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Twenty-four hour crisis assessment and treatment teams: too radical for the UK?†

In our special article (pp. 439–441, this issue) we have described the structure and function of a 24-hour crisis assessment and treatment team (CATT). Comprehensive, accessible, specialist, out of hours crisis services designed to facilitate community treatment are not new in the UK but they are not currently widespread. Services employing the CATT model have become widespread in Australasia and are considered to be a success there. In this paper we discuss some of the advantages of CATTs and some possible reasons why they are not more commonly employed in the UK.

The role of acute in-patient care

In the UK, in-patient care is still viewed as a 'gold standard' against which other models of care are measured. The ward is considered to be the best environment for optimising safety to self and others, and for carrying out a thorough biopsychosocial assessment. Patients are admitted to hospital for a variety of reasons: risk of harm to self or others, 'inability to cope' at home, deterioration because of poor compliance or for further assessment – sometimes because the patient is too complicated to deal with in a busy out-patient clinic. In some areas hospital is the only option for a patient who is deteriorating. In Victoria, Australia, this is not so. The state government has strongly encouraged services to provide care in the 'least restrictive setting': the patient's own home if possible (Victorian Government Department of Health and Community Services, 1994). In practice, Victorian clinicians do indeed consider the community to be the most desirable setting for the assessment and care of acutely unwell patients and in-patient care is only considered when this is infeasible or has already failed. Patients are only admitted when the CATT, acting as the gatekeeper for the ward, is convinced that all alternatives have been exhausted. Risk can often be managed in the community when 24-hour access to professional care is readily available. Poorly functioning or distressed patients can often cope at home with the extra support of regular home visits and supervision of medication. With the aid of a carer, a series of home visits can provide a more accurate assessment of psychosocial functioning than a period of time in the alien and disturbed environment of a psychiatric ward. This model of care does result in a small in-patient population with high morbidity, which has implications for ward design, staffing levels and frequency of consultant review.

†See pp. 439–441 this issue.

Relinquishing the gatekeeping role

In Victoria, psychiatrists have relinquished the gatekeeping role to CATT workers, who are mainly senior non-medical mental health professionals. Importantly, the professionals who perform this function are the same as the ones who are responsible for delivering the alternative to in-patient care. Acting as the first-line assessment service, CATTs thus shift the burden of acute assessment from junior doctors (who often work alone, with little previous experience in psychiatry) to a well organised, experienced group of health professionals.

In a well functioning CATT difficult cases are discussed with the team psychiatrist, but the non-medical staff who provide the bulk of care are well-placed to determine which patients can and cannot be managed in the community. This loss of power may be challenging for many consultant psychiatrists, who cling on to traditional roles and working practices. In this model non-medical staff have more independence, power and autonomy but they also have to own their role and accept responsibility for their decisions.

Continuity of care

In the UK, the same consultant is responsible for a patient's care regardless of which part of the service he or she is accessing. In Victoria, a patient may be the responsibility of more than one consultant within a short period of time as he or she moves between CATT clinic and ward. Thus, continuity of care has been exchanged for the greater flexibility and other benefits of 24-hour acute community care. With good communication and some consensus on treatment methods a lack of continuity is not usually problematic.

The system depends on good working relationships, efficient communication and clear demarcation of roles. A clinic worker who has known a patient for a long time may have to accept CATT advice regarding crisis management. Similarly a CATT worker should respect a clinic worker's formulation and long-term treatment plan. It is surprising how often the CATT is able to manage a patient during an acute phase of illness when the usual keyworker feels that admission is inevitable.

Criteria for treatment by the CATT

Some fear that psychiatric crisis services might become overwhelmed by distressed people with anxiety states and adjustment disorders (Pelosi & Jackson, 2000). This is no argument against their introduction. Service planners, clinicians and other agencies need to be quite clear that

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the service is for those with psychosis, severe mood disorders and those who are actively suicidal. In Victoria, referrals not meeting these criteria are directed to more suitable agencies.

Detaining patients

The process of detaining patients under the Mental Health Act (England and Wales) (1983) is sometimes slow and unwieldy. It may take several hours to assemble the necessary Section 12 approved psychiatrist, general practitioner (GP) and approved social worker in the early hours of the morning. The prospect of such a delay may erode the confidence of mental health workers and carers to cope with an ill person at home. In Victoria, the CATT-worker alone can facilitate immediate admission to hospital for assessment by a doctor. Such devolved responsibility enables staff to manage a sick patient at home with the confidence that he or she can be admitted immediately should the clinical situation deteriorate. This issue should have implications for the current review of the Mental Health Act in the UK.

Interface with primary care

The UK differs from many countries in that it has a well-developed system of primary care in which all citizens are allocated to a GP. It has been claimed that home treatment teams would erode the GP's role (Pelosi & Jackson, 2000). We believe that the majority of people with acute emotional and psychological distress should be managed primarily by their GP. We also believe that GPs would welcome immediate, specialist help with more serious forms of acute mental illness and that CATTs would be seen to complement rather than usurp the GP's unique role.

Reinventing psychiatric services

Mental health services in Victoria were subject to a complete re-evaluation in the early 1990s. As a result, a comprehensive and innovative 'Framework for Service Delivery' was published (Victorian Government Department of Health and Community Services, 1994). A statewide uniform model of service was designed with CATTs as an integral part. This has enabled a shift of resources from in-patient services to the community.

Over the past decade in the UK, government responses to the perceived crisis in the care of the mentally ill in the community have been rather piecemeal. A number of top-down edicts, such as the Care Programme Approach, have been issued with varying degrees of success and support from the profession. The development of community care with a much smaller in-patient bed base and home treatment teams requires a radical change in the way we work and share responsibility. It seems unlikely that a CATT simply tacked on to a pre-existing model of care would improve community care. A central plan to review strategy, service delivery and mental health legislation is surely required.

Whose voice is loudest?

Despite data suggesting that patients and carers prefer home treatment where possible (Dean *et al*, 1993), there may be resistance to plans to manage more patients with acute psychosis in their homes. The public continues to fear care in the community despite efforts by the psychiatric profession to reassure and to demonstrate that de-institutionalisation has not increased the low risk of homicide by those with mental illness (Taylor & Gunn, 1999). The sensationalist tabloid newspapers have a powerful voice in this matter, although it is not always clear whose interests they represent. The profession must ask itself whether public or patient opinion is more important.

Conclusion

We believe that a community-based service with a CATT at its heart is a safe, feasible and effective way of delivering acute psychiatric care. The majority of people in crisis owing to serious psychiatric illness can be managed at home without removing them from their usual social network, given the availability of a 24-hour responsive, accessible, specialist service.

It is unfortunate, however, that in common with many historical service developments, there is a dearth of published data to back up our views on the Victorian services.

We have been struck by many UK-based psychiatrists' unawareness of and hostility towards the development of crisis services with a reduced bed base and the resulting changes in working roles. We believe that with increased awareness and debate it should be possible to change those attitudes.

With current mental health legislation under review this could be the time for the UK to consider making radical changes. This would not be a leap in the dark but rather a case of adapting a tried and tested model to UK conditions.

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