



National Audit Office

Crisis Resolution and Home Treatment: The Service User and Carer Experience

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Introduction

1. This paper has arisen from the National Audit Office's value-for-money audit of Crisis Resolution Home Treatment (CRHT) services in England, the findings of which were published in December 2007 under the title *Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services*.¹ In addition to the fieldwork presented in the main NAO report, which includes an audit of referrals and admissions, a survey of referring clinicians, economic modelling and data analysis of team staffing, crisis episodes, hospital admissions and financial expenditure, the NAO also gathered a large corpus of material on service users' and carers' experiences of CRHT services. Due to limitations of space, this material could not be presented in detail in the main report; however, it was felt to be of sufficient interest to merit further exploration in a supplementary paper.
2. One of the measures of a successful CRHT team identified in the Department of Health's *Guidance Statement on Fidelity and Best Practice for Crisis Resolution Teams* is whether the team has "provided a service that users and carers value highly".² This echoes general principles outlined in the 2001 *Mental Health Policy Implementation Guide* and the 1999 *National Service Framework*, which identify 'effectiveness, utility and service user satisfaction'³ and 'experience of service users and carers'⁴ as key criteria for assessing mental health services. However, relatively little work has been published to date exploring what aspects of CRHT services are valued highly by service users and carers, and why. This paper examines the experiences of CRHT services reported by users and carers, and considers the themes and issues these experiences reflect, as well as their implications for future service development.
3. The NAO would like to thank the service users, carers and local CRHT teams who assisted with this project, as well as members of the National Institute for Mental Health in England Acute Care Programme Steering Group who provided comments on the draft. The NAO would also like to thank the mental health charity Mind for providing additional material from their 'WardWatch' campaign.

¹ National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services* (HC5 2007-08, 7 December 2007).
http://www.nao.org.uk/publications/nao_reports/07-08/07085.pdf

² Department of Health / Care Services Improvement Partnership, *Guidance Statement on Fidelity and Best Practice for Crisis Services* (December 2006), p. 3.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063015

³ Department of Health, *Mental Health Policy Implementation Guide* (2001), p. 104.

⁴ Department of Health, *National Service Framework for Mental Health* (1999), p. 39.

Part 1: Methodology

Background to data collection and analysis

- 1.1 The data used for this paper was collected from two main sources:
- Surveys – service user and carer satisfaction surveys that had been carried out by CHRT teams across England were collected, and the findings used to inform the Framework of data.
 - Focus Groups – the NAO commissioned the Health and Social Care Advisory Service (HASCAS) to run six focus groups, three with carers and three with service users, from which data on experiences of both inpatient services and CRHT teams were collected. The NAO also performed secondary analysis on material provided by the mental health charity MIND, who ran a number of focus groups exploring experiences of inpatient services as part of their ‘WardWatch’⁵ campaign in 2004-05. In all cases, the data were anonymised prior to analysis, and the names of individuals quoted in the paper have been changed.
- 1.2. The analytical method used is based on ‘Framework Analysis’, a technique developed at the National Centre for Social Research which involves the creation of “a distinct thematic framework comprising a series of main themes, subdivided by a succession of related subtopics”.⁶ The aim of this process is to gain in-depth familiarity with the data, and through this in-depth knowledge to identify recurring themes. These themes could be attitudes, behaviours, experiences or views. From these overarching themes, links between categories can be identified, as well as sub-themes that feed into the overarching topic.
- 1.3. Though information about service-user and carer experiences of CRHT has been collected on a local level, such material has not thus far been drawn together, analysed and reported on a larger scale. The 2007 NAO study on CRHT services, which involved close liaison with provider organisations across the NHS in England, offered an ideal opportunity to do so, and hence the NAO contacted the 89 teams who reported in the 2006 national CRHT survey⁷ that they had carried out service user/carers feedback work, and requested full details of their methodology and results. 29 teams were able to provide such material, and

⁵ See <http://www.mind.org.uk/News+policy+and+campaigns/Campaigns/Ward+Watch/>.

⁶ Ritchie J, Spencer L, and O’Connor W. ‘Carrying out Qualitative Analysis’, p. 220 in Ritchie J and Lewis J (eds), *Qualitative Research Practice* (London: Sage Publications, 2003).

⁷ Onyett S, Linde K, Glover G, Floyd S, Bradley S, Middleton H, *A National Survey of Crisis Resolution Teams in England* (London: Care Services Improvement Partnership, 2006).

with due regard to the diverse methodologies and the lack of NAO control over data collection, this was used as a basis for qualitative analysis. Transcripts from the NAO and MIND focus groups were used as an additional source of data, and analysed using the same qualitative framework applied to the survey material.

1.4. Although it is hoped that this paper offers useful insights into a significant corpus of new data, it is intended to be a first exploration of themes and issues rather than a comprehensive research study of service users' and carers' experiences of CRHT. A number of caveats should therefore be borne in mind regarding both the nature of the material gathered and the analysis conducted on it:

- 1) Lack of control over sampling and data collection – the NAO team gathered and explored all available survey documentation, but had no role in designing the sampling and data-collection methodologies on which it was based. Hence no attempt has been made to draw conclusions about individual teams or regions from the issues and views presented, or from the frequency of positive and negative comments on a given topic. Instead, the analysis focuses on identifying overarching themes, and exploring their implications for service users, carers and CRHT teams themselves.
- 2) No standardised survey template – surveys had been undertaken in different ways by individual CRHT teams, some more comprehensive and extensive than others. For example, while some organisations relied solely on qualitative feedback, others used closed questions to generate numerical data on aspects such as responsiveness of the service, or courtesy of team members. While these data will have been useful locally to help quantify teams' strengths and areas for improvement, they are less helpful for qualitative exploration of detailed themes and experiences. This limitation, combined with the issues outlined in 1), above, meant that meta-analysis of the numerical data was not attempted.
- 3) Lack of consistent details on age, sex, and ethnicity – such data were often not recorded in the material obtained from local teams, and hence it was not feasible to carry out associative analysis to identify linkages between these characteristics and the over-arching themes.⁸

⁸ The need for more robust and comprehensive recording of ethnicity data in mental health services is a recurrent theme in recent policy documents, regulatory reports and academic research. See, for example, Department of Health, *Delivering race equality: An action plan for reform inside and outside services* (2005); Healthcare Commission, *Count me in 2007* (2007) (http://www.healthcarecommission.org.uk/db/documents/Count_me_in-2007.pdf), and Aspinall P J, 'Informing progress towards race equality in mental healthcare: is routine data collection adequate?' in *Advances in Psychiatric Treatment* 12 (2006), 141–151.

- 1.5. There is clear scope for more comprehensive research on carers' and service users' experiences of CRHT services, possibly building on the themes and associations identified here and using a more standardised template for data collection and analysis. This latter improvement would help address one of the identified shortcomings of much current patient satisfaction work, namely that 'surveys are undertaken using locally constructed questionnaires, and that issues of validity are rarely addressed. [...] Issues of validity are complex, as there is no ultimate standard against which satisfaction can be assessed.'⁹ The Department of Health has a stated expectation that NHS organisations conduct regular service-user satisfaction exercises on key areas of service provision, and the main NAO report recommends that this expectation be reaffirmed with regard to CRHT teams.¹⁰ The NAO report also recommends that the Department should discuss with the Healthcare Commission (and its successor body the Care Quality Commission) how meaningful national data on CRHT services might be gathered as part of the national Patient Survey programme.¹¹

⁹ Graham J, Denoual I, Cairns D, 'Happy with your care?' in *Journal of Psychiatric Mental Health Nursing* 12, (2) (April 2005), p. 175.

¹⁰ National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services*, p. 7.

¹¹ Ibid.

Part 2: Key Findings

Service users and carers appreciate a holistic approach to CRHT, and often value personal engagement as highly as clinical expertise

2.1 In this paper, the term ‘team intervention’ is used broadly to describe a range of interactions - not exclusively clinical - between service providers and service users. It refers not only the administering of medication and associated advice, but also practical help (offering support on household and organisational matters) as well as personal engagement (how the user was spoken to, whether they felt understood or respected). In particular, the following were identified as key elements of CRHT interventions:¹²

- Personal engagement – covering the behaviours of team members, the bedside manner displayed, the listening and inter-personal skills demonstrated;
- Professional intervention – covering the provision of medical advice, administering of medication, referral to other treatments or services, techniques for dealing with anxiety or depression, and relapse prevention;
- Practical help – covering assistance with domestic tasks and responsibilities, including personal administration and the practicalities of day-to-day living;
- Information-giving – the provision of information on help available and contacts for emergency situations;
- Level of involvement - the level of collaboration between service user and provider, covering involvement in care plans, inclusion in decision-making, and the extent to which service users and carers felt informed about diagnosis and treatment.

Service users attach great importance to personal engagement

2.2 The feedback examined here reflects a strong relationship between satisfaction with service provision and the level of personal engagement received. Service users most frequently express their appreciation of CRHT teams in terms of qualities in their relationship with staff such as approachability, friendliness and receptivity. In expressing positive feedback on the

¹² These categories map approximately to four of the domains identified by Johansson et al. as having an influence on patient satisfaction with nursing care, namely ‘communication and information’, ‘participation and involvement’, ‘interpersonal relations between nurse and patient’ and ‘nurses’ medical-technical competence’. See Johansson P, Oléni M, Fridlund B. ‘Patient satisfaction with nursing care in the context of health care: a literature study’ in *Scandinavian Journal of Caring Sciences* 16, 4 (December 2002), 337-344. The theme of practical assistance with home living is more fundamental to CRHT than to the hospital-based model used by Johansson et al., and hence has been identified as a separate category here. The role of ‘physical environment’ (another of Johansson’s categories) occupies a unique status in the context of CRHT (not least because the home environment is shaped largely by service users and carers rather than service providers), and hence is dealt with separately below.

work of the teams, service users' language reflects a recurring pattern of characteristics and behaviours, which are summarised in **Figure 1** below. Despite the large variations in sentence structure and the large volume of responses, these key words were consistently drawn upon to describe service users' experiences.

Figure 1: Key Characteristics and Behaviours identified with Personal Engagement

Adjectives		Verbs
Pleasant	Reassuring	Listen
Understanding	Supportive	Advise
Nice	Honest	Empathise
Non-judgemental	Approachable	Give full explanations
Friendly	Helpful	Trust
Lovely	Comforting	Hear views
Kind	Informal	Make to feel at ease
Gentle	Polite	Treat with respect
Calming	Courteous	
Reliable	Knowledgeable	
Genuine	Flexible	
Down-to-earth	Patient	

- 2.2 A close relationship and trust facilitates open dialogue between service user and service provider. This contributes to a virtuous circle, encouraging the two-way flow of information. Service users are more likely to express their concerns, suggestions or worries if they feel they are being genuinely listened to by team members. Equally, if service users and carers feel that team members' concerns are genuine, they are more likely to respond positively to suggested treatment strategies or requests for information.¹³
- 2.3 Service users frequently indicated the paramount importance they attached to interpersonal recognition, and voiced dissatisfaction with clinical or 'professional' interventions where this quality was lacking or perfunctory.

'I don't find them very helpful, one because they just give you the medication. They come in and go. Secondly they come in and say, 'Everything alright?' And you say 'Yes' or 'No' as the case may be, and there are no follow-up questions.'

Maggie (CRHT service user)
Source: NAO service user focus group

¹³ Previous research has identified the importance of the 'therapeutic alliance' or 'worker-client connection' in models of mental healthcare comparable to CRHT. See, for example Gerber G and Prince P. 'Measuring Client Satisfaction with Assertive Community Treatment' in *Psychiatric Services* 50 (April 1999), 546-550; Solomon P and Draine J. 'Satisfaction with mental health treatment in a randomized trial of consumer case management' in *Journal of Nervous and Mental Disease* 182 (1994), 179-184; 28. Baronet AM and Gerber G. 'Client satisfaction in a community crisis centre' in *Evaluation and Program Planning* 20 (1997), 443-453, and Howgego I M, Yellowlees P, Owen C, Meldrum L, Dark F. 'The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management' in *Australian and New Zealand Journal of Psychiatry* 37 (2003), 169-183.

'They would come in. They'd ask, "How are you?" They'd give her the pills and then they would be out, with no real contact.'

Daniel (CRHT service user and carer)

Source: NAO service user focus group

'Wherever they come from, whatever profession, none of them I feel have listening skills. It's basic listening skills, basic counselling skills. In their training they should have to hear service users' experiences, so that they know where the service users are coming from, and the things that might annoy service users when they come to their home, and the things service users would like. Instead of saying, 'On a scale of one to ten, how do you feel?' and you go, 'Um...three', and they say, 'Are you sure you're not feeling like a five?' Or, worse, they just say, 'OK'. Like, then 'Why did you come see me anyway?'

Maggie (CRHT service user)

Source: NAO service user focus group

2.4 Service users frequently cited lack of receptivity on the part of team members as a cause of dissatisfaction with services. One respondent in local surveys complained that the team did not ask how he was feeling, or whether he wanted to talk about anything. Another felt that the team were 'more keen to put forward their suggestions than listen to mine'. Not being invited to speak about their concerns or feelings, or not having an immediate audience to listen to their worries can make users feel isolated and left out of the treatment process, unable to make a contribution.

2.5 Personal engagement was also important to carers, whether directed towards the service user or to themselves.

'On the few occasions I was with them, I noticed the social worker talked to J as if she was another woman friend, not as if she was a patient – that was immensely valuable.'

Philippa (carer)

Source: NAO carer focus group

'After the fourth day visiting my daughter, a member of staff talked to me in-depth. I was so distressed she took me aside, and I thought, 'Thank God, someone has finally treated me like a human being.'

Simone (carer)

Source: NAO carer focus group

2.6 Whether the service user is being treated on the ward or in the home, the clear message is that therapeutic benefits are gained from having someone to listen to and understand your situation:

'You're accepted for who you are, no matter what state you're in [...] The respect they show you is genuine. I guess it's unconditional positive regard, which is all really [...] I mean, you could argue that just that in a hospital would be enough.'

Janette (CRHT service user)

Source: NAO service user focus group

- 2.7 The emphasis placed on the personal side of intervention is evident in this quotation describing a service user's experiences of a local crisis house. So important is respect and acceptance from staff that she feels 'that just that [...] would be enough'. Service users frequently suggest that the personal side of treatment is paramount, and feel that a clinical or 'professional' intervention is not complete without it.
- 2.8 As is discussed later in this paper, apparent lack of personal engagement may often be linked to lack of resources and time. There are trade-offs between staying longer to be friendly and ask follow-up questions, and moving on to cover the case load and provide help to others. However, in addition to consideration of teams' caseload and resourcing needs, there is also scope for future research to explore how different care settings influence service users', carers' and workers' expectations of helping relationships. For example, service users may associate inpatient wards more with medico-professional than with social interaction, whereas the home setting may have a stronger association with informal and social visits, thus making the personal element more dominant. Further research might usefully explore the extent to which CRHT team members are equipped to work non-defensively in a home context with a high level of personal exposure, particularly where the majority of their training may have been based in inpatient settings.

Practical help can be instrumental in the care and recovery of service users

- 2.9 A number of service users reported occasions where practical help allowed them to maintain or resume normal life, avoiding the need for inpatient admission or helping them fit back after hospitalisation and cope with the challenges of everyday life. As part of CRHT teams' role in avoiding admissions and facilitating discharge,¹⁴ this practical process of doing 'whatever needs to be done to help that person survive in the community'¹⁵ is an important part of the care they provide. Below are some examples where service users have identified positively with the practical help they received.

¹⁴ *The NHS Plan: A Plan for Investment, a Plan for Reform* (2000), paragraph 14.31.

¹⁵ See Sainsbury Centre for Mental Health. *Crisis Resolution and Home Treatment: A Practical Guide* (2006), p. 18.

Case Study 1: Help with the locks

One service user recounted an incident when he was admitted to hospital in a crisis situation. In his crisis, he had left his flat unsecured. A member of the crisis team helped by changing the locks on his front door and re-housing his pet cat.

'I've got a good crisis team. If it wasn't for xxx turning up at my flat because I was ill and I never knew I left the door open, with my stereo and sentimental stuff [...] Thanks to xxx, she changed all the locks, gave my son a key [...] xxx organised to put my cat in a cat sanctuary.

Desmond (CRHT and inpatient service user)
Source: NAO service user focus group

Case Study 2: Help with the shopping

They came in and I said, 'I have no food.' They said, 'OK, write us a list and we'll go and do your shopping'. So I wrote out a list and they went out and did the shopping and I didn't pay for anything [...] It did help, because we didn't have a lot of food in the house. I think I had two children there. I think I said, 'We need some chicken burgers,' because that was the quickest thing to put on. On their own initiative they bought buns to put them in. Just a few things like that. They bought milk, which I didn't ask for [...] Sometimes it's just those little things that help.

Beth (CRHT and inpatient service user)
Source: NAO service user focus group

- 2.10 For many people, mental health problems can be compounded by associated practical difficulties in their everyday lives. One common practical problem mentioned by service users was the difficulty of retaining their home during long stays on the ward, particularly where they had no contacts outside hospital to help negotiate with key parties such as landlords or housing associations.

Case Study 3: No help with the landlord

'One of the excuses for sectioning me was that I was being threatened with eviction by my landlord and wasn't coping well with that. Up to when I was sectioned, my key worker was meant to be helping me, but when I was sectioned I was meant to deal with this by myself under heavy medication on the ward. For the first few days, I couldn't get out to sign my contract, my mobile phone had run out of battery, and I wasn't allowed home to get the charger [...] I knew from anecdotal experience that if I lost my home I'd be stuck on that ward for months and months so I struggled while heavily sedated to deal with this.'

Stephen (CRHT and inpatient service user)
Source: NAO service user focus group

- 2.11 Service users who lose their accommodation while on the ward will often end up staying in hospital even longer, since the lack of a suitable destination means they cannot be safely discharged.

'Now say you're in hospital for a year. They stop your benefits after six weeks, then you're on forty pounds per week to cover cigarettes and toiletries. Housing benefits are still paying rent for your flat, but when you come out after a year you find you've no home to go to. You shouldn't come out of hospital to find they've taken your flat away [...] And then you'll end up in a hostel or in sheltered housing waiting for a flat, and all your worldly possessions have been locked up and you have to start all over again. That's enough to give you another breakdown and put you back in there.'

Desmond (CRHT and inpatient service user)

Source: NAO service user focus group

2.12 CRHT teams are intended to mitigate some of these difficulties, either by avoiding admission altogether, or at least facilitating earlier discharge to minimise the impact of the admission on service users' lives. However, both these functions depend on CRHT teams gatekeeping¹⁶ all potential inpatient admissions - the former because admissions can only be avoided if home treatment is considered as an alternative at the point of admission, and the latter because the team are more likely to be involved in facilitating discharge when they are already gatekeeping the majority of admissions to the ward.¹⁷

2.13 The transition from hospital to home can cause difficulties even when the service user's accommodation is not at risk. Acclimatising to life outside the psychiatric ward can be challenging, and a gradual lead into domestic responsibilities can be helpful:

'Whilst I'm getting better I can use the crisis team back in the community [...] probably visits to the home – make sure I'm taking my medication. Just visit me, see if everything is OK – just getting me back into the community. Getting back into, you know, going up the road to do my shopping, do my cooking. And it doesn't take very long, but it does take a week or so and that is long enough for them to work with me. And then I'm absolutely fine, I get on with my life, I don't need them any more.'

Maggie (CRHT service user)

Source: NAO service user focus group

2.14 Other practical difficulties besides the transition from hospital to home can create unwanted challenges for service users, for example problems with debt.

'They never once asked me about any debts. I was actually up to my eyeballs in debts. And then I was discharged.'

Sarah (CRHT service user)

Source: NAO service user focus group

¹⁶ For the full definition and requirements of gatekeeping, see Department of Health / Care Services Improvement Partnership. *Guidance Statement on Fidelity and Best Practice for Crisis Services* (December 2006), p. 4.

¹⁷ See National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services*, p. 23 (para. 3.13) and the accompanying report, *Are Crisis Resolution & Home Treatment Services seeing the Patients they are Supposed to See?* (http://www.nao.org.uk/publications/nao_reports/07-08/07085_report_of_interviews.pdf), pp. 45f.

- 2.15 If the team are employing a holistic approach which acknowledges home and social factors as well as clinical issues, they should be well placed to identify such difficulties and signpost the service user to appropriate services, such as debt counselling. Some service users reported receiving valued help from teams in providing evidence to Housing Associations or Benefits Agencies, or liaising with the Citizens' Advice Bureau to help write off debt and manage credit facilities.

Information-giving – service users and carers value good provision of background information and key contacts

- 2.16 Apart from practical help, service users appreciate help in the form of information-giving, for example the provision of guidance and information on key contacts or emergency numbers. Service users' experience around guidance and information is varied. Some feel they are not provided with enough information, while others feel they are inundated with information, often at times when they are unable to make sense of it or put it to use. A number of service users suggested that having all the relevant information available in one place, and distilled down to the bare essentials for later reference, can provide a practical solution to the problem of too much information at once.
- 2.17 This solution is also applicable to the issue of staff continuity. Some service users report confusion over visiting arrangements, dates and times of appointments and the action plans or objectives discussed. Often, service users are uncertain when the next visit will be and with whom, and this can cause particular problems for people whose illness already makes it difficult to build trust. Providing documentation with the names and roles of team members, as well as who last visited and when the next appointment will be, can be helpful in reducing some of these anxieties.
- 2.18 Even basic help with terminology or with understanding the treatment process can be of great benefit, especially for people new to the service or to mental health problems. Often, it is easy to forget how specialised and complex the system is, or how the information may not be readily interpretable to an outsider. Unfamiliarity with terminology and processes can be a problem for service users and carers alike:

'It's so complicated. You have to have been in the mental health system for about three years before you understand the terminology.'

Pam (CRHT service user)
Source: NAO service user focus group

- 2.19 This point holds true for both acute inpatient and home treatment, and has been recognised by clinicians as well as service users and carers:

'There are few explanations, of what's going on, the routines, the acronyms and the checklists. We have our technical phrases, as every profession does [...] and we get used to them we forget how strange the world is in which we work [...] we shouldn't be afraid to explain and to use plain English (e.g. I'm here to 'help you leave hospital' not 'to facilitate your discharge').'¹⁸

- 2.20 Such feedback suggests that it is helpful to simplify language and make things more readily understandable and transparent for both service users and carers. As with personal engagement, the provision of basic information can facilitate service user involvement and contribute to the delivery of collaborative care.

Carers appreciate the benefits of home treatment, but emphasise the need for adequate support from the team

- 2.21 Caring for someone with mental health problems can be an emotionally and physically draining activity, demanding a great deal of time and energy. The chronic phases of severe mental illness can place a considerable ongoing burden on carers, and they frequently emphasize the need for support services such as respite care:

'This is another big crisis, because they don't really recognize the strain of caring for somebody with mental health problems. If someone's in a wheelchair, then that's obvious, it's physical, but it doesn't create so much mental strain.'

Jane (carer)
Source: NAO carer focus group

'We carers need some sort of support with the person we're caring for. We need a break. The majority of carers as time goes on are going to break down themselves. That's very important.'

Gladys (carer)
Source: NAO carer focus group

'I'm on anti-depressants and sleeping tablets; that's the only way I can cope.'

Mandy (carer)
Source: NAO carer focus group

- 2.22 Beyond carers' ongoing responsibilities for day-to-day care, service users in the acute phase of their illness require more intensive input and support. Providing this care through the CRHT service model - in which people who would previously have been hospitalised remain at home - can have considerable implications for carers. Many emphasise the benefits of their loved one remaining within the family environment, providing these are fully realised through sufficient support and expertise on the part of the team.

'There needs to be more consultation with carers if a patient is living at home, some kind of semblance of education as to what they should watch out for - simple things,

¹⁸ Dr Trevor Turner in Hardcastle M, Kennard D, Grandison S and Fagin L, *Experiences of Mental Health Inpatient Care* (2007), pp. 26-27.

for example regarding the interaction of medicines [...] So that must be taken into account, because we're going to be their nurse, consultant, everything at home.'

Akram (carer)

Source: NAO carer focus group

Involving carers contributes positively to their experiences of the service

2.23 Carers unanimously emphasise the importance of carer involvement. They value being included in the treatment and care plan of the service user. The chief benefits of carer involvement are twofold. The carer is often the person most in tune with the service user and aware of their behaviours, their needs and their relative states of mental health. A carer can offer the CRHT team a great deal of knowledge based on this close understanding and experience, and carers feel that teams should make the most of this extra insight whenever they can:

'There should be much more co-operation between medical staff and carers, because carers can give information about the patient that's not available to them. I see my daughter sitting opposite her CPN. The CPN says, 'You're looking well today, how are you today?' She says, 'Fine', whereas I know she hasn't been fine at all.'

Sarah (carer)

Source: NAO carer focus group

'They take the word of the patient. What the patient thinks isn't always true [...] But they listen to the patient and think the carer's trying to make trouble'

Catherine (carer)

Source: NAO carer focus group

'For me it was hard at the beginning [...] They didn't want to talk to me. They just said, 'I won't talk to you without your son being present.' They didn't understand my son's illness, but he used to tell me every single thing [...] Eventually they came to the understanding that we are partners in this, working together.'

Akram (carer)

Source: NAO carer focus group

2.24 The second reason why carer involvement is so important is because it allows the team to instruct and guide the key person responsible for the welfare of the service user about issues, side-effects or changes they should watch out for. This is especially important when the carer is new to the role, and may not have a great deal of understanding about their loved one's illness or how to deal with situations arising from it. If the carer is well informed and given basic guidance about what to expect or how to deal with certain situations, they are much better placed to work effectively with the team in managing more acute phases. Some carers, while acknowledging that they found home treatment a preferable option to admission, felt that more information and support was needed to help them manage their role:

'We would really welcome help on how to handle things like hearing voices; I've had no idea in the past. Do I say, 'That's rubbish!' or do I say, 'That must be very difficult

for you'? I've learned over the years how to support her, but early on a bit of advice on how to respond would have been so helpful.'

Sarah (carer)
Source: NAO carer focus group

Key factors affecting experiences of CRHT

2.25 Service users and carers report varying experiences of how the CRHT service is provided, and how these variations impacted on their view of the service. Some service users found their CRHT team punctual with visits and prompt at answering the phone, while others reported concerns that home visits had been delayed or cancelled, or that they had simply been diverted to an answerphone. Understandably, these diverse experiences left service users and carers with widely different impressions of the service, which they often attribute to levels of resources available to the team.

Phone contact

2.26 Some CRHT services offer existing clients direct phone access to the team, in some cases as a substitute for an actual home visit. Some service users agreed that there were instances where these two services can be used interchangeably, and that an effective phone line could provide appropriate support in many potential crisis situations:

'The fact I had that phone number - I was very, very anxious - that was something to hold onto, another holding device [...] I was sceptical at first, I thought it was just another way to save money [...] but when I experienced them I was pleasantly surprised.'

Silvia (CRHT service user)
Source: NAO service user focus group

2.27 Others, however, found that differences between the two mean that one cannot replace or substitute for the other, with one local survey respondent complaining of 'long, pointless, stressful phone calls where nobody ever understood why I called'. The overall message seems to be that phone calls, while an acceptable and efficient mode of intervention in some cases, need to be used with careful planning and in the context of individual need. Some local survey findings suggest it is helpful to agree modes of contact between the team and the service user (including carers) in advance, since this helps to manage expectations on all sides and ensure that telephone contact is not seen merely as a 'quick fix' driven by shortages of time or manpower.

2.28 Service users reported a number of common factors contributing to whether telephone contact with CRHT services was a positive or negative experience. In addition to obvious issues such as a fast response time or a sympathetic manner, some service users and carers raised a wider issue of whether they actually had direct telephone access to the CRHT

team, or whether this had to be mediated by other parties such as hospital switchboards, GPs or NHS Direct:

'I know it's not an ideal world, but we had to ring five to six weeks ago; it was a weekend. I asked to speak to the home treatment team, but they said, 'No'. They wouldn't see him because they don't know him. I wanted help, but they wouldn't come; they didn't come. And you know that if you go to A&E you can be sitting there for 4 hours [...] It's a complete nightmare sometimes.'

Joan (carer)

Source: NAO carer focus group

- 2.29 Practices and protocols regarding referral to the team vary from one locality to the next, an issue which has been explored in the *National Survey of Crisis Resolution Teams in England*.¹⁹ Some teams allow self-referral by known service users, while others require every potential candidate for CRHT (including people previously known to the team) to be assessed and referred to them by clinicians such as GPs or A&E liaison teams.
- 2.30 The main NAO study identified that a high proportion (over 30 per cent) of referrals received by teams in its sample were subsequently signposted or referred onward to non-acute services,²⁰ suggesting that they were not from the intended client group for CRHT (namely 'adults [...] with an acute psychiatric crisis of such severity that, without the involvement of CRHT team, hospitalization would be necessary'²¹). In reality (as the Department's policy guidance confirms²²), it will not always be desirable or practicable to divert every service user not fitting this criterion to other services such as Community Mental Health Teams. However, the needs of people not requiring the specific, acute intervention provided by the CRHT team must be weighed against the fact that CRHT teams have finite time and resources to gatekeep and home-treat their specific client group, and hence it may not be practicable to accept direct referrals from all routes (including carers and service users). If not properly managed, this situation can lead to frustration on the part of carers and service users who feel that they are facing a 'crisis', yet are not given direct access to the 'crisis' team:

'These people don't know how to recognize a crisis. For example, my son beating me up: just because I was alive and could talk, it wasn't a crisis!'

Akram (Carer)

Source: NAO service user Focus Group

¹⁹ See Onyett S, Linde K, Glover G, Floyd S, Bradley S, Middleton H, *A National Survey of Crisis Resolution Teams in England* (London: Care Services Improvement Partnership, 2006), pp. 53f.

²⁰ National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services*, p. 26.

²¹ Department of Health, *Mental Health Policy Implementation Guide*, p. 11.

²² *Ibid.*

- 2.31 An appropriate policy on self-referral, developed and implemented in conjunction with other services in the mental health care pathway, will help to manage demand for services and ensure that resources are targeted at the appropriate client group. In implementing the NAO's recommendation to develop comprehensive local protocols for mental health referrals,²³ local commissioners and providers should include and disseminate a clear route for service users and carers to access rapid support, which should include prompt onward referral to the CRHT team if appropriate.

Home visits

- 2.32 The main factors that appear to contribute to a good experience of home visits are:

Visiting times that are adhered to:

- 2.33 Expected visits that are made on time allow service users and carers to factor other activities into their day around the visit, and know they will not have to cancel or re-arrange prior engagements because of unpredictable visits by the team. If the visit is in response to a phone call, service users appreciate prompt visits because it affirms their belief in the service, provides them with physical help when needed and does not build anticipation unfairly.

'They just popped in and saw if things were OK [...] Everything they've said they'll do, they've done. They've been fantastic.'

Samantha (carer)

Source: NAO carer focus group

- 2.34 On the other hand, not knowing what time the team will arrive, or suffering short-notice cancellations (sometimes without any warning) were mentioned by service users and carers as examples of poor service provision that left them with bad impressions of CRHT. Some local survey respondents also mentioned that waiting for late or cancelled team visits could exacerbate existing anxiety associated with their illness.

'Last time she was under the acute service, they didn't come when they said they would, and they didn't ring when they said they would on several occasions [...] On one occasion when she was in a real crisis, she rang the duty system three times, before anyone actually came back to her to talk to her. But they told her no one would come because they were too busy.'

Donna (carer)

Source: NAO carer focus group

²³ National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services*, p. 9.

Knowing which members of staff will visit

2.35 This factor has two dimensions. Firstly, it relates to knowing the name of the staff member intending to visit. Being aware beforehand of who will be visiting (and not just when) can help make the intervention more personal from the outset, and also reduce anxiety on the part of service users who may already be feeling vulnerable owing to their illness. The second dimension relates to continuity, and the benefits of knowing the individual staff member from previous visits. The issue of staff continuity and its practical challenges are explored in more detail below

The Home as a Context for Care

2.36 An important finding from both focus groups and local surveys is that home treatment is less well received when the home environment is a contributing factor to mental health problems. Those who find the home a less stressful environment and associate the home with safety, comfort and well-being prefer being treated at home and appreciate that the CRHT service allows them to do this. A large number of local survey respondents reported the benefits of not 'being away from the reality of my life' and not 'having to enter the alien atmosphere of hospital'. One spoke of a 'lifeline service compared with being stuck in hospital with other patients'.

2.37 One of the three key objectives of crisis services is that 'patients should be treated in the least restrictive environment which is consistent with their clinical and safety needs'.²⁴ Recent analysis suggests higher service-user satisfaction with CRHT than with inpatient services,²⁵ and indeed other research has demonstrated how the ward environment can feel unsafe and restrictive to some service users.²⁶ However, service users' views of inpatient wards seem to depend partly on what kind of environment they are expecting or seeking. Focus group members recalling experiences of inpatient wards did raise concerns about security, safety and the uncaring attitudes shown by some staff, and these echo previous research on the experience of inpatient admission.²⁷ Yet some service users find that the hospital environment provides them with a greater sense of safety and security than their

²⁴ Department of Health / Care Services Improvement Partnership. *Guidance Statement on Fidelity and Best Practice for Crisis Services* (December 2006), p. 4.

²⁵ See Joy CB, Adams CE, Rice K, 'Crisis intervention for people with severe mental illnesses' (Cochrane Collaboration, 2006).

²⁶ See, for example, *Department of Health, Mental Health Policy Implementation Guide - Adult Acute Inpatient Care Provision*, p. 8 and pp. 22ff.; Glasby J and Lester H, 'On the Inside: A Narrative Review of Mental Health Inpatient Services' in *British Journal of Social Work* 35, 6 (September 2005), 863-879; and Wood D and Pistrang N, 'A safe place? Service Users' Experiences of an Acute Mental Health Ward' in *Journal of Community & Applied Social Psychology* 14 (2004), 1, 16-28.

²⁷ See above, note 26.

own home. In part, this can be due to the service user's recognition of their mental state, the risk they feel they pose to themselves or others, and the difficulties or triggers they experience at home. And while some find the routine of hospital oppressive, others find it a useful way to provide structure to their day, motivation to get out of bed and a group of people with which to socialize:

'I felt secure because it was an environment which made me feel safe from myself as well as preventing me from giving aggression to anyone else.'

Mark (inpatient service user)
Source: MIND Wardwatch focus group

'Because I had to be protected for my own safety...'

Steve (inpatient service user)
Source: MIND Wardwatch focus group

'If I had not been in hospital I would have certainly committed suicide so I was kept safe. It was a place mostly to stop me from harming myself.'

Lynne (inpatient service user)
Source: MIND Wardwatch focus group

'In hospital there would be more motivation to get up, to get dressed with other staff and other people around.'

Daniel (CRHT and inpatient service user)
Source: NAO service user focus group

- 2.38 Those who find the home a stressful environment or a trigger for anxiety or depression tend to prefer the ward as a break from their normal environment and an escape from their external problems or difficulties. For those users in the latter category, being treated at home can be less effective at alleviating crisis, particularly if the contributing factors are linked to the home environment itself:

'I needed to rest and break from my family. I felt more able to eat.'

Dave (inpatient service user)
Source: MIND Wardwatch focus group

'Time out was what I needed. Twenty-four hour care, someone keeping watch, as I was spooked at home following several night-time burglaries [...] lovely, calm, relaxed environment.'

Anne (inpatient service user)
Source: MIND Wardwatch focus group

'It gave me 'a break' from the pressures of my life which were making my illness worse.'

Beth (inpatient service user)
Source: MIND Wardwatch focus group

'It took the pressure off coping alone at home whilst my husband was at work. It gave me access to professional help. It also gave me an 'escape' from having to struggle to cope with everyday living.'

Celia (inpatient service user)

Source: MIND Wardwatch focus group

'Admittedly, the crisis teams have helped in some ways, but sometimes it's just not enough. [...] I think it's the idea of giving up on things. I don't have to think about my husband, my children. And I just collapse in a heap.'

Diane (inpatient and CRHT service user)

Source: NAO service user focus group

- 2.39 Service users have identified the environment in which care is received as an important factor in determining experience. The importance of environment in the context of inpatient care has been well documented and often leads to a preference for home treatment. However, it should be acknowledged that the home may not to be the most suitable context for care for everyone. There can be cases when the home itself holds triggers for anxiety, stress or depression and therefore produces an untherapeutic environment. In these circumstances, CRHT alone may not be appropriate, and a break from the home may be the only realistic option.
- 2.40 CRHT interventions should be based on a strong awareness of the service user's home environment, including any issues there that may trigger anxiety or stress. Part of the intended benefit of the CRHT model is that the team can observe people first-hand in the context of their home and social network, identifying possible problems and trigger factors more easily as most people behave more naturally in their own homes.²⁸ Thus the CRHT team should consider all such factors in assessing the feasibility of home treatment, including an appraisal of whether possible trigger factors are inextricable from the home environment itself.
- 2.41 In such cases, it may be beneficial to remove the service user from the immediate home context even if full acute inpatient admission is not necessarily appropriate.

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

Diane (CRHT service user)

Source: NAO service user focus group

²⁸ See Sainsbury Centre for Mental Health, *Crisis Resolution and Home Treatment: A Practical Guide* (2006), p. 11.

'And I just feel that it would have been nice to be in a crisis house even if just for a few days with people around and just to feel safe, rather than these people popping in for five minutes and then popping out again and you feeling exactly the same.'

Susan (CRHT service user)
Source: NAO service user focus group

2.42 A number of CRHT teams interviewed as part of the main NAO fieldwork commented that for some 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. Only two of the 25 sites visited had access to dedicated crisis house/respite facilities, while two other services had well-established and focused acute day-hospital services on site alongside the CRHT and ward facilities.²⁹ The recent Healthcare Commission *Acute Inpatient Mental Health Service Review*³⁰ will have provided an opportunity for commissioners to review the facilities available to local acute teams, and ensure that a range of options are available to meet all levels of need.

Team capacity and its impact on service

2.43 Feedback from many service users suggested that they felt CRHT services were suffering from a shortage of time and resources, which impacted on both the quality and quantity of treatment available. Analysis conducted by the NAO as part of its main report found that although CRHT services nationally are resourced at around 90 per cent of the estimated capacity required,³¹ there is wide variation in staff provision across Strategic Health Authority regions. The Department of Health estimates that 14 CRHT care staff are needed to serve a population of 150,000 people,³² yet the NAO found that only four regions out of ten are currently resourced to this level, and that provision in the least well resourced region is 25 per cent lower than that in the best.³³ The Department's own national survey of CRHT teams in 2006 identified similar problems, with only 40 per cent describing

²⁹ See National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services* (HC5 2007-08, 7 December 2007), p. 25 and the accompanying report, *Are Crisis Resolution & Home Treatment Services seeing the Patients they are Supposed to See?* (http://www.nao.org.uk/publications/nao_reports/07-08/07085_report_of_interviews.pdf), p. 38.

³⁰ Healthcare Commission, *The Pathway to Recovery - A Review of NHS Acute Inpatient Mental Health Services* (July 2008), (http://www.healthcarecommission.org.uk/db/documents/The_pathway_to_recovery_200807251020.pdf).

³¹ See National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services*, p. 15.

³² See Department of Health, *Mental Health Policy Implementation Guide*, p. 20.

³³ National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services*, p. 16.

themselves as fully set up to meet demand, and 50 per cent citing lack of resources or staff as an obstacle to implementation.³⁴

- 2.44 The impact of this lack of resources on service users and carers is reflected in feedback from both local surveys and focus groups, often highlighting the gap between expectations and actual service delivery.

'There's a big gap between kind intentions and what actually gets done.'

Sarah (carer)

Source: NAO carer focus group

'They promise you things they can't deliver.'

Laura (CRHT service user)

Source: NAO service user focus group

- 2.45 The capacity of the team has an effect on service provision because it impacts the length of the home visit or the phone call. Service users and carers report that they sense when visits are rushed, and that this can impact on the efficacy of the intervention:

'Sometimes they'd stay for just five minutes [...] She was saying, "I want help" and they would come for just five to ten minutes. Or maybe they were just starting something that could turn into help, but it was too rapid and putting her off balance, and she was being disappointed.'

Daniel (CRHT service user and carer)

Source: NAO service user focus group

'The crisis resolution team was meant to be the panacea of mental health. It was coming in to reduce the beds, get people well [...] pay electricity bills, do the shopping or help get people set up [...] and so I'm disappointed to see round here that they come in, make them take their medication and shoot off again.'

Liv (CHRT service user)

Source: NAO service user focus group

'We need more staff on these teams, and a longer period to assess the patient.'

Joan (carer)

Source: NAO carer focus group

³⁴ Onyett S, Linde K, Glover G, Floyd S, Bradley S, Middleton H, *A National Survey of Crisis Resolution Teams in England* (London, Care Services Improvement Partnership, 2006).

- 2.46 Service users from the CRHT client group may already be suffering from low self-esteem,³⁵ and having a team member stay and give them company helps them feel valued and improves personal engagement. Local survey respondents repeatedly emphasized how they value the time taken for the team member to sit and have a cup of tea, for example, and not convey a sense of haste to their visit. However, being able to make visits promptly whilst ensuring that the service user is safe and calm before the team departs can require considerable time and staff input, and hence these elements are likely to be the first to suffer if resources are constrained.
- 2.47 In discussing those times when they felt teams had been hurried or perfunctory, service users often expressed views on both the causes and effects of this treatment. Sometimes, it had a detrimental effect on their self-esteem, leaving them with the impression they were not worth more of the team's time. Others attributed it to the team being overworked and under-resourced, recognizing the team's difficulties and using them to excuse and explain the limitations of the service. In both cases, service users had strong views on the impact of time and resources on their experience of CRHT:

'They're very good in principle, but they're limited by lack of funding and lack of staff.'

Stephanie (CRHT service user)
Source: NAO service user focus group

'Home Treatment is not there long enough to even consider you a person. They come in to do their job and they see everyone as a five-minute stay because they're trying to get to their next job. And you just get the sense that you're a number rather than a person with an actual problem.'

Susan (CRHT service user)
Source: NAO service user focus group

- 2.48 Some of the problems which service users attribute to capacity may in fact be linked to staff continuity. Promises made by one team member may not be effectively relayed to other team members who subsequently visit that person, resulting in an avoidable expectation gap and erosion of the therapeutic relationship. The issue of staff continuity is discussed further in the next section.

³⁵ The link between severe mental illness, stigmatization and low self-esteem has been explored elsewhere, for example in Verhaeghe M, Bracke P and Bruynooghe K. 'Stigmatization and Self-Esteem of Persons in Recovery from Mental Illness: the Role of Peer Support' in *International Journal of Social Psychiatry* 54, 3 (2008), 206-218; Knowles R, Tai S, Jones S, Highfield J, Morriss R, Bentall R. 'Stability of self-esteem in bipolar disorder: comparisons among remitted bipolar patients, remitted unipolar patients and healthy controls' in *Bipolar Disorders* 9, 5 (August 2007), 490-495; and Shahar G and Davidson L. 'Depressive symptoms erode self-esteem in severe mental illness: A three-wave, cross-lagged study' in *Journal of Consulting and Clinical Psychology* 71(5) (2003), 890-900.

Continuity of Care

2.49 Research suggests that users of health services generally feel a strong association between perceived continuity of care and overall satisfaction,³⁶ and CRHT services appear to follow this pattern. Two main elements of continuity were identified by service users in the feedback analyzed here:

2.50 **Continuity between teams** – the need for a whole systems approach to the mental health care pathway is a key focus of recent Department of Health policy guidance.³⁷ Service users and carers echo the Department’s stated need for ‘overall service system co-ordination and coherence’ and ‘shared values, principles and processes across the whole service system’,³⁸ and feel confused and disappointed when that system appears to break down:

‘You’re left in limbo, if you’re not like familiar with it all, and for someone who is first approached by mental illness it can be a little bit about [...] co-ordination. Yes, it’s like the right hand doesn’t talk to the left hand. And that goes right down to the GP.’

Tiffany (carer)

Source: NAO carer focus group

‘I thought, “If he’s taken the pills, that’s really bad”, so I rang the crisis line [...] They said, ‘Who’s the CPN? I’ll get in touch with them in the morning’. This was Tuesday night. By Friday I hadn’t been able to get out of the house. I was in tears. I rang the CPN, and they hadn’t even left him a message.’

Mandy (carer)

Source: NAO carer focus group

‘When I was discharged, two weeks later, I had an appointment with my consultant who had not had my file back from the Home Treatment team. So Home Treatment had not informed him of my medication [...] and I just think it was a shambles’

Susan (CRHT service user)

Source: NAO service user focus group

2.51 **Continuity within teams** – This theme was among the most frequent emerging from local survey feedback. Service users expressed a clear preference for having the same person or group of people visiting them from the CRHT team, since this helps to build trust and allow the user to feel comfortable and build up a relationship with staff. Given that the CRHT model by its nature requires 24/7 input for an intensive and sustained period, it is not practical to avoid shift changes and staff rotation completely. However, service users can

³⁶ See, for example, Fan V, Burman M, McDonell M, Fihn, S. ‘Continuity of Care and other Determinants of Patient Satisfaction with Primary Care’ in *Journal of General Internal Medicine* 20 (3) (March 2005), 226-233.

³⁷ See Department of Health / Care Services Improvement Partnership. *Guidance Statement on Fidelity and Best Practice for Crisis Services* (December 2006), p. 3.

³⁸ Department of Health, *Mental Health Policy Implementation Guide - Adult Acute Inpatient Care Provision* (2002), p. 6.

find themselves disorientated and unsettled if these are not kept to a minimum, particularly if their condition makes them more vulnerable to such changes:

'You seem to talk to different people all the time. It'd be so much better if there was a key person, and each time they're on duty they'd talk to you.'

Monica (CRHT service user)
Source: NAO service user focus group

'I had the crisis team visit me at six every day. Every day they came to visit me it was a new face. I wasn't sure if they were real [...] I told them I feel frightened when there are faces I don't recognize.'

Desmond (inpatient and CRHT service user)
Source: NAO service user focus group

2.52 Some service users feel that they are not given the opportunity to develop a meaningful relationship with any one member of the team, and that a bigger burden is placed on them to remember the different names and roles of the staff. This may also hinder the development of the personal side to treatment that users value so highly, given that the ability to demonstrate empathy and understanding is restricted by the short period of exposure to that service user. This inevitably has a knock-on effect to how people feel towards the treatment they receive, with one local survey respondent reporting that the large number of different faces meant that there 'did not seem any point in investing in making a relationship with anyone.'

2.53 Passing on information between team members about the service user's history or care plan is vital to ensuring continuity of care. When this process is not handled adequately, the service user may have to repeat sometimes quite traumatic experiences to a different individual:

'There's also a problem of not seeing the same people all the time [...] and she didn't feel there was proper handover. [She said:] 'People didn't seem to know what I was talking about, but I don't want to keep giving the same bits of information over and over again'. The comment she got was 'I've just come on duty. I don't know what you're talking about.'

Donna (carer)
Source: NAO carer focus group

2.54 From a clinical and risk-management perspective, too, failure to communicate between team members can increase risks around aspects such as medication:

'The thing I got most annoyed with is that they don't read notes. And on the notes it said: 'Not to be given sleeping tablets because of the risk of suicide.' So say they come in the morning, and make you take your pills, but when they come in the evening, you're not due to take the medication until later that night, but they don't check that you're taking them. Meanwhile, I'm storing up tablets thinking, 'Oh this is going to be an easy way out!'

Susan (CRHT service user)
Source: NAO service user focus group

'The evening I came home, I was promised a visit by themselves to settle me in and bring my medications. I waited, waited and waited, clicking through the television, looking at it, just trying to kill time. By that time it's 11 o'clock, 12 o'clock, but nothing – no visit [...] When I did phone in the next morning, it had completely slipped their memory. I know they're overworked, they've got lots of meds to give out, they're under as much strain as anyone else, it's just that messages don't get relayed; people don't for whatever reason communicate.'

Michaela (inpatient and CRHT service user)
Source: NAO service user focus group

- 2.55 Because facilitating early discharge from hospital is one of their key intended functions,³⁹ CRHT teams are located at a key juncture between the acute and community elements of the care pathway. When the process is managed well, service users speak positively about the potential of CRHT teams to assist with discharge, particularly where this reduces disruption and dislocation from their everyday lives.

'Well, my team actually helped me get out of hospital [...] I was home for Christmas, which I spent with the kids.'

Desmond (CRHT service user)
Source: NAO service user focus group

'Their point is to try and prevent a crisis, but I also think they should be there at the other end when you leave hospital [...] because you do get institutionalised. It's hard to get back in the swing of things, you know, going back to Sainsbury's. So really, I think they should be there at the other end as well.'

Susan (CRHT and inpatient service user)
Source: NAO service user focus group

- 2.56 The main NAO study confirmed that teams are more likely to be involved in facilitating discharge where they are gatekeeping the majority of admissions, and hence have probably had contact with the service user before (and ideally during⁴⁰) their inpatient stay.⁴¹ It is

³⁹ Department of Health / Care Services Improvement Partnership, *Guidance Statement on Fidelity and Best Practice for Crisis Services* (December 2006), p. 5.

⁴⁰ See *A Positive Outlook - A good practice toolkit to improve discharge from inpatient mental health care* (Care Service Improvement Partnership, April 2007), p. 15: 'Where hospitalisation is required the CRHT team should stay involved in the ongoing care and discharge planning processes to ensure the service user is discharged/ transferred to the least restrictive environment as soon as it is clinically possible'.

particularly important that teams build on existing therapeutic relationships to assess that person's readiness for discharge on an ongoing basis. A number of local survey respondents felt that they had been 'pushed' into discharge before they were ready, or that they had not been adequately consulted about the decision to discharge. Service users and carers expressed concerns that, without a proper appraisal of the social factors and support mechanisms available outside the ward, early discharge could bring additional problems and risk of relapse.

'You can be discharged too early. You are sent out of hospital whilst you are still unwell. You're put in a dingy bed and breakfast with wall-to-wall loneliness, and expected to recover.'

Frank (carer)

Source: NAO carer focus group

- 2.57 Such comments reaffirm the need for a thorough risk-assessment prior to discharge, carried out in partnership with the service user and incorporating an ongoing assessment of social needs such as housing and employment as well as clinical issues.⁴²

⁴¹ See National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services*, para. 3.13, p. 23.

⁴² For more detail on issues around discharge-planning and risk-assessment, including good-practice examples, see *A Positive Outlook - A good practice toolkit to improve discharge from inpatient mental health care* (Care Service Improvement Partnership, April 2007), pp. 21ff.

Conclusion

1. The feedback examined in this paper appears to echo findings from other evidence sources, including those used in the main NAO report. When CRHT works well, service users speak highly of its benefits, in particular its role in keeping them out of hospital and in touch with their lives. They appreciate CRHT team members who engage with them as real people, acknowledging their wider circumstances and 'doing whatever needs to be done' – whether clinical or practical - to sustain them in their home during a mental health crisis. Those teams that do so most successfully also acknowledge the crucial role of carers, and in particular the insights they can provide into service users' lives and circumstances. In return, however, carers emphasize the need for sufficient support and information for when they are 'the nurse, the consultant, everything at home'.
2. Negative comments are often associated not with the CRHT model itself, but with either the way it is delivered or a perceived lack of resources available to do so – issues which, as outlined above (p. 14), may sometimes be facets of the same problem. The ten per cent shortfall in CRHT staff identified by the NAO appears to be felt on the ground as hurried or perfunctory visits, missed appointments or unanswered phone calls – experiences which undermine service users' and carers' experience of CRHT for reasons unrelated to its efficacy as a model of care. Resource shortfalls in CRHT teams may well be exacerbated by relatively poor understanding of their intended function and client group amongst potential referrers. Varying interpretations of the word 'crisis' have already been touched upon above (p. 15f.), and an NAO survey of referring clinicians confirmed that only 15 per cent of emergency medics, 18 per cent of GPs and 55 per cent of psychiatrists felt they understood fully the client group that their local CRHT would accept for referrals.⁴³ In addition to addressing the physical shortage of staff, clarifying the role and client group of CRHT teams through clear, agreed protocols would help to avoid inappropriate referrals and make the most of their specialised resources.
3. Another key message emerging from the feedback examined here is the need for a holistic assessment of service users' circumstances, and flexibility within the acute services used to address them. Despite the well-documented negative associations of inpatient wards, some service users report that in fact this setting was the right one for them, and that the situation in their home was one of the factors precipitating their crisis. Similarly, service users speak highly of halfway houses such as crisis accommodation, which help to offer a sliding scale of acute

⁴³ National Audit Office, *Helping People through Mental Health Crisis: the Role of Crisis Resolution and Home Treatment Services*, p. 26.

provision appropriate to their needs whilst combining the best features of CRHT and inpatient care.

4. As outlined in the Introduction, relatively little material has been published to date exploring what aspects of CRHT services are valued highly by service users and carers, and why. The Healthcare Commission's recent *Review of NHS Acute Inpatient Mental Health Services*⁴⁴ has thrown valuable light on the operational effectiveness of CRHT teams in gatekeeping and facilitating discharge, and these findings will be crucial in developing the future role of CRHT teams in the acute care pathway. To complement this work, however, and in line with the Department's own requirements,⁴⁵ the need remains for more comprehensive research on carers' and service users' experiences of CRHT services, possibly building on the themes and associations identified in this paper.

⁴⁴ Healthcare Commission, *The Pathway to Recovery - A Review of NHS Acute Inpatient Mental Health Services* (July 2008).

⁴⁵ Department of Health / Care Services Improvement Partnership, *Guidance Statement on Fidelity and Best Practice for Crisis Services* (December 2006), p. 8.

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