Section 1

Introduction and concepts

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Introduction

Sonia Johnson and Justin Needle

Crisis resolution teams (CRTs) have risen rapidly to prominence in the UK since the mid 1990s. We will go into a good deal more detail about the characteristics of these teams in subsequent chapters, especially Chapter 6, but it is probably helpful to begin with a working definition. As currently used, the term CRT is applied to specialist multidisciplinary teams that aim to:

- assess all patients being considered for admission to acute psychiatric wards
- initiate a programme of home treatment with frequent visits (usually at least daily) for all patients for whom this appears a feasible alternative to hospital treatment
- continue home treatment until the crisis has resolved and then transfer patients to other services for any further care they may need
- facilitate early discharge from acute wards by transferring inpatients to intensive home treatment.

A note on terminology: crisis resolution team, crisis assessment and treatment team and intensive home treatment team are currently used roughly synonymously in the UK. Crisis intervention team is an older term, which originally referred to services that applied crisis intervention theory to a broad range of psychosocial crises, not only those in which admission seemed imminent (Chapter 2). In the UK, the primary care physician is the general practitioner (GP), and the UK term will be used for this role throughout the book.

Prior to 2001, only a small handful of UK centres had CRTs, generally inspired by Australian models. As mandated by the *NHS Plan* (Department of Health, 2000), almost all English catchment areas are now served by CRTs, and several thousand staff have migrated into these teams. However, in contrast to the other types of functional team introduced alongside CRTs, assertive outreach teams and early intervention services for psychosis, very little literature had been published

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about these teams at the time their nationwide introduction was required, and this gap has subsequently been filled to only a very limited degree. Thus clinicians recruited to CRTs, service managers trying to sustain them, policy makers in other countries considering whether introducing them is a good choice and mental health services researchers seeking to understand their function and evidence base have had few written sources to consult on the following types of question.

- How did the CRT model develop and what ideas about the nature of crises and how to manage them underpin it?
- How much evidence is there for the effectiveness of CRTs?
- How do clinicians in CRTs assess patients and decide who is suitable for home treatment?
- What sort of care do CRTs provide to patients whom they accept for intensive home treatment?
- How do CRTs work with other components of the mental healthcare system, such as community mental health teams and inpatient wards?
- Can CRTs be enhanced by integration with other types of acute care, such as day hospitals and crisis houses?
- How do specialist CRTs doing only short-term work compare with community mental health teams (CMHTs) whose staffing has been enhanced so that they can provide intensive home treatment in a crisis as well as continuing care?
- How should CRTs be set up and organised, and what ensures their continuing effectiveness?

This book is intended to address all of these questions, drawing on the available research evidence and, above all, on the ideas and experiences of people who have been active in the development and implementation of the CRT model. We begin with the historical context. In Chapter 2, Sonia Johnson and Graham Thornicroft describe the gradual evolution of the CRT model as part of the deinstitutionalisation movement, which has dominated mental health service development in Europe and the English-speaking world over the past five decades. They describe various precursors that have influenced the current model and identify affinities with and distinctions from other significant community mental healthcare models, such as assertive outreach teams, crisis intervention teams and mobile crisis services. In Chapter 3, Gyles Glover and Sonia Johnson describe the emergence of a more definitive CRT model based on the precursors identified in Chapter 2, and its dissemination in Australia and in the UK, especially through the work in both countries of Dr John Hoult. This chapter also describes the impact on service use in England of nationwide implementation of the CRT model: a significant reduction in admission rates appears to have ensued.

Chapters 4 and 5 discuss the research evidence base for CRTs. When CRTs first became national policy in England, studies cited in support of them were generally investigations of pioneering services carried out in the 1970s and 1980s. The use of these studies as evidence was criticised on grounds of lack of relevance to the current context. As Sonia Johnson and Graham Thornicroft describe in Chapter 4, these criticisms have some weight, as the innovative teams investigated in these classic home treatment studies tended to work over a longer term with patients rather than withdrawing following the crisis. Comparison services were also very different from modern community mental health teams. However, as Sonia Johnson and Jonathan Bindman show in Chapter 5, a more convincing evidence base is starting to accumulate, and there are now substantial grounds for believing that CRTs reduce admission rates and are probably preferred by patients to hospital admission, though other differences in clinical and social outcome have not so far been demonstrated. Many unanswered questions about CRT effectiveness remain, however, and research in this area is impeded by considerable ethical and practical difficulties in recruiting people to studies at the time of a crisis.

Chapter 6 provides the context for the clinically oriented chapters that follow by describing the core CRT model. Sonia Johnson and Justin Needle draw on the available literature on CRTs and on interviews with key experts to outline, first, the rationale for CRT development and, second, the core organisational elements of CRTs and the main interventions they deliver. They find that CRTs are more a vehicle for delivering care than a specific type of treatment. There is a general consensus that principles such as focusing on crises sufficiently severe to warrant admission, gatekeeping hospital beds and working intensively in patients' homes are important, but within this framework a variety of philosophies of care and clinical approaches to the treatment of mental illness are possible. As CRTs provide only short-term treatment to patients whose needs are often very long term, the way in which they fit into and collaborate with the wider mental healthcare system is crucial. Jonathan Bindman addresses this in Chapter 7, focusing especially on the issue of maintaining continuity of care, which is identified in several chapters as the key challenge for CRTs. Lack of continuity, for example in therapeutic relationships, is a significant potential weakness of this model, and much care needs to be taken with communication and relationships with other parts of the service system and with the patient and his/her social network if short-term crisis treatment is to be a coherent part of an effective long-term strategy.

Chapters 8 to 18 are above all addressed to CRT staff and focus on various key aspects of CRT practice. In Chapter 8, John Hoult describes the process of carrying out an assessment for CRT care, emphasising the need for comprehensive social as well as clinical assessment. Mary-Anne Cotton concludes the chapter

by summarising the limited research evidence about which patient characteristics are associated with being treated at home rather than admitted to hospital. The idea of treating severely and acutely ill patients at home has from the start had opponents as well as advocates, and one of the main grounds for this opposition, as with community care in general, has been safety. Consequently, risk assessment that is as accurate as possible, both at initial assessment and repeatedly throughout the period of home treatment, is critical if CRTs are to achieve sustained acceptance and success. In Chapter 9, Neil Brimblecombe outlines a strategy for risk assessment and management in CRTs, emphasising the importance of gathering data on risk from all available sources and checking accuracy, constantly re-assessing risk and adopting a realistic approach in which hospitalisation is not seen as an outcome to be avoided at all costs. John Hoult, in Chapter 10, gives a very practical account of how to manage symptoms of mental illness, with a final section by Fiona Nolan outlining the potential contribution of psychological treatments to the work of CRTs.

As many of the contributions to the book emphasise, the CRT model is based on the assumption that social factors are of central importance in understanding and managing mental health crises, and the following two chapters are devoted to these. In Chapter 11, Jonathan Bindman and Martin Flowers argue for the great importance in CRT work of psychosocial interventions, and the need for all members of the team to be flexible and willing to take a strong interest in issues such as patients' housing, whether they have a source of money and food, and whether they have legal problems or difficulties caring for children. Chris Bridgett and Harm Gijsman focus in Chapter 12 on work with social networks, including the use of a social systems approach to crisis work, a very practical way of working where the fulcrum is the convening of a social systems meeting, attended by as many as possible of the patient's core social network.

A number of specific issues related to clinical practice are dealt with in the succeeding chapters. In Chapter 13, Mary Jane Tacchi and Jan Scott discuss the all-important issues of engagement and adherence: CRTs will not succeed in managing people at the severely mentally ill end of the spectrum if they do not have excellent skills in these areas. In Chapter 14, Alison Faulkner and Helen Blackwell emphasise the many benefits from the perspective of the service user of the availability of intensive home treatment, but also draw attention to some important pitfalls. Themes emerging from their chapter include the importance of making a range of alternatives to admission available, including residential as well as home-based services, and of continuing to try to improve the quality of care on hospital wards for those who do need to be admitted. Their accounts also make apparent the extent to which CRTs depend on good leadership and organisation and high-quality clinicians: without these there is considerable potential

for disruptions in continuity of care, sometimes of a dangerous nature, and for patients to become isolated at home and experience only brief and superficial contacts with a bewildering number of staff. In Chapter 15, Fiona Nolan and Sylvia Tang focus on early discharge from hospital wards, a CRT activity that has received less attention than diversion from admission but which is especially important if length of stay as well as number of admissions is to be reduced. The chapter also includes a more general discussion of the relationship between hospital and CRT, and of ways in which this may be enhanced by integrating different components of local acute care systems. In Chapter 16, Martin Flowers and Jonathan Bindman outline strategies for managing repeat CRT users, including advance directives and joint crisis plans. They identify an important goal for CRTs, to contribute to prevention or attenuation of the severity of future crises, especially among recurrent users of acute services. Chapter 17 returns to the salience of the social for CRTs: when patients are treated in their own homes rather than in an institutional setting, their social circumstances and identities are much more visible. Danny Antebi, Waquas Waheed, Sonia Johnson and Lisa Marrett discuss needs that are specific to members of particular ethnic or religious groups, or which vary by gender or sexual orientation. While specific knowledge about minority groups can be helpful, above all CRT staff need to approach all their patients with an open-minded, curious and non-judgemental attitude and to listen to and try to understand individual accounts of experiences and identity rather than relying on stereotypes. Finally, in Chapter 18, the complex issues of coercion and compulsion in CRTs are addressed by Jonathan Bindman, who describes the ways in which CRT practice may sometimes of necessity become coercive, and the need for open discussion within CRTs of the extent to which restricting freedom is ethically justifiable.

The focus shifts in Chapters 19 to 23 to variations on and enhancements of the CRT model. Alan Rosen, Paul Clenaghan, Feleena Emerton and Simon Richards in Chapter 19, and Roberto Mezzina and Sonia Johnson in Chapter 20, describe two internationally prominent and long-established service models, the Lower North Shore mental health services in Sydney and the Trieste model, respectively, in which intensive home treatment is not the province of a specialist team but one of a range of functions of a community team that also delivers continuing care. The advantages of such systems are above all in continuity of care, but as yet relatively little evidence is available regarding how the outcomes from intensive home treatment delivered in this way compare with those of specialist CRTs. In Chapter 21, Ciaran Regan and Claudia Cooper discuss the potential application of the CRT model to older people. So far, this group seems to have been relatively little served by CRTs, even where they do not explicitly exclude those beyond retirement age, and specialist CRTs for older people are very rare. This is

an issue of equity, as there is no reason why older people should not benefit from intensive home treatment. Chapter 22, by Mary Jane Tacchi, describes experiences of integrating intensive home treatment services with acute day care, thus increasing the range of available ways of caring for people in crises. Some people's home environments are such that they do not benefit from remaining in them during a crisis, and in Chapter 23, Brynmor Lloyd-Evans, Sonia Johnson and Helen Gilburt discuss the ways in which community-based crisis residential services can be combined with CRT care to offer an acceptable and appropriate alternative to admission for this group.

In the final section of the book, the perspective shifts to that of service managers and service planners considering how to set up and sustain CRTs. Chapter 24, by Martin Flowers and John Hoult, provides guidance on how to set up a team that is adequately resourced and sufficiently integrated into the local service system to meet local needs. Principles to follow in order to make sure the service survives and becomes a valued part of the local system are also set out. Key tasks in implementing the model are to recruit a staff team suited to this way of work and to provide appropriate training for them: in Chapter 25, Steve Ramsey and Warren Shaw discuss how to do this. To conclude the book, in Chapter 26, Stephen Niemiec outlines key issues in the operational management of CRTs, including ensuring the team is of adequate size, implementing shift systems and managing communication effectively.

Thus overall this book constitutes a toolkit that should go some way towards meeting the needs for information and guidance of those wishing to establish, manage, work in or investigate CRTs. Despite the paucity of previous literature describing or evaluating the CRT model, it is now relatively well established, with some consensus on its components and operational principles. However, as will become apparent in the chapters that follow, the model cannot be regarded as fixed in every detail. Different teams may follow the same organisational principles, for example rapid assessment in crisis and intensive contact at home, yet may vary considerably in the treatments they offer their patients and in the philosophy of care on which their service is based. There is still considerable scope for innovation within the framework of this model, for example in areas such as development of family interventions that work well in CRTs, and for investigation of what works best for whom in acute care systems that include CRTs. We, therefore, hope that this book will provide not only practical guidance on the current model, but also a starting point for further innovation and service development.

REFERENCE

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2

The development of crisis resolution and home treatment teams

Sonia Johnson and Graham Thornicroft

The history of crisis resolution and home treatment teams (CRTs) has not previously been very clearly documented. This chapter fills this gap by describing the development of the CRT model, identifying its main precursors and the contributions they have made to the current model. The focus will be on services for adults of working age, and an overview will be given of the history and characteristics of the main models that have contributed to the development of current CRTs. Research evaluations of these models are discussed in Chapters 4 and 5.

Information sources used in this history

The authors carried out a literature search regarding CRTs and other forms of intensive home treatment delivered in a crisis. They looked particularly for descriptions of how the models that appeared to be CRT precursors were organised and operated, and of their origins, including any theories that had informed their development and research evidence or clinical observations that influenced them.

As relevant written sources are few, one of the authors (SJ) also carried out a series of interviews with key people involved in the development of CRTs and their precursors.[1] Box 2.1 lists these people and says a little about them. The interviews took place in the course of 2002 and 2003 in a variety of locations, including participants' offices, a conference centre, one participant's home and Terminal 3 at Heathrow airport. Two interviews were carried out by phone. All were transcribed verbatim and content analysis was used to identify the main relevant themes and historical details.

[1] These interviews also form part of the basis for Chapter 6. They are referred to in the text as 'Bracken, interview', and so on.

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Box 2.1. Interview participants

Dr Patrick Bracken. Psychiatrist. Former home treatment consultant in Birmingham, developer of the Bradford Crisis Resolution Team (in operation since 1996). Also involved in establishing the Centre for Citizenship and Community Mental Health, University of Bradford.

Mr Martin Flowers. Psychiatric nurse. First leader of the South Islington CRT, one of the early UK model services, subsequently consultant on CRTs at the National Institute for Mental Health, England.

Dr John Hoult. Psychiatrist and researcher. Has replicated the Training in Community Living model in Sydney. Subsequently responsible for the development of CRTs in locations including Sydney, Birmingham, the inner London Borough of Islington and Essex.

Dr Matt Muijen. Psychiatrist and researcher at the Daily Living Programme, London. Subsequently involved in dissemination of the CRT model as Director of the Sainsbury Centre for Mental Health, London. Now Regional Advisor for Mental Health, World Health Organization European Office.

Dr Paul Polak. Former psychiatrist. Developer of a network of innovative community services in Denver, Colorado, in the 1970s. Since 1981, founder and Chief Executive of International Development Enterprises, working on the dissemination of affordable technologies in developing countries.

Mr Steve Ramsey. Psychiatric nurse. Member of the original Sydney team and subsequently involved in development and dissemination of assertive outreach and CRT services in Sydney. Now a freelance trainer on their implementation.

Professor Alan Rosen. Psychiatrist. Involved in the Australian implementation of the Training in Community Living model. Subsequently director of Royal North Shore Hospital and Community Mental Health Services, Sydney, where crisis resolution is integrated into a case management team. Posts at the Universities of Wollongong and Sydney.

Professor S. P. Sashidharan. Psychiatrist. Medical Director, North Birmingham Mental Health Trust and Professor of Community Mental Health, University of Central England. Involved in the development of CRTs in Birmingham.

Dr Dennis Scott. Retired psychiatrist. Developer of the Barnet Crisis Service, London.

Professor Leonard Stein. Psychiatrist. Developer of the Training in Community Living model and of CRTs in Madison, Wisconsin. Emeritus professor at the University of Wisconsin and medical director of the Dane County Mental Health Center.

Defining 'emergencies' and 'crises'

Some authors draw a distinction between psychiatric emergencies and psychosocial crises (Segal, 1990; Rosen, 1997). Emergencies tend to be defined as situations in which there is a need for immediate action, generally because of a high level of risk. A definition exemplifying this is Rosen's description of an emergency as 'a life-threatening situation demanding an immediate response', often requiring the attendance of emergency services such as the police and fire brigade. Other definitions have not set the threshold for defining an emergency quite so high but have emphasised the presence of substantial risk and an urgent need for professional intervention; they have also often defined a psychiatric emergency as something that occurs only in the context of a mental illness (Katschnig and Konieczna, 1990).

In contrast, the classical use of the term 'crisis' originates in crisis intervention theory (Caplan, 1961, 1964) and describes a general human response to severe psychosocial stress, rather than a manifestation of illness. In Caplan's (1961) formulation, a crisis is

> provoked when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many different abortive attempts at solution are made. Eventually some kind of adaptation is achieved, which may or may not be in the best interest of that person and his fellows.

Crises are thus periods of transition encountered by everyone, in which the potential role for professionals is to promote an adaptive way of coping, resulting in full recovery and, ideally, psychological growth.

In clinical practice, however, it is hard to set a clear boundary between emergencies and crises. Staff in services targeting people experiencing crises, classically defined, have found that individuals of previously good psychological adjustment with no diagnosable mental illnesses rarely present to them (Katschnig *et al.*, 1993), while difficulty adjusting to psychosocial stresses often contributes to the development of situations seen as psychiatric emergencies among people with severe mental illness (Jones and Polak, 1968). The usage of these terms has, therefore, shifted, so that recent discussions of service provision and evaluation have often used the term crisis in a more pragmatic way to describe situations in which there is an urgent need for professional intervention arising at least in part from mental health problems.

Where the central goal of crisis services is to prevent admission, as with CRTs, a still narrower definition tends to be used, reflecting this goal. Crises are viewed as situations in which current clinical and social problems and associated risks