Medicina Academica Integrativa, 2024; Vol. 1, No. 1 *Original paper*

UNDERSTANDING REPEAT PRESENTATION TO HOME TREATMENT TEAMS

Patricia Rubinic, Andrew Howe & Ketan Sonigra
Croydon Home Treatment Team, South London and Maudsley NHS Foundation Trust, London, United Kingdom

received: 25.07.2023; revised: 12.10.2023; accepted: 21.11.2023

SUMMARY

Background: *Increased number of individuals re-attending mental health services over short period of time observed across emergency departments, hospital and more recently home treatment teams.*
Due to gap identified in research on repeat presentations to home treatment teams we aimed to shed more light on factors impacting repeat presentations.

Subjects & methods: *The cross-sectional study design was implemented to examine common characteristics of high frequency users of Home Treatment Teams across South London and Maudsley NHS Foundation Trust. The quantitative data was extracted using Clinical Records Interactive Search (CRIS) system. The data on the total of thousand five hundred twenty-five service users was analysed conducted using Microsoft Excel looking at 3 groups of characteristics: socio-demographic, clinical & service use.*

Results: *From thousand five hundred twenty-five service users, eighty-five identified as high frequency users indicated by three of more attendances. Two socio-demographic characteristics differed between groups, with a higher prevalence of females and identified carers in high frequency group. In terms of clinical characteristics, both groups found to have highest number of psychotic and affective diagnosis, with no F99 or Z codes in high frequency group. Lastly, with regards to service use, high frequent users show greater number of attendances to A&E, psychiatric hospitals as well as longer length of stay & contacts while under the service. High frequency attenders also more likely to undergo mental health act assessment.*

Conclusions: *Clinical implications of our study include the need for training around working with female service users as well as implementing transdiagnostic way of working. Additionally, integrating identified carers into the care and the carer-focused support to be provided as part of the treatment. Lastly, the needs of high frequent attenders might be met by understanding of their use across crisis pathways and more specifically tailored to individual needs by examining separate geographic areas.*

Keywords: *high frequency users; home treatment team; socio-demographic; clinical; crisis*

* * * * *

INTRODUCTION

The Crisis Resolution and Home Treatment Teams (CRHTT) were introduced in 2001 in response to National Health Service's plan to reduce hospitalization by treating people with acute mental health problems in the community (Jacobs & Barenho 2011). In line with other emergency services, CRHTTs often work with service users who attend frequently, often referred to as 'frequent', 'repeat' or 'high frequency users'. There is no clear definition of repeat attenders ranging from three or more admissions in a year (Morlino et al. 2011) to three or more lifetime admissions (Webb & Langdon 2007) with greatest consensus on three or four admissions in 5-10-year period (Gastal et al. 2000). Subsequently, the profiles of repeat users vary widely though some common characteristics include being younger, having Psychotic, Affective and/or Personality Disorder diagnosis (Gastal et al. 2000), higher presence of disability, increased substance use, lower levels of social support and socio-economic disadvantage (Morlino et al. 2011). Other factors such as ethnicity and numbers of voluntary versus involuntary admissions remain inconclusive in association with repeat users (Korkeila et al. 2008, Hogson et al. 2001). As evidenced above the definitions, clinical and socio-demographic characteristics of repeat users are not clearly defined. Only one study examined characteristics of high frequency users within CRHTTs (Lunawat & Karale 2014), suggesting further research in this area in warranted. The aim of this study was to ascertain the characteristics of repeat attenders in crisis and home treatment teams due to identifying gap in the research and subsequent service provision resulting in high numbers of repeat attenders. Adopting the holistic approach and recognizing various factors impacting on someone's mental wellbeing, examined characteristics fall into three categories: clinical, socio-demographic and service use.

SUBJECTS AND METHODS

SUBJECTS

A cross-sectional descriptive study was carried out with the aim of examining common characteristics of high frequency users of Home Treatment Teams across South London and Maudsley NHS Foundation Trust. The study sample was determined based on all the referrals to South London and Maudsley NHS Foundation Trust Home Treatment Teams during selected time period, 01/01/2021 to 31/12/2021. The total of 2525 patient data was extracted, and all have been used for the purpose of this analysis. The age range has been 18-65 due to service eligibility criteria, with the average age of 37 years.

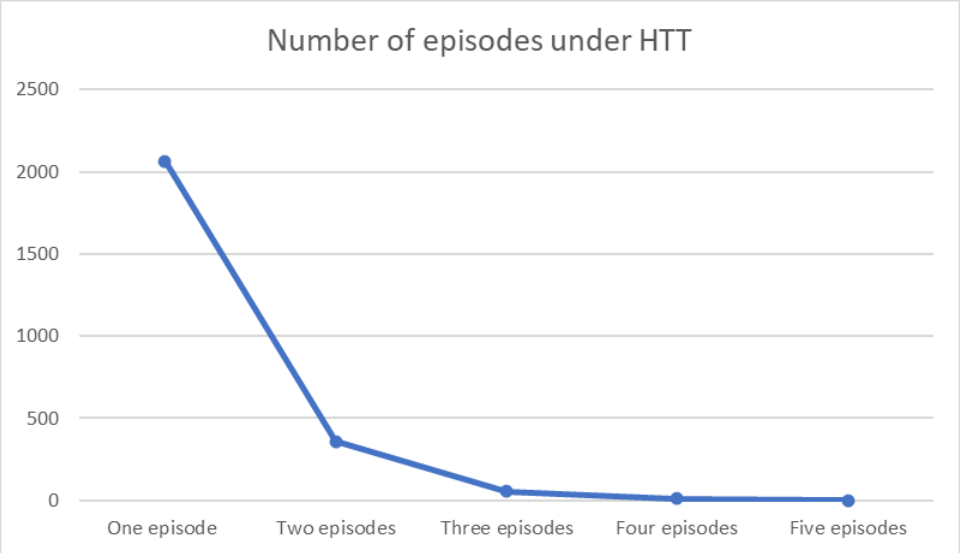

Figure 1.

METHODS

The Clinical Records Interactive Search (CRIS) system was used for quantitative data extraction. CRIS is a computer system facilitating research using quantitative and qualitative data from local electronic clinical records, anonymizing patient data and presenting its results in a format which can be statistically analyzed. After discussions with the CRIS team and completing project submission paperwork, the project was approved by the CRIS oversight committee which takes ethical and practical considerations into account. Treatment team episodes lasting three days or less were removed as a result of the referrals process within the Trust, where patients are referred and then assessed by HTT before being formally accepted. Hence, patients with length of stay of three days or less represent rejected referrals not treated by the home treatment team. The three-day limit was decided from discussions with CRHTT clinical staff and an analysis of the skew of patient data suggesting this patient group were outliers. The final data was extracted at patient and episode level, to allow triangulation of results and better understanding of changes between attendances of same patient. Episode level concerned one particular episode with the CRHTT, and patient level, focused on unique patient contacts within the data window. Different types of characteristics were extracted in three distinct categories: socio-demographic, clinical and service use portraying holistic approach to patient care. Socio-demographic characteristics included age, gender, ethnicity, sexuality, the presence of carer and accommodation status. Clinical data concerning diagnosis according to the International Classification of Diseases Volume 10 (ICD10 (World Health Organization 2019)). The electronic patient notes system allows for up to five diagnoses to be listed with one primary diagnosis. Finally, service use characteristics included duration of episodes, referral sources, discharge destination, number of admissions to mental health hospital, length of stay, use of the mental health act, and psychiatric emergency service use aiming to capture data on the type of services used and the manner of utilization of the same.

DATA ANALYSIS

The extracted data were analyzed using Microsoft Excel which was available to the research team and was appropriate tool for the descriptive analysis of the data.

RESULTS

The total of 2525 participants were separated into two different groups, high frequency attenders (n=85) and low frequency attenders (n=2440). The separation was based on the definitions from previous literature, high frequency attenders usually defined by minimum of 3 attendances in last year (reference), and the distribution graph of the obtained data in this paper, Figure 1.

Socio-demographic characteristics

Both high frequency attenders and low frequency attenders were of similar age, with the average age being 37.3 for former and 36.32 for the later. The distribution of gender was in favour of female participants accounting for 54.6% of the low frequency attenders sample and 68.2% of high frequency attenders. There were reports of 'Other' in gender category of low frequency attenders encompassing 0.1% of the sample. Ethnicity was split into five main groups White, Black, Asian, Mixed and Other. The results found indicate similar ethnic backgrounds in both groups. The low frequency group consisted of 39.4% White, 30% Black, 6.6% Asian, 4% Mixed and 6.2% Other ethnicity participants with 13.9% of the sample missing the data on ethnicity. The high frequency group consisted of 48.2% White, 36.5% Black, 2.4% Asian, 3.5% Mixed and 3.5% Other ethnicity participants in addition to 5.9% participants having no recorded data on ethnicity. Regarding sexuality, the sample contained considerable missing data with sexuality not recorded in 93% of low frequency attenders and 90.6% of high frequency attenders. For those with completed sexuality data, majority of participants were heterosexual, with 5.4% low frequency attenders and 7.1% high frequency attenders followed by 1.1% & 2.4% homosexual and 0.4% bisexual respectively. Social support network was assessed by looking at the presence of the carer. We focused on carers as this is recorded clearly in the electronic noted and therefore easy to quantify. More high frequency participants reported the presence of carer compared to the low frequency attenders, 60% and 34.6% respectively. Lastly, living conditions were taken into account by considering the type of accommodation participants were residing in. Higher levels of permanent accommodation observed in both groups, 93.1% low frequency attenders and 91.8% high frequency attenders with lower levels of temporary accommodation, 6.6% and 8.2 respectively. Only 0.3% of low frequency attenders did not have record on the accommodation circumstances.

Clinical characteristics

The findings on primary diagnosis indicate highest presence of psychotic disorders followed by mood disorders, unspecified mental disorders and disorders of adult personality & behaviour in low frequency attenders. Similar distribution observed in high frequency attenders with same levels of psychotic & mood disorders followed by disorders of adult personality & behaviour. The detailed distribution of primary diagnosis in both groups can be found in Table 1. The secondary & tertiary diagnosis were considered, and secondary diagnosis was only found in 2.4% of low frequency attenders sample and no tertiary diagnosis was present across the sample.

Table 1. ICD-10 diagnosis distribution between High frequency & Low frequency attenders

ICD-10 Diagnosis	Low Frequency Attenders (%)	High frequency attenders (%)
F01-F09	0.3	0
F10-F19	3.7	3.5
F20-F29	32.5	34.1
F30-F39	23.5	34.1
F40-F49	6.6	12.9
F50-F59	0.6	1.2
F60-F69	7.9	14.1
F70-F79	0.2	0
F80-F89	0.6	0
F90-F99	14.9	0
D82	0.04	0
G30-G40	0.08	0
M32	0.04	0
Z00-Z009	1.4	0
Z71	2.9	0
NULL	6.7	0

Characteristics of the use of the services

The use of different services including emergency services (defined as referral to psychiatric liaison services, Clinical Assessment Units of Place of Safety), psychiatric hospitals & CRHTT were taken into consideration. Additionally, movement to and from CRHTTs was examined. The average number of A&E attendance differed between high frequency attenders and low frequency attenders. The average number of A&E attendance was 9.04 for high fre-

quency attenders and 1.18 for low frequency attenders. The use of other emergency services such as Clinical Assessment Unit & Place of Safety did not greatly differ between groups with 1.3 and 1.4 average attendances for Clinical Assessment Unit and 1,62 and 1,2 for Place of Safety respectively.

erage for high frequency attenders and 22.2 on average for low frequency attenders. Lastly, the referral movement including referral source and discharge source did not greatly differ as observed in Figure 2 & 3. The majority of referrals came by Acute Referral Centre with higher number of ward referrals for high frequency attenders and greatest number

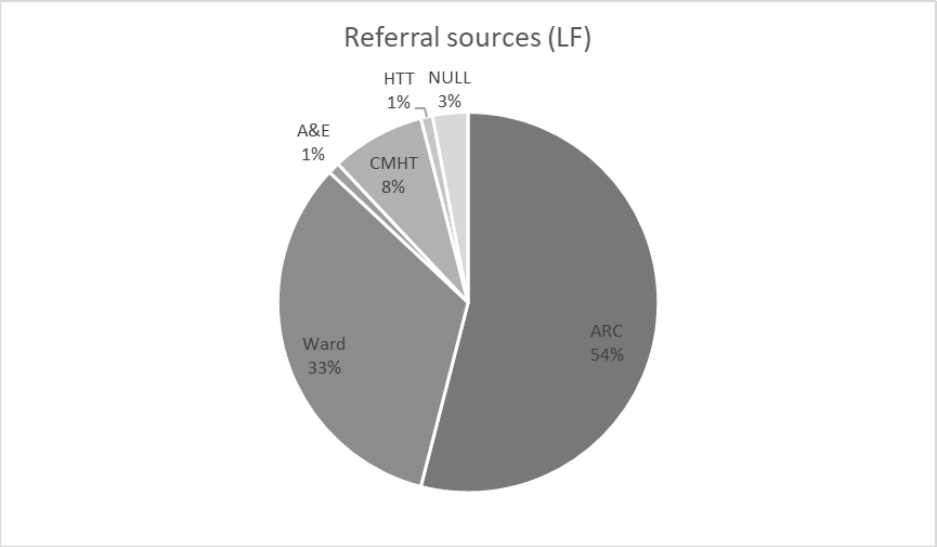

Figure 2.a

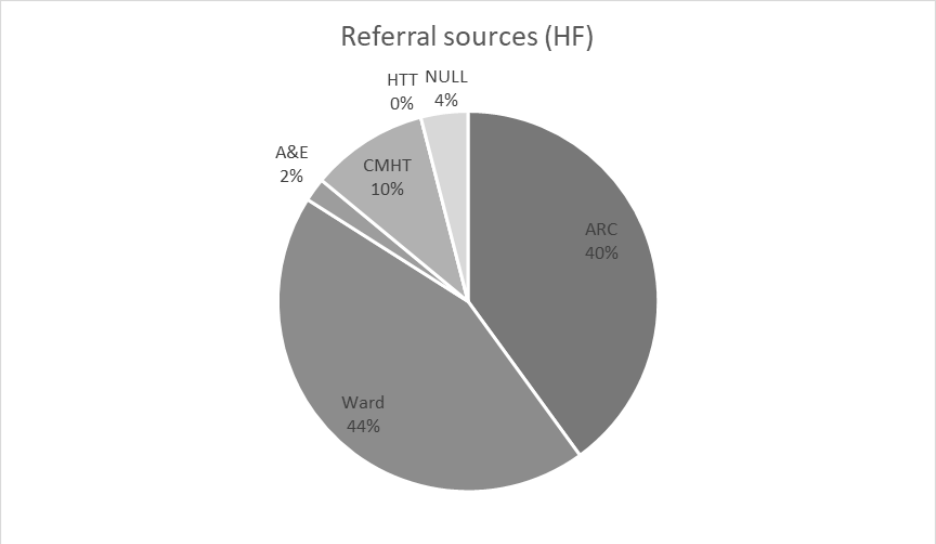

Figure 2.b

In terms of psychiatric hospital use, the number of admissions were higher for high frequency attenders with average number of admissions of 2.3 compared to 1.32 for low frequency attenders. Examining types of admissions groups differed in number of informal admissions versus admission under Mental Health Act, with low frequency attenders having higher numbers of informal admissions 62.5% whereas high frequency attenders presented with higher number of admissions under Mental Health Act, 62.4%. When admitted, high frequency attenders had a longer length of stay, on average 59.6 days in comparison with 39.1 for low frequency attenders. Length of stay under CRHTTs followed similar patterns, with 56.1 days on average for high frequency attenders and 22.2 on average for low frequency attenders. Lastly, the referral movement including referral source and discharge source did not greatly differ as observed in Figure 2 & 3. The majority of referrals came by Acute Referral Centre with higher number of ward referrals for high frequency attenders and greatest number of participants were discharged into the care of Community Mental Health Teams following CRHTT episode.

DISCUSSION

The results of this study indicate there are differences in some but not all characteristics of frequent attenders in comparison with non-frequent attenders.

Socio-demographic characteristics

The lack of difference in the age suggest need for greater

support from mental health services at specific life stage exhibited by frequency of attendance. The results from previous research are inconclusive as some found younger age to be associated with greater frequency of inpatient psychiatric admissions (Hadley et al. 1992) and multiple visits to emergency departments (Sulivan et al. 1993), while others found higher median age of repeat attenders of 44.4 (Wise-Harris et al. 2017) & 44.1 (Kingsford & Webber 2010).

repeat attenders (Surles & McGurrin 1987). In our study, no difference was observed in ethnicity of high frequency & low frequency attenders, which is in line with one study (Graca et al. 2013). The findings across other studies are inconsistent with some studies reporting higher number of frequent attenders of White background in CRHTT (Lunawat & Karale 2014) and in repeat admissions (Hadley et al. 1992, Hadley et al.1992), whereas some higher numbers of attenders from non-white background in emergency

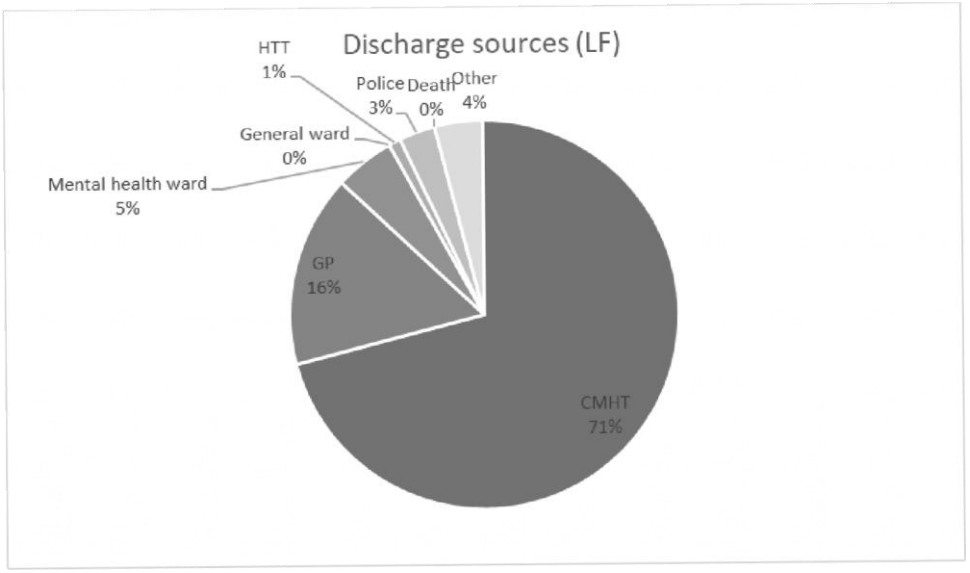

Figure 3.a

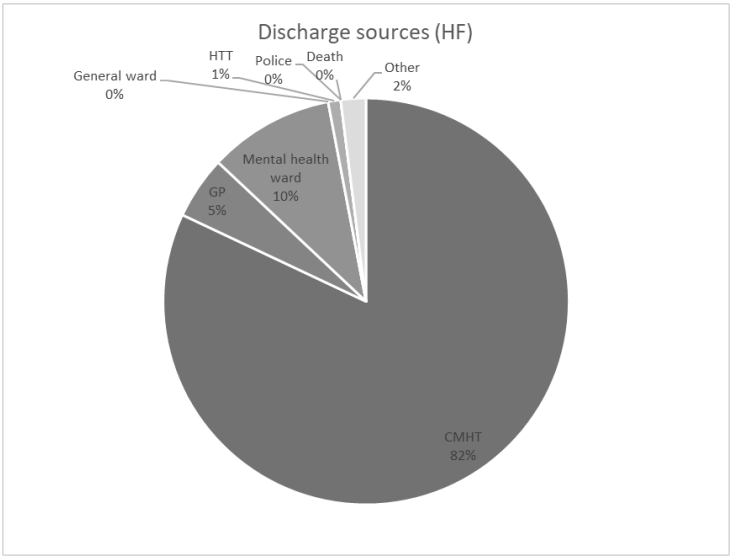

Figure 3.b

The median age found in this study, 37.3, was similar to age found in two studies of frequent users such as median age of just under 40 for inpatient admissions (Werbeloff et al. 2017) and 37 for CRHTTs (Lunawat & Karale 2014). There was a greater proportion of females in high frequency attenders group which is in line with some studies of repeat admissions (Schwartz et al. 1972) and CRHTT attendances (Lunawat & Karale 2014). Conversely, one study found no difference in gender distribution in repeat admissions (Graca et al. 2013) and another a higher rate of male

departments (Sulivan et al. 1993) and admissions (Havassy & Hopkin 1989). Due to lack of availability of data on the sexuality of participants in this study no concrete conclusion are drawn, however out of available data, the majority were found to be of heterosexual orientation. No other literature of frequent attenders examining sexuality could be obtained for comparison. Furthermore, high frequency attenders had a greater presence of carer when compared to low-frequency attenders. The results found in our study are in contrast with other available studies of repeat attenders

in different mental health services who found decreased social support leading to repeat admissions (Sulivan et al. 1993, Botha et al. 2010, Kingsford & Webber 2010) and greater number of emergency department attendances (Wise-Harris et al. 2017). Lastly, no differences in the type of accommodation, whether temporary or permanent, found between the two groups as both had higher levels of permanent accommodation. Few studies that looked at accommodation circumstances focused on levels of homelessness and inconsistent results found (Lay et al. 1996, Wise-Harris et al. 2017).

Clinical characteristics

Our results indicate similar distribution of ICD-10 diagnosis between high frequency & low frequency attenders with highest numbers of psychotic disorders and mood disorders with subsequent occurrence of adult personality & behaviour disorders. This suggests there is no specific diagnosis associated with repeat use of CRHTT, in this sample. The high presence of psychotic, affective & personality diagnosis are in line with other research on frequent attenders (Botha et al. 2010, Havassy & Hopkin 1989). Furthermore, finding no difference between two groups is in line with some research on frequently admitted patients (Graca et al. 2013) and repeat emergency department users (Sulivan et al. 1993), while in contrast to results from frequent attenders of CRHTTs where higher presence of personality disorder found (Luwat & Karale 2014).

Service use characteristics

In terms of use of emergency services only number of Psychiatric Liaison attendances were higher in frequent attenders' group. To our knowledge no other studies examined emergency service use, however our results indicate that not all emergency services are used in the same fashion amongst frequent attenders. The use of psychiatric hospital, length of stay & type of admission varied greatly between groups with more frequent, longer under the mental health act admissions in high frequency users as compared to low frequency users. These results are in line with previous research which indicated greater number of admissions within the frequent user group and a larger proportion of compulsory admissions (Graca et al. 2013, Sulivan et al. 1993). Additionally, longer length of stay under CRHTT found in the high frequency user group in this study. Though no other study examined length of CRHTT stays, these findings are in line with the use of other services such as hospital beds & emergency department (Graca et al. 2013). Lastly, the referral & discharge sources were examined which were found not to differ greatly between groups with slightly higher number of ward referrals for high frequency group indicating greater number of prior admissions and level of support required post-admission.

Implications for clinical practice

As the only socio-demographic characteristic that differed between high frequency and low frequency users was gender, with slightly higher female presence, no particular profile and/or set of characteristics that determines frequent users could be ascertained. Therefore, any specialist intervention aiming to provide support & reduce frequency of attendance needs to take this into consideration. The predominance of women in high frequency group could suggest a different type of care received by male and female service users. In the literature, women are more likely to access mental health services in general although there is evidence of higher use of mental health services in men with severe mental health problems (Masfety et al. 2014) which contrasts our sample. Our study examined high frequency users across 4 London boroughs (Southwark, Lambeth, Lewisham & Croydon) falling under South London and Maudsley NHS Foundation Trust which are known to differ in terms of social deprivation, availability of green space, environmental threats, levels of crime and discrimination, factors which are found to affect mental health (Rutter 2005, Helbich 2018, Lundt et al. 2018, Wang et al. 2019). Examining specific geographical areas could lead to finding set characteristics of high frequency users in specific areas which would align with community transformation and stipulate the need for place-based and integrated care systems accounting for social & contextual factors. Furthermore, one of the socio-demographic characteristics, sexual orientation, did not appear to be routinely collected which would need to be addressed for future work. The data on sexual orientation could offer context to early life experiences, disparities in mental health and ongoing level of psychosocial stress as research indicates elevated mental health problems for sexual minorities (Ploderl & Tremblay 2015), association between identity concealment and internalizing mental health problems (Pachankis et al. 2020) and victimization as mediator of mental health disparities (Burton et al. 2013). The lack of recorded data could represent the difficulties staff encounter in talking openly about sexuality with service users possibly calling out for additional training around the area. In terms of clinical characteristics, those who frequent use CRHTT are not from a particular diagnostic group and are likely to have varying treatment needs. Moreover, no F99 or Z codes in high frequency group implies that there is no diagnostic uncertainty in this group implying presence of evidence-based treatment. Perhaps, treatments are not taken up, there are implementation difficulties or the potential for relapse post treatment is not addressed in high frequency group. The service use characteristics found imply likelihood of high frequency users spending considerable amount of time in the acute and crisis pathway. Thus, any intervention needs to consider their relationship with care across wider system, for example the Open Dialogue model that brings the network together (Freeman 2019). Recently, there has been emerging evidence that Peer Led Transition can support

those who appear 'stuck' in crisis (Hancock 2022). Furthermore, type of admission also varied between low and high frequency groups with greater use of MHA within the high frequency group demonstrating more episodes where they lack capacity to make decision around their treatment. Higher number of episodes where capacity is lacking could potentially explain the high proportion of carers in this group. The results of high presence of carers within the high frequency group indicates the need of further integration of carer in the psychiatric treatment nationally (Carers Trust, 2013) by building on & incorporating family members/significant others support in CRHTT. Models such as Triangle of Care (Wothington & Rooney 2010) and frameworks such as Quality Network for Crisis resolution and Home Treatment Teams (Baugh & Talwar 2022) offer valuable resource and direction for this support. Evidence indicates that carers play important role during mental health crisis and enabling CRHTT to work effectively in supporting the client to recover at home, nevertheless the shift to community treatment as opposed to long term in-patient care can have significant impact on carer (Lavoie 2018). The higher presence of carers could also begin to explain the frequency of attendance to other crisis services with the additional support and prompting service users to either access help or conveying them to emergency services.

Strength and limitations

This is the first study to examine socio-demographic, clinical & service use characteristics of frequent users in CRHTT. Our study is easily replicated and could be of value for others trusts to note whether similar or different patterns emerge broadening our understanding of frequent users within CRHTT. Limitations present are data accuracy, lack of statistical analysis and areas left unexplored.
As this study used electronic records to obtain data there is possible lack of accuracy due to data not always being recorded correctly. Additionally, this study used descriptive analysis rather than robust statistical tests to ascertain differences between groups. Furthermore, solely presence of carer was examined without looking at whether there is only one or more carers present, relationship type and gender of named carer which could provide further implications for clinical work. Finally, it would be beneficial for future studies to examine whether geographical areas within the mental health trust are representative of the findings identified in this study.

CONCLUSION

High frequency attenders to Home Treatment Teams across South London and Maudsley NHS Trust found to have some common characteristics while some indicated no difference when compared to low frequency attenders. Gender in favour of female clients and greater of presence of carer in high frequency attenders group were only socio-demographic characteristics which differed between groups. No clinical characteristics differed between groups when primary, secondary & tertiary diagnosis considered. Some differences in service use observed such as greater number of emergency department attendance, more frequent & longer inpatient admissions under mental health act rather than informal admissions and longer length of stay under home treatment teams. All in all, further research is warranted to continue exploring precipitating & perpetuating factors by explore individual characteristics as well as the type of service provision.

Acknowledgment:
This paper represents independent research part funded by the National Institute for Health Research (NIHR) Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London.

Conflict of interest:
The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care.

References:

1. *Baugh C & Talwar K: QN-CRHTT Standards for Crisis Resolution and Home Treatment teams, 2022.*
2. *Botha UA, Koen L, Joska JA, Parker JS, Horn N, Hering LM & Oosthuizen PP: The revolving door phenomenon in psychiatry: comparing low-frequency and high-frequency users of psychiatric inpatient services in a developing country. Soc Psychiatry Psychiatr Epidemiol 2010; 45: 461-8.*
3. *Burton CM, Marshal MP, Chisolm DJ, Sucato GS & Friedman MS: Sexual minority-related victimization as a mediator of mental health disparities in sexual minority youth: A longitudinal analysis. J Youth Adolesc. 2013; 42: 394-402.*
4. *Carers Trust: The Triangle of Care Carers Included: A Guide to Best Practice in Mental Health Care in England Second Edition The Triangle of Care Carers Included 2013: A Guide to Best Practice in Mental Health Care.*
5. *Freeman AM, Tribe RH, Stott JC & Pilling S: Open dialogue: a review of the evidence. Psychiatr Ser 2019; 70: 46-59.*
6. *Gastal FL, Andreoli SB, Quintana MIS, Gameiro MA, Leite SO & McGrath J: Predicting the revolving door phenomenon among patients with schizophrenic, affective disorders and non-organic psychoses. Rev Saúde Pública 2000; 34: 280-285.*
7. *Graca J, Klut C, Trancas B, Borja-Santos N & Cardoso G: Characteristics of frequent users of an acute psychiatric inpatient unit: a five-year study in Portugal. Psychiatr Serv 2013; 64: 192-5.*
8. *Hadley TR, Culhane DP & McGurrin MC: Identifying and tracking "heavy users" of acute psychiatric inpatient services. Adm Policy Ment Health 1992; 19: 279-90.*
9. *Hancock N, Berry B, Banfield M, Pike-Rowney G, Scanlan JN & Norris S: Peer worker-supported transition from hospital to home—Outcomes for servce users. International Journal of Environmental Research and Public Health 2022; 19: 2743. https://doi.org/10.3390/ijerph19052743*
10. *Havassy BE & Hopkin JT: Factors predicting utilization of acute psychiatric inpatient services by frequently hospitalized patients. Psychiatric Services 1989; 40: 820-3.*

11. *Helbich M: Mental health and environmental exposures: An editorial. Int J Environ Res Public Health 2018; 15: 2207. doi: 10.3390/ijerph15102207*
12. *Hodgson RE, Lewis M & Boardman AP: Prediction of readmission to acute psychiatric units. Soc Psychiatry Psychiatr Epidemiol 2001; 36: 304-9.*
13. *Jacobs R & Barrenho E: Impact of crisis resolution and home treatment teams on psychiatric admissions in England. Br J Psychiatry 2011; 199: 71-6.*
14. *Kingsford R & Webber M: Social deprivation and the outcomes of crisis resolution and home treatment for people with mental health problems: a historical cohort study. Health Soc Care Community 2010; 18: 456-64.*
15. *Korkeila JA, Lehtinen V, Tuori T & Helenius H: Frequently hospitalised psychiatric patients: a study of predictive factors. Soc Psychiatry Psychiatr Epidemiol 1998; 33: 528-34.*
16. *Kovess-Masfety V, Boyd A et al. : Are there gender differences in service use for mental disorders across countries in the European Union? Results from the EU-World Mental Health survey. J Epidemiol Community Health 2014; 68 :649-56.*
17. *Kumar Lunawat V & Karale M: Repeat users of crisis resolution and home treatment team. Psychiatr Danub 2014; 26: 10-4.*
18. *Lavoie JA: Relative invisibility: an integrative review of carers' lived experiences of a family member's emergency mental health crisis. Soc Work Ment Health 2018; 16: 601-26.*
19. *Lay B, Lauber C & Rössler W: Prediction of in-patient use in first-admitted patients with psychosis. Eur Psychiatry 2006; 21: 401-9.*
20. *Lund C et al. :Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. Lancet Psychiatry 2018; 5: 357-69.*
21. *Morlino M, Calento A, Schiavone V, Santone G, Picardi A & De Girolamo G: Use of psychiatric inpatient services by heavy users: findings from a national survey in Italy. Eur Psychiatry 2011; 26: 252-59.*
22. *Pachankis JE, Mahon CP, Jackson SD, Fetzner BK & Bränström R: Sexual orientation concealment and mental health: A conceptual and meta-analytic review. Psychol Bull 2010; 146: 831.*
23. *Plöderl M & Tremblay P: Mental health of sexual minorities. A systematic review. Int Rev Psychiatry 2015; 27: 367-85.*
24. *Rutter M: How the environment affects mental health. Br J Psychiatry 2005; 186: 4-6.*
25. *Schwartz DA, Weiss AT & Miner JM: Community psychiatry and emergency service. Am J Psychiatry 1972; 129: 710-5.*
26. *Sullivan PF, Bulik CM, Forman SD & Mezzich JE: Characteristics of repeat users of a psychiatric emergency service. Psychiatr Serv 1993; 44: 376-80.*
27. *Surles RC & McGurrin MC: Increased use of psychiatric emergency services by young chronic mentally ill patients. Psychiatr Ser 1987; 38: 401-5.*
28. *Wang R, Helbich M, Yao Y, Zhang J, Liu P, Yuan Y & Liu Y: Urban greenery and mental wellbeing in adults: Cross-sectional mediation analyses on multiple pathways across different greenery measures. Environ Res 2019; 176: 108535. doi: 10.1016/j.envres.2019.108535*
29. *Webb S, Yágüez, L, & Langdon PE: Factors associated with multiple re-admission to a psychiatric hospital. J Ment Health 2007; 16: 647-61.*
30. *Werbeloff N, Chang CK, Broadbent M, Hayes JF, Stewart R & Osborn DP: Admission to acute mental health services after contact with crisis resolution and home treatment teams: an investigation in two large mental health-care providers. Lancet Psychiatry 2017; 4: 49-56.*
31. *Wise-Harris D, Pauly D, Kahan D, Tan de Bibiana J, Hwang SW & Stergiopoulos V: "Hospital was the only option": experiences of frequent emergency department users in mental health. Adm Policy Ment Health Ment Health Serv Res 2017; 44: 405-12.*
32. *World Health Organisation; ICD-10 2010; https://icd.who.int/browse10/2019/en#*
33. *Worthington A & Rooney P: The Triangle of Care; Carers included: A guide to best practice in acute mental health care. London: The Princess Royal Trust for Carers and the National Mental Health Development Unit 2010.*

Correspondence:
Patricia Rubinic,
New Admin Block, Croydon Home Treatment Team, Bethlem Royal Hospital,
Monks Orchard Road, BR3 3BX, United Kingdom
rrubinic@slam.nhs.uk