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.
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).

**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 deal with any aberration from the norm, such as people feeling low in mood secondary to life events, 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.

References


