transfer. The ongoing group of current residents appeared to be specifically characterised by significant fluctuations in their functioning over their length of stay.[i]
Caveat: The results of this study can only be tentative until they can be replicated in other similar units due to the small sample size.

i. King C, Singh K, Shepherd G. An analysis of process and outcomes for new long-stay patients in a 'ward-in-a-house'. *Journal of Mental Health* 2000; **9(2)**: 179-179

(Type IV evidence – observational cohort study of 20 severely disabled residents at a 'hospital hostel' in the UK (mean age 35.6 years; 90% with schizophrenia; male n=13). Residents were classified into 3 groups according to outcome: ongoing (n=7), discharged (n=8), transferred (n=5). Resident assessments were routinely completed every 3 months for patient behaviour, community contact and incidents of violent or aggressive behaviour.)

6.5j On the whole, residents were content with **community living arrangements** and **preferred these to hospital,** although levels of satisfaction varied across different residential projects. Residents lacked awareness of rights to and means of voicing concerns and making choices about major issues in their lives. They showed greater interest in individualised rather than group advocacy. Ideally, research and evaluation, to be truly user-focused, should be long-term and continuous in order to involve participants more fully, and should anticipate the structures and processes needed to act on findings.[i]
Caveat: The sampling strategy used in this study has not been fully reported and a small expenses payment was offered to participants.

i. McCourt CA. Life after hospital closure: users' views of living in residential 'resettlement' projects. A case study in consumer-led research. *Health Expectations* 2000; **3(3)**: 192-202

(Type IV evidence - qualitative study to determine the views and experiences of former psychiatric hospital patients in community-based residential projects in London, 4 years after hospital closure. 26 residents completed informal semi-structured interviews on current living arrangements, their opportunities to express their views and their interest in a formal user-group such as a residents' council or citizen advocacy scheme.)

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6.5k Level of satisfaction with the **community integrated living arrangement (CILA) residences** was fairly high and was comparable to levels reported in related research on independent living arrangements. Residents of CILA facilities had a mean rating of satisfaction with their residence of 5.2±1, "mostly satisfied," on a scale from 1 to 7. Residents with continuous supervision (mean ±SD=5.1±1) and those with intermittent supervision (mean ±SD=5.3±1) were equally pleased with their living arrangements. Residents' hospital use decreased significantly from 47.7±103 during the baseline year to 5.3±17 during the first year in community living arrangement facilities (repeated-measures t=3.67, df=73, p<0.001). CILAs helped maintain severely mentally ill individuals in the community.[i]

Caveat: The sample size of the study is small.

i. Hanrahan P, Luchins DJ, Savage C, Goldman HH. Housing satisfaction and service use by mentally ill persons in community integrated living arrangements. *Psychiatric Services* 2001; **52(9)**: 1206-1209

http://psychservices.psychiatryonline.org/cgi/reprint/52/9/1206 [accessed 29/07/05]

(Type IV evidence – observational study of 74 residents (43 residents lived in intermittent-care residences and 31 in continuous-care residences) from 9 randomly selected community integrated living arrangement (CILA) facilities in Chicago. Residents completed structured interviews on measures of housing satisfaction with 6 aspects of housing.)

6.5l Results showed that only 10% of current psychiatric inpatients need to remain in the hospital, and over 60% could **live independently in the community** with appropriate **supports.** Evidence supports concurrent validity of the planning model, but further work is needed to assess whether recommended **levels of care** effectively meet consumer needs in the least restrictive setting.[i]

Caveat: The results of this study may have limited generalisability to a UK setting.

i. Durbin J, Cochrane J, Goering P, Macfarlane D. Needs-based planning: evaluation of a level of care planning model. *Journal of Behavioural Health Services and Research* 2001; **28(1)**: 67-80

(Type IV evidence – validation study of the Comprehensive Assessment Projects (CAP), level-of-care model. 300 psychiatric hospital inpatients and 277 outpatients in Canada were assigned to 1 of 5 level-of-care placements: self-management (n=48), case management (n=145), intensive case management (n=211), residential (n=137), inpatient (n=36).)

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Day services

6.5m There is a clear need for randomised controlled trials of day centre care compared to other forms of day care, such as day hospitals .The reviewers feel that the inclusion of any studies less rigorous than randomised trials would result in misleading findings and that it is not unreasonable to expect well designed, conducted and reported randomised controlled trials of day centre care. More precise nomenclature would greatly help identify relevant work. At present non-randomised comparative studies give conflicting messages about the roles provided by **day centres and the clinical and social needs** they are able to meet. It is therefore probably best that people with serious mental illness and their carers, if given the choice, take a pragmatic decision on which type of unit best meets their needs.[i]

i. Catty J, Burns T, Comas A. Day centres for severe mental illness. *The Cochrane Database of Systematic Reviews* 2001, Issue 2. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001710/frame.html** [accessed 29/07/05]
(Type I evidence – systematic review of randomised controlled trials. No eligible studies were identified. Literature review to 1999.)

6.5n **Acute day hospitals:** Caring for people in acute day hospitals can achieve substantial reductions in the numbers of people needing inpatient care, whilst improving patient outcome. A sensitivity analysis of combined data suggested that day hospital treatment was feasible for at worst 23.2% (n = 2268; 95% CI 21.2 to 25.2) and at best 37.5% (n = 1768; 95% CI 35.2 to 39.8) of those currently admitted to inpatient care. Individual patient data from three trials showed no difference in the number of days in hospital between day hospital patients and controls. However, compared with controls, patients randomised to day hospital care spent significantly more days in day hospital care (n = 265; WMD = 2.44 days/month; 95% CI 1.97 to 2.70) and significantly fewer days in inpatient care (n = 265; WMD = –2.75 days/month; 95% CI –3.63 to –1.87). There was no difference between readmission rates for day hospital and control patients. Individual patient data from three trials showed a significant time–treatment interaction, indicating a more rapid improvement in mental state (n = 407; c^2 = 9.66; p = 0.002), but not social functioning amongst day hospital patients. Four of five trials demonstrated that day hospital care was cheaper than inpatient care (with overall cost reductions ranging from 20.9% to 36.9%).[i,ii]

i. Marshall M, Crowther R, Almaraz-Serrano A, *et al*. Systematic reviews of the effectiveness of day care for people with severe mental disorders: (1) acute day hospital versus admission; (2) vocational rehabilitation; (3) day hospital versus outpatient care. *Health Technology Assessment* 2001; **5**: 1-75

ii. Marshall M, Crowther R, Almaraz-Serrano A, et al. Day hospital versus admission for acute psychiatric disorders. *The Cochrane Database of Systematic Reviews* 2003, Issue 1. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004026/frame.html** [accessed 29/07/05]

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Day hospital versus outpatient care: There was some limited evidence to support the use of day treatment programmes for patients with anxiety or depression who have not responded to standard outpatient treatment. There was no evidence to suggest that day treatment programmes or day care centres were better or worse than outpatient care on any other clinical or social outcome variable or on costs. There were some inconclusive data on costs suggesting that day care centres could be more expensive than outpatient care.[i,iii]

iii. Marshall M, Crowther R, Almaraz-Serrano AM, Tyrer P. Marshall M, Crowther R, Almaraz-Serrano AM, Tyrer P. Day hospital versus out-patient care for psychiatric disorders. *The Cochrane Database of Systematic Reviews* 2001, Issue 2. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003240/frame.html**

[accessed 29/07/05]

(Type I evidence – systematic review and meta-analysis. For acute day hospital versus admission. 9 RCTs were included (involving 1568 randomised patients and 2268 assessed for suitability of day hospital treatment). Individual patient data were obtained for four trials (involving 594 people). For day hospital versus outpatient care 5 trials were included in the review. Literature search January 1967 to December 2000.)

Home treatment / crisis resolution

6.5o The benefit of **home treatment over admission** in terms of days in hospital was clear, but over other **community-based alternatives** was inconclusive. The services were homogeneous in terms of 'home treatment function' but fairly heterogeneous in terms of other components. There was some evidence for a group of services that were multidisciplinary, had psychiatrists as integrated team members, had smaller caseloads, visited patients at home regularly and took responsibility for both health and social care. This was not a cohesive group, however. The **sustainability of home treatment services** was modest: less than half the services whose authors responded were still identifiable. Services were more likely to be operational if the study had found them to reduce hospitalisation significantly.

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The evidence base for the effectiveness of services identifiable as 'home treatment' was not strong. Within the 'inpatient-control' study group, the mean reduction in hospitalisation was 5 days per patient per month (for 1-year studies only). No statistical significance could be measured for this result. For 'community-control' studies, the reduction in hospitalisation was negligible. Moreover, the heterogeneity of control services, the wide range of outcome measures and the limited availability of data might have confounded the analysis. **Regularly visiting at home and dual responsibility for health and social care** were associated with reduced hospitalisation. Few conclusions could be drawn from the analysis of service utilisation data. Only 22 studies included economic evaluations. They provided little conclusive evidence about cost-effectiveness because of problems with the heterogeneity of services, sample size, outcome measures and quality of analysis. Studies were predominately from the USA and UK, more of them being from the USA. [i-iii]

i. Burns T, Knapp M, Catty J, et al. Home treatment for mental health problems: a systematic review. *Health Technology Assessment (Winchester, England)* 2001; **5**: 1-139

ii. Catty J, Burns M, Knapp H et al. Home treatment for mental health problems: a systematic review. *Psychological Medicine* 2002; **32**: 383-401

iii. Burns T. Catty J. Watt H. Wright C. Knapp M. Henderson J. International differences in home treatment for mental health problems. Results of a systematic review. *British Journal of Psychiatry* 2002; **181**: 375-82

(Type I evidence – systematic review of 56 randomised controlled trials and 35 non-randomised studies on the effectiveness of 'home treatment' for mental health problems in terms of hospitalisation and cost-effectiveness. Main outcome measure was mean days in hospital per patient per month over the follow-up period. Literature search to 1999.)

6.5p **Home care crisis treatment**, coupled with an ongoing home care package, is a viable and acceptable way of treating people with serious mental illness. If this approach is to be widely implemented it would seem that more evaluative studies are needed. 45% of the crisis/home care group were unable to avoid **hospital admission** during their treatment period. Home care however may help avoid repeat admissions (n=465, 3 trials, OR 0.72 95%CI 0.54 to 0.92, NNT 11 95%CI 6 to 97), but these data are heterogeneous.

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Crisis/ home care reduces family burden (RR 0.34, 95% CI 0.20 to 0.59, NNT 3 95%CI 2 to 4) and is a more satisfactory form of care for both patients and families. No differences in death or mental state were found. All studies found home care to be more cost effective than hospital care but all data were either skewed or unusable. No data on staff satisfaction, carer input, compliance with medication and number of relapses were available.[i]

i. Joy CB, Adams CE, Rice K. Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *The Cochrane Database of Systematic Reviews* 2004, Issue 4.
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001087/frame.html
[accessed 29/07/05]
(Type I evidence – systematic review of 5 randomised controlled trials, comparing crisis interventions to standard care. Literature search to 2003.)

6.5q **Residential crisis programmes** may be a cost-effective approach to providing acute care to patients who have serious mental illness and who are willing to accept **voluntary treatment**. Where resources are scarce, access to needed acute care might be extended using a mix of hospital, community-based residential crisis, and community support services. Mean (SD) acute treatment episode costs was $3046 ($2124) in the residential crisis programme, 44% lower than the $5549 ($3668) episode cost for the general hospital. Total 6-month treatment costs for patients assigned to the 2 programmes were $19,941 ($19,282) and $25,737 ($21,835), respectively. Treatment groups did not differ significantly in symptom improvement or community days achieved. Incremental cost-effectiveness ratios indicate that in most cases, the residential crisis programme provides near-equivalent effectiveness for significantly less cost.[i]
Caveat: The results of this study may have limited generalisability to a UK setting and are restricted to voluntary patients not requiring detoxification or acute general medical intervention.

i. Fenton WS, Hoch JS, Herrell JM, Mosher L, Dixon L. Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. *Archives of General Psychiatry* 2002; **59(4)**: 357-64
(Type II evidence – cost and cost-effectiveness analysis of 119 patients (mean age 37 years, 52% male), willing to accept voluntary acute care, allocated to either the psychiatric ward of a general hospital (n=50) or a residential crisis programme (n=69). Unit costs and service utilisation data were used to estimate episode and 6-month treatment costs from the perspective of government payors.)

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6.5r Junior doctors need training in how to use **home treatment services** appropriately and a wider range of options are needed to manage patients in **crisis out of hours**. It is possible to target patients with severe mental illness in a home treatment setting, but a significant number will need transfer to in-patient care. 48% of referrals were not accepted, mainly because of lack of cooperation, risk of self or others or the illness not being acute enough. Referrals from junior doctors and accident & emergency were least likely to be accepted. 72% of patients accepted suffered **from schizophrenia, bipolar affective disorder or depression with psychosis**, similar to the diagnoses for in-patients. 22% of patients accepted had to be transferred to in-patient care later.[i]

i. Harrison J, Alam N, Marshall J. Home or away: which patients are suitable for a psychiatric home treatment service? *Psychiatric Bulletin* 2001; **25**: 310-313

(Type IV evidence – observational study measuring referral and immediate outcome for the 195 patients referred to and assessed by a home treatment service in Manchester over 6 months.)

6.5s Clinicians recognise the need for hospitalisation and alternatives, such as **intensive home care (IHC), day hospital and supervised residential settings**. Attention should be paid not only to the number of beds, but also the availability and ratios of community based services such as IHC and supervised residential settings. On a given day, only 62 of 212 inpatients were unsuited for any **alternative to acute care hospitalisation**. Alternatives essentially involve an array of the following: **supervised residential settings, day hospitals, and intensive home care** (2 to 6 hours weekly). The ratio of intensive home care workers required would be 25 per 100,000 inhabitants.[i]

Caveat: The results may have limited applicability to UK setting.

i. Lesage AD, Bonsack C, Clerc D,et al. Alternatives to acute hospital psychiatric care in East-end Montreal. *Canadian Journal of Psychiatry* 2002; **47(1)**: 49-55

(Type IV evidence – cross-sectional survey to determine the need for acute care beds in psychiatric hospitals. Treating physicians of all acute care inpatients on a given day (n = 212) and all new acute care admissions over a 2-week period (n = 125) completed an adapted version of the Nottingham Acute Beds Use Survey questionnaire.)

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6.5t The findings suggest that an **emergency housing programme** is a feasible mode of extended **community-based care** for many persons with serious and persistent mental illness. Residents who had been admitted to the emergency housing programme from inpatient psychiatric treatment showed a significant decline in acuteness of psychiatric symptoms. Psychiatric symptoms also improved for residents who were admitted to the programme from community-based service programmes and for residents admitted as an **alternative to inpatient treatment**, although the differences for these 2 groups were less prominent.[i]

i. Goodwin RLJ, Lyons JS. An emergency housing program as an alternative to inpatient treatment for persons with severe mental illness. *Psychiatric Services* 2001; **52(1)**: 92-95 **http://psychservices.psychiatryonline.org/cgi/reprint/52/1/92** [accessed 29/07/05]

(Type IV evidence – retrospective chart review of 161 people (mean age 37.5 years, 64% male) admitted consecutively to an emergency housing hospital-based programme in Chicago between October 1993 and November 1994. Data obtained in 1995 were analysed to evaluate the change in residents' clinical acuity and psychosocial status between admission and discharge.)

Intensive community support

6.5u The use of **intensive community support** does not lead to early discharge from inpatient care, but does lead to early community follow-up. However, the intervention was associated with a higher readmission rate in a subgroup of patients which can be characterised by fewer symptoms on admission and longer length of psychiatric history prior to admission. During the course of the trial overall bed occupancy fell in those sectors involved in the trial compared with those which did not take part. This may reflect an improvement in general **discharge planning** and the greater amount of community resources available following the introduction of the Community Link Teams.[i]
Caveat: It is unclear if an intention-to-treat analysis was used. There was an uneven distribution in sample sizes between the intervention (n=138) and control (n=87) groups.

i. Park B, Hampson M, Croudace T, Jones P. *RCT of intensive community support to facilitate early discharge from acute psychiatric inpatient care*. Final Report to NHS Executive Trent. Nottingham: Division of Pyschiatry, School of Community Health Sciences, University of Nottingham, 2003

(Type II evidence – randomised controlled trial of 255 patients allocated to either intensive community support (n=138, mean age 38.3 years, 48.9% male) or usual care (n=87, mean age 37.9 years, 57.5% male). Patients were reinterviewed at the point of discharge. Data on readmissions were collected for the 4-months from discharge date.)

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Partial hospitalisation

6.5v Although **partial hospitalisation** is not an option for all patients requiring intensive services, outcomes of partial hospitalisation patients in these studies were no different from those of inpatients. Further, patients and families were more satisfied with partial hospitalisation in the short term. Weaknesses of the studies limited the generalisability of findings. Positive findings require replication under the present circumstances of mental health care, and more research is needed to identify predictors of differential outcome and successful partial hospitalisation. A clearer definition of partial hospitalisation will help consolidate its role in the continuum of mental health services.[i]
Caveat: Two thirds of the studies were published over a decade ago, and a similar proportion were rated to be of substandard quality. Unpublished data does not appear to have been sought.

i. Horvitz-Lennon M, Normand SL, Gaccione P, Frank RG. Partial versus full hospitalization for adults in psychiatric distress: a systematic review of the published literature (1957-1997). *American Journal of Psychiatry*. 2001; **158**: 676-685

(Type I evidence – systematic review of 18 studies (10 randomised, 4 matched design and 4 observational/ other nonrandomised) published since 1950. A meta-analysis was based on 4 studies providing sufficient data to estimate effect sizes.)

6.5w The **partial hospitalisation programme** was well received by the clients and well used by clinicians. Although it initially reduced the pressure on **in-patient services**, the problems confronting the programme at the end of the evaluation mirrored those of in-patient units. The unit received over 200 referrals over 12 months, and more than 60% were for individuals who might otherwise have been admitted. The programme was associated with reductions in number and duration of hospital admissions and in bed occupancy rate; however, the proportion of urgent referrals to the programme doubled over the year, and after 12 months the occupancy rate was 96%.[i]

i. Tacchi MJ, Joseph S, Scott J. Evaluation of a partial hospitalisation programme: good news and bad. *Psychiatric Bulletin*. 2004: **28**; 244-247

(Type IV evidence – evaluation of a 50-place partial hospitalisation programme in Newcastle during its first year of operation. Data including diagnosis and source and reason for referral were recorded for the 271 consecutive referrals to the programme. 30 current attenders completed questionnaires to assess their views of the service offered. The admission units' activity was assessed for the for the year prior to and the year after the introduction of the service.)

6 DELIVERING SERVICES

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6.5x The use of **short-stay admission** coupled with **extended day care** and **crisis line support** can provide a viable **alternative to admission** to the acute ward. During the first year of operation 438 assessments took place with 27% of patients being admitted to a crisis bed and a further 25% supported via attendance at the unit. 12% needed in-patient admission and 10% were deemed not to require any involvement of the mental health service.[i]

Caveat: The results of the remaining 15% of assessments have not been reported.

The *evidence*

i. Wesson ML, Walmsley P. Service innovations: Sherbrook partial hospitalisation unit. *Psychiatric Bulletin* 2001; **25(2)**: 56-58

(Type IV evidence – survey of 438 assessments at a partial hospitalisation unit (age 16-64; 43% male). The authors describe an innovative system of providing mental health care in Southport, combining an extended day service with short-term hospital admission - the partial hospitalisation philosophy. Outcomes were admission and referrals of these assessments and length of stay.)

National Service Framework: key action 25

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

A range of specialist services should be available and accessible across Wales. These should include eating disorder services, mother and baby units, low secure care, liaison psychiatry, neuropsychiatry and early intervention services accessible to each Trust area.[Key action 25 paragraph 25.2]

What evidence is available regarding the range of specialist mental health services?

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6.6 Early intervention Services

6.6a The authors identified insufficient trials to draw any definitive conclusions on **early intervention for psychosis,** although five ongoing trials should report shortly. The substantial international interest in early intervention offers an opportunity to make major positive changes in psychiatric practice, but this opportunity may be missed without a concerted international programme of research to address key unanswered questions.

Two trials compared specific interventions with specialised teams. One small trial (n=59) was concerned with a phase-specific intervention (low dose risperidone and cognitive behavioural therapy) for people with prodromal symptoms. This group were significantly less likely to develop psychosis at 6 month follow up than people who only received care from a specialised team which did not involve phase-specific treatment (RR 0.27 CI 0.08 to 0.89, NNT 4 CI 2 to 20). This effect was not significant at 12 month follow up. Another study (n=76), comparing phase-specific intervention (family therapy) plus specialised team, with specialised team for people in their first episode of schizophrenia, found no difference between intervention and control groups at 12 months for the outcome of relapse but confidence intervals were wide. [i]

i. Marshall M, Lockwood A. Early Intervention for psychosis. *The Cochrane Database of Systematic Reviews* 2003, Issue 2.
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004718/frame.html
[accessed 29/07/05]
(Type I evidence – systematic review of 3 randomised controlled trials to evaluate the effects of early detection and treatment of people with prodromal symptoms; the use of early intervention teams for people in their first episode of psychosis; and phase-specific treatments for people in their first episode of psychosis. Literature search to July 2003.)

6.6b The lack of clearly demonstrated improvements for Croydon Outreach and Assertive Support Team (COAST) is consistent with the published literature so far. The fact that both groups improved in symptoms and functioning over the year suggests that while access to early intervention is helpful, **community adult mental health teams** should aim to offer high quality input at any stage of psychosis in order to meet client and carer needs. Overall both COAST and treatment as usual clients improved over time, but there were no significant improvements for COAST clients; a lack of significant results in the time x treatment interaction. There was a trend for COAST carers quality of life to increase. Bed days were also less in COAST, but not significantly so.
Caveat: Only a very small sample participated in the study.

i. Kuipers E, Holloway F, Rabe-Hesketh S, Tennakoon L. An RCT of early intervention in psychosis: Croydon Outreach and Assertive Support Team (COAST). *Social Psychiatry and Psychiatric Epidemiology.* 2004; **39(5)**: 358-363
(Type II evidence – randomised controlled trial to evaluate a new service in South London, UK, Croydon Outreach and Assertive Support Team (COAST) during its first year. Referrals were taken from local adult community mental health teams of those with documented first service contact in the last 5 years and a diagnosis of any functional psychosis. Those who consented (N = 59) were randomised to COAST or treatment as usual (TAU). Outcomes were evaluated at baseline, 6 months and 9 months on a range of standardised clinical and social measures.)

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6.6c An evaluation of an innovative service for people with early psychosis (the Lambeth Early Onset Service) concluded that there was limited evidence that a team delivering specialised care for patients with **early psychosis** is superior to standard care for maintaining contact with professionals and for reducing readmissions to hospital. No firm conclusions can, however, be drawn owing to the modest sample size. Compared with patients in the standard care group, those in the specialised care group were less likely to relapse (OR 0.46, 95%CI 0.22 - 0.97), were readmitted fewer times (β 0.39, 95%CI 0.10 - 0.68), and were less likely to drop out of the study (OR 0.35, 95%CI 0.15 to 0.81). When rates were adjusted for sex, previous psychotic episode, and ethnicity, the difference in relapse was no longer significant; only total number of readmissions (β 0.36, 95%CI 0.04 to 0.66) and dropout rates (β 0.28, 95%CI 0.12 to 0.73) remained significant.[i]

Caveat: The specialised care group at baseline had more features of better prognosis for sex, previous psychotic episodes, and ethnicity.

i. Craig TKJ, Garety P, Power P et al. The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. *British Medical Journal* 2004; **329**: 1067-1070

http://bmj.bmjjournals.com/cgi/content/full/329/7474/1067 [accessed 29/07/05]

(Type II evidence – block randomised controlled trial of 144 people aged 16-40 presenting to mental health services in Lambeth London borough for the first or second time with non-organic non-affective psychosis. Allocation was concealed in sealed envelopes to the Lambeth Early Onset Service (LEOS - community team providing an assertive outreach for early psychosis) or standard care delivered by community mental health teams. 18 month follow up.)

6.6d Establishing **early intervention services** nationwide will require significant new resources, including **specialist trained staff**, which could prove difficult to provide in inner-city areas. Rather than a single, uniform service model, several models of early intervention services based on locally determined need might be more realistic and appropriate, and also allow research into their relative efficacy. 295 cases of first-episode psychosis (annual incidence 21/100 000/year) were referred in the year 2000. Teams manage to engage most patients with first-episode psychosis. A total of 73% of cases of first-episode psychosis were on some form of **Care Programme Approach**. However, many teams did not have **adequately trained staff** to provide psychosocial interventions. Even where such staff were available, care was focused mainly on monitoring medication and risk assessment, with only half the teams providing psycho-educational programmes and only a quarter offering individual cognitive-behavioural therapy to those with first-episode psychosis.[i]

i. Singh S, Wright C, Joyce E, Barnes T, Burns T. Developing early intervention services in the NHS: a survey to guide workforce and training needs. *Psychiatric Bulletin* 2003; **27**: 254-8

(Type IV evidence – questionnaire survey of 39 mental health teams to establish the incidence, specialist staff availability, treatment provision and sociodemographic profiles of patients with first episode psychosis referred to all adult and child and adolescent community mental health teams in South and West London.)

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6.7 Liaison psychiatry

See also Section 6.1 and 6.4

6.7a An unmet need for **liaison psychiatry services** is clearly perceived across the south-west of England. Thirty-six questionnaires were returned (77%), covering 17 out of 18 trusts providing acute services. Five trusts (28%) have a comprehensive dedicated liaison psychiatry service. A further six trusts (33%) have a service for deliberate self-harm only. Many respondents were critical of what they perceived to be an inadequate service. Five trusts had introduced a service in the 12 months preceding the survey.[i]

i. Howe A, Hendry J, Potokar J. A survey of liaison psychiatry services in the south-west of England. *Psychiatric Bulletin*. 2003: **27**; 90-92

(Type IV evidence – cross-sectional survey to establish an overview of liaison psychiatry services in SW England. 47 questionnaires were sent to all clinical directors of medicine, accident and emergency, and mental health in trusts which provide acute medical services, 36 were returned.)

6.7b The **general hospital liaison psychiatry clinic** provides an acceptable setting in which to assess and manage patients referred from non-psychiatric colleagues. Four of five of all referrals presented with somatic complaints, and 41% had a concurrent physical illness. Although more than half (59%) had no previous psychiatric history, a surprisingly high number (35%) had significant functional impairment (scores of < 50 on the Global Assessment of Functioning scale). The lack of adequate psychological treatment services often provided a barrier to optimal management of some of the more disabled patients.[i]

Caveat: Proformas for data collection were completed by one consultant who was not blind to the referral source. Some of the assessments made at interviews were not standardised.

i. Bass C, Bolton J, Wilkinson P. Referrals to a liaison psychiatry out-patient clinic in a UK general hospital: a report on 900 cases. *Acta Psychiatrica Scandinavica* 2002; **105(2)**: 117-125

(Type IV evidence – longitudinal descriptive survey assessing 900 consecutive referrals to the outpatient clinic of the consultation-liaison (C-L) service at the University Hospital, Oxford, over seven consecutive years.)

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6.7c Data collected in a study to evaluate a **liaison mental health service** in East London offers an insight into a service that is a first point of contact for people with mental health needs that also meets the goals of the National Service Framework for Mental Health. Clients referred to the service during the study period had an average age of 33 and 57% were men. Urgent referrals (seen within one hour) accounted for 53%; emergency referrals (seen immediately) accounted for 30%; and non-urgent (seen within 24 hours) for 17%. Interviews showed that it was the first time many of the participants had used mental health services and they were glad to have had access to a specialist mental health professional. Clients valued the fact that staff were **qualified in mental health** and knew about mental health issues. Quantitative responses to the user-satisfaction survey showed a high level of satisfaction. Replies to the qualitative questions were not as complimentary. Although 24 people rated staff attitudes as positive, three rated them as negative. Waiting times produced the most dissatisfaction: 18 people said these were unsatisfactory, with only four being satisfied.[i]
Caveat: Only 27% of the 262 clients sent questionnaires responded.

i. Callaghan P, Eales S, Coats T, Bowers L, Bunker J. Patient feedback on liaison mental health care in A&E. *Nursing Times* 2002; **98(21)**: 34-36
(Type IV evidence – qualitative and quantative study of a liaison mental health service in East London. Clinical and non-clinical referrals to the service were assessed for one year, non-participant observation took place over 6 days to describe and understand the work of the service. Semi-structured interviews were conducted with 17 clients (median age 31 years; 59% male) and 71 user-satisfaction questionnaires were completed (27%).)

6.7d Secondary mental health services are being targeted towards the more needy patients. The **provision of special services** in practices can shift care further away from secondary care while still meeting **patients' needs**. 31 (30%) patients were currently out of specialist contact. No significant differences were found between those in and out of contact on any measures of diagnosis or psychiatric history. Those in contact had significantly more symptoms, poorer social functioning, poorer quality of life, and more needs for care. The proportion out of contact was significantly higher in two practices that had employed their own mental health professionals to provide services on site for severe mental illnesses. Two factors remained significant predictors of contact in a logistic regression model: whether or not the patient's practice offered a special service on site, and greater patient needs for care.[i]

i. Kendrick T, Burns T, Garland C, Greenwood N, Smith P. Are specialist mental health services being targeted on the most needy patients? The effects of setting up special services in general practice. *British Journal of General Practice* 2000; **50(451):** 121-126
(Type IV evidence – cross-sectional study of 102 patients (currently in specialist contact, n=71; out of contact, n=31; mean age 52.1 years; 51% male), identified from 26 South West London practices.)

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6.8 Levels of secure care

Low / medium secure care

6.8a Match between **need for and admission to medium security** is poor. Insufficient range of provision leads to inappropriate use of medium secure beds. Factors associated with being assessed as needing medium security (but not necessarily being admitted) included having features of acute **schizophrenia, non-compliance** with treatment, a history of sexually inappropriate behaviour, and being referred because of **self-harm**. A 'grave' current offence and a history of recent or many past custodial sentences were also important. For patients seen in prison, NHS or community services, just under a fifth of those assessed as needing medium security (especially long term) were not admitted, and just under a quarter of those admitted needed low or no security.[i]

42% of assessed patients needed **medium secure care**, one-third on a long-term basis. The assessing units refused some patients who needed medium secure care, and accepted some psychotic patients who did not require security.[ii]

A qualitative study based on the same initial sample found that a range of contextual pressures impinge on **admission decisions**, including the need to maintain a collaborative, shared vision amongst staff. Clinicians have a strong **gate-keeping role** in which collective views about appropriate patients, and the need to ensure turnover of places, are dominant considerations. The gate-keeping role involves managing expectations of referrers and managers, and the level of risk taken on by the medium secure service.[iii]

i. Melzer D, Tom BDM, Brugha T et al. Access to medium secure psychiatric care in England and Wales. 1: A national survey of admission assessments. *Journal of Forensic Psychiatry and Psychology* 2004; **15(1)**: 7-31

ii. Melzer D, Tom BDM, Brugha T et al. Access to medium secure psychiatric care in England and Wales.3: The clinical needs of assessed patients. *Journal of Forensic Psychiatry and Psychology*. 2004; **15(1)**: 50-65

(Type IV evidence – cross-sectional survey, part of the 'Pathways into medium secure psychiatric provision in England and Wales' study. 34 out of 37 medium secure units in England and Wales participated. Interview surveys were with a random sample of 391 principal clinical assessors of patients assessed for admission to the medium secure units in the first half of 1999.)

iii. Melzer D, Tom BDM, Brugha T et al. Access to medium secure psychiatric care in England and Wales. 2: A qualitative study of admission decision-making. *Journal of Forensic Psychiatry and Psychology* 2004; **15(1)**: 32-49

(Type IV evidence – qualitative part of the 'Pathways into medium secure psychiatric provision in England and Wales'. 36 medium secure units out of the 37 eligible participated. 55 lead clinicians from 36 medium secure units in England and Wales in 1999 were interviewed.)

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6.8b Uncoordinated development led to **under-provision despite high demand**. Certain regions prioritised offender patients and did not support local psychiatric services. New standards are required for service specification and resource allocation to redress inequality. Services differed according to location of patients before admission, their legal basis for detention, criminal and antisocial behaviour, diagnosis, security needs and length of stay. Regions with more resources and lower demand provided a wider range of services. Thames services were relatively under-provided during the study period, with North East Thames substantially reliant on admissions to private hospitals.[i]

i. Coid J, Kahtan N, Gault S, Cook A, Jarman B. Medium secure forensic psychiatry services: comparison of seven English health regions. *British Journal of Psychiatry* 2001; **178(1)**: 55-61

(Type IV evidence – retrospective record survey of admissions to 7 of 14 regional medium secure services and all high-security hospitals from all health regions in England and Wales between 1988-1994. Admissions data for 2608 patients, admitted on 3403 occasions were collected from medical records.)

6.8c The NHS meets only part of the **need for medium secure care** of the population of this London health authority. This comparison of the characteristics of **Black and White patients** does not help to explain why Black people are over represented in medium secure settings. The 90 patients in independent-sector units were similar to the 93 patients in NHS units except that they were more likely to have been referred from general psychiatric services (48% versus 19%) and less likely to have been referred from the criminal justice system or a high-security hospital (37% versus 63%). There were few differences between Black and White patients.[i]

i. Lelliott P, Audini B, Duffett R. Survey of patients from an inner-London health authority in medium secure psychiatric care. *British Journal of Psychiatry* 2001;**178(1)**:62-66

(Type IV evidence – cross-sectional census study of 183 patients (mean age 36 years; 87% male), in medium secure placements in an inner-London health authority in August 1997. The aim was to compare those accommodated in NHS facilities with those in independent units and compare patients from different ethnic groups. Data were collected by a combination of studying case notes and interviewing keyworkers or other senior staff.)

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High Secure Care

6.8d High secure **Responsible Medical Officers** (RMOs) reported that 500 patients (40%) could be transferred immediately to **lesser levels of hospital security** if such facilities existed. However 60% of patients were rated as continuing to require high secure care therefore special hospitals, or their equivalent, continue to be needed for the foreseeable future in England. Long-term **medium and low security facilities** constituted over half of the recommended alternative placements. Unmet needs for the total population were most frequently reported with daytime activities, substance misuse, sexual offending, safety to others, and psychotic symptoms. Most clinical and social needs were met.[i]

While it was possible to identify factors associated with the continued need for high security the false negative rate was high. Patients had very diverse needs that did not fit neatly into clustered sub-groups. Due to the heterogeneity of the individual patients currently in the high security psychiatric hospitals, future **service planning** will need to focus on individualised treatment packages that are based on individual assessments of need. Such assessments should be considered in the wider framework of risk and accountability.[ii]

i. Harty M-a, Shaw J, Thomas SD et al. The security, clinical and social needs of patients in high secure psychiatric hospitals in England. *Journal Of Forensic Psychiatry & Psychology* 2004; **15(2)**: 208-221

ii. Thomas S, Leese M, Dolan M et al. The individual needs of patients in high secure psychiatric hospitals in England, *Journal of Forensic Psychiatry & Psychology* 2004; **15(2)**: 222-243.

(Type IV evidence – observational study to describe the general characteristics and individual needs of all inpatients in 3 high security psychiatry hospitals in England (patients = 1255) in 1999-2000. Data were obtained from the High Secure Case Register, case-note reviews, and interviews with primary nurse to complete Camberwell assessment of need, and with high secure RMOs to complete adapted version of the Nottingham Acute Bed study questionnaire.)

6.8e This study provides little evidence that **medium-security services** reduce the demand for beds in Special Hospitals. The transfer of high-security beds to local services would have to take into account the threefold difference in levels of demand across regional catchment areas. A total of 2608 patients were admitted on 3403 occasions to medium security during the study period and 547 patients were admitted on 579 occasions to maximum security. Results demonstrate that local facilities would have to contain a significant proportion of patients whose violent and criminal behaviour cannot be managed in medium security and where in some cases all previous therapeutic interventions have failed to prevent a progression through successively higher levels of hospital security over time.[i]

i. Coid J. Are special hospitals needed? *Journal of Forensic Psychiatry* 2000; **11(1)**: 17-35

(Type IV evidence – comparative observational study to examine the implications of replacing special hospitals (maximum security hospitals) by high-security services at a regional level. Data were collected from to 7 of 14 regional medium secure services and all high-security hospitals from all health regions in England and Wales between 1988-1994.)

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6.8f There are very few official data available about placements following **absolute discharge**. Those discharged directly to the community spent significantly more time at risk in the community during follow-up than patients discharged to psychiatric hospitals (mean time 'at risk'=4.22 years, SD=2.4, compared to mean time 'at risk'=2.08 years, SD=1.98, respectively) but they were no more likely to be reconvicted than those discharged via a less secure hospital. One possible explanation is that **less secure hospital units** are not specifically equipped to treat people with a **personality disorder**. Alternatively, clinicians may be correctly identifying patients who are at greater risk of reoffending and thus recommending a more staged rehabilitation back to the community.[i]
Caveat: The sample in this study was small.

i. Jamieson E, Davison S, Taylor PJ. Reconviction of special (high security) hospital patients with personality disorder: its relationship with route of discharge and time at risk. *Criminal Behaviour and Mental Health* 2000; **10(2)**: 88-99

(Type IV evidence – follow-up analysis exploring the effect of discharge destination (community or hospital) on reconviction over a 9-year period in an annual discharge cohort of special hospital patients with personality disorder in England. A discharge cohort was identified consisting of 40 special hospital patients discharged in the community and 27 to a psychiatric hospital in 1984. Follow-up (maximum 9-year) data were available for 28 community patients and 22 psychiatric hospital patients.)

6.8g There is continuing demand from all parts of the country for **high-security hospital beds**. The smaller numbers admitted appear to include more demanding cases. Referrals to special hospitals showed no decrease during the 10-years; an apparent increase may reflect under recording before 1992. Admissions fell by about 16% over the 10-years, but with regional variation. Women, civil cases, admissions under the Mental Health Act 1983 (MHA) classifications of psychopathic disorder or mental impairment and directly from a court on a hospital order were most affected. There was an increase in admissions of pre-trial and sentenced male prisoners, and of transferred hospital order patients from other hospitals.[i]

i. Jamieson E, Butwell M, Taylor P, Leese M. Trends in special (high-security) hospitals: 1: referrals and admissions. *British Journal of Psychiatry* 2000; **176**: 253-9

(Type IV evidence – retrospective data analysis. England and Wales referrals data for 3521 episodes and admissions data for 1906 episodes were collected, between 1986 and 1995, from the special hospitals' case registers, reports published by the Department of Health and Social Security, and hospital records.)

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6.8h Among patients with psychosis, having a diagnosis of **schizophrenia** and being male increases the likelihood of special hospital admission. Suggestions that **ethnic minority patients** are much more likely to have engaged in serious violence and need **high-security placement** were not borne out. Schizophrenia was the almost invariable diagnosis for all special hospital patients. White patients in the community sample were significantly more likely to have affective components to their illness compared with African-Caribbean patients; unlike those in special hospitals. There was a small excess in the proportion of African-Caribbean patients in the special hospital group, controlling for diagnosis, gender and locality. Men were over represented in this group. [i]

i. Walsh E, Leese M, Taylor P, Johnston I, Burns T, Creed F *et al*. Psychosis in high-security and general psychiatric services: report from the UK700 and special hospitals' treatment resistant schizophrenia groups. *British Journal of Psychiatry* 2002; **180**: 351-357

(Type IV evidence – observational study comparing a national sample of 905 high-security hospital residents (mean age 38 years, 88.9% male) with a community sample from the UK700 trial of 708 patients in contact with general psychiatric services (mean age 36 years, 57% male). Sociodemographic and diagnostic measures were gathered for the special hospital sample from case records and notes, and from case notes and patient interviews for the UK700 sample.)

Single gender units

6.8i **Increased awareness** of the often inappropriateness of services for women in **mixed-gender units** has led to units deciding not to admit women patients and, inadvertently, more **single-gender beds for men** in NHS units than for women. The NHS units have to rely on private sector units to provide beds in **single-gender units for women**, perhaps at the expense of effective continuity of care. 1836 medium secure beds, housing 342 women patients, were identified. Women in the NHS were housed primarily in mixed-gender units (170 women, 94%). Most NHS beds in single-gender units were for men (56 beds), whereas most private sector beds in single-gender units were for women (79 beds).[i]

Caveat: The statistical methods used to analyse the data were not reported.

i. Hassell Y, Bartlett A. The changing climate for women patients in medium secure psychiatric units. *Psychiatric Bulletin* 2001; **25**: 340-342

(Type IV evidence – telephone survey of 39 NHS and one private medium secure units during a 6-month period. Data were collected on the number of women patients on their unit, the total number of beds on the unit, the patient mix of the unit and the amount of contact with women in secure hospitals.)

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6.9 Mother and baby units

6.9a An experimental study, linking a **mother-baby unit with Maternal and Child Health Nurses** (MCHNs) with education, liaison and prioritised tertiary assessment and admission found no differences between levels of depression between intervention and control participants. Differences, however, in adjustment to motherhood emerged between women in well-supported affluent areas and those in under-resourced lower socioeconomic areas. MCHNs were seen by women in all areas as the key people to turn to. Those in the lower socioeconomic areas reported greater difficulties in providing a service and women in these areas were less likely to access services external to their region.[i]

i Buist A, Milgrom J, Morse C, Durkin S, Rolls C. Integrating services in the recognition and management of postpartum depression. *Australian Journal of Primary Health Interchange* 2000; **(3-4)**: 74-79

(Type III evidence – non-randomised experimental study of 213 mothers with no major past psychiatric history (mean age 27 years, 85% from an Australasian background), were allocated to either the Maternal and Child Health Nurse (MCHN) intervention (n=120) or to a control group (n=93). Severity of depressive symptoms was measured at 9-months postpartum.)

6.9b Clinical and parenting outcomes, as reported by clinical staff, are usually good following **joint mother-baby admission**. Women with **schizophrenia** may need particular measures to improve their parenting. A marital approach to treatment, directed at the woman's relationship with her partner or the latter's own mental health may improve outcome. Good clinical outcome was reported in 848 (78%) cases. On each parenting outcome, good outcome was reported in at least 80%. The predictors of poor outcome were similar for all four outcomes. These were a diagnosis of schizophrenia, behavioural disturbance, low social class and either psychiatric illness in the woman's partner or a poor relationship with the partner.[i]

i. Salmon M, Abel K, Cordingley L, Friedman T, Appleby L. Clinical and parenting skills outcomes following joint mother-baby psychiatric admission. *Australian and New Zealand Journal of Psychiatry*. 2003; **37(5)**: 556-62

(Type IV evidence – observational study of data from 8 mother and baby units in the UK and 3 psychiatric units with facilities for joint mother-baby admission. Demographic and clinical information was collected between 1994 - 2000 on 1081 joint mother-baby admissions, including 224 women with schizophrenia, 155 with bipolar disorder and 409 with non-psychotic depression.)

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6.9c Units providing for **joint hospitalisation of mothers and babies** allow time to assess the problems and promote the possibility of a relationship between babies and mothers who suffer from psychiatric problems after delivery. Separations occurred in 23% of the joint admissions. Women with acute postpartum psychoses and major depressive disorders had better outcomes than those with **chronic psychoses**: at discharge, the latter were more often separated from their children. In those cases, however, mother-baby unit (MBU) admission provided time to arrange the best placement for the child.[i]	i. Poinso F, Gay MP, Glangeaud-Freudenthal NM, Rufo M. Care in a mother-baby psychiatric unit: analysis of separation at discharge. *Archives of Women's Mental Health*. 2002; **5(2)**:49-58 (Type IV evidence – longitudinal cohort study. Joint admissions to a mother-baby unit in France, were collected for 92 mothers (mean age 30 years; 39% with a history of psychiatric hospitalisation) and 100 children (up to 2 years old; 48 children with psychiatric disorder), between 1991-1998.)
6.9d It appears that some cases of **psychological distress in women following childbirth** may be inaccurately conceptualised as depression. Following the birth of a baby, the partner of a mother has a strong influence on her emotional health and should be included in any assessment and intervention. Clinically significant fatigue was almost universal in this cohort. Psychological distress clustered into three distinct groups: (i) probable depression; (ii) fatigue and distress; and (iii) fatigue only. It may be more accurate to conceptualise postpartum psychological distress either as a continuum, or as a wide range of distinct states, rather than as a dichotomous condition in which individuals are categorised as being or not being cases. In this cohort, the severity of distress was associated most consistently with the quality of a woman's relationship with her partner and with infants who were difficult to settle.[i]	i. Fisher JR, Feekery CJ, Rowe-Murray HJ. Nature, severity and correlates of psychological distress in women admitted to a private mother-baby unit. *Journal of Paediatrics & Child Health*. 2002; **38(2)**:140-145

Continued

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6.9d continued from previous page

A further analysis of the same survey sample found that **socioeconomic advantage** does not protect women from compromised postpartum health and wellbeing and some economically advantaged mothers experience such significant postpartum ill health they seek hospital admission.[ii]
Caveat: The study may have limited generalisability to the current situation in Wales. Socio-economically advantaged women who seek admission to a private facility may not be clinically similar to women admitted to NHS facilities in the UK. This might explain why the study group were not all found to have postnatal depression.

ii. Fisher JR, Feekery CJ, Amir LH, Sneddon M. Health and social circumstances of women admitted to a private mother baby unit: a descriptive cohort study. *Australian Family Physician* 2002; **31(10)**: 966-970
(Type IV evidence –cohort survey of consecutive admissions to a private hospital's mother baby unit with infant feeding or sleeping problems. 109 of eligible mothers 146 mothers (mean age 33.3 years) completed self-report questionnaires.)

6.10 Neuropsychiatry outreach service

6.10a An **outreach clinic** provides access to specialist expertise and increases local awareness of specialist services. Similar outreach clinics in other areas may enhance the clinical care of patients who are currently not being referred to **neuropsychiatry**. Referrals from West Kent increased from 87 in the four year period prior to the outreach clinic to 255 in the four year period that the clinic has been in existence. Forty-nine of these patients were first assessed in the outreach clinic. The number of referrals from East Surrey and East Sussex remained low in the same period.[i]

i. Leonard F, Majid S, Sivakumar K, Toone B. Service innovations: a neuropsychiatry outreach clinic. *Psychiatric Bulletin*. 2002; **26(3)**: 99-101
(Type IV evidence – review of referrals to an outreach clinic in West Kent over a four year period, compared with the referral pattern of adjacent health authorities.)

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6.11 Specialist mental health service for deaf people

See also Section 7.7

6.11a Expansion of community services for **deaf people** could reduce admission rates for deaf patients, delivering treatment benefits and cost savings. Out-patient and in-patient caseloads differ between the two services: 27% of the deaf out-patient caseload have **schizophrenia**, schizotypal and delusional disorders (compared with 19% of hearing patients) and 19% have neurotic, stress-related and somatoform disorders (compared with 8% of hearing patients). The general psychiatric service out-patient case-load had rates of 8% and 43% for **bipolar affective disorder and unipolar depression**, respectively, compared with 3% and 17% in the deaf group. Deaf patients have a mean length of stay of 59 days, compared with 30 days for the hearing group. In-patient treatment accounts for 89% of the annual treatment cost for the deaf patient population.[i]

i. Appleford J. Clinical activity within a specialist mental health service for deaf people: Comparison with a general psychiatric service. *Psychiatric Bulletin*. 2003; **27(10)**: 375-377

(Type IV evidence – comparison of clinical activity in Denmark House (a specialist mental health service for deaf people in England and Wales) with the activity in a general psychiatric service. Case mix and clinical activity were reviewed over a one-year period between April 1997 and 31 March 1998.)

6.12 Specialist services for comorbid substance abuse

See also Section 7.12

6.12a This specialist type of service may be more useful than other services in engaging patients with **comorbidity**. Systematic research is required in the UK to explore the effectiveness of this type of new service. More innovative resources need to be identified to specifically deal with patients with severe mental illness and **comorbid substance use**. The findings show that there was no relationship between responders to the service and basic demographic data. Patients with **bipolar affective disorder and personality disorders** were more likely to use the service than patients with unipolar disorder or **schizophrenia**. Despite the use of an assertive service, there was difficulty engaging patients with schizophrenia and comorbid drug use. These same patients also had a high level of criminal convictions as well as a trend towards using alcohol and cannabis as their main substances of misuse. At 18 months 38% of patients had failed to remain engaged with the service.[i]

i. Bayney R, John Smith P, Conyhe A. MIDAS: a new service for the mentally ill with comorbid drug and alcohol misuse. Psychiatric Bulletin 2002; **26(7)**: 251-254

(Type IV evidence - examination of case files of the first 80 patients accepted over a ten-month period to one of the first combined mental illness and drug and alcohol services (MIDAS) in the UK. Main outcomes measured were demographic details, diagnosis, associated substance use and length of engagement with the service.)

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6.13 Specialist services for eating disorders

6.13a The majority of people with **anorexia nervosa or bulimia nervosa** should be treated on an outpatient basis. For patients with bulimia nervose who are at risk of suicide or severe self-harm, admission as an inpatient or day patient, or the provision of more intensive outpatient care, should be considered. Psychiatric admission for people with bulimia nervosa should normally be undertaken in a setting with experience of managing this disorder.

Inpatient treatment or day patient treatment should be considered for people with anorexia nervosa whose disorder has not improved with appropriate outpatient treatment or for whom there is a significant risk of suicide or severe self-harm, or whose disorder is associate with high or moderate physical risk. People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring, in combination with psychosocial interventions. This should be provided within reasonable travelling distance to enable the involvement of relatives and carers in treatment, to maintain social and occupational links and to avoid difficulty in transition between **primary and secondary care services**.[i]

i. National Institute for Clinical Excellence. *Eating disorders. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. Clinical guideline 9. London: NICE. January 2004. Review date: January 2008 **http://www.nice.org.uk/pdf/cg009niceguidance.pdf** [accessed 29/07/05]

(Evidence based guideline with systematic literature search and expert consensus.)

6.13b Staffing and the professional background of the lead clinician vary appropriately according to whether services have in-patient beds or not. The monitoring of key features of services is a valuable exercise and can help address a range of questions raised in the commissioning of specialist services for people with eating disorders. Uniprofessional and multiprofessional specialist training in **eating disorders** is a priority for the NHS.[i]

i. Bell L. A survey of locality eating disorder services within England, Scotland and Wales. *British Journal of Clinical Psychology*. 2003; **20:** 6-14

(Type IV evidence – cross-sectional survey of locality eating disorder services within England, Scotland and Wales. 28 services (out of 35 identified) were included in the results.)

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6.13c Services for **anorexia nervosa** sufferers need to plan for prolonged **contact** with their patients and high rates of service consumption. Only just over a quarter of the patient cohort were ever admitted. Of a subset of 78 patients, first seen before 1994, nearly one-fifth failed to engage in treatment. Those who were admitted spent on average a total of 10 months in hospital, were in touch for four years and had over 100 therapy sessions. The majority who were treated solely as out-patients remained in touch with the service on average for over two years.[i]

Caveat: Indices of service consumption and recovery used are crude. It is possible some contacts with other secondary psychiatric services may have gone unrecorded, and only change in weight was used to measure recovery.

i. Palmer RL, Gatward N, Black S, Park S. Anorexia nervosa: service consumption and outcome of local patients in the Leicester service. *Psychiatric Bulletin*. 2000; **24(8)**: 298-300

(Type IV evidence - retrospective case note study on a cohort of 106 adult anorexia nervosa sufferers treated in a specialised secondary service.)

6.13d The study has highlighted the individual significance of anorexia nervosa and the differing requirements and expectations of sufferers. It is argued that planners of services for people with anorexia nervosa need to recognise these individual differences and be prepared to tailor services to the consumer's needs, paying particular heed to the high level of need for 'control' expressed by this client group.[i]

The results highlight the chronic nature of low self-esteem in anorexia nervosa and that greater emphasis should be placed on therapeutic initiatives to tackle this problem. The group as a whole showed continuing low self-esteem. Measures of low self-esteem were strongly related to measures of overall well-being and particularly highly correlated with the 'ineffectiveness' scale of the Eating Disorders Inventory.[ii]

Caveat: Results are based on a small sample from one eating disorders service.

i. Button EJ, Warren RL. Living with Anorexia Nervosa: The Experience of a Cohort of Sufferers from Anorexia Nervosa 7.5 Years after Initial Presentation to a Specialized Eating Disorders Service . *European Eating Disorders Review*. 2001; **9(2)**: 74-96

ii. Button EJ, Warren RL. Self-image in anorexia nervosa 7.5 years after initial presentation to a specialized eating disorders service. *European Eating Disorders Review.* 2002; **10(6)**: 399-412.

(Type IV evidence – qualitative study of interviews with 36 anorectic patients followed up 7.5 years after presentation at a specialist locally based eating disorders service for adults. Some quantitative measures were also collected including weight, BMI and clinical and social functioning measures.)

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6.14 Specialist services for personality disorders

6.14a Findings indicate that Henderson Outreach Service Team (HOST) referrals had high levels of psychosocial disturbance associated with moderate to severe **personality disorders**. The service provided psychodynamically oriented individual and group treatments that met service users' needs more appropriately than other local mental health services, but was unable to match the demand for treatment. Referring professionals valued the role of HOST in also providing specialist management advice. High levels of unmet need among the personality disordered population living in the community are highlighted. Findings have contributed to the reshaping of the service and its relationship to its parent institution (a residential therapeutic community), and have implications for the future development of therapeutic community treatment for personality disorders.[i]

i. Morant N, King J. A multi-perspective evaluation of a specialist outpatient service for people with personality disorders. *Journal of Forensic Psychiatry and Psychology*. 2003; **14(1)** 44-66

(Type IV evidence - observational study of a new outpatient service in London for people with personality disorders (Henderson Outreach Service Team: HOST) during its first 2 years of operation. Quantitative and qualitative data were collected for 4 strands of the investigation: clinical and socio-demographic characteristics of referrals; clinical activities of the service; service users' views of the service; and views of referring professionals.)

6.14b Previously reported reductions in psychiatric admissions following **therapeutic community treatment of personality disorder** are maintained over 3 years. The significant reduction in in-patient admissions seen in the first year was maintained over 3 years. Those with the poorest outcomes, suicide, accidental death or prolonged admission were all in the quartile with the shortest admissions (under 42 days) to the therapeutic community.[i]

Caveat: There is a possibility of bias as one of the authors works at Francis Dixon Lodge.

i. Davies S, Campling P. Therapeutic community treatment of personality disorder: service use and mortality over 3 years' follow-up. *British Journal of Psychiatry*. 2003; **44**: S24-27

(Type IV evidence – naturalistic clinical cohort study of patients admitted to inpatient therapeutic community (Francis Dixon Lodge) in Leicester between January 1993 and December 1995 was followed up for three years. All patients were traced at 3 year follow-up.)

National Service Framework: key action 26

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

A comprehensive evidence based range of psychological therapies is to be accessible across Wales, with access to more specialist services. [Key action 26 paragraph 25.3]

What evidence is available regarding the effectiveness of a range of psychological therapies?

See also Section 1.2 and 1.3

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6.15 Overviews of psychological therapies

6.15a Evidence based clinical practice guidelines are available to aid decisions about which forms of **psychological therapy** are most appropriate for which patients. They address who is likely to benefit from psychological treatment, and which of the main therapies available in the NHS is most appropriate for which patients.

The guidelines have been produced by a multi-disciplinary guideline development group, led by the British Psychological Society, and they have undergone extensive independent scientific review.[i]

i. Department of Health. *Treatment Choice in Psychological Therapies and Counselling*. London: Department of Health, February 2001 **http://www.dh.gov.uk/assetRoot/04/05/82/45/0405 8245.pdf** [accessed 29/07/05]

(Evidence based guidelines with a systematic search strategy for research published between 1990 - 1998. Evidence was systematically reviewed and appraised. Expert and user consensus was also used to ascertain consensus on treatment choice.)

6.15b Some forms of brief **psychological treatments**, particularly those derived from **cognitive/behavioural models**, are beneficial in the treatment of people with depression being managed outside hospital settings. Little can be said about the efficacy of different types of **individual versus group therapy** because all the trials comparing these formats used CT or BT. In these trials, greater efficacy for individual formats was suggested.[i]

Please see full report for statistical results for the 12 comparisons.

i. Churchill R, Hunot V, Corney R et al. A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. *Health Technology Assessment* 2001; **5(35)**: 173

(Type I evidence – systematic review of 63 randomised and controlled clinical trials comparing brief psychological therapies, including: behavioural psychotherapy, cognitive behaviour, interpersonal, psychodynamic, supportive, group and individual therapy. No literature search date reported.)

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6.15c Using a more conservative statistical approach, combination treatments were superior to single psychotherapy. This was the only statistically significant difference between treatments. The number of trials might be insufficient to show the statistical significance of a 19% absolute risk reduction in efficacy favouring psychotherapy or combination treatments over single antidepressants. **Psychotherapy** appeared to be more acceptable to subjects. When antidepressants were combined to **psychological treatments**, acceptability of the latter was significantly reduced. Remission rates were 20% for single antidepressants compared to 39% for single psychotherapy (DerSimonian-Laird Relative Risk (DL RR) 1.28, 95%CI 0.98 -1.67). Dropout rates were higher for antidepressants than for psychotherapy (DL RR 2.18, 95%CI 1.09-4.35). The number needed to harm (NNH) for a mean treatment duration of 17.5 weeks was 4 (95% CI 3 -11).

Comparison two found remission rates of 42% for the combination versus 23% for antidepressants (DL RR 1.38, 95%CI 0.98-1.93). Comparison three showed a 36% pooled remission rate for psychological approaches compared to 49% for the combination (DL RR 1.21, 95% CI 1.02-1.45). The number needed to treat (NNT) for a mean treatment duration of 15 weeks was 8 (95% CI 4-320). Dropout rates were higher for the combination compared to single psychological treatments (DL RR 0.57, 95%CI 0.38-0.88). The NNH was 7 (95% CI 4-21).[i]

i. Bacaltchuk J, Hay P , Trefiglio R. Antidepressants versus psychological treatments and their combination for bulimia nervosa. *The Cochrane Database of Systematic Reviews* 2001, Issue 4. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003385/frame.html**

[accessed 29/07/05]

(Type I evidence - systematic review of 7 randomised controlled trials to compare antidepressants with psychological approaches and comparing their combination with each single approach for the treatment of bulimia nervosa. Main outcome measures were efficacy (e.g. changes in bulimic symptoms), comorbidity and acceptability of treatment. Databases were searched for literature between 1996-2000.)

6.15d There is an urgent need for large randomised controlled trials of commonly used psychotherapies in older adolescents and adults with **anorexia nervosa**. No specific approach can be recommended from this review. The trials were small and used different types of **psychotherapy** and aggregation of data were not possible. No specific treatment was consistently superior to any other specific approach. Dietary advice as a control arm had a 100% non-completion rate in one trial.[i]

i. Hay P, Bacaltchuk J, Claudino A, Ben-Tovim D, Yong PY. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa. *The Cochrane Database of Systematic Reviews*. 2003, Issue 4. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003909/frame.html**

[accessed 29/07/05]

(Type I evidence – systematic review of 6 randomised controlled trials (2 of which included children or adolescents). Literature search to 2003.)

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6.15e Both **antidepressant medication** and **psychotherapy** may be considered first-line treatments for mildly to moderately depressed outpatients. An intent-to-treat analysis indicates that, according to measurements by independent blind raters, antidepressant medication (tricyclic antidepressants and phenelzine) and psychotherapy (primarily cognitive behaviour and interpersonal therapies) were more efficacious than control conditions, but there were no differences between active treatments. The percentages of **remission** for subjects randomly assigned to medication, psychotherapy, and control conditions were 46.4%, 46.3%, and 24.4%, respectively. Furthermore, significantly more dropped out of control conditions (54.4%) than either treatment with medication (37.1%) or psychotherapy (22.2%).[i]

Caveat: Unpublished research was not sought and only English language papers were included.

i. Casacalenda N, Perry JC, Looper K. Remission in major depressive disorder: a comparison of pharmacotherapy, psychotherapy, and control conditions. *American Journal of Psychiatry* 2002; **159(8)**: 1354-1360

(Type I evidence – systematic review of 6 randomised controlled trials including 883 patients with non-psychotic major depression (261 receiving medication, 352 receiving psychotherapy and 270 in control groups). Literature search to 2000.)

6.15f The results suggest that a substantial proportion of patients with **panic** improve and remain improved; that treatments for **depression and generalised anxiety disorder** (GAD) produce impressive short-term effects: that most patients in treatment for depression and GAD do not improve and remain improved at clinically meaningful follow-up intervals: and that screening procedures used in many studies raise questions about generalisability, particularly in light of a systematic relation across studies between exclusion rates and outcome.[i]

Caveat: Key papers in this area may have been missed due to a poor search strategy. Only English language published research was sought in the database Psychological Abstracts, and 8 journals.

i. Westen D, Morrison K. A multidimensional meta analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology* 2001; **69:** 875-899.

(Type III evidence - systematic review of 34 studies of manualized psychotherapies for depression (12 studies), panic disorder (17), and generalized anxiety disorder (GAD) (5). Literature search 1990-1998.)

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6.15g Psychological intervention for **post-partum depression** improves maternal mood (EPDS) in the short term. However, this benefit is not superior to spontaneous remission in the long term. Compared with the control, all three treatments had a significant impact at 4.5 months on maternal mood (Edinburgh Postnatal Depression Scale EPDS). Only **psychodynamic therapy** produced a rate of reduction in depression significantly superior to that of the control. The benefit of treatment did not reduce subsequent episodes of post-partum depression.[i]
Caveat: Only 71.5% women were followed up at 5 years.

i. Cooper PJ, Murray L, Wilson A, Romaniuk H. Controlled trial of the short and long-term effect of psychological treatment of post-partum depression. *British Journal of Psychiatry.* 2003; **182**: 412-419

(Type II evidence – randomised controlled trial of 193 women from Cambridge with post-partum depression. Women were allocated to routine primary care, non-directive counselling, cognitive behavioural therapy or psychodynamic therapy, and followed up at 9, 18 and 60 months post-partum.)

6.16 Behavioural therapy

Behavioural therapy for bulimia

6.16a There is a small body of evidence for the efficacy of **cognitive-behaviour therapy** (CBT) in **bulimia nervosa** and similar syndromes, but the quality of trials is very variable and sample sizes are often small. Active therapy appears to be associated with lower depression scores in all comparisons of more than three trials, except the CBT versus CBT augmented by Exposure and Response Prevention comparison, and the differences are largest where the control group is a "waiting list". When compared to studies of another **psychotherapy**, CBT had a statistically significant advantage on levels of **depression** scores and abstinence rates at end of treatment (the latter n=8 trials, RR=0.81, 95% CI 0.72 - 0.92).[i]

i. Bacaltchuk J, Stefano S. Psychotherapy for bulimia nervosa and binging. *The Cochrane Database of Systematic Reviews* 2004, Issue 3.
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000562/frame.html
[accessed 29/07/05]

(Type I evidence – systematic review of 34 randomised controlled trials evaluating the efficacy of CBT and CBT-BN compared with other psychotherapies in the treatment of adult patients with bulimia nervosa and related syndromes of recurrent binge eating. Literature search to 2002)

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6.16b The results of the current study compare favourably with other treatment outcome studies for **bulimia nervosa** and suggest that treatment gains are maintained after 3 years. At the 3-year follow-up, 85% of the sample had no current diagnosis of bulimia nervosa and 69% had no current eating disorder diagnoses of any sort. Failure to complete **cognitive-behaviour therapy** (CBT) was associated with inferior outcome. No clear advantages were evident for participants who completed **behavioural therapy** (BT) in addition to CBT. For subjects who did complete both CBT and BT, outcome was mostly stable from post treatment to follow-up.[i]
Caveat: The original study involved 135 women, of which 111 were actually randomised to a treatment group, however this three year follow-up analyses is based on 113 women.

i. Carter FA, McIntosh VW, Joyce PR, Sullivan PF, Bulik CM. Role of exposure with response prevention in cognitive-behavioural therapy for bulimia nervosa: Three-year follow-up results. *International Journal of Eating Disorders*. 2003; **33**: 127-135

(Type II evidence – follow-up analysis of a randomised controlled with 135 women in New Zealand (age 17 to 45 years). Participants received 8 sessions of CBT, then 111 were randomised to pre-binge cues (B-ERGP), exposure to pre-purge cues (P-ERP), or a relaxation control condition (RELAX). The results are based on 113 women who participated in the original treatment trial and attended a 3-year follow-up assessment.)

6.16c The results suggest that adding exercise to **cognitive behavioural therapy (CBT)** and extending the duration of treatment, enhances outcome and contributes to reductions in **binge eating** and body mass index (BMI). Subjects who received CBT with **exercise** experienced significant reductions in binge eating frequency compared with subjects who received CBT only (4.6 to 0.8 binge days per week from baseline to 16-months follow-up versus 4.8 to 2.5). The CBT with exercise and maintenance group had a 58% abstinence rate at the end of the study period and an average reduction of 2.2 body mass index (BMI) units (approximately 14 lb). BMI was significantly reduced in the subjects in both the exercise and maintenance conditions.[i]
Caveat: Response rate at follow-up was 74%. It is unclear whether an intention-to-treat analysis was conducted. Subjects received $200 to complete treatment and assessments.

i. Pendleton VR, Goodrick GK, Poston WS, Reeves RS, Forety JP. Exercise augments the effects of cognitive-behavioural therapy in the treatment of binge eating. *International Journal of Eating Disorders* 2002; **31(2)**:172-184

(Type II evidence – randomised controlled trial of 114 obese female binge eaters (mean age 45 years) assigned to one of four treatment groups: cognitive behavioural therapy (CBT) with exercise and maintenance (n=24), CBT with exercise (n=20), CBT with maintenance (n=23) and CBT only (n=17). 16-months follow-up.)

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Behavioural therapy for depression

6.16d There is limited evidence of poor-to-moderate quality that **computerised cognitive behaviour therapy** (CCBT) may be effective in the treatment of **depression, anxiety and phobias**. The evidence suggested CCBT is effective as therapist led CBT (TCBT) and treatment as usual (TAU). In studies reporting accurate estimates of therapist time CCBT appears to reduce therapist time compared with TCBT. CCBT may form a useful component of a stepped-care programme, being one of the options offered to patients as a first-line treatment approach. There is also evidence to support the effectiveness of Beating the Blues and FearFighter.

Cost-effectiveness findings are as follows: CCBT using Stresspac was found to cost more, but was no better in terms of patient outcomes than TAU. Cost per patient of Cope was less than the corresponding costs for CBT and drug therapy. CCBT using FearFighter was stated to be less costly than CBT and drug therapy. There was insufficient data in the Calipso submission to make any judgement regarding the efficient relative to alternative options. Compared with TAU, Beating the Blues appears to be a cost effective strategy for treating patients with anxiety and depression.[i]

i. Kaltenthaler E, Shackley P, Stevens K, Beverley C, Parry G, Chilcott J. A systematic review and economic evaluation of computerised cognitive behaviour therapy for depression and anxiety. *Health Technology Assessment* 2002; **6**: 1-89

(Type I evidence - systematic review of 16 studies (11 randomised controlled trials and 5 pilot/ cohort studies). 4 sponsor submissions were used in the cost effectiveness analysis including Ultrasis (Beating the Blues), Leeds Innovations (Calipso), University of Glasgow (Stresspac) and ST Solutions (FearFighter and Cope). Literature search 1996-2001.)

6.16e A systematic review of randomised controlled or controlled clinical trials of brief **cognitive-behavioural therapies** compared to other brief psychological therapies for **depression** is currently underway [i].

i. Churchill R, Hunot V, Corney R, Knapp M, McGuire H, Tylee A, Wessely S. Brief cognitive-behavioural therapies versus other brief psychological therapies for depression. (Protocol). *The Cochrane Database of Systematic Reviews* 2003, Issue 2 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004053/frame.html**

[accessed 29/07/05]

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6.16f In patients showing only partial response to **antidepressants**, the addition of **cognitive therapy** (CT) produced modest improvements in social and psychological functioning. The addition of CT produced statistically significant differential effects on two out of four measures of overall severity of depression; specific psychological symptoms; including guilt and self-esteem (F=6.7; d.f.=132; p=0.01) and hopelessness (F=6.7; d.f.=1323; p=0.01); and social functioning, including dependency (F=4.2 d.f.=1127, p=0.04), interpersonal behaviour (F=4.7, d.f.= 1128, p=0.03) and friction (F=5.35 d.f.=1128, p=0.02).[i] **Caveat:** Whilst full or partially complete ratings were obtained for 90% of subjects, 31 patients (19.6%) did not adhere to the protocol to the end of the study.	i. Scott J, Teasdale JD, Paykel ES, et al. Effects of cognitive therapy on psychological symptoms and social functioning in residual depression. *British Journal of Psychiatry* 2000; **177**: 440-446 (Type II evidence - randomised controlled trial of 158 psychiatric out-patients in Cambridge and Newcastle (aged 21-65) who had major depression within the last 18 months. Patients were allocated to receive clinical management (CM) alone or CM plus cognitive therapy (CT). The trial employed 20 weeks treatment and 1-year follow-up.)

Behavioural therapy for general anxiety disorder

6.16g Both **cognitive behaviour therapy** (CBT) and the complexity and severity of presenting problems appear to influence the long-term outcome of **general anxiety disorder** (GAD). Overall, 50% of participants were markedly improved of whom 30-40% were recovered (i.e. free of symptoms). Outcome was significantly worse for the study based in secondary care in which the clinical presentation of participants was more complex and severe. For a minority (30-40%), mainly from the secondary care study, outcome was poor. Treatment with CBT was associated with significantly lower overall severity of symptomatology and less interim treatment, in comparison with non-CBT conditions, but there was no evidence that CBT influenced diagnostic status, probability of recovery or patient perceptions of overall improvement.[i] **Caveat:** The number of participants followed up was very low (55% of in study 2, and only 30% in study 1). An overly positive picture may be presented as those followed up from study 2 were significantly more likely to have completed treatment, and in study 1 a higher proportion of those followed had a positive response to drug treatment and a shorter duration of disorder at the time of the original trial.	i. Durham RC, Chambers JA, Macdonald RR, Power KG, Major K. Does cognitive-behavioural therapy influence the long-term outcome of generalized anxiety disorder? an 8-14 year follow-up of two clinical trials. *Psychological Medicine* 2003; **33(3)**: 499-509 (Type II evidence - 8-14 year follow-up of two randomized controlled trials of cognitive-behaviour therapy for generalized anxiety disorder. Study 1 compared medication, placebo and cognitive behavioural therapy (CBT) in 111 primary care patients with GAD, whereas study 2 compared analytical psychotherapy or anxiety management training (AMT) based in secondary care in 110 patients.)

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Behavioural therapy for obsessive compulsive disorder

6.16h For **obsessive compulsive disorder** (OCD), **computer guided behaviour therapy** was effective, although **clinician guided behaviour therapy** was even more effective. **Systematic relaxation** was ineffective. Computer guided behaviour therapy can be a helpful first step in treating patients with OCD when clinician guided behaviour therapy is unavailable.

By week 10, mean change in score on the Yale-Brown OCD Scale (YBOCS) was significantly greater in clinician guided behaviour therapy (8.0) than in computer-guided (5.6), and changes in scores with both clinician-guided and computer guided behaviour therapy were significantly greater with relaxation (1.7) which was ineffective. Similarly, the percentage of responders on the clinical global impressions scale was significantly ($p<0.05$) greater with clinician guided (60%) than computer-guided behaviour therapy (38%), and both were significantly greater with relaxation (14%). Clinician guided was superior to computer guided behaviour therapy overall, but not when patients completed at least 1 self exposure session. At endpoint patients were more satisfied with either behaviour therapy group than with relaxation. Patients assigned to computer guided behaviour therapy improved more the longer they spent telephoning the computer (mostly outside the office hours) and doing self-exposure. They improved slightly further by week 26 follow-up, unlike the other two groups.[i]

i. Greist JH, Marks IM, Baer L, et al. Behaviour therapy for obsessive-compulsive disorder guided by a computer or by a clinician compared with relaxation as a control. *Journal of Clinical Psychiatry* 2002; **63(2)**: 138-145

(Type II evidence - randomised controlled trial of 218 subjects with obsessive compulsive disorder (OCD) from 8 North American sites. Subjects were allocated to 10 weeks of self exposure behaviour therapy guided by computer (BT STEPS) or by a clinician or by self exposure.)

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Behavioural therapy for schizophrenia

6.16i **Cognitive behavioural therapy** is a promising but under evaluated intervention. Currently, trial-based data supporting the wide use of cognitive behavioural therapy for people with **schizophrenia** or other psychotic illnesses are far from conclusive. More trials are justified and should be designed to be both clinically meaningful and widely applicable. Cognitive behavioural therapy in addition to standard care did not significantly reduce the rate of relapse and readmission to hospital when compared with standard care alone. A significant difference was observed, however, favouring cognitive behavioural therapy over standard care alone, in terms of being able to be discharged from hospital (RR 0.5, 95%CI 0.3 to 0.9, NNT 3 95%CI 2 to 12). For 'no important improvement in mental state' data showed a significant difference favouring the cognitive behavioural therapy group over standard care alone when measured at 13 to 26 weeks (RR 0.7, 95%CI 0.6 to 0.9, NNT 4 95%CI 2 to 8). After one year the difference was no longer significant [i].

i. Jones C, Cormac I, Silveira da Mota Neto JI, Campbell C. Cognitive behaviour therapy for schizophrenia. *The Cochrane Database of Systematic Reviews* 2004, Issue 4
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000524/frame.html
[accessed 29/07/04]
(Type I evidence – systematic review of 13 randomised controlled trials of cognitive behaviour therapy in patients with schizophrenia, aged 18-65 years. Literature search 1980 -2001.)

6.16j The **token economy** approach may have effects on negative symptoms but it is unclear if these results are reproducible, clinically meaningful and are maintained beyond the treatment programme. Token economy remains worthy of careful evaluation in well designed, conducted and reported randomised trials. Only three randomised controlled trials could be included in the analyses (total n=110). There were no usable data on target or non-target behaviour. One small study favoured the token economy approach for the outcome 'change in mental state' on the SANS-CV with improvement in negative symptoms at three months (n=40, WMD -12. 7, CI -21.44 to -3.96).[i]

i. McMonagle T, Sultana A. Token economy for schizophrenia. *The Cochrane Database of Systematic Reviews* 2000, Issue 3
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001473/frame.html
[accessed 29/07/05]
(Type I evidence - systematic review of 3 randomised controlled trials of token economies for people with schizophrenia or any other serious or chronic mental illnesses, compared with standard care. Literature search 1980-1999.)

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6.16k **Cognitive behavioural therapy (CBT)** shows transient advantages over routine care alone or supportive **counselling** in speeding **remission** from acute symptoms in early **schizophrenia**. Linear regression over 70 days showed predicted trends towards faster improvement in the CBT group e.g. for auditory hallucinations, resolution was faster in the CBT group than in the supportive counselling group (parameter estimate -0.93 95%CI -1.62 to -0.25 p=0.008). Uncorrected univariate comparisons showed significant benefits at 4 but not 6 weeks for CBT versus routine care alone on Positive and Negative Syndrome Scale total and positive sub-scale scores and delusion score and benefits versus supportive counselling for auditory hallucinations score.[i]	i. Lewis S, Tarrier N, Haddock G et al. Randomised controlled trial of cognitive-behavioural therapy in early schizophrenia: acute-phase outcomes. *British Journal of Psychiatry* 2002; **181**: S91-S97 (Type II evidence – a multi-centre randomised controlled trial in Manchester/Salford, Liverpool and north Nottinghamshire, of 315 people with schizophrenia and related disorders in their first (83%) or second acute admission. Participants were allocated to routine care plus a CBT programme, or supportive counselling, or routine care alone. Patients were followed up over 70 days.)
6.16l The study provides evidence for the feasibility and effectiveness for targeting **cognitive behavioural therapy** (CBT) on the appearance of early signs of relapse in **schizophrenia**. The results are discussed in context of the study's methodological limitations. A total of 13 (18.1%) participants in CBT relapsed compared to 25 (34.7%) in TAU (hazard ratio = 0.47, p < 0.05, 95% CI 0.24 – 0.92). In addition, the CBT group showed significantly greater improvement in positive symptoms, negative symptoms, global psychopathology, performance of independent functions and prosocial activities.[i]	i. Gumley A, O'Grady M, McNay L, Reilly J, Power K, Norrie J. Early intervention for relapse in schizophrenia: Results of a 12-month randomized controlled trial of cognitive behavioural therapy. *Psychological Medicine* 2003; **33**: 419-431 (Type II evidence - randomised controlled trial of 144 people with schizophrenia in Glasgow (aged 18 to 65), to evaluate the effectiveness of cognitive behavioural therapy (CBT) during prodromal or early signs of relapse in schizophrenia compared to treatment as usual. The trial lasted 12 months.)

Behavioural therapy for social phobia

6.16m These results affirm, in global terms, that **behavioural and cognitive treatments for social phobia** is clearly effective. Nevertheless, the homogeniety test did not reach statistical significance, so we can assume that the effectiveness of exposure techniques, cognitive restructuring techniques and social skills training can be considered homogeneous. This fact questions the underlying psychological principles in the effectiveness of BCT. The average effect size (weighted by the inverse of the variance) was 0.77 at the posttest and 0.95 at the follow-up.[i]	i. Pedro J, Gil PJM, Carrillo FXM, Meca JS. Effectiveness of cognitive-behavioural treatment in social phobia: A meta-analytic review. *Psicothema* 2000; **12**: 346-352. (Type III evidence – systematic review of 39 experimental studies of behavioural and cognitive treatments for social phobia. Literature search 1980-1997.)

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6.17 Family interventions

6.17a Clinicians, researchers, policy makers and recipients of care cannot be confident of the effects of **family intervention** from the findings of this review. Further data from already completed trials could greatly inform practice and more trials are justified as long as their participants, interventions and outcomes are applicable to routine care. Family intervention may decrease the frequency of **relapse** (RR 0.72, 95%CI 0.6 to 0.9, NNT 7 95%CI 5 to 16). These data are statistically heterogeneous, the trend over time of this finding is towards the null and some small but negative studies may not have been identified by the search. Family intervention may also encourage **compliance with medication** (RR 0.74, 95%CI 0.6 to 0.9, NNT 7 95%CI 4 to 19) but does not obviously affect the tendency of individuals/families to drop out of care (RR attrition at 3 months 0.86 95%CI 0.3 to 2.1). It may improve **general social impairment** and the levels of expressed emotion within the family.[i].

i. Pharoah FM, Rathbone J, Mari JJ, Streiner D. Family intervention for schizophrenia. *The Cochrane Database of Systematic Reviews* 2003, Issue 3 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000088/frame.html** [accessed 29/07/04]

(Type I evidence – systematic review of 28 randomised controlled trials examining the effectiveness of family psychosocial interventions in community settings for the care of those with schizophrenia or schizophrenia-like conditions. Most recent literature search November 2002.)

6.17b The findings suggest that implementation of **multiple-family group treatment** in a capitated community mental health setting improves **hospitalisation outcomes** without increasing the overall volume of outpatient mental health services. Multiple family group treatment was associated with a lower rate of psychiatric hospitalisation than standard care (1-year after baseline 9% of the intervention group were hospitalised, compared to 22% in the standard care group, p=0.03). The treatment was only marginally associated with lower use of crisis services (13% in the intervention received crisis care during the year after baseline, compared to 22% in the standard care group p=0.09), and it was not associated with the amount of outpatient time.[i]

Caveat: Follow-up was low, with 75.5% remaining in the study at 12 months.

i. Dyck DG, Hendryx MS, Short RA et al. Service use among patients with schizophrenia in psychoeducational multiple-family group treatment. *Psychiatric Services* 2002; **53**: 749-754. **http://psychservices.psychiatryonline.org/cgi/reprint/53/6/749** [accessed 29/07/05]

(Type II evidence - randomised controlled trial of 106 outpatients in Washington (aged 18-45 years, 77% male) with schizophrenia / schizoaffective disorder. Patients were allocated to psychoeducational multiple-family group treatment or standard care. Each patient was followed prospectively to determine service use for one year after the start date. The study is still in progress, therefore the outcomes have been reported for the first of the 2-year multiple-family group intervention.)

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6.18 Psychological debriefing after psychological trauma

6.18a There is no current evidence that single session **individual psychological debriefing** is a useful treatment for the prevention of **post traumatic stress disorder** (PTSD) after traumatic incidents. Compulsory debriefing of victims of trauma should cease. Single session individual debriefing did not reduce psychological distress nor prevent the onset of PTSD. Those who received the intervention showed no significant short term risk (3-5 months) of PTSD. At one year, one trial reported that there was a significantly increased risk of PTSD in those receiving debriefing (OR 2.88, 95% CI 1.11 to 7.53). There was also no evidence that debriefing reduced general psychological morbidity, depression or anxiety.[i]

A systematic review of randomised controlled trials of **psychological treatments** for post-traumatic stress disorder is currently underway.[ii]

i. Rose S, Bisson J, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *The Cochrane Database of Systematic Reviews* 2002, Issue 2 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000560/frame.html** [accessed 29/07/05]

(Type I evidence - systematic review of 11 randomised controlled trials of psychological debriefing in persons aged 16 years or above exposed to a traumatic event. Literature search Databases 1973 - 2000.)

ii. Bisson JI, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). *The Cochrane Database of Systematic Reviews* 2002, Issue 1 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003388/frame.html** [accessed 29/07/05]

6.19 Psychodynamic psychotherapy

6.19a Current data do not support the use of **psychodynamic psychotherapy** techniques for hospitalised people with schizophrenia. If psychoanalytic therapy is being used for people with **schizophrenia** there is an urgent need for trials. No trials of a psychoanalytic approach were identified. There is no evidence of any positive effect of psychodynamic therapy and the possibility of adverse effects seems never to have been considered. The psychodynamic approach may be more acceptable to people than a more cognitive reality-adaptive therapy.[i]

i. Malm, L, Fenton M. Individual psychodynamic psychotherapy and psychoanalysis for schizophrenia and severe mental illness. *The Cochrane Database of Systematic Reviews* 2001, Issue 3. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001360/frame.html** [accessed 29/07/05]

(Type I evidence – systematic review of 3 randomised controlled trials of individual psychodynamic psychotherapy or psychoanalysis for people with schizophrenia or severe mental illness. Literature search to 1999.)

National Service Framework: key action 26

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

All staff that provide psychotherapy and counselling should be appropriately qualified and receive formal supervision. [Key action 26 paragraph 25.3]

Which staff are appropriate to provide psychotherapy and counselling?

See also Chapter 8 for the following:

- Providing support for staff – Section 8.2
- Developing staff skills – Section 8.4
- Supervision and management of staff – Section 8.5

See also Section 6.1 for collaboration between primary care and mental health services

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6.20 Guidance on staffing and delivering psychological therapies in the NHS

6.20a Many therapies in the NHS are necessarily delivered by novice therapists or those with minimal training. The clinicial consensus was that while not necessarily problematic for straightforward presentations, it is safer practice for people in severe and complex difficulties and with greater risk of **self-harm** to be treated by therapists who are more skillful. This priniciple is relatively weakly supported by research evidence, possibly for methodolgical reasons but achieved a strong consensus.[i]

i. Department of Health. *Treatment Choice in Psychological Therapies and Counselling*. London: Department of Health, February 2001 **http://www.dh.gov.uk/assetRoot/04/05/82/45/04058245.pdf** [accessed 29/07/05]

(Evidence based guidelines with a systematic search strategy for research published between 1990 - 1998. Evidence was systematically reviewed and appraised. Expert and user consensus was also used to ascertain consensus on treatment choice.)

6.20b Best practice guidance is available to support improvements in the **delivery of psychological therapy** services. Issues of well trained and supported staff, clinical governance, and leadership and management is included.[i]

i. NIMHE. *Organising and Delivering Psychological Therapies*. London: Department of Health, July 2004. **http://www.dh.gov.uk/assetRoot/04/08/60/97/04086097.pdf** [accessed 29/07/05]

(Expert consensus guidelines.)

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6.21 Appropriateness of primary care staff delivering psychological therapies

6.21a In general, there is little available evidence on the use of **psychosocial interventions by general practitioners**. Of the psychosocial interventions reviewed, **problem-solving treatment for depression** seems the most promising tool for GPs, although a stronger evidence-base is required and the effectiveness in routine practice remains to be demonstrated. There is good evidence that problem-solving treatment by general practitioners is effective for major depression. The evidence concerning the remaining interventions for other health complaints (reattribution or cognitive behavioural group therapy for somatisation, counselling for smoking cessation, behavioural interventions to reduce alcohol reduction) is either limited or conflicting.

i. Huibers MJH, Beurskens AJHM, Bleijen, G, Schayck CP van. The effectiveness of psychosocial interventions delivered by general practitioners. *The Cochrane Database of Systematic Reviews* 2003, Issue 2. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003494/frame.html**

[accessed 29/07/05]

(Type I evidence – systematice review of 6 randomised controlled trials and 2 controlled clinical trials reporting the effectiveness of psychosocial interventions delivered by GPs. Literature search to January 2002.)

6.21b **Counselling in primary care** is associated with modest improvement in short-term outcome compared to 'usual care', but provides no additional advantages in the long-term. Patients are satisfied with counselling, and it may not be associated with increased costs. The main analyses showed significantly greater clinical effectiveness in the counselling group compared with 'usual care' in the short-term (standardised mean difference -0.28, 95% CI -0.43 to -0.13, n=772, 6 trials) but not the long-term (standardised mean difference -0.09, 95% CI -0.27 to 0.10, n=475, 4 trials). Levels of satisfaction with counselling were high. Four studies reported similar total costs associated with counselling and usual care over the long-term. However, the economic analyses were likely to be underpowered.[i]

i. Bower P, Rowland N, Mellor Clark J, Heywood P, Godfrey C, Hardy R. Effectiveness and cost effectiveness of counselling in primary care. *The Cochrane Database of Systematic Reviews* 2002, Issue 1. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001025/frame.html** [accessed 29/07/05]

(Type I evidence – systematic review of 7 randomised controlled trials of counselling interventions in primary care. A range of professional practioners were eligible for inclusion but only trials in which practitioners were trained to BACP accreditation levels or equivalent were included. Literature search 1996-2001.)

The *statements*

The *evidence*

6.21c **General practitioners** may require more **training and support** than a basic educational package on brief cognitive behaviour therapy to acquire skills to help patients with depression. Doctors' knowledge of depression and attitudes towards its treatment showed no major difference between intervention and control groups after 6 months. The training had no discernible impact on patients' outcomes.[i]

Caveat: There was large attrition from the groups (56%). 116 doctors were randomised, yet 55 did not complete follow-up. Patients received a £5 gift token for their time.

i. King M, Davidson O, Taylor F, Haines A, Sharp D, Turner R. Effectiveness of teaching general practitioners skills in brief cognitive behaviour therapy to treat patients with depression: randomised controlled trial. *British Medical Journal* 2002; **324(7343)**: 947-50

http://bmj.bmjjournals.com/cgi/reprint/324/7343/947

[accessed 29/07/05]

(Type II evidence – cluster randomised controlled trial of 84 general practitioners, and 272 patients with depression attending their practices (aged 18 and over, 70.6% female). Doctors were allocated to receive cognitive behaviour therapy training or waiting list control. 6 months follow-up.)

6.21d This trial demonstrated only very limited evidence of improved outcomes in those referred to **counselling** and increased **primary care treatment** costs in the short-term. Stricter referral criteria to exclude the more severely depressed in the group (BDI ≥ 24) might have yielded more conclusive results. There was an overall significant improvement in the actual scores over time, but there were no significant differences between the two groups on any of the measures at either 6 or 12 months. However fewer experimental group patients were still 'cases' on the BDI than controls at 12 months. There were no significant differences in the mean total costs, aggregate costs of services, or any service-group costs except for primary care, between the experimental and control groups over time.[i]

Caveat: The study did not have sufficient power to detect between group cost differences at the 5% significance level.

i. Simpson S, Corney R, Beecham J. A randomized controlled trial to evaluate the effectiveness and cost-effectiveness of psychodynamic counselling for general practice patients with chronic depression. *Psychological Medicine* 2003; **33(2)**: 229-239

(Type II evidence – randomised controlled trial with an economic evaluation of 145 patients from 9 GP practices. Patients were assigned to GP treatment and practice counsellor (mean age 42 years, 85% female) or control group of routine GP treatment (mean age 44 years, 75% female). Follow-up was at 6 months and 12 months.)

The *statements*

The *evidence*

6.21e The two treatments (**counselling** and **antidepressants**) were equally effective at eight weeks, both for the randomised group and when the randomised and patient preference groups for a particular treatment were combined, and that expressing a preference for either treatment conferred no additional benefit on outcome. These data challenge several assumptions about the most appropriate treatment for depression in a primary care setting.[i]
Caveat: The follow-up period was only 8 weeks. An intention to treat analyses was not reported.

i. Bedi N, Chilvers C, Churchill R, *et al*. Assessing effectiveness of treatment of depression in primary care. Partially randomised preference trial. *British Journal of Psychiatry* 2000; **177**: 312-318

(Type II evidence – partially randomised preference trial of 323 patients (mean age 37.8, 23% male), with major depression, from 24 general practices. Patients were randomised to either antidepressants (n=45), or counselling (n=40) or given their choice of either treatment (counselling n=108, antidepressants n=56).)

6.21f The standard therapist contact group showed the greatest treatment efficacy in this study. As it was of notably shorter duration than many other formulations of **cognitive behavioural therapy** (CBT), it represents a useful and efficient treatment for **panic disorder and agoraphobia** in primary care. The standard therapist contact group had the strongest and most comprehensive treatment response, showing significant differences from the bibliotherapy group on all endpoint measures, and the minimum therapist contact group on some endpoint measures. Patient clinical global improvement for standard therapist contact group = 1.7 (SD 0.83), bibliotherapy = 3.14 (1.19), minimum 2.12 (1.03) $F = 14.71$ $p<0.0001$. Some reduction in efficacy was therefore found for the reduced therapist contact groups.[i]

i. Sharp DM, Power KG, Swanson V. Reducing therapist contact in cognitive behaviour therapy for panic disorder and agoraphobia in primary care: global measures of outcome in a randomised controlled trial. *British Journal of General Practice* 2000; **50**: 963-938

(Type II evidence - randomised controlled trial of 104 panic disorder patients in Scotland to evaluate the efficacy in primary care setting of a cognitive behaviour therapy delivered at three levels of therapist contact: standard contact, minimum contact, and bibliotherapy. The trial lasted 12 weeks.)

National Service Framework: key action 27

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

All areas are to have a comprehensive range of rehabilitation services aiming to maximise the independence and recovery of users…There is to be a range of community rehabilitation services providing multi-agency care for users with long term needs and delivering an assertive community treatment methodology. There should be meaningful activities during the day which promote recovery and access to employment and education. [Key action 27 paragraph 26.1]

What is the effectiveness of different rehabilitation interventions?

See Section 1.7 for supported education and 3.4 for supported employment
See Section 1.1-1.3 for helping people to stay free of, or minimise effects of mental health problems
See also Section 6.15-6.19 for psychological therapies

The *statements* | The *evidence*

6.22 Rehabilitation

6.22a There is inconclusive evidence that **attention training** is effective in **schizophrenia**. Longitudinal efficacy studies are needed in which different aspects of attention are systematically exercised and assessed. Re-examination of findings from nine methodologically adequate studies using computer-based or non-computer-based training procedures provided inconsistent results.[i]
Caveat: Unpublished research was not sought. A formal method of assessing the study validity is not reported.

i. Suslow T. Attention training in the cognitive rehabilitation of schizophrenic patients: A review of efficacy studies. *Acta Psychiatrica Scandinavica* 2001; **103(1)**: 15-23
(Type I evidence – narrative systematic review of 9 randomised and non-randomised trials (n=395 patients) to review the literature on the efficacy of computer-based attention training programmes and cognitive training on attentional functioning in schizophrenic patients. Literature search to 1999.)

6.22b Data are inconclusive and provide no evidence for or against **cognitive rehabilitation** as a treatment for schizophrenia. Although cognitive rehabilitation was as acceptable as placebo and occupational therapy, with low attrition in both groups, no effects were demonstrated on measures of mental state, social behaviour, or cognitive functioning. An effect, in favour of cognitive rehabilitation, on a measure of self-esteem (Rosen, Self-Esteem Scale, mean difference 6.3 95%CI 1.07-11.53) is worthy of replication in any future trials.[i]

i. Hayes RL, McGrath JJ. Cognitive rehabilitation for people with schizophrenia and related conditions. *The Cochrane Database of Systematic Reviews* 2000, Issue 3 **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000968/frame.html**
[accessed 29/07/05]
(Type I evidence – systematic review and meta-analysis of 3 randomised controlled trials comparing cognitive rehabilitation to a placebo intervention (n=2) and cognitive rehabilitation to occupational therapy (n=1). Literature search to 1997.)

The *statements*

The *evidence*

6.22c Different **rehabilitation modules** and treatments currently contribute to improve the overall condition of persons with schizophrenia. The **coping skills module** examined in this study enabled participants to become aware of their capacities for coping and of the possibility of using them in troublesome situations. The experimental group exhibited a significant decrease in delusions (a drop in the Positive and Negative Syndrome Scale delusions score, $F(2, 132)=3.16$, $p<0.05$) and increase in self-esteem (Rosenberg Self-Esteem Scale, $F(2, 140)=3.08$, $p<0.05$), and maintained or improved hygiene levels (improvement on the Independent Living Skills Scale hygiene subscale score, $F(2, 120)=4.25$, $p<.05$).[i]

Caveat: Only 65.5% were assessed at follow-up, and participants were paid for each follow-up evaluation.

i. Leclerc C, Lesage AD, Ricard N, Lecomte T, Cyr M. Assessment of a new rehabilitative coping skills module for persons with schizophrenia. *American Journal of Orthopsychiatry* 2000; **70(3)**: 380-388

(Type II evidence –randomised controlled trial set in Montreal Canada, allocating 99 people with schizophrenia (mean age 40.6 years) to either an experimental group rehabilitation treatment plus the coping skills module (62% male) or a control group (70% male). Follow-up was at 6 months.)

Psychoeducation

6.22d Evidence from trials suggests that **psychoeducational** approaches are useful as a part of the treatment programme for people with **schizophrenia** and related illness. The fact that the interventions are brief and inexpensive should make them attractive to managers and policy makers. More well-designed, conducted and reported randomised studies investigating the efficacy of psychoeducation are needed. **Compliance with medication** was significantly improved in a single study using brief group intervention (at 1 year) but other studies produced equivocal or skewed data. Any kind of psychoeducational intervention significantly decreased relapse or readmission rates at nine to 18 months follow-up compared with standard care (RR 0.8 CI 0.7-0.9 NNT 9 CI 6-22).[i]

Caveat: Publication bias may have been introduced as a search for unpublished research is not reported.

i. Pekkala E, Merinder L. Psychoeducation for schizophrenia. *The Cochrane Database of Systematic Reviews* 2002, Issue 2.
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002831/frame.html
[accessed 29/07/05]

(Type I evidence – systematic review of 10 randomised controlled trials (n= 1125 participants, aged 15 to 58 yrs, 53.1% male) comparing psycho-education or patient teaching with standard care. Literature search 1999 to 2001.)

The *statements*	The *evidence*
6.22e **Group psychoeducation** is an efficacious intervention to prevent recurrence in pharmacologically treated patients with **bipolar I and II disorder**. Group psycho-education significantly reduced the number of relapsed patients (40 subjects, 67%, in the psychoeducation group fulfilled criteria for recurrence versus 55 subjects, 92%, in the control group, p<0.001) and the number of recurrences per patient (log rank1 =13.45, p<0.001) and increased the time to depressive (log rank1 =15.47, p<0.001), manic or hypomanic (log rank1 =7.79, p<0.006), and mixed recurrences (log rank1 =7.95, p<0.05). The number and length of hospitalisations per patient were also lower in patients who received psycho-education (14, 25% in the treatment group versus 21, 35%, in the control group, p=0.24).[i] **Caveat**: Follow-up percentage and whether or not an intention-to-treat analysis was used is unclear.	i. Colom F, Vieta E, Martinez-Aran A, et al. A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. *Archives of General Psychiatry* 2003; **60(4)**: 402-7 (Type II evidence – randomised controlled trial of 120 bipolar outpatients in remission in Spain (18-65 years of age, 63% female). Patients were allocated to receive, in addition to standard psychiatric care, 21 sessions of group psycho-education (n=60) or 21 (n=60) sessions of nonstructured group meetings. 2 year follow-up.)
6.22f In general, results do recommend **psychoeducative intervention at early psychosis**. However, psychoeducation was not optimally located in patients with a very short duration of illness. Psychoeducation showed a most preventive effect in patients with a medium duration of illness who already accept their illness but are not yet adhering to fatalistic assumptions often established to explain the manifestation of illness. In patients with long-duration of illness, attendance at psychoeducation did not modify rehospitalisation rate. This was true for patients with very short duration of psychosis. Only patients with medium duration of illness after psychoeducative intervention showed a reduced rehospitalisation rate.[i] **Caveat:** Only 65.9% participants remained in the study at 5-years follow-up and it is unclear if an intention to treat analysis was performed.	i. Feldmann R, Hornung WP, Prein B, et al. Timing of psychoeducational psychotherapeutic interventions in schizophrenic patients. *European Archives of Psychiatry and Clinical Neuroscience* 2002; **252**: 115-119 (Type II evidence - randomised controlled trial of 191 schizophrenic outpatients (58% male) in Germany with either a short (<5yrs), medium (5-7 yrs) or long (>7yrs) pre-therapy duration of psychosis. Patients were assigned to 1 of 4 different treatment groups with combined psychoeducation and cognitive treatment or a control group. Patients were assessed at baseline, 8 month treatment phase, and at 1, 2 and 5 year follow-up.)

The *statements*

The *evidence*

6.22g There are limits to which **psychoeducational interventions** can be simplified without loss of effectiveness in terms of **relapse prevention** in schizophrenia. Enhanced insight may be associated with increased **suicidal ideation**. The intervention failed to improve outcome. While insight and treatment attitudes improved, suicidal ideation increased. Of the intervention group 11 subjects (23.9%) changed to being scorers on the suicidal thoughts item, compared with only 2 subjects (5.6%) from the control group. This difference was statistically significant (p=0.01). Systematic management of treatment-emergent adverse effects offered no benefits although incapacitation from extrapyramidal side-effects at discharge predicted relapse.[i]

i. Cunningham-Owens DG, Carroll A, Fattah S, et al. A randomized, controlled trial of a brief interventional package for schizophrenic out-patients. *Acta Psychiatrica Scandinavica* 2001; **103**: 362-369

(Type II evidence - randomised controlled trial of 114 recently discharged schizophrenic patients (aged 16-64 years) recruited from 11 hospitals in Scotland. Patients were followed up at 12 months.)

National Service Framework: key action 28

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Ideally, children are not to be cared for on adult wards. However each area is to have a designated unit in which staff have undergone training and been police checked, with formal protocols in place for management of older adolescents if a brief say is needed on an adult ward in an emergency. [Key action 28 paragraph 27.1]

What protocols should be in place for management of adolescents if a stay on an adult ward is required in an emergency?

See Section 7.17

The *statements*

6.23a There is widespread recognition that the **care of young people** presenting with acute, severe mental illness is often unsatisfactory. This can involve a lack of any suitable bed, undue delay, or an inappropriate admission to an adult or paediatric bed. In fact, in England and Wales, some 600 young people are inappropriately placed each year on adult or paediatric wards. It is recommended that: young people aged under 16 years should not be admitted to adult psychiatric wards. Those aged 16 or 17 years can be considered for admission to adult psychiatric wards when a) no suitable specialist adolescent psychiatric bed is available, b) they have severe mental illness or c) acceptable standards of care are met. Further recommendations are that health commissioners need to develop appropriate services; and inappropriate admissions should be considered as a sign of inadequate resources and treated as an untoward or critical incident.[i]

The *evidence*

i. Royal College of Psychiatrists. *Acute in-patient psychiatric care for young people with severe mental illness. Recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists*. Council Report CR106 London: Royal College of Psychiatrists, 2002 (Type V evidence – expert opinion.)