

Transforming Mental Health Care

Assertive outreach and crisis resolution in practice

Anne Chisholm and Richard Ford

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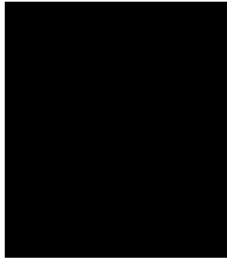
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List of abbreviations/acronyms

AO	assertive outreach
AOT	assertive outreach team
ASW	approved social worker
CBT	cognitive behavioural therapy
CMHT	community mental health team
CPA	care programme approach
CPN	community psychiatric nurse
CR	crisis resolution
CRT	crisis resolution team
HONOS	Health of the Nation Outcome Scale
MH-PIG	Mental Health Policy Implementation Guide
NSF	National Service Framework
NSF-MH	National Service Framework for Mental Health
PCT	primary care trust
SCMO	senior clinical medical officer
SHO	senior house officer
SMI	severe mental illness



Executive summary

Introduction

The *National Service Framework for Mental Health* (NSF-MH) (Department of Health, 1999) set out an ambitious agenda for mental health services in England. Two of its major components were the creation of assertive outreach teams (AOTs) for 'difficult to engage' people living in the community, and of crisis resolution teams (CRTs) to work as an alternative to hospital admission for individuals experiencing acute crises in their mental health.

This report pulls together some of the lessons learnt from a number of sites across the country in setting up these new teams. It illustrates both the benefits and the difficulties of establishing assertive outreach (AO) and crisis resolution (CR) teams, comparing the requirements of the Government's *Mental Health Policy Implementation Guide* (MH-PIG – Department of Health, 2001) with the reality of what is happening on the ground. It illustrates the importance of AO and CR as components of a wider system of mental health services in a locality, leading not just to the creation of discrete new services but to transformational change across the whole system.

The main findings of the report are listed below, and in greater detail in the final chapter of this report.

Setting up the new teams

When setting up a new AO or CR team, it is vital to obtain the views of users and their carers so that the creation of the new service is informed by their views from the very beginning. In general, users and carers value services that bring about good relationships with staff and give practical support, choices about care and new opportunities.

Eligibility criteria for AO services need to be clear, both to team staff and to those who refer users to them, and should reflect local circumstances. Rural AO teams, for example, may have quite different criteria from those of urban teams.

The number of people requiring support can be estimated from the known number of service users who either currently use existing crisis services or meet the eligibility criteria for AO. These figures will need to be reviewed regularly.

Teams may not be able to comply with the MH-PIG from the outset. It may take time to build up sufficient resources and to change working cultures.

AOTs and CRTs need a broad mix of staff in order to work effectively. Both types of team value support workers highly, and both require medical and psychological input. In many cases, the majority of team members are nurses.

Delivering the new services

Team working is essential for AOTs; it is valued by users and minimises risks to staff. However, it is not always possible or desirable for every team member to work with every user.

Most AO clients are referred by other mental health services, not directly by general practitioners (GPs). AOTs need to have a screening system in place to avoid inappropriate referrals and they should be careful not to take on too many people, given the intensity of work required with each client.

Screening is less important for CRTs, which may be able to divert clients from hospital admissions to other sources of support (such as crisis houses) if they cannot help them directly. Caseloads should be managed carefully.

Assessment and engagement can take several months in AO. It should take a bio-psychosocial approach to treatment and involve users throughout the process, engaging initially on terms with which the user is most comfortable. CR teams need to assess their users much more quickly. Both types of team should make risk assessment a priority at this stage.

CRTs normally work with clients for three to four weeks. During that time, care plans should be under constant review. Discharge plans should begin from the start. Care should be transferred to community mental health teams only when clients require no more than two visits a week.

AOTs offer a wide range of interventions, from helping clients to manage medication to practical support with everyday tasks, physical health care and help with education and employment. Some teams have the skills base to offer more specialist treatments, such as cognitive behavioural therapy (CBT). CRTs begin by offering help with basics such as food, money and dealing with distress. They later provide broader psychological and social support of a degree greater than is usually possible in hospital.

Achieving change

It should be recognised that the costs of the new teams must be covered in full. Half-funding will not achieve half the result. Where new services entail reductions in service elsewhere, bridging finance is needed to avoid initial problems.

Recruitment processes for the new teams should be robust and transparent. Attaining the right skill mix can be difficult and may require flexibility in team members. It may be difficult to recruit a social worker, for example, if other staff are not prepared to work in a multi-disciplinary way. Once staff are recruited, they should be trained together to ensure that each member understands the aims and philosophy of the team.

Setting up AO and CR teams means changing not merely structures and processes but cultures and attitudes within mental health services. Such a paradigm shift takes time and resources – it cannot be achieved overnight. It relies on an acceptance of the need for change, good project management and a shared understanding of how services will be improved.

Team leadership is essential, yet its value is often not recognised. Effective project management requires each member of the team to have clearly defined roles and responsibilities, and authority to make decisions must be clearly located. Senior staff support is important to overcome resistance to new ways of working. The 'human' impact of such change, both on staff and users, must be understood.

The real benefits of AO and CR come when they engender change across the whole system of mental health services, creating investment in better services throughout.

1

Introduction

The *National Service Framework for Mental Health* (NSF-MH) (Department of Health, 1999) set an ambitious national agenda to develop mental health services that are available 24 hours a day, seven days a week, and based on sound evidence of best practice. The services aim to improve outcomes, enabling a better quality of life for service users, their families and the whole community. The needs of families, other carers and service users must be placed at the centre of planning and practice. The mental health NSF was the first in a continuing series of framework documents covering major NHS priority service areas. It defines standards in five areas:

- mental health promotion;
- primary care and access to services;
- care of people with severe mental illness;
- carers of people with mental health problems;
- reducing suicides.

For people with severe mental illness the standards aim to ensure that:

- each person with severe mental illness receives the range of mental health services they need;
- crises are anticipated or prevented where possible and prompt and effective help is provided if a crisis does occur;
- there is timely access to an appropriate and safe mental health place or hospital bed, including a secure bed as close to home as possible.

Publication of the NSF was followed by the *NHS Plan* (Department of Health, 2000) which made mental health one of three clinical priorities, alongside cancer and coronary heart disease. The NHS Plan outlined specific service models and investment to achieve the NSF standards. Two of the major initiatives were to develop universal coverage of the whole country by 220 assertive outreach teams (AOTs) and 335 crisis resolution teams (CRTs). There is also a detailed *Mental Health Policy Implementation Guide* (MH-PIG – Department of Health, 2001), which sets out the structure for both types of team.

This report sets out the findings of a two-year study, funded by the West Midlands Partnership for Mental Health, the Department of Health and the Sainsbury Centre for Mental Health (SCMH), on the implementation of these two service models for people with severe and enduring mental health problems. In looking at these two models the report also comments on the wider system within which the services operate. The lessons learnt should prove helpful for the further development of these services and will be equally applicable to other future service developments. The report builds on the advice already given in the MH-PIG. It does not set out to challenge the AOT and CRT models but rather to learn the lessons of how they can be best tailored to local needs while retaining the core elements.

Methods

The study looked at numerous sites across the country. Some, such as North Birmingham, pioneered the use of AOTs and CRTs. Others had introduced them more recently. The teams chosen for the study reflect the diversity of sites in which new teams have to work.

The sites we visited were in:

- Barnsley
- Bradford
- Cornwall
- Herefordshire
- Nottingham
- Newcastle
- Norfolk/Norwich
- North Birmingham
- Tees and North East Yorkshire
- Walsall.

(A list of the sites and contacts is given in the Appendix.)

We interviewed team leaders and staff from the new teams as well as managers responsible for operational management and for overall implementation of the NSF. We also worked with service users in Walsall and Herefordshire, seeking their views on their involvement in the consultation on, and planning of, new services and on their requirements for what a crisis resolution service should offer.

NB. Direct quotes in this report have been edited where essential for clarity and conciseness.

2

Setting up assertive outreach services

In the following chapters we concentrate on key factors to be considered when setting up firstly AOTs and then CRTs. For both types of team we investigate experience in:

- the service model;
- what users and carers want;
- eligibility;
- identifying need;
- locally appropriate model;
- staffing and skill mix.

The service model

Assertive outreach originated in the United States, as assertive community treatment, in the late 1970s as a response to de-institutionalisation and the need to bring together the range of services required to support people with severe mental illness in the community (Drake, 1998).

In setting out the structure for AOTs, the Department of Health's MH-PIG follows the principles of assertive community treatment. It describes AO as a service for people with severe mental health problems and complex needs who have difficulty engaging with services and often require repeat admissions to hospital.

The service should be provided by a multi-disciplinary team, with a range of skills which enables them to provide the full range of interventions needed by their clients. The ratio of staff to clients should be sufficient to allow intensive working with individuals. The emphasis is on maintaining contact with service users and on building relationships. Treatment is provided on a long-term basis and the majority of services are delivered in the community.

The service is intended to:

- improve engagement;
- reduce hospital admissions;
- reduce length of stay when hospitalisation is required;
- increase stability in the lives of service users and their carers/family;
- improve social functioning;
- be cost-effective.

What do service users and carers want from services?

One of the first things that service developers need to understand is why service users are not engaging with services. In North Birmingham, for example, one of the main reasons was the style of service offered. This is a theme that emerges in most service user evaluations and is not just an issue for potential AO clients.

North Birmingham

The Health Authority, in collaboration with King's College Centre for Mental Health Service Development and the Northern Birmingham Mental Health Trust, held an extensive series of stakeholder conferences throughout 1994 – involving 500 people including general practitioners (GPs), service users, representatives of voluntary organisations and the private sector, and Trust staff. The main points that emerged were as follows:

- Most people said they could not get help when they needed it.
- The main reason for people disengaging from the service was the style of service being offered.
- Carers, particularly those with severely mentally ill relatives, wanted improved and increased assertive follow-up.
- Service users complained about a lack of things to do, poor housing and a lack of money; many people on the inpatient ward found it boring or traumatising.

(The Sainsbury Centre for Mental Health/Northern Birmingham Mental Health Trust, 1998)

Consultation will give valuable insights into how service users view existing services, although at times this may be uncomfortable for staff:

Herefordshire

“The task group on assertive outreach started with a big meeting which included representation from users, carers and teams. Two new user representatives came along to the assertive outreach meeting – one of them took over the meeting and told his story (and how that might have been affected by having an assertive outreach service). It was actually a good learning experience. However, some workers found this difficult to listen to.

“You can get very strong and passionate views, and meetings can be difficult. You have to be very careful about the terminology used, for example reference to compliance can be distressing to service users.

“For crisis services, we have handled things differently. We want to work with users and carers in a meaningful way to allow them to be listened to and allow them to say what they want to say. This can be difficult when professionals are present. Users need to be able to set their own agenda.”

(Service Development Manager)

Consultation should be about finding out what people want from services – but in practice it can end up being a one-way communication exercise if decisions have already been made, or if options for service development are limited, for example by inadequate resources.

At one site, the consultation was more about reassuring staff, service users and their carers that service changes would be beneficial than about seeking their views on the changes. Meetings were arranged with stakeholders including representatives of service users and their carers and the clients, community mental health teams (CMHTs), housing, and the voluntary sector. Decisions had already been taken about alterations to the service and, despite assurances to carers and clients that service delivery wouldn't change, this was not necessarily true for all of them, and they were not in a position to influence how things were done.

It was felt by some in this case that the facts should have been gathered, people's anxieties discussed and a clear vision determined before coming up with a plan.

In Herefordshire, a lack of resources meant that although consultation was taking place, it could not always be acted on. We talked to service users in Herefordshire about their involvement in developing plans for services. They suggested a number of reasons why consultation did not appear to be producing any results, including:

- failure to tackle priorities e.g. enhanced care programme approach (CPA);
- the lack of resources: “not in their plan, so they can’t resource it”; “low resources can lead to low morale”;
- lack of consultation: “things not happening because they haven’t consulted us – strategy already written”; “not understanding needs”;
- low staff morale: “9 to 5 attitude, low morale, under more stress, staff shortage plus sickness”;
- reluctance to change: “would have to stop doing some things”; “things would have to be done in a different way”; “service to meet our needs e.g. out of hours rather than us having to fit in with their service”;
- “and not fit in their service out of hours”.

User involvement in the consultation process, in addition to its importance in informing plans, can be valuable to the users themselves:

- “We can empower ourselves – and thus improve our mental health.”
- “We are independent, not paid, and so we are free to speak.”
- “We can learn about how mental health services work.”
- “We get more respect from professionals and other patients.”

But service users need to be supported. Interviewees stated that being a representative of other users could be a burdensome and exhausting job which could make them unpopular with others and, in these circumstances, their own health could be damaged.

Suggestions as to how this support could be provided included training in how to work on committees, more information about how services operate, and preliminary meetings with managers to help them prepare for the consultation process.

LEARNING POINTS

- Service users’ and carers’ views on problems with existing services and what changes they would like to see can be a powerful tool in challenging the way things currently work.
- The features of the new service models that service users appreciate are the positive relationships with staff, practical help and support, choices about their care, empowerment, and opportunities to move on.
- Consultation with service users and carers should take place at an early stage and the outcome should inform decisions about service developments, rather than the consultation simply being an occasion to tell the service users and carers about proposals.
- Other important stakeholders, such as staff and GPs, should also be consulted properly and informed of developments. This is time-consuming but necessary.

Eligibility criteria – who is the service for?

Although the criteria should reflect the local situation, the starting point should be the criteria set by the MH-PIG. These are based on evidence of effectiveness and cost-effectiveness.

The MH-PIG states that AO should be targeted at adults between the ages of 18 and approximately 65 who have one or more of the following:

- a severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability;
 - a history of high inpatient or intensive home-based care (e.g. more than two admissions or more than six months' inpatient care in the past two years);
 - difficulty in maintaining lasting and consenting contact with services;
 - multiple and complex problems including one or more of the following:
 - history of violence or persistent offending;
 - significant risk of personal self-harm or neglect;
 - poor response to previous treatment;
 - dual diagnosis of substance misuse and serious mental illness;
 - detention under the Mental Health Act (1983) on at least one occasion in the past two years;
 - unstable accommodation or homelessness.

Most of the teams that we visited had attempted to adhere to these criteria, although in some cases they had modified them. From a sample of ten AOTs, most specified severe mental illness and difficulty with engagement as inclusion criteria, whereas only half specified high use of inpatient beds (see Figure 1). There was some evidence that eligibility criteria are adjusted according to the level of local need. For example, in an area of relatively low need there might be a lower threshold for acceptance into the service than in an area of high need. This runs the risk of providing people with an intensive service from which they do not derive great benefit.

TEENEY (Tees and North East Yorkshire) AOT

“We don't really have the criterion of a person having to be difficult to engage because that would mean we would have a lot less on our caseload – so we tended to concentrate more on heavy service use ...”

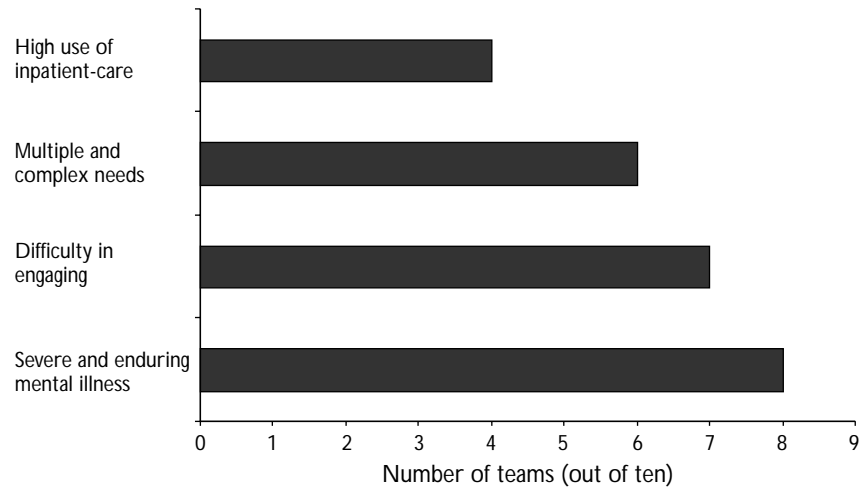
(Clinical Specialist)

Common exclusion criteria are:

- sole diagnosis of substance misuse;
- sole diagnosis of personality disorder.

Other teams do not exclude specific groups but deal with referrals on a case-by-case basis. Hemming *et al.* (2002) state that services should not be offered or declined on the basis of diagnostic category alone. For example, an individual with a personality disorder, with chaotic engagement and use of services, together with many complex social care problems, may well respond to the intensive support that AO can provide. The Norwich Intensive Support Team reports some success with people with borderline personality disorder, who make up around ten per cent of the caseload.

Figure 1: Adherence to Department of Health guidance on AO eligibility criteria – number of teams (out of the ten in our survey group) applying specific criteria



It is important that teams and those who refer to the team are clear about the eligibility criteria. A common cause of confusion appears to be the reference to clients as ‘difficult to engage’ or just ‘difficult’. For example, some of the teams we visited reported that their colleagues in CMHTs had been frustrated when clients had been rejected by AO services because they were not ‘difficult to engage’ and yet the CMHTs had found that they required intensive input.

There does appear to be some ambiguity about the term ‘difficult to engage’. The operational policy of the Cornwall AO service provides a helpful interpretation:

Cornwall

The AO service in Cornwall defines its clients as those who have difficulty in engaging meaningfully with existing mental health services. This could be characterised by:

- individuals feeling discriminated against and stigmatised by existing services;
- active refusal to engage;
- consistent problems with maintaining contact with existing services;
- existing services may have been unable to identify and engage an individual.

(Cornwall AO Operational Policy)

One particular criterion that appears to be applied by a number of teams is that they will only accept people who are already being seen by existing services. There is some logic behind this in that the AOT will be looking for evidence that engagement has been tried. However, this approach does potentially exclude people:

Nottingham

“All clients we have at the moment have been referred from other services known to mental health, so that’s CMHTs mainly, and forensic services. There have been a few who have moved out of another area into Nottingham and felt that they ought to come directly into AO. We are still trying to establish meaningful partnerships with homelessness services and voluntary agencies that may well have people within their services who need the AO service but who aren’t known to us as yet.”

(Team Manager)

In some parts of the country there are particular local needs that warrant the establishment of AOTs that work exclusively with specific communities. For example, there are several such teams in London, including the Antenna team in Haringey:

The Antenna service

The Antenna service in Haringey, London, aims to work with African and African Caribbean people aged 16-25. It has a clear early-intervention focus and has developed partnerships in education, training and employment. An important element of the service is improving partnerships between the black communities and local statutory health and social care agencies.

(Greatley & Ford, 2002)

Other AOTs with a specialist focus include those working with people with both a severe mental illness and a substance misuse problem.

LEARNING POINTS

- The eligibility criteria set out in the MH-PIG are based on evidence of effectiveness and cost-effectiveness and should form the basis for the new teams.
- Local needs assessment should be used to determine any variations in eligibility criteria. Specialist AOTs meeting the needs of specific communities, such as young black people, may be a useful part of the overall service in some areas.
- Taking on more people who do not meet the criteria for AO, or making the criteria more flexible, may not be helpful. It may be preferable for the team to cover a broader geographical area, or to reduce its capacity.
- It is very important that teams and those who refer to the team are clear about the eligibility criteria. It seems that there is often confusion about clients who are described as 'difficult to engage' or just 'difficult'.
- A number of teams are potentially excluding people who might benefit from AO by only accepting people who are already known to services – i.e. they are operating as a tertiary service. This may not be problematic if secondary services are accessible.

Identifying need

It is important to estimate the size of the client base in order to ensure that the new services have sufficient capacity to meet local needs, and to make well-informed decisions about the size, number and locations of the new teams. For AOTs the client base will be a fairly well-defined existing group, whereas for CRTs (discussed below) demand will fluctuate and the size of the service may be related to existing bed use and tied up with plans for changes to inpatient services. *Keys to Engagement* (The Sainsbury Centre for Mental Health, 1998a) estimated that the number of people requiring AO in any one area might vary from 14 to 200 per 100,000 in the adult population. The MH-PIG suggests an average caseload of 90 for a total population of 250,000.

The logical starting point for estimating numbers is to identify existing service users who meet criteria for AO. This can be done either by asking keyworkers across the service to review their clients against the criteria and identify those who meet them, or as part of a wider 'stocktake' of needs across the services.

Table 1: Identification of clients meeting criteria for AO

Site	Methodology	Results (number per 100,000 adult population)
North Birmingham – Yardley Hodge Hill locality (1995)	All medical and clinical staff and social workers were asked to complete a questionnaire designed to identify all clients with severe and enduring mental health problems who had contact with services at that time and might benefit from an AO service.	50
Walsall	Information was obtained similarly from team caseloads. Staff were given criteria for AO and asked to identify those people on their caseloads who met the criteria and who they considered might benefit from the service.	45
Herefordshire	The CMHTs were asked to put people forward on the basis of criteria drawn from <i>Keys to Engagement</i> and Department of Health guidance. The initial list was reviewed through an examination of case notes and assessment against AO criteria.	16
Cornwall	Asked the CMHTs to identify potential AO clients and also consulted with voluntary organisations for homeless people.	50
Norfolk	Issued questionnaires to CMHTs, social work teams and other community services, using a scoring system to identify those who would definitely and those who would probably meet the criteria for AO.	56
Nottingham	Used the original Birmingham criteria.	65

Our study sites have all adopted a similar approach to identifying the likely level of need for AO locally by using a stocktake of clients likely to meet AOT criteria. The results are shown in Table 1 above.

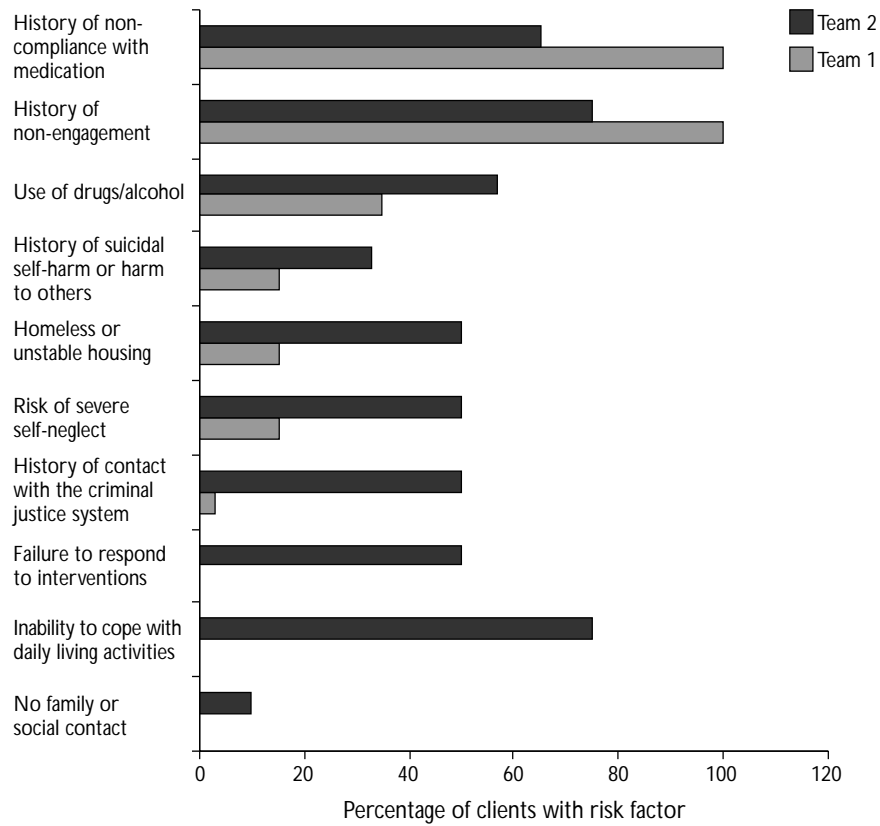
The results from such exercises provide a rough estimate of the likely numbers. In practice, not all of the people identified have subsequently been referred for AO, while other people, not included on the original lists, have been referred successfully.

The overall figures obtained in some of these areas mask the fact that there are quite wide variations between one locality and another, which do not necessarily match expectations in terms of objective measures of need, such as deprivation indices. For example, in Walsall the CMHT in one relatively deprived locality did not consider that any clients would need AO.

A number of reasons have been offered for such apparent discrepancies:

- Those people who need AO are not currently engaged in services at all, and therefore are not identifiable from existing caseloads.
- Many workers are unclear about what AO is intended to achieve. For example, data from two teams in Herefordshire shows wide differences in the types of client being put forward, in terms of complexity of need as measured by the number of risk factors present (see Figure 2 on p. 10).
- Even where apparently objective scoring systems are used, as in Norfolk, they are open to interpretation and it may be that CMHT workers either want to over-estimate the scores to demonstrate they are working with difficult people, or conversely do not put people forward because they want to demonstrate that they can cope with difficult clients.
- Workers may have failed to complete the forms because of lack of time or because they do not see the task as a priority.

Figure 2: Risk factors present among clients in Herefordshire identified for AO



It is perhaps understandable that the task can seem a bit academic when there is not yet a team in place to take on the people identified, and this may well explain why the people eventually taken are not the same as those initially identified.

The following example illustrates the conflicting factors that may influence which people are put forward for AO. Decisions are not always based on objective criteria. It can also be difficult to differentiate between clients who are 'difficult' and those who are 'difficult to engage'.

Norfolk

“My belief is that people know the people who are AO clients within your team because they are on the phone all the time or someone else is on the phone about them all the time. They are fairly easy to identify but you need to have someone with the confidence to do that. At the moment we are asking workers, some of whom have never been exposed to what an AO service looks like, to identify people just by these criteria, and some of them are just saying things like ‘this person has a housing need’.

“But certainly we felt that the criteria in the national implementation guidance were better than the longer list we had before, because the national implementation guide gives you a sub-set that the evidence has suggested are those that actually get a positive advantage over standard CPA if you actually work in this way with them.”

(Mental Health Partnership Manager)

It is helpful if staff from future referring teams are involved in the initial discussions about the objectives of the service and eligibility criteria. Even where eligibility criteria are understood, it may prove difficult for a variety of reasons to ensure their consistent application. It is therefore important to review the results objectively. The project manager/team leader could use this opportunity to visit all teams to inform them of the AO service and provide guidance on how to assess clients for eligibility. It may be helpful to do this with a questionnaire or assessment form which could include guidance on what is meant by particular terms such as non-engagement.

The information obtained from teams should then be analysed by the project manager, or others with knowledge of AO, in the same way as new referrals would be assessed. At this stage the process of refining the criteria to meet specific local needs could begin.

It will also be important to gather as much information as possible about people potentially in need of AO who are not known to the statutory services; although it is interesting to note that a number of the teams that we visited are working only with people referred from existing services.

LEARNING POINT

- For AO, an estimate of approximate numbers can be made on the basis of numbers of known service users who are likely to meet eligibility criteria. However, this should not be seen as a one-off exercise, since assessment and access issues need to be reviewed on an ongoing basis.

Determining the appropriate service model to meet local needs and objectives

The MH-PIG sets out the recommended service models for AOTs. However, local circumstances may require some variation of the standard model. Given that the recommended models are based on current research evidence of what works, it is important that any modifications are based clearly on local needs and retain as many of the core characteristics as possible. Some areas are having to compromise on issues such as team size or skill mix, because of a lack of resources or difficulties with recruitment.

The MH-PIG advises that AO services are best provided by a discrete, specialist team that has:

- staff members whose sole or main responsibility is assertive outreach;
- adequate skill mix within the team to provide all the interventions set out in the guidance;
- strong links with other mental health services and good general knowledge of local resources.

The guidance also specifies key criteria, based on research evidence, for effective team operation:

- ratio of service user to care co-ordinator of no more than 12:1;
- shared caseload and care co-ordination provided by the AO team;
- a single responsible medical officer who is an active member of the team;
- self-contained team responsible for providing the complete range of interventions;
- majority of services delivered in the community;
- emphasis on maintaining contact with service users and on building relationships;
- treatment provided on a long-term basis with an emphasis on continuity of care.

Most teams are being set up along these lines, although in practice there are different configurations.

Nottingham

“All of the localities include a bit of inner city, and a bit of rural. One team goes from the inner-city area all the way through to the border of Derbyshire. There are fewer people needing AO in the rural area. Most are concentrated in the city areas because obviously that’s where housing is – that’s where people migrate to. So people could potentially be doing a round trip of 30 miles if we went to the furthest point, but that is not happening all the time.”

(AOT Manager)

Bradford

“There was some debate about whether there would be one team or two, because Bradford and Airedale is a big patch with a total population of about 500,000. The decision was taken to have two teams because Airedale is a very rural area and it was felt impractical to have one team to cover the whole area.”

(Mental Health Planning Manager)

Some of the teams we visited are still building up their caseloads so have not reached their maximum caseload size. However, some are already starting to question the 12:1 ratio, considering that it may be too high in some areas where people have very complex needs. Table 2 sets out some options to be considered when deciding on an appropriate AO model.

Table 2: Options for assertive outreach

Number of potential clients	AOT requirements
>90	More than one specialist team.
50-90	One specialist team.
<50	Specialist team combining AO function with other functions, or including specialist workers as part of a CMHT.

The optimal size of team will depend on complexity of needs and subsequent implications for workload.

Location of the clients will also be important. For example, where teams have very small numbers of clients (fewer than 30), if the clients are spread evenly across CMHT localities, a CMHT-based approach may be appropriate. If they are concentrated in one locality, then some kind of specialist team may be preferable.

As noted above, there is little evidence available as to the effectiveness of alternative models of AO provision. This does not mean that alternatives should not be tried. The key factor in assessing feasibility should be adherence to the key principles of AO. Lachance and Santos (1995) consider the implications of modifying the critical elements of the Program for Assertive Community Treatment (PACT) model in rural areas – in this case South Carolina (see Table 3).

Table 3: Modifying the PACT model for rural areas

Critical element	Modifications
Multi-disciplinary team – able to perform a number of functions to minimise the need for referral to outside agencies and to reduce fragmentation of service delivery.	Programme initially staffed by two registered nurses who had additional experience in social work, rehabilitation, etc. These staff members were willing to work as generalists – focusing on the multi-service concept – so can function as if they were multi-disciplinary.
Shifts all day, 7 days a week (not an NSF-MH requirement) – staff to be available to provide out-of-hours emergency services, etc.	In rural area where 24-hour availability is impossible because of travel time in rural areas, staff safety issues and the limited availability of telephone services, PACT staff train family members and neighbours to effectively manage problem situations that occur after hours.
Manageable caseloads that do not vary in composition – staff ratio of 10-12 clients per clinician.	Rural programme maintains ratios within the range of 1:12 to 1:20, depending on staffing patterns at any given time. Staff report that they are unable to provide individually tailored skill teaching and high level of responsiveness when caseloads are in the high range.
Services ongoing and unlimited in duration.	These are retained in a rural team.
AO (range of interventions).	Interventions can be planned with consideration given to availability of personnel, travel time and staff safety.
In vivo treatment and rehabilitation – providing direct services in the clients’ natural settings.	In remote rural areas many clients live with extended families (not the case in UK), employment opportunities are limited and public transport is inadequate or even non-existent, posing a significant barrier. Nevertheless, the team can still help to support clients to meet individualised goals.

Choice of service model is not always based on needs and if it is influenced by the inadequacy of resources, this can result in an inappropriate model being selected.

Developing the service approach and philosophy

The approach to service delivery in AO and CR represents a move away from a traditional, often medically dominated, model towards a bio-psychosocial model of care which takes account of the wider needs of service users and acknowledges the possibility of recovery. Both services also require intensive contact with service users.

The teams we visited stressed this difference in approach as a key feature of AO.

Tees and North-East Yorkshire (TEENEY) AOT

“In one way I think we are more assertive in advocating for the client group rather than trying to grab them by the scruff of the neck and drag them into services. I think creativity and flexibility are the important features that we have tried to incorporate into the working model. I very strongly agree with the bio-psychosocial model.”

(Clinical Specialist)

Because of the intensity of input with AO clients it is important that staff are able to reflect on the relationship:

Bradford

“Since coming to work in this team I am more and more aware that one of the initial reasons for working in nursing and going into a caring profession is often that need to nurture – and there’s risk of over-nurturing, over-caring and taking away people’s responsibilities. I find I am always having to step back and reframe and refocus how I actually work with people and make sure I am not taking away responsibilities that someone could hold on to. In the team people will pick up on that and feel able to say ‘are we taking away some of their independence?’ – and the service user development worker will pick up on that, too.”

(Senior Nurse)

The culturally sensitive and socially oriented approach of the Antenna team in Haringey has been widely praised by stakeholders (Greatley & Ford, 2002). In other teams there was concern about the balance between social and medical issues – stakeholders felt the focus of work should be shifted away from concentration on medication and more towards social rehabilitation.

A service that is set up with a new hand-picked team of professionals who are keen to work in new ways will be well placed to work along these lines. However, it is unlikely that all teams will be able to fully embrace the new ways of working from the outset.

Potential problems may arise as a result of:

- staff joining the teams when they have not specifically chosen to work there but have been moved from other services;
- poor management and leadership with no clear sense of direction for the team;
- lack of co-operation from other parts of the mental health service e.g. if a team does not have its own consultant and has to work with others who may not necessarily share the team’s philosophy;
- lack of continuity with the rest of mental health service – this makes it difficult to transfer people to other services and, as people would continue to receive an assertive and intensive approach when no longer needed, may create dependence;
- inappropriate performance measures and targets – e.g. if an AO service is measured only by its impact on hospital beds this may change the focus of its work.

The new teams need to be supported in developing the new ways of working:

Bradford

“I feel very much that perhaps the most important aspect of my role is to be an advocate for the social model. The fact that the team has a consultant who isn’t prepared to simply make diagnoses and is always looking for opportunities to reduce people’s medication I think fits in very closely with the way other team members want to work, and so I hope that they feel that they get a lot of support when talking to people about medication. The social model also validates and empowers team members who have particular skills and experience in, for example, housing, or benefits – people with this sort of experience have been particularly sought for the team. It foregrounds their experience and puts my experience (and the medical view) into the background.”

(Consultant Psychiatrist)

To an extent the services may be perceived as a threat to existing teams, possibly by exposing poor practice. Clearly, to match the vision of the NSF-MH the rest of the service also has to change its approach. But this will not happen overnight. The new teams should start spreading good practice to other teams, in a sensitive way. To do this they need to ensure that they are working closely with the rest of the service and not seen as elite and separate. The Bradford AOT has identified liaison workers who work with individual CMHTs and are able to provide feedback and advice as well as acting as the contact point with the AOT.

LEARNING POINTS

- Slow build-up of resources may mean it is impossible to start up new teams at what would seem to be the ideal time from a practical viewpoint. If this is the case, fulfilling the MH-PIG will have to be regarded as the longer-term goal.
- More research evidence is needed to determine the right configuration of AOTs in rural areas.
- Developing a bio-psychosocial approach is important but it is an approach that may be at odds with practitioners' backgrounds and the orientation of other mental health services.

Staffing and skill mix

The MH-PIG suggests that for a team with a caseload of 90 there should be:

- 8 whole time equivalent (wte) care co-ordinators (to include an appropriate mix of psychiatric nurses, approved social workers (ASWs), occupational therapists (OTs) and psychologists);
- 0.5 wte consultant psychiatrist and 0.5 wte staff-grade doctor (with dedicated sessions for the team);
- support workers (number to be determined by the team);
- programme support staff: 1 wte administrative assistant, plus information technology (IT), audit and evaluation support.

Staff-to-client ratio

The number of care co-ordinators required is directly linked to the number of potential clients. Most of the teams that we have talked to are working on the assumption that their caseload ratio will be no more than 10:1. Some are questioning whether a caseload of ten is manageable when all the clients have very complex problems and a high level of need. Some sort of caseload weighting system may allow a fair allocation of resources to be made.

In creating its AOT, the Nottingham service is facing difficulties regarding increased workload, more complex cases, and higher expectations. Staff are concerned about whether they can provide the same level of support that they have been used to, and about how they will cope with taking on, and getting to know, four new clients a month on top of existing work:

Nottingham

“Caseloads for each of the three teams are set to increase from 30 to 90 clients and even though the staff numbers have increased, this is still causing concern to the staff. Clients potentially could have four contacts per week. It’s hard to conceptualise four contacts a week times 90 clients, face to face. In fact I think it’s nearly impossible, because what we are also experiencing is the multiple liaison with housing departments, benefit departments and GPs (in connection with clients’ physical health), not to mention trying to find the client, who is often not at home at the time we have arranged for the visit, and then the dual diagnosis [mental health and drug/alcohol problems] issue is becoming such a focus.

“Trebling the numbers will have quite a psychological impact ... I guess with any new client coming in it’s like opening a new page in a book. It takes time to get to understand the individual, build the relationship.”

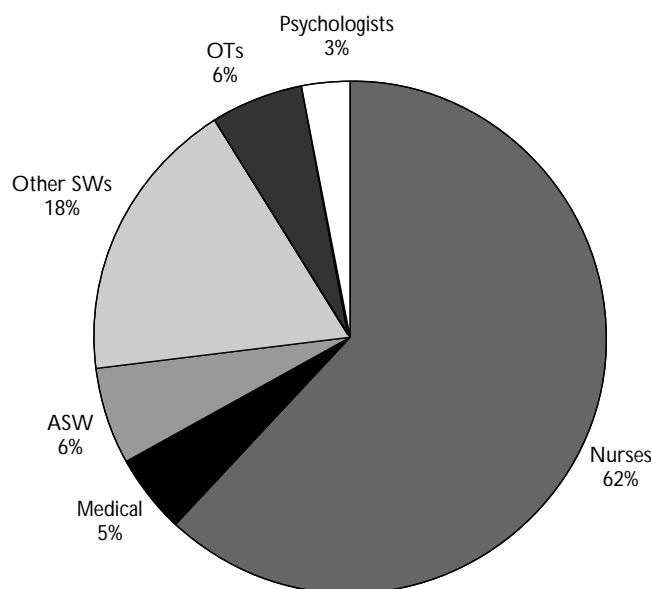
(AOT Manager)

Those staff used to working in generic CMHTs may find it difficult to understand why trying to reach an average caseload of 10 per team member should be perceived as a burden. Clearly, though, the teams themselves find this pressure very real. It may be a problem encountered particularly in the start-up phase of AOTs, when considerable work is needed to engage with people who have disengaged. There are usually multiple problems to be solved, some of a very practical nature, such as housing issues, but nevertheless very time-consuming. The difficulty for AOTs is knowing when it is safe to start reducing the level of input. This ‘titration’ of the intensity of service can only be achieved through skilled practice supervision as issues of dependency arise for both service users and staff.

Determining skill mix

The MH-PIG states that specialist skills will be needed, including in occupational therapy (OT), psychology, and approved social work – or at any rate there must be strong links to social services. The core group of care co-ordinators may come from a variety of professional backgrounds. In practice, the NSF-MH mapping data suggests, more than half of AO staff are nurses (see Figure 3).

Figure 3: Proportion of various professions in AO teams (not including support workers)



(NSF-MH Service Mapping Data, 2001)

The MH-PIG sets out the required skills in terms of professional mix. In reality the skills required are much more wide ranging and it could be argued that these skills and relevant experience are not linked to specific professions. Most of the teams that we visited stressed, for example, the importance of support workers, who can come from a wide variety of backgrounds, and of other specialist workers including, in some teams, user development workers:

Bradford

“Professionals come from backgrounds of oppressive practices. The support workers in our team are a vital part of the team. The team would be different if they weren’t there – it would be less effective.”

(Consultant Psychiatrist)

After the inclusion of a user development worker in a home treatment team was found to be successful, it was agreed that the Bradford AOT should include such a post. The service user development worker is part of the team, but doesn’t carry a caseload, and this allows her to be independent from the other team members. Her role is to ensure that the service user’s perspective is paramount in decisions about care and to challenge staff attitudes when appropriate. The role also includes liaison with local service user and community support groups:

Bradford

“There was a model, working well, of having someone with that user experience working in the team, constantly reminding practitioners: ‘Are you looking at this from the right perspective? Have you got the service users’ needs foremost in mind?’

“The role of the service user development worker in Bradford is very much about development work – not about getting them embedded in the day-to-day nitty gritty, because then they would almost become part of the team. One of the very important aspects of their role is to be independent, to be able to challenge us. Whereas if they were in the role of support worker, they would find that less easy to do because they would be starting to mingle too much and be tainted by the other team members’ attitudes.”

(Team Leader)

There are certain jobs that under current legislation only certain professions are authorised to undertake. Usually, only medical staff can prescribe medication (and in some areas they are the only people who can make the decision to admit somebody to hospital), nurses can administer medication, and ASWs are needed for Mental Health Act assessments. Table 4 shows comparative staffing levels in some of the teams we visited. The numbers include non-professionally aligned staff that are not care co-ordinators, so the mix is different from that given in Figure 3. Nevertheless, nurses still make up 40-50% of the total staff.

Table 4: Comparative staffing mix in a sample of AO teams

Teams	Ladywood	Walsall	Herefordshire	TEENEY	Bradford	Nottingham
Nurses	6 (48%)	4 (39%)	1 (40%)	6.5 (54%)	4 (36%)	7 (47%)
Medical	0.5 (4%)	0.2 (2%)	0	0	0.6 (5%)	0.5 (3%)
ASW	2 (16%)	2 (20%)	0.5 (20%)	1 (8%)	1 (9%)	2 (14%)
Other social workers	1 (8%)	0	0	2 (17%)	0	0
OTs	0.5 (4%)	1 (10%)	0	0.5 (4%)	1 (9%)	0
Psychologists	0.5 (4%)	0	0	0	0	0.3 (2%)
Support workers	2 (16%)	2 (20%)	1 (40%)	2 (17%)	3 (27%)	3 (20%)
Admin.	0	1 (10%)	0	0	0.5 (5%)	1 (7%)
Other	0	0	0	0	1 (9%)	1 (7%)

Medical staff

Medical staff are not fully integrated into all teams. However, it is helpful to have a few medical people to liaise with, even if they are not full members of the team:

Nottingham

“Within each team there was only one consultant that you had to relate to, and that has been valuable in terms of multi-disciplinary team working, and in terms of his being part of the team. That kind of relationship over a long period of time has worked well with all members of the team.”

(AOT Leader)

LEARNING POINTS

- There is a tendency for AOTs to be dominated by nurses, as they are the category of staff most readily available. The more a team is dominated by one profession the more difficult it will be for other professionals to enter the team. Experience over time suggests that a broad skill base is essential for AOTs.
- For AOTs medical input does not have to be within the team but it helps to have just one consultant psychiatrist to relate to.
- Support workers are highly valued on AOTs. The tendency is to under-estimate the need for support workers when setting up a new service.
- People who have used mental health services may be usefully employed in a variety of professional and non-professionally aligned roles. One service had established an innovative user development worker role.

3

Setting up crisis resolution services

The service model

CRTs have been in existence since the 1980s in the United States, Australia and the UK. Evaluations have shown positive outcomes in terms of reduced admissions and reduced lengths of stay, as well as clinical outcomes similar to those for inpatient treatment.

Terms such as 'home treatment team' or 'psychiatric emergency team' are sometimes used rather than crisis resolution team, which can be confusing. The essential service characteristic is that the team provides home assessment and treatment as an alternative to hospital admission for people experiencing an acute mental health crisis. The MH-PIG states that the service is for people with severe mental illness with an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary.

The aim of the service is to ensure that people experiencing severe mental health difficulties are treated in the least restrictive environment and with the minimum of disruption to their lives. The team should:

- be available 24 hours a day, seven days a week;
- act as a gatekeeper to acute mental health services, rapidly assessing individuals and referring them to the most appropriate service;
- remain involved until the crisis has resolved and the service user is linked into ongoing care;
- if hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge.

The following sections follow the development of the service models from planning to service delivery and monitoring, with examples of the issues that people have had to address.

What do service users and carers want from services?

For this study we talked to groups of service users in Walsall and Herefordshire about the sorts of things they wanted from CR services.

While some service users would welcome the chance to be supported at home, some did have concerns about the level of support they would get. Hospital stays can provide people with both support and social contact.

Positive aspects of being in hospital

"It's good to be with a peer group for support."

"My friends/relations send me get well cards/presents."

"There's someone to talk to."

"No household chores to do."

continued overleaf

“There are people to motivate you.”

“There’s structure to the day.”

“Someone makes sure you take your medication.”

How service users feel about being supported at home during a crisis

Some service users would prefer to be supported at home:

“I’d prefer treatment at home rather than treatment in hospital if resources are available.”

“You will be seen in your own environment – see how you are coping. It’s better in your own home, your own surroundings.”

“Keeping in the community means benefits don’t stop.”

“You get better quicker in the community.”

“I’d still want the option of one or two nights’ sanctuary (for others’/my family’s safety), but on the whole I’d prefer home treatment.”

Others were concerned they wouldn’t get the support that would be provided in hospital:

“I’d rather be in hospital than at home because personal care/tablets/doctors appointments etc. are sorted out.”

“At home I wouldn’t take care of myself – for example I wouldn’t get up – in hospital this wouldn’t happen.”

“It’s easier to acknowledge problems if you are in hospital care rather than at home.”

If being supported at home, users wanted to ensure that they got:

- practical support e.g. help with shopping;
- social contact;
- frequent contact with nursing and medical staff;
- help with medication.

Support needed at home

“You need support workers to keep in touch at least once a week.”

“You need someone to stop you being isolated.”

“You need someone to make sure you take medication.”

Some said they would need someone to visit them daily and that they would have to be able to contact someone day or night if necessary:

“They would have to help with medication and would have to counsel in person and offer help if one felt lonely. If one was depressed it might not be a good idea.”

“They would need to talk to the carer in the home to advise.”

“You would need someone to help you shop and generally help you get back into society.”

“You’d want other people around, like in hospital.”

“There should be a person who meets one to one to ask what you want, who has the resources to implement what you want.”

The most commonly expressed needs were for:

- someone to talk and listen to them;
- access to help when it was needed (available 24 hours a day, seven days a week);
- a place of safety or sanctuary;
- help with medication if needed, but alternatives to medication were also wanted.

One of the main concerns was about whether there would be sufficient resources to allow contact with professionals before, during and after a crisis so that service users were not left feeling vulnerable. Service users also wanted to play a more active role in planning ahead for how they should be treated during a psychiatric crisis. In Herefordshire, for example, service users wanted to have an 'advance directive' which would be part of their care plan.

Support for carers was also considered important. There is concern that a greater burden could fall on carers if people were supported at home rather than in hospital. Suggestions for the type of support which could be offered included:

- practical help;
- respite e.g. through admission to crisis house (or 'sanctuary');
- training to help carers identify early warning signs.

Clearly the earlier the consultation with stakeholders can begin the better, but thorough consultation which takes on board everybody's views takes time, and where sites need to be seen to be responding to the NSF-MH requirements it may be necessary to develop more concrete proposals at an earlier stage.

Newcastle

"I had to go round and speak to user and carer groups but not to enormous numbers of staff. During that process one of the psychiatrists became convinced that this was the way to go. In fact there were a number of psychiatrists scrambling to come on to the working group. We then seconded a consultant psychiatrist to work with me to go out and talk to the GPs, so for three months we went round to every single GP practice in the Newcastle/North Tyneside area and spoke to them about what was happening. I went to all sorts of district health authority meetings, programme board meetings and so on. We were talking to CMHTs and CMHT leaders, psychiatrist groups and regional psychiatry groups, user groups, carer groups..."

(Clinical Specialist)

LEARNING POINTS

- Service users' and carers' views on problems with existing services and how they would like to see these changed can be a powerful tool in challenging the way things currently work.
- The features of the new service models appreciated by service users are the positive relationships with staff, practical help and support, choices about their care, and empowerment.
- Consultation with service users and carers should happen at an early stage and should inform decisions about service developments rather than simply inform them of proposals.
- Other important stakeholders such as staff and GPs should also be actively consulted and informed of developments. This is time-consuming but necessary.

Eligibility criteria – who is the service for?

The MH-PIG states that CR/home treatment should be targeted at adults aged 16-65 years old with severe mental illness (e.g. schizophrenia, manic depressive disorders) who are undergoing an acute crisis of such severity that, without the involvement of a CR/home treatment team, hospitalisation would be necessary. In every locality there should be the flexibility to decide to treat those who fall outside this age group, where appropriate.

The guidance further states that the service is not usually appropriate for individuals with:

- mild anxiety disorders;
- primary diagnosis of alcohol or other substance misuse;
- brain damage or other organic disorders, including dementia;
- learning disabilities;
- exclusive diagnosis of personality disorder;
- recent history of self-harm but not suffering from a psychotic illness or severe depressive illness;
- crisis related solely to relationship issues.

In practice, rather than focusing on people with severe mental illness, teams are concentrating on whether the alternative would be hospital admission. This means that thresholds for accepting people may be affected by the availability of other alternatives to hospital admission, including services more appropriate than hospital, to which people with less severe problems can be diverted.

Barnsley

“We don’t exclusively focus on people with severe and enduring mental illness or people who are already being seen by the mental health service. We will accept people who are new to the service. So anybody who otherwise might be considered for admission to hospital is referred to the team.”

(Team Leader)

Handsworth

“We focus on any emergency referral to us of a person who is in crisis. They don’t necessarily have to be seriously mentally ill. Most of the people who are referred to us are in fact seriously mentally ill, but we get a lot of people referred who have relationship difficulties, emotional distress, suicidal intentions and so on – you need to do some brief work with them to make sure they can sustain themselves and go back to how they were before. So we don’t have strict criteria for exclusion.”

(Team Manager)

In practice, for the North Birmingham teams, around 75% of those offered home treatment will have a severe mental illness. It is important, however, to keep some client group focus. As noted in *Open All Hours* (Minghella *et al.*, 1998), mental health problems and crises can be categorised as:

- newly identified psychosocial crises involving people who have not had previous contact with specialist services – many may not suffer from a formal mental illness;
- recurring psychosocial crises in the case of people with mild or moderate mental health problems, drug or alcohol problems and/or personality disorders;
- problems relating to a long-standing, probably psychotic, disorder – these may include symptomatic relapse and/or social difficulties with potentially catastrophic consequences.

CR services should be focusing mainly on the third group. However, the needs of the other two groups will also have to be met somewhere within the overall mental health system. In many localities there is also a need for a service that can respond to life crises which, although they might not immediately warrant psychiatric admission, if not dealt with could result in a breakdown which might eventually lead to a psychiatric admission. These people would not meet eligibility criteria for CR. Their need is for more general support which does not have to come from statutory mental health services but could be provided by a range of statutory and non-statutory agencies.

Minghella *et al.* (1998) give the example of a community treatment team in Cornwall which responded to a less severely ill group of people (those with neurosis as opposed to those with psychosis). The latter made up over 60% of hospital admissions and, therefore, by focusing on the other group the team had little impact on admissions.

Walsall have had a similar experience with their crisis outreach service. The service was set up to be accessible to all people experiencing a mental health crisis, 24 hours a day and seven days a week. However, because it did not have a clear remit to reduce inpatient admissions and it had very broad eligibility criteria, it brought people into the service that were previously not known to mental health services and it had limited impact for those already known to the team.

CR teams have to be capable of rapidly assessing and identifying the appropriate service response for people referred to them. The triage role will be important in ensuring that people are diverted appropriately. For example, the Newcastle Crisis Assessment and Treatment (CAT) team has different triage levels which help to determine which clients will go on to be assessed by the team. This is done on the basis of information provided by the referrer. Those people not taken on will either be given advice or referred on to other services.

While the team is becoming established there may be a high number of referrals of people who do not need home treatment. Over time, with appropriate feedback to referrers, this should become less common.

From three of the teams that we visited it can be seen that triage is an important activity for CRTs. Significant numbers of people need referring on, either to hospital-based or other types of services (see Table 5).

Table 5: CRT referrals and assessments in three localities

Team	Proportion referred but not assessed	Proportion admitted following assessment	Proportion taken on by team following assessment	Proportion referred on to other services following assessment
Newcastle	20%	14%	40%	46%
Barnsley (sample from March 2002)	13% (7 out of 55)	8% (4 out of 48)	67% (32 out of 48)	25% (12 out of 48)
Yardley Hodge Hill (information from <i>Open All Hours</i>)**	n/a*	n/a*	58% (265 in first year of operation)	42% (192)

*n/a = not available

** (Minghella *et al.*, 1998)

It will be very important to clarify the purpose of the CR/home treatment service and to stress the target client group as well as specifically who the service does not cover. The lesson to be learnt when contrasting the experiences of the Walsall and Newcastle services is the need both to improve and to control access. The Newcastle team, by targeting its service at a particular group of service users has reduced the use of inpatient care. This enables easier access to inpatient care when it is needed. It also allows resources to be freed up and hence enables a better service overall. The Walsall team, while it may be offering a good service to those people it sees, has possibly increased the pressure on mental health services by improving access for some people whose needs might be more appropriately met in primary care.

LEARNING POINTS

- The eligibility criteria set out in the MH-PIG are based on evidence of effectiveness and cost-effectiveness and should form the basis for the new teams.
- CR/home treatment services should be targeted at people with severe mental illness. In practice, teams do not restrict the acceptance of referrals to this group but instead focus on those people who would otherwise require hospital admission.
- CRTs will need to undertake significant triage work to ensure that people receive the right service for their needs.

Identifying need

For AOTs it is fairly easy to identify a well-defined existing group, whereas for CRTs the demand will fluctuate and the size of the service may be related to existing bed use and tied up with plans for changes to inpatient services.

The MH-PIG recommends that an average team should cover a population of 150,000 and have the capacity for a caseload of 20-30 service users at any one time, i.e. equivalent to an average-sized acute psychiatric ward.

Again, this average figure is likely to mask wide variations depending on the level of psychiatric morbidity in the local area and the availability of other alternatives to hospital admission. There is a danger that blanket application of the MH-PIG recommended caseload may lead to a supply-led service and therefore, as with acute wards, variable thresholds for admission.

The client base for this service is clearly not a fixed group of individuals; nevertheless, it should be possible to estimate likely demand with reference to inpatient admissions.

In practice, the teams appear to have been set up without direct reference to the potential client base (and so they are effectively supply-led). Thus in Norfolk and Bradford, for example, home treatment teams serve only part of the population.

Of the teams we visited:

- Ladywood (adult population 34,000) – average caseload of about 20 people;
- Handsworth (adult population 32,000) – average caseload 20;
- Barnsley (adult population 140,000 approx) – caseload 15-20;
- Newcastle (adult population 430,000) – caseload 40-50.

LEARNING POINT

- It is more difficult to estimate need for CRTs than for AOTs, as potential clients are not known in advance. There is a danger of implementing service-driven as opposed to need-driven models. The initial capacity of the service should be determined by current use of other crisis and acute inpatient services. Again, this will need ongoing review to ensure that all the crisis/acute elements are working together and that each element has appropriate staffing levels, skill mix and client mix.

Determining a locally-appropriate service model

The MH-PIG sets out the recommended service models for CRTs. However, local circumstances may require some variation of the standard model. Given that the recommended models are based on the current best evidence of effectiveness, it is important that any modifications are based clearly on local needs and retain as many of the core characteristics as possible. Some areas are having to compromise on issues such as team size or skill mix because of a lack of resources or difficulties with recruitment.

The model for CRTs described in the MH-PIG is of a discrete, specialist team that has:

- staff members whose main or sole responsibility is the management of people with severe mental health problems who are in crisis;
- adequate skill mix within the team to provide all the necessary interventions;
- strong links with other mental health services and a good general knowledge of local resources.

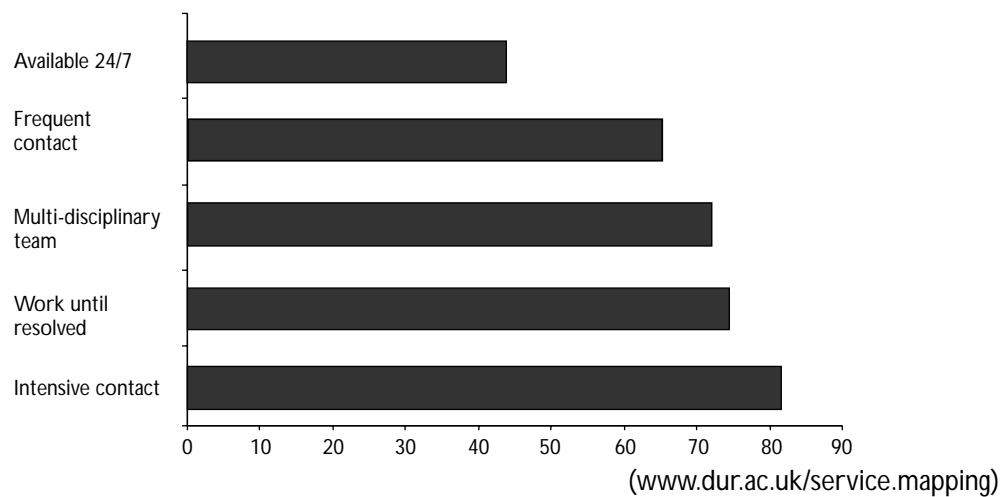
Key features:

- acting as a gatekeeper to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service;
- providing a service that is available 24 hours, 7 days a week.

The core tasks of a CRT are:

- gatekeeping inpatient admissions;
- targeting people who would otherwise need hospital admission.

Figure 4: Crisis resolution model fidelity



As with AO services, the choice of model can, in practice, be limited by resources:

Newcastle

“The service has been structured as one large team based in the same premises, not sectorised. There wasn’t enough money to establish two separate teams so I had to look at ways of getting savings out of economies of scale, so we went for one service with 24-hour telephone triage and a carers’ line. This means we’ve got people always on duty. We’ve got eleven CMHTs and seven wards. So we had to have one service because that’s all that could be afforded, rather than a whole series of teams which would have cost a lot more.”

(Clinical Specialist)

The balance between assessment followed by short-term intervention and diversion, and assessment followed by home treatment, may vary according to local needs. For example, inner-city areas with a high prevalence of severe mental illness (SMI) will see home treatment as a high priority. In other areas, where the pressure may come more from primary care referrals of people experiencing life crises, the short-term intervention role may appear more important. With limited resources this balance needs to be carefully managed.

Because of the conflicting priorities and the need to respond to concerns of referrers (especially GPs) some of the existing or proposed service models are failing to do this. For example, the Walsall Crisis Outreach service catered mainly for those people requiring short-term intervention or diversion and did not offer home treatment as an alternative to admission. So those people with severe mental illness who are already known to the service will have to be either admitted or referred back to the CMHT for support.

In Herefordshire a model was initially proposed which attempted to resolve issues relating to the rural nature of the area and the low critical mass of service users (see Box 1). Also, perhaps most importantly, it reflected the need to develop the service with few additional resources.

Box 1: Initial proposals for a crisis resolution service in Herefordshire

The model initially proposed in Herefordshire was to be targeted at people on enhanced CPA.

The starting point for crisis response would be through the existing CPA care plan. In response to service user requests for an 'advance directive', this would include a crisis plan based on agreement between the service user and the community team. Where possible crisis response would be based on this plan, although this might not be possible when, for example, a Mental Health Act assessment was necessary.

If a crisis management plan could not be immediately activated and assistance could not be accessed from the care co-ordinator/community team, a county-wide crisis team (consisting of medical, social work and nursing staff) would be available to make a rapid response and provide access to a range of service responses including:

- admission to inpatient care;
- support from a community support team of non-professionally qualified staff within the independent sector;
- access to a sanctuary house and support from a sanctuary team available out of hours.

This service proposal includes elements of the MH-PIG model but differs in having a separate crisis team (statutory sector) and community support team (independent sector). The rationale behind this lies with the expressed wishes of service users to have a more holistic and less medically oriented service.

Although the model proposed is an imaginative response to people's needs there are potential pitfalls which could prevent it working effectively. For example:

- If the care co-ordinator/community team are unable to respond, e.g. out of hours, then the decision on how to respond to the crisis will lie with the crisis team. As this team does not have control of the community support resources there may be a tendency to admit to inpatient care without considering alternatives.
- It is intended that the community support team will also provide ongoing support to people being seen by the CMHTs. Unless the team is well-resourced this is likely to result in conflicting priorities in much the same way as is experienced in generic CMHTs.

The solution may be to have an integrated team, which could be a joint statutory and independent-sector team but would, in effect, be very similar to a standard CR/home treatment team. The main difference would be in the mix of staff, with more emphasis on support workers.

This example perhaps illustrates the need to use the MH-PIG model as a starting point (as it is based on evidence of effectiveness) and to consider which elements have to be modified. It still does not fully address the problems connected with operating in a rural area and with a low critical mass of clients. But it may be that ultimately a standard home treatment team will be feasible in a rural area and that the additional time needed for travelling would be balanced by the low numbers of clients.

LEARNING POINTS

- Slow build-up of resources may mean it is impossible to start up teams at what would seem to be the ideal time from a practical viewpoint. If this is the case, fulfilling the MH-PIG will have to be seen as the longer-term goal.
- CRTs that are poorly integrated with other services, especially inpatient care, and/or lack sufficient professional skills may not reduce the use of inpatient care.
- Further research evidence is needed to determine the right configuration of CRTs in rural areas.

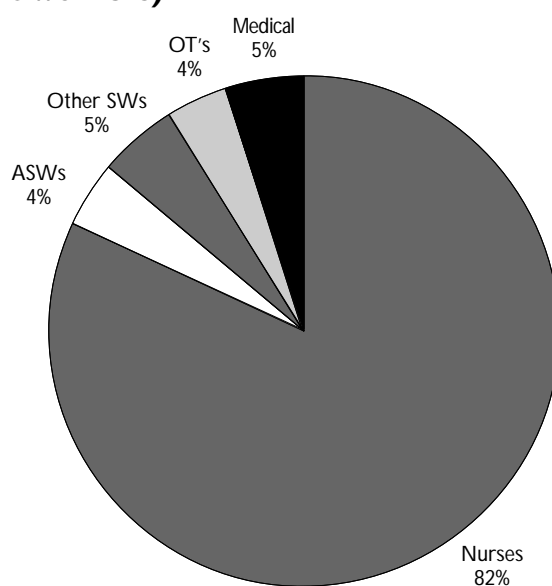
Staffing and skill mix

The MH-PIG suggests that for a caseload of 20-30 service users at any one time the team should be made up of a team leader plus 13 other staff. These will be designated, named workers, (who may include community psychiatric nurses [CPNs], ASWs, OTs, and psychologists) and support workers, some of whom may be service users. Medical staff (consultant and middle-grade cover) should work as active members of the team.

Skill mix

CR teams are more dominated by nursing staff than are AOTs (see Figure 3). National service mapping data (Figure 5) indicates that over 80% of the professional staff are nurses.

Figure 5: Proportion of various professions in CR teams (not including support workers)



(NSF-MH Service Mapping Data, 2001)

The teams that we visited made considerable use of support workers (see Table 6).

Table 6: Comparative grade mix from three crisis resolution teams

Teams	Handsworth	Ladywood	Barnsley
Team manager	1 (6%)	1 (6%)	1 (5%)
Nurses	9 (58%)	6 (36%)	9 (47%)
ASWs	1 (6%)	1 (6%)	0
Other SWs	0	0	1 (5%)
OTs	0	0	1 (5%)
Psychology	0	0	0
Support workers	3 (19%)	6 (36%)	6 (32%)
Consultant	0.5 (3%)	0.5 (3%)	0
Other medical	1 (6%)	2 (12%)	1 (5%)

The relatively high proportion of support workers in the Ladywood team was based on the experience gained in running the service, much of the need being for day-to-day practical support. There are also variations in nursing grade mix between teams. For example, the Barnsley team has quite a rich skill mix, with six G-grade nurses.

Staffing and skill mix may change over time as the needs of the team become clearer:

Handsworth

“We started with a core of nurses who already had experience in home treatment, which was very valuable. Medical staffing has doubled. Altogether, we now have thirteen nursing staff, a full-time social worker and three medical staff.

“The one thing that we do have to wait for is psychological assessment and psychological interventions; some psychological input would be useful – somebody experienced in doing brief therapy.

“The addition of the social worker, which has only happened in the last 18 months, has been absolutely excellent. She is an ASW. Having one full-time SW/ASW is very good, given that I had nothing before. They are all very busy. We have our own administrator. So at the moment I am quite happy with the resources that I am getting.”

(Team Manager)

The difficulties in recruiting psychology staff are common but may be overcome:

Newcastle

“The only members that we don’t have are psychology – there is a dearth of psychology resources in Newcastle. But I’ve got about 25 years of experience in psychotherapy, so the psychological component usually comes from me, but there are also other members of the team who have been trained in CBT [cognitive behavioural therapy] and family therapy, so there’s more than enough psychological capacity. I wouldn’t be averse to having a psychologist in the team but they’re as rare as hens’ teeth.”

(Clinical Specialist)

Social work input can also be invaluable to CRTs:

Barnsley

“Lots of the problems that we address in mental health are social problems really, and any care that I would provide would be very socially oriented. And I do get concerned at times when I come into team meetings and the discussion is all about what medication people are on. That’s talked about a lot, and that disappoints me a bit. We have to work very hard to get people to look at things from a social point of view.”

(Team Leader and Sector Manager)

LEARNING POINTS

- There is a great tendency for CRTs to be dominated by nurses, because they are the category of staff most readily available. The more a team is dominated by one profession the more difficult it will be for other professionals to enter the team. Experience over time suggests that a broad skill base is essential for both AOTs and CRTs.
- It is particularly important for CRTs to have medical staff input.
- Psychologists could potentially make a valuable contribution but are difficult to recruit. An alternative is to recruit or train other professionals, such as nurses, to carry out specific psychological interventions.
- Support workers are highly valued on both AOTs and CRTs. The tendency is to underestimate the need for support workers when setting up a new service.

4

Delivering assertive outreach services

The following chapters compare actual service delivery with the recommendations set out in the MH-PIG for AO and CR, starting with some of the operational issues and then moving on to experiences of working with clients:

- referral arrangement;
- assessment, including risk assessment;
- engagement;
- care planning, co-ordination and allocation of workers;
- interventions;
- relapse prevention and discharge.

Operational issues

Team meetings/communication

The new teams must have a shared approach to team working. This requires effective communication between team members via regular meetings. The meetings are primarily to discuss the care of service users but also provide opportunities for managerial and peer support and staff development.

Bradford

“We have a team meeting on Wednesdays – a two-hour meeting in the afternoon. The first hour is for the initial inquiry reviews. The second part alternates between team business one week and training the other week so there’s time for the training and development needs of the team.”

On a daily basis this is supplemented by opportunities for communication during the day:

“We start at 9.30 am with a handover meeting for half an hour – looking at the tasks for the day and identifying who is going to do which tasks. Then for the afternoon shift we have a quick run-through at 12 o’clock. A shift co-ordinator collates information about the contacts made during the morning and leads the handover to the afternoon team. At 4 o’clock – we have another handover/support meeting. This gives an opportunity at the end of the day for people to offload any issues that they feel uncomfortable about. There’s a chance then to discuss these issues as a team and ‘put them to bed’. We may put something in place to deal with a particular problem that has arisen. If you were working as an individual instead of as part of a team, often you’d go home with the problem still on your mind.”

(Senior Nurse)

Team-working practices with regard to safety issues have also been built up:

Nottingham

“We have a co-ordinator in the latter part of the day to make sure everyone’s back safely, and a board which everyone’s name is on and showing where they are going to be and the time they are going to be there.”

(AO Team Leader)

There are significant advantages to team working. In particular, users may benefit from contact with a consistent, relatively small group of people over many months or even years. This is often preferred to more intensive contact with just one individual who has to take leave and may move on to a new post. Similarly, for staff, the burden of caring for people, who in many cases have chaotic lifestyles, is shared by the team. However, in practice, these advantages have to be balanced by the time taken up by frequent meetings.

Table 7: Hours of operation

MH-PIG recommendation	Findings
8am to 8pm seven days a week.	Most teams do this or equivalent (sometimes flexible about times if not enough staff). Some teams only have sufficient resources to cover 9am to 5pm weekdays (and sometimes weekends).
Out of hours, one member of staff on call for phone advice. No provision for home visits. If visit required, referral to CR/home treatment team.	Some teams have more than one staff member on call, will do home visits, and provide own home treatment cover.

A number of AOTs provide their own crisis intervention cover through-on-call arrangements:

Bradford

“Bradford AOT operates 24 hours a day, seven days a week. We have an on-call rota of two members of staff between 8 in the evening and 9 in the morning. The shift system is based on some staff doing 9-5 and others afternoons.

“In an emergency, initial contact is made by phone with the first on-call person. The means of contact is through the hospital reception. They bleep the person on call and leave a message for them to contact a particular number. The person on call then rings the person and talks to them. Ideally they would try to resolve the situation by phone, but if required would go out. If there is a need to go out and visit, that’s where the second on-call person comes in. Visits are always made in pairs. For safety, the two meet up at the hospital and then go in one car to the area. They have an on-call bag with a number of resources – with care plans, medication charts, basic client details, a torch, a map.

“We have tried to have a system whereby individuals probably work one weekend every month and cover the on-calls for the weekend they are working and would then probably do one on-call a week.”

(Senior Nurse)

Some teams are less clear about the need for 24-hour cover:

Nottingham

“An audit concluded that actually the people who used the service were very few. A lot of the issues were social, rather than emergency, and there was nothing really that we were faced with that you couldn’t organise over the phone. So it then went to the telephone response service, but as of tomorrow this service will be moving to the Focus line – the crisis line service that is being set up in Nottingham. This will be the first point of contact and we’ll be the second point, should they not be able to deal with them.”

(Team Leader)

LEARNING POINTS

- Team working has significant advantages, but these must be realistically weighed against the time taken for communication when the whole team needs to know about every service user.
- Staffing arrangements need to ensure safe working practices, to minimise any potential risks to staff or others.
- Teams need to consider how much demand there is for out-of-hours services, and the most economical and effective means of providing these services where they are required.

Referral arrangements

The referral arrangements required of AOTs by the MH-PIG are set out below in Table 8 alongside the situation as it stands in the sites we visited.

Table 8: Referral arrangements

MH-PIG requirement	Findings
Team should accept direct referral for assessment from primary care, community mental health teams, early intervention teams, continuing care teams, forensic services.	A number of the teams are taking referrals only from existing services – and some only from CMHTs.
Links should be established with local services for homeless people, police and voluntary agencies so direct referrals for assessment can be made.	Some teams have more open referral criteria and will accept referrals from, for example, services for homeless people.
Initial multi-disciplinary screening to ensure service is appropriate for the service user.	Teams will discuss new referrals at weekly meetings with full team present, allowing multi-disciplinary discussion. Individual workers will also gather information e.g. from current keyworkers and others involved, and in some cases from independent review of case notes, to inform the team’s decision.

AO services need to build up their caseload gradually. When a team is just starting up this can cause some frustration to referrers and to staff who want to start working with people as soon as possible. However, the time can be put to good use during this initial phase. It is important to avoid the temptation to work too intensively with those clients taken on early.

Bradford

“We take referrals from resource centres. We were taking on about 5 or 6 clients a month when the team started, which was too many. I think the rest of the service got the message because we did some presentations to different teams and said we would be taking on people gradually. It was a new team so people had to get to know each other. It did feel as though a lot of people arrived all at once but now it’s more gradual.

“We were concerned about too much input at the beginning. We had four clients and staff members were fighting to work with them. I think we probably did see people more frequently then. But it was soon realised that if we saw a particular client every day, how were we going to tell them we couldn’t come so often once we had more clients”

(Team Leader)

Some teams have experienced slow rates of referral. Others are having to prioritise:

Nottingham

“We tried to follow the national guideline which suggested no more than between four and six a month. Each sector had a liaison meeting which every stakeholder could attend and bring their referrals to, then I would pick the four that would be prioritised. We would agree at that meeting about who everyone thought was important so there was parity across all referring agencies. And then every month each AO team would come away with another four for that month. So at the present moment we are running at between 45 and 50 in each team and that’s going up by four a month.”

(AO Team Leader)

But screening can cause resentment from referring teams:

Bradford

“With it being a new team we have had a chance to screen each new person who has been referred. Other teams have not warmed to that. The various names that we have been called – the unassertive outreach team, the passive outreach team! I suppose it’s our philosophical approach that leads people to describe us in that way – we have tried to be much less of the medical model.

“Some people have been referred and been turned away, but have come back again – we will re-assess. What we have often done, and hope the other teams appreciate, is help clarify with the referring team – go back with suggestions of things that it might be useful to do to engage that person.”

(Senior Nurse)

CMHTs may have anxieties about working with demanding clients. This again relates to the tricky question of whether AO is for people who are difficult to engage or for people who have a need for intensive community care which is difficult to provide.

The decision to accept a client on to the team caseload may take time:

Bradford

“The team use a colour-coding system for clients from referral to acceptance on to the team. All clients are recorded on a whiteboard.

“Red = initial inquiries (people newly referred and awaiting screening);

Purple = people who, after initial screening, are being further assessed. At this stage the care co-ordination responsibility remains with the referring team;

Green = care co-ordination taken on by the AOT.”

(Senior Nurse)

LEARNING POINTS

- In practice, most AOTs take their referrals from other mental health services and not directly from primary sources. It particularly helps if the approach is made by the CPA care co-ordinator.
- While they are starting up, AOTs need to take on service users in a gradual stream. It is also important that they do not over-provide intensive support that may then be difficult to withdraw.
- Screening is necessary but is often disliked by other services as it is seen as a barrier to access. It helps if the AOT has proactive liaison arrangements with other mental health services, so that it can then sensitively carry out triage and give advice.
- If AOTs prioritise working with people who are difficult to engage, the mental health system as a whole must acknowledge that there are other people who are well engaged with services, but who need intensive community support. If such support is not available from the AOT it will have to come from another team.

Assessment

Table 9: Assessment procedures

MH-PIG recommendation	Findings
Comprehensive multi-disciplinary needs assessment, including physical health assessment where appropriate.	Very detailed assessment process, which may take place over several months. Some sites use specific, user-focused assessment tools. Others use standard CPA assessment forms. Work with the service user and carers, referring team, etc.
Comprehensive multi-disciplinary risk assessment.	Some sites use standard risk-assessment tools e.g. in line with their CPA policy. Others use tools specifically developed and incorporated into assessment. Some sites feel this is an area which needs greater attention.

The assessment process can be long and detailed:

Bradford

“We have got a very important duty to try and help these people who have been so badly served by traditional mainstream services over the years: a duty to try and help them re-negotiate their lives, to try and make sense out of what’s happened. Often it’s a process of going back to what was the original problem they presented with.

“We call this a process of archaeology. If you watch archaeologists at work, they are dusting rubbish away to get at something that’s really very precious underneath. The tragedy is that for so many of the people we see, the precious thing that was originally there has been fundamentally changed by the engagement with services. So we have an important function in terms of helping people to understand what’s been happening, and trying to engage with them at their level. This is again where the medical model is such a disaster because it simply goes on perpetuating the idea that they are ill – and they never believed that in the first place. That for me is the great challenge.”

(Consultant Psychiatrist)

Efforts have been made to make assessment tools as user-friendly as possible:

Norwich

“The assessment form was piloted with some clients and they had some suggestions. Each section has a different colour so it’s not too overwhelming for clients. A worker can go in and say – let’s do the yellow section this week. We’ve tried to make it as user-focused as we can. And for some clients some really interesting stuff has come out, stuff that we didn’t know, even though we’d been in a relationship with them for three years.”

(Team Leader)

Nevertheless, there can be problems getting service users to participate in detailed assessments, so patience is needed:

Active Outreach, Norwich

“We have not been able to do the assessment with some clients so we allow the support workers to complete it, but they have to state clearly why, and hopefully at some point we’ll be able to do it with the client.”

(Team Leader)

Nottingham

“I guess what becomes interesting is that when you are trying to engage with people in a creative way. They are not always that keen to do a standardised assessment and it might take a long time to get to the engagement part of the assessment – or even to think about introducing it. So, I guess we try and look at our own views, and what we are picking up, rather than straightaway saying to the client ‘can we sit down and do this’. And a lot of social issues come into it – homelessness, bills, debt, benefits.”

(Team Leader)

Because of the nature of the clients, risk assessment is a very important part of the assessment process, and this will be an ongoing aspect of team working:

Bradford

“We use FACE risk assessment – it does have the risk-management plan. There’s no point in identifying risk if you don’t look at how you are going to manage it, and this does both.”

(Team Leader)

Teams appear to take appropriate steps to manage risks to staff but it is an area that perhaps needs further attention:

Nottingham

“We have had one assault on a member of staff and that’s had an impact. We are still trying to look at how to manage that – the lessons to be learnt – and I guess that just emphasises the unpredictability and vulnerability of our work.

“Certain areas we won’t go to after dark, certain people we would visit only in pairs, and in the case of certain other people we would say ‘we won’t come to your environment, we have to meet at a more public place’. That would be if they were associating with people who might be regarded as dangerous. With one particular client the police said they wouldn’t go into their environment on their own. So it isn’t necessarily the client – it could be who they are associating with or where they are living.

“You don’t always know all of that when you are getting to know people. It’s a question of trial and error sometimes – there’s not that much information available, really.”

(Team Leader)

Some teams are struggling to find appropriate measures to monitor progress. Although some teams use standard tools such as Health of the Nation Outcome Scale (HONOS), these are seen by others as too general. The AOT in Norwich has adapted a standard tool (the Avon Mental Health Measure) in developing its own assessment tool and it intends to use this for monitoring progress.

LEARNING POINTS

- Assessment is a detailed process that can take several months of working with a service user to complete.
- The process of assessment needs to be user-sensitive and involve users as much as possible.
- Assessment needs to be driven by a bio-psychosocial model that incorporates all aspects of life.
- Ongoing risk assessment and management must be a strong feature of the process.

Care planning and allocation of workers

Table 10: Care planning

MH-PIG recommendation	Findings
Statement of needs and production of care plan.	Care plan produced – in some teams e.g. Julian Housing (Active Outreach team in Norfolk) the care plan is owned by the service user.
Each service user assigned a care co-ordinator who has overall responsibility for ensuring appropriate assessment, care and review by themselves and others in the team.	All teams appoint care co-ordinators. Decision on who acts as care co-ordinator is taken according to the needs and preference of the service user.

Some teams use standard CPA documentation. Others have specific planning tools. Allocation of care co-ordinators takes account of service users' preferences:

Bradford

“In Bradford the liaison people initially take the referrals from the team that they are liaising with, do the initial assessment process, present back to the team – and then there will be the chance to allocate.

“The decision of who will be the care co-ordinator is based on a combination of things. If someone's been involved in the information gathering, and it's going to be very delicate in terms of working with this person, and they feel they've established some degree of rapport, then they may say they would like to continue. Sometimes there will be specific issues to take into account, such as language, gender or race. We try to be as flexible as possible.

“And people do express preferences – for example, that they would rather work with a male or a female worker. Sometimes people would rather not have too many people involved, or else they are quite open about wanting to work with a lot of people.”

(Team Leader)

It is vital that an allocated worker is responsible for care co-ordination for each service user. Equally, there must be strong liaison arrangements at the service level. The Bradford AOT has liaison workers who can facilitate communication in a practical way.

Through the liaison workers the AOT can pass back information on what works with particular clients – at the same time recognising that the generic team would not necessarily be able to offer the same level of input:

Bradford

“One of the things that we have discovered in one year of working with people is that sometimes a particular style is what causes people to engage. We are starting to look at how we as a service can meet people's needs, and that includes identifying a style that someone can work with. In this connection, we can take lessons that we learn with regard to particular individuals back to the referring teams. It's one area where the link workers can help. It all has to be fairly sensitive and gentle because some services are constrained by lack of time – they are working with vast numbers of people. Some of the mental health resource centres are staffed at a very low level – there are CPNs who have caseloads of 50 to 80 people.”

The team also has to maintain links with inpatient services:

“Just because someone was in hospital the team couldn't sit back and think 'they're being looked after'. That was the point at which you started to develop 'inreach' plans and to really liaise very closely with the ward so that they didn't feel 'AO have just had this person admitted and dumped them on us – where are they, what are they doing?'.”

(Team Leader)

The Antenna team in London has taken this a step forward and appointed a liaison worker. The user development worker post in Bradford has an element of liaison.

Links also need to be maintained with other agencies through which clients are being supported. It will be vital for the AOT to learn about the resources available to it in the wider community. Links with various organisations such as housing, voluntary organisations, police, education and employment organisations, should initially be established at this time and arrangements for ongoing liaison considered.

The MH-PIG also emphasises that the team as a whole should be known to, and develop a relationship with, each client (Table 11).

Table 11: Teamwork

MH-PIG recommendation	Findings
Staff know and work with all service users. Continuity of care is provided by the team as a whole.	In all but one of the teams this is the case, although service users may choose to limit the number of people who are involved. Efforts are made to reduce dependence on any one worker and even in the team that does not operate full team working there is some cross-cover by workers.

The two examples below illustrate how this works in practice

Bradford

“Ideally you try and get people to meet as many of the team members as possible so that they start to feel comfortable with them. This also has benefits in relation to the on-call, because it means that if someone rings up they are not talking to a stranger. We wouldn’t force people to meet all the team members, however. It’s not always possible but we try to give people the option of working with different people. And sometimes you get situations where people actually work on different things with different people and the nature of the contact is ‘with one person I’ll maybe talk about stuff that’s related to DIY and with another I’ll talk about something else’ – which mirrors real life. In some ways it also reflects some of the different skills of the various members of the team.”

(Team Leader)

TEENEY

“We appreciate the values of a whole-team approach but the constraints of CPA – the need for a care co-ordinator/keyworker – drag us more towards a case-management model. What we do stress is that we have cross-cover from other workers for each client. So every client has a keyworker and works with them in a case-management style but knows at least one other worker, and that facilitates cross-cover for annual leave, etc.”

(Clinical Specialist)

LEARNING POINTS

- Production of a care plan is a gradual process that can take up to six months.
- A pragmatic approach is needed to balance the benefits of whole-team working with the need to have a single worker identified as the care co-ordinator. Flexibility is required and user preferences should be taken on board.
- Teams also need liaison workers to relate effectively to a broad range of mental health and other agencies.

Engagement

Table 12: Engagement

MH-PIG requirements	Findings
Assertive engagement <ul style="list-style-type: none"> • high priority given to providing services and support to service users and family/carers in the initial stages of engagement; • persistent approach to engagement – repeated attempts at contact. 	For new teams this has been a major focus of their work. There are some good examples of imaginative ways to engage people, which usually focus on strengths and interests, and of persistence. Emphasis is given to taking things at the client's pace and being patient.

The engagement process is ongoing. Teams have used various means to engage with service users. Patience and persistence are the keys:

Bradford

“With one of the clients who was very difficult to engage, we actually arranged a series of breakfasts, taking him out for breakfast over a period of time to the point where yesterday he actually called in here. Money management is a big issue for him – he has a serious crack problem – he’ll often get his money one day and next day it’s gone. So again it’s trying to help him focus on how he might start to budget a bit more. You’re not immediately successful – it’s a pattern he’s been in for quite a few years.

“One young man had been quite mentally ill for a long period of time, not wanting to see anybody. He eventually ended up in prison, having assaulted someone in the street. We just kept sending letters to him about things that had nothing to do with mental health – how to spend your day, possibly study, training. We just kept sending them out. We tried to go round and he wouldn’t open the door. Eventually he came round and said, ‘I have had this letter – what sort of training can I do?’ So we just talked to him about training even though he was really poorly at the time. He wanted to do a theology course and he just started coming in and then started talking about his mental health problems.

“Another young woman came to us as result of a Mental Health Act assessment – it was either AO or she was going to go into hospital. So she came in quite fired up and quite angry. The team that were assessing her brought her here. It was in the early days when we were a bit naïve about these things. So she came here and shouted and yelled a bit and we just acknowledged that she was really angry about things. The team that were assessing her were able to avoid admitting her to hospital. She is still in contact – it’s a long-arm kind of approach because she doesn’t want a lot from us. What she definitely doesn’t want is a mental health service that monitors her very closely, but that sort of distance monitoring.”

(Senior Nurse)

Nottingham

“One particular individual was a very young man, very able, went to university then developed mental illness, struggled with coming to terms with that, and was non-compliant with medication. It always ended up with a relapse, partly because he didn’t want to take the medication. It was also a high-risk situation in terms of how he reacted when he became unwell. So he went to the acute ward – couldn’t be managed there, went to the forensic service, wasn’t managed there, went to Trent, which is the secure unit here, for a year. We followed him through that process and worked with him through all of that time to get some understanding of his mental health. He has managed to stay out for nearly 18 months now.

“We’ve got one lady who is in better mental health than anyone’s known her for ages and ages – it’s lovely to see and although I’m not saying this will last, she is actually beginning to talk about her understanding of her mental illness, talking about how she wants her care delivery, in a way that she’s never done before.

“But equally I could say we have some clients where the chaos is still going on and we are still trying to work out how to manage it.”

(Team Leader)

But engagement is not always successful:

Nottingham

“With quite a few people that we’ve just taken on we have lots of failed contacts, lots of chasing around and not finding them. And we’ve got a couple of clients who just don’t want the service at all. One only goes into the acute ward so we haven’t seen him in the home environment at all – he won’t have us anywhere near his flat. I’m not clear whether or not he should be with AO or whether the package of care offered to him via the acute service is suitable for his needs.”

(Team Leader)

Table 13: Frequency of contact

MH-PIG requirements	Findings
Frequent contact <ul style="list-style-type: none"> • capacity to visit seven days a week; • capacity to respond rapidly to changes in need and to provide intensive support in the community. 	Staffing levels and caseloads allow for visits seven days a week (but this relies on the fact that not all people will need such frequent visits).

The frequency of visits needed will vary according to the complexity of cases and the stage that has been reached in engagement. Teams working in inner-city areas may have people with higher needs than teams elsewhere.

Ladywood

“The people the assertive outreach team is looking after are those who need four or five visits a week. Staff may also need to double up on visits because of risks involved.

“Visits are shared among the team. Somebody might be being seen seven times a week but the keyworker might only see them once a week. It helps to avoid burn-out if different members of the team see the person.”

(Team Leader)

LEARNING POINTS

- AO teams need to take a long-term, persistent and, where necessary, intensive approach to engagement.
- Initial work should focus on issues users want to deal with. In the longer term AOTs should work with users to help them develop a better understanding of their mental health problems.

Interventions

Table 14: Practical support

MH-PIG requirements	Findings
<p>Basics of daily living</p> <ul style="list-style-type: none"> • Care plan should address all aspects of daily living; • Practical support, <i>provided by the team itself</i>, should be available e.g. help with shopping, domestic work (cleaning and improving living conditions), budgeting, etc; • Daily living skills training to raise independence of service user. 	<p>Great deal of emphasis is placed on practical support and the valuable role of support workers in providing this.</p> <p>Other workers, including psychiatrists and even psychologists, will also provide practical help in some teams.</p> <p>It can be time-consuming for care co-ordinators, with paperwork, etc. and liaison with other services e.g. housing and benefits.</p> <p>Efforts are made to improve living skills – although there may not be formal ‘training’.</p>

Nottingham

“A lot of the emphasis was on not only monitoring and health issues but practical things like helping with cooking and shopping, and ensuring the environment was clean and tidy. And that’s where the health-care worker role became very important in terms of the social issues as well as the practical issues.

“The carers thought this was great. Once they got their relative into the service, most carers valued what was being offered and the relationships that we established with them. We looked at employment opportunities and we made college links for the younger people. But we also offered that continuity [i.e. contact with a defined set of workers] within a team approach which is intrinsic to the therapeutic relationship.”

(Team Leader)

Table 15: Working with carers

MH-PIG requirements	Findings
<p>Family/carers’ and significant others’ support and intervention:</p> <ul style="list-style-type: none"> • Care plan for carers to be produced and reviewed regularly; • Psycho-education provided to family/carers/ significant others; • Behavioural family therapy (BFT) available over extended periods of time as appropriate. 	<p>Carers can be very important in helping engagement. But it is unclear whether they receive their own care plans.</p> <p>It is not clear whether all teams are able to offer BFT.</p>

Carers can play a very important role in supporting the work of the team and, in turn, will need support from the team:

TEENEY

“We have a client who is disengaged but he stays with his mother. We have an excellent relationship with his mother. Because of the relationship we built up (while the client was well) she will keep us informed and so the team can monitor the situation and be responsive if help is needed. She got a little bit down and we were able to increase the support for her.”

(Clinical Specialist)

Teams will also get involved with service users’ wider social networks:

Table 16: Compliance with medication

MH-PIG requirements	Findings
<ul style="list-style-type: none"> • Delivery and administration of medication to service users who require intensive monitoring; • Care designed to improve concordance (co-operation with treatment); • Service user involved in decision-making and monitoring effects of medication; • Standard tools for monitoring side effects to be used regularly by service user and staff. 	<p>Teams do supply medication (there can be problems with supply and storage, e.g. Bradford had to negotiate a service agreement with the Trust pharmacy).</p> <p>Bradford team has a very flexible approach in helping service users to make informed choices about medication.</p> <p>Some teams are using standard tools for monitoring side effects.</p>

Sometimes the key to engagement involves negotiating over medication:

Bradford

“Sometimes we find we work with people who have stopped their medication and aren’t struggling as much as might be anticipated. We have one client at the moment that we are very concerned about who wanted to stop medication – he stopped it completely dead without any gradual reduction, and he has been quite ill. But last night he agreed to start taking it again. So it’s always a process of negotiation, and maybe agreeing to some reduction but explaining all the time the possible effects of that.”

(Team Leader)

Table 17: Cognitive behavioural therapy

MH-PIG requirements	Findings
A range of techniques should be available within the team and used appropriately.	Not all teams are in a position to do this, because of limited psychology input, although in most cases other staff have had some experience.

The Norwich Intensive Support Team has had some success using dialectical behaviour therapy (DBT) with clients with personality disorders.

Table 18: Treatment of co-morbidities

MH-PIG requirements	Findings
<p>Regular assessment of common co-morbidities:</p> <ul style="list-style-type: none"> • substance misuse; • depression/suicidal thoughts; • anxiety disorders. 	<p>Substance misuse (usually of drugs) is a common problem and can be a very serious issue and difficult to manage – presenting a high risk to service users and staff. Teams have support from specialist drug services and in some cases dual diagnosis services. Personality disorder is also an issue for teams.</p>

Drug use can be a major problem and can lead to potentially dangerous situations for staff:

Ladywood

“A lot of new referrals have drug problems and even the long-term clients are getting involved. Dealers go round the area giving out free samples – targeting people with mental health needs who are vulnerable. Even with the clients you know, you may have to visit them in twos because of the people they are mixing with.

“There needs to be more appreciation of this problem – we may need more resources to help deal with it, for example more support workers.”

(Team Leader)

Table 19: Social systems interventions

MH-PIG requirements	Findings
Intervention should be provided to maintain and expand social networks and peer contact, and reduce social isolation.	This is an area which most teams are addressing – ‘social’ activities provided with team support, e.g. taking people to the cinema – but they are not sure whether they can expand social networks.

All teams were able to offer examples of involving service users in social activities. These included cinema visits, day trips, meals out, etc. Often these activities are used to help with engagement. There may be more scope for the teams to work at expanding social networks generally.

Table 20: Attention to service users’ physical health

MH-PIG requirements	Findings
<ul style="list-style-type: none"> Physical health problems, including nutritional and dental needs, should be identified and addressed. Health promotion and access to screening services should be encouraged. Team should provide help in keeping appointments with GP/hospital, etc. 	Physical health is included in assessment and practical support with attending appointments is given.

Physical health problems can often be overlooked and teams need to support people to get access to primary care and other health services.

Norwich (Intensive Support Team)

“With a lot of our client group once you stabilise them and get them engaged with primary care services, getting them to GP appointments or hospital appointments, you sometimes discover that they have serious physical illnesses. With one client the junior doctor at the general hospital implied it was ‘all in their head’.

“We also support people when they are admitted to hospital. We will visit them frequently, especially if they have no one else to support them.”

(Nurses)

LEARNING POINTS

- A broad range of interventions are offered – practical tasks linked with social support, medication, physical health care, and employment and education support.
- The teams actively engage with people who have co-existing substance misuse problems, although helping them is difficult.
- AO teams do not yet, on the whole, have the skill base to deliver more specialist interventions such as cognitive behavioural therapy (CBT). This skill gap may become more important as NICE guidance has now stated that all people with schizophrenia should be able to receive CBT (National Institute for Clinical Excellence, 2002).

5

Delivering crisis resolution services

Team meetings

Similar arrangements are in place for crisis resolution/home treatment as for AO. The following example shows how complex this can be and how meetings need to be sharp and focused:

Newcastle

“We have a team meeting once a month but we have line supervision twice a day so we are making decisions about the patients twice a day.

“We have a system of marking – because we have so many on the home treatment board we have to mark them in various ways. We’ve got a ‘traffic light’ system that tells us who we need to talk about daily or twice a day. So all the assessments get talked about first thing in the morning. We start with what happened last night, then we move to what we call the ‘red-lighters’ – they are high risk – and then we move to the people who are on intensive home-based treatment and get visited once or twice a day – they may or may not be red-lighters. Then we move on to the ‘green lights’, who are basically people who are either coming down from the red level or going up to the red. And then we talk about the blue flags, where a decision needs to be made.

“The meetings usually last an hour. So they’re pretty sharp and focused – they have to be!”

(Clinical Specialist)

24-hour availability

Table 21: 24-hour availability

MH-PIG requirement	Finding
The service should be available 24 hours, seven days a week.	Most teams are able to do visits out of hours.

Further requirements are stipulated for home treatment access:

- A shift system reflecting different working patterns is required. A minimum of two trained case-workers should be available at all times.
- Evening/through-the-night working is usually an on-call system.
- The medical on-call rota should allow a senior psychiatrist to undertake home visits 24 hours a day.
- Assessment team for acute assessment of new referral (available 24 hours a day): two trained case-workers and a senior psychiatrist are required.
- Home visits to known service users (available 24 hours a day): two case-workers are required.
- Staff from other teams could participate in the CR/home treatment out-of-hours rota.
- Arrangements for an out-of-hours service for young people under 16 years old can be established.

Newcastle

“We’ve got an early and a late shift. In the morning people will either start at 8 or 9 – there’s a handover at 9. There’s then a handover at 2 as the afternoon staff come on. The day staff finish at either 4 or 5, depending on when they started. The afternoon shift finish at 10. The night shift do 10.5-hour shifts – they start at 9.30 and finish at 8. The day staff work four days on, two days off. The night staff work three nights on and three nights off. They are quite happy with that. We’ve got slightly longer days because it’s an 8.5-hour day but then every six weeks the day staff get an additional week off.

“Two staff are sufficient to cover at night. Since we’ve been around we seem to have been able to reduce the sorts of referrals you get from A&E – they are our major referrers but because we interface with them so frequently, the only problems we have is when there’s a change of house officer. Sometimes the new senior house officers seem to refer anything and everything, so there’s always a difficult two-week period while they get bedded down to the way we work.”

(Clinical Specialist)

As for AO, some teams question the need for 24-hour cover:

Handsworth

“The actual number of times we are called out, out of hours, for our current people on the board is minimal. The staff complained to me the other day that for three nights they hadn’t been called out for any assessments, never mind anything on the board. I would like to point out that it’s due to the good and effective work done throughout the day that people don’t become distressed during the night.”

(Team Manager)

LEARNING POINTS

- Organisational arrangements for CRTs are complex and an efficient ‘board’ system is required.
- Liaison arrangements with A&E departments are crucial, especially out of hours.
- More mature teams find there is little demand for CR overnight.

Referral arrangements

Table 22: Referrals

MH-PIG recommendations	Findings
<p>Referral to the service should be easy and pathways of care clear to all those involved. The service should have a system in place that allows direct referrals from primary care, community mental health teams, ASWs, staff on inpatient wards, the criminal justice system, non-statutory agencies, former service users and their family/carers, A&E departments and other parts of the acute medical service.</p> <p>Links with other services (specifically AO and early intervention) need to be established so that:</p> <ul style="list-style-type: none"> • Handover and referrals are made easily. • Crises are anticipated and contingency plans are known to all involved in care. • Referring services are aware of who to contact out of hours. 	<p>Teams do accept referrals from a range of sources – but it is important that those referring understand the focus of the team, otherwise there is a danger that the team will be swamped with inappropriate referrals.</p> <p>This can be resolved over time through feedback to referrers. This needs to be ongoing, e.g. to allow for junior doctors rotating.</p>

Teams allow a range of referral sources but may require the person to have been seen by a doctor first:

Barnsley

“GPs can ring through direct, as can people working in CMHTs. Basically, anybody can refer as long as the person has been seen by a doctor – a GP or another mental health professional. So we are a secondary service in that sense.

“Because we’ve got both the home treatment role and the gatekeeping role there’s an overlap. But there are people that we’d go and see in A&E, for example, because if we didn’t see them the junior doctor might well admit them. So we will then go and offer home treatment, even if it is short term, to prevent that admission. It may be that we discharge them within three or four days.”

(Team Leader)

Handsworth

“Any urgent assessment in the Handsworth locality comes straight to Home Treatment. We have 35 GPs in the Handsworth locality, and any of them or their partners can refer to the team. So the majority of assessments come from the GPs. The next largest proportion I would say come from primary care liaison teams. These are people who are already engaged with the service, who may have a keyworker but who have suffered deterioration in their mental health and therefore need a specialist service.

“About 50% of the people that we see are not known to the service – they are not currently engaged with mental health services. They’re referrals that we get from GPs and from A&E. CMHT referrals account for about 25%. The other 25% are people whom we have seen in some sort of crisis out of hours, because they have been referred not by a CMHT but by A&E services or by an out-of-hours GP service. We don’t take self-referrals simply because we don’t have the capacity.

“Within the Handsworth locality we have a 24-hour crisis line number so we can give people who are not on home treatment alternative access [i.e. not via their GP] to mental health services throughout the night.

“People who have keyworkers within primary care or who attend outpatients, people whose home treatment has been discontinued, and people using rehab and recovery and assertive outreach services are all given a card with the freephone crisis line number on it. Sometimes you will get people passing the card on to somebody else, but we ask various questions when we take the call and we will know whether the caller is involved in services.”

(Team Manager)

Barnsley

“Occasionally we get inappropriate referrals relating to people who are not in psychiatric crisis and who are not going through A&E – the referral might come from a GP – but this happens less frequently now. As far as I am concerned it goes with the territory, and it’s about responding appropriately and being supportive – but being educational as well. We’ve had some problems, particularly when individual team members didn’t handle the situation tactfully – that’s very clear from some of the questionnaires that have come back to us. I can see exactly which situation is being referred to in a questionnaire. But that’s got a lot better now.”

(Team Leader)

Gatekeeping admissions

All the teams that we visited had a gatekeeping role. Sometimes the teams will take on people for a short time and deal with the immediate crisis just to prevent an admission to hospital.

Barnsley

“We have impressed on the staff in the team that, even if a referral from A&E is not a psychiatric emergency as such, they should nevertheless take the person on overnight, get them back home, organise the services for them, whatever it is that they need and then discharge them, rather than say ‘it isn’t our problem’ and leave it with somebody else. Because you know yourself, once someone’s admitted, the wheels of bureaucracy turn even more slowly, so they’ll end up being in hospital for a week or something.”

(Team Leader)

The situation can be helped by educating junior doctors. For example, one team routinely spent time with each new senior house officer (SHO) when they started their six month rotation.

It is important to have the consultant psychiatrists on board:

Barnsley

“The four consultants here are all very supportive of us. They wouldn’t dream of admitting people without going through the psychiatric emergency team – they are not precious about their beds. That’s the thing that makes it work – that all four of them are completely committed. It’s the junior medical staff that we’ve had more problems with.”

(Team Leader)

The decision to admit will depend on the circumstances:

Newcastle

“It’s case by case. It’s not the degree of illness that gets people admitted; it’s the degree of behaviour. We treat very, very psychotic, extremely depressed, extremely suicidal people – it’s not a problem. Really what makes a difference is whether you can establish a good working rapport with a person, take a good history, assess the risks. If you can agree to a plan, and everything adds up – OK, then you are all right, but in the end it comes down to your gut feeling about whether you are willing to take the risk of not admitting them to hospital. We do take risks but they are managed risks.”

(Clinical Specialist)

Occasionally, teams are put under pressure to admit people:

Barnsley

“One of the problems we have is that a community mental health nurse will ring us up and say ‘I need to contact you because you are the gatekeepers’, but they have already said to the patient ‘they’ll be coming and they’ll take you to hospital’. Now that’s happened on a number of occasions. It’s getting less frequent but when it does happen it’s frustrating because we go out there and think we could manage this situation at home, but we find it’s been taken out of our hands. It’s all part of the learning curve of the whole service really.”

(Team Leader)

The Handsworth Home Treatment Team has received housing association support in its aim to provide alternatives:

Handsworth

“In conjunction with Future Housing – a housing association in the Birmingham area dedicated mainly to African Caribbean people – we’ve opened our own respite house in Handsworth. It’s a five-bedroomed terraced house, which has been decorated internally to a very good standard. Future Housing supplies 24-hour support workers in there. We provide the crisis and nursing input for the house. And we have three beds available – each person has their own room – and that provides us with an excellent alternative. Future Housing has the responsibility of maintaining the house, furnishing it, insuring it, staffing it – all that is done for me and I supply the clients and the input to help.”

(Team Manager)

LEARNING POINTS

- In practice it is quicker to go and see people who may have been inappropriately referred, rather than have a lengthy dispute. This approach may also reduce inappropriate hospital admissions. But it must be done within a framework of proper risk management.
- Risk must be assessed and then managed.
- Over time teams need to be diplomatic, supporting and educating relatively inexperienced GPs and junior psychiatrists.
- Alternatives to CR, such as helplines, are important for people who need some help but not CR.
- Alternatives to hospital, such as crisis houses, can be supported by CRTs.
- Caseloads have to be carefully managed with some users being discharged within a couple of days. In the case of all users the intensity of care needs to be reduced through negotiation with the user.

Assessment

Table 23: Screening and assessment

MH-PIG requirements	Findings
Initial screening to ensure service is appropriate for the service user. If inappropriate, make referral to other services to ensure adequate continuity of care.	Screening is carried out before accepting on to home treatment. Team may refer on to more appropriate service, or advise the original referrer on suitable course of action.
If appropriate, multi-disciplinary assessment of service user’s needs and level of risk, including physical health assessment where appropriate.	Usually doctor and nurse are involved in assessment and can assess ASW if necessary, even if social workers are not part of the team. Barnsley team also has a support worker present during assessment as practical support is often needed Risk assessment is carried out. Ladywood, for example, developed its own risk assessment tool. Assessment of risk is integral to the decision about whether admission is necessary or what needs to be done to minimise risk and support the person at home.
Assessment should actively involve the service user, carers/family and all relevant others, e.g. GP.	Most assessments are in the client’s home but may be in other settings e.g. A&E. Service users and families are involved.

Newcastle

“We don’t see about 20% of people who get referred, so triage is a way of sorting priorities. We use seven different categories of triage. If a person is in category one, two or three they will be seen within a certain time depending on the level of urgency. For category four the team gives advice to the person referring. With category one there’s usually been a call to the police or the ambulance service because the person’s taken an overdose, so there’s nothing we can do about that. A person in category two will be seen within two hours and a person in three will be seen within four hours.

“About 40% of people get taken on for home treatment. With the rest, after they’ve been assessed and they’re not seen to be appropriate for the service, either they are referred on to alcohol and drug services, or they are referred back to a CMHT or back to a GP with a letter from us that states what we think is going on.”

(Clinical Specialist)

Handsworth

“We have a standard set of questions that we would ask. So when the GP refers in to the team, the one question we ask is, ‘is it urgent for today?’ If the GP says yes, then it is definitely our responsibility to assess the client. Once the information has come into the team, it usually goes to the most senior member who is on duty. We have a look at the information and if there is not enough we may phone the GP back or the client themselves or their carers. We have been known to ask the GP to keep the client in the surgery and we will go down there immediately. The assessment will be done by a senior nurse and an SCMO or a medic – two people will always do the assessment.”

(Team Manager)

Barnsley

“In March, for example, we had 55 referrals and we assessed 48 of them. So seven were very clearly not appropriate – that happens when people don’t have an understanding of the service. Out of the 48 we assessed we actually took on 32. Some were referred back to the sector team and four people were admitted.”

(Team Leader)

Assessment and management of risks is fundamental to the decision on whether to admit somebody or treat them at home. Staff use various standard tools to help assess risk. But it is important that staff have the confidence to manage risks effectively:

Barnsley

“The doctor had been very skilled in encouraging staff to take risks and I think they missed him quite a lot. So the level of risk that the team had been working with had gone down and that was reflected in the ward admissions going back up as well. Over the last few weeks we are pulling that back because, although we haven’t got a doctor, one of the SHOs has been a star and likes working with the team.

“We always have two people on a first assessment – not just for reasons of safety but also because two heads are better than one. Also it gives you the opportunity to talk to carers if they are around, or to set things up with them or for the purposes of getting a history about what’s been happening.

“The risky ones for me are people who are risky to other people. We’ve got someone on the caseload at the moment that I’m very unhappy about. I’m going to do something about it because I think he’s dangerous.”

(Team Leader)

Assessments need input from a doctor where medication is concerned, but other staff can take on other parts of the task:

Barnsley

“The people involved in the assessment vary – it doesn’t always have to involve a doctor specifically. As far as I’m concerned the first thing is about assessing what the person’s needs are – whether we can offer a service and engage with them.

“Out of hours, we have a doctor on call and we tend to go with them to assess the client. In A&E they are seen by a doctor before they are referred to us anyway, so if there’s a medication issue and the client needs advice, we discuss this with the doctor. But this can be sorted out the next day – it’s just about getting the client home and settling them.”

(Team Leader)

Decisions about whether a person should be taken on by a CRT can be made by nursing staff as well as by doctors:

Barnsley

“As the clinical nurse specialist for psychiatric liaison, I had the power to be able to admit and discharge, and so I became very confident about that. The consultant had a lot of confidence in me doing that as well, and I think that helped to build up confidence that a nurse can make these decisions. And then the fact that I was responsible for this team helped that along as well.”

(Locality Manager)

If the person is not taken on, various options are available – the team may continue to be involved with them. It is often a matter of finding appropriate alternatives:

Handsworth

“If home treatment isn’t indicated and, say, a Section paper is issued then it is my responsibility to find a bed. I have to contact the ASW. I have to make sure that someone is available to go with the ASW if necessary. And we wouldn’t pull out of that until the patient was in hospital. And even then we would continue to be involved with the patient while they were in hospital, to follow them through.

“If we feel that a person needs psychiatric help but not of an urgent or crisis nature, then we refer them to primary care. This is what happens in most cases, so I meet with my primary care colleague every Tuesday.

“Within the Handsworth locality, every other Tuesday all the managers of the various community teams meet in a managers’ meeting and we discuss every referral within the Handsworth locality – there are not that many.”

(Team Manager)

LEARNING POINTS

- An initial screen is needed to assess the urgency of response required from the team.
- Varying numbers of people will be assessed as not needing CR. Triage may mean up to 60% of referrals being signposted elsewhere. If the referral is passed back to the GP, further support may be required, for example from a practice-based CPN.
- CR practitioners need to develop confidence in their ability to assess risk. As confidence grows, less medical input is required, although there still must be some kind of on-call arrangement. CRTs have found that support workers play a useful role during assessment.
- Frequent liaison meetings are needed with the other functional mental health teams (such as AO and primary care liaison) to ensure that the system remains dynamic and not blocked.

Care planning and co-ordination

Table 24: Care planning and co-ordination

MH-PIG requirements	Findings
<ul style="list-style-type: none"> • produce a focused care plan; • decide on number of visits and level of input; • begin discharge planning at an early stage. 	Care planning via CPA. May start with simple care plan initially, as needs can change rapidly.
Designated named worker: <ul style="list-style-type: none"> • responsible for co-ordinating the service user's care; • provides continuity of care and ensures effective communication within the team. 	Teams operate a named worker system and will take a leading role in care planning while the person receives home treatment. Liaise with keyworkers in CMHTs.
Intensive support: <ul style="list-style-type: none"> • frequent contact including home visits throughout the crisis; • ongoing assessment of risk and needs; • service must have the capacity to follow the service user through the crisis. 	Provide as much support as needed but if a high number of visits are needed, e.g. more than three per day, may consider alternative. Care plan subject to constant review.

Handsworth

“If home treatment is indicated, a plan is made at that point as to what is necessary. If that is in the middle of the night, it can be a plan to cover the hours up to the following morning. For example, today it's Friday, and I would want to plan for over the weekend – what medication does that person have, what family support networks are available, how often will home treatment staff be visiting, what are the risks – and has risk assessment been done? The plan to cover the weekend would include – do you want to visit once a day, twice a day, does the client need to go to the respite home? The plan is based on what comes out of the assessment and then we act on the plan.

“Initially, on assessment, risk assessment will be carried out, and a care plan and a medical summary prepared. On Tuesdays and Thursdays we have the main review meetings. That means a multi-disciplinary review of every case in home treatment.

“Once somebody has come on to home treatment we operate a named nurse system. I will allocate a named nurse and two co-workers to work with each person. The main criticism that we have of home treatment is that the client sees too many people, so there's no continuity. That is difficult to overcome, but the named nurse system is helpful, because these three people should be the main people who go in, along with the doctor, to deliver the care.

“The nurse should meet with the co-workers and the client to go over the care plan. Once we have decided this is the main care plan that we are adopting, then of course the client has to be involved in it and agree that this is what they want.”

(Team Manager)

CRT involvement in a case can take place alongside the continued involvement of a CMHT, where they are already working with a person:

Barnsley

“We expect and encourage the sector team to continue their intervention. We have had to make sure that the team kept communicating with the sector team.”

(Team Leader)

The average length of time users receive care from a CRT is between three and five weeks, but there are variations depending on a person's circumstances:

Newcastle

“The average length of stay is about three to five weeks. We do take some people for much longer – some people we've been treating for three months, but there are not many of them and they are usually on their first episode of psychosis. And we figure it's just better to treat them in the community if we can, rather than admit them.”

(Clinical Specialist)

Barnsley

“The average length of stay is too long at the moment. Three weeks I would say. There are people who I think could be moved on faster than that because they're not SMI – it's a crisis and we ought to be facilitating that move on more rapidly. I had a weekend off and when I came back there were 18 names on the board, and that was just far too many. It's not rocket science; it's helping people get back control in their lives. Medication has a part to play but it's more about therapeutic use of self – that's what it's about.”

(Team Leader)

LEARNING POINTS

- CRTs have a named worker for each service user, although the care co-ordinator role under the care programme approach remains with the other services that the person was using before the crisis and/or will go on to use during and after the CRT's involvement.
- The short-term and changeable nature of CR work means that care plans have to be continuously under review. Formal multi-disciplinary reviews happen at least once a week.
- Care is intensive, with CRTs offering up to three visits a day before considering alternatives. Engagement is for a short period – on average three to five weeks.

Interventions

Table 25: MH-PIG requirements for interventions carried out by CRTs

<p>Medication:</p> <ul style="list-style-type: none"> • immediate, 24-hour access to medication; • delivery and administration of medication to service users who require intensive monitoring; • care designed to improve concordance (co-operation with treatment); • service user involved in decision making and monitoring effects of medication; • standard side effects monitoring tools to be used regularly by service user and staff.
<p>Practical help with basics of daily living:</p> <ul style="list-style-type: none"> • claiming benefits; • securing housing; • getting help with childcare.
<p>Family/carer support:</p> <ul style="list-style-type: none"> • ongoing explanation to family/carers; • education about the crisis and the service user's illness; • arrange practical help as needed.
<p>Interventions aimed at increasing resilience:</p> <ul style="list-style-type: none"> • range of therapies for both service user and family/carers should be available, including: <ul style="list-style-type: none"> – problem-solving – stress management – brief supportive counselling • interventions aimed at maintaining and improving social networks.
<p>Relapse prevention:</p> <ul style="list-style-type: none"> • individualised early-warning plan developed and on file; • plan shared with primary care, GP and others as appropriate; • relapse prevention plan agreed with service user and family/carers; • effort made to identify and reduce conditions that leave the service user vulnerable to relapse.

Barnsley

“Basically what we try to do is help the family regain its normal functioning, so it’s very practical. In terms of therapy it’s cognitive or PSI [psychosocial intervention] work with people who have got psychosis.

“It’s about engaging with people, so it’s about psychological support, practical support, continuing to monitor, giving the family respite – we work with the family as well. Support workers are brilliant – they will take people out for the whole day to give them a break. One used to work with MACA [Mental After Care Association]. It’s all very practical – it’s not rocket science.”

(Team Leader)

Newcastle

“We obviously use all the bio-psychosocial methods – from simple things like helping with the shopping, to helping get food and problem-solving; from biological treatments to CBT; from giving people medication and making sure that they take it, to side effect monitoring – the whole range of things. Talking to people. In my cynical moments I’ll say that the main difference between intensive home-based treatment and adult acute wards is that in intensive home-based treatment the staff talk with you. You are certain that you will get time with a staff member, spending at least half an hour to an hour with you – you won’t get that in an acute ward. That’s what makes the difference.”

(Clinical Specialist)

Handsworth

“Initially if somebody comes on who is very acutely ill, the first necessary thing to do is to alleviate some of the symptoms that that person will be experiencing. That is going to make the person and their relatives a little more at ease. Helping to reduce some of the distressing symptoms might be through the use of medication. For example, if they are not sleeping you give them something to help them sleep, if they are hearing voices... whatever medication that is decided. Sometimes we even feel that for the first couple of days that’s the best thing that we can do – assist the family, assist the client to actually administer medication and of course go in and look at anything else that needs doing. You are almost getting the patient to a stage where they will be able to discuss with you what it is that needs doing – and that’s for somebody who is extremely acutely ill.

“So it can be a medical model initially – because the person needs medication – and then you look at it from the social perspective. What intervention does that person need to help them with their social circumstances? If you were to ask me what model home treatment operates under, I’d say it is an eclectic model. You offer the person some assistance with what they are dealing with at the moment, whatever that individual needs. The nurses are out in the middle of the night and they pick somebody up – what are they supposed to do with somebody if they have no lighting in their house? So we have access to a fund – always £20 in the cupboard so that nurses can replace gas cards or whatever, and that is absolutely necessary to do the job we do.

(Team Manager)

LEARNING POINTS

- CRTs start with getting some basics sorted out – food, money and alleviating distress. This enables initial engagement.
- Over time CRTs undertake a broader range of psychological interventions and social supports. They also work with families.
- A positive aspect of CR is the amount of face-to-face support received, which may be more than someone would receive in a hospital setting.

Discharge

Barnsley

“As soon as anybody is taken on board you need to have an exit strategy.

“When the client is discharged it should never be a surprise to them. We are working towards that. If somebody is taken on board who is not known to the CMHT, one of the things to do is to notify the CMHT straight away that this is somebody who is likely to need follow-up.”

(Team Leader)

Newcastle

“About 43% of clients go back to the original service [usually CMHT] – they are people who are known to the service.

“‘Care complete’ – 35% of clients get seen and their care is complete, so they are referred back to their GP.

“Some 14-15% of clients are admitted to hospital. Of that group, 15% are referred to CMHTs as new clients. So we’ve taken away that front-end problem for CMHTs in terms of having to do acute or urgent work.”

(Clinical Specialist)

Handsworth

“The typical length of stay on home treatment is four weeks. At the end of the second week a keyworker should be allocated. The keyworker should be coming to at least one review meeting here. By the end of the four weeks the keyworker has probably seen the person with the nurses from home treatment at least twice. You have agreed with the keyworker what are the needs from now on and you are both agreeing with the client what home treatment will stop providing and what the keyworker will take on. In the discharge meeting we discuss where the medical follow-up is going to take place; which doctor is going to see the client and when; how often the keyworker will visit; and any unresolved issues with the care plan. The crisis line number and a week’s supply of medication is given to every patient, and a letter goes out to the GP within 12 hours – not the discharge summary but a nurse’s letter, so that if the patient after that goes to the GP to get their medication the GP knows what medication they are on.”

(Team Leader)

LEARNING POINTS

- CRTs start planning for discharge at the point of intake to their service.
- Active in-reach to hospital settings helps to ensure that people can gain access to inpatient care via the CRT and can be discharged safely via the CRT.
- Visits have to be down to about one or two a week before it is felt reasonable to transfer care to a CMHT with higher case loads.

6

Achieving change

The previous chapters have explored how AOTs and CRTs were established and how they began to function in practice. This chapter seeks to draw out some of the essential lessons for change. In doing this we have focused on key areas:

- financial resources;
- human resources;
- leadership and management;
- transformational change;
- project management in practice;
- change leading to further change.

Financial resources

Securing sufficient resources to set up and run the new teams is vital. The teams we visited have been funded in different ways. Some have struggled to secure sufficient resources to set up and run new services whereas others have been successful in bidding for funds.

In Walsall some service developments already had funding. Money for the crisis team came from the Mental Health Partnership Fund, with 30% from mainstream funding – following a successful joint bid from the community and mental health trust and the social services department. The AO service was funded from the Mental Health Grant. The original plan had been to have a combined CR and AOT, and when it was decided to run the services as separate teams, there was the potential problem of additional costs. This was resolved, however, by making changes to staffing levels.

In Herefordshire there had been much uncertainty about where the funding for the services would come from. It was also felt that, in a small service, there would be little scope for reallocating resources from elsewhere. Problems at the time included the following:

- The community and mental health trust started from a low resource base. An agreement to fund a fifth consultant psychiatrist post was the first major resource input into the trust's mental health service for about ten years.
- There was limited ability to reallocate from existing resources. It was hoped that over time it should be possible to reduce beds, although not in the short term. They were not optimistic that they could release large sums of money at the time.
- There was uncertainty about the availability and timing of modernisation money. Information on what money was going to flow down through the NHS Plan was unavailable, and they were concerned that anyway this would not come quickly.
- There was limited financial support to help with the costs of service developments. The overall resource implications of starting up AO and CR teams can be difficult to determine, in that savings may be expected in the long term in other services e.g. through reducing inpatient beds. Decisions need to be taken about how much of the money can be obtained from changes to existing services and how much needs to come from additional funding.

- Funds that should have been available were not being ring-fenced. There was a dispute over whether or not modernisation money had been ring-fenced for the new services, leading to uncertainty about the trust's capacity to implement them.
- Difficulties were exacerbated by funding cuts in social services. Social services departments face considerable difficulty in supporting AO and CR teams financially.

Herefordshire

“You also need to look at what is available in social services. There has been no allocation from within social services for financial support or any other support, so this needs to be sorted out. We are starting from a baseline of very limited resources – in social services terms, Herefordshire is a poor shire county – and we have had cuts year on year.”

(Mental Health Service Manager and Development Manager)

The above resource problems have all caused difficulties in trying to implement new developments. Although new money is available, in any one area funds may not be sufficient fully to fund all of the set-up and ongoing costs of running a team. For example, the Bradford AOT had to secure resources to top up their funding:

Bradford

“The original sum of money came through without difficulty. What was more difficult was persuading locally the PCTs [primary care trusts], who hold the purse-strings, to add to it the extra that was required. There was a considerable shortfall. The PCTs have lots of priorities – mental health isn't the only one. But eventually it dawned on them that they had all signed up to the service, therefore they couldn't leave the service short, so AO became priority number one.”

(Planning Manager)

Nevertheless, some services, such as the Barnsley Psychiatric Emergency Team and the Cornwall AOT, have been able to secure full funding of set-up and ongoing running costs:

Barnsley

“We were able to attract significant funding from all the partners. The health community made the psychiatric emergency and assertive outreach teams their priorities for development.

“We have an annual £0.5 million budget. We got another half million for setting it up. None of it is about re-provision – it's all new money, so that helps in being able to get on with doing what you want to do.”

(Team Leader)

It has already been noted that implementation of service developments may have to be staged to allow for slow release of resources. Clearly it is preferable to have the services fully funded from the beginning. The costs associated with setting up the team also need to be budgeted for. Box 2 outlines the costs involved in setting up and running selected teams.

Box 2: Costs of new services

Cornwall

Three AO teams, each with capacity for 60 clients:

- Start-up costs for the service (three teams) – £204,000
- Annual running costs – £660,000 (£220,000 per team)

(but some funding also came from social services modernisation funds – approx £120,000 to pay for social work input across the 3 teams).

The danger, if resources are tight, is that people will compromise on one or other aspect of the service, for example cutting down on set-up, management or staff costs. This may mean that the development does not achieve its intended outcome. For example an under-resourced CRT may fail to reduce the use of inpatient care if it cannot provide home treatment. The failure to reduce the use of hospital beds may in turn mean that funding cannot be released from the hospital sector to boost resources for the CRT to an effective level.

The above examples also show that there is, in the long run, potential to redesign existing services. Usually this means remodelling resources used for inpatient care or CMHTs. Although this may be desirable in service as well as financial terms, it is difficult to achieve at the same time as setting up the new service. Usually there is a time lag, maybe of two to three years, before the new service has the desired impact and enables further change to occur.

LEARNING POINTS

- Service developments need to be fully costed to take account of set-up costs as well as ongoing costs. Additional financial support may be needed to accomplish this in some areas.
- The implications of allocating only part-funding for a CRT or AOT should be fully thought through, as 50% of a full team may not bring about 50% of the benefit: it may not benefit users at all.
- Remodelling existing services to release resources is desirable, but this may delay the establishment of new services and there may be a need for bridging finance to ensure that developments are not delayed.
- Lack of transparency and consistency in the way modernisation monies are allocated causes difficulties for service planners and managers.

Recruitment

Recruiting the right staff is fundamental to the ways the new teams operate. These staff will either come from outside or be redeployed from other services. Overall the number of staff needs to increase, and over-reliance on recruiting internally can leave staff shortages in other parts of the service. Where staff are redeployed from existing services it is important to ensure that they have the right skills and are willing to work in new ways. Internal redeployment needs to be balanced with external recruitment, which can bring in staff with fresh perspectives.

In North Birmingham the new teams were originally set up by redeploying staff from existing resources and there was not always a good match between individuals and teams.

North Birmingham

“We ended up with round pegs in square holes and so we had to get them to see, through appraisals, what team they were best suited to. In an ideal world you wouldn’t end up with that scenario. It is very important to know what you are picking.

“We have been able to select all the new candidates. People for home treatment, assertive outreach, primary care – they are so different.”

(Locality Manager)

Staff in North Birmingham were largely given a choice of which team they wanted to go to. In one of the other teams we visited, not all staff were given the choice but were chosen by managers to move into the new service. Although this can work if the right people are chosen, and appropriate training and support are provided, it could lead to resentment.

Internal recruitment should be carried out to the same standards as external recruitment and requires:

- robust selection procedures;
- a clear idea of the skills, competencies and attitudes required for different teams;
- multi-disciplinary training;
- ongoing support and supervision to ensure that staff can maintain and develop new ways of working.

Some sites have experienced difficulties in attracting staff. In Walsall the setting up of the AOT was delayed by problems recruiting to the existing crisis outreach team. Some staff, including the team leader, were to be moved from the crisis team but this couldn’t happen until vacant posts there were filled.

Recruitment problems can arise from a particular local situation, and are exacerbated by national shortages. For example in Barnsley:

Barnsley

“We had some problems with particular members of staff which I think is a reflection of the kind of national problem really, in that there is such a shortage of nurses, and this is predominantly a nursing team. So it’s very difficult to recruit good nursing staff. I think it’s very difficult to recruit them anywhere but in a place with the kind of image that Barnsley has it’s even more difficult.”

(Team Leader and Sector Manager)

It helps to recruit key individuals first. For example, in Bradford:

Bradford

“The first two people to be recruited were our user development worker and team manager, and they then recruited the rest of us, with input from other senior people in the trust.

“The team manager and the user development worker then joined the project team and they took over the final stages. They were on all the interview panels and joined by other members of the project team. Recruitment was completed late 2000/early 2001. We had a good response to the national advert.”

(Planning Manager)

Being able to offer an attractive package can secure better staff:

Cornwall

“We wanted to recruit support workers for the team so we visited Bradford to look at the work being done there. We decided on a new grade of health-care worker and wanted to actively encourage people with experience of mental health services to apply. Enhanced payments for weekend working were rolled up into a salary package and we were able to offer a starting salary of £15,000. When the nine posts were advertised there were 400 enquiries and, in the end, we had over 150 applicants. Interviews were held with a service user panel and a professional panel. Appointments made included people who had had experience of using mental health services. Also some people came who had experience of working in similar teams.”

(Mental Health Manager)

Despite such successes there have been problems with recruitment of particular professions, most notably social workers. North Birmingham had problems negotiating social work input into the teams:

North Birmingham

“Not having the right staff to begin with caused a lot of problems because it wasn’t just nursing staff, it was social workers as well – so trying to get social workers involved in the concept of outreach widened their duties which were previously generic.

“We have just now got special duty payments for them – it has taken us four years. But the new social workers that have been recruited over the last 18 months/two years have jumped into it just like a fish into water.”

(Locality Manager)

Some sites have had to lower the entry criteria:

Bradford

“We recruited all the nurses and support workers in the first phase. We had more difficulty recruiting social workers. A number of efforts to recruit at various levels were made – each time we had to lower the entry criteria. Originally we went for ASWs; the next time we went for SWs with mental health experience and had more success.”

(Planning Manager)

Sometimes difficulties are due to historically poor relationships between health and social services. Generally, though, relationships with social services departments are improving and teams have integrated management:

Newcastle

“We are just now undergoing mainstreaming of social services and mental health together. So they are coming together and there are team leaders soon to be appointed who will be leaders of both social service and CMHT practitioners, so they will all be under the one umbrella.

continued overleaf

“But what helped was that we got a secondment of a senior social worker who came and worked with us for six months to do an evaluation. He really enjoyed it and could see the need to have social services here. Social services grew to trust us. When we first wanted to use crisis respite facilities, they just said, ‘No – there’s no way we’ll let you do it because every time we’ve let other people use it they’ve just abandoned the person.’ I said, ‘We’ll never do that – we’ll always remain actively involved while the client is in the care of social services’ and we stuck to our word. It was about changing the culture, saying that we were actually interested in delivering a better service for the patient and the carer – that’s what it’s all about.”

(Clinical Specialist)

There has been joint working over developing job descriptions and terms and conditions:

Bradford

“One job description was used in health and one in social services, so we took the best from both and brought them together into one document which we have been using as the template for jobs elsewhere. It satisfies both health and social services personnel requirements.

“Working weekends and evenings was always mentioned in the adverts – we had to be very clear that that was a requirement of the post.”

(Planning Manager)

Other reasons for difficulties with social work recruitment may include:

- Social workers do not find the jobs attractive, for example having to deal with difficult clients and working out of hours – nurses, especially if they have worked in inpatient services, are used to working shifts.
- Social workers may be unwilling to work in multi-disciplinary teams where they are in a minority. It is not clear whether the current skill mix in the teams is a reflection of a deliberate plan to have more nurses than social workers, or just a pragmatic response to recruitment difficulties.

Interestingly, the Walsall crisis outreach team was set up to have an equal mix of nurses and social workers and has consistently been unable to maintain this balance. It is perhaps encouraging that despite the lack of social workers in the teams, some of the team managers, e.g. Bradford and Walsall, do have social work backgrounds and are able to bring the vital social perspective.

Teams have been at least partly successful in attracting people with a range of relevant skills and backgrounds:

Newcastle

“We had no problems with recruitment. Not all staff were recruited from existing services – some were recruited from outside. Most of them came from inpatient units, which surprised me a bit then, but now I’m not surprised because they were used to 24-hour rosters and they wanted something different and something exciting. And of course they were the best people to come because they were the ones who were used to dealing with acute problems. So there was a bit of a brain drain from some of the wards.”

(Clinical Specialist)

Bradford

“People in the team have experience of working with people with dual diagnosis. In the reference to the skill mix and the skills requirement, we did say that that experience was desirable.

“Staff come from a range of backgrounds e.g. acute ward, rehab team.

“The support worker staff have experience of using services, which has been a key element in enriching this team’s skills and understanding.”

(Planning Manager)

Barnsley

“The Team Leader has a community background – there’s some staff from the wards, some staff from CMHT and one from assertive outreach. Support workers are a really interesting mix. One is actually a carer who has never worked in the health service before and has taken to it like a duck to water.

“We hoped that we’d attract more people who were either clients or carers, but only one applied. But she’s proved to be really good. She talks common sense.

“Support workers are people prepared to do practical kinds of stuff and when you are working with people in crisis you do need to go in and do some washing up or some housework or some fire-lighting or whatever. It doesn’t need a qualified member of staff to do that, but support workers are invaluable.”

(Team Leader and Sector Manager)

There can be difficulties in recruiting particular groups of staff e.g. those from minority ethnic communities:

Bradford

“We tried as hard as possible to attract staff to this team from minority ethnic communities. We were clear in the advert that we were trying to attract people from the ethnic communities. We weren’t that successful with the nursing posts but that’s a problem nationally, to get qualified Asian nurses. But some of the support worker posts were filled by people from the Asian community. It’s an ongoing issue for Bradford, as it is for other areas, to have a team whose make-up reflects the local population.”

(Planning Manager)

Medical staff recruitment has not been a problem for some teams because sector consultants have retained responsibility. However, where a dedicated post is agreed, and this is an additional post, external approval may be needed. This can be a long and protracted process.

LEARNING POINTS

- Teams have had some difficulties with recruitment of particular professions, notably social workers and medical staff. Skill mix may need to be revised to enable practical as opposed to ideal solutions.
- It is important to recognise that CR and AO are different and need different types of people, with different skills.
- There should be a balance between internal and external recruitment. Whichever is used there should be a robust method of selection.
- Innovative salary packages and/or reducing the essential criteria for a post can aid recruitment.

continued

- Many skills gaps are being filled by support workers. Their role needs to be recognised and rewarded. Many posts are currently posts at B-grade nurse level. The career pathways for these workers should be examined.
- Successful recruitment of social workers will depend, to some extent, on improved multi-disciplinary working at both the strategic and the operational level to ensure that agreements on funding can be reached and that social workers are attracted to working in the new teams.
- Staff will come with different backgrounds and experience, e.g. home treatment teams have recruited a mix of staff from inpatient and community services. Training provided for the new teams will need to reflect these varying backgrounds.

Training

The critical ingredient of team success lies in the practice of the team members. Effective practice within the context of a CRT involves more than a transfer of traditional inpatient hospital care to a home-based setting. If CRTs are to become more than 'meds on wheels' and avoid the criticisms currently levelled at ward-based care, of being non-therapeutic (The Sainsbury Centre for Mental Health, 1998b), then a transformation of traditional approaches to acute care and treatment is essential.

The Capability Framework (Lindley *et al.*, 2001), a national framework for effective practice underpinning the NSF-MH, offers a starting point to develop effective approaches to training and team development for CR services.

SCMH, in collaboration with the National Institute of Mental Health in England (NIMHE) has developed a national core-training programme for CR services and team leaders (O'Halloran *et al.*, 2002). This has been piloted extensively throughout the UK and is now being delivered in partnership with each of the NIMHE regional mental health development centres.

A structured training programme should be provided for the whole team. This should be based on an assessment of the current capabilities of the staff making up the team. One of the key purposes of the training will be to ensure that the whole team has a clear understanding of the philosophy of the service and what this means in terms of changes to traditional ways of working.

It is recommended that, with new teams, the first month, prior to taking on new cases, is spent in training and team development. There will be the usual variations in the experience and skill mix of the team members, and this initial month gives an opportunity for the members to meld as a team and to develop the necessary confidence, along with appropriate values and skills.

This may appear to be a luxury but it is time well spent. Most of the well-functioning teams currently in operation have invested in this level and intensity of training and development up front, to good effect.

The first two weeks are used in:

- getting to know the rest of the team;
- team development activities;
- finalising and refining operational policy;
- signing up to the goals and objectives of the team;
- getting to know the local patch in terms of available resources for use in crisis;
- understanding the wider system within the trust and the community beyond;
- making contact with key referrers;
- becoming familiar with team protocol and procedures.

The second two weeks are used in intensive training in identified areas of need including:

- values and attitudes;
- principles and practices of 'home' treatment and underlying philosophy of CR services;
- research evidence;
- culture, diversity and anti-discriminatory practice;
- gender issues;
- service user engagement and developing a working alliance;
- comprehensive, crisis-oriented needs assessment;
- symptom and mental state assessment;
- treatment planning and the care programme approach;
- risk assessment and management;
- assessing and managing acutely suicidal behaviour;
- appropriate use of the Mental Health Act and alternatives to hospital treatment;
- community treatment of acute psychosis;
- medication strategies;
- monitoring and managing side effects;
- basic cognitive and behavioural approaches to problem identification, goal setting and problem solving;
- motivational interviewing;
- medication concordance strategies;
- early intervention and relapse prevention;
- dual diagnosis, substance abuse and mental illness;
- working with families and the social support system;
- multi-disciplinary team work.

While some of this will be familiar to many members of a multi-disciplinary group of practitioners, much of it will not, particularly in relation to the specific application of these interventions within a crisis context.

Working with people in psychiatric crisis is a challenging area requiring a broad array of clinical and social care skills. This training should be seen only as a foundation; further skills will be refined and developed with experience. Many teams also express the need for additional in-depth training and practice development in specific areas several months after starting to operate. This allows time for the 'theory', taken on board in initial training, to be reflected upon and grounded in the day-to-day experience of real practice. Gaps can be identified in training and bespoke programmes developed to meet the emerging needs of the team.

LEARNING POINT

- Multi-disciplinary team training will be needed to ensure that the whole team has a clear understanding of the aims and philosophy of the team and how these may necessitate changes in the way they practise.

Leading change

With a new service, working to a model which in many ways challenges traditional ways of working, team leadership is essential. Ideally, the team leader should be in post well before the team becomes operational and they should be involved in planning and setting up the team. The team leader should have the authority to clinically manage, supervise and steer the team. They should be accountable for implementing the goals of the service, monitoring performance and evaluating effectiveness.

The MH-PIG recommends that all teams should have a team leader. It also recommends that the team leader for AO should have an active caseload; most of the team leaders we spoke to did. Given the potential size of the management task facing team leaders it could well be argued that it should

be a full-time job, but this needs to be weighed against the undeniable benefits of the team leader being able to set an example by working with, albeit fewer, clients. A number of teams have resolved this issue by appointing deputy team managers to share the management workload. Other teams also have specialist practitioner or nurse consultant posts to take on development work, evaluation and training.

Some of the AOTs that we visited have reported good team working (although not all are as multi-disciplinary as they would like). Success does seem to be linked to effective team leadership and in particular to having clear goals. The importance of team leadership becomes clear when it is absent. For example, one of the AOTs in North Birmingham started off without a team leader and no clear goals (despite the fact that a strategy had been developed and implemented in consultation with staff – illustrating the need to keep on reinforcing messages). The team soon reverted to more traditional ways of working; for example, they stopped working extended hours. Appointment of a team leader with a clear vision of how the service should work helped to turn the situation round.

Lack of leadership, even for a short time, can lead to teams reverting to old ways of working:

Barnsley

“The team leader was off sick at the same time as the team doctor left, and there were a lot of people on the caseload that the team wasn’t doing home treatment with – we were running around giving medication, starting to become like a CMHT and we had to work very hard at the beginning to pull that back.”

(Team Leader)

Managing a multi-disciplinary team requires recognition of the unique contributions of each individual and professional group:

Bradford

“Each person has unique skills that we bring no matter what our background – whether we are a service user development worker or a support worker or a nurse or social worker, psychologist, psychiatrist. We each bring our own unique professional and personal perspectives to people’s problems.”

(Consultant Psychiatrist)

Managing multi-disciplinary teams requires good management skills. As well as ‘creative tensions’ between AO and other teams there may also be tensions within the team between professional groups (although from discussions with the AOTs it appears that the team-working approach helps to prevent these arising in the first place).

Most of the teams we visited have paid particular attention to the need for staff support and supervision. This is achieved in a variety of ways:

- peer support through team-working – the shared caseload approach inherent in AO encourages this;
- line management and caseload management;
- professional supervision – either from professionals within the team or from outside;
- liaison with other teams e.g. through local or national AO networks.

LEARNING POINTS

- Team leadership is essential, although this is sometimes not recognised until it is absent.
- Effective delivery of the new service models will depend on good multi-disciplinary team working. In particular, the team approach to individual care associated with AO helps team working in general.

Transformational change

It is clear from the people we spoke to for this study that there is widespread belief that the NSF-MH implementation process to date has not fully taken account of the complexity of the task. In focusing on models, structures and targets the implementation process fails to take into consideration the major change in the culture and philosophy of service delivery that underpins the NSF-MH.

One Local Implementation Team (LIT) manager describes this paradigm shift: "The NSF calls for a fundamental shift in the way that services are delivered. In its simplest terms it is a shift from a medical model that delivers care to the individual patient to a... model of care delivery that works in partnership with a service user and their whole system. Fundamentally the NSF is about delivering a paradigm shift in care delivery and changing the culture and attitudes that underpin service delivery."

AO and CR services, if delivered according to best practice, offer good examples of this paradigm shift. They are not simply new ways of organising existing services. Iles and Sutherland (1997) identify three types of change:

- developmental change – improvement of an existing situation;
- transitional change – implementation of a known new state; management of the interim transition state over a controlled period of time;
- transformational change – emergence of a new state, requiring a shift in assumptions made by the organisation and its members.

In effect, NSF-MH implementation is being managed as transitional change when in fact it is really transformational change. To achieve this change across the whole mental health system will require change at three levels: organisational structures; organisational processes; and the culture and attitudes of the people within them.

To change the mental health system successfully, all three elements need to be addressed. Otherwise there is a danger that only the structures and processes will change, without the necessary change in culture and attitudes. Alternatively, culture and attitudes may change but without the necessary structures and processes to support them.

Difficulties in implementation, which have caused some people to question the validity of a number of the service models put forward by the NSF-MH, have probably resulted from insufficient attention being paid to one or other of these three factors. For example, a home treatment service which simply focuses on medication and monitoring, and which does not work on engaging service users and carers in trying to tackle the real issues that may have precipitated a crisis, is not working to the model of care envisaged by the NSF-MH. Similarly, intensive case management for people with severe mental health problems, which is sometimes wrongly equated with AO, simply takes one element of the AO model – high staff-to-client ratio – without addressing the fundamental change in attitude to service delivery that is of key importance to AO.

It is unsurprising that the NSF-MH targets have concentrated on changing structures and processes. It is difficult to quantify changes in attitude and culture (although feedback from service users would be one way of measuring them). The result has been that the perhaps excessive focus on the things that are easier to measure has diverted people from tackling issues that are more fundamental to the change process. An example of this concerns the CPA targets. It would be perfectly possible to

meet these targets (although many services still do not) without making the change in attitude necessary to ensure that care plans are developed in real partnership with service users and their carers. And real, user-focused, care planning is the fundamental building block of the whole system.

Learning the lessons about change

Lessons have been learnt in the past and the messages are remarkably consistent. They are well summed up by Dunning *et al.* (1999) in a review of 16 projects on implementing evidence-based practice promoting clinical effectiveness. The authors note that implementation:

- is a messy business;
- is not a linear task;
- takes time;
- is expensive.

They also note, though, that the effort put in is worthwhile and that change can be achieved if there is sound evidence on which to base the work and if a project approach to managing implementation is adopted. A project management approach provides essential structure to the change management process and has precedents in the psychiatric hospital closure programmes. Indeed, the changes that were achieved in the structure of services in North Birmingham are, at least in part, attributable to the adoption of a project management approach.

However, project management alone is unlikely to be sufficient to achieve the complex changes required by the NSF-MH. The changes are being imposed, to a certain extent, by national policy rather than local choice. The policy needs to be translated via local managers into behavioural changes on the part of practitioners, which should lead to more positive experiences for service users and their carers. Each tier has an important role to play in what needs to be seen as a dynamic process.

Evidence from this study suggests that the main factors in successful implementation of the new service models appear to be:

- an acceptance of the need for the service and a clear understanding of how it fits into the rest of the system (current and future);
- leadership from key individuals, e.g. lead clinicians or managers, linked with power to influence resources or behaviour;
- sufficient resources (money and time) to plan and implement the changes;
- good project management and communication with key stakeholders. Clear messages need to be passed down (and up) through the system. Unfortunately these can be distorted when people have their own agendas or vested interests. A culture of blame can develop through misunderstandings or when people see that things don't actually change.

As noted by Iles and Sutherland (1997) many approaches to organisational change give the impression that change is (or can be) a rational, controlled and orderly process. In practice, however, organisational change is chaotic, often involving shifting goals, discontinuous activities, surprising events and unexpected combinations of change and outcomes.

LEARNING POINTS

- The potential difficulties and complexities of implementation must be acknowledged. Performance management focuses on structural changes – little emphasis is put on changes to attitudes and culture.
- Implementing the NSF-MH represents a paradigm shift in mental health care that involves transformational rather than developmental or transitional change. Also, this is not just movement to a fixed point but a step forward in a dynamic system. *continued*

- To achieve real change (a paradigm shift) attention must be paid to three key aspects of the change process – structures, processes and people (culture/attitudes).
- Change is not easy, not linear, and takes time and resources.
- Change can be achieved with a sound evidence base, project management and an understanding of the dynamics of the process. It may not happen quite as expected and needs to be kept under review.
- Key factors for success include: acceptance of the need for the new service and understanding of how it will improve things; leadership; resources; and good project management.
- Ultimately, change needs to happen at the front line, enacted by clinical teams. But managers have a role in 'managing' the process and understanding the barriers.

Project management in practice

A good project management approach will be vital to the effective establishment of the new services. The development of some of the North Birmingham teams provides examples of a systematic approach to implementation.

Box 3: Development of assertive outreach in Yardley/Hodge Hill locality

Recruitment and active involvement of the team leader prior to the operational planning and development stage facilitated a personal investment in and ownership of team development. Local management support allowed the team leader a greater sense of personal autonomy when shaping the development plans for the team.

The team leader was recruited in March 1996 and was actively involved in co-ordinating the planning of the service over a five-month period in conjunction with locality management, social services and the consultant psychiatrist, who had previous experience of setting up and working within such teams. Key tasks included:

- establishing a framework for operational policy;
- holding planning meetings, at which health and social services were represented, to agree staffing levels and composition, day-to-day management and key operational procedures;
- liaising with existing mental health teams and keyworkers to identify an initial list of service users who were considered priority for referral to the AO team;
- familiarising staff from other teams with referral procedures and with how the AOT would integrate with other services.

Operational policy was drafted by the team leader and modified in consultation with other trust staff in the locality, the social services department, and voluntary sector and user groups.

(The Sainsbury Centre for Mental Health/Northern Birmingham Mental Health NHS Trust, 1998)

Most sites have set up steering groups with representation from key stakeholders. These groups need to have clear remits.

Box 4: Developing home treatment in Yardley/Hodge Hill locality

Working with local social services, the locality formed two groups:

- Operational Group – met every two weeks; agreed policies and procedures; identified issues and tasks; co-ordinated services; monitored process.
- Steering Group – met monthly to start with and then quarterly; included user group and voluntary organisation representatives and CHC [Community Health Council]; shared information; and acted as a means of consultation.

continued overleaf

- The team leader was recruited early in the process and worked in liaison with the steering groups to agree development plans and policies; explain to statutory and non-statutory agencies how the service would work; identify and establish links with community resources such as day centres; recruit, train and induct staff into the team; and establish team office space.

(The Sainsbury Centre for Mental Health/Northern Birmingham Mental Health NHS Trust, 1998)

Similar project management approaches have been used elsewhere:

Bradford

“Two project teams were set up at more or less the same time to look after the development and recruitment for two assertive outreach teams. Each project team had operational managers and senior nursing staff working together on small elements of activity to get the teams together. Some people looked at job descriptions and the recruitment processes. There was work done on the basic operational policies – there would be fine-tuning once the team started but it needed the bare bones and the direction that people were expecting to go in.”

(Planning Manager)

A lot of work may have to be done on reinforcing the models:

Small Heath (Birmingham)

“It was a lot of hard work – 12 months of change management. The main message of that was ‘just keep reinforcing the model every day’: myself spending time going over and over the model and where we were going; the chief executive coming and doing the same. When you have done it you forget how hard it was – you think it happened just like that – but it didn’t.”

(Former Locality Manager, Small Heath)

The support of senior managers can be a key factor in successful implementation:

Newcastle

“A project team chaired by a clinical specialist enjoyed the support of various senior people within the trust (chief executive, medical director, senior managers and the nurse leader) – they were completely in support of the service developments. They got sold on the idea and they were of enormous help.”

(Clinical Specialist)

With major service developments, a staged process may be needed:

Newcastle

“Because it was such a radical form of service delivery, we had to do it in a staged process otherwise it would have been too much of a paradigm shift. We also weren’t clear about what the demands upon us would be. The third reason why we rolled out gradually was so that we wouldn’t drain the existing workforce. We wanted them to be able to manage the workforce planning, so we staged it for those reasons.”

(Clinical Specialist)

The importance of adopting a systematic and open approach becomes very clear when things go wrong. In one site, problems with service developments arose from:

- lack of clarity about responsibilities for decision-making and managing the change process;
- limited consultation with key stakeholders;
- having to rush through the changes because of the delays in decision-making;
- distress caused to service users and carers about the changes to their service and uncertainty about what services would replace them;
- distress caused to staff by the way in which recruitment to the 'new' service was handled.

Staff involved felt the situation would have been helped by:

- setting a realistic timescale for the change;
- proper consultation with stakeholders, especially service users and carers;
- a more objective, honest and open process of decision-making and change management, with clarity about who has the authority to make decisions;
- having two people to manage a change process – one to deal with process issues and the other to offer the space, time and attention needed for 'psychological thinking'.

They made the following recommendations for future change management:

- Clearly identify individuals within the organisation who have skills in change management and a strategy to employ these skills when required;
- Learn lessons from the change-management process by evaluating its effect on all grades of staff;
- Pay close attention to recruitment and retention issues;
- Ensure that client need, rather than local politics and inter-directorate wrangling, is the driving force of change;
- Reward motivated and proactive staff groups and develop communication structures to allow for 'bottom-up influencing' of decision-making about service development.

LEARNING POINTS

- Successful implementation of the new teams requires a structured project-management approach involving key stakeholders and ideally led by the future team leader.
- Roles and responsibilities of the project team should be clearly stated, and authority for decision-making set out.
- The new models need to be constantly reinforced for the benefit both of the people who are going to work in them and of other services that will be working alongside them.
- Support from senior managers and clinicians can be a key factor in tackling resistance to the new services.
- Attention must be paid to the 'human' dimensions of service changes, including impact on staff and service users.

Change leading to further change

Most of the teams visited for this study see change as an ongoing, dynamic process. NSF-MH implementation is not just about receiving new money for AOTs or CRTs and setting these up as add-on extras to the existing system. It is about seeing new resources and new services as investments that can bring about additional dividends and further new resources.

Newcastle

“We’ve closed down six beds in some of the units but we’ve still got between 30 and 40 empty beds on any one day. So we can close a ward. We will close beds or their function will alter within about 12 months and that’s because we’ve obviously made some drastic service changes.

“What that’s allowed us to do is fix up the front end of the service and that’s given everybody a chance to catch their breath. And the psychiatrist’s group now are highly motivated towards re-engineering the rest of the service, so that we can make it more accessible. I’m now leading on that project, which we call the Clinical Pathways Project.

So we are actually re-engineering, looking at access to services, looking at points of entry, looking at the points of care that are delivered at various levels – say, within CMHTs and inpatient beds. And then we are looking at transitions between different parts of the service and then looking at exits and transfers. So we are trying to produce a service that is episodic but that is more geared towards acute care and episodes of acute care, with continuing care in another part of the service.”

(Clinical Specialist)

LEARNING POINT

- The real benefits of NSF-MH implementation come when system transformation begins to occur as investment in change creates further service improvements.

7

Learning points

This chapter pulls together the learning points listed in previous chapters.

What do users and carers want from services?

The lessons for AOTs and CRTs are similar:

- Service users' and carers' views on problems with existing services and how they would like to see these changed can be a powerful tool in challenging the way things currently work.
- The features of the new service models appreciated by service users are the positive relationships with staff, practical help and support, choices about their care, empowerment, and, in the case of AO, opportunities to move on.
- Consultation with service users and carers should take place at an early stage and the outcome should inform decisions about service developments, rather than the consultation simply being an occasion to tell the service users and carers about proposals.
- Other important stakeholders, such as staff and GPs, should also be consulted properly and informed of developments. This is time-consuming but necessary.

Eligibility criteria – who is the service for?

The eligibility criteria set out in the MH-PIG are a good starting point. More specifically, for AOTs:

- Local needs assessment should be used to determine any variations in eligibility criteria. Specialist AOTs meeting the needs of specific communities, such as young black people, may be a useful part of the overall service in some areas.
- Taking on more people who do not meet the criteria for AO, or making the criteria more flexible, may not be helpful as there is evidence that people who do not meet the MH-PIG criteria do not benefit from AO. It may be preferable for the team to cover a broader geographical area or reduce its capacity.
- It is very important that teams and those who refer to the team are clear about the eligibility criteria. It appears that there is often confusion about people who are described as 'difficult to engage' or just 'difficult'.
- A number of teams are potentially excluding people who might benefit from assertive outreach by only accepting people who are already known to services – i.e. they are operating as a tertiary service. This may not be problematic if secondary services are accessible.

And for CRTs:

- CR/home treatment services should be targeted at people with severe mental illness. In practice, teams do not restrict the acceptance of referrals to this group but instead focus on those people who would otherwise require hospital admission.
- CRTs will need to undertake significant triage work to ensure that people receive the right service for their needs.

Identifying need

- For AO, an estimate of approximate numbers can be made on the basis of numbers of known service users who are likely to meet eligibility criteria. However, this should not be seen as a one-off exercise, as assessment and access issues need to be reviewed on an ongoing basis.
- It is more difficult to estimate need for CRTs as potential clients are not known in advance. There is a danger of implementing service-driven as opposed to need-driven models. The initial capacity of the service should be determined by current use of other crisis and acute inpatient services. Again, this will need ongoing review to ensure that all the crisis/acute elements are working together and that each element has appropriate staffing levels, skill mix and client mix.

Developing the service approach and philosophy

- Slow build-up of resources may mean it is impossible to start up new teams at what would seem to be the ideal time from a practical viewpoint. If this is the case, fulfilling the MH-PIG will have to be regarded as the longer-term goal.
- More research evidence is needed to determine the right configuration of AOTs and CRTs in rural areas.
- Developing a bio-psychosocial approach is important but it is an approach that may be at odds with practitioners' backgrounds and the orientation of other mental health services.
- Poorly integrated arrangements for CRTs without sufficient professional skills may not reduce the use of inpatient care.

Staffing

- There is a tendency for both AOTs and CRTs to be dominated by nurses, as they are the category of staff most readily available. The more a team is dominated by one profession the more difficult it will be for other professionals to enter the team. Experience over time suggests that a broad skill base is essential for AOTs.
- It is particularly important for CRTs to have medical staff input. For AOTs medical input does not have to be within the team but it helps to have just one consultant psychiatrist to whom to relate.
- Support workers are highly valued on AOTs and CRTs. The tendency is to under-estimate the need for support workers when setting up a new service.
- People who have used mental health services may usefully be employed in a variety of professional and non-professionally aligned roles. One service had established an innovative user development worker role.
- Psychologists could potentially make a valuable contribution but are difficult to recruit. An alternative is to recruit or train other professionals, such as nurses, to carry out specific psychological interventions.

Operational issues

For AOTs:

- Team working has significant advantages but these must be weighed against the time taken for communication when the whole team needs to know about every service user.
- Staffing arrangements need to ensure safe working practices, to minimise any potential risks to staff.
- Teams need to consider how much demand there is for out-of-hours services, and the most economical and effective means of providing these services where they are required.

For CRTs:

- Organisational arrangements for CRTs are complex and an efficient 'board' system is required.
- Liaison arrangements with A&E departments are crucial, especially out of hours.
- More mature teams find there is little demand for CR overnight.

Referral arrangements**For AOTs:**

- In practice most AOTs take their referrals from other mental health services and not directly from primary sources. It particularly helps if the approach is from the CPA care co-ordinator.
- While they are starting up, AOTs need to take on service users in a gradual stream. It is also important that they do not over-provide intensive support that may then be difficult to withdraw.
- Screening is necessary but is often disliked by other services as it is seen as a barrier to access. It helps if the AOT has proactive liaison arrangements with other mental health services, so that it can then sensitively carry out triage and give advice.
- If AOTs prioritise working with people who are difficult to engage, the mental health system as a whole must acknowledge that there are other people who are well engaged with services, but who need intensive community support. If such support is not available from the AOT it will need to come from another team.

For CRTs:

- In practice it is quicker to go and see people who may have been inappropriately referred, rather than have a lengthy dispute. This approach may also reduce inappropriate hospital admissions.
- Over time the approach has become diplomatic, supporting and educating relatively inexperienced GPs and junior psychiatrists.
- Alternatives to CR, such as helplines, are important for people who need some help but not CR.
- Alternatives to hospital, such as crisis houses, can be supported by CRTs.
- Risk must be assessed and then managed.
- Caseloads have to be carefully managed with some users being discharged within a couple of days. The intensity of care should always be reduced through negotiation with the user.

Assessment**For AOTs:**

- Assessment is a detailed process that can take several months of working with a service user to complete.
- The process of assessment needs to involve users as much as possible.
- Assessment needs to be driven by a bio-psychosocial model that incorporates all aspects of life.
- Ongoing risk assessment and management must be a strong feature of the process.

For CRTs:

- An initial screen is needed to assess the urgency of response needed from the team.
- Varying numbers of people will be assessed as not needing CR. Triage may mean up to 60% of referrals being signposted elsewhere. If the referral is passed back to the GP, further support may be required, for example from a practice-based CPN.

- CR practitioners need to develop confidence in their ability to assess risk. As confidence grows, less medical input is required, although there still must be some on-call arrangement. CRTs have found that support workers play a useful role during assessment.
- Frequent liaison meetings are needed with the other functional mental health teams (such as AO and primary care liaison) to ensure that the system does not get blocked.

Care planning and team allocation

For AOTs:

- Production of a care plan is a gradual process that can take up to six months.
- A pragmatic approach is needed to balance the benefits of whole-team working with the need to have a single worker identified as the care co-ordinator. Flexibility is required and user preferences should be taken on board.
- Teams also need liaison workers to relate effectively to a broad range of mental health and other agencies.

For CRTs:

- CRTs have a named worker for each service user although the care co-ordinator role under the CPA remains with the other services that the person was using before the crisis and/or will go on to use during and after the CRT's involvement.
- The short-term and changeable nature of CR work means that care plans have to be continuously under review. Formal multi-disciplinary reviews happen at least once a week.
- Care is intensive, with CRTs offering up to three visits a day before considering alternatives. Engagement is for a short period – on average three to five weeks.

Engagement

For AOTs:

- AOTs need to take a long-term, persistent and, where necessary, intensive approach to engagement.
- Initial work should focus on issues users want to deal with. In the longer term AOTs should work with users to help them develop a better understanding of their mental health problems.

For CRTs, engagement is not a major issue.

Interventions

For AOTs:

- A broad range of interventions are offered – practical tasks linked with social support, medication, physical health care, and employment and education support.
- The teams actively engage with people who have co-existing substance misuse problems, although helping them is difficult.
- AOTs do not yet, on the whole, have the skill base to deliver more specialist interventions such as cognitive behavioural therapy (CBT). This skills gap may become more important now that NICE guidance states that all people with schizophrenia should be able to receive CBT (National Institute for Clinical Excellence, 2002).

For CRTs:

- CRTs start with getting some basics sorted out – food, money and alleviating distress. This enables initial engagement.
- Over time, they undertake a broader range of psychological interventions and social supports. They also work with families.
- A positive aspect of CR is the amount of face-to-face support received, which may be more than someone would receive in a hospital setting.

Discharge

This has not become an issue for AOTs to date.

For CRTs:

- CRTs start planning for discharge at the point of intake to their service.
- Active in-reach to hospital settings helps to ensure that people can get access to inpatient care and be discharged safely via the CRT.
- Visits have to be down to about one or two a week before it is felt reasonable to transfer care to a CMHT with the usual high caseloads.

Financial resources

- Service developments need to be fully costed to take account of set-up costs as well as ongoing costs. Additional financial support may be needed to accomplish this in some areas.
- The implications of allocating only part-funding for a CRT or AOT should be fully thought through, as 50% of a full team may not bring about 50% of the benefit. It may not benefit users at all.
- Remodelling existing services to release resources is desirable, but this may delay the establishment of new services and there may be a need for bridging finance to ensure that developments are not delayed. There needs to be more transparency and consistency in the way modernisation monies are allocated.

Human resources

- Teams have had some difficulties with recruitment of particular professions, notably social workers and medical staff. Skill mix may need to be revised to enable practical as opposed to ideal solutions.
- It is important to recognise that CR and AO are different and need different types of people, with different skills.
- There should be a balance between internal and external recruitment – but whichever is used there should be a robust method of selection.
- Innovative salary packages and/or reducing the essential criteria for a post can aid recruitment.
- Many skills gaps are being filled by support workers. Their role needs to be recognised and rewarded.
- Successful recruitment of social workers will depend, to some extent, on improved multi-disciplinary working at both the strategic and operational levels to ensure that agreements on funding can be reached and that social workers are attracted to working in the new teams.
- Staff will come with different backgrounds and experience, e.g. home treatment teams have recruited a mix of staff from inpatient and community services. Training provided for the new teams will need to reflect these varying backgrounds.
- Multi-disciplinary team training will be needed to ensure that all members of the team have a clear understanding of its aims and philosophy and the implications for changing the way they practise.

Leading change

- Team leadership is essential, although this is sometimes not recognised until it is absent.
- Effective delivery of the new service models will depend on good multi-disciplinary team working. In particular, the team approach to individual care associated with AO helps team working in general.

Transformational change

- The potential difficulties and complexities of implementation must be acknowledged. Performance management focuses on structural changes – little emphasis is put on changes to attitudes and culture.
- Implementing the NSF-MH represents a paradigm shift in mental health care that involves transformational rather than developmental or transitional change. Also, this is not just movement to a fixed point but a step forward in a dynamic system.
- To achieve real change (a paradigm shift), attention must be paid to three key aspects of the change process – structures, processes and people (culture/attitudes).
- Change is not easy, it is not linear, and it takes time and resources.
- Change can be achieved with a sound evidence base, project management and an understanding of the dynamics of the process. It may not happen quite as expected and should be kept under review.
- Ultimately, change needs to happen at the front line, enacted by clinical teams. But managers have a role in ‘managing’ the process and understanding the barriers.
- Key success factors include acceptance of the need for the new service and an understanding of how it will improve things, effective leadership, resources and good project management.

Project management in practice

- Successful implementation of the new teams requires a structured project management approach involving key stakeholders and ideally led by the future team leader.
- The roles and responsibilities of the project team should be clearly stated and authority for decision-making set out.
- The new models need to be constantly reinforced for the benefit both of the people who are going to work in them and of other services that will be working alongside them.
- Support from senior managers and clinicians can be a key factor in tackling resistance to the new services.
- Attention must be paid to the ‘human’ dimensions of service changes, including impact on staff and service users.

Dynamic system change

- The real benefits of NSF-MH implementation come when system transformation begins to occur, as investment in change creates further service improvements.



Appendix: List of contacts at organisations that participated in the study [during 2001]

Northern Birmingham Mental Health NHS Trust

Jo Beale, Director of Adult Services

Paul Stewart, Locality Manager, Ladywood and Handsworth

Professor Marcellino Smyth, Consultant Psychiatrist and Clinical Lead for Acute Services

Professor Sashi Sashidharan, Medical Director

Peter Imlah, Team Leader, Ladywood Assertive Outreach Team

Dr. Dermot McGovern, Consultant Psychiatrist, Ladywood Assertive Outreach Team

Shameemara Rajpar, Team Leader, Ladywood Home Treatment Team

Bev Walker, Team Leader, Handsworth Assertive Outreach Team

Dr. John Kennedy, Consultant Psychiatrist, Handsworth Assertive Outreach Team

Geraldine Hughes, Team Leader, Handsworth Home Treatment Team

Members of the Small Heath Home Treatment Team

Walsall Community Health NHS Trust (now Walsall Primary Care Trust)

Ruth Glassborow, General Manager, Mental Health

Jon Hanley, Team Leader, Assertive Outreach

Jeanette Scott, Deputy Team Leader, Assertive Outreach Team

Ian McArdle, Director of Mental Health

John Garrett, Mental Health Services Manager, Walsall Social Services

Deborah Scott, Team Leader, Crisis Outreach Team

Stella Spragg, Walsall Service User Network

Pat Nye, Walsall Service User Council

Louise Morris, NSF Officer

Members of Walsall North, East, South and West CMHTs

Herefordshire Primary Care Trust

Mike Thomas, Mental Health Services Manager

Sue Bennison, Service Development Manager

Dr. Chris Thomas, Medical Director

Lisa Paul, Assistant Psychologist, Leominster CMHT

Stephanie Carpenter and other members of the Leominster CMHT

Members of Hereford City CMHT

Christine Duthoit, CPN, Hereford City CMHT

Simon Thompson, Lead Clinician, Forensic Assertive Community Team

Mike Metcalfe, Partnership Officer, Herefordshire Planning and Partnership Unit

Jane Hutchinson and Fariz El-Shawk, Assertive Outreach Team

Wendy Jaques-Berg and others in Herefordshire User Group

Barnsley Community and Priority Services NHS Trust

Kath Hartley, Team Leader, Psychiatric Emergency Team

Wendy Beresford, Locality Manager

Bradford Community Health NHS Trust

Assertive Outreach Team members including:

Carole-Anne Farquhar, Team Leader

Dr. Phil Thomas, Consultant Psychiatrist

Cornwall Healthcare NHS Trust

Mike Riddell, Mental Health Implementation Manager

Nottinghamshire Healthcare NHS Trust

Mel McAdam, Team Leader (East), Assertive Outreach Team

Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

Steve Niemic, Specialist Practitioner, Psychiatric Emergency Team

Norfolk

Anne McCrudden, Team Leader, Active Outreach Team (Julian Housing)

Jane Lambert and Ivan Harwood, Senior CPNs, Intensive Support Team, Norfolk Mental Health Care NHS Trust

Rachel Newson, Project Director, Mental Health Service Integration, Norfolk Mental Health Partnership

Tees and North East Yorkshire NHS Trust (TEENEY)

Keith Ford, Specialist Practitioner, Assertive Outreach Team



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