Crisis care in England and Wales: evidence and implementation

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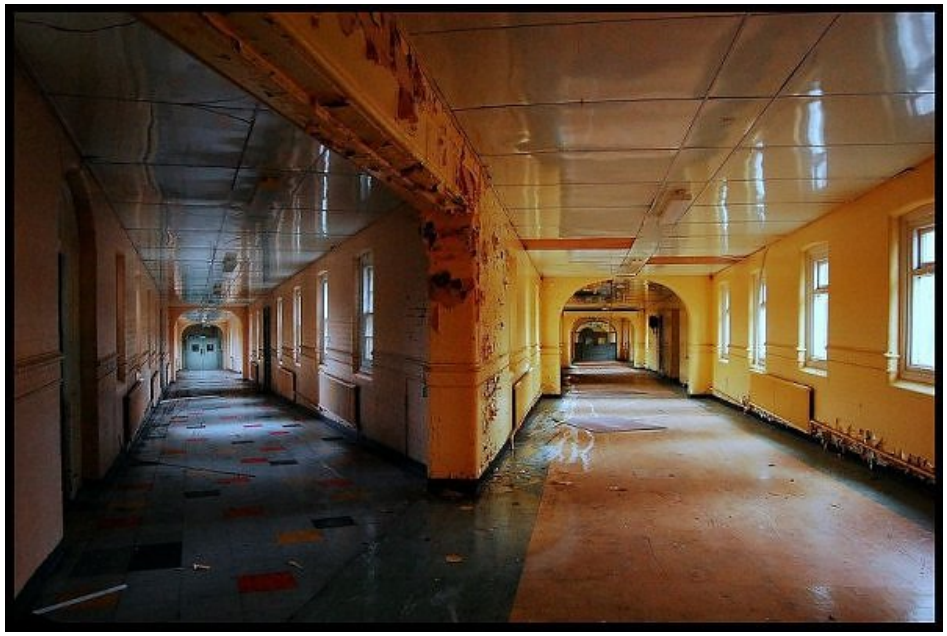
Outline

- Deinstitutionalisation and acute care in the UK
- Evidence on effectiveness and implementation of Alternatives to admission in the UK
- The CORE Study: a national programme to improve Crisis Resolution Team implementation

30 years of UK Asylum closures



Corridors at High Royds asylum, Yorkshire

109/127 asylums closed by 2013

Most people who would previously have been long stay asylum residents live uneventfully in community most of time and prefer to do so.

Concerns about UK acute inpatient wards

- Patient-patient and patient-staff aggression
- Traumatization experiences
- Limited therapeutic content
- Intense social contact exacerbating acute psychosis
- Loneliness through separation from social networks/ loss of community tenure/ loss of job/ welfare benefit problems
- Stigmatization in the community of origin
- Acquisition of drug habits/ contacts

Alternatives to acute admission

What are the alternatives?

Crisis Resolution/Home Treatment Teams

Crisis Houses/Residential alternatives

[Day Hospitals]

Potential Benefits

- More flexibility/choice for patients
- Retention of work, social welfare etc.
- Cost savings of reduced bed usage
- Recovery aided by resources in social network/context
- Opportunity to learn skills for coping with future crises

Crisis houses and other residential alternatives to admission

- Lit review of earlier studies suggests high satisfaction
- Alternatives Study (UCL/KCL): 131 services found: around 10% acute beds in England are in ‘alternatives’
- Spectrum from hospital-like with clinical staff to more explicitly alternative voluntary sector
- CORE survey – 25% of areas have them. Most are new, small and local.

Findings from crisis houses (Alternatives Study)

Compared with acute wards, crisis houses have:

- Very similar clinical population, but longer histories and less risk of violence in community alternatives
- Shorter stays and lower costs
- Less improvement during stay, but no greater readmission over subsequent year
- Significantly greater service user satisfaction even though content of care, contact time similar.
- **Still lacking:**
- Randomised controlled trial evidence
- More conclusive evidence as to how far they admit people who would otherwise be on acute wards.

Crisis resolution and home treatment teams

Mandatory in England 2001-2010 (NHS Plan)

Not much contemporary evidence when introduced.

Intended to:

Operate 24 hours

'Gatekeep' all acute admissions aged 18-65: no one admitted without their agreement

Visit intensively for limited period: 3-6 weeks

Deliver range of medical, psychological, social interventions to resolve crisis

UCL findings on crisis teams

Two studies

South Islington study – natural experiment comparing a cohort of crises before vs. after introduction of a crisis team N=200 (Johnson et al. 2005a)

North Islington study – **randomised controlled trial** comparing crisis team availability vs. standard care N=260 (Johnson et al., 2005b)

Findings

- **Reduction in admissions and bed use. Costs also less.**
- **Greater client satisfaction with crisis team**
- **No difference in compulsory admissions or any other outcome**

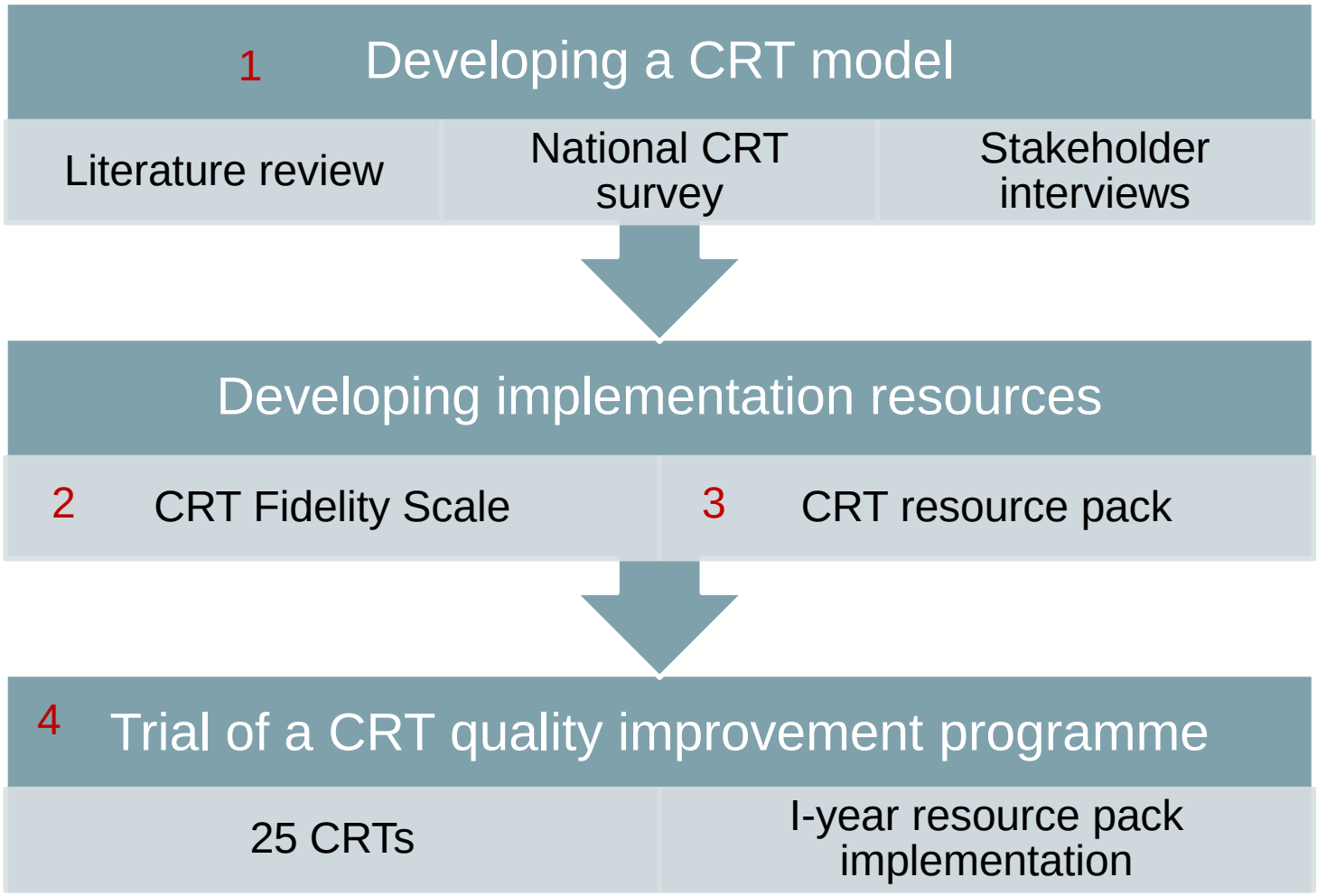
Workforce studies: Happy staff

CRT implementation in England 2000-2014: the wider picture

- Reductions in admissions and good satisfaction where model implementation is well resourced.
- **But** national data suggest little decline in overall admission rates/bed use.

- Compulsory admissions not reduced
- Some negative feedback from service users e.g. to MIND national enquiry on acute care
- Reports of large variations between areas in nature and quality of care.

The CORE research programme – specifying and optimising the CRT model 2011-2016



CORE Stage 1 – Developing an evidence base for a Crisis Team Fidelity Scale

Development work:

- CRT literature review – evidence from any type of study or guideline on ingredients of effective care
- CRT managers' survey – to define the current range of CRT practice in UK, explore managers' views & priorities
- CRT stakeholder interviews to obtain service user, carer, expert & clinician views of optimal practice

National Survey of CRTs 2013

- Responses from 88%
- Recognisable crisis team model in most areas.
- Departures from original model:
  - Majority include >65 years, PD,
  - Minority implement gatekeeping fully
  - Most do not visit at night
  - Most deliver medication, generally x2 daily. Around half say they provide brief psychological interventions, few provide practical social interventions

CORE Study Stage 1 – Qualitative interviews

- Good consensus between clinicians, service users and carers on *optimal* crisis care
- In practice:
  - Service users value treatment at home
  - …but complain of brief visits with too much focus on medication
  - Other interventions limited, including work with families
  - Lack of continuity of care problematic
- Impediments to good practice: lack of resources, lack of staff skills & training, blocks in system as a whole, pressures to work beyond core remit

CORE study stage 2 – Development of a fidelity scale

- Stage 1 work used to generate 232 potential statements about crisis team best practice
- Concept mapping process (Ariadne software) with 68 participants in London and Oslo – service users, clinicians, researchers
- Reduced to 39 items in 4 domains
- Piloted in 75 teams nationwide

Item 22

Prioritising good therapeutic relationships

Target

a) Recruitment involves procedures explicitly designed to identify staff with good interpersonal skills when working with service users.

b) The CRT takes steps to monitor and develop all CRT staff's interpersonal skills with service users and families.

c) The CRT explicitly seeks feedback from service users (e.g. via survey or audit) within the last year and demonstrates action to address resulting concerns and complaints.

d) There is all source agreement that staff are caring and professional in working with service users and families.

Why this is important

5: All criteria are met
4: Criterion D is fully met and 2 other criteria are met
3: Criterion D is fully met but fewer than two other criteria are met
2: Criterion D is partially met
1: Criterion D is unmet

CORE stage 3

- Development of an online resource kit to improve fidelity.
- So to improve therapeutic relationships…

Ways of doing this well

Several services have shared ideas about how to improve therapeutic relationships with service users.

Recruitment

West Kent CRHT have a whole day interview process with group and individual sessions, and include service users and carers on their interview panel. The document below describes how this approach works and the beneficial impact it has had on recruitment:

- West Kent CRHT case study (.doc)

Brighton and Hove CRHT use the following interview questions when they interview for Band 5 staff.

- Brighton and Hove CRHT Band 5 Interview Questions (.doc)

For Band 6 roles they ask candidates to prepare a 15 minute presentation based on a case study, and ask similar interview

Service user feedback

Edinburgh Intensive Home Treatment Team provide a service user satisfaction questionnaire to service users being discharged from the team.

- Edinburgh IHTT Service User Satisfaction Questionnaire (.doc)

Caring and professional staff

To encourage staff to think about how they interact with service users, the Barking HTT uses their Trust's Staff Charter, which sets out the values and behaviour they expect of staff.

- Barking HTT Staff Charter (NELFT) (.doc)

Field mentoring

Senior members of staff in the CRT can sometimes provide the most effective guidance to more junior staff members by accompanying them on visits and providing constructive feedback on how the staff members worked with service users. This can allow a focus on the actual behaviour of the staff member and their ability to develop good therapeutic relationships.

CORE stage 4 underway

- RCT comparing 25 teams receiving Resource Pack vs. 15 without
- Outcomes: admission rates, patient experience, staff morale

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More information:
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Conflict of Interest Disclosure

	Speakers & Planning Committee	Company/Organization	Details
A	I am a member of an Advisory Board or equivalent with a commercial organization.	NONE	
B	I am a member of a Speaker bureau.	NONE	
C	I have received payment from a commercial organization. (including gifts or other consideration or 'in kind' compensation)	Eli Lilly	**Payment for license to use product.**
D	I have received a grant(s) or an honorarium from a commercial organization.	NONE	
E	I hold a patent for a product referred to in the CME/CPD program or that is marketed by a commercial organization.	NONE	
F	I hold investments in a pharmaceutical organization, medical devices company or communication firm.	NONE	
G	I am currently participating in or have participated in a clinical trial within the past two years.	Otsuka Pharmaceutical Development & Commercialization	**Local Investigator for Phase 3 Open-label study of depot anti-psychotic medication.**
H	**Other potential conflict of interest: NONE**		