

REPEAT USERS OF CRISIS RESOLUTION AND HOME TREATMENT TEAM

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SUMMARY

CRHT services have reduced admissions to psychiatric hospitals. Some patients use CRHT services repeatedly. We reviewed the first 30 patients who were repeat users of the CRHT services, Luton, between 1 August 2010 and 31 July 2011. The repeat users were a small group of patients needing disproportionately large amounts of resources from the CRHT service. The factors associated with repeat use of CRHT were past psychiatric admission and the diagnoses of emotionally unstable personality disorder, self-harm behaviour and substance misuse. Identifying the factors leading to repeat CRHT use could lead to providing a more tailored service and reduce repeat use of these services. It appears that repeat CRHT service use might be the result of the interaction of a wide range of factors relating to underlying disorder, substance misuse, self harm behaviour, employment status and social support. It is also important to note that many of the patients are liable to relapse as they go through stressful life situations, despite adequate medication and psychosocial intervention. It can be difficult to identify all the factors that contribute to a pattern of repeat presentation to CRHT services. However, identification of such factors might help clinicians to offer more targeted services and might also assist commissioners in focusing resources effectively. They might need more intensive community-based programs to identify and treat the relapses. The CRHT teams should include all the appropriate professional disciplines required to provide community care for these challenging service users.

Key words: crisis services - repeat users

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INTRODUCTION

There is relatively little literature on the subject of repeat CRHT users. Against this background, we endeavoured to identify factors associated with repeat CRHT use in our service.

The CRHT services are a frontline mental health service acting as an intermediary between community and inpatient services. The crisis teams provide an alternative to inpatient acute care services, offering assessment as well as direct care in response to mental health crises (Johnson 2007, Karlsson et al. 2008a). Over the last ten years, developing CRHT services has resulted in many changes in community and inpatient services such as - Jethwa et al. (2007) evaluated the long-term effects of introducing CRHT services in Leeds and demonstrated a statistically significant reduction in admission rates of 37.5% in the first year. They also reported shorter inpatient stays.

Although readmission to inpatient psychiatric wards have been reduced, CRHT teams have to manage some patients who present repeatedly. According to the 2007 National Audit Office report, this group includes patients with personality disorder, dual diagnosis, substance misuse, self-harm and eating disorders, as well as victims of domestic violence. Young people and those from culturally diverse societies were also at greater risk of repeated CRHT use.

According to Harrison et al. (2011) 39% of individuals treated by CRHT teams had complex care needs and were repeat presenters. This is a high proportion of the total number and this subgroup required a

disproportionately large amount of resources. The National Audit Office report (2007) stated that CRHT teams managed 95,397 episodes involving 75,868 individual service users. This suggests that nearly 20,000 episodes were those of repeat users.

BACKGROUND TO THE CRHT SERVICES

The concept of home treatment dates back to Stein and Test (1980). Many people view this as the dawn of community treatment as then most care was still delivered in large institutions. In the UK, a community health team structure was developed from the 1960s onwards, stimulated by the requirements of the Mental Health Act 1959 for the informed treatment of inpatients alongside treatment of detained patients (Burns 2004).

Worldwide there has been a move away from treatment in large institutions. This was driven partly by government for financial reasons and partly by therapeutic liberalism (Bachrach 1997). As a result, most Western countries are moving rapidly from institutional care to community-based mental health care. Models of community care are being established. This is to minimise hospitalisation and maximise the acute care and rehabilitation within the context of the family and the immediate social environment of the individual (European Commission 2005). The crisis or CRHT teams provide an alternative to inpatient acute care services, offering assessment as well as direct care in response to mental health-related crises (Johnson 2007, Karlsson et al. 2008).

The functions and characteristics of individual CRHT teams vary greatly. Typically they are multidisciplinary, have a high staff-patient ratio and carry out rapid assessments. They provide short-term care (up to six weeks) and focus on attending to both clinical and social needs (Heath 2005). They target people who would be admitted to an acute hospital bed without such intervention. They provide intensive home treatment whenever feasible, with 24-hour availability and home visits of up to three times a day. These teams can offer inpatient beds if necessary.

There is clear evidence showing that patients do not like hospital inpatient admission for a number of reasons, including stigma (SCMH 1998). In 2007, McCrone, estimated a saving of £610 in health costs per patient if home treatment and inpatient services are considered together for a single mental health crisis. A Cochrane analysis (Joy et al. 2006) concluded that home treatment is considerably more cost effective than inpatient hospital care.

METHODS

This was a retrospective study. The subjects were patients presenting to the Luton CRHT. This is a consultant-led service providing crisis assessment and home treatment to a population of about 200,000, with considerable ethnic diversity.

We analysed the first 30 repeat users of CRHT services between 1st August 2010 and 31st July 2011. Those patients who had 2 or more admission with the team during the period were considered repeat users and the diagnosis was established by routine assessments by doctors. We compared the demographics and various clinical parameters and applied the independent t-test where appropriate.

FINDINGS

Between 1st August 2010 and 31st July 2011 there were 884 users of the CRHT services, creating 987 episodes, implying that 103 of the latter were repeat episodes (10.4%). We analysed the first 30 repeat-user patients. This sample consisted of 22 females (73.3%) and eight males (26.7%) (Figure 1, Figure 2).

Seven of the 30 patients were 25 years of age or younger. The mean age of the entire group of 30 patients was 37 years (range 20-66, standard deviation 12.01 years).

The mean ages of the male and female patients were 43.78 years (standard deviation 13.78 years) and 34.7 years (standard deviation 10.72 years), respectively.

The mean age of the male patients was higher than that of the female patients but this difference did not reach statistical significance (independent t-test: $t=1.81$, $p=0.08$).

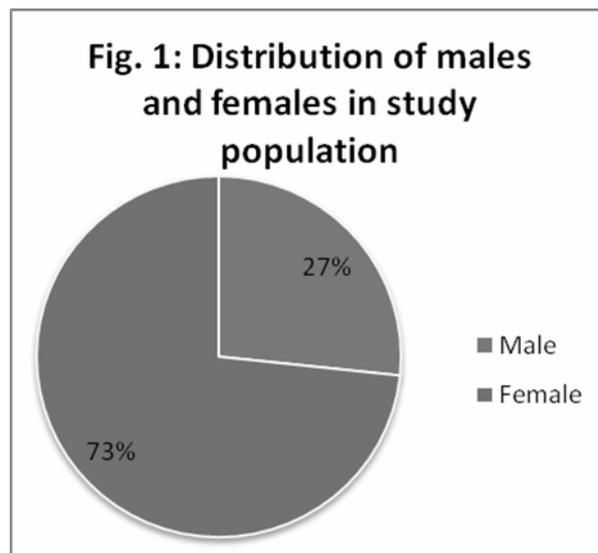


Figure 1. Gender

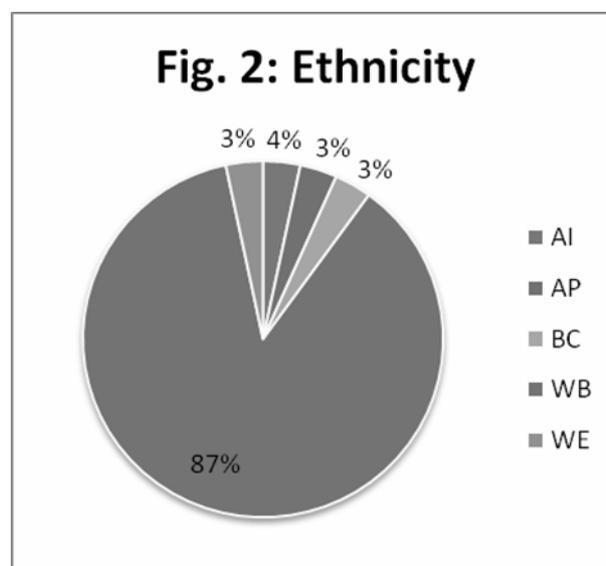


Figure 2. Ethnicity

The diagnoses were as follows:

- Emotionally unstable personality disorder borderline type, ICD10 F60.31, 11/30(33%);
- Paranoidschizophrenia, ICD10 F20, 4/30 (13.3%);
- Schizoaffective disorder ICD10 F25, 1/30 (3.3%);
- Recurrent depressive disorder 8/30 (26.6%);
- Bipolar affective disorder, ICD10 F31, 5/30 (16.6%);
- Alcohol dependence as a primary diagnosis ICD10 F10, 1/30 (3.3%) (Figure 3).

16/30 (53.3%) had a history of substance abuse during the first episode. This increased to 29/30 (96.7%) during the second episode.

Of the total number only 5/30 (16.6%) had co morbidity with substance abuse.

20/30 (66.7%) had a history of self-harming behaviour (Figure 4, Figure 5).

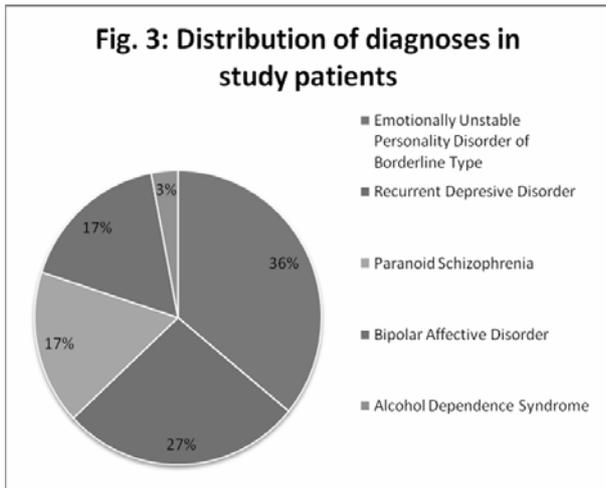


Figure 3. Diagnoses

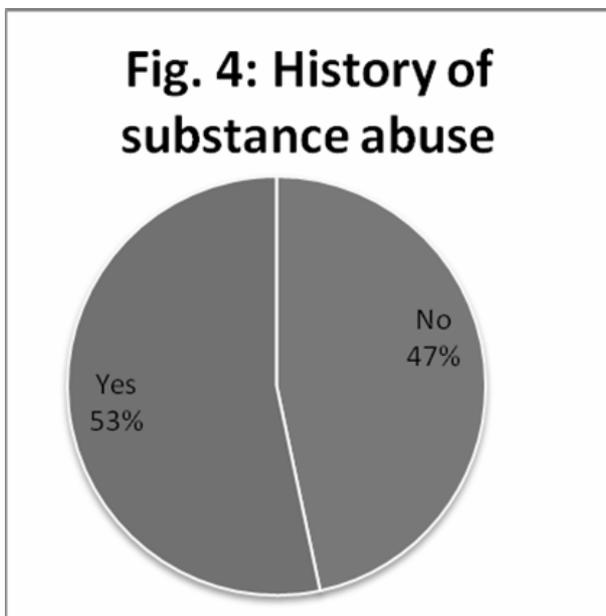


Figure 4. Substance abuse

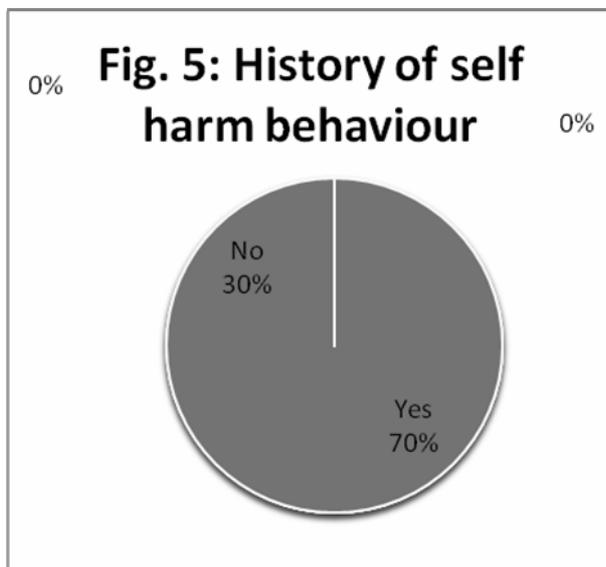


Figure 5. Self Harm

24/30 (80%) had a history of past psychiatric hospital admission and 15/30 (50%) had a history of compulsory admission under the Mental Health Act (Figure 6).

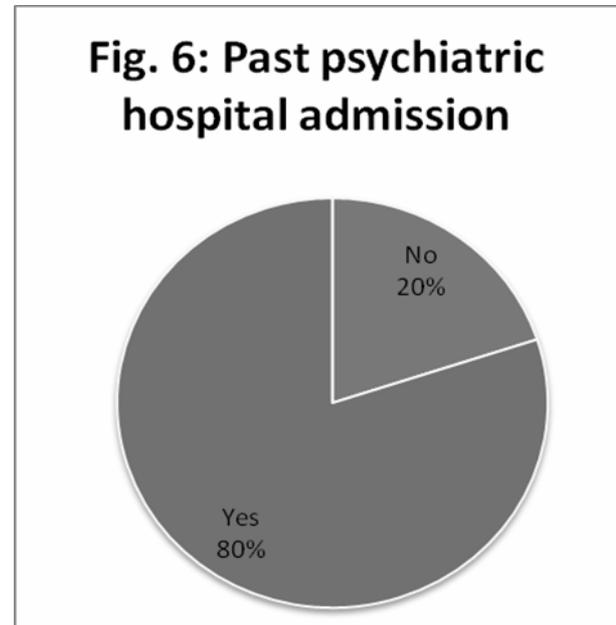


Figure 6. Past Admissions

None of the repeat users were homeless. It should be noted that homelessness was not an exclusion criterion for accessing the CRHT. Only 16.7% had some kind of employment at the time of first episode and the same figure of 16.7% was noted during the second episode. There was no statistically significant difference between males and females for past psychiatric hospital admission (Fisher's exact test: $p=0.65$). There was also no statistically significant difference between those who were employed and those who were unemployed with regard to past psychiatric hospital admission ($p=0.65$) or employment status ($p=0.65$). Most repeat users were white British (26/30, 86.7%) and most were not married (20/30, 66.7%).

DISCUSSION

In study, the diagnosis of emotionally unstable personality disorder, self-harm behaviour, substance misuse and past psychiatric admission were the factors associated with repeat use of CRHT.

Whether to include patients with personality disorders in CRHT services has been an issue of debate. Previous guidance from the Department of Health and the policy guidance from the Welsh Assembly suggested that home treatment is not suitable for those with personality disorders. However, the current working guidelines suggest that these patients should not be excluded from CRHT services.

If the aim of CHRT services is to decrease hospital admissions, then working with patients with personality

disorder is essential. This is because these patients are demanding of hospital inpatient services but often do not benefit from them. Patients with personality disorders are likely to use hospital admission or home treatment as coping mechanisms to deal with crises. These individuals are likely to be repeat users of CRHT services because of this. Refusal of either hospital admission or home treatment is likely to result in an increase in self-harming behaviour.

Brimblecombe studied 293 patients and showed that two factors predicted a high probability of hospital admission during a course of home treatment: suicide risk at the commencement of treatment and previous hospitalisation. No difference was found in this study between the two groups on age, sex, gender, diagnosis, source of referral, place of assessment, previous self-harm and previous violence. Brimblecombe's criterion of failed home treatment was admission to an inpatient unit, whereas the criterion in this study was repeat use of home treatment. In the study, high suicide risk led to hospital admission. This finding is consistent with this study which revealed that self-harm was a risk factor for repeat home treatment. Substance misuse increases the risk for aggression and self-harm and so, appears to be a risk factor for repeat CRHT.

It appears that repeat CRHT service use might be the result of the interaction of a wide range of factors relating to underlying disorder, substance misuse, self harm behaviour, employment status and social support. It is also important to note that many of the patients are liable to relapse as they go through stressful life situations, despite adequate medication and psychosocial intervention. It can be difficult to identify all the factors that contribute to a pattern of repeat presentation to CRHT services. However, identification of such factors might help clinicians to offer more targeted services and might also assist commissioners in focusing resources effectively.

Therefore when working with repeat users, CRHT teams should develop an enhanced crisis plan or joint crisis plan to inform the lessons learnt from one crisis to the next. This should include information about 'Relapse Signature' (i.e. early warning signs which are usually specific and unique to the individual) and psychological as well as social difficulties which trigger the crisis. This should involve not just the service user but his carer(s) and should be shared with all the services and agencies involved like Community Mental Health Team, Community Drug and Alcohol Teams, Early Intervention Teams, Eating Disorder Team, Probation Services etc. All the professionals involved should maintain a reliable and consistent approach. Crisis plan should facilitate cooperation and frequent liaison between all those involved. Besides a clear pathway is described as to what would help the patient in crisis (Flood 2006). All this are thought to empower individuals and help them feel more 'in control' (Henderson 2009) and to facilitate detection and treatment of relapse (Sutherby 1999).

Enhanced crisis planning interventions may be cost-effective method of reducing relapses and readmissions for people with severe mental illnesses. It may also have the potential to reduce both compulsion and costs (Flood 2006). For a crisis plan intervention to be effective, it is important that the crisis plan is up to date and thoroughly reviewed by healthcare professionals, family and the individuals collectively. The care plan should be tailored to the views and needs of the service user. It should also include all contact details including out of hours. The crisis plan should designate directive actions to be taken in a crisis by the patient, their carer and care co-ordinator.

Service users should be encouraged to carry CRISIS CARDS which provide immediate information about their preferences. So they are a form of Advance statement or advance directive. In the crisis card two aspects are addressed: crisis prevention and provisioning of practical information for future psychiatric emergency care. Therefore the crisis cards help the individuals advocate for themselves if they are unable to express their wishes in a crisis.

CONCLUSIONS AND RECOMMENDATIONS

This study has provided a profile of patients that are likely to require repeated contact with CRHT services. Patients with emotionally unstable personality disorder of the borderline type, recurrent depressive disorders, a history of self harm behaviour and a history of substance misuse are more likely to present as repeat users. They may need more intensive community-based programs to identify and treat the relapses. The CRHT teams should include all the appropriate professional disciplines required to provide community care for these challenging service users.

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References

1. *Bachrach L: Lessons from the American experience in providing community - based services. In Leff J (Ed) Care In the Community: Illusion or Reality? Wiley, Chichester, 1997.*
2. *Brimblecombe N, et al.: Home treatment as alternative to inpatient admission. Journal of psychiatry and mental health nursing 2003; 10:683-687.*
3. *Burns T: Community Mental Health Teams: A Guide to Current Practices. Oxford University Press, Oxford, 2004.*
4. *European Commission: Improving the mental health of the population: Towards a strategy on mental health for the European Union. (Green Paper) COM (2005) 484. Brussels. EU Health and Consumer Protection Directorate-General, 2005.*

5. Flood C. et al.: Joint crisis plans for people with psychosis: economic evaluation of a randomised controlled trial. *BMJ*. 2006; 333:729.
6. Harrison Judy et al.: From home treatment to crisis resolution: The impact of national target. *The Psychiatrist* 2011; 35:89-91.
7. Heath D: *Home Treatment for Acute Mental Disorder- An Alternative to Hospitalisation*. Routledge, New York, 2005.
8. Henderson C, et al.: Views of service users and providers on joint crisis plans: single blind randomized controlled trial. *Soc Psychiatry Psychiatr Epidemiol* 2009; 44:369–376.
9. Jethwa K. et al.: Effects of a crisis resolution and home treatment team on in-patient admission. *Psychiatric Bulletin* 2007; 31:170-172.
10. Johnson S: Crisis resolution and intensive home treatment teams. *Psychiatry* 2006; 6:339-342.
11. Joy CB et al.: Crisis intervention for people with severe mental illnesses (review). *The Cochrane library*, 2008, issue 1.
12. Karlsson B. et al.: From good intentions to real life: introducing crisis resolution teams in Norway. *Nursing Inquiry* 2008; 15:206-215.
13. McCrone P et al.: *Helping people through mental health crisis*, NAO, 2007.
14. Sutherby K et al.: A study of 'crisis cards' in a community psychiatric service. *Acta Psychiatrica Scandinavica* 1999; 100:56–61.
15. SCMH: *Acute Problems. A survey of the quality of care in acute psychiatric wards*. London: The Sainsbury Centre for Mental Health, 1998.
16. Stein L, and Test M: *Alternative to Mental hospital treatment I conceptual model, treatment program and clinical evaluation*. *Archives of General Psychiatry* 1980; 37:392-397.

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