

What can crisis houses contribute to the acute care system?

Sonia Johnson, Angela Sweeney, Sarah Fahmy, Nicola Morant, Emma Burgess, Mike Slade, Zoe Fox, Fiona Nolan, Rose McCabe, David Osborn, Helen Gilbert, Brynmor Lloyd-Evans

UCL

Kings College London
University of Exeter

Plan

- Crisis houses – history and definition
- Distribution in UK (CORE study)
- Characteristics and outcomes (Alternatives study)
- Therapeutic alliance & service user satisfaction (TAS 2 study)
- What can crisis houses contribute to an acute care system?

Why look for alternatives to acute admission?

- More flexibility/choice
- High cost of inpatient care – resources might be better spent on initiatives to improve recovery
- Dissatisfaction with hospital environment among service users and staff
- Stigma associated with becoming an inpatient
- Doubts about therapeutic effectiveness of hospital
- Greater access to social network/context when crisis managed in community

Crisis houses



- Residential alternatives to admission
- 24 hour staffing, community setting
- Spectrum from hospital like to user-led and more genuinely alternative (but radical models rare in UK)
- Often advocated, rarely policy
- UK provision (2012-14) – 25% of areas have access to at least one
- Tend to be integrated with local acute catchment area services
- May be managed by crisis team leaders
- Some areas – extensive use for hospital transfers
- Mixture of statutory and voluntary sector provision
- Worldwide – many examples from 1950s, not usually standard

The Alternatives Study (2006-2011)

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
- Better service user satisfaction even though similar interventions, time spent with service users.



Stakeholder views of the role of crisis houses in the system

- Not identical in function to acute wards, but overlapping
- Take pressure of acute wards in various ways – some diversions, some shorter admissions, some crises pre-empted
- Work best with good relationships with rest of system, clear sense of role & limitations
- People would always like them to do more

The Alternatives Study 2 (TAS 2: 2011-13)



4 crisis houses, 16 inpatient wards – inner London Trusts
Service user researchers collected most data

Quantitative:

Hypotheses:

- Is therapeutic alliance stronger in crisis houses than acute wards?
- How far could stronger therapeutic alliance account for better satisfaction?

Qualitative:

What do acute service users want from relationships with staff?

Satisfaction, therapeutic alliance and other measures of patient experience in crisis houses and acute wards.

Measure		Crisis houses N = 108	Acute wards N = 247
Satisfaction: CSQ total	mean (95% CI)	27.5 (26.6, 28.3)	21.0 (20.2, 21.8)
Therapeutic alliance: Average STAR	mean (95% CI)	37.2 (35.5, 38.8)	28.3 (27.1, 29.5)
Therapeutic alliance: General STAR	mean (95% CI)	36.5 (34.7, 38.2)	25.6 (24.2, 27.0)
Recovery: RAS total	mean (95% CI)	102.3 (97.2, 107.4)	120.9 (117.1, 124.8)
Informal peer support: Adapted IPR total	mean (95% CI)	68.4 (65.5, 71.3)	57.1 (54.9, 59.3)
Negative events committed by service users weighted by impact: NES-P	median (IQR)	0 (0, 3)	3 (1, 8)
Negative events committed by staff weighted by impact: NES-S	median (IQR)	0 (0, 2)	3 (0, 9)

doi:10.1371/journal.pone.0100153.t002

Sweeney A, Fahmy S, Nolan F, Morant N, et al. (2014) The Relationship between Therapeutic Alliance and Service User Satisfaction in Mental Health Inpatient Wards and Crisis House Alternatives: A Cross-Sectional Study. PLoS ONE 9(7): e100153. doi:10.1371/journal.pone.0100153

<http://www.plosone.org/article/info:doi/10.1371/journal.pone.0100153>

Multivariable model for client satisfaction

	Regression coefficient	P =
Crisis house vs. ward	-1.38 (-3.16, 0.4)	0.12
Therapeutic alliance score (STAR)	2.19 (1.39, 2.98) Per 10 units	<0.0001
Informal peer support	0.5 (0.08, 0.92) Per 10 units	0.02
Detained under MHA	-1.26 (-2.72, 0.19)	0.09
Past admission	0.28 (-0.84, 1.4)	0.61
Negative events on ward	-0.35 (-0.52, -0.18)	<0.0001
Gender, age, diagnosis ethnic group – also included and non-significant		

Qualitative findings: What do service users want from their relationships with staff?

Basic human qualities

- Lie at the heart of all positive therapeutic alliances
- Caring, warmth, kindness, honesty, trusting and trustworthy, non-judgmental, genuine, calm, sense of humour
- Small things valued – how was your day?
- More important than physical environment/facilities

Interviewer: When they're being really nice, what kind of things might they be doing or saying?

Um, just when I ask for things they'll be getting me things, sometimes coming up to me asking how my day is and how am I getting on and stuff like that.

Interviewer: And how does that feel when they come up to you...?

It feels that you're, you're important, yeah, and you've got a reason for being in here.

Acute ward service user

What do service users want from their relationships with staff?

A vocation, not just a job

Service users value dedicated staff members: compassionate, go out of their way to help – particular people sought out.

Staff who try to understand service users as individuals

“Professionalism Plus”:

Professional qualities valued (dependability, respect, clear communication, keeping to their word) but insufficient without strong interpersonal skills and attributes.

Recovery & hope

“If someone's really positive about your recovery it's so reassuring and gives you hope as well because sometimes the thing you need more than anything in these places is hope.”

And what they don't want

- Staff who are simply doing a job:
 - uncaring, going through the motions, don't make time for people, get to know them or engage in small talk.
- Or more 'actively negative'
 - e.g. belittling, patronising, confrontational, not treating as adult
 - Described in both acute wards and crisis more associated with acute wards

Sometimes, ah, certain members of staff, they can be a bit difficult... because of their attitude; they don't have the right attitude for the job, really. They're supposed to be a carer, and the guy doesn't care. He just cares about himself; he doesn't care about the people, he just wants to get his money and go home. He wants to keep his job, basically, but makes your life hell while he's doing it.

Acute ward service user

Autonomy and responsibility

- Loss of freedom, pressure to negotiate for basic liberties experienced by both detained and voluntary patients
- Loss of autonomy as an adult – need to ask for basics like a cup to make tea
- Very marked effect on dynamics of relationship – significant impediment to warm relationships from staff and patient perspectives
- But staff taking responsibility necessary at times.

I think the ward atmosphere can feel a bit like being inside a pressure cooker, and, um, if you don't have the freedom to get out, it can lead to explosions.

What do crisis houses add to acute care systems?

- Valued where they are available by both service users and referrers
- Complement crisis teams by offering peer support, social contact, more extensive staff contact
- Strengths – warm relationships, time to talk, less loss of liberty and autonomy
- May be good for particular clinical groups
- But still not clear how much impact on admissions
- Likely to be best as part of acute care system offering flexibility and choice

This presentation includes independent research undertaken as part of the TAS2 study, funded by the National Institute for Health Research (NIHR) under its Health Services and Delivery Research Programme (project number 09/144/50). The views expressed are those of the author and not necessarily those of the NHS, the NIHR or the Department of Health.

Thanks to: many participating service users and staff