National Audit Office

Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services

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Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services

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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

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5 December 2007

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Photographs courtesy of Justine Desmond Photography and South London and Maudsley NHS Foundation Trust

KEY FACTS

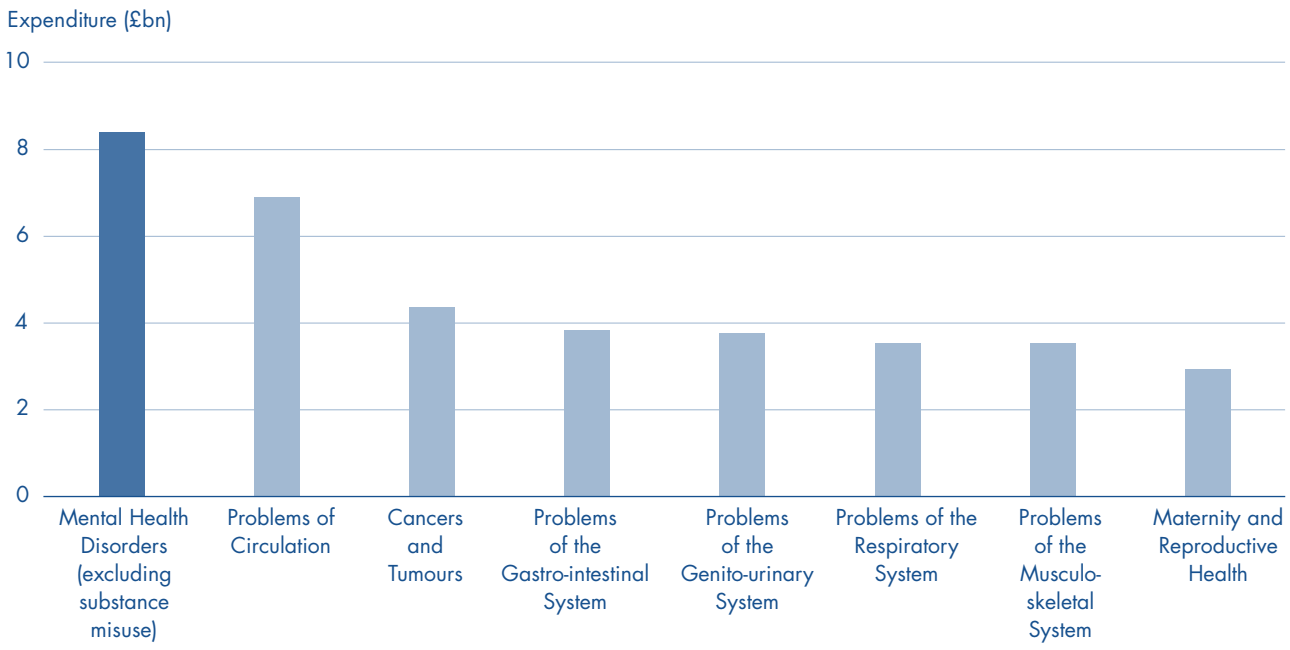
How many people are affected by mental illness?

- At any one time, one in six British adults are experiencing at least one diagnosable mental health problem.[1]
- One quarter of routine GP consultations are for people with a mental health problem.[2]
- The most common mental health problems are anxiety or depression, but it is estimated that at any one time one in 100 people will have a psychotic illness such as schizophrenia or bipolar affective disorder (manic depression).[3]
- 84,702 people were admitted to inpatient wards in England with a psychosis, depression or anxiety disorder in 2005-06.[4]

What does mental illness cost the economy and the NHS?

- Mental illness costs the economy and the Exchequer in the region of £47 billion each year, including over £15 billion in lost employment and £10 billion in benefits payments.[5]
- In 2006-07 the NHS spent £8.4 billion on mental health services (excluding substance misuse) for all age groups. This was the highest spend on any individual area of healthcare, over £1.5 billion more than on coronary heart disease and almost twice as much as on cancer **(Figure 1)**.

1 The NHS spends more on mental health than on any other area of healthcare



Source: Department of Health Resource Account, Gross Expenditure by Programme Budget category for the year ended 31 March 2007

What are Crisis Resolution Home Treatment teams?

- Crisis Resolution Home Treatment (CRHT) teams help people through short-term mental health crises by providing intensive treatment and support outside hospital, ideally at home.
- They are made up chiefly of mental health nurses, with additional input from consultant psychiatrists, social workers, occupational therapists and psychologists.

Who are CRHT teams intended to treat?

- CRHT teams provide acute home treatment for people whose mental health crisis is so severe that they would otherwise have been admitted to an inpatient ward. Users of CRHT are typically suffering from severe mental illness such as psychosis, severe depression or bipolar affective disorder (manic depression).
- CRHT teams also allow people to be discharged earlier from inpatient wards and receive treatment in their homes whilst still in the acute phase of their illness.

How many CRHT teams are there, treating how many people?

- Providing comprehensive CRHT services has been a Departmental Public Service Agreement target in recent years, one of only two such targets relating to adult mental health services.[6]
- By 2005, the Department aimed to establish 335 CRHT teams across England, delivering 100,000 treatments to people in their homes.
- In 2006-07 the Department reported 343 teams in place, delivering 95,397 episodes of CRHT.

Are other countries also using CRHT?

- CRHT is a key element of mental health service provision in both Australia and North America.[7] CRHT services have also been set up in a number of other countries, including Germany, China, Sweden, India and New Zealand.[8]
- Developing CRHT services has also been a recent priority in the rest of the United Kingdom. The Scottish Government published National Standards for Crisis Services in November 2006,[9] and aims to implement them fully by 2009. The Wales Audit Office reported in December 2005 that CRHT services were in place or being set up in nine of Wales's 22 Local Health Board areas.[10] Health and Social Care Trusts in Northern Ireland are now also developing and operating CRHT services.

SUMMARY

1 The NHS in England spent over £8 billion on mental health in 2006-07, more than on any other category of health problem. Most people with mental health problems receive treatment in the community, for example from their GP or a Community Mental Health Team. But acute services are also a crucial part of mental health services.

2 Severe psychiatric illnesses are often episodic in nature, with stable periods of less intense symptoms interrupted by periods of crisis in which symptoms become intense. In recent years Crisis Resolution Home Treatment (CRHT) services have been developed to provide acute care for mental health service users[a] living in the community and experiencing a severe crisis requiring emergency treatment. Previously, such treatment could only have been provided by admitting the service user to an inpatient ward. The introduction of CRHT services was one of the key elements in the 1999 National Service Framework for mental health; the NHS Plan (2000) made the provision of CRHT services a national priority; and the Department of Health's (the Department's) 2002 Public Service Agreement included targets both for the number of teams and the number of people treated.

3 The main aim was to provide service users with the most appropriate and beneficial treatment possible. But CRHT was also intended to reduce inpatient admissions and bed occupancy, support earlier discharge from inpatient wards and reduce out-of-area treatments (where a bed can only be found for a person outside local NHS services).

4 In examining whether these aims of the CRHT policy are being achieved, we focused on the degree to which CRHT teams are fulfilling their intended role within the Department's mental health service model. Our examination included a detailed referral and admissions audit of CRHT teams and inpatient wards, a survey of referring clinicians, focus groups and feedback from service users and carers, economic modelling and data analysis covering team provision, activity, inpatient admissions and expenditure.

Key findings

5 CRHT teams have been rapidly implemented across most areas of the country. £183 million was spent on providing CRHT services in 2006-07, an increase of 409 per cent in real terms since 2002-03. The Public Service Agreement target of establishing 335 teams was met by 2005. The target for treating 100,000 people a year has not yet been achieved, with 95,397 episodes of CRHT provided to 75,868 individual people reported in the year to 31 March 2007. From 2008-09, the Department plans to introduce more locally managed and outcomes-based metrics of performance alongside these targets.

6 The introduction of CRHT teams has been associated with reduced pressure on beds, and the teams are successfully reaching service users who would otherwise probably have needed admission. CRHT teams are also supporting the earlier discharge of people from inpatient treatment – for example in around 40 per cent of the discharges in our sample.

a Note: 'Service user' is the established term used in the NHS for people being treated by mental health services. As this report is aimed partly at a professional NHS audience, for ease of reference this term has been used throughout.

7 However, while reported CRHT staff head-count nationally is at around 90 per cent of the total requirement estimated by the Department, there are wide regional variations in team provision relative to local need. Many teams lack dedicated input from key health and social care professionals, particularly consultant psychiatrists. This can restrict their ability to provide comprehensive, multi-disciplinary care, as well as the extent to which they are integrated and accepted within local mental health services. We estimate that an additional £10 to £30 million of resources (depending on exact skill mix and variable costs such as training) would have to be diverted into CRHT services each year to increase capacity and improve multi-disciplinary and medical input.

8 A key function of CRHT teams is the assessment of treatment required by a service user, made in the early stages of an acute psychiatric crisis, which considers whether CRHT would be a safe and clinically beneficial alternative to admission for the person concerned ('gatekeeping'). We found that having a CRHT staff member at the assessment makes it far more likely that the assessment will consider whether CRHT is an appropriate alternative to admission, and increases the chances that the CRHT team will be involved in an early discharge.

9 Yet our sample testing of 500 admissions showed that only half, rather than all as intended, had been assessed by CRHT staff before being admitted. Around one in five of our sample admissions were considered by ward managers to be appropriate candidates for CRHT. Other health professionals making referrals to acute mental health services could have better awareness and understanding of how the community and inpatient elements of an acute service operate, which would make the user's route through such services more efficient.

10 Our economic modelling estimated that an acute mental health service making full use of CRHT services in appropriate cases costs approximately £600 less per crisis episode than one in which CRHT is not available – chiefly because some admissions will be avoided altogether and others will shorter, reducing the costs incurred with overnight stays. Increasing the proportion of cases in which CRHT is considered offers scope for further efficiency savings – on a cautious estimate of some £12 million a year and potentially much more. Realising such savings needs careful management, however, especially because very ill service users will form an increased proportion of those remaining in inpatient wards.

Value for Money Assessment

11 The evidence base suggests that when used appropriately and safely, CRHT brings clinical benefits and increased patient satisfaction. It can also reduce the stigma and social exclusion frequently faced by people suffering from acute mental illness. The Department has made rapid progress with the implementation of CRHT since 2001, and many service users across England are seeing its benefits. But there is further scope to maximise its impact and improve value-for-money by ensuring CRHT teams are properly resourced, fully functional and integrated within local mental health services.

Our Conclusions and Recommendations

For the Department of Health

i *Issue: The current CRHT target regime has been an effective driver to implementation, but is limited by its focus on outputs (e.g. CRHT episodes) rather than outcomes (e.g. benefits to service users). The Department plans to place less emphasis on existing targets for the number of teams and episodes and to encourage the introduction of more locally managed and outcomes-based metrics of performance.*

Recommendation: **The Department** should take this opportunity to develop metrics allowing a rounded assessment of the local acute services of which CRHT are part, for example service-user outcome data. Such metrics should be developed in conjunction with the Information Centre for Health and Social Care, and could be drawn from sources such as the current Care Services Improvement Partnership/Department of Health National Outcomes Measures project or existing local NHS pilot schemes.

ii *Issue: At present, few local organisations obtain and report service-user feedback on CRHT services, and those that do are doing so in a piecemeal and ad hoc fashion.*

Recommendation: **The Department** should make clear to **local commissioners and provider trusts** its expectation that they conduct regular service-user satisfaction exercises on key areas of service provision, including CRHT and its interfaces with the wider mental health pathway. **The Department** should also discuss with the **Healthcare Commission** (and its successor body) how meaningful national data on CRHT services might be gathered as part of the national Patient Survey programme.

iii *Issue: The Mental Health Minimum Data Set (MHMDS) is intended to collect data on each individual service user, and ensure that all their contacts with specific services are recorded and reported on an individual basis. This would provide crucial information for systematic monitoring of service standards and performance.*[11] *However, although basic data are being reported by all mental health providers, other key information is often not recorded.*

Recommendation: **The Department** should encourage Trusts to improve their use of the Mental Health Minimum Data Set to support planned improvements in monitoring. **The Department** should discuss with the **Information Centre** and the **Healthcare Commission** (and its successor body) how to best support this aim through NHS bodies' annual performance assessments.

iv *Issue: Reducing Out-of-Area Treatments (OATs) was one of the aims of the CRHT policy, but there are currently no routine national data available to analyse the extent to which this is being achieved. The Healthcare Commission has been exploring the possibility of a routine OAT measure as part of its 'Better Metrics' project.*[12]

Recommendation: **The Department** should work with the **Healthcare Commission** (and its successor body), **the Information Centre** and **local NHS bodies** to produce a robust, national OAT dataset.

For NHS Commissioners and Providers of Acute Mental Health Services

v *Issue: At national level, numbers of reported CRHT staff are at approximately 90 per cent of the estimated level required. However, there are wide regional variations in team provision relative to local need, and many teams lack dedicated input from key health and social care professionals, particularly consultant psychiatrists.*

Recommendation: **NHS commissioners** should work with **mental health provider trusts** to assess current CRHT capacity in the context of local need, and invest sufficient resources to make fully staffed 24/7 CRHT teams an integral part of the local mental health care pathway. This should include ensuring that CRHT teams receive full clinical input and support from consultant psychiatrists, both to provide appropriately skilled and multi-disciplinary CRHT teams and to encourage acceptance and knowledge of their role within local mental health services.

vi *Issue: To realise the full benefits of CRHT, teams need to be a fully functional and integral part of acute mental health services, gatekeeping all potential admissions and communicating effectively with inpatient services to facilitate early discharge.*

Recommendation: **Clinical directors and service managers** should seek to maximise effective collaboration and communication between all elements of the acute mental health pathway by, for example:

- Encouraging regular dialogue between CRHT and inpatient teams regarding referrals, admissions and discharges. Depending on local service configuration, this may be facilitated by co-locating CRHT and inpatient teams on the same site. Consideration should be give to this option when updating or replacing acute mental health facilities.
- Recording at the point of inpatient admission both the purpose of the admission and an indicative discharge date, with both inpatient and CRHT teams monitoring progress against this timetable.
- Integrating training for CRHT and acute inpatient services to equip staff to operate in both settings.
- Considering the use of staff rotation and joint roles for acute care staff and managers between inpatient and CRHT teams.

vii *Issue: The Department's aim is for CRHT teams to gatekeep all potential admissions to inpatient wards. But we found that CRHT staff had been involved in only 53 per cent of our sample of admissions, and had had a bearing on the decision to admit in only 46 per cent. The likelihood of CRHT teams being involved in admissions was greater for teams available 24/7.*

Recommendation: In addition to Recommendations v and vi (above), **provider trusts** should enforce written policies and procedures requiring every inpatient admission to be preceded by a CRHT gatekeeping assessment. If, in exceptional circumstances, an admission has occurred without such an assessment taking place, trust policy should require the CRHT team to have contact with the service user within 48 hours of admission.

viii *Issue: CRHT services are generally receiving appropriate referrals, but could function more efficiently if referrers better understood the appropriate client group. The majority of potential referrers to CRHT services do not feel they fully understand local CRHT services or the client group these services are intended to serve.*

Recommendation: **NHS commissioners** should work with **local mental health providers, acute trusts, GP practices and Local Implementation Teams** to jointly develop, negotiate and agree comprehensive local protocols for mental health referrals.

ix *Issue: Alternatives to admission as well as home treatment (e.g. crisis houses, respite housing, acute day units) provide valued support for acute services, but provision is patchy.*

Recommendation: **Commissioners** should use data from the forthcoming Healthcare Commission Acute Inpatient Mental Health Service Review to review provision of crisis accommodation and respite facilities in the context of local need. They should work with **provider trusts, local government bodies and third-sector organisations** to ensure that a suitable range of crisis houses, respite facilities and acute care are available within the local community.

PART ONE

The Department introduced Crisis Resolution Home Treatment to transform acute mental health services

Acute services are a crucial area of mental health provision

1.1 A total of £8.4 billion was spent by the NHS on all mental healthcare (excluding substance misuse) in 2006-07, and local organisations reported £4 billion of direct expenditure on mental health services for working-age adults. This covered a wide variety of services **(Figure 2)**, but over £1.7 billion (43 per cent) was on so-called 'acute' services, which treat episodes of serious mental illness that have a rapid onset and relatively short duration.

CRHT teams are intended to provide an alternative to inpatient treatment

1.2 Most people with mental health problems receive treatment in the community, for example from their GP or a Community Mental Health Team. But acute services are also a crucial part of mental health services. Severe psychiatric illnesses are often episodic in nature, with sufferers experiencing both stable phases and periods where their symptoms become more intense. During such periods, they require acute mental health services to provide intensive monitoring and support and help them return to stability.

2 Acute services account for over forty per cent of direct expenditure on mental health for working-age adults

Mental Health Service Categories	2006-07 Expenditure (£m)	
Acute Services		
Acute Inpatient Units	577	
Secure and High-Dependency Care	730	
Access & Crisis Services (including £183 million on CRHT teams, £109 million on Assertive Outreach teams, £51 million on Early Intervention services and £16 million on A&E Liaison services)	411	
Total for acute services		1,718
Non-acute services		
Clinical Services (non-acute, including liaison services and outpatient clinics)	253	
Community Mental Health Teams (including carer support and respite services)	593	
Continuing Care (including 24-hour nursing and rehabilitation services)	442	
Accommodation (including supported housing and care homes)	386	
Day Services (including drop-in centres and employment schemes)	153	
Psychological Therapies (including psychotherapy and counselling services)	146	
Other non-acute services (including services for offenders, advocacy and user groups)	314	
Total for non-acute services		2,287
Overall direct expenditure on adult mental health		**4,005**

Source: Department of Health/Mental Health Strategies, 2006-07 National Survey of Investment in Mental Health Services

NOTE

These figures exclude a further £985 million of indirect costs, capital charges and overheads not attributed to specific service categories.

1.3 At one time, such services were available only in hospitals, with people in crisis having to be admitted as inpatients to receive the treatment they needed. More recently, and in common with practice in a number of other countries,[13] the Department of Health has aimed to ensure that prompt and effective help in times of crisis is provided in an appropriate and safe place as close to home as possible. This aim reflects the development of new clinical techniques and drugs facilitating treatment outside hospital, as well as a growing recognition since the middle of the twentieth century that institutionalisation is the least beneficial option for many users of mental health services.[14] Long inpatient stays can mean service users become disconnected from their home and working lives, leading to increased social exclusion, stress and risk of relapse after discharge.

> "When you come out after a year you find you've no home to go to [...] 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...."
>
> *Service User (Source: NAO)*

1.4 However, the community services put in place to support this change sometimes found it difficult to respond fully to the needs of all service users. In 1998, the Government announced additional funding for improving mental health services; and followed this in 1999 with a National Service Framework (NSF) for mental health, setting out its intentions for the standards and service models that mental health services should provide.

1.5 One of the key elements of the NSF was the introduction of CRHT teams, which were intended to ensure that inpatient care was used appropriately, and only where necessary, with good-quality intensive treatment in the community being offered in its place. The July 2000 NHS Plan[15] made the provision of CRHT services a national priority as an alternative to admission to hospital for people suffering from acute mental illness,[16] and the 2002 Policy Implementation Guide for Acute Inpatient Care emphasised the need for effective joint working between CRHT and other local acute mental health services.

1.6 The CRHT policy is supported by a Cochrane Review (an authoritative meta-analysis of all existing research on the subject) which shows that CRHT results in higher service user satisfaction and equal or better service user outcomes than inpatient treatment alone.[17]

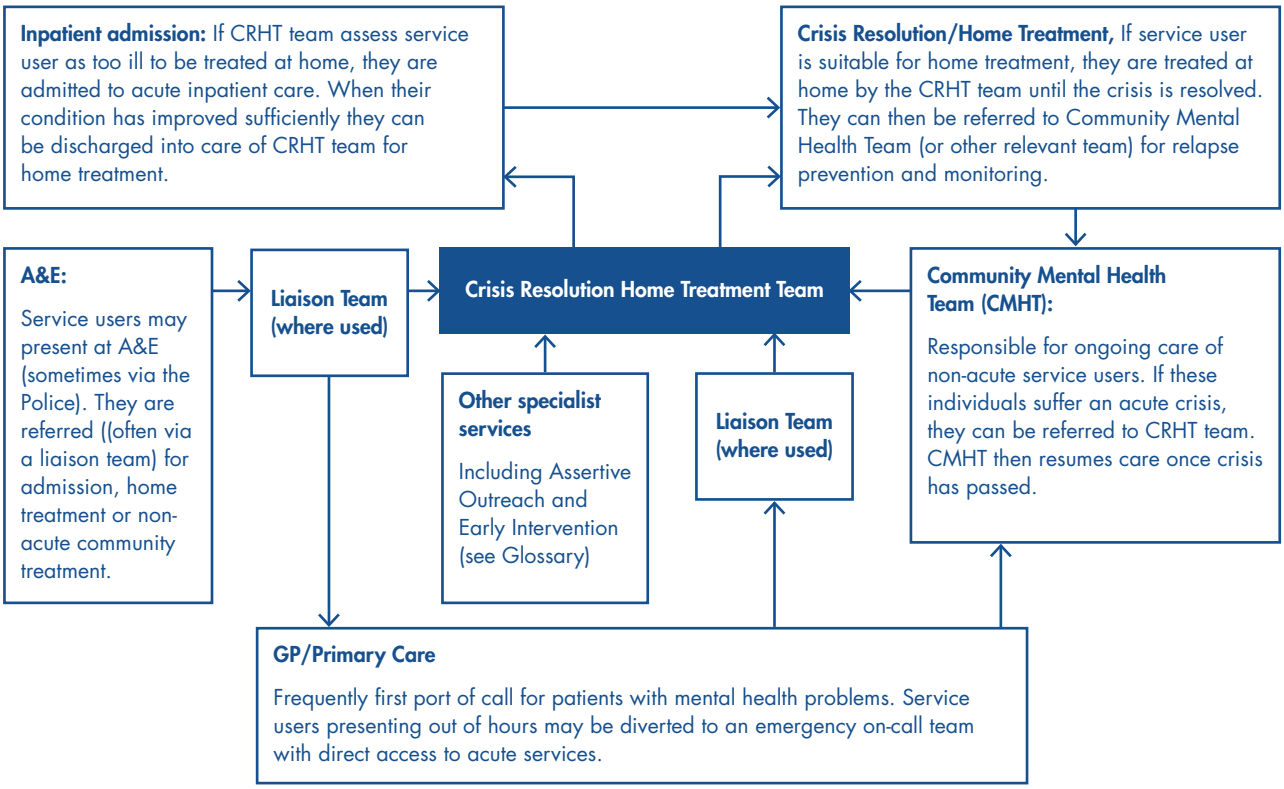
1.7 Beyond these benefits to service users, CRHT was expected to reduce pressure on acute inpatient units by 30 per cent,[18] as well as reducing out-of-area treatments (where a bed can only be found for a person outside their local area) and supporting early discharge from inpatient wards. The Department also believed that home-based support would offer a more acceptable and culturally sensitive form of treatment for some ethnic minorities.[19]

CRHT teams should play a pivotal role within local mental health services

1.8 CRHT teams represent a radical change in the provision of acute mental health care, and are intended to play a pivotal role at the centre of mental health services **(Figure 3)**.

1.9 One of the key intended functions of CRHT teams is as a 'gatekeeper' to inpatient mental health services, which means that they should be involved whenever a person in crisis is being considered for admission to an inpatient ward. The team should assess whether admitting that person is indeed the best option, or whether they can be treated safely and beneficially in their own home. If the latter option is appropriate, the team provides intensive home treatment until the crisis is resolved, at which point the person should be returned to the care of non-acute community health services (Figure 3). Even where admission is required, the CRHT team can help the service user to achieve earlier discharge and receive intensive treatment in their own home.

3 CRHT teams work alongside a variety of other mental health services



Source: National Audit Office

NOTE

This diagram is intended to be an indicative guide to key local mental health services and the main interfaces between them. However, local service configurations can differ from this model in a number of respects. For example, in some localities, direct referrals to the CRHT team take place from GPs/primary care, A&E and service users or carers themselves. While circumstances and service configurations will vary from one area to another, there is a risk that CRHT teams receiving direct referrals without appropriate liaison will have to assess more service users who are not suitable candidates for inpatient admission or home treatment. See below paragraph 3.32.

There have been two key performance targets for implementing CRHT

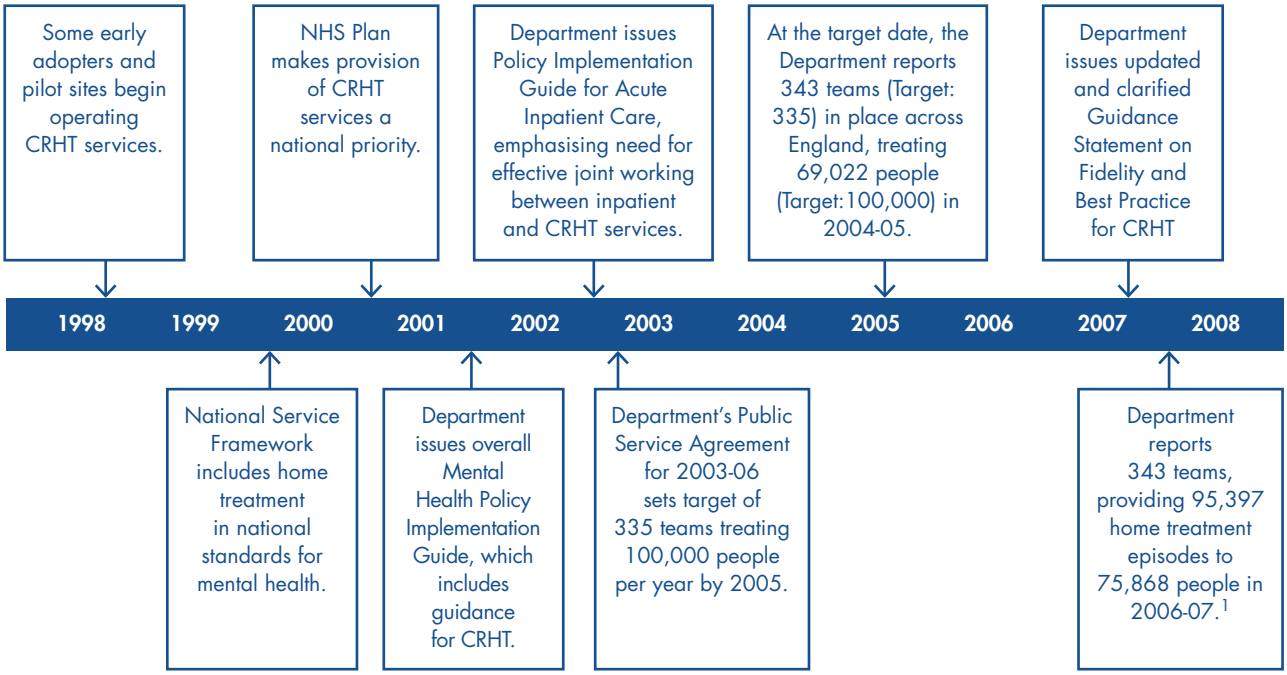
1.10 The aim of introducing CRHT services across England was incorporated as two key targets in the Department's 2002 Public Service Agreement, covering the period 2003-06:

- To expand national capacity to deliver CRHT to 100,000 people annually by 2005.
- To create 335 crisis teams by the end of 2004.[20]

The Department used calculations based on needs-weighted populations to split these national figures into regional targets for Strategic Health Authorities (SHAs). The SHAs then divided these regional figures into local targets for the individual NHS bodies in their area. Primary Care Trusts were charged with commissioning sufficient services to fulfil their share of the 100,000 treatments ('episodes'), while NHS mental health trusts were required to set up and operate their allocated number of the new teams.

1.11 The full timeline for CRHT implementation, including milestones for these key performance targets, is shown in **Figure 4.**

4 The CRHT policy was first set out in 1999 and due to be fully implemented by 2005



Source: National Audit Office

NOTE

1 The guidance for reporting CHRT activity was amended in 2005-06 (see below, note to Figure 7).

PART TWO

CRHT teams have been rapidly implemented across most of the country

Expenditure on CRHT services has increased rapidly in recent years

2.1 The Department gave PCTs discretion as to how much of their overall funding allocation they spent on delivering CRHT services, with the one key requirement that they should meet their local share of the national targets within the specified timeframe.

2.2 Reported expenditure on CRHT services grew rapidly between 2002-03 and 2006-07. While PCTs' overall spend on mental health increased by 27 per cent in real terms between 2002-03 and 2006-07,[21] spend on CRHT increased by 409 per cent in the same period, from £31 million in 2002-03 to £183 million in 2006-07.[22]

2.3 However, expenditure on CRHT services by individual PCTs for 2006-07 ranged from under 1 per cent of the total mental health budget in some areas to over 10 per cent in others. Taking account of factors such as local deprivation, cost of living and morbidity, NHS spend on CRHT per 1,000 of weighted population ranged from £1 or less in some areas, to over £7.50 in others **(Figure 5)**.

Most of England now has access to CRHT services, although there is evidence that some teams are under-resourced

2.4 The Department's definition of a fully functional CRHT team envisaged that it should consist of around 14 staff, serving a population of approximately 150,000 people. It should also fulfil a number of 'fidelity criteria', based on established good practice in CRHT. According to these criteria, the team should:

- Be multi-disciplinary (i.e. including nursing, psychiatry, psychology, social care and occupational therapy).
- Be available to respond 24 hours a day, 7 days a week.
- Have frequent contact with service users, often seeing them at least once on each shift.
- Provide intensive contact over a short period of time.
- Stay involved with the service user until the problem is resolved.
- Have the capacity to offer intensive support at service users' homes.

2.5 The Department met its target of establishing 335 CRHT teams by the end of 2005, although in some instances this involved adapting the method of counting teams to reflect local conditions.[23] For example, in some cases very large single teams serving sizeable populations were treated as two teams for the purposes of counting. These adjustments were made through discussion between local teams and provider organisations, the National Institute for Mental Health in England, Strategic Health Authorities and the Department to ensure that the resulting service models were robust, evidence-based and properly resourced to cater for local need.[24] The Healthcare Commission, who measure CRHT team implementation as part of their 'Annual Healthcheck'[25] (previously 'star ratings') validated these local adjustments and confirmed that by 31 March 2007,[26] all NHS provider organisations had met or exceeded their share of the 335 team target.

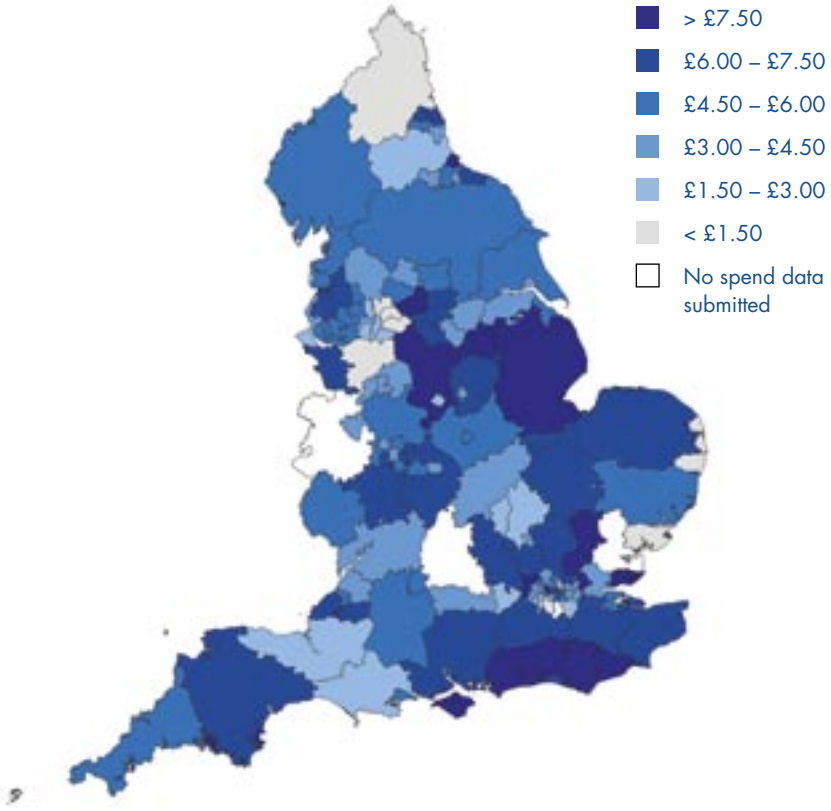
2.6 The presence of teams around most of the country is confirmed by the results of our national survey of referrers, where only 11 per cent of respondents overall reported that there were no CRHT services available locally. However, even where respondents reported a CRHT team in their local area, some said that the service had insufficient

resources to meet local demand. Of the respondents who reported having a local CRHT team (n=533), 20 per cent said that these services were under-resourced. The Department's own national survey of CRHT teams in 2005-06[27] suggested that these concerns were shared by the teams themselves, with only 40 per cent describing themselves as fully set up to meet demand, and 50 per cent citing lack of resources or staff as an obstacle to implementation.

2.7 At national level, the total number of whole-time-equivalent CRHT care staff (excluding managers and administrative support) in place as at 31st March stood at 4,390. Applying the Department's estimate that approximately 14 team members are required for a population of 150,000, and taking no account of factors such as staff mix or seniority, this suggests that CRHT services nationally are resourced at around 90 per cent of the estimated capacity required.

5 Expenditure on CRHT services in 2006-07 varied widely between Primary Care Trusts

Reported spend on CRHT teams per 1,000 of weighted population (aged 15-64)



Source: National Audit Office analysis of Department of Health/Mental Health Strategies Finance Mapping data using Department of Health population estimates (2006-07 PCT configuration)

NOTE

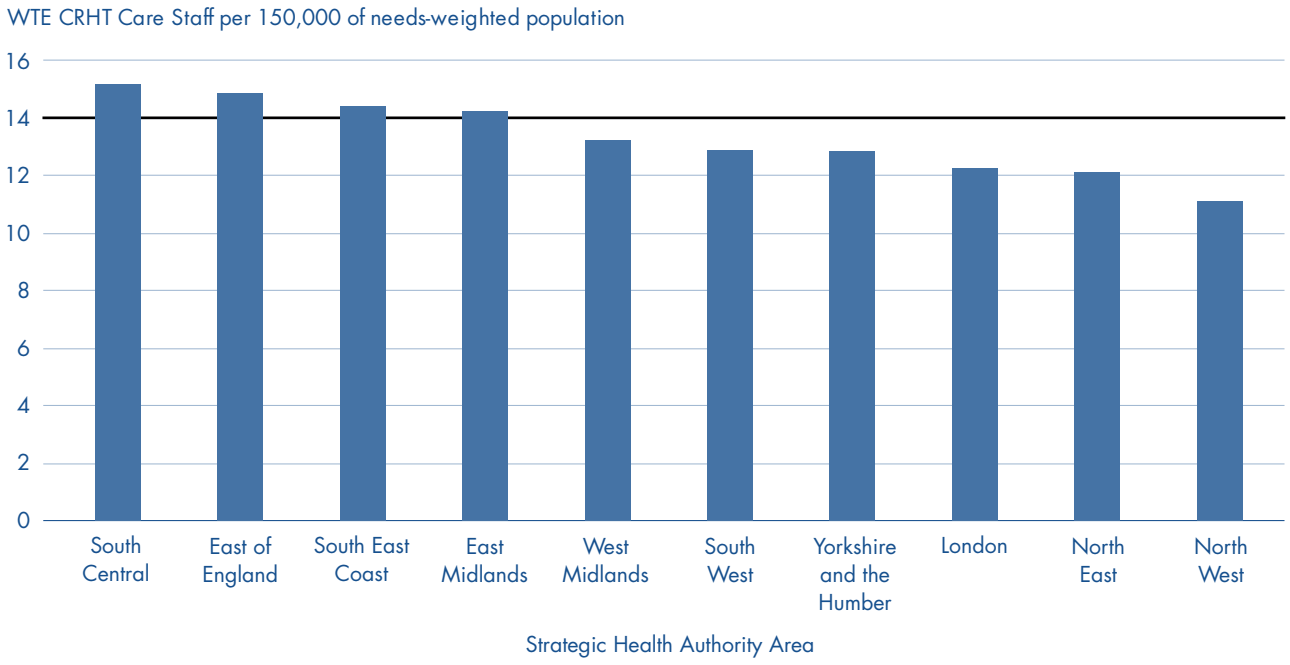
To give comparability between different geographical areas, figures have been adjusted using standard Department of Health indices for local costs and need.

2.8 However, more detailed analysis reveals wide variation in CRHT staff provision across SHA regions, with only three regions (North East, West Midlands and London) achieving 14 or more whole-time-equivalent CRHT care staff per 150,000 of population. Once populations are weighted to reflect differences in local mental-health need, four regions achieve 14 care staff or above **(Figure 6)**, and provision in the least well resourced region (North West) is 25 per cent lower than that in the best (South Central).

2.9 As outlined above (paragraph 2.4), the Department's policy guidelines for CRHT also specify that teams should be multi-disciplinary, with input from a variety of health and social care professionals. While most CRHT services are nurse-led, there is evidence that having a consultant psychiatrist as a member of the team both enhances the skill mix of the team and improves levels of gatekeeping (see below, paragraph 3.19).[28] Yet 50 per cent of teams report having less than a 0.5 whole-time equivalent consultant psychiatrist on their books, and almost a third of teams receive no dedicated consultant psychiatrist input at all. Dedicated input from Approved Social Workers (another key element of a multi-disciplinary CRHT service) is similarly limited, with fewer than half of teams reporting even part-time input from this specialism.

2.10 While detailed factors such as transport links, urban/rural settings and varying local service configurations will also affect CRHT resource requirements, the above analysis gives an indication of how current CRHT staff resources compare to likely need. It also provides a basis to estimate the cost of increasing CRHT staff levels and skill mix to recommended levels across all ten SHA regions. We estimate that increasing CRHT resources to at least 14 care staff per 150,000 of weighted population in every region using mental health nurses alone would cost the NHS between £10 million and £17 million per year (depending on the extent of additional training and other variable costs). The same increase in overall head-count, but equipping every team with full-time medical input (including at least a 0.5 whole-time equivalent consultant) and a full-time Approved Social Worker could cost as much as £30 million per year. However, if this additional expenditure resulted in more effective CRHT services as intended, it would also be likely to generate cost savings through improved gatekeeping and avoided admissions (see below, paragraph 4.2).

6 Levels of CRHT staff resources relative to need vary widely across SHA regions



Source: National Audit Office analysis of Department of Health/Mental Health Strategies Service Mapping data 2006-07, using aggregated Department of Health PCT population estimates, weighted using mental health needs indices and normalised

The national target of 100,000 CRHT episodes has yet to be achieved, and around half of PCTs are failing to meet their local allocation

2.11 The second target, of carrying out 100,000 episodes of CRHT per year, has yet to be achieved, although latest figures suggest that the Department came close to doing so in 2006-07. These show 95,397 episodes of CRHT delivered to 75,868 individual people in the year to 31 March 2007. **Figure 7** shows progress reported nationally against this target to date.

2.12 As the target was not reached by the March 2005 deadline specified in the Public Service Agreement, it was rolled forward as a PSA 'standard' for the period 2005-2008, and the Department has continued to monitor and report progress against it. Like the 335 team target, it remains part of the Healthcare Commission's Annual Healthcheck on local NHS bodies, although in this case it is used to assess the commissioning PCT rather than the provider Trust.[29]

2.13 Individual PCTs' performance for CRHT episodes in 2006-07 is shown in **Figure 8 overleaf**. The red shades indicate where the PCT reported failing to meet its allocated target, and the blue where the PCT reported meeting or exceeding its target.

7 The number of reported CRHT episodes/service users treated has increased rapidly between 2002-03 and 2006-07

Year (1 April-31 March)	CRHT episodes carried out	CRHT service users treated
2002-03	28,460	28,460
2003-04	45,769	45,769
2004-05	69,022	69,022
2005-06	83,804	67,580[1]
2006-07	95,397	75,868[1]

Source: Department of Health Local Delivery Plan Returns

NOTE

1 The Department's guidance for the definition of a CRHT episode was modified in 2005-06 to allow repeat episodes with the same person to be counted separately. Previously, repeat episodes delivered to the same person could not be counted against the episode target, and hence the 'episodes carried out' and 'service users treated' figures are the same prior to 2005-06. The modified guidance also tightened the definition of a CRHT episode (for example confirming that one contact between a team and a service user does not equal one episode), hence the apparent fall in the number of service users treated between 2004-05 and 2005-06.

2.14 As Figure 8 shows, in 2006-07 just over half (78 of 152) of PCTs failed to meet their allocation of the national target. Of the 78 that failed to meet their allocation, 12 were within ten percent of their episode target but 23 missed their target by more than 50 per cent. Of the 74 that met their allocation, 35 were within ten per cent and 14 exceeded their target by more than 50 per cent.

2.15 Although the maps at Figure 8 and Figure 5 do suggest some broad associations between PCTs' spend on CRHT and their performance against the target, two other factors are also relevant. In addition to residual data-quality issues (see below, paragraph 2.16), local variations in commissioning practice can also have an impact. For example, where groups of neighbouring PCTs commission services jointly, they often apportion the bulk of this expenditure to a single 'lead' organisation, meaning that more direct correlations between spend and activity may not be apparent. Also, local variations in the way teams are set up and resourced can affect the effectiveness of local spend, as is considered further in Part 3 below.

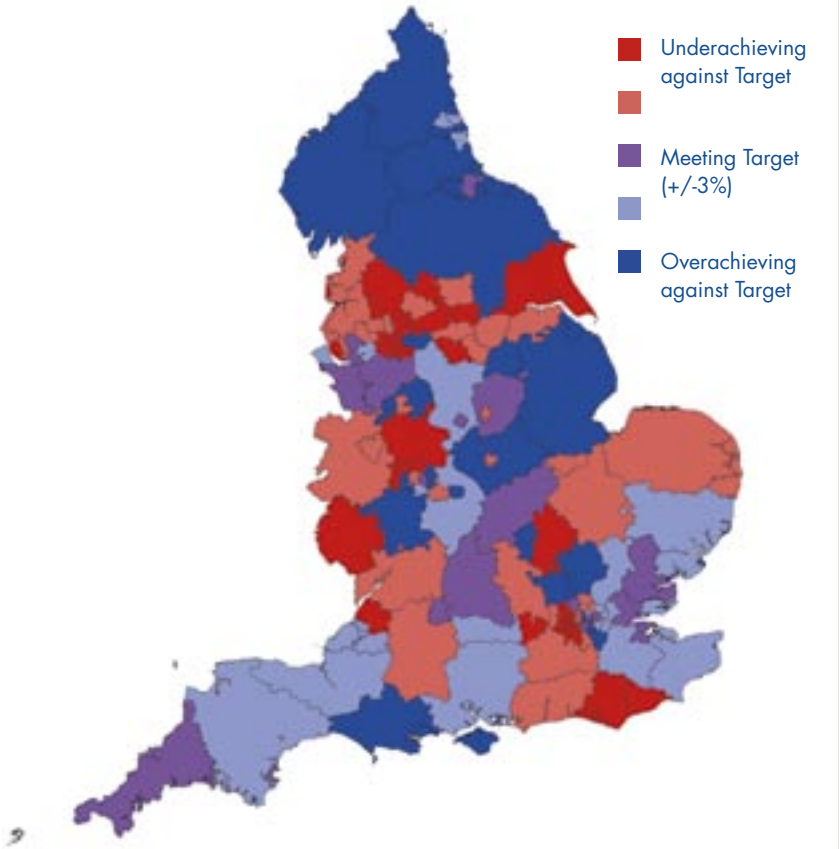
There have been concerns over data quality for CRHT episodes, which the Department has sought to address

2.16 There have been a number of difficulties with the recording and reporting of CRHT episode data. These were first identified in Summer 2004, when the Department's monitoring of NHS bodies' performance in their Local Delivery Plan Returns (LDPRs) revealed a different data profile from what would have been expected had the guidance for capturing episode data been followed.

2.17 The Department took action to investigate these concerns, and carried out a pilot survey of 30 well-established teams to examine how the data was being recorded. The survey identified that different teams were using inconsistent methods of counting activity which failed to comply with national guidance. The Department therefore commissioned a larger technical review to examine the data being presented in the LDPRs. This found a number of causes for concern, chiefly:

- Teams had been reporting activity which they felt constituted valid CRHT episodes, but which did not fit the strict definition of an episode set out in the Policy Implementation Guidance.
- There were risks of duplicate episode data, either through teams reporting repeat episodes with the same service user (which were not allowed under the definition of an episode in place at the time), or through PCTs being unable to filter information so that only activity relevant to their own catchment area was included.

8 There has been large variation in individual PCTs' reported performance against their CRHT episode target



Source: Healthcare Commission data for 2006-07 NHS performance rating

2.18 To address these concerns, the Department issued revised guidance on counting CRHT episodes in November 2005. CRHT teams are now required to report performance against a tighter definition of a CRHT episode, hence the apparent reduction in the number of service users treated between 2004-05 and 2005-06 (Figure 7).

Although not based on robust modelling, the 100,000 episode target has driven rapid implementation of CRHT. However, more sophisticated metrics are now needed

2.19 The Department acknowledges that the national CRHT episode target was not derived from detailed modelling of likely demand. Although it gave some consideration to the caseloads reported by early adopter CRHT teams and hospital admissions of the relevant client group, the Department saw the target chiefly as a driver to implementation rather than a precise representation of demand for the new service.

2.20 In setting a target for episodes, the Department was emphasising the outputs achieved by CRHTs rather than outcomes. Accordingly, although both the team target and episode target remain part of the Healthcare Commission annual health check for 2007-08,[30] the Department is planning to supplement these targets by encouraging the development of more locally managed and outcomes-based metrics from 2008-09.[31] This provides an opportunity to implement metrics that allow a more rounded assessment of the local acute services of which CRHT teams are part. Measures supporting a more integrated view of the whole acute care pathway (e.g. monitoring the ratio between inpatient admissions and CRHT episodes), rather than focusing on its individual elements in isolation, would help to encourage a 'joined-up' approach by local teams and service providers.

2.21 To utilise metrics based on mental health outcomes, the NHS and the Department will require high-quality and complete data on individual service users treated. The Department's tool for recording and reporting such information is the Mental Health Minimum Data Set (MHMDS), which is intended to collect data on each individual service user, including diagnosis, care provided and an assessment based on the Health of the Nation Outcomes Scale (HoNOS). This dataset would therefore lend itself well to outcome-based measures for acute mental health services, particularly if it included details of which specific team provided a given intervention.

2.22 However, the MHMDS is not currently able to record detailed information about which individual team has carried out which intervention along the care pathway. Nor has it been fully implemented in all provider Trusts. Although basic data is being reported by all mental health providers, under 10 per cent of records nationally are being completed with HoNOS scores, and only a quarter with team type.[32] This severely limits the usefulness of MHMDS as a reporting and performance-measurement tool.

PART THREE

CRHT teams are making a significant impact, but could do even more

Experiences of CRHT reported by service users, carers and clinical staff suggest both benefits and areas of concern

> "He doesn't like taking his medication – he thinks it makes him tired. But they'd come and talk to him. […] They'd do a bit of setting up […], someone to talk to for 10–15 minutes, then he'd take it for them – really good."
>
> *Carer (Source: NAO)*

3.1 There is clear scope to obtain wider and more detailed feedback from service users and carers about their experience of CRHT services. At present, those relatively few local organisations who are seeking such feedback are doing so in a piecemeal and ad hoc fashion. To learn more about experiences of CRHT services, we collated and analysed all available service user and feedback material on CRHT teams (covering 29 teams), as well as running six focus groups of service users and carers. The positive aspects and areas of concern mentioned by these groups are shown in **Figure 9**.

3.2 In addition to our analysis of service-user and carer feedback, we also interviewed 25 ward managers and 25 CRHT managers, asking them to state the positive effects and areas of concern regarding CRHT for people in crisis. The most common responses are shown in **Figure 10**.

> "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… For example regarding the interaction of medicines: 'this will be the reaction'. So that must be taken into account, because we're going to be the nurse, consultant, everything at home."
>
> *Carer (Source: NAO)*

3.3 Several CRHT and ward managers interviewed at the 25 sites gave views on whether CRHT causes an increased burden on carers. CRHT managers reported a number of examples of where carers' preferences had an influence on the decision to admit. One such example was where carers had requested that a service user be admitted, perhaps because they were not coping with the situation, or were feeling threatened.

9 Service users' and carers' experiences of CRHT reflect both positive aspects and areas of concern

Positive Aspects

- The welcome option of an alternative to hospital admission.
- The opportunity to remain in a familiar environment and retain links with everyday activities.
- The comfort of knowing that help was available 24 hours a day if needed.
- The provision of practical help, such as taking medication, arranging transport to and from appointments and assisting with everyday tasks such as shopping.

Areas of Concern

- Demands on staff and resources meant that service users were not always seen as frequently, promptly or for as long as they wished.
- Communication problems between inpatient and CRHT teams on discharge had sometimes meant interruptions in care.
- Users experienced anxiety or distress if their call could not be answered immediately, or if a visit was postponed or cancelled.
- Changes between shifts meant that service users were seen by several different team staff members in succession, making it more difficult to build trust and therapeutic relationships between service user and provider.

Source: National Audit Office focus groups and analysis of service user feedback

3.4 In our examination of admissions, of the 320 cases where a preference had been indicated by a service user or carer, we found 81 per cent of decisions had been in line with those preferences. The majority of cases (69 per cent) where the preference had no influence were compulsory detentions under the Mental Health Act, where it may not be feasible to take such preferences into account.

CRHT services have been associated with reduced pressure on beds

3.5 Department of Health guidance states as one of the key objectives for CRHT that 'inpatient admissions and pressure on beds should be reduced'.[33] This aim was also set out in the NHS Plan, which stated that CRHT teams would help to 'reduce pressure on acute inpatient units by 30 per cent.'[34]

3.6 Since 2000-01 (the year the NHS Plan was published) overall adult acute inpatient admissions in England have decreased by 21 per cent **(Figure 11)**. The number of occupied bed days has fallen by 11 per cent in the same period.[35] While both figures are lower than the 30 per cent aimed for in the NHS Plan, they do indicate that the roll-out of CRHT has been accompanied by significant progress in the direction intended.

10 CRHT and Ward Managers also report both positive aspects and areas of concern

Positive Aspects

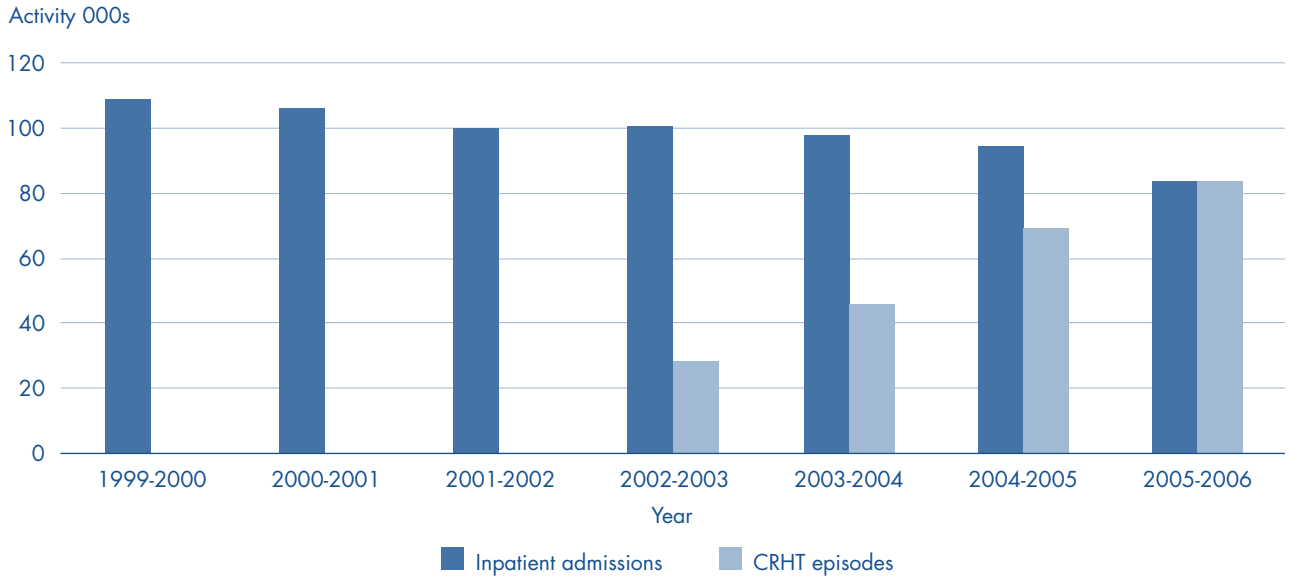
- Increased service user choice.
- Keeping service users in a familiar environment.
- Decreased stigma experienced by the service user.
- Enabling the service user to stay connected to their social networks.
- More appropriate admissions resulting, with beds taken by those who really need them.

Areas of Concern

- Risk of increased pressures on carers when service users are treated at home.
- Decreased expertise and/or loss of jobs on inpatient units.
- Capacity to treat at home did not always meet demand.
- Some service users (and carers) sometimes preferred admission, so offering home treatment may be contrary to their first choice.

Source: National Audit Office interviews with CRHT and ward managers at 25 NHS sites

11 Inpatient admissions have fallen as CRHT treatments have increased



Source: North East Public Health Observatory analysis of Hospital Episode Statistics and Department of Health Local Delivery Plan Returns

NOTE
2002-03 was the first year the Department collected CRHT episode data.

3.7 As Figure 11 reflects, overall inpatient admissions have fallen as the number of CRHT episodes has increased. However, the reduction in the number of admissions is considerably smaller than the number of CRHT episodes, for a number of reasons:

- A CRHT episode can be followed by an admission, for example where the service user's crisis worsens and the CRHT team decides that admission is now necessary.
- CRHT teams have an important role in enabling early discharge following an admission (see below, paragraph 3.11), and the Department's revised 2005 guidance allows cases where teams provide CRHT to an inpatient on discharge to be counted as episodes.[36] Our examination of inpatient admissions found that approximately four out of ten discharges were early discharges with support from a CRHT team (paragraphs 3.12 and 3.13).
- One further explanation for this large disparity between new CRHT episodes and reduced admissions is suggested by our referrals audit, which found that CRHT teams assessed 15 per cent of the referrals they received as being inappropriate, but nonetheless agreed to accept that service user as a CRHT client.

3.8 A 2006 study of inpatient admissions and CRHT team data by researchers at the North Eastern Public Health Observatory found that PCT areas with CRHT teams – particularly with 24/7 access – reported greater reductions in inpatient admissions than those without. Between 1999 and 2004, inpatient admissions fell by 10 per cent more in the 34 PCT areas with CRHT teams in place since 2001, and by 23 per cent more in the 12 of these on call around the clock than in the 130 areas without such teams by 2003-04.[37]

3.9 Our own analysis of inpatient bed days (which differ from admissions by taking into account variations in the length of stay) between 1999-2000 and 2005-06 found that those PCT areas with a 24/7 CRHT team in place by 2000-01 saw considerably greater reductions in bed usage than those without access to a team during the same period. Average inpatient bed days per head of population (weighted for mental health need) fell by 21 per cent in the group with access to a 24/7 CRHT team compared to 10 per cent in the group without any access to a CRHT team by 2005-06 **(Figure 12)**.

3.10 More direct evidence of the contribution of CRHT teams to reducing admissions was provided by our interviews with CRHT managers about the recent referrals received by their teams. Out of a sample of 500 such referrals, 234 referrals had resulted in the service user receiving CRHT. Of these, the managers reported that they thought that over half were 'very likely', and another third were 'quite likely', to have been admitted if the CRHT team had not been in place.

12 Early adopters of 24/7 CRHT teams have seen greater reductions in inpatient bed days than areas without teams

Source: National Audit Office, using North East Public Health Observatory analysis of Hospital Episode Statistics and Adult Service Mapping

CRHT teams are facilitating early discharge but their involvement is currently limited

> "Well, my team actually helped me get out of hospital [...] I was home for Christmas, which I spent with the kids."
> *Service user (Source: NAO)*

3.11 The Department intends one of the core functions of CRHT teams to be facilitating early discharge of service users from inpatient wards. Having been involved in all admissions through their gatekeeping role, the team should be well placed to identify the reasons for admission and – through close contact with the inpatient team – monitor whether these reasons continue to exist, and what needs to happen prior to the service user being discharged. Even if the service user has been admitted without CRHT involvement, the CRHT should still play a role in facilitating early discharge.[38]

3.12 In our interviews with ward managers about the most recent admissions to their wards we asked about the involvement of CRHTs in discharges. In a sample of 500 admissions, 189 service users had already been discharged by the time of the interviews and the managers reported that CRHT staff had been involved in 43 per cent of these discharges. They reported that involvement of CRHT staff had resulted in earlier discharge in 85 per cent of these cases.

3.13 Among the 311 cases where discharge had not yet occurred, the managers reported that CRHT staff were very or quite likely to be involved with 53 per cent of these cases, and the managers thought that this would result in earlier discharge in some four out of five of these cases. The likelihood of CRHT staff involvement was much higher when CRHT staff were gatekeeping the majority of the admissions to the ward – 70 per cent of cases compared to 47 per cent (both figures excluding "don't knows").

3.14 There is scope to raise awareness of the contribution CRHT teams can make to facilitating early discharge. In our referrer survey, only three per cent of respondents overall – and seven per cent of psychiatrists – mentioned the ability to facilitate discharge as a strength and benefit of CRHT services. We also found that in around one case in every eight in our admissions audit, either the CRHT team was unaware that a service user had been discharged, or believed that the service user had been discharged when they had not. This suggests scope to improve communications and joint working between ward and CRHT staff to improve the identification of people who would benefit from CRHT support following discharge.

3.15 Full national data on the extent to which teams are facilitating early discharge has been limited to date, but the Healthcare Commission is currently gathering bespoke data as part of its Acute Inpatient Mental Health Service Review. The resulting report, due to be published in Spring 2008, will provide a much more detailed picture of how successfully teams are facilitating early discharge from acute inpatient wards.

More admissions could be gatekept

3.16 The Department's aim[39] is that "everybody (including people in need of mental health act assessments) requiring emergency access to acute mental health services (CRHT and inpatient) should go through a full gatekeeping process", which requires:

- "The CRHT team actively involved in all requests for admission.
- The CRHT team being notified of all pending Mental Health Act (MHA) assessments.
- The CRHT team assessing all these cases before admission happening.
- The CRHT team being central to the decision making process in conjunction with the rest of the multi-disciplinary team."

3.17 In our interviews with ward and CRHT managers, we explored the extent to which CRHT is being considered as an alternative to inpatient admission. In our sample of 500 admissions, we found that CRHT staff had been involved in 53 per cent of admissions and had had a bearing on the decision to admit in 46 per cent. Having a CRHT staff member at the assessment significantly improved the chances that the assessment would consider whether CRHT was an appropriate alternative to admission – CRHT had been considered in 87 per cent of cases where CRHT staff had been involved in the admission but in only 12 per cent of cases where they had not.

3.18 We found that the policy of gatekeeping all potential admissions is being interpreted and implemented differently in different areas. For instance, both ward and CRHT managers told us that there are occasions when the CRHT staff need not have a bearing on the decision to admit. But when ward manager and CRHT manager views on specific cases were compared, they disagreed on whether CRHT staff should or should not influence the decision to admit in a third of cases.

3.19 The common reasons given for those admissions where an assessment for CRHT did not take place were:

- **Where the admission was part of a Mental Health Act assessment.** Practice differed between teams on whether to involve CRHT staff in assessments for formal admission (i.e. detentions under the Mental Health Act). CRHT staff were involved in about a third of such assessments but such assessments also made up 44 per cent of the cases in which CRHT teams were not involved in the decision to admit. Even so, CRHT staff were not involved in 42 per cent of admissions not involving detention, indicating significant scope for them to be productively involved in more admissions. And even where an admission involves detention, there will be potential value in early involvement of the CRHT team to support planning for discharge after the completion of inpatient treatment.
- **Where CRHT and medical staff work in teams that are separate rather than integrated.** As outlined above (paragraph 2.9), CRHT teams are staffed primarily by nurses, and in some areas contain no medical staff. CRHT managers reported that where medical staff operate in teams separate from the CRHT team, the lack of an integrated pathway for the referral and assessment process creates a key barrier to effective gatekeeping. Consultant psychiatrists managing acute teams that were separate from CRHT teams were principally identified as by-passing the CRHT teams, but assessments elsewhere, for example by duty doctors in accident and emergency departments, were also identified. Altogether, direct admissions by medical staff were highlighted on 27 per cent of the cases in which CRHT teams were not involved in the decision to admit.
- **Where the admission was the result of a transfer from another inpatient ward.** Interviewees reported that transfers are often the result of an agreement established between inpatient units, with early discharge/discharge to CRHT possibly being considered at the next ward round or bed management meeting, after the service user has settled into the receiving ward. Such transfers were highlighted in eight per cent of the cases in which CRHT teams were not involved in the decision to admit.

3.20 Our analysis compared whether teams that were staffed 24/7 were involved in the majority or minority of the admissions reviewed, and compared this against teams that were not. It shows that teams that are staffed 24/7 are significantly more likely to be involved in the majority rather than the minority of admissions.

3.21 The Healthcare Commission has been collecting bespoke data from every provider trust on the proportion of admissions gatekept by CRHT teams. This data, due for publication in Spring 2008, will provide a more detailed picture of how far gatekeeping has been achieved across the country, as well as highlighting potential to improve gatekeeping levels to those achieved by the best-performing organisations.

Around one in five admissions might still be avoided

3.22 Both ward and CRHT managers reported instances of patients being admitted even when the managers considered the service user an appropriate candidate for CRHT – ward managers reported this in 16 per cent of the 500 admissions examined. CRHT managers reported that for 20 per cent of the service users referred to them who had subsequently been admitted, the admission would have been better avoided.

3.23 The reasons given why service users had been admitted in these cases varied widely, but included insistence by the Consultant Psychiatrist, accommodation problems or homelessness, patient preference and carers' anxiety about being able to cope. These indicate areas in which strengthening CRHT services and links to other services would provide scope to further reduce admissions in appropriate cases.

Some local NHS providers report a reduction in out-of-area treatments associated with CRHT teams, but routine data is not available nationally

3.24 One of the intended impacts of CRHT services was that there would 'generally be no out-of-area admissions which are not clinically indicated'.[40] An out-of-area admission (or out-of-area treatment, 'OAT'), occurs when a service-user is admitted to an inpatient ward outside pre-arranged service agreements or geographical catchment areas, often owing to lack of local bed capacity. OATs generally cost more than local NHS admissions, and often take service users further away from their homes, families and social networks.

3.25 A number of NHS providers report a reduction in OATs associated with their CRHT teams, but there are currently no routine national OAT data available to inform robust large-scale analysis. The Department and the Healthcare Commission have attempted to develop a standard metric for OATs, but have faced difficulties in defining the catchment areas and service relationships beyond which an admission can be considered an OAT. Until these difficulties are resolved, a full and robust analysis of the extent to which CRHT teams are reducing OATs will remain extremely difficult.

Alternatives to admission as well as home treatment (e.g. crisis houses, respite housing, acute day units) provide valued support for acute services, but provision is patchy

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

3.26 The broad range of choice for a person in crisis remains quite limited: they can either engage in short-term intensive home-based treatment, or be admitted to hospital. Indeed, very few alternatives to hospital are available to CRHT teams beyond their own staff providing therapy to service users in service users' homes. Several CRHT managers suggested that access to alternatives to hospital admission could increase their capacity for delivering CRHT: four of the 25 identified a need for short term respite or crisis accommodation, and three identified a need for acute day hospitals.[42]

3.27 Respondents 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. In some instances, CRHT teams are making use of temporary accommodation such as Salvation Army hostels, night shelters and bed and breakfast accommodation.

3.28 Healthcare Commission data from their 2006 review of Community Mental Health services[43] reported 420 crisis accommodation places across the whole of England; 46 per cent of the 174 Local Implementation Teams in England reported that they had no crisis accommodation places available, rising to 59 per cent for out-of-hours places. £8.5 million (0.2 per cent of all mental health spend on working-age adults) was spent on crisis accommodation in 2006-07.[44] The Healthcare Commission has also been assessing availability and take-up of alternatives to admission as part of its 2007 Acute Inpatient Mental Health Service Review, and will be reporting detailed findings in Spring 2008.

CRHT services are generally receiving appropriate referrals, but could function more efficiently if referrers better understood the appropriate client group

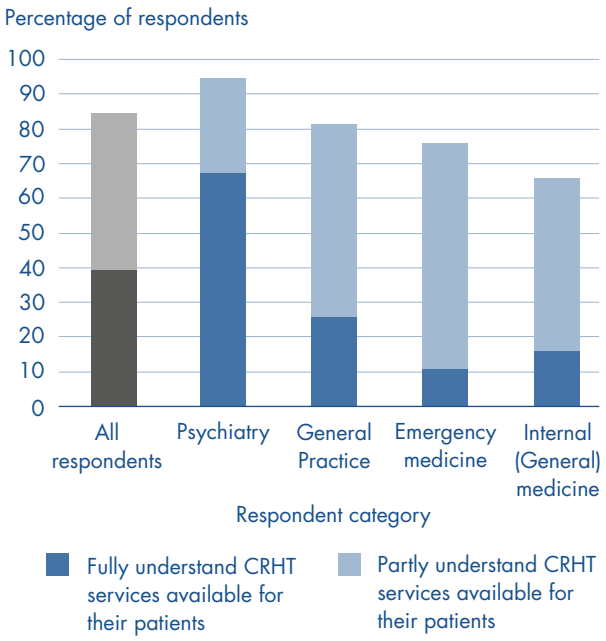
3.29 CRHT teams provide an essential element of an acute care service, but they need to be clearly understood and accepted by other players in the complex landscape of mental health services (Figure 3). Failure to develop proper communication links can mean that CRHT teams spend time assessing inappropriate referrals, since referrers may not understand what CRHT teams do and who their client group is. This can introduce inefficiencies into an already complex system.

3.30 Although only eight per cent of respondents in our referrer survey cited poor communication and continuity with other services as a shortcoming of CRHT services, and only ten per cent mentioned lack of clarity around referral criteria, many referrers did not feel they understand fully either the services which CRHT teams can provide or the client group they are intended to serve. As **Figure 13** illustrates, while 85 per cent of referrers overall stated that they understood at least partly the CRHT services available to their patients, only 39 per cent stated that they understood these services fully. Within individual specialties, this proportion was particularly low within emergency medicine (11 per cent), general practice (26 per cent) and internal general medicine (16 per cent). Even amongst psychiatrists, many of whom will have regular contact with (or even be providing) CRHT services, a third felt they did not understand fully the CRHT services available to their patients.

3.31 We also asked if respondents understood the client group that their local CRHT team accept for referrals. Although 81 per cent overall stated that they understood this client group at least partly, only 15 per cent of emergency medics, 18 per cent of GPs, 16 per cent of internal general medics and 55 per cent of psychiatrists said they understood fully the client group that their local CRHT team would accept for referrals.

3.32 The Department's intention is that CRHT teams only see service users who are acutely ill. However, our audit of 500 referrals to CRHT services suggested that teams are assessing and treating some service users who are not in this category. In at least 169 of our 500 sample referrals, it appeared that the CRHT team had diverted or signposted the patient to non-acute services (such as primary care or Community Mental Health Teams). This again indicates a lack of understanding among referrers of the intended role of CRHT teams, and several teams commented to us that it represented a poor use of their specialised resources.

13 The majority of referring clinicians feel they understand CRHT services at least partly, but few feel they understand them fully



Source: National Audit Office survey of 597 referring clinicians, excluding 64 who reported that there were no local CRHT services

PART FOUR

When operating as intended, CRHT services can benefit service users and reduce costs

Clearer communication and more joined-up patient pathways would benefit service users

4.1 Previous research into CRHT and service user satisfaction suggests that the majority of service users and carers prefer the option of CRHT to inpatient admission.[45] Our analysis of qualitative service user and carer data suggests that many negative experiences of NHS mental health services are linked to perceived breakdowns between different elements of the care pathway, and in particular the interface between inpatient wards and community teams (including CRHT). Conversely, a smooth transition from one element of the service to another can have a positive impact both on the personal confidence of service users and carers and on more practical issues such as safety and medicines management.

Economic modelling suggests savings to the NHS if CRHT inpatient services are considered as an alternative to admission in appropriate cases

4.2 Although the main aim in introducing CRHT services is to improve service, they also offer scope for improving the efficiency of mental health spending, for two reasons:

- **Shorter periods of treatment compared to in-patient treatment.** The median length of stay for admitted patients in England is 40 days for schizophrenia and 33 days for bipolar disorder,[46] whereas CRHT usually stretches over a period of around 28 days.
- **Lower costs per day of treatment.** The average cost per inpatient day is £201.[47] Costs of providing CRHT will depend on factors such as the intensity or level of visits needed, but typically, the cost per day for home visits is between £43 and £21.[48]

4.3 We commissioned the London School of Economics and King's College, London to develop a decision model to compare the costs of a service in which CRHT is available as an alternative to inpatient treatment, and considered in all appropriate cases, with one in which it is not. For each of these approaches, the model identifies the treatment pathways available, assesses the probability of each path being used, and uses estimates of the cost of each path to estimate the likely costs of the two approaches.

4.4 The probabilities used in the model were based where possible on our audit of 500 admissions and 500 referrals across 25 sites in England, as well as other literature. Where no evidence was available, we used estimates which were discussed with members of our expert panel. The costs assigned to the different services were taken from various published sources.[49]

4.5 The economic modelling concluded that a mental health service in which CRHT is available, and considered in all appropriate cases, would save approximately £600 per crisis episode compared to a service in which CRHT is not available or considered. The difference in costs arises chiefly because some admissions will be avoided altogether, or will be of a shorter duration, reducing the costs incurred with overnight stays.

4.6 The modelling included sensitivity analysis to assess the potential impact of local variations in service and to check the sensitivity of conclusions reached to variations in the probability estimates. The sensitivity analysis showed that the conclusion that services which consider CRHT as an alternative to admission would be more efficient was robust under a wide range of probabilities.

Efficiency savings could be created if CRHT services saw more of their intended client group

4.7 Our examination of inpatient admissions (paragraph 3.17) found that CRHT staff had been involved in 53 per cent of admissions, and that having a CRHT staff member involved significantly improved the chances that the assessment would consider whether CRHT was an appropriate alternative to admission. Department of Health policy is that CRHT teams assess all potential admissions so that home treatment may be given in all appropriate cases, and we therefore estimated the potential impact if this was done.

4.8 The potential impact depends mainly on the extent to which the proportion of cases in which CRHT teams were involved in admissions (the "gatekeeping rate") can be increased, and results in more patients being identified as being appropriate cases for CRHT. As a minimum, analysis of gatekeeping rates among the 25 teams we examined showed that, although the average gatekeeping rate was 53 per cent, the rate for individual teams varied from 5 per cent to 85 per cent. On the basis that those teams below the average increased gatekeeping to the average, we estimated a potential for savings to the NHS of around £12 million a year. Even greater savings might be possible from further increasing gatekeeping, potentially saving up to £50 million a year if the gatekeeping rate could be raised to 90 per cent. Achieving such savings would be conditional on success in addressing the issues highlighted in Part 3 above, but their achievement would provide the means of making the resourcing improvements highlighted in Part 2.

Realising these benefits requires careful management

4.9 Our interviews with CRHT and ward managers highlighted a number of potential impacts on inpatient units from increasing the use of CRHT **(Figure 14)**, both in terms of the profile of the service users that would remain in inpatient care and the impact on staffing.

4.10 Accordingly, in realising benefits from the greater use of CRHT, local planners need to recognise that the staffing requirement of inpatient facilities will not decrease in proportion to any reduction in the inpatient population. Any potential savings from the CRHT team reducing pressure on the wards will therefore need to be balanced with the continuing need of patients and staff on the wards for a high-quality therapeutic environment. There will also be value in developing staffing arrangements such as joint management structures or rotation of inpatient and CRHT staff, both to promote effective communication and relationships between inpatient and CRHT services and to help manage this potential impact on the working environment of staff in inpatient wards.

14 Increasing the use of CRHT could have impacts on inpatient units

According to CRHT and ward managers, the impacts of CRHT teams include:

- A reduction in admissions had happened in some sites or was expected to happen in others.
- Service users in inpatient wards would, on average, be more acutely ill and exhibit higher levels of challenging behaviour, since less ill service users would increasingly be treated at home and make up a smaller proportion of those admitted.
- Similarly, levels of risk and violence on the inpatient wards could increase because of the changing profile of those being admitted, particularly a larger proportion of service users with acute psychosis, mania or dual diagnosis (suffering from more than one condition).
- Quality of inpatient care was suffering due to the drain of experienced staff from the wards to community teams.
- A higher proportion of admissions would be appropriate, and admissions would be shorter due to the ability to discharge people earlier into home treatment.

Source: National Audit Office interviews with CRHT and ward managers at 25 NHS sites

GLOSSARY

Acute services/care	Acute services treat episodes of serious illness with a rapid onset and relatively short duration (as opposed to 'chronic' illnesses which have indefinite duration).
Annual Healthcheck	The Healthcare Commission's (q.v.) framework for assessing the performance of NHS Trusts and Primary Care Trusts. It replaced the previous 'star rating' system from 2005-06.
Assertive Outreach Team	Assertive Outreach Teams provide intensive support for people who are 'difficult to engage' in more traditional services.
Care pathway	A pre-determined plan designed for service users with a specific diagnosis, which determines the route they take through relevant health services.
Care Services Improvement Partnership (CSIP)	A regionally based Department of Health-funded organisation that aims to support NHS mental health and care services in implementing national policies, share positive practice and research, and encourage organisations to work in partnership across sectors.
Community Mental Health Team (CMHT)	A multi-disciplinary team offering specialist assessment, treatment and non-acute care to people in the community.
Crisis Resolution and Home Treatment (CRHT) team	A service aimed at treating adults with severe mental health difficulties in the least restrictive environment and with the minimum disruption to their lives. It acts as a "gatekeeper" for admission to acute mental health services, and where appropriate provides intensive multi-disciplinary treatment at the service user's home. Where hospitalisation is necessary, the team also assists in planning and facilitating early discharge.
Early Intervention (EI) service	Early intervention services provide treatment in the community for young people with psychosis, seeking to improve their long-term health and well-being by early diagnosis and treatment.
Emergency medicine	As used to classify respondents in our referrer survey, a clinician working in an accident and emergency department.

Gatekeeping	A key intended function of CRHT teams (q.v.), whereby they should assess every person requiring access to acute (q.v.) mental health services. The team should play a central role in deciding whether the service user should be admitted, given CRHT at home or redirected to another service.
Healthcare Commission	An independent body which inspects the quality and value for money of healthcare and public health, equips patients and the public with information about the provision of healthcare and promotes improvements in healthcare and public health.
Health of the Nation Outcome Scales (HoNOS)	A standardised mental health outcome assessment measure, based on a series of scales completed after routine clinical assessments.
Hospital Episode Statistics (HES)	An official dataset managed by the Information Centre (q.v.) containing details of all admissions to NHS hospitals in England.
Information Centre (for Health and Social Care)	A special health authority responsible for providing data to help the NHS and social services run effectively.
Internal General Medicine	As used to classify respondents in our referrer survey, a clinician who identifies with general medical care in a secondary care setting in favour of a speciality or sub-speciality interest.
Local Delivery Plan (LDP)	The framework agreed between individual Strategic Health Authorities and Primary Care Trusts for the delivery of local healthcare priorities.
Local Delivery Plan Return (LDPR)	A return made by Primary Care Trusts (q.v.) to Strategic Health Authorities (q.v.), reporting progress against targets in Local Delivery Plans (q.v.).
Local Implementation Team (LIT)	Local Implementation Teams plan and monitor the mental health National Service Framework (NSF) locally. They are made up of representatives from most agencies responsible for planning, commissioning and providing mental health services locally, and include representatives of the voluntary sector and service users and carers.
Mental Health Act (MHA)	The Mental Health Act allows people with different types of defined 'mental disorder' to be 'sectioned' or detained for treatment against their will.
Mental Health Minimum Data Set (MHMDS)	A dataset managed by the Information Centre (q.v.) intended to cover adult (including elderly) service users in England receiving specialist mental health care. Since April 2003 all providers have been required to maintain such a dataset. MHMDS currently includes over 100 data items. These items include: demographic information, such as age, sex and ethnicity; information on care management; assessment information such as diagnosis and HoNOS (q.v.) rating and details of care provided.
Mental Health Trust/Foundation Trust	An NHS organisation providing specialist mental health services, commissioned by one or more Primary Care Trusts (q.v.). Mental Health Trusts provide the majority of staff and resources for CRHT teams, with additional input from local social services.

National Institute for Mental Health in England (NIMHE)	An organisation now subsumed within the Care Services Improvement Partnership (q.v.). Its three strategic priorities are: system transformation, workforce development and ensuring that service users have rapid access to the best possible care.
National Service Framework (NSF)	The NSF for mental health was introduced by the Government in 1999. It establishes a set of minimum national standards of clinical quality and access to services in mental health. The objective of the NSF is to drive up performance and decrease geographical variations in care standards.
Out-of-Area Treatment (OAT)	An admission of a service-user outside pre-arranged service agreements or geographical catchment areas, often owing to lack of local bed capacity. OATs generally incur higher costs than treatments carried out under existing service agreements.
Policy Implementation Guide (PIG or MHPIG)	A number of policy documents produced by the Department of Health to support the NHS in implementing the National Service Framework for Mental Health (including CRHT).
Primary Care Trust (PCT)	The organisation responsible for planning and commissioning health services and improving the health of a local population. There are 152 Primary Care Trusts in England (303 prior to 1 October 2006).
Strategic Health Authority (SHA)	The body responsible for performance-managing NHS organisations within its geographical region. There are 10 SHAs in England (28 prior to 1 July 2006).

APPENDIX

Methodology

1 We designed this study to examine whether the Department of Health's aims for Crisis Resolution Home Treatment services are being delivered. This involved an audit of whether CRHT teams were seeing the people they are supposed to see, of how CRHT services are configured across England, and of their performance and funding. We did not examine clinical effectiveness; rather, the purpose was to examine whether the planned activity and intended impacts prescribed for CRHT services were taking place on the ground. The main strands of our methodology are set out below.

Audit visits

2 We commissioned a specialist mental health consultancy, Practice-Based Evidence, to conduct 25 audit visits to sites across England, representing a cross-section of location, structure and current practice. The audit visits (conducted over February to April 2007) consisted of scripted interviews with 25 ward managers regarding the most recent 20 admissions to that ward, followed by further questions regarding their relationship with, and understanding of, the CRHT team attached to that ward. The CRHT team that served this ward was also interviewed regarding these admissions, its working relationship with the ward staff, and the last 20 referrals/assessments. Details of the work done and the findings are set out in *Are Crisis Resolution & Home Treatment Services Seeing The Patients They Are Supposed To See?* available on the NAO website.

Economic modelling

3 We commissioned the Centre for the Economics of Mental Health, Health Service and Population Research Department, King's College London, to construct an economic model to assess the impact of considering CRHT as an alternative to inpatient services in all appropriate cases. The model was developed to compare the costs of two service models for treating people experiencing a psychiatric crisis. In the first, Home Treatment (HT) is considered as an alternative and supporting service alongside inpatient services; in the second, CRHT services are not available. Probability and cost values for the model were obtained from a NAO audit of CRHT teams and published figures. Sensitivity analyses were carried out to assess the robustness of the model. The full paper describing this work is available on the NAO website.

Referrer survey

4 The survey sought the opinions of potential referrers to CRHT services. Doctors.net.uk (who provide internet services to some 142,400 doctors across the UK), carried out the survey and a summary of their findings is available on the NAO website. The main fieldwork took place between 16 and 26 March 2007. Respondents were taken from the disciplines of Psychiatry, Emergency Medicine, General Practice and Internal General Medicine. Additional fieldwork was undertaken between 1 and 5 June 2007 to include additional respondents in the Psychiatry speciality. In total, 597 respondents participated. The main areas covered in the questionnaire were: the number of patients that respondents are seeing with a mental health concern; action for presenting patients; understanding of CRHT services; strengths and weaknesses of CRHT services; CRHT service referrals and inpatient admissions. In addition to the initial analysis by Doctors.net.uk, the NAO conducted further in-house analysis and coding of the qualitative responses received to open questions.

Focus Groups and Service User feedback

5 We contacted the 89 CRHT teams who reported in the 2006 national CRHT survey[50] that they had carried out patient/carer feedback work, and requested full details of their methodology and results. 29 teams were able to provide us with such material. This, with due regard to the diverse sampling and survey methodologies and the lack of NAO control over data collection, was used as a basis for qualitative analysis to identify key themes and experiences. We also commissioned the Health and Social Care Advisory Service (HASCAS) to convene and facilitate six focus groups to obtain the views of carers and service users regarding both CRHT and inpatient services.

Activity, finance and service mapping

6 To explore patterns of CRHT and inpatient service provision, activity and financial expenditure, the following datasets were analysed at Primary Care Trust/Strategic Health Authority and national level:

- Hospital Episode Statistics (1999-2006)
- Adult Mental Health Finance Mapping (2002-2007)
- Adult Mental Health Service Mapping (2000-2007)
- Department of Health Local Delivery Plan returns (2002-2007)
- Department of Health/ONS population data (2001 census, using updated Department of Health PCT-level estimates for 2007 analysis where appopriate)

The Department's Mental Health Needs index was used to produce weighted populations for each PCT and SHA area, and historical financial figures were uplifted to 2006-07 levels using the Hospital and Community Health Services Pay and Prices Index, (Curtis and Netten 2006); as the 2007 uplift figure was not yet available, this was predicted using an average of the percentage increase over the previous four years. Expenditure was made comparable between areas by applying the Department of Health's 'Market Forces Factor' and 'Emergency Ambulance Cost Adjustment' indices to the crude expenditure figures.

Expert Panel

7 The National Institute for Mental Health in England Acute Care Programme Steering Group acted as a reference panel for this study. We also liaised regularly with the Healthcare Concordat Mental Health Advisory Group (which comprises regulatory and research bodies within the mental health sector). The following individuals provided extra individual input to this report, for which we are grateful:

Nick Adams, Acute Lead, CSIP West Midlands

Ian Allured, Regional Director East and Adult Mental Health Lead, Health and Social Care Advisory Service

Fionuala Bonnar, Programme Director Service Improvement, CSIP London Development Centre

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10 http://www.wao.gov.uk/assets/englishdocuments/Adult_Mental_Health_Services_Baseline_Review.pdf, p. 24. The Welsh Assembly reports that 16 LHB areas currently have CRHT services with varying levels of provision, and that six LHBs have services in development.

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38 *Guidance Statement on Fidelity and Best Practice for Crisis Services*, p. 5.

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44 Source: Department of Health/Mental Health Strategies, *National Survey of Investment in Mental Health Services 2006/07*.

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48 The cost per week of CRHT input per patient is estimated at £244 (Curtis and Netten, 2006), i.e. £976 per month. Results from Onyett et al. suggest that 63 per cent of patients receive at least daily contact with CRHT teams (defined here as 'high input'), whilst 27 per cent receive less than daily contact ('low input'). High input has been assumed to be twice as intensive as low input. Therefore (0.63 x cost of high input) + (0.37 x cost of low input) = £976. As the cost of high input is assumed to be twice that of low input, the two amounts come to £1198 and £599 respectively. These equate to £43 and £21 per day.

49 For more information regarding the methodology and sources used, please see the supplementary report *Model to assess the economic impact of integrating CRHT and inpatient services,* available on the NAO website.

50 Onyett et al. (2006). 89 of the 177 respondents answered 'yes' to the questions 'Are you evaluating the work of the team?' and 'Does the evaluation draw directly on the experience of users of the service and people that support them?'

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The role of Crisis Resolution and Home Treatment services

A report by the Comptroller and Auditor General

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