Care Services Improvement Partnership **CSIP**

Guidance Statement on Fidelity and Best Practice for Crisis Services

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<u>**GUIDANCE STATEMENT ON FIDELITY AND BEST PRACTICE FOR CRISIS RESOLUTION TEAMS**</u>

Introduction

Crisis resolution (CR) teams are a key step in implementing the Mental Health National Service Framework.. They form part of the drive to ensure inpatient care is used appropriately, and only where necessary; with good quality intensive treatment in the community being offered in its place. PSA/ NHS plan targets for 2004 and 2005 set out, respectively, numbers of CR teams expected to be in place, and the numbers of home treatment episodes completed. The latter was seen as the most meaningful measure of their activity.

We have come to the end of our target period now, and many services can feel proud of what they have achieved. We now need to think about how these important service improvements can be sustained and developed into something flexible and comprehensive that more fully meets the needs of the local population and dovetails with other community mental health services. For those areas that have struggled to implement, we need to continue to press for improvement, whilst giving the most appropriate support and guidance.

This statement therefore observes where Crisis teams have worked well, and not so well; describes the key features, and develops a description of what is likely, in the future to constitute a good Crisis Resolution Home Treatment service that is likely to reap maximum benefit for service users. There is an emphasis, also, on a whole systems approach with CRHT services working closely with other services as part of an acute care pathway.

1.   Background

Successful CRHT teams have:

- Met their targets for numbers of home treatment episodes
- By the same token, avoided costly and disruptive inpatient admissions for large numbers of service users.

- Allowed mental health providers and local commissioners to refocus resources from inpatient to community based care. Research has shown that areas with CRHT teams operating in 2002 had a 10% lower admission rate than areas without CRHT teams. If the CRHT team was operating 24 hours a day 7 days a week there was a further 22% reduction. It was pointed out that the additional reduction might not be exclusively caused by 24/7 functioning as other attributes of a fully functioning team might also contribute.[1]
- Established rewarding and interesting new work for MH staff.
- Provided a service that users and carers value highly, and that supports their continuing engagement with their families and community.
- Given their local health communities a working model of "acute care outside of hospital" on which to build approaches to implementing "Our Health Our Care Our Say".

Following a detailed survey, and expert seminars, it is now possible to highlight the features of CRHT teams that need to be in place, if these benefits are to be fully realised. We have grouped them under the following headings:

- Staffing and resources
- Gatekeeping role
- Referral pathways
- Whole system working
- Audit and Development

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[1] Forthcoming publication by Glover et al in British Journal of Psychiatry.

2. Key Fidelity Issues for CRHT Teams

2.1 Staffing and Resources

1) It was recommended in the PIG guidance[2] that a standard team covers a population of approximately 150,000 and has a caseload of 20 – 30 users at any one time. As caseload per 100,000 will vary depending upon the mental health needs of the population, caseload should be the main determinant of the required capacity. A standard team of size 14 is broadly appropriate for a caseload of 25 people requiring home treatment at any one time. Over a full year this should mean that the standard team delivers around 300 home treatment episodes[3]. The national survey on crisis teams showed that about 9 per cent of teams have 9 or fewer staff i.e. less than two thirds of their recommended 14. Looking at overall staffing capacity across England it concluded that this was about 88 per cent of recommended levels i.e. there was a deficit of about 12 per cent relative to the policy recommendation.

2) Areas of greater need in terms of both deprivation and psychiatric morbidity indices will require a higher staff to population ratio. Typically these will be inner city teams of large conurbations. While this serves as a rough guide, providers must ensure sufficient staff to cover shifts adequately.

3) While home treatment constitutes **the major part** of a CRHT team's responsibilities there are other tasks the team has to attend to such as assessing new referrals, liaising with other parts of the service on care of cases, case reviews, staff training etc. However, the demand for home treatment should be the main determinant of staffing capacity.

4) The team should have the ability to provide mobile, 24 hour seven day per week home treatment to people on its caseload.

2.2 Gatekeeping inpatient admissions and supporting early discharge

5) It is important that mental health in-patient services and crisis services are joined up locally. It is necessary for a crisis team to act as gatekeeper **for all people** requiring access to inpatient services or other emergency care. Gatekeeping is an essential component of CRHT. Only by the local crisis team assessing all people who potentially require admission, can three key objectives for crisis services be achieved:

   i) Patients should be treated in the least restrictive environment which is consistent with their clinical and safety needs
   ii) In-patient admissions and pressure on beds should be reduced
   iii) Equity of access to an alternative to admission for patients and families must be ensured.

Fulfilling the gate keeping role depends upon the cooperation of all the components of a trusts mental health services. CR teams work best in integrated acute care pathways and it is important to note that teams don't just triage admissions as an 'add-on' to the service. Teams have found that it is critical to success to enlist the support of Trust management (including chief executives, medical directors and the board). Trust management must make sure that gatekeeping happens.

Features of Gatekeeping

Everybody (including people in need of mental health act assessments) requiring emergency access to acute mental health services (CRHT and In-patient) should go through a full gatekeeping process. This requires:

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[2] Mental Health Policy Implementation Guidance: Crisis Resolution Home Treatment Teams. DH.
[3] This is consistent with the PSA target of 100,000 home treatment episodes in 2005-6 delivered by 335 teams

i) The CRHT to provide a mobile 24 hour, seven day week response to requests for assessments.

ii) The CRHT team actively involved in **all** requests for admission.

iii) The CRHT team being notified of **all** pending mental health act (MHA) assessments.

iv) The CRHT team assessing all these cases *before* admission happening.

v) The CRHT team being central to the decision making process in conjunction with the rest of the multi-disciplinary team.

6) Trusts need to ensure that clear governance / policy arrangements are in place regarding the decision making process.

7) Effective liaison with in-patient services will also allow a crisis team to take responsibility for patients who are suitable for early discharge into their care.

Features of Early Discharge

Early discharge means discharge at a time earlier than would happen if intensive home treatment was not available and is still part of an acute episode of care. Facilitating early discharge remains a core function of the work of CRHTs and it is recommended that teams develop a systematic approach to providing this.

Having been involved in all admissions (through the gatekeeping role), the team is in an ideal position to identify the reasons for admission and through close working relationships with the inpatient unit systematically review whether these reasons continue to exist, and what needs to happen prior to the individual being discharged. If for some reason (and against best practice) had been admitted without CRHT involvement, there is no reason why the team should not play a role in facilitating early discharge. But this process is likely to work best if there has been earlier contact between the service user and the team.

2.3.1 Referral Pathways - A&E

8) Experience has shown that some crisis services are working in close liaison with A&E and are receiving a high proportion of their referrals from them. In many 50-60 per cent of referrals to crisis services have been coming from A&E.

9) CRHT teams ought not to become de facto A&E Liaison teams. They must not spend most of their time doing A&E assessments with the result that they have little time left to do their primary task which is home treatment. Evidence from a number of areas indicates that up to 90% of mental health presentations to A&E do not require home treatment.

10) The impact of having a high proportion of A&E referrals is:

i) To consume CRHT resources in carrying out unnecessary assessments

ii) To neglect other ways of establishing access to CRHT services e.g. via Gatekeeping in-patient admissions which would result in the team seeing more patients who qualify for home treatment

iii) To have excessive resources committed to assessments impacts on teams' capacity to deliver meaningful home treatment and affects team thresholds for admission to a detrimental effect.

11) It is not suggested that A&E is an inappropriate referral source. But good practice should include a filtering role for nurses operating within A&E. Using CRHTs simply to avoid an undue wait in A&E for someone with a mild or moderate mental disorder is inappropriate.

12) Nurse led A&E Mental Health Liaison Services which are separately resourced from CRHT need to be established in accordance with local need. In this way only genuine emergency cases who are possible candidates for admission are referred to CRHT teams.

13) It is noted that some teams default out of hours work to A&E. This is not felt to be good practice when <u>home</u> treatment and assessment

are seen to be the cornerstone of CRHT procedure.

2.3.2 Referral Pathways - Primary Care

14) Just as the crisis teams are spending too much time doing A&E assessments, some teams are being excessively burdened by having to assess 'crisis' referrals from GPs of people who are very unlikely to require hospital admission or home treatment (acute care). Often the CRHT team has evolved from a previous service that provided that function (primary care crisis intervention team).

15) Taking appropriate referrals from GPs of patients who might need admission is an important function of a CRHT team, but a screening process is needed so the team can get on with its main task of doing home treatment.

16) Effective pathways of care should include gateway/ link workers in conjunction with graduate workers to provide a bridge between primary and secondary care with CMHT's as the single point of access.

2.5 Whole system working.

17) CRHT teams do not operate in a vacuum. They are part of a trusts' acute care system and are affected by, and have an effect on, that system and beyond. The components most affected by a CRHT team are the in-patient service, the day hospital and CMHTs. All levels of management and clinical staff need to work together to ensure the CRHT teams position within the acute care system is an effective one. There is evidence from the National Survey that the role of CRHTs continues to be poorly misunderstood and implemented by senior managers and clinicians in some parts of the country.

18) Experience to date has shown that the attitudes and behaviours of consultant psychiatrists in the acute components have a powerful effect on how well CRHT teams can do their job. It is most important that these consultant psychiatrists give CRHT their full support and commitment in the implementation of policy guidelines.

19) Not infrequently the introduction of CRHT teams throws up problems in the operation of the acute service components which had not been apparent earlier. Examples of such problems include:

- The uncovering of low intensity of follow up of cases.
- The inability of some CMHTs to increase the intensity of visits in the early stages of a patients relapse or to resume work with the patient when the crisis is resolved.
- The lack of family support.
- The delaying of a discharge until a consultants' ward round.
- Extended leave from in-patient services rather than discharge to CRHT.

20) Acknowledging these difficulties provides an opportunity to correct these problems or to look again at the acute service organisation as a whole in order to improve effectiveness.

21) There has, in many areas, been an evolution of services from primary care crisis teams, day services, A&E Mental Health teams into CRHT teams. For these teams, in particular, it is often difficult to re-focus their work to those with whom there will be the greatest impact on inpatient bed use.

22) In addition many teams have been established for some time offering home treatment over extended hours but without targeting those in acute need primarily as an alternative to hospital admission.

23) CRHT needs to focus its work toward those who need an intensive level of care during an acute episode. Thresholds of

acuity should overlap with those of acute admission wards (although some patients may be below the threshold for Acute In-Patient care they have deteriorated to a level that a standard community team is no longer appropriate.)

24) It should be noted that ongoing developments in acute inpatient care are extremely relevant. Policy Implementation Guidance on acute inpatient care was issued in April 2002 postdating the 2001 guidance on crisis services. The 2002 guidance recommended that provider trusts should set up Acute Care Fora to provide local co-ordination and leadership on acute care. The remit includes a requirement to pay particular attention to interface issues between CRHT teams and inpatient wards. Many of these Fora have been set up and, although this varies, there are good examples of ongoing partnership working between acute leads (inpatient and CRHT) at local level. Helpful practice models for jointly managing inpatient and crisis services include one trust which has integrated both services into a single team based in the same building.

25) It is recommended that acute care pathways should be developed and agreed locally. These should include the role of the CRHT in the care system and its interactions with primary care, A&E, community teams and inpatient care. The inclusion of jointly agreed pathways in local protocols should help address the issues of inappropriate referrals and insufficient gatekeeping referred to earlier.

2.7   Personality Disorders

26) While the policy guidance on CRHT advises that home treatment is 'not usually appropriate' for people with an exclusive diagnosis of personality disorder this has been followed by guidance on personality disorder not being a 'diagnosis of exclusion'[4]. Given that personality disorder is an important factor in quite a lot of admissions, crisis services should seek to serve these users as clinically appropriate. This work often involves short periods of home treatment. At the same time it is important that thresholds of severity and acuity are at the same high levels as described elsewhere in this document. It should be noted that the July 2003 policy implementation guidance makes recommendations on the commissioning of specialist community personality disorder teams. Where available this resource should also help to maintain PD users in the community.

2.8   Dual Diagnosis

27) Dual diagnosis is an important and complex issue for mental health services including crisis services. It is not addressed here in the detail it merits. However it must be noted that a high proportion of admissions to many psychiatric wards involve a substance misuse as well as a separate mental health diagnosis. This raises important issues about joint working with inpatient services and the skill mix available within crisis teams. No detailed guidance is offered here but it should be noted that Policy Implementation Guidance on Dual Diagnosis was issued in April 2002. This included the statement that "… crisis resolution services will be foci for work with the group (dual diagnosis) and must be equipped to take opportunities and tackle challenges".

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[4] 'Personality Disorder – No longer a Diagnosis of Exclusion' Policy Implementation Guidance, NIMHE, July 2003.

2.9 Training and Practice Development

The introduction of CRHT challenges established practices. There is a need for effective leadership, training and practice development to support change and develop the workforce. Ideally training will have been provided prior to teams becoming operational but equally an ongoing package of training and practice development is essential to sustaining quality services. A skills audit can reveal a range of gaps in skills and training which exist within the team and inform developments but the points below are the essential areas in which training and practice development are necessary (some of which could usefully be undertaken alongside members of other local teams). The Creating Capable Teams Approach and the Effective Teamworking and Leadership in Mental Health Programme are both useful resources to help take these objectives forward (see www.csip.org.uk).

- Understanding the proposed model and reflecting on its implementation within the context of local services.
- Risk assessment and management, particularly factors which modify risk and support balanced risk taking. This needs to be embodied in local policy that covers the whole local service system.
- Team working, clarifying individual roles and responsibilities within the team approach and identifying where the CRHT fits into the wider local service.
- Skills training may include evidence based and values based interventions such as psycho-social interventions, solution focussed brief therapy, Family and social systems interventions and skills to manage self-injurious and suicidal behaviour based on principles of evidence based interventions such as CBT, DBT, problem solving and S.T.O.R.M.

3.0 Audit

Teams should audit their activity and outcomes for the following reasons:

28) To provide feedback to themselves about their effectiveness and possible need to change.

29) To help ensure the sustainability of CRHTTs. New services are vulnerable to having their value queried; a demonstration of effectiveness helps sustainability.

30) Teams should be able to demonstrate the number of referrals into the service (by source), the number of assessments undertaken (by source) and as a proportion of those subsequently onto home treatment by both type (presenting problem / diagnosis) and source.

31) They should also evaluate service user satisfaction.

32) CRHTs also need to evaluate their influence on the rest of the local service system and in particular inpatient bed use. However, it is important to recognise that the relationship between community team activity and bed occupancy and length of stay is complex. For example CRHTs may disproportionately reduce inpatient stays for those people whose acute episode is fairly quickly resolved meaning that those who are admitted stay for longer on average. When exploring trajectory targets for admission, for example, it will be important to ensure that this is informed by good local intelligence on how the whole local service is influencing the use of beds.

3.1 Conclusion

There is much to celebrate in terms of the implementation of this crucial element of local service provision. At the same time there are many areas where CRHTs have yet to reach the 'critical mass' in terms of staff capacity and their place within the local service system to realise their positive potential to serve people in the least restrictive settings possible. Where this is the case, strong local leadership must reappraise local practice and resource allocation to ensure that all CRHTs are able to demonstrate the positive effects already being demonstrated in many parts of England.

3.2 Recommendations

- CRHT teams gatekeep ALL requests for acute in-patient beds 24/7. It is their core function next to provision of home treatment as an alternative to admission.

- CRHT teams need to ensure that they target those individuals in need of emergency care for severe mental health problems and principally target secondary care, acute presentations in offering an alternative to inpatient care.

- Within a whole system approach, filters (Gateway workers for primary care and Mental Health professionals within A&E) need to be in place to assess primary care and A&E mental health presentations to avoid CRHTs spending disproportionate time assessing and signposting.

- In line with "New Ways of Working" Psychiatrists need to engage with CRHT teams and in particular with gatekeeping and early discharge functions. They should reflect on their roles within Acute Care (Inpatients and CRHT) in line with 'New Roles for Psychiatrists'.

- Maintain a national data set for Crisis Resolution Home Treatment teams, building on the research data set assembled from the national survey of crisis services.

- A Collaboration to develop routine outcome measures for CRHT teams using the existing regional networks of crisis teams and acute care fora.

- Collect evidence and support research which offers insight into:
  - Integrated working across acute pathways of care.
  - Community pathways models of work.
  - Other interfaces of CRHT work (as well as acute inpatient care), where there is an impact on whole systems.

- Develop clearer commissioning guidelines for CRHT services

- Review impact of this policy at 2 years.