



National Audit Office

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

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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 be 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 given 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.