Correspondence

In praise of crisis resolution and home treatment teams

Festina lente

These are times of major change for psychiatric services in general and consultants in general adult psychiatry in particular. The locus of psychiatric care has moved from asylums to the community mainly during the past two decades. The backbone of psychiatric services has become sectorised community mental health teams (CMHTs) in which a consultant psychiatrist in conjunction with a team manager lead what might be called an 'elliptical group' (an ellipse has two centres). The CMHT is responsible for patients from a clearly defined geographical area and provides a full range of treatments (Harrison & Traill, 2004).

It may be the case that we have arrived at another critical point in the evolution of psychiatry when change is necessary; this time moving from care in the community to care in patients' own homes.

In a relatively short space of time many of the recently created crisis resolution and home treatment teams (CRHTs) have established themselves as powerful 'field players' taking the role of gatekeepers in respect of in-patient bed utilisation. As CRHTs can provide medical, social and psychological input, are capable of rapid response, are available 24/7 and are able to spend time flexibly with patients on an as-required basis, they plug a vital gap between CMHTs and in-patient psychiatric units. Patient satisfaction has been reported to be high and preliminary audits indicate that in-patient bed occupancy has decreased. In addition these new services appear to have closer links to primary care. Perhaps in the future the CRHT may become the dominant centrepiece of a jigsaw puzzle in which CMHTs, assertive outreach teams, early intervention teams and rehabilitation teams are subcontracted, thus ensuring continuity of care.

These things having been said, it is known that a significant number of consultants currently feel under pressure. Large personal case-loads (Tyrer *et al*, 2001), frustration and job dissatisfaction (Kennedy & Griffith, 2001) in the context of an increased amount of required paperwork and reporting and the ever-increasing power/demand of the 'consumer' are leading many to opt for early retirement (Kendell & Pearce, 1997). The role of the consultant psychiatrist is under scrutiny (Royal College of Psychiatrists, 2004). Perhaps it is not surprising that the Department of Health is heavily promoting the development of CRHTs together with further development of assertive outreach and early intervention teams. Despite this Harrison & Traill (2004) concluded in their survey that equal numbers of consultants 'agreed and disagreed with the development of specialist roles' and that 'the most strongly held negative view was that the new teams would have a negative impact on their parts of the service'.

In light of the above it is likely that there will be considerable resistance to change. In sociological terms, resistance to change is normal, welcome and not always a bad thing. People are naturally afraid of what changes may bring. High levels of stress are strongly correlated with low job satisfaction. But the converse is also true, with high job satisfaction counteracting resistance to change. Adaptability and innovation form the basis for radical means of change (Binney & Williams, 1997). Cultural change is understandably difficult and slow and therefore it is of a paramount importance to set realistic and well-understood goals – otherwise low morale and cynicism may quickly overcome the change-makers.

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In-patient CRHT consultant psychiatrists as 'osmotic agents': one year's experience

In Devon – a predominantly rural area of the UK covering a large geographical patch with dispersed centres of population – we have noticed some encouraging preliminary results with the intensive crisis resolution/home-treatment team (CRHT) in