Mental health crisis care: commissioning excellence

A briefing for Clinical Commissioning Groups
November 2012

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Executive summary

Crisis and acute services are a crucial part of mental health care, helping people when they are most unwell and vulnerable. There are two main components – crisis resolution and home treatment teams (CRHTs) and inpatient services. However, a wider range of community provision can help make sure that everyone in mental health crisis gets the help they need at the right time.

Mind's independent inquiry (2010–11) found that excellent care exists, but that too often people are turned away and struggle to get help. In some places, inpatient wards are not safe or therapeutic.

We learned from mental health trusts (Freedom of Information request 2012) that there are huge variations between areas in rates of access to crisis care, staffing levels and the options available for those who want a safe place to go that is not hospital.

The current economic climate and ongoing service reforms are placing huge pressure on health and social care budgets, and the same pressures also have a huge impact on people with mental health problems. The Government's NHS Mandate and Mental Health Implementation Framework *No health without mental health* reflect the importance of investing in crisis care.

It is more important than ever that Clinical Commissioning Groups (CCGs) commission acute and crisis care that:

- is humane, compassionate and respectful
- is easily accessible for people in crisis
- has enough skilled staff to provide a timely, effective and sensitive response
- offers a level and mix of services that meet the crisis needs of all the communities in the local population
- works to prevent mental health problems developing or worsening and to promote recovery in collaboration with the wider system of mental health care services.

Introduction

I needed a safe place – somewhere where I could not seriously harm myself until I recovered emotionally.

As new commissioners, you have a critical opportunity to sustain and improve crisis care available in your communities.

Crisis and acute mental health services are a crucial part of mental health care, helping people when they are most unwell and vulnerable.

- Crisis resolution and home treatment teams (CRHTs) are part of secondary mental health services. They provide intensive support at home to people who would otherwise be admitted to hospital.
- Acute wards are for people who cannot be cared for safely at home and admission is usually determined by the CRHT.
- Crisis houses, acute day services and other community provision extend the scope of help that can be offered in a range of settings.

Mind set up a year-long independent inquiry (2010–11) into crisis care and, in August 2012, we sent out a Freedom of Infomation (FOI) request asking mental health trusts (England) about their CRHT services.

This briefing sets out what we have found out and what it means to you as commissioners. It also highlights what we recommend you factor into your approach in order to:

- meet the urgent needs of people in mental health crisis
- help you meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge by intervening in a timely way and preventing the need for more costly care.[1]

This is not a comprehensive briefing on commissioning acute mental health care. Other resources are listed on page 10.

Visit **mind.org.uk/crisiscare** to:

- find out why crisis care is so important to people
- download our inquiry report *Listening to experience*
- read more detail on the FOI findings for your area
- and hear why people across the country are supporting Mind's campaign.

Listening to experience: learning from Mind's independent inquiry

It feels like I literally have to have one foot off the bridge before I can access services.

We found that too often, people are turned away and struggle to get help. Their crisis calls may go unanswered or they are told they are not ill enough to qualify for help. That's not acceptable: an emergency is an emergency.

In some places, inpatient wards are not safe or therapeutic. People may be left isolated, frightened and unsupported. Sometimes people are so traumatised by the care they received that they would do anything not to return.

Some black and minority ethnic groups seem to be treated more neglectfully or coercively than other people.

We found that excellent crisis care exists. It saves lives. But we need it available for everyone.

Our inquiry panel found that we need to concentrate on four areas:

Humanity

Acute and crisis care should be built on human values and embody a culture of service and hospitality so that people are treated in a warm, caring and respectful way.

Commissioning for people's needs

As well as meeting people's common needs for care, safety, respect and someone to talk to, services should reflect the diversity of needs. For example, the needs of different black and minority ethnic communities or the differing needs in urban and rural areas.

Choice and control – shared decision-making

Commissioners need to factor in enough resources to commission a range of services with sufficient capacity to enable service user choice. People should be trusted to understand their own needs and have more say over what happens to them through the use of joint crisis plans[2] and other shared decision-making tools.

A shared approach to healing and recovery

Psychiatrists play a valuable role in crisis care, but others' skills are important and should be used to best effect – professionals, support workers and peer workers who have themselves experienced mental health problems.

Read more about our findings in our *Listening to experience* report at **mind.org.uk/crisiscare**

What mental health trusts told us

We learnt from our independent inquiry that people struggled to get help – often using expressions like being 'batted away' or 'deflected'. This concerned us greatly, so we asked mental health trusts, through a FOI request, about the capacity of CRHT services, which are the gateway to access.

We wanted to find out about issues like staffing levels and service activity, including ethnicity data. Crisis houses and other alternatives to hospital were regarded very positively in our inquiry, so we also asked about the range of options available in addition to hospital admission and home treatment.

We received 44 substantive responses from 52 trusts about services in 2011–12.[3]

We found:

- Huge variations: between trusts in the rates of access to their crisis care services.
  - referrals to crisis teams ranged from 42 to 430 people per 10,000 population (average[4] 107)
  - new episodes of home treatment ranged from 8 to 104 per 10,000 population (average 41)
  - hospital admissions – ranged from 5 to 56 per 10,000 population (average 20).
- Under-staffing: 4 in 10 trusts had staffing levels well below the Department of Health guideline of 14 staff to 25 service users.[5]
- Limited options: only 12 trusts said they had more than one alternative option to hospital and home treatment, while five reported none. Just seven out of 26 trusts said they had one or more crisis houses. In 2007, 38 per cent of trusts had two or more types of option.[6]
- Ethnicity differences: there were variations in access to crisis services for people from different minority ethnic groups. In many areas, minority ethnic groups – especially Indian, Pakistani and Chinese people, had lower rates of access than white British people. Those who were referred generally had equal or higher rates of access to home and hospital treatment. In some areas, especially in London, black communities had much higher referral rates.
- Variations in intensity of support: the average number of face to face contacts for people receiving home treatment ranged from 1 to 23 (average 8).

Preliminary findings from a survey of crisis teams by researchers at University College London[7] add to the picture.

- Only 35 per cent of crisis teams can offer access to a crisis house.
- 81 per cent of crisis teams can offer telephone contact to service users 24/7, 86 per cent can assess new clients at A&E 24/7, but only 39 per cent can visit service users at home 24/7.
- 55.5 per cent of crisis teams accept self-referrals from known clients, but just 21 per cent from unknown clients.

Other significant issues raised by our FOI inquiry were:

- the impact of changing to more centralised systems for accessing crisis services.
- the outcomes of referral and assessment where high proportions of those referred were neither accepted for home treatment nor admitted to hospital.

Visit **mind.org.uk/crisiscare** to find out more about your local area.

What our findings mean for you as commissioners

Support the crisis teams – if they are in crisis themselves they can't help us!

Variations between mental health trusts in referrals and service activity

We understand that referral and service activities will vary between different areas. Services may differ in capacity and the way they are organised. Different parts of the local mental health care system may not be working as effectively as others to prevent crises. There may be varying levels of awareness and understanding about local crisis care teams and their roles. Then again, it may well be that there are a lack of sufficient crisis care services being commissioned.

We recommend you commission the right level and mix of local crisis care services so that people get the help they need. Urgently. And as close to home as possible. You can achieve this by understanding the need, demand, service capacity and service use in your areas.

Staffing levels and intensity of support

The staff to service user ratio across the trust area may be higher than suggested in policy guidance for very good reasons such as the number of teams in a trust area, geography and population density or dispersal. Indeed it may be that these levels should be considered standard to meet rising demand. The benchmark relates only to caseload, and a trust with staffing appropriate to the caseload may still be overstretched if it carries out a high level of assessments.

It is likely that teams in areas with lower than recommended staffing levels are overstretched. This may result in compromised safety, people being turned away who need the service, and a less intensive service than is needed. This chimes with the findings of our 2011 inquiry. It may also be relevant to the recent finding that deaths by suicide of people in the care of CRHTs are now higher than those of inpatients.[8]

The best current benchmark is that the crisis team must have the capacity to allow for twice daily home visits to take place, as planned[9] – yet our investigation suggests that on average crisis teams are visiting service users every three days. While visits may be more frequent in the early stages, this still calls into question the capacity of teams to fulfil their role.

24/7 availability is a core characteristic of crisis teams and is essential to their effectiveness. The UCL preliminary data shows that only 39 per cent of crisis teams are able to visit people in crisis on a 24/7 basis. In other areas people will have to manage with telephone advice or get to A&E in order to be helped by the team out of hours.

We recommend you study and understand the implications of staffing levels in the local context and make sure that contracts promote safe staffing levels which allow for a timely and effective response to people in crisis.

A range of options

Having a range of options can facilitate service user choice, meet a diversity of needs, and help CRHTs to work more effectively.[10] Examples include:

- crisis houses, sanctuaries and recovery houses
- retreats/respite care
- peer/survivor-led services
- host families
- crisis-focused therapeutic programmes.

Benefits may include staying closer to home, maintaining family and community ties, working through a crisis with less medical intervention, having time out from stress and making a better transition[11] from hospital to community services. Research into residential alternatives to hospital shows greater satisfaction than with hospital admission and no significant difference in costs and outcomes.[12]

We recommend you involve your communities in reviewing what mix of options would best serve local needs, and make sure you engage black and minority ethnic communities in this process.

Black and minority ethnic communities

Ethnic differences in service access and use may reflect the level of mental health problems among people from that ethnic group, different barriers to accessing care, or differences in how people are treated. It is important to make sure that all communities can access timely help that meets their needs and that existing inequalities are challenged.

Our investigation suggests that people from black and minority ethnic communities are receiving treatment once they are seen by crisis teams but some may experience barriers to initial referral, especially those from Indian, Pakistani and Chinese backgrounds. Timely help from a crisis team may also help reduce the disproportionate admission to hospital of people from black groups by more coercive routes.

We recommend you look at relevant data for your areas and discuss it with the black and minority community groups affected and health care staff. This can form the basis for a genuine partnership in which people from black and minority ethnic communities define their own needs and priorities.

Access arrangements

Centralised or single point of access referral systems may simplify access but, in some cases, they can also conflict with other care aims such as providing continuity of care and easy re-access for people who already know staff who are familiar with what works for them. Whatever the referral system, there is a real risk of harm if those staffing the contact number are not suitably trained.

We recommend that you make sure services give people easy access to crisis care and that the first point of contact acts as a gateway to help and not a barrier.

Discharge, no action

In some areas a high percentage of people referred to the team were discharged without further action from the team.[13] It may be that a crisis assessment was sufficient to resolve the situation. The referrer may not have understood the remit of the team. However we know of people's complaints that they are told they are not ill enough to help and are left unsupported. We hear of GPs' concerns that people are referred back to them when they think they need more specialist care.

We recommend you make sure that the way services are configured does not leave a gap in provision for people in or on the brink of mental health crisis.

Recommendations from our 2011 independent inquiry

Humanity

- Include an organisation's value base as a criterion in awarding contracts and assessing performance and hold providers to account using measures that include service use and carer satisfaction.

Commissioning for people's needs

- Commission a wide range of effective psychological therapies that are available to all who need them including people using acute and crisis mental health services

Choice and control

- Commission from a range of providers including specialist providers in black and minority ethnic communities
- Set standards with providers to embed shared decision-making in their practices through joint crisis care planning.

You can download the report *Listening to experience* mind.org.uk/crisiscare

Legal rights and duties

As commissioners, you will want to make sure that providers of services you commission meet their legal duties and uphold people's rights. These include:

- Human Rights Act 1998 – protecting individuals from bad practice by public bodies.
- Equality Act 2010 – tailoring services for equal access.
- Mental Health Act 1983 – following both the procedures and guiding principles of least restriction, respect and participation.
- Mental Capacity Act 2005 – empowering and protecting people who may lack capacity to make some decisions for themselves.
- Health and Social Care Act 2012 – parity for urgent mental health and physical health care.
- Convention on the Rights of Persons with Disabilities – setting out how to ensure disabled people's rights are protected.

Crisis care in action

Here are some inspiring examples of excellent crisis care in action.

Hertfordshire NHS Foundation Trust offers a stay with a host family as part of its acute mental health care for people in crisis. The crisis team provide professional care while the service user lives with a supportive family.

Hertfordshire Mind Network and Mid Herts Mind provide peer support to people during a hospital stay and when they leave. Peer mentors use their own experience to support people and help with reintegration into community life.

The Maytree Respite Centre in London provides a sanctuary for people in suicidal despair – short residential stays in a calm, safe, homely environment in which to talk, reflect and rest.

Swindon Mind's Crisis house provides a non-medical approach that helps people find solutions to their problems and avoid the need for more intensive care.

Visit **mind.org.uk/crisiscare** for more examples.

Resources

No health without mental health for clinical commissioning groups (Mental Health Strategic Partnership, 2012). http://www.mind.org.uk/assets/0002/1268/No_Health_Without_Mental_Health_CCG.pdf

Quality Standard for service user experience in adult mental health (National Institute for Health and Clinical Excellence, 2011). http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14

Acute care guidance from the Joint Commissioning Panel for Mental Health, in progress. http://www.rcpsych.ac.uk/policy/projects/live/commissioning.aspx

London Health Programmes' Models of Care project: case for change document and models of care for Londoners with long term mental health conditions or experiencing a mental health crisis (2011). http://www.londonhp.nhs.uk/services/mental-health/mental-health-project/

Star Wards http://www.starwards.org.uk/ and Wardipedia http://www.wardipedia.org/ for inpatient care inspiration

'Triangle of Care' carers included: a guide to best practices in acute mental health care (Princess Royal Trust for Carers and National Mental Health Development Unit, 2010). http://www.carers.org/news/mental-health-and-triangle-care

Home Treatment Accreditation Scheme: Standards for Home Treatment Teams – Pilot Edition. (Royal College of Psychiatrists Centre for Quality Improvement, 2012). http://www.rcpsych.ac.uk/quality/qualityandaccreditation/hometreatmentaccreditation.aspx

Endnotes

1. Government research has estimated gross national savings of £224 million a year by 2014–15 by improving the acute care pathway: Department of Health (2011), No health without mental health: the economic case for improving efficiency and quality in mental health

2. Joint crisis plans, developed by the person at risk of crisis with their care team in an independently facilitated process, have been shown to reduce the use of statutory powers to detain and treat people against their will. Henderson C., Flood C., Leese M. et al (2004), 'Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial', *British Medical Journal*, doi:10.1136/bmj.38155.585046.633 (7 July 2004)

3. Not every trust answered every question

4. We are using the median average throughout.

5. Department of Health (2001), *Mental health policy implementation guide*

6. Healthcare Commission (2008), *Pathway to recovery*

7. The following data are from the preliminary findings of the National Survey of Crisis Resolution Team Practice conducted as part of the CORE Programme at University College London. The survey is independent research funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research programme (Reference Number: RP-PG-0109-10078). The views expressed in this briefing/release are those of Mind and not necessarily those of the research author(s) which in turn are not necessarily those of the NHS, the NIHR or the Department of Health.

8. University of Manchester, *The National confidential inquiry into suicide and homicide by people with mental illness: annual report 2012*

9. College Centre for Quality Improvement (2012), *Home Treatment Accreditation Scheme: Standards for Home Treatment Teams – Pilot Edition*. Royal College of Psychiatrists

10. National Audit Office (2007), *Helping people through mental health crisis: the role of crisis resolution and home treatment services*.

11. The Schizophrenia Commission (2012), *The Abandoned Illness: a report by the Schizophrenia Commission*. Rethink Mental Illness

12. Osborn D.P.J., Lloyd-Evans, B., Johnson S. et al (2010), 'Residential alternatives to acute in-patient care in England: satisfaction, ward atmosphere and service user experiences', *British Journal of Psychiatry*, 197, s41–45.

13. Trusts answered the relevant question differently, so interpretation is not completely clear.

For more information on our campaign and how we can work together for excellent crisis care, contact:

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