the columns

correspondence

Crisis intervention in the UK

Sir: Protheroe and Carroll (*Psychiatric Bulletin*, November 2001, **25**, 416–417) are clearly enthusiasts for crisis services. They relate that they are struck by the lack of awareness of and hostility towards the development of crisis services. Could it be that it is not lack of awareness of such services, but an awareness of the lack of up-to-date evidence for or against such services? The evidence base from randomised controlled trials for crisis intervention services is weak. Most of it is around 20 years old and only one study is derived from the UK. The older research studied hybrids of crisis intervention and assertive community treatment, rather than pure crisis intervention. Even the most up-to-date research of a service that approximates to crisis intervention, a study of the Daily Living Programme (Muijen *et al*, 1992), did not compare home treatment with the cornerstone of modern day community care – the community mental health team, using the framework of the Care Programme Approach. What is more, the terminology of crisis intervention, or home treatment as it is otherwise known, is inadequate and confusing and prevents adequate conclusions being formed.

Protheroe and Carroll complain that UK-based psychiatrists are hostile towards the development of crisis services. If indeed this is the case, such hostility is not reflected in the sentiments of health authority chairs and trust chief executive officers who responded to a recent questionnaire study: all health authorities and 97% of trust chief executive officers were in favour of the principle of providing home treatment (Owen *et al*, 2000). It would be interesting to know just how prevalent such hostility actually is among UK-based psychiatrists.

The authors note that the public continues to fear care in the community despite the evidence that de-institutionalisation has not increased the low risk of homicide by those with mental illness. This is a specious argument. Homicide is an uncommon event, violence on the other hand is not and its consequences can be very serious. Between 10% and 40% of patients commit assault before admission to hospital and 28% of discharged patients have been found to have committed at least one violent act within a year of discharge (Monahan, 1997; Steadman *et al*, 1998). As with intensive case management (Walsh *et al*, 2001), crisis intervention has not so far been demonstrated to reduce the frequency of violent episodes committed by patients. This is neither argument for nor against crisis intervention, but simply a statement that we just don't know what the impact of crisis intervention is on violence.

Finally, with regard to issues relating to the detainment of patients under the Mental Health Act, the authors' views may be too radical for liberal-minded UK psychiatrists. Our current system of detention of patients may be considered too slow and unwieldy by the authors, but the alternative proposal of a single individual (a crisis assessment and treatment team worker) alone being able to swiftly effect the deprivation of an individual's liberty is surely much more open to abuse than the English and Welsh system: surely our more elaborate processes of application are meant to serve as a safeguard for patients.

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National Confidential Inquiry

Sir: Following the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Appleby *et al*, 1999) we compared our services to the recommendations made for follow up of high-risk patients discharged from in-patient care.

Of 158 admissions to our service between 1 August 1999 and 31 January 2000, 40 were identified as high risk because they required one to one continuous nursing supervision. Eleven were offered follow up within 48 hours, 25 between 48 hours and 4 weeks and one after 4 weeks after discharge. Three had no follow up arranged. Twenty-three patients had trial leave before discharge.

Care Programme Approach was completed in 38 cases and six patients had the risk assessment form completed at discharge. Thirty-seven patients had discharge summaries – one recorded the nature of risk and two the need for special observation during admission. Thirty-eight patients were discharged with medication supply of less than 14 days and one with 19 days (missing data=1).

Following discharge, seven patients were involved in nine adverse incidents (seven overdoses, one suicide and one violence to property). Three of these adverse incidents occurred within 1 week of patient discharge and two of these patients had follow-up appointments within 48 hours, including the patient who committed suicide.

Seventy-three per cent did not meet the recommended guidelines for follow-up; 95% met the guidelines for 2-weeks supply of medication. There was a lack of documentation in discharge summaries of the nature of risk. Risk assessment forms were not completed on discharge in 85% of cases.

We have concerns that the recommendations are not being adhered to locally and suspect our service is similar to others nationally. To implement the recommendations considerable changes need to be made to existing practice.

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