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Editorial

Taking the drama out of crisis

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In the eight years since they were advocated by the United Kingdom (UK) National Service Framework for Mental Health (Department of Health, 1999), crisis and home treatment teams have become the 'must have' for all mental health providers. Hyped by enthusiasts and driven by national targets, they are perceived to represent an alternative to hospitalisation and apparently welcomed by patients and their families. Just as 'Care in the Community' emptied asylums of the chronically ill, so 'home treatment' is seen, in some quarters, as a way of reducing inpatient provision still further.

For those running a traditional UK psychiatric inpatient service, the move to dedicated teams with a remit to divert from hospital admission and facilitate early discharge has shown early promise, with around 10–20% cut in admissions and a trend towards a fall in the duration of admissions (Glover et al., 2006). It is likely that, with time, the proportion of patients who can be managed effectively at home will be distilled, leaving a core of those with complex problems who require longer admissions or whose discharge is stalled by accommodation issues so that these differences will become less pronounced and length of stay may increase.

For those with experience of psychiatric care, it makes intuitive sense that not all patients could be managed at home. The requirement for a place of safety in which a patient's disturbed behaviour and risk can be contained and their illness managed is unlikely to be satisfied at home in all cases. In a study of the Central Manchester 'Home Options Service' (Harrison et al., 2001), nearly half of all referrals for home treatment were not accepted due to issues of poor co-operation, and/or risk to self or others. Even with the advent of the 2007 Mental Health Act, there is still no framework for enforcing community treatment upon a patient who has not first been subject to detention in hospital under section 3 (detention for treatment for up to six months) or a Part III order; assessment, or even transfer to supervised community treatment from section 2 (detention for assessment/treatment for up to 28 days) is not possible (Department of Health, 2008). The issue of risk appears to strike at the *raison d'être* for inpatient units.

It is no great surprise that, given a choice, most service users would state a preference for being treated at home over being treated in hospital. There is considerable naivety in extending this simple statement to a general perception that all patients are best managed at home regardless of diagnosis or level of severity. Patients with predominant diagnoses of schizophrenia or bipolar affective disorder, taken on for home treatment, had a one in five chance of requiring admission at a later stage (Harrison et al., 2001). The study did not analyse the effect of this on their total illness duration, any untoward incidents associated with the change in management or the lasting effects on their psychosocial network. Questions regarding patient preference have generally disregarded the real world scenario of being faced with an immediate admission and possibly shorter

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illness duration versus a period of failed home treatment followed by a longer period in hospital, possibly formally detained.

While views of informed users are essential to assist the debate, little attention has been given to the plight of carers whose home and families may be, for a period of time, converted into a psychiatric unit in the community. Few Crisis Resolution Home Treatment (CRHT) teams are resourced to provide 24 hour nursing for a patient in their own home and, where home treatment is an option, the family will necessarily absorb a proportion of the stress and distress of the patient's condition. Östman (2007) studied the effect of severe mental illness on 162 relatives of patients who had been admitted to hospital, formally or informally, with a variety of psychotic disorders. A significant impact upon their lives was noted, including having to give up work and leisure time, isolation from the company of others and damaged relationships. Participants described wishing their ill relative had never been born (21%) and suffering their own mental health problems as a consequence (40%). Ten per cent had considered suicide. Relatives living with the patient reported that the patient had a negative perception of them and were more likely to have their lives affected adversely than those living apart.

In Gloucestershire UK, a 40% cut in acute bed numbers with the development of CRHT teams has more than doubled the proportion of patients detained under the Mental Health Act. This is interesting for two reasons. First, it suggests that the increase is greater that would simply be explained by the reduction in beds. One explanation might be that a group of patients are identified for home treatment which fails and admission to hospital occurs later, at a point where detention is necessary. This possibility is supported by the finding that 20% of patients initially accepted for home treatment have to be transferred to inpatient care later (Harrison et al., 2001).

Second, it represents a higher proportion of patients on acute wards who require more intensive input. There has been no change in PICU provision, but the characteristics of some patients managed on the open wards are the same as those who would previously have been sent to PICU. Research is needed to establish whether the management of such challenging patients in an open ward environment has advantages over the more restrictive PICU approach. This could spell either the end of PICU as currently configured, or the development of smaller wards along PICU lines to manage those patients whose level of risk or disturbance makes it impossible for them to be managed in a home environment.

The history of community interventions in psychiatry has been driven by the desire to provide less restrictive, normalising care away from the institutional arrangements of the past. These laudable aims have, in turn, been subverted by a cost-conscious wish to close hospital beds and the focus has therefore been on home treatment as a way of providing an alternative to admission. The quality of care provided at home has often taken second place to user satisfaction as a measure of benefit. Outcomes, other than in terms of numerical reductions in numbers and duration of admissions, are rarely considered. Further, although there are general statements in the literature about what home treatment can provide, there is no convincing evidence of criteria against which patients can be judged to provide an objective measure as to whether home or hospital treatment is likely to benefit them more.

In his review of the implications for inpatient care of the rise of crisis and home treatment, Smyth (2003) cited evidence, including an Audit Commission report, to support his argument that the decision to admit to hospital has previously been a matter of the individual style of the treating consultant who is generally only 'dimly aware' of the idiosyncratic criteria used. He suggested that this individualism is reduced when a multidisciplinary team is involved in deciding the merits of admission versus home treatment. However, without evidence of the benefits versus risks of home treatment, it is surely impossible to determine whether a team decision is better than that of an individual or, indeed, whether it is simply the individual style of working of a team,

as opposed to the idiosyncratic style of an individual, that determines the need for admission: and gets it wrong for 20% of patients, perhaps to their significant detriment.

Without a detailed and critical analysis of the home/hospital treatment debate conducted, without the dramatic rhetoric, by neutral observers rather than enthusiasts, it will be impossible to decide what the merits of these approaches are likely to be. In turn, the role of inpatient care, and therefore the future of psychiatric intensive care, is likely to remain uncertain. Such an evaluation will need to consider, not just the negative affect of admission on the patient, but its benefits, and the possible harm inflicted on both patient and family if the reason for home treatment is simply to avoid admission rather than to offer an active and planned alternative to hospital care. Until then it will remain unclear whether home treatment is a positive development leading to a reorganisation of hospital care, or a costly disaster requiring the future re-provision of inpatient services once the initiative has been wrested from the zealots.

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