Alternatives to acute admission – what do we know?

Sonia Johnson

Mental Health Sciences Unit

UCL

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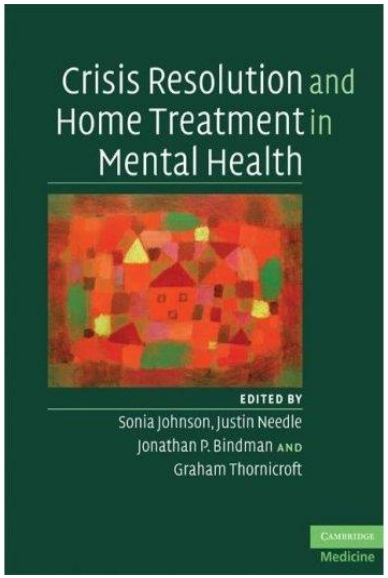
50 years of the quest to develop effective alternatives to acute admission: why?

- More flexibility/choice
- High cost of inpatient care – resources might be better spent on initatives to improve recovery
- Dissatisfaction with hospital environment among service users and staff
- Stigma associated with becoming an inpatient
- Doubts about therapeutic effectiveness of hospital (at least in England)
- Greater access to social network/context when crisis managed in community
- May learn more skills for coping with future crises in vivo

Admission alternatives



Crisis teams

1930s- Amsterdam

24 hour multidisciplinary teams providing visiting at home

Residential alternatives to hospital

1950s- California

e.g. Crisis houses in community with 24 hour staff, short admissions

Acute day hospitals designed to prevent admission
1920s- Russia

Short term daily attendance

Crisis resolution and home treatment teams: aims

Crisis resolution teams are multidisciplinary teams which:

a. Assess all patients who are being considered for hospital admission

b. Provide intensive home treatment instead of admission whenever possible

c. Facilitate early discharge from hospital

d. Discharge patients as soon as the crisis has resolved and a longer term management plan has been agreed.

CRTs – history and key features

- Precursors in Australia and USA
- Mandatory in England 2001-2010 (NHS Plan)
- Intended to:
  - Operate 24 hours
  - Gatekeep all acute admissions aged 18-65
  - Visit intensively for limited period
  - Deliver range of medical, psychological,social interventions to resolve crisis

Evidence in 2000 of limited relevance to current context

BJPsych The British Journal of Psychiatry

CPD ONLINE

The British Journal of Psychiatry (2005) 187: 68–75

Outcomes of crises before and after introduction of a crisis resolution team

SONIA JOHNSON, MSc, MRCPsych

Department of Mental Health Sciences, Royal Free and University College London Medical Schools, University College London, and Camden and Islington Mental Health and Social Care Trust

FIONA NOLAN, BA, RMN, CORE (British Psychological Society)

Sub-Department of Clinical Health Psychology, University College London, and Camden and Islington Mental Health and Social Care Trust

JOHN HOULT, MD, FRANZCP

Camden and Islington Mental Health and Social Care Trust

IAN R. WHITE, MSc, MRC

Biostatistics Unit, Cambridge

PAUL BEBBINGTON, PhD, FRCPsych and ANDREW SANDOR, MRCPsych

Department of Mental Health Sciences, Royal Free and University College Medical Schools, University College London, and Camden and Islington Mental Health and Social Care Trust

BMJ

Crisis resolution teams keep people at home

Coronary heart deaths: primary v secondary prevention
How your patients can reduce their risk of cancer
Quality of living environment and obesity
Managing soft tissue sarcomas
Confession of a climate criminal

UCL findings on crisis teams in Islington

Two studies

South Islington study – natural experiment comparing a cohort of crises before vs. after introduction of a crisis team N=200

North Islington study – **randomised controlled trial** comparing crisis team availability vs. standard care N=260

Findings

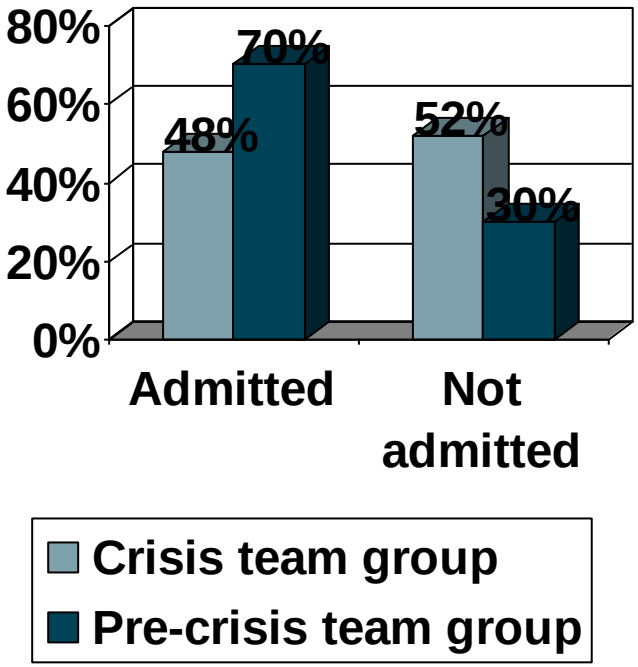
- **Reduction in admissions over 2 months and (in randomised trial) 6 months. Costs also less.**
- **Greater client satisfaction with crisis team**
- **No difference in compulsory admissions or any other outcome**

Qualitative study: Patients liked being at home but reservations about continuity and limited contact/content of interventions

Workforce studies: Happy staff

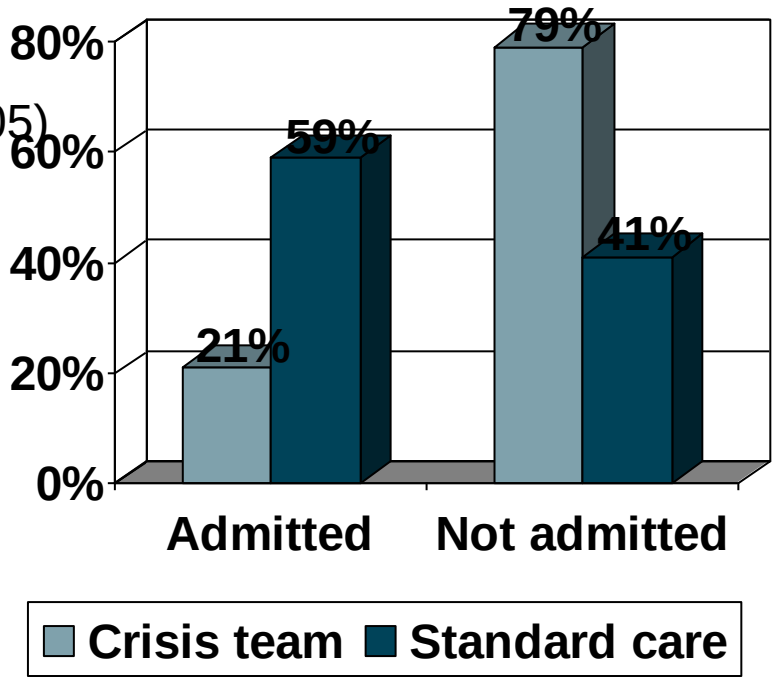
Admission rates with and without crisis team (6-8 weeks)

Natural experiment (p<0.0005)

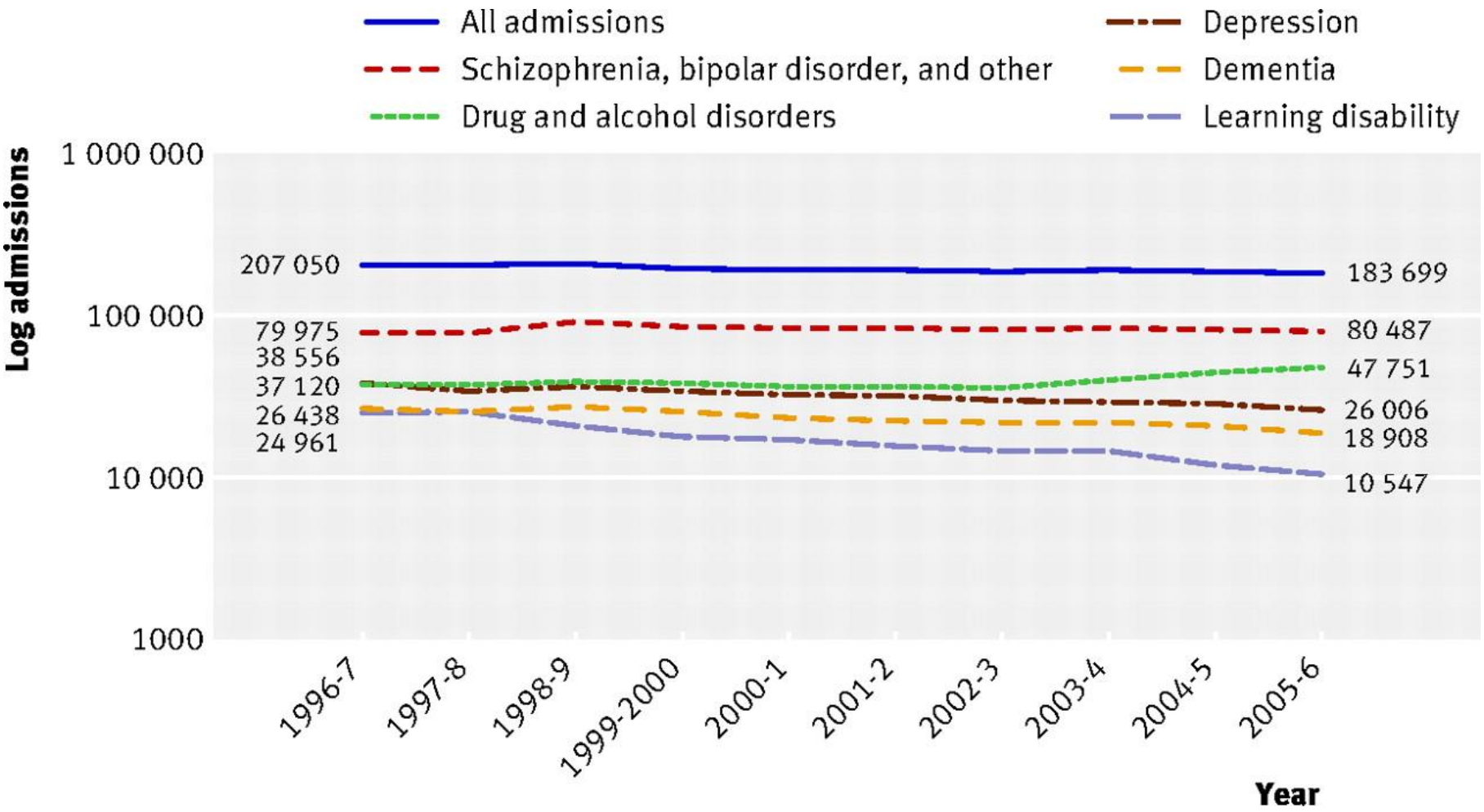


(p<0.0005)

Randomised controlled trial (p<0.0005)



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



Keown P et al. BMJ 2008;337:bmj.a1837

CRT implementation: the wider picture

- Reductions in admissions, good satisfaction in several catchment areas with well resourced, well led implementation **But** not always replicated, and national data suggest little decline in overall admissions
- Readmissions to crisis teams are high – 50% one or more further periods on caseload in a year
- Compulsory admissions may have risen
- Various qualitative studies suggest service users tend to be pleased to stay home, but often ambivalent about quality of service received.
- Gaps in evidence: only one recent RCT, more evidence needed on best practice/how to achieve successful implementation

Crisis houses and other residential alternatives to admission

- Long history in several countries, strongly advocated by service users but not national policy/little rigorous evaluation
- 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 in community from hospital-like with clinical staff to more explicitly alternative voluntary sector
- Almost all services well integrated into local catchment areas

Findings from crisis houses (Alternatives Study)

Compared with acute wards, community alternatives have:

- Very similar clinical population, but longer histories and less risk of violence in community alternatives
- Shorter stays and lower costs in alternatives
- Less improvement during stay, but no greater readmission over subsequent year
- Significantly greater service user satisfaction even though content of care, contact time similar.

Gaps in evidence: few recent RCTs, little evidence on why satisfaction greater

Acute day hospitals

- Long history, never national policy.
- Evidence from a limited number of RCTs tends to suggest can substitute for some acute admissions with good outcomes (Priebe, Kallert)
- Recent fall from fashion but may meet needs for social contact and activity, allow more extensive therapeutic programmes

Crisis teams as part of an acute care pathway

- Recent thinking – should consider acute care system as a whole, offering choice and flexibility among integrated components.
- The London Borough of Camden
  - Brief stay assessment wards with daily consultant psychiatrist reviews
  - Crisis team based in hospital, attend ward reviews every day for early discharge
  - Staff rotate between acute services, including crisis houses and ‘recovery centre’
  - Substantial initial reduction in bed use

Why is the evidence on crisis alternatives not stronger?

- Practical difficulties recruiting and randomising at time of a crisis
- Ethical difficulties with transient loss of consent
- Pressures against researching something that is already policy (England)
- Ambivalence re methods like clinical trial in alternative services

Current work at UCL aimed at addressing gaps in evidence

CORE programme (2011-2016) *RP-PG-0109-10078*

- Intended to generate evidence on improving CRT implementation and quality
  - Development of model of good practice and fidelity standards, testing of method for implementing these
  - Development and testing of a self-management intervention to reduce relapse after period of crisis team care

TAS 2 (2011-2013) NIHR HRSDO *09/1001/51*

- Has explored therapeutic relationships in crisis houses and tested hypothesis that these account for greater satisfaction

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