Acute inpatient wards and residential crisis alternatives: results from a UK multi-site study, The Alternatives Study

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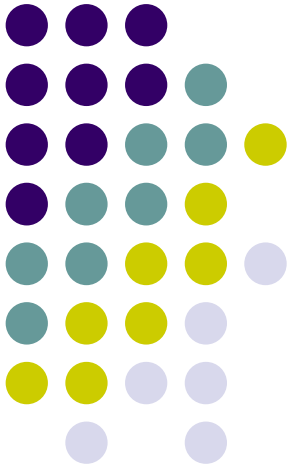
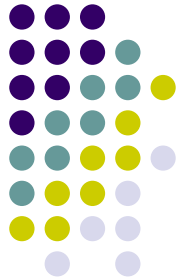


The Alternatives Study (TAS)



A national study evaluating residential and inpatient alternatives to standard hospital acute mental health wards

- NIHR SDO programme
- Study duration: 2005-2009
- Collaboration between Institute of Psychiatry & University College London

THE TEAM

CORE RESEARCH TEAM

IOP	UCL
Helen Gilburt	**Bryn Lloyd-Evans**
Mike Slade	**Sonia Johnson & David Osborn**

OTHERS INVOLVED INCLUDE:

Graham Thornicroft	Jed Boardman	Diana Rose
Sarah Byford	Morven Leese	Barbara Barrett
Alain Gregoire	Nicky Malone	Rachel Skinner
Dorota Jagielska	Geoff Shepherd	Nicola Morant

Why are alternatives of interest?

- Problems with acute inpatient care (bed pressures, high cost, user dissatisfaction)
- Patient satisfaction may be greater with community-based crisis houses than acute wards (Lloyd-Evans et al 2009)
- Potential synergy with crisis teams
- But little evidence in a contemporary UK context

TAS: Outline

Phase 1

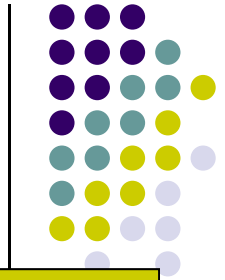
A survey of alternatives in England

(Johnson et al. 2009)

Phase 2

An evaluation of 6 alternative services, comparing with local acute wards

Phase 1: the National Survey



Criteria: In England, for adults 18-65 who would otherwise go to acute ward
In community AND/OR for specific group AND/OR
Specific therapeutic orientation AND/OR fixed length of stay

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Identification: via Trusts, internet,
National Mapping, literature, expert sources

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362 wards and residential services screened

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131 met criteria

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109 responders (81%)

Types of Alternative (from Two-Step Cluster Analysis)

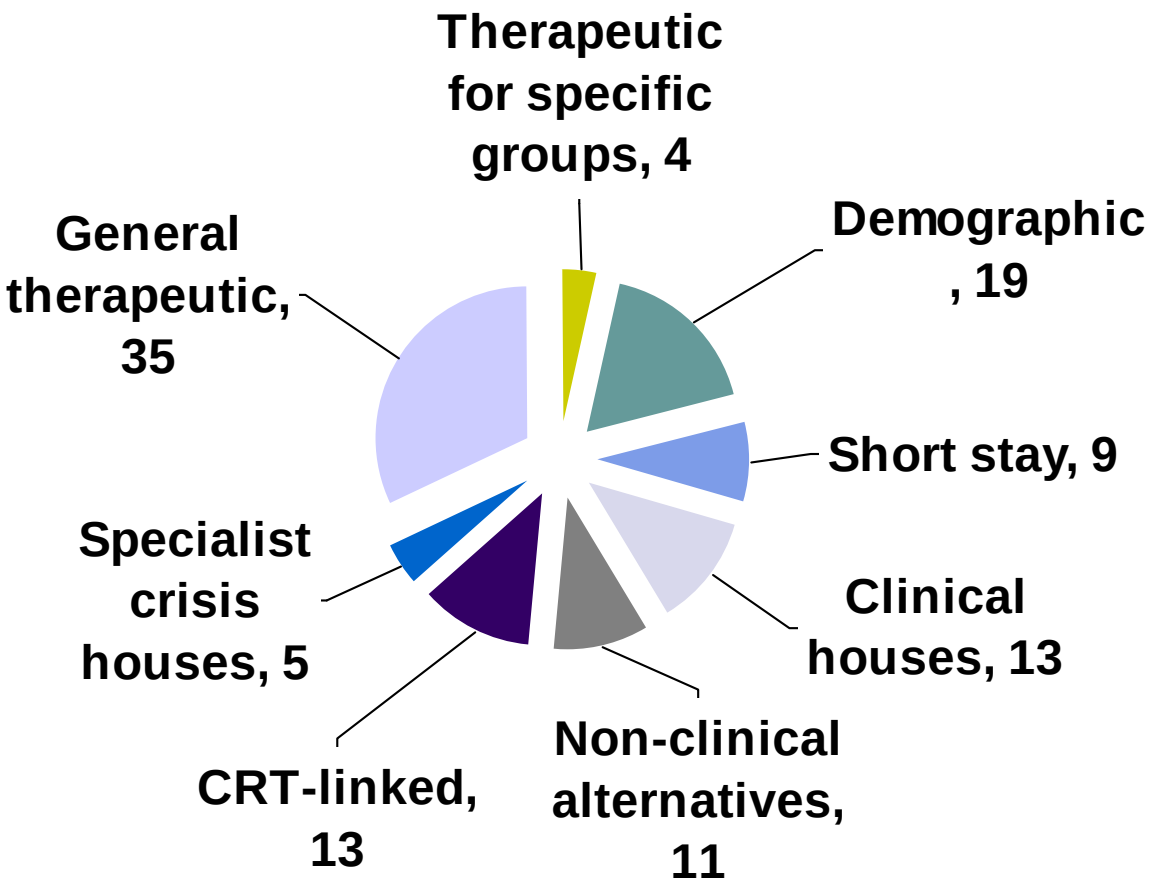
Hospital clusters

- General acute wards with therapeutic models
- Wards for specific Demographic groups
- Therapeutic wards for specific diagnoses
- Short stay wards

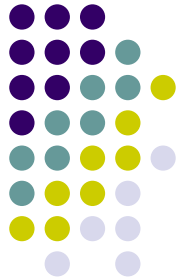
Community clusters

- Clinical community houses
- Short-stay CRT linked beds
- Non-clinical alternatives
- Specialist crisis houses

Distribution of services



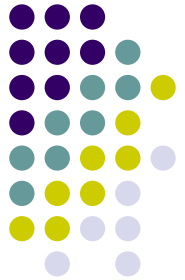
TAS Phase 2: Main Elements



Alternatives were compared with local acute wards:

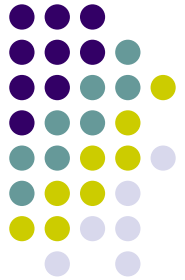
- Characteristics of service users
- Short and medium term health outcomes
- Service user satisfaction
- User and carer experiences
- Content of care
- Costs and cost-effectiveness

TAS Phase 2 – alternatives included



- Clinical crisis house –shared base and staffing with CMHT, sectioned patients admitted.
- Crisis beds – within a long-stay hostel, beds managed by CRT for brief admissions.
- Two non-clinical alternatives – both run by voluntary sector, one BME focused
- Brief stay ward – 3 day admission ward for all voluntary admissions.
- ‘Tidal Model’ ward

TAS main results: data sources



- Tidal model ward and local comparison service were excluded from main analyses.

- Clinical outcomes - cohorts of 35 consecutively admitted patients: health ratings by staff at admission and discharge and 1-year service use from electronic records (10 services, n=359)

- Satisfaction – questionnaires completed with 40 patients close to discharge (6 services, n=227)

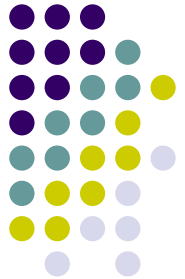
- Content of care - direct observation, 1-week staff activity log, patient questionnaires (6 services)

TAS: Limitations

Inferences about individual services should be drawn with caution from TAS results:

- Heterogeneity among services: main results may not apply to all services
- Inadequate statistical power for individual service comparisons
- Naturalistic methods and clinician-recorded data in some components

Who uses alternatives?

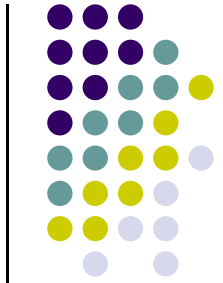


Four factors were independently associated with admission to alternatives rather than standard inpatient services:

- Known to services
- Patient initiated help-seeking
- Lower risk of harm to others
- Not detained

Not: severity of symptoms, risk to self, compliance with medication, demographic characteristics

Who uses alternatives: conclusions

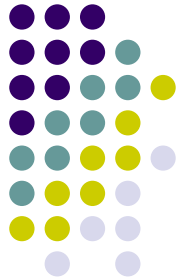


- Alternatives are not for the worried well: they do serve an SMI client group

- Large overlap with acute wards in population served but limitations re managing risk and containment

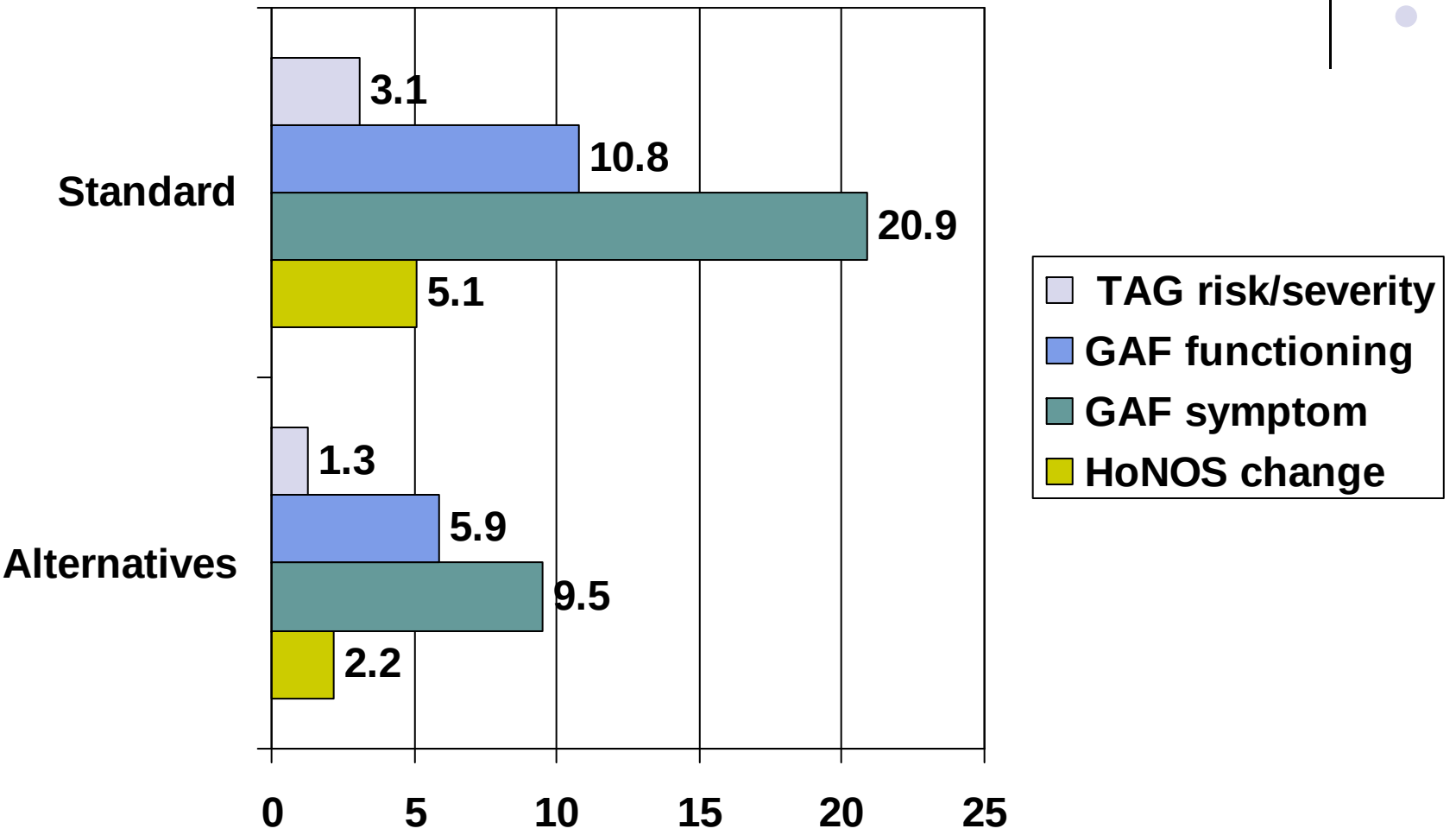
- Alternatives serve known clients because:
  - Risk management easier with knowledge of history?
  - Problems with access to alternatives for new clients?

Clinical outcomes: short-term

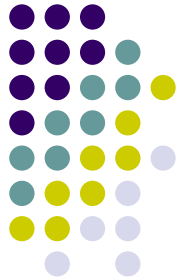


- At admission, patients in standard wards had slightly more severe symptoms
- Improvement in symptoms and social functioning during admission was greater at standard wards
- The relationship between length of stay and improvement is complex

Improvement during admission on key indicators



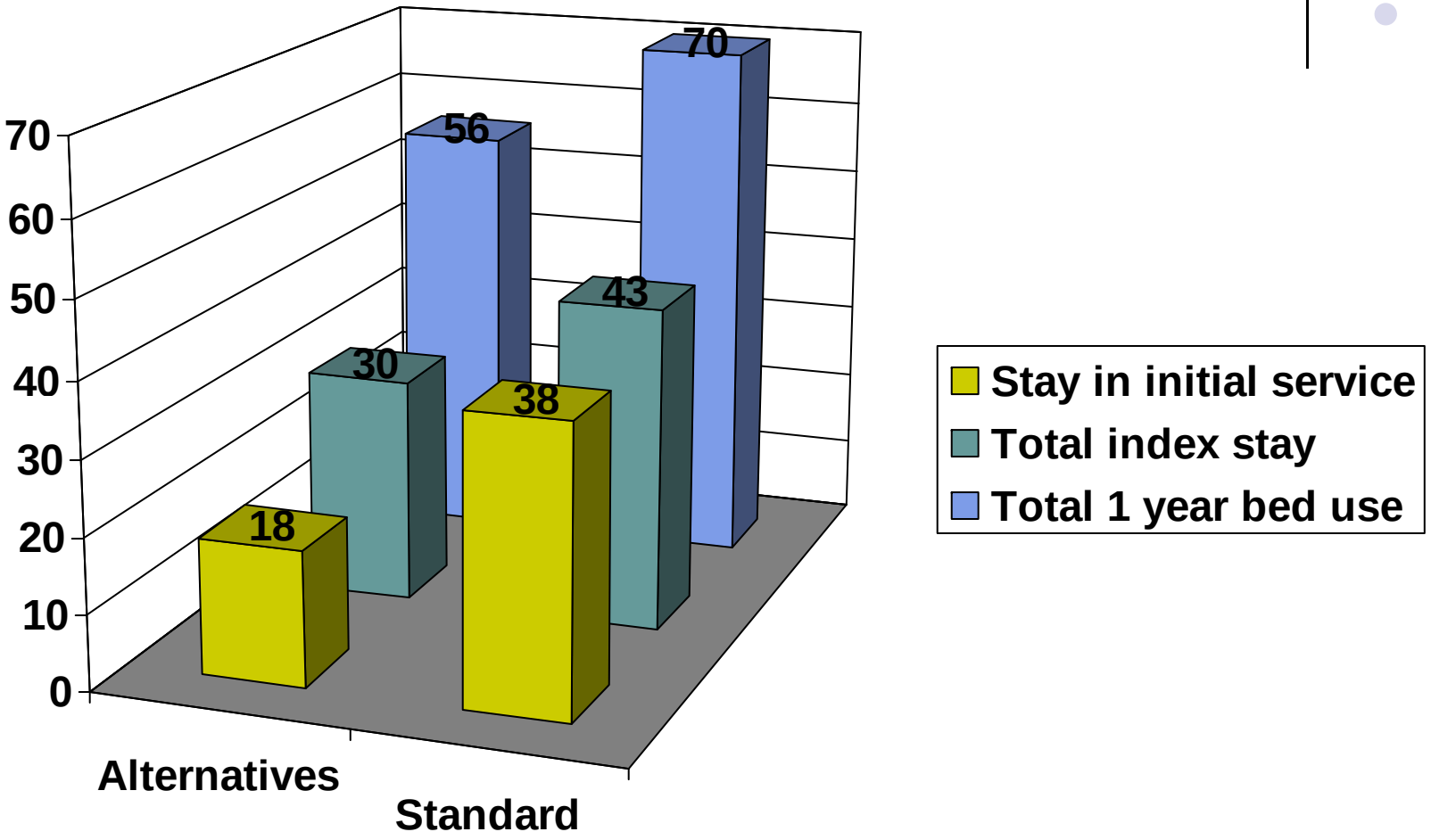
Service use



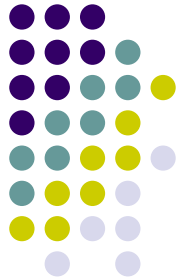
- Initial admissions were shorter at alternatives than standard wards (18 vs. 38 days)

- There was no significant difference in subsequent inpatient and community service use over 1 year follow-up

Length of stay: initial admission and 1 year admissions

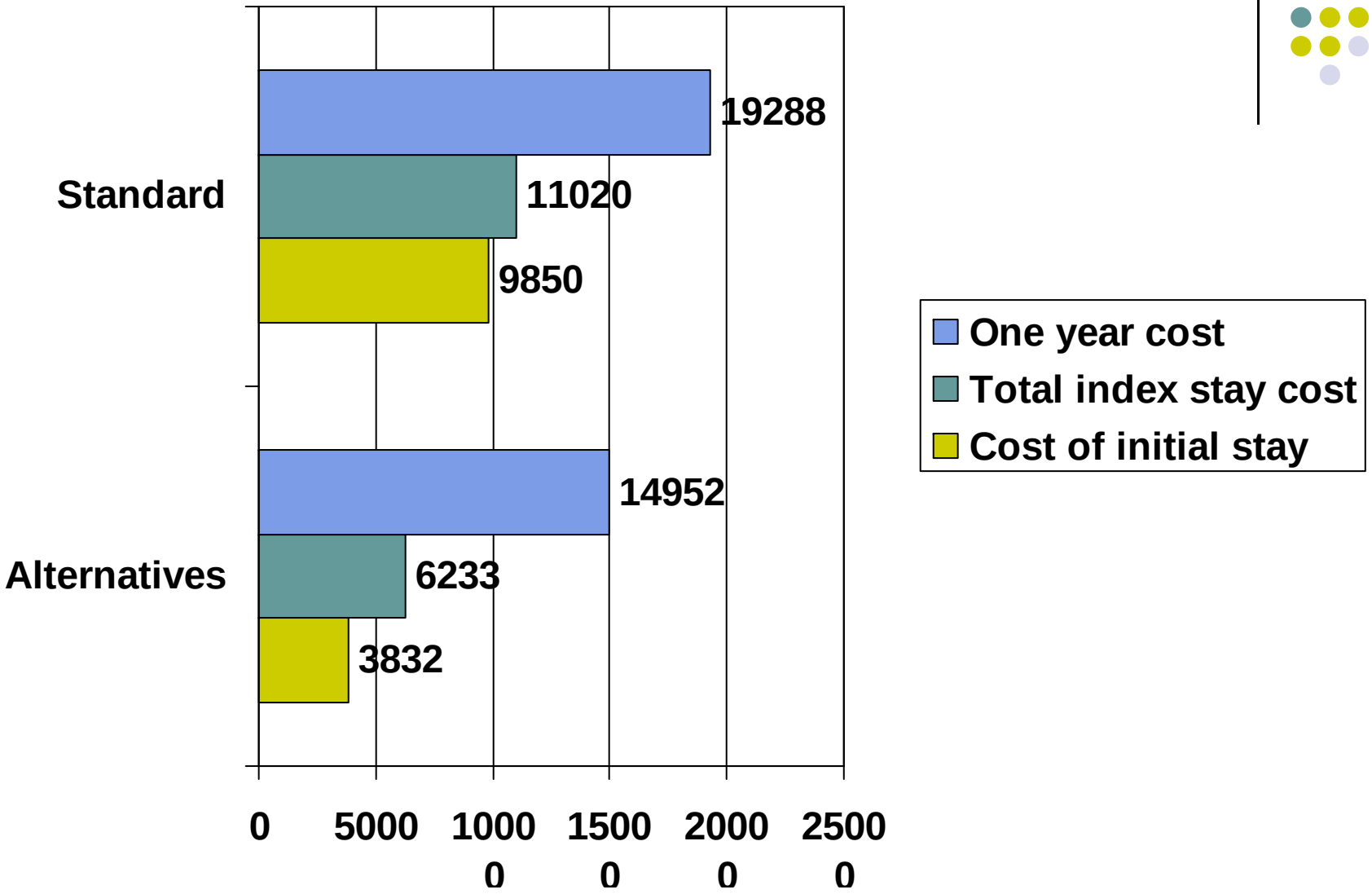


Costs



- Cost data strongly reflects inpatient bed use
- Mean cost per patient was less at alternatives than standard wards for initial admission (3.8k vs 9.8k) and 1-year follow up (15.0k vs 19.3k)

Cost: initial admission and 1 year



Clinical and cost outcomes

- Alternatives have shorter admission and are cheaper than standard wards.
- Patients improve less during admission at alternatives but are no more likely to be readmitted.
- Differences persist with statistical adjustment for baseline differences

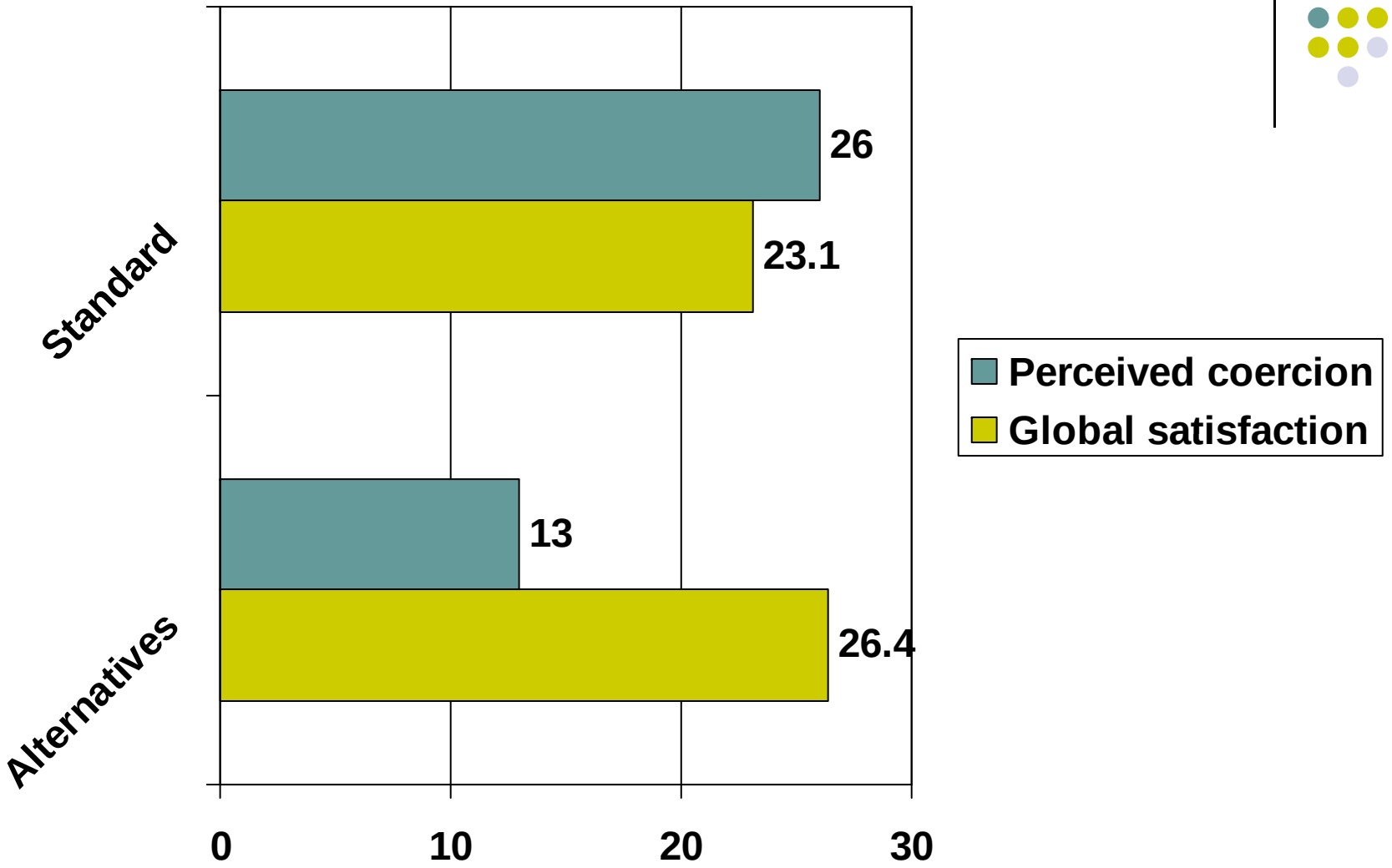
But this was not a randomised study

Satisfaction with services

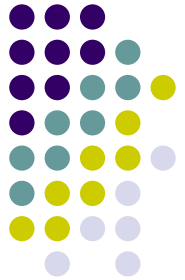
- Satisfaction was greater at alternatives than standard services. There was less perceived coercion.

- These findings were consistent for community alternatives. Differences remained significant after adjustment for MHA status.

Satisfaction and perceived coercion

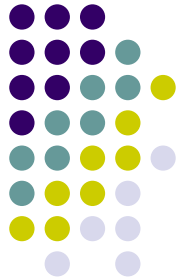


The care provided



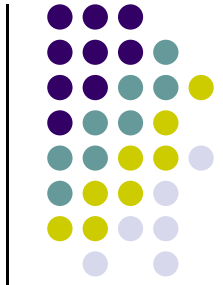
- Staff spend no more time with patients at alternatives than standard services.
- Alternatives may provide more psychological and fewer medical-type interventions than standard wards but differences are modest.
- Care looks quite similar overall
- Patients reported less anger and aggression at alternatives (Ward Atmosphere Scale data).

Conclusions: quantitative findings



- Evidence regarding the clinical and cost-effectiveness of alternatives compared to standard wards is not clear cut.
- Evidence regarding patient satisfaction supports the provision of alternatives.
- There is variation in alternatives' role, patient population, length of stay and cost: attention to local needs is important.

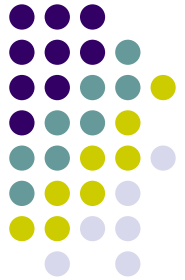
A second view of alternatives



Qualitative interviews with service users, carers and stakeholders

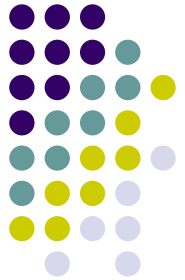
- Experiences of service users using alternative and standard services
- Experiences of carers of service users using alternative and standard services
- Understanding of the development, and role of the service within a local system

Data sources



- 40 service users admitted to an alternative service who had also had previous admissions at standard services
- 25 carers of service users admitted to an alternative service who had also had previous admissions at standard services
- 35 key stakeholders of participating alternatives (managers, service planners, referrers)

Experiences of service users



Patients reported an overall preference for residential alternatives.

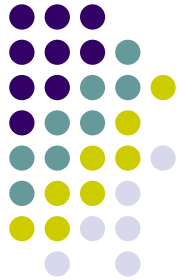
These were identified as:

- Having patients with lower levels of disturbance
- Being safer
- Having more freedom
- Having decreased levels of coercion
- Being less paternalistic

Experiences of service users 2

- Relationships with staff were key to patients' experience at alternatives and standard service
- Patients' experience of staff was variable at all services
- No clear differences in the types of interventions provided were elicited

Experiences of carers



- Carers valued alternatives as having better communication and a better atmosphere than inpatient wards

- But they often felt ignored in all types of service

Carers main priorities:

- Good care for the patient
- Being kept informed
- Courtesy from staff

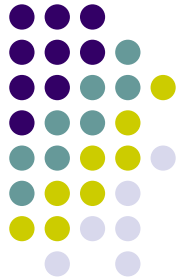
Stakeholder views: Role of alternative services

Four different roles were identified for alternatives:

- Acute admission equivalent to a standard acute ward
- Sub-acute care
- Step-down care, allowing early discharge from hospital
- Respite care

All alternatives were seen as serving a mixture of purposes.

Patient populations



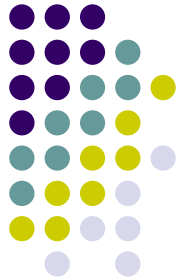
No specific clinical group targeted by Alternatives

Alternatives restricted in level of disturbance and risk they could manage by staffing levels and expertise and the built environment.

Possible developments..

- Managing people with Personality Disorders?
- Widening eligibility – accepting detained patients?

Referrals



Most referrals came from local specialist mental health services, and above all crisis teams.

Self referrals and GP referrals were seen to divert alternatives from a focus on acute crises.

Obstacles:

- Individual practitioners and teams referral preferences
- Complex referral procedures
- Lack of night staff

Alternatives' function in local service systems

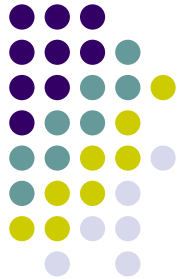
All alternatives were closely linked in with local NHS service systems.

Close links with other community services, especially Crisis Resolution Teams, were of central importance in allowing non-clinical alternatives to manage severe and acute crises

Alternatives were seen to reduce the pressure on standard acute wards and to offer choice

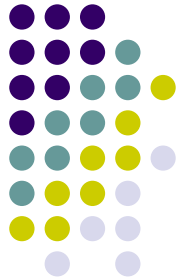
Criticism of alternatives: could do more?

Overview



- Alternatives to admission are widespread
- Purpose and population are similar to but not the same as hospital
- Shorter stays, lower costs, less improvement – readmissions no greater by one year
- Preferred by service users
- Not highly distinctive in model or care provided
- Valued by others in service system
- Synergy with Crisis Resolution Teams may result in greater effectiveness for both models

Future plans



- Greater patient satisfaction with Alternatives was not explained by clinical outcomes or differences in care provided.
- A follow-up study is planned to compare therapeutic alliance in Alternatives and inpatient wards and explore factors which enhance staff-patient alliance.
- Comparison between UK and Norway of characteristics and outcomes of people admitted to acute wards?

References

Literature review – alternatives to acute wards

Lloyd-Evans, B., Johnson, S., Jagielska, D. and Slade, M. (2009) “Residential alternatives to acute psychiatric hospital admission: systematic review” *British Journal of Psychiatry* 194(8) pp 109-117

Alternatives Study - Phase 1

Johnson, S., Gilburt, H., Lloyd-Evans, B., Boardman, H., Leese, M., Osborn, D., Shepherd, G., Thornicroft, G. and Slade, M. (2009) “Alternatives to hospital admission: emerging models and populations served.” *British Journal of Psychiatry* 194(5) 456-463

Alternatives Study – Phase 2

6 papers in British Journal of Psychiatry supplement: in press – due Summer 2010

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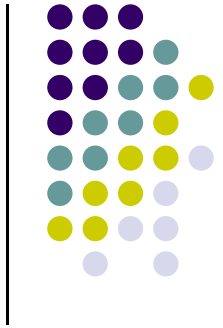

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