Community Alternatives to Hospital in a Mental Health Crisis

IMPACT Facilitator Project 2023-24 (Wales)

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Project Background

IMPACT is a UK centre for implementing evidence in adult social care, with the vision that '*good support isn't just about 'services' – it's about having a life'*. In pursuit of this, the key objectives for the centre are to enable practical improvements on the ground and make a crucial contribution to longer-term cultural change. One way to achieve this is through Facilitator projects. Facilitators lead a twelve-month evidence-informed Theory of Change project to support bottom-up change. Findings and outcomes are shared for replication across the sector.

This IMPACT Facilitator project, hosted by Shared Lives South East Wales, explored community-based alternatives to psychiatric wards during a mental health crisis. Shared Lives provide short-term residential placements with experienced community carers who share their life and home to support recovery from mental health crisis and other social care needs. The project had a particular focus on placements offered by Shared Lives South East Wales, and also draws on evidence from crisis sanctuaries, crisis houses, and other local projects in the community. These models provide personalised, supportive care outside of institutional settings, aiming to improve the recovery experience, prevent further crisis escalation and reduce avoidable re-hospitalisation.

Pre-Project Evidence

Initial Evidence Review

The initial IMPACT Evidence Review can be found on the IMPACT website. This highlighted several key findings:

- Benefits of community-based recovery: There is a link between community-based approaches and improved quality of life in mental health crisis care. Informal networks, family, and community are protective factors against hospital admissions.
- Barriers to access: Some individuals cannot access community mental health crisis care due to self-harm or suicide risk, addiction, risk of violence, unstable housing, or homelessness. Community care is not available to people subject to compulsory detention (sectioning).

- Systemic challenges:
    - Urgency versus quality of crisis response: Crisis teams struggle balancing the urgency of responses with the complexities of thorough risk assessment and safety assurance during mental health crises.
    - Hospital discharge: Lack of support and planning during the high-risk period following hospital discharge contributes to repeated readmission.

- Limitations of the evidence:
    - Research gaps: Data on the effectiveness of community-based services is limited, largely due to the diversity and fragmentation of these services.
    - Representation gaps: There is a lack of representation from people with lived experience and frontline professionals in existing studies, and little consideration of factors such as race and ethnicity underscoring the need for more inclusive research.

IMPACT Project Aims and Theory of Change

The aims of the IMPACT Facilitator project were to:

- Improve the confidence of families to support a relative in accessing mental health crisis support in the community.
- Increase understanding of staff and carers in how risks can be effectively managed in community settings.
- Identify opportunities to increase inclusivity and overcome barriers to accessing community care in mental health crisis.

Project Engagement

How Evidence was Collected

Insights were gathered through conversations with community mental health projects and professionals. Table 1 outlines the direct engagement which has contributed to this report.

Evidence gathered to inform the project		
Organisation	Participants	Number
Shared Lives SE Wales	Workers	2
Shared Lives SE Wales	Carers	8
Student Support Services	Frontline and Strategic Staff	7
Crisis Sanctuaries	Service Leads	5
Crisis Houses	Service Lead	1
	Total	**23**

These individual discussions were augmented with a Co-production Workshop attended by managers and co-ordinators at Shared Lives (n=6 attendees).

Alongside direct engagement, the Facilitator conducted scoping and information gathering activities to ensure a clear understanding of local activities. This included reviewing written feedback gathered from individuals with lived experience of crisis support in the community by one local organisation that provides therapeutic alternatives to hospital for people who are experiencing a crisis. Additionally, scoping activities undertaken included:

With Shared Lives:

- Attendance at mental health placement planning meetings
- Shadowing Shared Lives Workers and wider team

Other organisations:

- Visit to 2 crisis sanctuaries
- Visit to 2 crisis houses
- Correspondence with Wales Applied Risk Reduction Network risk experts

- Observation of 4 Multi-Disciplinary Team (MDT) meetings at NHS Psychiatric Wards
- Observation of Shared Lives Carers meetings
- Observing a carer review
- Shadowing pre-placement meetings with individuals
- Reviewing written case studies from Shared Lives
- Correspondence with a NHS safety planning expert
- Visit to local 111(2) mental health triage centre
- Conversations with third sector about complementary community services

Analysis

Insight from direct engagements were written up and analysed qualitatively, with common themes identified as noted in this report. Specific examples of success in community crisis care and problems experienced by frontline workers are highlighted.

Project Outcomes

Key Findings

Support for the Community-Based Models of Crisis Care:

- Social support: Support from family is an important factor in recovery and reducing readmission for individuals. However, some family caregivers reported that they struggled to manage acute symptoms or with capacity to provide sufficient levels of care. Shared Lives placements are valued as an alternative to family care. Carers and community crisis workers can help individuals to maintain connections and strengthen support networks, for example, by facilitating a visit to/from family and supporters.
- Homely environment: Many valued familiar and comfortable home environments that community alternatives provide. These environments promote life skills, such as cooking or cleaning. Home environments can be

especially valuable for those who feel overstimulated by bright or loud hospital environments.

- Community inclusion: Carers include individuals in their family and community life, and provide the opportunity to participate in recovery activities. Many promote community engagement such as through community projects or art and crafts spaces, attending religious services, or college courses.
- Training: Community crisis carers come from a range of personal and professional backgrounds (including mental health, fostering, social care) and provide flexible, person-centred support for multiple, complex or additional care needs. Community crisis projects organise specialist training to enable placements to go ahead, for example, training for managing physical health conditions such as epilepsy or how to manage ligature risk.
- Support: Carers are supported 24/7 by both the Shared Lives team and NHS crisis teams.
- Eligibility criteria: Whilst the IMPACT evidence review suggests individuals can be excluded due to specific criteria such as being subject to compulsory detention (sectioning), having a risk of self-harm or suicide or substance use issues, Shared Lives respond to each referral individually and on merit rather than having any specific exclusion criteria.

Challenges:

- Availability: Carers may have limited availability, especially during peak periods such as public holidays. This can be especially limiting for people with co-occurring health needs, accessibility requirements or preferences such as gender of carer, or bringing their pets.
- Out-of-area placements: Limited availability in the local area may necessitate a move of location, therefore reducing access to the individual's support network.

- Practical challenges: Placements can be delayed as overstretched systems result in incomplete or delayed paperwork, or due to delays in accessing prescription medication from pharmacies.
- Lone working: Carers may feel alone in their work, and some struggle with the emotional toll of managing high-risk cases without the support of colleagues.

Barriers to Accessing Community Crisis Care:

A number of barriers to access were identified, including:

- Restricted referral pathways: In the specific location of the Facilitator project, referral pathways to Shared Lives are via four crisis teams and one older adult team. This may affect access to the scheme, especially for older adults and hard-to-reach groups that might not be registered for local NHS services, such as refugees and students.
- Geographical issues: NHS crisis teams sometimes reject potential placements where available carers are outside of NHS administrative boundaries; collaboration and delegation between teams in different NHS administrative areas is limited.
- Exit Planning: Unstable housing can reduce access to community crisis projects that require a clear exit plan.

Managing Risk in Community Mental Health Crisis Projects:

A key finding from this project was around the importance of managing risk in community crisis projects. Community care offers small and homely placements. Whilst there are benefits to this, this also means additional risks require to be considered:

- Individuals cannot always be supervised as there is no night shift and carers need to manage other responsibilities.
- Individuals may be exposed to external risks such as access to alcohol or drugs.

- Home environments may be shared with children or young people, who may be exposed to traumatic incidents, such as self-harm or suicide attempts.

Reflecting this, there are risk assessment procedures in place around community crisis care. Shared Lives Carers receive a risk assessment document from the NHS before agreeing to host a placement, using the Wales Applied Risk Research Network (WARRN) approach, developed specifically for the assessment and management of serious risk for users of mental health services. WARRN emphasises the importance of co-producing plans with individuals to create tailored strategies for managing their specific risks and empowering them to take an active role in their own recovery.

However, during this project some challenges were identified with this:

- Risk assessments are occasionally outdated or incomplete which may undermine their usefulness
- IT systems: Social care providers and NHS providers store WARRN documents on non-compatible IT systems, requiring additional administration in collaborative working.
- Not widely understood: The WARRN team offer a one-day training programme for non-clinical practitioners and additional Risk of Suicide Protocol training. However, in practice, the formulation-based approach to risk assessment advocated by WARRN risk experts was reported to be not widely understood, and elements such as co-production and contextualisation of past risk can be overlooked.

To address their concerns around risk, carers reported developing and implementing their own house rules including supervision of medications, limited or prohibited consumption of alcohol, curfews and visiting restrictions. Often, this appeared to be ad-hoc and carers were reliant on their experience with such risks. In some cases, this created conflict between carers and individuals, which led to early termination of placements. To support managing risk, carers reported they would like:

- Face-to-face training.
- Peer support opportunities.
- Improved links with experts in mental health crisis.

- Better links to organisations providing additional support.

Community care is effective for many, but is not neccessarily the right option for everyone. Some individuals may prefer hospital care for its structure or group therapy options. It is important to remember that a clinical ward remains an option if the community setting is not the best fit.

Outputs

Outputs to maximise engagement with this project are:

- Linktree: An online list of relevant projects providing local community-based support for mental health crisis, and where to find them.
- Information guides: with a focus on increasing confidence in community crisis care, managing risks in a community setting and inclusivity.

Both resources are accessible on the IMPACT website

How did we make a difference?

- Increased awareness of community alternatives: The project has raised awareness about the effectiveness of community-based care models as viable alternatives to hospital admissions during mental health crises. Through this work, families, professionals, and commissioners are now more informed about Shared Lives placements and other community crisis care options.
- Highlighted the importance of family engagement: the importance of co-production and co-ownership of safety strategies has been highlighted with the aim of ensuring that families feel more confident and informed about the care their family member receives in community settings. This approach potentially fosters better collaboration and a stronger support system for individuals in crisis.
- Amplified front-line voices: by sharing information gathered, the project has helped to amplify the voices of carers and crisis workers about their experiences of providing care in the community, along with their suggestions of what may improve or better promote community crisis support.

What worked well on the Facilitator Project?

The project identified strengths in community-care options. These included:

- Person-centred approach: Placements are personalised to meet individual needs, and many benefit from care in welcoming and homely settings. Individuals can remain connected in their community whilst receiving care.
- Short-term mental health placements: The flexibility of short-term placements (up to 4 weeks) allowed for crisis intervention and reduced the need for hospitalisation.

These elements highlighted the potential effectiveness of community-based care models in supporting individuals through mental health crises.

What did not work so well?

- Limited availability and accessibility: There were challenges with the availability of community placements. The need for more mental health carers and flexible services to accommodate a wider range of individuals, especially those with complex needs, was a recognised gap. Lack of secure ongoing funding exacerbated these challenges.
- Challenges with risk management: Ensuring safety and managing risks in the community was a key challenge.
- Lack of support for carers: Increased collaboration with experts in mental health crisis may help increase carers confidence in hosting individuals with complex mental health needs and support debriefing following challenging incidents.
- Communication and coordination Issues: At times, there were gaps in communication, for example NHS workers noted that there were IT incompatibilities between health and social care systems which led to additional administrative tasks. Although in a good position to contribute to contextualised risk assessments, carers are currently unable to update WARRN documentation.

What Opportunities are there for Wider Impact on Policy and Practice?

- Benefits of community-based recovery: Evidence collected supported a link between community-based approaches and improved quality of life in mental health crisis care. Informal networks and family can sometimes reduce the risk of hospital admissions, but organised care in the community should be considered where this is not feasible. Community connection was reported as an important aspect in recovery.
- Urgency versus quality of crisis response: Crisis teams struggle balancing the urgency of crisis responses with a person-centred approach to coproducing risk assessment.
- Limitations of the evidence:
    - Research gaps: There is increasing recognition of the effectiveness of community-based services, with more efforts to collect qualitative feedback from service users, family and supporters, and front-line professionals. There is diversity and fragmentation between models for Adult v. Child & Young Peoples (CYP) community crisis response.
    - Representation gaps: There is increasing recognition of the importance of representation from people with lived experience and frontline professionals in crisis research. The role and involvement of family and supporters in recovery is also being increasingly recognised in research. There remains limited consideration of factors such as race and ethnicity.

The project presents several opportunities for wider impact on policy and practice:

1. Promote community-based care: Raise awareness of community crisis care options, emphasising the benefits of a person-centred, community-integrated alternative to hospital, and how safety risks can be managed effectively in the community.
2. Evidence-informed and inclusive commissioning of services: Advocate for consideration of diverse populations in mental health commissioning, ensuring services reflect the needs of all communities, including people with complex needs or facing multiple disadvantages.

3. Including individuals and families: Develop a clear process to formalise opportunities for co-production and involvement of family and supporters in crisis care planning to increase personalisation of care and ownership/self-management of risks.

4. Support community crisis workers and carers: This includes providing community crisis workers and carers with additional opportunities for peer support and face-to-face training with mental health experts.

Summary

This Facilitator project explored community-based alternatives to hospital care during mental health crises. Evidence supporting such alternative models emphasise personalised, supportive care outside hospital settings aiming to improve recovery, prevent crisis escalation, and reduce re-admission. The project aimed to reinforce the role of community care as a valid option, and advocate for inclusive, evidence-informed approaches to mental health crisis care.

The IMPACT Facilitator project findings highlight both the strengths and challenges of a range of community options (including Shared Lives) as an alternative to hospital care for individuals experiencing mental health crises. The Facilitator found that a homely, non-clinical environment has potential to foster recovery, emotional well-being and skill development while promoting inclusion in family and community life. However, challenges include a lack of availability of carers who can meet complex, co-occurring needs in some areas. Additionally, gaps between health and social care support and communication between professionals were noted.