Edinburgh CHP - NHS Lothian

Review of Edinburgh’s Intensive Home Treatment Teams and Mental Health Assessment Service - Year 2

Kathleen Stewart
Nurse Consultant for Acute Mental Health

July 2011
Executive Summary

The establishment of Edinburgh’s two Intensive Home Treatment Teams (one for the North and one for the South of the city) and the Mental Health Assessment Service (MHAS) back in 2008 reflected a shift in the balance of acute mental health care from hospital to the community (Scottish Executive, 2006). IHTTs reduce hospital re-admissions and facilitate early discharge by providing an intensive 24/7 community alternative to hospital care, and MHAS assess individuals in crisis for the presence of mental health problems which would benefit from the involvement of other specialist mental health services or agencies thus reducing inappropriate hospital admissions.

A previous report circulated in November 2009 provides a detailed description of the function and activity of the different elements of this service during its first year. This paper focuses primarily on 2010, the second year of operation.

✔ The development of IHTT and MHAS facilitated the planned reduction to the current level of 80 acute beds for Edinburgh, reflecting the shift to community based treatment consistent with the principle of care in the least restrictive environment. NHS Lothian now has the lowest number of acute beds per capita in Scotland (13 beds per 100,000).

✔ Since IHTT/MHAS began, there has been a 32% decrease in average annual admissions to REH, a 32% drop in mean re-admissions and the mean duration of hospital stay has fallen by 6 days.

✔ In 2010, IHTT had 1374 referrals, providing intensive home treatment for 498 individuals. 31% of IHTT caseload was referred by MHAS, 25% by CMHT and 23% by REH acute wards.

✔ Over the 12 months, IHTT worked with men (41%) and women (59%) aged 18 to 65, considered a significant risk to themselves or others, from a range of socio-economic and diagnostic groups usually on a daily basis with the average duration of contact lasting 3 weeks.

✔ IHTT service user feedback, collated routinely is very positive. 87% of respondents reported clinical improvement, with 43% feeling totally recovered at discharge from the teams and 96% felt safe during IHTT treatment.

✔ MHAS received 3885 referrals in 2010. More than half were from RIE (Accident and Emergency Department and Lothian Unscheduled Care Service), 12% were from GPs, 20% were self referrals and the police referred 11%.
3716 assessments were carried out, averaging 310 per month. 51% of activity occurred at RIE ‘out of hours’ making it the busiest site.

Following assessment, the majority of people were discharged back to their GP; 6% were taken on by IHTTs (teams from East- and Mid-Lothian and Edinburgh); 6% required medical admission to CAA6 at RIE; 10% were admitted to psychiatric care; 14% were referred back to CMHT or PCLT and 4% were taken in to police custody.

Although challenging, formal feedback was obtained for the first time about MHAS service users’ experiences with the majority of respondents rating the quality of service as excellent, very good or good.

Service User Feedback

IHTT
“Had I not had input from IHTT I would have been admitted to hospital, which would have set my recovery much further back and increased my feelings of being unable to manage my mental health.”

MHAS
“Waited an hour but was ok about this as it was such a benefit to just go along without an appointment. I'd expected a longer wait. I didn't feel rushed at all and that was important. The nurse specialist I saw was a very good listener and absolutely non-judgemental. I appreciated the way I was treated as an active participant in decisions and not just sucked into some kind of ‘process’ that was out with my control. This [Information given] was particularly helpful. It was much more pleasant than I’d feared it would be - nice, bright, cheerful waiting room that was quiet and restful while I was there. The receptionist was lovely - very friendly and welcoming which immediately put me at ease when I was feeling anxious on arrival.”
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Purpose of the Report</td>
<td>6</td>
</tr>
<tr>
<td>1.1 Introduction</td>
<td>6</td>
</tr>
<tr>
<td>1.2 Intensive Home Treatment Teams</td>
<td>6</td>
</tr>
<tr>
<td>1.3 Mental Health Assessment Service</td>
<td>6</td>
</tr>
<tr>
<td>2  Impact of IHTT and MHAS</td>
<td>7</td>
</tr>
<tr>
<td>3  IHTT Referral Activity</td>
<td>8</td>
</tr>
<tr>
<td>3.1 Eligibility Criteria for Intensive Home Treatment and Referral Routes</td>
<td>8</td>
</tr>
<tr>
<td>3.2 Triage Outcomes</td>
<td>10</td>
</tr>
<tr>
<td>3.3 Outcome of IHTT Assessment</td>
<td>11</td>
</tr>
<tr>
<td>3.4 Outcome of Intensive Home Treatment</td>
<td>11</td>
</tr>
<tr>
<td>3.5 ‘Triage only’ and ‘Assessed/not taken on’ Referrals</td>
<td>12</td>
</tr>
<tr>
<td>3.6 Referral Source for People Taken on for Intensive Home Treatment</td>
<td>13</td>
</tr>
<tr>
<td>3.7 IHTT Caseload, Pattern and Duration of Contact</td>
<td>13</td>
</tr>
<tr>
<td>3.8 Caseload Composition – Age, Gender, Diagnosis</td>
<td>15</td>
</tr>
<tr>
<td>3.9 In-reach and Early Discharge Work</td>
<td>16</td>
</tr>
<tr>
<td>3.10 Gate-keeping</td>
<td>16</td>
</tr>
<tr>
<td>3.11 IHTT Service User and Carer Feedback</td>
<td>17</td>
</tr>
<tr>
<td>3.12 Staffing</td>
<td>17</td>
</tr>
<tr>
<td>4  MHAS Referral Activity</td>
<td>17</td>
</tr>
<tr>
<td>4.1 Source of Referrals</td>
<td>18</td>
</tr>
<tr>
<td>4.2 Assessments</td>
<td>19</td>
</tr>
<tr>
<td>4.3 Outcome of Assessment</td>
<td>21</td>
</tr>
<tr>
<td>4.4 Breaches within Accident and Emergency Department</td>
<td>21</td>
</tr>
<tr>
<td>4.5 MHAS Service User Experience</td>
<td>22</td>
</tr>
<tr>
<td>4.6 Staffing</td>
<td>22</td>
</tr>
<tr>
<td>5  Out of Hours Working</td>
<td>22</td>
</tr>
<tr>
<td>6  Adverse Events</td>
<td>23</td>
</tr>
<tr>
<td>7  Awards, Presentations and Publications</td>
<td>24</td>
</tr>
<tr>
<td>8  On-going and Future Developments</td>
<td>24</td>
</tr>
<tr>
<td>9  References</td>
<td>25</td>
</tr>
</tbody>
</table>
Appendices
1. Impact of IHTT/MHAS on General Adult Mental Health Services, REH 26
2. IHTT Service User Feedback 2010 28
3. Service User Feedback - Mental Health Assessment Service 36

Tables
1. Referrals to IHTT 8

List of Figures
1. Monthly Referrals to IHTT 10
2. Outcome of Triage 10
3. Outcome of IHTT Assessment 11
4. IHTT Outcomes 12
5. Referral Source for ‘Triage only’ & ‘Assessed/not taken on’ 12
6. Referral Source for IHTT Caseload 13
7. IHTT Contacts 14
8. IHTT Duration of Contact 15
9. Age/Gender of IHTT Caseload 15
10. Diagnosis 16
11. MHAS Referrals 2010 18
12. MHAS Referral Source 18
13. MHAS Assessments 19
14. Location and Time of Assessment 19
15. Location/Time of Assessment 2007-2010 20
16. Assessment by Weekday 20
17. MHAS Outcome of Assessment 21
1 Purpose Of The Report

This report has been prepared for Edinburgh’s Joint Mental Health Group. Since a comprehensive and detailed review of Edinburgh’s Intensive Home Treatment Teams (North IHTT and South IHTT) and the Mental Health Assessment Service (MHAS) was previously circulated in November 2009, this paper primarily focuses on 2010.

1.1 Introduction

The IHTTs and MHAS operate under the auspices of Edinburgh Community Health Partnership and were introduced in 2008 prior to wider changes within the acute model of care.

The teams have successfully contributed to a reduction in the number of admissions, re-admissions and a shorter length of stay for people admitted to hospital. Service user feedback continues to show high levels of satisfaction with the quality of service delivered and the difference it makes to people’s lives and recovery where there is a viable alternative to hospital admission.

This report gives a brief overview of the function of the different service elements and describes activity during 2010, the second year of operation.

1.2 Intensive Home Treatment Teams

The development of Edinburgh’s IHTTs in October 2008 was influenced by key policies and legislation in mental health in Scotland. Lothian wide stakeholder events involving service users, carers, GPs, mental health practitioners, managers and staff unions resulted in a ‘high fidelity’ model being adopted.

Available 24/7, the truly multi-professional teams provide a rapid response, intensive specialist assessment, treatment and risk management in a community setting, focusing on people who might otherwise require hospital admission.

Person centred and recovery focussed approaches enable people in crisis to be treated in the community with minimum disruption to their lives and less stigma associated with hospital admission. For some individuals, the IHTTs have:

- broken the cycle of admission
- facilitated early discharge for those admitted
- prevented admission for individuals new to mental health services.

1.3 Mental Health Assessment Service

MHAS, a reconfiguration of the Psychiatric Emergency Team, has been operational since September 2008. The primary function of this nurse-led team is to screen individuals in crisis for the presence of mental health problems which
would benefit from involvement in specialist mental health services. The team can rapidly assess and intervene, thus contributing to a reduction in inappropriate hospital admissions.

MHAS operates across 2 sites - 24/7 at the Royal Edinburgh Hospital (REH) and ‘out of hours’ at Edinburgh Royal Infirmary (RIE) - providing an inclusive service. Referrals come from GPs, emergency services, social and voluntary agencies, from within mental health services or people who self-refer.

Comprehensive assessment, risk assessment and crisis management are undertaken for people often presenting with suicidality, self harm behaviour and other complex needs. Support, information and psycho-education are provided to service users and carers, and can be linked in to other services for on-going support or short term follow-up by the team.

2 Impact of IHTT and MHAS

Appendix 1 illustrates how IHTT/MHAS have impacted on Edinburgh’s general adult mental health services.

Reduced admissions

Between 2004 and 2008 the average number of admissions per annum was 1260 (Appendix - Figure 1). Since the establishment of IHTT/MHAS this has dropped to 857, a 32% decrease.

Edinburgh currently has 80 acute beds with IHTT facilitating the planned closure of 25 beds in December 2008 and a further reduction of 12 beds in the summer of 2009, enabling the relocation of East Lothian’s in-patient service to REH. NHS Lothian now has the lowest number of acute beds per capita in Scotland (13 beds per 100,000 population) (Scottish CRHT Network, 2010).

Although the yearly average for admissions under detention decreased by 28% in 2009/2010, they consistently comprise around 22% of all admissions.

Reduced re-admissions

The HEAT Target to reduce the number of re-admissions (within 1 year) for those people that have had a hospital admission of over 7 days by 10% by the end of 2009 (Scottish Executive, 2006) influenced the initial development of the IHTTs.

Since this service has been operational, there has been a 32% drop in the mean number of re-admissions as defined by the Scottish Executive (2006) compared to previous years (Appendix - Figure 2).
Reduced length of hospital stay
Mean duration of stay in hospital has also been shortened by six days since the introduction of IHTT (Appendix - Figure 3).

Lower bed occupancy
The mean occupied bed days has fallen from 89% pre-IHTT/MHAS to its current level of 77% (Appendix - Figure 4).

3 IHTT Referral Activity
Table 1 shows the number of referrals and people taken on for intensive home treatment since the teams were first established. In 2010, 1374 referrals were made resulting in 498 people being provided with intensive home treatment. Of these, 385 avoided hospital admission, and 113 had a shorter length of stay in hospital with early discharge support from the teams.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Referrals</th>
<th>Taken on for home treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008 (from 27/10/08-31/12/08)</td>
<td>284</td>
<td>106</td>
</tr>
<tr>
<td>2009</td>
<td>1520</td>
<td>514</td>
</tr>
<tr>
<td>2010</td>
<td>1374</td>
<td>498</td>
</tr>
<tr>
<td>Totals</td>
<td>3178</td>
<td>1118</td>
</tr>
</tbody>
</table>

3.1 Eligibility Criteria for Intensive Home Treatment and Referral Routes
The term ‘crisis’ is defined in many different ways and is often experienced as a combination of feelings and/or physical manifestations such as depression, despair and powerlessness (Bristol in Mind, 2004). Within the context of IHTT, crisis involves the presentation of an individual whose normal coping mechanisms and resources have become overwhelmed by the onset or relapse of severe mental distress or illness. The crisis renders the individual and carer unable to manage their circumstances, presenting a risk to themselves or others thus requiring a same day specialist assessment of their mental health needs.

People being referred to IHTT are:

- Aged between 18 and 65
- Resident within the City of Edinburgh either permanently or temporarily
- Considered to be at significant risk of self harm and/or a significant risk to others due to mental ill health
- Considered for imminent hospital admission or where intervention from
IHTT is likely to avert potential admission and escalation of crisis necessitating admission
- Seen by the referrer on the same day

IHTT target those in acute need primarily as an alternative to hospital admission. People referred have a range of characteristics including those with more severe mental illness who without intensive home treatment would require in-patient care. IHTT cannot be overwhelmed by the need to carry out assessment of people who are unlikely to require hospital admission since this will detract from the principal tasks of gate-keeping, intensive home treatment and hospital in-reach to facilitate early discharge.

Referrals to IHTT can be made by:
- Mental Health Assessment Service (MHAS)
- Community Mental Health Teams (CMHT)
- Acute in-patient service
- Primary Care Liaison Teams (PCLT)
- Emergency Social Workers (MHOs)
- Liaison Psychiatry Service
- Edinburgh Crisis Centre
- General Adult Consultant Psychiatrists

IHTT do not take self referrals – these are directed to MHAS.

GP referrals for urgent same day mental health assessments shifted to a single point of access via MHAS in February 2010 (GP requests for non-urgent mental health assessments are directed to the referral coordinator within the appropriate CMHT). Since then monthly referrals to IHTT have fallen slightly (Figure 1) with the exception of August 2010.
All referrals are ‘triaged’ by the shift-coordinator for each team.

### 3.2 Triage Outcomes

In 2010:

- 57% of referrals (777) lead to assessment for IHTT suitability.
- 22% (302) did not fit the criteria for intensive home treatment and referrers were given advice and/or ‘signposted’ to other appropriate services.
- In 21% of cases (295), the need for admission was clear at the point of triage. The main reasons for this include too high risk of harm to self/others for treatment within the community and the person already being detained under the mental health act (Figure 2).
3.3 Outcome of IHTT Assessment

777 people were assessed for intensive home treatment (Figure 3):

- 64% (498) were provided with intensive support at home. NIMHE (2004) suggests that established teams would offer intensive home treatment after assessment to around 50% of referrals, thus focusing on those with severe and enduring mental illness and who are at risk of hospital admission.

- 24% (185) were assessed as not suitable for home treatment. In such cases, IHTT offered signposting/advice to referrers and where indicated referred individuals to other services such as CMHT, PCLT, GP, specialist services and/or non-statutory organisations to better meet their needs.

- 12% (94) were assessed by IHTT; however hospital admission was indicated (e.g. risks too high, patient unwilling to engage with IHTT and not considered safe enough to remain at home without intensive home treatment).

![Figure 3: Outcome of IHTT Assessment](image)

3.4 Outcome of Intensive Home Treatment

498 people received support from the IHTTs (Figure 4):

- 87% (431) completed their episode of care and were discharged with follow-up from their GP, CMHT, PCLT or as an Out-patient.

- 13% of people (67) initially taken on for intensive home treatment have subsequently required hospital admission primarily due to increased risk that could not be managed safely within the community setting.
3.5 ‘Triage only’ and ‘Assessed/not taken on’ Referrals

The source of all referrals not meeting the criteria (‘triaged only’ or ‘assessed and not taken on’) for intensive home treatment is illustrated in Figure 5. In 2010, 24% of these were from in-patient services, 25% from CMHT and 16% from MHAS.

Operational policies are currently being developed to provide better clarity around the role and remit of different elements across the acute and community care pathways.
3.6 Referral Source for People Taken on for Intensive Home Treatment

MHAS, CMHT and the acute wards account for 79% of all referrals taken on for intensive home treatment (Figure 6).

MHAS – Almost one third (31%) of IHTTs caseload are referred by MHAS. This 8% increase on Year 1 may reflect the shift to a single point of referral for urgent same day mental health assessment for GPs in February 2010 and bedding in of the teams.

CMHT – 25% of IHTT case work involves people already under the care of CMHT.

In-patient services - 113 people admitted to hospital had a reduced length of stay. This early discharge work accounts for 23% of the teams’ overall caseload (a 3% increase compared to Year 1).

3.7 IHTT Caseload, Pattern and Duration of Contact

Caseload Capacity

The daily caseload for each team averages 20-25. Capacity is influenced by the acuity of individual service users and by the intensity of contact required to maintain safety within the community setting.

Pattern of Contact

The initial period of contact is most intense with up to twice daily visits (infrequently three) which is reduced over time depending on the level of risk and needs of the individual. 24 hour telephone support is also regularly accessed by
both service users and carers.

Contact activity for IHTT according to time/day of week is shown in Figure 7. This includes planned visits and unscheduled care (assessments and visits). Most contacts occur ‘in-hours’ (Monday-Friday, 9am until 5pm) and at weekends. 10% of IHTT contacts occurring on weekdays from 5pm and 9pm are predominantly planned visits for people requiring either more intensive support from the teams (for example, a second daily visit) or are planned around the service user’s needs or preferences for support in the evening. Whilst IHTT staff work alongside MHAS overnight mainly carrying out assessment work, some people on IHTT caseload do require intensive support during this period, accounting for 4% of all contacts.

![Figure 7: IHTT Contacts (Jan 2009-June 2011)]

**Figure 7: IHTT Contacts (Jan 2009-June 2011)**

- **Weekday 9am-5pm**: 65%
- **Weekday 5pm-9pm**: 10%
- **Weekday Nights (9pm-9am)**: 4%
- **Weekend (Sat 9am-Mon 9am)**: 21%

**Duration of Contact**
The length of IHTT involvement in anyone’s care and treatment is dependent on individual need of the service user (Figure 8). Mean and median lengths of contact are 23 and 22 days respectively. Where IHTT discharge to CMHT, joint planning is undertaken to help ensure the person experiences a more seamless transition from one team to another. In the event of any delay in handing over to the key worker within CMHT, IHTT continue to provide an appropriate level of care rather than the person being left without any support in the interim period.
3.8 Case Load Composition – Age, Gender, Diagnosis

IHTT provides intensive home treatment to people aged 18-65. Over the period of 2010, 59% of service users were women, 41% were men (Figure 9).

All people taken on for intensive home treatment are considered a significant risk to themselves or others as a result of mental illness. Mood disorder and psychosis continue to be the most prevalent diagnoses for people using the service (Figure 10).
3.9 In-reach and Early Discharge Work

IHTT are able to facilitate earlier discharge, providing intensive support and assessment which can continue in the home setting. This should be available once the pressing or immediate requirements for admission are no longer exerting such an influence on the person’s presentation within the in-patient environment. Although 113 people were provided with early discharge support from IHTT, a further 117 referrals from the acute wards were not taken on as early discharges.

Changes in the configuration of the in-patient service to single sex wards aligned to North and South of the city, new ways of working for Consultant Psychiatrists, the proposed relocation of IHTT to REH site and initiatives developed through an acute care ‘Rapid Improvement Event’ (including the introduction of ‘Daily Clinical Meetings’ involving IHTT and the in-patient team) will continue to enhance the integration of Edinburgh’s acute mental health service.

3.10 Gate-keeping

Gate-keeping refers to screening all possible hospital admissions and is one of the primary functions of IHTT. If service users are being admitted to hospital without the knowledge or involvement of IHTT, this limits the teams’ effectiveness and impacts on the wider service through potentially inappropriate admissions. Importantly, it also means the principle of ‘least restrictive alternative’ may not have been considered in every admission.
In 2009 a monthly average of 20 admissions by-passed IHTT however this has dropped to around 5 per month and appears more prevalent when locum doctors are used to cover services.

The acute care redesign, new consultant job plans and the acute mental health ‘rapid improvement event’ all support the need for robust measures to protect IHTTs gate-keeping function. The Acute Care Pathway Management Group meet regularly to discuss interface and operational issues and will continue to monitor any admissions by-passing IHTT.

3.11 IHTT Service User and Carer Feedback
Service user and carer feedback is routinely sought at time of discharge from IHTT. In 2010, 131 questionnaires were returned giving a response rate of 26%. Appendix 2 summarises user’s experiences. Since only three carers completed a questionnaire this has not been included.

3.12 Staffing
The initial IHTT/MHAS review highlighted the need for additional staffing based on the city’s population size and guidelines by the National Audit Office (2007), however there have been no changes to the funding available for the teams.

The merger and co-location of the teams at the REH site are currently undergoing organisational change processes and include the proposal for the loss of one nurse team leader across the LHPs and IHTTs.

It is anticipated that the merging of the IHTTs will promote flexibility across the teams during periods of high clinical activity and therefore reduce Nurse Bank costs.

4 MHAS Referral Activity
In 2010, 3885 referrals for an urgent mental health assessment were made to MHAS (Figure 11).
4% (169) of these resulted in no further contact by MHAS. Reasons for this include:

- the person not attending for assessment
- the person not waiting for assessment
- the person absconding from A&E before assessment can be carried out
- triage and advice/signposting referrals to other services

4.1 Source of Referrals

More than half of all referrals are from the RIE site (A&E, Combined Assessment Area 6 and Lothian Unscheduled Care Service), 12% are from GPs, 20% are self referrals and 11% are police referrals (Figure 12).
4.2 Assessments

3716 face to face assessments were carried out by the team in 2010 (Figure 13), averaging 310 assessments per month.

Although providing a 24/7 assessment service at the Royal Edinburgh Hospital, RIE remains the busiest site, generating 51% of all activity in the ‘out of hours’ period (Figure 14).

Since 2007/2008, the number of assessments at REH has generally fallen (Figure 15), particularly ‘within hours’ (Monday to Friday, 9-5). Reasons for this may
include:

- the introduction of the IHTTs (also carrying out mental health assessments)
- the encouragement of CMHT/PCLT key workers being the first point of contact for people already engaged in mental health services during hours
- people are more likely to present in crisis ‘out of hours’.

Figure 15: Location/Time of Assessment
2007-2010

Figure 16 shows MHAS assessment activity by weekday across both sites. REH is busiest on Mondays and Tuesdays, and weekends are the busiest periods for RIE activity.
4.3 Outcome of Assessment

Following assessment by MHAS:

- 52% of people were referred back to the care of their GP
- 6% were taken on by the IHTTs (including Midlothian, East Lothian and Edinburgh’s IHTTs)
- 6% required medical admission to CAA6 at RIE
- 10% of people required admission to psychiatric hospital
- 14% were referred back to CMHT/PCLT for on-going support (Figure 17)

![Figure 17: MHAS Outcome of Assessment](image)

4.4 Breaches within the Accident and Emergency Department

The four hour waiting time target for Accident and Emergency Departments (A&E) was set by the Scottish Government in 2004 and became a standard upon delivery in 2007 (ISD, Scotland). This means that patients should be seen and then admitted, transferred or discharged within four hours. The four hour target applies to all areas of emergency care such as assessment units, minor injury units, community hospitals, health centres, anywhere where A&E type activity takes place.

Data obtained from A&E suggests that MHAS have at most 2-3 breaches per month, however further investigation of these instances most often show a delay in:

- referral to the MHAS practitioner (some referrals by A&E have been made close to the 4 hour target)
- waiting for transport to REH
• waiting for a bed within Combined Assessment Area 6
• waiting for arrival of other mental health services/practitioners, e.g. IHTT, CAMHS, Specialist Registrar.

It remains unclear whether figures collated by the Scottish Government reflect amended data.

4.5 MHAS Service User Experience

Obtaining feedback from MHAS service users has proved challenging. Over the period September 2010 to April 2011, a two phase, mixed method approach was used to gather information from people using this service. Although only 39 respondents completed the feedback form and findings represent only a small proportion of people in contact with MHAS, this has at least provided some useful insight into their experiences. A full summary is available in Appendix 3.

4.6 Staffing

The staffing resource for MHAS has not changed since the initial reconfiguration of the service although data shows increasing levels of referral and assessment activities for the team.

5 Out of Hours Working

When the teams were first established, primarily for safety reasons, IHTT practitioners were based at the MHAS office within REH overnight and MHAS nurses provided an ‘out of hours’ service across both RIE and REH. In response to REAS Clinical Director’s ‘Single Out of Hours Mental Health Service for NHS Lothian’ proposal, an ‘out of hours’ service including junior doctors (to meet their training needs) was initiated in February 2010.

Overnight working arrangements for IHTT and MHAS staff have evolved since the teams were set up and currently:

One MHAS nurse (8pm until 8am) and one junior doctor (9pm-9am) work at RIE. The second MHAS nurse on duty works across RIE or REH depending on assessment activity and time of arrival of IHTT nurses to REH site.

Two IHTT nurses work overnight (one from each team, 8.45pm until 8.15am). After handover at their respective bases the two nurses do any planned IHTT visits prior to arrival at MHAS office at REH. Thereafter they carry out initial mental health assessments of people presenting to REH and ‘suitability for IHTT’ assessments, they provide telephone support to IHTT users and carers and go on any unscheduled visits required by people on IHTT caseload who are in crisis/distress that can only be managed face-to-face in the home setting.
Although IHTT data (Figure 7) shows reduced contacts ‘out of hours’ on weekdays (5pm until 9am) users continue to require access to this service 24/7 (and feel reassured by its 24/7 availability, according to their feedback). ‘Out of hours’ however is the busiest period for MHAS activity, particularly at RIE (Figures 14/15).

It is proposed that IHTT and MHAS form an integrated ‘out of hours’ team from 5pm weekdays and weekends. It is anticipated that the operational policy for out of hours working will:

- Be facilitated by the co-location of the three teams on the one site
- Provide enhanced flexibility in managing periods of high clinical activity across the service
- Provide clarity about roles, responsibilities, procedures and the interface between different teams/services, benefitting practitioners and people using this service
- Promote a whole team approach for out of hours working (including junior doctors)
- Give cognisance to the whole ethos of intensive home treatment and its availability 24/7, in keeping with the high fidelity model adopted for Edinburgh’s teams by NHS Lothian.

6 Adverse Events

In 2010, 34 DATIX forms were completed for IHTT and MHAS. The main themes to emerge include assault on staff, patient absconding, abuse; threats of violence and violence predominantly in the ‘out of hours’ period.

Three ‘Significant Adverse Event Reviews’ were carried out. Enquiry into these incidents have highlighted:

- Quality of assessment and clinical documentation have generally been of a good standard
- Communication between teams/professionals and quality of some record keeping could be better on occasion
- Joint assessment is considered best practice where different teams are involved

IHTT and MHAS work with significant numbers of people posing a high risk of self harm and suicide. Sadly, three people who had been in contact with the service completed suicide in 2010. Suicide Reviews showed:

- Difficulties in sharing information where multiple assessments have been carried out by different teams within Lothian and elsewhere in Scotland.
• The need to improve ways of informing teams / individuals about suicides that have happened and how debrief is carried out.

• The need for a protocol for liaising with families following a suicide where the person has had only one contact with mental health services prior to ending their life.

7 Awards, Presentations and Publications
IHTTs awarded ‘Psychiatric Team of the Year’ by the Royal College of Psychiatrists - November 2010

IHTTs finalists for ‘Best Service Redesign’ at NHS Lothian’s ‘Celebrating Success’ event - September 2010

MHAS finalists for Scottish Health Award 2010 ‘Team of the Year’ - November 2010


Poster presentation at Royal College of Psychiatrists AGM, Edinburgh entitled 'The impact of crisis resolution and home treatment services on service user experience and admission to psychiatric hospital’ Vicky Barker, Mark Taylor, Ihsan Kader, Kathleen Stewart, Peter LeFevre - June 2010


8 On-going and Future Developments
• Planned merger of the two IHTTs to form one city wide team
• Co-location of IHTT with MHAS at REH site
• Continued development of in-reach and early discharge work
• Development of operational policies for all services across the acute care pathway to promote clarity, consistency and set standards
• Formation of an integrated ‘out of hours team’
• IHTT inclusion criteria for people aged 65 and over who are already engaged with adult mental health services
9 References


APPENDIX 1: IMPACT OF IHTT/MHAS ON GENERAL ADULT MENTAL HEALTH SERVICES, REH

Figure 1: Admissions to REH

<table>
<thead>
<tr>
<th>Year</th>
<th>Voluntary</th>
<th>Detained</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>1074</td>
<td>307</td>
</tr>
<tr>
<td>2005</td>
<td>919</td>
<td>286</td>
</tr>
<tr>
<td>2006</td>
<td>944</td>
<td>274</td>
</tr>
<tr>
<td>2007</td>
<td>1033</td>
<td>259</td>
</tr>
<tr>
<td>2008</td>
<td>993</td>
<td>213</td>
</tr>
<tr>
<td>2009</td>
<td>756</td>
<td>185</td>
</tr>
<tr>
<td>2010</td>
<td>574</td>
<td>199</td>
</tr>
</tbody>
</table>

Figure 2: Re-admissions to REH

<table>
<thead>
<tr>
<th>Year</th>
<th>Readmissions</th>
<th>Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>410</td>
<td>971</td>
</tr>
<tr>
<td>2005</td>
<td>370</td>
<td>835</td>
</tr>
<tr>
<td>2006</td>
<td>337</td>
<td>881</td>
</tr>
<tr>
<td>2007</td>
<td>320</td>
<td>972</td>
</tr>
<tr>
<td>2008</td>
<td>284</td>
<td>922</td>
</tr>
<tr>
<td>2009</td>
<td>282</td>
<td>659</td>
</tr>
<tr>
<td>2010</td>
<td>184</td>
<td>589</td>
</tr>
</tbody>
</table>
### Figure 3: Mean Length of Stay (days) for Edinburgh Adult Mental Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Informal</th>
<th>Formal</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>27.7</td>
<td>47.3</td>
<td>32.1</td>
</tr>
<tr>
<td>2005</td>
<td>31.9</td>
<td>52.5</td>
<td>36.8</td>
</tr>
<tr>
<td>2006</td>
<td>29.3</td>
<td>46.2</td>
<td>33.1</td>
</tr>
<tr>
<td>2007</td>
<td>25.4</td>
<td>47.9</td>
<td>29.9</td>
</tr>
<tr>
<td>2008</td>
<td>26.6</td>
<td>49.2</td>
<td>30.6</td>
</tr>
<tr>
<td>2009</td>
<td>25.3</td>
<td>42.5</td>
<td>28.7</td>
</tr>
<tr>
<td>2010</td>
<td>21.0</td>
<td>36.4</td>
<td>24.8</td>
</tr>
</tbody>
</table>

### Figure 4: Occupied Bed Days (%) ADC Wards

<table>
<thead>
<tr>
<th>Year</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>94.7</td>
</tr>
<tr>
<td>2005</td>
<td>96.1</td>
</tr>
<tr>
<td>2006</td>
<td>90.6</td>
</tr>
<tr>
<td>2007</td>
<td>80.7</td>
</tr>
<tr>
<td>2008</td>
<td>81.0</td>
</tr>
<tr>
<td>2009</td>
<td>79.2</td>
</tr>
<tr>
<td>2010</td>
<td>74.5</td>
</tr>
</tbody>
</table>
Appendix 2: IHTT Service User Feedback 2010

The purpose of this report is to provide a brief summary of service user feedback obtained for Edinburgh’s Intensive Home Treatment Teams. Although carer feedback is also sought routinely, only three completed questionnaires were returned during 2010, therefore this is not included in this paper.

In 2010, 131 questionnaires were returned giving a response rate of 26%.

Main findings:

- 84% of users found it quite easy to access IHTT by phone; 1% found it not very easy and the remaining 14% did not try to phone the teams.
- 87% of people felt well or mostly better at the end of their time with IHTT. 11% felt the same or a bit better and three people report feeling no better.
- 95% of users felt given enough information, 3% felt they were not given enough information, the remainder replied ‘they didn’t know’.
- 92% of users reported feeling able to talk to the teams when they needed to all or most of the time. One person said they never felt able to talk to the team, one person gave no response and the remaining 6% felt able to talk to the team a little of the time.
- 76% of respondents felt listened to by staff all of the time, 21% most of the time, 2% a little of the time and two people felt not listened to.
- 73% of users felt that staff were responsive to their needs all of the time, 25% felt this was most of the time, two people felt the staff were responsive a little of the time and one person felt the staff were not at all responsive.
- 91% of respondents felt involved in decisions regarding their care and treatment, 8% report they did not feel involved; two people did not answer this question.
- 130 of the respondents felt treated with respect by staff and one person did not answer this question.
- 95% of users felt staff did what they said they would do, 5% said they did not know.
- 96% of respondents felt safe all or most of the time while being supported by IHTT, four people felt safe a little of the time and one person felt not at all safe.
- At the end of their time with IHTT, 83% of people felt prepared for moving on, 12% felt unprepared, five people fed back they did not know and one person did not answer this question.

In June 2010, the feedback questionnaire was modified to gauge whether it is helpful for service user’s to receive a copy of the discharge summary from IHTT. Of the 64 questionnaires returned since including this question, 92% of
respondents felt it was helpful; four people felt it unhelpful although no further comments were offered regarding this and one person gave no answer.

**Conclusion**

The vast majority of respondents to the questionnaire provide positive feedback about their experiences with IHTT. Particular themes from qualitative comments suggest people value the level and quality of support, avoidance of hospital admission and improved recovery facilitated by home treatment. A very small minority of respondents report less positive experiences whilst with IHTT. Where negative comments are included in the questionnaire, this is highlighted to senior staff for further discussion and reflection at team meetings to identify potential improvements that may be needed. Finally, feedback to date suggests service users find it helpful to get a copy of their discharge summary from IHTT. Unless clinically indicated, it is recommended that this continues.

Collated responses to the questionnaire and additional comments from service users are included below.
IHTT Service User Feedback - Questionnaire Responses

**Age of IHTT respondents**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td>9</td>
</tr>
<tr>
<td>25-44</td>
<td>58</td>
</tr>
<tr>
<td>44-64</td>
<td>64</td>
</tr>
</tbody>
</table>

**How easy was it to access IHTT by telephone?**

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quite easy</td>
<td>110</td>
</tr>
<tr>
<td>Not very easy</td>
<td>1</td>
</tr>
<tr>
<td>Didn't try</td>
<td>18</td>
</tr>
<tr>
<td>No answer</td>
<td>2</td>
</tr>
</tbody>
</table>

**How much better did user's feel during time with IHTT**

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well</td>
<td>56</td>
</tr>
<tr>
<td>Mostly better</td>
<td>58</td>
</tr>
<tr>
<td>Same/bit better</td>
<td>14</td>
</tr>
<tr>
<td>Worse/no better</td>
<td>3</td>
</tr>
</tbody>
</table>
**Were you given enough information about your care and treatment?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>125</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

**Did you feel able to talk to the team involved when you needed to?**

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>A little of the time</th>
<th>Not at all</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>33</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Did you feel listened to?**

<table>
<thead>
<tr>
<th>All the time</th>
<th>Most of the time</th>
<th>Little of the time</th>
<th>Not at all</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>27</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Were staff responsive to your needs?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All the time</td>
<td>95</td>
</tr>
<tr>
<td>Most of the time</td>
<td>32</td>
</tr>
<tr>
<td>Little of the time</td>
<td>2</td>
</tr>
<tr>
<td>Not at all</td>
<td>1</td>
</tr>
</tbody>
</table>

Did you feel involved in decisions about your care and treatment?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>119</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
</tr>
<tr>
<td>No answer</td>
<td>2</td>
</tr>
</tbody>
</table>

Did you feel you were treated with respect?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>130</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
</tr>
</tbody>
</table>
Did you feel staff did what they said they would do?

- Yes: 125
- No: 6
- Don't know: 6

Did you feel safe while being supported by IHTT?

- All the time: 84
- Most of the time: 42
- Little of the time: 4
- Not at all: 1

At the end of your time of IHTT support, did you feel prepared for moving on?

- Yes: 109
- No: 16
- Don't know: 5
- No answer: 1
Did you find it helpful to get a copy of the discharge summary?

Yes: 59
No: 4
No answer: 1
Additional comments by IHTT service users:

“I feel very positive about the future.”
“I was really happy with the care that I received.”
“I would have been unable to cope or stay at home without the care of the IHTT.”
“They not only supported me but my family.”
“My family and I are incredibly grateful to this service and the amazing people within the team.”
“I am glad you now have the IHTT because it meant I didn’t have to go into hospital.”
“Thank you for what was a good experience.”
“The team were fantastic, always giving 100%, they could have done no more to help and I will always be thankful I had their support when I needed it.”
“In an ideal world I would like them to be a permanent fixture.”
“I really felt the gap has moved on – I cannot say enough to express what an excellent team of very dedicated professionals I encountered when supported by IHTT. “
“Although I find it difficult to trust people I do not know I found all staff who visited me aware of this and they were very good at helping me feel safe.”
“Had I not had input from IHTT I would have been admitted to hospital, which would have set my recovery much further back and increased my feelings of being unable to manage my mental health.”
“Too many new faces to get really involved with talking about problems or how I was feeling.”
“The IHTT team were fantastic and I am truly grateful for their help and support, definitely a preferable option to hospital. The support to carers was not obvious.”
“Very grateful this service exists as I don’t feel I would have made a quick recovery in hospital.”
“The IHTT were excellent, at a point when I was low and struggling they provided a refuge and source of support.”
“I feel that the support I received from IHTT made me feel safe and wish that I had access to them earlier in my illness.”

IHTT Service Users, 2010
Appendix 3: Service User Feedback - Mental Health Assessment Service

Introduction
This report provides a summary of service user feedback obtained for the Mental Health Assessment Service (MHAS), operating as a nurse led team under the auspices of Edinburgh CHP since September 2008.

The primary function of MHAS is to screen individuals in crisis for the presence of mental health problems which would benefit from involvement in specialist mental health services. The team can rapidly assess and intervene, thus contributing to a reduction in inappropriate hospital admissions.

MHAS operates across 2 sites, the Royal Edinburgh Hospital (24/7) and Edinburgh Royal Infirmary (out of hours), providing an inclusive service. Referrals come from GPs, emergency services, from within mental health services, social and voluntary agencies or people can self refer.

Comprehensive assessment, risk assessment and crisis management is undertaken for a monthly average of 310 people, many presenting with suicidality, self harm behaviour and other complex needs. Support, information and psycho-education are provided to service users and carers, and they can be linked in to other services for on-going support or short term follow-up by the team.

Rationale
Until now, no formal feedback mechanism has been used to ascertain the views of people using this service. It is anticipated that feedback about their experiences could identify potential improvements to the way the service is being delivered, whilst also acknowledging areas of good nursing practice.

Since people present in crisis and extreme distress, careful consideration was given to this process to avoid causing further upset to respondents.

Method
Phase 1:
- Themes contained within the questionnaire are similar to those within UDSET (a User Defined Service Evaluation Tool); some are specific to operational aspects of MHAS.

- Practicalities of issuing a questionnaire to people in distress were discussed with representatives of the Patient’s Council to determine the optimum method of obtaining their views.
A covering letter, the questionnaire and pre-addressed envelopes were given to people presenting at the end of their assessment by MHAS practitioners.

Completed questionnaires were returned to the Nurse Consultant using the ‘freepost system’ already operational for the Intensive Home Treatment Teams.

The initial feedback period of September 2010 was extended to the end of November 2010 due to low response rates.

Phase 2:
- In February 2011 meeting with Edinburgh User’s Forum (EUF) to discuss people’s experiences of using MHAS.
- EUF involvement in accessing a wider group of service users – feedback questionnaire posted on-line via EUF website and ‘Kwik Surveys’ (a free and unlimited survey tool); stalls set up at the Royal Edinburgh Hospital on two occasions.

Findings
39 questionnaires were returned (25 from phase 1 and 14 from phase 2). Although a low response rate given MHAS clinical activity levels, feedback obtained provides some insight into people’s experiences of using this service:

- Over half of respondents were aged 25-44, 77% were female, 33% male.
- 29 out of 39 respondents were assessed at Royal Edinburgh Hospital, mostly within hours (Monday – Friday, 9am-5pm) and were predominantly referred by their GP or self referrals. 56% of respondents have had ‘previous contact’ with the service.
- Although a telephone booking system is in operation for people referred to MHAS, the vast majority were not given a pre-arranged appointment for their assessment. Where an appointment time was provided, respondents found this very helpful.
- In most cases (25 of 39) there were no delays in waiting for assessment. Where this did occur, waiting times ranged from 10 – 45 minutes although one person waited for an hour. Additional comments
from service users involved convey that this was not problematic for them and staff explained the reasons for any delay.

- 26 respondents felt they had enough time and privacy for their assessment all or most of the time, however 8 felt this not to be the case. Comments from one service user (appendix 1) illustrates how challenging this can be at the Royal Infirmary site, where staff had to move the person in the bed to a more private area for the assessment.

- 28 of the 39 respondents felt staff explained clearly their role and the purpose of the assessment. (One respondent ticked ‘no’ regarding this question, their additional comment was that they were a ‘regular’).

- 29 respondents felt able to talk to staff involved in their assessment all or most of the time. Four people felt able to do this only a little of the time and six felt unable to talk to staff.

- 28 respondents felt listened to by staff all or most of the time, three a little of the time and eight did not feel listened to.

- 26 respondents felt treated with respect all or most of the time. Three felt this to be the case only a little of the time and eight did not feel treated with respect (the questionnaire was ‘double sided’ - two respondents seemed unaware of this and did not complete the remaining questions).

- 23 respondents felt they were given enough information about how to get help in a crisis.

Overall, the majority of respondents rated the quality of the service received as excellent, very good or good. Five people rated this as fair, nine people rated it as poor and two people did not complete the questionnaire.

**Service Users’ Qualitative Feedback**

Narrative comments by service users convey their lived experience of using the service. The main themes to emerge include helpfulness of staff, feeling treated with respect and being listened to, not feeling rushed, being able to attend without an appointment and active involvement in decision-making.

Some negative comments evolved around perceptions of staff attitudes relating to the diagnosis of ‘borderline personality disorder’ and one service user described mixed experience of using MHAS, highlighting issues around communication and the nature of telephone support.
Conclusion
Obtaining feedback from MHAS service users has proved challenging and the findings discussed here represent only a small proportion of people using the service. Most respondents describe positive experiences in their contacts with MHAS and staff have valued the opportunity to reflect and learn from the feedback provided. The need for information about service user experience is essential in ensuring a quality service is being delivered all of the time, therefore further consideration needs to be given to alternative methods of gathering feedback for this service.

Collated questionnaire responses and some narrative comments are included below.
MHAS Questionnaire Responses

### Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 18</td>
<td>2</td>
</tr>
<tr>
<td>18-24</td>
<td>4</td>
</tr>
<tr>
<td>25-44</td>
<td>12</td>
</tr>
<tr>
<td>45-64</td>
<td>8</td>
</tr>
<tr>
<td>65+</td>
<td>6</td>
</tr>
</tbody>
</table>

### Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
</tr>
</tbody>
</table>
Who referred you to this service?

Were you given an appointment to attend MHAS?

Were there any delays in waiting for assessment?
Did you feel you had enough time and privacy to discuss your situation during assessment?

- All of the time: 20
- Most of the time: 5
- A little of the time: 3
- Not at all: 2

Did staff clearly explain their role and purpose of the assessment to you?

- Yes: 30
- No: 10

Did you feel able to talk to staff involved in your assessment?

- All of the time: 18
- Most of the time: 14
- A little of the time: 4
- Not at all: 2
- Blank: 2
**Did you feel you were listened to by staff?**

- All of the time: 20
- Most of the time: 10
- A little of the time: 2
- Not at all: 4
- Blank: 0

**Did you feel that you were treated with respect by staff involved in your assessment?**

- All of the time: 22
- Most of the time: 6
- A little of the time: 4
- Not at all: 4
- Blank: 0

**Did you feel as involved as much as you wanted to be in decisions about your follow-up care and treatment planned (if any) at the end of your assessment?**

- All of the time: 18
- Most of the time: 10
- A little of the time: 4
- Not at all: 8
- Blank: 0
How satisfied were you with the conclusion/outcome of your assessment?

- Completely: 16
- Mostly: 14
- A little: 10
- Not at all: 12
- Blank: 2

Were you given enough information about how to get help in a crisis or when urgent help is needed in the future?

- Yes: 25
- No: 15
- Blank: 5

Overall, how would you rate the quality of service you received during contact with MHAS?

- Excellent: 14
- Very good: 13
- Good: 4
- Fair: 6
- Poor: 8
- Blank: 2
MHAS Service User's Comments

- Went to REH thinking admission might be necessary but gladly staff judged that illness would pass that night.

- Nurse X pushed my bed to a private cubicle to speak to me…felt treated with respect…before I left casualty Nurse X came back to make sure I was still ok to go home.

- I thought the gentleman that saw me was very helpful, good at listening and was understanding to my needs. He gave me excellent advice on how to cope with situations and clearly explained what help was available to me in a crisis. I didn't have to wait for an appointment and I thought it was handy that he was there on that night. Very great service received. Thanks.

- Waited an hour but was ok about this as it was such a benefit to just go along without an appointment. I'd expected a longer wait. I didn't feel rushed at all and that was important. The nurse specialist I saw was a very good listener and absolutely non-judgemental. I appreciated the way I was treated as an active participant in decisions and not just sucked into some kind of 'process' that was out with my control. This [Information given] was particularly helpful. It was much more pleasant than I'd feared it would be - nice, bright, cheerful waiting room that was quiet and restful while I was there. The receptionist was lovely - very friendly and welcoming which immediately put me at ease when I was feeling anxious on arrival.

- They say BPD is no longer a diagnosis of exclusion but this is not my experience. As soon as staff note this on your records the change in attitude is marked. An attitude of laissez-faire became immediately apparent. This is very unhelpful.

- I was pleasantly surprised…down to earth no nonsense approach was encouraging. I felt that I was listened to and not viewed as 'strange'. I was impressed by the professionalism and accuracy to which the staff assessed my situation, thanks.

- Helped me to get the emergency care I needed, all my questions were answered so helped me through my darkest times, I was made to feel as if I did really matter and that I was worthy of their help. After I left my appointments, they didn't feel as if they were final and that I couldn't ask for their help again. All staff I came across via my assessment were very polite and most of all they let me know that they were there for me and where applicable they could help in some way to help me get better.

- If a long wait is likely the staff should at least tell you what is expected, introduce themselves in advance. The 'piped' music being played (classical)
was depressing and annoying. The staff seemed to have an agenda in advance perhaps from looking through my records before my assessment. I am in no way confident of being treated fairly if I visit the assessment service at the Royal Edinburgh!

- The staff I saw treated me as an equal and listened actively to what I said. When struggling to speak they waited patiently for me to answer and I did not feel rushed. They believed how I was feeling at that time. Due to the set up if you are already being seen by CMHT having to go home and wait overnight for them to assess me was very distressing however MHAS staff appreciated this and accepted my feelings about it honestly and respectively and I appreciate that this process is what is in place. When next in crisis outwith times CMHT work I would not hesitate to contact MHAS again.

- It was good that I was able to be seen straight away. I found this service for me personally, helped a great deal. Also knowing that the service is available to me, if I may need it in the future is a huge reassurance. Thank you to the two people that assessed me, you were very kind and helpful.

Service Users, Sept 2010 - April 2011