

Boring but important: the community mental health team

Green and Gowans are right to worry about what has happened to the seriously mentally ill when the number of psychiatric beds has been mercilessly cut.¹ However, it may be misleading when they talk of 'a lack of evidence for community teams' and then talk about crisis teams (CTs). The fact that CTs — often heralded as 'the' alternative to admission — perform poorly under scrutiny² does not mean that community care is by necessity poor.

The rise of the so-called functional teams — CT, assertive outreach (AO), early intervention for psychosis — has not led to great (or at least greatly demonstrable) advantages for patients. A particularly salutary tale comes from the work of Killaspy *et al.*³ They used the community mental health team (CMHT) as treatment-as-usual comparator for an intensive case management model, the AO team. But be careful what the placebo is. While briefer follow-up looked promising,⁴ this longer follow-up eventually found AO to do scarcely better than the CMHT for a lot more clinical effort and presumably, cost.³ Early intervention for psychosis services, too, have had questionable benefits.⁵

All of this could, and should, be seen as evidence of the value of generic boring-but-important community mental health care on the district psychiatry model.⁶ The CMHT suffers from having come into the world essentially before the era of the randomised controlled trial, but some other research also indicates its usefulness among even the most severely ill long-stay patients.⁷

The authors here hint at a problem at the other side of the hospitals, acute presentation, which may explain their focus on CTs.¹ When justly lamenting the increasingly poor provision of inpatient care for the most mentally ill in our society, though, it is as well to talk of the tangible relative success of the CMHT rather than the straw man of the CT.

Alasdair Forrest,
CT2 in Psychiatry, Parkhead Hospital,
Glasgow.

E-mail: alasdair.forrest@nhs.net

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Invest in community-based solutions that address individuals' needs: not more beds

Green and Gowans¹ discuss the balance between the community and inpatient care of patients with mental health problems. They provide an analysis of resource allocation in mental health care with which I fundamentally disagree. Their core proposal is for more investment in psychiatric beds, with the possibility of improved primary care mental health as an afterthought. In contrast I suggest that a continued shift in investment towards community-based care is required, but with general practice and the third sector playing strong core roles. Within the confines of a limited NHS budget, following 3 years of decline down to 13%, I concur with others that a higher share goes to mental health care.²

While I agree with Green and Gowans that reductions in psychiatric bed availability have driven the reduction in admissions, there has been considerable investment in home treatment/crisis teams to support the policy.³ In contrast to many policies directing reorganisation of services there is relatively good evidence that home treatment teams can support individuals to stay safely out of hospital and provide a better experience of care during a crisis.⁴ While practice is highly variable, and this needs addressing, I have witnessed first-hand the benefits of a well-functioning crisis team and inpatient acute care system. Analyses of admission decisions also suggest that many inpatient stays are not necessary.⁵ The problem is likely to lie in implementation and a risk averse culture in the NHS.

While we need to optimise our response to crises, it is possibly more important to focus on generating positive outcomes; there are a range of community-based interventions, such as early intervention for psychosis, smoking cessation, and support into work which are likely to be cost-effective.³ Community-based mental health services need to be able to perform three interlinked key functions, and general practice has a role to play in each:

- promoting better mental health and social outcomes, such as feelings of resilience, hope and wellbeing; having a home, and being in work;
- proactively managing specific short and longer term mental health problems, such as bouts of depression with anxiety, relapsing post-traumatic stress disorder with comorbid substance use, and the physical health needs of individuals with psychosis and dementia; and
- anticipating and responding to crises.

I suggest that future research should not be centred primarily around the epidemiology of the current inherently flawed diagnostic classification system, as implied by Green and Gowans, but should instead focus on understanding individuals' needs for services (along with their strengths and resources). Patients' personal goals, the links between their individual patterns of emotion, thinking, behaviour, and social situation define the services that are needed. Alongside self-management, carers, and family, resources