Community services versus crisis resolution teams

Danny Allen reviews the literature on the subject and draws on his experiences to examine what works best for patients

Summary

Crisis resolution and home treatment teams were set up across the UK as part of the NHS Plan (Department of Health 2000). Ten years on, the evidence base for these services is poor and the author questions whether they offer the best care to people who need support.

Keywords
Assertive outreach team, community mental health, crisis resolution home treatment team

THE CONCEPT of home treatment dates back to Stein and Test (1980). Many people would view this as the dawn of community treatment in the United States in a time when most care was still delivered in large institutions. In the UK, a community mental health team (CMHT) structure was developed from the 1960s onwards, stimulated by the requirements of the Mental Health Act 1959 for the informal treatment of inpatients alongside treatment of detained patients (Burns 2004).

Worldwide, there has been a move away from treatment in large institutions, driven partly by government for financial reasons and partly by 'therapeutic liberalism' (Bachrach 1997).

In the UK, the move to community care has been supported by the care programme approach (CPA) (Department of Health (DH) 1990). However, the introduction of crisis resolution and home treatment teams (CRHTTs) was a deliberate political act, starting with Modernising Mental Health Services (DH 1998) and progressing to the NHS Plan (DH 2000). Money for mental health services, in such short supply, would be made available only for certain prescribed services, including CRHTTs.

Stein and Test (1980) could be viewed as the forerunners of generic UK CMHTs, assertive outreach teams (AOTs) and crisis resolution and home treatment teams (CRHTTs).

The evidence base for AOTs – or assertive community treatment – is strong, with more than 75 scientific studies supporting its use. However, its benefits are modest: reduced length of hospitalisation, improved housing stability and some improvement in symptoms and quality of life (Mueser *et al* 1998).

The generic UK CMHT model is not so different from AOTs, with two thirds of all patient contact by community nurses and social workers occurring outside formal care settings. Where caseloads are low, the CMHT model is even closer to the AOT model (Burns *et al* 2000).

Service changes

In contrast, in the case of CRHTTs, there have been two main drivers. The first has been pressure from users and carers. In areas where services are poor and waiting lists long, they have been struck by the disparity of emergency provision between mental health services and general medical services (Burns 2004).

The second is the inexorable decline in bed numbers from the days of asylums, encouraged by enthusiasts for the CRHTT model (Smyth and Hoult 2000). While there have been several examples of services where bed use has declined after the introduction of CRHTTs (Dean *et al* 1993). The reality is that managers close beds and teams, then have to make do with what is left. The introduction of CRHTTs in some areas could have reduced bed use because there was simply a need for more input of staff and better care – in other words in 'failing services', where bed use was artificially high due to poor generic services (Coid 1994).

Furthermore, CRHTTs are often different from beacon services on which the model was based.

The policy implementation guide (DH 2001) recommends 14 full-time staff for a population of 150,000. Our team is typical of many others and has double that population for the same number of staff, suggesting a significant disparity between theory and practice.

As yet, there is no well-evidenced study of generalised effectiveness of CRHTTs (Burns 2000) and no one has demonstrated that a reduction in bed use has any advantage for either the people who would otherwise use them or their carers (Burns 2004). This fact seems to be ignored by enthusiasts of the scheme who take it as a given that being at home is better than being in hospital.

Paradoxically, our clinical experience indicates that this may become truer as wards grow to be increasingly disturbed environments, treating only the most ill and sectioned patients, with all other patients treated in the community or in an acute day hospital (Allen *et al* 2009).

Case management

Smyth and Hoult (2000) describe the features of an effective home treatment team in Box 1. It has been argued that these amount to 'intensive case management' and that most of them are characteristic of modern CMHTs (Burns 2000). But one needs to question how many aspects of this ideal model, over and above the generic CMHT level, are actually present in most CRHTTs.

Our team, which relies heavily on the associated use of an acute day hospital, provides assessments only after hours. No treatment takes place after 9.30pm and our commissioned response time is six hours (Allen *et al* 2009). People rarely get more than one visit a day and there is little flexibility to spend time with the social network – it is the assertive outreach team that does this. Lastly, medical staff rarely accompany the team and are not available round the clock, other than being on call in the traditional way.

There is no evidence from randomised trials of a significant fall in overall hospital use by people subject to intensive case management or any significant gains in clinical or social functioning (Burns *et al* 1999). We only have anecdotal evidence about which features of intensive case management are critical to its success (Burns *et al* 2000).

Case management, intensive or otherwise, is a structure for delivering treatments rather than a mode of treatment (Holloway 1991, Waite *et al* 1997). In addition, there has been no study of what evidence-based interventions are delivered by CRHTTs or generic CMHTs (Burns *et al* 1999). There has also been no attempt to measure the rates of treatments that we already know cause differences in outcome, for example behavioural family management in schizophrenia (Mari and Streiner 1994) or compliance enhancement therapy for maintenance antipsychotics (Kemp *et al* 1996).

Box 1 Features of an effective home treatment team

- Available 24 hours a day, seven days a week.
- Capable of rapid response, usually within the hour in urban areas.
- Able to spend flexible time with patients and their social network, including several visits daily if needed.
- Addressing the social issues surrounding the crisis from the outset.
- Having medical staff to accompany the team at assessment who are available round the clock.
- Able to administer and supervise medication.
- Able to provide practical, problem-solving help.
- Able to provide explanation, advice, and support for carers.
- Providing counselling.
- Gatekeeper to acute inpatient care.
- Being involved throughout the crisis until its resolution.
- Ensuring patients are linked up to further continuing care.

User feedback

There is a dearth of research into service user satisfaction, but one study (Brennan 2007) mirrors my experience. The lack of continuity of care is a major issue. Service users often see multiple members of staff, are unable to establish therapeutic relationships and dislike retelling their story on each visit (Brennan 2007). This is a significant issue since the one-to-one therapeutic relationship is important for most patients (Toynbee and Allen 2009).

Many people reported that lack of time was an issue – staff seemed to be rushed during appointments and people often expected more visits than they received.

Respondents reported receiving emotional support and help with medication, but they also wanted more practical support; less than 40 per cent said they received advice on accessing other services.

In this same study, more than 35 per cent of respondents were unhappy with the arrangements for their discharge. Many did not feel well enough to be discharged and reported that arrangements were either inadequate or not adhered to.

Discussion

I worked in a CMHT for ten years and now work in a CRHTT, where many of our clients do not have problems that require hospital admission. Our team has been honed to look after those with a wide range of conditions (Allen *et al* 2009), and it is widely recognised that there is a group of patients who have similar needs for supervision, such as evening visits, as those who need immediate admission (Burns 2004).

However, CMHTs have no incentive to innovate; AOTs work longer hours and previous calls to lengthen working hours in CMHTs have been quashed because of our existence. In addition, if we deal with any aberration from the norm, such as people feeling low in mood secondary to life events, this deskills CMHT staff. Again and again, we are called to deal with minor exacerbations, such as people whose psychotic symptoms recur and who may need an increase in medication that I would not have handed over to colleagues or admitted to hospital when I worked in a CMHT.

A decade ago it was possible to say that 'no key worker would wish to transfer care in the community to another team just when a patient whom they have known for years is going through a personal crisis or a relapse of their illness' (Pelosi and Jackson 2000). But now care co-ordinators in CMHTs are often part-time and have rarely known people for years. They are encouraged by policies and procedures, based on a risk averse culture, to make such referrals. At the end of the episode, when CRHTTs hand care over to CMHTs, there is often pressure to remove remnants of illness, as if this has become beyond the remit of a CMHT.

Many people are deemed by us to have borderline personality disorder and associated conditions but, even where this view is shared by the CMHT, expectation of what we can achieve is often unrealistic. People with this spectrum of diagnoses are recognised as being prone to crises, and the evidence base and my experience indicate that they are often made worse by the transference and counter-transference in a setting with multiple staff involvement (Friedman 2008). My experience in a CMHT was that few of the people who are assertively followed up present in crisis. Yet the incentives in the new system are geared towards pushing any problems towards CRHTTs, potentially deskilling CMHT staff.

Conclusion

Trusts were able to access money made available through the NHS Plan (DH 2000) through CRHTTs. Yet the teams were not piloted and the research evidence for their efficacy is sparse. They take human and financial resources from generic CMHTs and deskill their workers. CRHTTs are achieving a reduction in hospital admissions and bed usage, but whether that causes less morbidity or offers a more pleasant experience for services users or carers is poorly evidenced. The teams are based on a model that ignores the importance of sustaining, supporting and nurturing relationships – which should be the mainstay of generic CMHTs – in favour of a one size fits all model of home visiting for any condition.

The previous government vested so much importance in these teams that it was unlikely to have wanted to abolish them.

The evidence favours a model of care of generic teams with smaller caseloads and features often found in assertive outreach teams, who would be able to deal with crises more readily. This could be achieved, in all likelihood, within existing resources.

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