A National Survey of Crisis Resolution Teams in England

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Executive Summary

Aims of the survey
This survey aimed to provide a rich team-level description of the current state of implementation of crisis resolution or home treatment (CRT) teams in England, including perceived obstacles to implementation and potential ways forward.

Methodology
In order to promote the application and ownership of the findings of the survey the methodology involved team managers entering data directly via a web-site with telephone interviewer support. It also relied heavily on NIMHE development centre crisis resolution leads with respect to both designing materials and helping to collect the data. They will also be key to subsequent dissemination of the findings in this report. Their local intelligence allowed us to build a complete picture of CRTs building from the Durham University Service Mapping data. The survey included any local arrangements that had been designed to achieve the outcomes required of a CRT locally (as described in the Mental Health Policy Implementation Guide; MHPIG). A 73% response rate was achieved with most of the data collected between October 2005 and the end of January 2006.

Main findings
Numbers of teams and their locations
243 crisis resolution teams were identified. Some of these were merged teams making comparison with performance management data problematic. Teams were often subdivided for the purpose of counting teams for performance management.

Fifty five percent of teams were in urban localities, 36% suburban, and 10% rural. Around a third of teams had been taking referrals for less that a year with urban teams tending to be more established. There was no effect of urban location on the estimated percentage of caseload comprising people with severe and enduing mental health problems.

Overall progress on implementation based upon policy guidance
Only 70 teams (40%) described themselves as fully set up to meet the needs of the numbers of people in their patch who fulfilled the MHPIG criteria for CRT. Their report was corroborated using a simple scale assessing compliance with MHPIG requirements. Urban teams were the most likely to describe themselves as fully set up and conformed more to the MHPIG requirements.

Team caseloads
The mean current caseload size was 20 which is at the lower end of the MHPIG recommended range. Using the MHPIG and population data to make crude projections from the survey sample to the population as a whole (without controlling for demographic differences between regions) revealed that CRTs were seeing 59% of the projected target number of clients. Teams in the South East and South West were seeing the lowest numbers and the East and West Midlands the highest.

Age and size of teams were moderate predictors of caseload size. Older teams accepted proportionately more referrals for assessment and for ongoing work.

An estimated mean of 65% of team caseloads were judged to comprise people with severe and enduring mental health problems. All services reported accepting clients diagnosed with psychoses or affective disorders. Eighty four percent also accepted referrals of people with a diagnosis of personality disorder. Forty two percent would accept referrals with a diagnosis of substance misuse disorder.

Staffing

Teams were at around 88% of their recommended staffing capacity using the same method for projection described above. Staff capacity mirrored caseload size by region as reported above. Almost all teams had input from nurses (98%) and most had support workers (69%), but less than half had input from any of the other disciplines.

The input and role of psychiatrists

Forty four percent of teams had input from consultant psychiatrists at a mean 0.5 full time equivalent. A dedicated consultant with other medical staff was the predominant arrangement for medical cover in teams (46%). Twenty nine percent of teams received support from a community mental health team (CMHT) consultant. The functional role where teams have their own dedicated consultant was much more common in urban localities.

Gatekeeping and out of hours access

Nearly all teams, regardless of location, reported that they aimed to provide an alternative to hospital admissions to those people experiencing acute mental health difficulties. However only 68% of teams claimed that they acted as the gatekeeper to the acute inpatient beds, by assessing people referred for hospital admission. A difference between aspiration and current practice is therefore evident.

Fifty three percent of respondents reported operating a 24 hour, 7 day per week home visiting service. Sixty seven percent were available on call or on duty between 10pm and 8am. Sixty three percent reported providing a 24 hour telephone support service. All forms of out of hours access was much more usual in urban locations.

Assessment and home treatment

On average around a fifth of referrals were not accepted for assessment. Overall only two-fifths of referrals were taken on for ongoing work.

Interventions provided

The most widely and intensively provided interventions post assessment were risk assessment, monitoring of mental state, help with self-help strategies, delivering psychosocial interventions and administering medication. Around a third to a half of teams provided other key interventions around once a week or more frequently, such as therapeutic work or practical help for family members, help with housing, income, activities of daily living or expanding social networks. Thirty percent of teams reported never using advance directives. Seventy three percent of teams could initiate new medication regimes and this was most available among rural teams.

Working with the wider local system

The major and most intensive sources of referrals were CMHTs, inpatient services and A&E. Over two thirds of CRTs received weekly or more frequent referrals from primary care. Urban teams were less likely to have primary care as a frequent source of referrals.

Almost all teams described themselves as able to facilitate early discharge. Nearly half of urban teams received referrals from inpatient units at least once a day compared with 25% of suburban teams and 14% of rural teams.

Teams referred on to CMHTs inpatient services and primary care with the most frequency. Ninety three percent of respondents reported delays in referral on to the local CMHT when the crisis had resolved.

Management of teams
Eighty eight percent of teams had their own designated manager. The distribution of responsibilities for management tasks suggests a strengthening of the role of team managers with less authority for management tasks assigned to senior medical personnel or professional line managers.

Obstacles to implementation
Lack of resources and particularly staff were the most frequently cited obstacle to effective implementation- although with resources in place CRTs were not perceived as difficult to recruit to. The recruitment of medical staff was seen as the main priority, with a particular concern to achieve effective consultant cover. Social workers and ASWs were the next major staffing priority.

Inter- team problems were the next most frequently cited obstacle to effectiveness, particularly with respect to the CMHT capacity problems referred to above. The next most frequently cited concern was the local attitude of medical staff to CRTs, and issues related to change and reorganisation.

Actions and resources for development
In line with the obstacles cited above, more staff was the most frequently cited "useful developments or actions that would improve the effectiveness of the service". Beyond this the perceived priority was an improved local crisis response through greater availability of crisis beds and housing and a better coordinated "whole systems" response. Although some practical innovations were cited, in general this referred to the need for a better local understanding of the CRT's gate keeping role.

Seventy one percent of teams reported that they were evaluating their work, although only a third claimed to be able to supply further written details of the evaluation and half drew directly on the experience of service users.

Effective team working and collaboration with other parts of the local system were cited as the key factors underpinning successful CRT working.

Fifty two percent of respondents had received formal training on the establishment or running of crisis resolution services. Very often this had been provided by the Sainsbury Centre for Mental Health which has ceased training provision. Outstanding training needs concerned interventions and clinical skills; collaborative working; understanding wider trust systems and policies; and management support and leadership.

Respondents saw CSIP as a resource for networking and sharing information, training and bespoke team support.

Conclusions
Although almost all teams aspire to offer an alternative to admission, around a third is not involved in gatekeeping. Just over half offer a 24 hour, seven-day per week home visiting service and teams report considerable pressure of referrals for assessments that do not subsequently lead to home treatment. This is likely to impact on capacity for home treatment and therefore the likely impact on inpatient bed use.

Urban teams make up the majority of CRTs, operate with greater fidelity to the MHPIG, and take on a larger proportion of referrals for ongoing work.

CRTs widely reported a lack of staffing as the key obstacle to effective operation. This was corroborated by projections based upon the MHPIG.

Working collaboratively with other parts of the local service system was perceived as a significant challenge to proper implementation of an effective CRT function.

Teams were seeing fewer clients than anticipated. This may reflect the lack of staff referred to above. It may also reflect a need to remain targeted in the face of pressures to broaden the role of the team.

That only 40% of teams in England saw themselves as fully set up suggests that we have yet to achieve a sustainable “critical mass” of CRT activity nationally.

Recommendations

In order for CRTs to fulfil their potentially invaluable role the importance of adequate resources and a focus on gatekeeping and home treatment needs to be reiterated at all levels, particularly among commissioners, local managers and senior medical staff.

More sophisticated local whole systems approaches that link service capacity to demand need to be achieved. These need to be informed by evidence on how to provide effective care in the least restrictive setting, and require dedicated service improvement support and strong local leadership that enables teams to see beyond their own part of the service.

As with any survey the current findings rely heavily on self report and further in-depth research into factors unpinning the success of CRT working should be explored using the database developed here for sampling sites.

The current database should also be linked to contemporaneous data on hospital bed use to explore factors of team organisation and operation that most influence changes in use of inpatient care.

Direct web-based data entry by teams could continue to be used to complement performance management processes thereby creating an increasingly valid description of current implementation.

A National Survey of Crisis Resolution Teams in England

Introduction

This report describes a national survey of the development of crisis resolution teams (CRTs) in 2005-6. It forms the first part of a larger study that links data on teams from the current survey to national statistics on inpatient bed use, thereby testing hypotheses concerning the relationship of features of team organisation and operation to the use of local inpatient services. The study particularly focuses on developments across rural, urban and suburban localities in the light of concerns that the national models proposed are more suited to urban localities (Kennedy and Smyth, 2003).

A brief history of the development of CRTs in England

Crisis resolution teams first came to prominence in the context of a wave of government funded demonstration projects into the late 1980's. Their design was particularly influenced by the pioneering work of Hoult in New South Wales, Australia (Hoult, 1986). These teams provided a 24-hour service to users in their own homes to avoid hospital admissions where possible and provided the maximum opportunity to resolve crises in the contexts in which they occurred. Their role in the mental health system is to ensure that individuals experiencing severe mental distress are served in the least restrictive environment and as close to home as possible.

Although the Mental Health Policy Implementation Guide (MHPIG; Department of Health, 2001) advocated local flexibility regarding client groups, crisis teams are most commonly targeted on people with severe mental distress who might require hospital admission. The team therefore needs to sit in the pathway between community-based referrers and in-patient care and be able to act as a point of assessment and as a gatekeeper to other parts of the mental health system for people in severe distress. The team will therefore usually need the capacity to provide immediate home treatment 24 hours a day, 7 days a week.

Clients will often be people with an existing diagnosis of severe mental disorder such as schizophrenia, manic depressive disorder, or severe depressive disorder. The guidance recommended excluding people with mild anxiety disorders, a primary diagnosis of alcohol or other substance misuse, an exclusive diagnosis of personality disorder, a recent history of self harm in the absence of a diagnosis of psychosis and where the crisis related solely to relationship issues. How realistic it is to apply these exclusion criteria to an out of hours service and to those in crisis remains to be seen. Other key features of a crisis resolution team operation include:

- Remaining involved with the service user until the crisis has resolved and they are linked into on-going care.
- Where hospitalisation is necessary, being actively involved in discharge planning and providing intensive care at home to enable early discharge.
- Working to reduce future vulnerability to crisis.

From prior experience, the MHPIG highlighted the following key principles of care:

- A 24-hour, 7-day a week service.
- Rapid response following referral.
- Intensive intervention and support in the early stages of the crisis.
- Active involvement of the service user, family and carers.
- An assertive approach to engagement.

- Time-limited interventions with sufficient flexibility to respond to differing service user needs.
- An emphasis on learning from the crisis with the involvement of the whole social support network.

Joy *et al*'s, (2001, updated 2006) systematic review of crisis intervention reported only a limited effect on admissions but found home care to be as cost-effective as hospital care with respect to loss of people to local services, deaths and mental distress. Results were seen to depend on effective implementation. Burns *et al* (2001) also reviewed the evidence for the impact of CRTs on admissions and concluded this was not strong when compared with other community based services. Visiting users at home regularly and taking responsibility for both health and social care reduced days in hospital but for other service components outcomes were inconclusive. Ford & Kwakwa, (1996) observed that poorly delivered crisis services can have a detrimental effect on clients and increase their admissions to hospital.

Joy *et al*'s review found that routing all referrals for in-patient care through the crisis service appeared to be critical to their success in offering a realistic alternative to admission. Such teams are therefore likely to be highly dependent on support from those practitioners who can circumvent the system by making direct admissions to in-patient care.

The aim of CRTs is not to keep individuals out of hospital at all costs but rather to make the most appropriate use of inpatient care. The effect on length of stay is therefore a key consideration. Where admission to hospital does occur, the intervention of a CRT can reduce length of stay by up to 80% (Audini *et al*., 1994) It is also possible however that an effective CRT can increase average length of stay in hospital because those people that get admitted require longer admissions. It may be that CRTs have the biggest impact on those users who would in any case only require short periods of admission, which in itself does not detract from their important role in local service provision.

Generally clinical and social outcomes from CRT have been judged to be similar to inpatient treatment, though the focus to date has been on clients diagnosed with a functional psychosis, (Smyth *et al*, 2000). CRTs are also judged to have reduced the burden on families, and were preferred by both users and families (Joy *et al*, 2001; Dean, *et al*, 1993).

Recent British studies have compared CRTs with community services. Johnson *et al*, (2005) compared users immediately before and following the introduction of a CRT and found significant differences in bed use (20% lower for CRT group) and admission (77% of pre and 49% of post introduction of CRT were admitted) but effects were smaller than previous studies. There were also marked differences reported in user satisfaction with the pre CRT group reporting mild dissatisfaction and the CRT group very positive satisfaction. Clinical and social outcomes were similar between the groups. A randomised control trial (Johnson *et al*, 2005) of 260 users compared CRT interventions with a control group receiving acute inpatient care, crisis houses and community mental health teams. The CRT users were less likely to be admitted to hospital in the 8 weeks after the crisis and there was a reduction in admission (59 to 22 %) but no impact was evident on compulsory admission. Other clinical and social outcomes were similar and users were only slightly more satisfied.

A small number of studies have compared use of CRT for different diagnostic groups. People diagnosed with severe disorder have been found to be more likely to be accepted for CRT with around 70% of the caseloads of urban services reported as comprising people diagnosed with schizophrenia and related disorder or severe mood disorders

(Harrison *et al* 2001, Bracken and Cohen, 1999, Mingella *et al*, 1999). Tomar and Brimblecombe (2003) found that service users experiencing first episode psychosis could be effectively managed at home by a home treatment team.

Another key outcome of CRT working is the morale of staff. Minghella *et al*., (1998) found low levels of burnout and high job satisfaction in crisis resolution teams compared with results from a previous study of community mental health nurses (CMHNs) and inpatient staff.

CRTs have attracted considerable controversy with some psychiatrists arguing that they are unnecessary in a UK context. They have argued that improved communications between existing community mental health teams, primary care and inpatient units would achieve similarly improved outcomes (Pelosi & Jackson, 2000) and that British mental health service already contains and delivers most of the features of effective CRTs, (Burns *et al*, 2000). In terms of local sustainability of the stand-alone CRT model, Burns suggests that they are either unsuccessful and collapse or successful, but demonstrate such good working examples to other service providers that they eventually make themselves redundant.

CRTs have been identified as an area of major new investment. Spending on access and crisis services rose from £152 million in 2001/02 to £229 million in 2003/04, a real terms increase of 51%. In 2004, £17 million was made available to mental health trusts to improve access to services for people in crisis (Appleby, 2004). Trusts were expected to use this sum to improve the coordination of crisis services, such as mental health teams providing liaison to emergency departments, crisis resolution teams and gateway staff.

The performance management context

Standard four of the National Service Framework (Department of Health, 1999) made it clear that users should be able to access services 24 hours a day, 365 days a year. The NHS Plan Department of Health, 2000) subsequently set the national target of 335 crisis resolution teams serving 100,000 users by December 2004

“Improvement, Expansion and Reform” (Department of Health, 2002) described the requirements for delivery of the NHS Plan through a new Local Delivery Plan process and included the Public Sector Agreement targets. Crisis services are referred to generically as part of the PSA aim of “Transforming the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities”. Under “Objective II: improve health and social care outcomes for everyone” was the target of “Improving life outcomes of adults and children with mental health problems through year on year improvements in access to crisis and CAMHS services, and reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010” . Specifically the guidance required that the NHS “Offer 24-hour crisis resolution to all eligible patients by 2005” based upon the expansion of CRTs to 335 by 2004

Although the white paper on community services, “Our health, our care, our say” (Department of Health, 2006) makes no new specific recommendations with respect to CRTs, the whole thrust of the policy is towards home-based care (see chapter six).

In March 2004, there were 168 CRTs recorded nationally (Durham mapping data; see www.dur.ac.uk)]. These teams mostly met the criteria set out in the mental health policy implementation guide, although 64 of the 168 did not operate 24 hours a day, seven days a week.

Methodology

Survey design

The survey adapted and extended the schedule used in the national survey of community mental health teams (CMHTs; Onyett *et al*, 1994). The questionnaire had seven sections covering (a) who is in the team and what they do, (b) who the team's work is for, (c) what the team does, (d) how it works with other local services, (e) how the team is lead and managed, (f) how the work of the team is evaluated and (g) issues around training and development. Fifteen drafts of the schedule resulted from consultation within the research team and CRT networks managed through NIMHE development centres. Additionally, versions of the questionnaire were piloted with 10 services which identified new and established, rural and urban teams. When finalised, the questionnaire was redesigned for online data entry.

Inclusion criteria

In order to support the developmental nature of the survey, entry criteria for teams were permissive. We included any local arrangements that have been designed to achieve the outcomes required of a CRT locally (as described in the MHPIG). The survey included Local Implementation Team nominations of emerging or transitional teams, CMHTS with dedicated home treatment functions, and day hospitals with home treatment functions. Other crisis services such as crisis houses or foster families, A&E liaison, discharge support or step down provision that did not specifically aim to achieve the same breadth of outcomes as crisis resolution were not included. As the study progressed a filter was developed for more complex service arrangements. CMHTS who self defined as providing home treatment were only included where respondents were able to describe this as a distinct activity and to report on separate caseloads.

Database development

The national adult mental health mapping exercise (www.dur.ac.uk) database reports for September 2005 provided an initial listing of 268 teams. NIMHE established a support structure for the implementation of CRTs with the creation of lead roles for crisis resolution team development within the eight development centres (hereafter referred to as CRLs). The CRLs were asked to verify the accuracy of the Durham team listing against their own databases of manager contacts for geographical patches. This exercise generated a database of 246 teams which formed the basis for first contact by letter. Database contact details were further revised following interviewer contact with services. Three teams were removed from the listing as these were either not set up or had ceased to exist. The final team count was therefore 243. Appendix A outlines the disparities which existed between the Durham mapping report and the survey team data base. Many differences appear to relate to team amalgamations. Large disparities in team numbers exist in London (Durham 53/Survey-41) and South Yorkshire (Durham-28 and Survey-18). The most recent Durham report (March 2006) identifies 271 teams which suggests that team growth has been limited over the last year.

Research collaborations

The process of the research aimed to enhance the developmental impact of the survey. Preparatory work with CRLs took place over a seven-month period and questionnaire design was informed by the interests of clinical networks and developers. CRLs provided support for the study throughout the research process and were also invited to participate as interviewers. There appeared to be a good fit between their organisational remit for audit and review and the study aims. Collaboration aimed to:

- Secure widespread commitment of CRT managers to participation in the study
- Stimulate interest in development of a data base of CRTs and to connect managers into the processes through which new knowledge was produced and disseminated.
- Promote ownership of the data base and begin a dialogue about the potential of research for team audit and review which is less associated with performance management routines.

Dissemination has been designed to establish regular review and updating of the data base within clinical networks. A public web site was created to facilitate information giving to all stake holder groups, (see http://www.crisisresolutionsurvey.info) and is embedded in the NIMHE Knowledge Community (a web based resource for information sharing and dissemination).

Survey conduct

The survey was administered to all CRTs in England. The letter was addressed to colleagues using addresses derived from the database development described above. A letter describing the project invited inquiries from recipients who required further information to proceed with participation in the study (see Appendix B). Respondents were asked to access an online questionnaire using a unique password and identification number and instructed to complete this in preparation for a telephone interview (see http://www.dur.ac.uk/service.mapping/crs).

Preparatory data inputting by respondents was reported as taking two hours. Interviewers contacted services to verify receipt of a letter by an appropriate person, support the logging on process and establish phone interview times. Interviewers were allocated a listing of team identification numbers and were able to log on in the same way as respondents to view and download questionnaires for their allocated interviewees.

During the telephone interview, the completeness and accuracy of the questionnaire was reviewed and respondents were asked to expand on open text questions. Interviewers subsequently inputted any revisions online. Five CRLs were involved in interviewing (an individual commitment of 10 interviews each) and were provided with two days training on interview conduct. Prompts were given for open text questions and interviewers were directed to note the discussion, using the language of respondents and to read this back before entries were made to the online form. A glossary of key terms (such as “gate keeping”; “caseload”) was embedded in the questionnaire to support the conduct of interviews.

Time frame for data collection

Piloting of the questionnaire took place between February and April 2005. Small numbers of teams logged on during August and September 2005. The majority of logging on by respondents occurred between October and Dec 2005 and continued to the end of Jan 2006. Closure on contacting respondents for follow up telephone interviews was at the end of January 2006 and data cleaning was completed by February 14th 2006 The database remains open to managers to log on and update their forms.

Research governance

An application was made to the Northern and Yorkshire Multi-Centre Research Ethics Committee (MREC) in late March 2005 and approval was given in mid July 2005. Approval was also sought from 71 NHS R&D organisations related to identified trusts. Organisations were sent by post a pack of information that including a project protocol,

evidence of MREC approval, a letter outlining how crisis team leaders would be approached and a detailed letter providing information that would have been required to complete the nationally agreed R&D pro-forma.

Six weeks after the initial mailing a reminder letter was sent to organisations that had not responded to correspondence. Many organisations made additional requirements before allowing the study to proceed such as the completion of a local protocol. There were several requests to apply for an honorary contract with the provider organisation and for further details of the indemnity arrangements. One organisation asked for a clinical trials agreement. Correspondence relating to ethical approval is contained in Appendix C.

Analysis of quantitative data

Most of the analysis presented here is merely descriptive rather than analytical. Where analysis was conducted the paucity of existing research to guide the formulation of hypotheses for this national survey demanded an exploratory approach. Explorations of associations were informed by salient issues concerning CRT development such as the applicability in rural environments. Relevant statistics are reported but the small numbers of self-identified rural teams in this study suggest a conservative interpretation of findings that require further corroboration through subsequent inquiry.

Non-parametric tests were used because variables were not normally distributed. The Kruskal-Wallis test (K-W χ^2) was used for examining associations between interval level variables and nominal level variables with more than two categories. The chi-square coefficient (χ^2) was used to examine associations between nominal level variables with only two levels.

Exploring main effects using *post hoc* multiple comparisons employed the Mann Whitney U test for associations between interval level variables, and chi-square for associations between two-level categorical data (see appendix D and significant differences indicated in text in the manner U>R, etc.). The Spearman rank correlation coefficient (r_s) was used to examine relationships between interval level variables because distributions were rarely normally distributed. All analyses were conducted using SPSS for Windows (version 13; SPSS Inc., 1989-2004) and significance was set at the five percent level (though the actual p values are reported).

Analysis of qualitative data

The survey instrument included questions that invited free text entries. In some cases these were entered directly by respondents and in others by interviewers. The main object of these items was, in keeping with the survey method, to find out what respondents cited most frequently as issues (e.g. training needs) or specific aspects of operation (e.g. those disciplines most difficult to recruit to). The analysis therefore organised the data thematically into categories, maintaining a record of the number of references to a particular issue or aspect of operation. In some cases responses are reported verbatim to give a fuller flavour of the issue but these should be interpreted cautiously as the response may have been mediated by an interviewer. For simple text data (e.g. naming disciplines) it was simply organised into categories and presented as a table in descending order of the number of references. For more complex material (e.g. perceived obstacles to implementation, priorities for development and the support sought from NIMHE) mind mapping software was used to keep track of the number of references and organise the material into categories and subcategories. The use of ordinary qualitative data analysis software did not appear to be warranted as (a) the source data, having been entered via a web page, was very easy to retrieve and contextualise, (b) there was a small amount of data and (c) the aim of analysis was a simple categorising and counting task rather than a deep thematic analysis, The software (Visual Mind 6.0.8, business edition; 1998-2004;

Mind Technologies) allowed very flexible organisation and navigation of material, and was also used to present the findings back to key stakeholders allowing very direct interrogation of the material from the output of the analysis itself. This output is available as WORD documents from the first author.

Results

Data cleaning

Levels of completion for each team's online questionnaire were checked and substantially incomplete questionnaires were excluded from the study. This represented 66 teams and useable questionnaire were derived from 177 teams. Of these questionnaires, data quality for differing sections varied. The number of teams we were able to report on is identified in each table.

Response rates by region

Table 1 shows percentage response rates by region. This is based upon the number of usable replies divided by the numbers of known teams. These response rates differ slightly from the response rates used for the projections on team and caseload size. To increase validity the response rates for the staffing and caseload sections of the questionnaire were deployed for that analysis.

Table 1. Percentage response rate by region

Region	Response Rate
North East	88
North West	68
East Midlands	65
West Midlands	79
Eastern	46
London	76
South East	70
South West	89
England	73

Description of respondents

Table 2 provides a description of survey respondents. The majority of respondents defined their role in managerial terms (90% of the total sample). A further 6.5% and 3% responded as practitioners and from other roles respectively. Two responses involved the collaboration of the team as a whole.

Table 2. Description of respondents.

Job Title	Frequency
Manager	
CRHT Team Manager/leader	114
Service Manager	15
Deputy Manager	7
CRHT & other management responsibilities	4
Area Manager	3
Clinical Manager/leader	4
Project Manager	2
Development Manager	1
Operational Manager	1
Total	151
Practitioner	
CPN/Senior Clinical Nurse	6
Lead Practitioner	2
Crisis Services Clinical Lead	2
Modern Matron	2
Total	12
Other	
Crisis Team as a whole	2
Team Coordinator	5
Total	7

The number of CRTs nationally

The national annual adult mental health mapping exercise (www.dur.ac.uk) database reports for March 2005 provided an initial listing of 268 teams. Review of this by CRLs against their own databases of team manager contacts for geographical patches generated a revised list of 246 teams which formed the basis for first contact by letter. Three were subsequently removed as they had either not been set up or had ceased to exist. This left a final team count of 243. Appendix A outlines the disparities which exist between the Durham mapping report and the survey team data base. Many appear to relate to team amalgamations. Disparities were largest in London (Durham mapping: 53; survey: 41) and South Yorkshire (Durham mapping: 28; survey: 18). The most recent Durham report (March 2006) identifies 271 teams suggesting that subsequent team growth has been limited.

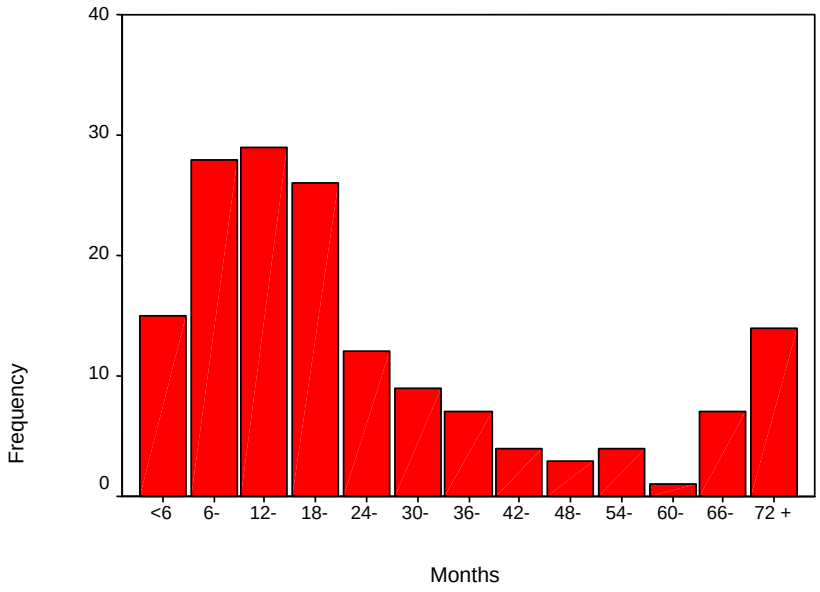
Location of teams- urbanicity

Using definitions adapted from Perlman *et al*, (1984) 54.5% of respondents described their locality as urban in that they worked within a city or town with a population of at least 50,000. Rural teams were those worked in localities defined as having "No town of 10,000 or more and less that half the population live in towns/villages of 2500 of more" and comprised 9.6% of the respondents. A further 36% described their localities as "mixed/suburban" being neither of the above. It is likely that the descriptions were used loosely by respondents as team managers were unlikely to have very detailed knowledge of local demographics. Nonetheless, significant differences in implementation were evident across the urban-rural dimension (hereafter referred to as "urbanicity").

Age of teams covered

The mean age of teams covered was 30 months but the distribution was heavily skewed towards younger teams (median = 20 months). Thirty two percent of teams had been taking referrals for a year or less. Thirty four percent started taking referrals in 2004.

Figure 1. Length of time teams have been accepting referrals (months)



Urbanicity was significantly related to team age with urban teams being the oldest and rural the youngest, (K-W χ^2 =9.01, df 2, p=0.01; U>S). Team age was not related to the size of teams.

Team size

The largest proportions of teams fall with the recommended range of 10-14 members (31%) though substantial proportions are larger (see Table 3). There are six teams which are under five staff which are emerging services. The 8 teams between 5-9 staff were predominately rural teams and two stated that they are local pilots. The largest teams of 58 and 47 were services which had organised as two sub teams under a single management structure. Teams in the upper range of 30 -39 were mainly stand alone teams. Only one of these functioned as two sub teams. Larger teams functioned as a broad emergency service and often incorporated an A&E function within the team.

Some were providing a service on a borough wide or city wide basis.

Table 3. Team size.

Team size	Number of teams	Percent of teams
Less than 5	6	4
5 to 9	8	5
10 to 14	51	31
15 to 19	43	26
20 to 24	24	15
25 to 29	15	9
30 to 34	10	6
35 or more	8	5
Total	165	100

There was significant effect of urbanicity on team size (K-W χ^2 =8.72, df 2, p=0.01) wherein urban teams were significantly larger than suburban ones (see appendix D). This effect endured for team size as measured in FTE (K-W χ^2 =7.99, df 2, p=0.02) and when admin staff were excluded from the analysis (K-W χ^2 =8.88, df 2, p=0.01, wherein urban teams were also significantly larger than rural ones).

Projections on team size

A team size of 12 is the usual minimum complement required to provide a 24-hour rota (allowing for annual and study leave; NIMHE West Midlands, 2004). With 12 in the team, staff are on-call between four and six times within each 4 week period. The MHPIG refers to 14 “designated named workers as the norm covering populations of approximately 150,000.

A simple projection was used to estimate the deviation of team sizes nationally from that recommended in the MHPIG (assuming the recommended team size to be 14 per 150,000). The following crude projections were not able to take account of urbanicity or deprivation and so must be interpreted cautiously. The projections also make the assumption that responders were representative of the population of teams as a whole. The following projections were yielded. Note that in Table 4 100 in the “Deviation” column would represent projected team sizes exactly in accordance with MHPIG recommendation, 102, that the projected team size was 2% over the recommendation, etc.

Table 4. Deviation from team size using MHPIG guidance.

		Deviation = Sample estimate as percentage of projected			
Region	Projected number of staff	Team size in people	Team size in people exc admin*	FTE	FTE exc admin
North East	696	100	93	97	91
North West	631	102	96	97	92
East Midlands	382	126	107	122	105
West Midlands	491	106	99	104	97
Eastern	499	96	83	91	80
London	670	96	92	94	91
South East	745	73	68	67	63
South West	457	81	74	75	70
England	**4,571**	**95**	**88**	**91**	**85**

The descriptions of staffing from the MHPIG would suggest the figure of 14 was not meant to include administrative staff. For the sake of these projections then the forth column above (*) is probably most usefully interpreted. This would suggest that the East and West Midlands are most adequately staffed and the South East and South West the least. For England overall the figures would suggest that CRTs have achieved 88% of their recommended staffing.

Team development of capacity

The teams in the survey are relatively young, 63% of them taking referrals for less than two years. Teams under a year old have been undergoing considerable change. Younger teams, between one and two years old, grew more than those aged two years or more, a net increase of more than three compared with one member of staff on average (see Table 5). Two figures for percentage change are presented; the mean for individual team percentage increase and the percentage increase in the mean team size. As would be expected growth was much higher for younger teams according to either measure.

Table 5. Length of time taking referrals related to team size

Mean changes in team size in the past year	How long been taking referrals		
	1 year, less than 2	2 years or more	Total
Team size a year ago	16.7	16.6	16.6
Team size at interview	19.9	17.6	18.6
Net staff change	3.2	1.0	1.9
Team percentage net change	28	9	17
Mean net change as % of mean team size a year ago	19	6	12
Number of teams	39	55	94

Nearly two in five teams (38%) aged at least two years experienced no net change in staff (see Table 6) Teams taking referrals for between one and two years were more likely to have grown by at least a quarter (36%).

Table 6. Team age related to staff growth.

Percent distribution of type of change in past year	How long been taking referrals			Number of teams
	1 year, less than 2	2 years or more	Total	
Reduction	*8*	18	14	13
Same size	*23*	38	32	30
Increased by <25%	33	27	30	28
Increased by 25% or more	36	*16*	24	23
Total %	100	100	100	
Number of teams	39	55		94

The teams surveyed thus include a substantial number still undergoing development. Especially for teams under a year old but also for those just a year ahead of them, there would seem to be a rapid building up of team capacity. Younger teams have greater staff capacity than their more established counterparts (see Table 7). Teams taking referrals for at least two years had one and a half fewer staff on average, than those aged less than two years, measured in terms of number of people or full-time equivalents (FTEs).

Table 7. Team age related to capacity.

How long been taking referrals	Mean per team in terms of :		Number of teams
	Number of staff	FTE	
Less than a year	17.9	17.2	*47*
1, less than 2 years	17.5	16.9	*50*
2 years or more	16.0	15.4	*57*
All teams	17.0	16.4	*154*

Team composition

The following section considers team staffing in relation to multidisciplinary mix within teams, FTE contribution to teams and the proportion of the CRT workforce represented by disciplines. The MHPIG on the disciplinary mix for CRT staffing describes four disciplines, community mental health nurses, social work, occupational therapy and psychology as well as support workers as potential designated named workers. Services are advised to employ a skill mix that can deliver on the appropriate range of interventions.

Total workforce profile

Community mental health nurses (CMHNs) were the main professional group in teams and were the main nursing category representing 55 % of total CRT workforce (see Table 8). Representation from other nurses was low. The other main staff group in teams were support workers (14%) with a smaller input from social time recovery workers (4%). Medical staff represented 5.2% (consultants 2.6%) of the workforce. Social workers and approved social workers (ASW) were present in small numbers representing 10.3 % of the total workforce.

Table 8. Workforce profile.

Discipline	Number of staff	Percent of workforce	Grouped disciplines	Percent of workforce
Community mental health nurses	1,633	54.4		
Nurses (other than CMHNs)	57	1.9		
			Nurses	56.3
Approved Social Workers	180	6.0		
Other Social workers	136	4.5		
			Social workers	10.5
Consultant psychiatrists	79	2.6		
Staff grade medical staff	56	1.9		
Junior medical staff	20	0.7		
			Medical staff	5.2
Occupational therapists	62	2.1		
Clinical Psychologists	13	0.4		
Other specialist therapists	4	0.1		
			Other specialist	2.6
Social time recovery workers	123	4.1		
Support workers or other generic mental health workers	422	14.1		
			Support workers	18.2
Administrative staff (including receptionists)	151	5.0		
Others	67	2.2		
Total	3,003	100		

Staff profiles within teams

Levels of part-time working in teams were low for the main disciplines of nursing and social work (see Table 9.). Input from psychiatrists was small with only 44% of teams having any input at all. The amount of input was also small (compared for example to the mean 0.75 equivalent input in CMHTs in 1995; Onyett *et al*, 1994). In contrast, support workers appear to be making a significant contribution to teams (compared for example, with only 0.69 FTE in CMHTs in 1994). Of the 8% (13) of teams who employ a psychologist 46% (6) were full-time posts and 54% were part-time representing very small amounts of input into teams. For occupational therapists, 30% of teams reported input and 18% were part time.

Table 9. Profile of disciplines within teams.

N=164	Mean number in people	Percentage of teams with input	Mean FTE per team	Percentage Part-time
Community mental health nurses	9.9	98	9.7	6
Nurses (other than CMHNs)	0.3	12	0.3	4
Approved Social Workers	1.1	49	1.1	10
Other Social workers	0.8	45	0.8	7
Occupational therapists	0.4	30	0.3	18
Consultant psychiatrists	0.5	44	0.4	44
Staff grade medical staff	0.3	27	0.3	39
Junior medical staff	0.1	11	0.1	25
Support time recovery workers	0.8	24	0.7	7
Support workers, other generic Mental health workers	2.6	70	2.5	8
Clinical Psychologists	0.1	8	0.1	54
Other specialist therapists	0.0	2	0.0	25
Administrative staff (including receptionists)	0.9	50	0.8	26
Others	0.4	19	0.4	21
All disciplines	18.3		17.6	10
All except administrative, others	17.0		16.4	9

Profile by staff group

Nursing

CMHNs were the main grouping of nurses. In 32 teams (18%), nurses were the only non-medical profession represented in teams. The largest proportion of teams (48%) employed between seven and nine nurses and only 13% of teams had five or less. Eighty eight percent of teams did not employ nurses other than CMHNs. In two teams, “other nurses” were the main nursing group which may reflect use of agency staffing.

Nursing grades were as recommended by the MHPIG, being mainly F or G with a majority of G grades.

Table 10. Percent distribution of grade of nurses within the CRT workforce

GRADE	E	F	G	H	I	Consultant	Total
All teams (n=162)							
Percent in grade	10	28	49	9	3	1	100

Social work

Twenty seven percent of teams did not have any input from social work staff. Social work input was a mean of 0.8 for social work and 1.1 for approved social workers input to teams. Small numbers of teams were employing larger numbers of approved social workers. Five teams have five approved social workers (3% of teams) and four had six or more (2% of teams). The incorporation of emergency duty teams into crisis teams was ongoing in some areas at the time of the study. Only 21% of teams benefit from the combination of skills of both approved social workers and other social workers (see Table 11)

Table 11. Proportion of ASWs and Social Workers in teams.

Social work input	Number of teams	Percent of teams
Neither	45	27
Approved only	46	28
Other only	39	24
Both	34	21
Total	164	100

Occupational Therapy

Seventy percent of teams do not have an occupational therapist (OT). Where they are employed, the majority were just one post (24% of all responders).

Psychologists

Only 8% (13 teams) reported having a psychologist. Six of them are full time and seven part-time. This represents an equivalent of 9.5 full-time posts.

Mental health workers

Generic support workers formed the main professionally non-affiliated staff group. However 31% of teams did not employ any. The largest proportion of teams (33%) employed two or three workers. In 9% of team they were a large staff group of five.

Social time and recovery (STR) workers are a relatively new role and 76 % of team did not employ them. 10% of teams had one. For a small number of teams (9) they were the dominant support worker role representing four staff.

Other specialist therapists

Specialist therapists such as family therapists were a rarity in teams. Only 2% of teams (3) reported a post and it was not specified what the posts were.

The medical workforce and arrangements for medical cover

Consultant psychiatrists

Twenty four percent (39 teams) of teams had one full time consultant post and in 16% of teams they were part time ranging from 0.2 to 0.8. Only 4% of teams had more than one full time equivalent.

Other medical staff

Staff grades formed the main medical cover in 10% of teams and worked with consultants in 17% of teams (see Table 12). Eighteen (11%) teams reported having junior medical staff. The majority of these teams (13) had one fulltime post.

Table 12. Proportion of psychiatrists and staff grades in teams.

Psychiatrists and staff grade	Number of teams	Percent of teams
Neither	75	46
Consultant only	44	27
Staff grade only	17	10
Both	28	17
Total	164	100

Medical cover

A dedicated consultant with other medical staff was the predominant arrangement for medical cover in teams (46%, see Table 13). Twenty nine percent of teams received support from a CMHT consultant. A lead role or special interest in home treatment by a CMHT consultant was also cited as an “Other arrangement”, either within arrangements wherein CMHT consultants provided the main cover or alongside a dedicated consultant. Two respondents described sessional support by a CMHT consultant for users new to the service.

Table 13. Arrangements for medical cover.

Arrangements for Medical cover	Number of teams	Percent of teams
Dedicated consultant with other medical staff	81	46
Dedicated consultant without other medical staff	15	9
Dedicated medical staff but no dedicated consultant	18	10
Medical input from consultant in CMHT or their junior staff	51	29
No medical input	3	2
Other	9	5
Total	177	100

There is a slight disparity between the table above and the workforce data in that 55% of teams reported having a dedicated medical consultant cover in contrast to the 44% of respondents reporting having dedicated consultant input. Workforce data was obtained by

teams specifying the numbers of medical posts in the team. It is likely that the generic questions on cover allowed for some teams to be construing “dedicated” consultant input as coming from outside the team.

59.8% of urban teams reported having dedicated consultant cover, compared with 43.8% of rural teams and 47.6% of suburban teams.

Other (non-consultant) medical staff was the main form of medical cover in 10% of teams. Three teams (2%) stated they have no medical input at all.

There were no significant main effects of urbanicity with respect to arrangements for medical cover.

Service user and carer posts

Eighteen (10% of teams) report having a post filled by someone because they are a service user (see Table 14). Only 2 were exclusively development posts with the majority combining a clinical and development role.

Table 14. Frequency of user posts and whether clinical or developmental.

Specific service user post, a clinical role or a development role or some combination of the two?		
	Frequency	Percent
Clinical	6	33
Development	2	11
Combination	10	56
Total	18	100

Seven teams (4%) reported a specific post filled by someone specifically to support work with carers. The majority of these were practice related.

Table 15. Frequency of carer posts and whether clinical or developmental.

Specific work with carers post, a clinical role or a development role or some combination of the two?		
	Frequency	Percent
Clinical	4	57
Development	1	14
Combination	2	29
Total	7	100

Ethnicity of team staff

The format for collecting ethnicity data was taken from the National Mental Health and Ethnicity Census, 2005 (http://www.mhac.org.uk/census). Table 16 represents the total breakdown for ethnicity in the CRT staff population. The total profile for non white ethnic groups was 14%, and of these 7% were black British and 5% were Asian or Asian British.

As a crude indicator of representativeness comparison with the results of the 2001 Home Office census released in 2002 describes the minority ethnic community population as 7.6% of the total UK population (4,694,681 people out of a total population of 58,848,579). The non-white ethnic minority population was over represented among staff by a factor of two.

Table 16. Staff ethnic groupings.

Ethnic group		Number of staff	Percent of workforce	Grouped Number of staff	Grouped Percent of workforce
White					
	British	2,447	82.9		
	Irish	35	1.2		
	Other	38	1.3		
Total				2,520	85
Black or Black British:					
	British Caribbean	65	2.2		
	African	136	4.6		
	Any other Black background	12	0.4		
Total				213	7
Asian or Asian British					
	Indian	53	1.8		
	Pakistani	37	1.3		
	Bangladeshi	19	0.6		
	Any other Asian background	39	1.3		
Total				148	5
Mixed					
	White and Black Caribbean	14	0.5		
	White and Black African	10	0.3		
	White and Asian	5	0.2		
	Other	5	0.2		
Total				34	1
Other Ethnic Groups					
	Chinese	10	0.3		

Ethnic group		Number of staff	Percent of workforce	Grouped Number of staff	Grouped Percent of workforce
	Any other	25	0.8		
Total				35	1
All ethnicities		2,950	100		100

Breakdown by discipline of ethnicity

Medical staff reflected the most ethnically diverse profession and occupational therapists and psychologists the least. Psychologists and occupational therapists were predominately white British and had no representation from non-white ethnic groups. This needs to be set in the context of the very small numbers of both professions in the workforce. Consultants reflected a small representation of other white ethnic groups (9%) and a quarter of their workforce was from non-white ethnic backgrounds, reflecting a range of ethnicities and with a higher representation for people of Asian backgrounds (19%).

This profile was similar for both staff grades and junior doctors. Representation of non-white groups in the medical workforce of CRT was higher than national figures for psychiatrists (see Table 17). (http://www.rcpsych.ac.uk)

Representation of non-white ethnic groups was lower for the main professional groups. Nursing and social work were comparable at 10% and 15% with representation from across the range of ethnicities. Support workers had a similar breakdown to nursing and social work with 14 % from non-white ethnic background with representation across ethnic groups. Only 7% of administrative staff were from non-white ethnic background with representation of Asian and Black British (African and Caribbean)

Table 17. Ethnic composition of medical workforce.

Ethnic classification	UK 2001 Census (%)	Members and Fellows, Royal College of Psychiatrists, December 2005 (%)
White	92.1	68.6
Asian	4.0	15.1
Black	2.0	2.6
Chinese	0.4	0.7
Mixed	1.2	1.4
Other	0.4	2.8
Undeclared		0.6

Team size and disciplinary mix

The following analysis excluded administrative staff because of the MHPIG reference to "designated named" workers". Table 18 illustrates the percentage of teams containing a

given discipline as a percentage of the total number of teams in that size category. As would be predicted the range of disciplines evident in teams increases with team size.

Small teams were less likely to have ASWs as part of the social work input. The presence of ASWs increases with team size. Smaller teams are more likely to include non-CMHN nurses. They do not have STR workers. Specialist therapists were only present in teams over 25.

Table 18. Disciplinary input related to team size.

Percentage of teams with input	Team size					
	Under 10	10 - 14	15 - 19	20 - 24	25 +	Total
Community mental health nurses	92	98	100	92	100	98
Nurses (other than CMHNs)	15	8	14	17	12	12
Approved Social Workers	15	35	53	58	70	49
Other Social workers	38	41	44	42	55	45
Occupational therapists	31	22	30	25	45	30
Consultant psychiatrists	8	16	53	50	85	44
Staff grade medical staff	8	12	40	29	42	27
Junior medical staff	0	2	9	13	30	11
Social time recovery workers	0	16	35	25	30	24
Support workers or other generic mental health workers	38	65	72	88	73	70
Clinical Psychologists	15	2	14	4	9	8
Other specialist therapists	0	0	0	0	9	2
Administrative staff (including receptionists)	23	29	51	63	82	50
Others	15	6	16	25	39	19
Number of teams	13	51	43	24	33	164

Recruitment issues

Ease of recruitment

Despite the major concerns about recruitment described later with respect to obstacles to implementation, when asked, “Compared with the rest of your local mental health service, would you describe the team as being generally as easy, or as difficult to recruit to, or about the same?”, 48% of teams described their team as being comparatively easy to recruit to, 23% more difficult and 29% about the same. It seems therefore the biggest obstacle to recruitment is simple paucity of resources.

Table 19 identifies nursing as the modal discipline group in terms of *ease* of recruiting (67%). Support workers accounted for nearly 18% of responses. The ASW and

psychology roles were identified as *easy* to recruit by only 1% of respondents combined. Three teams were not able to identify any discipline as being *easy* to recruit.

Social work was identified as the modal discipline group considered most difficult to recruit, followed by psychology and occupational therapists (45%, 28% and 12% respectively). A small percentage identified recruitment difficulties across multiple disciplines (stating "all hard to recruit.")

Table 19. Disciplines considered most easy to recruit.

Discipline	Frequency of references
Nursing	122
Support Work	32
All disciplines easy	7
Social Work	6
OT	4
No disciplines easy	3
No difference	3
ASW	2
Psychology	2
Total	181

Table 20. Disciplines considered most difficult to recruit.

Discipline	Frequency of reference
Social Work	160
Psychology	99
OT	43
Nursing	17
All hard to recruit	15
ASW	8
Medics	5
Social Care	4
None hard to recruit	3
Support Workers	3
Consultant Pharmacist	1
Senior Practitioner Role	1
Total	359

Recruitment strategies

Participants were asked to share "any good ideas about recruitment to the team". Strategies were multileveled and emphasised the local context as a source of new workers. Benefits to recruitment derived from the impact of a well functioning team and good communication with other teams. References (number of references shown in parentheses) were made to developing a good service and reputation (7) building positive relationships with CMHTs and wards (3) and efforts made by CRT staff to seek out good staff in other teams (3).

Some teams emphasised the importance of partnership in recruitment planning as a way of reducing competitiveness in the service (3). A range of initiatives were described to improve links between teams or across agencies and to communicate the nature of crisis work to potential workers. Team initiatives included:

- Use of rotational contracts between ward and CRT (7)
- Shadowing of the CRT (4)
- Encouraging students, developing placements and running induction days (3)
- Creating a bank of staff which provides short term contracts with the crisis team, to facilitate work experience prior to full employment (3)
- A link worker, funded jointly by CRT and wards (3)
- Link nurses between the ward and team (2) to build crisis skills in ward staff.
- Informal visits and open days (2)
- Secondment from the ward and community (1)
- 3 month short term placements with team (1)
- Making a video of the service (1)

Leadership had a bearing on how teams were seen by potential workers or was seen as a means to exert influence over the recruitment process. One team highlighted the impact of a credible team manager in attracting new staff. Others reported benefits from the manager or team taking lead responsibility for recruitment rather than the human resources department (3). Leadership from a manager with a social care background had improved the recruitment of social care staff in one team.

An involved approach by teams' managers in recruitment practices was also described with reference to increasing interpersonal contact and information giving to applicants. For example it was advocated that managers should meet all applicants before interview, brief them, check their level of interest, and follow up enquiries about the post before the closing date (4).

Teams referenced the value of crisis work to personal development and the importance of articulating this to those recruiting and supporting the development of staff. The work could be seen as a specialism, with challenges and strengths such as the team approach (3). Developing competencies for crisis work were cited as assisting staff development within the team (2) and the acquisition of crisis skills could be included in personal development plans of staff from other service areas (1).

The provision of robust clinical supervision and personal development was also highlighted (1). Recognition of professional diversity in support arrangements helped to attract and keep difficult to recruit professions. For psychologists this involved strong links with the psychology department (1) and for social work, access to dedicated supervision and peer groups to reduce isolation (1).

Teams had used grading to demark and stabilise crisis work as advanced practice within differing career progression structures. Increasing the grading of OTs for crisis work (1) and grading crisis work at grade E or F for nurses had proved effective.

Teams also described the organisation of shift patterns to enable extended time out and derive benefits from out of hours work. A range of examples were given such as long days, (e.g. 12 hour shifts and 3 days off (2); 7 days in a fortnight (1); 10 hour shifts with four days off (1)

Flexibility about types of staff also enabled access to a broader recruitment pool. Participants described recruiting for personal attributes (1) and advertising of posts as mental health practitioner and open to any profession (4). Flexibility about the grading of staff enabled staff to grow into the work (1).

Agency staff were routinely used by some services to address recruitment difficulties for social work and OT and to cover out of hour work. This was well established in some teams who had evolved "permanent agency" (3) to reduce the negative effects on staff stability.

Team client group

Inclusion by diagnosis, whether known and severity

All services reported accepting clients' diagnosed with psychoses or affective disorders whether known or not (see Table 21). There was however some minor variation for clients diagnosed with personality disorder or anxiety disorders. The high proportion of teams accepting clients with a diagnosis of personality disorder is notable. The MHPIG suggested excluding personality disorder where this was the exclusive diagnosis, though this was advocated prior to the release of the NIMHE London Development Centre, (2003) report on the diagnosis not being a basis for exclusion. Services were much less likely to accept service users with a diagnosis of substance misuse. This is in line with the MHPIG which suggested exclusion of organic disorder and substance misusers where this was their primary diagnosis. The fact that such high proportions are seen in this context perhaps suggests high levels of flexibility on the part of teams in light of presenting need.

Table 21. Client groups accepted for possible home treatment by diagnoses and whether known to services or not.

Diagnoses	Percent Known	Percent New
Psychosis	100	100
Affective disorders	100	100
Anxiety disorders	89	84
Personality disorders	89	84
Substance misuse disorders	48	42
Organic disorders	18	17

There was an effect for urbanicity with respect to new people and people known to the locality presenting with anxiety problems (χ^2=8.77, df 2, p=0.012; χ^2=8.56, df 2, p=0.025 respectively). Suburban teams were most likely to exclude in both cases (for new 27% compared with 19% of rural teams and only 9% of urban teams; for known 19% compared

with 7% of urban teams and no rural teams). This might be an effect of the presence of alternative services for this client group in comparatively wealthy localities.

Teams were asked to estimate the percentage of the team caseload comprising people with severe and enduring mental health problems (see Table 22). They were asked to use the top tier of their local CPA as the source of the definition. The mean was 65% and median 70%. One in five teams estimated that this group represented less than 50% of their caseload. The minimum proportion was 10%. The upper range 80 -100% accounted for two in five teams. Six percent of teams claimed that the caseload consisted entirely of people with severe and enduring mental health problems.

The relationship between the percentage of caseload consisting of people with severe and enduring mental health problems and urbanicity was not significant (K-W χ^2=1.68, DF 2, p=0.43).

Table 22. Estimated percentage of team caseload which comprises of people with severe and enduring mental health problems

Estimated percentage	Percentage of teams in range	Number of teams
10% -50%	20	35
50%- 80%	40	68
15% of teams replied exactly 50%		
80%-90%	20	34
17% of teams replied exactly 80%		
90%-100%	14	24
10% of teams replied exactly 90%		
100%	6	11
Total	100	172

Age limits

Forty four percent of teams operated a 16-65 age range. A fifth went from 17 or 18 up to 65. A further 16% went from 16 with no upper age limit and 20% of teams adopted other arrangements.

Upper age limits

Sixty two percent of services set the upper age limit at 65 (see Table 23). Twenty six percent set no upper age. A small number of services were working to a higher age limit than 65 and specified an age which reflected a range from 70 to 100. Forty two percent of respondents indicated that limits differed for those new to the service in contrast to those known.

Respondents were asked to provide explanatory detail where limits differed from those referrals that were new to the service as compared to those known. It would appear that *known* service users generally remained with adult services (if they continued to have a functional diagnosis), and hence were accepted for referral by CRTs when their needs required. Within this context there exists variation between teams. Some offered an

assessment if the illness was functional, while other teams would accept referrals onto caseloads and offer home treatment. In contrast, some teams would not offer a service to *known* service users of older adult services. In one case, teams would accept *known* clients *awaiting* a response from services for older adults.

There existed differing interpretations to the questionnaires description of 'known to the service' with some defining *known* in generic terms (e.g. '*known to mental health services',* while others were more specific in their interpretation, (e.g. '*receiving a service from adult mental health', 'in contact with adult mental health within the last year',* on '*an active caseload'*).

For clients *new* to the service, the majority identified their age limit as being 65 years of age.

Table 23. Upper age limit for referral.

Age limit	Number of teams	Percent of teams
No limit	46	26
64	6	3
65	109	62
70	9	5
73	1	1
75	4	2
90	1	1
100	1	1
Total	177	100

Lower age limits

Most services (64 %) set a lower age limit of 16 (see Table 24). A small number of teams (4) set this at 14.

Table 24. Lower age limit for referral.

Age limit	Number of teams	Percent of teams
No limit	1	1
14	4	2
16	114	64
17	25	14
18	33	19
Total	177	100

The majority (79%) of services reported no alternative emergency service for young people, particularly in suburban areas where 91% of teams reported no service.

A third of services reported that limits differed if people were in full-time education compared to those not. The lower age limit was identified as 16 for children not in full time education, compared to a higher age boundary of 18 or older for children in full time education. Respondents understood 'not in full time education' as both embracing children "*of working age"*, in *"full time work"*, *"out of the school system"*, or more specifically children *"living independently"'*. There was clearly variability in the meaning attributed to these descriptions.

Children in full time education generally remained the responsibility of child and adolescent mental health services (CAMHS) up to the age of 18, when they became eligible for adult services and thus referrals could be directed to the CRTs. Again, interpretation of the description of *"in full time education"'* varied. For example, the lower age boundary in some services was 18 or 19 years old if in full time education. Others described offering a service *"when full time education ends"*. This could imply either the ending of compulsory schooling (16), a period of higher education (16-18), or at the end of a university career (21). Thus, it would appear age boundaries are determined and dependent in some cases upon the type of full time education establishment attended.

Team crisis response

Out of hours availability for on call

112 teams (67% of respondents) were available on call or on duty between 10pm and 8am. This is later corroborated by an item on telephone support where 37% of services reported a lack of 24 hour cover. An estimated average of 19 call outs during these hours was received per month (median 10; maximum 150). There was no effect of urbanicity for this variable with a similar proportion of suburban and rural teams offering this cover (58 and 60% respectively) compared with 74% of urban teams.

Response time

Our analysis of response times omitted cases where respondents had entered zero. Half the respondents responded within an hour to an urgent request for assessment at weekdays and weekends (see Table 25). However, 23% of teams reported taking four or more hours to respond at weekdays, after working hours on weekdays and at weekends. There was no effect of urbanicity on response times.

Table 25. Response time for assessment.

How quickly the team responds to an urgent request for an assessment (hours)			
Percentage respond in	During working hours	After working hours on weekdays	At weekends
1 hour	50	49	50
2 hours	24	25	26
3 hours	4	3	1
4 Hours	21	19	19
More than 4 hours	2	4	4
Total (%)	100	100	100
Mean	2.2	2.3	2.3
Number of teams	*161*	*148*	*149*

Home visiting

Only 91 (53%) of respondents reported operating a 24 hour, 7 day per week home visiting service. Only six of these teams were rural. In contrast 64% of urban teams reported operating this level of cover, and 39% of suburban teams (χ^2=11.4, df 2, p<0.005).

For those not providing a round the clock home visiting service the mean length of cover was 12.4 hours (median 13) on weekdays and 12.1 (median 2.5) at weekends. For 84% of the 63 teams for whom we had usable data on these figures, weekend and weekday hours were the same. They were longer on weekdays for 13% and longer at weekends for 3%.

For those not providing a 24 hour service, start times during the week ranged from between 7am and 10am (see Table 26). The most common arrangements were an 8am or 9am start. End times ranged between 4pm and midnight with 9pm and 10pm the most common end times. Of these teams 14.3% ended at 5pm or before at weekends (and 10.8% on weekdays). However, it is important to note that these teams represented only 6% of our sample as a whole.

Table 26. Start time for home treatment service.

Start time					
Weekdays			Weekends		
Times	Frequency	Percent	Times	Frequency	Percent
700	3	4.1	700	4	6.2
730	3	4.1	730	3	4.6
745	1	1.4	745	1	1.5
800	29	39.7	800	23	35.4
815	1	1.4	815	1	1.5
830	1	1.4	830	1	1.5
830	2	2.7	830	1	1.5
900	30	41.1	900	27	41.5
930	1	1.4	930	1	1.5
1000	2	2.7	1000	3	4.6
Total	73	100.0	Total	65	100.0

Table 27. End time for home treatment service.

End time					
Weekdays			Weekends		
Times	Frequency	Percent	Times	Frequency	Percent
1600	1	1.4	1600	3	4.8
1630	1	1.4	1630	1	1.6
1700	5	7.0	1700	7	11.1
1900	1	1.4	1800	1	1.6
1930	1	1.4	1900	1	1.6
2000	7	9.9	1930	1	1.6
2030	4	5.6	2000	4	6.3
2100	21	29.6	2030	3	4.8
2130	7	9.9	2100	14	22.2
2200	19	26.8	2130	7	11.1
2230	1	1.4	2200	16	25.4
2300	1	1.4	2230	1	1.6
2400	2	2.8	2300	1	1.6
Total	71	100.0	2400	3	4.8
			Total	63	100.0

Common arrangements for home visiting for those services not providing a 24hr service were a limited out of hours service ending at 9pm or 10pm. However a small number of teams (12) provided no out of hours home visiting service beyond 4pm or 5pm.

Telephone support

For the 34 teams for which we had useable data on these variables, 25% offered the same length of telephone support at weekends and weekdays. Only one team offered cover for a longer period at weekends. For the remaining eight teams cover was longer on weekdays than at weekends. Most common start times at weekends were again 8am (20%) and 9am (56%) and most common end times were 9pm (26%) and 10pm (18%). Twenty one percent of teams ended their service at 5pm.

Call outs at night to visit service users at home

Teams who said they were on call or on duty between 10pm and 8am were asked to provide details of how often on average per month they were called out to visit a user at home. The overall mean was 3.7. However, 42% reported that they were never called out to visit a user at home. The 59 teams (58%) who were called out reported a mean 6.3 occasions, with the distribution again skewed with median of 3, and a maximum of 60 estimated visits in one case (interquartile range 1-8). There was no significant effect for urbanicity.

Telephone support

Sixty three percent of respondents reported providing a 24 hr telephone support service. For those not providing a 24 hour arrangement, the amount of telephone cover out-of-hours averaged 12.3 (median 12) hours on weekdays and 11.7 hours (median 12) at weekends.

Start times ranged between 8am and 5pm and end times between 5pm and midnight at weekdays. Most common start times were 8am (28%) and 9am (49%). Two teams (5%) reported telephone support beginning at the end of the working day at 5pm.

The most common end times on weekdays were 9pm (37%) and 10pm (24%). For 10% of teams, the phone service ended at 5pm, operating only within working hours.

For the 34 teams for which we had useable data on these variables, 25% offered the same length of telephone support at weekends and weekdays. Only one team offered cover for a longer period at weekends. For the remaining eight teams cover was longer on weekdays than for weekends. Most common start times at weekends were again 8am (20%) and 9am (56%) and most common end times were 9pm (26%) and 10pm. (18%)

Seventy seven percent of urban teams, compared to 44% of rural and 59% of suburban teams provided 24 hour telephone support. This effect did not reach statistical significance.

Telephone calls at night

Teams who said they were on call or on duty between 10pm and 8am reported a mean of 62 telephone calls at night per month (excluding call out and home visits covered above]. However, the distribution was skewed with a median of only 21. There was no effect of urbanicity. Only 25% reported that responses were based on actual data.

Service plans for out of hour arrangements

Forty one percent of teams reported there were plans to change the hours of the service. Teams without clear proposals to change their hours of service identified review or audit

measures in place to map current and future need. The financial position of funding bodies, competing priorities and recruitment difficulties were identified as barriers to the development of the out-of-hours function. All teams described plans to extend their out-of-hours function, however the extent to which this target included 24 hour provision varied amongst teams.

The gate keeping function

Almost all teams (93%, 165 teams), regardless of urbanicity, reported that they aimed to provide an alternative to hospital admission to those people experiencing acute mental health difficulties. However, only 68% (115) of teams agreed that "The team acts as the gatekeeper to the acute inpatient beds by assessing people referred for hospital admission" highlighting a difference between aspiration and their current practice. Of these, 14% estimated that they were involved in gate keeping all referrals for admission and a further 74% of teams considered that they were involved in more than 60% of referrals. Only 12% reported being involved in between 40 and 60% of referrals and a small number (4%) less than 40%. It is important to note that gate keeping in this context refers to whether the team was involved in decisions to admit or not, not whether they were successful in keeping people out of hospital.

Only 43% of teams could report that "A senior psychiatrist can undertake home visits 24 hours a day through the medical on-call rota" with no effect of urbanicity. Fifty one percent of teams reported that the team can override decisions to admit made by others, including consultants and junior doctors, who are not part of the team.

Involvement in mental health act assessments

Most services (71%) were involved in Mental Health Act assessments to some extent. However, as Table 28 indicates, even for those involved in assessments this was far from routine practice. Only 8% were involved with all mental health act assessments.

Table 28. Involvement in mental health assessments.

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The team is involved in local Mental Health Act assessments		
	Percent of teams	Number of teams
Agree	71	115
Disagree	26	43
Unsure	3	5
Total (n=163/92%)	100	163
Of those who agreed, percentage of local mental health act assessments the team is involved in		
	Percent of teams	Number of teams
Everyone- 100%	8	9
Most-between 60 and 100%	26	30
About Half- between 40-60%	16	18
Less than 40%	50	57
Total (n=114/64%)	100	114

There was an effect of urbanicity with rural teams being most likely to be involved in mental health act assessment (χ^2=12.96, df 4, p=0.01; 85% compared with of 79% of urban and 54% of suburban teams). This is likely to be an artefact however, in that rural locations may have had lower incidences of formal assessments. In an urban location where more assessments are undertaken teams may have a lower awareness of the volume of assessments that they know nothing of.

Intensity and duration of input at point of crisis

Ninety five percent of teams reported that, “The team stays intensively involved for as long as necessary for the immediate crisis to be resolved” with no effect of urbanicity.

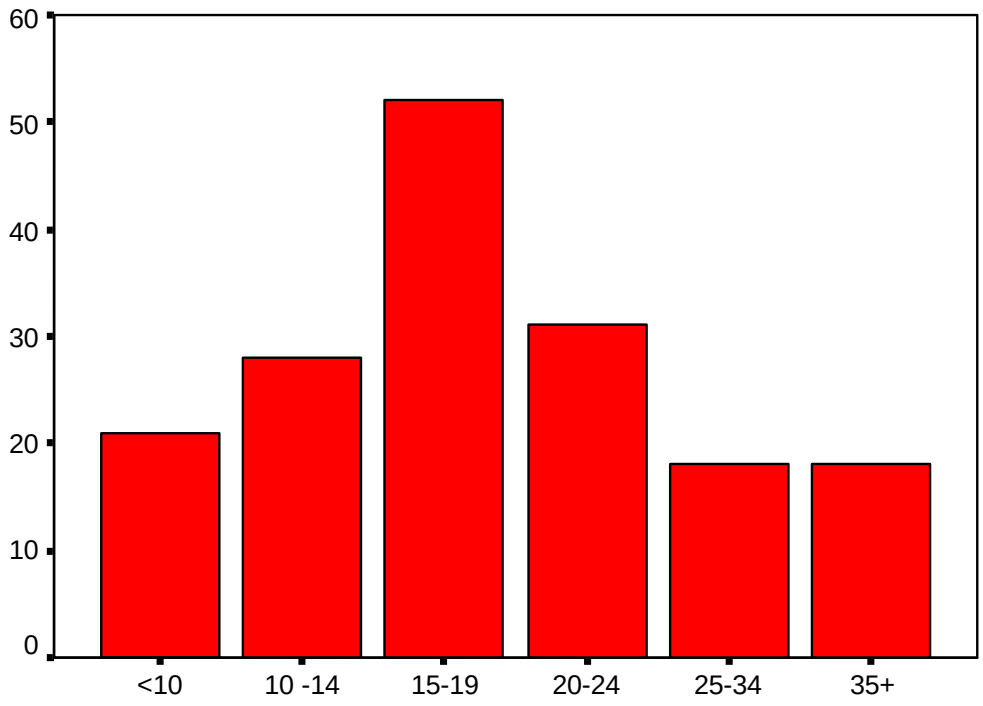
Overall team activity

The section aims to contextualise team activity in relation to the MHPIG and key variables described earlier such as team size, age and urbanicity. In so doing the aim is to provide a more developmental understanding of team performance. In light of the MHPIG description of “designated workers”, team size included for present purposes, all staff except administrative and ‘other’ disciplines.

Caseload

“Improvement, Expansion, and Reform” (Department of Health,2002) clarified that “When using service mapping data to estimate a baseline for the number of people in receipt of crisis resolution services the national assumption is that when fully staffed a crisis resolution team will have a caseload of 20-30 users”. When prompting by interviewer was required, case load figures were derived by asking the respondent to count the numbers of people on the board that day. This may have included those people in a process of assessment as well as receiving home treatment. The mean for current caseloads was 19.93 (median 18).

Figure 2. Distribution of size of team case load.



There was a wide distribution with a maximum caseload of 75. Twelve percent of teams reported that their maximum was lower than 15 and 37 % were above 30. The maximum team caseload size that teams would work to was 27 (median 24, see Table 29).

Table 29. Caseload activity, maximum and projected.

	Current Total for caseload for the team as a whole	Maximum total caseload, for the team as a whole, that they will currently work to	Expected team caseload by December 2005
Mean	20	27	24
Range	65	75	64
Percentiles 25	12	20	16
50	18	24	20
75	23	30	30
N Valid	168	151	155
Missing	9	26	22

There was a very significant effect of urbanicity on current caseload (K-W χ^2 = 12.24, df=2, p=0.002; U>S, p<0.0005) and differences in maximum caseload and expected caseload though not to a degree that reached significance (K-W χ^2 = 4.07, df=2, p=0.13; K-W χ^2 = 5.72, df=2, p=0.06) . There was a significant effect for urbanicity for the difference between current and maximum caseloads as a proportion of the current caseload (K-W χ^2 = 7.39, df 2, p=0.02). This suggests that urban teams were more often reporting that they were working to less than their current capacity. However, these effects did not endure when restricting the analysis to the 83 teams that reported basing their estimates upon actual data.

Current caseloads were positively correlated with both team size (on all measures of team size, p<0.005; see Table 30) and age, as was the maximum caseload that the team would work to and the projected team caseloads. Associations with the difference between current and maximum caseloads were not significant. Although the associations are statistically significant the amount of variance explained is small suggesting that team size is only a moderate indicator of caseload size.

Table 30. Team caseload related to size and age of the team.

		Team size	Team age (months)
Current total caseload for the team as a whole	Correlation Coefficient	.280	.241
	Sig. (1-tailed)	.000	.001
	N	160	154
Maximum caseload*	Correlation Coefficient	.319	.269
	Sig. (1-tailed)	.000	.001
	N	138	133
Expected team caseload by December 2005	Correlation Coefficient	.373	.185
	Sig. (1-tailed)	.000	.014
	N	147	142
Difference between maximum and current caseload as percent of current	Correlation Coefficient	-.053	-.081
	Sig. (1-tailed)	.268	.176
	N	138	133

*Data excludes cases where current>maximum.

Exploring the association between team age and caseload in more detail revealed that teams taking referrals for at least two years reported mean current caseloads of 21.5, around two more on average than those taking referrals for between one and two years and five more on average than teams taking referrals for less than a year, for whom current mean caseload was 16.3. Teams aged two years or more were in the lower range of the MHPIG recommendations (20-30). Teams between one and two years are close to

the minimum recommended caseloads, but teams less than a year old fall well below recommended levels.

Individual worker load

The MHPIG recommendations would yield a mean individual caseload size of 1.8 (caseload of 25 with 14 designated workers). When standardised for team size the current findings suggest that teams are working on average below this level irrespective of team age, with even those aged two years or more only averaging 1.6 per FTE. For younger teams the combination of higher staffing and lower caseload means that caseload per team member falls even shorter of MHPIG recommendations (see Table 32).

Stability as well as age appears to be important. The highest caseload per team member, (1.6) was evident in teams with no net change in staff during the past year (see Table 31).

Table 31. Case load related to team age.

How long been taking referrals	Mean team caseload	Mean caseload per		Number of teams
		Team member	FTE	
Less than a year	16.3	1.0	1.0	42
1 year, less than 2	19.7	1.2	1.2	42
2 years or more	21.5	1.5	1.6	46
All teams	19.3	1.2	1.3	130

Table 32. Case load related to staff growth.

Level of change in study teams[1]	Mean team caseload	Mean caseload per		Number of teams
		Team member	FTE	
Reduction	22.1	1.3	1.3	11
Same size	21.0	1.5	1.6	27
Increased by <25%	19.0	1.1	1.1	22
Increased by 25% or more	21.6	1.2	1.2	17
Taken referrals less than year	16.3	1.0	1.0	42
Total	19.2	1.2	1.2	119

Projections on number of clients currently on caseload

The MHPIG advocates caseloads of 20 to 30 service users at any one time. Clearly this will vary according to the demographics of the area. Inner city teams may cover

[1] Teams sampled are those more than a year old, with at least 5 staff a year ago.

populations of 40 – 60,000, while teams in less deprived areas could cover a population of 200,000. Therefore interpretation of these projections carry the same caveats as applied to the projections on team size above. The projections assumed (as per the MHPIG) that the caseload size should be 25 per 150,000 of the population.

Table 33. Deviation from projected caseloads using MHPIG guidance.

	Projected total caseload	Current caseload deviation
North East	1,243	47
North West	1,126	70
East Midlands	683	73
West Midlands	876	90
East of England	891	54
London	1,196	68
South East	1,330	43
South West	816	46
England	8,161	59

As would be predicted from the analysis of team size, the South East and West are seeing the lowest numbers of clients compared with the MHPIG with the West and East Midlands seeing the most. Overall, CRTs are estimated to be seeing 59% of the numbers of clients recommended by the guidance. The extent to which these differences reflect demographic differences between the regions has yet to be explored. Overall however, these figures may imply that CRTs are not serving enough clients or that the MHPIG guidance is not realistic given the staffing levels achieved and the nature of the work.

Team receipt of referrals for assessment and ongoing work

Respondents were asked to consider the average number of referrals that were accepted for assessment and the average number of referrals taken on by the team for on-going work per month over last year. This analysis is particularly salient in light of respondents concerns regarding the limited capacity to do home treatment because of pressure of referrals and assessment work (see below). Responses are explored in four ways: as number of referrals; the subsequent actions (as a percentage of the numbers referred) and numbers referred, controlling for team size and caseload. The mean for the average number of referrals was 69 (See table 34). The distribution of referrals was heavily skewed. (See Figure 3).

Table 34. Referrals per month, numbers accepted for assessment and numbers taken on.

N=136		Average number of referrals per month	Average number of referrals per month accepted for assessment	Average number of referrals per month taken on for on-going work after the initial assessment
Mean		69	51	23
Percentiles	25	33	25	15
	50	50	40	20
	75	84	70	28

Figure 3. Average number of referrals per month

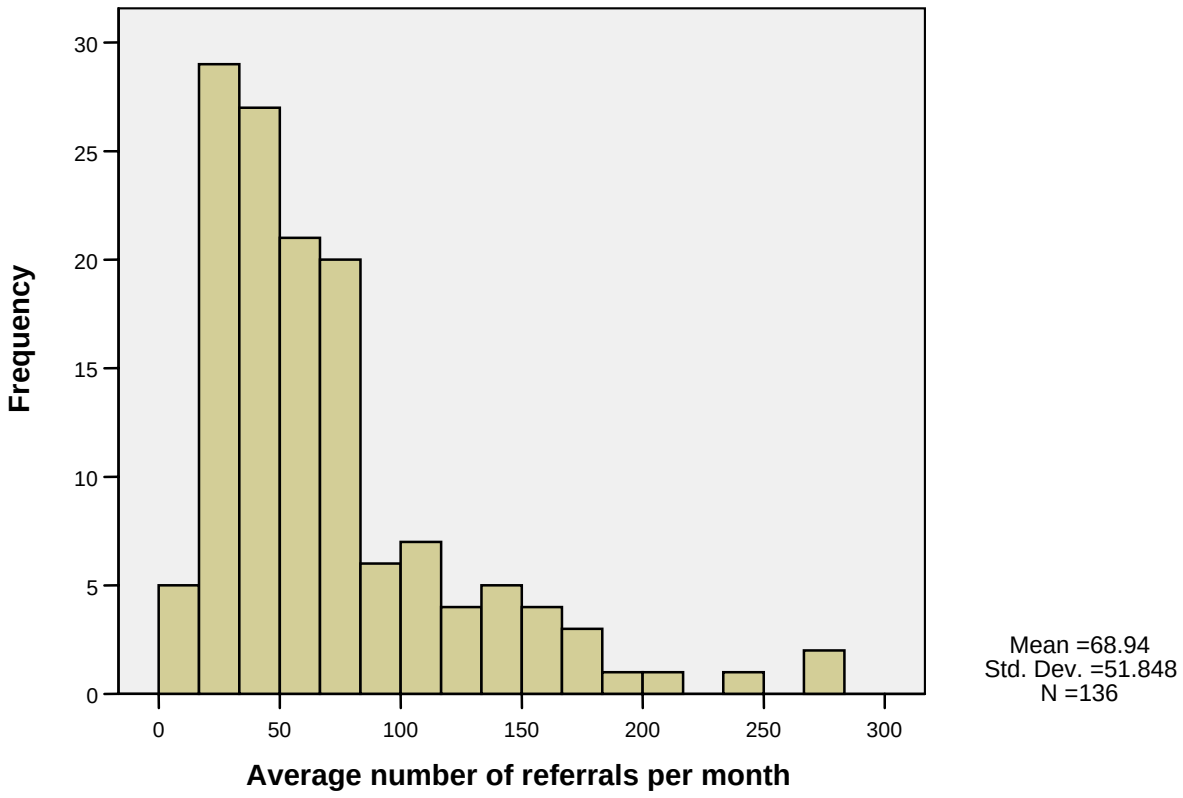


Figure 4 illustrates the number of referrals that are accepted for assessment. It is notable that around a third of referrals are assessed but not taken on for ongoing work. The mean for referrals which are assessed only was 35%. (See Table 35).

Around a fifth of teams report that in excess of 50% of their assessments are not taken on for ongoing work (38, 21.3%).

Figure 4. Average number of referrals per month accepted for assessment.

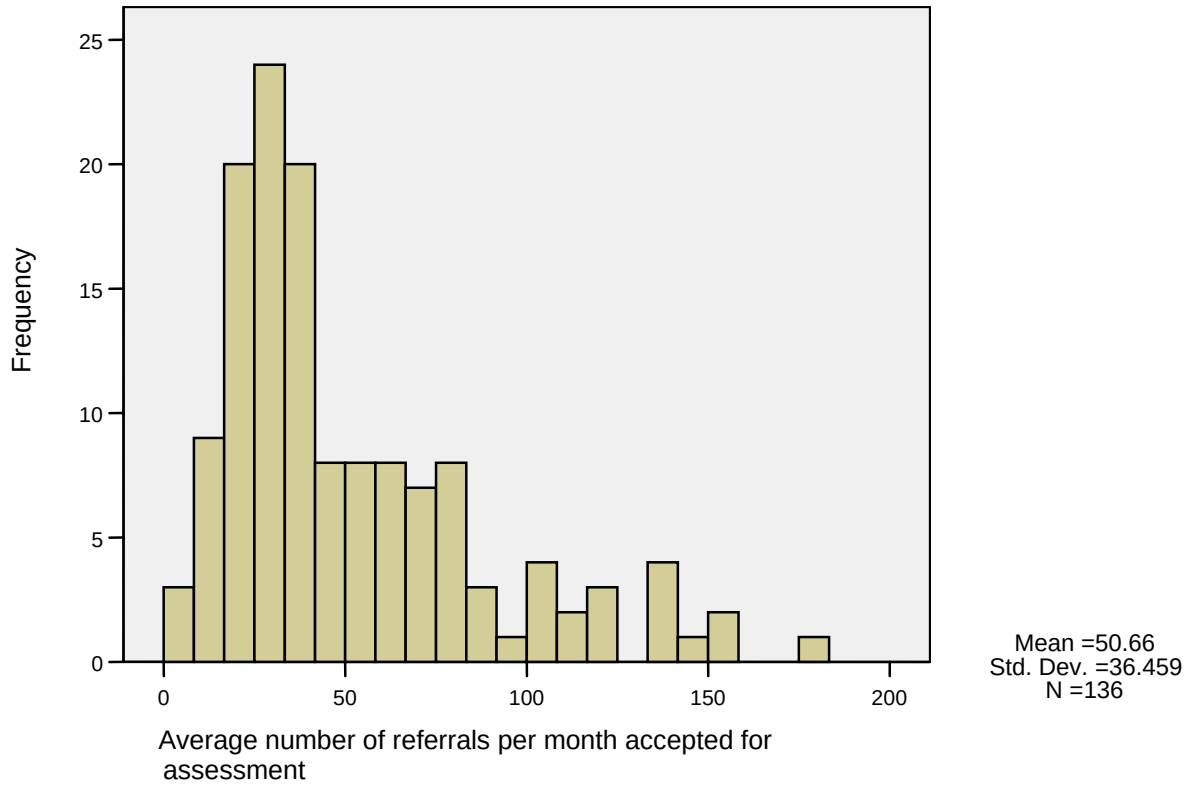


Table 35. Actions following referral.

		Percent of referrals not accepted for assessment	Percent of referrals assessed only - not taken on for ongoing work	Percent of referrals taken on for ongoing work
Mean		22.2	34.7	43.1
Percentiles	25	.0	15.2	24.5
	50	19.0	33.3	40.1
	75	34.4	50.0	59.4
	N.77%	136	136	136

There were significant main effects for urbanicity on the average number of referrals (K-W χ^2 = 9.2, df=2, p=0.01), the numbers accepted for assessment (K-W χ^2 = 7.51, df=2, p=0.02) and the maximum number of referrals accepted (K-W χ^2 = 7.27, df=2, p=0.03). There was no effect with respect to the numbers taken on for on-going work. All rankings were urban highest and rural lowest (see appendix D).

When exploring the proportion of referrals taken on for assessment and ongoing work within teams an effect of urbanicity was found for the percentage of assessments taken on for ongoing work (K-W χ^2 = 6.17, df 2, p=0.05) and a variable computed to explore the percentage of referrals that got an assessment only (K-W χ^2 =7.42, df 2, p=0.02). Urban teams take on a significantly higher proportion of their assessments than suburban or rural. However, none of these effects endured among the 83 teams who claimed to be basing their findings on actual data rather than estimates with the exception of the percentage of referrals taken on for ongoing work (K-W χ^2 =7.88, df 2, p=0.02).

Table 36 describes the relationship between team age and team activity. Considering all three outcomes, referrals to younger teams aged less than two years, are more likely to be referred on and less likely to be taken on for ongoing work than referrals to teams aged two years or more. Younger teams carry lower caseloads and accept proportionately fewer referrals for assessment and hence for ongoing work. The differences were accentuated when standardized for team size (see Table 37)**.**

Table 36. Average monthly referrals related to team age.

Means, reported average monthly referrals during past year	How long team been taking referrals			All teams
	Less than a year	1 year, less than 2	2 years or more	
Referrals	71	70	67	69
Accepted for assessment	50	51	51	51
Taken on for on-going work after the initial assessment	22	22	24	23
Number of teams	*34*	*44*	*48*	*125*

Table 37. Team Load.

Means, reported average monthly referrals during past year standardized for team size, caseload	How long team been taking referrals			All teams
	Less than a year	1 year, less than 2	2 years or more	
Mean per team member				
Referrals	3.8	4.0	4.0	4.0
Accepted for assessment	2.8	2.9	3.2	3.0
Taken on for on-going work	1.3	1.3	1.7	1.4
Mean Per FTE				
Referrals	4.0	4.2	4.1	4.1
Accepted for assessment	2.9	3.0	3.3	3.1
Taken on for on-going work	1.4	1.4	1.7	1.5
Mean per current caseload				
Referrals	4.9	4.4	4.1	4.5
Accepted for assessment	3.3	3.2	3.3	3.3
Taken on for on-going work	1.4	1.3	1.4	1.4
Number of teams (n=125 /71%)	*34*	*44*	*48*	*125*
Number of teams, standardized by caseload	*32*	*37*	*37*	*105*

Team activity post assessment

Intensity of contact with users

Respondents were asked to describe the proportion of the team's caseload that received visits at differing frequencies. One hundred and sixty teams reported the frequency with which users were seen following assessment but for eleven of these cases data was unusable because reported percentages did not total 100. Average contact frequencies for the remaining 149 are shown in Table 38. Table 38 describes the average proportion reported by teams and indicates that the highest proportion of caseloads was visited daily.

Table 38. Intensity of contact.

Proportion of caseload that is visited	Percentage
Twice a day or more often	20
Daily	43
Less often than daily but more than once a week	31
Once per week or less frequently	6

Table 39 considers in more detail levels of team visiting at the higher rates of frequency combining the top two categories (visited daily and twice a day or more often). Fifteen (10%) teams reported seeing all current users at least daily. A further 45 (30%) reported seeing 80% or more users daily. Sixteen teams (11%) reported seeing less than a quarter of users daily. Few service users were visited more than once a day. Forty two teams (28%) reported seeing a quarter or more of users at least twice a day (see Table 40). Twenty four teams (16%) reported never seeing users with this intensity.

Table 39. Proportion visited daily.

Proportion of caseload visited at least daily	Percent of teams	Number of teams
Less than 25%	11	16
25% - 40%	8	12
40%- 50%	11	16
50%- 60%	10	15
60%-70%	7	11
70% -80%	13	19
80%- 90%	17	25
90%-100%	13	20
All seen daily (100%)	10	15
Total	100	149

Table 40. Proportion visited twice daily.

Proportion of caseload twice a day or more often	Percent of teams	Number of teams
None	16	24
Less than 10%	13	19
10% less than 25%	43	64
25% or more	28	42
Total	100	149

Duration of contact with users

Guidance (NIMHE, West Midlands, 2004) suggests that the usual length of involvement of CRTs would be for period of 4-6 weeks. Respondents reported that the average length of involvement of a client during any given episode was a mean of 27 days, (median 21 days).

Table 41. Duration of involvement.

Number of days	Average length of involvement of a client during any given episode of work	Longest time will stay involved with a client during any given episode of work
Mean	26.9	75.6
Lower quartile	15	42
Median	21	56
Upper quartile	30	90

The mean longest time that teams will stay involved is 75.6 days with the median considerably less, at 56 days. More than four out of five teams (82%) reported a longest duration in the range four weeks to three months. (Table 42) There was no significant association between duration of contact and urbanicity.

Table 42. Longest time of involvement.

Percent distribution of longest time will stay involved during any given episode	Percent of teams	Number of teams
Under 4 weeks	4	5
4 weeks less than 6	15	19
6 weeks less than 10	42	55
10 -12 weeks/ 3 months	25	33
More than 3 months	15	19
Total	100	131

Table 43 describes in more detail the duration of team involvement with service users. A significant number of teams sustained contact for under three weeks and only 22% of teams reported that contact is sustained over a month.

Table 43. Average length of involvement in episode of care.

Percent distribution of average length of involvement during any given episode of work	Percent of teams	Number of teams
Under 2 weeks	11	15
2 weeks less than 3	20	26
3 weeks less than 4	22	29
4 weeks/one month	24	32
More than a month	22	29
Total	100	131

Range and intensity of activity

Table 44 illustrates the breadth and intensity of interventions provided by teams. Interventions are presented with those activities provided by many teams at high intensity of provision (daily or more often) presented first.

Table 44. Breadth and intensity of interventions provided by teams.

Activity	2-3 times Daily	Daily	At least once a week	Less often	Never
Monitor mental state?	76.9%	23.1%			
Provide risk assessment?	53.6%	39.3%	6.5%	.6%	
Provide multidisciplinary assessments?	28.6%	36.9%	25.0%	8.9%	.6%
Provide help with self help strategies?	27.4%	48.2%	20.8%	3.0%	.6%
Deliver psychological interventions?	36.9%	35.7%	13.7%	11.9%	1.8%
Administer medication?	33.1%	34.9%	9.5%	16.6%	5.9%
Provide multidisciplinary assessments?	28.6%	36.9%	25.0%	8.9%	.6%
Provide help in practical ways (e.g. shopping cleaning etc)?	19.3%	44.6%	22.3%	10.8%	3.0%
Ad hoc-unplanned meetings among staff to exchange information?	29.8%	33.9%	30.4%	5.4%	.6%
Deliver medication?	32.9%	28.1%	24.0%	13.2%	1.8%
Provide strengths assessment?	25.3%	30.4%	19.6%	17.7%	7.0%
Provide uni-disciplinary assessments?	29.3%	24.6%	24.0%	10.8%	11.4%
Provide help with activities of daily living?	16.8%	35.9%	31.1%	15.6%	.6%
Assess physical health?	18.7%	33.1%	15.7%	28.9%	3.6%

Activity	2-3 times Daily	Daily	At least once a week	Less often	Never
Arrange meetings of clinical staff to review work with individual clients?	14.4%	34.7%	47.9%	2.4%	.6%
Provide help with increasing social networks?	8.3%	40.5%	36.9%	13.1%	1.2%
Do training in identifying early warning signs of relapse for family members or other supports?	1.2%	6.5%	25.0%	38.7%	28.6%
Practical help for family members or other supports?	10.8%	31.7%	35.3%	19.8%	2.4%
Do other therapeutic work with families or other supports?	14.3%	30.4%	32.1%	20.2%	3.0
Provide help with housing needs?	7.9%	35.2%	35.8%	18.8%	2.4%
Provide help with maximising income?	4.8%	11.4%	44.9%	35.9%	3.0%
Use advance directives to help plan care?	1.8%	13.7%	39.9%	39.3%	5.4%
Provide access to a safe place for sanctuary? (See also next section)	1.8%	2.4%	18.1%	48.8%	28.9%
Undertake Mental Health Act assessments?	1.2%	6.5%	25.0%	38.7%	28.6%
Direct involvement in finding employment or other meaningful occupation?	1.8%	10.8%	16.2%	41.3%	29.9%

The most widely and intensively provided interventions post assessment were risk assessment, monitoring of mental state, help with self help strategies, delivering psychosocial interventions and administering medication.

It is surprising that small numbers of teams were providing and delivering medication less than weekly (17% and 13% respectively). The level of medical input is likely to have a bearing on this. The majority of teams provided multidisciplinary assessments either weekly or more often. Fifty four percent of teams provided unidisciplinary assessments on a daily or twice daily basis. It is evident that both forms of assessment were occurring

together in many teams. Assessment is an area where professional diversity may be important and this finding is perhaps unsurprising given the comparatively homogeneous workforce for CRTs with respect to discipline. Only a small number of teams (11%) reported never undertaking unidisciplinary assessments which may reflect differences in team philosophy rather than practice.

Around a third to a half of teams provided other key interventions with around once a week or more frequently, such as therapeutic work or practical help for family members or other supports, help with housing, income, activities of daily living or expanding social networks. Arranging reviews and *ad hoc* meetings with staff formed a significant part of team activity with the majority of teams reporting that this occurred more than weekly. The majority of teams provided training in early warning signs for family member or supports and in 40% of teams this occurred daily or more often. Frequencies for therapeutic work with families and providing practical help to them were similar and were for the majority of teams provided either weekly or daily. Nineteen percent of teams undertook this work less often than weekly. Some teams were working on a weekly basis with advance directives but many teams did this work less often and 30% had no contact at all.

Most teams (71%) undertook mental health act assessments; the majority on a less than weekly basis and only 29% said they did not provide this. The majority of teams provided help with maximising income and housing needs weekly or less often. Reports for direct involvement in employment (more than signposting) suggested that this is undertaken less often than housing or income management and it is more likely to be not provided at all (30%).

There was an effect for urbanicity for the frequency of delivery of medication (χ^2 =23.5, df 8, p=0.0003; U>S and R), uni-disciplinary assessments (χ^2 =17.4, df 8, p=0.02, S>R) and. The provision of practical help (e.g. shopping and cleaning; χ^2 =17.48, df 8, p=0.02; R<S and U).

Seventy three percent of teams overall could initiate new medication regimes (e.g. Clozaril). A significant effect of urbanicity was evident (χ^2 =6.3, df 8, p=0.04; where “disagree” and “unsure” categories were collapsed). This was most available among rural teams (87%; though the significant post hoc finding was U>S)).

Provision of a safe place of sanctuary

Table 45 below indicates that providing access to a safe place for sanctuary aside from acute in-patient care was offered at some level of intensity for more than four fifths of teams. Table 48 below summarises the descriptions of “the safe place for sanctuary” sought where teams indicated that provision could be accessed. The highest reference was to crisis beds in the community. Only two teams had their own beds. The next highest was for crisis houses and respite housing. The eight references to hospital beds are likely to be statements of ‘no available resource’ and admission as the only resort rather than beds deemed as separate from routine in-patient admission in some way The lack of non-medical crisis accommodation was a concern of many teams and is discussed in detail in the section on development.

Table 45. Nature of provision of safe place of sanctuary.

Safe place of sanctuary	Frequency
Crisis bed in community	16
Respite housing	12
Crisis house	12
Bed and breakfast	11
Hostel housing	8
Hospital	8
Women Refuge	8
Crisis unit	4
Private landlord	3
Crisis bed connected to team	2
Bed-sit	1
Supported living flats	1
Bed in residential unit	1
Nursing home	1
Police station	1
Nursing care unit 24 hrs	1
Two bed roomed flat rehab	1

The team approach or named worker systems

Ninety four percent of teams described operating a "teamwork approach where the team as a whole manages the caseload as opposed to team members maintaining individual caseloads". However, on the question "Do you operate a 'named worker' system or similar where individual clients have particular workers associated with them", 66% of team also replied affirmatively; indicating that they did not see these conditions as exclusive.

When looking at responses to both questions, 62% of teams said that they operated a teamwork approach *and* a 'named worker' system (110 teams). Only 26% reported that they operated a team approach and not a 'named worker' system (46 teams) and 2% operated a 'named worker' system and not a teamwork approach (4 teams).

Team work with other local services

Referrals from other services

The main sources of referrals were CMHTs, inpatient units and A&E (see Table 46). Seventy one percent of team reported receiving referrals daily or more often from CMHTs and half of teams received referrals from inpatient services on a weekly basis with 30% receiving referrals daily or more often.

The majority of services received referrals weekly or more often from primary care. Over half of teams received referrals from the voluntary sector less frequently than weekly and 36 % do not get any referrals. Sixty one percent of teams never received referrals from services for black and ethnic minorities.

Table 46. Frequency of referrals received from other services.

	2-3 times daily	Daily	At least once a week	Less often	Never
From CMHT/PCLT	24.7%	45.8%	28.9%	0.6%	
From Inpatient unit	7.3%	28.0%	54.3%	10.4%	
From Assertive Outreach Team	1.2%	3.0%	21.7%	59.0%	15.1%
From Rehab and recovery/continuing care team	.6%	1.8%	13.4%	45.7%	38.4%
From Early intervention in psychosis team			17.1%	51.2%	31.7%
From Substance misuse team		1.8%	11.4%	63.9%	22.9%
From Primary care team (inc. GPs)	20.0%	24.2%	23.0%	16.4%	16.4%
From Users themselves	3.7%	10.4%	23.9%	31.9%	30.1%
From User's family or friends	1.2%	10.4%	20.1%	40.9%	27.4%
From Accident & Emergency Depts.	20.6%	26.7%	30.9%	17.0%	4.8%
From Voluntary sector		1.2%	10.3%	52.7%	35.8%
From Voluntary and community services specifically for black and minority ethnic communities			1.8%	36.7%	61.4%
From Police		3.1%	20.5%	50.9%	25.5%
From Other alternatives to in-patient care	.7%	2.9%	5.1%	39.9%	51.4%
From Other	1.0%	6.7%	13.3%	29.5%	49.5%

Half of the sample also received referrals from other sources, mainly weekly or less often (each being single reports unless otherwise specified). Specialist teams and services, voluntary and statutory organisation were all cited. There was little common reporting on the nature of these.

The other referral sources were:

- ASW duty desk (3)
- Emergency reception centre (2)
- Homeless project (2)
- Law centre
- Housing department
- NHS walk in centre
- Drug service alcohol service
- Mental health
- Deliberate self harm
- Police surgeon
- Paramedics
- NHS direct
- Forensic service
- Acquired brain injury unit
- Out of areas team (2)
- CAMHS (2)
- NHS direct
- Military welfare
- Probation
- Salvation army hostel
- Care of the elderly
- Dual diagnosis
- Child and family team
- Psychology
- Women's refuge
- Supported rehab
- Homeless outreach team

Urbanicity was significantly related to the frequency of referrals from inpatient care, which was highest for urban teams and lowest for rural teams (χ^2=14.03, df=6, p=0.029; U>R). Nearly half of urban teams (46%) received referrals from inpatient units at least once a day compared with 25% of suburban teams and 14% for rural teams (2 teams).

Urbanicity was also significant with respect to referrals from primary care but the relationship is less straightforward (χ^2=15.94, df=8, p=0.043; U<R). Nearly one in four urban teams (22%) never received referrals from primary care teams while this applied for only 10% of suburban and 7% of rural teams (1 team).

Referrals to other services

Teams referred with the most frequency to CMHTs, inpatients and primary care (see Table 47). A quarter of teams refer on to the voluntary sector weekly and a half less than weekly. Forty six percent of teams made no referral on to BME services and when they do it is less frequently than weekly. The majority of service referred on to alternatives to inpatient care and a quarter did this weekly or more often.

Table 47. Frequency of referrals made on to other services.

	2-3 times daily	Daily	At least once a week	Less often	Never
To CMHT/PCLT	6.7%	24.8%	58.2%	9.1%	1.2%
To Inpatient unit	.6%	7.9%	61.0%	30.5%	
To Assertive Outreach Team		.6%	3.1%	62.6%	33.7%
To Rehab and recovery/continuing care team		.6%	6.9%	42.5%	50.0%
To Early intervention in psychosis team		.6%	6.7%	57.7%	35.0%
To Substance misuse team		3.1%	28.2%	57.7%	11.0%
To Primary care team (inc. GPs)	2.5%	18.4%	39.3%	30.7%	9.2%
To Accident & Emergency Depts		3.1%	18.5%	54.9%	23.5%
To Voluntary Sector	.6%	8.0%	25.8%	49.1%	16.6%
To Voluntary and community services specifically for black and minority ethnic communities		.6%	6.3%	46.9%	46.3%
To Police		.6%	5.5%	60.7%	33.1%
To Other alternatives to in-patient care	1.4%	3.5%	21.1%	38.7%	35.2%
To Other		3.8%	5.0%	28.8%	62.5%

Thirty seven percent of teams referred to “Other” organisations. Many cited specialist services, advisory and voluntary organisations and again there was little multiple reporting. The other services were:

- ASW duty desk (3)
- CAMHS (2)
- Homeless project (2)
- Law centre
- Day service crisis house
- Probation
- Salvation army hostel
- Emergency reception centre (2)
- Out of areas team (2)
- NHS Direct
- Military welfare
- Housing department
- NHS walk in centre
- Drug service alcohol service

- Mental health care of the elderly
- Deliberate self harm
- Police Surgeon
- Paramedics
- NHS direct
- Forensic service
- Acquired brain injury unit
- Dual diagnosis
- Child and family team
- Psychology
- Women's refuge
- Supported rehab
- Homeless outreach team

Urban teams made referrals to the voluntary sector more often than did suburban or rural teams (χ^2=16.34, df=8, p=0.038; U>S). Forty four percent of urban teams made referrals at least once a week, 26% of suburban and 13% of rural teams (2 teams). More than a fifth of suburban teams (23%) and 20% of rural teams (3 teams) never made referrals to the voluntary sector, twice as many as urban teams (11%). The relationship was more pronounced in respect of referrals to voluntary and community services specifically for black and minority ethnic communities (χ^2=32.05, df=6, p=0.0005; U>S and R) though this will be due to the greater number of such services in urban areas.

Referral to CMHTs

151 teams (93% of respondents) reported "experiencing delays in passing a case on to the local community team (e.g. CMHT/PCLT) when the crisis has resolved". For 81 (54% of these teams) this only happened when there was no allocated care coordinator with the team being referred on to. For the remaining 70 teams this also occurred where the individual had an allocated care coordinator.

For the biggest proportion of respondents encountering delays the problem occurred with less than 25% of cases (46%). A further 37% reported the delays for 25-50% of cases, 9% 50-75% and 5% reported that they had delays for over 75% of cases.

Care coordination

In all but two teams (1%) the care coordinator role usually remained with the existing care coordinator while the CRT was involved with the individual. In light of the finding above with respect to CMHTs this report was clearly a report of protocol rather than what happens in practice, as a significant number of teams are reporting finding that no care coordinator is allocated.

Interagency working with respect to medical cover

Only 18 teams (11%) reported that "All referrals need to be seen by a doctor before the team can accept them onto the team caseload ". However, once a client is involved with the team, 51% reported that "Each consultant is responsible for patients/users from his/her patch that are seen by the CRT" and 34% of respondents agreed with the statement that "The team's psychiatrists have responsibility for the psychiatric input to all of our patients/users".

As described above, 51% of teams reported being "able to override decisions to admit made by others, including consultants and junior doctors, who are not part of the team". 53% of teams reported that "Prescribing medication is mainly done from within the team".

Facilitating early discharge

Ninety four percent (100% of rural teams) reported that “When hospital admission is required the team is able to facilitate early discharge by providing intensive input in the community for those that still fulfil the criteria for the team”. Rural teams have less frequent referral from inpatient units which is likely to reflect the use of beds generally (see above).

Meetings

Teams reported a mean of 3.2, (median 3) types of meetings that the members of the teams attend. Approximately a third of teams reported one or two types of meeting, a third exactly three and a third four or more.

Table 48 reveals that in terms of involvement with other services, CRTs were most strongly linked into inpatient services and this extended to involvement in acute care forums.

Table 48. Meetings attended by teams.

Meeting	Frequency	Percentage of respondents	Percentage where meeting does not exist
Ward reviews	138	83	0
CMHT/PCLT reviews	127	77	0
Acute care forums	101	62	6
Assertive outreach meetings	39	24	4
Early intervention meetings	23	14	22
Other	45	55	11

Teams also reported on other types of meetings they attended. Day service meetings and bed management meetings were the most common reports; the latter again indicating links to the ward and an investment in a gate keeping role (see Table 49).

Table 49. Other meetings attended by teams.

Meeting	Frequency
Day service	7
Bed management meeting	6
CMHT manager meeting	4
CPA meeting	4
Liaison SHO meeting/junior doctors	2
Triage with primary care /GP forums	2
Steering group for CRT	2
Hostel meeting	1
Child and family meeting	1
Community opportunities (employment)	1
Rehab and recovery pathway meeting	1
Clinical governance	1
Police	1
Risk panel	1
Interface meeting (CMHT specialist team)	1
A&E	1
Dual diagnosis	1

Team leadership and management

Management arrangements

For this analysis comparisons are made with the national survey of CMHT conducted in 1993 (Onyett *et al*, 1994). Although the comparative data are old it does provoke questions about trends in team practice over the intervening period and this is the only source of comparative data available.

Table 50 reveals that most teams had their own designated manager. There are few recent comparative data on teams and their management. The CMHT survey found that 75% of community mental health teams had their own managers. It is likely that the arrangements described below partly reflect the extent to which CRTs were stand-alone teams or integrated into existing teams.

Table 50. Management arrangements.

Management arrangement	Frequency	Percentage
It has it's own designated manager	146	88.0
It is managed by a manager with other team management responsibilities	11	6.6
There is no identified manager	1	0.6
Other	8	4.8
Total	166	100.0

Distribution of management responsibilities

Respondents were asked to consider a range of planning and management responsibilities and to select from a range of responses the party that had *most* responsibility for the task in question. When making comparisons with the CMHT survey it is important to note that the current survey differed in that two new categories were used: “consultant nurse”, and “commissioners or purchasers of this service”. In comparing the distribution of most responsibility it is important therefore to bear in mind that the distributions were made over an extra two categories.

Team managers were most often identified as having most responsibility for key management tasks (more so than in the CMHT survey; see Table 51), though in some cases the team as whole was more often mainly responsible. For example, the team as a whole was more likely to be responsible when deciding which referrals are accepted day to day (52%), when to close cases (63%) and the allocation of cases (46%). This mirrors findings in the CMHT survey and so may not be unique to CRTs.

The role of management or steering groups was significant in deciding the client group of the teams, organising the evaluation and/or review of team policy and practice and assessing the level of demand for crisis resolution services in the local community.

The only area in which commissioners sometimes took most responsibility was in assessing the level of demand for crisis resolution services in the local community (10%) or deciding the client group of the team (9%).

The senior medical member of the team was seen as most responsible for over-ruling the clinical decisions of team members if necessary in 10% of teams though more usually this was the responsibility of the team manager (79%). This compares with 21% and 20% respectively in the CMHT survey indicating a significant strengthening of the role of managers and a decline in the role of medical staff in assuming primacy in clinical decision making.

The only area in which significant proportions of teams typically left the decision to individual team members was deciding which referrals the team accepts day to day (19%), allocating cases to team members (12%) and clinical supervision (10%). However, this compares to 21%, 18%, and 15% respectively in the CMHT survey. More striking is the fact that in the CMHT survey 68% of teams left decisions as to when to close cases to individual team members in contrast to only 8% in the present survey, a major shift towards this being a team decision. This might again reflect the particular salience of good

risk management for this client group or a more general trend towards more integrated team working among community teams.

Perhaps, the most striking contrast with the earlier CMHT data is the high proportion of teams where the team manager is most responsible for clinical supervision (62% in comparison with 15% in the CMHT survey). This is mainly at the expense of the role of professional line managers. Half of teams in the CMHT survey reported that professional line managers were mainly responsible for supervision in comparison with only 13% in the present survey. It is likely that this partly reflects the comparatively homogeneous nature of CRTs in that they mainly comprise nurses. Alternatively it may reflect a more general trend towards supervision across disciplinary boundaries. The same phenomenon can be observed with respect to authorising leave. The proportions regarding this survey with respect to the CMHT survey are 93% vs. 33% for team managers, and only 4% vs. 55% for professional line managers (see appendix E for a full table of the earlier CMHT findings). It would be of interest to repeat the CMHT survey to see if these trends are reflected in CMHTs also.

Table 51 Distribution of management responsibilities.

	Team manager and/or co-ordinator	Team's senior doctor e.g. consultant or specialist registrar	Consultant nurse	Individual team members	Professional line managers	Other individual managers or planners outside the team	Management or steering group	Team as a whole	Commissioners or purchasers of this service
Deciding the client group of the team.	41.0%	1.2%	.6%	5.2%	.6%	2.9%	16.2%	22.5%	8.7%
Deciding which referrals the team accepts day-to-day.	28.3%		.6%	18.5%				52.0%	
Deciding when team members should close cases.	22.0%	4.6%	.6%	7.5%	1.2%	.6%		62.4%	
Allocating cases to team members.	33.5%			12.1%	1.2%	.6%		45.7%	
Clinical supervision of team members.	62.4%	1.7%	1.7%	9.8%	12.7%	1.2%		8.7%	

	Team manager and/or co-ordinator	Team's senior doctor e.g. consultant or specialist registrar	Consultant nurse	Individual team members	Professional line managers	Other individual managers or planners outside the team	Management or steering group	Team as a whole	Commissioners or purchasers of this service
Authorising team members leave.	93.1%	.6%		.6%	4.0%	.6%		1.2%	
Liaising with senior management over team issues.	94.2%		.6%	.6%	1.2%	.6%		2.9%	
Representing the team at public meetings.	82.7%	.6%		2.9%	2.3%	1.7%	1.2%	8.7%	
Over-ruling the clinical decisions of team members if necessary.	78.6%	10.4%	1.7%	1.2%	1.2%	.6%		5.8%	
The managing the day-to-day running of the team	82.7%		4.6%	4.6%	1.2%			6.4%	
Organising the evaluation and/or review of team	79.2%		1.2%		2.3%	1.2%	10.4%	5.8%	

	Team manager and/or co-ordinator	Team's senior doctor e.g. consultant or specialist registrar	Consultant nurse	Individual team members	Professional line managers	Other individual managers or planners outside the team	Management or steering group	Team as a whole	Commissioners or purchasers of this service
policy and practice.									
Assessing the level of demand for crisis resolution services in the local community.	57.8%				1.7%	9.2%	17.9%	2.3%	10.4%
Building working relationships with other key local services	65.9%			4.6%		1.2%	1.7%	24.9%	.6%

Overview of team fidelity

An implementation measure of fidelity to MHPIG guidance was developed from the range of variables studied. These were derived through review of the guidance and seeking expert advice within the research team and beyond, asking respondents to prioritise those features which they felt to be most indicative of fidelity as described by the MHPIG and the extant literature. This resulted in a simple six point scale based on the following variables.

1. The team aims to provide an alternative to hospital admission for those experiencing acute mental health difficulties.
2. The team provides a 7-day per week, 24-hour home-visiting assessment service.
3. The team provides a 7-day per week, 24-hour telephone support service.
4. The team is available on call or on duty between 10pm and 8am.
5. The team stays intensively involved for as long as necessary for the immediate crisis to be resolved.
6. The team acts as the gatekeeper to the acute inpatient beds by assessing people referred for hospital admission.

150 teams answered all six questions. Nearly all (98%) indicated they aimed to be an alternative to hospital admission and that they would stay involved with a case until the crisis was resolved (97%). Seventy two percent reported gate keeping hospital admission, 67% as being on call between the hours of 10pm and 8am, and 55% and 63% respectively as providing home visiting and telephone based support 24 hours per day seven days per week (24/7). These raw figures suggested some inconsistencies in the responses so two filters for implausible answers were introduced. The first excluded teams giving incompatible answers for 24/7 home or telephone support and night-time on call provision. The second excluded teams reporting a gate keeping function without 24/7 on-call. These tests excluded 39 of the 150. Using this cleaned data, teams reported meeting a mean of 4.9 of the criteria.

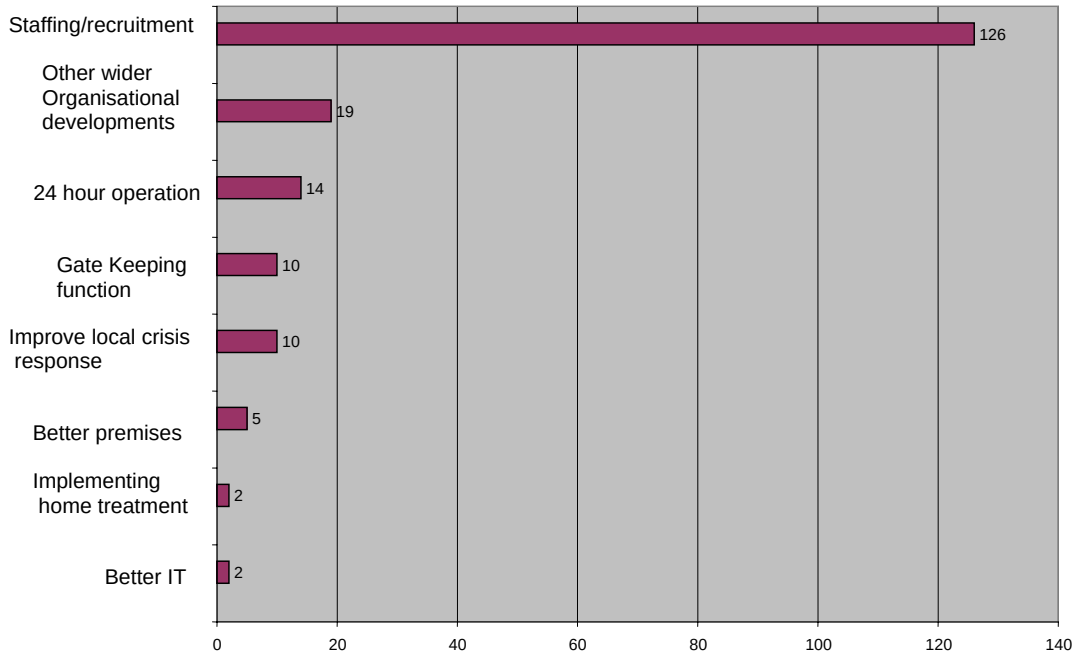
In addition, teams were asked, “Would you describe your team as fully set up to meet the needs of the numbers of people in your patch who fulfil the criteria for CRT as defined in the Policy Implementation Guide?” The 70 (40%) teams replying affirmatively had significantly higher fidelity scale ratings (mean 5.3 vs. 3.9, $p<0.0001$). They were also older (34 vs. 25 months; fidelity and team age were weakly but significantly correlated, $r_s = 0.22$, $p<0.01$). However, the relationship between fidelity and team age was not simple. Those in their first year reported fewer fidelity markers using the cleaned fidelity scale above (4.4) but one team more than five or more years old reported providing neither home or telephone support on a 24/7 basis and two reported not acting as gatekeepers. Eighty eight teams said they did not expect to be fully set up by December 2005. Differences with respect to fidelity were most evident on whether the team provided a 24-hour home visiting assessment.

There were also significant effects of urbanicity for the fidelity measure (K-W $\chi^2=9.44$, df 2, $p=0.01$; U>S) and whether teams judged themselves to be fully set up (K-W $\chi^2 =9.29$, df 2, $p=0.01$: U>S). The lowest proportion of teams that were reporting themselves as fully set up were suburban (25%), followed by rural (38%) and urban (50%) teams.

Priorities for development for teams to describe themselves as fully set up

As described above in the discussion on fidelity, only 70 (40%) of teams described themselves as fully set up. Following this question respondents were asked to describe “What would you need in order to describe yourself as fully set up (beyond just funding)?” The bar chart in Figure 5 describes the number of references in a range of categories. These key themes are returned to in greater detail with respect to a later question concerning “The most useful developments or actions that would improve the effectiveness of your service?”

Figure 5. Frequency of references to priority developments in order to be fully set up.



Staffing and recruitment was the major concern by a long margin (126 references). Of these 80 references were to specific disciplines with medical input (27) being the largest category and within this consultant cover was the biggest priority (12). Social workers or ASWs were the next priority (16) followed by occupational therapy (8), psychology (7), nursing (usually F grade; 6), administrative staff (5), service user development roles (3), carer development roles (3), support workers (3), link workers to wards, and health care assistants to support each shift. There were 15 references to the need for more staffing in order to be a multidisciplinary team or have the full complement of staff.

Other wider organisational developments formed the next major category (19). This included a very diverse range of developments such as training or teaching (3), redesign of day services to fit better with the CRT function (2), "chang[ing] the culture in acute psychiatry that equates psychosis with inpatient care", organisational development work to look at ways in which CMHT and crisis team working can engage users better and do better preventative work, clearer referral pathways, changing the practices and understanding of some of the other services, combining teams, creating more robust management structure, "Movement on the model", focussing on early discharge and improved user involvement.

Achieving 24 hour operation was the next major category (14) which bore heavily on the need for more staff above. Getting the gate keeping function in place was the next most frequently cited (10). There was reference to the need for management support to back up decisions make by the team to not admit in the face of medical opposition.

There was an equal number of references to improving the local crisis response (10) including joint working out of hours with other teams (3) establishing a crisis line, telephone support, crisis houses, crisis accommodation, crisis beds and stopping the diversion of resources away from CRT (e.g. to cover A&E).

Finally there was a miscellany of references to the need for better premises (5), implementation of home treatment (2), improve IT (2) including implementation of the Electronic Patient Record.

Perceived obstacles to implementation

Teams were asked to describe the major threat to their continued effectiveness. They had the opportunity to describe the top three. Numerical references below are to the number of references to that particular theme.

One team reported that “There are no significant threats- the team has clear roles and is well resourced” and another stated that there were “No obvious threats” to this “well established service”. However, they were very much the exception. In general concerns focussed around lack of resources. There were 129 references to lack of staff and 82 references to other financial or resource constraints.

Within the staff issues, lack of medical cover or input was the most often cited concern (38). This was predominantly a concern for senior medical cover, for example to “fight our corner with other medics” and enable gate keeping. Lack of this sort of cover was also associated with problems prescribing and risk management. Recruitment and retention generally were the next most often cited staff concerns, with a desire to recruit nurses, social workers, administrative and support workers cited. On the former there were three references to concerns about Agenda for Change with the comment that “It will have a negative impact as bandings do not support CRT as a career progression.

Within the many (82 references) concerns about funding and finance issues, the most frequent references (12) were to the resulting lack of training opportunities. There were also concerns about specific cuts to the team itself, day hospital and ASW and emergency duty services. Reference was also made to bed cuts increasing the pressure on the service, or resources not transferring from inpatient beds when an impact on admissions had been achieved.

The next major category of concern (67 references) related to inter-team problems. The dominant concern was with CMHT capacity problems (24). There was reference to CMHTs being "in a desperate state of burnout and poor resources. They are evasive about contact and don't ring back" with the effect that CRTs had to take on and hold cases for long periods with no one to refer on to. More general interface/communication problems (13; often exacerbated by poor IT) was next most often cited within the inter-team problem category followed by lack of joint working at practice level, too many referrals, difficulties in working with primary care, and other teams appearing to be jealous or threatened by CRTs, notably CMHTs and inpatient

services. The concerns with primary care again bore on capacity problems but also a perceived lack of understanding of the role of the CRT and work with severe mental health problems generally.

The forth major category (55 references) was to medical culture, practices or attitudes. The latter was the most often cited issue manifest in vocal opposition to CRTs or not using CRTs unless beds were full.

General concerns about reorganisation and change formed the next major category (46 references) with concerns about amalgamation of teams reported most often (10). This bore on a concern in some cases that this would make teams too large to be workable. Further concerns were expressed about the constant and continuous pace of change and the uncertainty it created.

There were nearly as many references to wider organisational issues (44) and within this category lack of support and understanding from senior management was cited most often. This was linked for example to feeling under constant pressure to demonstrate an impact on beds, a concern that change was too target driven and feeling under threat of reduced resources if targets were not met. Concerns about organisational issues were diverse but included a sense that “there was no broad ownership or understanding of the home treatment philosophy of care, reflected for example in a lack of consensus locally about risk taking. There was also concern about competition between difference parts of the service. One manifestation of this concerned beds where there were reports of the threshold for admission lowering as CRTs made an impact. One respondent commented, “"When it was suggested that we could close another ward because the CRT were so effective- within 48 hours the beds were full”

There were 34 references to concerns about diversion of resource away from home treatment, mainly due to the load created by requests for assessment. There were 12 references to inappropriate referrals and A&E liaison work was cited as a source of unnecessary assessment work (15).

There were 26 references to denial or lack of support for the team’s gate keeping role (aside from the concerns about medical attitudes referred to above).

There were an identical number of references to expectations of the CRT being too high or unrealistic with pressure to take on work outside of the original remit, (e.g. A&E work; covering for CAMHS, assertive outreach and older adult services out of hours and also learning difficulties. One respondent commented that, “The risk is that we become something for everyone to cover the holes in existing services".

Burn out and low morale was referred to as an obstacle to effectiveness (19 references). One commented, "Even highly motivated staff are very affected by the intensity and distressing nature of practice. Have to work against the 'toughing it out' mindset that makes people continue past their limits". There were references to sheer overworking and the lack of choice and reward associated with out of hours working.

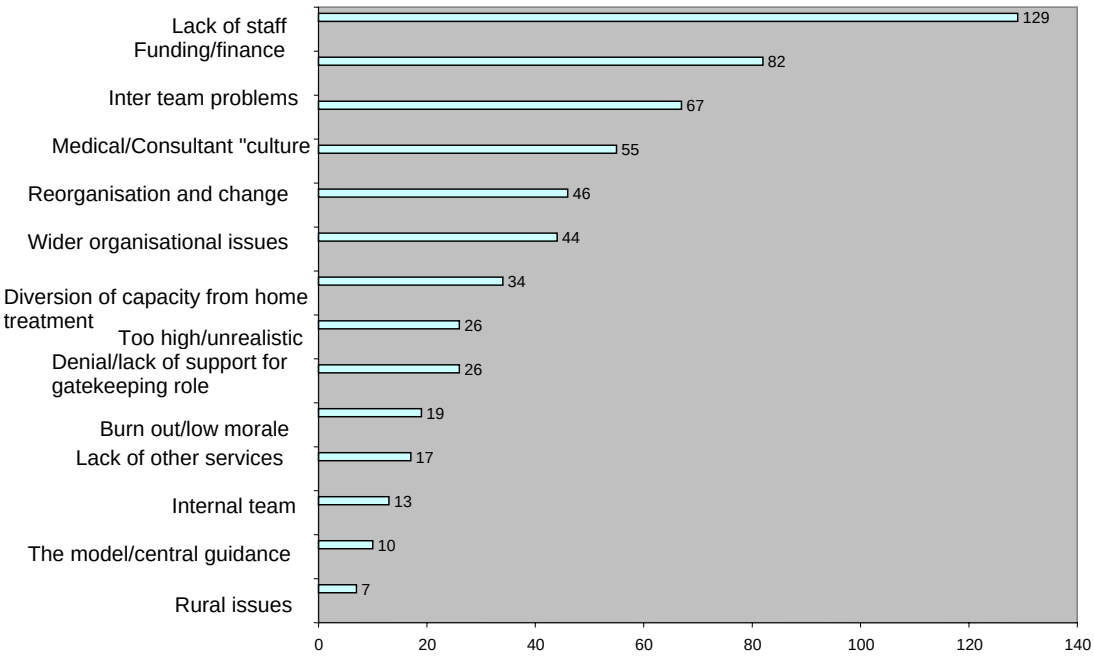
Lack of services was cited as the next major category (17) with crisis houses or beds being most frequently cited. Day care, housing (particularly long term placements), appropriate respite care, other alternatives to admission and services such as early intervention and rehab were identified as gaps in provision that impacted on the effectiveness of CRTs.

There were 13 references to internal team problems such as lack of cohesion, staff not wanting to do on call, or lack of staff support. There were 10 references to higher level issues such as perceptions that the guidance on CRT was inflexible in being too target driven or that CRT was falling off the political agenda.

There were only seven references where the issues were framed as rural problems. These concerned the distances that needed to be travelled, the lack of resources in rural areas and the importance of acknowledging differences in culture.

In summary, Figure 6 reveals that the greatest concerns among respondents were with respect to lack of resources to meet the demands both of out of hours working and the assessment load. The major resource concern was for lack of staff. However, collateral resources at a local level was also a major issue, particularly with respect to the capacity of CMHTs. Aside from issues of resourcing, respondents also reported that lack of support and understanding of CRT at local level, particularly from medical staff but also from senior managers.

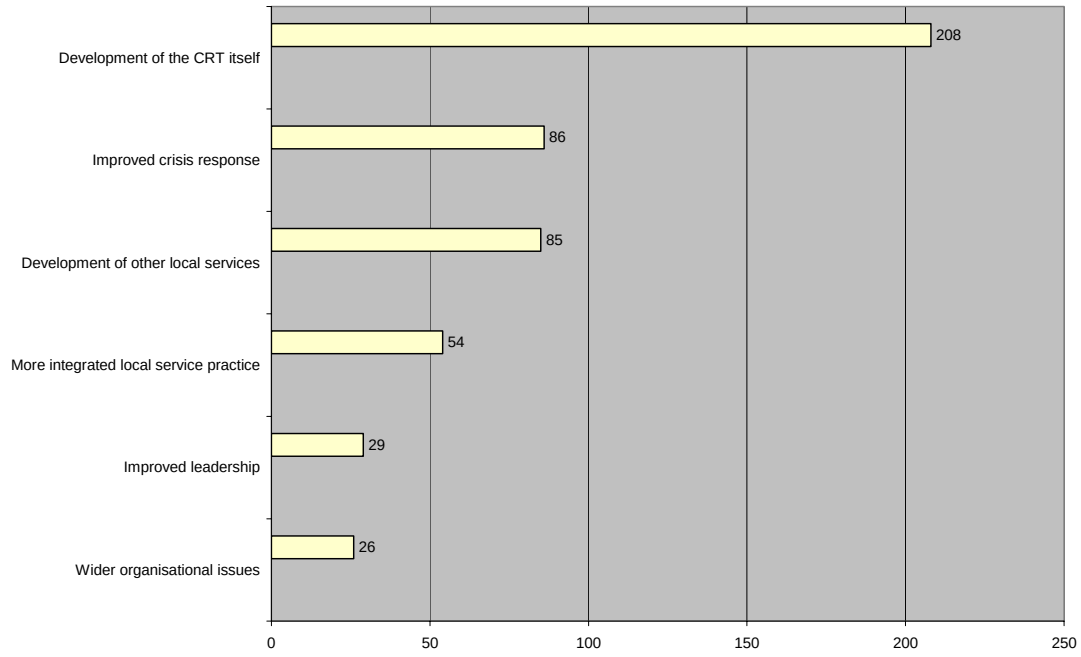
Figure 6. Frequency of references to obstacles to implementation.



Priorities for development and solutions emerging

Respondents were invited to describe, “The most useful developments or actions that would improve the effectiveness of your service?” The biggest category (see Figure 7) concerned developments for the team itself (208) and as would be predicted from the analysis of obstacles to effectiveness above; more staff was the most widely sought development (86). Within this category medical input was most widely sought (30), particularly dedicated consultant cover (18). There were three references to seeking cover that covered both inpatient and community services. Most other comments concerned recruiting to full complement in order to fulfil the right range of functions.

Figure 7. Frequency of references to priorities for development.



Again reflecting the above analysis, respondents highlighted general lack of resources as the next most significant category with respect to developments for the team itself (22 references) with a further 19 references to the need for a new or different base for the team. There were 15 references to the need for development support and supervision and within this category time for the team to be “away from the clinical arena to look at team building and skill development” was most often sought. Aside from these priorities there were a further 13 references to training. Combining this category with the one above would have made general development support requests second only to the need for more staff in terms of numbers of references within the developments for the team itself.

Other issues for team development were the need to extend hours (11), improve IT (9), and clarify the role of the team (4).

Going beyond developments for the team itself, the next major category concerned improving the local crisis response generally (86). Within this category, the most frequent references were to more alternative responses to crisis (61) and crisis beds (24) and crisis houses (18) dominated within this category. Reference was also made to the need for cash to pay for B&B accommodation or other crisis beds, safe houses (particularly for homeless people), better triage with ASWs and locating the mental health act assessment process away from the emergency duty team out of hours.

Respondents clearly recognised however, that an improved crisis response was not just about resources. Within this category, there were 19 references to the need for a more coordinated response: "A true whole systems approach to manage admission requests working in a joined up way rather than as separate departments". Of the 19 references, 14 bore on the need for trust wide acceptance of the CRTs gate keeping role. Other ideas for improvement included better developed pathways, protocols and criteria (including the recruitment of a pathways development worker); a "strategic manager" for the emergency service covering out of hours crisis work to provide an overview; "one consultant wards" to promote effective gate keeping; and a hospital night project to coordinate services.

The next major category concerned the development of other local services (85) and here (as would be predicted from the analysis above) CMHTs predominated (18) followed by day care (10), primary care (8), A&E liaison services (7), respite care (6), services for people diagnosed with personality disorder (6; particularly “borderline”), early intervention (4), housing (4), hostels (4; particularly for homeless people) and inpatient services (3), other access and assessment services to allow CRTs to do more home treatment (2).

The next major category (which can be partly regarded as an extension of the concern to provide an improved local crisis response above) was more integrated local service practice (54) references. This particularly related to inpatient services (13) and the scope to work more closely to promote early discharge (6). Concrete ideas included inpatient staff having increased decision making powers so they do not have to wait for ward rounds, developing criteria for early discharge, changing cultures so inpatient staff do not feel they have to create the "perfect patient" for the CRT to take them on, and discharge liaison nurses or link worker roles dedicated to promoting early discharge.

CMHTs were the next most frequently cited (7) part of the local service with which the CRT sought more integrated practice. Ongoing and better education and understanding regarding CRTs was advocated for the whole local system and referrers (6) with enhanced communication and better links to primary care (7). There were three references to ‘networking lead’ roles aimed at developing better relationships and closer joint working across interfaces. The need for one operational policy for all CRTs in the Trust (4) and a trust-wide robust risk management policy (2) was also highlighted. A better developed care coordinator role was seen as a means to improved joint working, and it was felt that currently there was “variable practice and abdication of the role in some cases”.

The next major category was the need for improved leadership (29). This most often concerned change and development (16). One respondent referred to "Implementation of a planned approach to service development so that team development is part of a whole system plan" and another to the need "to sustain a development culture around the team which allows it to mature". The theme of CRTs needing to be better understood emerged again: “For the trust.. to listen to experienced people within the workforce and organisations such as NIMHE when attempting to change services". There was also reference to the need for “permission to look at alternatives to the MHPIG model and use current resources where needed”. Many of the other responses concerning leadership related to the need for a more coordinated local service response as described above. This related strongly to the next major category which concerned wider organisational issues (26) and again highlighted the need for improved understanding of CRT locally and the need for a trust wide approach. Reference was made to the need for locally appropriate development, where it could be acknowledged that there is "very limited need for a 24 hour service in this area”. There were also references to the need for a challenge and alternative to the predominant medical model.

Activities which contribute to the success of the team

Teams were asked to comment on any activities which contributed to the success of the team. Activities which supported an effective team approach emerged as a central theme (91 total references) incorporated interprofessional working (25), team ethos (31), support and training (20) and communication (15). A multi-disciplinary

team approach enabled the sharing of clinical decision-making, and "increased the range and variety of work" for staff members. Excellent written and verbal communication between team members were essential to successful practice, as was a culture of debate and challenge, allowing for the open expression of views (15). One team reported upon the "strength of relationship between consultant and team manager". Some respondents described the qualities of staff members as critical to team success; staff being highly skilled, experienced at responding and working with crises, committed and focused (10 references). Others described the "richness in multi-disciplinary membership" and the role of "timely and appropriate psychosocial assessment". Teams valued the contribution of different disciplines and perspectives and cited dedicated medical input (4), a "user development worker role" (3), occupational and family therapy. Team working was nurtured through a culture of reflective practice (2) and staff care (5). Examples of positive practice were cited such as taking an "active role in watching for team stress". Regular team meetings and team away days provided the context for development e.g. "weekly facilitated staff dynamic sessions". Teams valued peer support (3) and supervision for staff members (7).

Collaboration with other parts of the mental health service was described on a spectrum of effective communication, through to active liaison and joint working (35 references) Regular attendance at ward conferences and effective communication at the interface with other stakeholders was crucial. A supportive relationship with other services (informal advice and supervision), and partnership working ("crisis management planning for CMHT staff") was cited. Whole systems change for teams involved a willingness to explore rather than undermine differences in practice, to clarify and educate regarding the role and function of the service. Examples of innovative inter-agency working (4) included a mental health nurse position within the custody suite of the local Police Station, and close partnership working with probation. One team manager described the ease of accessibility to effective local services (e.g. drug and alcohol, CAB and emergency housing).

Respondents described a commitment to service user collaboration in care planning, risk assessment and positive risk management (7 references). One team actively involved a service user in the facilitation of support services.

Strong leadership at team manager level was cited as being a success factor by three teams only, though it needs to be considered that in most cases the leader of the team was the respondent and so they may have been less likely to reference their own contribution to the team's success. Senior management commitment and support of the home treatment model was valued.

Team training and development

Training received

86 teams (52% of respondents on this item) reported that they had received "any formal training around the establishment and/or running of crisis resolution services ". Table 52 describes the provider of training received. The strong contribution of the Sainsbury Centre for Mental Health is notable. Higher education had a very limited role in provision of training.

Teams were asked to reflect on what aspects of this training were most useful (see Table 53). Team building was the most popular element

Table 52. Providers of the training.

Training Provider	Frequency (no of references)
Sainsbury Centre For Mental Health	57
Accessing local mental health services & expertise including NIMHE support through regions	24
CRT Services and other expertise	8
Non-specified conferences & workshops	4
International Experts	2
Higher Education Institutions e.g. Skills Based Training on Risk Management (STORM). Manchester University.	2
"Organisational & Personal Development Consultants"	1
Independent trainer/clinician consultant	1

Table 53. Aspects of training found most useful.

Aspects of Training found most useful	Frequency (no of references)
Team Building	22
Risk Assessment-Risk Management	18
Theoretical Aspects of Model	12
Establishment of Team Identity- Confirmation of	7
Networking with other teams and practitioners	6
Experiential Knowledge	5
Did not find useful	3
Did not participate	2

Identified training needs

Teams were asked to identify their top three training needs. Responses fell into the following broad categories.

1. Interventions and practice skill; (240 references).
2. Collaborative working (134 references)
3. Understanding wider Trust systems and policies (23 references);
4. Management support and leadership (6 references).

Interventions and practice skills

Further training and support was required to operationalise the social/recovery/strengths model of care:

- Psychosocial assessment;
- developing a skills base and expertise in social systems intervention;
- relapse prevention;
- understanding the complexity of benefits and housing provision, and
- promoting social inclusion.

Teams also wanted training to focus upon interventions and clinical skills appropriate for the CRT setting.

- Cognitive behaviour therapy
- Cognitive analytical therapy
- Dialectical Behaviour Therapy
- Solution Focussed Brief Therapy;
- Family Work;
- Motivational Interviewing;
- Other clinical skills e.g. counselling
- Medical Issues
    - o Nurse Prescribing;
    - o Patient Group Directives (medication module);
    - o Mental Status Examination.

Interventions and specific skills to work effectively to meet the needs of groups with complex needs were also sought. The groups included:

- Personality disorders;
- Dual diagnosis and substance misuse;
- Self-harm;
- Victims of domestic violence;
- Eating Disorders;
- Young people;
- Culturally diverse groups e.g. cultural competence, sexual diversity training.

Services identified a number of clinical skills to be explored specifically in relation to the delivery of the CRT model.

- Crisis assessment
- Discharge planning;
- Crisis call handling;
- Concordance/medication management/storage;
- Case Management;
- Care planning;
- Alternatives to admission; *"How, when, what is appropriate".*
- Relapse prevention.

Collaborative working

There were three dimensions of collaborative practice described:

1. Collaborative care planning and risk management with service users;
2. Team effectiveness and development;
3. Whole systems working.

To support collaborative care planning and risk management with service users and carers teams needed support in:

- Engagement skills;
- Understanding diversity;
- Risk assessment and management
  a) Risk assessment in a CRT context;
  b) Positive risk taking in a community setting;
  c) Joint working – multi-agency co-ordination.

Training around risk assessment and management was a central theme, representing 83 references. Respondents offered little detail of their specific needs around these risk dimensions.

To support inter-professional working, teams needed support to develop a common purpose and shared practices. The following were highlighted:

- Clarifying future plans for team development.
- Team policies and practice: referral process, reflecting upon service criteria, implementing more robust systems around the gate keeping process.
- Inter-professional Practice: Joint caseload management, case presentation, multi-disciplinary working - clarification of roles and responsibilities within teams e.g. integrating social work practice.
- Developing the skills and experience of specific roles e.g. STR, support worker training.
- Reflective practice - assisting a reflective process within teams e.g. challenging existing practices *("bad habits"),* learning from good practice.
- Research & Audit - commitment to evidence-based training, developing and using outcome measures, evaluation.
- Communication: Written skills (e.g. documentation skills, recording, report writing, note-keeping) and verbal communication within a team approach (e.g. case presentation).

Training needs to support a focus on whole system working was also evident:

- Integration: Working across services/developing clear referral pathways e.g. managing gate keeping from inpatient, CMHT and primary care services, effective triage;
- Effective communication e.g. assertiveness training and confidence building to challenge other disciplines/teams within the wider crisis service;

<u>Understanding wider Trust systems and policies</u>

This included:

- Child Protection updates,
- Mental Health Law;
- Other legal/ethical issues specific to CRHT context;
- Other mandatory training e.g. IT skills, Breakaway training, First Aid, Health and Safety.

Management Support and Leadership

This included:

- Support for clinical management of team e.g., reducing isolation and impact of high expectation attached to role ;
- Leadership at different levels to support team structure e.g. deputy;
- Mentorship skills;
- Supervision skills;
- Change management.

Support sought from CSIP

Respondents were asked, “What do you feel NIMHE and its local development centres should be doing to support the development of crisis resolution/home treatment services?” (see Figure 8). The most frequently cited activity was support to networking (61) with requests that forums are made more accessible (12). Participants valued the informal sharing of information and ways of working (6) with "reassurance that life could be worse". Other ideas included developing on-line communities, and expanding networks to make them more inclusive.

Training was the next most frequently cited support (40) with 15 references to delivery, particularly at team level and with respect to advanced practice in psychosocial interventions. Help was also sought in identify training need and developing training strategy (7)

In addition to references to networking, sharing information was the next most often cited support (37) and particularly with respect to promoting positive practice (27).

Bespoke team-level support was sought (33) mainly in the form of away days and mentoring. There was a sense that NIMHE should be “Getting out to teams more”, "To better acquaint themselves with service delivery and challenges and diversity of service delivery" and provide "Hands on" support for implementation, particularly for new teams.
Local systems level support (26) mainly took the form of local influencing (12), for example educating others on role and function of CRTs (9). NIMHE was requested to help commissioners value the importance of an alternative to admission, campaign for sufficient resources and help engage medical staff. NIMHE was also seen as a potential advocate for supporting working as a whole system rather than in isolation (7) and supporting CMHTs in changing their role.

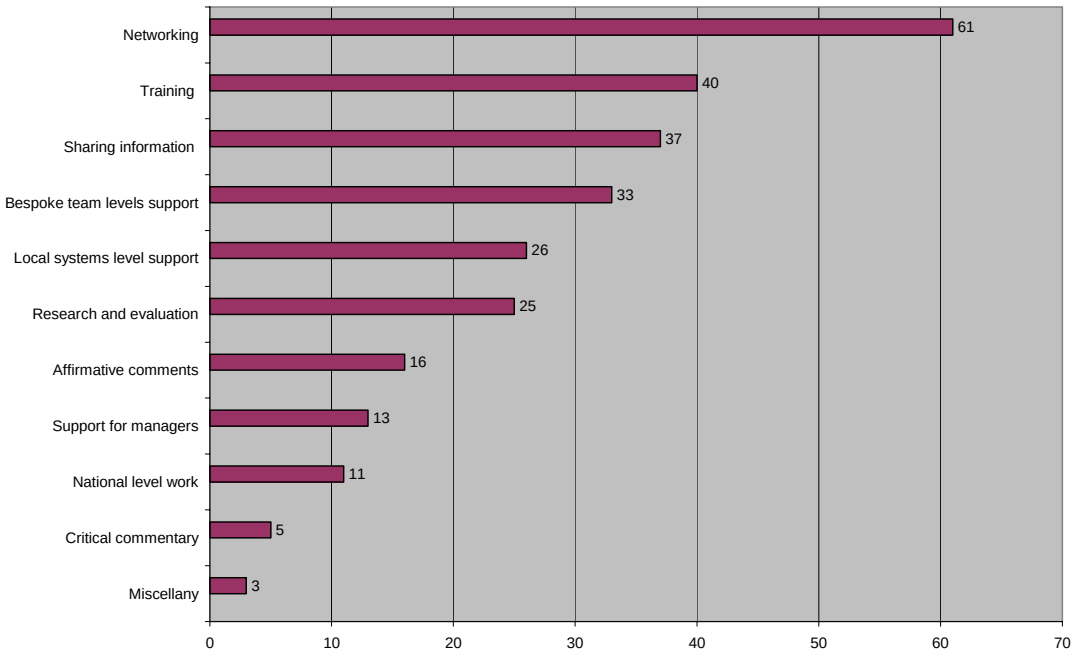
Research and evaluation support was referred to 25 times, including help to establish good data collection and analysis (8), evaluation support (3) and helping teams to publish their work (3).

Support specifically for managers was the next most frequently cited form of support (13) with particular support for mentoring of managers. National level work was also highlighted (11), for example continuing to feedback to the department of health about the realities of CRT service provision and needs (6).

Miscellaneous comments concerned a view that "Given the investment in home treatment it would be wise for the implementation to be closely monitored by NIMHE", a concern for better definition of role and function of NIMHE and a desire that NIMHE focus on how to meet local need, rather than national targets. There were 16 affirmative comments about NIMHE and 5 critical comments. Affirmative comments generally referred to feeling supported by local RDCs or networks that "has proved to

be very useful". Critical comments included that NIMHE seemed "divorced from real ground level issues" and had "An expectation that things are progressing in line with expectations". There was concern over lack of direction in networking and lack of influence over commissioning structure and in one case a concern that the existing network is "macho and excluding and old boys".

Figure 8. References to support sought from NIMHE



Team evaluation

116 teams (71%) reported that they were evaluating the work of the team, although only a third claimed to be able to supply further written details of the evaluation. Forty percent of these 116 teams described using published outcome measures to describe the work of the team. The most commonly cited measures were clinical audit (40 references) and qualitative evaluation/outcomes (27). Other measures cited were published outcome measures/rating scales (7) and policy/best practice guidance (5).

Thirty one percent of evaluating teams (21% of all respondents) reported that an external body was involved in the evaluation. The most frequently cited external body were user and carer groups (see Table 54).

Table 54. External bodies and evaluation.

Categories	Frequency
Service User/Carer Involvement/User Focused Monitoring Groups (UFM),/Patient Public Forum (PCT)	9
SCMH	5
Clinical Governance	4
University Depts	2
Strategic Health Authority	1

Seventy five percent of evaluating teams (50% of all teams) reported that the evaluation drew directly on the experience of users of the service and people that support them. Teams were asked to indicate how and questionnaires were the most frequent response (36). Other methods were informal feedback (32); interviews (7) and forums (1)

Forty nine percent of evaluating teams reported that their evaluation drew directly on the experience of staff within the team. A range of methods were cited as indicated in Table 55. Only 18, 1% of evaluating teams drew on the experience of primary care staff.

Table 55. Methods used to draw on the experience of members of staff.

Categories	Frequency
Formal Supervision/Team meetings.	27
Questionnaires	9
Interviews	1
Focus Groups	1
Informal Feedback**	7
External Surveys e.g. team survey from SCMH	2

The survey also explored the availability of extant information to support evaluation. by asking about local evidence that the team had any impact on (a) hospital admissions (or discharges, if that is what the local IT department collects); (b) bed usage in local admission wards; or (c) use of extra-contractual referrals (ECRs). The questionnaire stated, “It is hoped your IT department produces these statistics. Please ask them if you haven’t already done so”. Table 56 below reveals that in general there was a paucity of contextual information available from the perspective of respondents though there was marginal improvement after the team started taking referrals.

Table 56. Perceived availability of local information to inform the impact assessment of CRTs

Were there any statistical data on...	Before the team started taking referrals,		After the team started taking referrals	
	N	%	N	%
Admissions (or discharges) per annum from your catchment area?	82	33	89	36
Bed occupancy in your acute wards from your catchment area?	83	34	85	35
Use of ECR/OATS beds for acute patients from your catchment area?	70	29	76	31

Discussion

Methodological issues

This survey devoted much of its resource to being developmental in approach, involving relevant stakeholders (such as team managers in NIMHE CRT networks and RDC crisis leads) in the planning, design of the survey instrument and implementation. The benefits of this in terms of dissemination and impact on services have still to be evaluated.

Unlike previous data gathering exercise such as the Durham mapping exercise, the survey approached teams directly for routine information about services. The method produced a comparatively high response rate for a survey, using both postal and telephone interview methods. A significant time investment was involved for managers and levels of completion of the questionnaire were variable. The picture remains incomplete and it is important to speculate about why some teams did not respond despite repeated contacts. It is possible that the importance of reported numbers of CRTs as an indicator of performance in star ratings may have contributed to a defensiveness from some respondents. It is certainly reasonable to speculate that non-responders are unlikely to be within teams that are performing with more fidelity to the MHPIG than responders. The study included a large numbers of new teams and we were unable to determine how far team age was significant in non-response. There may also have been problems of differential responding due to comparative lack of awareness of developments by NIMHE crisis leads, for example in those large patches covering more rural areas. It is hopefully beneficial that the data entry portal remains open for such teams to enter information at a later point. To be really useful to policy makers however, CSIP and the Department of Health will need to work together to ensure that the database is updated at regular intervals.

A weakness, common to most survey data, is that the study relied exclusively on self report with limited external validation of findings. Where actual data were sought to support responses this was often unavailable and weak audit systems were in place in many teams. The reliability of information may have been reduced where respondents were non-managers who were less likely to have an accurate overview of service activity.

There was some evidence that respondents were reporting openly and accurately about sensitive areas of development. Thus, large numbers of team defined themselves as 'not fully set up' and this was corroborated in relation to independent fidelity counts for teams. The non-confidential nature of the study, with the expectation that NIMHE crisis leads would become aware of the development of the team, may have assisted open reporting. However, it is likely that some responses were based upon team protocols and policies rather than observable and measurable behaviour or team practices.

The use of phone interviews to support self completion was advantageous in this setting. Follow up of written contact by phone proved critical to engaging services in the study as details were often inaccurate or did not reach the intended respondent due to administrative problems. However securing initial contact and an interview by phone required repeated follow up and support. Managers were under pressure and involved in both clinical work and the task of developing a new service. Access to a private space for a phone interview proved difficult and office environments were often noisy. Data inputting by managers in advance of an interview varied considerably and reduced scope for quality control by interviewers who were unable to consistently screen questionnaires. Ease with an online form also varied and some respondents required practical support to log on. Procedural instructions such as use of "add" buttons were not consistently followed.

Phone interview support appears to have held particular benefits to completion of open text questions which were well detailed. Some data entry was more mediated through interviewers than others and in interpretation of results the extent to which the language used authentically represents that of the respondents needs to be considered

We radically underestimated the challenge of linking geographical details obtained from respondents to the areas covered by Hospital Episode Statistics and the linkage of this survey dataset to such information remains the focus for further work.

The numbers of clients served and capacity in relation to targets

By March 2004 the number of CRTs nationally had risen from only 35 in 2000 to 168, employing 2,173 staff across the country (Appleby, 2004). The present study finds 243 teams wherein (crudely scaling up on the basis of a 73% response rate) we estimate that there are around 4114 staff. Perhaps the most significant overall finding of the survey is the apparent shortfall of staff and caseload against MHPIG expectations. On the basis of our crude projections there are 88% of the recommended staff serving 59% of the projected target number of clients.

Exploration of this disparity between the findings of performance management and the actual level of implementation on the ground should be conducted in a context where everyone feels safe to participate lest the wrong conclusions get drawn. The easiest conclusion to draw is that CRTs lack the staff resources to meet demand and this is why such a large proportion to not see themselves as fully set up. It is clear from the interviews and the reporting of obstacles to implementation that there is concern about lack of resource to deliver against expectations.

Arguably, the situation could be improved simply by directing more resources towards CRTs so that they could expand their caseloads to meet the MHPIG guidelines. However, a more progressive response would be to revisit the question of (a) whether CRTs are currently targeting the right clients, and (b) whether there is an

unmet need that individuals that would benefit from CRT input currently fail to receive it. On (a) it seems that there is some suggestion that wherever CRTs are (e.g. urban or rural) they are working with people who have severe and enduring mental health problems. However, particularly for rural teams, there seems to be an issue of CRTs being asked to undertake a significant amount of assessment work that then does not lead to input from the team. This would suggest the need for clearer protocols and understanding of the role of CRTs at a local level.

The second possibility (b above) concerning unmet need would require examination of the circumstances and presenting difficulties among those people currently being admitted. This would allow exploration of whether the full potential to avoid admission is being realised locally. At the moment it seems likely that both (a) and (b) are likely to be true and intertwined in that assessment load means that CRTs are less able to assertively address the needs of the full range of individuals presenting for admission.

Issues in implementation and delivery

Despite the generally positive picture of CRT development evident from performance management data, at team manager level the perspective is that only 40% of teams would describe themselves as fully set up, primarily because of lack of staff.

The “NHS- Five years on” document (Appleby, 2005) stated that in 2003, 62% of crisis resolution teams provided 24-hour cover. The present study found that only 53% of respondents reported operating a 24 hour, 7 day per week home visiting service. These teams were more likely to be urban. The most often cited obstacle to further delivery is again lack of staff.

Lack of demand for CRT has not emerged as a salient issue. It is clear that teams see themselves as still in development with at least two in five reporting that they, for example, plan to change the hours of their service to better meet local need.

Almost all teams regardless of urbanicity aimed to provide an alternative to hospital admission to those people experiencing acute mental health difficulties but in practice there is a clear difference between this aspiration and current practice in that only 68% agreed that “The team acts as the gatekeeper to the acute inpatient beds by assessing people referred for hospital admission”. The fact that only around a third of teams operated a functionalised consultant psychiatrist role will exacerbate this problem, particularly in rural areas where the model is even less prevalent. Other local operational difficulties are also evident however, particularly a concern that the gate keeping function often does not operate optimally at local level. This has been related in some cases to lack of understanding and support of the CRT role from senior medical staff and local managers.

Lack of fidelity among rural teams should not be taken to suggest that the MHPIG model from the policy implementation guide is inappropriate. Nonetheless, the reasons why it is difficult to achieve merit closer examination and the possibility that proposed levels of, for example, out of hours cover might not be deemed necessary by local stakeholders. Furthermore, it may be that different approaches to implementation may be warranted and we hope that this is illuminated by the second stage of this study where team dimensions are linked to outcome in terms of bed use.

There is clearly considerable scope for closer integrated working with primary care (particularly in urban areas), CMHTs, the voluntary and community sector and in-patient care. In relation to the latter, there is scope for more shared working and rotation across inpatient and community care for people in the acute phase of their distress. This is also likely to promote effective recruitment and the optimal access to the right expertise at the best time point. This should be a focus for further research and capturing of positive practice.

"Our health, our care, our say" (Department of Health, 2006) stresses the need to support users to help them to make choices and take control of their health and wellbeing by understanding their own health and lifestyle better, with more support on prevention and promoting their independence. For CRTs the most widely and intensively provided interventions post assessment were risk assessment, monitoring of mental state, help with self help strategies, delivering psychosocial interventions and administering medication. Wider "whole life" issues such as attending to issues of housing, finance and employment were provided much less frequently. This may simply reflect an appropriate allocation of roles within the local service system with such issues being better addressed by care coordinators in collateral CMHTs. There is however an imperative to ensure integration across parts of the local service system. In general the CRTs appeared to have high levels of joint working with other parts of the service but particularly lamented the capacity problems of CMHTs when it came to referring back for the more holistic support described above. This highlights the need for approaches to understanding and developing more effective local service systems through systematic analysis of demand, capacity and throughput. Perhaps, the apparently strengthened role of team managers suggested by this study is a resource in this regard that can be further built upon. Local community team managers might need to work in closer collaboration to build locality based identifications and practices based upon strengthened shared understanding of how their local service system operates.

Implications for development and support

Although the MHPIG envisaged that CRTs will usually be providing the crisis response for clients of the ACT and early intervention team out of hours, it is important to stress that the MHPIG does not propose that crisis response work would be restricted to the crisis resolution service. For example, where the assertive outreach team is involved with the individual concerned they would normally offer the appropriate response within working hours. Where continuing input is needed following a crisis the assertive outreach team, CRT and the other parts of the local service system would be expected to work together to ensure that the least restrictive and stigmatising setting for care is available. The whole system should work together to avoid hospitalisation and restrictive care wherever possible and opportunities to provide care in the community or service user's own home should be grasped.

This study has highlighted that from the perspective of CRTs, this level of integrated locality based working remains a challenge, particularly with respect to the acceptance and understanding of their gate keeping role, the ease of transfer back to CMHTs and opportunities for working on early discharge with inpatient staff. The MHPIG guidance remains relevant in this context. It states that to establish effective joint working links need to be established between the teams within a locality so that:

- Handover and referrals are made easily.
- Crises are anticipated and contingency plans are known to all involved in care.

- Early intervention and assertive outreach service users are aware of whom to contact out of hours.
- Staff from the assertive outreach team and/or early intervention team can participate in the crisis resolution/home treatment team out of hours rota. It may also be advantageous to involve inpatient staff in these rotas so that they do not feel like an excluded part of the wider system and are able to contribute their skills, expertise and knowledge of the user to promote continuous and effective care.
- Local arrangements are made between the crisis resolution team, the early intervention team and child and adolescent mental health services to ensure rapid access to an out of hours crisis service for users under 16 years old.

It is clear that the cornerstone of such integrated working remains an up-to-date care plan developed through the care coordination process (e.g. Bristol MIND, 2004). This care plan should include individually tailored contingency plans that specify what works well for a particular person in a given circumstance and what actions should be specifically avoided. Wallcraft *et al*, (2003) highlighted the importance that users attached to a positive response to crisis, with many favouring crisis houses and the use of crisis cards so that users could exercise a meaningful choice when in crisis.

Another issue for local development is the need for better information at a local level to inform the impact of new developments such as the implementation and development of CRTs. It may well be that the local availability of such information was better than our respondents realised. However, their lack of awareness remains an issue in itself as they should be instrumental in collecting relevant information and feeding back relevant details to inform team and local systems development.

With respect to local providers of development support, CSIP's role had a generally positive profile, though respondents saw it principally as a resource for networking and sharing of positive practice rather than hands-on support. To-date the largest provider of this sort of training has been the Sainsbury Centre for Mental Health which has recently decided to close its training section. Whether CSIP or other organisations will step in to address this gap in provision remains to be seen. It is clear that there is a considerable further desire for renewed training (e.g. with respect to team and individual practitioner competencies). Teams are still comparatively new and will need further support to fully realise their potential, particularly if they continue to expand.

Implications for performance management and commissioning

Arguably, it is not helpful to differentiate the implications for performance management from the implications for development and research as each is in pursuit of the ultimate aim of improved delivery. A main benefit of this data gathering exercise has been to establish a resource for understanding implementation which can complement the perspective gained through PCTs and health authorities in their commissioning role. It thereby provides a triangulated and more valid statement of the current reality on which to base improvement activity. It is partly for this reason that the data entry portal has been left open with the ambition that data entry for this, and perhaps other aspects of local service delivery, can be collected on an ongoing way from those closest to the reality of local delivery. Indeed, by developing such a portal to include routine outcome measurement this triangulated approach could serve to inform local commissioning on an ongoing basis. .

Implications for future research

Despite significant ground work to enhance engagement many teams did not participate even with follow up by researchers and crisis leads. Routine data collection is politically sensitive particularly where services are newly established. Although CSIP was aligned with development it was not necessarily seen as independent from scrutiny processes. We underestimated the labour intensive nature of contact and support required in the context of the pressures on new teams. Telephone contact was a critical to a high response rate and good practice in telephone interviewing need to be better explicated for use in mental health. The involvement of untrained interviewers in dispersed locations although assisting research impact posed a challenge for quality control and needed to be better supported for instance at the level of release from work role to participate.

When linked with data on outcomes in terms of bed use, the current sample will provide a powerful sampling frame for further inquiry into models of provision. For example, in depth qualitative studies of particular sites that appear to have been effective in a particular context (e.g. rural localities) are likely to be invaluable. Similarly, capturing positive practice (e.g. on staff recruitment and local team and inter-team working) within a locality merits further attention. However, given the overriding concerns about levels of staffing, a comprehensive analysis will also need to explore where commissioning has ensured that the right levels of funding have been in place to achieve the required capacity.

The importance of a whole systems view of local provision has been a theme of this discussion. Broader concurrent description of collateral teams (e.g. a renewed CMHT survey) would help contextualise the current findings, for example with respect to whether the changes noted from Onyett *et al*, (1994) with respect to the distribution of management responsibilities reflect a phenomenon that is unique to CRTs or relates to wider trends. The new formation of a research group on acute care within the Mental Health Research Network (spanning inpatient care and CRTs) should also serve to promote joint exploration of the relationship between these two parts of the local service system, for example whether there are avoidable admissions that are failing to be prevented by CRTs, or could be prevented if adequate CRT provision was in place.

A comprehensive evaluation of services needs to take account of the net benefit of running the service in a way that encompasses outcomes for users, the effects on their social supports, service use, hospitalisation, involvement in the criminal-justice system and other indicators of community mental health. Very few studies have achieved such comprehensive evaluation although Hoult's study (1986) of the Crisis Intervention Service in New South Wales and the Madison experiment before it (Stein and Test, 1980) are notable exemplars. Both supported the development of intensive community interventions. Provan and Milward (1995) also looked at the whole system of community support. They examined the "network effectiveness" of four community mental health services. Evaluating networks rather than specific organisations recognises that outcomes for users will depend on the actions of a range of agencies. Provan and Milward found that integration of providers was unlikely to improve outcomes unless the network was stable, adequately resourced and centrally and directly controlled. This echoes our respondents call for a more integrated and coordinated local crisis response to which they can meaningfully contribute. Attention needs to shift towards evaluating whole systems in this cause so that the enormous potential contribution of CRTs can be properly evaluated.

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Acknowledgements

This study involved a great many individuals in both its planning and delivery.

We are particularly grateful to Dr Geoff Tomlinson (Consultant Psychiatrist, Plymouth Home Treatment Team) for his enthusiasm in getting the study off the ground. We are also highly indebted to the CSIP crisis leads, Kevin Heffernan, Bill Peacham, Martin Flowers, Pat McGlyn,Les Mitchell and, Nigel Crompton. Dr John Hoult provided expert advice on the questionnaire and assisted our contact with London teams. Tom Dodd, the national CSIP lead for team working, was an invaluable advocate and support to the study.

Kannan Suresh Babu provided invaluable help in to obtain ethical permission from the study and Willm Mistral (Bath University) provided crucial extra supervision and support to our talented lead researcher. Christine Callum provided statistical expertise and Siobhan Ramsey was responsible for the web site development. Jean Alger-Green at CSIP-SW provided invaluable business support and administration.

Finally, we would like to acknowledge and thank our respondents who took significant time during their busy working lives to provide us with the information we needed to describe the picture of CRT development presented here.

Appendix A. Mapped disparities between the Durham service mapping database and the survey database

STRATEGIC HEALTH AUTHORITY	SURVEY DATABASE		DURHAM DATABASE (September 2005)	
	Number of teams	Comments on discrepancies, where identified.	Number of teams	Comments on discrepancies, where identified.
Avon Gloucestershire & Wiltshire	13	1 team in Gloucester	12	No teams in Gloucester
Bedfordshire and Hertfordshire	8		8	
Birmingham & Black Country	15	1 team in Dudley	16	2 teams in Dudley
Cheshire & Merseyside	11		10	
County Durham & Tees Valley	8		7	
Cumbria & Lancashire	14	Inclusion of extended CMHTs in West Cumbria and Carlisle, and recognition of a Penrith and Eden CRHT not on Durham Database	11	
Dorset & Somerset	5	1 team in Dorset	6	2 teams in Dorset
Essex	8		8	
Greater Manchester	10		11	
Hampshire & Isle of Wight	8	East Hampshire team was reported as having 4 staff members and was not included	9	
Kent & Medway	6		6	
Leicestershire, Northants & Rutland	4	1 team for Leicester County	5	2 teams for Leicester County
Norfolk, Suffolk & Cambridgeshire	10	2 teams in Central Norfolk 1 in Cambridge 1 in Peterborough	9	3 teams in Central Norfolk None in Cambridge or Peterborough
North East	5	1 team for Hull &	9	2 teams for Hull & East

STRATEGIC HEALTH AUTHORITY	SURVEY DATABASE		DURHAM DATABASE (September 2005)	
	Number of teams	Comments on discrepancies, where identified.	Number of teams	Comments on discrepancies, where identified.
Yorkshire & North Lincolnshire		East Riding 1 team for Yorkshire 1 team for North East Lincolnshire		Riding 2 teams for Yorkshire 2 teams for North East Lincolnshire 1 team called "Hambleton & Richmondshire"
North Central London	9	1 team for Barnet	10	2 teams for Barnet
North East London	8	1 team for Barking & Dagenham 1 team for City and Hackney 1 team for Newham 1 team for Tower Hamlets 1 team for Walton Forest	15	2 teams for Barking & Dagenham 3 teams for City and Hackney 3 teams for Newham 3 teams for Tower Hamlets 2 teams for Walton Forest
North West London	9	1 team for Hillingdon 1 team for Brent 1 team for Ealing	14	2 teams for Hillingdon 3 teams for Brent 2 teams for Ealing
Northumberland, Tyne & Wear	5	1 Sunderland team	6	2 Sunderland teams
Shropshire & Staffordshire	7	1 team for Staffordshire Morland	9	3 teams for Staffordshire
South East London	11		10	
South West London	3		4	
South West Peninsula	9		10	
South Yorkshire	6	1 team for Sheffield	7	2 teams for Sheffield
Surrey and Sussex	12		12	
Thames Valley	11		10	
Trent	13	1 Derby City team	14	2 Derby City teams
West Midlands South	7	1 Worcestershire team	8	2 Worcestershire teams
West Yorkshire	7	1 team in Leeds	12	6 teams in Leeds

Appendix B. Correspondence pertaining to implementation of the survey

National Institute for
Mental Health in England

C/o Division of Psychiatry
Duncan MacMillan House
Porchester Road
Nottingham
NG3 6AA

Tel 0115 9691300
Fax 0115 9555352

joanne.greenwood@nottingham.ac.uk

The Team Leader

19th December 2005

Dear Colleague

Re: National Crisis Resolution Team Mapping Exercise:

As you will be aware Crisis Resolution (or Home Treatment) teams have a central role to play within the local mental health service. Development nationally is recognised to be variable and dependent upon local circumstances. The policy section of the DOH and the National Institute for Mental health in England have funded a national survey of crisis resolution teams. The study aims to map the organisation and operation of CRTs in England. This will create a database resource to inform future research and development activity, highlight positive practice, and promote further action-orientated research.

We are writing to you to ask if you would be prepared to participate in this survey. *Participation is entirely voluntary; however your involvement will be vital to us gaining a national picture of teams. It would be most helpful if you could inform Joanne Greenwood by email of your willingness or not to participate in this study.*

The survey will involve some gathering of information in preparation for a telephone interview which will take approximately 1 hour.

If you have any general queries or concerns at this stage please do not hesitate to contact Karen Linde on 07808673240.

The process for participating in the study is as follows:-

- Please log onto the National Crisis Resolution Team Questionnaire site at

  http://www.dur.ac.uk/service.mapping/crs

- Use your unique ID and password to access a questionnaire for your team. These are ID: «ID» password: «Password» . If you have difficulty accessing the form on line please contact: [Karen Linde on 07808673240]

A public web site for the study http://www.crisisresolutionsurvey.info provides general information about the study and invites your comment about this exercise.

- Begin by familiarising yourself with the questionnaire and identifying information you may need to gather in advance. You can begin to complete the questionnaire on line in preparation for the interview. The form can be printed out if necessary. You can return to the form at any time using your name and password to continue entering the information.

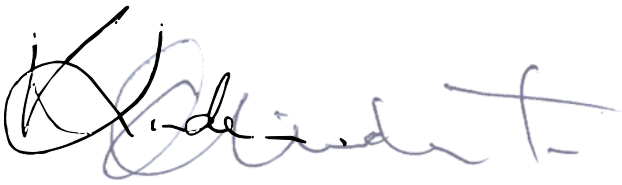
- *An interviewer will contact you to confirm a date and time for a telephone interview.*

- During the interview you will be talked through your entries, helping you to fill in any gaps that might be unclear or more difficult to fill out. You will need to assign at least one hour to this task.

Thank you for your consideration of this request.

Yours sincerely,

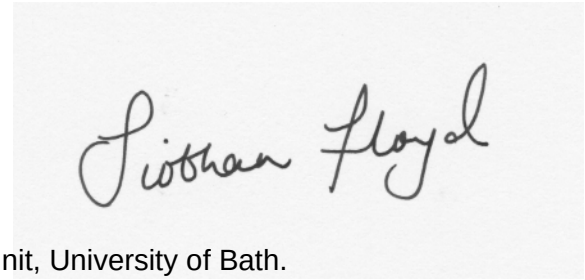
Tom Dodd
NIMHE Community Teams Lead



Karen Linde
University of Leeds

Hugh Middleton
University of Nottingham and NIMHE East Midlands Acute Care Lead

Prof Steve Onyett
Senior Development Consultant, NIMHE-SW/ Visiting Professor, UWE



Siobhan Floyd
Mental Health R&D Unit, University of Bath.

Appendix C. Correspondence concerning ethical approval

Northern and Yorkshire Multi-Centre
Research Ethics Committee
Sunderland Teaching Primary Care Trust (South Office)
Administration Corridor
Ryhope Hospital
Ryhope
Sunderland SR2 0LY

Tel: 0191 569 9559
Fax: 0191 569 9545

18 July 2005

Prof. Gyles Glover
Professor of Public Health
Durham University
Elvet Riverside Building
New Elvet
Durham
DH1 3JT

Dear Prof. Glover

Full title of study: **Implementing new service models in mental health - the impact on admissions and use of detention under the mental health act.**
REC reference number: **05/MRE03/30**

Thank you for your letter of 15 July 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

The further information was considered at the meeting of the Committee held on 18 July 2005. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The Committee has designated this study as having "no local investigators". There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application Electronic Version		09 May 2005
Investigator CV Professor Gyles Glover		14 March 2004
Investigator CV Professor Steve Onyett		14 March 2004
Protocol Summary of Proposal		(None Specified)
Copy of Questionnaire	Draft 14	(None Specified)
Letters of Invitation to Participants	2	18 April 2005
Response to Request for Further Information		15 July 2005
Response to Request for Further Information		09 May 2005
Letter supplying missing information from Application Form		21 March 2005

Management approval

You should arrange for all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant care organisation before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/MRE03/30	**Please quote this number on all correspondence**

With the Committee’s best wishes for the success of this project,

Yours sincerely

Dr Simon Thomas
Chair
Email: sandy.brunton-shiels@suntpct.nhs.uk
Enclosures: Standard approval conditions

Northern and Yorkshire Multi-Centre
Research Ethics Committee
Sunderland Teaching Primary Care Trust (South Office)
Administration Corridor
Ryhope Hospital
Ryhope
Sunderland SR2 0LY

Tel: 0191 569 9559
Fax: 0191 569 9545

18 July 2005

Tom Dodd
National Institute for Mental Health
Dual Diagnosis Lead, Osprey House,
Albert Street, Redditch,
Worcestershire
B997 4DE

Dear Tom Dodd

Full title of study: **Implementing new service models in mental health - the impact on admissions and use of detention under the mental health act.**
REC reference number: **05/MRE03/30**

The Research Ethics Committee has reviewed the above application in accordance with the standard operating procedures for RECs.

The Committee has issued a favourable ethical opinion of the application.

The Chief Investigator has been notified of the Committee's opinion in our letter of 18 July 2005. The letter gives full details of the documents reviewed.

The Committee has designated this study as having "no local investigators". There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/MRE03/30	**Please quote this number on all correspondence**

Yours sincerely

Miss Sandy Brunton-Shiels
Committee Co-ordinator
Email: sandy.brunton-shiels@suntpct.nhs.uk

Appendix D. Probability levels for post hoc analysis following main effects

	Urban v Rural		Urban v Suburban		Suburban v Rural	
Chisquare	Significance		Significance		Significance	
Fully set up to meet the needs of the people in patch who fulfill criteria for CRT?			U>S	0.002		
New to local service: Anxiety disorders generally included for possible home treatment?			U>S	0.003		
Known to local service: Anxiety disorders generally included excluded for possible home treatment?			U>S	0.028		
Team provides 7-day per week, 24-hour home-visiting assessment service	U>R	0.043	U>S	0.002		
The team is involved in local Mental Health Act assessments			U>S	0.004		
Frequency team provides uni-disciplinary assessments?					S>R	0.029
Frequency team delivers medication	U>R	0.001	U>S	0.027		
Frequency team provides help in practical ways (eg shopping, cleaning)	U>R	.003			S > R	.006
The team initiates new medication regimes (Disagree/unsure collapsed)			U>S	0.032		
Frequency of referrals from Inpatient unit	U>R	0.041				
Frequency of referrals from Primary care team (inc. GPs)	U<R	0.016				
Frequency of referrals to Voluntary Sector			U>S	0.035		
Frequency of referrals to Voluntary and community services specifically for black and minority ethnic communities	U>R	0.005	U>S	0.000		
Mann Whitney						
Average number of referrals per month	U>R	0.012				
Average number of referrals per month accepted for assessment	U>R	0.009				
Maximum referrals in one month accepted for assessment over the past year	U>R	0.003				
% assessments taken on for ongoing work	U<R	0.007				
Percent of referrals assessed only - not taken taken on for ongoing work	U>R	0.003				
Team size			U>S	0.026		
Team size excl administrative and others			U>S	0.022		
Team FTE			U>S	0.017		
Team FTE excl administrative,others	U>R	0.041	U>S	0.017		
Fidelity			U>S	0.001		
Months team been taking referrals			U>S	0.003		
Caseload			U>S	0.001		
Difference between maximum and current caseload as percentage of current			U>S	0.022		

Appendix E. Comparative data on distribution of management roles from CMHT survey

Management responsibility	Team manager or coordinator	Team's senior doctor. e.g. consultant or senior registrar	Individual team members	Professional line managers	Other individual managers or planners outside team	Management or steering group	Team as a whole	No one takes most charge
Deciding the client group of the team	6.1 (7.7)	3.4 (2.7)	7.1 (5.9)	4.0 (4.1)	10.4 (10.4)	22.6 (19.9)	42.8 (45.7)	3.7 3.6)
Deciding which referrals the team accepts day-to-day	12.2(16.5)	3.1 (4.1)	20.7(17.4)	2.7 (1.4)		0.3 (0.5)	58.6(57.8)	2.4 (2.3)
Deciding when team members should close cases	6.4 (8.7)	1.4 (1.8)	68.1(65.8)	3.7 (3.7)		0.7 (0.5)	17.6(17.8)	2.0 (1.8)
Allocating cases to team members	19.8(26.3)	2.0 (1.4)	18.4(16.6)	2.0 (2.3)		1.0 (0.5)	51.2(48.8)	5.5 (4.1)
Clinical supervision of team members	14.8(18.8)	3.8 (4.2)	14.5(14.1)	50.0(44.6)	2.1 (2.3)		10.7(11.3)	4.1 (4.7)
Authorising team members' leave	32.9(42.1)		4.4 (3.6)	55.4(47.1)	1.7 (1.4)	0.3 (0.5)	3.7 (3.6)	1.7 (1.8)
Liaising with senior management over team issues	55.0(71.9)	8.7 (4.1)	4.4 (1.8)	16.4(12.7)		5.4 (4.5)	9.4 (4.5)	0.7 (0.5)
Representing the team at public meetings	38.2(47.5)	4.4 (4.6)	18.9(16.0)	9.1 (7.8)	1.7 (1.8)	4.1 (1.8)	14.2(15.1)	9.5 (5.5)
Over-ruling the clinical decisions of team	20.3(25.9)	21.3(18.4)	0.7 (0)	32.5(29.7)	0.7 (0.9)	2.8 (3.3)	9.1(10.4)	12.6(11.3)

Management responsibility	Team manager or coordinator	Team's senior doctor. e.g. consultant or senior registrar	Individual team members	Professional line managers	Other individual managers or planners outside team	Management or steering group	Team as a whole	No one takes most charge
members if necessary								
Managing the day-to-day running of the team	62.0(78.2)	2.4 (0.9)	6.1 (3.2)	6.4 (3.6)	0.3 (0)	1.0 (0.5)	13.8(10.0)	8.1 (3.6)
Organising the evaluation and/or review of team policy and practice	42.8(54.5)	3.3 (2.3)	1.3 (0)	6.0 (5.9)	1.7 (0.5)	13.4 (9.5)	29.8(27.0)	1.7 (0.5)
Assessing the mental health service needs of the local community	13.2(17.4)	2.4 (1.8)	2.4 (1.8)	1.7 (1.4)	21.7(19.6)	19.3(17.8)	28.1(31.1)	11.2 (9.1)
Overall percentage mean	27.0(34.6)	4.7 (3.9)	13.9(12.18)	15.8(13.7)	3.4 (3.1)	5.9 (4.9)	24.1(23.6)	5.3 (4.1)

Appendix F. Glossary of acronyms and terms

CMHT	Community Mental Health Team. Sometimes also referred to as a primary care liaison team.
CRL	Crisis Resolution Lead
CRT	Crisis Resolution or Home Treatment Team
K-W	Kruskal-Wallis Test Statistic.
MHPIG	Mental Health Policy Implementation Guide