

Multidisciplinary crisis intervention service – a registrar's experience

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Recent years have seen a steady move from a hospital based psychiatric service into a community orientated one. Mental health carers and psychiatrists need to be trained in order to be able to meet the changing demands placed upon them (*Lancet*, 1985).

In 1968 a Royal Commission on medical education suggested that every psychiatrist should be familiar with the conduct of community psychiatry (Freeman, 1985). However, the requirements for this training remained ill-defined and in September 1986 a Collegiate Trainees' Committee (CTC) Working Party was convened for this matter (Scott, 1988).

The Napsbury Community Crisis Intervention Service (CCIS) was established in 1970. Most publications on this service have focused on the advantages of the service for patients. (Ratna, 1982). This article describes a 15-month experience as a registrar on the CCIS. I will comment on the advantages and disadvantages of this experience in terms of working and training in community psychiatry.

The setting

The psychiatric service of Barnet Health Authority is divided into two sectors, the Edgware and Barnet sectors. The Edgware sector covers a population of approximately 150,000 and is run from Napsbury, a Victorian psychiatric hospital near St Albans. The Barnet sector covers a population of approximately 200,000 and is run from a psychiatric unit at Barnet General Hospital. Both sectors have separate crisis intervention teams. Each team comprises a junior doctor, psychiatric social worker, and a community psychiatric nurse. A consultant is on-call for medical back-up.

The service is a secondary referral one and accepts requests for assessment from GPs, police stations and accident and emergency departments. Patients are usually seen at the place where the request was made, i.e. private home, casualty department, or police stations.

The experience

Most junior doctors are placed on the CCIS after a minimum six month period in general adult psychiatry.

While working within the community crisis intervention service the junior doctor gains the experience required for basic training in the community outlined by the CTC working party. This means that the junior doctor is an active member of a clinical multidisciplinary team; he or she is able to learn about alternatives to admission in the context of emergency work, and experiences contact with statutory bodies. While working in the community the junior doctor keeps in close contact with primary care services.

Of these experiences I have found the home assessment to be an invaluable one. Even for patients subsequently admitted to hospital, home assessments have given me an insight into their functioning at home and I have learnt about social support networks.

Difficulties

It has been noted that the concept of multidisciplinary team gives rise to conflict between psychiatrists and other professionals (Stuart & Waters, 1985). In my experience the amount of conflict varies, but I have found a good working team is able to tolerate disagreements and nevertheless come to a conclusion that is acceptable to all involved.

The decision about whether the patient should be cared for in the community or in hospital gives particular rise for disagreements within the crisis team. Although decisions are made as a team, responsibilities fall on the members as individuals.

Crisis work is time-consuming. An assessment lasts on average one to two hours. But I have experienced visits that took over three hours. Additionally, there are transport problems which are specific for the Greater London area.

Comments

To my knowledge there is no other training scheme in the UK that offers involvement in acute community care at such an early stage. The constant availability of consultant back-up for advice and consultation is therefore paramount.

I have found my experience working within the CCIS a challenging and rewarding one. It has given me the opportunity to meet and liaise with many professionals of different disciplines.

I feel that the roles and responsibilities within a non-hierarchical multidisciplinary team need to be defined. In my own experience I found it challenging to explain and defend my assessment and opinion to other professionals. Some have proposed that a doctor should take a leading role within community care (Stuart & Waters, 1985). This requires the acquisition of the necessary skills and experiences. In this respect CCIS work has given me the opportunity of gaining management skills, and of professional and personal growth.

References

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Expert opinion

Community ward rounds

(T. BURNS (1990) *Health Trends*, **22**, 62–63)

It is interesting to observe just how much (or little) psychiatric services adapt to changing circumstances. The progressive move to community care, with the resettlement of seriously ill patients outside hospital and the avoidance of admission for many acutely ill patients, has shifted the focus of the psychiatric team away from its traditional institutional base – or rather the focus should have shifted. Yet it is probable that many psychiatrists, while paying lip service to the needs of patients in the community, have not altered their weekly routine. Hospitals, and the security they represent, retain their magnetic attraction for many staff. But with the growing number of out-patients and chronically disabled patients being supported by team members outside hospital, how should the multidisciplinary team respond?

Nine years ago my sector team moved to a smaller ward. It soon became apparent that the ward staff expected the same amount of consultant time to manage a smaller number of patients. No extra time would be free for the growing army of patients outside the hospital walls. Our solution was to create an in-patient and an out-patient team. Each team

consisted of a consultant, SHO/registrars and social worker. The out-patient team also had the services of two community psychiatric nurses (CPNs). I began to hold weekly 'out-patient rounds' (Pullen, 1987). These meetings are the equivalent of the conventional ward round. New patients are discussed in detail, problems with current patients or families are aired, and occasionally patients, couples or families are brought into the meeting for a 'case conference'. This is also the forum for setting up joint home visits, to negotiate a change of key worker or for any team member to raise problems for discussion and obtain support. Finally, this is the forum for team planning.

Tom Burns (1990) describes a similar, but rather more structured 'community ward round' in his Wimbledon service. To the list of functions above, his meetings add the allocation of new patients, the making of diagnoses on patients presented, and a review of all patients after eight sessions to prevent the development of excessive case loads. A number of rating scales are used, especially by the CPNs.

I have some reservations about the Wimbledon model, which perhaps reflect my own inability to move fully towards a team with very blurred roles. I