Commentary Template for NCF Cochrane Corners

Crisis intervention for people with severe mental illness.

Background

Crisis intervention service principles and dedicated crisis intervention teams have been part of mental health nursing practice since 2005; many countries, such as the UK, have embedded crisis intervention services into statutory service on a national basis. Clinical nurse practitioners play a key part in the delivery of crisis intervention services and manage the gateway for service users when considering voluntary or compulsory admission to hospital.

In the ten years since the development of crisis intervention services, there has been a need for a systematic evaluation of their efficacy as compared to standard hospital admission processes. This is especially relevant for mental health nurses as the value of therapeutic approaches within nursing care delivery is vital in prevention of unnecessary admission of patients to hospital. Nursing care and intervention is also pivotal in coordinating timely admission to hospital and in the prevention and management of re-admission rates.

This review seeks to evaluate the existing evidence base for the effects of crisis intervention models of service provision for people with severe and enduring mental illness, as compared to standardised hospital care. This evaluation applies to patients experiencing an acute phase of mental illness and excludes studies which apply to patients experiencing alcohol or drug misuse. The review will allow nurse practitioners, senior nurse managers and commissioners of care to evaluate whether existing models of service provision and clinical intervention provide optimum levels of therapeutic efficacy.

Objectives

To review the effects of crisis intervention models for anyone with serious mental illness experiencing an acute episode compared to the standard care they would normally receive. If possible, to compare the effects of mobile crisis teams visiting patients' homes with crisis units based in home-like residential houses.

Intervention/Methods

The review considered randomised controlled trials and widened the previous diagnostic criteria to include "adults with either a severe mental illness" and "adults with severe mental health conditions". People with one particular condition only (eg. severe depression) were excluded from the review, however studies with mixed conditions were included. This was in addition to people defined as having schizophrenia, related disorders and delusional disorders, by any means of diagnosis.

The review compared studies using crisis intervention services which were additionally defined as being “out of hours” as well as mobile intervention teams. These services must have had a specific intention to treat an acute psychiatric episode. The review included standard care as defined by normal acute hospital inpatient provision, together with mixed comparators for different forms of crisis intervention delivery settings.

Outcome measures included admissions to hospital, number of days in hospital together with the number of staff / service user contacts. Secondary outcome measures included specific clinical outcomes, (eg. improvements, medication concordance and relapses), together with a range of social outcomes including measures of costs of treatment.

Results

When comparing measures of crisis intervention with standard hospital care, reduced hospital use was more favourable in crisis resolution than standard care, but not to a significant extent. The use of crisis intervention in the UK did reduce hospital admissions. Hospital readmission rates were mixed for standard and crisis care. Measures of global and mental state were significantly improved for crisis intervention over standard care. A clear finding was that people having their crises managed by resolution services were more likely to stay in care for at least a year. Family burden and patient / relative satisfaction scores were more favourable for crisis intervention care. Economic costs for crisis care were significantly cheaper than standard hospital care.

It wasn't possible to compare measures for mobile and residential crisis intervention services, however mobile teams did appear to be slightly more successful at preventing hospital readmission as compared to standard care.

Conclusions

The authors of the review have stated: “Should we acquire more data from existing studies, we would probably know much more about the effects of crisis intervention. Much important data within the included studies were not reported clearly and therefore clinicians, funders and recipients of care may feel that they have been let down by the research community. There are very few data on the role crisis intervention plays in treatment of people with severe mental illnesses. Currently, it is implemented without good evidence.”

That said, crisis intervention care, both in a home or a community setting, was found by this review to provide a package of support that was worthwhile, acceptable and less expensive than standard ‘hospital’ care. Furthermore, crisis care avoided repeat admissions to hospital; improved the mental state of service users more than standard care; was more acceptable and satisfactory to service users and placed less burden on families and carers.

Implications for Practice

This updated systematic review comparison of crisis intervention and standard hospital care is important as we are now into a decade of embedded crisis intervention service provision which is enmeshed with direct nursing care and delivery for inpatient, outpatient and community mental health nursing.

While more data is clearly required in order to provide good evidence for the continuance of crisis intervention services, it appears that service delivery by crisis intervention teams is valued by patients and carers. It is also cost-effective, serving to improve readmission rates and global measures of wellbeing for service users.

This is important for nurses as the ethos of crisis intervention theory, together with its associated therapeutic principles of clinical practice appears to be supported by the available evidence.

While further studies are required to establish the therapeutic efficacy of crisis intervention teams, nursing practitioners can be more confident that the direction of trend for crisis intervention principles is concordant with good “ethics of care” principles.

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