Crisis resolution and home treatment teams are popular with many users, but have yet to fully establish their place in local service systems

One foot in the door

KEY WORDS

Crisis resolution
Home treatment
National audit
Gatekeeping
Practice development

Rapid and appropriate responses to a crisis at any time, day or night, have long been a priority asked of mental health services by service users and carers. The Department of Health recognised this in the national service framework for mental health,[1] and set targets for mental health services in England to implement 335 crisis resolution and home treatment (CRHT) teams treating 100,000 people by 2005.[2] However, success should not be measured simply by the narrow definition of attaining a target. We need to fully appreciate what these teams are actually doing: is it what was intended, and how do they relate to the wider picture of service provision? To answer these and other searching questions, in 2007 the National Audit Office (NAO) conducted a value for money study into the clinical and economic effectiveness of CRHT teams.[3]

We, with the service user-led ARW Consultancy, conducted a specific part of the fieldwork interviews and reporting for the study.[4] We conducted structured interviews with 25 CRHT team managers and 25 ward managers at 25 sites across England. We investigated the impact these teams were having on assessments for hospital admissions, and how well the teams were understood by other parts of the local mental health services. The fieldwork consisted of detailed investigations of samples of 500 hospital admissions and 500 referrals to the CRHT teams. Key findings from the review are reported here.

What's in a name?

One of the fundamental difficulties these new teams face stems quite simply from what they are called. We found combinations of crisis resolution, crisis response, crisis assessment, rapid resolution, and home treatment, implying a wide range of functions. Are they crisis assessment teams? Do they focus on gatekeeping to reduce hospital bed use? Do they focus on short-term intensive home treatment as an alternative to hospital admission? Do they work closely with inpatient units to facilitate early discharge to home treatment? Do they offer service users and carers greater personal choice, or limit the choice to get through the crisis? The different names imply different expectations of what they can do, and also reflect the different models of operation across the 25 sites we visited. For the purpose of this article we will be adopting the generic term used by the National Audit Office of crisis resolution and home treatment.

Not only are they expected to do so many different things for different people and services, they are also expected to be closely aligned to so many different services. Do they link primarily to inpatient units? Do they base themselves in A&E departments? Do they link closely with community mental health teams (CMHTs), who provide a high proportion of the referrals? What about their relationship to GP referrers, and helping them to use them more appropriately?

CRHT teams are part of a systemic vision for new service development, whereby a range of specialist services link together locally to meet a range of specific needs. However, systemic problems require systemic solutions, and it is arguable that the new picture is a fragmented pattern, replacing the previous picture of one over-stretched and exhausted team responsible for doing everything. From the Department of Health through to local trusts, the detailed systemic thinking required of an organisation to accommodate a flexible set of services appears to be lacking. Different localities set up CRHT teams in different ways, linked to different priorities, largely in response to cost pressures rather than clinical need. Scarcity of resources will always be an issue, but this suggests organisations are looking for short-term measures to make cost savings and to respond to narrowly defined targets.

Impact of targets

The National Audit Office report identified many positive achievements, as well as necessary improvements.[3] In 2006–07 the Department of Health reported 343 teams in place, delivering 95,397 episodes of treatment and support to 75,868 people.[3] Overall, the NAO value for money study concluded that the introduction of CRHT teams had contributed to reduced pressure on beds, reached some people who would have otherwise been admitted to hospital, and supported earlier discharge in up to 40% of the patient sample

AUTHORS

Steve Morgan
Practice Based Evidence
www.practicebasedevidence.com

Kirt Hunte
Team manager
South Camden Crisis Response & Resolution Team

investigated. It also found that the cost of treating a crisis episode is some £600 less in an acute care service that is making full use of its CRHT service than in one in which a CRHT service is not available.

Local commissioners were given a national average figure for size of team (14 per 1000 population). Some appeared to have met the target, a few surpassed it, and many fell woefully short of the resources needed by this definition to deliver an effective service. The NAO concluded that the targets had helped to drive forward the rapid implementation of the national policy. However, at several of the sites we visited this target-orientation was said to have seriously distorted the delivery of the service. In more than 10% of the CRHT referrals examined, teams were taking on people who would not normally have met their criteria, purely to achieve a numerical target, with fears that funding would be withdrawn if they did not. This meant they were providing a lesser service for people with severe mental health needs.

The NAO report recommends that the Department of Health place less emphasis on outputs (ie. CRHT episodes), and instead develops measures of outcomes (ie. benefits to service users) to give a more 'rounded' picture of local acute services. The Department of Health plans to place less emphasis on numbers of teams and episodes and encourage trusts to use more local and outcomes-based measures of performance for 2008–09. We would further argue that these targets should also include who the teams should be working with, how they should be working, and how a CRHT service should function in relation to the rest of the local mental health system. We need to shift attention more to the qualitative details and relationships within and between the services.

Gatekeeping role

The intention of the Department of Health is for CRHT teams to be the 'gatekeepers' to all admissions to mental health services, meaning that they will be the sole point of assessment through which people must pass and where decisions will be made about the appropriate course of treatment. Hospital admission – the traditional model for people who are in crisis – may not be the most appropriate response. Alternatives (such as home treatment) help reduce hospital bed use, support earlier discharge, and reduce the use of out-of-area referrals.

Our investigation indicated that the gatekeeping function was not being applied consistently. Asked whether a member of the CRHT team had been involved in assessing all crisis referrals, CRHT team managers replied yes in only 46% of cases, while ward managers said that the option of home treatment was considered in just 51% of cases. Ward managers reported that, where the CRHT team had been involved, they had some influence on the final decision in 89% of cases. Greater active involvement was found in CRHT teams that operated 24/7 (11 of the 25 teams), and less involvement in assessments that took place at night (ie. during on-call hours for over half of the sample of CRHT teams). The data could be analysed in more specific ways to provide greater detail around these figures.

Table 1 lists a number of areas where information and practice development could be targeted to improve the levels of gatekeeping. Ward managers identified 17% and CRHT team managers 20% of hospital admissions that might have been avoided with better consideration of the alternatives. However, there were inconsistencies across CRHT teams as to what effective gatekeeping should include: some accepted without much question a lesser role in Mental Health Act assessments and ward transfers. Over a third (36%) of the 500 admissions we reviewed were formal, but only 36% of these involved CRHT staff in the assessment, and only 12% of the teams managed their local approved social work rota within the team.

We would argue that involvement doesn't always have to mean an active CRHT team presence in the assessment, but that CRHT staff should be informed so they can express an opinion as to whether their presence may be of benefit or not. The factors most clearly identified in our sample that would increase the level of effective gatekeeping were:

- consultant psychiatrists better signed up to the gatekeeping role of the CRHT team
- access to better alternatives to admission – specifically crisis/respite houses and day care services
- a stronger CRHT team influence on bed management in their locality
- clearer local policies about the roles and functions of the CRHT team.

Table 1: Why CRHT staff were not involved in assessment for admisssion (CRHT team managers)

	Frequency	*Valid %*
Out of area/not our CRHT team	63	25.7
CRHT team by-passed by consultant psychiatrist	45	18.4
MHA/emergency duty team assessments	38	15.5
Transfer between units/wards	20	8.2
CRHT team not developed/contactable	18	7.3
CRHT team by-passed by doctors in A&E	10	4.1
Drug issues (inc detox)	16	6.5
Assertive outreach service user	6	2.4
CRHT team performed bed management role only	6	2.4
CRHT team by-passed by CMHT to consultant psychiatrist	3	1.2
Planned admission not involving CRHT team	2	0.8
Other	18	7.3
TOTAL	**245**	**100.0**

Home treatment

Part of the CRHT team's essential gatekeeping function is to assess whether home treatment is a viable alternative to hospital admission. Our research indicated that home treatment was being provided as an alternative, but that capacity was compromised to varying degrees by other, locally determined priorities, or simply by teams' inability to meet all demands placed on them. →

The majority (82%) of our sample of ward and CRHT team managers strongly agreed that all admissions should be assessed for the potential for home treatment. CRHT team managers claimed that 23% of hospital admissions could be in home treatment if the capacity and intention was there, and that 74% of those currently in home treatment would most likely have been admitted to hospital if the CRHT option had not been in place.

When asked to state the benefits of home treatment for people in crisis, the most common responses from a sub-sample of 50 ward and CRHT team managers were:

- increased patient choice (n=17)
- keeps patients in a familiar environment (n=14)
- decreased stigma experienced by the patient (n=12)
- enabling the patient to stay connected to their social networks (n=11)
- more appropriate admissions resulting, with beds taken by those who really need them (n=7).

When asked about the negative effects, the same sample suggested:

- there may be increased pressures on carers when patients are treated at home (n=12)
- decreased expertise and/or loss of jobs on inpatient units (n=5)
- capacity to treat at home may not meet demand, creating disappointment, particularly where there are local pressures on the CRHT team to perform (potentially inappropriate) crisis assessments (n=5)
- some patients (and carers) will prefer an admission (n=5)
- inconsistent responses can develop, especially where communication is poor (n=4).

Service users and carers offered very similar views in focus groups and in an analysis of local surveys of client feedback conducted by the NAO for the review (see table 2).

Table 2: Users' and carers' view of CRHT[3]

Benefits
The option of an alternative to hospital admission
The opportunity to remain in a familiar environment and retain links with everyday activities
The comfort of knowing help is available 24 hours a day if needed
The provision of practical help with, for example, taking medication, arranging transport to and from appointments, and everyday tasks such as shopping
Areas of concern
Demands on staff and resources mean that service users are not always seen as frequently, promptly or for as long as they would like
Communication problems between inpatient and CRHT teams on discharge has sometimes meant interruptions in care
Users experienced anxiety or distress if their telephone call could not be answered immediately or if a home visit was postponed or cancelled
Shift changes mean that service users can be seen by several different team members in succession, making it difficult to build trust and a therapeutic relationship

However, only four of the 25 sites offered other, community-based alternatives to hospital admission such as respite/crisis houses and acute day units, making treatment in the patient's own home the only alternative for the vast majority of people. Several CRHT team managers said that access to alternatives to hospital admission could increase their capacity to deliver CRHT: four wanted more short-term respite and crisis accommodation, and three identified a need for acute day hospitals. Interviewees said that, for some service users and carers, a period of time out of the home environment but not in hospital would contain the crisis, but that there were no facilities locally to provide this interim option. Some CRHT teams were using Salvation Army hostels, night shelters and bed and breakfast accommodation.

Early discharge

Our sample of ward managers estimated that the CRHT team was quite likely or very likely to be involved in 53% of discharge decisions, and of these 43% were quite likely or very likely to happen sooner than if the team had not been involved. CRHT staff had been involved in 43% of the decisions about the 189 hospital admissions in our sample that had already been discharged at the time of interview, and of these 85% were thought to have been discharged early as a result of their involvement. While these are positive results, there were also significant discrepancies in the information provided: ward managers and CRHT team managers gave conflicting information about whether the person had been discharged or not in 12% of the 500 admissions we reviewed. This suggests a need for improved data collection and communication between acute inpatient and CRHT services.

The CRHT teams that were more successful at gatekeeping admissions were also generally found to be those who were more involved in promoting early discharges. This suggests that, where there is a culture of considering the option of home treatment at the point of admission, consideration of early discharge into home treatment remains throughout the duration of the admission. This is an important point for consideration when teams are reviewing practice development.

Potential for burden

A policy of providing treatment and support to the person in a familiar place (ie. their home) can also result in greater expectations of service users and, in particular, carers to actively manage the crisis, at a time when they might prefer respite.

> 'If the problem lies within your house, things in the home or something happened in your home, you want to get away from it – just go away from it a few days to give you breathing space.' (Service user)

However, many local evaluations of CRHT teams identify increased satisfaction among service users and carers that there is an alternative to hospital admission. The National Audit Office study received 29 replies describing local initiatives for establishing service user and carer feedback, and one of the report's recommendations is that the Department of Health should lead on promoting more systematic feedback in all services.

Our interviews identified that some people newer to services appreciated the alternative option to hospital, and some with longer experience of mental health service use were initially sceptical but were won over by the experience of home treatment. Decisions to admit were at least partially influenced by service users, carers or both in 259 out of the 500 hospital admissions we reviewed. For service users, this was more often agreeing to, rather than influencing, the decision. Carers had more influence on the decision to admit, largely because they were not able to cope at home even with support, or the levels of risk were considered too great. Of the 320 cases where a preference was expressed, 81% of decisions appeared to be in line with service user and carer preference. Of those that clearly went against service user preferences, 69% were Mental Health Act assessments.

However we cannot ignore the many cases where the pressures the service places on users and carers are not adequately backed by support from the CRHT team. Crisis and respite facilities are poorly developed. We can dress up home treatment as being more beneficial by helping a person to stay in familiar surroundings, but are we clear just how dependent we are on the informal carers? Are we increasing the burden on people who are generally not listened to, are poorly supported, and need a break from the caring role themselves?

Practice development

Training alone does not guarantee that good ideas become embedded in routine practice. Facilitated practice development needs resourcing, so that teams can reflect on their purposes and functions, and how these are articulated in service provision. Little or no attention has been paid to systemic practice development, with the result often being confusion and frustration between different parts of the service and individuals.[5] The 25 CRHT team managers were asked what hindered local service integration. Their responses are listed in table 3.

Conflicting messages emerged from the analysis of the 500 referrals to CRHT teams: 84% were considered appropriate by the teams, yet 34% were either redirected to non-acute services or had no need of any service. Either CRHT teams are perhaps not as efficient in identifying who they should be working with at the point of referral, or they are fulfilling a signposting function that the referrers should be doing themselves.

CRHT teams have a distinct community focus, but they are primarily acute care teams, and their introduction has significant impacts on inpatient units. Our interviews identified the potential for increased levels of risk and illness on wards, and a drain of many experienced staff to community teams. Successful CRHT teams need to be part of stronger acute care pathways. This can be achieved in a number of different ways, not just by merging them into unitary acute care teams. There is an urgent need to prioritise efforts to strengthen these relationships and identify the evidence for which combinations work most effectively.

The National Audit Office value for money assessment concluded: 'The evidence base suggests that when used appropriately and safely, CRHT brings clinical benefits and increased patient satisfaction. It can also reduce the stigma and social exclusion frequently faced by people suffering from acute mental illness [...] many service users across England are seeing its benefits. But there is further scope to maximise its impact and improve value-for-money by ensuring CRHT teams are properly resourced, fully functional and integrated within local mental health services.'

However, the study also reported wide regional variations in team provision relative to local need; that many teams lack dedicated input from key health and social care professionals – particularly consultant psychiatrists and approved social workers; that CRHT teams are currently involved in the assessment of only about half of hospital admissions, and that other parts of the mental health system need better awareness of how CRHT and the inpatient components of an effective acute care service function. Moreover, there is a pressing need to introduce a systemic approach to training and practice development both within CRHT teams and across local systems. ■

Table 3: Barriers to local service integration (CRHT team managers)

- Poor understanding and expectations of what the CRHT team is set up to do among many primary care and other secondary care teams (n=5)
- Different geographical sectors within the same trust working to different systems and protocols (n=3)
- Different expectations of what level and form a crisis response should take, particularly where GPs have different expectations or information about accessing CRHT services (n=3)
- CMHT staff inappropriately trying to use CRHT resources to cover their own annual leave or other workload pressures (n=3)
- Conflicts among mental health professionals over the definitions of a crisis (n=3)
- CMHT staff passing on straightforward needs for medication reviews to the CRHT team on the assumption that the CRHT team has quicker access to medical staff (n=3)
- Consultant psychiatrists not using early discharge into home treatment properly, preferring to continue to use extended ward leave (n=3)
- A&E staff seeing CRHT as just being an out-of-hours liaison team, when in fact CRHT should be working to a more tightly defined client group if their resources are to be used most efficiently (n=3)
- Assertive outreach team staff not being clear what they expect from CRHT input, and informing CRHT staff too late about their need for additional support (n=3)
- Assertive outreach team consultant psychiatrists retaining a historic ownership of specific beds, and using these to by-pass the CRHT team gatekeeping function (n=3)

1 Department of Health. Mental health national service framework: modern standards and service models. London, Department of Health, 1999.

2 Department of Health. Improvement, expansion and reform: the next three years. Priorities and planning framework 2003–2006. London: Department of Health, 2002.

3 National Audit Office. Helping people through mental health crisis: the role of crisis resolution and home treatment services. London: National Audit Office, 2007. www.nao.org.uk

4 National Audit Office. Are crisis resolution and home treatment services seeing the patients they are supposed to see? London: National Audit Office, 2007. www.nao.org.uk

5 Morgan S. Crisis response and resolution team and community mental health teams: developing team relationships. A report of practice development in South Camden. Unpublished report, 2003.