to assess their symptom levels at the same time. Still, considering some global rating of symptom severity would be helpful.

How patient satisfaction with mental health care should be assessed in research and practice depends mainly on the scope and purpose of the assessment. Quantitative scores as provided by the established scales can be helpful, if an adjustment for confounders is possible. Some scales are short and simple to use, and provide helpful scores for research studies and broader evaluations of services or treatments. When using the scales, one might, however, also want to be aware of their limitations.

When satisfaction scores are obtained to evaluate services, substantial differences of such scores between services or significant changes over time are unlikely, when all confounders are considered. Frequent measurement of satisfaction scores may, therefore, not be very informative. Also, differences on quantitative scores alone will not be a precise guide for which aspects of care should be improved to raise the satisfaction of patients. For this, one may want to analyze subscales or single items of scales. Even these scores, however, have limitations, as no scale covers all aspects of care, and low satisfaction scores do not necessarily indicate what exactly should be done to make patients more satisfied.

Better than quantitative scales, open questions on what specifically patients are satisfied or dissatisfied with can elicit information on a wide range of aspects of care that may be relevant in a given context and that professionals can potentially act on. For example, if patients express dissatisfaction with the behaviour of one particular staff member or with the timing of home visits or with the dose of their medication, clinicians may change these aspects of care and thus directly improve patient satisfaction.

Finally, no scale or survey can replace the most important procedure to assess patient satisfaction with care in practice, which is a direct and open communication between patients and clinicians about patients' experiences, appraisals and wishes. This can facilitate ongoing consideration of these experiences and views in shared treatment planning and service development.

Stefan Priebe[1], Elisabetta Miglietta[2]
[1]Unit for Social and Community Psychiatry, Queen Mary University of London, London, UK; [2]Section of Psychiatry, Department of Neuroscience, Biomedicine and Movement Science, University of Verona, Verona, Italy

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Community alternatives to inpatient admissions in psychiatry

The aim of treating people experiencing a mental health crisis in settings other than hospital inpatient wards is not new[1]. A system of family foster care for people with mental health problems at times of need was established in Geel, Belgium, 700 years ago. In the 1930s, A. Querido set up a home treatment admission-diversion system in Amsterdam, The Netherlands. In the 1970s, P. Polak developed in Colorado a network of crisis services including family placements, crisis beds, an acute day unit and treatment by mobile mental health teams. The first recognizable modern multi-disciplinary crisis resolution home treatment team was founded by L. Stein in Colorado in the 1970s.

The attractions of averting hospital admission where possible are obvious. Inpatient care is very costly. Potential harms to patients from hospital admission include: institutionalization and dependency; distress from enforced social proximity to others, or from separation from friends and family; harm from other patients or staff; loss of employment or housing tenure; the development of unhelpful coping strategies; stigma[2]. Some of these harms may be mitigated by alternative residential crisis provision. Treatment at home during a crisis offers positive opportunities: to identify and modify social and environmental precipitants of crisis, enlist family support, develop coping skills applicable to people's normal social context, and offer a more equal basis for collaborative relationships between staff and patients.

Patients tend to strongly advocate alternatives to admission being available. The provision of a range of crisis services, from which patients and staff could collaboratively choose the best option, appears evidently desirable. A number of community service models now have trial evidence as viable alternatives to inpatient admission for many patients. Acute day hospitals may be able to treat as many as one in five patients who would otherwise be admitted to acute wards, with comparable outcomes[3]. Crisis resolution teams can reduce inpatient admissions and increase satisfaction with acute care[4]. Residential crisis houses may have greater patient satisfaction and lower costs than inpatient admission, with comparable effectiveness[5].

Despite this promising evidence, community crisis alternatives have struggled to become fully embedded in national acute care systems. Crisis resolution teams are probably the most widely adopted model, but have only been implemented nationally in England and Norway. Community crisis models, even where they do act effectively as an alternative to admission, risk being labeled as a luxury and vulnerable to cuts.

Community alternatives are unlikely ever to replace psychiatric hospitals completely: some patients may always be un-

willing to accept treatment, or pose such a high risk that secure accommodation is required. No crisis alternative has demonstrated any impact on rates of compulsory hospital admission.

Four challenges can be identified for community crisis alternatives to thrive in modern mental health systems, as detailed below.

Rapid response. In many countries, lack of bed availability can lead to delays in admissions, or patients being admitted far from home. In principle, though, referral routes to inpatient wards are clear and new patients can be accepted rapidly at any time. Community alternatives, in order to provide a genuine crisis service, must seek to match this. Yet in England, for example, crisis resolution teams' response time targets for initial assessment of patients referred in crisis vary from one hour to one week[6].

Managing acuity. While community alternatives must set responsible limits on levels of risk which can be safely managed, an ability to accept acutely ill and distressed patients, even where some risks are present, is essential. Referral processes, staffing levels and skill mix, the physical environment, and organizational culture have been identified as modifiable barriers to successful management of acuity in community crisis services[7].

Role clarity. Community alternatives may offer either comparable treatment to inpatient wards in an alternative setting, or distinctly different care from psychiatric hospital. Crisis resolution teams typically emphasize the former, providing clinical treatment from a multi-disciplinary team to all those for whom hospital admission might be averted. Residential crisis houses may seek a more niche role, to provide different, innovative and potentially more appropriate care for a specific demographic or clinical group. The Soteria model of crisis houses provides the best known example of this. Developed in California in the 1970s, Soteria houses offer a minimum medication-use, non-hierarchical residential treatment setting for people with first-onset psychosis in crisis[8]. Being perceived by local commissioners and service planners as having a clearly defined role is a key factor influencing the sustainability and survival of crisis alternatives[7].

Implementation. Community crisis alternatives face the common challenge of replicating the benefits observed from early adopters and initial evaluations, when scaled up. The English experience of implementing crisis resolution teams nationally exemplifies this. Reductions in inpatient admissions anticipated from trials have not been consistently reproduced[9] and implementation of national policy guidelines has only been partial[6]. High model specification, rigorous assessment of adherence, and programmes to support implementation may be required to maximize the benefits of crisis alternatives.

Potential unintended consequences of crisis alternatives should also be considered. Outcomes for rare adverse events, such as suicides, are poorly evaluated by individual studies. Community alternatives may attract skilled staff away from inpatient wards and, by accepting the more compliant, less high-risk patients, may raise the overall levels of disturbance and acuity on acute wards. Increasing the complexity of local acute care systems presents challenges to maintaining continuity of care. Overall length of stay in acute care could be increased, if crisis alternatives were commonly used as a "step down" provision from inpatient wards.

Community crisis alternatives, which offer a cheaper alternative to inpatient admission, as well as a potentially less frightening, stigmatizing and socially dislocating experience, have a positive role to play in sustaining deinstitutionalization. Yet, there is little consensus within or across countries about optimal acute service configurations. The next challenge for researchers is to move beyond evaluating individual service models to system level evaluation, which can identify service components and configurations which provide the best outcomes for patients within mental health acute care systems.

Brynmor Lloyd-Evans, Sonia Johnson
Division of Psychiatry, University College London, London, UK

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Drop-outs in psychotherapy: a change of perspective

Research including almost 84,000 adult psychotherapy patients from 669 randomized controlled and uncontrolled trials shows that almost 20% of patients prematurely terminate psychotherapeutic treatments, with no differences in drop-out rates among the different approaches (e.g., cognitive-behavioral, humanistic or psychodynamic)[1].

No differences between diagnostic groups seem to exist, except for personality and eating disorders showing higher drop-out rates. Rates were also found to be higher in patients not receiving their preferred treatment, in treatments that are not time-limited or manualized, in psychotherapy performed by trainees, in effectiveness studies (as opposed to efficacy studies) and in younger patients[1]. A recent meta-analysis found that almost 29% of children and adolescents dropped out from cognitive-behavioral therapy[2].

There are different ways to operationalize and measure drop-out[1]. In randomized controlled trials, for example, patients who unilaterally do not finish the prescribed treatment