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Crisis resolution/home treatment teams, gate-keeping and the role of the consultant psychiatrist†

AIMS AND METHOD

The working relationship between consultant psychiatrists and crisis resolution/home treatment (CRHT) teams varies quite widely. Data from the national survey have been used to investigate the effects of consultant psychiatrist intput upon functions of the CRHT team. Logistic regression was employed to consider the effects of team size, team maturity and consultant input upon gate-keeping and fidelity to model (how many of six criteria teams' activities included).

RESULTS

There were statistically significant effects of size and maturity upon fidelity, and of maturity and consultant input upon gate-keeping.

CLINICAL IMPLICATIONS

The relationship between the consultant psychiatrist and other elements of the acute care pathway is an important determinant of how it functions. Depending upon how they relate to them, consultants can assist or hinder a team's capacity to fulfill their intended purposes.

This report summarises findings with respect to the role of consultant psychiatrists from a national survey of the implementation of crisis resolution/home treatment (CRHT) teams (Onyett *et al*, 2008, this issue).

Method

This analysis of the implications of senior medical input to CRHT teams uses the data-set generated by the national survey with particular focus on the key performance indicator. We have tried to establish whether or not CRHT teams fulfilled their 'gate-keeping' role.

Results

Team characteristics

As reported by Onyett *et al* (2008, this issue), teams' maturity (the number of months since the teams started taking cases) and size (whole time equivalent clinical staff) were among the data collected by the survey.

Gate-keeping capacity was assessed by first asking respondents whether their CRHT team aims to provide an alternative to hospital admission for individuals experiencing acute mental health difficulties. Where they agreed (152 teams out of the total 243 surveyed) they were asked to estimate the proportion of all proposals for hospital admission the team succeeds in gate-keeping. The responses were:

- everyone (100%) – 16 teams (10%)
- most (60–100%) – 85 teams (56%)
- about half (40–60%) – 26 teams (17%)
- less than 40% – 25 teams (16%).

Fidelity to model

This was estimated by asking respondents to report how many of the six fidelity criteria their team fulfilled (Table 1 in Onyett *et al*, 2008, this issue;).

†See original paper pp. 374–377, this issue.

Medical input

Medical input into the teams was assessed in the following three ways.

Team composition

Medical staff made up 5.2% of the reported CRHT workforce. They were found in 89 teams (53% of 167 providing workforce data): 50% were consultant psychiatrists, 36% staff grades and 14% trainees.

Medical membership of the team

Respondents were asked to give the nature of medical input to their team. These were as follows:

- dedicated consultant with other medical staff – 81 teams (45.5%)
- dedicated consultant without other medical staff – 15 teams (8.4%)
- dedicated non-consultant staff – 18 teams (10.1%)
- input from CMHT consultant or their trainee – 51 teams (28.7%)
- no medical input – 3 teams (1.7%)
- 'other' – 9 teams (5.1%).

Medical involvement

There were 160 respondents who gave opinions on the following.

- 'A senior psychiatrist can undertake home visits 24 hours a day with the team through the medical on-call rota': 43% agreed, 52% disagreed.
- 'The team's psychiatrists have responsibility for psychiatric input to all our patients/users': 33% agreed, 62% disagreed.
- 'Our crisis resolution team covers several consultant patches. Each consultant is responsible for patients/users from his/her patch that are seen by the team': 51% agreed, 46% disagreed.
- 'The team can over-ride decisions to admit made by others, including consultants and trainees who are not part of the team': 50% agreed, 39% disagreed.

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Logistic regression (SPSS version 14.0 for Windows) was used to explore relationships between the independent variables of team size (smallest, smaller, larger and largest), team maturity (youngest, younger, older and oldest) and medical input (from the team's dedicated consultant or from elsewhere), and the dependent variables of gate-keeping (60% or fewer proposals for admission) and fidelity to model (five or six criteria met or four or less criteria met). Out of the total 243 teams in the survey, 134 supplied enough information to enter into this analysis. It revealed a significant effect of medical cover and maturity, but not team size, upon gate-keeping (medical cover: Wald=9.396, d.f.=1, P=0.002; maturity: Wald=12.356, d.f.=3, P=0.006; team size: Wald=0.937, d.f.=3, P=0.816), and a significant effect of maturity and team size, but not medical cover, upon fidelity (maturity: Wald=13.284, d.f.=3, P=0.004; team size: Wald=13.74, d.f.=3, P=0.003; medical cover: Wald=0.041, d.f.=1, P=0.839).

Discussion

As of January 2006, CRHT teams were operating with a wide range of complements and differing models of medical cover and degrees of maturity. There are systematic relationships between these team characteristics and the success or otherwise with which they achieve gate-keeping and fulfil fidelity criteria which have implications for how teams might continue to develop. Mature teams with a dedicated consultant psychiatrist are better gatekeepers than their counterparts, whereas larger and more mature teams are better at meeting fidelity criteria, irrespective of whether or not they have a dedicated consultant. The effect of maturity upon teams' abilities to achieve their aims is consistent with earlier findings (Glover *et al*, 2006); the effect of medical cover upon gate-keeping is not surprising but previously unreported.

Respondents were also asked to comment upon perceived obstacles to implementation (Onyett *et al*, 2008, this issue). The most serious obstacle (129 references) was perceived to be a lack of staff, after that other financial or resource constraints (82 references), inter-team difficulties (67 references) and medical/consultant 'culture, practices or attitudes' (55 references). These appeared to reflect perceptions (and perhaps experiences) of reluctance among some medical staff to actively and positively engage with the intentions and aspirations of CRHT teams.

Some respondents, for instance, referred to experiences of medical staff bypassing their teams' gate-keeping role. Where this was the case several respondents expressed frustration with their not having their own medical team member available to negotiate with other medical staff on the team's behalf. These impressions are qualitatively derived from (largely nursing) staff's views, but a statistical relationship between the presence of a dedicated consultant and successful gate-keeping supports their reports.

Development of CRHT teams is driven by the view that alternatives to admission when in crisis are both desirable and possible (Hoult *et al*, 1984; Johnson *et al*, 2005). Frequently expressed concerns about acute care (Lelliott *et al*, 2006) include a firm view that any approach to addressing them requires strong working relationships between in-patient units and their local community services (Department of Health, 2002). Crisis resolution/home treatment teams are intended to provide an important feature of this liaison. In doing so they must be free to occupy a central place in the acute mental healthcare system. In most places CRHT teams are an innovation and wider changes are needed in service organisation and patterns of clinical responsibility and decision-making. The importance of team maturity in determining an influence upon admissions, gate-keeping and fidelity emphasises this. The CRHT team is more than just an innovative technique; in order to have greater effect it needs time to 'bed in', which in this context almost certainly means time for working relationships and expectations to evolve. Though changing, the role of the consultant psychiatrist holds a central place in these relationships, perhaps as a 'boundary spanner' (Richter *et al*, 2006) promoting more effective inter-team working. Our evidence suggests that improvements in outcome are most clearly seen where psychiatrists have embraced recent service developments and used their informal power to support them. Issues of authority and collaboration within and between elements of the acute care pathway, as well as clinical outcomes, deserve further study.

Declaration of interest

None.

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