3
Crisis Intervention and Home Treatment

I just assumed once you got in that state you were whipped off to hospital.

(Helen)

3.1 Summary

As part of the transfer of resources from inpatient to community-based care, there has been a marked increase in varieties of ‘crisis intervention’ service in the past few years. Brimblecombe (2001: 5) remarks that some of these services provide extended hours and have ‘an explicit or implicit aim of reducing acute admissions to psychiatric wards’. A popular form of service that has been piloted in many countries has been the ‘home treatment’ or ‘home care’ programmes. There have been a plethora of studies comparing hospital treatment with home treatment programmes over the past 40 years which have repeatedly demonstrated that home-based care offers a better quality of service to users and is cost-effective (for an overview of the research see, for example, Orme and Cohen 2001; Smyth and Hoult 2000). Recent government reviews in the United States and the United Kingdom have recognized the importance of offering crisis intervention services to avoid hospital admission (Department of Health 1999, 2007; President’s New Freedom Commission on Mental Health 2003). At the time of writing, however, there is still a marked variation in the both the breadth and depth of crisis provision offered from area to area (Brimblecombe 2001; Hogan et al. 1997).

This Chapter investigates the background and development of crisis intervention services, before exploring the foundation, development and progress of the Bradford Home Treatment Service in the United Kingdom. This alternative to hospitalization operated successfully in
Bradford for 7 years and was given ‘Mental Health Beacon’ status for 3 years by the NHS (see National Health Service 2002). There was national media coverage on the workings and philosophy of this home treatment team, particularly focusing on their ‘radical’ user-centred approach to care (for example, see BBC 2002; James 2000). Falling into line with current mental health policy, the Bradford Home Treatment Service is now the ‘Bradford Crisis Resolution Home Treatment Service’. The significance of this change will also be addressed. The author worked closely with the Bradford Home Treatment Service in the early years of its operation (1996–1999). The narratives from a number of users from this service will be reproduced later in this book and compared with those users who received hospital treatment.

### 3.2 Crisis intervention

Since the 1950s and 1960s the idea of ‘preventative psychiatry’ has gathered pace within the field of mental health, expanding public consciousness of the everyday afflictions of stress, worry, disturbance, depression, neuroses, and so on. If not understood and ‘treated’, these disturbances could possibly lead to more serious mental illnesses. Caplan (1964) was a key writer on the subject and influenced the development of ‘crisis intervention’ services. He identified three phases of the ‘crisis’: the first phase is the rise in tension where a person realizes something is wrong; the second is the point of crisis, where a person’s internal resources are exhausted and overcome; and the third represents the resolution of crisis through either growth or stagnation. According to Caplan, the second phase – when people are most open to suggestion – is the appropriate time to intervene with therapy. From this initial concept of intervening in a person’s crisis other writers developed the definition further. Renshaw (1989) described the concept as providing appropriate help quickly to clients with identifiable psychological crises, with the aim of returning clients to their pre-crisis level of functioning. Appropriate intervention depends on mental health personnel identifying who is in crisis, what stage the crisis has reached and what kind of help is needed.

With the help of such writers in the 1960s, crisis intervention extended further the services available in the community for people with mental health problems, usually taking a more focused approach to those in need and, in this way, separating themselves from aftercare and outpatient services. Newton (1989) described three basic ways in which crisis intervention services could operate: they could run parallel