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Efficacy of mental health crisis houses compared with acute mental health wards: a literature review

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Key points

- *Crisis houses are more satisfactory to service users than acute wards, but service users who accessed crisis houses rated their rate of recovery lower*
- *Service users admitted to crisis houses experience fewer negative events, have more choice and autonomy, and receive more holistic care and informal peer support*
- *They said that they had less access to pharmacological treatments in crisis houses*
- *The literature suggests that service users are more satisfied with their care, the more time they spend with staff during their stay in either environment*

Abstract

Background Crisis houses are an alternative to acute psychiatric hospital admission.

Aim To review evidence of the efficacy of mental health crisis houses as an alternative to acute hospital admissions.

Method A systematic search of studies drawing on eight databases was undertaken, with a total of 135 articles identified. After the selection process, six quantitative and two qualitative studies met the inclusion criteria of the review. Of these, the quantitative studies were assessed for methodological quality using a 21-item tool and all studies were analysed using thematic synthesis.

Findings Four of the studies were rated methodologically strong and two as methodologically moderate. It was found that people admitted to crisis houses experience fewer negative events, have more autonomy, receive more holistic care and spend more time with staff members. They also receive more peer support and report more therapeutic relationships with staff.

Conclusion Service users who access crisis houses rather than acute wards tend to rate their recovery as lower and think that pharmacological treatments are less available. Crisis house admissions are shorter and less expensive than acute ward stays, but do not always prevent admission to hospital.

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Keywords

community, community care, mental health, mental health inpatients, mental health service users, psychosocial

Introduction

The Mental Health Crisis Care Concordat (Department of Health (DH) 2014) outlines four stages of mental healthcare: access to support before crisis point, urgent and emergency access to crisis care, treatment and care in crisis, and promoting recovery. It states that people experiencing mental health crises must have access to support before crisis point is reached, and have 'access to crisis houses or other safe places where people can receive attention and help' (DH 2014).

Paton et al (2016) evaluated the clinical and cost effectiveness of the models of care at each of the four stages identified in the concordat (DH 2014). Most of the evidence was rated as low quality using GRADE (Grading of Recommendations, Assessment, Development and Evaluations) (Guyatt et al 2008), a systematic approach for making clinical practice recommendations, but this may be due to the difficulty of conducting research into complex interventions for people experiencing acute mental health crises. In most of the studies, the risk of bias was unclear or there were confounding variables. There were also gaps in the research on subjects such as accessing support before a crisis, and urgent and emergency access to crisis care. Guyatt et al (2008) conclude that more high quality research is needed.

In Wood and Pistrang's (2004) study, service users said they had felt vulnerable and helpless during stays on acute wards, which they said lack hygiene facilities and home comforts. Service users also described buildings as being in poor physical repair, and some said acute wards do not provide culturally appropriate care and facilities. Service users have also reported experiences of violence and fear, and the unavailability of staff members (Gilburt et al 2008).

Crisis resolution and home treatment teams are an established home-based alternative to hospital admission (Carpenter et al 2013). They provide care to people in settings, including their own homes, other than hospitals for up to 24 hours a day (Mind 2018). Like most community mental health teams, crisis resolution and home treatment teams have a multidisciplinary approach (Burns 2004).

Residential alternatives to hospital admission referred to as crisis houses, which are usually small, with domestic environments (Sweeney et al 2014), were developed recently. Gender-specific support is usually available to women (Howard et al 2010), who are more likely than men to experience mental health problems and gender-based violence (World Health Organization 2019). According to Missing Link (2019), female-only crisis houses offer choice, safe environments, gender-specific responses and positive role models for women.

However, evidence suggests that service users with histories of violence are less likely to be admitted to crisis houses than those without such histories. No one can be admitted to crisis houses compulsorily, and force, restraint or seclusion are inappropriate in these environments (Sweeney et al 2014). Arguably, therefore, if crisis houses provide services only to people perceived to have less illness acuity, they may not be true alternatives to acute psychiatric hospital admission.

There is evidence that crisis houses are more cost effective (Sledge et al 1996, Lloyd-Evans et al 2009), or at least no more expensive, than acute mental health hospitals (Howard et al 2010). They are also considered to be at least as clinically effective in improving symptoms and functioning, and service users report higher satisfaction (Howard et al 2010). Female patients in particular prefer residential alternatives to hospital (Killaspy et al 2000), because for example they find female-only crisis houses more homely and less stigmatising and coercive, staff are more available and there are no male service users (Howard et al 2008).

A Cochrane review of crisis intervention found that community crisis mental healthcare is worthwhile, acceptable and less expensive than standard care. It also found that crisis houses reduce the number of repeated admissions to hospital, improve

the mental state of service users, are more acceptable and satisfactory to service users, and place fewer burdens on families and carers (Murphy et al 2015). However, the authors conclude that more research is needed to create a stronger evidence base.

Rationale for literature review

There are several measures, such as cost effectiveness, hospital admission rates, service users' levels of satisfaction and standards of therapeutic care, that can be used to assess the efficacy of mental health crisis houses.

In a literature review comparing mental health residential alternatives with acute admission wards, Lloyd-Evans et al (2009) found that the former are more cost effective and satisfactory to service users, but conclude that more evidence is needed to evaluate efficacy and define who are best served by crisis houses. This is supported by Parker et al (2015) who state that 'increased research efforts to understand and synthesise the literature are needed, as well as efforts to ensure better coordination and comparability of services research in the future'.

Determining which features of crisis houses contribute to their efficacy as potential alternatives to hospital admission has implications for future research into effective home treatment team interventions because home treatment teams often work with service users accessing crisis houses as an alternative to admission. It may also direct future alternatives to inpatient environments, which may lead to the further development of crisis houses or even the transfer of successful components of crisis house care to acute mental health wards or other healthcare settings. These clinical implications are especially pertinent in the current social, political and financial context of mental healthcare because of the perceived need to develop effective alternatives to admission to acute mental healthcare settings, which are considered expensive and potentially distressing environments.

Aim

The aim of this article was to systematically review the available evidence of the efficacy of mental health crisis houses as an alternative to acute hospital admission.

Method

A systematic search of studies was conducted using the databases the Cochrane Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PsycINFO, PubMed, Science Direct and Web of Science, with the following terms: 'crisis house*', 'residential alternatives (to acute admission)', 'alternatives to acute care' 'alternatives to standard acute care' 'sub-acute care', 'comparison', 'compared to', 'efficacy', 'vs', 'versus', 'acute or hospital' and 'care or wards or admissions'. This review explores the search terms with no defined measure of outcome, such as service user satisfaction, cost effectiveness, acute admission rates and bed occupancy, and the measure of efficacy in each study is discussed.

Peer-reviewed journals from health-related academic databases were included to maximise the trustworthiness of the data; the journal articles had already been subjected to rigorous academic scrutiny. Literature was used if it met the inclusion criteria:

» The study compares mental health crisis houses to acute admission wards.
» Participants were aged 18-65 years.
» The study was published from 2006 onwards; Lloyd-Evans et al's (2009) literature review examines studies published until 2006.

The exclusion criteria were:

» Participants were aged under 18 or over 65 years.
» Crisis houses did not provide 24-hour residential care.
» Crisis houses were for people with non-acute mental health problems, relating for example to domestic violence, physical health problems, support with housing difficulties, or drug and alcohol problems.
» Duplicate articles.

Thomas et al (2004) designed a 21-item tool that provides overall methodological ratings of 'strong', 'moderate' or 'weak' based on eight areas of methodological quality (Box 1). This tool was developed due to the increasing need for practice to be guided by evidence. It was thought in this case to be the most appropriate for the research question because it has been used in public health and nursing research and in a previous review of the crisis house literature (Lloyd-Evans et al 2009). Its potential weakness is that it does not examine relevant ethical and legal issues.

Box 1. Areas of methodological quality

- Analysis
- Blinding
- Confounders
- Data collection methods
- Intervention integrity
- Selection bias
- Study design
- Withdrawals and dropouts

(Thomas et al 2004)

The findings of all of the studies, including two qualitative studies briefly discussed but not analysed using the tool, were synthesised and coded using thematic synthesis to identify the most common themes in the literature (Thomas and Harden 2008).

Search and selection processes

A total of 135 articles was identified, with 65 being duplicates and 31 being excluded because they do not meet the specific inclusion criteria. Table 1 shows the number of articles identified and retrieved from each database, retrieved after duplicates were removed, excluded and included based on the preferred reporting items for systematic reviews by Moher et al (2009).

Table 1. Articles identified, included and excluded

Database	Number of articles			
	Identified	After duplicates removed	Excluded	Included
Cochrane Library	7	5	5	0
CINAHL	27	1	0	1
MEDLINE	4	1	0	1
PsycINFO	23	22	18	4
PubMed	13	5	5	0
Science Direct	54	0	0	0
Web of Science	7	3	3	0
Total	135	37	31	6

Table 2 shows the number of articles excluded with the reason for exclusion. The main reason for exclusion (*n*=15) was that the study does not compare acute mental health wards and crisis houses. Seven articles were published too early to be included, two were excluded on the basis of being alternatives to long-term residential care, two explored patients predominantly with physical health needs, two explored dementia care, and one discussed issues relating to child and adolescent mental healthcare. A further two studies used purely qualitative methodology so it would have been impossible to assess the quality of the studies using Thomas et al's (2004) tool.

Table 2. Reasons for exclusion of articles								
Database	**Not a comparison**	**Published too early**	**Alternative to long-term residential care**	**Physical health needs**	**Dementia care**	**Qualitative methodology**	**Children and adolescent mental health care**	**Total**
Cochrane	0	0	0	2	2	0	1	5
CINAHL	0	0	0	0	0	0	0	0
MEDLINE	0	0	0	0	0	0	0	0
PsycINFO	8	7	2	0	0	1	0	18
PubMed	4	0	0	0	0	1	0	5
Science Direct	0	0	0	0	0	0	0	0
Web of Science	3	0	0	0	0	0	0	3
Total	15	7	2	2	2	2	1	31

Results

Table 3 summarises study characteristics, namely publication year, study design, participants, setting, measure, as well as the overall rating using the quality assessment tool (Thomas et al 2004) and findings.

Table 3. Summary of data						
Primary author and publication year	**Rating**	**Study design**	**Participants**	**Setting**	**Measure**	**Findings**
Hawthorne et al (2009)	Strong	Questionnaire	93 patients, all veterans, randomly assigned to hospital (*n*=45) or short term acute residential treatment (START) (*n*=48)	START service or acute admission ward for veterans, San Diego California	Ward Atmosphere Scale (WAS) (Friis 1986)	The START environment was rated more favourably, with lower levels of anger and aggression, higher levels of support, and more problem orientation, order and organisation
Howard et al (2010)	Moderate	Pilot patient-preference randomised controlled trial	103 women assigned to randomised (*n*=42) or patient preference (*n*=61) arms	Two crisis houses, London	Level of functioning and symptoms, quality of life, unmet needs, satisfaction, coercion, and stigma	No significant difference in outcomes or costs for any of the groups, but women who obtained their preferred intervention were more satisfied with their treatment
Lloyd-Evans et al (2010)	Strong	Semi-structured interviews and quantitative investigation	23 interviews with professional stakeholders. Quantitative data: 871 of 919 eligible staff and 314 of 447 eligible service users	Four alternative and four standard inpatient services, London	Camden Staff-Patient Activity Record, Camden Record of Inpatient Care Events and Camden Content of Care Questionnaire (Lloyd-Evans et al 2010)	Alternative services were perceived to be more collaborative and informal, and to give patients more time. The multiple method quantitative assessment found no significant difference in intensity of staff-patient contact at alternative and standard services. Community alternatives were perceived to offer more psychological care, standard wards more physical and pharmacological care
Osborn et al (2010)	Strong	Questionnaire	314 patients	Four residential alternatives compared with four standard	A Client Satisfaction Questionnaire (Attkisson and Greenfield 1994), the	Service users from alternative services reported greater levels of satisfaction, perceived less coercion and

				services, London	Service Satisfaction Scale – Residential Form (Attkisson and Greenfield 1994), the WAS and the Admission Experience Scale (Gardner et al 1993)	having more 'voice', greater autonomy, more support and less anger and aggression than in the ward environment
Siskind et al (2013)	Strong	Quasi-experimental using matched controls	193 crisis house patients and 371 matched controls	A four-bedroom crisis house compared with standard acute inpatient care, Brisbane, Australia	Cost and length of hospitalisations, demographics and illness acuity were compared one year before and one after an acute index episode of residential care involving hospital and/or the residential alternative	Patients spent 5.35 fewer days in the residential alternative than the controls after adjusting for illness acuity, living conditions, marital status and emergency department presentations. The cost per day of a stay in the residential alternative was less than that of standard acute care
Sweeney et al (2014)	Moderate	Cross-sectional design. Mixed methods with structured and semi-structured interviews	108 crisis house and 247 acute ward service users	16 inpatient wards in two NHS trusts and four crisis houses, London	A scale to assess therapeutic relationships (McGuire et al 2007), a client satisfaction questionnaire (Attkisson and Greenfield 1994), the Interpersonal Relationship Inventory: Abbreviated Version (Tilden et al 1994), the Recovery Assessment Scale (Giffort et al 1995) and the Negative Events Schedule (Johnson et al 2009)	Therapeutic alliances, service user satisfaction and informal peer support were scored higher, and recovery and negative events were scored lower, in crisis houses than in acute wards. Perceptions of kindness and empathy, and amounts of service user autonomy and liberty, influence the therapeutic alliance

Findings

Eight articles in total were retrieved using the inclusion criteria. Six of the studies (Table 3) had quantitative or mixed methods designs and could be quality assessed using Thomas et al's (2004) tool. Four of these were considered 'strong' and two 'moderate'.

A further two qualitative studies were retrieved. In one, Morant et al (2012) conducted semi-structured interviews with mental health professionals from residential services other than standard acute inpatient admission services. Their findings suggest that crisis houses are more holistic in their approach to mental healthcare, but that residential alternatives are perceived to be less appropriate for highly disturbed patients because they provide less comprehensive treatment packages than hospital settings. In the other, Gilburt et al (2010) conducted interviews with service users in residential alternatives who had previously experienced inpatient stays. Patients reported an overall preference for residential alternatives, where they say there are lower levels of disturbance and less coercion and where they had more freedom and felt safer. There were no reported differences in service users' relationships with staff or the care they received between the two types of service.

The findings of all of the studies were analysed using thematic synthesis (Thomas and Harden 2008) and six themes emerged (Table 4). The research suggests that service users who are admitted to crisis houses rather than acute wards experience fewer negative events, such as anger and aggression, perceive that they have more choice and autonomy, receive more psychological and holistic care, spend more time with staff, have more therapeutic and empathic relationships with staff, and receive more informal peer support.

Table 4. Emergent themes

Main theme	Subthemes
Adverse events	» The extent to which patients experience anger, aggression, disturbance » Fewer adverse events in crisis houses » Service users felt safer in crisis house environments
Autonomy	» Liberty, receiving preferred intervention, collaboration, less coercion, 'voice', autonomy, influence over type of care received and freedom were associated with service user satisfaction and were more associated with crisis house environments than acute wards
Relationships	» Therapeutic alliance, kindness, empathy, warmth, honesty, trustworthiness, reassurance, helpfulness, calmness, humour were associated with satisfaction in both environments, but tended to be more associated with crisis house environments
Type of treatment	» Fewer comprehensive treatments were available, but more psychological and holistic treatments, in crisis houses » Acute ward environments offered more pharmacological treatments
Staff-patient contact	» Staff time was important in both environments and increased care of any type was associated with more satisfaction » Staff were perceived to be more available in crisis house alternatives than on acute wards
Informal support	» Peer support was an important component of the support felt to be available in crisis houses

Discussion

Service users who received their preferred intervention, in a crisis house or on an acute ward, were more satisfied with their care. This finding has clinical implications in situations where it is clinically safe and possible to offer service users the environment they feel is most conducive to their recovery. However, although such decisions are usually made with service users, they are often determined by professional assessment including assessment of risk, the individual's mental capacity to make specific decisions about their care and providing care in the least restrictive environment available, a guiding principle of the Mental Health Act 2007.

Service users tend to experience more adverse events, such as disturbance, anger and aggression, on acute mental health wards than in crisis houses. Staff on acute wards must continually develop strategies for de-escalation and managing conflict, and service users who have been involved in distressing incidents should be offered support and opportunities to reflect on the incidents with staff members to reduce their distress in accordance with National Institute for Health and Care Excellence (2017) guidelines on the management of violent and aggressive behaviours in people with mental health problems.

Service users in crisis house and ward environments reported that the staff characteristics most important in the development of therapeutic alliance are kindness, empathy, warmth, trustworthiness, calmness and humour. This finding has implications for the recruitment of support staff, nursing students and qualified nurses. Interviews and group tasks could be undertaken to assess for these characteristics, and specific training could be delivered to increase staff awareness of the importance of these characteristics to service user satisfaction. It may also be helpful to foster a culture in which these characteristics are valued by the workforce. Mental health staff must be well supported in their roles and have access to frequent, meaningful supervision that offers them opportunities to reflect on issues and to reduce the risk of burnout and frustration.

The findings suggest that there was a perception that pharmacological treatments are more available on acute wards and more psychosocial interventions are available in crisis house environments. This may be because the medical model of care and psychiatry-led approaches tend to be adopted on acute wards more than in crisis house or community environments, where service users should be offered a choice of pharmacological and psychosocial interventions.

Service users tended to view the amount of time they can spend with staff as more important than the interventions provided, and this was often associated with greater service user satisfaction. This finding has implications for practice. For example, 'protected patient engagement time' (McAndrew et al 2014), a specific time of day when ward staff can spend one-to-one time with service users without interruption by other clinical or administrative duties, could give service users

opportunities to express their preferences for care, which could then be discussed at the next multidisciplinary meeting. This can empower service users by giving them choice and autonomy.

This finding also has implications for recruitment. If protected time with staff is more valuable to service users than the interventions they are offered, it may be cost effective to employ more unregistered members of staff or volunteers to be available to service users, so more time is spent on being together rather than on the delivery of specific interventions. This is pertinent to the current nursing climate, in which recruiting and retaining qualified mental health nurses are often difficult. It may also be applicable to general hospital settings, where not all tasks need to be carried out by registered practitioners.

Many of the studies cite the importance of peer support to service users during episodes of acute mental health crisis and there may be opportunities to increase such support, for example during recovery from acute episodes of illness. This finding may have wider nursing implications, such as the facilitation of peer support for people with acute or chronic physical health problems.

The findings also suggest that the physical environments of acute mental health settings are important to service users, with crisis houses being perceived as 'homely' or as having more 'home comforts'. The extent to which elements of a homely environment can be replicated on an acute psychiatric ward or in general hospital settings, wherever safe and possible, should therefore be considered.

Methodological issues

A significant methodological issue when comparing crisis houses and acute wards is the extent to which they cater for service users with similar clinical needs. Crisis houses do not usually accept service users who are detained under the Mental Health Act 2007, exhibit signs of violence and aggression, or are undergoing detoxification from drugs or alcohol. Comparisons between the two environments can therefore be limited.

There may also be inherent biases in qualitative and quantitative methods in this area of research. In qualitative research, service users may feel obliged to be complimentary about the care they have received; in quantitative research, for example involving a Likert scale, service users may be required to select categories that do not adequately reflect their range of experiences in the care environment.

A methodological issue highlighted by use of the evaluation tool (Thomas et al 2004) was how few of the studies discuss the reliability and validity of the measures used in them.

Ethical and legal considerations

Few of the studies consider whether asking acutely unwell service users to participate is ethically valid and whether they had the mental capacity to participate in research when experiencing acute episodes of mental health problems. There may be ethical implications of asking such service users whether they think they are being treated kindly, for example, because some may feel obliged to be complimentary about the care they receive.

Strengths and limitations

This review used the same quality assessment tool (Thomas et al 2004) as the previous literature review by Lloyd-Evans et al (2009). This was thought to be the most appropriate tool because it was designed to fulfil a growing need for evidence-based practice and has been used in health research before. These factors add validity to the use of the tool for this research topic and add consistency to reviews of evidence on the efficacy of crisis houses.

This review has attempted to incorporate qualitative evidence of the efficacy of crisis houses compared with that of acute wards by using a thematic analysis, drawing out relevant themes from the available qualitative and quantitative data.

Future research

This review highlights some important similarities and differences between care in crisis houses and care on acute wards, but does not establish clear cause-and-effect relationships between the numerous, complex variables involved. Future methodological designs could reduce or control the extent to which several confounding variables may affect results.

Areas for future research include identifying which service users benefit most from crisis houses (Siskind et al 2013), exploring how 'things are done, rather than what is done' in acute care (Lloyd-Evans et al 2010) and assessing service users' levels of satisfaction at different points in their care (Osborn et al 2010).

Osborn et al (2010) argue that quality of care, clinical progression and recovery are important variables to be explored further, along with interpersonal and relationship variables. How people can benefit from crisis house admission to avoid subsequent hospital admission should also be explored.

Mental health services are increasingly focusing on the needs of carers of people with mental health problems (Cleary et al 2005), but carers' perspectives have not been widely explored in the literature. One subject for future research could be how collaboration with carers affects recovery and satisfaction in acute mental healthcare environments.

Conclusion

Most of the research findings in this review describe crisis houses as more satisfactory to service users than acute wards, but service users who accessed crisis houses rather than acute wards rated their rate of recovery lower. They said that they had less access to pharmacological treatments in crisis houses and, although admissions to crisis houses did not last for as long and were less expensive than those to acute ward, crisis house stays do not necessarily prevent subsequent admissions to hospital.

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