Crisis resolution and home treatment in England: where are we now?

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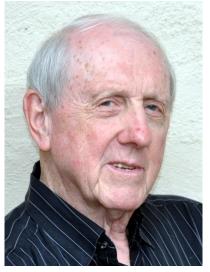
Principal Investigator, CORE Study

Plan

- A very short history of crisis teams
- How successful has the English crisis team policy been?
- CORE study: purpose and structure
- What are the key ingredients of good crisis teams? Findings from CORE preliminary work

A very brief history of crisis teams

- Precursors from 1960s in USA, Australia, Canada, England – never a national policy

- Growing interest in UK in the 1990s: models in Birmingham, Islington, Bradford.

- Late 1990s – "crisis in acute care", very high bed occupancy, many admissions to private beds

- 2001: NHS Plan – crisis teams, assertive outreach, early intervention mandatory

- Much debate – too much fragmentation? Too little evidence?

- Internationally – followed only by Norway

Why develop crisis teams?

- Pioneers with variety of rationales

- Some common themes:

- Avoiding hospital: expensive, stigmatised and unpopular, better to be able to invest resources elsewhere

- Therapeutic relationships may be 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

- More likely to acquire sustainable coping skills

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

The NHS Plan

Advice from John Hoult: CRT pioneer

- **Make 3 phone calls**

(To key involved others before initial assessment: information gathering and early engagement with social systems)
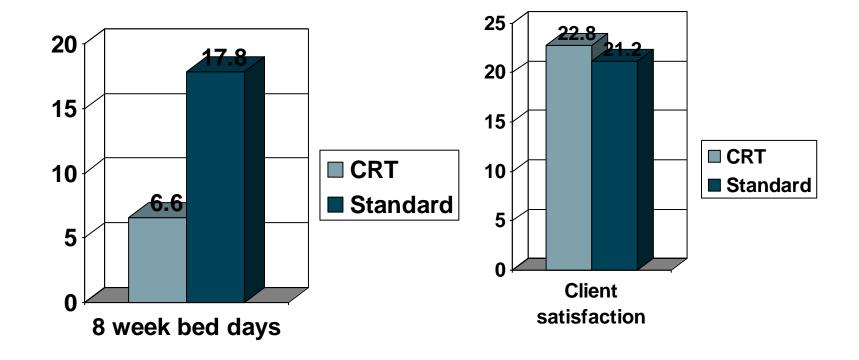
- **Meet "survival needs"**

(CRTs must address someone's immediate, urgent concerns before expecting engagement with/benefit from treatment. A first CRT visit may involve: buying food, fixing the door lock, unblocking the sink etc)

Primary outcomes of North Islington Crisis Resolution Team study

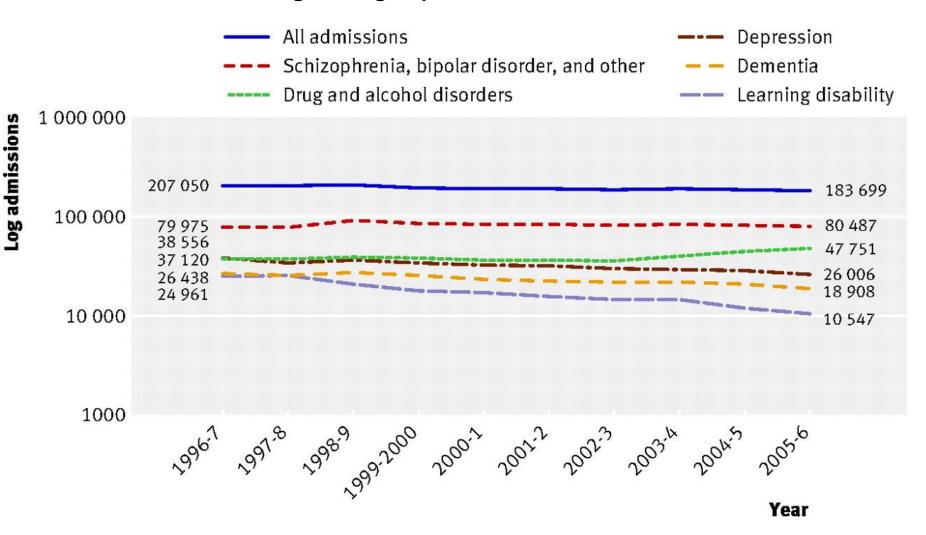P < 0.0005, adjusted

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 some cause for concern:

- Uncertainty as to whether fall in admissions uniformly achieved (NB current bed crisis)

- Compulsory admissions still rising

- Significant service user and carer dissatisfaction e.g. MIND Acute Care report, #crisisteamfail

- Is risk management adequate? Average of 150 suicides per year for CRT patients: now higher than for inpatient wards (Hunt et al. 2014)

- High readmission rates? Approx 50% in 1 year in Candi

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

While there were some very positive experiences of CRHTs, there were also major frustrations and problems to do with the capacity of teams, their responsiveness, the effectiveness of their help and their role in gatekeeping acute hospital admissions. To some extent problems were attributed to understaffing, but the threshold at which they accept people into their own or hospital care is another critical factor.

Many of the problems we heard about arise from the working practices, culture and dynamics of crisis and inpatient teams. Lack of humanity, depersonalised care, treating the illness or managing the crisis rather than supporting or healing the individual, and emphasising risk rather than needs, were all themes that arose.

CRT optimisation: a policy priority

- NHS England *Crisis Care Concordat*

- CQC *Mental Health Crisis Report*

- MIND *Acute Care Campaign*

The CORE Programme

- A 5-year research programme : 2011 - 2016
- Funded by a DH NIHR Programme Grant
- Managed by Camden and Islington NHS FT/UCL

Aims:

- **Develop evidence about how to optimise CRTs**
- **Test a service improvement programme for CRTs**

(Other workstream – trial of peer supported self-management in CRTs)

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

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

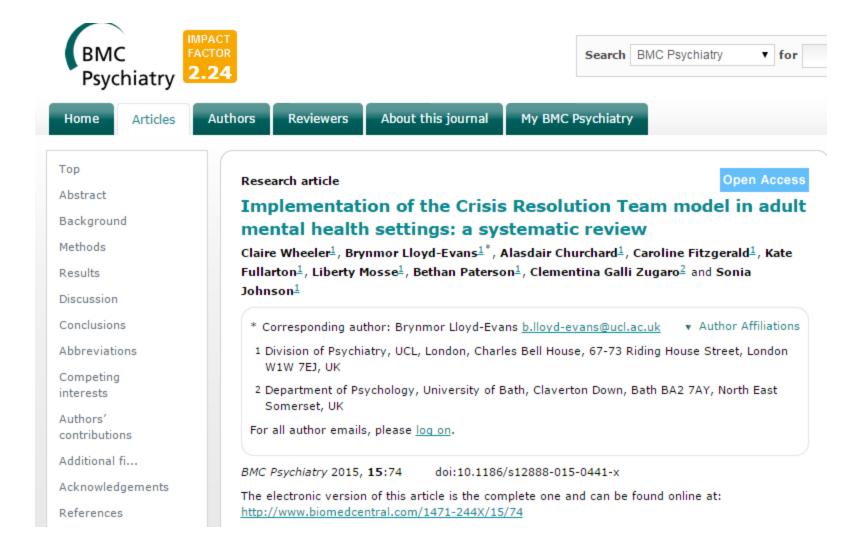# Stage 1: Identifying critical ingredients of CRTs (2011-13)

- ## A systematic literature review (Wheeler et al. 2015)

Quantitative studies n=25; qualitative studies n=24; guidelines n=20

- ## A national survey of CRTs (Lloyd-Evans et al. submitted)

Questionnaire to all CRT managers in England regarding CRT service delivery and organisation + what supports effective CRT care (n=188 – 88% response rate)

- ## Interviews with CRT stakeholders (Morant et al. in preparation)

Interviews with service users n=41; carers n=20, mental health staff, managers and commissioners (26 focus groups and 9 individual interviews) CRT developers n=11

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Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review

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Systematic review – critical ingredients of crisis teams

Not much evidence overall

- Quantitative studies: suggest gatekeeping, extended hours & medical cover are important to effectiveness in reducing admissions

- Qualitative studies: stakeholders value integration/continuity with other services, time to talk, not seeing too many people, rapid access and accessibility.

National survey of CRT managers

Many gaps between reality and intended model:

- 39% full 24 hour service

- 54% no upper age limit

- 30% present in person at all MHA assessments

- 33% psychologist in team

- 49% would help with shopping

Stakeholder qualitative interviews in 10 Trusts (1)

Service users & carers emphasised the 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
- Involving the family
- Regularity of contacts, reliability in keeping appointments

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

Stakeholder interviews in 10 Trusts (2)

Mental health staff also advocated:

- CRT role clarity and clear care pathways
- Pressures when other services in pathways not available/functioning
- Good working relationships with: inpatient services, Psychiatric Liaison, community teams

Resource constraints (time and skills) sometimes limited:

- Establishing relationships, continuity
- Working with families
- Thinking beyond the immediate crisis (relapse prevention)
- Duration of visits

In summary

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

BUT

Not consistently implemented as intended e.g.

- Gatekeeping and 24 hour access not at all consi   y impede intended effect on admissions

- Therapeutic relationships – particularly challenging with CRT working pattern, 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