Reviewer's report

Title: Treatment and outcomes of crisis resolution teams: a prospective multicentre study

Version: 1 Date: 26 September 2011

Reviewer: Tanya Nelson

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Manuscript Review
Treatment and Outcomes of Crisis Resolution Teams: a prospective multicentre study
Hasselberg N, Grawe R, Johnson S and Ruud T.

Overall, it was an enjoyable paper to read and contributed a good working knowledge of how crisis teams operate in Norway and what their outcomes are. Often mental health treatments are described as 'black box' i.e. no one really know what goes on and this is a good attempt to describe what constitutes a treatment episode in a crisis resolution team.

The abstract is clear, concise and an accurate summary of the paper.

The background gives a balanced overview of crisis team implementation and function in Europe over the last 10-15 years, outlining advantages, such as reduction in admission and improved patient and carer satisfaction, with possible reduced care costs. It mentions no difference in other outcomes such as clinical or social benefits compared to standard care. It raises that there are few disadvantages and highlights areas of discrepancies in the research findings, particularly with respect to compulsory admission under the mental health act 1983 in 2 areas as well as poorer outcomes for some groups of people, such as older people, those from socially deprived areas, and those referred from enhanced CMHTs. Clear aims. Was one of the aims to compare Norwegian CRTs with UK/European teams? As it is mentioned in the conclusions of the Abstract, it might be worthwhile mentioning in the aims. (POINT 2)

Methods. Good study design in that it was prospective giving a better data sample than a retrospective design. Interesting description of the arrangement of mental health services in Norway. See point 3. Large sample of patients from the 8 teams. Good choice of scales used. Using HONOS scales instead of diagnosis was a good way of solving the problem of the missing diagnoses due to a lack of psychiatrists or psychologists in teams.

Clear results section.

The Discussion draws attention to and explores the main findings of the paper. It highlights the fact the CRTs in Norway do not concord to the UK model in many ways. It seems surprising as Norway implemented the model based on the UK. It leaves me wondering why they departed from the model in so many key ways, as
I highlighted below in point 3. Was this a policy decision? A resource decision? Geography? There was a predominance of the people with less severe forms of mental illness being treated by the crisis teams in 2005/6. Perhaps, as home treatment seems to have increased in the study in 2010, there has also been a shift in emphasis of caseload? The outcomes of treatment were good and the authors acknowledge that this might in part be due to evaluation from the staff as mentioned in point 5 below.

Balanced strengths and limitations section.

Discretionary Revisions

1) In the last para of the conclusions of the abstract the word ambulatory could be replaced with ‘face to face’ treatments or ‘face to face home’ treatments, to make the sentence more specific.

2) Was one of the aims to compare Norwegian CRT s with UK/European teams? As it is mentioned in the conclusions of the Abstract, it might be worthwhile mentioning in the aims.

3) Was struck that the teams were set up in Norway with little emphasis on gatekeeping hospital admission, few with psychiatrists and most teams did not meet the CRT model as described by the PIG in the UK (such as targeting patients with SMI), which they based their service implementation upon. It is known that the closer one adheres to the model described, the more effective the crisis team (Glover et al Onyett et al). I see that you have discussed this extensively in your paper ‘An implementation of the crisis resolution team model in Norway: Are the crisis resolution teams fulfilling their role? I think it would complete the background to refer to this paper to acknowledge that this issue had been considered. Although it is not the exact scope of the paper, it is a related issue. Have they made an impact on other parts of mental health services, such as inpatient admission and decreased pressure on outpatients? One would not think so given the configuration and remit of the teams.

4) One of your conclusions from the 2005 data is that there needs to be more home treatment, yet you say in the setting section that there are indications of more home treatments occurring from the survey in 2010 (your ref 22), indicating that this is actually happening. Perhaps there could be a suggestion that a re-survey should take place.

5) By having the clinicians from the team collect the data is there some risk of observer bias, especially with respect to gathering HONOS and GAF scales at initial assessment and discharge? You make mention of this in the discussion section.

6) Reasonable approach to use an imputation model for missing values for the CRT that did not measure length of treatments. It was a shame that this data could not have been retrospectively collected if at all possible.

7) In the results section, sentence 4, the term ‘involvement’ would benefit from some clarification as to what this consisted of. Although you do address this in greater detail in the discussion.
8) The HONOS and GAF scores all decreased by a statistically significant amount, could this be affected by an observer bias, as in point 5?

9) In the section predictors of a favourable outcome of crises, again, an explanation of what is meant by a high degree of ‘involvement’ on the CPPS subscale would be a benefit understanding of what that involves.

10) There is some UK evidence to indicate that UK crisis teams differ in their patient caseload diagnostic composition. In Tacchi et al (2003) evaluation of an emergency response service, the reason for referral to the team was predominantly for depressed and suicidal patients rather than for patients with severe mental illness.

Minor Essential Revisions

1) In para 5 of the Measures subsection, there is a typographical error. In the last sentence it should read ‘registration form’ rather than ‘from’.

References


Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.