Community Mental Health Teams for People With Severe Mental Illnesses and Disordered Personality

Darren Malone1,2, S. Marriott3, G. Newton-Howes4, S. Simmonds5, and P. Tyrer6
2Mental Health Services for Older People, Rotorua Hospital, Rotorua, New Zealand; 3Paterson Centre for Mental Health, St Mary’s Hospital, London, UK; 4Hawkes Bay District Health Board, Napier, New Zealand; 5Academic Unit of Psychiatry, St Charles Hospital, London, UK; 6Paterson Centre for Mental Health, London, UK

Background: Closure of asylums and institutions for the mentally ill, coupled with government policies focusing on reducing the number of hospital beds for people with severe mental illness in favor of providing care in a variety of nonhospital settings, underpins the rationale behind care in the community. A major thrust toward community care has been the development of community mental health teams.

Key words: severe mental illness/schizophrenia/community mental health teams/hospital care/systematic review/meta-analysis

Objectives
To evaluate the effects of community mental health team (CMHT) treatment for anyone with serious mental illness compared with standard nonteam management.

Search Strategy
We searched The Cochrane Schizophrenia Group Trials Register (March 2006), manually searched the Journal of Personality Disorders, and contacted colleagues at ISSPD (http://www.isspd.com/) international society for study of personality disorders, and in forensic psychiatry.

Selection Criteria
We included all randomized controlled trials (RCTs) of CMHT management vs nonteam standard care.

Data Collection and Analysis
We extracted data independently. For dichotomous data, we calculated relative risks (RRs) and their 95% confidence intervals (CIs) on an intention-to-treat basis, based on a fixed-effects model. We calculated numbers needed to treat (NNT)/harm where appropriate. For continuous data, we calculated weighted mean differences again based on a fixed-effects model.

Results
CMHT management did not reveal any statistically significant difference in death by suicide/suspicious circumstances (n = 587, 3 RCTs, RR = 0.49, CI = 0.1 to 2.2), although overall fewer deaths occurred in the CMHT group. We found no significant differences in the number of people leaving the studies early (n = 253, 2 RCTs, RR = 1.10, CI = 0.7 to 1.8). Significantly fewer people in the CMHT group were not satisfied with services compared with those receiving standard care (n = 87, RR = 0.37, CI = 0.2 to 0.8, NNT = 4, CI = 3 to 11). Also, hospital admission rates were significantly lower in the CMHT group (n = 587, 3 RCTs, RR = 0.81, CI = 0.7 to 1.0, NNT = 17, CI = 10 to 104) compared with standard care (figure 1). Admittance to accident and emergency services, contact with primary care, and contact with social services did not reveal any statistical difference between comparison groups.

Authors’ Conclusions
Community mental health team management is not inferior to nonteam standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide. The evidence for CMHT-based care is insubstantial considering the massive impact the drive toward community care has on patients, carers, clinicians, and the community at large. Full details are published on the Cochrane Library.

References
**Fig. 1.** Hospital Admission—up to 12 mo.