Home Treatment Accreditation Scheme (HTAS)

Standards for Home Treatment and Crisis Resolution Teams - Fourth Edition

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Foreword

Crisis resolution and home treatment services are central to the acute mental health care pathway. These play a vital role by providing intensive treatment in the patient's home as an alternative to a hospital admission.

Since the establishment of HTAS, emphasis has been on continuously improving quality of such teams via the accreditation process and by providing high quality evidence-based standards. At the time of publishing the standards, nationally, there is expansion of services providing crisis response and home treatment.

The HTAS standards incorporate evidence-based fundamental attributes of high-quality clinical care in patients' homes. The access and home treatment provisions would be clearer to stakeholders including patients and family/carers. These standards provide a guide to achieve close-knit integration with the rest of the mental health system, thereby delivering continuity of care and effective therapeutic outcomes. Great emphasis is on ensuring that the standards provide guidance to crisis and home treatment services in order to operate effectively as an intensive specialist community-based alternative to inpatient care and not merely as generic crisis services.

To develop the standards, HTAS has cross referenced against other guidance and consulted member services of the network.

I would like to thank the many healthcare professionals and HTAS staff who have worked to develop this fourth set of HTAS standards.

Dr Pranveer Singh
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Chair of the HTAS advisory group

Introduction

The Home Treatment Accreditation Scheme (HTAS) was established in 2012 to support in the quality improvement of crisis resolution and home treatment teams in the UK and Ireland and is one of over 20 networks within the College Centre for Quality Improvement (CCQI) within the Royal College of Psychiatrists.

These standards have been developed from key documents and expert consensus and have been subject to extensive consultation with professional groups involved in the provision of crisis resolution/home treatment services, and with people who have used these services and their families/carers.

The standards have been developed for the purposes of review and accreditation as part of the Home Treatment Accreditation Scheme (HTAS), however, they can also be used as a guide for new or developing services.

Terms

In this document, the crisis resolution/home treatment team is referred to as 'the team' or 'the home treatment team'. Teams have differing titles and through consultation it has been agreed that 'home treatment team' captures these services most effectively.

Since home treatment teams differ widely in their configuration and the models used, these standards focus on the function of a team in order to make them as widely accessible as possible. The standards are applicable towards the care of adult and older age patients.

Please note that throughout this document, people who are cared for by home treatment teams are referred to as 'patient'.

Categorisation of standards

To support their use in the accreditation process, each standard has been categorised as follows:

- **Type 1:** failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment;
- **Type 2:** standards that an accredited team would be expected to meet;
- **Type 3:** standards that are aspirational, or standards that are not the direct responsibility of the team.

The full set of standards is aspirational, and it is unlikely that any team would meet them all. To achieve accreditation, a team must meet 100% of type 1 standards, 80% of type 2 standards and 60% of type 3 standards.

Our Aims

HTAS aims to ensure that people who experience mental health crises and their family/carers receive high quality care from their home treatment team, with fair access for all. We recommend that home treatment teams might achieve this by following some of our core principles:

- People experiencing a mental health crisis should receive timely care in the least restrictive environment suitable for them.
- Pharmacological and bio-psycho-social treatments should be considered equally.
- People experiencing a mental health crisis and their families or carers should be supported to be involved in making decisions about their care as fully as possible.
- Families or carers of those experiencing a mental health crisis should be supported appropriately in their own right, and involved with their loved one's care as much as possible.
- Nobody should be admitted to an inpatient mental health ward without the knowledge of the home treatment team.
- The home treatment team should work with staff from inpatient mental health wards to ensure that people are discharged from the ward as soon as clinically possible.
- Home treatment team staff should be appropriately trained and supported to carry out their jobs competently, safely, and with regard to their wellbeing as practitioners.
- Care from the home treatment team should be available to all regardless of age, disability, sex, gender reassignment, marital status, maternity, ethnicity, religion or sexual orientation, and the team should reach out to underrepresented groups.
- The home treatment team should have good links with other mental health and physical health services, and social care.

The Standards

Service Provision and Structure

Policies and Protocols			
No.	**Type**	**Standard**	**Ref**
1.	1	Clear information is made available, in paper and electronic formats, to patients, family/carer and healthcare practitioners on: • A simple description of the service and its purpose; • Clear referral criteria; • How to make a referral, including self-referral if the service allows; • Clear clinical pathways describing access and discharge (and how to navigate them); • Main interventions and treatments available; • Contact details for the service, including emergency and out of hours details. **Guidance:** *This information is co-produced with patients.*	1
2.	1	Staff members follow a lone working policy and feel safe when conducting home visits.	1
3.	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.	13
4.	1	Confidentiality and its limits are explained to the patient and their family/carer at the initial assessment, both verbally and in writing. The patient's preferences for sharing information with third parties are respected and reviewed regularly.	1
5.	1	All patient information is kept in accordance with current legislation. **Guidance:** *This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	1

6.	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment are performed in accordance with current legislation.	1
7.	1	Policies/protocols are reviewed *at least* every 3 years. **Guidance:** *This includes assessing for equality impact at least every 3 years, to ensure equality of service.*	2
8.	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency. **Guidance:** *This includes guidance about when to call 999.*	13
9.	1	The team follows a protocol to manage patients who discharge themselves against medical advice. This includes: • Recording the patient's capacity to understand the risks of self-discharge; • Putting a crisis plan in place; • Contacting relevant agencies to notify them of the discharge; • Following locally agreed protocols.	1
10.	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	1
11.	1	Staff members share information about any serious untoward incidents involving a patient with the patient themselves and their family/carer, in line with the Duty of Candour agreement.	13
12.	1	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	1
13.	1	There are policies and procedures for managing complaints.	2

14.	2	Services are developed in partnership with appropriately experienced patients and family/carers, who have an active role in decision making.	1, 3
Access			
15.	1	The acceptance criteria ensure that self-harm, substance misuse, dual diagnosis, learning disability or personality disorder are not barriers to appropriate team response.	2
16.	2	The team is able to triage direct referrals from people and/or their family/carer who are experiencing a mental health crisis of a nature and degree that would otherwise necessitate hospital admission.	3
17.	1	The team is able to respond to requests for gatekeeping assessments. **Guidance:** *This should include emergency departments, mental health liaison teams, GP's and mental health services.*	11
Initiating Assessment			
18.	1	The home treatment team, or another specialist mental health service, is able to undertake assessments 24 hours a day, 7 days a week. If an assessment is delegated to another service out of hours, the home treatment team is fully aware of those assessments and monitors their quality.	4
19.	1	The team has the capacity to allow for two home visits over a 24-hour period for each patient as clinically required ***Guidance:*** *A number of patients may require a minimum of two visits to monitor and administer medications and/or as part of identified clinical needs.*	3, 4
20.	2	The team provides patients and family/carers with information about expected waiting times for assessment and treatment.	1
21.	1	The team is able to conduct assessments in a variety of settings.	3, 4

22.	1	The team has an agreed response time for accepting referrals, and the outcome is agreed with the referrer. ***Guidance**: Response times must be agreed in line with current national guidance and/or as agreed with clinical commissioning group.*	1
23.	1	There is 24 hour access to interpreters who are sufficiently skilled to provide translation is available. **Guidance:** *In exceptional circumstances, and after careful consideration, family members may act as translators. Particular consideration is given to any young carers fulfilling this role.*	1, 13
Liaison and Interface with other Services			
24.	1	The team is able to refer to child and family support services including child protection.	2
25.	1	The team facilitates access to independent advocates to provide information, advice and support to patients, including assistance with advance statements.	2
26.	1	Patients with drug and alcohol problems have access to specialist help e.g. drug and alcohol services.	2
27.	1	There is a written acute care pathway which has been locally developed and agreed, that ensures continuity of care between services. **Guidance:** *This includes interactions with primary care, emergency departments, community teams and inpatient care, psychiatric intensive care units and crisis beds.*	4
28.	2	Health records can be easily accessed by other teams who may be involved with the patient's care during the episode. **Guidance:** *This could include psychiatric liaison teams, emergency departments, acute inpatient wards and primary care.*	5

29.	1	The service/organisation has a pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.	1
30.	1	There is active collaboration between Children and Young People's Mental Health Services and Working Age Adult Services for patients accessing the home treatment team who are approaching the age for transfer between services.	1
31.	1	Outcomes of referrals are fed back to the referrer. If a referral is not accepted, the team advises the referrer of alternative options. The rationale and discussion are documented in the patient's notes.	1
32.	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.	1
Liaison with Inpatient Care			
33.	1	The team works closely with acute inpatient care, including gatekeeping and facilitating early discharge. **Guidance:** *This can be achieved by operational policies, ward rounds, joint acute care reviews, supported leave arrangements, sharing the same base location, shared consultant responsibility or shared acute care workers.*	3, 4
34.	1	The team gatekeeps all acute inpatient beds. **Guidance:** *This must be achieved by a face-to-face contact and/or is at discretion of the team, once a face-to-face contact has taken place.*	5
35.	2	If hospitalisation is required, the patient is informed of the reasons why home treatment was not appropriate, the purpose, aims and outcome of the admission.	3

36.	1	The patient and their family/carers are involved in discharge planning from acute inpatient services to the home treatment team.	3
37.	2	The team offers home treatment on transfer from acute inpatient services within 24 hours of discharge, where clinically indicated.	3, 4
Liaison with Community Mental Health Services			
38.	1	The home treatment team is able to transfer care to a community mental health team as required.	7
39.	2	Local information systems are capable of producing accurate and reliable data about delayed transfers from the home treatment team to the community mental health team, and action is taken to address any identified problems.	7
40.	2	Teams provide specific transition support to patients when their care is being transferred to another community team, or back to the care of their GP.	1
41.	1	When patients are transferred between community services there is a handover which ensures that the new team has an up-to-date care plan and risk assessment.	1
42.	3	When patients are transferred between community services there is a meeting in which members of the two teams meet with the patient and their family/carer to discuss transfer of care.	1
43.	2	There is a clear system for regular sharing of key clinical information between the team and inpatient and community teams. **Guidance:** *This could include regular meetings with inpatient and community services or sharing of information via an agreed pathway.*	3
Audit			

44.	2	The team continuously audits service provision and outcomes, including feedback from patients and their family/carer.	2, 3, 5
45.	2	The standard of care provided is audited to ensure it is consistent 24 hours a day, 7 days a week. **Guidance:** *Standards should be maintained if fewer staff work out of hours, or if the responsibility for home treatment passes to another team out of hours.*	5
46.	2	The team actively encourage patients and carers to be involved in quality improvement initiatives.	1
47.	1	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. **Guidance:** *Written information is offered to patients and family/carers about how to give feedback to the team, including compliments, comments, concerns and complaints.*	1
Crisis Houses			
48.	3	The team has access to a crisis house.	7
Please Note: If standard 48 is 'Not Met', the following standards are not applicable.			
49.	1	The team liaises with crisis houses. **Guidance:** *This should include communication protocols, visiting frequency, reviews, etc.*	7
50.	1	Clinical responsibility while the patient is in a crisis house is clearly defined.	7
51.	1	Responsibility for the storage and administration of medication while the patient is in a crisis house is clearly defined.	7
52.	1	There are arrangements for emergency medical care while the patient is in a crisis house.	7

Staffing and Training

No.	Type	Standard	Ref
The Multidisciplinary Team (MDT)			
53.	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	1
54.	2	Appropriately experienced patient or family/carer representatives are involved in the interview process for recruiting staff members.	1
55.	1	The team has a team lead.	3
56.	1	The team has dedicated registered mental health nurse(s).	3
57.	2	The team has dedicated social worker(s).	3
58.	2	The team has dedicated support worker(s). **Guidance:** *For example, healthcare assistant, occupational therapist support worker, psychology assistant, etc.*	3
59.	2	The team has dedicated pharmacist(s).	5
60.	1	The team has dedicated consultant psychiatrist(s).	5, 7
61.	3	The team has dedicated non-medical prescriber(s).	8
62.	1	The team has input from occupational therapists. **Guidance:** *To provide an occupational assessment for those patients who require it; to ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs.*	1

63.	2	The team has access to peer support worker(s). **Guidance:** *A patient or carer representative employed by the team to support other patients and/or carers.*	3
64.	1	The team has access to approved mental health professional(s) (AMHPs).	5
65.	1	The team has access to administrative assistance to meet their needs.	3, 9
66.	1	The team has input from psychologist(s). **Guidance:** *The psychologist working in the team play many different roles, from direct work with patients through to indirect work. They ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway.*	1,10
Induction, Appraisal and Supervision			
67.	1	All staff receive a formal induction programme, by the end of which they understand the functions of the team, including the principles of home treatment services.	3
68.	1	All staff receive a formal induction programme, by the end of which they understand the functions of the team, including the home treatment model and its implementation in the local context.	4
69.	1	All staff receive a formal induction programme, by the end of which they understand the functions of the team, including the roles and responsibilities of team members and staff in other services.	4
70.	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. **Guidance:** *This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.*	1

71.	2	All new staff members are allocated a mentor to oversee their transition into the team.	1
72.	1	All staff have an annual appraisal and personal development planning.	2
73.	1	All clinical staff members receive individual clinical supervision at least monthly, or as otherwise specified by their professional body. **Guidance:** *Supervision should be profession-specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications.*	1
74.	2	All staff members receive individual line management supervision at least monthly.	1
75.	3	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet to think about team dynamics and develop their clinical practice.	1
76.	2	Team managers and senior managers promote positive risk-taking to encourage patient recovery and personal development. They ensure staff members have appropriate supervision and MDT support to enable this.	2
77.	2	The whole team meet monthly to discuss service development. The meeting is structured to ensure staff can contribute meaningfully to discussions.	5
78.	1	The service actively supports staff health and well-being. **Guidance:** *For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	1

79.	1	All staff members are able to take breaks during their shift that comply with the European Working Time Directive. **Guidance:** *They have the right to one uninterrupted 20 minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	1
80.	1	All staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	1
81.	2	Staff take part in team building on an annual basis, training in colleague support and working within the team framework.	3
Staff Training			
82.	1	All staff have completed their statutory and mandatory training. **Guidance:** *This includes equality and diversity, information governance, basic life support.*	1
83.	2	All staff have received training in delivering crisis resolution/home treatment interventions. **Guidance:** *This may include psychosocial interventions, conflict resolution, activity scheduling, solution focussed brief therapy, family and social systems interventions, values-based practice, and skills to respond appropriately to self-injurious or suicidal behaviour.*	3
84.	2	All staff have received training in carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	1

85.	1	All staff who administer and/or deliver medication have received training as required by their role and are assessed as competent on an annual basis. **Guidance:** *This could include storage, administration, legal issues, encouraging concordance and awareness of side effects and secure handling of medications and stationery (e.g. FP10).*	3
86.	1	All staff have received training on the use of legal frameworks, including the Mental Health Act (or equivalent) and Mental Capacity Act (or equivalent).	1
87.	1	All staff have received training on safeguarding vulnerable adults and children. **Guidance:** *This includes recognising and responding to the signs of abuse, exploitation or neglect.*	1
88.	1	All staff have received training in risk assessment and risk management. **Guidance:** *This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.*	1
89.	2	All staff have received training in alcohol and substance misuse.	2
90.	2	Patients and family/carers are involved in delivering staff training face-to-face.	1, 2
91.	1	All staff have received training in physical health assessment which includes; understanding physical health problems, physical observations, when to refer for specialist input and an awareness of co-morbidities.	1, 5
92.	1	Staff have received training in recognising and communicating with patients with cognitive impairment or learning disabilities.	1

Assessment, Care Planning and Treatment

Assessment			
No.	**Type**	**Standard**	**Ref**
93.	1	The assessment includes a screening to establish if home treatment is appropriate for the patient and their family/carers.	3
94.	1	The patient's primary carer(s) or nearest relative(s) are identified and recorded.	10
95.	2	The patient is asked who they would like to be present during the assessment and their family/carers and relevant others, e.g. their GP, are invited to be involved in the assessment. Possible relationship tensions are considered when organising the assessment.	3
96.	2	The team ensure that the patient and their family/carers understand the purpose of the assessment.	3
97.	2	The patient is informed at the assessment that home treatment is a brief intervention, the expected length of time they would be involved with the team and the nature of the team approach.	5
98.	1	Patients receive a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development; • Suicide risk.	1
99.	1	The routine assessment includes an investigation into the nature of the crisis, and the presented problems.	3
100.	1	The routine assessment includes the identification of the clinical signs and symptoms, including ability to self-care, if mental health problems are found.	3
101.	2	The routine assessment includes a social assessment. **Guidance**: *This includes education and employment.*	5

102.	2	The routine assessment includes the identification of immediate social stressors and social networks. **Guidance:** *If this is not possible at the first point of contact, it should be completed as soon as possible as part of the ongoing assessment.*	3
103.	2	The routine assessment includes psychiatric history including past records and family history. **Guidance:** *If this is not possible at the first point of contact, it should be completed as soon as possible as part of the ongoing assessment*	3
104.	1	A physical health review takes place as part of the initial assessment, or as soon as is practically possible. **Guidance:** *The review includes but is not limited to: Details of past medical history; Current physical health medication, including side effects and compliance with medication regime; Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use.*	1
105.	1	Staff members arrange for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan.	1
106.	1	The routine assessment includes a multidisciplinary assessment of the patient's needs.	3
107.	1	The routine assessment includes identification of dependants and their needs, including childcare issues, and any young or adolescent carers, and other people affected by the crisis and associated risk to them. **Guidance:** *This includes the names and dates of birth of any young people. If this is not possible at the first point of contact, it should be completed as soon as possible as part of the ongoing assessment.*	2, 3
108.	2	The routine assessment includes planning for supported transition to other services.	2
109.	1	All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	1

110.	1	The patient and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment. **Guidance***: A second opinion can be sought from within or outside of the team.*	1
Risk Management			
111.	1	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.	1, 3
112.	1	Risk assessments and risk management plans are updated according to clinical need or at a minimum frequency that complies with national standards.	1
113.	2	Family/carers are routinely offered the opportunity to meet separately from the patient to discuss risk management, where appropriate.	5
114.	1	If a patient does not attend for an assessment, the assessor contacts the referrer. **Guidance:** *If the patient is likely to be considered a risk to them self or others, the team contacts the referrer immediately to discuss a risk action plan.*	1
115.	1	The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient.	1
116.	1	While identifying patients for home treatment to facilitate early discharge, consideration is given to the increased risk of suicide post-discharge from hospital.	11

Care Planning			
117.	1	The team works within the CPA Framework, or equivalent.	2
118.	1	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy. **Guidance:** *The care plan clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *Measurable goals and outcomes;* • *Strategies for self-management;* • *Any advance directives or statements that the patient has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework.*	1
119.	1	The patient and their family/carer (with patient consent) are offered a copy of the care plan and the opportunity to review this.	1
120.	2	Patients' existing crisis plans are identified, utilised by the team and shared with family/carers where appropriate, in the event that they require home treatment.	2
121.	1	Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	1
122.	3	A Wellness Recovery Action Plan (WRAP), My Crisis Plan, or similar, is offered to all patients. **Guidance:** *These plans focus on the patients' strengths, self-awareness, sustainable resources, support systems and distress tolerance skills and should reference the management of transitions.*	2
Medicines Management			
123.	1	The team has a nominated medicines management lead.	8

124.	1	There is a written policy governing self-administration of medication, including supervision of the patient and recording.	8
125.	2	There is a written policy governing the removal and gradual reintroduction of medicines in situations where there is an acute risk of suicide or self harm.	8
126.	2	Everyone under the care of the team has a medicines chart, and all medicines that are administered or supervised by the team are recorded on the chart.	8
127.	2	The team has rapid access to medication, 24 hours a day.	8
128.	1	The team has 24 hour access to prescribing advice from a consultant psychiatrist or independent NMP.	8
129.	2	On admission to the home treatment team, a team member will obtain a medication history from the patient, as well as contact the patient's GP and carer or get access to Summary Care Record to obtain a copy of their medicines records as per Trusts Medicines Reconciliation policy. **Guidance:** *This includes current medicines for mental and physical health, medicines history, recent laboratory results and any other issues which may impact on medicines.*	8
130.	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	1
131.	1	Patients who are prescribed mood stabilisers or antipsychotics are offered and encouraged to have the appropriate physical health assessments at the start of treatment and continued as per NICE guidance. **Guidance:** *This will need to be communicated to the community mental health team or the GP to continue the physical monitoring on discharge.*	1

132.	1	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. **Guidance:** *Side effect monitoring tools can be used to support reviews.*	1
133.	2	The plan for managing medication concordance is agreed with family/carers and reviewed regularly.	3
134.	1	Patients (and their family/carers, with patient consent) are helped to understand the purpose, expected outcomes, interactions, limitations and side effects of their medications and to enable them to make informed choices and to self-manage as far as possible.	8
135.	3	Patients, family/carers and prescribers are able to contact a specialist pharmacist and/or pharmacy technician to discuss medications.	1, 8
136.	1	When a patient is discharged from the home treatment team, a detailed account of the medicines prescribed is provided to their community mental health team, GP and the patient. This should include with reasons for all new medicines started, doses increased or reduced, and all medicines stopped.	8
Psychosocial Interventions			
137.	1	The team provide a repertoire of evidence based psychological interventions. **Guidance:** *This may include, anxiety management, relapse prevention, de-escalation intervention, graded exposure and crisis resolution*.	9
138.	2	Patients and their families/carers can be signposted to gender-specific services. **Guidance:** *For example, women- or men-only groups.*	3, 10

139.	2	The team is able to provide a range of therapies to patients and their family/carers based on need. **Guidance:** *Interventions could be drawn from the following approaches:* *1. Cognitive Behavioural Therapy (CBT) approaches including Dialectical Behaviour Therapy (DBT) and Mindfulness-Based Cognitive Therapy (MBCT)* *2. Psychodynamic approaches including Interpersonal Psychotherapy (IPT) and Cognitive Analytic Therapy (CAT)* *3. Psycho-educational approaches* *4. Solution-Focused Brief Therapy (SFBT)* *5. Problem-Solving approaches* *6. Family Interventions for Psychosis* *7. Motivational Interviewing* *8. Person-Centred approaches* *9. Systemic approaches* *10. Stress management* *11. Supportive counselling* *12. Relapse prevention.*	3
140.	1	Staff members who deliver therapies and activities are appropriately trained and supervised.	1
141.	1	The team supports patients to undertake structured activities such as work, education and volunteering. **Guidance:** *For patients who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes. This is managed through the care plan.*	1
142.	2	The team supports patients to continue to attend community resources where this has been assessed for risk, such as faith communities and Alcoholics Anonymous.	2
Discharge Planning			
143.	1	Involvement of the team is time-limited, and people are discharged when acute care is no longer necessary.	3
144.	2	The home treatment team begins discharge planning at the point of assessment, and this is communicated to relevant parties.	3

145.	2	The team is able to facilitate discharge and transfer of care to an appropriate service, dependent on clinical situation and local service provision. **Guidance:** *This could include primary care, community mental health services, early intervention teams, continuing care and other mental health services.*	3
146.	2	The patient and their family/carers (where appropriate) are informed as early as possible of when their care is going to be transferred from the team.	5
147.	1	A clear discharge plan is given to the patient on discharge and sent to all other relevant parties within 48 hours of discharge. This plan includes details of: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • When, where and who will follow up with the patient as appropriate.	1
148.	2	Families/carers are informed and involved when discharge is planned, if consent has been given by the patient. **Guidance:** *This includes what contact they can expect and how to plan themselves for the event.*	5
149.	1	Clinical outcome measurement data is collected at assessment and discharge, as a minimum. Staff can access this data.	1, 5
150.	2	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	1

Patient and Family/Carer Experience

Contact with Patients and Family/Carers			
No.	**Type**	**Standard**	**Ref**
151.	1	The team contacts the patient and their family/carers to agree on contact times, frequency and duration of contact, and ensures they are informed about unavoidable delays.	1, 2, 5
152.	2	The patient reaches an agreement with the team about where they would like their assessment to take place and the team is able to conduct visits remotely. **Guidance:** *Visits could be conducted via, for example, Skype or FaceTime.*	3, 5
153.	1	Patients and their families/carers are given a direct contact number to access help, 24 hours a day.	2, 3
154.	1	Staff have their ID badge available on their person whilst working.	1
155.	1	Patients feel treated with compassion, dignity and respect, listened to and not stigmatised by staff. **Guidance:** *This includes respect of a patient's age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.*	1, 5

Information for Patients			
156.	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. This includes: • Their rights regarding consent to care and treatment; • How to access advocacy services (including independent mental capacity advocate and independent mental health advocate); • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.	13
157.	1	Patients are given verbal and written information on their rights under the Mental Health Act if under a community treatment order (or equivalent) and this is documented in their notes.	13
158.	1	Patients are asked if they and their family/carers wish to have copies of letters about their health and treatment. **Guidance:** *This should be achieved in line with the national policy or the NHS trust guidance about copying letters to patients and family/carers.*	1, 3
159.	1	The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	1
160.	2	Written information is offered to patients and their families/carers about transitional support services. **Guidance**: *This includes mentoring, befriending, mediation and advocacy.*	2

161.	1	Patients are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan.	1
162.	2	The team can signpost on to agencies who will advise on how to create an advance directive, if requested.	5
163.	1	The team supports patients to access: • Housing support; • Support with finances, benefits and debt management; • Social services.	1
164.	2	Before discharge, crisis plans are reviewed and explained to the patient, with the involvement of their care coordinator (where allocated), and support is provided to complete these.	2
Support for Family/Carers			
165.	1	There is a designated staff member to support carers.	1
166.	1	Family/carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	1
167.	2	Family/carers are offered individual time with staff members to discuss concerns, family history and their own needs.	1
168.	2	The team provides each carer with accessible carer's information. **Guidance:** *Information is provided verbally and in writing (e.g. carer's pack). This includes:* • *The names and contact details of key staff members in the team and who to contact in an emergency;* • *Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	1
169.	2	The team creates a plan around the whole family/group of carers, so that responsibilities of care are divided fairly.	3

170.	1	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. **Guidance:** *This advice is offered at the time of the patient's initial assessment, or at the first opportunity.*	1
171.	3	The service actively encourages carers to attend carer support networks or groups.	1, 10
172.	1	If the carer is 25 or under, contact with Young Carer, or Young Adult Carer services is facilitated.	10
173.	2	The team ensures that children and other dependants are supported appropriately.	10
174.	2	Families/carers are given information on mental health problems, what they can do to help, their rights as carers and an up to date directory of local services they can access.	10
175.	1	The team knows how to respond to carers when the patient does not consent to their involvement.	1

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Glossary

Activity scheduling: A behavioural therapy for depression which encourages scheduling activities which improve mood.

Acute inpatient care: Care provided on a residential psychiatric ward in a hospital.

Administer medication: To prepare and check medications, ensuring that the right amount goes to the right person at the right time.

Advance statement/directive: A document drawn up by a patient when they are well, saying how they want to be cared for if they become unwell.

AMHP: Approved Mental Health Professional. Staff trained in the use of the Mental Health Act.

Carer: A person who looks after a person with mental health problems. In this document usually refers to an informal carer, e.g. a relative or friend.

Carer link/lead/champion: A staff member within a team nominated to promote the recognition of, and support for, carers.

Carer Support Service: A local service which may provide information, individual support and peer support for carers.

CAT: Cognitive Analytic Therapy. A 'talking therapy' which aims to identify and change patterns of behaviour which lead to a target problem.

CBT: Cognitive Behavioural Therapy. A 'talking therapy' focussing on challenging and changing negative thoughts and behaviour patterns.

Clinical supervision: Clinical supervision provides an opportunity for staff to; reflect on and review their practice; discuss individual cases in depth and change or modify their practice and identify training and continuing development needs.

Conflict resolution/de-escalation: Resolving a conflict situation and preventing it from becoming a major incident.

CPA: Care Programme Approach. A way of coordinating care for people with mental health problems and/or a range of different needs

CPN: Community psychiatric nurse. A nurse specifically trained in mental health problems who sees people outside of hospital.

Crisis: An episode of mental illness which is severe enough that the person experiencing it would usually be admitted to hospital.

Crisis bed: A bed in a non-hospital residential home (see crisis house).

Crisis house: A non-hospital residential home for people experiencing an episode of severe mental ill health. Stays are short term and provide a break for family/carers.

Crisis plan: A document drawn up by a person when they are well, usually with their Care Co-ordinator. It includes relapse warning signs, what they can do to manage the situation themselves, who to contact and when, and what has been helpful and unhelpful in the past

Crisis resolution/home treatment team: Some teams call themselves 'crisis resolution', others call themselves 'home treatment', and some are both. These teams all treat people with severe mental health problems outside hospital - in their own homes or in suitable residential facilities.

DBT: Dialectical Behaviour Therapy. A 'talking therapy' involving acceptance of the patient's present feelings, changing behaviours such as self harm or attempts to take one's own life, and mindfulness or meditation exercises.

Dependents: Children or adults who depend on a person (i.e. the patient) for everyday care.

Dual diagnosis: Experiencing both severe mental illness and problematic drug and/or alcohol use.

Early intervention team: A team which works with people who are at risk of, or currently experiencing, their first severe mental health episode.

Family and social systems therapy: Therapy that takes into account a patient's social connections and how these may worsen their mental health, or improve it

Gatekeeping: Where a home treatment team provides a face-to-face assessment to anyone at risk of admission to a psychiatric ward, to ensure they are treated in the least restrictive environment possible. Home treatment is provided as an alternative to hospital.

Graded exposure therapy: A 'talking therapy' addressing anxiety and phobia by gradually exposing a patient to the threatening situation under relaxed conditions until the anxiety is gone.

Independent advocate: A person who helps views of patients to be heard by service managers and protects vulnerable people.

Management supervision: Usually a one-to-one meeting in which a staff member is supported by a more senior staff member to reflect on their work practice.

MDT: Multidisciplinary team. A team made up of different kinds of health professionals.

Mediation: Mediators act as a go-between for people with legal disputes. Some are trained in helping people with mental health problems.

Mental Health Act: A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interest or for the safety of themselves or others.

Mental health advocacy: A group of people with similar experiences who meet to discuss and put forward shared views to service managers.

NICE: National Institute for Health and Clinical Excellence. Publishes guidance for health services

NMP: Non-medical prescriber. Health practitioners other than doctors who are qualified to prescribe medicines.

OT: Occupational therapist. They aim to promote independence by providing help for people to complete activities in daily life.

Peer support worker: A patient or carer employed by the team to support other patients and/or carers.

Positive risk taking: Allowing people to take responsibility for their actions, to empower them and to improve understanding of decision making and consequences.

Primary care: Usually the first port of call for health problems. Includes general practitioners (GPs), dentists, community pharmacies and high street optometrists.

Psychosocial interventions: Therapies that do not use drugs. Psychological or social techniques which are used to improve mental health.

Single point of access: All referrals are sent to one place, instead of to specific services. A central team assesses the referrals and decides which service they are most appropriate for.

Solution focussed brief therapy: A therapy focussing on the present and future and what a patient can achieve.

Support worker: An unqualified professional, e.g. healthcare assistant, occupational therapy support worker, psychology assistant, etc.

Triage: To screen information about a person referred to a service to see if they are appropriate for the service.

WRAP: Wellness Recovery Action Plan. A document designed with the patient, stating everyday activities they can do to keep well, and triggers or warning signs that they are becoming unwell

Young Carers Service: A service which may provide information, individual support and peer support for carers under the age of 25.

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