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Highlights of this issue

Edited by Derek K. Tracy

The periodic table

Which elements constitute 'good' care (and what does that mean?). As a home treatment team (HTT) consultant, I have laboured with the reality that the HTT evidence base is not very strong. My bias is that it is an absence of evidence rather than evidence of absence, so it is good to have a couple of relevant papers in this month's *BJPsych*. Bryn Lloyd-Evans et al (pp. 314–322) report on their Crisis team Optimisation and RElapse (CORE) service improvement programme. This is predicated on the fact that there had been a lack of consensus on how HTTs 'should' operate, and CORE provides an optimised template to minimise the enormous variability. Fifteen teams received an intervention to enhance team fidelity, ten did not. The active intervention showed no improvement in the primary gain of patient satisfaction, although reduced in-patient admissions were shown. I am reminded of the challenges of *what* to measure in complex real-world services.

Stulz et al (pp. 323–330) randomised over 700 Swiss adult patients in crisis to either HTT or admission with subsequent community-based treatment as usual without HTT. As HTT was the novel intervention, only those allocated to HTT subsequently had informed consent sought. What this meant was that, for example, those randomised to the active arm but acutely suicidal or unable to consent to HTT had an initial stabilisation on a ward. Those in the active HTT arm showed a 30% reduction in hospital admission duration per patient in the 2 years following, although the mean number of admissions per patient and the average overall duration of treatment (in-patient + HTT) did not differ. I think that peer support workers (PWPs) are a potentially innovative addition to HTTs; such work is beginning to happen, but we await more data. Charles et al (pp. 301–307) systematically reviewed the broader literature on PWPs. Six thematic areas emerged: role expectations, initial training, type of contract, role extension, workplace support and recruitment. Research increasingly supports PWPs assisting empowerment, hope, relationships and recovery; this work advocates more evaluation of role modifications to optimise to specific clinical settings.

If not now, when?

Socioeconomic deprivation is a cause and perpetuating factor of mental ill health. The gap between mental health need and treatment has been estimated to be up to 50%, but this is clearly locally variable, and it has been debated how well funding maps onto more regionalised geographies. The funding model in the UK is based on what is known as weighted capitation, with separate calculations for various substreams, including mental health, that aggregate to form a clinical commissioning group budget. This is then used to commission local services. Anselmi et al (pp. 338–344) challenge this model, producing needs-weights based on demographic records of over 43 million adults in England registered with a general practitioner, to estimate individual- and area-level costs of care. They found higher costs associated with: being Irish, Black African or Caribbean, or mixed heritage; a past physical health admission; living alone or in care or communal settings; and with living in an area with greater rates of benefit payments or severe mental illness. The authors argue that their model is based upon more accurate data and has a higher predictive value than the one in current use. Utilising it would see an enormous 12% (£9 billion) of the total healthcare budget redistributed.

We are all aware of the disheartening employment figures for those with serious mental illness. 'Sheltered workshops' have been shown to have significant limitations in bridging the gap to competitive employment, with better results for 'supported employment' wherein individuals are supported and paid while they maintain or search for new positions. What has been less clear is by how much and how long this should be continued. Rössler et al (pp. 308–313) test the impact of 'placement budgets' for supported employment. A total of 116 participants were randomised to either 25, 40 or 55 h placement budgets; placements and support with a job coach continued for 2 years, and all were followed-up for a further 3 years. Interestingly, more restricted time budgets for finding work enhanced outcomes over greater levels of input. Successful employment appears most likely to occur in the first months of a search; the authors argue time restriction acts as an incentive to find work.

There are three main groupings of supported accommodation for those with complex and serious mental illnesses: residential care, supported housing and floating outreach. In the UK, about 60 000 people are so housed; however, there have been few data to support their effectiveness in 'moving on' to more independent forms. Helen Killaspy et al (pp. 331–337) prospectively followed-up over 600 participants – spread relatively evenly across the three residential groups – over 2.5 years. Just over two-fifths successfully moved on over this time, with success most common in the floating outreach group (where two-thirds did so). The authors note how very few who make this transition had subsequent hospital admissions. They contrast their findings with the typical 2-year accommodation contract most such individuals in England will get, which risks premature moving with greater rates of failure. We have good data here – will it result in the needed funding? Will Marsh writes more in this month's Mental Elf blog: https://elfi.sh/bjp-me23.

If this is a man

You're in favour of equality, not least parity of esteem between mental and physical health services, right? You no doubt cheer support for the Convention on the Rights of Persons with Disabilities. So, you agree we should not be able to detain capacitous individuals with any mental illness?. Less sure now? Paul Gosney & Peter Bartlett debate (pp. 296–300) what they call 'the most important legal instrument that no one in psychiatry ever discusses'. The Convention precludes involuntary treatment of capacitous individuals; as this only occurs in those with mental illnesses, current laws are therefore discriminatory. To stay in the Convention would be to agree to parity – and stopping such treatment in mental illness. It has certainly seemed a priority for the current government to pull the UK from a raft of international treaties, but this issue is more complex than some inane simplistic slogan like 'get Brexit done'.