



The Sainsbury Centre

for Mental Health

Mental Health Topics

Crisis Resolution

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Part One: Model

1. Introduction

In a crisis resolution context, a 'crisis' is defined as the breakdown of an individual's normal coping mechanisms. Crises may vary in form – they may be developmental, situational, or a result of severe trauma. Crisis resolution services are concerned with those crises associated with severe mental illness (Rosen, 1997).

Gerald Caplan first used 'crisis' as a specific psychiatric term in his book *Principles of Preventive Psychiatry* (Caplan, 1964). It began an extensive debate on 'crisis theory' but the definition is now dated, as it was very influenced by Freudian and biological thought.

In an attempt to integrate evidence including social support, coping theory and traumatic stress research, Schnyder (Schnyder, 1997) developed a seven-point model of psychiatric crisis intervention. This involved 1) establishing contact; 2) problem analysis; 3) problem definition; 4) goal definition; 5) working on the problem; 6) termination and 7) follow-up.

The NHS Plan calls for the creation of 335 crisis resolution teams over the next three years to provide an immediate response to crises (Section 14.31.). When this was released in July 2000, there were fewer than half a dozen teams in existence within the UK.

References

Caplan, G. & Felix, R.H. (1964) *Principles of Preventative Psychiatry*. New York: Basic Books.

Rosen, A. (1997) Crisis Management in the Community. *Medical Journal of Australia*, **167** (11-12) 633-638.

Schnyder, U. (1997) Crisis Intervention in Psychiatric Outpatients. *International Medical Journal*, **4** (1) 11-17.

2. Core characteristics

Crisis resolution is an alternative to inpatient hospital care for service users with serious mental illness, offering flexible, **home-based** care, 24 hours a day, seven days a week.

- interventions are intensive and short-term, often just two to three weeks;
- rapid response – in urban areas staff are available within the hour;
- frequent daily visits to each client and their social network if required;
- medical staff are available around the clock;
- medication can be administered;
- social issues are addressed as part of the overall care plan;
- support and education is available to family and carers
- services act as gatekeepers to acute inpatient care;
- involvement continues until the crisis is resolved;
- clients are then referred on to other relevant services (Smyth & Hoult, 2000).

Other names for crisis resolution services:

- home-based crisis services
- home treatment services
- acute home treatment
- early intervention services
- crisis services*
- out-of-hours services*
- rapid response services*
- psychiatric emergency services.*

*These terms can also be applied to services that do not fit the crisis resolution model described above.

References

Smyth, M.G., Houlst, J., Pelosi, A., & Jackson, G. (2000) The Home Treatment Enigma. *British Medical Journal*, **320** 305 –309

3. Key principles

- Crisis management is a process of working through the crisis to the point of resolution.
- Successful client engagement is paramount. The formation of a therapeutic alliance with the client is essential before any interventions can be successful.
- Services take a holistic approach, looking at all the factors involved in the crisis, including biological, psychological and social issues, and using a range of interventions to address these.
- The individual's social network has a powerful effect on the person's mental health and treatment must directly address these significant social issues.
- Crisis staff should approach work with users from a 'strengths' rather than an 'illness' model, and draw on the innate strengths of service users in order to support them.
- Educating the service user will comprise a significant part of the crisis work and should help clients learn behaviours to improve and maintain their mental health. The approach should be one of collaborating with the user or their family by 'doing work with them', rather than 'doing work on them', so as to promote their 'ownership' of the crisis.

4. Clients

- The clients of home-based crisis services are primarily those who:
- are experiencing a crisis as a result of serious mental illness and;
- are vulnerable or disabled to the extent that they need intensive or extended hours treatment and support and;
- would otherwise be likely to require inpatient treatment and;
- are over the age of 16 (crisis resolution is part of adult services).

5. The model

Structurally:

A crisis resolution service does not have to adopt any particular structure, but must adopt the essential elements for meeting its service delivery objectives. Service design can be customised to suit local needs and circumstances. In urban areas, the most appropriate model may be a discrete crisis resolution team that exists alongside other services such as mainstream community mental health teams (CMHTs), assertive outreach teams and acute inpatient units.

In rural areas or less densely populated areas, where a discrete crisis resolution service may not be cost effective, crisis resolution workers may be included within another appropriate service. For example, one or more generic CMHTs might provide a crisis resolution service through either dedicated specialists within the team and/or a rota of staff.

Clinically:

An initial crisis assessment is done which takes account of all the factors involved in the crisis, including social, financial and accommodation issues. A crisis management plan is drawn up based on this assessment's outcome. A variety of treatments are used to help control the most

acute symptoms and reduce the likelihood of relapse. Typically, these will involve administration and monitoring of medication plus dealing with the other relevant factors. .

Family, social or cultural supports are included in both the assessment and the crisis management plans. Details of 24-hour contacts are also made available. Short-term respite accommodation may be offered if the home environment becomes too stressful. Crisis houses play an increasingly important part in the whole systems approach to mental health service delivery. They can provide alternatives to hospitalisation as well as respite for service users and their carers / families.

The clinician's role in a crisis can sometimes involve correcting inappropriate or ineffective previous clinical interventions, such as inappropriate diagnoses or types of treatment, inappropriate prescriptions or over-medication (Rosen, 1997). The settings of crisis resolution (such as the client's own home) might also mean that he or she is free to express tensions (for a limited time) that would be unacceptable in hospital and this can sometimes help to promote crisis resolution.

References

Rosen, A. (1997) Crisis Management in the Community. *Medical Journal of Australia*, **167** (11-12) 633 – 638.

6. How it differs from assertive outreach

	Crisis resolution	Assertive outreach
Length of involvement	Short term, usually 2-3 weeks	Longer term, frequently several years
Clients	May have no previous contact with psychiatric services	Established psychiatric history
Referrals	Accepted from GPs, A&E department and clients themselves (if already known)	Usually require referral from secondary service
Hours of operation	Always 24 hour	Usually more limited
Service delivery	Rapid response – usually within one hour	Longer response time, especially for clients not previously known to service
Other	Act as gatekeepers to inpatient beds	Usually no gatekeeping role

7. Background research

Research has shown the following results:

- **Better service retention:** service users prefer non-inpatient solutions to their mental health crises and this is reflected in higher rates of service retention in crisis resolution services than standard hospital treatment (Dean *et al.*, 1993) and (Joy *et al.*, 1998).
- **Reduced admissions and bed use:** home-based crisis resolution services can reduce hospital admissions by between 55% – 66 % (Kiesler, 1982). But results depend on effective implementation - poorly delivered crisis services can have a detrimental effect on clients and increase their admissions to hospital (Ford & Kwakwa, 1996).
- **Reduced duration of admissions:** where admission to hospital does occur, the intervention of a crisis resolution service can reduce length of stay by up to 80% (Audini *et al.*, 1994).
- **Clinical outcomes similar to inpatient treatment:** studies have largely focused on cases where 75% of clients experienced a functional psychosis. (Smyth & Hoult, 2000).

- **Low staff burnout rates:** Minghella (Minghella *et al.*,1998) found low levels of burnout and high job satisfaction in crisis resolution teams compared with results from a previous study of CPNs and inpatient staff.

Minghella (Minghella *et al.*,1998) also found that crisis services led to:

- an increase in the use of community services
- a decreased use of hospital beds
- a decreased unit cost of acute care
- a decrease in the number of people who receive acute inpatient care.

Other views of crisis resolution services

Despite these positive findings, there has been much controversy over the establishment of discrete crisis resolution teams. Anthony Pelosi and Graham Jackson are two psychiatrists who have argued against "costly, short term psychiatric treatment teams that are totally unnecessary within the health care system of the United Kingdom" (Pelosi & Jackson, 2000). They favoured the improvement of communications between existing community mental health teams, general practitioners and inpatient units.

Another criticism is that conventional British mental health treatment already contains and delivers most of the features of 'home treatment' proposed by Smyth and Houlton (Burns, 2000). Burns suggests that mental health services that are well linked to primary care and offer reasonable access soon find that 'crises' become a small part of their work. He thinks that crises services are either unsuccessful and collapse or, if successful, demonstrate such good working examples to other service providers that they eventually do themselves out of a job. Burns argues that home-based crisis resolution teams need to show their sustainable superiority over well co-ordinated existing mental health services.

References

- Audini, B., Marks, M., Lawrence, R., Connolly, J. & Watts, V. (1994) Home based versus out-patient/in-patient care for people with serious mental illness. *British Journal of Psychiatry*, **165** 204-210.
- Burns, T., Harrison, J., Marshall, J., Hogan, K., & Orme, S. (2000) Psychiatric home treatment. *British Medical Journal*, **321** 177.
- Dean, C., Phillips, J., Gadd, E., Joseph, M. & Emglund, S. (1993) Comparison of a community-based service with a hospital-based service for people with acute, severe psychiatric illness. *British Medical Journal*, **307** 473-476.
- Ford, R. & Kwakwa, J. (1996) Rapid reaction, speedy recovery. *Health Service Journal*, 18 April 30-31.
- Joy, C.B., Adams, C.E. & Rice, K. (2001) *Crisis intervention for people with severe mental illnesses*. *The Cochrane Library*, Issue 1. Oxford: Update Software.
- Kiesler, CA. (1982) Mental hospitals and alternative care: non-institutionalization as potential public policy for mental patients. *American Psychologist* **37** (4) 349-60.
- Minghella, E. (1998) Home-based Emergency Treatment. *Mental Health Practice*, **2** 10-14.
- Pelosi, A.J. & Jackson, G.A. (2000) Home treatment enigmas and fantasies. *British Medical Journal*, **320** 308-309.
- Smyth, M., Houlton, J., Pelosi, A. & Jackson, G. (2000) The Home Treatment Enigma. *British Medical Journal*, **320** 305-309.

Part Two: Setting up a Service

1. Key factors

Some of the key areas are:

- area to be served
- target population
- budget
- determining what service users want
- service structure
- separate teams vs. integrated crisis resolution services
- team size
- staffing and skill mix
- medical input
- staff training and team building
- partnership arrangement and relationship to other services
- premises and service location
- writing an operational procedures manual
- service evaluation / data collection.

2. Needs assessment

Determining the catchment area to be served involves assessing:

- population size (growth trends, population by ethnicity, trends)
- existing services (statutory and voluntary)
- special needs (mental health issues, race, gender, disability)
- hospital admission data (admission, MHA sections, duration of stay)
- key medical staff (psychiatry, nursing, psychology contact)
- overall mental health service network
- gaps in the mental health service network.

Working through the areas above will give a picture of the type of crisis resolution service most suited for each local area. There is a danger of crisis services becoming a sticking plaster for all the faults in existing services. Crisis services must be established as a part of an integrated system.

Target population

- The target population that meets the criteria for crisis resolution needs to be clearly defined. Clients will be primarily those with severe mental illnesses who are having an acute episode or are in crisis.
- As part of adult mental health services, services will generally target those over 16 years.
- They are not usually targeted at people who have a primary diagnosis of drug or alcohol dependence, learning disability, brain damage or dementia, unless there is an issue of dual diagnosis.
- The service should clearly state whether or not it will work with clients with drug and alcohol problems. This will be influenced by what services already exist for this group. In many areas crisis resolution services face pressure to undertake community detox services, particularly if detox takes place in adult psychiatry wards. There needs to be a clear policy on this.

Common issues to clarify might include:

- acceptance and exclusion criteria for referrals
- substance misuse
- personality disorder
- mental illness with a learning disability component.

3. Budget

- The budget will determine the scope of the crisis resolution service.
- Minghella (Minghella *et al.*, 1998) found the overall service costs for a 14-staff crisis service to be £481,000 in 1997, including overheads and costings. (See table below: 'Costs for inpatient versus crisis team').
- Budget management should rest directly with the crisis service manager.
- Staffing levels will be directly affected and budget development needs to take account of issues such as:
 - 'on call', call-out overtime
 - unsociable' hours pay
 - transportation - such as taxis and mileage pay.
- A preliminary evaluation study should be undertaken to determine the most cost-effective form of crisis resolution service to be implemented as an alternative to hospitalisation, (e.g. staff mix, separate or integrated service).
- The evaluation should consider how economically viable the chosen model will be. Evaluation aims should include a consideration of costs (Knapp, 1994).

Costs for inpatient versus crisis team (based on 1997 figures):

	Inpatient beds £	Crisis service £
Staff costs	644,301	369,696
Supplied/overheads	245,448	84,317
Capital	79,003	27,360
Total	968,752	481,373
Bridging costs = £1 per head on top of mental health spend		

Source: Minghella *et al.*, 1998.

References

Knapp, M., Beecham, J., Koutsogeopoulou, V., Hallam, A., *et al.*, (1994) Service use and costs of home-based versus hospital-based care for people with severe mental illness. *British Journal of Psychiatry*. **165** 195-203.

Minghella, E. *et al.*, (1998) *Open all hours: 24-hour response for people with mental health emergencies*. London: The Sainsbury Centre for Mental Health.

4. What service users want

The literature shows that service users and their carers want a range of services available 24 hours a day. For example, a major goal of MIND's Breakthrough campaign was 24-hour access to services in every area.

Grey and Baulcombe (1996) stated that services users wanted:

- a service that was accessible 24 hours a day
- face to face counselling
- a service in their own home
- a service that would accept self-referrals
- telephone counselling.

Additionally, the Audit Commission report on A&E (accident and emergency) services (1996) indirectly supported service users demands for services by stating that service users receive poor care in A&E departments and that psychiatric support to A&E was generally inadequate.

Additionally:

- Research should be conducted into local users' service demands.

Previous research into users' requirements for a rapid response service has not distinguished between different types of need, but established a desire for a service that meets all their needs

5. Structures

The service structure can be established in two main ways:

- as a self-contained crisis resolution service, possibly with optional assertive community treatment functions or
- as an extended hours service that stems from a standard community mental health team.

Separate versus integrated crisis services?

It is important to determine whether local needs dictate separate or integrated crisis resolution services. Two broad approaches can be adopted (Johnson & Thornicroft, 1995):

- One approach is the development of a separate, often centralised specialist service, exclusively for people in a crisis, (e.g. discrete crisis teams).
- The alternative approach is the development of an emergency component as an integrated part of routine mental health care. Here the crisis service is not the responsibility of a separate team, but of staff who undertake all aspects of mental health work with people who may or may not be in a crisis.
- The second approach may be one where staff from locality teams may be used to provide out-of-hours cover across a whole district.

Separate crisis resolution team advantages:

- staff develop a high level of skills in working with people in a crisis;
- teams can be more flexible since staff don't have permanent cases;
- easier to provide a rapid response since this is the sole responsibility;
- staff are recruited to work in a 24-hour service.

Separate crisis resolution team disadvantages:

- a potential lack of integration with other services;
- crisis service may become blocked if there are no services to refer cases on to;
- continuity of care may suffer when clients are referred on;
- there may be a confusing proliferation of different teams.

Integrated crisis resolution and standard CMHT services advantages:

- same staff working with all clients – easier continuity of care;
- less likely that clients will 'fall through the net' since there is no need to refer people on to another team or service.

Integrated crisis resolution and standard CMHT services disadvantages:

- the same professional has to cope with disparate groups of people;
- a wide range of skills is needed by each worker;
- stress on staff if they have to work both 9-5 and out-of-hours shifts;
- difficult to maintain contact with crisis clients when they have long-term cases;
- crisis cases will be potentially disruptive to long-term case work of the service.

References

Johnson, S & Thornicroft, S. (1995) Emergency Psychiatric Services in England and Wales. *British Medical Journal*, **311** 287-288

6. Staffing

Size

The service should aim to have enough staff to cover two shifts per day, seven days a week. At the same time, team size must be kept manageable enough for communication purposes - between 10 and 15 staff.

Staffing and skill mix

How much work the service can take on will be dictated by both the funding and staffing levels.

General staffing considerations:

- Inner city populations will generate more work than rural or suburban populations.
- There need to be adequate staff to manage the treatment phase. A good rule of thumb would be to plan for a maximum of twice daily visits.
- In urban areas, there should be two shifts daily seven days per week, (i.e. a morning and afternoon/evening shift). Night shifts can be covered by 'on call' staff. Overtime situations may arise when crises emerge at the end of evening shifts.

Medical input - general guidelines:

- Input from psychiatrists is essential for crisis resolution services.
- A consultant psychiatrist should have designated medical responsibility for home-based crisis service clients.
- The consultant psychiatrist should be available for a minimum of two weekly sessions to go out and review the cases. In addition, it should also be possible to have access to associate specialists for urgent consultations.

Staff training and team building

Crisis resolution work involves a major re-orientation for staff who have been accustomed to working in different ways. There should therefore be an emphasis on training.

Areas to be included in staff training:

- overview of classifications of mental illnesses
- theory and practice of crisis intervention
- comprehensive assessment skills, including risk management
- forming therapeutic alliances with users and carers
- physical illness that the client presents as psychiatric illness.

Knowledge of local resources including:

- GP practices
- community mental health teams (CMHTs) and the wider mental health and social services systems
- local hospitals
- community welfare agencies
- accommodation: hostels / B&Bs / boarding houses
- day programmes
- police and legal agencies
- other health professionals.

Major psychiatric treatments including:

- medication management
- problem identification and problem-solving
- social systems intervention
- evidence based family interventions
- cognitive and behavioural treatments.

7. Partnerships

Partnership arrangements and relationship to other services

- For continuity of care, crisis resolution services must establish and maintain good liaison arrangements with hospital inpatient units, day hospitals, community mental health teams (CMHTs), GPs, and other local statutory and voluntary services.
- Links should be forged with the hospital pharmacy.
- Team managers should ensure that the team's goals and objectives are clear and understood by team members at the beginning. Once this is done the team should meet with other services before operation begins to work out ways to avoid potential problems.

8. Gatekeeping

The crisis resolution service should be the sole route via which all psychiatric hospital admissions are made. This will involve an agreement on the following groups:

- **The inpatient unit:** an agreement is needed that the ward will only accept admissions from the crisis resolution service. All other requests made to the ward will be diverted by the ward staff, who will request the caller to contact the crisis service.
- **The accident and emergency department:** Negotiations need to be conducted with the person or group who have been supplying psychiatric services to the department, and agreement sought that all crisis cases, and those considered for admission, will be referred to the crisis resolution service. It will need to promise a speedy arrival at the department, as it will often be full and staff will not want it blocked with patients waiting for a lengthy psychiatric assessment. Likewise, time can be saved if the A&E staff notify the crisis service immediately they suspect a person is in crisis.
- **The local catchment area CMHT(s):** all cases that team members think need admission should be referred immediately to the crisis resolution service for a community assessment.
- **Emergency duty teams:** If a person is referred for a Mental Health Act assessment, it should be agreed that the crisis resolution service and its on-call psychiatrist should attend to ensure that "other methods of care or treatment are available" (Mental Health Act) and are considered.
- **Junior doctors:** Junior doctors are often involved in the decision to admit patients or not, especially during regular office hours. This usually occurs in the A&E Department, though it may also occur on the ward or outpatient clinic. In the early days of a crisis resolution service's operation, junior doctors may find it unsettling to refer a client – who they have made a decision to admit – to a home-based service of nurses and social workers. These negotiations require diplomacy, as crisis workers may need junior doctors' help in matters such as prescribing medication.
- **Consultant psychiatrists:** This group ultimately has the power of deciding whom to admit and discharge. Their support is critical and influences all other groups. They need to share their power with the service and encourage other groups to do the same. With careful discussion, most consultants will come to value a home-based crisis resolution service in their patch and discuss cases they would previously have thought needed admission. Once the consultant understands the crisis service's way of working, its gatekeeping role generally ceases to be an issue.

What happens if the crisis resolution service does not establish a gatekeeping role?

If an agreement over the gatekeeping is not reached, and clients are admitted without referring to the crisis service, then it will be frequently by-passed. This will create the following problems:

- clients who don't require admission are not provided with more appropriate services;
- team members become demoralised and may leave the team;
- bed reductions do not occur and management, paying for the same number of inpatient beds as well as the crisis resolution service, will query the latter's value.

Discharging clients from inpatient care

- A crisis resolution service is involved with discharge decisions. In fact, the service can allow clients to leave the ward earlier than usual, because it provides them with the same support as the hospital. It can visit several times a day, monitor the client's progress and administer medication.
- If ward staff have no previous experience of this service they may be apprehensive regarding the client's welfare. Crisis service staff need to discuss this with ward staff and the consultant psychiatrist to agree a policy on this.

9. Premises

The following issues should be considered when establishing a separate crisis resolution team service base:

- location (site should be central to the service's catchment area);
- parking for vehicles;
- security for staff (this is important given potential for late hours);
- office space should be open plan;
- administrative staff should be able to see who is in the office at any time, as well as being able to view staff and clients entering and exiting;
- safe interview spaces for staff to meet clients.

10. Operational procedures

Topics to be included in an operational procedural manual:

- service aims and objectives, rationale and goals
- client group
- referral process - acceptance and exclusion criteria
- shift system / out of hours medical cover / on-call arrangements
- criteria for hospitalisation
- assessment guidelines – risk assessment / medical assessment
- recovery plan and care review forums
- inter-agency working guidelines / personal safety / communication
- internal policies
- staff roles, job descriptions
- team management
- organisational structure
- discharge from inpatient unit
- discharge from crisis resolution service
- refusal of service
- respite services
- appendix – including local standards and protocols.

Not only should this provide the opportunity for a common understanding within the team about what they do, how they do it, and for whom, it should also provide a resource for new team members. It should also help others such as registrars, visitors and students to understand how the team works.

Refusal of service: Currently, it is not possible to compel a person to receive treatment or management in the community. When someone refuses treatment, a decision must be made as to whether it is imperative that he or she be treated immediately (involving an assessment and subsequent sectioning under the Mental Health Act) or whether it is practical to wait until the situation calms in the hope the person accepts community treatment.

11. Evaluation

Key areas in designing an evaluation:

- During the setting up of a new crisis service, thought needs to be given to the type of data to be collected and the evaluation process. It is important to know who receives what services from whom, and with what effect.
- It will also be important to determine what these services cost.
- Key service indicators should be agreed before the service begins seeing clients.
- Service evaluation should be aimed at determining whether the service goals and objectives have been achieved.

Key areas to consider for decisions on data collection:

- What is the core data needed by the service to function properly?
- Does a service evaluation process exist that demands specific data?
- Who are the key stakeholders and what are their information needs?
- Which standard forms exist and what needs to be designed especially for the new service (referral, assessment, case summaries, case note recording, treatment, discharge information)?
- Thought must be given to the types of information required and ensure that, where possible, information is routinely collected from all clients.
- Systems for storing all forms separate from client file information, should be established.
- Databases should be developed to extract relevant information for analysis.
- Consultation between those designing data collection and the clinical staff involved in collecting it is vital. If the two groups do not work together from the beginning, data systems may prove ineffective.

12. Summary

Minghella and Ford (Minghella & Ford, 1997) made several conclusions about setting up new services:

- Implementing change requires consideration of the local history, culture and context. It is vital to understand the needs of local priority groups.
- When implementing new services, the attitudes and skills of staff need to be addressed.
- Separate teams can work well and target effectively. For crisis response, they need to access most referrals from secondary (now debatable) sources and act as gatekeepers to hospital beds, which requires a psychiatrist's input.
- Caution is necessary to avoid a proliferation of teams and poor service co-ordination. It may be more useful to view separate teams as a lever for change.
- Setting up separate teams can lead to inequity of resource allocation. This may in turn affect targeting and service co-ordination. If resources are directed primarily to specialist's teams, other services will be hard-pressed and there may be a temptation to dilute the specialist service so as to address under-resourcing elsewhere.
- Separate teams for people who are severely mentally ill may mean service gaps or overlap, unless a local needs assessment of the identified client groups has been carried out. Such an assessment must recognise the diversity of needs, including service use. If not, planning, financial and training resources may be misplaced.

References

Minghella, E. & Ford, R. (1997) All for one or one for all. *Health Service Journal*, **107** (5544) 30-31.

Part Three: Running a Service

1. Introduction

In the previous two sections we described the crisis resolution model and the stages involved in setting up a team. We emphasised that the preliminary steps involved key stakeholder consultations, establishing a team budget, agreeing service evaluation procedures and securing appropriate premises for a staff base.

Procedural policies should be drafted, but will be further informed by practice. It is not unusual to have to review written policies after 'going live.'

There are four main elements to running a new crisis resolution team:

- clinical issues
- staffing issues
- administration
- data collection and evaluation.

2. Clinical issues

Some of the most important clinical issues are:

- client group – stating who crisis resolution is for
- eligibility criteria
- medical staff - how consultants and medics interact with the service
- shift and on-call arrangements
- the stages in community crisis resolution treatment from referral to discharge
- engagement and assessment
- treatment and care reviews
- relationship with inpatient unit
- discharge from services
- respite care access.

3. Clients

Who a crisis resolution service is for

The main target group will often be adults between 16–65 years of age, whose mental illness is of such severity that they are at risk of requiring psychiatric hospitalisation.

The focus will generally be on individuals with either a psychotic or depressive illness who are currently experiencing an acute episode. Suicidal acts or threats, or acts or threats of violence towards others may be common scenarios when clients are first seen.

Given these broad client referral types, the service must also be flexible, both in terms of age and psychiatric diagnosis. For example, a referred client who is over 65 years old can be accepted if he or she still receives adult services. Also, someone diagnosed with personality disorder or a dual diagnosis of mental illness and alcohol or substance misuse who is in crisis may also be accepted. Referrals will often need to be determined on an individual basis.

Who a crisis resolution service is *not* for:

Anxiety disorders: The service is not for people with mild anxiety disorders. For example, people with agoraphobia, who would probably benefit more from behavioural therapy.

Alcohol or substance abuse: Crisis services are also not for people with a primary diagnosis of alcohol or substance abuse. People who have mental illness as a primary diagnosis, may often have problems with alcohol or substance abuse as a *result* of their mental illness, but if this is not the case, appropriate specialist services should be sought.

Organic disorders: The service is also not for people with brain damage or other organic disorders, such as dementia.

Learning disabilities: Crisis resolution services cannot be expected to treat individuals with a primary diagnosis of learning disability. Referrals may however, be accepted where there is also a strong mental illness component present combined with a mild learning disability and no other local services are available.

Overdose cases with no mental illness: It is not appropriate to refer cases of individuals who have recently overdosed but who are not suffering from a mental or severe depressive illness.

Relationship issues and situations of domestic violence: Again, if mental illness is not a feature in such situations, this would be an inappropriate referral.

Deciding eligibility criteria

It is important to determine whom the service is for before the team takes action. The service manager should develop a clear written policy to be circulated to potential referrers. These would include local GPs, A&E (accident and emergency) departments as well as CMHTs (community mental health teams). Where possible, some face-to-face management discussions about referrals should occur before the team becomes operational.

Such a policy should state both acceptance and exclusion criteria. However, it may only be the actual trial and error of operational practice that refines these criteria.

4. Staffing

Skills mix: A good skills mix should be sought when recruiting the staff. The team should be multi-disciplinary and include nurses, social workers, support workers, occupational therapists, psychologists and medics whose skills will help serve the local population best. For example, staff may be recruited based on specific skills around dual diagnosis. The team should reflect the local population in terms of race representation, major local languages and ethnicity.

Handovers: Acute cases should be discussed at daily or even twice daily client handovers. This should involve a daily cross shift meeting, attended by both morning and afternoon staff. This way the whole team is involved and all staff can cover for each other in case of unplanned staff absences. It is also highly advantageous if the psychiatrist is available to attend.

Supervision All staff should be supervised, including separate managerial and clinical supervision. Managerial supervision can help to identify the whole staff training and personal development needs. It can also help identify when team building skills are required. Clinical supervision can help in problem-solving and skills sharing. General business and staff development meetings should also be regularly scheduled. Individual and group supervision should be available.

Case manager allocation: Crisis resolution staff do not normally take over the 'keyworker' role during the crisis period. Although a team approach will be the reality of working, each client should have a nominated 'case manager' allocated as soon as they are taken on by the service. This case manager will be responsible for playing a leading role in devising treatment plans and ensuring they are carried out.

Sub-acute case reviews: In addition to the cross-shift meetings of acute client cases, there should also be individual client reviews of clients who are no longer seen daily and awaiting discharge. These meetings might focus on ensuring that all move-on arrangements for clients who are no longer in crisis, but not yet discharged, are being managed.

Medication reviews: During acute treatment a client's medication may need to be adjusted so it is advisable to have a doctor working full-time with the service. Nursing staff also have a particular role in identifying problems with medication, such as side effects and a failure to respond and should be encouraged to identify and report such problems as they arise.

Guidelines for emergencies: Written emergency procedures must exist for staff giving instructions on what to do if clients self harm, die, harm people or damage property. Team managers must ensure that these are available and that they give practical guidance (such as: "In the case of client self harm, staff must call an ambulance or take the person to A&E and not wait for another staff member to arrive. The client's relatives must be contacted upon arrival at the A&E.")

5. Medical staff

It should be clear which consultant will have overall medical responsibility for the clients of the service. There should also be clear availability of senior registrars and junior doctors. There should be clear line budget allocations for medical salaries and sessions required. Also, on-call medical cover rotas should be established with a 'back-up' doctor clearly designated.

6. Shift and on-call

Establishing operating hours of the service

In general, the team should operate seven days a week, 24 hours per day throughout the year. This can be done if two shifts a day are scheduled for mornings and afternoons. It is useful to have one person operating an 'on-call' system during each shift to respond to new referrals. For late overnight shifts, two people should be available via a pager system for safety reasons in case night call-outs occur.

Depending on the amount of call-out that occurs after hours, it may be necessary to check that the after hours on-call staff get enough rest before coming on duty again. Experience suggests that while calls may be received each night by on-call staff, only once or twice a week are actual visits necessary.

Treating acutely mentally ill people in a community setting means that there must be some form of medical cover available at all times. During office hours, this will usually be the service's own doctor or the local psychiatric medical staff. At other times, there needs to be a roster of medical staff who have had psychiatric training.

Further points to consider when arranging the shifts and adequate team shift cover:

- A general rule is that morning shifts should have more staff scheduled than afternoon / evening shifts to liaise with agencies that operate regular office hours.
- To manage costs, fewer staff should be scheduled on weekends and public holidays, as many agencies will be closed.
- Managers should monitor the effect on those staff who volunteer for frequent overtime. While this is often welcome when needed, it may lead to burnout issues. If unplanned cover frequently occurs, managers need to resolve the problem promptly.

7. Care planning

It is important for managers and practitioners to carefully manage the whole process from client referral, through treatment to discharge from the service. This is important as the nature of crisis work often involves a rapid client turn over. Failure to carefully monitor the care process could give confusing messages about it to clients, carers, referrers and other professionals. For example, crisis staff need to adhere to clear negotiations with referrers and clients about when the crisis is over. Failure to do so could blur the issues, potentially drifting into medium-term to long-term work and even deprive other clients in crisis of a service.

Schnyder's (Schnyder, 1997) seven-points model of psychiatric crisis intervention describes the crisis resolution service as involving: 1) establishing contact; 2) problem analysis; 3) problem definition; 4) goal definition; 5) working on the problem; 6) termination and 7) follow-up.

Ramsey and Harris (Ramsey & Harris, 2000), take another approach when they detail the operational activities of home-based crisis resolution. They list the crisis service activities as involving:

- referrals
- pre-assessment phase
- initial assessment (first face to face contact)
- risk assessment
- indications for hospitalisation
- treatment
- medication
- support and practical help
- social systems intervention
- counselling and specific psychological interventions
- discharge.

References

Ramsey, S. & Harris, J. (2000) *Manual for home treatment teams*, (2) 3-15 (second draft). London: The Sainsbury Centre for Mental Health (unpublished).

Schnyder, U. (1997) Crisis Intervention in Psychiatric Outpatients. *International Medical Journal*, 4 (1) 11-17.

8. Referrals

In the UK, most referrals will come from GPs, community mental health teams (CMHTs) / social services and from hospital A&E departments. A smaller number of referrals will come from other sources such as hospital inpatient units, police, voluntary organisations, emergency duty teams and private psychiatrists.

An obvious advantage in direct self-referral by clients previously known to the service is that it is reassuring and quick. The disadvantage would be in inappropriate self-referrals being made by clients and or carers.

Crisis resolution services should have a standard referral form to be used. This should include the following:

- Check area (if client is actually within the catchment area).
- Is the referral a mental illness problem? (If not, it is inappropriate to accept it.)
- Does it meet the service's criteria?
- Is it a crisis? (If not, the case should be referred to the CMHT.)

- Determine the client's social system (family, carers, GP, psychiatrist, keyworker, if they are receiving any treatment).
- Does the client have a psychiatric history?
- Is it an emergency? How quickly do you need to act? (Consider risk, current location of client, whether the situation is likely to escalate if there is not an immediate response.) It is rare that workers have to rush out.
- Does the client know that the crisis resolution team has been contacted? Are they expecting a visit?
- Develop an initial plan of action and advise the referrer.

9 Assessment

Pre-assessment

After the referral has been taken and before the client is seen for the first time it is useful to take some time to:

- Collect useful additional information (old notes, discharge summaries). These can be faxed. It is important to keep a professional objectivity about information that may be dated or unclear or that does not 'fit' with other held information. Professionals may often base reports not on first-hand knowledge, but on older, out-of-date information or subjective feelings, particularly with challenging service users.
- Determine the priorities – is there an immediate risk of harm?
- Work out how soon a response is needed. Although crisis resolution involves a rapid response – it does not need to be so hasty as to avoid preparation.
- Work out where the assessment will take place and who should be there. It is important someone from the client's social system is involved. Always take another member of staff to first-time referrals.

Initial assessment (first face to face contact)

The initial assessment in a crisis resolution context differs from a Mental Health Act assessment where the likeliest outcome is hospital admission. Here staff do the assessment and aim to treat the person in the least restrictive environment. Inpatient assessment should be based on no other safe and effective options being available.

The aim of the initial assessment is therefore to:

- assess whether the client has a mental illness;
- determine what immediate action is required;
- determine what the next step might be, and
- what further information is required.

The location of this face-to-face contact will be decided at the close of pre-assessment. It is most likely to be where the person was at the time of referral. It may be at a hospital A&E, a police station or somewhere other than the person's own home. It is unlikely to be in the worker's office or own territory.

On arrival, the worker needs to look at what is happening, at how things are organised and who is there? The worker needs to carefully observe the interactions between all those present. Sometimes the client will not want to talk to the worker, he or she should not accept this initial refusal, but remain friendly and keep talking in an attempt to develop a rapport with them and to gain their confidence. The worker should listen carefully to what the client is saying and be attentive.

Judgements about the level of chaos and risk will need to be made and reappraised throughout the initial assessment contact. If it is a dramatic situation, it will be necessary to act immediately, keeping personal safety in mind. For example, if family members are provoking each other, they may need to be separated during the interview. A structured interview is usually not as effective as

an open-ended one in these situations, so a flexible approach is key.

Crisis resolution assessments can be lengthy, with an initial assessment taking up to two hours. At the end of the assessment it might seem that there is no option except to admit the client to the hospital and this should then be arranged.

10. Risk issues

The current climate for UK mental health services is strongly influenced by the media portrayal of 'risk', despite research evidence to the contrary (Taylor & Gunn, 1999).

A worker's engagement skills are particularly important for good risk assessment. For example, a client being assessed may be reluctant to discuss mental health issues, but willing to engage with discussions of their own priorities such as housing or money.

Risk assessment involves gathering information and analysing potential behaviour outcomes. It means identifying specific risk factors that are relevant to the client and the context where they might occur. This process requires the linking of historical information to current circumstances (Morgan, 2000).

This is where hearsay from neighbours, old case summaries and even at times carers and family members may sometimes be misleading. Risk assessment is best shared, particularly when discussed with a colleague.

Indications for hospitalisation

Many cases which have involved hospitalisation could have been managed in the community (Ramsey & Harris, 2000).

The main indicators for hospitalisation are:

- Disorganised and aggressive behaviour from someone who refuses to co-operate, even after much persuasion by a team or members of his / her social network.
- Psychological disturbance of a nature too extreme to be tolerated outside a contained hospital environment.
- Excessive use of drugs and / or alcohol, particularly where the client cannot safely be treated by detox at home, as continued substance misuse will interfere with the treatment of his or her mental illness.
- The person presents a danger to others, which is not going to change and requires containment.
- Persistent acting out behaviour, or the threat of it, indicative of borderline personality disorder, even after protracted discussions with team members.

The decision to admit or not will generally be made by the team in consultation with medical staff working with the team.

References

Morgan, S. (1998) *Assessing and Managing Risk: Practitioner's handbook* (21-42). Brighton: Pavilion Publishing.

Ramsey, S. & Harris, J. (2000) *Manual for home treatment teams* (2) 3-15 (second draft). London: The Sainsbury Centre for Mental Health (unpublished).

Taylor, P. & Gunn, J. (1999) Homicides by people with mental illness: myth and reality. *British Journal of Psychiatry*, **172** 9-14.

11. Treatment

During the assessment and initial intervention stages, staff may be confronted with 'resistance' from other care providers, the family or the wider social network. Staff need to know how to negotiate these difficulties by being knowledgeable about the evidence for their chosen approach. They also need to be able to assure the client and others of the service's competency in this area and address the anxieties of the various people involved. All staff should be capable of developing explicit contingency plans to address their concerns.

When resolving a crisis, the worker is on the client's territory and he or she has a much greater level of control over the interaction in a clinic or hospital setting. Clients can ask staff to leave if they are unhappy with what is happening. Workers need excellent engagement skills which involve good listening and the ability to let the client know that they hear and are attempting to address his or her agenda. The frequency of contact will depend on each client's needs and their position on the continuum between crisis and discharge.

The overall treatment plan will include:

- engagement
- medication management
- support and practical help
- social systems intervention
- counselling and psychological interventions
- education on maintaining good mental health and recognising signs of relapse.

Respite care

Studies from both the US and Australia demonstrated that the provision of respite facilities can decrease the need for hospital admissions. Often clients are admitted to the hospital because the family or carer needs respite rather than their need for 24-hour nursing needs. In other situations, the home environment may be contributing to the client's stress and may lead to a relapse. Respite often works well for clients who live in extreme isolation. If possible, crisis services should have access to a respite house.

12. Discharge

It is the team's responsibility to ensure that clients are engaged with longer-term services before they withdraw crisis resolution services.

Preparing for a client discharge should include:

- anticipating, planning and arranging a handover with the community mental health team after the crisis is resolved;
- conducting a joint meeting with the client's community mental health team keyworker, crisis resolution worker and where appropriate, the client's social network;
- creating a relapse plan;
- holding a CPA (care programme approach) meeting and documenting decisions/issues;
- completing a discharge summary that provides information for the service to whom the client has been referred - including relapse indicators.

13. Administration

Administrators should ensure the availability of clinical documentation such as:

- referral forms
- assessment forms
- initial contact forms
- caseload boards
- acute boards
- medication sheets
- discharge forms.

Other issues are:

- clinical information
- medication
- communication
- rosters
- annual leave
- sick leave
- office procedures
- transport.

14. Evaluation

Office forms that deal with referral, assessment, treatment and discharge are essential to the team and key stakeholders. The information desired should be routinely extracted and entered into a team database

Daily diary records should be maintained to record which clients are seen, by whom, where and for how long.

Service commissioners should specify in advance what core information is required. Internally the team will want to keep additional information to help monitor and improve team performance. A steering group to provide advice and support may prove useful during the first year of operation.