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## From home treatment to crisis resolution: the impact of national targets

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**Aims and method** The home treatment service in central Manchester was established in 1997 to provide an alternative to in-patient care: referrals were only taken from secondary care services. In order to meet national crisis resolution and home treatment (CRHT) activity targets, referral routes were extended to primary care from 2008. To examine the impact of these changes, details of all referrals to the service were collected for a 6-month period in 2008/2009. Referral sources, demographic details and diagnosis were compared with similar data from 2005.

**Results** There was a marked increase in the number of individuals accepted by the service in 2008/2009 with a corresponding reduction in duration of contact. Primary care referrals were not accepted in 2005 but accounted for 20% of people treated in 2008/2009. This was mirrored by a change in diagnostic profile, with the proportion of individuals with mild to moderate illness increasing from 25 to 50%. In 2005, 70% of individuals treated had complex care needs compared with 39% in 2008/2009.

**Clinical implications** The strict imposition of numerical activity targets can have a significant impact on service delivery. Although more individuals have been treated under the new arrangements, the emphasis has shifted away from the intensive care of those with severe mental illness.

**Declaration of interest** None.

The development of crisis resolution and home treatment (CRHT) teams has been a central tenet of English mental health policy since 2000.<sup>1</sup> Although the policy implementation guidance<sup>2</sup> was highly prescriptive in relation to staffing and operation of CRHT teams, there were relatively few such teams in operation in the UK at that time. Since then there has been unprecedented investment and growth in CRHT services, with the National Audit Office reporting a 400% increase in spend on CRHT between 2002 and 2007, with 343 teams in operation across England in 2006/2007.<sup>3</sup> These new teams have been intensively performance managed, with each expected to provide a threshold number of episodes of care as part of the local primary care trust annual targets.

Although there is good research evidence that well-resourced teams can reduce length of stay and hospital

admission rates,<sup>4,5</sup> concern has also been expressed that the purely numerical activity targets can result in a shift away for the care of the most severely ill in order to maximise throughput.<sup>3</sup> The lack of medical involvement in services has also been cause for concern, with the National Audit Office<sup>3</sup> reporting that almost a third of teams have no dedicated psychiatrist and more than 50% have less than a half-time equivalent.

Manchester was one of the first centres to develop an acute home treatment service<sup>6</sup> and repeated activity audits during the past 10 years have provided a unique opportunity to explore in more detail the impact of national targets. The home treatment service in central Manchester was established in 1997, with a focus on providing a 24-h alternative to in-patient care for those with acute or severe mental illness.<sup>6</sup> The staffing levels and method of operation

were very similar to those subsequently recommended by the Department of Health.<sup>2</sup> The service has previously demonstrated an ability to care for people with acute symptoms comparable to those seen in in-patients but at a lower overall cost.<sup>7</sup>

Until 2008, the home treatment service only accepted referrals from within secondary care, with urgent primary care referrals triaged by other community mental health services. Data on referral source, patient demographics and diagnosis were collected over 6-month periods in 1999<sup>8</sup> and 2005. From inception to 2008, all individuals taken on by the service were reviewed by a psychiatrist during their admission, and the majority underwent physical examination during their contact with the service. To meet local activity targets, referral routes into the service were extended to include primary care from early 2008. This was accompanied by a small increase in staffing and much greater managerial focus on throughput.

## Method

A single data collection sheet was used to prospectively record information on all referrals to the service in a 6-month period from November 2008 to May 2009. Referral sources were grouped into five categories: accident and emergency (A&E), out-patients, community mental health teams, in-patient service and primary care. For individuals accepted by the service, an ICD-10 diagnosis<sup>9</sup> was taken

from the clinical record. This was later grouped into five categories: schizophrenia and related disorders, bipolar affective disorder, psychotic depression, less severe depressive categories and other diagnoses. Individuals were also grouped into those already under secondary care, with an established care plan, and those not previously known to services. The data items and codings replicated those used in earlier service evaluations. The data were entered into SPSS (version 15 for Windows) for analysis and compared with the data-set from 2005. Diagnostic categories from the original 1999 sample were also included to allow a longer-term perspective.

## Results

In total, 301 people were treated by the CRHT service during the 6-month period in 2008/2009, compared with 128 over a similar period in 2005. The mean duration of contact with the service fell from 69 to 24 days. Compared with 2005, a higher proportion of people were referred from primary care and A&E, and a lower proportion from all secondary care sources (Table 1).

Only 39% of individuals in the more recent sample were already known to services and in receipt of a care programme approach (CPA) care package, compared with 70% in 2005 ( $P < 0.005$ ). This is reflected in the diagnostic groups, with a significant increase in the proportion of individuals treated for less severe illnesses (including mild to moderate depression, anxiety, adjustment reactions, personality disorders in 2008/2009 and substance misuse) and a reduction in the proportion of individuals with schizophrenia and related disorders compared with both 1998 and 2005 (Table 2). The proportion of people treated with severe mental illness (schizophrenia and related disorders, bipolar disorder and psychotic depression) fell from 75% in 2005 to 50% in 2008/2009, whereas the proportion with mild to moderate illness (less severe depression and other diagnoses) rose from 25 to 50% ( $P < 0.001$ ).

## Discussion

The original central Manchester home treatment service was one of only a handful of such teams in the UK. The primary aim of the service was to look after people with

**Table 1** Source of referrals for individuals accepted by the crisis resolution and home treatment service over 6-month period

	2005	2008/2009
	n (%)	
Accident and emergency	10 (8)	71 (24)
Community mental health teams	42 (33)	97 (32)
Out-patient department	44 (34)	16 (5)
In-patient unit	32 (25)	58 (19)
Primary care	n/a	59 (20)
Total	128	301

n/a, not applicable.

**Table 2** Diagnostic groups for individuals accepted by the crisis resolution and home treatment service

	1998	2005	2008/2009
	n (%)		
Schizophrenia and related disorders	47 (47)	63 (49)	84 (28)
Bipolar affective disorder	13 (13)	24 (19)	44 (15)
Psychotic depression	10 (10)	9 (7)	22 (7)
Less severe depression	24 (24)	28 (22)	116 (39)
Other diagnoses <sup>a</sup>	7 (7)	4 (3)	35 (11)
Total	101	128	301

a. Other diagnoses for 2008/2009 include: anxiety disorder ( $n = 12$ ), personality disorder ( $n = 9$ ), alcohol-related disorder ( $n = 10$ ), obsessive-compulsive disorder ( $n = 4$ ).

acute and severe mental illness at home as an alternative to admission. It was therefore agreed from the outset that the service would only take referrals from within secondary care, as would be the case for individuals requiring admission.

As far as possible the service mirrored the functioning of an in-patient unit: all service users had a full psychiatric history and regular medical reviews, most had a physical examination and investigations and psychotropic prescribing was taken over by the home treatment service using in-patient type prescription cards. Individuals were with the service long enough for a full needs assessment and could be offered short-term psychosocial interventions. Discharges were planned around CPA reviews and the team doctors provided discharge summaries.

The service had changed dramatically by 2008, with throughput more than doubling and 20% of referrals coming directly from primary care. The average duration of contact with the service also fell significantly. There have been benefits, including reduced pressure on community mental health teams, more rapid access to help for individuals not under care, and more individuals receiving care from the service. However, this has been accompanied by a shift in emphasis away from those with established mental illness and towards primary care referrals, with new challenges resulting. The team doctors are not able to see all patients, hence fewer have full histories, physical examination or investigations and prescribing arrangements are less clear. Although data on contact with doctors were not collected as part of this audit, a separate data collection has indicated that the proportion of individuals being reviewed by a psychiatrist has fallen to around 60%.

As individuals are with the service for such a short time, the main interventions for those with less severe illness are assessment, support and signposting to other services. The treatment paradigm for this work is unclear and there is little research evidence to assess its effectiveness.

### Implications

There has been an unprecedented and rapid expansion of CRHT teams in the UK. The strict implementation of purely numerical targets has helped to push these developments

forward, but may have had unforeseen consequences in shifting established home treatment services towards a focus on less severe illness and reducing the quality of interventions offered.

As national targets are relaxed, commissioners should be seeking a broader range of quality and outcome measures for crisis teams. If doctors continue to be underrepresented in the work of crisis teams, it is essential that other staff have appropriate training and supervision and that rigorous pathways and protocols are developed to ensure the care of people with more severe illnesses is not neglected.

### About the authors

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