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correspondence

Crisis resolution and home treatment teams for older people

Dibben *et al*'s paper on the impact of crisis resolution and home treatment teams (CRHTT) on hospital admission rate, length of stay and satisfaction among older people with mental illness in West Suffolk is praiseworthy (*Psychiatric Bulletin*, November 2008, **32**, 268–270). Although the CRHTTs were unable to reduce the length of hospital stay, they significantly reduced admission rate. Does this study provide enough evidence for developing similar services for older people elsewhere? The answer is both yes and no.

Yes, because, in spite of certain limitations, this is the first planned study in the UK to provide the much needed evidence for setting up CRHT-type services for older people in line with those originally introduced for working-age adults. But the answer is 'no' because we do not know whether such services are necessary and cost-effective. It is worrying to discover that the CRHTTs in Suffolk were set up following closure of a dementia ward and two day-hospitals. What is surprising is that there are five older age community mental health teams (CMHT) for a population of only 47 000 older people. In Hertfordshire, which is not far from Suffolk, we have only two CMHTs for a similar population. We have been managing the service needs reasonably well with limited contribution from the adult CRHTTs in our area. We are curious to know how Suffolk Mental Health Trust is able to afford more than one CRHTT despite having so many CMHTs for older people. If these services were the knee-jerk products of the unplanned closure of acute assessment ward and day hospitals, the future of those CRHTTs hangs in balance. The ever-hanging financial sword may drop on them sooner or later.

Moreover, to develop new services at the cost of well-established services may be a short-sighted step. Older patients with both functional and organic mental health problems can be managed well by using adequately resourced day hospitals and minimum number of hospital beds. We have been doing so quite successfully in West Hertfordshire for the past 10 years. We have managed this by enabling and encouraging the existing CMHTs to provide assessment and treatment to patients in the community using the principles of New Ways of Working. If we can do that with only two CMHTs for an elderly population of 44 000, why are five CMHTs needed in Suffolk for a similar population?

The authors describe the CRHTTs in Suffolk as a 'practitioner-led service which provides short-term assessment and management at the time of a crisis'. If our guess is correct, by 'practitioner-led' they mean 'non-doctor led'. Specialist mental health teams for older people have traditionally been led, but not necessarily managed, by old age psychiatrists. To develop new teams led by non-psychiatrists is a risky initiative. At a time when national dementia strategy (www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/olderpeople/nationaldementiastrategy/index.htm) and quality of care are on the horizon, to see the introduction of practitioner-led teams is very worrying indeed. One of the recommendations of the national dementia strategy is 'good-quality early diagnosis and intervention for all'. Who would provide diagnosis and a treatment plan for an acutely ill patient in crisis? Before one can offer a suitable treatment plan, one needs to know what is wrong with the patient in the first place. Teams which are not led by psychiatrists tend to manage crisis without carrying out a thorough assessment and investigations. In the elderly, this practice creates a risk of overlooking medical problems and therefore complicating the crises further. Delaying admissions to hospital by providing inadequate home treatment may be harmful to older patients. Not surprisingly, Craddock *et al* (2008) in their wake-up call for British psychiatry, warn that the 'downgrading of medical aspects of care has resulted in services that often are better suited to offering non-specific psychosocial support, rather than thorough, broad-based diagnostic assessment leading to specific treatments to optimise well-being and functioning'.

On balance, however, we are in favour of developing acute community psychiatry services for older people, as long as they do not undermine the spirit of multidisciplinary team working of traditional CMHTs and day-hospital services, and improve patient care in older service users. They should be complementary to each other rather than mutually exclusive.

CRADDOCK, N., ANTEBI, D., ATTENBURROW, M-J., *et al* (2008) Wake-up call for British psychiatry. *British Journal of Psychiatry*, **193**, 6–9.

Tinde Boskovic Staff Grade Old Age Psychiatrist, ***Arun Jha** Consultant Old Age Psychiatrist, Hertfordshire Partnership NHS Foundation Trust, Logandene Care Unit, Ashley Close Hemel Hempstead, Hertfordshire HP3 8BL, email: arun.jha@hertspartsft.nhs.uk

doi: 10.1192/pb.33.2.75

Dibben *et al* (2008) have carried out a useful evaluation of a newly established crisis resolution and home treatment service for older people. However, they have made a serious error in the interpretation of their results.

They have compared the 6-month periods before and after the local CRHTT extended its remit to include patients aged over 65 years. A crisis was defined as 'an event where admission was being considered'. The main findings are as follows: 'In the pre-CRHTT period there were 65 crisis events which resulted in 65 admissions. After the introduction of the CRHTT there were 102 crisis events of which only 70 required admissions. Of these, 66 crisis events led to direct hospital admission and 4 required admission after a brief period of home treatment.' It is impossible to agree with the conclusion that 'overall, the CRHTT reduced admissions by 31%'. There was, in fact, a slight increase in admissions and a substantial increase in proposed admissions after this service was made available.

Dibben *et al* briefly allude to the likely cause for this. Crisis resolution and home treatment teams act as extra gatekeepers to in-patient care after other mental health clinicians have made the decision that admission is required. I cannot imagine how any experienced clinician who knows their patients and the local service and who takes pride in their work