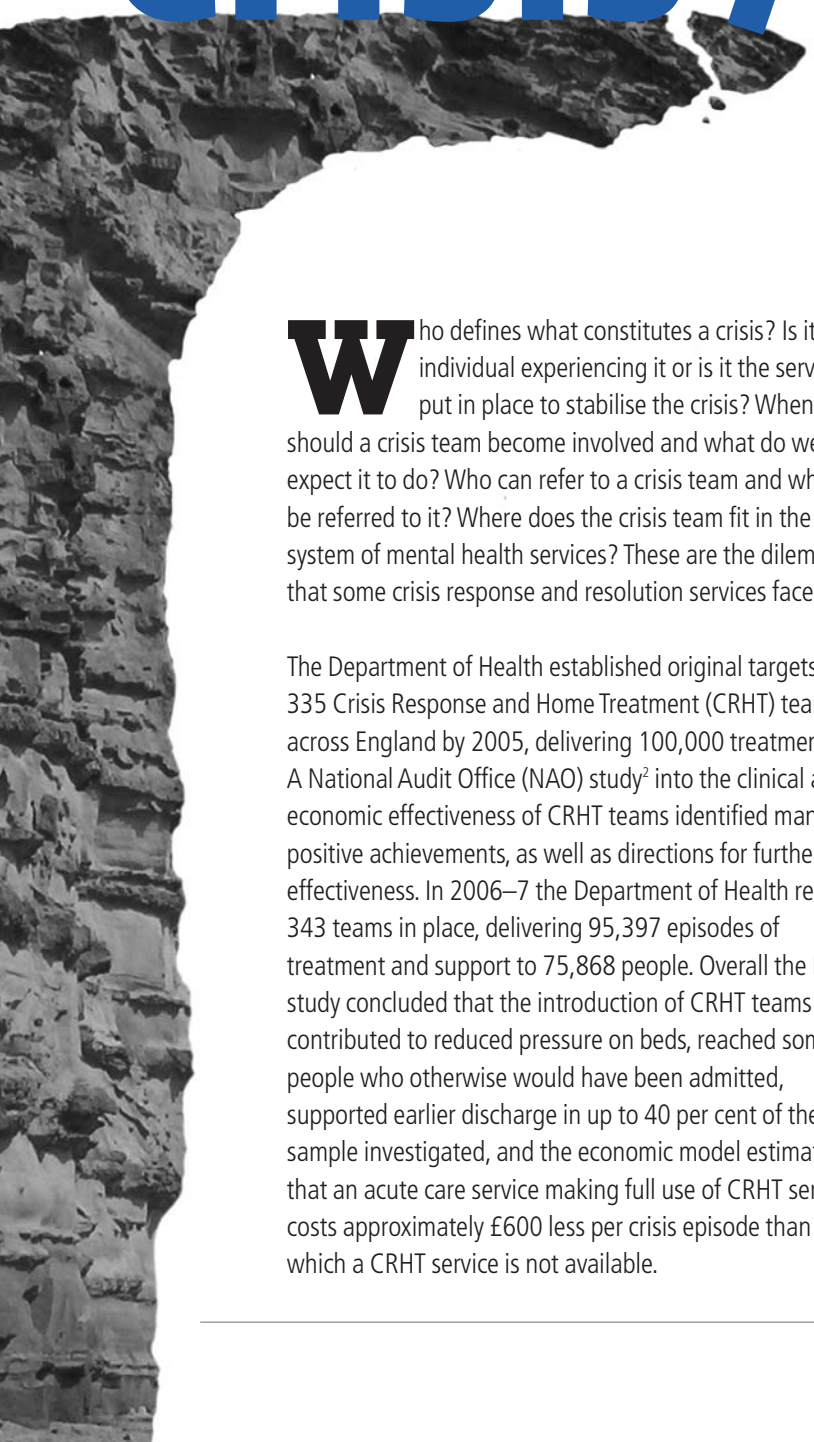
Everybody wants a good crisis response and resolution service. But the process of setting one up can raise as many questions as it answers, say Kirt Hunte and Steve Morgan

Whose crisis?



Who defines what constitutes a crisis? Is it the individual experiencing it or is it the service put in place to stabilise the crisis? When should a crisis team become involved and what do we expect it to do? Who can refer to a crisis team and who can be referred to it? Where does the crisis team fit in the wider system of mental health services? These are the dilemmas that some crisis response and resolution services face.

The Department of Health established original targets of 335 Crisis Response and Home Treatment (CRHT) teams across England by 2005, delivering 100,000 treatments.[1] A National Audit Office (NAO) study[2] into the clinical and economic effectiveness of CRHT teams identified many positive achievements, as well as directions for further effectiveness. In 2006–7 the Department of Health reported 343 teams in place, delivering 95,397 episodes of treatment and support to 75,868 people. Overall the NAO study concluded that the introduction of CRHT teams has contributed to reduced pressure on beds, reached some people who otherwise would have been admitted, supported earlier discharge in up to 40 per cent of the sample investigated, and the economic model estimated that an acute care service making full use of CRHT services costs approximately £600 less per crisis episode than one in which a CRHT service is not available.

However, the NAO study also reported wide regional variations in team provision relative to local need; that many teams lack dedicated input from key health and social care professionals, particularly consultant psychiatrists and approved social workers; that currently the CRHT teams were only involved in the assessment of about half of inpatient admissions; and that other parts of the mental health system need better awareness of the functioning of CRHT and inpatient components of an effective acute care service.

Crisis in systems

The introduction also highlights the disconnection between findings based on research methods and local practical dilemmas in trying to get people to agree what they are doing and how they work together effectively.[3] CRHT teams are set up to provide desired alternatives to hospital admission for many people in an acute crisis. But the quality of the service can be easily compromised when cost-effectiveness is the primary aim. The CRHT team can be quickly scrutinised and reconfigured as a result of shifting local commissioning priorities and targets. Consequently, staff can find themselves in a crisis regarding who they should be working with and what targets need to be met. Little or no attention is paid to systemic practice development, with the result being confusion and frustration between teams and individuals at the sharp end of service delivery.

Issues of power and politics distort decisions that should be based on clinical need

Despite providing the rapid response that service users and carers have been asking for, a further consequence of confusion within services can be the placing of an additional burden of responsibility on carers in particular to manage their way through the crisis with less support than they require.

Defining a crisis

One of the most fundamental issues that needs attention within local services is the confusion over definitions. What is a crisis, and how does crisis and emergency differ? The principles of crisis working can be identified in the treatment of wounded soldiers dating back to the World Wars: treat them where they lie, treat them right away, treat them in the context of their immediate environmental situations, and expect a speedier recovery. The debate about crisis theory and crisis intervention was initiated in mental health services by Caplan,[4] and plays itself out in subtle little conflicts within local services today.

At the broadest level, the definition of a crisis lies in the eye of the beholder. If a person asking for help says the situation is a crisis, then it is a crisis. However, this definition is not very helpful for supporting a CRHT team to focus its limited resources. The reality is that not everyone can have access to a CRHT service, and inequalities of opportunity usually mean that those least able to argue their need, or unable to engage a legal advocate, lose out. The potential population can be narrowed by screening for specific psychiatric diagnoses, and refined further by specifying elements of risk. The degree of serious imminent risk may result in the situation being defined as a psychological emergency, for which emergency services *not* the CRHT team are most appropriate.

In a crisis resolution context, a crisis is defined as the breakdown of an individual's normal coping mechanisms, which can be developmental in origin, situational or a result of severe trauma. Tensions frequently arise between, and even within, clinical teams about the real or perceived lack of clarity in definition and interpretation of terms. Conflicts may result from different thresholds of tolerance of crisis situations or interpretations driven by personal motivations or agendas. In the absence of a clear and definitive statement, it becomes more important that practice development at a local systems level should be engaged to establish agreement of a broad definition, and more specifically to agree joint working protocols for resolving the differences arising in specific detailed cases.

Early discharge

A further potential crisis for CRHT teams is the diverse expectations of the range of functions implied by their name. Prior to the establishment of CRHT teams, admissions normally meant people staying on wards until they were well enough to manage with or without the support of a non-acute community service. CRHT teams are set up with a clear expectation that they can provide short-term, intensive, acute care in the community, normally in people's own homes. This means logically that many people should be eligible to be discharged sooner with this type of acute support.

However, as with definitions of crisis, the concept of early discharge can be interpreted and used differently. Issues of power and service politics easily intrude to distort decisions that should be based on clinical need. It may be seen as a challenge to the consultant psychiatrists' role in deciding when someone is to be discharged. In some cases, CRHT resources are misused as a means of monitoring a decision to grant leave from a ward rather than discharging directly into home treatment. At an organisational level, CRHT resources may become the means of meeting a service target rather than a specific clinical need (i.e. achieving seven-day follow-up targets as part of a suicide prevention strategy). Ultimately, early discharge should be a collaborative and clinically based decision by acute care services that a person can be discharged to the intensive home treatment support of a CRHT team. They are *discharged* rather than on temporary leave, and it is happening sooner than if no CRHT existed, or only the resources of a non-acute service were available.

In a crisis resolution context, a crisis is defined as the breakdown of an individual's normal coping mechanisms, which can be developmental in origin, situational or a result of severe trauma

Our practice development approach to good systemic working would aim to achieve clear criteria for implementing early discharge into home treatment by involving representatives of all stakeholders coming together to discuss how best to manage the transition between services.

Potential for burden

An otherwise good policy of locating treatment and support to the person in familiar places (usually their home) can also result in greater expectations and burdens placed on service users, and particularly carers, to manage the crisis actively at a time when their preference is respite. Many local evaluations of CRHT teams identify increased satisfaction among service users and carers with an alternative to hospital admission. Yet we cannot ignore many cases where the pressures the service places on people are not adequately backed by the promises of support by the CRHT team.

1. Department of Health (2002) *Improvement, expansion and reform – the next 3 years: Priorities and planning framework 2003–2006*, London: Department of Health.
2. National Audit Office (2007) *Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services.* www.nao.org.uk/publications/nao_reports/chronindex.asp?type=vfm
3. Morgan, S. (2003) *Crisis response and resolution team and community mental health teams: Developing ream relationships, a report of practice development in South Camden.* Unpublished report of a systems approach to joint working.
4. Caplan, G. (1964) *Principles of preventive psychiatry*, New York: Basic Books.