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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.

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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



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could find such input from a separate team useful. However, there are times when it could be handy to arrange a bit of extra support for patients whose illness has deteriorated, and for distressed people who are experiencing a psychological or social crisis. In those circumstances, busy clinicians will simply lower their threshold for the stated intention to admit to hospital and pull in nurses from the crisis team knowing that they will assist the patient in the community for a couple of weeks. Of course, this is not a rational way to use health service resources but it is an inevitable result of the diversion of staff to sub-specialist teams with such narrow and largely pointless clinical duties.

The actual data obtained by Dibben *et al* will be useful in countering recent suggestions from crisis specialists that their services should be expanded to include older adults (Cooper *et al*, 2007).

Another letter commenting on this paper (Jha & Boskovic, 2008, this issue) demonstrates that there are psychiatrists who are thinking very clearly about how best to provide effective, efficient and comprehensive mental healthcare to older people. I urge policy makers to seek advice on service models from the authors, Drs Jha and Boskovic, and other experienced old age psychiatry clinicians. They must not repeat the mistakes that have been made with services for working-age adults and foist unnecessary crisis resolution teams on older people with mental disorders.

COOPER, C., REGAN, C., TANDY, A. R., *et al* (2007) Acute mental health care for older people by crisis resolution teams in England. *International Journal of Geriatric Psychiatry*, **22**, 263–265.

DIBBEN, C., SAHEED, H., KONSTANTINOS, S., *et al* (2008) Crisis resolution and home treatment teams for older people with mental illness. *Psychiatric Bulletin*, **32**, 268–270.

JHA, A. & BOSKOVIC, T. (2008) Crisis resolution and home treatment teams for older people (letter). *Psychiatric Bulletin*, **33**, 75.

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We thank Dr Pelosi for his interest in our study on the impact of a CRHTT for older people (*Psychiatric Bulletin*, November 2008, **32**, 268–270). However, there is no misinterpretation of data, as suggested by Dr Pelosi. We tested chi-squared differences in the proportion of total number of admissions over number of crisis events and not total number of admissions *per se*.

We agree that it is possible, but far from definite, that some of the patients seen by the crisis team may have been sub-threshold for admission and we clearly stated this in our discussion: 'It may be argued that individuals who received home treatment only were below the "admission threshold" and the referrals to the CRHTT had been generated by the availability of this new service.' However, by treating people early, one could argue that the CRHTT play an important role in preventing possible future admissions. As Dr Pelosi mentioned in his letter, crisis team support might 'come in handy' at the time of deterioration of illness, social or psychological crisis.

The views of patients and carers are also important when developing new services. Our study showed that carers showed a trend towards greater satisfaction with the CRHTT compared with hospital admission. This is in keeping with a Cochrane review (Joy *et al*, 2006) which has shown that home treatment is a more satisfactory form of care for adults of working age with severe mental illness and their families. Cooper *et al* (2007) also make the point that home treatment may be important in maintaining the independence of the older person.

As responsible clinicians who take pride in our work we should always strive to offer the best evidence-based care and review our practice accordingly. We have suggested that a gold standard double-blind randomised control trial needs to be done in older patients, including an economic evaluation. Nevertheless, our pragmatic study design shows that such a service may be helpful.

COOPER, C., REGAN, C., TANDY, A. R., *et al* (2007) Acute mental healthcare for older people by crisis resolution teams in England. *International Journal of Geriatric Psychiatry*, **22**, 263–265.

JOY, C. B., ADAMS, C. E. & RICE, K. (2006) Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Review*, **4**, CD001087.

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## NICE guidelines for epilepsy in learning disabilities service

The National Institute for Health and Clinical Excellence (NICE) guidelines for epilepsy issued in October 2004 include special considerations for the care of women with epilepsy and people with learning disabilities.

We audited our practice with four guidelines:

1. Yearly structured reviews considering treatment effectiveness, tolerability, side-effects and adherence.
2. Risk assessment which includes bathing and showering, using electrical equipment, sudden unexpected death in epilepsy and managing prolonged or serial seizures.
3. To discuss the risk of higher mortality in people with epilepsy and learning disabilities with the individual, their family and/or carers.
4. Women with epilepsy and their partners must be given information and counselling about contraception, conception, pregnancy and caring for children.

Data were collected by audit from both community and in-patient case notes. The first cycle, completed in October 2005 ($n=12$), found that structured yearly reviews were done for 58% of the patients and risk assessment for 75% (but did not include sudden unexpected death in epilepsy), but no advice was given to women (0% of cases) and increased risk of mortality was not discussed (0% of cases).

After raising the awareness within the team about NICE guidelines, the second cycle completed in September 2006 showed some improvement, with structured yearly review completed in 100% of cases, risk assessment in 75%, and advice given to women in 50%; however, increased risk of mortality was still not discussed (0%).

A checklist for NICE guidelines has been included in medical notes and it was agreed within the team that if the risk of increased mortality was not discussed with patients or carers, it should be clearly documented with reasons.

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## Taking the path less trodden: UK psychiatrists working in low- and middle-income countries

The project run in Ghana by the South West London and St George's Mental Health National Health Service (NHS) Trust, Royal College of Psychiatrists and Challenges Worldwide, is a good model for developing opportunities for UK



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