Training for crisis resolution home treatment teams

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The changing training needs of the mental health workforce have been increasingly highlighted in recent years with the national development of new services like crisis resolution/home treatment teams. This article presents some key changes made to short training courses in crisis resolution.

Since the publication of The NHS Plan (DH, 2000) and the National Service Framework for Mental Health (DH, 1999) there has been a policy-driven emergence of a variety of new community services across the NHS. These include assertive outreach, early intervention and crisis resolution services. The need to train the workforce for these teams has posed a significant challenge for post-registration options. The Sainsbury Centre for Mental Health (SCMH) has provided a broad range of training for mental health practitioners throughout the UK.

Background
In 2000 The NHS Plan identified the need for 335 crisis resolution/home treatment (CRHT) teams to be set up in England by 2004. For the vast majority training was a 10-day programme, in conjunction with the National Institute of Mental Health for England, delivered in situ (Box 1, p20).

While people were consistently positive about the training, its actual impact on practice remained unclear. There was a feeling that we needed to re- think how to optimise the learning for people, facilitate changes in practice, be creative and flexible, while providing value for money. It was agreed that we needed to be more hands-on and contribute for a longer period of time.

Practice development days
The focus of the training providers should be on specialist areas of CRHT and the principles and objectives of the practice development days are:

- The day is not an assessment or test of the team but offers an opportunity to build on current training;
- Several sources of information contribute during the day, which include working alongside staff on assessments and home visits, and facilitating a case presentation from the team’s current caseload;
- A discussion between key players in the whole mental health system may be facilitated;
- Areas of good practice are highlighted and issues that may require further attention are identified and fed back verbally and in a short written report;
- An evaluation of the training is carried out.

Experiences so far
From the point of view of the trainers, having the opportunity to work alongside teams is hugely advantageous. It allows issues to be immediately raised and suggestions made as appropriate. Furthermore, there is a real opportunity to assess the learning that has taken place. For example, with one team it was clear that there was a gap in understanding and practice around the social systems approach (Bridgett and Polak, 2003a; 2003b).

Participating in a team’s multidisciplinary handover provides trainers with important insights. It is a chance to evaluate the diversity and suitability of the caseload and highlight any difficulties that
may be affecting the functioning of the team. Listening to case discussions also enables trainers to consider the framework and interventions being used for each crisis client. While this may offer some immediate assistance with a complex case, the real benefits are in the longer term and build upon important issues from training. Application of the social systems model, for example, is referred to in all discussions, with emphasis on this as a guiding principle for the team’s work. While the case studies used in training may be useful to engage practitioners in theory, facilitating the application of these with their own cases is far more pertinent.

The same principles apply when a particular case is presented with a team. It is often someone with complex needs the team may be struggling to support or who is causing conflict between practitioners. The relevance of protected time each week for case presentations is discussed during the training. Often this practice may not have been implemented so revisiting its benefits for team effectiveness with a real case can be motivating for practitioners.

**Relationships are central**

The relationships that trainers build with a team are invaluable. Practice development days should not be perceived as threatening but should be welcomed as learning opportunities. Practitioners are keen for trainers to accompany them to see service users and informal opportunities to discuss clinical or operational issues are readily taken. For example, we often spend time with individuals in the office, working through particular cases or offering ideas about referral procedures. Having good relationships and humour seem to be key factors in the success of these days.

There are a number of ways in which these clinical issues can be taken forward by the practitioners and this forms part of the feedback to the team. Following a discussion between the trainers, recommendations are first offered to the team leader at the end of the day, which will include a variety of strategies and people who may be identified and championed as agents of change. Investing in these days is encouraged in the form of future reviews or annual ‘MOTs’.

Feedback from practitioners so far suggests that they value input from external trainers. Team leaders seem to find this external input particularly useful to help identify strengths as well as issues that need to be tackled. Acknowledgment of difficulties allows an open discussion about where the service ‘is at’ and where it ‘is going’.

**‘MOTs’ for teams**

Staff turnover is likely to mean that relatively quickly there may be new additions to the team, who have not participated in the initial training, and key people may have left the service. There are essential principles of crisis resolution and home treatment that all team members should be aware of but there is also an argument for refresher courses for all staff. This is because the model may become diluted due to staff changes and organisational pressures. An opportunity to discuss and ‘problem-solve’ cases with reference to any new pressures can be an important exercise and is crucial for sustainability.

In our experience the first year or so can be spent by the team trying to establish itself within the local mental health system, often tackling operational issues such as gatekeeping. For those teams that have been through a training programme, it is at this stage they may need to refocus on issues such as interventions, positive risk taking and the processes of crisis resolution.

Revisiting their operational policy and interface issues are frequently at the forefront of the concerns raised. Revisiting such issues during a review day, which may involve time out from the team, and a practice development day enables the team to build on the initial training as well as picking up on new areas.

Acknowledging from the outset that there will be different training needs at different stages of a team’s evolution should encourage commissioners of training to spread any available funding over a number of years. Ideally there would be ongoing available funds to enable development and then sustainability. Services as well as practitioners need ongoing investment if they are to remain up to date and effective in an ever-changing health system.

The different and changing needs of every team cannot be addressed in any amount of initial training. A routine hands-on MOT yearly, in addition to team away-days, may be inestimable in its value to a team’s progression and its effectiveness within the whole mental health system.