A Review of Crisis Resolution Home Treatment Services In Scotland

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(Version 4: November 2011)
Preface

This report is intended to help NHS Tayside in the planning and development of a Crisis Resolution Home Treatment Service. It draws on all of the main available research evidence from the UK, and more importantly upon the experience of nine other services in Scotland. Some of these have been operating some form of a Crisis Resolution Home Treatment Service for several years now. These clearly have had a positive impact on acute mental health care.

It is often said that new services should “draw on best practice”. In the review of services in Scotland a variety of approaches was found around the core concept of crisis response and intensive home treatment as an alternative to inpatient admission. Therefore it is difficult to point to a single example of best practice. What the review did offer was a long list of good ideas, practical experience and alternative solutions to follow. This in many ways is probably more helpful than having an example of “best practice”. Instead, it will allow services in Tayside to work through locally what needs to be done with a good understanding of what the important issues are and the implications of tackling them in different ways. There is no doubt that obtaining this information has been much quicker and the results much richer than if it had had to be done simply by designing a service from scratch. There is nothing like practical experience to highlight what are the opportunities and the potential pitfalls. Indeed, as an aside, one of the main lessons to come out of the review was the great benefits to be gained by looking at other services and how they operate, not to provide an answer but to develop better questions in reaching an answer.

None of this information would have been obtained if it were not for the generosity of a large number of colleagues working in these nine services reviewed. In every case those colleagues always went the extra mile to be helpful. Part of this was no doubt due to their pride in and commitment to their services, but also everyone seemed willing to take the time to reflect upon what they were doing and where they were going. It also has to be said that those with whom we met were always open and candid about the issues, as well as well-informed and perceptive.

We circulated an earlier draft of this report to each of the services that we had visited and asked them to validate the information presented about their own service. We responded to those comments and corrections that we received, and amended the report accordingly. Two of the services unfortunately did not come back to us, despite being offered two extensions to enable this. We are however sure that we have represented the overall nature of these two services accurately. We of course remain responsible for any remaining inaccuracies, and for the overall analysis.

We would like to record our sincere thanks to all these colleagues in other Boards who took time to speak to us and who helped us greatly with getting the information about their services. Without that generosity, the report would not have been possible in any form at all.

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October 2011
EXECUTIVE SUMMARY

- Crisis Resolution Home Treatment (CRHT) services are associated with the extension of community care for people suffering from serious mental illness. Specifically CRHT is concerned with the delivery of an acceptable level of care during the acute phases of severe mental illness.

- CRHT as a distinct approach to acute mental health care has an established international record in reducing admissions by providing intensive treatment at home for people who would otherwise have to be admitted to inpatient care.

- There is an extensive research base which demonstrates the value of CRHT as a prevention of admission service and a way to shift the balance of care to the community. Research findings on other aspects of CRHT services are more limited.

- While providing an alternative to admission is the primary function of a CRHT service, intensive home treatment can also be used to support the early discharge of patients.

- The Scottish Executive published National Standards for Crisis Services in November 2006, and in 2007 there was a commitment in Delivering For Mental Health to make sure that people were managed and cared for more effectively in the community and inappropriate admissions avoided through fully achieving the crisis standards by 2009.

- In Scotland no particular model of a crisis resolution and home treatment service was advocated. This was in contrast to England and Wales where there was extensive guidance on the make-up and operation of CRHT teams, and a timetable for their establishment. Instead the Scottish Government emphasised the achievement of two outcomes:
  - Reduce hospital admission rates by 10% (by end December 2009).
  - Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% (by end December 2009).

- According to the Scottish Crisis Resolution/Home Treatment Network, in November 2010 there were six Boards that provided a CRHT service function:
  1. Ayrshire & Arran
  2. Borders
  3. Dumfries & Galloway
  4. Forth Valley
  5. Greater Glasgow & Clyde
  6. Lothian

- In some Boards there is more than one service covering different local areas. Using the Scottish Crisis Resolution/Home Treatment Network’s definition of CRHT there are 19 distinct services in Scotland.
The review looked at nine services, two of which were in Boards not included in the Crisis Resolution/Home Treatment Network’s definition of such a service:

1. Renfrewshire
2. Forth Valley
3. Lanarkshire
4. South Glasgow
5. Inverclyde
6. Aberdeen/Aberdeenshire
7. North Edinburgh
8. Midlothian
9. Ayrshire & Arran

The services demonstrated different characteristics, and three categories were developed for the study to highlight these:

1. **Separate/Stand Alone** – there is a separate dedicated team covering all of the main professions and support involved in crisis resolution and intensive home treatment. (Forth Valley, Edinburgh and Renfrewshire.)

2. **Partially Integrated** – there is a separate dedicated team covering some of the professions and support involved in crisis resolution and intensive home treatment, but other inputs such as psychiatry are drawn from generic mental health teams so the teams' operations have to be closely aligned. (Ayrshire & Arran, Midlothian and South Glasgow.)

3. **Fully Integrated** – the carrying out of crisis resolution and intensive home treatment is not down to a specific, separately identified group of staff but is a function undertaken by some members of the wider mental health team as part of the patient pathway rather than as a separate service. (Inverclyde and Lanarkshire. Grampian did not have a formal CRHT type service.)

All CRHT services were introduced after extensive planning of the way the service would operate and engagement of stakeholders involved in the wider acute mental health pathway. Usually CRHT services were introduced as part of a wider review of mental health strategy which helped to clarify their function and place in the acute mental health pathway.

All CRHT services have a strong multi-disciplinary team approach based round a core of mental health nurses and access to a senior psychiatrist, along with input from other disciplines of which occupational therapy, social work/social care and psychology are the most prominent.

There is some variation across the services reviewed in terms of staff numbers and mix, but all teams operate with a more or less consistent range of staff and similar capacity.
CRHT teams have a very strong focus upon prevention of admission in taking on patients, and do not offer a wider range of services either in the community or inpatient setting.

Established services in Scotland have successfully reduced admissions, and there has been associated with this a reduction in the number of acute psychiatric beds although other factors have been associated with bed closures while the link between the existence of CRHT services and comparative acute beds rates is uncertain.

Most CRHT services also support earlier discharge but the extent to which CRHT services undertake this varies considerably and there is scope for most services to extend this function.

Different approaches to referrals are adopted in different services, but usually the referral arrangements are comparatively open and CRHT services usually undertake an initial screening/triage before undertaking an assessment of whether a person should be taken on for intensive home treatment.

Broadly CRHT services provide the same type of intensive home treatment, but there is important variation in the average length of stay of patients for intensive home treatment indicating differences in the approach to the management of crises and handover to Community Mental Health Teams and GPs.

Stand alone CRHT services have a gate-keeping role for inpatient admissions, while in partially integrated services this role is shared to various degrees with other clinicians and services. Both arrangements largely work, although the exclusive admission rights of stand alone CRHT teams took some time to become accepted by some psychiatrists. In fully integrated services, responsibility lies with the admitting clinician in the usual way.

Of the different models reviewed – especially the differences between the stand alone and partially integrated approaches - it is not possible to determine which one is best at delivering the benefits of a CRHT – reduced admissions. While the structure and organisation of the services is important, so are the philosophy, attitude and outlook regarding the acute patient pathway.

CRHT are likely to be a lower cost option than inpatient care, but they still require a comparatively high level of investment to replicate to a significant extent the capacity found in inpatient wards.

Fully integrated services offer a potential opportunity to deliver CRHT services more flexibly and at lower costs, but this requires further investigation not least because the two services studied have not been running sufficiently long enough to demonstrate that they can produce the same impact on admissions and the precise resource put into crisis resolution/intensive home treatment is difficult to identify.
In many of the services reviewed, consideration is being given to integrating existing CRHT teams both vertically (with other services) and horizontally (with other CRHT teams) to improve flexibility and economies of scale.

It is possible that the tasks carried out by CRHT services, most obviously-intensive home treatment, are undertaken by generic mental health services even where there is not an explicitly identified crisis resolution/home treatment service.

There is a need to improve the data collected about CRHT services to improve evaluation and future planning.
INTRODUCTION

This is a report of a review of psychiatric services in six Scottish Health Boards that variously go under the heading of crisis resolution / intensive home treatment / avoidance of admission. The review was undertaken to gather information and evidence from the operation of proven services to help inform NHS Tayside about the options available and important considerations requiring attention connected with such services that could be used in help the planning and development of a similar type of service. It is however hoped that the review findings will also be of value to other Boards whether they have or are planning to have a service of this type.

BACKGROUND

Crisis Resolution Home Treatment (CRHT) services are associated with the extension of community care for people suffering from serious mental illness. Specifically CRHT is concerned with the delivery of an acceptable level of care during the acute phases of severe mental illness.

Severe psychiatric illnesses are phasic. Following initial treatment, people usually experience long periods of relative stability, but relapses can occur for a variety of reasons such as exposure to environmental stresses or poor compliance with medication. During a relapse sufferers will experience a sudden exacerbation of acute symptoms such as delusions and hallucinations, and consequently will have disturbed and difficult behaviour. A number of people may become a risk to others or to themselves. Intervention at this stage is obviously crucial to bring relief for the sufferer and their carers, and to prevent further deterioration. Community care services as they originally developed from the early 1960s onwards were able to care for people at home during the relatively stable periods, but had not been able to respond effectively to acute phases or relapses in a person’s home. This created a cyclical pattern whereby people were admitted into hospital for short periods during a crisis, then discharged back into the community until a further crisis arose.

Breaking this cycle required the development of some form of care that could adequately treat these psychiatric crises in the home environment. In the 1970s, building on pioneering work like Amsterdam’s 24 hour ‘first aid’ emergency home service, specific crisis intervention models began to be developed and introduced in a number of countries. By the beginning of the 1990s home or residential treatment crisis interventions were the conventional model in North America and Australia and were being developed in several other countries.

In 1999 the then UK Labour Government introduced a National Service Framework (NSF) for Mental Health in England. One of the central elements of the NSF was the introduction of CRHT teams. These teams were intended to make sure that what was in place – intensive treatment in the community – would support a reduction in in-patient admissions and earlier discharge for those who were admitted. In July 2000 the NHS plan for England made the provision of CRHT Services a national

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1 The term used throughout this paper for the sake of consistency is Crisis Resolution Home Treatment (CRHT) Services. This is not the term used in the five Boards visited, where different labels have been applied. It is however a fairly common label elsewhere.
priority. The consequence of this was that the approach taken was quite prescriptive. Two key targets were set in 2002:

1. To expand national capacity to deliver CRHT to 100,000 people annually by 2005.

2. To create 335 Crisis Teams by the end of 2004 to deliver the above.

These national targets were broken down into local targets based on population. In addition, the Department of Health issued a Guidance Statement on Fidelity and Best Practice for Crisis Services. Among other things this set out criteria for the staffing and operation of the CRHT teams. The development of CRHT teams was supported by extensive NSF funds, although Primary Care Trusts were given discretion as to how much of their overall funding allocation was spent on delivering CRHT Services. Between 2002/03 and 2006/07 spending on CRHTs across England increased by over 400%.

It is worth remembering that the introduction of the CRHTs was supported by evidence from practice in other countries, some earlier adopters and pilot sites in England, and a Cochrane Review. Influential on the Department of Health’s thinking had been that of Professor Sashi Dharan, Medical Director of North Birmingham Mental Health NHS Trust.

In Wales a similar approach to England was adopted. The Welsh Assembly Government set a target in 2005 to have a CRHT services in every Local Health Board by 31 March 2006.

However, in Scotland a different way forward was adopted nationally. The Scottish Executive published National Standards for Crisis Services in November 2006. This was a response to a commitment made in Delivering for Health for a national standard for mental health crisis to be in place by December 2006. The document provided a range of quality standards, expectations and desired outcomes for mental health crisis response. In Delivering For Mental Health (2007) a commitment was made to make sure that people were managed and cared for more effectively in the community and inappropriate admissions avoided through fully achieving the crisis standards by 2009.

The standards produced by the Mental Health Foundation – and which were to be performance managed along with the other commitments in Delivering For Mental Health – did not suggest adoption of CRHT or anything similar, but did make reference to a ‘crisis service’ and set out the broad tasks and functioning of such a service. Without doubt there was more flexibility in the Scottish arrangements. Nonetheless, two outcomes were expected:

- Reduce hospital admission rates by 10% (by end December 2009).

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2 Joy CB, Adams CE, Rice K, Crisis intervention for people with severe mental illnesses (Cochrane Collaboration, 2006)
• Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% (by end December 2009).  

Following the introduction of CRHTs in England from 2003 onwards, there was a considerable outpouring of research and evaluations of the changes introduced and what difference they were making. This has meant that – in addition to the historic international evidence base – this study has been able to make reference to reasonably extensive research base with a specific UK concern. A total of 30 research papers and other studies into CRHTs and related topics with a UK - very largely English - focus have been considered in the preparation of this report (Appendix 1). Not surprisingly many of the studies have been concerned to demonstrate whether or not CRHTs have made a difference. These have provided controlled before and after or comparative studies of the difference made by these services. The differences considered most were admissions, discharges and bed-days, but other outcomes were also covered including patient experience and costs. In these studies, little was said about the actual operation of the services, and with most studies it was difficult to identify if there were crucial ingredients that contributed to the resulting benefits from introducing a CRHT team/service and if so what they were.  

There have also been wider evaluations in terms of what happened after 2003. These have taken a wider range of services to review (for example by using national data). These wider evaluations have considered not just the impact of the services on the objectives set, but on matters such as differences in structures and functions of CRHT teams across England, the variable speed and extent of implementation of the concept, important factors that have made - or that are assumed to have made - a difference, and costs.  

On top of these various research reviews of what has happened, there was in addition considerable guidance of how to establish, operate and develop CRHT services. Some of these have come from the Department of Health in England, but the (then) Sainsbury Centre for Mental Health published several guides and pieces of advice (in addition to providing on-site advice and support).

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3 The outcomes were described as ‘desired’ but the second was a HEAT Target to which Boards were committed to achieving through the Local Delivery Plan.
4 The studies looked at are listed in Appendix 1.
It should also be added that, even although there was considerable guidance and targets regarding CRHT services in England, the wider evaluations have pinpointed variation in the composition and practice of the teams. Some of these were associated differences in outcomes. These studies – which in some cases were self-selecting and in instances overlapped in terms of data and information sources – do give strong evidence that CRHT teams in England and Wales did bring about a reduction in the number of admissions.

The various studies do however reveal considerable differences in the extent of the reduction. Variation would be expected given the differences in pre-existing levels of admissions and the behaviour of wider acute psychiatric and community services. Another major factor would also have been the wide variety in the composition and operation of CRHT services across England despite a fairly prescriptive central policy. (A good example of this is differences in the hours of operation of these services: not all were 24/7.) In short, the composition and operation of the service was seen to have important implications for the primary purpose of CRHT services – keeping people out of hospital – and other outcomes.

In this respect, it is important to note a recent report from the Audit Commission in England. The Commission undertook a review in 2010 of the resources used in adult mental health on the lines of the efficiency of the adult mental health acute care pathway. They identified a significant variation in admission rates after adjusting for age, sex and deprivation. One important issue that they addressed was the commitment to CRHT services (which they measured by spend). The Commission’s findings were that there was not a (negative) correlation between bed days and the spend on CRHT teams. The conclusion that they reached was that there was variation in the effectiveness of CRHT teams in terms of gate keeping. Indeed they found no correlation between gate-keeping rates (i.e. the proportion of admissions gate-kept by CRHT teams) and bed days. The Audit Commission argued that other factors need to be taken into account in considering the use of beds, not just the existence of a CRHT team per se. The Commission for their part highlighted the following factors: the existence of a properly integrated pathway to which all medical staff adhere; the hours of operation of the CRHT team; the appropriateness (and hence number) of initial referrals to the team; and the actual number of available beds (i.e. beds will always get used).

The research evidence overall does not provide an absolute indication of what factors are the most important, but it is possible to list some of the factors in addition to overall funding that were highlighted as impinging upon delivery of the intended outcomes:

1. The extent to which the CRHT team was the gatekeeper to admission (i.e. there were no other pathways to admission)

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8 Gyles Glover, Gerda Arts and Kannan Suresh Babu Crisis resolution teams and inpatient mental health care in England. In a few Primary Care Trusts there was in fact an increase. These have not been followed up to see whether they were the consequence of adjustments in behaviour to the new service or a permanent feature.

9 Audit Commission Maximising resources in adult mental health, June 2010. See also NHS Confederation/Audit Commission/National Mental Health Development Unit, Efficiency in mental health services, Briefing February 2011, Issue 214.
2. Staffing out of hours/weekends

3. Liaison between CRHT teams and inpatient services (which particularly affected the level of early discharges)

4. Input from consultant psychiatrists – either in terms of the time input from consultants or whether they were integrated with the CRHT team.

5. Inappropriate referrals because of referrers not understanding the purpose of the CRHT team.

In terms of offering firm conclusions on the development and operation of crisis services, the evidence from the research provides some points to take into account in the early stages of introducing crisis type services. It is important to recognise that the wide variation in England in practice and outcomes makes it difficult to draw very reliable conclusions. The points are therefore in the category of ‘things to look out for or confirm’ – and which were included in the visit to Scottish services – not circumstances with a high probability to happen. The points are:

1. There is important variation in the impact on the reduction of admissions, most obviously around age and sex and voluntary/involuntary admission. There was no clear pattern however, and some of the findings pointed to opposite conclusions. **Consideration:** Crisis services may more readily suit certain patient groups more than others, so to have a maximum impact a one-size fits all approach may not be best and forecasting the impact on the population as a whole from a part of it may be problematic.

2. CRHT Teams were seen to be by some as a model suitable for predominantly urban populations. **Consideration:** Establishing intensive and very responsive emergency outreach services may be difficult to justify in resource terms in sparse population areas.

3. There was an emerging view that CRHT teams were really effective at reducing short term admissions, leading to a rise in the average length of stay while not having a commensurate impact on bed usage. **Consideration:** A prevention of admission service if only able to stop the shorter stay admissions may not so readily generate savings to invest elsewhere, especially if the average intensity of inpatient care rises.

4. The evidence on patient benefit is, not surprisingly given the difficulties in obtaining useable data, limited. The evidence from the Cochrane Systematic Review would, on the evidence available, suggest no difference in mental state between homecare and hospital provision, but would indicate positive benefits from homecare in terms of burden on families and on patient satisfaction. Accepting its limitations, the published evidence does not highlight an increase in suicide numbers associated with a shift away from inpatient care.

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10 The position in Wales is particularly helpful in raising some issues for Scotland. See Richard Jones & Brahms Robinson A National Survey of Crisis Resolution Home Treatment Services in Wales (University of Swansea, 2008)
Consideration: While CRHT services may have an impact upon the balance of care, is there comfort that it offers at least as good longer term patient outcomes as inpatient care?

5. Home treatment is a lower cost alternative to inpatient care for those patients who are appropriate for home treatment. The National Audit Office Report in 2007\(^{11}\) suggested that this was due to both lower costs per day of treatment and because of fewer average days of treatment at home compared to inpatient care. (This may not be the case if – as suggested above - home treatment is largely associated with preventing admission for those whose inpatient stays would have been a short one.) The National Audit Office also commissioned an economic study to compare the cost where home treatment is an alternative to and supporting service alongside inpatient services with the costs where it is not. The study concluded that a saving of £610 per crisis episode would be achieved where CRHT was available compared to where it was not. The numbers of studies are however few. Most of the published studies considered so far have focused upon the impact of CRHT, particularly upon admissions. Most of these studies have said little or nothing about the actual operation of these services. \(^{12}\) Consideration: To what extent are CRHT services not only effective, but cost-effective?

On balance the published evidence on CRHTs may not be very conclusive but it is largely very positive. CRHT teams offer a reduction in admissions, reduced bed usage, are cheaper to operate and achieve similar outcomes to inpatient care while conferring other benefits to patients and their families. Certain disadvantages do emerge in the published literature on a similar basis as points to look out for. None of these look to be endemic to CRHT services, but potential risks. These are:

1. A higher number of involuntary admissions
2. A de-skilling of those working in mainstream community services
3. A break in continuity of care as people shift from the Community Mental Health Team (CMHT) to the CRHT service and back again
4. CRHT services being used in dealing with patients for whom a hospital stay at that stage was not a serious prospect (i.e. using expensive resources unnecessarily).

The quite extensive evidence base on CRHTs can be summarised to be helpful but far from conclusive on those aspects of importance to those establishing and operating some sort of CRHT service. This is especially the case if one wishes to explore the different options and avoid some of the pitfalls likely to befall a new service. The limits of the literature for development purposes are:

\(^{11}\) National Audit Office, *Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services*, 27-28,

\(^{12}\) Paul McCrone, Martin Knapp and Jess Hudson *Model to assess the Economic Impact of integrating CRHT and Inpatient Services* (2007, Centre for the Economics of Mental Health, Health Service and Population Research Department, King’s College London).
1. The wide variation in results – most of it reporting on the same ostensible model – has not been reliably explained so it is not possible to draw on what works well and what does not.

2. (Linked to the above) CRHTs were seen as an investment – which is broadly correct – but it is not possible to discern the different returns associated with different levels of investment. (Is there a critical threshold to make a difference? Do very well resourced services really make that much of a difference?)

3. The evidence is skewed to a particular model of CRHT that was to a large extent prescribed in England but there are other options for delivering these kinds of services that need considered.

4. The research evidence is concentrated upon the first two years of operation of these services, limiting the lessons to be had from more mature services.

5. Most of the evidence has looked into outcomes and consequences, but not on the actual process of introducing such services.

6. There are advantages in being able to understand directly the wider context within which particular services operate – most obviously the system of acute psychiatric care – to gain a better understanding of the impact of CRHT on other services and vice versa.

7. The evidence being almost exclusively English-based is not able to take into account specific features of Scotland’s mental health system and geography. (For example, England spends proportionately more on mental health, but has fewer beds per 100,000 adult population.)

THE SCOTTISH SERVICE VISITS

Service visits were undertaken to the following services:

1. Renfrewshire
2. Forth Valley
3. Lanarkshire
4. South Glasgow
5. Inverclyde
6. Aberdeen/Aberdeenshire
7. North Edinburgh
8. Midlothian
9. Ayrshire & Arran

The approach of the visit was to use a semi-structured interview of service leaders, supplemented by written information such as reports, protocols and evaluations provided by the services. In addition, on two of the visits (Forth Valley and Edinburgh) there was attendance at operational meetings of the local crisis service. In Greater Glasgow and Clyde there was a separate visit to hear about the wider, long term development and strategy for crisis services across the area.
The semi-structured interview was the principal means used to obtain a set of data on each service. The questions asked of each service were identical for the purpose of providing a common profile across all services to make it easier to draw conclusions of the comparative benefits and disadvantages of the various models and approaches that were reviewed. The questions had been developed from a review of the research and related evidence discussed. The foundation to the questions was therefore centred upon the idea of an English and Welsh CRHT team. The English experience had in fact been used to inform – if to varying degrees – the majority of services visited. There were nonetheless important differences in the way the different sites visited operated their crisis services and how they perceived the purpose of these. Certainly in some cases there was not a distinct crisis team, or even such a service in two cases. This meant that some questions - such as those on the operation of the team - were not always applicable. Some of the responses therefore generated a nil return. However, in such instances alternative supplementary questions were introduced, for example how mainstream services were organised to respond urgently to people at risk of admission.

It is also important to note that the different sites had been operating the services under consideration for different periods of time. Two of the services visited had really only been operating for a year, while others had been operating for over five years. This also had implications for the extent to which certain questions could be answered. The most obvious example here was in the response to what reviews and changes have been undertaken since the service was first inaugurated.

These two caveats apart, all those interviewed were willing and able to provide answers to all of the questions, and in sufficient detail to allow the overall purpose of the study to be tested out across the nine services.

Validating the data received from the semi-structured interviews has been important. Responses from the interviews have been checked back against the internal documents supplied (although in practice respondents usually referred directly to the documents while responding during the interviews) and other sources wherever reasonably possible. By the same token, the lead respondent in each site has been offered the opportunity to check the veracity of what we have said about their service in case we did not fully understand the point that was being made.

The review visits did not seek to obtain the views of those other than whom we interviewed – usually some combination of mental health service managers, lead clinicians and crisis service managers. The findings are not therefore presented as a survey of - or assessment from - the full range of stakeholders. We recognise that consequently certain nuances of how services operate and differences of opinion about their positive and not so positive aspects have not been picked up.

In the course of the review visits this did not emerge as a serious challenge to meeting successfully the review’s purpose. In the first place, much of the data sought was more inclined to be the facts surrounding how a service operated, much of which was set out in formal documents anyway. Secondly, all those interviewed were suitably candid about issues and problems, recognising that we were there to learn and that understanding some of the pitfalls was an important part. Many quite openly highlighted where there were different views locally. Thirdly, it is valid to say that,
from all the sources we attempted to use, none of the services came across as controversial or the focus of conflict. The evidence points to these services having a largely positive standing within the wider mental health service. This is not to say that all stakeholders were signed up to all aspects. Clearly there will be tensions and different expectations, not least in the wider community and inpatient services when there is a separate team. It would be a first to find a unity of views across mental health services. What we did not find was a consistent set of important issues of disagreement or fault-lines which raise questions whether such services are sustainable. The problems, such as they were, were local. This was not a surprise. CRHT services could not operate effectively if there was not harmony with the wider primary and secondary care services with which they interacted.

This leads on to another point to note about the interview questions. It was obvious from the outset that crisis resolution home treatment type services could not be reviewed in isolation. A number of the questions therefore addressed directly interactions with other services. In practice, all of the respondents found it necessary to give a full explanation of how the crisis service operated without moving on to talk about inpatient services, GPs, CMHTs, Accident & Emergency, liaison services and so on.

The standard ‘questionnaire’ used in the semi-structured interviews concentrated on the following areas:

1. **Overview of the Service** – what is it called, why was it established and what in general terms does it exist to do?

2. **Timescale** – when and how was it established?

3. **Purpose** – What is the overall purpose (or purposes) of the service and what are the main KSFs?

4. **Operation** – What are the main operational features of the service, including patient groups, exclusions, referrals, gate-keeping to inpatient beds, contact with clients location and workload.

5. **Team Composition** – What is the make up of the team, including the specific input from psychiatrists and how is the team/service led?

6. **Links To Other Services** – interactions with CMHTs inpatient services, A&E, Liaison Service, and GPs/Primary Care?

7. **Impact** – What benefits has the crisis service brought in terms of: Prevention of Admissions and Readmissions; Early Discharge; LoS in Hospital; Patient Outcomes; Patient Experience; and Any Others?

8. **Intended Changes** – What are the next steps in the development of the service? Are there any important issues that need addressed?
9. **Data** – What data is specifically collected on the team’s activities? How helpful is this?

10. **Any Other Points** – Are there any other comments?

**FINDINGS**

The presentation of the findings from the study follows the same structure as the interviews.

*Overview*

According to the Scottish Crisis Resolution/Home Treatment Network, in November 2010 there were six Boards that provided a CRHT service function:

1. Ayrshire & Arran
2. Borders
3. Dumfries & Galloway
4. Forth Valley
5. Greater Glasgow & Clyde
6. Lothian

In Lothian there are five CRHT services, eight in Greater Glasgow & Clyde and three in Ayrshire & Arran, so in fact there are 19 distinct services across Scotland. The review visited seven of these nineteen services, but also visited two not on the list: Lanarkshire which had piloted a CRHT team at Hairmyres Hospital but which had more recently developed a distinctive kind of model for crisis response; and Grampian (Aberdeen and Aberdeenshire) which had a crisis team but in different terms to a CRHT type of service. Grampian in particular was a useful alternative approach to look at as a way of gaining a better understanding of the issues around the operation and impact of CRHT services. Indeed, the position in Grampain is interesting because its is strongly questioned whether adopting a CRHT would necessarily confer additional benefits with better ‘performance on admission rates, length of stay and use of detention compared to Lothian one of Scottish trail blazers of the CRHT concept.  

A very important point that emerged from the review was that there are a number of distinct models flying under the flag of a CRHT service. This has made the review both more difficult to report – there are many differences to accommodate – and more valuable – there are different approaches and ideas upon which to draw. Three

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14 The nurses in Ayrshire & Arran are aligned to one of the three localities and work with the local CMHTs, although the team is managed as a single staff group.
15 S M Casserly and A Palin ‘CRHT services and inpatient bed closures: the whole story.’ *The Psychiatrist*, October 2011. (Online) (Correspondence reply to V Barker, M Taylor, I Kader, K Stewart and P Le Fevre ‘Impact of crisis resolution and home treatment services on user experience and admission to psychiatric hospital’. *The Psychiatrist* March 2011, 106-110.)
different types of CRHT services have been identified for present purposes. These are set out below.

1. **Separate/Stand Alone** – there is a separate dedicated team covering all of the main professions and support involved in crisis resolution and intensive home treatment. The examples from the review were Forth Valley, Edinburgh and Renfrewshire.

2. **Partially Integrated** – there is a separate dedicated team covering some of the professions and support involved in crisis resolution and intensive home treatment but other inputs, including psychiatry, come from other separate teams. The CRHT team is aligned, very closely aligned to, or is part of wider mental health teams. The examples from the review are Ayrshire & Arran, Midlothian and South Glasgow. Each of these three are however quite different in many important respects. In Ayrshire & Arran the team only comprises the nurse element of the CRHT service – the rest is obtained from the wider mental health service in each locality; in South Glasgow the CRHT team works in conjunction with the CMHT, in effect supplementing its work; and in Midlothian the Intensive Home Treatment Team had nurses and some other clinical staff but acted as part of the wider mental health team in Midlothian – being like a team within a team.

3. **Fully Integrated** – the carrying out of crisis resolution and intensive home treatment is not down to a specific, separately identified group of staff but is a function undertaken by some members of the wider mental health team as part of the patient pathway rather than as a separate service. The examples from the review are Inverclyde and Lanarkshire.

In many ways these differences are important, not least in terms of the organisation and resources of CRHT services. However, it is also clear that to some extent what was actually being provided to patients under these different categories was not that different. In many ways the biggest differences were the names on the signs on the offices and on staff badges. To what extent these differences in type of service mattered and in what way will be picked up in the Conclusion section.

These differences were even reflected in the different names given to the services:

- Renfrewshire - Intensive Home Treatment Team
- Forth Valley - Intensive Home Treatment Team
- South Glasgow - Crisis Team
- Inverclyde - Mental Health Team
- Edinburgh - Intensive Home Treatment Team (x2) and Mental Health Assessment Service (x1)
- Midlothian - Intensive Home Treatment Team
- Ayrshire & Arran - Crisis Resolution and Home Treatment Team

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16 To avoid any confusion, the term Crisis Resolution Home Treatment is used throughout accepting that the names of the services are often different. Note that different services may operate out of hours, and hence the name of the responsible team changes at this time.
Grampian - Crisis Team along with CMHT, Urgent Referral Team and Liaison Team
Lanarkshire - Crisis Response from each CMHT (10 teams) plus Mental Health Assessment Team at three Accident & Emergency Departments

Establishment of Services

One common feature of the services that stood out pretty starkly was the amount of time and effort that had gone into the establishment of the CRHT service. In some cases the service had emerged out of existing teams who had a partially similar role. For example, in Ayrshire & Arran the current CRHT service could trace its lineage back to Home Option Teams established in 1999, although the CRHT service proper was not put in place until 2009 with an important investment. Similarly, in Edinburgh it was stated that the planning of the introduction of the service dated back seven years. Even in these cases where the planning timescales were shorter, it was evident that intensive planning of a minimum of a year had been undertaken. Many of the services – for example Forth Valley and Glasgow – had drawn extensively from the practice of English CRHT services such as Newcastle. Services such as Glasgow and Forth Valley had had training provided by the (then) Sainsbury Centre for Mental Health which had been active in studies and development work on acute mental health services in England. In Edinburgh, the service had received training from the Shared Perspectives Group (a working element of the Sainsbury Centre for Mental Health) and who had assisted in the setting up of several teams in England. Some of the staff who played crucial roles in establishing the new CRHT services (e.g. Edinburgh, Inverclyde) had worked previously in English services. It is also important to note that there was both within and across certain Health Board areas opportunities for cross fertilisation and learning from concrete experience of running services in a Scottish context.

In every case, the introduction of the CRHT service was an important initiative linked to bed closures and rebalancing care provision that marked a significant change in the wider mental health services in the area/locality. There were tensions before, during and after their establishment between the CRHT teams and inpatient and wider community mental health services. In Ayrshire & Arran for example there were clearly different views among consultant staff about how best to manage patients although over a comparatively short period of time and through staff turnover a more unified view had emerged. (Where crisis/home treatment services were fully integrated the tensions not surprisingly were less.) For the review it was not possible to undertake a full historical analysis, but the evidence gained suggested that for the most part the teams got up and running and working constructively with other parts of the mental health service without significant impediments.  

This reflected two broad and interrelated factors. Firstly, there was sufficient support for the overall concept of a Crisis Resolution Home Treatment Service across the principal stakeholders. This was an essential pre-condition acknowledged by several of those who had led the introduction of the service. There was no real scope to

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17 It is acknowledged that there may be another way of look at the causation here – which came first?: CRHT services were not/could not be introduced until there was a sufficient clinical consensus about its role on inpatient care and appropriate alternatives to it.
impose such a change, even if anyone had wanted. Secondly, there was considerable engagement of the stakeholders prior to the establishment of the new service, either as part of the development process for the new service and/or as part of the pre-existing teams that evolved into the CRHT service. This engagement included promoting both the concept of a CRHT service and mapping out the roles and relationships with other parts of the acute mental health service. Four ingredients were in place in every case of engagement: strong consultant psychiatrist leadership prepared to act as a champion and make a positive commitment to spend time working with the wider mental health service; people with the necessary experience and understanding of service design and development; an unambiguous message from senior management that this was the strategic direction for the area; and a willingness to learn from other services. These may sound obvious requirements, but it is important to stress that it is the extent to which these building blocks were in place that came across during the review. Those who were involved in the development of the services and part of the review demonstrated certain important traits: having a very clear vision of what services should look like; a sense of the validity and authority of what they were seeking to do; considerable experience in the field of development and change of mental health services; and an open and reflective view about how services should evolve.

It is important to stress that all of the above needs to be put firmly in the context that in every case the introduction of CRHT services was connected to acute bed closure/rebalancing of care planned to happen at the time or soon after the CRHT became operational. The bed closures/rebalancing of care were however always clearly linked to a wider strategy for mental health services, which in most cases saw additional investment. CRHT services did not gain a potentially damaging reputation as a money saving ploy, but were quite explicitly linked to a wider set of changes to modernise mental health services. In most cases part of the savings from the bed closures were directly used to fund the CRHT service, although here there was variation in the link between the two: in Forth Valley the CRHT team was funded completely out of the savings from closing 15 beds; in Edinburgh the new service was funded 50% through the closure of 25 beds and a reduction in Consultant sessions and 50% new money; and in Midlothian and Inverclyde funds released by bed closures were used in part to fund improvements to community services in part related to prevention of admission.

Finally, it is worth further emphasising in this section that the establishment and operation of CRHT services were in some cases closely aligned to other service initiatives and services. In other words, the CRHT team was not the only service that had a part to play in preventing admission, either directly or in a supporting role. In Edinburgh the Intensive Home Treatment Team (IHTT) was complemented by the introduction of the Mental Health Assessment Service (MHAS) which provides a nurse-led screening service prior to involvement by the IHTT. The MHAS played an important and conscious part in controlling the workload of the IHTT. In Midlothian the CRHT was introduced alongside a number of other new community services designed to support a shift in the balance of care. In Ayrshire & Arran a reorganised mental health acted as the gatekeeper to the CRHT team. Finally, in Glasgow the CRHT team worked in conjunction with the CMHT, in effect supplementing its work. In a further twist in Inverclyde the CRHT service was integrated into a total mental health service covering inpatient and the community.
Purpose

The purpose of every CRHT service was to achieve a reduced level of admissions, although in Lanarkshire the emphasis was upon reduced lengths of stay and earlier discharge. The focus upon reduced admissions (and other aspects of bed usage) was not any surprise, but it is worth remembering that the CRHT service was very much fixed on this task, and was not formally or informally there to provide a service for a wider range of crises or community support.

However, in all services the CRHT team function also extended to supporting ‘early’ discharge, which along with reduced admissions would enable less usage of acute psychiatric beds. The picture was however very mixed. In Edinburgh supporting early discharge took up ‘about 20% of the team’s work’ (2009), but it was noted that there were constraints on the time available for in-reach work. It was made clear that the IHTT would not in any case be involved in all discharges, and in fact it had turned down slightly more cases referred to it than it took on. In Midlothian the team also had a formal role in supporting discharge but this in effect involved contact with all Midlothian patients discharged back to the community. However, the Midlothian IHTT was much more closely integrated into the wider mental health service and had a less distinct role from other parts of the service being a part of the Midlothian Integrated Mental Health Team. In Glasgow the balance of work of the CRHT was said to be 50/50 between prevention of admission and support for early discharge.

There are clearly important differences in practice around discharge. This is in part down to how the CRHT team is conceived – which in effect means how closely it is integrated with other teams and hence shares a broader role – and team capacity to divert time from prevention of admission to in-reach work on the wards. In the latter case capacity to undertake in-reach work can be influenced by the location of the team in relation to hospital beds. Co-location of the CRHT service with the inpatient beds is an obvious boon for in-reach work to support early discharge.

The main indicators of success of the operation of the CRHT were admission rates, occupied beds days and length of stay, although this is supplemented by user satisfaction measures. The measures of success therefore focus very much upon process rather than outcome. Success for all services is very clearly seen over and above providing good care for the individual patient to be achieving a shift in the balance of care.

Operation

It was in the operation and composition (see section below) of the CRHT teams that the greatest differences between those services reviewed were found. The main aspects upon which the operation of the team will be considered are:

1. Referrals
2. Treatment
3. Gatekeeping Role
4. Discharge
5. Hours of Operation
Referrals

An important access component of any acute mental health care is the ability to respond quickly and appropriately to a person who presents in crisis. Therefore, a central question in the operation of any such service is that when faced with a person potentially in crisis, how a professional or other person can access the crisis response service. The table over summarises the position.

Most of the CRHT services reviewed adopted an open approach, accepting referrals from a range of professionals. The one exception was Inverclyde where it is primarily GPs who are the referral route – into the general mental health team who then decide whether a CRHT type response is required.

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Discussions and guidance in the early days of CRHTs in England had emphasised the importance of referral criteria. This was about making sure that crisis services did not become a referral route to be used for any mental health issues (and hence become swamped) or where referred people for whom the service was not designed (e.g. older people, those with a learning disability, personality or with substance misuse). With a generally open approach to referrals it might be expected that referral criteria were fully and tightly defined. In practice this has not really been the
situation. Instead, while services have obviously taken time to explain and re-emphasise their role and hence who should be referred, all but one service responds to a referral by undertaking a screening or triage. Therefore, the teams are in effect making the decisions about whom they take on through assessing the patient rather than relying upon applying tight criteria upon the referrer.\textsuperscript{18} As one team put it: ‘we are simply seeing [in the assessment process] whether we can or cannot help the person given what we are able to do’.

Of course the risk – and one about which many services were concerned when they were setting up – was that the referrers would send so many people for screening and assessment that the service would be unable to carry out its treatment role. The approach taken in practice was therefore to rely upon the judgement of the referrer and to make sure that the referrer was acting on contemporaneous and first hand information, i.e. they seen the patient that day.

In this context it is essential to remember that one of the principal roles of the CRHT is to respond to people who may require admission. Therefore, the system depends to some important extent upon the ability of professionals in the mental health field to be able reliably to make such an appraisal or assessment. The kinds of referrers on the lists – GPs, CPNs, Police Surgeons, and Liaison Consultants – would be more than expected to be in a position to make such a decision and to have undertaken an initial assessment. In most respects, this is no different in making an inpatient referral where a CRHT service does not exist. It is also equally important to remember that the referral in the first instance is for an assessment, not for intensive home treatment. In other words, it is perhaps not surprising that the arrangements generally worked because those referring were not being asked to do something that different from what they would otherwise be doing: making a referral for to assess someone who may need for more intensive care than can be provided by the local team without at least some enhancement of the inputs available. The referrers already had experience of such clinical decisions and acknowledged that these are admission/prevention of admission services, not an outlet for any mental health problem.

None of the teams once they were established highlighted a problem of ‘over-referring’ or high numbers of ‘inappropriate referrals’. The one exception to this was that in Edinburgh the team had stopped taking direct referrals from GPs in February 2010 because of the pressure on the specific demand for assessments, which was reflected in the fact that after triage/screening the service would take on only one-third of those patients who were assessed.

Therefore, the evidence highlights that there are not major issues with referrals. A comparatively open set of arrangements can work because of the expertise of the referrers and because of the pre-assessment screening/triage. Even in the case of less experienced or senior referrers none of the teams reviewed were indicating significant difficulties, or at least problems that would not manifest themselves whether or not a CRHT service existed.

\textsuperscript{18} In NHS Lanarkshire referrals were taken from other services (e.g. addictions, CAMH, Older People, Learning Disability) in the area which did not have an out of hours component and managed the patients until the main service opened.
Another side to the referral process however are the cases where it is deemed that the patient is not suitable for intensive home treatment – whether at the point of screening/triage or at assessment. The arrangements for onward referral – either for inpatient care or to some other community support – again do not present particular problems, although like any decision to dispose of a referral there can be clinical differences of opinion. In particular, the overall impression from the review is that the CRHT team had the links with the CMHT to facilitate a hand back. Where there has been more of an issue in some areas was onward referral to other specialist services, especially substance misuse. Here there were in some cases examples of problems in handover and clarity of responsibility. This obviously needs addressed. Mental health services are experiencing increased referrals of people with substance misuse problems, and this is affecting the work increasingly of the CRHT service. It would be wrong however to identify this as an issue peculiar to CRHT; it is a wider problem affecting mental health services more widely.

As mentioned above, screening/triage represents an important part of the work of the CRHT team. Most screenings are undertaken for obvious reasons over the ‘phone between the referrer and the designated member of the CRHT team (duty coordinator), and requires collecting a significant amount of information on the patient’s history and condition. For example, in North Edinburgh the Triage Form – apart from the patient’s personal details, current support, risk assessment and outcome – has 20 questions about the person referred and their circumstances. In Forth Valley, the team secretary takes the call and a trained member of the Intensive Home Treatment Team asks the questions regarding the appropriateness of the team undertaking an assessment. There are similar arrangements in Inverclyde where the medical staff undertake the assessment. In South Glasgow the CMHT – which is the route for all admissions – undertakes the initial assessment, and one option is to bring in the crisis team which acts as an adjunct to the CMHT. In the integrated approaches in Lanarkshire (part of CMHT) and Inverclyde part of the community and inpatient mental health team) the position is less clear cut in that the route to intensive home treatment is not a separate decision making process as it is in Edinburgh, and it is within that team that the assessment is undertaken. In Ayrshire & Arran the initial screening was done by the mental health duty worker to whom all referrals were directed who would then decide according to criteria whether to send the patient to the CRHT team (If there was any doubt the charge nurse in the team would be contacted for further discussion.)

After any initial triage or screening, all of the teams undertook a broader assessment of the patient. This could still result in the team deciding on an alternative to intensive home treatment, for example because the patient posed a particular risk or because of home circumstances. The assessment process is however otherwise focused upon establishing a care plan for a person’s treatment while there are still in crisis.

There were differences in the location of the assessment. In Forth Valley, Ayrshire & Arran, South Glasgow and Lanarkshire the assessments always took place in the patient’s home unless there was a good reason not to do so, but in Renfrewshire patients were asked primarily to come to the hospital for reasons of safety or staff time, although home assessment was not excluded if deemed appropriate. In Inverclyde the assessment centre at the hospital was also used as a base, as it was for all mental health assessments.
**Treatment**

Following the assessment, patients were given a care plan. This might be a modification of the patient’s existing care arrangements if the patient was already receiving care. (It is worth remembering that – like an inpatient service – established CRHTs – have return patients with whom they are familiar and for which the planning of treatment is usually easier. A figure of 50% of patients being already known to the service was quoted in one area, but no hard figures were made available on this aspect.) As in the inpatient situation, there was not unexpectedly variation in the care received by the patients receiving intensive home treatment reflecting different needs and conditions. In general terms, patients began with intensive intervention (up to three home visits a day) which reduced as the person’s crisis began to recede below even daily contact.

Most services adhered to some extent to the National Standards for Crisis Services that overall contact (receiving crisis intervention or support from a specialist service or a CMHT or other linked service) should be no longer than 21 calendar days unless exceptional circumstances apply. However, the position is more complex, although 21 days performs some sort of ‘benchmark’. Firstly, patients stayed for a range of time periods under the team. In Lanarkshire, 21 days was some sort of ceiling. Elsewhere, it was a looser standard. In Ayrshire & Arran a sample of activity showed that 9% stayed beyond 21 days. In Midlothian the ability of the Intensive Home Treatment Team to be flexible rather than adhere to any standard time period was positively emphasised by team members. Figures from North Edinburgh show that the mean and median lengths of contact are 23 and 22 days respectively highlighting that intensive home treatment often lasted longer than the 21 day mark. It was a regular occurrence here for patients to have significantly longer times with the team (60-140 days were the monthly maximum days with the team). Length of time with the team was not associated solely with severity of illness, but also with the cycle of time which it took people to get out of crisis – some of which could be forecast with return patients – and a recognition that the time taken for a person’s crisis to resolve or abate varied. Secondly, the average length of stay under a CRHT service varied. As noted, in Edinburgh it was around 22/23 days, but in Forth Valley it was just over 15 days. These results suggest that broadly CRHT services provide the same type of intensive home treatment, but there is important variation in the average length of stay of patients for intensive home treatment indicating differences in the approach to the management of crises and handover to Community Mental Health Teams and GPs by CRHT services.

While overall across the teams it was comparatively unusual for patients to go beyond three weeks, the length of stay for patients covered the full range of time periods. Indeed, many patients recorded comparatively short lengths of stay, including less than a day. There were various reasons for this: in practice home treatment did not work out for the patient and alternatives had to be found; some patients continued to deteriorate necessitating an admission; and some patients could have their crisis resolved rapidly, for example through medication reviews. In

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19 Scottish Executive Delivering for Health Delivering for Mental Health *National Standards for Crisis Services* November 2006, p4
some areas in particular it was stressed that the CRHT services had proved particularly effective at picking up people who in the past were admitted to an inpatient ward and then discharged quickly because the admission had reflected a lack of alternatives to a crisis being available and/or considered rather than they had very intensive needs. This variation in length of stay has to be seen very much in light of CRHT services providing not a set programme of care but being what one service described as a ‘mobile ward’. In other words, the team do very much what inpatient wards do, and take the same range of time periods to do it. The value of the national standard for 21 days therefore is perhaps not as helpful as it might initially have been seen, and did not seem to figure larger in the way services were managed.

Gatekeeping Role

One of the functions often seen as being important about the CRHT teams is it acting as the ‘gatekeeper’ to admission to inpatient beds. Control over admissions is argued to be essential to the operation of CRHT teams by making sure all potential referrals are considered by the team, i.e. their function is not by-passed by admissions without the team’s involvement. Two separate stand alone teams: Forth Valley and Edinburgh, perform this function. (Consultants within the Renfrewshire service continue to have rights of admission). This has implications for the admitting rights of consultant psychiatrists. In the two areas mentioned, there was reluctance on the part of some consultants to see rights of admission taken away. In both these services there was initially an element of non-compliance with admissions by-passing the team. This has reduced over time as the team’s role has become both better understood and more widely accepted. In Edinburgh about 20 admissions per month (out of an average of 78 admissions per month by-passed the team in 2009, but by the following year this had fallen to just 5 (out of an average of 64). The team in Renfrewshire had had considerable dialogue with GP referrers, and this had come to pay off in terms of acceptability of the arrangements. The referral and admission arrangement had become generally accepted and now there were few complaints in this regard. However, it should be noted that in Forth Valley there remain some issues about different referral routes for GPs, and it is reported that 17% of admissions do not go through the CRHT team.

In the partially integrated teams the crisis service played a shared part in admissions, but obviously had not an exclusive role where the admitting rights rested with the consultant in the CMHT. In these services there was no suggestion that the crisis service was being undermined by not having a gatekeeping role. Indeed, the arrangement on a shared basis seemed to work well, and at least as well as the stand alone teams with their formal admitting rights. There were still examples of the CRHT team being kept out of the loop, and not involved, but these were few in number. The flexibility possible with strong working relations across the teams was seen as a positive compared to a consistently uniform approach for admissions.

Discharge

There were few problematic issues highlighted about arrangements for discharging from the CRHT team. As mentioned, it was common for there to be a shared period of care with the CMHT prior to discharge anyway and some CRHT services were
working alongside or indeed as part of the CMHT. Similarly where the patient was discharged back to the GP, there had been good level of communication from the CRHT services and the patient's family doctor. One of the features generally found of CRHT teams and services was that they invested significant time in communication and keeping others informed. Moreover, it was seen in every service that the introduction of CRHT services had raised the need for improved patient histories which were of course not only valuable to CRHT services but also to those providing follow up care.

**Hours of Operation**

The national standard for Crisis Services is that the service needs to be available 24 hours a day, seven days a week. All of the services operated on a so-called 24/7 basis with the exception of Forth Valley and Renfrewshire. However, in the evenings/overnight and at weekends different, more restricted arrangements operated.

In some cases, what was put in place was a more limited version of the CRHT team. In Edinburgh the IHTT and the MHAS form an integrated ‘out of hours team’ from 2100 hours to 0800 hours with junior doctors joining them at 2100 hours. Two IHTT staff are on duty and are predominantly based within the MHAS office at the Royal Edinburgh Hospital. One of the MHAS nurses on duty covers the Royal Infirmary of Edinburgh. While the IHTT will join the Out of Hours Team, the work of the IHTT will always take priority. Similar arrangements operate on Saturdays and Sundays and Public Holidays. From midnight until 0800 hours the out of hours team in Edinburgh carry out urgent mental health assessments and provide cover for Mid and East Lothian’s IHTT case load. In Ayrshire & Arran and Glasgow a similar ‘downsized’ out of hours team operated covering a wider geographic area. In the two fully integrated services of Lanarkshire and Inverclyde the service – if on a smaller scale – continued to provide the assessment service available during in-hours on an out of hours basis.

In Forth Valley and Renfrewshire the CRHT service provided in-hours was replaced by something different out of hours. In Forth Valley the service after 2100 hours during the week and after 1800 hours at weekends was provided by the on-call duty psychiatrist and ward staff (although GPs were expected to do more triage work). In A&E there was still the Liaison Team. It was very similar in Renfrew. In Forth Valley it was hoped to extend the hours of the CRHT service, but in Renfrew this was not such a priority. In both cases, the patient – if this was the agreed outcome of the assessment – would be handed over to the CRHT team the following working day.

It is hard to point to evidence that suggests unequivocally that a down-sized CRHT service produces better results than a ward based alternative out of hours. Some of the reasons for this are: the relatively small numbers of people presenting after (say) 2100 hours or 2200 hours; that the services of the team (for example merged across the Board area) are in some cases constrained (for example have responsibility for assessing other categories of patients); the role of liaison services in A&E continues; the reasons for this are: the relatively small numbers of people presenting after (say) 2100 hours or 2200 hours; that the services of the team (for example merged across the Board area) are in some cases constrained (for example have responsibility for assessing other categories of patients); the role of liaison services in A&E continues;
and that the CRHT teams are able to pick up patients presenting overnight early the following morning therefore only delaying their involvement.

**Workload**

There were differences in the intensive home treatment workload in terms of the teams as measured by the number of patients that were under the care of the team. It is important to remember that the input to individual patients varied from three visits a day to some telephone support so it is limited what can be drawn from the figures. In addition, intensive home treatment is not the only work of the CRHT service. Unfortunately, there is no consistent information available across the different teams about the wider range of work undertaken by these services.

The Forth Valley, Renfrewshire, Edinburgh, Glasgow and Ayrshire & Arran teams are providing treatment for around 20/25 patients at anyone time – as might be expected from evidence elsewhere on team capacity. There are of course fluctuations over time in the numbers, but no team talked of the numbers going significantly above that level for any sustained period while some noted that to some degree numbers receiving treatment were managed in the same way as ward patients through the planning of discharges.

In Midlothian the position is different. The team was originally set up to provide treatment for no more than 8 patients at anyone time, but over the 4 years of its operation the average number on the caseload has come down to nearly half that. At the same time the number of admissions to the IHTT has fallen slightly. There has also been a fall in its activity in terms of the number of home visits, the number of clinic appointments and the number of telephone calls, as well as visits to patients on the ward. However, the number of referrals to the team had grown from 237 in the first year to 547 in 2010/11. This reflects that the team has become involved in much more screening/triage work.

In the case of Lanarkshire, crisis referrals to the CMHT are recorded, as is the period of time of the crisis, but being a fully integrated CRHT service this work falls to the CHMT. So knowing the caseload does not allow for even a broad comparison with CRHT teams. (No information on crisis work was available from Inverclyde.)

**Team Composition**

The composition of the teams varies. Most obviously this occurs because the concepts of the teams themselves are different: are separate/stand alone; partially integrated; and fully integrated teams.

The three separate/stand alone teams have certain similarities. They have a core Registered Mental Nurse staffing with consultant psychiatrist input, supported by psychology, occupational therapy and social work (with an administrative support capacity for the team). In Forth Valley, there is also an input from a pharmacy technician.

For the partially separate teams there are quite distinct arrangements.
In Ayrshire & Arran (17) and South Glasgow (17) the team was made up of nursing staff, and all other functions - including psychiatry - are drawn from the wider mental health team. In Ayrshire & Arran this included quite explicitly access to the range of psychiatric specialties/sub-specialties. The position in Midlothian was again slightly different. The core of nurses was supplemented by a clinical support worker, an occupational therapist (half time), and (until recently) a half time staff grade doctor. Other disciplines readily available to the IHTT included mental health officers, a physiotherapist, a psychologist and social workers. Although these are not formally part of the team, the ‘crisis nature’ of the work of the IHTT appeared to result in them getting more or less quick access to the disciplines required. Indeed, in no case was access to the important disciplines not in the team highlighted as a serious difficulty for partially integrated teams, although overall it was not as rapid if the function was a team member.

In the fully integrated CRHT service the CRHT service was within the wider mental health team, so there was no distinct staffing group at all. In Lanarkshire each CMHT (of which there are ten) had had its staffing increased by two nurses and a support worker. These staff were to enhance the capacity of the CMHT, not necessarily to undertake CRHT work but to allow others to do this. Similarly in Inverclyde the existing mental health team - which covers both hospital and community services - had seen additional investment which included increasing nursing staff on the ward and leads for psychiatry, psychology and primary care health professionals. This investment was part of a wider improvement to mental health services linked to a new but reduced hospital inpatient base of which a crisis team was a part.

**Impact**

**Admissions**

The purpose of the CRHT services was first and foremost to reduce hospital admissions and to shift the balance of care away from inpatient care. The different CRHT services that have been operating for a sufficient time (18 months) have all had an impact on admissions. Some of the results have been quite spectacular. It is of course difficult to make comparisons across the different services: they had different starting positions; factors other than CRHT will influence admission rates; and the services have been operating for different time periods and there does appear to be a maturing process with these services. What is not open to doubt is that CRHT has had an impact.

In Greater Glasgow which introduced CRHT services early in the 2000s, the number of admissions fell 26% between 2003 and 2010 and readmissions with 28 days of discharge fell by 46% over the same period. The numbers are however even more impressive for Renfrewshire (admissions down 50% and readmissions down 49%) where the CRHT service was not introduced until 2008 and Inverclyde (admissions

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21 The Ayrshire Crisis Resolution and Home Treatment Team is aligned with the three localities and the CMHTs based there. There remains a single manager for the 27 nurses in the team, but for day to day decisions on care team members are managed through the CMHT. Obtaining the necessary clinical inputs for a CRHT service was put down to a process of ‘negotiation’. While not completely problem free, overall there was not seen to be any adverse impact on getting the care people needed.
down 56% and readmissions down 50%) where a CRHT service is just in the process of being introduced.

In Edinburgh a similar picture resulted. Between 2004 and 2007 the average number of admissions per annum at the Royal Edinburgh was 1274. In 2010 the number was 773 – a drop of 39%. A similar picture emerges with readmissions. In 2007 the number of readmissions was 320. In 2010 it was 184, giving a reduction of 43%. (It is important to note that the analysis produced in Lothian includes the Mental Health Access Service – not just the Intensive Home Treatment Team as a contributing factor.) In Midlothian, over the four years since the team was put in place admissions have dropped 33%, even although the team was introduced at the same time as beds had been contracted to accommodate the closure of Rosslyn Lee, i.e. there has been an increasing impact long after the team has been introduced. In Forth Valley admissions fell by 16% but readmissions (as defined by the former HEAT Target) by 53%.

In Ayrshire and Arran the introduction of the service was supposed to achieve a 10% reduction in admission and readmission (over 7 days) rates by the end of 2009 in line with national targets. However between 2005/06 and 2009/10 the number of admissions had already fallen 15% and readmissions were down 50% suggesting that other factors are at play in affecting admissions. Interestingly, admission numbers stayed almost completely flat between 2008 and 2010 which appeared to be both the result of having already achieved reductions and the bedding in of the new service. The position was further blurred because there was reduction in admission to the Intensive Psychiatric Care Unit by over one-fifth. This highlights that introducing a CRHT service is not a guarantee of an immediate impact on admissions. It would be too early to assess the impact of the new arrangements introduced in Lanarkshire with the enhancement of capacity of the CMHTs but early indications, alongside more robust accountability arrangements between CMHTs and associated inpatient wards, suggests healthy improvements in bed usage.

**Bed Use**

It was not just on admissions/readmissions that CRHT services were supposed to have an impact. The emphasis upon supporting early discharge would also reduce the need for beds by facilitating earlier discharges that would otherwise have happened. This was not necessarily expected to produce a reduction in average length of stay - because it was believed that preventing admissions would raise the average level of severity of illness and hence the need for a longer hospital stay – but would certainly contribute to the downward demand on available beds. There is no doubt that bed usage and bed numbers have fallen. Again it is not possible to

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22 This is drawn from an internal evaluation report. In V Barker, M Taylor, I Kader, K Stewart and P Le Fevre 'Impact of crisis resolution and home treatment services on user experience and admission to psychiatric hospital'. The Psychiatrist March 2011 the team report a 24% decrease in acute psychiatric admissions in the year after the IHTT began operating.

23 The HEAT Target was concerned to achieve a fall in the number of patients re-admitted for seven days or more in the past 12 months.
attribute all of this to CRHT services being introduced, but the number of beds taken out of the system and bed usage associated with CRHT\textsuperscript{24} is as follows:

<table>
<thead>
<tr>
<th>Area</th>
<th>Beds Closed</th>
<th>Bed Days (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forth Valley</td>
<td>26 beds</td>
<td>30%</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>78 beds</td>
<td>25%</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>30 beds</td>
<td>40%</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>25 beds</td>
<td>56%</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>37 beds</td>
<td>41%</td>
</tr>
<tr>
<td>Midlothian</td>
<td>24 beds</td>
<td>14%</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>18 beds</td>
<td>10%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>N/A beds</td>
<td>N/A%</td>
</tr>
</tbody>
</table>

One of the other features associated with CRHT services in some areas has been the reduction in average length of stay in inpatient acute wards. For example, in Forth Valley it fell 12%, 19% in Edinburgh and 4% in Ayrshire & Arran. Equally, in Glasgow it has stayed level and has actually increased in Renfrewshire by 19%. An increase in average length of stay is not necessarily unexpected because of a higher threshold of admission applying with a CRHT service. However, the position is more complex. CRHT services have undertaken early discharge work - if to varying degrees - which would help push down length of stay from what it would otherwise be. Interestingly the team with the greatest emphasis upon discharge planning was Glasgow, but average length of stay as mentioned has remained more or less static.

It would appear that there is a complex interaction of factors impinging on average length of stay which result in a significant variation in the impact of a CRHT service being introduced. Not surprisingly, there has been a similar picture with bed occupancy. In some areas it has fallen - in Edinburgh (81-74.6%), Midlothian (74%-64%) and Forth Valley (83-64%), but has remained largely flat elsewhere, or indeed risen slightly in Ayrshire & Arran (54.9%-56%). Again the interrelationship between the factors that affect the use of beds is complex and the impact across the different services far from uniform. Not surprisingly, the need for the existing bed complement is being discussed in various forms in the areas with reduced occupancies.

Forecasting the impact of introducing a CRHT on inpatient hospital services is not straightforward.

**User And Carer Views**

The introduction of what represent new or largely new services necessitates assessing the impact on services users including carers. All services have undertaken some sort of patient satisfaction survey.\textsuperscript{27} A number of these have been

\textsuperscript{24} It is important to note that these figures relate to different time periods based upon the introduction of CRHT services and latest available data, although some of the time periods do not match exactly the operation of CRHT services. The precise association between CRHT and bed usage as ever has to be treated cautiously. Not all beds were closed at a single point.

\textsuperscript{25} Related to both Edinburgh Intensive Home Treatment Teams – North and South.

\textsuperscript{26} The beds in Midlothian were closed in effect prior to the CRHT team being introduced. This was to facilitate the closure of Rosslyn Lee Hospital. Prior to the team coming on board, and to facilitate the closure of beds at Rosslyn Lee, bed usage had already been significantly reduced. This allowed the 24 beds to close. However since the team has been operating bed usage has fallen further, but there has not been any further reduction in bed numbers from the 8.

\textsuperscript{27} See for example V Barker, M Taylor, I Kader, K Stewart and P Le Fevre ‘Impact of crisis resolution and home treatment services on user experience and admission to psychiatric
quite detailed in terms of the aspects of the service about which they have sought views. Some have however been part of a wider review of views on mental health services more generally, including of course those on inpatient care. Overall the surveys reflect positive levels of satisfaction with the CRHT services. It is difficult to draw any particular conclusions from this. Firstly, the response rates mean that only a small minority of views is represented. Secondly, it was not possible to assess the method of surveying for any biases. Having said that, it would be churlish not to acknowledge the consistent message from surveys of CRHT services – and not just the ones reviewed here – being largely a positive one, particularly in comparison to inpatient care.

**Intended Changes**

The services reviewed here have been operating for different periods of time. Some are by now well-established, others are just beginning to be bedded-in and deliver results. The longer established services have already been through changes not surprisingly. The composition of the teams has changed, in part due to identified needs but also because of changing funding conditions. There has also been ongoing work to communicate and consolidate the CRHT role in the acute mental health pathway in each area. The important point is that no team or service has fundamentally changed. Fundamental change of the concept of the CRHT service as conceived in each area is not on the agenda. No one is going back to the drawing board. There are still developments and improvements that local teams - even in the well-established ones - are considering. In Forth Valley for example there is a desire to see a 24 hour service and to address some of the outstanding issues around GP referrals. The Edinburgh service will also soon be co-located on the Royal Edinburgh Hospital site that will open up opportunities for closer working with the Mental Health Assessment Service and in-reach work to the wards.

Apart for these enhancements, it is also evident that there is consideration being given to the cost-effectiveness of CRHT services. Inevitably these services as a 24 hour crisis response service have peaks and troughs in activity. They also provide similar services to other parts of the mental health service. These two factors now appear to be pushing for the stand alone and partially integrated services to be consolidated either vertically and/or horizontally. This is of course spurred on by the wider funding context facing the NHS. In terms of horizontal integration, Lothian is planning to merge the two Edinburgh teams offering greater economies of scale and flexibilities and consideration is being given to merge the Midlothian team with its equivalent in East Lothian. In Greater Glasgow & Clyde consideration is being given to consolidation also, although a range of possibilities was being considered. One of the factors here is that the services across the Greater Glasgow & Clyde area, as we have seen, are quite different in several important regards, including catchment population. In Forth Valley, where there is one team for the whole area, horizontal integration is not a possible route. Instead, consideration has been given to vertical integration, not least the opportunity to exploit the overlap between the CRHT teams and the inpatient team.

hospital’. *The Psychiatrist* March 2011 which reports very high comparative levels of satisfaction with the new Edinburgh service.
It is not the purpose of this review to report on plans that are emerging, and which certainly remain to be finalised. What the above does however highlight is that for new and existing CRHT services (except those that are fully integrated) there are important considerations about organisational configuration. This relates to the geographical coverage of a team and the fact that the wider the coverage the greater the opportunities for economies of scale and flexibility. (This consolidation already happens out of hours in Lothian and Greater Glasgow.) What is of course important is whether there are disadvantages alongside these opportunities. The question of vertical integration is even more fundamental. At its heart is a question that has underpinned much of this review – how far is there a need for a separate, distinct service focused upon crisis resolution and then follow up home treatment and how far is possible to undertake these distinct activities through a generic mental health team? Again there are factors to balance here, and what may be right for one area might not be for another because of a whole host of factors around the ethos and organisation of the wider mental health services. Nonetheless, having piloted a standard CRHT team, Lanarkshire has positively chosen to go down the route of providing crisis resolution and home treatment responses through their CMHTs without recourse to any separate grouping of staff or team at all. All of these important issues will be picked up on in the Conclusion section.

**Data And Information**

All services reviewed were able to provide data and information about the CRHT services and the impact they had on inpatient care. In some cases this was supplemented by quite detailed data on what the CRHT service did and to whom they did it. Sometimes the data was available for a number of years so that comparisons of the practice and the impact of CRHT services could be charted over time.

Overall, however, the data and information that services – or others – were collecting – proved not to be helpful in undertaking the review of the services. Many of the difficulties confronted would be common across many services, and in many respects responsibility for this goes well beyond the teams involved. The problem highlighted here related to basic data. It is not about what might be required for some detailed research project. Nor is about getting validated data from ISD and not relying on locally generated figures, helpful though this would be. It is about something else. Firstly, the scale and depth of data available were limited. Secondly, even within those first limitations there is nowhere near anything approaching consistency of the data/information collected across different services. It was not easy to make comparisons even regarding some of the basic features of CRHT services by using the data. Thirdly, there was little attempt to link the pieces of data together to paint a picture of how the acute mental health pathway and the role of CRHT within worked. This meant that there was not the opportunity to gain a fuller understanding of the services and what they were doing by reference to the scale of the activities and results. There is a case for a common data set to be agreed by the different CRHT services, and indeed possibly all acute mental health

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28 No judgment is made about data and information available to deliver the service to patients. This was not reviewed and no analysis was undertaken. At the individual patient level, the information available and how it was managed did come across as begin fit for purpose, and in cases innovative.
care to provide some critical information about CRHT services and allow for meaningful compression. This will be returned to in the Conclusion because it is essential to any improved understanding for current CRHT services and how they might develop.
CONCLUSIONS

The review of CRHT services was undertaken specifically to help with the development of such services in one Board area. The messages should however be of value to existing CRHT services and to Boards who are planning to introduce them. The conclusions in a very practical way point to what are the important factors of which account should be taken when establishing or reviewing CRHT services.

Most of the messages emerge out of the principal finding that there are different ways to organise and operate CRHT services. The conclusions are therefore less about which is the best option, but indicate what the relative merits of different arrangements are.

Having said that, from the review it was often difficult to draw out significant differences from one approach over another. Part of this may have been down to the absence of good comparative data across a range of outcomes. The review also highlighted quite strongly that, despite different ways of organising CRHT services, much of what these services actually did in managing patients was similar although certainly not identical. Philosophy, attitude and outlook override any organisational set-up in terms of making a difference, and this was at least implicitly recognised by those who set out CRHT services given the preparatory work undertaken. This does not mean that the way services are organised is irrelevant, not least because mental health services and geography vary from one place to another. It does however remind us that organisational labels and team composition are not necessarily definitive in telling us what the service does.

The main conclusions are listed below.

1. **CRHT Offer Effective Alternatives To Hospital Bed Usage**

There is no doubt that CRHT services do deliver ‘what it says on the tin’. These services have reduced admissions. For services that have operated for some time these benefits have been substantial. Less clearly in terms of hard measurement, CRHT has also reduced the demand on bed usage by enabling patients to be discharged earlier from the inpatient ward. CRHT has helped to facilitate a definite shift in the balance of care. Interestingly, the original research on teams in England had highlighted that they might be more effective at certain types of patients or geographic settings. (See pages 7-8 above.) The review found no consistent evidence to support these contentions, although none of the areas covered were ‘remote’. There was a general acceptance that CRHT services could never be a complete alternative to admission, and what mattered was to maximise the opportunities to offer people appropriate treatment at home.

2. **There Is No One Model That Obviously Is Best At Reducing Bed Use**

There is no indication from the review (even allowing for the small numbers of services reviewed) about which model or make-up of service is best at delivering these results. This is because the services operated in different contexts – notably numbers of beds and admission rates – which make comparison problematic. Those services which we termed ‘fully integrated’ are still in their early stages of evolution
and it is not possible to say that they have (and therefore can) deliver the scale of benefits that stand alone and partially integrated services have done but at a potentially lower cost.

3. **Introducing A CRHT Service Requires Extensive Pre-Planning**

The success of the services to deliver the benefits achieved has depended on a high level of pre-planning around the introduction of the CRHT services and engagement of the stakeholders in the acute mental health pathway. Buy-in at the crucial beginning stages was never absolute, but it was sufficient for the services to work effectively from day one. It might be felt that these are lessons for any service, but there are two points. Firstly, in comparison to the norm of other service developments, a lot more time and effort was invested upfront in establishing these services. They were planned in detail, had strong clinical leadership and obvious senior management support. Secondly, CRHT services at the beginning were in a slightly precarious position. They could not afford to fail (or at least fail very often) to manage people in crisis effectively. Otherwise referrers and others would have resorted back to inpatient admission and pulled the carpet from under the CRHT service. They had to get it right pretty much straight away and pretty much consistently. There was less scope for experimental approaches and first-hand experiential ‘learning on the job’. The plan had to be right first time.

4. **The Introduction Of CRHT Services Has Always Been Set In A Wider Strategic Context**

The introduction of the CRHT services was done in the context of a wider strategic review of mental health services. This helped stakeholders to make sense of reasonably radical changes to acute care and to feel comfortable with the changes. On the other side, CRHT was therefore linked to a wider improvement of services, and was not seen as some crude bed closure, cost cutting exercise. To repeat a point, there was a broad philosophy and ethos surrounding acute mental health care which gave a direction and underpinning to CRHT services which was very helpful to their introduction. Some of this stemmed from the recently enacted Mental Health (Care & Treatment) (Scotland) Act 2003 which emphasised a philosophy of minimum restraint.
5. **CRHT Services Require Investment**

All the services reviewed have required a reasonably substantial investment – sometimes assisted by savings from bed closures. There is no evidence that the workload of wards can be absorbed without replicating something approaching a similar scale of capacity. There are ways to keep the investment costs down (some of which will be considered below) and certain inpatient costs around hotel services and some clinical input will legitimately no longer be needed, but for the stand alone team a staff group of 14-20 (most but not all full time) is the ‘going rate’ to meet the needs of the people presenting with a serious illness. There was nothing from the review that suggested that a partially separate team operated with a lighter staffing level, not least because they had similar nursing staff levels and required the same sort of input from other clinical staff. In short, there is no significant variation around the total staffing commitment (fully integrated services apart where the staffing commitment is difficult to assess). There are not different models in the sense that teams can vary fundamentally in terms of their size. This is no different to the position of an acute ward. The differences have been the mix of staff, and even more so the way staff are organised and the size of population that they serve.

6. **Multi Disciplinary Service**

Moving from the size of the team to composition, CRHT services are multi disciplinary like a ward team. These are not – and cannot be – a nurse only team. There has to be active involvement of a senior doctor, and this needs to be on a 24 hour basis. The position in practice operated in a way similar to cover for an inpatient ward, although the greater role for CRHT team nurses did reduce the involvement of medical staff out of hours. In the stand alone teams there were senior doctors attached. In Forth Valley (population 242,000) the team has one full time and one half time consultant psychiatrist dedicated to the work of the team; in Edinburgh (population 550,000) the two CRHT teams each have a consultant psychiatrist and share a staff grade doctor who currently spends two days a week with each team.

In other areas the consultant input came from within the local mental health team. There were no concerns expressed in those areas that this was a problem because of the partially integrated model of CRHT established. Here the senior doctor was acting in a more conventional way through the wider mental health team; the CRHT service supplemented or complemented the CMHT or equivalent. (In Midlothian the CRHT team had a half time staff grade doctor but following a resignation this post was given up as a saving so that medical input now comes exclusively from the existing three consultants. This has yet to be tested out but the lead psychiatrist believed in the context of Midlothian that it was possible for this to work.) In fully integrated services medical cover in this sense was not an issue – or at least was an issue for the wider mental health team which would in any case have to manage admissions. However, what came across was that CRHT services were associated with an extended role and greater freedom for senior nurses compared with what

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29 The one caveat would be that CRHT services are an alternative service to appropriate admissions. If there was a high level of admissions that were not necessary, then it would not be required to have the staffing of a ward type service, although other, less intensive community alternatives would probably be needed.
they would experience on the wards. This has implications for recruitment and training.

Beyond that there is no doubt – whether as part of the team or accessible to it - occupational therapy, psychology and social work/care input is a constant requirement of a CRHT service. Other disciplines had less of an ongoing involvement in the day to day work of the service, but clearly different patients would present with a variety of needs. (This however is an area where data was somewhat in short supply, and the conclusion is based on what was said during the interviews.)

7. **Cost-Effectiveness**

In current times with financial pressures there is an inevitable question not only about effectiveness but cost-effectiveness as well. This is difficult to answer because CRHT services can never stand alone completely, and may well be helped by levels of funding elsewhere in mental health such as in the CMHT, especially for partially or fully integrated services. Nor is it in any way suggested that the services reviewed displayed examples of cost-ineffectiveness. However, certain cost issues did arise which any existing or proposed service would be advised to consider. CRHT services are comparatively expensive and only ever have a limited number of patients on the books. An example would be a CRHT team with around 20/25 people on its caseload, and undertaking 15 assessments and ‘admitting’ 5 into home treatment every week, and costing in the region of £500k. It has already been noted that to work a CRHT service needs a core of staff, and research evidence has highlighted that failure to meet this has important implications for the effectiveness of the CRHT service. Within that context, the review did find variations across services which will have implications for costs and hence are worth examining. These are:

- The catchment area of the service, or put another way how many teams are needed, and hence what team overheads are required.
- Staff mix and grades varied considerably without it being immediately obvious how this linked to the effectiveness of the service.
- Duplication of work with other mental health services – for example duplication of assessments.
- Length of stay and speed of discharge from intensive treatment.
- Opportunities for CRHT teams to share other functions with other teams in less busy times – for example support for discharge – and to be enhanced from other teams when the pressures are on. Put another way, there may be some – if limited – scope for flexibility around different teams providing back-up to each other.

8. **Total Bed Numbers And CRHT**

While there is good evidence that CRHT services reduce reliance on beds, across Scotland there is no absolute association between bed numbers and the existence of CRHT services. Of the six Boards officially designated by the Scottish Crisis Resolution/Home Treatment Network as having CRHT services, two are well above the Scottish average for the rate of beds held, while two not designated (Tayside and
Grampian) are at or below the Scottish average. This reflects the obvious point that different Boards are at different stages in the process of reconfiguring beds, and in simple terms there is some catching up to do. This is not the full explanation. Three other points need to be borne in mind. Firstly, CRHT services mature and become more accepted over time. The impact on the need for beds is not just the existence of CRHT, but how long it has been established and how the acute mental health pathway has evolved as a result. Linked to this is the view that for most, if not all, CRHT services, there is scope to do more to support for earlier discharge. Secondly, other factors influence bed numbers. This needs further investigation, but the main factors are the efficiency of the inpatient services (the bit after admission and before discharge, i.e. not influenced by CRHT), different clinical thresholds, differences in psychiatric morbidity, the wider management of emerging crises by CMHTs and other community services (preventive care), and geography including the location of inpatient services. Thirdly, as will be discussed further below, it might be possible to have some of the same results of managing acutely ill patients under CRHT without actually having a formalised CRHT service. (This is in part the argument of the integrated services.)

9. **Core Ingredients Of A CRHT Service**

While variety around organisation and operation was the output from the review, it is possible to go underneath these and identify core ingredients of the CRHT service. The main question then becomes about how best to organise locally to make sure that these core ingredients are maximised rather than adopting an ‘off the shelf’ model. The ingredients are:

a. An absolute focus upon preventing admission to hospital. This also means that the CRHT service does not act as a wider community service responding to every person with a crisis. (Indeed, the term ‘crisis’ might be misleading – the focus is **risk of inpatient admission**.)

b. An ability to respond urgently.

c. A high level of clarity held by the team and other parts of the mental health system about what the service exists to do and for whom.

d. A need to manage/filter the referrals to the team to avoid the situation where there are too many people requiring assessment which impacts adversely on the capacity of the team both to assess people as a matter of urgency and to provide intensive treatment.

e. A significant role for nurses in assessment, care planning and treatment delivery – which is probably greater than found in inpatient and general community services.

f. Identified medical input (usually on a dedicated basis, but not as an essential ingredient).

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30 See again Scottish Crisis resolution/Home Treatment Network, **Service Mapping Report**, November 2010.

31 In many respects this would appear to be what happened – if not entirely consciously – in the services reviewed. Models were adapted to local conditions but the overall philosophy and main functions were retained.
g. A capability 24 hours a day, 7 days a week (although not necessarily at the same level or in the same way out of hours as in hours).

h. Access on the same rapid basis to professions other than nursing and medicine, of which the most important are occupational therapy, psychology, and social work/social care/mental health officer role.

i. A gatekeeping role for admission to inpatient beds for the CRHT, although this may not be a sole responsibility and might be on a shared basis with other teams. (The reason for involvement of the CRHT service is principally to eliminate the possibility of alternative pathways to admission, and effectively two pathways being on offer.)

j. Recruitment arrangements to the CRHT which recognise the specific demands of the job which are different to some degree to those found both in inpatient and CMHT work.  

k. Rigorous risk management arrangements compatible with working in people’s homes with potentially high risk patients (and possibly with other family members living there) without the restraints found in an inpatient environment.

10. **Important Factors In The Design Of CRHT Services**

While the conclusion made here is that there is no evident best model to adopt in terms of the structure and organisation of a CRHT, there still are certain factors to consider here, namely:

a. A stand alone service can act more readily as an advocate and champion for CRHT services than a partially integrated one, and therefore makes more sense when the levels of support across the wider mental health service for CRHT are low or uncertain. Other things being equal, a stand alone service makes a more obvious starting point.

b. A partially integrated service is less likely to generate tensions with the wider mental health service and offers opportunities for greater flexibility around accessing non-core clinical staff.

c. CRHTs probably work better with broad or softly applied referral criteria (to allow each patient’s suitability for home treatment to be based on a thorough assessment of their case history) and so some pre-assessment screening triage needs to be in place to prevent the service being swamped. This should on balance be done by the CRHT team itself, but this requires a good appreciation by referrers of who are suitable for assessment so that screening does not become an excessive call on the team’s time) and a recognition that this time consuming work is important to the overall service.

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32 Interestingly, there were different views on this point. Some services highlighted the distinct nature of working in a CRHT service (especially the breadth of skills and intensity of work) while others saw no difference between CRHT work and wider community work, so CRHT teams were simply supplementing rather than extending the range of skills and attributes available. The latter was the minority view.
d. In line with the point above, there is no reason to limit tightly the list of those who can refer to CRHT services. Obviously the arrangements have to be compatible with the wider arrangements for referral and for handover, but looking to have a range of professions and groups coming into contact with people with mental health problems who are able to refer enhances the responsiveness to deal with people in serious crisis.

e. Whether stand alone or partially integrated, larger teams with wider catchment areas offer important economies of scale and greater flexibility, but this has to be balanced against the demands of geography and travelling. There is also an important link to be maintained with local community mental health and other services. However, if the travelling time issue can be addressed – obviously for home assessments and home treatment – there is no strong reason why not to consider a service that covers a much larger catchment area than the original concept of a CRHT serving a population of 150,000 (with a staff group of 14). This already happens in a number of places reviewed anyway, although there are wide differences in catchment area sizes (about a sevenfold difference).

11. **Crisis Resolution And Home Treatment Without A CRHT Service?**

The review of the Grampian service raised some important questions regarding CRHT services. Grampian has a small crisis team of 3 members but does not have a CRHT service. However, it has fewer acute beds than some areas with CRHT services in Scotland, has the lowest overall mental health bed base in Scotland, one of the lowest average lengths of stay, average readmission rates and does not have a level of admissions out of line with other comparable Boards. It is acknowledged that psychiatric morbidity will be lower comparatively in Grampian and there is a fairly stable population, but clearly according to several important indicators the service is working well. With the information available it was not possible to test the hypothesis, but it is worth asking whether the service in Grampian may be an advanced example of a fully integrated CRHT service that has not adopted the language and organisational features common to CRHT but which still manages potential admissions effectively. The service in Grampian has evolved over many years and is based around close working between GPs and CMHTs, good procedures for urgent access to consultant by GPs, a strong liaison service in the acute hospital and developed community services that are well equipped to sustain people at home. Therefore, it is not unreasonable to ask whether they offer an effective way to prevent admissions without the formalities of a CRHT service. Of course the hypothesis may not be right, but it is legitimate to raise it. For areas about to embark on introducing CRHT, it is worth asking the question - ‘are we already doing some of this, but we don’t just formally recognise it?’ It is also worth highlighting that – while CRHT services are clearly beneficial – they may in some part be rectifying problems and gaps elsewhere along the acute mental health pathway by not responding to some emerging psychiatric crises as well as possible.

12. **Wider Outcomes**

It is already evident that CRHT can deliver benefits in terms of use of inpatient beds. There is however a question about other wider outcomes. All CRHT services rest to some extent on an article of faith (supported by limited research evidence). This is
that CRHT in the circumstances where it is used as an alternative to inpatient admission will provide comparable outcomes. Little outcome data is currently collected about mental health services generally, and it would be difficult to establish proper environments to make valid comparisons between the two treatment options. (Equally it is not known where inpatient care stands comparatively.) What we do know is that research evidence and (the more limited surveys of the services) suggest that patients prefer a service that keeps them at home compared to admission to an inpatient bed. Indeed, the survey evidence gathered by the services suggests that patients and carers regard these services positively in their own right. The services reviewed also indicated that there is no evidence to the effect that they are associated with increases in adverse incidents, most obviously suicides. There was also no evidence presented which suggested that two other concerns about CRHT mentioned in some of the ‘research’ literature proved to be important: short stay intervention teams breaks the continuity of care for people who will have an ongoing mental illness and an ongoing relationship with a CMHT; and - by not admitting to a hospital - the physical health needs of people with mental health problems can get overlooked. The reason for this is that in reality the CRHT team can only work if it works closely with other services.

13. **Data And Information**

The information collected by CRHT services is limited. This has implications for the extent to which the benefits – and the possible less positive results as well – can be assessed. To some extent this is simply a result of the fact that the purpose of the teams are important, but simple – to reduce the use of inpatient care, and admission in particular. There is always data on this. However, the information does not often allow for a wider assessment to be made. In particular, it is not possible to say much about other factors that influence admissions, discharges and bed usage, and equally why the rate of available acute beds varies. At best, we can say CRHT services make a positive difference, but looking across different services it is not possible to make any realistic assessment about whether services have done as well as they could. It would be acknowledged that this is not straightforward, especially taking account of morbidity in the community, but these are important longer term pieces of information that would be helpful.

CRHT services also undertake a range of work beyond home treatment, including in-reach and screening referrals. Data on the quantity of this work is not being captured to give a proper picture of the work undertaken by team members and possibly others in the CMHT.

It would be valuable to support more thorough evaluations and reviews of CRHT to have the following data set:

- Inpatient admission numbers and rates
- Inpatient bed occupancy

33 During the course of the study it was highlighted that some patients still prefer an inpatient admission – usually because this is what they have been used to over several years. This does not raise any particular problems because, if a patient is not able to comply positively with the intensive home treatment regime, the alternative option would be to admit them.
- Referral numbers and sources of referral to CRHT service
- Number of screening/triages undertaken
- Assessments undertaken by CRHT service
- Workload by different profession: screening; assessment; treatment; inpatient discharge; and other
- Outcomes of assessments, including not only those taken on for intensive home treatment but disposals to other services
- Number of readmissions to CRHT service
- Number of patients admitted to intensive home treatment who ‘fail’ and why
- Numbers of patients discharged with receiving service, linked to profile of patient e.g. condition, length of stay.

**EPILOGUE**

The conclusion about having a consistent data-set across the main activities highlights an important point from this review: we know considerably more after the review than before, but for want of a little more data it would be possible to know considerably more. What remains in particular to be clarified is the position of what were termed ‘fully integrated’ services. The two considered in the review were in the early stages of development so it was not possible to get close to a definitive view. Even in the course of time, it will be not straightforward because of problems associated with separating out the ‘CRHT’ element of generic mental health teams. Nonetheless, the next stage in reviewing services must be to get a better handle upon what opportunities really exist to deliver a CRHT service without having to establish a specific team for the purpose. Of course, as many might highlight, it will be necessary to find out not just whether such services can be delivered without some form of designated team, but also whether this can be done consistently given other priorities and demands facing a CMHT. A lot of the answers here will depend on the wider organisation of mental health services – a point made consistently throughout this review. For the time being, those wishing to establish CRHT services at least have the reassurance that – whether fully or partially integrated – CRHT teams have a strong record of shifting the balance of care. There is an answer that would seem to work and which can be adapted for local circumstances. Whether at this stage other Boards would wish to follow Lanarkshire and Inverclyde by having a CRHT service delivered by the generic mental health team is another matter. Certainly it would not be possible at this time to say that the record of achievement is there, but equally those involved in those services have reason to believe that it will be. Similarly, as recent correspondence in *The Psychiatrist* journal highlights, the service in Grampian would ask ‘whether a CRHT Service would provide any additional benefits to the population of Grampian, where continuity of care based on Primary-Care and Local Authority aligned services remains the cornerstone of practice.’ The Grampian service draws on a similar point to that made on pages 31-

34 S M Casserly and A Palin ‘CRHT services and inpatient bed closures: the whole story.’ *The Psychiatrist*, October 2011. (Online) (Correspondence reply to V Barker, M Taylor, I Kader, K Stewart and P Le Fevre ‘Impact of crisis resolution and home treatment services on user experience and admission to psychiatric hospital’. *The Psychiatrist* March 2011, 106-110
32 which highlights that there is no inevitable one to one relationship between the key indicators of 'performance' and the existence of a CRHT type service.

There is no doubt that the evidence would suggest that CRHT services have generally – but certainly not universally and consistently – delivered important benefits for patients and services. The evidence is there, not least in term of the number of studies in addition to what was obtained through this review. It is not evident, and worthy of further consideration, whether a CRHT service is the only means to these benefits. Or more accurately – echoing discussion of stroke units the benefits they deliver – less about the organisation, the entity, the name on the door, and much more about focused, effective practice. In this line of argument, CRHTs are a means to re-focus practice dramatically in a one-off event. Maybe elsewhere there have been several, less dramatic, but collectively just as significant, events.
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