special articles

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Accredited accommodation: an alternative to in-patient care in rural north Powys

Various alternatives to psychiatric in-patient care have recently been reviewed (Boardman & Hodgson, 2000). The Accredited Accommodation Scheme in north Powys represents a novel, local alternative to in-patient care, for a targeted group of patients with enduring forms of mental illness.

We were prompted into considering this alternative by retrospective analysis of admissions over a 2-year period, which suggested that 12% of admissions did not require 24-hour specialist care. These admissions showed certain characteristics. Patients were already well-known to the community mental health team (CMHT); a precipitating stress could often be readily identified, or there was some degree of social isolation and a need for a level of support not available at that time other than in hospital; patients were considered to have limited coping resources, regardless of specific diagnosis; admissions were relatively short; in each case there was not considered to be significant risk of harm to self or others; and no changes to specific treatment were required.

Additional driving factors for the development of this particular scheme were the low population density of rural north Powys, and the planned closure of the Mid Wales Hospital in October 1999, with an associated reduction in the available number of admission beds.

Having identified this group of patients not requiring specialist 24-hour care, we were led into considering an alternative to admission based on ordinary existing housing stock within north Powys, owned by responsible, nurturing individuals who might act in a fostering capacity for relatively short periods. In this respect, the scheme resembles the family-based crisis home approach developed in Denver in the 1970s (Brook, 1980).

The Accredited Accommodation Scheme

The scheme serves an identified population of 19 140 in north Powys, with an age range of 18–64 years, and became operational in January 1999 as a 6-month pilot. It has subsequently been permanently financed by monies released by the closure of the Mid Wales Hospital.

Patients eligible for the scheme are identified through discussion between CMHT members and medical staff, using broad criteria as already outlined and deciding who will benefit from this largely social model of care. At the present time there are 25 patients enrolled on the scheme, 10 men and 15 women, with diagnostic categories including schizophrenia, affective disorders, neurotic and stress-related disorders, and personality disorders.

Four carefully selected providers have been identified to provide the requisite short-term adult fostering in a nurturing and homely environment. Providers receive basic training in first aid and are police vetted and reference checked. No specific training in management of psychiatric crises is given, and no experience in caring for patients with mental health problems is required, given the relative stability of patients enrolled on the scheme. However, advice is given on how to access specialist support, should this be needed.

A contract is drawn up between the trust and providers, specifying all conditions and responsibilities and insurance liabilities. Providers are paid £31.70 per nightly stay, in line with the mental illness residential rate (2000), and an additional fee of £100 per annum as a retainer. A support worker (a full-time member of the CMHT) in regular contact with care managers is employed to liaise between individual patients, their care managers and
the providers. Careful selection of patients for the scheme and good preparation prior to actual use of the scheme largely obviates the need for specialist support for providers during each episode.

Patients identified as being suitable for the scheme are introduced to all providers by the support worker to ensure familiarity, and at this stage patients tend to express a clear choice about which provider they would like to stay with.

Although the initial intention was for the scheme to be responsive mainly at times of crisis, it has expanded to a predominantly elective facility with planned periods of care (up to 5 days maximum) as part of each patient's overall care plan, which is drawn up by the care manager in conjunction with the patient and support worker. In this respect the scheme has provided a rehabilitative

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facility, helping patients to re-learn tasks in a more homely setting.

Effectiveness of the scheme

The initial pilot scheme ran from 5 January 1999 to 5 July 1999. As the scheme was considered to be successful in its overall objective of offering an alternative to hospital for a defined patient group, it was put into permanent status from 5 July 1999.

In order to try and assess the cost-effectiveness of the scheme, actual in-patient bed use of patients on the scheme was calculated for the 2 years prior to entry to the scheme (total number of days in hospital); and compared to that following introduction of the scheme. There was found to be a significant reduction in hospital bed usage following introduction of the scheme, reducing from 241 to 14 days during the first 6 months, and from 567 to 0 for the second 6 months (there was an increase in the number of patients enrolled after the first 6 months).

Estimates of projected savings based on the assumption that rate of admission post-scheme would be the same as that pre-scheme, suggest that there may be projected savings of over £40 000 per annum. However, it is accepted that these estimates are open to question and that underlying assumptions may not be valid. However, for an individual patient using the scheme for 14 days, for example, the comparative costs would be £444 for the scheme (purely accommodation costs) and £1535 for in-patient stay. It is acknowledged that even this comparison is fraught with difficulties. The cost of the scheme is indicated in Table 1.

Table 1. The cost of the scheme (6 July 1999 to 5 January 2000)

	Cost (£)
Training of staff	50.00
Extra support of care managers @21 hours	309.00
Team leader/administration @30 hours	500.00
Extra travel to visit schemes	170.00
Support worker travel	950.60
Payments to providers for travel/meetings/ insurance/retainers	300.25
Payments to providers for accommodation (based on mental illness residential rate of £31.70).	2019.90
Support worker pay	5438.00
Total (6 months)	**9737.75**
Aggregated cost of scheme per annum	19 475.50

Comment

Early evaluation suggests that the accredited accommodation scheme might well provide a useful cost-effective alternative to admission for a group of patients with enduring mental illnesses, whose use of hospital beds is potentially quite high. However, results are described only for the first year, so must be viewed with some caution. In addition, the scheme was introduced around a time when other changes were taking place, such as a major relocation of in-patient beds, and the introduction of an extended shift system for CMHT members.

The scheme is based on clinical need, and is in keeping with recommendations of the *National Service Framework for Mental Health* (Department of Health, 1999), with the aim of ensuring a spectrum of care is available from independent living in one's own accommodation to supported housing through to hospital care. It must be stressed that the model of care described is largely social in nature, and cannot be compared to interventions offering specific and intrusive treatments such as assertive outreach or home-based treatment programmes.

Another attractive feature of the scheme is that it depends on ordinary housing stock already in existence (no new builds, purchases or adaptations required). This is of particular relevance in such a large rural catchment area, where a similar centralised facility would be much less accessible, and the possibility of more patient choice is also introduced. Indeed, patients have indicated their satisfaction with the scheme, which is seen as less stigmatising than admission to hospital, enabling patients to spend time in a supportive environment with caring and listening people who can be seen to have lives beyond psychiatric services.

There is also some evidence that dedicated staffed facilities are associated with high staff turnover, possibly relating to the stressful nature of the work (Bond *et al*, 1989). In summary, the scheme is a useful means of encouraging patient choice, destigmatising psychiatric services and supporting people towards independence and autonomy.

Clearly, the scheme will need further monitoring and evaluation. Recruitment and characteristics of providers, and their homes, and matching with particular patients' needs is an area of practice that is being refined. The expansion of patient numbers in the scheme is also planned in the near future.

References

BOARDMAN, A. & HODGSON, R. (2000) Community in-patient units and halfway hospitals. *Advances in Psychiatric Treatment*, **6**, 120–127.

BOND, G. R., WITHERIDGE, T. F., WASMER, D., *et al* (1989) A comparison of two crisis housing alternatives to psychiatric hospitalisation. *Hospital and Community Psychiatry*, **40**, 177–183.

BROOK, B. (1980) Community families: a seven-year program perspective. *Journal of Community Psychology*, **8**, 147–151.

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health – Modern Standards and Service Models*. London: Stationery Office.

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