

# **Designing mental health services for people in crisis: evidence, practice and policy**

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# Plan

- The NHS's struggle with the delivery of acute mental health care
- How successful has the English crisis team policy been?
- CORE study: an approach to service improvement for crises
- Findings regarding current crisis team fidelity
- What more can we do?

## Achievements (1) Asylum closures



Corridors at High Royds asylum, Yorkshire

109/127 asylums closed by 2013

TAPS study (Leff, Thornicroft et al): Few adverse outcomes for resettled residents

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

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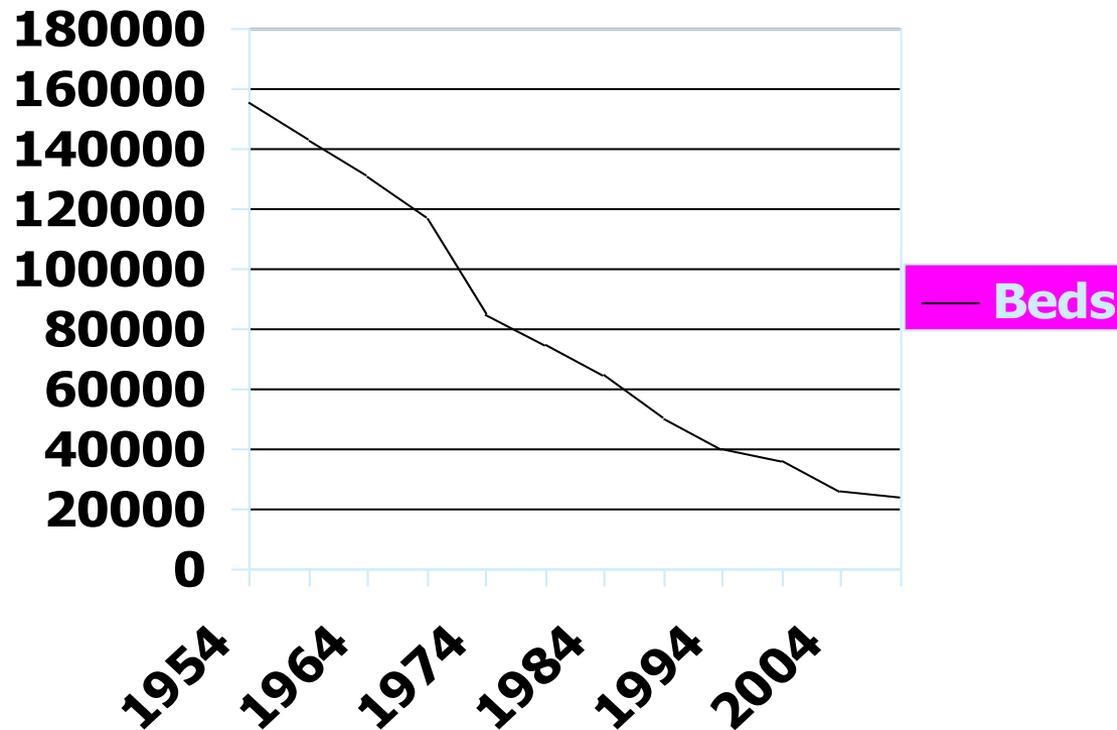
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# Achievements (2) Decline in overall bed numbers without significant danger to public



# The struggle to meet acute care needs in England

- **Late 1990s** – “**Crisis in acute care**”: >100% bed occupancy, overspill into private beds, long journeys for care, patient and staff dissatisfaction.
- **From 2000** National mental health care policies – crisis teams, assertive outreach, early intervention mandatory
- **2015** – “**England’s mental health services in crisis**” >100% bed occupancy, overspill into private beds, long journeys for care, patient and staff dissatisfaction

# NEWS HEALTH

16 October 2013 Last updated at 00:15



## England's mental health services 'in crisis'

By Michael Buchanan

BBC News

**The mental health service in England is in crisis and unsafe, says one of the country's leading psychiatrists.**

Dr Martin Baggaley, medical director of the South London and Maudsley NHS Trust, spoke out as an investigation by BBC News and **Community Care** magazine reveals more than 1,500 mental health beds have closed in recent years.

Many trusts have all their beds filled.

Care Minister Norman Lamb said the current situation was "unacceptable" and provision must improve.

While there was a drive to treat more people in the community, he said beds must be available when patients needed them.

### System 'inefficient, unsafe'

Freedom of Information requests were sent to 53 of England's 58 mental health trusts, by BBC News and Community Care, and 46 trusts replied.



Care Minister Norman Lamb; "I know there are problems and I am absolutely determined that we address them"

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## Acute care in 2015



- At least 9% reduction in beds: 2011-2014
- No new investment in community services
- More people in mental health service system despite policies focused on reducing dependence
- Current debates:
  - Why is there a bed crisis despite national policies to develop community care?
  - Do we just need more beds OR is there still scope to increase the effectiveness and availability of community alternatives?

social care professionals and policy makers.

Five main themes have emerged:

- 1 The so-called bed or admission crisis is very significantly a problem of discharges and alternatives to admission and can only be addressed through changes in services and the management of the whole system.
- 2 There is a spectrum of pressure and performance ranging from units with demoralised staff who are trapped in a constant process of crisis management to those where staff work purposefully to deliver high quality care and services.
- 3 Although the Commission heard many positive stories of care, it is clear that many patients and carers feel disenfranchised and excluded. There is a need for greater engagement and implementation of best practice.

*Royal College of Psychiatrists, 2015*

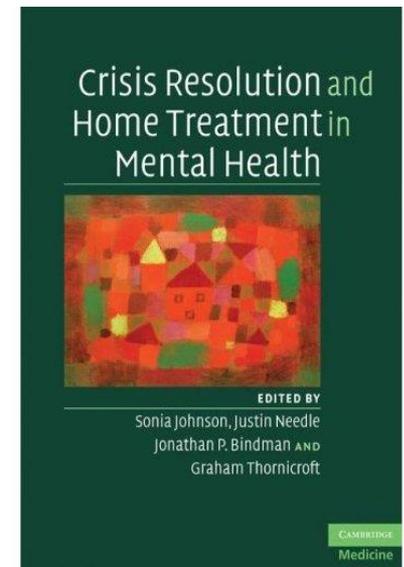
The Commission to review the provision of acute inpatient psychiatric care for adults



Improving acute inpatient psychiatric care for adults in England

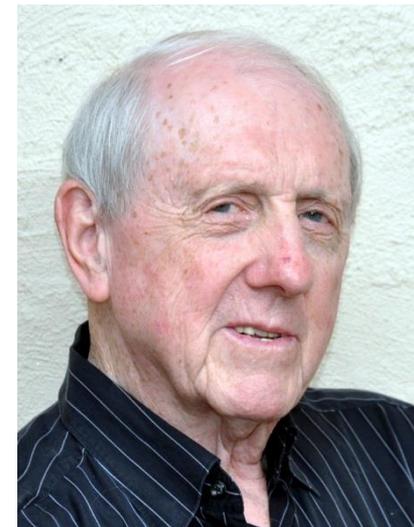
# Crisis resolution and home treatment teams

- Central to England's policy for addressing acute care crisis of 1990s
- Separate specialist teams – 24 hours, short term engagement at brink of admission
- Precursors since 1960s in USA, Australia, Canada, England
- 2001: NHS Plan – crisis teams, assertive outreach, early intervention mandatory
- Much debate – too much fragmentation? Too little evidence?
- Internationally – followed only by Norway



## The rationale for crisis teams

- Hospital admission is expensive, stigmatised and unpopular, better to be able to invest resources elsewhere
- Therapeutic relationships stronger and more equal on patients' home ground
- Social networks can be mobilised more effectively
- Working in community makes social triggers to crisis more visible
- Skills learnt for coping with crisis in community
- *Open Dialogue* of the 1990s?



# Crisis resolution and home treatment teams: key features

Intended to:

Operate 24 hours

Focus only on people at risk of admission

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

Use assertive engagement strategies to prevent admission

Visit intensively for limited period: 3-4 weeks

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

Strong focus on network – systems meetings to address social triggers, mobilise network



# BMJ

27 September 2020



## Crisis resolution teams keep people at home

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# UCL findings on crisis teams in Islington

## Two studies

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

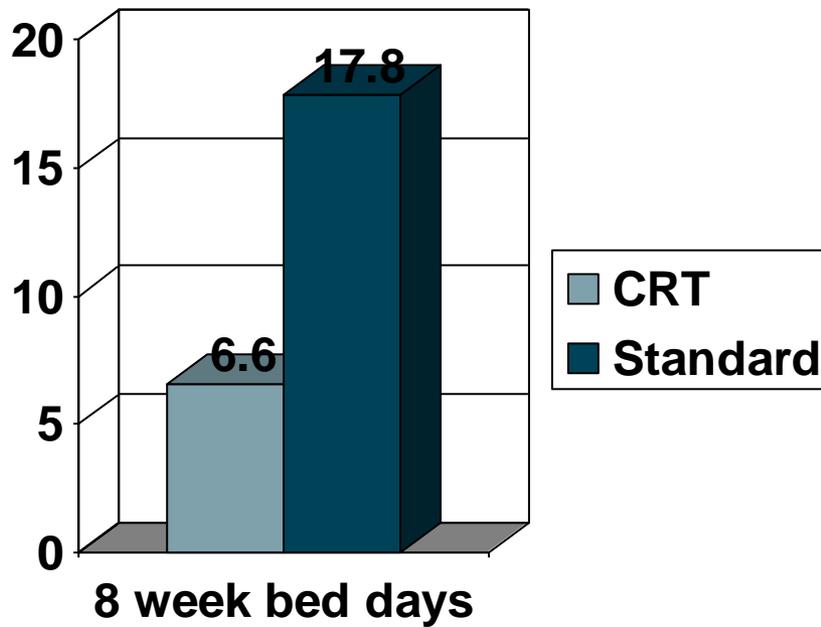
North Islington study – **randomised controlled trial** comparing crisis team availability vs. standard care N=260 (Johnson et al., 2005b)

## Findings

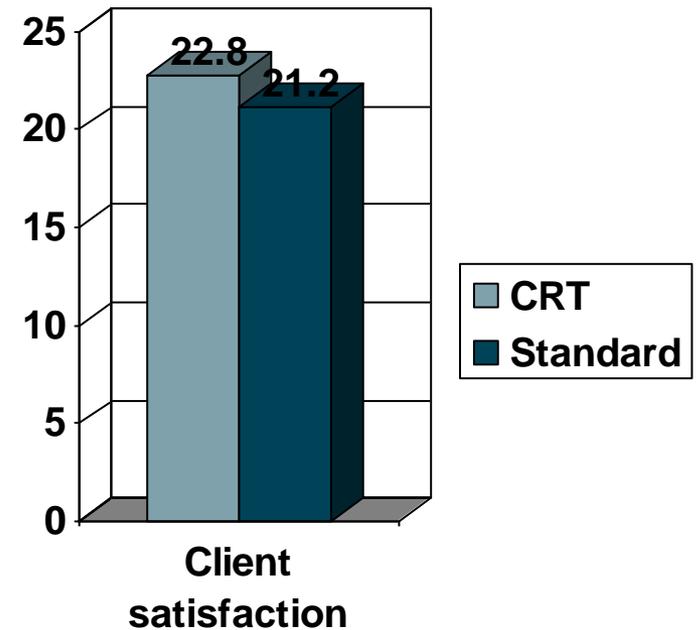
- **Reduction in admissions and bed use. Costs also less.**
- **Greater client satisfaction with crisis team**
- **No difference in compulsory admissions or any other outcome**

**Workforce studies:** Happy staff

# Primary outcomes of North Islington Crisis Resolution Team study



$P < 0.0005$ , adjusted



$P = 0.01$ , adjusted

## CRTs – achievements and cause for concern

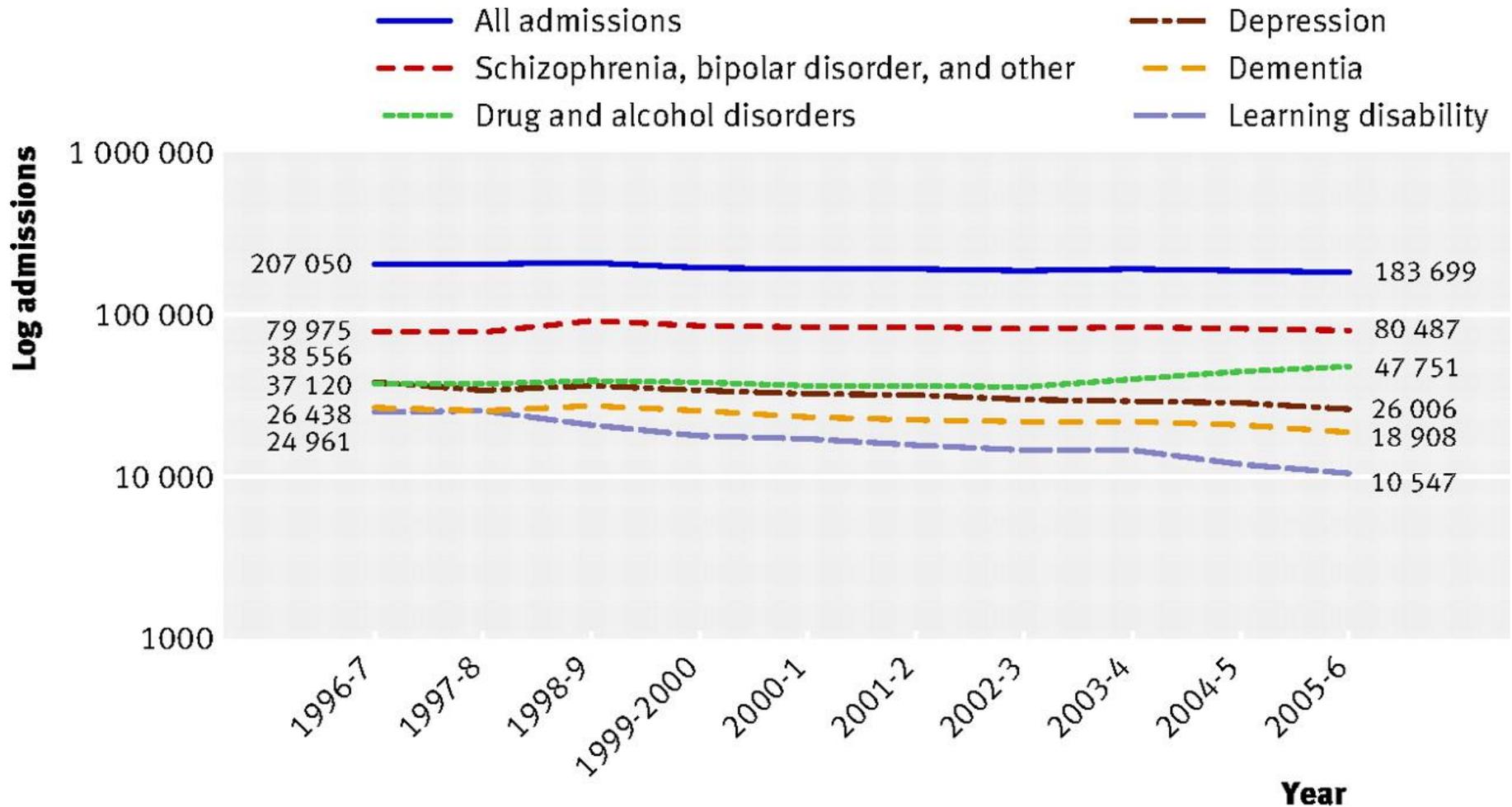
A nationwide shift in resources, staff, treatment focus

Research – fall in admissions, good satisfaction achievable

BUT cause for concern:

- **Uncertainty about extent to which admissions really being prevented nationwide.**
- **Compulsory admissions** – rising steadily for 20 years
- **Pressure cooker effect on wards**
- **Significant service user and carer dissatisfaction** e.g. MIND Acute Care Report, #crisisteamfail, “Right Here Right Now”
- **Is risk management adequate?** Substantial suicide rate
- **High readmission rates?** Approx. 50% in 1 year in Camden and Islington

## Changes in admission rates (on logarithmic scale) to NHS hospitals for different diagnostic groups of mental disorders, 1996-2006.



#mhcrisiscare

**Only 14%**  
of people who told us about  
their experience of crisis...

felt the care they received was  
**right and helped resolve the crisis**



**Right here, right now: our report on mental health crisis care**  
[www.cqc.org.uk/rightthere](http://www.cqc.org.uk/rightthere)



## **CRT optimisation: a policy priority**

- NHS England ***Crisis Care Concordat***
- CQC ***Mental Health Crisis Report***
- MIND ***Acute Care Campaign***

# The CORE Programme (*NIHR*)

- A 5-year research programme : 2011 - 2016

## Aims:

To address national implementation problem by:

- Defining best practice in crisis teams
- Testing a method of improving adherence to this



# The CORE Team

**Study Lead:** Sonia Johnson

**Study manager:** Bryn Lloyd-Evans.

**Deputy manager:** Danni Lamb

**Co-applicants and site leads:** David Osborn, Fiona Nolan, Wendy Wallace, Steve Pilling, Nicola Morant, Steve Onyett, Gareth Ambler, Louise Marston, Rachael Hunter, Oliver Mason, Claire Henderson, Alison Faulkner, Tim Weaver, Richard Gray, Sarah Sullivan, Nicky Goater

**Researchers and volunteers:**

Current: Kate Fullarton, Beth Paterson, Michael Davidson, Monica Leverton, Ed Mundy, Tom Mundy, Puffin O'Hanlon, Elaine Johnstone, Liberty Mosse, Jonathan Piotrowski, Jingyi Wang, Becky Forsyth, Rajvi Kotecha, CORE Public Involvement Advisory Groups, CORE facilitators

Past: Hannah Istead, Sarah Fahmy, Emma Burgess, Alasdair Churchard, Claire Wheeler, Johanna Frerichs, Caroline Fitzgerald

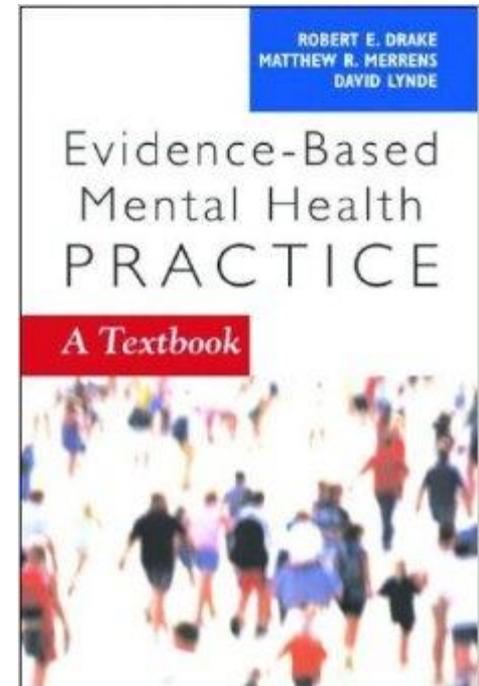
UCL, Camden and Islington NHS foundation Trust, Kings, Bristol,



# A model for improving implementation: the Evidence-Based Practices Program - USA

## Steps:

- **Clear definition of a model of best practice – evidence, expert opinion, stakeholder views**
- **Development of a “*fidelity scale*” to assess adherence to this model**
- **Feedback to services from a fidelity review**
- **Development of implementation resources to help achieve high model fidelity**



# Evidence for EBP

- Large scale evaluations in US of EBP approach
- Examples include Assertive Outreach, Individual Placement and Support, Illness Management and Recovery
- Fidelity of routinely implemented interventions often low initially
- A multimodal program to improve implementation generally raises fidelity – most effect in year 1.
- Effect on outcomes demonstrated in some studies e.g. IPS



# CORE Study: overview

1

- Develop a model of best CRT practice
- Evidence review, national survey, stakeholder interviews

2

- Develop a “fidelity scale” to assess teams’ model adherence
- Assess UK CRT fidelity in a 75-team survey
- Gather best practice examples and resources from CRTs

3

- Develop quality improvement resources for CRTs
- Test CRT “Resource Pack” in a 25-team cluster randomised trial

# CORE Study phase 1 – national survey of CRT practice

- Model of short term intensive service still in place in most areas

Many differences between reality and intended model

- 39% full 24 hour service
- 54% no upper age limit
- 30% present in person at all admissions



## CORE Study phase 1 – evidence on critic

Few clear findings from systematic review

Some (low quality) evidence for:

- Gatekeeping
- Medical staff within team
- Extended hours



# CORE Stage 1 – service user and carer views on good crisis team care

Importance of:

- Rapid, easy access to CRTs
- Kind staff with “time to talk”
- Opportunities to build relationships
- Continuity of care and clear information
- Choice about types of treatment – not just medication
- Involving the family
- Regularity of contacts, reliability in keeping appointments

Only a small minority report wholly negative experiences, but many are mixed.

# Crisis team and referrer views on best practice

Not very different from service users

Also advocated

- Crisis team role clarity and clear care pathways
- Sub-acute services for distressed people not requiring admission
- working relationships with: inpatient services, Psychiatric Liaison, community teams

Would like to do more:

- Establishing relationships, continuity
- Working with families
- Thinking beyond the immediate crisis (e.g. relapse prevention)

# Developing a CRT Fidelity Scale: the concept mapping process

232 statements relating to CRT best practice  
were generated from CORE development work

These were refined to 72  
statements for concept mapping

CRT stakeholders  
(n=68) prioritised and  
grouped statements

39 item  
scale

Camden and Islington   
NHS Foundation Trust



# core Crisis Resolution Team Fidelity Scale Version 2

  
**core**  
Crisis Resolution Team Optimisation  
and Relapse Prevention

## **CORE study stage 2 – Development of a fidelity scale**

- 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 – 5 point scale
- Wide range of items – team organisation, place in system, interventions delivered
- Piloted in 75 teams

## Example of a fidelity item

2. The CRT is easily accessible to all eligible referrers

Scoring criteria:

a) The CRT has no paperwork preconditions before referral

b) The CRT is directly contactable for referrals by phone

c) The CRT decides whether to assess clients directly following referral, without prior assessment from another service

d) The CRT contact details and referral routes are publicly available

5: All criteria are met

4: Three criteria are met

3: Two criteria are met

2: One criterion is met

1: No criteria are met

## CORE CRT Fidelity Survey results

- 75 teams
- Range of total scores: **73-151** (min=39; max=195)
- Median total: 122
- **Item mean 3.1/5**
- **Most items** – some high scores
- **Most teams** – some high scores
- **Very few teams put whole package together**

# CRT Fidelity compared to DH guidelines

DH guidelines 2001	Fidelity review results
Time-limited intervention	Item 10 – 87% of teams scored 3 or higher
Multi-disciplinary team	Item 27 – 84% of teams scored 3 or higher
24/7 service	Item 5 – 75% of teams scored 3 or higher
Working with families	Item 13 – 56% of teams scored 3 or higher
Rapid response	Item 1 – 35% of teams scored 3 or higher
Intensive support	Item 38 – 24% of teams scored 3 or higher
Preventing future crises	Item 24 – 3% of teams scored 3 or higher

## Crisis teams in 2015

- Potential to reduce admissions, offer choice, improve service user experiences

**BUT .**

- Overall model fidelity – low to medium (similar to USA)
- Gatekeeping and 24 hour access not at all consistent – may prevent intended effect on admissions
- Therapeutic relationships – particularly challenging but key to service user experience
- Family work – intended to be central, but often squeezed
- Psychological and social interventions – tend to fall away under pressure and without necessary training

**Benefits of crisis team model questionable if not achieving intended effects on admissions, service user experiences**

## Next research steps

- **CORE stage 3 (2014-2016):** Development of a resource kit to improve fidelity.
- **Comparison of 25 teams with resource kit vs. 15 without :**
  - Does the resource kit improve fidelity?
  - Is greater fidelity associated with fewer admissions and better experiences?

## What else can we do? (1) Crisis houses

- Long history internationally
- Strongly advocated by service users
- Weak RCT evidence – greater satisfaction, similar outcomes
- 25% of English catchment areas have them
- Spectrum from hospital-like to more explicitly alternative
- Mostly not very radical – integrated into local acute care systems with crisis teams.
- Synergy with crisis teams – offer social contact, support, refuge from unsuitable home



## Evidence on UK 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.
- Much better therapeutic alliance and peer relationships

## What else can we do? (2)

### Acute day hospitals

- Long history, never national policy.
- Evidence from a limited number of RCTs tends to suggest can substitute for some acute admissions  
Out of fashion - but may meet needs for social contact and activity, allow more extensive therapeutic programmes.
- Some integration with crisis teams
- ?Rebirth under new names e.g. recovery centre



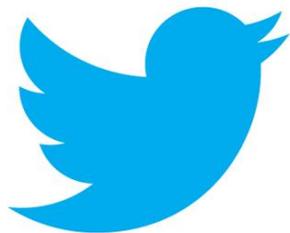
## The acute care system

- Acute care research is difficult
- Most focuses on single models
- But – stakeholders really want care from integrated system that offers:
  - Speedy entry and triage
  - Choice, flexibility to meet different needs
  - Smooth and rapid transitions & continuity
  - Crisis prevention as well as response
- The next research priority – acute care systems

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The views expressed are those of the author and not necessarily those of the NHS, the NIHR or the Department of Health.

[www.ucl.ac.uk/core-study](http://www.ucl.ac.uk/core-study)



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