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ARTICLE



# A scoping review of studies into crisis resolution teams in community mental health services

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**ABSTRACT**

**Background and purpose of article:** Crisis Resolution Teams (CRT) for rapid assessment and short-term treatment of mental health problems have increasingly been implemented internationally over the last decades. Among the Nordic countries, the CRT model has been particularly influential in Norway, where 'Ambulante akutteam (AAT)' is a widespread psychiatric emergency service for adult patients. However, the clinical practice of these teams varies significantly. To aid further development of the service and guide future research efforts, we carried out a scoping review to provide an up-to-date overview of research available in primary studies focusing on phenomena related to CRTs in English and Scandinavian literature.

**Methods:** A systematic literature search was conducted in the bibliometric databases MEDLINE, Embase, PsychINFO, Scopus, and SveMed+. Included studies were thematically analyzed using a qualitative method.

**Results:** The search identified 1516 unique references, of which 129 were included in the overview. Thematic analysis showed that the studies could be assigned to: (1) Characteristics of CRTs ($k = 45$), which described key principles or specific interventions; (2) Implementation of CRTs ($k = 54$), which were descriptive about implementation in different teams, or normative about what clinical practice should include; and (3) Effect of CRTs ($k = 38$).

**Conclusions:** The international research literature on CRTs or equivalent teams is extensive. Many subthemes have been studied with various research methodologies. Recent studies provide a better evidence base for how to organize services and to select therapeutic interventions, but there is still a need for more controlled studies in the field.

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## Introduction

Crisis resolution teams (CRT) offer rapid assessment and short-term treatment for people suffering from acute exacerbation of mental disorders or development of new mental health problems that cannot be handled by the primary health service or other parts of the specialist health service [1,2]. An aim of CRT services is to prevent emergency admissions by offering home-based treatment for people in acute mental crises [2,3] and to have a gatekeeper function for hospitalizations. The theoretical framework is influenced by early crisis theory, directions that challenge the traditional balance of power between patient and therapist, and the belief that situations are best coped within a patient's home environment rather than in an isolated hospital ward [2,4]. The CRT model has an interdisciplinary approach of specialist competence and gives rapid assessment, 24-hour availability, intensive home treatment (preferably, with several visits daily), assistance to shorten hospital admissions, and collaboration with other support agencies to ensure further treatment options.

The CRT model has been particularly prevalent in the United Kingdom, where it has been implemented to varying degrees [5]. Outside of the UK, Norway is one of the countries where the model has been most widely implemented. Here, CRTs for adults are mainly organized in community mental health centers (distriktspsykiatriske senter – DPS) as part of secondary mental health care. The first teams were established in 1999/2000, and in 2012, there were 61 active CRTs in Norway [1]. The Norwegian health authorities' recommendations for CRTs are close to the the UK model, although individual psychiatric services are free to make adjustments to the service to meet local needs and characteristics. National guidelines highlight elements such as service user participation (including patients' relatives), interdisciplinarity,

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and extended opening hours, rapid assessment of mental health problems, short-term adapted outpatient treatment, attention to the needs of patients' children, and collaboration with relatives and other support agencies [1]. As in the UK, the Norwegian CRTs varies in terms of organization, staffing, opening hours, and services offered [6,7].

Previous reviews of CRT-studies are somewhat dated and have focused on limited areas of the research literature. A Cochrane review [8] from 2015 included eight randomized controlled effect studies (from 1964 to 2010), only one of which dealt with a pure CRT service [9]. The authors concluded that home treatment might be an alternative to hospitalization, but emphasized the scarcity of high-quality evaluative studies. A more comprehensive literature review from the same year [10] included 49 primary studies, as well as 20 policy guidelines and reports from experts and decision-makers. The study identified longer opening hours, access to a specialized mental health care professional, collaboration with local services, and availability of home treatment as essential principles for implementing the service, but also pointed out that the quantitative evidence was sparse and recommended developing a more precise definition of the CRT model to make it easier to systematize further knowledge. Other reviews of somewhat older dates [11–13] provided preliminary evidence that CRT may reduce inpatient treatment and costs as well as increase patient satisfaction. Two overview studies published twelve years ago [14,15] focused on identifying active elements of CRTs in Norwegian psychiatric services. Factors such as accessibility, compassion, and providing help to cope with the crisis in daily life were found to be central [14], furthermore the need for a better description of therapeutic interventions in CRTs was highlighted [15]. Other literature reviews have examined more limited issues, such as crisis management with elderly patients [16], helpful interventions at different points in times during a crisis [17], and factors that may promote early discharge from psychiatric services [18].

The purpose of this study is to provide a broad and up-to-date overview of existing research on properties and phenomena related to CRT and similar teams, in the form of a scoping review, a so-called exploratory research overview [19]. In contrast to systematic reviews, which aim to synthesize findings across studies in order to answer specific research questions, the purpose of a scoping review is to describe the current extent and nature of research evidence in the field. The scoping review will be able to identify knowledge gaps, generate hypotheses for future research, and guide interested parties towards relevant studies. By using broad inclusion criteria, the present scoping review included studies pertaining to CRT work and subjected this body of evidence to a thematic analysis. The various clinical topics and areas of research were identified. Main features in the literature will be presented to illustrate the topics that have been investigated.

## Material and methods

### Literature searches

Structured searches were performed in the reference databases MEDLINE, Embase, PsychINFO (all *via* Ovid), Scopus, and SveMed + (by co-author SAP). The applications were last updated on 7 September 2020. The search strategy applied in the databases was designed to cover alternative free-text terms used to refer to outpatient emergency teams and similar services. The searches used the Boolean operators 'or' and 'and', as well as a proximity operator that indicated the permitted distance between the relevant free-text words (see Supplementary Information for a detailed description of the search strategy adopted in the different databases).

### Inclusion and exclusion criteria

We included primary studies focusing on phenomena related to CRT or similar teams that provide rapid interventions for adult patients in mental crisis published in scientific journals, in English or Scandinavian languages. Comments, letters, or studies concerning teams exclusively targeting populations with severe mental illnesses such as ACT (Assertive Community Treatment) and FACT (Flexible Assertive Community Treatment) were excluded. Also excluded were studies without a specific focus on CRT or similar teams, but where patients or employees from CRT had participated together with patients or employees from emergency departments and the like.

### Selection of studies

All references from the various databases were collected in an EndNote library, and we removed duplicates. Based on the title and summary, the references were sorted as either included, excluded, or uncertain by the first author (KHH). The full text was reviewed in cases where it was unclear whether inclusion criteria were met. The last author (TH) reviewed the lists to ensure consensus. KHH and TH discussed whether the uncertain references should be included.

### Data synthesis

KHH and HB performed a qualitative thematic analysis based on the full texts in which the included studies were categorized into subgroups based on their topics, as follows. First, relevant information was registered in a table, including the year of publication, nationality, research questions, methodology and findings. Each study was assigned one or several keywords that reflected its thematic content. The keywords were inspected to identify thematic similarities. Similar themes were grouped together under parent categories, and new categories were developed to embrace those that did not fit into the existing ones. Each parent category was further developed into subcategories. Throughout the process, there were discussions until consensus was reached. Finally, a quantitative analysis (frequency analysis) was performed for each parent category and subcategory. We summarized the number of publications according to the research methodologies, nationalities, and languages (English or Scandinavian).

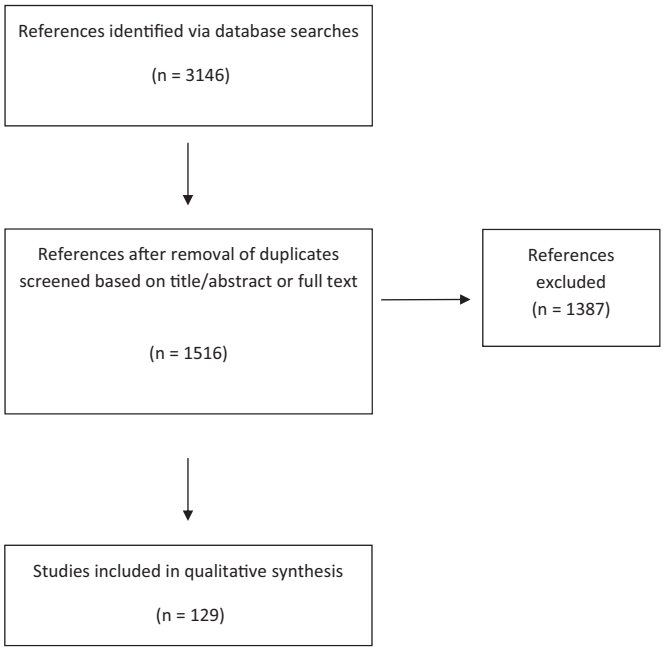


**Figure 1.** Flowchart illustrating the process of identifying and selecting studies for inclusion.

## Results

A total of 1516 unique references were identified. Of these, 129 were included according to the inclusion and exclusion criteria. See Figure 1 for a flowchart illustrating the process of identifying and selecting studies for inclusion.

The following terms for CRT interventions were included in the literature search: Crisis Resolution Home Treatment Teams (CRHTT), Intensive Home Treatment Teams (IHTT), Home Treatment Teams (HT), and the Norwegian Ambulant Akutteam (AAT), but the abbreviation CRT covers all of these in the following text.

As shown in Table 1, we developed three main categories in the thematic analysis: (1) Characteristics of CRTs, (2) Implementation of CRTs, and (3) Effect of CRTs.

### *Characteristics of CRTs*

This main category ($k = 45$, 35% of the total sample of publications) concerned the characteristics or contents of CRT treatment. The first and largest ($k = 33$) subgroup described various *Principles* that were considered important in the treatment context. These studies were mainly interview-based and qualitative ($k = 25$), and 17 of the studies were conducted in the United Kingdom, 15 in Norway, and one in Spain. Eight of the publications were only available in Norwegian. As examples of results in this subcategory, one study found that patients benefitted from access to service user support as well as from available and attentive therapists who offered psychosocial therapeutic approaches both for current crises and for mental illnesses that had lasted over time [20]. Other studies concluded that access to practical assistance [21], accessibility, flexibility, and being taken seriously, understood and met as a fellow human being [22], and attention towards the perspective of patients' relatives [23] and their parental roles [24], are all essential principles in CRT care.

The second subcategory ($k = 12$) described various specific *Interventions* that had been tested in CRT care. Most studies ($k = 10$) had a quantitative or mixed design. Eight studies were conducted in the UK and four in the Netherlands, and all were published in English. Regarding findings, improved outcomes were reported for a support program based on self-help and support from user representatives [25,26], and eye movement desensitization and reprocessing (EMDR) [27], and null results were found for social network activation [28] and the use of feedback tools [29,30]. Other interventions investigated in smaller studies were art therapy, specific intervention for dementia problems, and psychoeducation [31–33].

### *Implementation of CRTs*

The largest category of studies, with 54 publications (42% of the total number of studies), described how CRTs have been, or should be, implemented in practice. The majority of these articles ($k = 41$) were categorized in the subgroup *Descriptive*, as they mainly focused on describing various issues related to the actual implementation of CRTs in different practice settings. Of these, six studies had a qualitative research methodology (interviews with patients and/or staff), one study, a mixed qualitative/quantitative design, while the remaining studies utilized quantitative methodologies (analyses of different types of archival data and/or questionnaires). Most studies were conducted in the United Kingdom ($k = 26$), followed by Norway ($k = 7$), but studies conducted outside of Europe were also represented, including Australia ($k = 2$) and South Korea ($k = 1$). Three studies were published in Norwegian, one in Danish, and the remaining in English. To exemplify findings in this subcategory, a case study [34,35] demonstrated a great breath and variation in what employees, decision-makers, and service users thought was helpful after the implementation of CRTs; one analysis of archival data [36] identified risk factors for hospitalization after contact with a CRT, and another [37] found indications that CRTs were developing towards becoming a team for second opinions. Another study described the development of an early CRT in Norway [38].

About a quarter of studies in this main category ($k = 13$) were classified as *Normative* since they focused on what elements CRT implementation should contain. In this subcategory, most studies were quantitative ($k = 11$); one study was qualitative, while another had a mixed design. All studies were conducted in the United Kingdom ($k = 10$) or Norway ($k = 3$), and all were published in English. Several of the normative studies were connected to studies utilizing 'the CORE CRT Fidelity Scale' [25,39]. This scale measures a team's fidelity towards a standardized CRT model and enables systematic research and comparison between teams [40,41]. One controlled trial reported that training and higher fidelity to the CRT model reduced hospitalizations, but did not contribute significantly to perceived patient satisfaction [42]. Similarly, a prospective study found that extended opening

**Table 1.** Characteristics of Crisis Resolution Teams (CRTs) studies, sorted by thematic category.

| Category | *k* | Research design | Methodology | Country | Language |
|---|---|---|---|---|---|
| *Characteristics* | 45 | | | | |
| Principles | 33 | Quantitative; $k = 6$ [57–62]. Qualitiative; $k = 25$ [63–86]. Mixed; $k = 2$ [87,88]. | Controlled trial + naturalistic experiments; $k = 1$ [58]. Archival data; $k = 2$ [59,60]. Survey; $k = 3$ [57,61,62]. Interview; $k = 24$ [63–73,75–86]. Interview + observation; $k = 1$ [74]. Survey + interview; $k = 1$ [88]. Observation + archival data + interview; $k = 1$ [87]. | UK; $k = 17$ [57–62,78–87]. Norway; $k = 15$ [63–77]. Spain; $k = 1$ [88]. | English; $k = 25$ [57–62,70–76,78–88]. Norwegian; $k = 8$ [63–69,77]. |
| Interventions | 12 | Quantitative; $k = 7$ [29–92]. Qualitiative; $k = 2$ [33,93]. Mixed; $k = 3$ [26–32]. | Controlled trial; $k = 3$ [29,30,90]. Archival data; $k = 4$ [27,89,91,92]. Survey; $k = 1$ [28]. Interview; $k = 1$ [93]. Interview + survey; $k = 1$ [33]. Litterature study + interviews; $k = 1$ [26]. Archival data + interview; $k = 1$ [32]. | UK; $k = 8$ [26,27,32,33,90–93]. Netherlands; $k = 4$ [29–89]. | English; $k = 12$ [29–32]. |
| Implementation | 54 | | | | |
| Descriptive | 41 | Quantitative; $k = 34$ [58,60,94–122]. Qualitiative; $k = 6$ [123–128]. Mixed; $k = 1$ [129]. | Controlled trial + naturalistic experiments; $k = 1$ [58]. Archival data; $k = 17$ [36,51,60,98,99,100,104–106,110–112, 116,117,119,120,122]. Survey; $k = 13$ [49,94–96,101–103,107–109,113,114,118] . Interview; $k = 4$ [123,124,126,128]. Interview + observation; $k = 2$ [125,127]. Survey + Interview; $k = 1$ [129]. Archival data + survey; $k = 3$ [97,115,121]. | UK; $k = 26$ [36,51,58,60,97,98,100–104,107–109, 112,114,118,119,120,121,124–129]. Norway; $k = 7$ [94–96,110,116,122,123]. Denmark; $k = 1$ [115]. Ireland; $k = 3$ [106,111,113]. Australia; $k = 3$ [99,49,117]. South Korea; $k = 1$ [105]. | English; $k = 38$ [58,60,94,97–114,117–129]. Norwegian; $k = 3$ [95,96,116]. Danish; $k = 1$ [115]. |
| Normative | 13 | Quantitative; $k = 11$ [5,6,39,40–43,44,130,131,132]. Qualitiative; $k = 1$ [133]. Mixed; $k = 1$ [134]. | Protocol; $k = 1$ [39]. Controlled trial; $k = 1$ [42]. Archival data; $k = 2$ [131,132]. Survey; $k = 2$ [5,130]. Interview ; $k = 1$ [133]. Archival data + survey; $k = 3$ [43–92]. Archival data + interview; $k = 1$ [40]. Survey + interview; $k = 2$ [41,134]. | UK; $k = 10$ [40–89,131–134]. Norway; $k = 3$ [43–6]. | English; $k = 13$ [40–134]. |
| Effect | 38 | Quantitative; $k = 36$ [3,9,25,29,30,39,42,43, 46,47,50,54,90,135–157]. Mixed; $k = 2$ [158,159]. | Protocols; $k = 4$ [25,29,39,54]. Controlled trial; $k = 10$ [9,30,42,46,47,90,141,150,153,159]. Pre-post comparison; $k = 1$ [144]. Archival data; $k = 17$ [136,138,139,142,143,50–147,148,149, 151,152,154,155,156,157]. Archival data + survey; $k = 5$ [3,43,135,137,140]. Archival data + interview; $k = 1$ [158]. | UK; $k = 21$ [39,42,90,135,136,104,142–50, 146–148,150–152,155,158]. Norway; $k = 3$ [43,137,156]. Denmark; $k = 1$ [138] . Netherlands; $k = 3$ [29,30,54]. Ireland; $k = 1$ [145]. Germany; $k = 1$ [149]. France; $k = 1$ [154] . Switzerland; $k = 4$ [46,47,157,159]. Spain; $k = 1$ [139]. USA; $k = 2$ [141,153]. | English; $k = 37$ [3,9,25,29,30, 39,42,43,46,47,50,54,90,135–155,157–159]. Norwegian; $k = 1$ [156]. |

*Note*. UK: United Kingdom. Eight studies are included in two categories and consequently, the total number of studies reported in the table ($k = 137$) exceeds the number of studies included in the scoping review ($k = 129$).

hours were associated with reduced hospital admissions [6]. However, studies on British teams have reported that organization and service offerings vary significantly [5]. Great variation has also been demonstrated for the development of Norwegian teams [43], and Norwegian CRTs have been implemented without the requirement of important elements from the British model, including home treatment, gatekeeper function, 24/7 opening hours, and opportunity for rapid response [44].

### *Effect of CRTs*

The third category ($k = 38$; 29%) consisted of studies examining the effect of CRTs. Of these, ten studies reported the results of controlled studies with and without randomization, and four were protocols for randomized controlled trials (RCTs), one of which had not published results. The remaining 24 studies compared outcome measures before and after the introduction of a CRT without a control group. All studies were quantitative, but two also included qualitative material. Studies in this category were conducted in ten countries, although most studies ($k = 21$) were conducted in the United Kingdom. With the exception of one article published in Norwegian, most were published in English. The outcome of interest in most of these studies was the number of admissions. A reduction in hospitalizations with CRT was demonstrated by randomizing patients to access to home treatment or standard treatment [45,46], comparing admission areas with and without access to CRTs [3,9], team training in the model [42], access to support programs based on self-help and peer-support [25], as well as in retrospective comparisons of hospitalization rates and other outcomes before and after the implementation of home treatment [47,48]. These studies reported little or no effect of CRT on other parameters, such as the use of coercion or symptom change. Still, patient satisfaction was higher among those receiving home treatment in some studies [47,48].

## Discussion

The literature search revealed extensive research on CRTs with a substantial variation in research questions and methodologies. Most studies were conducted in the UK, followed by Norway, and about a tenth of studies was only available in Scandinavian languages. The majority of studies ($k = 41$) described different features of the implementation of CRT in various clinical settings (*Descriptive* subcategory in *Implementation* category). The second-largest subcategory focused on identifying principles that characterize CRT work (*Principles* subcategory in *the Characteristic* category, $k = 33$). About a third of the studies ($k = 38$) investigated the impact of CRT on hospitalization rates and other outcomes (*Effects* category). Smaller subcategories of studies aimed to establish what elements should be present in the implementation in order for CRT to be a viable alternative to hospitalizations (*Normative* subcategory in *Implementation* category, $k = 13$) and investigated specific therapeutic interventions in CRTs (*Interventions* subcategory in *Characteristics* category, $k = 12$). Results across the studies indicate that CRT may be a promising alternative to hospital admissions, but elements such as specialist competence among employees, extended opening hours, continuity of care, close follow-up, and solid collaboration with other service providers may be prerequisites if such a team is to function as an alternative to admissions. Of the 129 studies identified in this review, only three [49–51] reported negative consequences for patients or caregivers receiving help from CRT. Although this small number of three studies does not suffice to resolve a concern, we acknowledge that possible adverse outcomes after CRT care need to be monitored carefully in further research, and if necessary, action taken to avoid.

This scoping review aimed to provide an overview and description of the total body of evidence related to CRTs. A detailed assessment of the quality of the individual studies falls outside the scope; however, there seems to be a clear trend that the quality of the research in this field is moving upwards in the hierarchy of evidence [52]. The early studies, mainly classified as Characteristics and Implementation in this review, utilized naturalistic, qualitative, and descriptive research designs. Although valuable for the in-depth understanding of clinical phenomena and the generation of hypotheses, generalizable conclusions about CRTs' effects or mechanisms of action cannot be drawn based on these studies, this research provided knowledge of characteristics of individual CRTs and acute mental health care in general. In recent years, however, larger controlled and randomized controlled trials have been conducted [42,46,53]. Another example is an ongoing prospective RCT study in the Netherlands [54] comparing the effect of intensive home treatment to treatment at admission.

Our scoping review complements previous reviews by providing a broad overview of all available research into CRTs for adults, categorized by topics. One strength is the inclusion of studies published in Scandinavian languages, whose results are otherwise less available to an international public. Due to the exclusion of studies not exclusively focusing on CRT's for adults, potentially relevant knowledge generated through research on similar models of care (e.g. ACT, FACT, and teams targeting children or families in crisis or adults with specific diagnoses; such as elderly with dementia) are not covered in this scoping review. Also, we have not formally assessed the quality of each original study. Nevertheless, we believe that summaries of the results may give a solid fundament for hypotheses and tentative conclusions.

Some promising directions for further research stand out in this body of research. First, as presented in the *Normative* subcategory of *Implementation* studies, studies of fidelity to the CRT model may improve the operationalization of the model and thus contribute to more unambiguous answers to what is useful in such an approach [7,41]. Reliable and valid CRT fidelity instruments would help to understand what distinguishes CRT from other current models of community mental health care (such as HT, CRHT, ACT and FACT) and to what degree these models overlap.

Second, the need for more knowledge about effective psychological or therapeutic interventions within CRT care has been pointed out [15]. While relatively few studies were classified as *Interventions* here, we consider this line of research to be particularly promising in terms of clinical utility. The literature search identified two additional studies that were excluded from the review due to the inclusion of a patient sample treated in a hospital ward. These investigated, respectively, the effect of exposure therapy (EMDR) [55] and short-term psychological crisis intervention with a cognitive approach [56] in acute and crisis psychology services. The studies reinforce the impression that the field is moving towards the development of evidence-based interventions in acute health care. In a future assessment of research in the area, it may be useful to include interventions conducted both among psychiatric emergency in- and outpatients. This approach may broaden the picture of what works where, when, and for whom when in need of emergency mental health care.

This overview of knowledge regarding CRTs gives the opportunity to be used as decision support for further development of the services. Results indicate that CRTs may, as intended, decrease hospital admissions by facilitating the resolution of the crisis in patients' homes. This may be particularly true when CRTs are implemented according to the standardized CRT model, although it remains somewhat unclear, to date, what the necessary and effective elements of CRT work are. Ongoing studies will provide more knowledge on the impact of CRTs in the future.

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No potential conflict of interest was reported by the authors.

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