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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Adrian Blaj Specialist Registrar in General Adult Psychiatry, Complex Cases Service, Addenbrookes Hospital, Hills Road, Cambridge, CB2 2QQ, UK. Email: Adblaj@aol.com

Kader Sirajudeen Associate Specialist in Psychiatry, Crisis Resolution and Home Treatment, Luton, UK

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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

averting admissions. The in-patient CRHT consultant works as an 'osmotic agent'.

To explain this metaphor one should consider mental health teams as having 'semipermeable membranes', rather than being watertight compartments. Consider an in-patient team and a crisis resolution team as being separated by such a membrane. The pores are large enough to let some particles (i.e. patients) pass freely while the passage of others is inhibited. This two-way process is analogous to the teams' functions of gatekeeping and promoting early discharge. Within this model, the consultant provides supervision and leadership (a key role in monitoring, allowing and facilitating the osmosis) to both the CRHT and the in-patient team.

With this approach the bed occupancy rate in the Mid Devon County area has dropped by 35% over the past 10 months. We registered a decreased number of involuntary hospital admissions and a lower prevalence of antipsychotic polypharmacy when compared with previous approaches.

The new approach is substantially in line with the final report *New Ways of Working for Psychiatrists*, issued in the UK by the National Steering Group, co-chaired by the National Institute for Mental Health in England (NIMHE) and the Royal College of Psychiatrists (Department of Health, 2005).

Our preliminary experience suggests that the new model and the review of the in-patient CRHT consultant's role might affect positively the utilisation of specialty mental health services, thus achieving a pragmatic balance between community and hospital care.

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Massimo (aka Max) Lanzaro In-patient/Crisis Home Treatment Team Consultant Psychiatrist, Devon Partnership NHS Trust, Wonford House Hospital, Dryden Road, Exeter EX2 5AF, UK. Email: maxlanzaro@btinternet.com.

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Discovering the true value of partnership with the voluntary sector

Tait & Shah (2007) hail the benefits of partnership in the community with the voluntary sector, and outline challenges for the future. They acknowledge that most psychiatrists already have practical experience of working with charities providing mental healthcare, but overlook the wider context, hinted at only by reference to Aldridge's (2005) publication for the Social Market Foundation.

The voluntary sector has been an innovator in the provision of care environments throughout the journey of psychiatry from alienism to social inclusion, driven by strong founding values. For example, the Retreat at York, St Andrew's Healthcare in Northampton and Together (formerly the Mental After Care Association) are legacies of 18th- and 19th-century philanthropy and social reform. These charities are now working with Mind, Rethink, Turning Point, the Richmond Fellowship, Carr Gomm and others under the umbrella of the voluntary sector Mental Health Providers Forum (http://mhpf.org.uk/members.asp) to improve provision for service users.

It is important to understand the current government's strategic intent for partnership working in mental health – to create better value through inclusion of not-for-profit providers. Shah & Tait note that competition between the voluntary and statutory sectors can be a bar to partnership, and suggest that that some mental health professionals see voluntary sector community staff as 'amateurs'. However, government agencies have pressed competitive re-tendering and cost improvements on these charities, while the national initiatives listed by Shah & Tait fail to deliver on the principle of full cost recovery, leaving providers struggling to meet their costs through fundraising.

In an ideal world the government would have a longer-term view, and see how best to enable the 'value chain' between the public and voluntary sectors, to use a modern market term that covers cooperative relationships between companies. This would require a higher resourcing level, just as the government has provided to kick-start private sector healthcare initiatives such as the private finance initiative (PFI) and independent sector treatment centres (ISTCs). This would accelerate the development of the partnerships envisaged by Tait & Shah, bringing in the long-term better, innovative and more efficient services. Nevertheless it is clear that the voluntary sector has a growing role in the future of psychiatric care.

Declaration of interest

P.A.S. is a trustee of the Mental Health Provider Forum, St Andrew's Healthcare and the Royal College of Psychiatrists, and a former trustee of Together.

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Philip A. Sugarman Chief Executive Officer and Medical Director, St Andrew's Healthcare, Northampton, UK. Email: psugarman@standrew.co.uk

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