OPEN ALL HOURS

24-hour response for people with mental health emergencies

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BRIEFING 2

The aim of The Sainsbury Centre for Mental Health is to improve the quality of life for people with severe mental health problems by enabling the development of excellent mental health services which are valued by users, carers, and professionals. The Sainsbury Centre seeks to achieve this by influencing policy and practice through a co-ordinated programme of research & evaluation, communication and development.

Copies of *Open All Hours* are available from The Sainsbury Centre @ £12 plus 10% p&p.
Tel. 020 7827 8352 (Publications),
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Comprehensive mental health services are at a critical stage of development. Health Authorities, Trusts and Local Authorities are seeking to develop a range of services to support people with different levels and durations of need. In order to facilitate this, The Sainsbury Centre has produced a range of reports to cover each of the major service elements and processes involved in establishing comprehensive care. Each report is accompanied by an Executive Briefing aimed at Chief Executives, Directors and Members. These reports are as follows:

- *Keys to Engagement*, published in March 1998, sets out a strategy for meeting the needs of people with severe and enduring mental health problems who are hard to engage. It describes how to develop assertive outreach and other essential services for the group;
- *Aiming for the Best*, published in May, looks at developing the capacity and competencies for commissioning mental health services;
- *Laying the Foundations*, also published in May, sets out the basic principles for determining service and Trust configurations;
- A new report, to be published in September 1998, will highlight the problems with current acute inpatient services and set out a strategy for overcoming them;
- *Open All Hours*, the report summarised in this briefing, deals with crisis services and presents an evaluation of the Psychiatric Emergency Team (Home Treatment Team) in North Birmingham.

Crisis Services

Why and what crisis services?

Traditionally crisis services, especially for the most severely mentally ill, have been provided through admission to acute inpatient wards, often via A&E departments. In some cases this may be necessary, but:

- it is an expensive solution
- A&E Departments provide a poor environment for the initial response to mental health crises
- many inpatient settings also provide a poor therapeutic environment
- inpatient stays are disruptive to patients' lives
- there is little evidence that inpatient stays are cost effective interventions across the range of psychiatric crises.

However, community services have been slow to develop other 24-hour crisis provision. A recent survey found that only 11% of Trusts had such services. What is more, planners and managers are faced with a confusing array of possible models for community crisis services, with little evidence on efficiency or effectiveness. The questions asked by managers cover two main areas:

- what are the needs and demands that services should respond to?
- how can these needs be met efficiently and effectively?

What are crises and crisis services?

All of us experience crises during our lives, and many of us emerge stronger as a result. However, crisis in the context of a severe mental illness (whether or not it is enduring) can be very damaging. Crisis services are required when:

- people's mental health has deteriorated so much that they may harm themselves or others, and
- they are in need of intensive specialist support and treatment.

Community crisis services up and down the country are described in a variety of different ways including:

- out of hours service
- rapid response service/team
- early intervention service/team
- psychiatric emergency service/team
- home treatment team.

This can lead to confusion, but these services all offer ways of dealing with mental health crisis outside hospital.

Needs and Demands

What are the needs?

Three groups of mental health crisis have been identified:

- new crises involving people who have not previously been in contact with services. Some may not have a diagnosable mental illness
- recurring crises occurring for people with mild to moderate mental health problems, substance misuse or personality disorder
- crises occurring for people with severe and enduring mental health problems.

If a crisis service is accessible to all, people from the first two groups are likely to form the majority of referrals. A service which is accessible only to people already in contact with specialist mental health services is more likely to focus only on people in the third group. Services which increase their accessibility tend to see a large growth in the first two categories but few extra people with severe mental illness.

What do users want?

Users have been critical of existing services which are based largely around A&E departments. These offer a potentially unsafe and unfriendly environment and the availability of specialist assessment is limited.

Users have been calling for more sensitive services to be available 24 hours a day, 7 days a week, with the following elements:

- face to face counselling
- service available at home
- self referral possible
- telephone counselling.

What support does primary care need?

Primary care staff play a crucial role in the early recognition and assessment of mental health problems. GPs see themselves as the first port of call for people in crisis and are sometimes critical of the support they receive from specialist services. There is a consensus with service users that rapid access to an experienced professional is required. GPs' preferences include:

- 24-hour availability of key worker/community mental health nurse
- a single point of access to specialist services
- availability of home assessment.

How can Services meet Needs?

Services tend to adopt two broad approaches to meeting these needs:

- developing separate services exclusively for people in crisis
- developing an emergency component to mainstream mental health care.

Both approaches have advantages and disadvantages, but one of the biggest problems for the second approach is obtaining staff with the necessary skills to handle crises and work out of hours.

What staff are required?

Where crisis teams have developed, they usually consist at least of social workers and community mental health nurses. However, the inclusion of a psychiatrist is also likely to be important, as they have control over hospital admission and can manage medication. Teams without psychiatrists have found that out of hours admissions to hospital have increased as newly identified patients requiring services often need medical assessment, or because admissions are arranged without the team's involvement.

Is 24-hour care really necessary?

Although users and GPs are calling for 24-hour care, it is not clear that where services work well, a full crisis team is actually required 24 hours a day. Where services are in frequent contact with severely mentally ill people the need for rapid response can usually be predicted and met within reasonable hours (say 9am to 9pm). An on-call service will normally be sufficient to meet those unpredictable crises which do occur out of hours.

What did the Research Show?

The report details the results of an evaluation of the Psychiatric Emergency Team in North Birmingham. This is a multi-disciplinary community based team which can provide support within people's own homes. It provides counselling, practical help, monitoring, and liaison with other services and is available 24 hours a day. A group of 58 service users using the Emergency Team, was compared with 58 people using a traditional acute hospital based service.

What issues did the research address?

The aim was to establish whether the Team, working alongside reduced inpatient beds, could deliver safe and effective emergency care and within this to ask:

- is such a service economically viable?
- can the service provide an effective alternative to traditional hospital care?
- what does the service provide to whom?

The results are summarised below:

Inpatient bed use

In the six months before the study, there was little difference in levels of bed use between the two sets of service users. But during the study there were only 27 hospital admissions of people receiving support from the Emergency Team as opposed to 61 in the group receiving a conventional service.

Effectiveness

At follow-up there was no difference between the two groups in terms of reduction in their psychiatric symptoms or the occurrence of untoward incidents or re-admissions.

Case Study: "Jean"

A 57-year-old woman, "Jean", who had a long history of mental illness, was referred to the Psychiatric Emergency Team by her consultant. She was unmarried, lived alone, and had spent four weeks in hospital 3 months prior to the referral.

Jean was experiencing severe depressive symptoms, including hearing voices, agitation and poor sleep. She had stopped taking medication. The team worked with her for just over 6 weeks and saw her a total of 57 times. On most visits they gave her medication.

Staff also offered practical support including liaising with the Neighbourhood Office, taking her to and from day hospital, which she had previously stopped attending, and helping with housework. The team also supported Jean's neighbour, who was her main carer, and liaised with other professionals such as her existing CMHT keyworker.

Initially, Jean's mental health seemed to improve, but as Christmas approached her symptoms worsened. During this time the team made extra visits and, despite the seriousness of her mental state, were able to avoid a hospital admission.

Costs

The overall cost of the emergency team working with reduced inpatient beds was significantly lower – the cost was around £2,750 per client, but for the conventional service it was around £4,000 per client. However, it is important to note that setting up an emergency team requires bridging money which can only be recouped from savings on inpatient care in the longer term.

User satisfaction

Users within both groups were generally satisfied with the services they received, but users of the emergency team particularly valued:

- 24 hour availability
- quick response
- the practical help and support they received.

Human resource implications

Staff enjoy working in the emergency team and there is high job satisfaction, with low turnover.

The study showed that a period of multi-disciplinary training and induction was invaluable. There was a particular emphasis on assessment, engagement and relapse prevention. A knowledge of local services and resources is also essential.

Service Development Implications

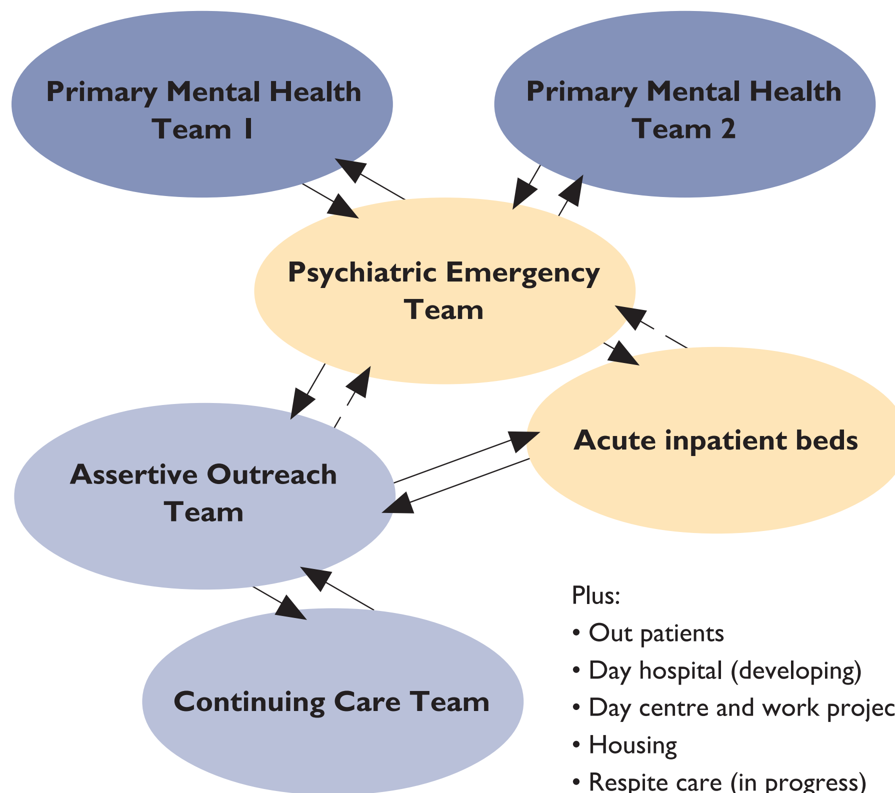
In deciding how to develop crisis services locally, it is important to:

- identify all current crisis services within the area
- collect information on the functions, hours and client base of these services
- consult local stakeholders
- assess individual and population needs.

In planning the service it is important to take account of the following principles:

- service users with the greatest needs and the poorest histories of engagement should be prioritised
- the service should be multi-disciplinary, including psychiatrists
- it must be integrated with all other local mental health services so that appropriate referrals can be made - otherwise the crisis service will become clogged up. An integrated model of service provision, as used in North Birmingham, is shown below.
- inpatient beds are still needed as part of a comprehensive service.

Service delivery



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