King Edward's Hospital Fund for London

King's Fund Centre

(7 September 1978)

# CRISIS INTERVENTION

Report of two one-day conferences held on 25 May 1978 and 7 September 1978.

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| Chairman for 25 May | Dr. D.H. Clark, Consultant Psychiatrist, Fulbourn Hospital, Cambridge |
| Chairman for 7 September | Dr. J.K.W. Morrice, Consultant Psychiatrist, The Ross Clinic, Aberdeen |

## INTRODUCTION

Whilst crisis intervention appears to offer exciting possibilities, giving staff the opportunity of working directly in situations of acute distress when possibilities for change are high, doing it has sometimes proved to be more difficult than was at first thought.

Until recently, crisis theory and crisis intervention services have been a relatively neglected area in Great Britain. But with the sectorisation of the large psychiatric hospital and the use of district general hospital units, the possibilities have increased of teams developing who can become familiar with a geographical area and think through new ways of working to meet need.

Where crisis intervention approaches have been established, experience suggests that it is a way of working which relies on good multidisciplinary working. Flexible teamwork and the growth of reliance and trust between the individuals involved appear to be essential.

As one method amongst a range of possibilities, crisis intervention has to clearly establish its links with other services which may be needed to provide support in the longer term for the individual and for his family.

## PRESENTATION BY THE TEAM FROM NAPSBURY HOSPITAL

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| Representatives on May 25 | Dr. T. Farewell | Consultant Psychiatrist |
| | Mr. E.F. Stiven | Principal Social Worker |
| | Sister Anik Webb | Community Nursing Sister |
| Representatives on September 7 | The above people plus | |
| | Dr. L. Ratnasabapathy | Consultant Psychiatrist |

### Origins of team

The crisis intervention team started as a result of lengthy research during the 1960s of the services based at Napsbury. These were institution-centred and appeared to be producing increasing numbers of chronic patients. Research on admission procedure revealed that the process whereby the 'label' of illness was attached to an individual was ill-understood by patients, their families and the professionals concerned, and that the first diagnosis of mental illness had in itself, fundamental repercussions upon the person's subsequent life. As a result a deliberate decision was made to focus skills and resources on this crisis/admission period and away from other aspects of hospital care. A team was set up consisting of a junior doctor and social worker and/or nurse with back-up from a senior social worker and a consultant to visit cases who were being referred for admission.

Current service

The population served by the team based at Napsbury Hospital is 150,000. Three consultants are involved and there are fully developed out-patient and community nursing services, but no day hospital and scant local authority day facilities. The service is a 24-hour day, seven day week, one, covering all groups including psychogeriatrics. 98% of referrals come from GPs and about 45% of these come outside normal working hours.

A social worker, nurse and doctor are on duty call at any one time. Usually two members of this team will go out to visit and visits are followed by team discussions the next day. While a crisis lasts one team member is allocated as the 'key worker', to stay with the situation and to be contacted if there is a recurrence. Contracts are often made with individuals and their families, specifying a time period during which work will be undertaken.

There is a weekly meeting to discuss all cases which have been seen. Back-up from a consultant and senior social worker is available, and use is made of radio contact to avoid delay and travelling. The medical secretary is responsible for dealing initially with the referral and contacting team members and is seen as a vital part of this service.

Observations

Experience of this work suggests:

1. A lot of emergency work is recurrent - i.e. repeats of some of the components of an earlier failed psycho-social transition, rather than a true 'crisis' when a major change is having to be faced.
2. Crisis intervention has to take place in the home situation in order to begin to understand how the crisis has arisen.
3. Emotions are raw at crisis point and a team can work harder and faster than at any other time. Psychotic symptoms, for example, can sometimes disappear rapidly in an interview as the reasons emerge for the current breakdown and stress being experienced.
4. During a crisis there is a fluidity of roles which the team can work with, leaving the responsibility for facing the situation with the individual and his family, and making explicit the choices available for relieving stress.
5. Crisis work depends on sharing of both information and support between team members. It is emotionally draining and team members need to be aware of the effect which it has on both themselves and others.
6. Whilst initially working with a co-therapist can be inhibiting, through time it can become a rewarding and supportive experience.
7. Flexibility and time are essential ingredients of this type of work. Team members have to make themselves available for however long it takes to pick up the key elements in a crisis situation.
8. A crisis team needs an infrastructure of traditional treatment resources to back up and develop its work.
9. Research conducted into the outcome of a crisis intervention service for psycho-geriatric patients in this catchment area suggests that it results in less use of long-term residential resources than both hospital and community-based services and a lower death rate than either.

Questions raised

Is there evidence that crisis intervention is effective?

Team Statistics for Napsbury show a decline in the hospital population and a drop in admission rates since the early 1970s. Admission rates at the hospital are now below the national average, as are numbers of new chronics. For the first two years the crisis intervention team was under a lot of pressure from referrals, but this has now eased off.

Is it possible to operate a crisis intervention team in an area of greater size with a sparse population?

Team The service at Dingleton Hospital has a crisis intervention team operating in an area of sparse population. The Napsbury team cuts down travelling by using radio contact.

This approach assumes that the individual's rationality is intact and stresses that reasons must be given to explain a crisis arising. Doesn't this mean that the individual and his distress are demeaned?

Team Our approach means that responsibility for the crisis is held within the family situation and not removed by removing an individual. Not assuming rationality and taking away choice can be a worse indignity to the individual.

Is this approach an abregation of clinical responsibility?

Team No, we are giving the best advice possible based on the opinions of a team of experts.

Does the team become involved with psycho-geriatrics in the area?

Team We have a good deal of involvement with this group. We operate on the same principles and do not like to remove the individual from the home situation if it is still familiar to him. The nursing service does a lot of support work directly and also through friends and relatives.

Can this approach work only when the family is involved?

Team No, we work with all 'significant others' - e.g. friends and neighbours, if it seems appropriate and the individual agrees.

What do you consider is the optimal number and composition of a team?

Team Two seems the best number to meet both the needs of the family and the therapists. The combination of disciplines is sometimes shaped by the nature of the crisis. It is important to recognise the unique skills and resources which each discipline commands and select accordingly.

How much contact do you have with health visitors?

Team Our nurses are all attached to health centres and call in daily to discuss with staff problems which have arisen. Where a health visitor is known to an individual or family the team may supply support, through discussion, in order to supplement her work.

Is your approach accepted and practised throughout the hospital?

Team The process by which the crisis intervention service gained acceptance from the hospital was a very painful and difficult one. Now each of the three sectors

in the hospital use this model in different ways, reflecting differences in outlook, facilities and resources.

How does this approach cope with accidents, suicides etc. and who is considered clinically responsible for such outcomes?

Team — Our research to date suggests that such occurrences are rare and compare favourably with similar in-patient statistics. The team will visit homes where an overdose or suicide has occurred in order to work with the anger and grief generated. The consultants involved must assume ultimate clinical responsibility for the actions of those under their control, and the social workers their different and individual responsibility. The patients' responsibility for their own act is, however, paramount and it is central to our way of working that no professional undertakes responsibility for something beyond his control, or allows it to be assumed that he does so.

## PRESENTATION BY THE TOWER HAMLETS TEAM

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| Representatives on May 25 | Dr. C.M. Parkes | Consultant Psychiatrist, London Hospital |
| | Ms. P. Fawcett | Community Nursing Officer |
| | Mr. M. Smith | Social Worker, Tower Hamlets SSD |
| | Dr. D. Hick | GP |
| Representatives on September 7 | Miss L. Pallas | Community Psychiatric Nurse |
| | Dr. G. Waldron | Psychiatrist |
| | Mr. J. Watson | Social Worker |

### Origins of team

The crisis intervention service in Tower Hamlets was started after lengthy discussions between Dr. Parkes and staff at the London Hospital and social work staff in social service area teams in Bethnal Green. These discussions ranged over local psychiatric problems, relationships between health and social service personnel and the elements required for a community-based psychiatric service.

Agreement was reached two years ago to start a restricted crisis intervention team drawing on psychiatrists and social workers on a rota system and drawn up in the hospital and the social service area teams covering the catchment population.

### Current service

The crisis intervention service is now a joint-financed project for the next five years. It is community-based, working from an office administered by a voluntary organisation. It serves a population of 60-70,000 from 9.00 a.m. to 5.00 p.m., Monday to Friday. Because of the restricted hours it uses the hospital service at St. Clements to 'hold' emergency situations.

The service started with a broad definition of crisis and as the work has developed, boundaries between 'psychiatric' and 'social' crises have not clearly emerged. About one third of referrals are from GPs, one third from social workers and the rest from a number of other local agencies. About a quarter of the cases seen are already known to other professionals on a long-term basis.

The orientation of the team is one of 'problem' rather than 'illness' and the unit of care is seen as the family or social unit faced with the crisis rather than the individual. An attempt is made to avoid attributions of mental illness unless it emerges that this would be to an individual's advantage. Most problems are concerned with the breakdown or breakup of families.

The team visiting usually consists of a psychiatrist, a nurse and a social worker. Weekly assessment meetings are held to discuss with a senior social worker and a cons.psychiatrist, situations which have been worked with during the week. The immediate handling of the crisis is reviewed and a plan of treatment is worked out. Other members of local agencies are invited if it is appropriate. These meetings are found to be invaluable for supporting workers and aiding learning to work with other professionals.

Observations

Whilst there has been only a short time period to evaluate the work a number of features have emerged:

1. Working with the family together on its 'problem' often results in the disappearance of symptoms of acute mental illness in the individual.

2. Families in 'chronic' situations who are referred in acute crisis respond well.

3. Marital 'yo yo' situations are very difficult, particularly when children are involved.

4. In some situations the team are initially welcomed and then there is a 'closing in' with the family showing little interest in working for fundamental change.

5. Team members have to work at coming to terms with the feelings of being intruders into the homes and lives of vulnerable individuals.

6. Families appear to value the mixture of practical and therapeutic help which the team is able to offer.

7. The nurse member of the team is regarded by some families as a less threatening figure to relate to as she does not have the statutory powers of the other two professions involved.

8. It is vital to develop good links with other agencies, statutory and voluntary, in order that crisis situations are identified early and caring networks can be used as required to provide ongoing support.

9. Evaluating this service raises difficulties, because it is not solely founded on preventing hospital admissions.

10. Definitions of crisis are often ambiguous. It is important to make a distinction between a situational crisis and an emotional crisis.

    Situational crisis - life situations which carry high risk of mental illness but which can also generate growth: services which are developed to help in this area are keen to promote healthy rather than unhealthy development. They focus on bereavement, retirement, birth, etc..

    Emotional crisis - associated with an episode of acute distress in a person's life. They can arise in situational crisis but are not necessarily linked.

Questions raised

How many referrals are handled a week?

Team — With the expansion of the service we expect this to increase to 3 - 4. There is no work with psychogeriatrics, who have a separate crisis service.

How does the restricted nature of the service affect the timing of the crisis work?

Team — Some situations can be held by other services. Sometimes it is better to wait until the family can be together before the team intervenes. On some occasions the situation has closed up by the time the team arrives.

In a situation of limited resources is it best to start a crisis intervention service in a limited fashion or wait until full coverage is possible?

Team — A limited service is better than nothing, given the waiting lists for the traditional services. It is also cheaper than traditional approaches.

Is the alternative label of 'social problem' really so different from 'mental illness'?

Team — Yes, 'problem' is less stigmatised and families are more willing to share in working on a problem.

What is the role of the GP in relation to this service?

Team — The GP can play an invaluable part. GPs are invited to the weekly meetings to share in developments.

How are families supported in coping with a mentally ill person in the home?

Teams — The crisis which is being worked with can often be one for the support systems rather than the individual. Other services often need to be called on to work with the family's problems in the long term. The Napsbury team, for example, is able to refer to groups established in the hospital's outpatient department for relatives of patients and relatives of psychogeriatric patients.

Why is a doctor needed in the team?

Teams — Given the broad definition of crisis used in the Tower Hamlets service, a psychiatrist is sometimes not a necessary team member. Doctors do however hold the key to a number of resources which the team may have to call on and the Napsbury team consider the involvement of a psychiatrist to be important.

Are you concerned in your work with the prevention of crisis?

Teams — Many crises are normal processes of growth - periods of stress and uncertainty which can lead to change. The aim of a crisis intervention service is to support people in order to maintain this process rather than to defuse or dampen it.

## POINTS FROM DISCUSSION GROUPS

It was felt that whilst crisis intervention had features in common with other ways of working, it also had some unique qualities, namely:

1. A family/social psychiatry approach which challenged some of the assumptions of the individual/medical model, but is not "anti-psychiatric".

2. It offered the chance of psycho-therapeutic intervention at a stage when a fluid emotional situation existed and opportunity for change was therefore at a peak.

3. It gave the patient and his family a better understanding of the options being considered and the reason for the final treatment choice. Both teams commented on the very positive feedback they received from families with whom they had worked.

Whilst team members appeared to derive satisfaction from this way of working, there were also costs in terms of the intensity of involvement which was necessary in crisis situations. In order to help the team cope, the following were important:

1. Careful staff selection

2. Good staff support systems - e.g. the London Hospital team's weekly meetings

3. Close working relationships between team members. If these existed then team members could compensate if one of their number was not able to participate fully on any occasion.

4. Diminishing rivalry between professional groups - particularly social workers and community nurses. This could be achieved if it was recognised that each team member shared an area of common clinical concern as well as their own professional focus and skills. Lack of confidence appeared to be at the root of rivalry and this could diminish if each member was able to develop and display his own particular skills.

The links which the crisis intervention team builds with other agencies and teams working in the same geographical area are vital. The primary care team has a key role to play in alerting the service to the need for specialist intervention, and where its links with the crisis intervention team are good, the opportunity to work in a preventive fashion increases. The use of volunteers and their organisations in providing a supportive service can result in sensitive and personal response to crisis as well as a saving on the use of more expensive resources. Back-up services from both health and local authorities are a crucial foundation for the successful operation of a crisis intervention team.

It is important to bear in mind that a crisis intervention service is part of a total network of services in which team members also play a part. The balance between the parts of this network, the distinctions between primary and secondary care, need to be clearly established and accepted.

The costing of this service appears to be lower than that of traditional services. However, evaluation to date may have failed to pick up fully the cost to family and community which crisis intervention as a part of a community care approach, necessitates. Evaluation of this type of service is problematic, particularly in measuring family burden.

The problems of confidentiality when records are shared between team members and radio contact is used, are very real. They necessitate that high professional standards be established with respect to all information concerning client families.

## QUESTIONS RAISED IN PLENARY SESSION

Surely this method is what the general practitioner service has, or should have been doing for years?

Teams — There are important differences in using a team rather than an individual. The quality of the work is different. In using a 'specialist' team the patient and his family may reveal information which they would feel uneasy about sharing with a known practitioner whom they would see after the crisis situation. The team is organised so that it can be available for a longer period of time at a moment of crisis than a GP in a busy practice.

Has this approach any relevance to the situation of patients who have been discharged from hospital and are living in isolated, boarding house situations?

Teams — This group may not have the confidence to ask for help and may not be encouraged by landladies to do so. If a crisis intervention team was contacted they would deal with the crisis which had arisen.

Surely this approach undermines the right of the individual to have his own private pain individually treated?

Teams — Crisis intervention is just part of a range of treatment responses. It is directed to particular situations. It does not remove the right of an individual to be treated in a traditional way.

How far have you been able to include in your evaluations of the service you offer, a measure of burden on the family?

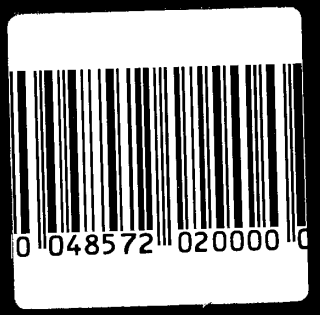
Teams — This is a complex question which we have, as yet, not fully studied. Crisis intervention involves the family and the team is available for the family to contact. We work directly with the problem which the family experiences as a burden.

If your community nurses were attached to GPs, surely they could identify crisis at an earlier stage?

Teams — The community nurse attached to a primary health care team has a primary responsibility to that team. She would not therefore, have access to the crisis team as is now the case. There is a need to keep a clear distinction between primary and secondary care or else the community nurse will experience conflicting demands on her time and skills. As a member of the crisis intervention team, the community nurse can offer specialist support to GPs and health centres.

## CONCLUDING REMARKS

These conferences have explored and established that crisis intervention is a new way of working with particular situations of stress. It defines the problems being faced differently from the traditional medical model and it depends on the work of a closely-knit team of professionals. It therefore challenges the way our current services operate and the established roles which have developed for the professions involved. It is a response to need and to change which deserves serious consideration.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