



QN-CRHTT

QUALITY NETWORK FOR
CRISIS RESOLUTION AND
HOME TREATMENT TEAMS

Practice Guidelines for Crisis Line Response and Crisis Resolution and Home Treatment Teams

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Foreword

The Quality Network for Crisis Resolution and Home Treatment Teams (QN-CRHTT) at the Royal College of Psychiatrists undertakes quality improvements initiatives, including setting out standards for crisis resolution and home treatment teams (CRHTTs).

CRHTTs over the last two decades have continued to be adapted to the needs of the local systems in the United Kingdom with variations in models.

CRHTT services may face various challenges due to pressure on services. To ensure the highest quality of clinical care for patients under CRHTT services, as part of the quality improvement initiative, QN-CRHTT has undertaken a consultation, leading to the development of guidance that has received a wide range of input from mix of multidisciplinary staff including consultant psychiatrists, nurses, social workers, psychologists, commissioners and representatives from NHS England.

Within various teams, there are good examples of delivering clinical care. As an example of one way of working, the practice outlined in the guidance draws upon the evidence-based principles and is also based on clinical expert consensus.

Overall, this guidance intends to support practice implementation of CRHTTs. Adoption of a good quality framework that not only reflects the CRHTTs role in promoting clinical effectiveness but most importantly has a significant value in improving patient care.

During the process of the development of this document, we have received remarkable feedback in terms of the value of this resource. We hope that future revisions will continue to be benefited from further feedback.

I would like to thank those involved in the consultation and development of this guidance. I am also grateful to the QN-CRHTT and CCQI team for all their work in organising and supporting this quality improvement initiative.

Dr Pranveer Singh
QN-CRHT Advisory Group Chair
Lead for guidance development

Purpose and scope of the guidance

This guidance provides a model framework that could be adapted in practice for the varying models of services that provide urgent and emergency response, crisis resolution and home treatment, to people experiencing a mental health crisis.

The purpose of this practice guidance is to:

- Help services to improve their support for parents with crisis and their carers/families;
- To contribute towards improving the quality of care and service delivery within crisis services by way of potential adoption of practice principles as outlined in the guidance.

The first section is dedicated to the crisis response lines that have been established over the last few years within England.

The second section provides practice guidance for the home treatment teams that have been established since year 2000.

It is relevant to people with mental health problems, regardless of the type or severity of the problem, or presence of comorbid drug/alcohol use or physical, neurodevelopmental or learning disabilities.

This guidance should be read alongside the QN-CRHTT standards available on our website.

Commissioners and providers wishing to gain an overview of how a high-quality crisis and home treatment care services are delivered would find the guidance beneficial while setting up and commissioning.

This guidance and the access and quality benchmarks set out within this guidance were developed based on NICE guidelines and quality standards, published literature evidencing best practice care, existing services demonstrating positive practice and expert consensus from stakeholders.

A list of Expert Reference Group members is provided at the end of this document.

Introduction

This document sets out a best practice procedure for the crisis resolution and home treatment teams (CRHTTs) day-to-day practice in relation to providing care for the patients referred to CRHTT.

The model of CRHTT functions and framework is locality based, adapted to suit the requirements of the local services and commissioning arrangements. However, the key principals behind the processes in this document are based on the principles set in NHS Mental Health implementation plan (2019/20-2023/24), and standards set by the QN-CRHTT.

Definitions

Throughout this document the term patient is used to describe people who are under the care of the team and receive treatment. Some people also use the term service user.

The term carer is used to describe a friend, family member or companion who supports a person with ill mental health.

Service description and models

CRHTTs since their establishment in 2000, have been subject to regular transformations. At the time of producing this guidance nationally, there are various models in place. However, an additional new function of providing a 24/7 response to urgent mental health crisis has been implemented over the last years. To provide this new function, in various places a new team such as first response team or crisis lines have been setup. In other places, the existing CRHTT has been provided additional funds to deliver the new 24/7 function.

The local system should work together to apply the local needs and current pathways to form a service model that provides 24/7 urgent response to mental health crisis. This should be based on principles of being an open access service that accepts self-referrals via 111 or locally agreed access numbers. The size of the service should be sufficient to ensure that evidence-based treatments are always available and there is adequate staffing. People experiencing a mental health crisis should be able to access and receive 24/7 care that meets their needs.

Urgent and emergency response service (crisis line response)

What is a mental health crisis?

A mental health crisis is self-defined as a severity where an urgent response from mental health services is required.

Aims and Objectives

The 24/7 service creates the ability to provide an emergency and urgent response that will align with the existing mental health services in the respective localities to ensure seamless pathways. The service will offer support and operate screening and triage assessment to identify the appropriate care option for people presenting in mental health crisis.

The service should provide an expert assessment 'within hours' for emergency referrals.

A 24/7 service will improve patient experience and outcome through:

- Providing a 24/7 single point of access via 24/7 crisis line (eventually via NHS 111) and enable self-referral for people requiring an urgent response from mental health services;
- Providing an initial telephone triage and support;
- Identification and referral on to appropriate care pathways as necessary;
- Providing a face-to-face response for people requiring an urgent and emergency assessment;
- Providing expert advice to the wider professional community;
- Providing support to carers and significant others who contact the 24/7 service;
- Improving access to services outside of A&E;
- Embracing the opportunity for innovative approaches to improving the quality of care and evidence-based approaches to providing care;
- De-escalation of the presenting 'crisis' and
- Improved service user experience, including feelings of being safe and supported and better access to community services.

All legal obligations must be adhered to, including:

- Duty of Care
- Mental Capacity Act
- Mental Health Act
- Safeguarding needs
- Equality Act.

If at any point, the police or blue light services become involved, the appropriate pathway for blue light services should be followed.

Inclusion and Exclusion Criteria

Inclusion criteria

A service must establish clear inclusion criteria. This may include people of working and older age experiencing a mental health crisis of a nature requiring an urgent or emergency response.

Exclusion criteria

The service should signpost people to other services who would not benefit from its input. For instance, those who are suffering from cognitive impairment or are under the influence of alcohol or substances that impairs their ability to engage in a mental health assessment. The service may be unable to initiate assessment for people who require an urgent physical health treatment rather than mental health input.

Referral pathways

A qualified practitioner will first undertake a brief initial screening assessment to determine an appropriate outcome by using the UK triage scale as a guide. This may include:

- Telephone support.
- Signposting to community resources, which may include alternative accommodation (sanctuaries).
- Liaising with current NHS trust services.
- Identification and arrangement of or for a face-to-face full assessment.
- Where a full face-to-face assessment is indicated, to determine whether it is an emergency assessment and a response in 0-4 hours is required or an urgent assessment where a response in 4-24 hours is required.
- Provide professional advice to other teams and services, where an emergency physical health need is identified to contact 999 emergency services.

When a person seeks help for a mental health crisis from a primary care service, the responding professional (for example, GP or practice nurse) should have access to help and advice from a mental health professional 24/7.

For individuals under the influence of substances, the service will use their clinical judgment to consider how beneficial a full triage would be at the time of the referral, it may be more suitable to arrange contact when the level of intoxication is decreased. In cases of immediate risks related to the patient's or others safety, consider liaising with appropriate services such as the police, street triage and ambulance services.

Should a Mental Health Act assessment be required, this should be discussed with the Clinical Team Lead and a referral is made to the Approved Mental Health Professional (AMPH) service.

Triage assessment and clinical pathways

Basic information to establish in the first contact with the person:

- Circumstances of the crisis, ascertain if an emergency or urgent response is required.
- Demographic information – i.e., name, address, date of birth.
- Ascertain where the person is and if they are currently safe.
- If known to current mental health services, check clinical records for any alerts and risk history.

- Complete a triage assessment including an initial risk assessment using an approved screening tool.
- Provide tele-consultation to de-escalate the person's immediate crisis.
- Referral and/or signposting to other services and/or providers.
- Recommend face-to-face assessment.
- Use of an appropriate triage resource such as the [UK Mental Health Triage Scale](#) to note the urgency of response.

Where a face-to-face assessment is required, it is recommended that the assessing team will deploy two clinicians to attend; this would ideally be at the person's location, though where increased risk is identified an alternate location can be identified, such as the team base or local hospital.

Where a patient is known to services and requires a face-to-face assessment, it is recommended to obtain collateral information from the treating team and/or conduct a joint assessment with their Care Coordinator where this does not delay an assessment being completed or disrupt current treatment plans.

Face-to-face assessments will be undertaken using trust/organisation approved initial and risk assessment tools, which will include physical health baseline screening.

The assessing staff will determine and agree with the person and carers the outcome plan and produce a written copy addressed to GP and all parties involved in the person's care. This may include:

- Offer of treatment to crisis cafes/Sanctuaries as appropriate.
- Signposting to community resources such as the Samaritans and other local support organisations.
- For patients requiring inpatient admission, an internal referral should be made to the CRHTT to review the patient's suitability and needs for CRHTT as an alternative to hospital admission.
- Informal admission.
- Referral to Approved Mental Health Practitioner (AMHP)/Emergency Duty Service (EDS) for a Mental Health Act assessment.
- Referral to internal and external mental health professionals and providers.
- Where an emergency physical health need is identified, to contact 999 emergency services.

Following the conclusion of the assessment of the person in crisis, the person is considered to be transferred/referred or signposted to appropriate services, being provided with the outcome or plan and onward referrals being made.

Planning continued care

Staff should decide whether further assessment, discharge, follow-up care and treatment or admission is appropriate and make any referral to the appropriate service. Ideally, referrals to other services should be accepted 24/7. However, if a referral to another service cannot be accepted immediately, the staff involved should ensure that the urgent and emergency mental health care plan meets the person's needs until the referral is accepted and follow-up arranged within a clinically appropriate timeframe.

Urgent and emergency mental health plans should be created jointly with the patient, submitted and made accessible to appropriate services, including primary care, within 24 hours.

Providing a compassionate, supportive and least restrictive response

A mental health crisis differs from person to person, and may include feeling extreme emotional distress, high levels of anxiety, disinhibition, thoughts of self-harm or taking one's own life. Some people in crisis experience unsettling deviations from reality such as hallucinations or hearing voices, both of which may be unpleasant and can evoke fear and paranoia. Therefore, it is vital that professionals responding to people in mental health crisis provide an appropriate, compassionate and empathetic response to support the person.

CRHTT staff should receive appropriate training to allow them to respond non-judgementally, with compassion and understanding to patients and carers. There are occasions when the use of restrictive options such as immediate response from the police, ambulance or mental health assessment may be most appropriate to ensure the health, safety and well-being of the person in crisis and/or others. However, staff should always strive to follow the least restrictive route to provide care and support, where possible.

Providing individualised person-centred care

All pathways should be tailored to an individual's personal circumstances, particularly taking into account culturally specific beliefs, needs and values. Where the pathway does not fit the person's circumstances, clinical/professional judgement and the person's wishes should be used to provide the most appropriate care, with the person at the centre.

If the person's presentation changes, for example, if there is an alteration in their physical health (including any problem related to intoxication), a different pathway

might need to be followed. If at any point, the police or other blue light services become involved, the appropriate pathway for blue light services should be followed.

Providing psychologically informed care

A psychologically informed approach focuses on understanding the interacting psychological and emotional aspects of life that contribute to behaviour, relationships and well-being.

Providing support for family members and carers

Families and carers of people in crisis are likely to experience emotional strain, stress and may feel unsupported when using services. Access to someone who can provide advice, support or 'lend a helping hand' to families and carers is often what is needed most, and research shows working closely with families of people with mental health problems can improve suicide prevention and reduce a person's level of risk.

As part of delivering timely and compassionate care, and in line with the Care Act 2014, family members and carers should be supported in accessing carers assessments and/or family support services. Families and carers should be included in developing any plan to support the person. For example, providing a carers information pack and offer of time to talk to carers.

Providing a plan

All patients should have a jointly developed plan of care. This could be an urgent and emergency mental health care plan, developed as part of the pathway. If a patient already has an existing care plan, this should also be utilised. It may be appropriate to amend, update and review the existing plan to fit the current situation. All plans should first and foremost be person-centred and should involve families and carers where appropriate. Principles of shared-decision making should be followed. A copy should be made easily available to the person and their family, carer or support network as appropriate.

Mental capacity

Staff working with people experiencing a mental health crisis should be aware of issues and legislation relevant to capacity, consent and information sharing as outlined in the Mental Capacity Act and Mental Capacity Act Code of Practice and refer to these for further guidance on this topic. Staff should consider a person's capacity while initiating care and at each decision-making point.

Particular attention should be paid to sections 1–6 of the Mental Capacity Act, in order to understand legal duties as well as limitations. While involvement of families or carers is encouraged throughout the pathway, a person in mental health crisis may refuse to give consent for professionals to contact them. If a person is considered to lack capacity to make this decision, professionals may still contact the family or carer if it is in the person's best interests. A best interest decision would need to be made and recorded under the Mental Capacity Act.

Where a person lacks capacity in line with the Mental Capacity Act, all attempts should be made to contact someone from the person's support network, (such as a family member or carer) who knows the person and their wishes, to make sure the urgent and emergency mental health plan is appropriate.

Safeguarding

Staff should always have the patient's well-being and safety in mind. All staff have a duty to raise a safeguarding concern when they are concerned that a vulnerable person is experiencing or is at risk of experiencing abuse or neglect. Safeguarding enquiries should be undertaken as part of the biopsychosocial assessment and any safeguarding concerns should be addressed in a timely manner in conjunction with social care services. Specific attention should be paid to the needs of older adults in the interest of safeguarding. Appropriate action should be taken to assess and act upon the needs of any children and young people or dependants. The Care Act 2014 should be observed; the Social Care Institute for Excellence (SCIE) has published information for implementing the Care Act 2014.

Managing intoxication or withdrawal due to alcohol or drug use

Mental health crises are often caused, precipitated or complicated by the use of alcohol or other substances. As a general principle, intoxication, any drug or alcohol problems, or coexisting conditions (that is, any mental health problem that occurs alongside the alcohol or drug use) must not prevent people in crisis from accessing physical or mental health services. Intoxication by, or withdrawal from drugs and/or alcohol, should never be used as a reason to exclude a person from receiving mental health crisis care. This is particularly vital as death by suicide is common in people with experiencing mental health problems, who also have a history of drug and alcohol use.

However, it should not be assumed that all people who present to services and are intoxicated, need mental health care. If the patient's physical well-being is at significant risk due to use, intoxication or withdrawal and the person cannot be appropriately cared for within a community setting, arrangements should be

made for the person to attend the emergency department (ED). The severity of the intoxication or withdrawal might necessitate emergency medical care regardless of whether a mental health problem is suspected. This is the case whether the person is dependent on drugs or alcohol, severely intoxicated, or experiencing an adverse physical reaction due to use or withdrawal (drug or alcohol use history notwithstanding).

If the person experiencing a possible mental health crisis is intoxicated by drugs and/or alcohol but they are not considered to be at significant physical risk, sometimes it may be challenging to ascertain what kind of mental health support is necessary. However, an appropriate response may be to undertake a risk assessment, if possible, with a focus on their physical environment, and if a safe plan can be made encourage them to contact the service again the following day once they are not intoxicated. Depending on the situation and risks, the police may need to be contacted depending on the level of risk and professional and/or clinical judgement about the need for this.

Choosing an assessment site for undertaking face-to-face assessment

The choice of location for assessment should be taken after a risk assessment of both the patient and the site to be used and consent obtained. Most patients will prefer to be seen at home but for some patients an alternative location such as a nearby clinic room or GP practice is preferred. For some patients where there are concerns about the safety of the assessing team a clinical space will be preferred. The patient's family members and carers should be involved in choosing the assessment site and should take part in the assessment process, where appropriate. If a patient needs to be assessed somewhere other than on private premises, another locally agreed appropriate and safe environment should be used.

The assessing team will remove themselves from the assessment at any point, where they feel personal safety may be compromised. It is the responsibility of the staff members to ensure that they make use of lone working protocols in line with the local policies and procedures.

The assessing team will ensure that accurate up-to-date information is ascertained during the initial assessment, including a collateral history from the patient's family members, carers or next of kin where possible.

The use of prescribed medication i.e. PGD's/or assessment by Non-Medical Prescribers may be offered where appropriate and when it will support the patient's immediate needs.

The completed face-to-face assessment will be sent to the patient's GP and other identified professionals involved in the patient's care preferably by the next day. Where immediate information exchange is required, a verbal report will be made or a brief email sent.

The local systems should have a process for team decision making and escalation of complex or high-risk cases to ensure that senior clinical advice and support is available 24/7.

Where complex cases are identified a multi-professional discussion will be initiated, led by the Clinical Team Leads to agree an action plan.

Where a patient making contact with the 24/7 service whose permanent residence or GP is not within the local area, the local service to the patient's location will undertake the initial face-to-face assessment and if required make the necessary referrals on.

Crisis Resolution and Home Treatment Teams (also known as HTT)

Purpose

CRHTTs provide intensive support at home for individuals experiencing an acute mental health crisis as an alternative to hospital admission. CRHTTs gatekeep ALL requests for acute in-patient beds. They serve to facilitate good functioning of inpatient units by facilitating early discharge and reduce the length of hospital admissions.

Home treatment by definition is an appropriate alternative to hospital admission for working age and older adults with severe mental illness (e.g. Schizophrenia, manic depressive disorders, severe depressive disorder) with an acute psychiatric crisis of such severity that, without the involvement of a CRHTT, hospitalisation would be necessary. Such patients should be willing to receive home treatment which can be safely provided in their home environment.

Home treatment for crisis resolution:

- Be available over seven days a week.
- Provide home assessment, treatment, intervention and/or support as an alternative to hospital admission.
- Provide support to the care co-ordination function of the community teams to ensure appropriate service access and management of acute relapse.
- Provide short-term interventions and management of an individual's care during the period of acute relapse, including signposting to other services or other support services.
- Continue until the crisis necessitating input from the CRHTT has been resolved.

General principles

Treatment interventions, procedures and protocols will be evidence-based and, where appropriate compliant with the QN-CRHTT standards and NICE (National Institute of Clinical Excellence) guidelines.

Access and availability (Response of the CRHTT)

Referrals for home treatment interventions are accepted by the team from the following sources:

- Self-referrals/relatives/others (via the urgent and emergency response function).
- Ambulance/street triage/ED (via the urgent and emergency response function).
- General Practitioners (GPs).
- Community adult and old age mental health teams.
- Child and Adolescent Mental Health Services (CAHMS) (in case of teams providing care to children and adolescents).
- Approved Mental Health Practitioners (AMPH) service.
- On call doctors.
- Outpatient clinics.
- Mental health assessment unit.
- Liaison psychiatry teams.
- Inpatients.
- Section 136 suites.

Mode of referral

Telephone referrals to CRHTTs are accepted from a professional who has seen the person within the last 24 hours and has gathered as much clinically relevant information as they reasonably can. This allows for greater discussion, information exchange, decision making and prioritisation within the CRHTT.

Referrals must be made by direct telephone contact with the CRHTT.

Referrals made without prior telephone discussion by fax, e-mail or letter will not be accepted. Patients should not be promised prior to agreeing with CRHTT that they would be followed up by CRHTT.

Under normal circumstances a member of the team making the referral should participate in a joint assessment with staff from the CRHTT.

Telephone referrals will be taken by the Shift Coordinator who will take all the details necessary to complete the appropriate CRHTT referral form. The process of taking the referral is normally sufficient for the purposes of screening and triaging the referral.

Under certain circumstances, if the referral is complex, the Shift Coordinator will discuss the referral with an appropriate senior practitioner within the CRHTT.

The Shift Coordinator will ensure that the referral is discussed within the team and that the arrangements for the assessment are made and communicated to the referrer.

After taking the details of the referral, it is anticipated that the initial response (contact with the patient) from the CRHTT will be completed within one to four hours. Any cases that are not contacted within this time should have a clearly documented rationale. The urgency and priority of the referral will ultimately be determined during the referral process.

There will be occasions where the CRHTT may be requested by the referrer to conduct a face-to-face review on the same day of the referral. The Shift Coordinator should consider any such requests on a case-by-case basis, taking into account any current and historical risk information. Where a decision is made to offer a patient a same day face-to-face assessment, the Shift Coordinator will consider the appropriate level of staffing to attend the assessment and assessing staff will ensure that all lone working procedures are adhered to.

In any circumstances where a request is made to CRHTT for assessment and the patient refuses to either see staff from the CRHTT, engage with the assessment process or becomes un-contactable, CRHTT staff should refer to the specific trust/organisation risk management guidance.

Referrals will be considered strictly against service criteria. This is to maximise the availability of service to those who are in greater need. The CRHTT will provide advice and information about those referrals that do not meet their criteria for acceptance into the service.

Information required for referral:

- Name;
- Address, including postcode;
- Contact telephone number and mobile if applicable;
- Date of birth;
- Next of kin contact details;
- GP;
- Rationale for referral;
- Need for interpreter;
- Presenting symptoms and circumstances;
- Relevant background information/history;
- Up to date risk assessment;
- Medication;
- Use of drugs/alcohol – current and historical;
- Whereabouts/support networks;

- Relapse signature;
- Expected input from CRHTT;
- Involvement with other services;
- Agreement of service user to CRHTT involvement.

The CRHTT requires that ALL risk information is passed on to them as part of the referral and communication process. Referrers are expected to be proactive in passing on this information.

CRHTT initial assessment/review

CRHTT initial assessments will be carried out at the most appropriate location, with the safety of CRHTT staff and the patients being considered paramount.

Most commonly the team's initial assessments are undertaken at the patient's home. Some patients may prefer to be seen at the mental health unit. In-reach assessments should be seen at the ward prior to discharge/leave.

Wherever feasible, all attempts should be made to undertake a joint assessment with the referrer. Particularly for patients who are repeatedly referred to CRHTT, efforts will be made to conduct a joint assessment with the care coordinator/referrer prior to taking on the patient onto the CRHTT caseload.

During the initial assessment, the assessing staff will establish whether the patient is deemed appropriate for a hospital admission and can be safely managed at home.

Following all assessments, the CRHTT worker/s involved will complete all of the standard assessment documents as listed below as a minimum:

- CRHTT initial assessment profile including the collateral history section.
- Risk assessment.

In circumstances where the above documents are not fully completed, then the reasons should be recorded and a plan for completing the above documents should be formulated.

It is the responsibility of the CRHTT staff to ensure that accurate, up-to-date information is collected at the initial assessment including **collateral history from patients' carer/family member wherever this is possible.**

The completed initial CRHTT assessment should be sent to the referrer, GP and all parties involved in the patients care including the outpatient consultant

psychiatrist where applicable, preferably by the next day. Where immediate information exchange is required, a verbal report will be made, or a brief email should be sent and followed up by the initial assessment.

The person(s) completing the assessment will communicate and discuss the assessment findings in the multi-disciplinary team (MDT) handover whenever applicable and with the Shift Coordinator and agree on outcomes and follow up care with the patients and carers.

Outcomes of the CRHTT assessment

After assessment, the assessors will draw up a care plan and risk management plan. Possible outcomes following CRHTT assessments include the following:

- Home treatment episode.
- Admission to mental health inpatient unit.
- No further follow-up from specialist mental health services (referred to GP with a plan for further management).
- Referred to and accepted by another mental health service.
- If, following an assessment home treatment is not indicated, then it is the responsibility of the CRHTT staff to inform the referring individual of the outcome and any possible recommendations/interventions necessary for follow-up the next working day.

If home treatment is not appropriate but a referral to another agency is indicated, then the CRHTT staff will ensure that this is effectively communicated to the referrer.

If an assessment is required under the Mental Health Act, the Approved Mental Health Professional (AMHP) has a responsibility to coordinate the process ensuring that every one's welfare is safeguarded in collaboration with CRHTTs, and the team will remain actively involved until their involvement is no longer necessary or required.

It is the responsibility of the CRHTTs to notify the GP and/or all professionals involved in patient's care in writing as outlined in communication section of this guidance.

Decisions related to CRHTT initial assessment should be agreed between the referrer and the CRHTT. Where the referrer and or assessor are in discrepancy regarding the outcomes of an assessment, there should be an escalation policy locally.

Home treatment provided by the CRHTT

Following a complete assessment and when a patient is taken into the caseload for home treatment, it is recommended that within 24-72 hours all patients will have:

- A comprehensive risk assessment.
- A physical health screen, with base line observations. Bloods, urinalysis and other investigations to be carried out as per clinician's judgment of outcome of handovers/clinical reviews.
- A fully negotiated and comprehensive care plan.
- A carers assessment referral initiated (if indicated).

Home treatment options will be appropriately planned by the team with the patient and their carer fully involved, with patient consent. Intervention options will be explored, and the possible consequences of each option discussed.

Patients and carers will be informed that throughout their care under the CRHTT, support is available seven days a week. The patient will also be informed that their individual care plan will be reviewed constantly in response to their (and their carers) changing needs.

All patients taken on for home treatment will be provided with a service leaflet that outlines the level of service they should expect to receive from the crisis team.

It is expected that patients are under the crisis home treatment for an average of three to six weeks. Consideration should be given to classify those who remain on the caseload for more than eight weeks as delayed discharges and such cases should be highlighted to the service manager to establish and address the reasons for the delayed discharge.

The team should be able to provide intensive treatment at home or in a non-hospital setting. This may initially include two or more daily contacts, which is then reduced to less than once daily when the patient is approaching discharge from the CRHTT. Where clinically indicated, the team should have the capacity to allow for two home visits over a 24-hour period (such as for purposes of medicine administration).

RAG rating

CRHTTs may use a RAG rating system to monitor treatment progress. Below is an example implemented in practice:

Red
• Initial assessment and risk assessment completed.

- Patient requires crisis intervention and qualifies for hospital admission unless agrees to work with CRHTT.
- Further assessment needed by Band 5 and above up until 72 hours.
- Need for referrals to other agencies identified (and initiated wherever certain and appropriate).
- Not suitable for closure.
- Requires MDT management.
- Low threshold for admission.
- For the first three days all patients are offered agreed contacts of which one should be face-to-face. Subsequently frequency of contacts reviewed in MDT handover/clinical review.
- This rating would reflect that the patient is still early on the treatment recovery pathway and remains with symptoms/presentation requiring ongoing home treatment. The rating should reflect that RED rated patients are still experiencing predominant symptoms of a mental disorder or crisis which is yet to respond to crisis interventions.

AMBER

- Referrals initiated to other agencies such as community services and psychological therapies.
- Home treatment interventions delivered by experienced qualified staff.
- Weekly review of care plan or as based on clinical judgment/risk.
- Referrals to other agencies initiated and progressing.
- This rating reflects that the patient has made substantial recovery on the crisis pathway and they are towards the completion of crisis and home treatment.

GREEN

- Aims of home treatment met.
- Referrals to other agencies completed.
- There is a good understanding why the crisis occurred and what may be required to avoid a re-occurrence in the future.
- Coping strategies have been explored with the patient and his/her career/family.
- Patients and the carers are clear about the withdrawal from the team and aware of the ongoing care arrangements involving the appropriate services or other relevant services, including re-directing back to primary care services.
- Patients and family members and carers should have the opportunity to comment on the service they have received and contribute to service improvement.
- Ready for conclusion from home treatment.

Care planning

People who have experienced a mental health crisis and have had contact with a mental health service should always have a jointly developed plan in place as an outcome. This could be an urgent and emergency mental health care plan, developed as part of the pathway, or it may be appropriate to follow any existing plan the person might have. It may be appropriate to amend, update and review the existing plan to fit the current situation. All plans should first and foremost be person-centred and should involve families and carers where appropriate. Principles of shared-decision making should be followed.

Following the identification of a patient's needs, a care plan for home treatment will be formulated with explicit details of the interventions that will be delivered.

The care plan should be shared with the patient and discussed where appropriate with carers and other staff involved in the patient's care.

The patient's care plan will be evaluated daily during the team's handover meetings and formally reviewed by the full CRHTT MDT during clinical reviews.

As part of the care planning process there will be particular emphasis on what needs to be achieved to facilitate discharge from the CRHTT.

Due to the approach used by CRHTTs, patients (and their carers) should be made aware of the likelihood of contact with several members of the team during the assessment and treatment period.

As soon as it becomes apparent that a patient will require ongoing care from secondary services, a referral for a care coordinator should be made by the CRHTT. The expectation is that allocation of a care coordinator by the respective team will be made within one week of this referral and the crisis team informed at the earliest opportunity. The care coordinator and the CRHTT will work jointly with the patient to facilitate transfer to the care of the care coordinator when CRHTT intervention is no longer indicated.

As part of the care planning process there should be ongoing reviews of the arrangements for facilitating home treatment including the frequency of visits.

Consideration should always be given to the patients and carers wishes, and in accordance with the most up-to-date risk information.

For patients subject to the Community Mental Health Framework for Adults and Older Adults (CTP in Wales, or equivalent), discharge should be planned in conjunction with the patient's care co-ordinator and whenever possible the care coordinator should be invited for a joint visit prior to discharge.

Upon discharge from the CRHTT, the CRHTT staff member completing the discharge will ensure full completion of the CRHTT discharge summary and will

ensure that this is forwarded to all professionals who will be involved in the patient care. The CRHTT keyworker has the responsibility to ensure that all relevant documentation has been completed and forwarded.

There are times when patients and their carers are anxious about being discharged by the CRHTT. It is therefore important that the process of discharge is adequately discussed during the care planning and implementation phase of care. Consideration should be given by the MDT regarding the timing, venue and persons present at the time of discharge from the home treatment caseload.

Where the patient does not appear to be responding to home treatment, or risk factors appear to be worsening (as perceived by the patient, their carer or professional staff from within the CRHTT or other involved teams), the CRHTT staff will sensitively discuss the option for hospital admission with both the patient and their carers.

Where the patient refuses an informal admission to hospital, this should be escalated to senior clinical lead and/or medical staff. If a decision is taken to conduct an assessment under the Mental Health Act, the Shift Coordinator will make the necessary arrangements to coordinate.

Crisis resolution focused interventions (part of the Community Mental Health Framework for Adults and Older Adults/CTP or equivalent)

Patients requiring CRHTT will receive crisis intervention in all domains identified as necessary to achieve crisis resolution.

Patients will be offered a variety of interventions within a **biopsychosocial framework** which could include the following:

- Crisis assessment and management
- Medical reviews
- Occupational Therapy reviews-as required
- Counselling
- Social engagement
- Practical help and support
- Medication (dispensing, administering, monitoring side effects and reviewing of medication)
- Anxiety management
- Regular risk assessment
- Carers Assessments
- Discharge planning
- Relapse management including signposting to psychosocial agencies such as MIND/Synergy/Oasis/CDAS/Mosaic housing etc.
- Family support/intervention.

Care will not be limited solely to the mental health crisis but will be holistic in nature and include consideration of physical health and the psychological and social aspects of patient care.

Telephone contact as an intervention

Telephone contact will be used as an adjunct to home visits but should not serve as a replacement. Initially, telephone contact should be used to agree on the time and venue of visits.

Therapeutic telephone contact can be used for supportive purposes. During the telephone conversation patients should minimally be risk assessed about risk to themselves or others. In circumstances where the telephoning staff member becomes concerned about the patient's immediate safety, this should be highlighted to the Shift Coordinator who will consider planning a same day home visit or another phone call depending on the severity. All telephone conversations should be documented.

Physical health

Patients should be offered an initial review of their physical health as soon as possible at the start of home treatment. This is an initial assessment of possible needs. Any physical health problems that may contribute to deterioration in the

person's mental state should be identified, including identification of substance use disorders. Specifically:

- A full medical history should be taken, as well as documentation of the person's current physical state and any prescribed medication for physical health problems.
- Whether it is safe to start or continue medication for a mental health problem should be reviewed in light of this assessment.
- For patients commenced on psychotropic medications, the physical health and blood investigations (such as for metabolic screening) should be arranged in light with NICE guidelines. The physical health review should also consider the impact of lifestyle on cardiometabolic risk, in addition to the person's nutrition and dietary requirements. The person should go on to receive appropriate follow-up care to manage any physical health problems. There should be ongoing management of physical health conditions, including oral and dental health.
- In circumstances of acute physical health emergency, the team is able to take appropriate actions such as making a referral to emergency services, 111, GP or making a call to 999 services.

Where concerns are identified, staff should facilitate/signpost review by GP/A&E as responsibility for the physical health of patients living in the community remains with the primary care.

Involving and supporting family members and carers

Families and carers of people in crisis are likely to experience emotional strain, stress and may feel unsupported when using services. Access to someone who can provide advice, support or 'lend a helping hand' to families and carers is often what is needed most, and research shows working closely with families of people with mental health problems can improve suicide prevention and reduce a person's level of risk.

As part of delivering timely and compassionate care, and in line with the Care Act 2014, family members and carers should be supported in accessing carers assessments and/or family support services. Families and carers should be included in developing any plan to support the person. Professionals should be mindful that family members or carers may be unable to provide the support that is necessary.

Every new carer will be offered individual time with staff at least once during the episode of care to discuss concerns and their own needs. The team will have a carers lead.

Box 1: The key elements to achieving a Triangle of Care

The six key standards state:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2. Staff are 'carer aware' and trained in carer engagement strategies.
3. Policy and practice protocols re: confidentiality and sharing information, are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6. A range of carer support services is available.

From: Carers Trust. The Triangle of Care. Carers Included: A Guide to Best Practice in Mental Health Care in England. London: Carers Trust; 2013

Risk assessment and management

A specialist toolkit produced by the NCISH 2019 recommends that community mental health services should include a 24-hour CRHTT with sufficiently experienced staff and staffing levels. CRHTTs should be monitored to ensure that they are being used safely. Patients' contact time with the CRHTTs should reflect the specialist and intensive nature of that role. The assessment for CRHTT takes into account individual circumstances and clinical need, recognises that CRHTT may not be suitable for some patients; especially patients who are at high risk or who lack social support (e.g. psychotic/severely depressed with increased risks and living alone). The patient's choice of obtaining treatment at hospital or at home should be also taken into account.

Data from the NCISH, noted that there had been a 60% reduction in in-patient suicides from 2005–2015 (Hunt et al. (2016)). Furthermore, it is noted that risk had been transferred to the CRHTTs. This is because CRHTT had become the default for acute mental health care because of the pressure on in-patient beds.

It is in the interest of patient's safety that CRHTT provides home treatment for their benefit, not because of pressure on in-patient beds.

The NCISH noted, overall, the annual number of suicides under CRHTT increased over the report period initially reflecting its increasing use. Recent estimates mean there are now around two to three times as many patient suicides under CRHTT. This highlights the importance of reducing suicide in this setting.

The NCISH (Kapur et al. 2016) found a high prevalence of risk factors among suicides under CRHTT, such as adverse life events (49%), living alone (44%), or

recent discharge from in-patient care (34%). Therefore, the suitability of home treatment for socially isolated people in suicidal distress, or those with limited perceived social support, needs to be reviewed and considered on a case-by-case basis. Additionally, home treatment may not be appropriate if the home environment has the potential to exacerbate a mental health crisis. Furthermore, NCISH, 2015 noted, of those people who died by suicide while under the care of CRHTTs between 2012 and 2013, 37% had been under CRHTT for less than a week, which may reflect the acuity and severity of their illness.

The CRHTT caseload should consist of patients who would otherwise require care in the hospital setting were it not for support of the team.

Clinicians must keep risk assessment and management at the forefront of the practice. It is known that self-harm is one of strongest predictors of suicide, including among older people. Suicide occurs more frequently with the coexistence of psychiatric and physical illness.

It is important that a holistic and person-centred assessment of all patients is undertaken before considering if they are suitable for CRHTT input. The assessment should take account of the amount of psychological and social support that the patient will require to keep them safe when under the care of the CRHTT.

All staff within the CRHTT will work in accordance with evidence-based and recognised standards of risks assessment and management.

Upon initial assessment a risk profile template is completed by CRHTT staff. Risk assessments are updated on a regular basis in response to changes in the service user's presentation and management.

At the point of discharge, a risk assessment section in the discharge notes will be completed by the CRHTT staff member completing the discharge.

CRHTT staff will adhere to local incident reporting systems that provide guidance on the role of staff in the event of any incident including serious incidents, drug errors and near misses. All staff act in line with the Duty of Candour.

Service developments in CRHTTs need to be monitored carefully with respect to patient safety to ensure that the right care is being delivered to the right patients. The services development should take place with involvement of appropriately experienced patients and family/carers with active role in decision making.

Record keeping

Following each contact, it is essential that the contact is documented and communicated to relevant team members and/or the Shift Coordinator who will update the caseload list.

As part of the clinical entries in relation to either a 'face-to-face' or telephone contact, it is recommended to have details on progress, risk assessment and risk management plan.

The CRHTT will collate all care records for the patients while patient is under the care of the team.

Communication within and out of the CRHTT

Due to the virtue of risk carried by the CRHTT and its pivotal role within the community, primary care, A&E and inpatient services, communication within the service and out of the CRHTT is of utmost importance. Timely and good quality communication between healthcare professionals, patients and relatives is fundamental responsibility of the CRHTT and each member should keep it at the forefront of their practice at all times.

One of the core functions of the CRHTT is clinical risk management; it is imperative that referrers provide as much information as possible to CRHTT when referring for home treatment. Referrers are expected to be proactive in passing on comprehensive information.

All assessments should be documented. For all referrals accepted for screening, CRHTT will notify the outcome of their screening assessment regarding the suitability of home treatment after reviewing the patient, in writing or through the telephone. Following this, a copy of CRHTT initial assessment will be sent to GP and copied to all professionals involved in the patient's care.

Following acceptance of a patient on the CRHTT caseload the team should inform the GP/treating teams/referrer and request a list of current medication from GPs and, where applicable, medical case records within the first 24 hours.

All patients discharged from the CRHTT will have a discharge summary produced and sent to their GP including copies to appropriate health and/or social care professionals with five days of discharge from the CRHTT.

The CRHTT will maintain regular communication with the care co-ordinators and encourage joint working as indicated.

Where the CRHTT make a referral, for example for a Mental Health Act assessment or a safeguarding referral, the request is made in writing and recorded in the patient's records.

Handover

CRHTT is a frontline service managing high-risk patients; therefore, handover meetings play a vital part in providing a safe and effective service. Given the importance of the handover process this time is considered protected.

A team handover will take place twice a day to discuss all current patients and new referrals to the team. Current patients' responses to interventions is reviewed and where necessary modification is made to individual treatment plans. Emphasis is on team planning and implementation of care. Issues of risk are discussed including the planning of visits and safety precautions.

To facilitate efficient handover process, structured evidence based tools such as SBAR are beneficial. Handovers may be chaired by the Shift Coordinator who can use and update the 'handover sheet' and whiteboards with key information and plan. Any work and referrals (irrespective if taken on) from the previous shift is discussed. It is recommended that handover should occur when there is a shift change.

Clinical reviews/MDT reviews

The CRHTT will have regular clinical reviews. The clinical reviews are more comprehensive in nature than the handovers. All staff on duty are required to attend. During the review, each patient under the team's caseload is systematically reviewed to determine the appropriateness of the existing care plan, risk management and discharge plans. These meetings should facilitate input from all members of the team across staff disciplines to ensure that concerns and differences of professional opinion are fully discussed, and a course of action agreed.

For all new patients to the CRHTT, a full initial assessment should be presented to the meeting and discussed. For follow-up patients on the caseload, the patient's circumstances which led to home treatment, background history, physical health, medication compliance, treatment so far, risks and future plans should be discussed.

During the meeting there should be formal documentation about the progress over last week, risk assessment and management with a plan to be followed. The Shift Coordinator will assist by collating information from patient case files. They will present the cases on their own or jointly with another CRHTT staff member.

Although the handover and clinical reviews are considered protected time, referrals will still be accepted during these meeting.

Medicines management

Patients receiving home treatment will have, where necessary, reference to their medication needs including safe administration of medication, identified and recorded within the care plan.

In order to safely treat patients, the CRHTT will follow the pathway consistent with the NHS trust/organisation medicine management policy. The following would be of paramount value:

1. Medicine reconciliation: The aim of the medicine's reconciliation is to ensure that medications prescribed at the time of accepting patients on CRHTT caseload for home treatment correspond to those that the patient is taking at the beginning of home treatment. This provides a safeguard in order to ensure drug errors are not made. In the event when CRHTT start working with the patient, the team will contact the GP requesting a list of all current medicines being prescribed.

The Shift Coordinator or a nominated person, leads on the responsibility for ensuring that all new patients taken on for home treatment have a request being sent to GPs for a list of medicine and also recent physical health tests. The team administrator staff member would assist.

All of this information will be documented and checked by the Shift Coordinator (qualified staff). Any concerns will be discussed immediately with medical staff/independent nurse prescribers.

At the time of initial home visits and where access is available to patient's medicine packs, staff will ask to see the medicine packs and ask whether the patient has been taking the medicines, including all physical health and complimentary medicines. The result will be documented in the initial assessment profile as part of the medicines reconciliation process.

2. Prescribing: Medical staff members of the CRHTT will initiate new medication and provide prescriptions. This may be supplied using the NHS trust/organisation inpatient drug charts via the NHS trust/organisation pharmacy services or from community pharmacies using FP10 prescriptions. Independent and supplementary nurse prescribers are also able to prescribe medications and are encouraged to follow the prescribing plan jointly with the team Consultant Psychiatrists.

Outside of normal hours, the CRHTT has access to medications via patient group directions (PGDs) and suitably trained staff can dispense pre-packs of anxiolytic and hypnotic medications such as Lorazepam 1mg PRN max QDS and Zopiclone 3.75 mg Nocte. The register for these products MUST be completed every time they are issued.

3. Administering medication and delegation: All patients under the care of the CRHTT will have care plans to reflect their medications needs. The safe administration is paramount and should be incorporated in the care plan. The possible options for the administration in the CRHTT are:

- a) Self-administration: The patient may be able to take responsibility for taking their own medications. If this is the case, then this should be documented in their care plan. The CRHTT staff member on every visit will review the patient's ability to do so and assure themselves that patients fully comply with self-administration.
- b) Prompting/encouraging: A qualified member of staff can undertake this role or delegate to a Support Worker to prompt the patient to self-administer medicines. Arrangements will be recorded in the care plan.
- c) Supervised medication: Some patients will require supervision whilst taking their medication. This will be documented in the care plan, including what arrangements for supervision have been arranged. This will be reviewed regularly in team meetings with the aim of empowering patients as needed to take control of self-administration as early as possible.

4. Medications at Discharge: On discharge from the CRHTT, a detailed account of medication prescribed to the patient will be provided to the patient's GP and relevant professionals via the discharge summary. The discharging professional will record the diagnosis/problem and medicines prescribed on the discharge summary.

Joint working with community services

Transfer of CRHTT patients to community services:

The community team will be alerted by CRHTT in cases of new individuals to the service requiring further ongoing input from the appropriate community teams. This advance planning from both teams can allow time for appropriate and considered allocation of case coordinators from within the community teams.

The CRHTT identifies patient needs as early as possible during the treatment episode (while patients are RED or AMBER) and shares risks and patient/carer

needs with community teams as appropriate, as part of anticipated Community Mental Health Framework for Adults and Older Adults (CTP or equivalent) transfer.

To promote robust information sharing between CRHTT and community services, the CRHTT should provide a clear written summary of patients' needs and after care plans.

Community teams should allocate a care coordinator/key worker as soon as possible preferably within a week, following the summary provided to community teams. To ensure continuity of care, the CRHTT jointly with the appropriate community team, will plan a face-to-face meeting for the handover of care within the seven days of patient being graded to green on RAG rating.

It is anticipated that the community services prioritise care coordinator allocation to CRHTT to assist the CRHTT to fulfil its function of rapidly taking on and discharging patients when home treatment is no longer indicated.

Transfer of patients from community services to home treatment:

Community teams can alert CRHTT staff of concerns about individuals, prior to a potential crisis presenting. When a crisis occurs, which the community team has not completely predicted, foreknowledge of concern helps the CRHTT in their assessment and care planning.

In circumstances of patients requiring home treatment as an alternative to hospital admission, the community team should request a joint review with the CRHTT. This joint visit is reassuring to the patient and allows the process of sharing key information in relation to risks management plan of the proposed home treatment. The CRHTT will continue to provide intensive treatment until the resolution of the immediate crisis. Following the resolution of the crisis, patient care is then transferred to community teams via a joint face-to-face meeting involving the care coordinator/key worker and CRHTT.

Facilitating early discharge from hospital: In reach

Communication is essential for patient safety. It should not be assumed that the forward caring team would have taken on this responsibility, until a clear agreement has been reached. A key principle behind the facilitating early discharge from hospital would be to ensure that it is a joint process between the ward and the CRHTT consisting of seamless transfer of care to CRHTT with a comprehensive plan for management in community as per the identified Community Mental Health Framework for Adults and Older Adults standards (CTP standards for Wales, or equivalent).

Early discharge is the process by which the CRHTT identifies and works with patients who are still acutely unwell to;

- 1) facilitate their discharge from hospital and
- 2) commence home treatment.

This is a primary function of CRHTT. In order for early discharge to take place, there must be evidence to show that the presenting risks and symptoms of the patients have reduced to a point where home treatment is safe for the service user, their family members and carers and CRHTT staff member.

The CRHTT then manages the patient in their respective community setting in accordance with the process of home treatment detailed above (home treatment section). This home treatment should continue until the patient's mental health has improved to a state where they can either be transferred to secondary mental health services for care coordination as per the Community Mental Health Framework for Adults and Older Adults (CTP for Wales or equivalent). Where a patient's mental state deteriorates following early discharge, readmission to hospital may be considered.

During the process of accepting a referral for an inpatient admission, the admission ward staff should capture the reasons why the patient needs to be admitted to hospital and identify what needs to change before home treatment by the CRHTT can be reconsidered.

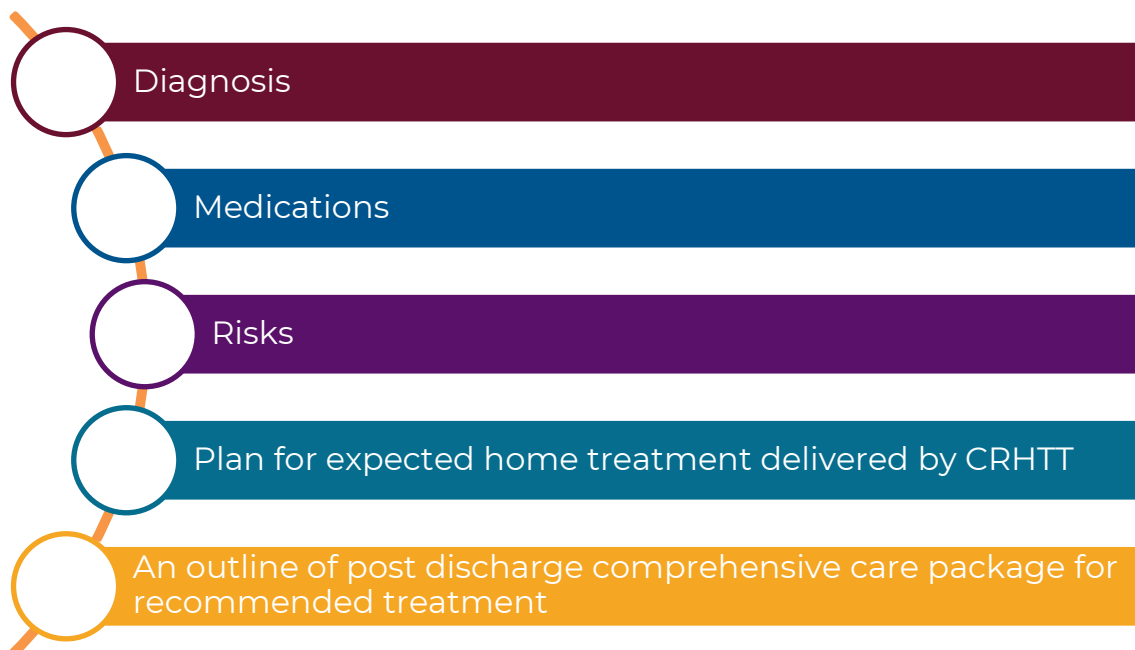
During each weekday the CRHTT will allocate a staff member of the CRHTT to liaise with the inpatient wards to identify any potential referrals and to review all referrals for early discharge.

The CRHTT will consider all new admissions to the inpatient ward for early discharge right from the point of admission. This will be done by attending daily ward rounds and reviews together with ward staff. The ward and CRHTT should work jointly to identify suitable patients for home treatment. The CRHTT will be available for the purposes of facilitating early discharge as needed unless ward staff recognises patient not suitable until a date in future.

The CRHTT will have an active role in screening all patients daily as identified by the nursing/medical staff of the wards suitable for early discharge. Identification of patients for early discharge can be initiated by the CRHTT staff member attending as well as by ward nurses or medical professionals. However, all referrals should have been discussed with the relevant inpatient Responsible Clinician (RC). If, after a CRHTT assessment, the patient is not accepted for home treatment, the CRHTT must clearly identify the reasons why early discharge is not appropriate and identify what changes to the patient's presentation need to occur before early discharge by the CRHTT will be reconsidered.

The following steps should be completed by the referring ward as part of the early discharge process:

- The referrer should contact the relevant CRHTT and complete/update the patient's risk assessment.
- The patient should be aware of a referral to the CRHTT and should have indicated a degree of willingness to engage with the team.
- It is necessary that the inpatient medical team agrees with the CRHTT taking over the patient's care and are actively involved in devising care plan during with CRHTT involvement. Contingency planning in case of changes in presentation would be an essential component of this plan.
- Discussion with the community care coordinator (if involved) and any family members and carers is essential.
- It is recommended that referrals for further service provision should be initiated by ward staff as soon as possible after admission (i.e. community mental health team, Psychology, Outpatient follow up and Forensic Assessment etc.)
- Once early discharge has been agreed, an individualised plan for 'early discharge' will be jointly completed by the CRHTT, the patient and staff from the ward. This plan will include the following:



It is the responsibility of the ward medical staff to document the above in the inpatient notes prior to handing the patient's care to the CRHTT.

Following an agreement with CRHTT staff, the patient will either be discharged to the care of CRHTT or sent on trial leave with a consideration to discharge to CRHTT made as soon as feasible. The CRHTT will then take possession of patient's case notes.

In instances of leave support, the CRHTT should attend ward reviews to provide feedback. An electronic copy of case entries should be sent to the ward consultant, ward manager and care coordinator (wherever applicable) prior to the ward round/review.

For patients going on leave from inpatient services, the to take out (TTA) medication will be arranged and provided to the patient by ward to patient. However, repeat prescriptions if needed can be arranged by the CRHTT.

For patients discharged from the ward, a discharge notification should be completed with TTA's arranged prior to patient leaving the ward. Further, prescriptions, if necessary, will be arranged by the CRHTT.

It is the responsibility of the inpatient team to formally discharge the patient from the hospital.

The CRHTT will attend weekly inpatient and community interface (MDT) meetings to feedback on ward patients under CRHTTs care and be an integral part of the compilation of crisis contingency plans and risk management for patients in community with indicators of imminent relapse.

Conclusion of home treatment

Planning for the withdrawal of home treatment will begin early, the expectation is that the patient will have progressed through the Traffic Light process (and achieved green status) and the identified outcomes will have been met.

Prior to discharge the CRHTT should ensure that:

- The decision to discharge the patient from the CRHTT should be made after consultation between CRHTT staff, the community team, the care co-ordinator, medical staff, patients and carers
- Symptoms and risks should have improved to a degree where hospital admission is no longer necessary.
- There is good understanding (patient, family members, carers and relevant others) of why the crisis occurred and how it could be avoided in the future.
- Coping strategies have been explored with the patient and family member/carer.
- A plan addressing relapse prevention is in place.
- A risk assessment has been completed.
- The patient, family members and carers have had an opportunity to express their views about the service and contribute to service improvement.

No access visits and non-engagement of patients

It is not legally possible to compel a person to receive treatment or management in the community.

When someone refuses treatment, staff must consider whether the patient's refusal to adhere to the treatment plan is likely to result in a deterioration of the patient's condition, which will involve a danger to the self or others. Staff must decide whether it is appropriate to assess and refer the patient under the Mental Health Act.

In the event of a patient refusing or failing to engage with home treatment, CRHTT staff should follow the NHS Trust/organisation policy for patients who disengage from mental health services or allow no access to staff for the purpose of home treatment.

In circumstances when patients repeatedly do not respond to CRHTT calls or deny access to their home, it is important to ascertain their safety and well-being prior to concluding on further course of action.

Should a patient fail to allow access, or not be at home, the staff must continue attempts to make contact with the patient and keeping in mind confidentiality remits, consider contacting relatives/carers to establish the patient's whereabouts and safety.

All attempts to make contact must be documented. In the event of failed visits, the staff member must refer to the patient's care plan, which must include a contingency plan for this event, and take appropriate action. The staff member should consider an option of a police welfare check following a discussion with the senior clinical lead and or medical staff.

Once the CRHTT MDT is satisfied with the evidence that patient is not at immediate risk of any nature and is choosing not to engage with home treatment, the team should plan an aftercare follow up and communicate their finding to all professionals involved in the care to ensure a follow up is available. Prior to discharge wherever practical, the CRHTT will do an unannounced visit and in the event of no access, staff deliver a letter to the patient inviting them to make contact in the next three days informing that on the contrary they will be discharged back to the referrer/GP as appropriate.

For patients known to existing mental health services their treating team should be updated on the patient's progress, risks and CRHTTs involvement. Joint further care should be planned with an emphasis that the responsible community teams take the lead in the care as crisis home treatment is no more feasible. The CRHTT should then complete the discharge paperwork.

For patients known to primary care, the GP should be informed of the patient's disengagement through a telephone conversation and a discharge note sent.

Considering patients care plan and confidentiality remits, the CRHTT should involve the carers/family members and carer in the discharge process of all patients.

In circumstances where patients have chosen not to engage with home treatment, the CRHTT should inform the carers/family members of their discharge unless patients have wished not to contact the family members and carers while providing consent in relation to information sharing.

The decision to break confidentiality must only be made in consultation with the MDT, senior CRHTT clinical leads and/or Consultant Psychiatrist, and by following

strict guidelines (please refer to the trust/organisation's Confidentiality Policy for more information).

CRHTT staffing

The CRHTT should be multi-disciplinary in nature to ensure holistic assessment and planning of care. All disciplines would ensure an appropriate skill mix. The team is advantaged by the manager who provides the leadership to CRHTT and is responsible for the safety, effectiveness and quality of the service provided, including the achievement of performance targets, and team leaders who are responsible for the day-to-day delivery of services by the CRHTT. It is recommended that the team has a Team Lead, dedicated Registered Mental Health Nurses, dedicated Support Worker(s), dedicated Pharmacist, Consultant Psychiatrist, input from Occupational Therapists, Psychologists, access to administrative support and AMHP(s).

Each profession will work within its legal remit, codes of practice and **lead** on their areas of speciality but will also undertake tasks required of all clinicians in the CRHTT to ensure delivery of the service. At all times clear line of management are identifiable by banding rather than professional discipline.

All new staff must complete a period of induction in line with the Trust/organisation's policy and more locally within the CRHTT. This must be monitored by the supervisor and team manager.

Estimate of MDT staffing in CRHTT

All teams participating in the review process with the Quality Network for Crisis Resolution and Home Treatment Teams (QN-CRHTT) as part of the Royal College of Psychiatrists, are asked to provide contextual data to enable the peer-reviewers visiting them to learn about their service prior to their peer review visit, as part of the self-review process. The HTAS National Report (2020) showed that, all accredited teams had a caseload where the mode was 25 (mean= 33; median = 28, range = 12- 51) patients.

With regards to staff members, all accredited team had a mode of 23 (mean = 31, median = 29.5, range = 18 to 50) staff.

Planning assumptions for CRHTT working from 08:00 am to midnight

While planning for resources for the team, it is recommended to take into consideration whether the services operates in an urban, rural or mixed area. Considerations should be given to population density, morbidity and the travel times required for staff.

Following is an indicative staffing estimate of a CRHTT functioning until midnight: The calculations for suggested CRHTT staffing number are formulated taking into consideration the range of tasks that team members undertake on a daily basis. This is then also calculated against the average caseload to establish staffing number needed to complete activities daily.

The following activity is undertaken by each staff member:

- Assuming that in a daily handover/MDT meeting- approximately five minutes is taken to discuss each patient for an average caseload of 25-30 patients. Total MDT time required is: 125-150 minutes.
- Home visit interventions- Approximately 40 mins to one hour face-to-face contact.
- Travel time- 30 minutes. Three contacts per day. Total: 1.5 hours approximately.
- Admin- case recording/care planning/risk assessment updated/any other admin related tasks: approximately 1.5 hours daily.

On the basis of having a caseload of 25-30 patients, the assumptions would be that:

30% of the caseload are seen daily **RED**, 15% seen twice daily (eight patients to be seen daily, two patients seen twice daily) = 12 **RED** visits daily.

40-50% are **AMBER** and seen every other day (10-15 patients) = Five to 7.5 **AMBER** visits daily.

10-20% are **GREEN** and seen at least once every three days (three to six patients) = One to two **GREEN** visits daily.

Total number of visits required per day with an average caseload of 25-30 patients: 18-21.5 visits daily

One member of staff is able to complete a maximum of three face-to-face contacts on a 7.5 hour shift. Therefore, a total of six to 7.5 staff each day is required for the purposes of intensive crisis resolution.

This, however, does not include the need for some visits to be undertaken by two staff members (double handed visits), that are likely to require additional staffing for further roles such as:

- Duty Nurse/Shift Co-ordinator (one staff member per shift).
- Gatekeeping/urgent and emergency response (minimum of two staff per shift).
- In-reach role (minimum of one staff per shift).
- In addition to the above nursing staff, CRHTT should have medical staff including daily input from a Pharmacist. One WTE Consultant Psychiatrist and one WTE middle grade doctor. One WTE Team Lead and one WTE Service Manager. One WTE Psychologist and one WTE Social Worker, one WTE Occupational Therapist, one to two Support Workers and admin/secretarial support. It is recommended having a mix of MDT professionals on shift.

Leaflets and carers pack

Leaflets allow us to provide printed information to our patients, thus sharing our knowledge and expertise with our patients and enabling them to make informed choices.

The CRHTT will provide the core CRHTT leaflet in various languages and formats (such as in braille as required) that would be easy to read and outlines the care to be provided at the first point of contact to patient and carer. According to the need of the patient, a resource pack should be available with presence of various leaflets about mental health conditions, medications and available services in the area (such as recovery colleges, crisis houses and voluntary sector organisations). A carer's pack will be available which is to be provided to carers.

Staff appraisal, supervision and workforce development

All CRHTT staff members must have an annual appraisal and monthly line management and clinical supervision. Weekly team clinical MDTs involving the Consultant Psychiatrist may serve as team clinical supervision. The CRHTT will regularly run 'in-house training and reflective practice forum' with a frequency of six weeks.

All CRHTT staff members must maintain compliance with mandatory training as per the NHS Trust/organisation policy. They must also have received training in or have knowledge in holistic approaches to mental ill health and crisis; biopsychosocial interventions and NICE approved treatments.

Regular team training sessions and speakers from partner organisations will be organised. Training sessions will be delivered by team members of all disciplines including the medical staff. This may take the form of a journal club with discussion.

Each CRHTT staff member is responsible for ensuring that they maintain the required training hours for registration with their professional body and for ensuring that their registration is in date.

Quality, governance and performance outcomes

Activity and outcomes should be audited to maintain a good standard of care and quality in CRHTTs. This includes:

- Providing feedback to CRHTTs about their effectiveness and the continuing need to develop.
- CRHTTs should be able to demonstrate the number of referrals into the service, the number of assessments undertaken and as a proportion of those subsequently taken on to home treatment by type and by source.
- CRHTTs should also evaluate patient and carer satisfaction.
- CRHTT monitoring and implementing findings from learning derived from serious incidents, complaints and compliments.
- CRHTTs will also need to consider evaluating their influence on the rest of the local service system and particularly in-patient bed use.
- CRHTTs will regularly audit the quality of assessments, documentation and the discharge summaries communication out of the CRHTT.

The CRHTT will continue to develop quality measures to ensure that the service is meeting the needs of the local population and partner groups.

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NHS England

Appendix 1: Summary of CRHTT service developments

Since the initial establishment of the CRHTTs, some key developments of those of particular interest for the policy implementation are as following:

In 2016, a commission was set up, chaired by Lord Crisp to review the provision of acute inpatient psychiatrist care for adults in England. The report included 12 recommendations which emphasized the need to ensure Crisis Resolution and Home Treatment Teams are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.

Research indicates that poorly resourced CRHTTs contribute to poor quality care and an increase in suicides. (Hunt et al 2016, Appleby, National suicide prevention alliance 2017). CRHTTs are now a priority for suicide prevention.

In England there are three times as many suicides under CRHTT as in inpatient care; in 37 per cent of cases, the patient has been under CRHTT for less than a week (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2015a). Although a greater proportion of patients are treated in the community, the inquiry questioned the ability of CRHTT teams to provide adequate support.

The King fund report (2015) produced on mental health pressure, highlighted there has been a long-term reduction in the number of psychiatric beds in England. These reductions have been associated with a number of national policies (Imison et al. 2014) including the implementation of guidelines on suicide reduction and standards for inpatient care, resulting in a move from large, outdated hospitals to smaller purpose-built premises, and the development of specialist community teams under the National Service Framework.

Much of the pressure on beds can be attributed to insufficient support in the community and a lack of alternatives to hospital (The Commission on Acute Adult Psychiatric Care 2015). The UCL CORE study examined the operation of 75 CRHTTs across England and found that there was not a single area where the average performance across teams scored 'good' in relation to best practice. Performance was poorest in relation to being able to respond quickly to referrals and offer frequent visits. In 2014/15 the number of contacts CRHTTs had with patients fell by six percent (Health and Social Care Information Centre 2015b). Particular concerns have been raised about the ability of CRHTTs to provide 24/7 support; the Care Quality Commission's work on acute care found that 65 per cent of organisations reported out-of-hours care was not of equal standard to care provided at other times (Care Quality Commission 2015c).

The NHS England five year forward view recommends "For crisis and acute care, the majority of costs will be for new staff in crisis resolution and home treatment teams (CRHTTs) to ensure that effective service models can be properly resourced. A typical CRHTT per 150,000 population would carry a home treatment caseload of 20-30 people, and would comprise a consultant psychiatrist, mental health nurses,

approved mental health professionals, occupational therapists, psychologists and support or peer workers.” The five year forward view mandates that every area would have a 24/7 Crisis Resolution Home Treatment (CRHTT) function for adults, operating in line with best practice by 2020/21 and maintaining coverage to 2023/24.

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