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Assessment and documentation of substance abuse by crisis resolution home treatment team: A quality improvement project

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Abstract:

AIM: Substance abuse is associated with mental health crises, leading to increased attendance in A and E and hospital admissions. This quality improvement project (QIP) evaluated the assessment and documentation of substance abuse of patients admitted under the crisis resolution home treatment team (CRHT) as well as any change following a teaching session as an intervention.

METHODS: Data from 40 consecutive patients admitted under the CRHT from the 1st of September 2023 were collected. The CRHT uses the "Core Crisis Resolution Team Fidelity Scale" as the standard of practice and this was utilized as the benchmark for the QIP. A teaching session for nursing staff was conducted as an intervention. Following the teaching session, the second cycle of data was collected from 40 consecutive patients.

RESULTS: Substance abuse was documented by CRHT in 30% of patients (12/40). However, the proportion was 70% (28/40) when documentation by other secondary services, such as mental health liaison, community mental teams, and the sources of referral were considered. Following the educational session, CRHT documented substance abuse for 37.5% (15/40). When documentation by secondary services was checked, the percentage of patients with documented substance abuse was 67.5% (27/40).

CONCLUSION: The QIP suggested a minor improvement in the documentation of substance use after the educational session of the nurses. Multiple sessions of sessions, a longer period before reassessment to allow change of practice, and a prompt in the evaluation document might improve the assessment and documentation of substance use by the patients in CRHT.

Keywords:

Crisis, home treatment team, psychiatry, substance abuse

Introduction

Crisis resolution home treatment team (CRHT) is a service that was introduced into the United Kingdom in 2000 by the Department of Health with the publication of the national health service (NHS) plan.[1] This was in response to a high rate of inpatient psychiatric admissions and low satisfaction with care seen in the UK in addition to the increase in complexity of mental health crises. It aimed to ensure there was consistent community-orientated care for patients experiencing acute psychiatric crises across the country. 2001–2002 was the first period in which the NHS plan was formally implemented which led to an increase in the number of outreach teams and crisis resolution teams (CRTs) offering home treatment.[2,3]

CRHTs aim to provide support to adults with severe mental illness who would need intensive support or admission. They also aim

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to always provide a community-based service accessible for patients; guidance from the Department of Health stating "24 h a day, 7 days a week." The guidance also advised CRHTs to "gatekeep" inpatient mental health services. This involves assessing patients who have deteriorated in their mental health and then considering home treatment, if suitable, or arranging inpatient admission. Furthermore, CRHTs were asked to also be actively involved in discharge planning and provide care at home to enable early discharge. The aim of this is to ensure that patients are treated in the least restrictive environment and to reduce the time patients spend as an inpatient.[4]

CRHTs in the UK treat patients who are experiencing an acute deterioration in their mental health in the community by providing numerous interventions. These include ensuring there is a comprehensive initial assessment, managing symptoms, providing education about mental health and identification as well as correction of any potential triggers. Psychiatrists also help provide care to patients in CRHTs, ensuring they operate with a team-focused approach to help patients.[5]

Treatment in the patient's residence by CRHTs is emphasized. These are founded upon the idea that hospital admission carries a huge stigma and some patients find that unacceptable. It has been recognized that social and environmental triggers can be better addressed with treatment at the patient's own home.[6,7]

Substance abuse is a very important consideration in psychiatric illness. Substance abuse can lead to deterioration in mental health for some patients. They can also interact with medications that have been prescribed to help patients. A review of drug interactions with medications highlighted that psychotropic medications can interact with drugs leading to reduced efficacy or adverse reactions.[8] In the context of psychiatry, one study has shown that cannabis can increase the effect of lorazepam and therefore could lead to patients accidentally overdosing.[9]

In the context of CRHT, there are a limited number of studies evaluating substance abuse for patients under CRHT. A multicenter study of 4 UK centers highlighted that 44% of patients reported a drug or alcohol use problem over the year before the publication of the study. Furthermore, 75% of drug service users and 85% of alcohol service patients had a psychiatric disorder in the year leading up to the study.[10] This study highlights the importance of ascertaining which patients have substance abuse, especially when they are admitted under the CRHT, to provide them with further support. As well as this, the studies have shown the importance of education on substance abuse for both patients and health-care professionals.

The CRHT uses the "core Crisis Resolution Team Fidelity Scale" as the standard to benchmark its practice.[11] These were the standards that were used in this quality improvement project (QIP). The Fidelity Scale has 39 different items. Item 11 specifies guidance about the assessment of patients: "Item 11: The CRT assertively engages and comprehensively assesses all service users accepted for CRT support. A structured assessment is carried out documenting substance abuse." Included in this item is criteria which states that a structured assessment must be carried out with 12 points that need to be documented. One of these points includes ensuring substance abuse is documented. Each item is scored from 1 to 5. To attain the minimum score, it requires 80% of patients to have documentation, and to attain the maximum score it requires documentation for 90% of patients. Joint assessments or any documentation within 2 days of admission to CRHT by other secondary mental health services such as the Mental Health Liaison Service, community teams, or any other service that has referred the patient can be used.

This QIP aimed to evaluate the documentation of substance abuse of patients admitted under the CRHT in a city in the Midlands, UK. Specifically, we investigated the percentage of patients with documented substance abuse by a member of the CRHT. Secondary aims included evaluating if a specific substance and frequency of use was documented. A teaching session for nursing staff, comprising of information about substance abuse and substance interactions with medications, formed the intervention, and data will be recollected to evaluate for improvement.

Methods

This was a QIP comprising two cycles with an intervention implemented after the first cycle.

The first cycle involved collecting the data from the first 40 patients admitted under the CRHT from the September 1, 2023 where available. Some patients were removed from the consecutive list for the following reasons: They did not have a first assessment, there was insufficient documentation on the online system or they did not engage with the CRHT.

All data were anonymized to ensure patient confidentiality was maintained.

Data collected included age, gender, diagnosis, substance abuse, which service documented the substance abuse first, did CRHT document a substance abuse, which substance was abused (if any), frequency of use, and which services were documented for patients that may use their services for substance abuse.

The intervention was a teaching session delivered to the nursing staff. They are, primarily, the team members responsible for visiting patients at their residences, and are usually the first to assess patients on referral to the CRHT. The session was held on the October 18, 2023 with 7 members of the nursing staff. I produced a presentation and highlighted the results of the data collection from the first loop. I also explained the importance of substance abuse in the context of mental health by explaining interactions with medications, how substance abuse can affect patients, and ways to provide support to them. Using the teaching, I encouraged them to always ask about substance abuse when seeing any new referrals to the CRHT. Data were collected from the nursing staff to evaluate the impact of the teaching session.

The second cycle was started in early December. Data were collected from the first 40 patients admitted under CRHT from the November 1, 2023. The same exclusion criteria from the first cycle were used and the same data were also collected.

Results

Data were collected from 40 patients in the first cycle. There were 16 males and 24 females. The age ranged from 19 to 61, with the mean age being 38.7 years old. The most common diagnosis was emotionally unstable personality disorder (EUPD) with 13 patients. CRHT documented substance abuse for 12 out of 40 patients (30%). When including secondary services, there was documented substance abuse for 28 out of 40 patients (70%). Out of the 28 patients, 7 had abused substances, with 5 having alcohol, 1 was misusing cannabis, and 1 was misusing cocaine. Two patients had a recovery service documented in the notes that they attend for support.

Data were collected from the nursing staff that attended my teaching session on the October 18, 2023. Three nurses responded to the survey sent. They were asked to rate their knowledge (on a Scale of 1–5 with 5 being the best) of substance abuse and interactions with medications before the session. They rated their knowledge as 2, 3, and 4 out of 5. After the session, 1 rated their knowledge as 4, and 2 rated their knowledge as 5/5. All the nurses felt the teaching session provided new insights and information they were not aware of. They also highlighted that the session allowed them to reflect on the importance of substance abuse.

I also collected data from 40 patients for the second cycle. There were 13 males and 27 females. The age ranged from 21 to 64 years old with the mean age being 40.7 years old. Six patients had the most common diagnosis of EUPD. CRHT documented substance abuse for 15 out of 40 patients (37.5%). When including secondary services, there was documented substance abuse for 27 out of 40 patients (67.5%). Out of 27 patients, 9 abused substances, 5 using cannabis, and 4 using alcohol. Two patients had a recovery service documented in the notes. The frequency of substance use was documented twice in the first cycle and once in the second.

Table 1 provides further data that was collected for both cycle 1 and cycle 2.

Discussion

The results showed an improvement in the documentation of substance abuse from the CRHT team after the intervention. This improvement implies that the teaching session may have been impactful to the nurses. The standard of documentation was poor in comparison to the standards. The standards give out a minimum score of 1 when at least 80% of patients' notes are documented with substance abuse. Even when including secondary service documentation, the maximum percentage of documentation was 70%. Therefore, improvements still need to be made to hit the targets suggested by the standards.

The teaching session given to the nurses was the intervention in this QIP. There was an improvement, postintervention, from 30% to 37.5% of patients having documented substance abuse. However, 7 nurses attended the teaching session, with 3 providing feedback so it is difficult to ascertain whether the improvement was directly due to the session or because of other variables. The CRHT has approximately 15–20 nurses who conduct assessments, so most of the CRHT nurses did not attend the teaching session.

The data from this QIP showed a small percentage of patients who abuse substances. There are a few reasons why this may have been seen. One of them being that patients in the region do not abuse substances. However, studies have shown that the prevalence of substance abuse is around 59.8% in patients with schizophrenia.[12] Another reason is that patients may not wish to disclose their substance abuse. A study investigating the disclosure of drug use by patients organized a questionnaire to be given to those patients. The study noted that 47.8% of participants disclosed their drug use to a health-care professional and they reported experiencing poorer quality of care. Therefore, further work must go into de-stigmatizing substance abuse and providing nonjudgmental avenues for patients to disclose it for services to deliver further support for them.[13]

In addition to this, the documentation of the frequency of substance use was poor. This is important as the use of

Table 1: Summary of cycle 1 and cycle 2 results

Demographics	Cycle 1 (*n*=40), *n* (%)	Cycle 2 (*n*=40), *n* (%)
Gender		
Male	16 (40)	13 (32.5)
Female	24 (60)	27 (67.5)
Age range	19–61	21–64
Mean age	38.7±13.7	40.7±14.7
Documentation		
Documentation of substance abuse by CRHT	12 (30)	15 (37.5)
Documentation of substance abuse including secondary services	28 (70)	27 (67.5)
Substance abuse		
Total number of substance abuse	7 (17.5)	9 (22.5)
Alcohol abuse	5 (12.5)	4 (10)
Cannabis abuse	1 (2.5)	5 (12.5)
Cocaine abuse	1 (2.5)	0
Frequency of substance abuse documented	2 (5)	1 (2.5)
Service use for substance abuse documented	2 (5)	2 (5)

CRHT=Crisis resolution home treatment team

substances such as alcohol in high frequencies could lead to illnesses that can impair health and require specialist treatment.[14] Furthermore, studies have shown that people with mental illness are at increased risk of overdose and death due to accidental overdose.[15] By healthcare professionals also understanding the frequency of use, they can provide support for patients to highlight their concerns and also identify those that may be at higher risk of overdose or sudden deterioration in their health.

People who abuse substances are typically vulnerable and usually have more unmet needs such as not being able to access counseling or medication help.[16] Therefore, it is important to highlight these findings and improve education on documenting substance abuse, especially from CRHTs. CRHTs provide a range of support such as education and addressing environmental triggers of mental health deterioration.[5] By identifying patients who abuse substances, CRHTs can provide extra support and help address their needs in a more targeted manner.

To continue this project forward, an audit of data across the month of December would be useful to assess the long-term impact of the single teaching session. As well as this, delivering further teaching sessions intermittently may also reinforce the importance of documentation and ensure most of the nurses in the CRHT have teaching on this topic. This is important to ensure there is continuous improvement in services.

There were some limitations and points of improvement with this QIP. The first limitation was that data was collected from 40 patients. To make a statistically significant change, a larger cohort of patients could have been used whilst ensuring they were admitted over a period of a few months. As well as this, the data collected in the second cycle was very close to the intervention to the date of the intervention. Whilst a teaching session should have an immediate impact, it may take some time for the action points to be implemented. Therefore, there is a possibility that the data may not have reflected any changes because of the intervention. As the teaching session was attended by approximately half of the nursing team of which 3 out of 7 filled out the survey, this is also a limitation of the study due to the lack of feedback on the effectiveness of intervention and a lack of overall engagement.

Further interventions could be investigated, for example, creating a proforma for nurses to use when assessing patients which includes a section to document substance abuse. This intervention is likely to be more beneficial as staff that were unable to attend the teaching or had forgotten the key points would still be able to follow the pro forma and document substance abuse. It is important not to discredit education. If a pro forma was created alongside providing teaching sessions, this may be the best approach as it will be sustainable and the education can be passed on to nurses who may join the team at a later point with regular auditing to acknowledge the progress of any interventions. As well as this, involving patients may be useful as they can be educated on the importance of disclosing substance abuse and of the services that can be there to help them. They can also provide feedback on the current system which can be used to improve practice and ensure care is collaborative and patient-centred.

Conclusion

To conclude, the evaluation of substance abuse documentation has provided valuable insights into current practice with the intervention showing some benefit in improving documentation and nursing staff knowledge.

This QIP has highlighted the importance of education on substance abuse in the context of psychiatric illness. Therefore, it must be considered by health-care professionals working with patients experiencing deterioration in their mental health.

This QIP has provided a good starting point for interventions and projects to further improve substance abuse documentation. It has highlighted gaps, especially with documentation of frequency and services used. By addressing these gaps and building upon the successes identified in the project, the CRHT can further improve the high-quality care it provides to patients.

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Conflicts of interest

There are no conflicts of interest.

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