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Audit in practice

Huddersfield (West) crisis intervention team: four years follow-up

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The Huddersfield crisis intervention team began crisis intervention work after visiting well-established crisis intervention centres and reviewing the literature. In Huddersfield health district there are four adult psychiatrists, each covering a sector of about 54,000 population. At the time of the establishment of the crisis team, the health district was not sectorised. Since 1 February 1989 the district has been sectorised into four parts and the Huddersfield Crisis Intervention Team covers the Huddersfield West Sector

Crisis theory – its application in psychiatry

Crisis theory originated in the work of sociologists at the turn of the century, and was developed in the psychiatric field by Lindemann (1944), who used it to understand and assist the survivors of the Coconut Grove Nightclub fire in Boston. Gerald Caplan, a psychoanalyst, went on to develop further the psychiatric implications (1964), and proposed that "a crisis occurs when an individual faced with an obstacle to important life goals, finds that it is for the time being unsurmountable to the utilisation of customary problem solving methods". When a stress exceeds the capacity of usual mechanisms a crisis ensues. Crisis provides the opportunity to learn and to improve an individual's coping strategies. Minimal intervention would have maximum impact on the person who is in crisis and the person's family. It has been found from the studies of Langsley (1968). Ratna (1978), Hoult (1986), and others that people presented as psychiatric emergencies could be dealt with by a crisis intervention approach and this could reduce hospital admissions, length of stay and costs.

Development of Huddersfield Crisis Intervention Team

Historical aspects

A small multidisciplinary group of mental health professionals formed a study group in February 1985, reviewed crisis intervention literature, and visited Napsbury, Dingleton and Coventry crisis intervention teams.

Crisis intervention in practice

During the initial stages the team started work on a small number of psychiatric emergencies referred to the team. The crisis referrals were followed up intensively (sometimes more than once a day) at the patient's own home in the community involving the patient's family and other relatives and neighbours when required. Crisis team members developed confidence and skills during this period, treating patients successfully at the patient's own homes.

Pilot research project (1 January–30 June 1986)

Huddersfield Health District appointed a part-time senior research psychologist to evaluate the crisis intervention team's work.

Outcome of evaluation (October 1986)

Huddersfield district health authority, after studying the outcome of the evaluation, decided to set up the first fully staffed crisis intervention and community mental health team in Huddersfield West Sector from 1 April 1987.

Pilot research project

During the pilot research period of six months, 54 psychiatric referrals to the community mental health team were identified as being in crisis and were offered crisis intervention as a primary form of management. The sample comprised all emergency referrals to one consultant psychiatrist received during working hours from general practitioners from January to June 1986. Of these, the first 15 referrals who achieved the criteria for acceptance into the project, and who agreed to co-operate, were examined in detail. The criteria were that they had not had a psychiatric admission within the previous two years, were not abusing alcohol or substance, and that

there was no evidence of organic brain impairment. The 15 cases were studied in detail with therapeutic outcome, cost effectiveness, and burden on carers being evaluated. At initial assessment, the GHQ 30-item version was administered to these patients. The Social Behaviour Assessment Schedule, which is a semi-structured interview designed to quantify objective and subjective burden, was administered to their carers. These measures were administered within one week of the client's first interview with the crisis team by a research psychologist who had no clinical role in the team, and were repeated within two months after discharge by the team, at which time the client also completed a consumer questionnaire borrowed from the work of the Coventry crisis intervention service.

The mean score of those patients who accepted crisis intervention was reduced during therapy from 22 to 7.5. This represented a significant reduction ($U = 13.00$, $P < 0.05$).

(a) Burden on carers

The Social Behaviour Assessment Schedule offers the opportunity to examine objective (O) and subjective (S) burden on the carer. Pre- and post-assessment showed significant reduction in all areas ($P < 0.05$), greatest percentage reduction occurred in the BEH (O) and BEH (S) scales where both relate to the symptomatology the client is displaying, and the distress the informant experiences from it.

(b) Costs

An analysis was also made of the cost of traditional treatment, based on length of stay from January to June 1984 and 1985, typical bed costs and out-patient costs after discharge, compared with the cost of crisis intervention, based on professional time with clients, travelling time and travelling expenses. The results show the mean cost per patient of the crisis team is six times less, compared to patients who have undergone hospital treatment.

(c) Effect on hospital admissions

An examination was made of psychiatric admission figures for the four consultant psychiatrists working in the district using three admission wards for the six months from January to June 1984, 1985, and 1986. The examination of the total admission figures of all the consultants indicated a steady increase over the three matching six month periods. Against this trend, the crisis team consultant admissions showed a gradual decline. Admissions under the consultant working in the crisis team were closely examined separately and in some detail. Length of stay figures of the crisis team consultant admissions indicated a significant decrease from 1984 to 1986, with new length of stay reduced from 23 days to 17 days ($P < 0.05$). First admission figures for the three six-month periods showed that in 1984 and 1985 nearly half of the crisis team's consultant admissions were first admissions. In 1986, only approximately one-fifth were first admissions. The difference between 1984 and 1986 is significant ($P < 0.05$).

(d) Total sample

Of the 54 clients offered crisis therapy as the primary form of management, only 11 (20%) were admitted to hospital. The results of this primary study show encouraging effects of the crisis programme on all the main areas of interest and are very much in agreement with the findings of other large scale studies.

Current situation

(a) Base

Huddersfield Health District has provided a building in the community as a base for the Huddersfield crisis intervention team members to work. This is not used for the purpose of clinics. It is used for interaction between the staff, for case reviews and teaching purposes.

(b) Catchment area

The team provides a crisis intervention service to Huddersfield West sector which consists of about 54,000 population.

(c) Staffing levels

The staff includes a consultant psychiatrist, associate specialist (five sessions), SHO/registrar in psychiatry (five sessions), two community psychiatric nurses, three crisis therapists, one research assistant, and a secretary. Crisis therapists could be from any professional background. All non-medical posts in the crisis team are advertised openly in all professional journals and any professional could be appointed based on their skills and experience.

Operational policy

(a) Crisis and community mental health team work in practice

All emergency and non-emergency referrals will be assessed and followed up for treatment at home during weekdays from 9 a.m. to 5 p.m.

(b) Organisation of referrals

Referrals are accepted only from general practitioners. Emergency referrals are seen on the same day by the duty therapists and non-emergency referrals will be brought to the multidisciplinary crisis referrals meeting. Team members take up referrals

TABLE I
Total number of bed occupancy days

	Before sectorisation (1.2.88–31.1.89)	After sectorisation (1.2.89–31.3.90)
Crisis team	2570	1638
Each of the other teams (average)	4302	3760

from the meeting, and will assess the patients at their own home. Acute and non-acute referrals are discussed regularly in the weekly case review meetings until their discharge.

(c) Keyworker concept

The keyworker will co-ordinate the management of the patient at home with the support of the multidisciplinary crisis team until his/her discharge. If during the period of treatment the patient needs to be admitted to hospital, the keyworker will continue to follow up the case in the hospital in liaison with the patient's family until the discharge.

(d) Duty therapist

Two members of the team would be available for emergency calls every day. One of them will be a non-medical therapist and the other a medical therapist.

(e) Follow-up after resolution of the crisis

Patients who are in crisis are followed-up intensively as many times as necessary, and after resolution of the crisis they will be followed up depending on the clinical need until discharge. Assessment and follow-up until discharge will be carried on in the patient's own home.

Liaison with general practitioners, health visitors, social workers and other agencies

Huddersfield crisis intervention team members frequently meet the GPs and other agencies involved in mental health care. The team works in close communication with all the carers and agencies necessary for the management of patients' care.

Effect of crisis intervention on hospital beds

As outlined in Table I, the crisis intervention team's work has resulted in low occupancy of the acute psychiatric unit from the sector covered by the crisis team compared with three other psychiatric teams in the same district. All four teams provide a service to catchment areas of equal size with no significant difference in the number of referrals received. The crisis team's bed occupancy is significantly lower than any of the other three teams. The crisis intervention team has succeeded in reducing hospital beds both before and after sectorisation in Huddersfield health district.

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