Mental Health Crisis in Secondary Care

The Tower Hamlets Experience

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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
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).
• 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.’

• RCPsych - Guidance for commissioners of acute care – inpatient and crisis home treatment (2013)

‘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
Spread of CRT and growth in UK

- Polak set up Crisis services in Scotland and took it with him to US; Hoult visit him there and introduced it to Australia and later brought it to London, UK (1960s to 1995)

- In 2000, there was a launch of the national policy in UK in the NHS Plan (Department of Health 2000)- Policy Implementation Guide (PIG) (Department of Health 2001) mandated the development of CRT/HTTs

- 335 CRTs across England by 2009
HTT – Current Evidence

Base - The Good

• **Improves Patient Safety:** 24 hr crisis care was associated with reduction of 2 suicides / 10 000 patient contact per year (from 11.44 per 10 000 to 9.32 after (p<0.0001). (While et al 2012 - looking into data nationally 1997-2006)

• **Improves Patient Experience:** Overall patients like CRT/ HTT: (Carpenter et al 2013); (Johnson et al reported a highly significant difference in patient satisfaction pre- and post-CRT implementation)

• **Value for Money:** most studies have shown reduced admission rates to inpatient units- HTT/ CRTs are cheaper than hospital admission (Carpenter et al 2013)
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.
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
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 - alternative to hospital admission / patient choice
  - 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; CORE study for HTT in 2013
  - Initiation of Clozapine Titration at crisis house (QI initiative/alternative to hospital)
Crisis Houses – Range of Models of Care

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.

Between two extremes:

Crisis House A
- Mental Health Services Provided by NHS
- No integration of care pathways
- 3rd Sector

Crisis House B
- Mental Health Services Provided by NHS
- HTT
- 3rd Sector
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:
- Better therapeutic alliance
- Better service user / patient 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.
The TH HTT and Crisis
House Model

1. An **integrated HTT and CH model** offers an effective alternative to hospital admission. CMHT/ Specialist team as **Single Point of Entry**

2. Pitching the service at the right level: **Clear vision - role of HTT and CH** offering an alternative to hospital admission or facilitating early discharge

3. **Positive Risk taking** and **collaborative crisis planning** with patients

4. **Early senior clinical and medical review** and decision making

5. Ensure **throughput to allow a manageable case load**

6. **Joint working** with other teams including joint visits at **assessment and discharge** where appropriate and possible to allow safe handover of care and better patient experience.
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)
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)
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>
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)
## 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 <strong>crisis planning</strong> increased from 16.7-26.7% to 79.5%</td>
<td>• <strong>Discharge notification template modified to include ‘crisis plan’ section</strong></td>
</tr>
<tr>
<td>• Patients were unaware of their crisis plans</td>
<td>• <strong>Training</strong> 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>• <strong>Share Discharge notifications which included ‘crisis plan’ with patients</strong></td>
</tr>
<tr>
<td>• Joint meeting with care-coordinator involving patients/ carers to share (crisis) plan at discharge from HTT</td>
<td></td>
</tr>
</tbody>
</table>
Measuring Outcome: Do Patients Get Better?

<table>
<thead>
<tr>
<th>N=19 2014</th>
<th>Mean entry</th>
<th>SD entry</th>
<th>Mean exit</th>
<th>SD exit</th>
<th>Mean diff.</th>
<th>Mean diff. SD</th>
<th>Effect size (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Honos Total Score</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>24.84</td>
<td>7.24</td>
<td>18.42</td>
<td>5.59</td>
<td>6.42</td>
<td>5.57</td>
<td>0.99</td>
<td>(0.31, 1.66)</td>
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<tr>
<td><strong>Factor 1 (2014)</strong></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5.31</td>
<td>2.73</td>
<td>3.94</td>
<td>2.27</td>
<td>1.37</td>
<td>1.80</td>
<td>0.54</td>
<td>(-0.11, 1.19)</td>
</tr>
<tr>
<td><strong>Factor 2 (2014)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.95</td>
<td>3.42</td>
<td>3.58</td>
<td>2.99</td>
<td>2.37</td>
<td>2.50</td>
<td>0.74</td>
<td>(0.07, 1.39)</td>
</tr>
<tr>
<td><strong>Factor 3 (2014)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.16</td>
<td>3.00</td>
<td>4.58</td>
<td>2.17</td>
<td>1.58</td>
<td>2.29</td>
<td>0.60</td>
<td>(-0.05, 1.25)</td>
</tr>
<tr>
<td><strong>Factor 4 (2014)</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3.37</td>
<td>1.74</td>
<td>2.10</td>
<td>1.24</td>
<td>1.26</td>
<td>1.41</td>
<td>0.84</td>
<td>(0.17, 1.50)</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)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Rate</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you feel that your concerns were listened to by HTT staff during your episode of care with HTT?</td>
<td>12</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>1. Did you understand your care plan?</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>1. Were your views taken into account when your care plan was written?</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>1. Were your views taken into account when considering medication?</td>
<td>12</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>1. Were you given a contact for crisis during and at discharge?</td>
<td>12</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>1. Has your NHS worker checked how you are getting on with your medication?</td>
<td>12</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>1. Did you have contact for crisis when you were being cared for by HTT?</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>1. Has someone discussed the availability of psychological/talking therapy with you?</td>
<td>12</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>1. Have you had a joint meeting at discharge?</td>
<td>12</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>1. When is the last time you had someone to one time whilst under care of the HTT?</td>
<td>12</td>
<td>7 x On day of discharge</td>
<td>1 x 3 days ago</td>
</tr>
<tr>
<td>1. Did you feel your views taken into account during your care with HTT?</td>
<td>12</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>1. Did you have trust and confidence in the professionals seeing you while you were with HTT?</td>
<td>12</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>1. Overall rating of care your received from HTT?</td>
<td>12</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

#### 2013 pilot (n=12)
‘In modern services, the ultimate arbiter of the success of treatment should be the service user.’ (Slade 2012)

From October 2014 TH HTT would attempt to collect Patient reported outcome measures (PROM) using a locally developed tool DIALOG
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

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

Complaints

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

Overall Comments

- Positive Staff Impact: 35%
- Negative Staff Impact: 3%
- Fears of Relapse/Concerns of Moving On: 15%
- Overall Gratitude: 9%
- Complaints: 6%
- Ambivalent: 32%
TH HTT and CH Provide Value for Money

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>5 Beds</td>
<td></td>
<td>373</td>
<td>304 (2011 – no ref cost since)</td>
</tr>
<tr>
<td>7 Beds</td>
<td></td>
<td>266</td>
<td></td>
</tr>
<tr>
<td>10 beds (current)</td>
<td></td>
<td>186</td>
<td></td>
</tr>
</tbody>
</table>

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

- TH Mean Length of Stay- **29.5 days**; average cost of episode of inpatient care = **314 x 29.5 = £9263**

- TH HTT Cost per episode reduced from- **£ 3,235.10 (2009)** to **£3,156.02 (2011)**
Quality Improvement

- Evidence based care; Improve patient safety and experience
- ELFT QI initiative with strategic focus on harm reduction and providing right care
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/CRTs DO NOT reduce detentions under MHA

5. CRTs and HTTs are similar BUT not the same!
Debate?

- **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**
Whole System View

- Bed Management is complex and multifactorial

- **Better ward environment**: reduced violence on the wards; better staff morale

- 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**.

- Tower Hamlets pilots national pilot of Psychiatric Police Liaison service (NHS England funded)
Innovations and sharing good practice:

- What works in Mental Health (NHS England)
- Research (CORE/ TAS/ Trailblazer)
- Partnerships work!

www.crisiscareconcordat.org.uk
Questions?

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

Thank you...