ARE CRISIS RESOLUTION & HOME TREATMENT SERVICES SEEING THE PATIENTS THEY ARE SUPPOSED TO SEE?

- A REPORT OF INTERVIEWS WITH CRHT AND WARD MANAGERS ACROSS 25 SITES IN ENGLAND, REGARDING 500 REFERRALS TO CRHT TEAMS AND 500 ADMISSIONS TO INPATIENT WARDS DURING Jan-Apr 2007

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Chapter 1: The project successfully generated reliable evidence from 25 sites operating varying CRHT service models

The project remit was to identify 25 sites in England that would illustrate a cross-section of how CRHT services were operating

1. The project remit :

    - To identify 25 sites across England that represent a cross section of location, structure and current practice (see Appendix 1 for a summary of the identified 25 sites by different characteristics).
    - To examine the gatekeeping process through an audit of the 20 most recent hospital admissions at each of the 25 sites (500 admissions in total), interviewing a Ward Manager and a CRHT Manager separately about each of the 20 admissions within their site.
    - To identify the extent to which CRHT teams and inpatient wards agree on who the CRHT intended client is, what service should be provided including common processes (e.g. arrangements for patient discharge) and whether these conform to the Department of Health's policy model.
    - To examine whether referring services are sending appropriate referrals to CRHT teams by auditing the 20 most recent referrals to the CRHT team for assessment (500 referrals in total), interviewing the CRHT Manager about the source, appropriateness and outcomes of each referral.
    - To develop a database of the audit (500 admissions and 500 referrals) and interviews (25 Ward Managers and 25 CRHT Managers).

2. Information was gained from two sources (CRHT and Ward managers and teams) for this research, which focussed on auditing the care pathways of 500 admissions to hospital and 500 referrals to CRHT teams. The research question for this piece of fieldwork was 'whether CRHT services are seeing the patients they are supposed to see' as intended by the Department of Health's policy.[1]

3. This report represents only part of the overall NAO fieldwork which examines the value for money provided in the provision of CRHT services across England; the other strands of fieldwork capture the views of a wider range of stakeholders (i.e. service users, carers, Community Mental Health Teams, Primary Care referrers) and focus on other relevant research questions, such as reviewing the national

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009350 ; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063015

policy management framework and carrying out cost modelling of how CRHT services are provided.

Project personnel

- Steve Morgan ~ *Practice Based Evidence* (A Practice Development Consultancy for Mental Health): Project Manager, interviewing, data entry and reporting
- Kirt Hunte ~ Team Manager of the South Camden Crisis Response and Resolution Team: interviewing and informing reporting
- Roberta Wetherell and Andrew Wetherell ~ Joint Directors of *ARW Training & Consultancy*: interviewing, data entry and informing reporting
- Nick Gauntlett: data entry
- Charlotte McKinley: administrative liaison and data coding
- Jess Hudson: NAO Project Manager

4. The Project Team wish to extend special thanks to the 25 Ward and 25 CRHT personnel across the sites that gave their time, effort and support to engage with the interviews that underpin this report.

Although all data was collected via interview, interviewees used case notes for the vast majority of the interviews, providing highly reliable results overall

Ward Manager responses regarding 500 admissions reviewed

	Frequency	Percent	Valid Percent	Cumulative Percent
Memory: very reliable	66	13.2	13.2	13.2
Memory: fairly reliable	28	5.6	5.6	18.8
Memory: not reliable	6	1.2	1.2	20.0
Case notes: reliable	399	79.8	79.8	99.8
Missing	1	.2	.2	100.0
Total	500	100.0	100.0	

CRHT Manager responses regarding 500 admissions reviewed

	Frequency	Percent	Valid Percent	Cumulative Percent
Memory: very reliable	52	10.4	10.4	10.4
Memory: fair reliability	2	.4	.4	10.8
Case notes: reliable	446	89.2	89.2	100.0
Total	500	100.0	100.0	

How reliable is this information (regarding 500 referrals to CRHT)?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very reliable	498	99.6	99.6	99.6
	fair reliability	2	.4	.4	100.0
	Total	500	100.0	100.0	

CRHT teams were created to introduce efficiencies into the acute mental health care pathway, diverting inappropriate admissions by providing home treatment

5. The implementation of Crisis Resolution & Home Treatment teams introduces a new dimension to delivering acute care beyond inpatient admissions alone. Their introduction is expected to provide 24-hour responses to crises in the community, not just relying on the hospital services of A&E and psychiatric wards, and GP services. Their core function is to provide *acute* mental health care, delivering therapeutic services to people outside inpatient wards, in the community.

6. CRHT teams are expected to provide a range of functions, all of which should improve the efficiency of the acute care pathway.

Evidence from 25 Ward Manager Interviews when asked to identify the most significant functions that CRHT teams should perform

Key function A: Gatekeeping hospital admissions (x25)

This is the process in which CRHT staff are involved in all potential admissions to inpatient wards in order that inappropriate admissions can be prevented, and the CRHT team provide treatment to the patient at home or in the community instead. Some managers reported that the gatekeeping function was enabled by the support of the inpatient unit, with more appropriate admissions and a decrease in the number of sectioned patients resulting, but others said this function was hindered by Consultant Psychiatrists by-passing the team.

Key function B: Supporting early discharge (x22)

This function is performed by CRHT teams that are able to discharge patients from inpatient wards and take-over their care at home or in the community. The discharge is earlier than it otherwise would be because the patient is still in a psychiatric crisis but is able to be better treated at home and so is discharged into the care of the CRHT team. Some managers said this function was supported by daily/weekly review meetings, support from the inpatient staff, and sharing medical staff across the inpatient and CRHT teams; but others reported the function was hindered by an over-use of ward leave, poor understanding of the function by Consultant Psychiatrists, insufficient social

services delaying some discharges, and where there was a physical distance between the inpatient and CRHT teams.

Key function C: Providing home treatment and alternatives to hospital (x16)

CRHT teams are able to provide intensive acute care, at least equivalent to the supervision provided in inpatient wards, in patient's homes or in the community. This involves providing one-to-one counselling, ensuring users comply with their medication needs and supporting carers and service users to manage the psychiatric crisis to resolution. Managers reported that support for the function came from being staffed 24/7, but it could be hindered by disproportionate time spent doing assessments which could make providing home treatment unfeasible (and hence devaluing the process of the assessment in the first place). Other barriers reported were an organisational culture not fully embracing the potential of CRHT teams, relationships with A&E creating inefficiencies and a disproportionate focus on medication drops.

Key function D: Integrating with the acute care pathway (x8)

CRHT teams operate in the community setting but provide intensive acute care to patients experiencing a mental health crisis. This is different from (non-acute) community mental health services which supervise service users during periods when their mental health has stabilised for a period of time. The acute care pathway was previously only served by inpatient wards, but CRHT teams are intended to provide a bridge with inpatient wards, ensuring that the admissions that occur are appropriate and best serve the needs of service users, rather than creating dependencies or disruptions to the service user's life that can exacerbate their mental health condition. Some teams reported that improving integration between the CRHT team and the inpatient ward was supported by bringing the ward and CRHT teams under a single management and within close proximity of each other, creating a unified Acute Care Team. But the function could be hindered by a lack of consistency of skills of staff on the CRHT and inpatient teams.

Key function E: Providing crisis assessments (x6)

CRHT teams must assess patients who are experiencing a mental health crisis or breakdown and who may be considered for admission to an inpatient ward. The CRHT staff, alongside other mental health staff, must assess the patient's level and type of need and make decisions to admit or home-treat based on that assessment. The CRHT team must have the capacity to deliver home treatment, otherwise the assessment becomes perfunctory, with little value added at all to the acute care pathway. The function should not be confused with an A&E liaison function, which involves hospital-based assessments of patients, with limited scope to follow-up with treatment or intervention.

[Note: All 25 CRHT Managers agreed with the functions identified here]

7. Different names are applied to these teams across the country, such as:

- Crisis Resolution & Home Treatment teams
- Crisis Resolution Teams
- Rapid Response & Resolution Teams
- Home Treatment Teams
- Crisis Assessment & Treatment Teams

For the purpose of this report we will be using Crisis Resolution & Home Treatment (CRHT) teams as the generic term to refer to all of these teams, although locally the team may go under another name.

Chapter 2: The Department of Health intends that CRHT teams act as 'gatekeepers' to admission, but in fact this function is under-realized

> "The [function of gatekeeping is the] routing of all potential acute admissions through a single point in order to determine the optimal level of care. This involves the clinical decision, made collaboratively, to provide care at home or via inpatients. All referrals for inpatient beds should come through the CRHT team. Whenever possible this will involve collaboration with the care coordinator and sector Consultant Psychiatrist.
>
> Each CRHT service will manage the throughput of referrals in close collaboration with multidisciplinary colleagues, while at the same time offering a range of community based options; in particular that of intensive home based treatment.
>
> The aim of the assessment by the CRHT team is to determine what input may be offered to the service user and/or carer by the CRHT team rather than to repeat the clinical assessment already undertaken by the referrer. It is considered good practice for the assessment to be undertaken collaboratively by the referrer and CRHT clinician together if possible, to facilitate collaborative working, as well as effective communication and care planning."
>
> From Liverpool CRHT 'Operational Specification and Protocol for Crisis Resolution and Home Treatment' (p8):

CRHT staff are critical to ensuring that potential admissions are assessed for whether treatment at home would provide a better alternative

1. One of the essential purposes of providing acute care in the community should be to reduce the need for admission to inpatient beds. A measure of the effectiveness of these teams will be their ability to work closely with the inpatient wards in order that only those in real need of a bed take it, and those for whom an alternative will be more clinically beneficial and cost-effective receive that alternative instead.

2. Evidence was taken on whether a CRHT staff member was involved in the assessment for 500 admissions and whether those assessments had included consideration of whether home treatment was an appropriate alternative to admission. The results show that having a CRHT staff member at the assessment significantly improves the chances that the assessment will consider the home treatment option.

was CRHT staff involved in assessment? * Was there an assessment of whether home-based treatment was appropriate Crosstabulation

Count

		Was there an assessment of whether home-based treatment was appropriate		
		No	Yes	Total
was CRHT staff involved in assessment?	No	170	23	193
	Yes	29	226	255
Total		199	249	448

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	261.837[b]	1	.000		
Continuity Correction[a]	258.739	1	.000		
Likelihood Ratio	293.814	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	261.253	1	.000		
N of Valid Cases	448				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 85. 73.

3. The evidence also suggests that where CRHT staff are involved, they do have a bearing on the decision to admit (for 87% of cases). Ward managers reported that CRHT staff had a bearing on the decision to a great extent in 75% of admissions, indicating the value they add to the clinical assessment.

was CRHT staff involved in assessment? * did involvement or not of CRHT staff have a bearing on decision to admit? To what extent Crosstabulation

Count

		did involvement or not of CRHT staff have a bearing on decision to admit? To what extent				
		Great extent	Some extent	No extent	Not sure	Total
was CRHT staff involved in assessment?	Yes	201	30	33	3	267

4. This evidence strongly supports the inclusion of CRHT staff as gatekeepers; it shows that assessments are much less likely to consider home treatment as an alternative to admission without a CRHT staff member present.

5. This evidence strongly supports the inclusion of CRHT staff as gatekeepers; it shows that assessments are much less likely to consider home treatment as an alternative to admission without a CRHT staff member present.

There was no evidence to suggest there were particular 'peak' times of the day or week for admissions

6. The following data identifies when the 500 admissions under investigation took place, by time of day and by day of the week. The evidence does not suggest any particular 'peak time' in admissions:

Admissions: What part of the day?

	Frequency	Percent	Valid Percent	Cumulative Percent
9-5	197	39.4	39.4	39.4
5-10pm	126	25.2	25.2	64.6
Across the night	91	18.2	18.2	82.8
Missing	86	17.2	17.2	100.0
Total	500	100.0	100.0	

Admission: What day of the week?

		Frequency	Percent	Valid Percent	Cumulative Percent
	SUN	47	9.4	9.4	9.4
	MON	79	15.8	15.8	25.3
	TUE	93	18.6	18.6	43.9
	WED	69	13.8	13.8	57.7
	THU	80	16.0	16.0	73.7
	FRI	87	17.4	17.4	91.2
	SAT	44	8.8	8.8	100.0
	Total	499	99.8	100.0	
	Missing	1	.2		
Total		500	100.0		

Admissions: What part of the week?

	Frequency	Percent	Valid Percent	Cumulative Percent
Saturday & Sunday	91	18.2	18.2	18.2
Friday	87	17.4	17.4	35.6
Monday-Thursday	321	64.2	64.2	99.8
Missing	1	.2	.2	100.0
Total	500	100.0	100.0	

7. The 500 admissions reviewed were largely (87%) inside CRHT operating hours.

Admissions by part of the week: Inside/outside CRHT operating hours

		Inside/outside CRHT operating hours			
		Inside	Outside	missing	Total
What part of the week	Saturday & Sunday	76	14	1	91
	Friday	73	12	2	87
	Monday-Thursday	285	31	5	321
	Missing	1	0	0	1
Total		435	57	8	500

Admissions by part of the day: Inside/outside CRHT operating hours

		Inside/outside CRHT operating hours			
		Inside	Outside	missing	Total
What part of the day	9-5	194	3	0	197
	5-10pm	109	17	0	126
	Across the night	55	36	0	91
	Missing	77	1	8	86
Total		435	57	8	500

Admissions: Total numbers Inside/outside CRHT operating hours

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Inside	435	87.0	87.0	87.0
	Outside	57	11.4	11.4	98.4
	missing	8	1.6	1.6	100.0
	Total	500	100.0	100.0	

Evidence did suggest that admissions across the night were less likely to involve CRHT staff

8. There was evidence to suggest that CRHT staff were significantly less likely to be involved in assessments when the admissions occurred across the night. However, admissions across the night were more likely to be outside of CRHT operating hours. No significant difference was found for admissions at varying parts of the week.

Admission at day or night * was CRHT staff involved in assessment? Crosstabulation

Count

		was CRHT staff involved in assessment?		
		No	Yes	Total
day or night	9am-10pm	132	175	307
	across night	49	39	88
Total		181	214	395

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.433(b)	1	.035		
Continuity Correction(a)	3.937	1	.047		
Likelihood Ratio	4.421	1	.035		
Fisher's Exact Test				.039	.024
Linear-by-Linear Association	4.422	1	.035		
N of Valid Cases	395				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 40.32.

Inside/outside CRHT operating hours * Admission at day or night Crosstabulation

Count

		Admission at day or night		
		day	night	Total
Inside/outside CRHT operating hours	Inside	303	55	358
	Outside	20	36	56
Total		323	91	414

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	67.584[b]	1	.000		
Continuity Correction[a]	64.762	1	.000		
Likelihood Ratio	55.948	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	67.421	1	.000		
N of Valid Cases	414				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 12. 31.

What part of the week * was CRHT staff involved in assessment? Crosstabulation

Count

		was CRHT staff involved in assessment?		
		No	Yes	Total
What part of the week	Saturday & Sunday	38	49	87
	Friday	43	42	85
	Monday-Thursday	130	176	306
Total		211	267	478

CRHT teams that were not staffed 24/7 had less success in gatekeeping admissions

9. A concern for successful gatekeeping is where admissions occur outside of the hours when the CRHT team is fully staffed. Of the teams visited, 11 were staffed 24/7, 13 operated on-call and 1 was covered at night by another team

10. Our analysis compared whether teams that were staffed 24/7 versus teams that were not were involved in the majority or minority of the 20 admissions reviewed in this research. It shows that teams that are staffed 24/7 are significantly more likely to be involved in the majority rather than a minority of admissions.

CRHT involved in < or > 50% of the 20 admissions per site * staffed 24/7 or not Crosstabulation

Count

		staffed 24/7 or not		
		not staffed 24/7	staffed 24/7	Total
CRHT involved in < or > 50% of the 20 admissions per site	CRHT involved in 0-10 / 20 admissions	140	60	200
	CRHT involved in 11+/20 admissions	140	160	300
Total		280	220	500

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	26.515[b]	1	.000		
Continuity Correction[a]	25.577	1	.000		
Likelihood Ratio	27.030	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	26.462	1	.000		
N of Valid Cases	500				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 88. 00.

11. This evidence suggests CRHT services should be staffed 24/7 for more effective gatekeeping. However, one CRHT Manager did suggest that 24/7 staffing needs to be clearly linked to a local audit of activity. Where only a few night-time crises happen or where they are rare, it could be unduly costly to have waking staff on duty all night. These hours are far less likely to be times when CRHT staff members can make efficient use of their time by following up other functions such as routine home treatment. In instances where local audit identifies a relatively low level of crisis assessment activity across night hours, 24/7 staffing could potentially be achieved using an integrated acute service model, whereby on-call CRHT team members assist with staffing of wards overnight.

The gatekeeping function overall is not as consistently applied as policy intends

12. A true measure of the effectiveness of the gatekeeping function will be derived from the actual involvement of CRHT team staff in the assessments for admission. CRHT Managers claimed that they were involved in only 46% of assessments for the 500 admissions reviewed in this fieldwork.

Was CRHT staff involved in the assessment? (CRHT Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	245	49.0	49.0	49.0
	Yes	231	46.2	46.2	95.2
	Not sure	24	4.8	4.8	100.0
	Total	500	100.0	100.0	

13. Corresponding Ward Manager responses to the same question were that CRHT staff were involved in 53% of assessments.

Was CRHT staff involved in assessment? (Ward Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	211	42.2	42.2	42.2
	Yes	267	53.4	53.4	95.6
	Not sure	22	4.4	4.4	100.0
	Total	500	100.0	100.0	

14. However, when asked which of the occasions on which CRHT staff were involved did they actually have a bearing on the decision to admit, ward managers agreed this occurred on 231 occasions, 46%. This evidence indicates that the intended policy that *all* potential admissions are gatekept by CRHT staff is not being achieved.

was CRHT staff involved in assessment? * did involvement or not of CRHT staff have a bearing on decision to admit? To what extent (Ward Manager responses)

Count

		did involvement or not of CRHT staff have a bearing on decision to admit? To what extent				
		Great extent	Some extent	No extent	Not sure	Total
was CRHT staff involved in assessment?	Yes	201	30	33	3	267

15. When Ward Managers were asked which admissions included an assessment for whether home treatment may be an option, this was reported for only 51% of cases.

Was there an assessment of whether home-based treatment was appropriate (Ward Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	204	40.8	40.8	40.8
	Yes	253	50.6	50.6	91.4
	Not sure	43	8.6	8.6	100.0
	Total	500	100.0	100.0	

16. If people are admitted without considering what alternatives (such as home treatment) are appropriate, then there is no process in place to consider whether people would be better treated closer to home, without the disruption caused by admission. It follows that admissions will be higher in number and that some beds will be inappropriately taken by people who are not necessarily best-served by being admitted, and that the availability of beds for other potential patients is restricted. The Department of Health's intended impacts will not be achieved if 'all potential admissions' (as is intended) are not assessed for the applicability of home treatment.

The ability of CRHT teams to effectively gatekeep admissions is being diminished by common barriers

17. We asked for the reasons why CRHT staff were or were not involved in the 500 admissions. Ward Managers identified the following reasons why CRHT staff were not involved in over 200 of the 500 admissions:

reason given * was CRHT staff involved in assessment? Crosstabulation (Ward Manager responses)

Count

		was CRHT staff involved in assessment?		
		No	Yes	Total
Reason given why CRHT staff was/not involved	Already being treated	0	28	28
	Bed management function	3	12	15
	Consultant by-passed CRHT	11	0	11
	CRHT recommended admission	1	29	30
	CRHT gatekeeping role	0	50	50
	Ward from transfer	9	2	11
	CMHT bypassed CRHT	6	0	6
	MHA assessment	20	16	36
	Planned admission	8	0	8
	CRHT unavailable (out of hours etc)	18	3	21
	A&E request assessment	1	21	22
	CMHT request assessment	0	6	6
	Transfer from out of area	10	0	10
	Consultant attached to CRHT	1	5	6
	Consultant attached to both CRHT & CMHT	1	1	2
	Other referred to CRHT	1	9	10
	Not informed	12	0	12
	CRHT bypssed (other)	11	1	12
	CRHT assessed	2	39	41
	Referred by GP	1	9	10
	CRHT not involved	11	0	11
	Other reason for admission	40	24	64
	Assessed but no further CRHT action	1	0	1
	Patient wanted admission	1	1	2
	Carer wanted admission	0	1	1
	High risk	5	7	12
	Out of area	14	0	14
	Not in team's patch	15	0	15
	Not available	3	1	4
Total		206	265	471

18. Similarly we asked Ward Managers for the reasons why an assessment for the applicability of home treatment did or did not take place:

What reason for home assessment taking/not taking place - coded * Was there an assessment of whether home-based treatment was appropriate Crosstabulation

Count

		Was there an assessment of whether home-based treatment was appropriate			
		No	Yes	Not sure	Total
What reason for home assessment taking/not taking place - coded	Gatekeeping function is routine for CRHT	0	28	1	29
	Transfer	18	0	0	18
	CRHT bypassed	29	0	0	29
	out of hours	10	1	0	11
	Already being home treated/service user	0	41	0	41
	MHA	20	1	3	24
	Arrested	3	0	0	3
	Homelessness/accom modation issues	11	2	1	14
	Medication monitoring	3	0	0	3
	Risk / clinical need	22	15	0	37
	CRHT was requested at assessment	0	17	1	18
	Planned admission	5	0	0	5
	Issues of drug/alcohol management	3	0	1	4
	Out of area service user	13	1	3	17
	Other	36	0	5	41
	Missing/ no reason/ unclear	31	147	28	172
Total		204	253	43	500

19. The common reasons given for why an assessment for the applicability of home treatment did not take place are typically the same reasons given for why CRHT staff were not involved:

    - Where the CRHT was deliberately by-passed – typically by medical staff;
    - Where the admission was the result of a transfer (from another inpatient ward) or was from outside the local area;
    - Where the admission was part of a Mental Health Act assessment or arrest.

20. When CRHT Managers were asked for the reasons why their team was not involved in the assessment for admissions the answers for the 245 occasions they were not involved were as follows:

Reason why CRHT staff were not involved in the assessment for admission (CRHT Manager responses)

		Frequency	Valid Percent
Valid	Out of area/ not our CRHT team	63	25.7
	CRHT team by-passed by consultant psychiatrist	45	18.4
	MHA/ Emergency Duty Team assessments	38	15.5
	Transfer between units/wards	20	8.2
	CRHT team not developed/contactable	18	7.3
	CRHT team by-passed by doctors in A&E	10	4.1
	Drug issues (inc detox)	16	6.5
	Assertive Outreach service user	6	2.4
	CRHT team performed bed management role only	6	2.4
	CRHT team by-passed by CMHT to Consultant Psychiatrist	3	1.2
	Planned admission not involving CRHT team	2	.8
	Other	18	7.3
	Total	245	100.0
Missing	System	255	
Total		500	

21. CRHT Managers reported that the medical profession acts as a key barrier to effective gatekeeping by CRHT teams (highlighted in 45 of the 245 admissions they were not involved in). Not only are Consultant Psychiatrists specifically identified as by-passing the teams, but also assessments in A&E were thought to by-pass the CRHT teams (largely conducted by duty doctors) and where other community teams specifically by-passed the CRHT team it was identified as being the result of a doctor's involvement. Combining A&E, AOT, CMHT, and planned admissions which by-passed the CRHT team, this adds a further 21 occasions.

22. 'Out-of-area' and responsibility of neighbouring CRHT teams was the reason given for 63 admissions where CRHT staff were not involved. This refers to a wide range of circumstances such as transfers from hospitals outside of the Trust, specialist supported residential placements that were not available through resources within the Trust, being picked up by Police in other areas, arriving at local railway stations, being seen by CRHT teams in other areas of the same Trust or in other Trusts. Unit-to-unit transfers where the CRHT team are not involved (a further 20 occasions) were highlighted as well as out of area admissions as common barriers faced by CRHT teams to gatekeeping all potential admissions.

23. Some CRHT teams are routinely involved in Mental Health Act (MHA) assessments whereas others have agreed that where a MHA assessment is happening, they need not be involved in the assessment. The evidence shows that the CRHT team was not involved in 61% of formal admissions (detentions) whereas for informal admissions they were significantly more likely to be involved in the assessment for admission.

Was a CRHT staff member involved in assessment for admission * Admission a detention or not Crosstabulation (CRHT Manager responses)

Count

		Admission a detention or not		
		no	yes	Total
Was a CRHT staff member involved in assessment for admission	No	136	109	245
	Yes	167	64	231
	Not sure	19	5	24
Total		322	178	500

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.007[a]	2	.000
Likelihood Ratio	17.208	2	.000
Linear-by-Linear Association	16.295	1	.000
N of Valid Cases	500		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.54.

24. Ward managers were asked whether the CRHT staff should have had a bearing on the decision to formally admit (detain) patients. Respondents disagreed whether all formal admission decisions should be influenced by CRHT staff or not, but were significantly less likely to say that CRHT staff should have a bearing on the decisions regarding formal admissions (44%) than on the decisions regarding informal admissions (69%). CRHT managers responded similarly, saying that they should influence 58% of formal admissions and 75% of informal admissions (Chi square value = 15.22; $p<0.001$).

Should involvement of CRHT staff have a bearing on the decision to admit? * Admission a detention or not Crosstabulation (Ward Manager responses)

Count

		Admission a detention or not		
		no	yes	Total
Should involvement of CRHT staff have a bearing?	No	99	99	198
	Yes	221	77	298
	not sure	2	1	3
Total		322	177	499

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	30.345[a]	2	.000
Likelihood Ratio	30.174	2	.000
Linear-by-Linear Association	29.042	1	.000
N of Valid Cases	499		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 1.06.

25. Other common reasons were where issues of homelessness meant that home treatment would not be a viable alternative, or where the service user was not local, making home treatment impracticable. Interestingly, clinical need and risk being high were reasons given both for and against considering whether home treatment was an appropriate alternative to admission. This indicates where the intensity of the CRHT service offered may vary considerably, for instance where crisis housing is available to support CRHT teams with homeless service users, or where CRHT teams are staffed and skilled to meet the demands of patients requiring intensive home treatment.

Staff across teams have inconsistent ideas about when CRHT staff should and should not be involved in (gatekeeping) admissions

26. These barriers clearly need addressing if the gatekeeping of admissions is to be achieved at a more effective level – and at a level which policy directs. However, what is important to note is that on some occasions both ward and CRHT Managers agree that there are occasions when the CRHT staff need not have a bearing on the decision to admit. Ward staff felt CRHT staff need not have a bearing on the decision in 40% of cases, and CRHT staff themselves agreed that in 30% of admissions overall, they need not influence the decision.

Should involvement of CRHT staff have a bearing? (Ward manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	198	39.6	39.9	39.9
	Yes	298	59.6	60.1	100.0
	Total	496	99.2	100.0	
Missing	Total	4	.8		
Total		500	100.0		

Should the CRHT involvement in decision to admit have a bearing on the outcome? (CRHT Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
	No	152	30.4	30.4	30.4
	Yes	344	68.8	68.8	99.2
	Not sure	4	.8	.8	100.0
	Total	500	100.0	100.0	

27. Interestingly when Ward Manager and CRHT Manager responses were compared, they agreed regarding whether CRHT should or should not influence the decision to admit on 65% of cases.

Should involvement of CRHT staff have a bearing? Ward Manager responses * should the CRHT involvement in decision to admit have a bearing on the outcome? CRHT Manager responses Crosstabulation

Count

		should the CRHT involvement in decision to admit have a bearing on the outcome? CRHT Manager responses			
		No	Yes	Not sure	Total
Should involvement of CRHT staff have a bearing? Ward Manager responses	No	90	107	1	198
	Yes	60	235	3	298
	not sure	1	2	0	3
Total		151	344	4	499

Circumstances of adimission * Should CRHT involvement in decision to admit have a bearing on the outcome? CRHT Manager responses * Should involvement of CRHT staff have a bearing? Ward Manager responses Crosstabulation

Count

Should involvement of CRHT staff have a bearing? Ward Manager responses			Should CRHT involvement in decision to admit have a bearing on the outcome? CRHT Manager responses			Total
			No	Yes	Not sure	
No	Circumstances of adimission	Transfer from local ward	6	1	0	7
		Transfer from PICU	7	0	0	7
		Transfer from hospital out of area	4	0	0	4
		Via A&E	3	4	0	7
		Via Police	0	10	0	10
		Arrested	3	2	0	5
		Suicide attempt	4	8	0	12
		Threat of risk to self (inc self harm)	9	17	0	26
		Risk to others	5	9	0	14
		Medication review	2	0	0	2
		Planned detox	5	0	0	5
		Patient requests admission	1	0	0	1
		Mental Health Act	8	2	0	10
		Non compliance with medication	6	7	0	13
		Refusing services	0	2	0	2
		Deterioration of mental state - psychotic	2	6	0	8
		GP	0	1	0	1
		Admitted by consultant	0	1	0	1
		Planned admission	0	1	0	1
		Deteriorating mental state non specified	11	9	1	21
		Other	14	27	0	41
	Total		90	107	1	198
Yes	Circumstances of adimission	Transfer from local ward	1	1	0	2
		Transfer from PICU	3	0	0	3
		Transfer from hospital out of area	2	2	0	4
		Via A&E	3	4	0	7
		Via Police	2	3	0	5
		Arrested	2	4	0	6
		Suicide attempt	5	42	0	47
		Family request CRHT assessment	0	1	0	1
		Threat of risk to self (inc self harm)	7	43	0	50
		Risk to others	2	15	0	17
		Medication review	3	4	0	7
		Patient requests admission	0	1	0	1
		Mental Health Act	3	15	0	18
		Non compliance with medication	1	11	1	13
		Refusing services	4	0	0	4
		Deterioration of mental state - psychotic	2	7	0	9
		Deterioration of mental state - bi polar	1	6	0	7
		GP	1	2	0	3
		CRHT already involved	0	1	0	1
		Admitted by consultant	0	1	0	1
		Planned admission	0	1	0	1
		Deteriorating mental state non specified	8	25	1	34
		Other	10	46	1	57
	Total		60	235	3	298
not sure	Circumstances of adimission	Suicide attempt	0	1		1
		Threat of risk to self (inc self harm)	0	1		1
		Non compliance with medication	1	0		1
	Total		1	2		3

28. The evidence shows that there is not agreement across areas regarding which circumstances mean the CRHT team should or should not influence the decision to admit. This shows that different teams are operating different forms of gatekeeping, since the occasions where gatekeeping is not felt to be necessary are inconsistent across teams. For example, some teams are accepting their non-involvement in Mental Health Act assessments as being a concession to a lack of resources, and some on the basis that their only role should be to find a bed. Some teams are accepting that transfers between units will happen without their involvement.

29. Gatekeeping is a crucial factor in the cost-effectiveness of overall acute mental health service delivery. The CRHT team may be the best service to be involved in some Mental Health Act assessments, and they may be needed to assess whether a transfer between units is no longer necessary where home treatment would provide a better alternative. CRHT teams need clearly agreed protocols with other mental health teams about being informed and involved in all potential admissions. These may vary across services due to local circumstances and support services, but within one service, there should be agreement across all professionals about why and how CRHT teams are incorporated into the acute care pathway.

Ward managers and CRHT managers agreed that around one in five admissions could still be avoided

30. Ward Managers said that on 17% of admissions the patient was an appropriate candidate for home treatment. This was echoed by CRHT Managers reporting that of the patients who were referred to them but were subsequently admitted (n=74), 20% of those admissions should have been avoided.

At the time of admission was this person an appropriate candidate for home treatment? (Ward Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
	No	374	74.8	74.8	74.8
	Yes	82	16.4	16.4	91.2
	Not sure	44	8.8	8.8	100.0
	Total	500	100.0	100.0	

Where patient was admitted, would this have been better avoided? (CRHT Managers)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	53	10.6	71.6	71.6
	yes	15	3.0	20.3	91.9
	not sure	6	1.2	8.1	100.0
	Total	74	14.8	100.0	
Missing	N/A	426	85.2		
Total		500	100.0		

31. We coded the reasons given as to why people were being admitted despite being appropriate candidates for home treatment:

Please describe why person (appropriate for home treatment) was admitted - coded (Ward Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Carers anxiety about being able to cope	4	.8	5.1	5.1
	Planned admission	1	.2	1.3	6.3
	Consultant's insistence	9	1.8	11.4	17.7
	Drug review	3	.6	3.8	21.5
	Out of area transfer needing brief admission	3	.6	3.8	25.3
	Patient considered risk to self	4	.8	5.1	30.4
	Patient considered risk to others	1	.2	1.3	31.6
	Accommodation/homelessness issues	7	1.4	8.9	40.5
	Service user preference	3	.6	3.8	44.3
	Other	27	5.4	34.2	78.5
	Non complience with services	1	.2	1.3	79.7
	Patient presenting differently on ward then in community	3	.6	3.8	83.5
	Patient requesting admission	4	.8	5.1	88.6
	More experienced assessor might not have admitted	2	.4	2.5	91.1
	CRHT uncertain on provision of home treatment	1	.2	1.3	92.4
	CRHTs hours not sufficient	2	.4	2.5	94.9
	Missing	4	.8	5.1	100.0
	Total	79	15.8	100.0	
Missing	System	421	84.2		
Total		500	100.0		

32. Many reasons were suggested, but an accumulation of 'Insistence by Consultant Psychiatrist', 'Patient requesting admission/service user preference', 'Carers anxiety about being able to cope', 'Patient presenting differently on ward than in community' indicates areas where the CRHT needs to focus the messages more clearly as to what it is they provide, and why it can be effective. High levels of clinical risk, accommodation issues or homeless service users and 'hours of availability' are challenges for some CRHT services but not for others. The intensity of the CRHT service offered, such as being fully staffed 24/7 and having crisis housing support, is likely to impact on the level of avoidable admissions CRHT teams can prevent.

33. The 25 CRHT Managers were asked what they would need in order to increase the capacity for delivering home treatment:

- 13 identified increased staffing resources, particularly to cover the range of expected functions they should be providing (with 2 also identifying the large travelling distances as a further impact on their available resources)
- 5 focused on the need for Consultant Psychiatrists to change their attitudes towards accepting and working with the potential offered by CRHT teams
- 4 identified the need to develop alternatives to hospital admission that could provide short-term respite or crisis accommodation
- 3 identified the need for Acute Day Hospital facilities as an adjunct to the intensive support that CRHT staff provide, enabling people to receive treatment and support in safe settings outside their home without the need for admission

34. Similarly, CRHT Managers said the factors that would enable gatekeeping to be more effective were:

- Having Consultant Psychiatrists signed up to the function (x5)
- Having access to alternatives to hospital admissions, such as dedicated crisis/respite facilities (x2)
- Having a clear Trust policy regarding how access to available beds will be managed (x3)
- Having Ward staff prepared to challenge and re-direct those staff members who attempt to by-pass the CRHT team (x3)

35. This evidence illustrates there is significant scope for improving the incidence of the gatekeeping function. This should be enabled in part by addressing the development of closer relationships between wards and CRHT teams. More effective communication can be achieved between the ward and CRHT team regarding who is on the ward at any point in time, what the patients needs are, and how all potential admissions could be more appropriately assessed. Eleven of the sites specifically identified they had recently developed specific CRHT team link-workers with the wards in order to improve on these areas of communication.

36. Some perceptions from CRHT staff highlight the barriers they are experiencing:

- "Some Consultant Psychiatrists by-pass CRHT teams because they feel we are challenging their decision-making power, and their perceived personal ownership of the beds."
- "Some Consultant Psychiatrists and other professionals in other teams seem to think we are just questioning their professional judgement, so they look to avoid us."
- "The clinical judgement of individual professionals is going to be limited by their personal range of knowledge and experiences, and sometimes we can all get stuck in one way of thinking about how we see someone else's needs. Only CRHT teams know what it is that they can really offer that may be different to what has always been tried by others before."
- "As CRHT teams we need to recognise the validity of the assessment by other specialist teams (e.g. Assertive Outreach, Early Intervention, Eating Disorders, Drug and Alcohol). But we also need them to inform us sooner when a person is going into crisis so we can at least be aware and available to offer additional support."
- "The only way we can resolve some of these conflicts that diminish our gatekeeping role is for us to persuade others that we are there to support them, not to challenge them."

Good practice examples

Central Norfolk (City) CRHT: focusing attention on inappropriate admissions

A&E department assessments, particularly at night, are often conducted by junior medical staff. The clinical presentations are often characterized by volatility, acute distress, intoxication and statements of intended risks to self or others. The cautious approach of inexperienced staff not fully aware of alternative types of support will be to admit to a hospital bed. Ward staff frequently know the person from previous admissions, or find that a few hours on the ward results in a rapid settling of the clinical picture. The result is a feeling that use of the hospital bed was inappropriate, and the person may be occupying the bed for several days before they are seen by a Consultant Psychiatrist and discharged.

In the Norwich team a short-term study was conducted involving CRHT staff in A&E assessments. The positive outcome was that of reducing inappropriate admissions by 80%. Not only is this a more cost-effective approach to delivering a service, but it also reduces the unnecessary experience of hospital admission for a significant number of people.

South Kensington and Chelsea CRT: identifying what can improve the level of gatekeeping

The team identified that close proximity to the wards and developing good working relationships across other parts of the local service can support effective gatekeeping of hospital admissions. The team's base is located immediately between the two wards for which they gatekeep admissions, so that the three doors share a common entrance. This makes for good accessibility and ease of communication between all staff across the wards and crisis team. Further work has focused on good working relationships with Approved Social Workers so the team are informed early about all Mental Health Act assessments; and with the Trust Bed Manager so they are also informed of all homeless persons and out-of-area placements in the system. The result is that this team can confidently claim near to 100% gatekeeping of hospital admissions.

The gatekeeping function of CRHT teams is closely aligned to the responsibility for managing the allocation of beds, although this bed management function is not consistently implemented across teams

37. The bed management function differs from gatekeeping. Where the latter is about assessing the suitability of hospital admission or a viable community-based alternative, bed management is about finding the most suitable or available bed when admission is deemed most appropriate. The function is as much about managing throughput and flow of the use of all beds, in order to ensure the correct people are accessing the appropriate and available beds. Hence, it takes a strategic view of the allocation of beds for specific purposes. It takes an overview of who is in which beds, who is on leave, who is in secure accommodation, who is out-of-area, and who could move into other supported accommodation to free-up a bed for another purpose.

38. Traditionally, bed management has been performed by Consultant Psychiatrists responsible for dedicated beds or wards, with a separate Bed Manager role to oversee the whole picture. Managing over-occupancy has often been a significant challenge where there are more people allocated a bed than there are actual beds available. This is only made possible by keeping some people 'on leave' outside of the hospital though still technically under the care of the inpatient unit. It can become a difficult balancing act of using the beds for those in most need, while judging who can remain outside of hospital but come in for regular reviews.

39. With the introduction of the CRHT gatekeeping all admissions, it becomes clearer that CRHT teams might take over part or all of the bed-management function; or at least should be on very good terms with anyone else within the local service designated as the bed manager. However, this introduces a risk that in some areas, 'battles' may ensue between bed managers and CRHT teams over the management of beds.

40. Some CRHT Managers interviewed identified the bed-management function as a subsidiary task devolved to them by Consultant Psychiatrists and Approved Social Workers (ASWs) during the process of Mental Health Act assessments. They described their involvement as 'only' identifying the available bed, rather than being informed from the outset so they could consider the value of their involvement.

41. Several interviewees stressed the importance attached by Ward and CRHT Managers to weekly 'bed management' meetings. These were seen as essential forums for key personnel to review the current bed state, including out-of-area placements, and to identify people with the potential for early discharge. They were talked about as being positive forums for inter-team and multidisciplinary communication, and clear decision-making. CRHT managers were aware of 69% of the 500 admissions reviewed in this research.

Did CRHT know that this person is currently admitted (CRHT Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	146	29.2	29.2	29.2
	Yes	346	69.2	69.2	98.4
	Not sure	8	1.6	1.6	100.0
	Total	500	100.0	100.0	

42. If CRHT staff were involved in the admission, they were significantly more likely to know a named patient was currently admitted. Ensuring that CRHT teams gatekeep all admissions will enable them to perform a strong bed management function.

Was a CRHT staff member involved in assessment for admission * Did CRHT know that this person is currently admitted Crosstabulation (CRHT Manager responses)

Count

		Did CRHT know that this person is currently admitted			
		No	Yes	Not sure	Total
Was a CRHT staff member involved in assessment for admission	No	130	111	4	245
	Yes	1	228	2	231
	Not sure	15	7	2	24
Total		146	346	8	500

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	184.757[a]	4	.000
Likelihood Ratio	229.804	4	.000
Linear-by-Linear Association	67.958	1	.000
N of Valid Cases	500		

a. 3 cells (33.3%) have expected count less than 5. The minimum expected count is .38.

43. Other mechanisms were also identified by the Ward and CRHT managers for enabling the teams to be up-to-date on who was admitted to which bed, most notably the daily contact of ward link-workers from the CRHT, and two sites where Ward managers attended morning handover meetings at the CRHT team.

Good practice example

West Cheshire CRHT: taking more control of the bed-management function

Integrating the bed management function more closely within the CRHT enhances the ability of the team to identify where the available beds are when an admission is needed, as well as prompting where in the system they may need to be focusing more attention on assessing the potential for early discharge into home treatment. In West Cheshire there is a dedicated administrative post located within the CRHT office specifically to capture and monitor this information across the locality served. It may give the office an appearance of being 'mission control', but this greatly speeds up the ability to locate a bed when needed, rather than having to start a process of phoning around all wards each time an admission is being considered. The following is an extract from the local policy that establishes the effective protocol:

From West Cheshire *'Policy for the Management of Beds within the Adult and Older Peoples Mental Health Division*' (p.7):

"Each CRHT has a set of 'ward boards' detailing all inpatient wards in each area. Each board will be designed with the layout of the individual ward to create a visual representation of each ward within the CRHT, with each patient named in each bed with details of community team/consultant/Mental health Act status, leave status and date of admission.

In each CRHT team there will be a dedicated Bed Coordinator (administrative and clerical post) who will be the point of contact for bed allocation. The shift coordinator will perform bed coordination/management duties out of hours.

The bed coordinator will contact the wards in their area twice a day to determine the current bed state. In each base the bed coordinator will be

responsible for keeping the ward boards up to date. It is vital that any movement of service users internally or across units within the Trust be communicated through to the local CRHT team.

The bed coordinator will report updated ward information, out-of-hours admissions to external providers, and send this to the Trust-wide Bed Manager, who will compile and send out a list each morning to all interested parties. Local bed managers will produce a daily bed management report for the Trust Bed Manager".

Chapter 3: Assessing a mental health crisis is a critical function of CRHT teams, but it must be efficiently organised so that the home treatment function is not compromised

1. Assessments gauge the acuity of the crisis for an individual patient in relation to their ability to cope with or manage their situation. The assessment should determine the most appropriate care pathway, in the least restrictive environment for the circumstances. Alternatives to admission include providing support to the person in their own home, involving the support of family or other carers, and possibly the use of crisis/respite houses or acute day hospitals which provide a sanctuary without the need to admit overnight or for several nights.

2. Contrasting opinions were expressed about the impact of this function on CRHT teams. Two CRHT Managers clearly identified the focus on crisis assessments as an important contribution to effectiveness of gatekeeping. However, two other CRHT Managers also indicated that the pressure to do crisis assessments as a priority, particularly covering A&E, took resources away from their ability to provide effective home treatment. A disproportionate level of priority given to performing assessments mitigates a team's ability to provide an intensive level of home treatment as this monopolises their time.

Mental Health Act assessments often exclude CRHT staff, although this should only be the case where CRHT staff have been consulted prior to the assessment taking place, and where they have agreed that their presence is not required

3. In extreme cases where the crisis is of a type where professionals deem there is a need for hospital admission by detention, this is enabled by invoking the Mental Health Act 1983. An Approved Social Worker (ASW) is duty bound to consider all care options for a person being assessed under the 1983 Act, the preferred option being the least restrictive and appropriate that addresses the identified need. With the introduction of CRHT teams, ASW's now have home treatment as an additional option for the provision of care. Should home treatment be considered appropriate by the ASW, there needs to be an assessment by a CRHT practitioner, to agree that home treatment is appropriate and available and to formulate a plan of care. To avoid a person requiring repeat assessments in this process the ASW and CRHT practitioner should jointly conduct the assessment wherever possible.

4. Evidence from the 500 admissions reviewed in this research showed that 36% of admissions were by sections of the Mental Health Act. The evidence showed that the CRHT team was involved in 36% of formal admissions (detentions) whereas for informal admissions they were significantly more likely to be involved in the assessment for admission.

Was a CRHT staff member involved in assessment for admission * Admission a detention or not Crosstabulation (CRHT Manager responses)

Count

		Admission a detention or not		
		no	yes	Total
Was a CRHT staff member involved in assessment for admission	No	136	109	245
	Yes	167	64	231
	Not sure	19	5	24
Total		322	178	500

5. Most usually the ASW rota is managed centrally within Trusts, and CRHT teams who have ASWs within their numbers contribute their time to the external rotas. Only 3 out of the 25 CRHT teams audited in the study manage the ASW rota within their resources. 22 of the sites depend on communication from ASWs working an external rota or rotas. Successful gatekeeping was felt to be enhanced in the 3 sites, who manage the rota themselves, and also in some areas that identified that the ASWs shared an office or were in close proximity. Other teams have to rely on the quality of the working relationships, which increases the risk that they are not informed early enough in the process of a Mental Health Act assessment to become involved.

6. The sooner the CRHT team is informed that an assessment is going to take place the more effectively it can contribute to the process. 'Informed', here, does not mean needing to be automatically present at all assessments, as in most cases this only serves to add more people to an already difficult situation. Informed means the team has the opportunity to discuss whether they already know the person from previous contact, and whether any CRHT staff are well suited to being present at the assessment – this will depend on all the staff involved being prepared to consider whether home treatment is an option and hence whether there is value in including a CRHT team member at the assessment. Being informed late in the process, or after the assessment has already occurred should not be commonplace, as this will only serve to increase frustration and alienation between staff where they feel there are deliberate exclusions or failings in the intended system.

7. The CRHT team may perform a bed-management function locally, and in such cases they would be informed where an admission is taking place. However, it is important that the communication is timely rather than a cursory afterthought. Some CRHT Managers suggested they were either being informed when the decision was made for admission, to then find the available bed; or they felt they were being informed too late in the process to have any influence. There should be communication between staff involved in *all* assessments, including MHA assessments, as to whether a CRHT team member should be present. The supposition should be that they should be present, although in some cases, such as MHA assessments, it may be concluded that the CRHT staff member need not attend. This remains faithful to the role of gatekeeping all potential admissions.

Good practice examples

East Elmbridge and Mid Surrey CATT: providing a clear distinction between being informed and being involved

It is routine for this team to be informed of all Mental Health Act assessments at a reasonably early stage in the process. However, they only become actively involved in the process at the point where a section is discounted. This protocol recognizes that the team play an important function backing up alternatives to hospital admission, and it also contributes to a near 100% success at the gatekeeping hospital admissions function.

Central Norfolk (City) CRHT: managing the ASW rota can enhance mutual understanding of roles

This is one of only 3 teams in the study that manage the ASW rota for their area of the Trust from within the team itself. As a result they are immediately aware of 100% Mental Health Act assessments, greatly strengthening the gatekeeping function. This arrangement also further enhances the understanding of the acute care roles that are performed by Social Workers traditionally employed in the social care sector, and health care staff traditionally employed by the Trusts.

Chapter 4: Home Treatment offers key benefits for patients, but capacity to provide it could be improved with more rigorous implementation of the intended policy

> "Home treatment is primarily for service users who have a diagnosis of serious mental illness. However, others (including people with a diagnosis of personality disorder, and those with a learning disability experiencing an acute mental health episode) may be suitable particularly if they have been considered for adult inpatient care or require more intensive home-based care that is over and above that which can be offered by the CMHT."
>
> From Liverpool CRHT 'Operational Specification and Protocol for Crisis Resolution and Home Treatment' (p12)

1. Home treatment will primarily attempt to offer what a hospital admission would provide, but for a short intensive period of time in the person's own home environment. It will consist of several therapeutic interventions, ranging from the need to provide medication to stabilise acute mental distress, to providing supportive counselling, education about the illness and its treatments, and practical help and support to manage all aspects of daily living. It requires working with an awareness of common risks in the home, such as access to means for self harm and/or relationship conflicts.

2. Home treatment can more directly connect with and involve the carers and relatives of the individual. It focuses on supporting the person to work through their distress without having to move out of the familiarity of their home (if the service user lives in rented accommodation being admitted can lead to losing that home). Home treatment also enables the service user to progress through a period of crisis without creating a dependence on admission, which can help it become a learning process whereby the service user and carers can learn more about their own coping mechanisms and warning signs that a crisis may be about to onset, and how to use them in the future.

Home treatment offers choice to the patient and several other patient-centred benefits, although there are particular risks to the system and staff if the acute pathway is disjointed

3. When asked whether all potential admissions should be assessed for the suitability of home treatment, out of a combined total of 25 Ward Managers and 25 CRHT Managers: 41 strongly agreed, 4 agreed, 1 was not sure, 3 disagreed, and 1 strongly disagreed.

   Ward Managers stated:

   - Hospital should be the last resort (x3)
   - More appropriate admissions result (x3)

- Every patient should at least have the option of home treatment (x3)

CRHT Managers stated:

- Only CRHT staff know what it is they can provide and for who (x6)
- Being involved, or gatekeeping, does not always necessitate a face-to-face assessment of the service user but can in some circumstances require only communication between professionals (x4)
- It offers greater choice regarding a patient's treatment (x2)

The 'strongly disagree' comment was that Mental Health Act assessments and Specialist Team assessments do not need further CRHT assessment.

4. When asked to state the *positive* effects of providing home treatment for people in crisis, out of a combined total of 25 Ward Managers and 25 CRHT Managers, the most common responses were:

    - Increased patient choice (x17)
    - Keeping patients in a familiar environment (x14)
    - Decreased stigma experienced by the patient (x12)
    - Enabling the patient to stay connected to their social networks (x11)
    - More appropriate admissions resulting, with beds taken by those who really need them (x7)

5. When asked to state the *negative* effects of providing home treatment for people in crisis, out of a combined total of 25 Ward Managers and 25 CRHT Managers, the most common responses were:

    - There may be increased pressures on carers when patients are treated at home (x12)
    - Decreased expertise and/or loss of jobs on inpatient units (x5)
    - Capacity to treat at home may not meet demand, creating disappointment, particularly where there are local pressures on the CRHT team to perform (potentially inappropriate) crisis assessments (x5)
    - Some patients (and carers) will prefer an admission so offering home treatment may be contrary to their first choice (x5)
    - Inconsistent approaches can develop, especially where communication is poor (x4)

6. One Ward Manager captured a flavour of the impact home treatment is having within their local service: "I've been proved wrong… Home Treatment has kept some very risky people out of hospital."

Acute alternatives to admission can support CRHT teams to provide home treatment but these were only in evidence on four of the 25 sites.

7. The broad range of choice remains quite limited for a person in crisis requiring more support than primary care or community mental health teams can offer: they can either engage in short-term intensive home-based treatment, or be admitted to hospital, voluntarily or by detention. Indeed, very few alternatives to hospital are available to CRHT teams beyond their own staff providing therapy to patients in their homes. Only two of the sites visited had access to dedicated crisis house/respite facilities (East Elmbridge and Mid Surrey CATT and Yardley Hodge Hill HTT), and two other services had well established and focused acute day hospital services on site alongside the CRHT and ward facilities. (South Tyneside CRHT and Eastbourne CRHT). In some instances CRHT teams are making use of putting support into temporary accommodation such as Salvation Army hostels, Seaman's Missions, night shelters and Bed & Breakfast accommodation (e.g. Plymouth Inner City HTT).

8. Where acute alternatives to hospital admission were identified it was with positive descriptions of how they supported the effective implementation of the range of CRHT team functions. East Elmbridge and Mid Surrey CATT staffed and managed a 7-bed crisis house, which is used for very short admissions and for respite, and Yardley Hodge Hill HTT jointly gatekeep a 6-bed crisis house with their neighbouring patch HTT. The facility is staffed by a voluntary sector agency

9. Two sites have integral Acute Day Hospital facilities sharing the same building as the CRHT and wards:

    - South Tyneside CRHT ~ staffed and managed by the CRHT, this facility is gatekept by the CRHT and the wards. It provides an alternative to hospital admission, complementing intensive home treatment resources by providing a space where people can attend during the day, feeling safe and contained through their experience of distress. It provides day-patient monitoring of some elements of treatment such as the Clozaril medication clinic. It also enables early discharge into home treatment for some people by introducing them to the option and CRHT staff while they are still hospital inpatients. This is done through planned contact with a facility immediately adjacent to the ward.

    - Eastbourne CRHT ~ using voluntary transport schemes this facility cuts down on the volume of travelling time required by CRHT team staff across a large semi-rural patch.

10. At many of the other sites visited Ward and CRHT Managers spoke of the need for crisis/respite and for acute service specialist day hospital facilities in order for them to be more effective in managing the functions of gatekeeping hospital admissions and early discharge into home treatment. Most of these staff members still see the gulf between providing a level of intensive treatment in the home, and

the need for hospital admission, with no other midway options. They also recognised that for some people (service users and carers) periods of time out of the home environment but not in hospital would be sufficient to contain the crisis, but that no facilities were available to provide this interim option of support.

Offering home treatments only to people who would otherwise be admitted would release further CRHT team capacity

11. CRHT Managers suggested that on average 23% of current admissions could be reduced if CRHT teams could meet the demand. They also suggested that an average of 74% of their clients currently receiving home treatment would have been admitted to hospital if CRHT services were not available. This suggests that there is room for improvement, where CRHT teams could enable more inappropriate admissions to be avoided. This would be helped by ensuring that the home treatments they provide are for the intended client – that is, someone who otherwise would have been admitted to hospital.

CRHT Manager responses

	What percentage of current admissions could be reduced if CRHT could meet demand	Of Home Treatment patients what percentage would have been admitted if CRHT services were not in place?
Number of responses	25	24
Missing	0	1
Mean	22.76	74.42
Median	25	80

12. When asked about the current percentage of admissions that could be replaced by home treatment if the CRHT team had the capacity to meet demand, responses ranged from no increase up to a 65% increase. Four sites recorded no reduction on the basis that they considered themselves to be at full capacity and successful at gatekeeping

13. CRHT managers reported that in order to supply the level of service that would meet this demand, the following would be needed:

    - More staff (x11)
    - Improved links between a CRHT Consultant Psychiatrist and the other Consultant Psychiatrists (x5)
    - Access to a crisis house (x4)
    - Access to an Acute Day Hospital (x3)

14. The CRHT Managers were interviewed about 500 referrals they had most recently received, and of the 234 that had resulted in the patient receiving home treatment, they estimated that over half were very likely, and another third were quite likely to be admitted if the CRHT team was not in place. This suggests that when referrals come into the CRHT team, an appropriate client base is likely to result.

If the CRHT team wasn't in place, how likely is it the patient would have been admitted? (CRHT Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very likely	127	25.4	54.3	54.3
	Quite Likely	78	15.6	33.3	87.6
	not sure	16	3.2	6.8	94.4
	quite unlikely	9	1.8	3.8	98.3
	very unlikely	4	.8	1.7	100.0
	Total	234	46.8	100.0	
	N/A	266	53.2		
Total		500	100.0		

15. When asked about the percentage of patients currently receiving home treatment who would most likely have been admitted if there was no CRHT, the responses ranged from 30-100%. Of the 13 cases above that were either 'quite unlikely' or 'very unlikely' to be admitted, yet were still receiving home treatment, the reasons given indicate goodwill on behalf of the CRHT teams rather than sound clinical reasons for using their resources in these ways. Providing a female staff member to give depot injections, providing short-term support to users experiencing difficult social circumstances, providing additional support to the regular community team, and monitoring levels of risk were among the reasons presented. As these reasons are contrary to the intended policy they provide further areas where CRHT teams can improve on the effectiveness and efficiency of delivering a CRHT service.

Good practice example

East Yorkshire IHTT: conducting local audits to support the development of new or expanded CRHT services

The capacity to deliver home treatment as an alternative to hospital admission depends on the successful implementation of the Department of Health policy across all areas. Some parts of the country are patchy in their degree of implementation, yet sufficient evidence is now available to guide local audits, on which new service developments can be justified.

One of the sites visited was the East Riding of Yorkshire, where only one out of four patches covered by the inpatient services is served by an Intensive Home Treatment Team during the day (the whole East Riding is covered for crisis assessments by Hull CRHT at night). Based partly on the success of home treatment in the established patch, the local service took two snapshots of all inpatients across the area 4 months apart during 2006 through case note analysis by 3 experienced community practitioners and the Unit Nurse Manager. Initial findings were then discussed with the relevant Consultant Psychiatrist and where possible the multidisciplinary team. The audit concluded that with a fully functioning CRHT

41% of admissions may have been avoided, and 68% of those admitted may be suitable for early discharge. The report's author acknowledged these figures to be slightly higher than national results published in the British Journal of Psychiatry (Glover, Arts and Babu, 2006), but nonetheless they supported plans for future service development with a steady reduction in beds contingent on CRHT development.

The value of the home treatment option has been highlighted through the need to initiate two other important functions: to have in place the ability to gatekeep admissions in the first place, and the ability to discharge people earlier into an intensive home treatment alternative. For other areas of the country not currently served by these types of teams, or where the service is clearly under-resourced, this example of local auditing linked to national messages can provide compelling evidence for new service development.

Chapter 5: CRHT teams are facilitating earlier discharges where the ward and CRHT team are integrated, but there is room to improve performance in this area

1. The term 'early discharge' means discharge earlier than would have happened if intensive home treatment was not available. If a patient is discharged to the CRHT team they are expected still to be in crisis and hence in need of acute care, but this care is judged to be most appropriately provided at home, enabling the discharge from hospital. The discharge is earlier than otherwise would occur – in a 'normal' discharge the crisis would have resolved and the patient could be discharged to CMHT for non-acute supervision.

> "The factors for early discharge are based on the identified reasons and risk factors for hospitalisation. Once these factors have been addressed, discharge can take place to the on-going care of the CRHT team. The CRHT team will need to demonstrate that they have taken the service user's views into account as part of the decision-making process. CRHT clinicians will identify the factors that resulted in hospitalisation and through a collaborative process with the service user, carers, care coordinator and inpatient team, develop a plan for early discharge.
>
> The traditional practice of extended leave for service users being discharged from acute inpatient facilities is not necessary with the availability of home treatment teams. Individuals should only have leave periods for overnight or weekends as part of a discharge plan. Service users detained under the Mental Health Act may require longer periods of leave.
>
> There should be no requirement for extended periods of leave beyond this and care teams need to make a decision to consider discharge or early discharge to the Home Treatment Team. The Home Treatment Team does not 'support' individuals on extended leave."
>
> From West Cheshire ('Policy for the Management of Beds within the Adult and Older Peoples Mental Health Division' p. 12):

CRHT teams are engaged in around half of discharges, with the likely result that the discharge is earlier than it would otherwise be

2. The early discharge function is completely aligned to the concept of reducing lengths of hospital admissions by supporting the service user within the least restrictive environment at the earliest opportunity. Early discharge to a CRHT team would mean the patient is still in need of acute care, but that the appropriate level of care would be better provided at home than on the ward. It is critical that CRHT teams remain faithful to only providing care for acute mental

health crises. This would not be the case if the discharge was not 'early', since discharge in that case would mean the crisis had passed.

3. Ward Managers reported that CRHT staff were likely to be involved in around half of the discharges of current admissions (n=311), and of discharges that had already occurred (n=189) CRHT staff were indeed involved in 43%. Where patients were currently admitted, Ward Managers predicted that where CRHT staff were likely to be involved, 43% of those discharges would be sooner than if CRHT staff weren't involved. In the discharges that had involved CRHT staff (n=81), 85% were judged to have been sooner than would otherwise have been the case if CRHT team were not involved.

How likely is it the CRHT will be involved in discharge? (Ward Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very likely	127	25.4	40.8	40.8
	Quite Likely	37	7.4	11.9	52.7
	Don't Know	42	8.4	13.5	66.2
	quite unlikely	27	5.4	8.7	74.9
	very unlikely	78	15.6	25.1	100.0
	Total	311	62.2	100.0	
Missing	N/A	189	37.8		
Total		500	100.0		

How likely is it that if the CRHT are involved the patient will be discharged sooner than if not involved? (Ward Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very likely	87	17.4	28.0	28.0
	Quite Likely	48	9.6	15.4	43.4
	Don't Know	65	13.0	20.9	64.3
	quite unlikely	29	5.8	9.3	73.6
	very unlikely	82	16.4	26.4	100.0
	Total	311	62.2	100.0	
Missing	N/A	189	37.8		
Total		500	100.0		

Was CRHT involved in deciding circumstances (when/how) of discharge? (Ward Manager Responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	94	18.8	49.7	49.7
	Yes	81	16.2	42.9	92.6
	Not sure	14	2.8	7.4	100.0
	Total	189	37.8	100.0	
Missing	N/A	311	62.2		
Total		500	100.0		

If CRHT team was involved in discharge, how likely do you think the discharge was sooner than if CRHT had not been involved (Ward Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very likely	51	10.2	63.0	63.0
	Quite likely	18	3.6	22.2	85.2
	Don't know	6	1.2	7.4	92.6
	Quite unlikely	3	.6	3.7	96.3
	Very unlikely	3	.6	3.7	100.0
	Total	81	16.2	100.0	
Missing	N/A	419	83.8		
Total		500	100.0		

CRHT and Ward staff had conflicting information regarding the discharge status of around one admission in every eight

4. When we compared CRHT Manager and Ward Manager responses, there were clear examples where the two teams had different information regarding whether a person had been discharged or not. In 32 cases this was because the discharge was not to the CRHT team being interviewed (for instance the discharge was to another area) but in 63 cases (around one case in every eight) there was confusion regarding discharge status of patients between the Ward and CRHT staff – this indicates a lack of coordination. It signifies an area where improved communications and joint working between wards and CRHT teams could lead to further success in the identification of people appropriate for early discharge, and would ensure the CRHT teams have an up-to-date knowledge of which patient is where across the acute care services.

Has this person been discharged? (Ward Manager responses) * Has this person been discharged? (CRHT Manager responses) Crosstabulation

Count

		Has this person been discharged? (CRHT Manager responses)			
		not yet been discharged	has been discharged	98	Total
Has this person been discharged? (Ward Manager responses)	person not yet discharged	280	14	17	311
	person has been discharged	49	125	15	189
Total		329	139	32	500

CRHT teams with a strong gatekeeping function were more likely to be involved in discharges

5. CRHT teams which were gatekeeping the majority (>50%) of the admissions to the ward are significantly more likely to be involved in discharges than teams who gatekeep a minority of admissions.

RHT involved in < or > 50% of the 20 admissions per site * likely/unlikely CRHT i involved in discharge Crosstabulation

Count

		likely/unlikely CRHT is involved in discharge		
		unlikely	likely	Total
CRHT involved in < or > 50% of the 20 admissions per site	CRHT involved in 0-10 / 20 admissions	57	50	107
	CRHT involved in 11+/20 admissions	48	114	162
Total		105	164	269

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	15.134[b]	1	.000		
Continuity Correction [a]	14.157	1	.000		
Likelihood Ratio	15.099	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	15.078	1	.000		
N of Valid Cases	269				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 41. 77.

6. It follows that where a culture of considering home treatment as an option occurs at admission, that this consideration remains with staff throughout the patient's stay in hospital and is significantly likely (chi square value 14.65, $p<0.001$) to lead to the involvement of CRHT team for an early discharge.

Crosstabulation (Ward Manager responses)

Count

		Was there an assessment of whether home-based treatment was appropriate (at admission)		
		No	Yes	Total
likely/unlikely CRHT is involved in discharge	likely	74	118	192
	unlikely	61	37	98
Total		135	155	290

7. This indicates that the value of having CRHT staff gatekeeping admissions lies not only in diverting inappropriate admissions and enabling home treatment. It also assists CRHT teams in enabling early discharge.

8. CRHT teams appear to have limited ability to perform early discharge where Consultant Psychiatrists have failed to acknowledge the option of 'early discharge to home treatment'. Instead some psychiatrists persist with the long-standing practice of granting extended leave then re-calling patients to a ward round to decide on whether they can be discharged.

9. However, from the descriptive responses of the CRHT Managers it would appear that they do have some influence on gaining early discharge with some admissions that they were not initially involved in, even within 24 or 48 hours of the initial admission.

10. With the expectation that intensive home treatment is available as an alternative to using hospital beds where appropriate, the preference is to discharge early, whilst retaining the option to re-admit the person if treating them at home becomes unsustainable. Previously, a person no longer able to remain at home would have been recalled from ward leave. So, patients do not need to be clear of symptoms in order to be discharged. One Ward Manager suggested "Ward staff have become more focused and goal-oriented towards early discharge… they have reclaimed proper clinical nursing skills." However, others did raise concerns that early discharge could hinder the development of ward staff skills because as soon as the person becomes able to take advantage of more therapeutic input they are discharged into the care of CRHT staff. Some teams reported that they had mitigated this risk using a more integrated 'Acute Care Team' model, including both ward and CRHT staff.

11. Early discharge is also enabled through the use of Acute Day Hospitals (e.g. South Tyneside CRHT and Eastbourne CRHT). These provide patients with additional daily respite community resources, as well as home visiting from CRHT teams, hence reducing the need for a hospital admission over the period of crisis.

Good practice examples

West Cheshire CRHT: a policy for managing quick discharges of people not known to the local services at the point of initial assessment

A frequent occurrence in A&E Departments during night hours is the difficult, potentially risky presentation by someone not known to the local services, or for whom adequate information is not readily available. These assessments can be difficult judgement calls (e.g. where a person is saying they feel suicidal and/or may be under the influence of drugs or alcohol). Erring on the side of caution, hospital admission is usually the considered option. However, the person may present a very different settled and less risky picture even within a matter of hours, and then find themselves staying on the ward unnecessarily, sometimes for days, waiting to be seen by a Consultant Psychiatrist before being discharged. West Cheshire have developed a protocol for accepting the difficulty these decisions

present, but still promoting fast discharge where the need for the bed quickly diminishes.

The West Cheshire 'Policy for Fast Track Discharge from Inpatient Units following Informal Admission for Further Assessment' states:

'If the patient is not under the care of secondary mental health services at the time of admission, the length of admission and specifically the authority for discharge, normally lies with the Consultant Psychiatrist and the appropriate multi-disciplinary team (MDT) for the area of their normal residence. Admission for further assessment is appropriate if the initial CRHT Team assessment proves inconclusive for the presence of a Serious Mental Illness, with potential risks deemed to be significantly high. The inpatient assessment period will be up to a maximum of 72 hours. CRHT Team staff will continue their active involvement with the ongoing assessment, ensuring a follow-up visit is made to the ward within 24 hours of admission and further visits within the 72 hour assessment period. [...] If at any point during the maximum 72 hour assessment period the Inpatient / CRHT MDT concludes that any further period as an inpatient is not indicated, the authority and accountability to discharge lies with the core Fast Track MDT [...] The discharging core Fast Track MDT will consist of:

- Ward Manager or delegated senior ward staff (most senior staff on duty in the absence of the Ward manager);
- Senior CRHT Team staff members.

North-East Derbyshire CAHTT: having a dedicated daily link to the ward

A specific part-time post has been identified for providing dedicated time to the daily linking with the ward, with purpose of attending ward rounds and identifying admissions that by-passed the CAHTT, and the potential for any early discharge patients. This depth of focus on the link provides much more than an additional link-work function tacked onto an already busy practitioner. The potential has been realised to develop a genuinely strong personal relationship, virtually seen as a regular part-time member of the ward team as well as the CAHTT.

North East Cornwall Home Treatment Team East: reviewing all admissions rapidly

The team are based next door to the ward. Staff visit the ward daily and attend bed management meetings, and hence are able to identify and review any admissions which have bypassed the Home Treatment Team within 24 hours.

Chapter 6: CRHT teams need to be better understood by the teams and services that refer to them in order to ensure they provide the intended functions

1. CRHT teams provide an essential element of an acute care service, but they need to be clearly understood, accepted by and have good communication links with, the complex patchwork that makes up primary and secondary mental health services. Failure to develop these links can lead to CRHT teams spending unnecessary amounts of time assessing inappropriate referrals, and naturally leads to conflicts and misunderstandings. Not having a good understanding of what CRHT teams do and who their client is, is likely to promote misunderstandings for professionals involved with caring for mental health patients. This can introduce inefficiencies in an already complex system.

2. When asked about the main issues that influenced integration between the CRHT team and other teams, the main responses were as follows:

Evidence from CRHT Manager when asked what the key issues were that influenced integration with other parts of the service:

- Many primary care and other secondary care teams demonstrate poor understanding and expectations of what the CRHT team is set up to do (x5)
- Different geographical sectors within the same Trust are working by different systems and protocols (x3)
- Different expectations of what level and form a 'crisis' response should take, particularly where GPs have different expectations or information about accessing CRHT services (x3)
- CMHT staff inappropriately trying to use CRHT resources to cover their own annual leave or other workload pressures (x3)
- Conflicts among mental health professionals over the definitions of a 'crisis' (x3)
- CMHT staff passing on straightforward needs for medication reviews to the CRHT team on the assumption that the CRHT team has quicker access to medical staff (x3)
- Consultant Psychiatrists not using the function of early discharge into home treatment properly, preferring to continue with the long-term activity of granting extended ward leave (x3)
- A&E staff seeing CRHT as just being an out-of-hours liaison team, when in fact CRHT should be working to a more tightly defined client group if their resources are to be used most efficiently (x3)

- Assertive Outreach Team staff not being clear what they expect from CRHT input, and informing CRHT staff too late about their need for additional support (x3)
- Assertive Outreach Team Consultant Psychiatrists retaining an historic ownership of specific beds, and using these to by-pass the CRHT team gatekeeping function (x3)

3. Evidence suggests that CRHT teams feel they are working well with the majority of potential referrers to their services. We asked how many calls the teams took that were not progressed any further, which would suggest their time was being inappropriately engaged. However, most teams said that the volume of such calls was now low and easily manageable, at around ten a week. Indeed, many calls were other professionals 'testing the water', and these were not seen as at all a problem but rather they signified open communication channels across professionals.

number of calls that are not progressed during an average week

		Frequency
Valid	1-10	15
	11-20	6
	21-30	3
	Total	24
Missing	not sure	1
Total		25

4. When asked about the volume of phone calls that were received during a week that did not progress to assessment, the figures were below 10 for 14 teams, and above 60 for 2 teams. This indicates that some teams have clearly communicated their role to the teams that refer to them, whereas some teams may still be dealing with a large number of calls which they feel are unnecessary, which may also have subsequently resulted in inappropriate referrals for assessment. CRHT teams should clearly communicate who the team's client base should be, and let potential referrers understand how and when the CRHT team should be approached, if they are to improve current relationships and extinguish current resentment on both sides.

5. Analysis of 500 recent assessments referred to the 25 CRHT teams shows that CRHT staff felt that for the majority (84%) of cases, referrals were appropriate.

Did the CRHT team regard this referral as appropriate? (CRHT Manager responses)

where is the referral for assessment from? * did the CRHT regard this referral as appropriate? Crosstabulation

			did the CRHT regard this referral as appropriate?			
			No	Yes	not sure	Total
where is the referral for assessment from?	service user	Count	4	2	0	6
		% within where is the referral for assessment from?	66.7%	33.3%	.0%	100.0%
		% within did the CRHT regard this referral as appropriate?	6.2%	.5%	.0%	1.2%
	carer	Count	1	4	1	6
		% within where is the referral for assessment from?	16.7%	66.7%	16.7%	100.0%
		% within did the CRHT regard this referral as appropriate?	1.5%	1.0%	7.1%	1.2%
	primary care GP	Count	5	59	4	68
		% within where is the referral for assessment from?	7.4%	86.8%	5.9%	100.0%
		% within did the CRHT regard this referral as appropriate?	7.7%	14.0%	28.6%	13.6%
	primary care other	Count	1	5	0	6
		% within where is the referral for assessment from?	16.7%	83.3%	.0%	100.0%
		% within did the CRHT regard this referral as appropriate?	1.5%	1.2%	.0%	1.2%
	A&E out of hours	Count	11	52	0	63
		% within where is the referral for assessment from?	17.5%	82.5%	.0%	100.0%
		% within did the CRHT regard this referral as appropriate?	16.9%	12.4%	.0%	12.6%
	inpatient ward	Count	7	72	2	81
		% within where is the referral for assessment from?	8.6%	88.9%	2.5%	100.0%
		% within did the CRHT regard this referral as appropriate?	10.8%	17.1%	14.3%	16.2%
	CMHT	Count	11	121	2	134
		% within where is the referral for assessment from?	8.2%	90.3%	1.5%	100.0%
		% within did the CRHT regard this referral as appropriate?	16.9%	28.7%	14.3%	26.8%
	other mental health team	Count	4	24	0	28
		% within where is the referral for assessment from?	14.3%	85.7%	.0%	100.0%
		% within did the CRHT regard this referral as appropriate?	6.2%	5.7%	.0%	5.6%
	police	Count	1	6	0	7
		% within where is the referral for assessment from?	14.3%	85.7%	.0%	100.0%
		% within did the CRHT regard this referral as appropriate?	1.5%	1.4%	.0%	1.4%
	other	Count	8	27	5	40
		% within where is the referral for assessment from?	20.0%	67.5%	12.5%	100.0%
		% within did the CRHT regard this referral as appropriate?	12.3%	6.4%	35.7%	8.0%
	A&E psychiatric liaison	Count	12	49	0	61
		% within where is the referral for assessment from?	19.7%	80.3%	.0%	100.0%
		% within did the CRHT regard this referral as appropriate?	18.5%	11.6%	.0%	12.2%
Total		Count	65	421	14	500
		% within where is the referral for assessment from?	13.0%	84.2%	2.8%	100.0%
		% within did the CRHT regard this referral as appropriate?	100.0%	100.0%	100.0%	100.0%

CRHT teams are being confused by others, and are confusing themselves, with non-acute community mental health services

6. The main sources of referrals are from CMHT, A&E (24/7), inpatient unit, and GPs. Some of the 25 sites accept referrals from all sources, but the majority of CRHT teams expect service user, carer and voluntary sector agencies to be triaged through their local CMHTs during normal working hours rather than come directly to the CRHT (6 sites include GP referrals in this category). This requirement also supports the widespread understanding that the CMHT is most commonly the first point of contact for new people with community services. More frequently self-referrals from service users or carers will only be accepted from people already known to the CRHT team. The main reason for this is to target limited resources so that time is not spent assessing non-acute cases, but rather to work with the highest priority need for intensive acute care.

7. Service users and carers, police, primary care and A&E and other mental health teams tended to send inappropriate referrals more than the average 13% of the time. Inadequate assessments before a referral is made to CRHT may result in too heavy a load for the CRHT team – resulting in them spending significant amounts of time assessing referrals, which in turn mitigates their ability to actually deliver home treatment services. Without the ability to deliver home treatment, there is little or no value in the assessments themselves which can do no more than signpost the patient to the appropriate service, which won't include home treatment in any case.

8. However, CRHT teams assessed 15% of the referrals they thought were inappropriate and agreed to accept that patient as a home treatment client. This clearly suggests that CRHT teams are making questionable decisions regarding their appropriate client base. A CRHT team should only be offering home treatment for those patients who would otherwise be admitted.

did the CRHT regard this referral as appropriate? * did the CRHT refuse or accept this patient as a home treatment client? Crosstabulation

			did the CRHT refuse or accept this patient as a home treatment client?		
			refuse	accept	Total
did the CRHT regard this referral as appropriate?	No	Count	55	10	65
		% within did the CRHT regard this referral as appropriate?	84.6%	15.4%	100.0%
	Yes	Count	140	281	421
		% within did the CRHT regard this referral as appropriate?	33.3%	66.7%	100.0%
	not sure	Count	9	5	14
		% within did the CRHT regard this referral as appropriate?	64.3%	35.7%	100.0%
Total		Count	204	296	500
		% within did the CRHT regard this referral as appropriate?	40.8%	59.2%	100.0%

9. On at least 169 of these 500 referrals it appears that the CRHT team was involved in diverting or signposting the patient to other non-acute services. Indeed, 106 of these referrals were thought to be appropriate by the CRHT team. This indicates an inappropriate application of CRHT team function and an inefficient use of CRHT team time. The risk remains that CRHT teams are being confused by others, and are confusing themselves, with non-acute community mental health services. CRHT teams themselves must be wary of providing home treatment services to inappropriate clients and assessing inappropriate referrals.

whether accepted or rejected for home treatment, what outcome for service user? * did the CRHT regard this referral as appropriate? Crosstabulation

Count

		did the CRHT regard this referral as appropriate?			
		No	Yes	not sure	Total
whether accepted or rejected for home treatment, what outcome for service user?	admission to inpatient	6	68	1	75
	acute treatment from CRHT	4	244	3	251
	another acute treatment pathway	1	0	1	2
	another non acute treatment	38	87	6	131
	other	13	9	3	25
	no further mental health service needed	3	10	0	13
	don't know	0	3	0	3
Total		65	421	14	500

10. The third of referrals that then resulted in non-acute and other (including non-mental health) service signposting calls into question the initial assessments made

by referrers that CRHT input was necessary. Of all referrals 22% were signposted to another non-acute treatment pathway (usually GP or CMHT). And a further 9% were signposted to 'other' local services such as Cruise bereavement counselling, Rethink, MIND, Asylum Seekers services, criminal justice services, Citizens Advice Bureaux, Children & Families support services, medical wards, etc. While there is still a valuable if limited role to be played in assessing referrals which are then signposted to the appropriate service, this role would more usually be expected of CMHTs.

11. This indicates a need for local service systems to re-focus efforts on how they understand the CRHT service; different parts of the services need to understand each others' roles better if inefficiency and duplication are to be avoided. Several Ward and CRHT Managers claimed that CRHT teams were being seen as new dumping grounds, and as a solution to many of the gaps identified in services locally.

12. It should be the responsibility of each CRHT team to monitor the referrals they initially consider appropriate for assessment but then end up diverting the service user to other non-acute sources of intervention. They should be feeding this information back to the specific referrers in order to try and improve their assessments before referring for CRHT. Where some referrers are consistently identified as making inappropriate referrals this would indicate a need to educate them about the roles and functions of CRHT teams.

13. The main reasons given for why referrals were refused or rejected for home treatment were as follows:

Evidence from CRHT Manager Interviews:

Reasons given for refusing to take referrals for home treatment:

- Not appropriate for home treatment ~ e.g. not fitting the criteria set out in the local Operational Policy, or not at sufficient levels of risk to justify a crisis intervention response, with a conclusion that the CRHT team clearly disagreed with the referrer's assumption of a potential need for hospital admission (x66);
- Signposted to other appropriate community based services (x38);
- Assessed by the CRHT team as needing hospital admission (x30);
- Users or carers stating they did not want to engage with CRHT, hence resulting in an admission to hospital (x20);
- No mental health crisis, the nature of the crisis being purely a social context such as accommodation or relationship issues, or a drug problem independent of mental health symptoms (x18);
- Primary alcohol problem (x14);
- Primary physical health concerns (x7);
- Other legal problems such as imminent deportation or current contact with the criminal justice system as the primary issue of concern (x6).

Reasons given for accepting to take on referrals for home treatment:

- Identified as being a part of the CRHT team gatekeeping function (x25);
- Assessed as appropriate for home treatment ~ as a general statement (x22);
- Having to meet locally determined targets, but otherwise not the most appropriate service users that the team should be working with (x14);
- Need for further/on-going assessment in order to determine the specific nature of the crisis or most appropriate type of intervention (x13);
- CRHT team to offer just very short-term support and intervention, as the crisis is assessed to be a temporary condition, or while waiting for the more appropriate team to be able to engage (x13);
- Facilitating early discharge from ward (x7);
- Provide support across a weekend/Bank holiday where the usual team is not operating and the likelihood would be admission without this additional intensity of support (x6);
- Monitor medication and mental state (x6).

14. The level of referrals rejected on the basis they were not appropriate for home treatment indicates an ongoing need for better education across the mental health system about the role, functions and limits that need to be applied by CRHT teams if they are to be cost-effective and clinically beneficial. The levels where there was no mental health crisis assessed, and where the primary problem was drugs, alcohol, physical or criminal justice issues, also indicates a lack of clarity in many referrers about why they are seeking to involve a CRHT team. Merely circulating a copy of a written Operational Policy or making brief presentations to other teams/services is insufficient to get the message across, and will lose its power as staff turnover in other services progresses. Furthermore, the incidence of locally determined targets influencing CRHT teams to work with people otherwise not suitable for the service indicates a lack of awareness by service management on how to maintain the focus of the teams.

There are different approaches adopted locally to address inter-team conflicts

15. Concern was raised in a few interviews that resources are inappropriately diverted to all assessments coming through A&E. However, other sites felt that locating CRHT staff strategically in A&E out-of-hours to do joint assessments with SHOs was at least successful in cutting down the number of inappropriate hospital admissions. Managing or working closely with Deliberate Self Harm teams was also seen as an efficient use of resources, particularly linked to the population seen at A&E departments.

16. There is an issue which deserves attention in local services about other staff feeling that CRHT teams are questioning or undermining their professional judgements. There was a call from 2 interviewees to establish 'minimum

standards' of what should be expected of other staff in terms of informing the CRHT team early of someone deteriorating, stating what they are doing within their own resources to manage or halt the slide into crisis, and when they might need the further involvement of the CRHT team. Such standards should be about reinforcing that everyone has skills for assessing crises in their own service setting, but recognising the need for flexibility in how to make best use of each teams' skills in line with the specialist functions they are expected to provide. These standards should reiterate the message that the CRHT team is there to provide specialist back-up and intensive support, rather than to question or take over the assessment of others.

17. Other inter-team conflicts emerge through occasional examples of Community Mental Health Teams being slow to allocate care coordinators (to patient on discharge from CRHT to CMHT) as a result of trying to manage their own team workload pressures. However, there were many examples highlighted by CRHT Managers of good local working relationships:

When asked what initiatives helped to promote better integration with other parts of the services the 25 CRHT Managers identified:

- CRHT staff attending the regular CMHT meetings, where resources permitted (x12)
- Attending local forums where managers of all services met to discuss issues and service developments (x5)
- Inviting other staff to spend time with the CRHT team to see how it works (x5)
- Inviting staff from other teams to attend CRHT handover meetings (x4)
- Doing joint assessments with staff from CRHT and other teams (x4)

18. In 6 CRHT Manager interviews, it was raised that confusion exists between CRHT teams and Assertive Outreach Teams, particularly regarding their roles in crisis management and facilitating early discharge. Unlike the capacity issues faced by Community Mental Health Teams, Assertive Outreach teams are tasked to work with a client group who traditionally do not engage well with mental health services. The needs of this client group mean that they are often frequent or long-term users of hospital beds, living chaotic lives chequered with health and social crises. These teams are expected to deliver a much higher intensity of support, to identify and work with crises to a much higher degree, and to maintain a high degree of contact throughout hospital admissions thus enabling early discharge. Consequently, they work with smaller caseload numbers, often through a team approach not dissimilar to CRHT teams. In many ways they are seen as the crisis team for their own client group, and understandably, there is a more significant degree of overlap with the expectations placed on CRHT teams.

19. The confusion arises mainly where the Assertive Outreach team may require the additional support outside of the extended hours they already offer, particularly if it is finely balanced as to whether the person may need hospital admission. Jointly developed protocols between these services at a local level should aim to recognise the roles each play, but emphasise the need for Assertive Outreach staff to 'alert' CRHT staff sooner of a possible need for back-up support. The earlier alert does not necessarily mean an immediate response from the CRHT team, but the latter can be left feeling helpless if the request for support is immediate and too late for anything else but admission to be considered. Local protocols should also recognise the central gatekeeping/bed-management roles of the CRHT team, while recognising the functions that Assertive Outreach can perform without need for duplication of effort. It is essentially about good two-way communication.

Chapter 7: Service User/Carer preferences do influence admission decisions, so they need to be fully informed of the range of options[2]

1. Two of the sites visited were able to demonstrate significant examples of service-user feedback data, but it is strongly recommended that all teams should be able to benefit from a consistent, centralised system of capturing patient feedback, rather than each team to attempt their own satisfaction surveys. This would afford rigorous collection methodologies, economies of scale regarding data collection costs, and would also allow much improved rigour in the analyses and hence usefulness of the data. The Department of Health should capture national data on acute mental health care services which should be monitored over time.

2. Based on the questions asked of service providers in this fieldwork, the main messages emerging were:

Evidence from Ward and CRHT Managers when asked about their experience of service user preferences regarding home treatment and admission:

- Newer patients tended to prefer home treatment
- People with experience only of admission would tend to state a preference for admission in the first instance
- Some service users and carers shifted in favour of home treatment after they had experienced it
- People living with their families preferred a home treatment option that enabled them to stay in their family environment
- Some of the pressure for admission came from carers
- Many people with a personality disorder stated a preference for admission
- Admission was the better option for homeless people, those needing detention/containment, and where home was a significant part of the problem (instigating or furthering the mental health crisis).

[2] Caution is advised where service user/ carer views are presented solely by service providers. Separate consultation (outside of this piece of research) with these groups has gained more information regarding their satisfaction with how the services are performing.

Decisions to admit were at least partly influenced by service users, carers or both together in 259 of the admissions reviewed

3. We asked Ward Managers whether the preferences of service users and/or carers influenced the decision to admit:

Did the preference of service user/carer influence the decision to admit? * Admission a detention or not Crosstabulation (Ward Manager responses)

Count

		Admission a detention or not		
		no	yes	Total
did the preference of service user/carer influence the decision to admit?	service user influenced decision	113	20	133
	carer influenced decision	55	40	95
	both carer and user in agreement	28	3	31
	preference had no influence	19	42	61
	no preference made	63	51	114
	Dont know	44	22	66
Total		322	178	500

4. For service users, the majority of their input was that they agreed with the admission rather than seriously influenced it. On some occasions an informal admission was agreed upon as an alternative to being detained under the Mental Health Act. Where the patient was being detained under the MHA, user preferences were less likely to influence the decision to admit.

5. In several cases, users requested hospital admission, for instance when they felt unsafe at home. Such indications were given as examples where preferences did influence the decision to admit. However, interestingly there were examples of the patient preferring not to be admitted (for example stating that they wanted to stay at home) but this preference did not have any influence on the decision to admit.

6. Carers' requests for a patient to be admitted were reported as examples where preferences had an influence. They might report that they were not coping with the situation, or feeling physically threatened by the service user. Having no support at home is another circumstance that may influence whether a service user is admitted or not.

7. Several interviewees discussed whether home treatment places an increased burden on carers; carers may feel more out of control with intermittent visits to their home than they would if the patient was admitted. The challenge for mental health staff assessing users for admission is partly to assess the needs accurately, but also to focus on how home treatment is presented as an option to people. 3 CRHT Managers talked of how service-user and carer perceptions

had changed as a result of being supported through the experience of home treatment, and how they had now come to prefer it as an option.

8. Of the 320 admissions where a preference was indicated, 81% of decisions were in line with the preferences. The majority of cases (69%) where the preference had no influence were associated with detentions under the Mental Health Act. This is a positive finding that services are taking the wishes of service users and carers into account, to some extent, when assessing the need for admission or alternative treatments.

Patients in crisis have to interact with different members of staff regardless of whether they receive home treatment or admission. Continuity of staff through the crisis will not be possible

9. An issue highlighted by 3 Ward Managers was that many service users and carers were disinclined to engage with home treatment because it involved the need to cope with different people visiting. This is a criticism that has been more widely levelled against home treatment. One CRHT Manager specifically acknowledged that their team actively tries to minimise the number of team members who will have contact with a service user. However, a distinction needs to be clearly drawn between CRHT and other community services. CRHT teams are not tasked with establishing long-term relationships with service users; by definition they are meant to be focused on brief or short-term contact. For this reason the basis of the therapeutic relationship is entirely different, and the established rules of community engagement through CMHT and Assertive Outreach services do not apply. A person is in crisis, and as such should be engaging primarily with a 'crisis resolution service', not specific individual practitioners. The staff on a ward would be the alternative staff that a patient would need to interact with.

Good practice examples

Eastbourne CRHT: conducting a local survey of service user views

The local service recognized that if a new type of service is established, even in line with national recommendations, it is vitally important to seek the views and experiences of those who are required to use the new service. A Service User Satisfaction Survey was designed, both to gain feedback on specific questions about the service received, but also to gather respondents' open-ended comments. Every user who has been on the home treatment caseload is given the opportunity to provide feedback about their experience with the team. The results have been collated into a specific report, which offers feedback not only to the team and the Trust, but also to the service users and carers involved or potentially in contact with the CRHT team.

100 responses were received across Jan-Nov 2006 (30% response rate). The report includes a balanced list of positive and negative written feedback quotations. The quantitative results included:

· Understanding what the team would offer (41% some extent, 25% large extent, 21% completely);

- CRHT preferable to admission (some extent 16%, large extent 30%, completely 40%);
- Personal choice for home treatment or hospital admission (some extent 21%, large extent 14%, completely 31%, not at all 34%);
- Helpfulness of subsequent home visits (very helpful 21%, quite helpful 32%, quite unhelpful 9%, very unhelpful 7%);
- Helpfulness of telephone contact (very helpful 36%, quite helpful 44%, quite unhelpful 12%, very unhelpful 8%);
- Appropriateness of timing of discharge from CRHT (some extent 30%, large extent 17%, completely 32%, not at all 21%);
- Overall satisfaction (some extent 27%, large extent 27%, completely 37%, not at all 9%).

National surveys of service user opinion of an acute care service provide valuable evidence for service developments, but should not detract from engaging local views about local services.

Leicester City CRHT: finding a meaningful role in the team for a service user

One of the challenges across all types of mental health teams is to develop meaningful roles for talented service users in the overall functioning of the team. In Leicester, they have worked in collaboration with a citywide service user group to develop a specific role within the CHRT for taking a lead on service-user engagement within the service. The team is employing a service user (who was formerly a voluntary worker with Leicestershire Action for Mental health Project) for 4 days per week as a Service User Development Worker. His main remit involves linking with the voluntary sector both locally and nationally. He also has a role in engaging service-user views at the point of discharge out of CRHT, and ensuring a service-user opinion can be applied to all other aspects of team and service development. The claims at this stage are for a 93% satisfaction rate from 900 interviews.

A very high return is achieved, firstly though focusing on exit interviews rather than questionnaires; but also because service users connect in a different way to being interviewed by another service user.

Chapter 8: CRHT teams provide acute care, and success will depend on integrating them effectively in the acute care pathway

1. Inpatient units are repeatedly criticised in national reports for their poor-quality environments, for their lack of therapeutic activity beyond containment and medication, and for the drain of staff from inpatient units into the new community teams.[3] Whilst CRHT teams are specifically implemented to deliver an acute care service to people in crisis, the emphasis has largely been on them as an addition to the community teams, alongside Community Mental Health Teams, Assertive Outreach Teams, and Early Intervention Teams. As a result they may have lost the focus of their core business: *community* orientation should not in any way dilute their *acute* orientation. CRHT teams must be absolutely clear about their focus and functions.

There are important risks to patients and staff working on inpatient wards to consider with the successful emergence and application of CRHT

2. If the functions outlined in chapter one are carried out effectively, we should expect dramatic impacts for the inpatient units particularly from effective gatekeeping and early discharge into home treatment:

   Ward Managers stated that:

   - Levels of acuity and challenging behaviour are likely to increase on the inpatient wards (x12)
   - A reduction in admissions had happened in some sites or was expected to happen in others (x10)
   - Levels of risk and violence on the inpatient wards would increase because of the changing profile of those who are being admitted, particularly more acutely psychotic and manic patients, and with increasing levels of substance abuse (x7)
   - Inpatient quality of care was suffering due to the loss of experienced staff from the wards to community teams (x6)
   - A higher proportion of admissions would be appropriate and shorter admissions to the wards would also result due to the ability to discharge people earlier into home treatment (x5)

   CRHT Managers stated that:

   - Levels of acuity and challenging behaviour on wards are likely to increase as a resulting picture of those who need inpatient admission (x12)

[3] Department of Health (2002) *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*. Also: Sainsbury Centre for Mental Health (2005) *Acute Care 2004: A National Survey of Adult Psychiatric Wards in England*

- A reduction in the number of admissions through more effective gatekeeping (x9)
- Decrease in number of beds may threaten a loss of inpatient jobs as there are fewer numbers of people needing admission (x6)
- Levels of risk and violence would increase as part of the picture of those in need of hospital admission (x5)
- Greater joint working with CRHT staff will enhance the skills of less experienced inpatient staff (x5)

3. Admissions and overall bed occupancy may reduce, with more appropriate admissions. However, the actual admissions would present higher degrees of challenging behaviour, risks and acute disturbance. The emerging inpatient profile would require skilled and confident ward staff to manage the clinical challenge; yet concerns were repeatedly raised about losing skilled and experienced staff to the attraction of community teams. Interviewees highlighted how in some cases effective CRHT teams were diminishing the possibilities for ward staff to develop their assessment and therapeutic management skills by replacing them at assessments. Furthermore, some Ward Managers pointed to the additional impact of successful early discharge on the skills development of inpatient staff: just at the point when patients on the ward become ready to benefit from therapeutic work, they are discharged.

4. The Agenda for Change initiative has largely resulted in a higher pay banding award for community staff than ward staff, detracting from the thought of a career in acute inpatient care for most and fuelling a feeling that you need to complete an apprenticeship on the ward before quickly leaving to community-based posts.

5. A number of Ward Managers wished to highlight concerns that a cost-driven service will look to effective CRHT teams as a way of closing more wards. However, if accompanied by reducing the staffing complement on the remaining wards there is a serious risk that what results is an increasing level of unmet need and disturbance for the remaining inpatients. The most serious scenario is that wards could deteriorate further, as the neediest patients are served by the least skilled and experienced staff.

6. Ward Managers were asked to identify which ward staff were involved in the assessment of the 500 admissions and the evidence supports these concerns that ward staff are gaining reduced assessment skills: Ward staff were recorded as being involved in only 13% of the 500 admissions. Of the thirty five admissions involving Nursing Bands 5 and 6, nineteen were inter-ward transfers, which involves more in the way of administrative negotiations than actual clinical assessment skills. However, some Ward Managers did point to an expectation that closer working between ward staff and CRHT staff would help to raise the overall skills levels, and this was happening in cases where the identity linked to being an ‘acute care service’ was more strongly fostered.

Ward Staff involved in the assessment
(Ward Manager responses)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	consultant	10	2.0	2.0	2.0
	grade 5&6	35	7.0	7.0	9.0
	Combination	12	2.4	2.4	11.4
	Bed management	1	.2	.2	11.6
	Manager Band 7	6	1.2	1.2	12.8
	N/A	436	87.2	87.2	100.0
	Total	500	100.0	100.0	

Some teams report that the acute pathway is more efficient where ward staff and CRHT staff adopt a more integrated approach to working

7. There appears to be a shift in recent years towards an integrated acute pathway, with CRHT teams moving to be physically closer to the inpatient unit they serve. Of the 25 sites visited in this study the following configurations of wards and CRHT offices were noted:

    - Shared office between inpatient and CRHT staff (x1)
    - Shared building on the same community site (x1)
    - Shared building on a hospital site ~ Psychiatric Hospital or General Hospital (x7)
    - Shared hospital site but different buildings (x4)
    - Separate hospital/community sites (x12)

8. At least 5 of the CRHT teams had moved from separate sites to shared buildings/sites during the last two years, with claimed improvements in communication between parts of the acute care service, but also with recognised improvements in the functions of gatekeeping and early discharge. Whilst it is also recognised that CRHT teams will usually experience better communication and working relationships with some of their referrers if they share buildings (e.g. Community Mental Health Teams, Assertive Outreach Teams, ASW rotas), the issue is not about creating new mini-institutions. The

focus clearly should be on *strengthening acute care*, while also working on better means of communication with other community services.

9. Some Ward Managers could see the possibility of creating a more attractive acute care career structure through closer merging of ward and CRHT staffing. Two of the sites visited are progressing with this initiative.

Most of the teams visited could provide CRHT services 24/7, but the correct hours of operation were not necessarily known by the managers of the wards that the team works with

10. The intention outlined in the Department of Health's policy is for CRHT teams to provide a 24-hour service. We investigated what the operational hours were, and if they were clearly understood by the associated services. When asked about their hours of operation:

    - 11 CRHT teams were staffed 24/7
    - 13 teams were on-call at night
    - 1 team was covered at night for crisis assessments by a neighbouring CRHT in the Trust

11. When the 25 Ward Managers were asked to state the operating hours of their associated CRHT not all were able to respond with accuracy:

Did they know the correct CRHT operating hours? (Ward Manager responses)

	Frequency	Percent	Valid Percent	Cumulative Percent
Incorrect	60	12.0	12.0	12.0
Correct	440	88.0	88.0	100.0
Total	500	100.0	100.0	

Ward managers and CRHT managers did not agree about which admissions were known to the CRHT team, which suggests the teams could work more closely together

12. When the Ward Managers were asked if they thought the admission was known to the CRHT they recorded a 'No' in 15% of cases. When the CRHT Managers were asked about the 500 admissions, they in fact reported they did not know about 29% of cases. Agreement between the teams was 71%. This questions the quality of the mechanisms in place in some instances for close communication and joint working between the wards and community teams that deliver an acute care service.

Do you think this person's admission is known to CRHT team? (Ward Manager responses) * Did CRHT know that this person is currently admitted (CRHT Manager responses) Crosstabulation

Count

		Did CRHT know that this person is currently admitted (CRHT Manager responses)			
		No	Yes	Not sure	Total
Do you think this person's admission is known to CRHT team? (Ward Manager responses)	No	47	26	2	75
	Yes	77	307	5	389
	Not sure	22	13	1	36
Total		146	346	8	500

13. This suggests that the ward and CRHT teams are not as well integrated as they should be. Even where the gatekeeping function is not successful, the CRHT team ought to be aware of all admissions. This would at least mitigate the impact of missing inappropriate admissions as it would enable teams to re-assess patients once admitted. Without such a function, where admissions are missed, the patient is less likely to be served by the CRHT team.

14. The CRHT Managers were asked whether they re-assessed admissions that they were initially not involved in: 16 of the 25 teams said they did. The implications were that this process does have a positive impact on promoting early discharge, with 4 CRHT Managers claiming people could be discharged within 24 hours as a result, 3 claiming discharges within 48 hours, and a further 5 claiming earlier discharge over a variable time period.

Does the CRHT team re-assess admissions? (CRHT Manager responses)

		Frequency
Valid	no	8
	yes	16
	not sure	1
	Total	25

15. Mechanisms that can facilitate improved communication between CRHT and ward teams are close proximity and integration with the wards, a link-worker visiting the ward on a daily basis, and Ward Managers attending CRHT handover meetings. The benefits identified were the ability to use this process to reinforce the importance of the gatekeeping role by CRHT teams, the shortening of inappropriate admissions, and a sense of improved communication between the different parts of the acute care services. However, they also acknowledged the difficulties of quick re-assessments and changed decisions for service users and carers, the impact of available resources to meet the need, as well as the potential conflicts with staff who had originally recommended the admission.

16. Inter-unit transfers (between wards, PICUs, and the occasional transfer from prison) appeared to be a typical instance where admissions to the ward may go unnoticed by the CRHT team. At present, the most usual process seems to be agreement established between units to manage a transfer, with early discharge/discharge to home treatment only being seriously considered at the next ward round or bed management meeting, after the person has settled into the receiving ward. In a few instances Ward and CRHT Managers were able to offer anecdotal evidence of people being discharged into home treatment at the point where ward transfers were being considered. These instances included rare occurrences where, as some individuals had been waiting in secure accommodation for a long enough period that they no longer needed any inpatient facility for clinical reasons. There is no reason why these instances should be exceptions rather than the norm.

17. It is recommended that the receiving ward in any inter-unit transfer should automatically consider informing the local CRHT team, so some consideration could be made about the potential for discharge into home treatment at the earliest point. In some instances a patient could be transported by usual means between units, but a brief assessment at the receiving unit could mean the person does not occupy a bed at all before being discharged. The emphasis is placed on the receiving unit largely due to pragmatic circumstances; as the forwarding unit will have a priority to free their bed, while the receiving unit would also benefit from considering options that may occasionally free their bed sooner.

Good practice examples

East Lincolnshire CRHT: developing the integrated acute care team

The CRHT and ward teams that serve the patch around Lincolnshire centred on Boston have progressively merged in recent years. From a position where the community team were located in a separate community base, they initially moved into offices below the two wards they served. A management decision to close one of these wards placed enormous pressures on the remaining ward and team, but co-location through opening up the two ward areas into one acute care service has helped manage the resources most efficiently.

The two staff teams now share the same open plan office, so that white boards are clearly visible in the same room listing ward bed state and home treatment caseload. New posts are now being advertised as acute care rotation posts, and existing members of staff in both teams are encouraged to think of themselves as being part of the single service. The benefits they report at their present stage of integration are:

- Improving the career pathway and avoiding loss of staff from ward to community;
- Delivering structured acute care through a whole systems approach;
- Reasons for admission and for early discharge into home treatment are more explicitly understood by staff working across acute care functions;
- Acute inpatient admission is considered a brief intensive specialized intervention;

- More flexible use of resources in response to demand;
- Opportunities to more flexibly use the skills mix across the acute care staff complement.

The full integration is not completely achieved yet, and the relationship between one ward and one CRHT enables the process to be simplified. However, the relationships between staff across the two parts of the service are an excellent example of putting common sense into service delivery.

Central Norfolk (City) CRHT: creative approaches to the challenge of integration

This service has chosen to work towards an integrated Acute Care Team through being based on the same site but not in the same building. CRHT staff daily visiting the ward, and ward staff enabled to complement CRHT capacity while operating around 60% bed occupancy. The issue is inequalities of pay between ward and community staff, but this service is temporarily using enhanced pay for ward staff in order that the important service development can happen (while still advocating formal resolution of the banding issue).

Liverpool CRHT: separate teams but developing stronger links

The CRHT has recently moved from a separate community base to ground floor offices in a shared building with the inpatient wards. In the current absence of an integrated acute care team these separate teams have looked to develop their links more strongly as a stepping stone towards greater integration. Good Ward/CRHT team links happen through Ward Manager's daily attending CRHT morning handover, and CRHT team identifying clear link-workers for each ward to keep up-to-date on admissions, and identify potential people for early discharge. Sudden improvements in the quality of communications have been reported by both managers interviewed, and by the wider service management group. This is forming the basis for positive reflections for further service development to strengthen the acute care sector.

18. The Ward and CRHT Managers were all asked to consider if they had any concerns about the possible success and sustainability of the policy that all potential admissions should be assessed for the suitability of home treatment. Concerns were raised, and covered many issues such as threats to the continued capacity to deliver, continued conflict with or misunderstandings by other professionals, and that the geographical area covered by many rural and semi-rural teams makes it unworkable.

Interviewees expressed concerns regarding potential risks of perverse activity resulting from the way CRHT team targets have been set

19. 2 Ward and 4 CRHT Managers expressed specific concerns, but most others also had general comments to make about the interpretations made by management and commissioners of the overall policy for implementing CRHT teams. These ranged from the differences in local funding arrangements being used to support service

development, which may in some instances distort the messages about effective implementation communicated through the Department of Health Policy Implementation Guidance, to more of a specific target-based culture that actively distracts teams away from responding appropriately to clinical need.

20. One distortion of practice emerges through targets set for number of 'contacts' that need to be made each month. Whilst targets are acknowledged as having value in focusing a team on its core business and to be efficient in the use of resources, a linking of numbers to funding seriously distorts the main drivers of service delivery. In the case of number of contacts per month, teams will be better served focusing on lower level needs in order to achieve greater throughput. They are also better served focusing on increasing the ratio of assessments they do in relation to taking on intensive home treatment work. If they discharge someone with good reason, but because of personal circumstances they are re-referred in crisis within 14 days, it only counts as one client contact for statistical returns, placing increased pressure on a service to find other client contacts from somewhere.

21. Chapter 6 referred to instances where CRHT teams were accepting assessments and taking some people on beyond the assessment, where in both instances it was inappropriate according to clinical need and to the policy. Some reasons given were that this was for the purpose of meeting targets, not for clinical need. Where targets create a contradictory direction from intended policy, there are risks to the effectiveness and efficiency of the policy.

22. Response times for CRHT teams to meet with and assess a person based on national recommendations may take no account of local characteristics. This was a particular and consistent issue raised in all 5 rural and many of the semi-rural sites visited. Response times usually set as a result of urban-based research do not take account of the poor quality roads, the large geographical areas covered by some teams, or local traffic flows (e.g. the affect of summer holiday traffic on local road systems). Teams sharing these concerns were generally able to recognise the need for time management through linking visits in geographical areas, but separate crises may not easily fall within geographical areas.

23. For some teams they can often have most members of staff out on visits for the whole shift, only communicating by phone to respond to other needs that may emerge. Whilst they will do everything possible to be flexible in response to needs, the limits of this flexibility can occasionally be stretched beyond what is reasonable. Yet, the pressure associated with the need to meet targets can add an unnecessary burden on these staff members. What is needed is a more flexible establishment of targets based on local negotiation in relation to reasonable local circumstances.

Many CRHT teams are recently emerging with more steadfast and better understood key functions

24. The issue that emerged for at least 5 sites was the extensions of age ranges beyond the 'working age' bracket through local changes in service structures. Some CRHT teams and wards were experiencing a need to respond to 16-18 year old service

users in designated adult services. Many more were concerned that by not providing a service to older adults (over 65), this would result in frail elderly people having to be accommodated in wards otherwise populated by disturbed younger adults. These issues have not yet been consistently responded to, so different policies are operating in different areas.

25. The implementation of CRHT teams was seen as one of the most significant service changes in its own right. Most of the teams having been initiated from 2004 onwards (see Appendix 1). The introduction of these services has a knock-on effect on other services. Newer services generally appear to have been through or are currently going through a natural evolution of conflict ~ being misunderstood, challenged and by-passed in their earlier stage of development, before emerging from these experiences to look again at how they establish their position, (e.g. some teams were instructed to merge with or take-over from A&E Liaison teams that pre-dated them).

26. 12 out of the 25 CRHT Managers reported significant improvements or achievements through changes within the last year, ranging from positive service expansion, to developing a clearer acute care service identity, to having to re-focus the service after an initial period of unclear or unstable team development.

Staff skills and development needs remain a priority when making adaptations to service delivery (such as introducing CRHT) that affect the whole acute care pathway

27. Concerns for the actual levels of skill for many staff in the different parts of the acute care system were expressed by some Ward and CRHT Managers. These covered:

- The need to recruit people with the right attitudes and skills for the challenges of acute care service delivery, particularly in the changes identified on wards through increasing levels of acuity, disturbance and risk;
- The lack of ability of some staff of all professional backgrounds in all parts of the system to manage risks without being over-cautious;
- The challenge of trying to achieve the necessary consistency and quality of staffing across the acute care sector services (ward and CRHT);
- The need to achieve a greater level of understanding by CRHT staff and staff in other teams of the roles CRHT teams should perform and the value of joint working across the system;
- Engaging some CRHT staff to see that an Acute Care Team means they are responsible for working more closely with and on the wards; they are not just to see their role as working to a community-focused remit outside of the ward environments.

Recommendations

1. **Commissioners and providers should review local service models and consider how to maximise communication and co-operation between CRHT and ward staff.**

   - A community orientation should not in any way dilute the CRHT team's acute orientation. Mechanisms that can facilitate communication and co-operation between CRHT and ward staff include close proximity and integration with the wards.
   - Staff skills and development needs remain a priority when introducing CRHT services, which affects the whole acute care pathway. Developing and maintaining necessary skills among both CRHT and ward staff can be achieved through a flexible arrangement of available resources (e.g. shared teams with one ward-based office, or shared buildings, or shared sites, or closer link-working arrangements with CRHT staff expected to have a higher presence on inpatient wards), including the development of rotation posts and designated 'Acute Care' Consultant Psychiatrist posts that split the consultant's time between both inpatient wards and CRHT teams
   - The impact of CRHT teams on the functions of other community teams should be managed through developing a 'whole systems approach' to communication and joint working - to include minimum expectations of how community mental health teams respond to a crisis within their own resources, and when they call in the specialist support of CRHT teams. The CRHT team is there to provide specialist back-up and intensive support, rather than to question or take over the assessment of others. Local teams need to recognise the roles each play - this should reinforce that everyone has skills for assessing crises in their own service setting, but recognise the need for flexibility in how to make best use of each teams' skills in line with the specialist functions they are expected to provide. For instance the need for Assertive Outreach staff to alert CRHT staff of a possible need for back-up support. The earlier alert does not necessarily mean an immediate response from the CRHT team, but the latter can be left feeling helpless if the request for support is immediate and too late for anything else but admission to be considered.

2. **There must be communication between CRHT and ward staff regarding all potential admissions**

   - CRHT teams need clearly agreed protocols with other mental health teams about being informed and involved in all potential admissions including transfers and MHA assessments. These may vary across services due to local circumstances and support services but within one service, there should be agreement across all professionals about why and how CRHT teams are incorporated into the acute care pathway.

- At present the most usual process for gatekeeping seems to be agreement established between units to manage a transfer, with early discharge/discharge to home treatment only being seriously considered at the next ward round or bed management meeting, after the person has settled into the receiving ward. The receiving ward in any inter-unit transfer should automatically consider informing the local CRHT team, so some consideration could be made about the potential for discharge into home treatment at the earliest point. This could mean the person does not occupy a bed at all before being discharged.

3. CRHT teams can do more to enable early discharge

- The value of having CRHT staff gatekeeping admissions lies not only in diverting inappropriate admissions and enabling home treatment, but also in enabling early discharge.

- The discharge status of around one admission in every eight was confused between the Ward and CRHT staff. Improved communications between wards and CRHT teams should lead to further success in the identification of people appropriate for early discharge, with a reduction in the use of 'extended ward leave' and encouraging opportunities for ward-based staff to follow the process of early discharge into the community.

- All services should consider a 'Fast Track Policy' (such as described in the West Cheshire example) where admissions can be re-assessed by CRHT staff, enabling discharge in a quicker time than having to wait for the next ward-round.

4. Trusts should specify and monitor a clear acute care pathway into and through local services, to inform all potential referrers, service users and carers

- It should be the responsibility of each CRHT team to monitor the referrals they initially consider appropriate for assessment but then end up diverting to other non-acute services. They should be feeding this information back to the specific referrers in order to try and improve referrer's assessments. Where some referrers are consistently identified as making inappropriate referrals this would indicate a need to educate them about the roles and function of the CRHT team.

- Some CRHT teams have clearly communicated their role to the teams that refer to them, whereas some teams may still be dealing with a large number of calls which they feel are unnecessary, which may also subsequently result in inappropriate referrals for assessment. CRHT teams should clearly communicate who their client base should be, and let potential referrers understand how and when the CRHT team should be approached, if they are to improve current relationships.

5. Trusts should consider the value added by commissioning 24/7 staffing and support housing/ day hospitals

- High levels of clinical risk, accommodation issues or homeless service users and 'hours of availability' are challenges for some CRHT services but not for others. The intensity of the CRHT service offered, such as being fully staffed 24/7 and having crisis housing support is likely to impact on the level of avoidable admissions CRHT teams can prevent.

- Crisis and respite alternatives and acute day-hospital facilities should be investigated as key elements to a strengthened Acute Care Service. Ward and CRHT Managers spoke of the need for these facilities in order for the CRHT service to be more effective in gatekeeping hospital admissions and facilitating early discharge into home treatment. Most of these staff members still see the gulf between providing a level of intensive treatment in the home, and the need for hospital admission, with no other midway options that might be sufficient to contain the crisis.
- 24/7 staffing could potentially be better utilised where CRHT staff and ward staff work together as an integrated Acute Care Service, so the wards would benefit from CRHT staff on duty overnight.

6. Acute Care Services should have a coordinated bed management function

- If CRHT staff were involved in the admission, they were significantly more likely to know a named patient was currently admitted. Ensuring that CRHT teams gatekeep all admissions will enable them to perform a strong bed-management function. At the least the CRHT team should be on very good terms with anyone else within the local service designated as the bed manager. There should be agreed ways of enabling the CRHT team to be up-to-date on who was admitted to which bed; examples identified were the daily contact of ward link-workers or where ward staff attended morning handover meetings at the CRHT team.

7. CRHT teams must remain faithful to providing a service for the intended client

- CRHT teams could enable more inappropriate admissions to be avoided by ensuring that the home treatments they provide are for the intended client – that is, someone who otherwise would have been admitted to hospital.

8. Trusts should consider addressing a range of training and development needs:

- Developing a better understanding across all Trust personnel of what the acute and non-acute teams do, supporting CRHT staff to more clearly articulate and present what they do;
- Every new worker in each Trust to spend a day with local CRHT/Acute Care Team (inc. SHOs and GP Trainees);
- Skills to manage increasing risk, acuity, and challenging behaviour;
- Team-building for Acute Care services;

- Negotiating skills and decision-making skills (inc collaborative decision-making with Consultant Psychiatrist and other staff);
- Risk-taking skills and plans (inc. replacing more ward leave with early discharge into home treatment).

9. The Department should improve the specification of targets

- Targets should be determined based on local information that is directly relevant to promoting good practice and local area characteristics – such as information on demand and taking into account capacity which may be influenced by factors such as rurality and availability of crisis support housing. Commissioners should involve Ward and CRHT Managers in the shaping of the specifications.

10. The Department should capture service user and carer feedback

- All teams should be able to benefit from a consistent, centralised system of capturing patient feedback. This would provide rigorous collection methodologies, economies of scale in data collection costs, improving the usefulness of the data and potential for analyses. The Department of Health should arrange the capture of national data on acute mental health care services (for both patients cared for in wards and in the community) which should be monitored over time to provide information for the improvement of services.

Appendix One: The 25 Sites Visited

REGION	Site ID	Name	Year Started	% HT clients SMI	24/7 staffed	24/7 Phone avail	No night calls/ month	No night visits/ month	Team has own consultant psychiatrist	Estimated level of Gatekeeping	MHA	Urban or Rural
South West	01	Bristol N	2002	95%	NO	YES	27	6	YES	40-60%	60-100%	URBAN
		Bristol S	"	"	"	"	"	"	"	60-100%	<40%	
		Bristol C	"	"	"	"	"	"	"	"	"	
	02	Plymouth Inner City HTT	2000	90%	YES	YES	29	6	YES	60-100%	60-100%	URBAN
	03	North East Cornwall Home Treatment Team East	2004	30%	YES	YES	280	28	NO	<40%	<40%	MIXED
South East	04	East Elmbridge and Mid Surrey CATT	2004	92%	NO	NO	10	0	YES	100%	<40%	MIXED
	05	Eastbourne CRHT	2004	95%	NO	YES	0	0	NO	<40%		MIXED
	06	N. Oxfordshire CRHT	2004	100%	NO	YES	62	30	NO	60-100%		MIXED
London	07	Lewisham HTT	2001	90%	YES	YES	14	15	NO	<40%	<40%	URBAN
	08	S. Kensington & Chelsea CRT	2001	80%	YES	NO	20	10	NO	60-100%	100%	URBAN
	09	Havering HTT	2005	60%	NO	NO	0	0	YES	40-60%		URBAN
	10	Hillingdon CRT										URBAN
Eastern	11	Norwich City CRHT	2004	80%	YES	YES	14	4	NO	100%	60-100%	URBAN
	12	N. Essex Central CRHT	2004									MIXED
	13	Cambridge County CRHT	2006									RURAL
East Midlands	14	Leicester City CRHT	2004	35%	YES	YES	84	27	YES	60-100%	<40%	URBAN
	15	N.E. Derbyshire CATT	2003	45%	YES	YES			YES	40-60%		URBAN
	16	E. Lincolnshire CRHT	2005	20%	YES	YES	25	62	YES	60-100%	60-100%	RURAL

REGION	Site ID	Name	Year Started	% HT clients SMI	24/7 staffed	24/7 Phone avail	No night calls/ month	No night visits/ month	Team has own consultant psychiatrist	Estimated level of Gatekeeping	MHA	Urban or Rural
West Midlands	17	Yardley Hodge Hill HTT	1995	85%	YES	YES	250	40	NO	60-100%	60-100%	URBAN
	18	Dudley HTT	2004	90%	NO	YES			YES	60-100%	<40%	URBAN
	19	Shropshire CRHT	2005	80%	NO	NO			NO			RURAL
North West	20	Liverpool CRHT	2005	75%	NO	NO			NO	60-100%	60-100%	URBAN
	21	Chester CRHT	2004	80%	NO	NO		50	NO	60-100%	<40%	MIXED
	22	West Cumbria CRHT										
Northern, Yorkshire & Humber	23	North East Yorkshire CRHT	2003	20%	NO	NO	15	22	YES	100%	<40%	MIXED
	24	South Tyneside CRHT	2004	50%	YES	YES	250	45	YES	60-100%	<40%	URBAN
	25	East Yorkshire IHTT	2004	50%	NO	NO	0	0	NO	60-100%		RURAL

Summary based on: A National Survey of Crisis Resolution Teams in England (Onyett et al., 2006)

- Geographical distribution = 4 London sites and 3 sites from each other region [NB 3 Bristol sites are now 1 team]
- Age of teams distribution = 1: 1995; 1: 2000; 2: 2001; 1: 2002; 2: 2003; 10: 2004; 4: 2005; 4: No data [of which 1 thought to be 2005; 2 thought to be 2006]
- %SMI = 1: 100%; 6: 90%+; 9: 50%+; 5: <50%; 4: No data
- 24/7 H/V = 11: Yes; 10: No; 4: No data
- 24/7 Phone = 14: Yes; 7: No; 4: No data
- Night calls = range of 0-280 /month
- Night visits (inc. to A& E) = range of 0-62/month
- Own Consultant Psychiatrist = 11: No; 10: Yes; 4: No data
- Gatekeeping success = 3: 100%; 12: 60-100%; 3: 40-60%; 3: <40%; 4:No data
- MHA involvement = 1: 100%; 6: 60%+; 9: <40%; 9: No data
- Urban/Rural Mix = 13: Urban; 7 Mixed; 4: Rural; 1: No data