



The Progress and Impact of a Crisis Resolution Home Treatment Team

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Plan of the lecture

- Background
- Underlined principles
- UK overview
- North Wales situation
- Home Treatment model
- Statistics
- Conclusions



Background

- Crisis resolution old issue
- Emergency Psychiatric and Crisis Interventions Services in Europe; WHO; 1993
 - Crisis not necessarily related to mental health
 - Medicalisation is not necessary or desirable
 - 3 groups of people need crisis intervention:
 - Acute psychiatric conditions
 - Psychosocial crisis
 - Chronic psychiatric patients
 - Trieste is mentioned!



Background (2)

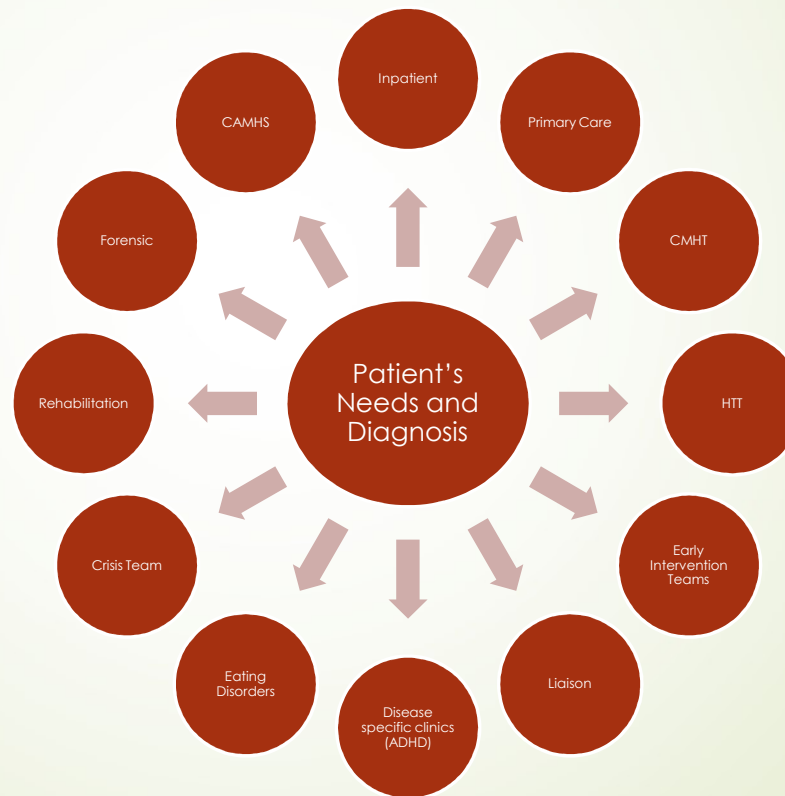
- ▶ Problems encountered in crisis interventions:
 - ▶ Short therapeutic relationship
 - ▶ Encounter with distressed, aggressive, potentially dangerous patients
 - ▶ Rapid decisions based on scanty information
 - ▶ Practical issues (shifts; short contacts, etc)
- ▶ Generalism Vs Specialism
 - ▶ Integration with general health services
 - ▶ Stand alone service



My beliefs...

- ▶ Treating people in crisis at home is the best option
- ▶ Normalisation is the key to resolve crisis
- ▶ For some patients being admitted to hospital can result in harm
- ▶ Psychiatry should move forward towards more community care
- ▶ Attachment theory should inform service design

Current British system





Current acute care system

- ▶ Inpatient beds
- ▶ Crisis Resolution Home Treatment Teams
- ▶ Liaison Services
- ▶ Few places in the UK have alternative to admission (crisis homes, etc)
- ▶ Very different models across the UK




Current acute care system (2)

- ▶ The King's Fund (2017):
 - ▶ The number of general and acute beds has fallen 43% since 1987/88
 - ▶ Effort made to treat effectively people in the community
 - ▶ Research shows very different success, depending upon resources invested



North Wales

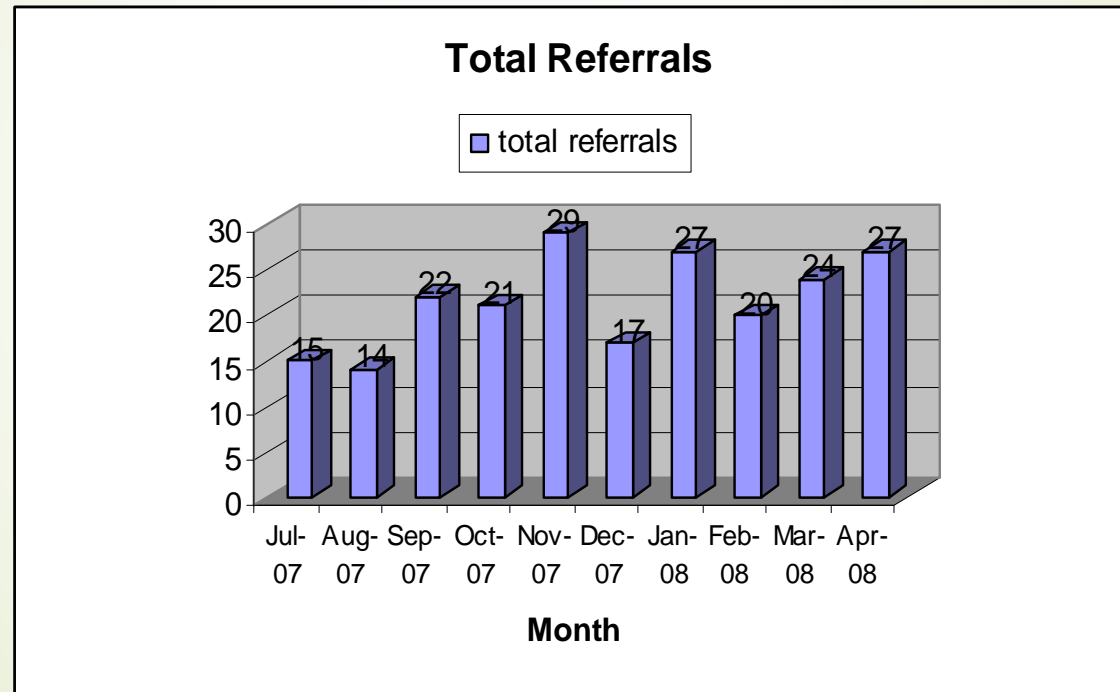
- ▶ 685.000 population
 - ▶ Very rural
 - ▶ 3 District General Hospitals
 - ▶ HTT introduced in 2007
- 



Home treatment teams

- ▶ Act as gatekeeper to hospital admission
- ▶ Review inpatients to facilitate discharge
- ▶ Help community teams to treat acute cases in the community
- ▶ Accept referrals from different sources

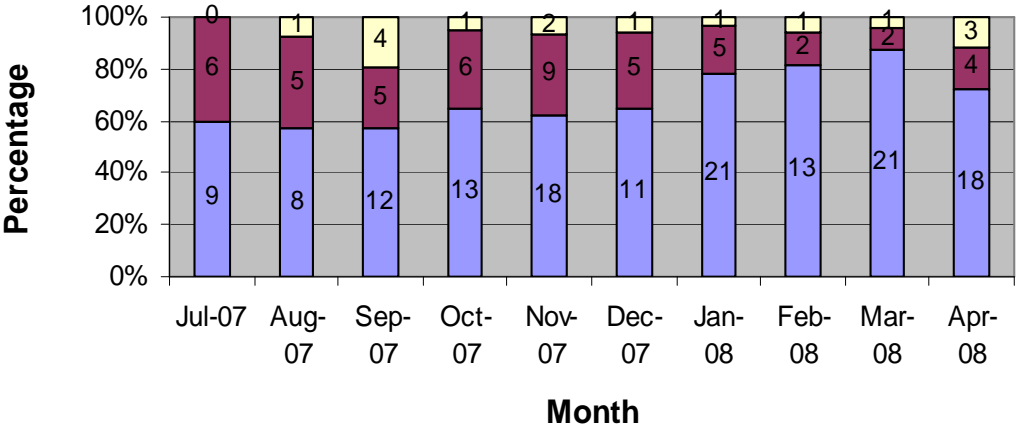
Total referrals





Outcome of Assessment

■ total accepted for treatment ■ total returned to referrer
■ total admitted to Llwyn-Y-Groes



What Impact Have CRHT Had?

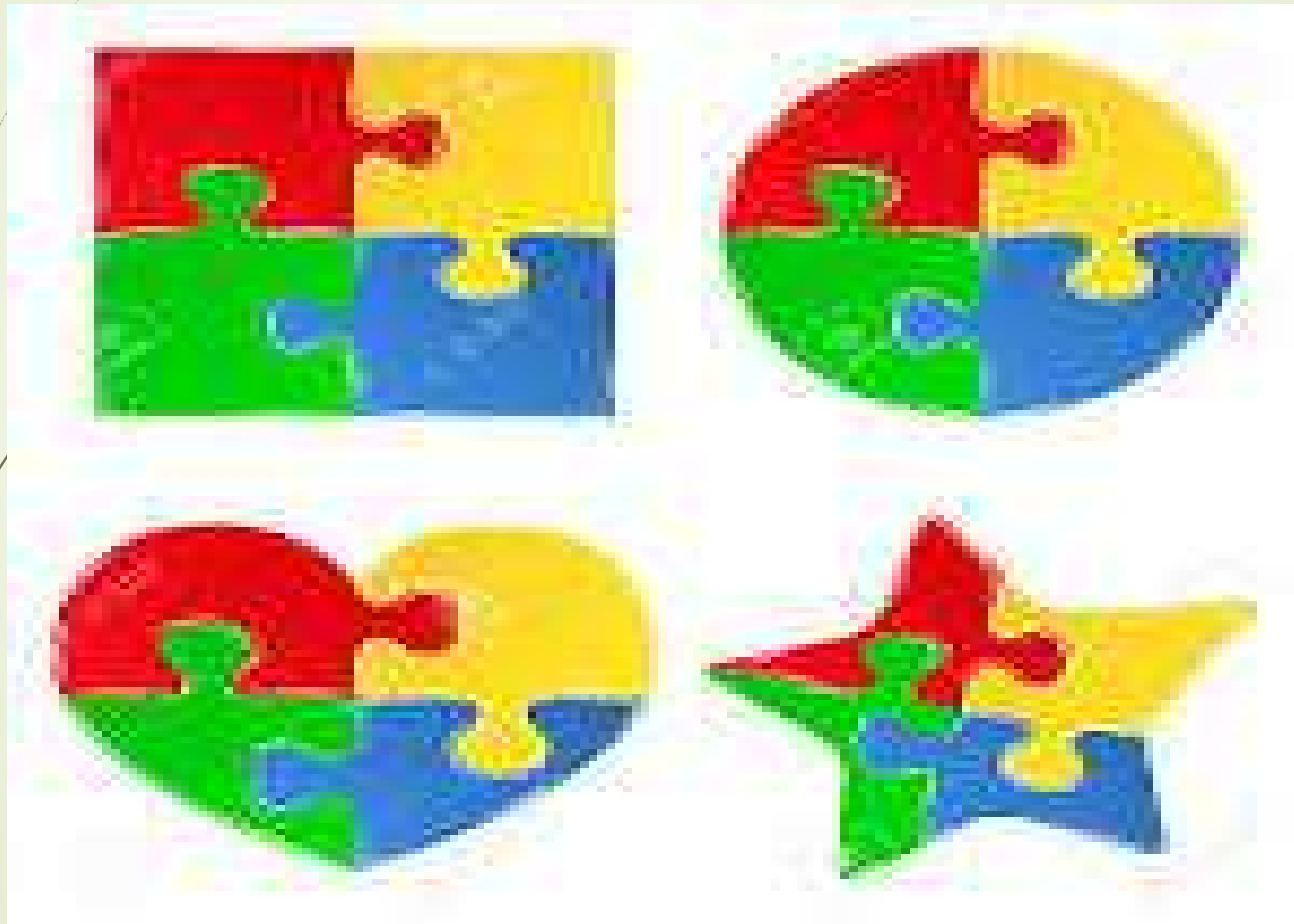
Date	Pre-CRHT No. Admissions	Pre-CRHT Total Days Inpatient stay	Date	Since CRHT No. Admissions	Since CRHT Total Days Inpatient stay	Difference in admissions	Difference in days
Oct-06	19	486	Oct-07	16	249	3	237
Nov-06	19	522	Nov-07	25	672	-6	-150
Dec-06	17	374	Dec-07	11	148	6	226
Jan-07	24	562	Jan-08	17	318	7	244
Feb-07	18	442	Feb-08	14	129	4	313
Mar-07	20	823	Mar-08	13	104	7	719



Pre & Post CRHT Difference

- Total Admissions pre-CRHT: 117
- Total Admissions post-CRHT: 96 (**21=17.9%**)
- Total Days Stay pre-CRHT: 3209
- Total Days Stay post-CRHT: 1620 (**1589=49.5%**)

Does it Work?



Does it work for everyone?





Does it really work?

Listening to Experience. An Independent Inquiry into Acute and Crisis Mental Healthcare MIND Report (2011)

“Difficulties in accessing help”

“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.”



Cont.

What people need in crisis:


“A safe place”

“Access to a timely, effective response”

“A place to go”

“Family and friends”

“Choice and control”



Can Attachment Theory help?

- ▶ *Caregiver provides secure attachment by:*
 - ▶ *Providing a secure base*
 - ▶ *Being available and flexible*
 - ▶ *Being sensitive and responsive to distress*
 - ▶ *Intervening when needed*
- ▶ *Attachment style determines how patients present to services will seek help and how they behave*



Do services provide a safe base and secure attachment?

- ▶ Services promotes:
 - ▶ Insecure ambivalent attachment
 - ▶ Insecure avoidant attachment
 - ▶ Disorganised
- ▶ Services transfer patients (in crisis) from one place to another, from one team to another



Should we change our services?

- ▶ *Using Attachment Theory to inform the design and delivery of Mental Health Services: a systematic review of the literature.* Bucci et al. (2015)
 - ▶ Models to promote secure base and supporting recovery
 - ▶ National Advisory group for Dep. of Health (2007): “attachment theory provides a universal evidence based theory that should inform MH policies to promote psychologically safe services“



Suggestions from literature

1. Provide a secure base: safe environments, meaningful relationship with staff, training to avoid over-involvement or conflicts
2. Continuity of care: stability of staff, building stable relationships over time
3. Availability and flexibility
4. Sensitivity and responsiveness: compassion



Cont.

5. Provide a corrective emotional experience: encourage independence, providing non-contingent positive interactions
6. Support for staff: understand attachment and their style. Caseload
7. Support for informal carers
8. Moving on: discharge and transition



Final thoughts

- ▶ Treating acute cases and crisis in the community is possible and desirable
- ▶ We should combine specialist and generalist roles within services
- ▶ Following attachment principles for service deliver should promote efficiency, independence and improve outcomes
- ▶ Cost effective
- ▶ Potentially a burden to families



THANK YOU