Journal of Psychiatric Intensive Care

Journal of Psychiatric Intensive Care
Vol.3 No.2:71–73
doi:10.1017/S1742646408001180

Editorial

Changing the script

Marcellino G. Smyth

Professor of Social & Community Psychiatry, Birmingham City University and Consultant Psychiatrist West Cork Mental Health Service

In the previous article, Dr Fear raises important issues regarding the consequences of the availability of Crisis Resolution and Home Treatment (CRHT) teams and their impact on acute care environments (Fear, 2007). Are his concerns justified or are they perceptions based on attributing system effects to these teams, which are not supported by evidence or argument?

By their nature and purpose Crisis Resolution/Home Treatment (CR/HT) teams are targeting acute cases which would otherwise be admitted (i.e. in the absence of the intensive support that CR/HT can deliver). If they were not so targeted, then there would be less impact on admission diversion, fewer acute presentations that could benefit from treatment in the home environment, and overall less justification for this initiative. It is not at all surprising given this arena of activity, that some cases will require admission to hospital. These admissions will be arranged either immediately after CR/HT assessment (therefore not having any home treatment) or subsequently despite the best efforts of home treatment (e.g. because of accommodation instability, lack of clinical progress, lack of cooperation, relative's wishes, change in course of illness, new risk issues etc.). The home treatment service referenced by Fear (Harrison et al., 2001) was a 1998 hybrid day hospital/home treatment initiative, established before the Department of Health Mental Health Policy Implementation Guidelines for CR/HT teams (Department of Health, 2001). It could not be considered representative or as having high fidelity to Department of Health specifications. It is also problematic to reference this team's non-acceptance of 48% of acute cases as a general indictment of CR/HT, when the authors state that 23% were inappropriate referrals in the first place; patients who were not sufficiently ill to merit consideration for this approach.

The practice of acute psychiatry is not an exact science and is challenging whether the treatment should be at home or in general or PICU inpatient settings. Proponents of CR/HT have for 30 years been at pains to point out that inpatient care remains a vital component of safe acute care delivery, that they admit when necessary, and that a percentage (around 20%) of cases will still require inpatient care despite CR/HT. Are these 20% to be regarded as Dr Fear suggests as 'CR/HT failures'? What about the 80% CR/HT successes? Are we expected to make acute provision strategy decisions based on the 20% such as to stop all home treatment and restore the other 80% admissions to having an inpatient episode unnecessarily? By comparison, a certain number of general acute ward admissions will require PICU care. Do PICU staff label these cases as 'inpatient ward failures' or do they routinely recognise the complexity and variable course of serious mental illness with changing needs for the most appropriate level of support?

The more sinister proposition raised by Fear is that cases admitted after initial home treatment are somehow more ill because they did

Correspondence to: Professor M. Smyth, Department of Psychiatry, Bantry Hospital, Co. Cork, Ireland.

not have inpatient care in the first place. Fear offers no data to support this hypothesis probably because no such evidence exists to my knowledge. Multiple controlled trials of home treatment versus hospital groups have demonstrated equivalent diagnostic and morbidity profiles. Kluiter (1997) pooled 8 studies involving 610 patients and calculated the average ratio of inpatient hospital days as 17:60 for the home group compared to the hospital group. From such literature and practice the notion that admitted CR/HT patients are always more ill than direct admissions does not stand up. The reasons for their admission can be (as listed above) due to social/accommodation factors as much as clinical reasons. It seems counterintuitive to suggest that some acute care in the community is worse than none at all. Cullivan (2006) said that to make the assumption that all admissions are failures of home treatment would suggest an impressive evidence base which is simply not yet available.

Fear describes a general perception that ''all patients are best managed at home regardless of diagnosis or level of severity''. He provides no evidence to support this general perception. It would be unethical for CR/HT teams to conscionably persist through ideology in offering home treatment beyond a point where it ceased to be adequate or delaying arranging admission while the patient deteriorated and risks escalated. In practice these teams keep the issue of admission under constant review when appropriate because this is the reality of responsible psychiatric practice. They have good experience of what they can offer, of when this is compromised or not enough, and of what is required for the most appropriate care.

The issue of relatives' burden is highly relevant in both settings. The West Midlands group Carers in Partnership have produced a detailed and extensive account of their range of views about CR/HT which make for serious consideration from clinicians (NIMHE/UCE, 2004).

Fear is correct to highlight the impact of CR/HT on the resultant profiles of general inpatient populations. If all cases being admitted have serious mental illness then by definition (as has happened) inpatient environments are skewed towards the more challenging range. If the rate of Mental Health Act detention per unit is higher accordingly, this is not the same as saying that the rate of MHA detention is higher overall for a given catchment area. This is borne out by the statistics from the Department of Health which do not show an increase in national annual rates of detention following the introduction of CR/HT (Department of Health, 2004). However, I do not think that these new challenges for inpatient environments have received enough attention (Smyth, 2003). I am struck by how many 'open' wards now have routinely locked doors. I am not placed to know whether these new pressures on general inpatient units have further translated into increased rates of PICU admission.

Polarised academic debate surrounding home and hospital acute treatment is long established, but may be sterile in changing opinions. Political motivation to reduce beds excessively compounded by disinvestment only adds to the tension. Centre stage is the aim to offer choice of treatment setting in voluntary acute presentations, and if home treatment is not available then that choice is limited. If admission is out of the question because of a dominant team ideology than that too is a problem. From patient testimonies we know that reducing the inevitability of admission for every acute relapse can profoundly alter the nature of an individual's engagement with mental health services. It can dramatically change the script of their meanings attached to being unwell and stimulate recovery. Even when there is a different experience narrative, many will still value their care in inpatient wards more highly. Individuals with experience of both can now tell teams their preference, some wanting CR/HT teams to persist in visiting at home through manic episodes when they dread admission, while wanting admission when depressed and hopeless fearing being alone. Others will want the exact reverse. As for dogma: *Exit stage left*.

https://doi.org/10.1017/S1742646408001180 Published online by Cambridge University Press

References

Cullivan, R. (2006) Admission is not a failure of Community Care. *Psychiatric Bulletin*. 30: 470.

Department of Health (2001) *Mental Health Policy Implementation Guide*.

Department of Health (2004) In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1993–94 to 2003–04. *Statistical Bulletin*. 2004/22.

Fear, C. (2007) Taking the drama out of crisis. *Journal of Psychiatric Intensive Care*. 3(2): 67–70.

Harrison, J., Alam, N., Marshall, J. (2001) Home or away: Which patients are suitable for a psychiatric home treatment service? *Psychiatric Bulletin*. 25: 310–313.

Kluiter, H. (1997) Inpatient treatment and care arrangements to replace or avoid it. *Current Opinion in Psychiatry*. 10: 160–167.

NIMHE/UCE (2004) *Carers Views. Carers in Partnership. Crisis Resolution & Home Treatment Expanded Guidelines*. Ed. Smyth M. Centre for Community Mental Health BCU: 83–100.

Smyth, M. (2003) Crisis resolution/home treatment and inpatient care. *Psychiatric Bulletin*. 27: 44–47.

https://doi.org/10.1017/S1742646408001180 Published online by Cambridge University Press