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Crisis resolution/home treatment and in-patient care

With the development of crisis resolution/home treatment (CR/HT) teams according to the National Health Service (NHS) Plan and Policy Implementation Guidance (Department of Health, 2000), it is important to anticipate the issues involved in their collaboration with acute in-patient units. What are the implications for in-patient care (IC) of CR/HT availability? How can we realise the opportunities that full integration can offer towards an improved acute service?

This article examines these questions through both the experience of North Birmingham and the work of the West Midlands Mental Health Development Team across newer CR/HT initiatives in the region. The background and recent history is set out with the suggestion of major themes and the problems of poor integration, and the advantages of a fully-collaborative approach are explored.

Background and recent history

Before examining the interface, it is useful to describe some overarching themes. First, there were problems with IC before the advent of CR/HT availability. Second, we cannot escape a focus on 'admission' as the gateway between both services and the clinical necessities, patient and carer rights, and conceptual themes that surround this bridge. Third, when we look for literature around service integration in this area, it is almost non-existent, with the result that opinion and experience shape positions and approaches. Last, we can recognise that both services are affected by the changing social position of psychiatry (e.g. the response to public safety imperatives and the culture of risk management that place additional pressures on acute services).

It is unfortunately easy to list the concerns that exist regarding IC in the UK. There have been availability problems with bed pressures, over-occupancy and high extra-contractual referral rates (Ward *et al*, 1998; Greengross *et al*, 2000). The treatment culture has been described as stigmatising, controlling and institutionalised, and this has not been helped by old and poor standard ward conditions. The Sainsbury Centre for Mental Health (1998) report found low morale, high staff sickness rates and high reliance on agency nursing staff. There has been an increasing proportion of patients detained under the Mental Health Act, patients with more challenging behaviour and comorbidity with substance misuse problems (Shepherd *et al*, 1997; Ford *et al*, 1998). In-patient care has had difficulties in adequately serving the needs of women and ethnic minority groups. The environment has been described as dangerous (to patients and staff; Atakan, 1995), and atherapeutic (Muijen, 1999).

Given this list of difficulties, CR/HT services must have seemed an attractive proposition. However, until the inclusion of this model in the NHS Plan, there had been resistance despite positive research accounts over the previous decade (Smyth & Hoult, 2000). A large part of this resistance arose from the recognition that IC was a fundamental component of good and safe psychiatric practice. Even though no CR/HT proponents claimed that IC was no longer necessary, the threat to already shrinking availability was explicit to stretched clinicians. Justifiable concern was fuelled by polarised debate and dichotomised positions (Deahl & Turner, 1997) in a climate of increased admission pressures (e.g. the effect of the Care Programme Approach in doubling admissions; Marshall *et al*, 1997), and increasing detention under the Mental Heath Act (Vass, 2001). The capacity for CR/HT services to offer a feasible alternative to admission (whether in some or many, but never all cases), challenged the 'essentialness' of IC provision and became a symbol of the hospital versus community debate. The 'shadow' of this admission question and its symbolism has not gone away. It is hard to say to what degree resulting professional polarisation from the grand debates, and an unnecessarily oppositional culture, could still linger.

Another imbalance in the argument was that despite the essentialness of IC being recognised, it was seldom enshrined or written about positively (being fundamentally a historically derived service). The many important research questions concerning the therapeutic ingredients of IC were neglected, with 'a real paucity of even reasonable quality research, and virtually none which would meet the standard set by research councils' (Gournay, 2001). In-patient care remained something of a 'black box' experiment in our era of evidence-based practice.

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The home treatment perspective on in-patient care

Let us examine the following pairs of statements as might be made by an advocate of CR/HT. On the one hand: 'CR/HT can be a better service compared with IC, because it can avoid admission' and 'CR/HT services, to be effective, should have avoidance of unnecessary admissions as a stated aim'.

On the other hand: 'In clinical practice, CR/HT teams admit when necessary' and 'In-patient treatment remains a valuable and intrinsic component of acute psychiatric services, even with CR/HT availability'.

Do these sets of statements reflect some cognitive dissonance, or do they all seem logical? Workers in CR/HT would support each of these positions, because in daily practice they are not divisive. They refer to different necessities and opportunities, which need to overlap. The statement that needs to be included is of course 'IC can be a better and more appropriate service than CR/HT because of the additional intensivity of assessment, care and safety which is offered'. All of the propositions should include the rider: '. . . for this individual (and/or carers) at this particular time'.

In North Birmingham, six mature CR/HT teams (ranging from 3 to 10 years of operation) cover a population of 550 000. These teams were developed according to the model of home treatment practised in Madison, Wisconsin (Stein & Test, 1980) and Sydney (Hoult, 1986). Looking back, anticipated tensions around admission diversion proved largely developmental. New teams needed to reduce admissions if they were to manage acute presentations of severe mental illness at home. They did need to challenge established sets of admission expectations, which in the context of intensive community support, were less compelling. The task of delivering safe and appropriate care between both settings included the remit to gatekeep admissions, but not a mission to avoid admission *per se* (even though they were reduced as a natural result of effective operation). Any consideration of the politics of home treatment and IC could not be further from the minds of clinicians exploring depression and suicidal ideation in someone's home. With the daily reality of patients receiving acute care across the continuum of CR/HT and IC, the politics and the old polarised arguments became more remote, such that it was possible to forget them while focusing on the challenge of integration.

The importance of integration

When a new community-based acute service is being developed, it makes sense to ensure that both IC and CR/HT can complement each other. The recent in-patient guidelines make repeated reference to this aspiration (Department of Health, 2002). However, project teams developing CR/HT are facing a dilemma because it can feel like there are two different things going on at the same time. CR/HT is separating out of IC provision (and also the community mental health team), and needs to have a distinct identity and way of working. By contrast, the need to achieve joint working and efficient collaboration within the total system of acute care is also critical. One way of exploring this tension is to look at the implications for IC of CR/HT availability in first a problematic way and then more constructively.

Development of CR/HT can be problematic for IC, if the resultant admitted population by definition becomes more difficult to manage, with more complex clinical and social problems. Highly skilled and experienced staff from wards can populate new community teams (especially CR/HT and Assertive Outreach), with an increasing reliance on the wards of agency and bank staff. By default, the IC environment could become more custodial rather than therapeutic, with remaining staff feeling marginalised. Overall, divisive misconceptions can isolate IC, which then feels undervalued and not connected to the whole system. Just when the task of integration of both services is paramount, the relationship could become even more stretched.

What benefits can integration of both services achieve? There should be reduced IC admission pressures (Smyth & Hoult, 2000), more time to develop in-patient therapeutic relationships and deliver structured care plans. Additionally, integration improves IC awareness of social and community issues and problems, which can include shared case work and more explicit awareness of why admission was appropriate and under what circumstances it needs to continue. It is important to remember that CR/HT teams can commonly facilitate early discharge of admitted patients while continuing to provide ongoing acute care at home. Close working can refine joint discharge planning and the development of more personally tailored crisis plans for repeated presentations (in which the balance of CR/HT and IC may be anticipated). Joint working also informs the quality of risk assessment and management.

Admissions are reduced with CR/HT because the clinical decision-making around admission is shifted to a consensus base (as against the individual clinician), because of the feasible alternative support available, and because assessors (who always include psychiatrists) increasingly develop expertise at judging the necessity of admission in the context of the additional choice that CR/HT offers.

The importance of individual clinicians' admission decision-making style is both intuitive and has emerged in an Audit Commission report (Audit Commission, 1994). Striking differences in admission rates for psychosis prevailed across equivalent catchment areas. Gerson & Bassuk's (1980) review of over 70 univariate studies identified clinician-related variables along with clinical and social factors. Later review of multivariate studies (Marson *et al*, 1988) identified psychosis, behavioural disturbance and risk to self or others as the main variables, but again noted the extent to which clinician style still emerged across these variables. In one report, clinician style could account for 90% of the variance (Apsler & Bassuk, 1983). Furthermore, clinicians were only 'dimly aware' of the individual criteria by which they operated. This issue of style includes not only maturity, experience and training, but also personality. Some

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psychiatrists might be uncomfortable, whereas others will welcome the opportunity for CT/HT through joint assessment to routinely impact on individual clinician decision-making around admission.

Psychiatric hospital admission remains a significant personal event that can have a lifelong impact, but can also be life-saving. CR/HT teams look towards admission (or supported respite) as a clinical or social requirement, considering asylum in its positive sense. This, however, becomes more difficult if the experience of IC is negative, for reasons over which staff working there have little control. CR/HT teams are more preoccupied with trying to deliver intrinsic advantages of this model that go beyond the avoidance of admission. In the interplay of integrated CR/HT working, most attention shifts to the potential of supported early discharge through CR/HT when admission had occurred. Thus, disagreement around the appropriateness of admission becomes less common than new sets of arguments concerning the appropriateness and capacity for supported early discharge. Most clinicians will agree that once admission has occurred, it requires a particular process to undo it, with recall of the simple fact that the admission was organised for considered reasons.

Achieving integration

What factors should we consider in order to achieve integration?

As a first step, structuring linkages between CR/HT and IC from the beginning is important (rather than trying to establish them later on). Operational policies might include CR/HT attendance at ward rounds, routine screening for early discharge, joint acute care reviews, supported leave arrangements, etc. Whereas policy after policy is one way to achieve this, it might prove mechanistic or even institutional. Far preferable is the emergence of linkages through a shared value base and mutuality; joint working is easier if teams share the same base location. The more natural collaboration that follows from one consultant having responsibility for acute care in both settings contrasts with the logistic difficulties of achieving repeated sets of linkages across a series of consultant teams. An emerging theme is that ease of collaboration is inversely proportional to the number of consultants linked to each CR/HT team and ward.

The National In-patient Strategy Group has recently provided comprehensive and welcome guidelines aimed towards improving in-patient facilities, staffing and practice. Collaboration of CR/HT and IC is emphasised, in part through the development of Acute Care Forums.

The 'model integrity' of CR/HT teams in terms of a sustained focus on severe mental illness needs monitoring. If these teams are, by their availability and responsiveness, seeing a high quota of inappropriate referrals involving crisis but not mental illness, this will detract from their efficiency in managing acute illness in the community. With the change to primary care commissioning, this danger could become more real than apparent, and sensible discussion at locality implementation groups is required. However, gatekeeping all potential admissions means that CR/HT has to decide how to respond to a range of crises, not necessarily involving severe mental illness. The request or demand for 'admission' from referrers (which increasingly includes admission and/or acute home treatment), puts pressure on skilled professional judgement and resources. 'Potential admission' should probably outdo 'presence of severe mental illness' for greater CR/HT impact. Local discussion will need to achieve the right and most efficient balance.

The contractual possibilities for acute care workers operating in both settings flexibly, and according to demand, is worth considering (and has training implications). Further evidence will be useful concerning the characteristics and needs of different populations (e.g. CR/HT alone, IC followed by CR/HT, etc). What ingredients of care are important during these different phases? What is going on at the points of clinical decision-making between the transitions?

Conclusions

With increasing availability of CR/HT, we need to refine the common purpose of acute care, drawing on the best elements of both services in a non-divisive way and incorporating structured collaboration in practice. In addition to the systems analysis perspective of this article, a focus on individual care pathways can provide further clarity. Thus we should ask which patients benefit from CR/HT or IC and under what clinical (e.g. depressed or hypomanic phases of bipolar disorder) or social circumstances (e.g. access to house, relatives support, etc)? Overall, the aim of achieving integration will be frustrated by repeating old arguments but stimulated by asking new questions.

Declaration of interest

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PHILIP TIMMS

The consultant psychiatrist – a remembrance of things past?

The gilt seems to have rubbed off the gingerbread for the three members of our local community consultant group. We have senior lecturer contracts, have worked as consultants in inner London for 10 years and might be expected to be secure and content with our respective lots. Yet, we find ourselves increasingly uncomfortable with our place in the scheme of things.

We could just be dissatisfied doctors. Psychiatrists are reported to have retired early because of increased workload and loss of control over their work (Kendell & Pearce, 1997). We experience many of the pressures that lead to unhappiness, psychological distress, alcohol abuse and suicide in doctors generally (British Medical Association, 2000). However, there may be more to it than this. A recent survey of general psychiatrists (Kennedy & Griffiths, 2000) has highlighted problems experienced with role ambiguities and we have become interested in one of these. We just don't feel like consultants. We are not sure what it should feel like, but we do know that cognitive dissonance is bad for us. So we have tried to consider what a consultant might be, should be, and even whether it has ever been a helpful model for psychiatry.

So, what is a consultant?

The *Oxford English Dictionary*'s definition is: 'a consulting physician . . . who is called in by colleagues, or applied to by patients, for advice in special cases'. The traditional consultative model is still widely held, but has its origins in the Edwardian era of the charity hospitals. A consultant would regularly visit a hospital to teach, run ward rounds, conduct particularly difficult operations or see perplexing cases. He (rarely she) was used sparingly for his expertise and experience and would be paid little, mainly deriving status from his position. He would earn the bulk of his living from private practice. He was, literally, consulted. He came and went, but the resident hospital staff supplied the bulk of continuing therapeutic work. This model worked for several reasons. Effective interventions were few and comparatively simple, so most could be delegated. Society was more deferential and the attention of the consultant was seen as a privilege, not a right. This model of detached, expert care held mainly for those of modest means and for the poor. Private patients would receive more regular and continuing care. Medical provision reflected the social strata of society. Individual and continuing attention for the well-off; intermittent, pro bono advice for the poor. His detachment from the humdrum and his socio-economic alignment with the upper classes gave the consultant an aura of prestige, power and distance.

During the 1930s, consultants became more a part of the hospital, but they were not paid their full worth and were expected to run substantial private practices. In 1948, Aneurin Bevan confronted the reluctance of the consultants to be absorbed into the socialistic enterprise of a National Health Service (NHS). His cynical but clear-sighted decision to 'stuff their mouths with gold' (Abel-Smith, 1964) dragged them in. Consultants they remained, but there had been a fundamental change in their position. No longer independent contractors, they were now, for at least part of every week, salaried employees. However, in many respects, they still behaved more like independent contractors. The notion of complete clinical independence was maintained, with no expectation that a consultant should be supervised in any way at all. This gave rise to the impression, and sometimes the practice, of waywardness – the consultant could do what he or she liked without reference to the rest of the system. The air of detachment and privilege persisted. The consultant was part, and yet not part, of the NHS health team. One irritating manifestation of this semi-independent status was the right of the consultant to continue in private practice, often in NHS time, on NHS premises, with NHS staff. Consultants were respected for

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