Alternatives to Hospital Admission in Mental Health Crisis

The Tower Hamlets Experience

Rahul Bhattacharya
Consultant Psychiatrist. Tower Hamlets Home Treatment Team, ELFT
Honorary Senior Clinical Lecturer, Bart & The London School of Medicine

Improving Mental Health Crisis Care, Healthcare Conference UK, 8th July 2014
Outline

• Where is Tower Hamlets
• Evolution of Home Treatment Teams (HTT) and Crisis Resolution Teams (CRT) or CRHT etc.
• Evidence Base for CRT and HTT
• Crisis House- Evolution of Evidence Base
• Tower Hamlets Home Treatment Team and Crisis House- model
• Tower Hamlets Home Treatment Team- some findings
• Relationship with local acute inpatient unit
• Learning Points
Tower Hamlets
London Borough of Tower Hamlets

- Tower Hamlets population (254,100 in 2011) will continue to increase.
- Highest population growth rate (29.6% from 2001 census) seen across England and Wales
- 7th most deprived local authority district in England out of 326 local authority districts
- High Economic, Ethnic and Religious Diversity
Early models of Community Crisis Teams

- Deinstitutionalisation - Asylums closing
- Awareness of the ‘Rovolving door phenomenon’ (Re-admissions)
- First Crisis and Home Treatment Team formed in Holland 1935 (psychiatrist and SW carrying out home visits for referrals for admission)
- Worthing experiment: (UK, 1956) same as above- result in falls in admissions to two local hospitals by 55% and 79% (Carse 1958)
- ‘Crisis Team’ (Polak, 1960) -treated people in their own home when they presented in ‘crisis’; Dingleton, Scotland (Polak’s home town)- Proposed relapses were due to a change in the patient’s ‘social system’, i.e changes in their home environment.
- Polak introduced CRT to Denver, Colorado, US where it became popular in the 1970s (Polak 1976). Polak’s innovations included a team which assessed all individuals referred for admission at home and offered 24-hour home treatment whenever feasible
- Hoult visited Polak and took the idea from US to Oz
Developing Specialist Crisis Teams

- John Hoult et al in Sydney, **Australia in 1979 (Hoult 1991)** AND Stein et al in Madison, **Wisconsin, US in the late 1970s (Stein 1980)** set up team not different from current CRTs

- Both Stein and Hoult concluded that the crisis treatment function would be better **split off from continuing care** (Johnson 2008a)

- In the state of Victoria, Australia introduced a requirement for Crisis and Home treatment teams in 1994 – operating since (Johnson 2013)

- 1995, John Hoult, arrived in the UK from Australia, established the Yardley Psychiatric Emergency Team (Minghella 1998). This can be seen as the first full UK implementation of the CRT model (Johnson, 2013).

- The model was replicated in a variety of centres, e.g. Bradford and Islington, London
Spread of CRT and growth in UK

- In 2000, there was a launch of the national policy in UK in the NHS Plan (Department of Health 2000)
- This and the subsequent Mental Health Policy Implementation Guide (PIG) (Department of Health 2001) mandated the development of CRT/HTTs
- 335 CRTs across England by 2009
Crisis Resolution - Hypothesis

- Many patients and carers associated hospital admission with increased stigma (Rose 2001) – best avoided!

- Crises have important social and environmental triggers (Polak 1970). Treatment in the home allows these to be better assessed and addressed. Social Systems approach (Bridgette and Polak, 2003)

- Coping skills are most effectively applied in the context in which they have been learnt (Stein 1980). Therefore, after home treatment, recovery skills learnt are more generalisable (more effective at building resilience to cope with future crises).
HTT – Current Evidence Base-The Good

- **Improves Patient Safety:** The provision of **24 hr crisis care** was associated with the biggest fall in suicide rates Nationally: from 11.44 per 10,000 patient contacts per year before to 9.32 after (p<0.0001). (While et al 2012- looking into data nationally 1997-2006)

- **Value for Money:** 12 ‘pre- and post-CRT comparison’ studies compared outcomes before and after the introduction of an HTT/ CRT- 8 studies showed **reduced admission rates**; 4-no difference (Carpenter et al 2013)

- **Improves Patient Experience:** Overall patients like CRT/ HTT: All 7 quantitative studies report overall positive in patient experience; 1 CRT showed only a trend (not a statistically significant difference between inpatient and CRT satisfaction, Carpenter et al 2013); Johnson et al reported a highly significant difference in patient satisfaction pre- and post-CRT implementation
HTT – Current Evidence Base- Not so Good

- Compulsory admissions (detention under MHA) were NOT significantly reduced (9 studies -2 reporting a decrease, 1 -not significant; 2 no difference; and 5 reporting an increase- Carpenter et al 2013)

- Keown et al reported that involuntary admissions had increased by 64%, directly associated with a reduction of 62% in provision of beds

- Tyrer and colleagues found a higher number of deaths by suicide in an area covered by a CRT compared with another area locally that had none

- Glover et al and Jacobs and Barrenho managed to arrive at different conclusions about the effect that 24-hr crisis teams had on reducing bed numbers.
Residential Alternatives to Hospital admission

• **Family Sponsored Homes** - placement of acutely unwell patients with carefully selected families have been described (Polak and Stein and others largely in the US) - rarely used in England (1 in Wales)

• **Hybrid facilities** that offer crisis admission alongside other types of community care. Probably the best known example is the community centres in Trieste (Italy) which combine crisis beds with a comprehensive range of other services (Mezzina & Vidoni, 1995). Similar services have also been described elsewhere in Italy and in France (Katschnig et al, 1993).

• **Crisis House** - The residential alternative to admission which has been most prominent in the UK is the crisis house (Johnson 2007)
Crisis Houses – The current situation

• In 2006, **40 Crisis House services were operating in England**, offering a range of service models

• They are typically **smaller** than inpatient wards, with no more than 10 beds (Johnson et al 2009)

• Crisis houses are not ‘standard’ across England or UK

• Neither are they ‘standardised’

• ‘Dial House’ in Leeds- non-residual crisis service working 6pm- 2am
Crisis Houses – Range of Models of Care

Between two extremes:

1. Responsibility: Crisis House services sometimes admit patients under multiple teams (CRT and AOS) or act completely independently based on self-referral.

2. They may or may-not be well integrated with HTT.

3. May be run by NHS or voluntary sector.

Crisis House A

Mental Health Services Provided by NHS

Crisis House B

No integration of care-pathways

Mental Health Services Provided by NHS

HTT

HTT

3rd Sector
Despite a long history dating back at least to the 1960s, relatively little research has examined such alternatives.

**Service user satisfaction is greater** (than acute psychiatric inpatient wards) - review of predominantly US studies (Llyod-Evans et al, 2009)

**UK: Service user experiences of a women’s crisis house** - ‘crisis house staff are seen as more (compared to neighbouring hospital) informal, approachable and thought to have more time than hospital’ (Johnson et al 2004)
Crisis House – Emerging evidence

- Recent unpublished research (2012, NIHR funded) comparing 4x Crisis Houses (TAS study) and neighbouring inpatient wards (PET study) patients.
- TH Crisis House was one of the recruitment sites for the TAS study
- **Improved Patient Satisfaction at Crisis Houses** was due to improved:
  - therapeutic alliance
  - service satisfaction
  - peer support at crisis houses
- **Patients at crisis houses experienced fewer negative events.**
- There was **No significant difference in self-rated recovery** between wards and crisis houses
HTT – Strategies and Policies

- Mental health Crisis Concordant- published 18th February 2014

‘Depending on local circumstances and the evidence in JSNAs, health and wellbeing boards might choose to review: …. Whether **sufficient resources are available within the crisis care pathway to ensure patient safety, enable service user and patient choice and to make sure individuals can be treated as close to home wherever possible.**’


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

‘(ACCESS to CRT/ HTT) **local inpatient and CMHTs, and self-referrals are normally accepted** from patients and carers already known to the team. **Whether other key agencies such as GPs, social services, third sector providers and the police should be able to refer directly to the CRHT is still debated.**

- RCPsych accreditation standards in relation to HTAS 2012-13
- CORE study best practice guidance standards, 2013-14
- PIG guidelines related to NSF for HTTs
What have we been doing at Tower Hamlets?

- Benchmarking our service:
  - TH HTT was ‘Accredited’ under the RCPsych HTAS scheme- Jan 2013
  - TH HTT participated in NIHR funded CORE study and scores above the mean score- 2013

- Research and Innovation:
  - TH HTT was the site for the NIHR funded ‘Trailblazer’ project between 2008-9 and clinical practice was adapted from the project such as improved use of ‘crisis plans’ (Tan et al 2012)
  - TH Crisis House opened in 2010
  - TH HTT was one of the pilot sites for a ‘Cultural Consultation Service’ for their patients between 2010 and 2011- a National Pilot Scheme
  - Re-structuring the TH HTT team to have a clear vision ( 1/3 of team cut!)
  - Pilot site for TAS study for Crisis Houses in 2012
  - Pilot site for CORE study for Home Treatment Teams in 2013
## Trailblazer – Lessons and Changes

<table>
<thead>
<tr>
<th>Results</th>
<th>Change in Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between 2006/7 to 2008/9 crisis planning increased from 16.7-26.7% to 79.5%</td>
<td>• Discharge notification template modified to include ‘crisis plan’ section</td>
</tr>
<tr>
<td>• Patients were unaware of their crisis plans</td>
<td>• Training of staff on crisis planning</td>
</tr>
<tr>
<td>• Patients and carers felt there was a lack of communication between them and services</td>
<td>• Share Discharge notifications which included ‘crisis plan’ with patients</td>
</tr>
<tr>
<td></td>
<td>• Joint meeting with care-coordinator involving patients/ carers to share (crisis) plan at discharge from HTT</td>
</tr>
</tbody>
</table>
## Trailblazer – Lessons and Changes

<table>
<thead>
<tr>
<th>Patients Appreciated:</th>
<th>Responsive Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Flexibility</td>
<td>In 2010 opening of Crisis House in partnership with the Look Ahead</td>
</tr>
<tr>
<td>• Choice/ as an alternative to admission</td>
<td>By 2014 TH HTT is involved in facilitating discharge in 45% of inpatients (March 2014 data)</td>
</tr>
<tr>
<td>Early Discharge from inpatient care</td>
<td></td>
</tr>
<tr>
<td>In the BME consultation the importance of how the Bangladeshi community sees mental illness as a issue for the entire family as opposed to the individual was highlighted</td>
<td>• General improvement of training in dealing with diversity</td>
</tr>
<tr>
<td></td>
<td>• Albeit brief access to the Cultural Consultation Service (2010-11)</td>
</tr>
</tbody>
</table>
# Measuring Outcome: Do Patients Get Better?

<table>
<thead>
<tr>
<th>N=19</th>
<th>Mean entry</th>
<th>SD entry</th>
<th>Mean exit</th>
<th>SD exit</th>
<th>Mean diff.</th>
<th>Mean dif. SD</th>
<th>Effect size (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Honos Total Score</td>
<td>24.8</td>
<td>7.24</td>
<td>18.42</td>
<td>5.59</td>
<td>6.42</td>
<td>5.57</td>
</tr>
<tr>
<td></td>
<td>Factor 1 (2014)</td>
<td>5.31</td>
<td>2.73</td>
<td>3.94</td>
<td>2.27</td>
<td>1.37</td>
<td>1.80</td>
</tr>
<tr>
<td></td>
<td>Factor 2 (2014)</td>
<td>5.95</td>
<td>3.42</td>
<td>3.58</td>
<td>2.99</td>
<td>2.37</td>
<td>2.50</td>
</tr>
<tr>
<td></td>
<td>Factor 3 (2014)</td>
<td>6.16</td>
<td>3.00</td>
<td>4.58</td>
<td>2.17</td>
<td>1.58</td>
<td>2.29</td>
</tr>
<tr>
<td></td>
<td>Factor 4 (2014)</td>
<td>3.37</td>
<td>1.74</td>
<td>2.10</td>
<td>1.24</td>
<td>1.26</td>
<td>1.41</td>
</tr>
</tbody>
</table>
Capturing Patient Experience

Patient and Carer Feedback from HTAS and CORE projects were obtained and largely positive (more for patients than carers)

2013 pilot (n=12)

<table>
<thead>
<tr>
<th>TH HTT Service User Experience Questionnaire</th>
<th>Response Rate 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please Answer All Questions</td>
<td></td>
</tr>
<tr>
<td>1. Did you feel that your concerns were listened to by HTT staff during your episode of care with HTT?</td>
<td>Yes 11 (+ 1 x “most of them”) = 12</td>
</tr>
</tbody>
</table>
| 1. Did you understand your care plan?       | Yes 12  
|                                             | No 0             |
| 1. Were your views taken into account when your care plan was written? | Yes 12  
|                                             | No 0             |
| 1. Were your views taken into account when considering medication? | Yes 11  
|                                             | No 1             |
| 1. Were you given a contact for crisis during and at discharge? | Yes 11  
|                                             | No 1             |
| 1. Has your NHS worker checked how you are getting on with your medication? | Yes 11  
|                                             | No 1             |
| 1. Did you have contact for crisis when you were being cared for by HTT? | Yes 12  
|                                             | No 0             |
| 1. Has someone discussed the availability of psychological/talking therapy with you? | Yes 9  
|                                             | No 2             |
|                                             | Not Applicable 1 |
| 1. Have you had a joint meeting at discharge? | Yes 7  
|                                             | No 2             |
|                                             | Not Applicable 3 |
| 1. When is the last time you had someone to one time whilst under care of the HTT? | 7 x On day of discharge  
|                                             | 1 x 3 days ago   |
|                                             | 4 x no response  |
| 1. Did you feel your views taken into account during your care with HTT? | Yes 11  
|                                             | No 1             |
| 1. Did you have trust and confidence in the professionals seeing you while you were with HTT? | Yes 11  
|                                             | No 1             |
| 1. Overall rating of care your received from HTT? | 5 4 3 2 1 0 0 0 | 5 x no rating given |
|                                             | Good 7 Average Poor 5 x no rating given |
Crisis House Service User Feedback

- Total CH admission over the 1st 27 months - 148
- Total CH service users given survey – 118
  (30 or 17% unplanned discharges, including emergency admission to mental or acute hospital settings/ disengagement etc.)
- Feedback forms received – 75 (63.5% response rate)
Results – Thematic Analysis

- Positive: 81%
- Ambivalent: 15%
- Negative: 4%

Customer service, staff support and service user involvement
Results – Thematic Analysis-2

Complaints

- Staff: 84%
- Service: 7%
- Rx: 7%
- Nil: 2%
Results – Thematic Analysis - 3

Overall Comments
Aim to provide an Equitable Service

- TH HTT works with working age adults from the age of 18 years with no upper age limit.
- TH HTT has good relationships with the Learning Disability Service.
- Open to referrals from 16-18 year olds (from CAMHS to offer brief period of home nursing).
- The ethnic break-up of the TH HTT case load is not far from the ethnic break up of the local population.
Ethnicity Breakdown of TH Crisis House patients
(2012 audit - 27 months of Crisis House – 148 admissions)
Ensure Safe and Responsive Communication

In 2011 TH HTT introduced a single page discharge notification (Initial Discharge Notification or IDF) aiming to deliver this within 24 hours of discharge of patients from the service (review of Jan – June 2013)
Developing a clear model: CRT or HTT?

- Potential conflict between the goals of ‘crisis team’ which aims as responsiveness with ‘home treatment’ where the focus is to offer an alternative to hospital admission.
- Not everyone in crisis needs or wants to be seen at home.
- Not everyone who needs to be seen at home is in crisis – facilitating discharges from hospital.
- Gate-keeping and facilitating discharge functions aim to offer alternatives to hospital admission.
CRT or HTT?

- **Crisis intervention team** is theoretically rooted in crisis intervention theory and Social Systems model to a broad range of psychosocial crises, **NOT necessarily as an hospital admission** (Johnson 2013).

- Potentially Crisis intervention services that do not work on offering an alternative to hospital admission the focus may drift towards mainly recruiting a ‘worried well’ population who **might not otherwise be seen by secondary mental health services** (Katschnig 1991).

- In TH HTT with the re-structuring in 2011, we decided to focus on offering an **alternative to acute inpatient hospital admission**.
Mental Health Crisis

Level 1: General population

Filter 1: Illness behaviour

Level 2: Psychiatric disorder in primary care

Filter 2: Recognition by primary care clinician

Level 3: Conspicuous psychiatric morbidity

Filter 3: Referral to specialist care

Levels 4 and 5: Specialist care

TH HTT and Crisis House

Inpatient Care

PICU
Who Are we seeing?

HTT Case load by Cluster (n)

[Bar chart showing case load distribution by cluster number, with peaks at clusters 12 and 13.]
Inpatient Occupancy as a marker of effectiveness of providing a true alternative

TOWER HAMLETS YTD OCCUPANCY

Ref: Do the right thing: how to judge a good ward RCPsych OP79 (2011)
Offering an alternative to hospital care? (1/8/2012 – 31/7/2013)

3. TOWER HAMLETS

3.1 Graphs by week (vertical axis shows number in a given week)
Helping people come out of hospital quickly

(Feb-March 2014)

<table>
<thead>
<tr>
<th>Total Discharges</th>
<th>Facilitated Discharges</th>
<th>% Discharges Facilitated</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>47</td>
<td>55</td>
</tr>
</tbody>
</table>
TH HTT and CH Provide Value for Money

Mean Length of stay for hospital nationally - 32 days; therefore mean cost of an episode of inpatient admission is – 304x32 = £9728

TH Mean Length of Stay - 29.5 days; average cost of episode of inpatient care = 314x29.5 = £9263

TH HTT Cost per episode reduced from - £3,235.10 (2009) to £3,156.02 (2011)
What Does this all mean?

- Bed Management is complex and multifactorial
- We found that following the re-structuring of TH HTT and the opening of the Crisis House there was a reduction in inpatient bed day usage (Occupancy)
- Average length of stay reduced from 56 (2008-9) to 36 days (2012-13) to 29.5 days at present (April 2014)
- Better ward environment; reduced violence on the wards; better staff morale
Can all this be something else?

- **CMHTs** were re-structured with front end consultant delivered **GP facing** services with **single point of entry**

- **Continuity of care** between community and inpatient units (not functionalization)

- There was also more proactive **management of** ‘placements’ and inpatient ‘**delayed discharges**’ by a dedicated re-settlement team.

- Tower Hamlets also had a pre-existing separate local psycho-social service (not offered at home) the **Crisis Intervention Service Team**.
Summary

1. CRT/ HTT reduce suicide (Improve Patient Safety)

2. Patients like CRT/ HTTs and Crisis House as they offer a better environment, reduce stigma and offer choice (Patient Experience)

3. From TH HTT the evidence is that an integrated HTT with Crisis House is clinically effective, reduces bed use and is cheaper (Effective and Value for Money)

4. HTT/ CRT do not impact on detention

5. CRTs and HTTs are similar but there are differences
Questions?

“No, you back off! I was here before you!”