The crisis team as part of comprehensive local services

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An attempt to categorise the nature of the work done by an inner city crisis intervention service (CIS) which is part of a comprehensive community mental health service is described. The work of the CIS as it relates to models of crisis intervention recognised in the literature is outlined. The role of this CIS in providing additional intermittent support to individuals receiving long-term community care is commended.

The Mental Health Advice Centre (MHAC) in Lewisham was one of the first community mental health centres in the United Kingdom. Previous descriptions of the work of the centre have been reported (Bouras & Brough, 1982; Boardman *et al*, 1987). Tufnell *et al* (1985) queried how integration into a comprehensive service would develop. This paper updates the evolution of the MHAC service and reports specifically on the nature of the work undertaken by the inner city crisis intervention service (CIS). We review 100 consecutive cases seen in routine work and categorise them by crisis intervention type.

There has been no such review of the work of a CIS. Punukollu (1991) examined the work of the Huddersfield crisis service, but specifically excluded all patients who had had a psychiatric admission in the past two years. Other studies have focused on certain patient groups such as those requiring urgent psychiatric admission (Dean & Gadd, 1990; Merson *et al*, 1992; Muijen *et al*, 1992). Merson *et al*'s (1992) study of the Early Intervention Service in Paddington excluded those who had already been in contact with psychiatric services. Muijen *et al*'s (1992) three year research study comparing home and hospital treatment for seriously ill patients facing immediate admission only included 20% of those with previous admissions. The Birmingham study by Dean & Gadd (1990) was also a time-limited research project. Burns *et al*'s (1993) case control study addressed community outreach compared to traditional consultant/community psychiatric nurse (CPN) care.

In the routine work of the Lewisham CIS some cases fit the 'classic crisis intervention' model described by Caplan (1964) and some fit the 'alternative to admission' model of Stein & Test (1980) or Hoult (1986). In addition, there are cases which have more in keeping with domiciliary assessment of out-patient type referrals similar to those described by Burns *et al* (1993). Because of shortage of beds in the inner city area the CIS also offers an early discharge programme to some individuals who would otherwise have remained in hospital for a longer time. The other service that CIS staff provide is additional back-up for 'acute on chronic' support of continuing care patients.

Setting

The Lewisham Mental Health Advice Centre is the community mental health centre providing comprehensive services for the 16–65 year age group from a total population of 84 000 in an inner London area. The Jarman score for the area is −10.5. The MHAC relates to two 15 bedded in-patient wards. The service provided from the centre has three components.

(a) The walk-in service offers a centre-based assessment and treatment service and is open three mornings a week for referrals, which may be from professionals or by self-referral. Clients are seen on the first occasion without an appointment.

(b) The continuing care service (Concare) comprises all the services available for those with long-term mental health problems and includes individual key-workers using a case management model, out-patient clinics and a small day centre on different sites. A case register is kept of all patients who are

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likely to require ongoing treatment from the team. The pre-existing register, which began in 1989, has provided the basis for developing the care programme approach and supervision registers for the catchment area. All staff attached to the centre carry a Concare caseload in addition to either working for the CIS or for the walk-in service.

(c) The third component of the community services for the district is the CIS. At the time of this study the CIS consisted of a senior registrar (0.7 whole-time equivalent), two community psychiatric nurses (1.6 WTE) and a senior social worker (0.5 WTE). Two consultant psychiatrists attended weekly reviews and were involved actively in cases if necessary. The CIS operates between 9 a.m. and 5 p.m. and provides domiciliary assessment and treatment services for cases deemed by the referrer to be urgent. It also caters for those unable to get to the centre because of physical disability or phobic disorder. Outside office hours crises are dealt with by the local accident and emergency department and an on-call psychiatrist.

The study

One hundred cases were reviewed. They were seen between April and July 1993. The 100 referrals comprised 95 individuals. Five individuals were referred more than once during the research period. The total number of referrals to the CIS during the year 1993/94 was 347.

The research team consisted of current members of the CIS team plus a consultant psychiatrist who previously worked as part of the CIS. At the end of the research period cases were ascribed crisis case type under the headings: Alternative to Admission; Concare; Out-patient type; Classic Crisis; Early Discharge; Information Only; Other, on the basis of the referral information and initial assessment. Case type agreement reached 85%. Diagnosis was made in clinical team meetings and recorded using ICD–10 (World Health Organization, 1992). When cases were closed up to three categories of treatment used were recorded.

Findings

Of the 100 referrals, 57 were women; 62 were under 40 years of age; 27 were married or cohabiting. Only 18 were in any form of employment and 12 were homemakers. Twenty-six were living alone and six others lived in supported residential settings. Sixteen were African Caribbean of whom four were British born. A further ten referrals were individuals of other non-white ethnic minorities.

Table 1 shows the breakdown of case types. Thirty-six per cent of cases fitted the 'alternative to admission' model; 24% were additional support to Concare case management work. Domiciliary out-patient type assessment (15%) slightly exceeded 'classic crisis' work (12%). Early discharge from admission wards formed a smaller proportion of the work.

Table 1 also details the previous history of referrals. The majority of cases had previous psychiatric contact and 56% had had past admissions to a psychiatric unit.

A third of referrals came from other parts of the catchment area service; 28% came directly from general practitioners (GPs) and 18% were self referrals from previous patients or their carers. Ninety-five individuals were registered with a total of 66 GPs in 37 different practices. Out of the 100 referrals, 13 were not seen. In most cases this was because either the individual moved away or the referrer took some alternative action prior to the visit. Nineteen per cent of referrals received more than five visits from the team; 29% received between two and five visits and 39% received only one visit. The majority of the 'support for Concare' cases required only one visit before being handed back to the case manager.

Table 1. Case type

		Past history	Past admissions
Alternative to admission	36	23 (64%)	20 (56%)
Support Concare	24	24 (100%)	24 (100%)
Out-patient type	15	6 (40%)	1 (7%)
Classic crisis	12	4 (33%)	2 (17%)
Planned discharge	5	4 (80%)	4 (80%)
Unplanned discharge	3	3 (100%)	3 (100%)
Other	1	1 (100%)	0 (0%)
Info/alert	4	3 (75%)	2 (50%)
Total	100	68 (68%)	56 (56%)

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Fifty-four per cent of cases were seen on the day of referral and 60% within 48 hours. In 81% of cases contact was made on the day of referral and in 92% contact was made within 48 hours. Carers were involved in 53% of referrals. One year after referral 46% of the cases were still in contact with services from the MHAC.

Table 2 shows the breakdown of case type by diagnosis. The commonest diagnostic group was schizophrenia and related conditions. Neurotic and personality disorders made up less than 25% of referrals.

Table 3 looks at types of treatment offered by case type. Twenty-three per cent of the referrals were admitted during the course of the intervention. Thirty-eight per cent were prescribed medication by the CIS. In 32% of cases the CIS undertook specific psychological treatment such as problem solving, focused counselling or a behavioural programme. In 7% of cases practical help with benefits or household matters was given; 15% were referred on to other services (four cases to the drug and alcohol service; two cases to elderly services; four to social services and three to specialist psychotherapy). Among the 'alternative to admission' group, 14 were new to the centre and 22 were known to the centre. Three of the new to the centre cases were admitted during the intervention while 13 of the known cases were admitted (χ^2=3.5 n.s.).

Conclusions

This study highlights the amount of work performed by the Lewisham CIS that relates to the chronic continuing care population. Classic crisis intervention formed only a small part of the work (12%). This was in part because the walk-in service is available and offers short-term problem solving psychological help.

The demographic data revealed that the ethnicity of those referred reflected the ethnic mix of the local population. This was contrary to our expectation and at variance with Muijen *et al*'s (1992) study which had an excess of ethnic minority patients compared to the local population. The finding that very few patients (18%) were in employment was consistent with figures for those admitted to local psychiatric wards. Patients living alone were no more likely to be admitted to hospital than those who were not. This was contrary to Dean & Gadd's (1990) findings but consistent with Muijen *et al*'s (1992) study and Burns *et al*'s (1993) study.

Table 2. Diagnosis

	n	Schizophrenia (%)	Affective (%)	Neurotic (%)	Substance use (%)	Personality (%)	Organic (%)	Unknown (%)
Alternative to admission	36	19	8	2	3	3	0	1
Concare	24	14	5	1	2	1	0	1
Out-patient type	15	1	4	4	2	2	1	1
Classic crisis	12	0	2	6	1	3	0	0
Early discharge planned	5	2	1	1	1	0	0	0
Early discharge unplanned	3	2	1	0	0	0	0	0
Information only	4	2	1	0	0	0	0	1
Other	1	0	0	0	1	0	0	0
Total	100	40	22	14	10	9	1	4

Table 3. Treatment

	n	Admission informal (%)	Admission formal (%)	Medication (%)	Psychological (%)	Practical help (%)	Referral on (%)
Alternative to admission	36	9	7	17	9	1	3
Concare	24	2	2	11	7	0	3
Out-patient type	15	1	0	5	5	5	4
Class crisis	12	1	0	2	7	1	3
Early discharge planned	5	0	0	3	3	0	2
Early discharge unplanned	3	1	0	0	0	0	0
Information only	4	0	0	0	0	0	0
Other	1	0	0	0	1	0	0
Total	100	14	9	38	32	7	15

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Most patients were suffering long-term severe mental illness and only 32% of referrals were previously unknown. Schizophrenia and related disorders comprised 40% of the sample which compared similarly with Muijen *et al*'s (1992) study (49%). Nearly a quarter of the patients had affective disorders. There was a surprisingly higher number of patients with alcohol problems than anticipated given the presence of a local specialist service for such patients. These patients were excluded from the study by Punukollu (1991).

The CIS did not prevent known patients from being admitted to hospital but there was a trend for new referrals not to be admitted. Dean & Gadd (1990) found that patients who had been admitted in the past were more likely to be admitted again. We found that only four of the 'support to Concare' group were admitted even though the group as a whole had severe major mental illness. The provision of back-up to key-workers or case managers enables efficient use of staff resources and we consider the role of the CIS in providing such back-up is a particular strength of the MHAC service.

The attempt to identify cases by type has been a useful training focus for new and existing CIS team members and will continue to be part of the ongoing audit of the service.

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