CRISIS RESOLUTION HOME TREATMENT
OPERATIONAL POLICY

<table>
<thead>
<tr>
<th>DOCUMENT VERSION CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Type and Title:</td>
</tr>
<tr>
<td>Authorised Document Folder:</td>
</tr>
<tr>
<td>New or Replacing:</td>
</tr>
<tr>
<td>Document Reference:</td>
</tr>
<tr>
<td>Version No:</td>
</tr>
<tr>
<td>Date Policy First Written:</td>
</tr>
<tr>
<td>Date Policy First Implemented:</td>
</tr>
<tr>
<td>Date Policy Last Reviewed and Updated:</td>
</tr>
<tr>
<td>Implementation Date:</td>
</tr>
<tr>
<td>Author:</td>
</tr>
<tr>
<td>Approving Body:</td>
</tr>
<tr>
<td>Approval Date:</td>
</tr>
<tr>
<td>Ratifying Body:</td>
</tr>
<tr>
<td>Ratified Date:</td>
</tr>
<tr>
<td>Committee, Group or Individual Monitoring the Document</td>
</tr>
<tr>
<td>Review Date:</td>
</tr>
</tbody>
</table>
SUMMARY

Lincolnshire Partnership NHS Foundation Trust (LPFT) is commissioned to provide 3.8 Crisis Resolution Home Treatment teams. The teams are required to be Policy Implementation Guide compliant and to operate from four localities.

Enclosed is the Operational Policy for Crisis Resolution Home Treatment Services which Lincolnshire Partnership NHS Foundation Trust provides.

The policy sets out how the Division will operationalise Crisis Resolution Home Treatment Services.

This operational policy is Trust wide. It includes elements to help manage the interface with Older Peoples Services, Child & Family Services and Learning Disability Services.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Mission Statement</td>
<td>5</td>
</tr>
<tr>
<td>Location of Teams</td>
<td>5</td>
</tr>
<tr>
<td>Objectives</td>
<td>6</td>
</tr>
<tr>
<td>Service Principles and Provision:</td>
<td></td>
</tr>
<tr>
<td>- Crisis Referrals</td>
<td>6</td>
</tr>
<tr>
<td>- Gatekeeping Inpatient Admissions and Supporting Early Discharge</td>
<td>7</td>
</tr>
<tr>
<td>- Community Assessment and Treatment</td>
<td>7</td>
</tr>
<tr>
<td>- Mental Health Act Assessments</td>
<td>8</td>
</tr>
<tr>
<td>- User and Family/Carer Involvement</td>
<td>8</td>
</tr>
<tr>
<td>- Referral Criteria</td>
<td>9</td>
</tr>
<tr>
<td>Referral Process:</td>
<td></td>
</tr>
<tr>
<td>- New Referrals</td>
<td>10</td>
</tr>
<tr>
<td>- Inappropriate Referrals</td>
<td>10</td>
</tr>
<tr>
<td>- Crisis Alerts</td>
<td>11</td>
</tr>
<tr>
<td>Working Arrangements</td>
<td>11</td>
</tr>
<tr>
<td>Assessment Process</td>
<td>12</td>
</tr>
<tr>
<td>Worker Safety</td>
<td>13</td>
</tr>
<tr>
<td>Service Delivery:</td>
<td></td>
</tr>
<tr>
<td>- Service User Contact</td>
<td>13</td>
</tr>
<tr>
<td>- Medical Treatment</td>
<td>14</td>
</tr>
<tr>
<td>- Medication Management</td>
<td>14</td>
</tr>
<tr>
<td>- Carrying Medication</td>
<td>14</td>
</tr>
<tr>
<td>- Crisis Intervention</td>
<td>14</td>
</tr>
<tr>
<td>- Support for Carers</td>
<td>15</td>
</tr>
<tr>
<td>- Information &amp; Education</td>
<td>15</td>
</tr>
<tr>
<td>- Monitoring</td>
<td>15</td>
</tr>
<tr>
<td>- Review</td>
<td>16</td>
</tr>
<tr>
<td>- Crisis Transfer Planning</td>
<td>16</td>
</tr>
<tr>
<td>Emergency Respite Accommodation</td>
<td>16</td>
</tr>
<tr>
<td>Lincolnshire Partnership NHS Foundation Trust – Adult Acute Services:</td>
<td></td>
</tr>
<tr>
<td>- Admission</td>
<td>17</td>
</tr>
</tbody>
</table>
• Inpatient Liaison 17
• Inpatient Discharge Planning 17
• Out of Hours Backup 17
• Inappropriate Referrals 17

Initial Risk Assessment:
• Risk to the service user or others 18
• Risk to staff 19
• Staff Safety 19
• Risk to Children 20

Interface with Learning Disability Services and Child & Family Services:
• Policy in relation to Learning Disability Services 20
• Policy in relation to Child & Family Services 21

Training & Development 22
1. INTRODUCTION

Lincolnshire Partnership NHS Foundation Trust aims to provide a Crisis Resolution and Home Treatment (CRHT) service in a safe and least restrictive environment. The focus of the service is to meet the needs of service users, who are experiencing acute mental health crisis. All interventions provided by the service are short term, focused on the safety, well-being and empowerment of the service user and their carer/family during the period of the crisis. All treatments are based on appropriate assessment, which ensures that the service users needs are met and that their carers are also supported. The service will encourage service users to participate in the development of their assessment of needs and care plans and to take the appropriate level of responsibility.

The CRHT Service is intended to complement and work in partnership with existing service providers. It is expected that service providers currently involved with the service user will retain an appropriate level of involvement in the care and treatment of the user alongside the CRHT Service.

2. MISSION STATEMENT

The CRHT Service will provide assessment and home treatment to adults between the ages of 16 and 64 experiencing severe mental health difficulties, in the least restrictive environment, with the minimum of disruption to their lives. For adults over the age of 65, the service will offer an assessment for people experiencing functional mental illness only, during “out of hours” (1700 – 0900 Monday to Friday; weekends and bank holidays). At all other times the older people service in the Trust will provide this service for people suffering from both organic and functional mental illness. Older people services will support the CRHT service in the assessment of organic mental illness and CRHT will support the management of older people following assessment during non office hours with functional illness to enable older peoples services to take over in office hours.

3. LOCATION OF TEAMS

3.1 Lincoln Team – Peter Hodgkinson Centre

The CRHT will be based at the Peter Hodgkinson Centre and will provide the service to patients normally resident in Lincolnshire. This will include Lincoln, Gainsborough, Market Rasen and Caistor.

3.2 Boston Team – Dept. of Psychiatry, Pilgrim Hospital

Louth Team – Louth County Hospital

The CRHT will be based over two sites and will provide the service to clients resident in Lincolnshire. This will include the localities of Boston, Spalding, Louth/Horncastle and Skegness.

3.3 Grantham/Stamford Team

The CRHT will be based at the Sycamore Assessment Unit in Grantham and will provide the service to clients resident in Lincolnshire. This will include the localities of Sleaford, Grantham, Bourne and Stamford.
4. OBJECTIVES

The CRHT primary function is to provide a service to people who are having an acute mental health crisis and may require hospital admission.

The service will operate 24 hours a day, 7 days a week, providing emergency community assessments within a four-hour response time.

It will provide 7 days a week home treatment between 8.00 am and 10.00 pm.

The service aims to provide a locally based, seamless range of services, which will facilitate the following:

- Seven days per week home treatment between 8 am and 10 pm.
- Emergency community assessment available 24 hours, 7 days a week, within a four-hour response time.
- Emergency assessment at A & E Department available 24 hours, 7 days a week, to ensure that A & E waiting time targets are met (maximum wait of 4 hours).
- The CRHT service will offer an assessment following all new referrals of deliberate self-harm – this will replace and enhance the current Deliberate Self Harm Service. This service will operate within the age range of adults 16 to 64.
- Provide appropriate access to inpatient care when required.
- Those adults aged 65 or over, will be assessed, supported and referred to appropriate elderly service (out of hours; weekends and bank holidays only).
- Emergency assessment of patients aged 16 to 64 admitted to General Hospital presenting co-morbidity of physical and mental health needs.
- Provide services that are sensitive to BME and Diversity. CRHT assessments will utilize translations services to facilitate appropriate access to services.

5. SERVICE PRINCIPLES AND PROVISION

5.1 Located at the CRHT Service base.

**Crisis Referrals** 24 hours a day, 7 days a week (including bank holidays).

All crisis referrals will be referred to the Triage Co-ordinator.

All new referrals will require a full health care assessment by a qualified health practitioner prior to acceptance by the Triage Co-ordinator.

This should have taken place face-to-face during the previous 24 hours and ensures the person is medically fit and able to be assessed by Mental Health Services.

This would usually have been carried out by the person’s GP but could also be carried out by A & E acute hospital staff or PCT out of hours staff. The CRHT service will work closely with ULHT A & E Departments to ensure the earliest identification of need for CRHT services.

The triage service will provide a telephone assessment of any situation deemed appropriate for the service, based on the criteria and categorized clinical response, according to the priority and current demands upon the service.
5.2 **Gatekeeping inpatient admissions and supporting early discharge**

It is important that mental health inpatient services and crisis services are joined up locally. It is necessary for a crisis team to act as gatekeeper for all people requiring access to inpatient services or other emergency care. Gatekeeping is an essential component of CRHT. Only by the local crisis team assessing all people who potentially require admission, can three key objectives for crisis services be achieved:

i) Patients should be treated in the least restrictive environment which is consistent with their clinical and safety needs

ii) Inpatient admissions and pressure on beds should be reduced

iii) Equity of access to an alternative to admission for patients and families must be ensured

Fulfilling the gatekeeping role depends upon the co-operation of all the components of a Trust’s mental health services. Crisis teams work best in integrated acute care pathways and it is important to note that teams don’t just triage admissions as an “add-on” to the service. Teams have found that it is critical to success to enlist the support of Trust management (including chief executives, medical directors and the board). Trust management must make sure that gatekeeping happens.

**Features of Gatekeeping**

Everybody (including people in need of mental health act assessments) requiring emergency access to acute mental health services (CRHT and in-patient) should go through a full gatekeeping process. This requires:

i) The CRHT to provide a mobile 24 hour, seven day week response to requests for assessments

ii) The CRHT team actively involved in all requests for admission

iii) The CRHT team being notified of all pending mental health act (MHA) assessments

iv) The CRHT team assessing all these cases before admission happening

v) The CRHT team being central to the decision making process in conjunction with the rest of the multi-disciplinary team

Trusts need to ensure that clear governance/policy arrangements are in place regarding the decision making process.

Effective liaison with inpatient services will also allow a crisis team to take responsibility for patients who are suitable for early discharge into their care.

**Features of Early Discharge**

Early discharge means discharge at a time earlier than would happen if intensive home treatment was not available and is still part of an acute episode of care.
Facilitating early discharge remains a core function of the work of CRHTs and it is recommended that teams develop a systematic approach to providing this.

Having been involved in all admissions (through the gatekeeping role), the team is in an ideal position to identify the reasons for admission and, through close working relationships with the inpatient unit, systematically review whether these reasons continue to exist, and what needs to happen prior to the individual being discharged. If for some reason (and against best practice) a service user had been admitted without CRHT involvement, there is no reason why the team should not play a role in facilitating early discharge, but this process is likely to work best if there has been earlier contact between the service user and the team.

5.3 **Community Assessment and Treatment**

The CRHT Service will provide holistic community assessment and treatment:

- For individuals with acute mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary assessment in accordance with CPA policy (including risk assessment) and community based home treatment between the hours of 8 am – 10 pm.
- Between the hours of 10 pm and 8 am, an ‘on call’ crisis assessment including a risk assessment.
- Remain involved with the service user and provide intensive intervention until the crisis has been resolved.
- Following resolution, the CRHT service will facilitate effective liaison with other services to ensure smooth transition to the most appropriate service.
- The case management responsibility for the user during the crisis will be jointly managed with the care coordinator of the service user if already known to the service and consultant psychiatrist, including review of the care plan. Provision of crisis intervention should form part of an ongoing and comprehensive care plan.
- The CRHT Service assessment begins at the point of referral to the Triage service and the outcome of this assessment will determine whether a full assessment and ongoing intervention is offered, within the CPA framework and Crisis Resolution Home Treatment care pathway.
- Translation services will be accessed to facilitate communication throughout the assessment if needed.

5.4 **Mental Health Act Assessments**

The Trust will ensure ASW provision is available within office hours, outside of which the Social Services Emergency Duty Team remain responsible. If the request is from a medical member of staff, they will liaise with the ASW in the coordination of the assessment.

The CRHT should be informed of all MHA assessments that are taking place, and involved in identifying “least restrictive” alternatives for individuals.

5.6 **User and Family/ Carer Involvement**

The CRHT Service will involve the user and their carer/family in all treatment planning and care management. The crisis worker will provide the necessary
information, support, advice and guidance, including an assessment of carer needs in line with the CPA policy, if the service user is not already known to the Trust at the point of referral. The service user will be referred to the Community Mental Health Team (CMHT) following discharge, if appropriate.

The CRHT service will work with statutory bodies to ensure adherence to policy around Child Protection, Protection of Vulnerable Adults, MAPPPA as per LPFT CPA policy guidance. This includes the identification of young carers and their referral for support. The CRHT service will also work closely with the Police Local Authority Liaison Officer.

If, at any time during the assessment or any point of contact with the service user, there are concerns about a child’s welfare, the Trust policy will be instigated and the Lincolnshire Area Child Protection committee (LACPC) initiated.

5.7 Referral Criteria

The CRHT will accept service users for assessment and treatment if the following criteria is met:

- The person is experiencing an acute disruption to their ability to function adequately as a result of a mental health crisis
- The person appears to have a psychiatric disorder and is at risk of admission
- The person is aged between 16 and 65 years
- If the person is aged 65 and over, and suffering from functional mental illness an assessment only will be offered (out of normal working hours).
- With presentations of co-morbidity a predominant mental health need component to the crisis is identified.

6. REFERRAL PROCESS

The referral protocol for the CRHT Service aims to make the referral process as simple as possible within the following parameters:

6.1 Crisis referrals to the CRHT Service will be accepted 24 hours a day, 7 days a week, via the Triage Coordinator.

6.2 Referrals will be accepted from:

- Service User's GP
- Mental Health Professionals
- Police
- General Hospital*
- Voluntary Agencies
- Armed Services
- Service user or Carers, if known to the service
- Local Authority Statutory agencies
* It is particularly important that the ULHT A & E Departments and in-patient services are offered a comprehensive service of assessment and/or advice when referring an individual with a mental health crisis, in line with government initiatives. This will include making links with Emergency Care Centre’s and supporting A & E and acute ward staff in training, the use of protocols and the management of mental health.

Referrals or admissions of existing or known users, who are suffering a relapse or a return of acute mental health symptoms and who self-refer or whose carer requests help, will be accepted by the CRHT Service, but their care management will be transferred to their care coordinator the next working day.

6.3 **New Referrals**

All new referrals will require a full health care assessment by a competent qualified health practitioner prior to acceptance by the Triage Coordinator. This should have taken place face-to-face during the previous 24 hours and ensures the person is medically fit. This would usually have been carried out by the persons GP but could also be A & E acute hospital staff or PCT Out of Hours staff.

Patients referred to Crisis Resolution Teams must have an up to date assessment of their physical needs conducted as part of the process.

Responsibility for the physical health of patients living in the community remains with the primary care teams. If admitted to a Psychiatric Unit, responsibility for physical care transfers to the receiving psychiatric team for the duration of the in-patient stay. At the time of referral to the Crisis Resolution Team, information about the patient’s current physical state must be provided. This should include any current physical illnesses, medication and past medical history.

It is likely that the bulk of referrals to the Crisis Resolution Teams will continue to be made by the General Practitioner (given the nature of the above requirements). However, referrals will also be received from non-medical staff including first contact nurses. It is imperative that the referrer has actually seen the patient and thereby retains the ability to provide the above information accurately. In the circumstances where that is not possible, it is appropriate to request the General Practitioner to carry out that assessment.

It is essential that the nurse or other non-medical staff (e.g. Social Workers employed by Crisis Resolution Teams) retain the right to request a physical examination or assessment of patients referred to Crisis Resolution Teams.

Crisis Resolution Teams should not be seen as providing a primary care service. Referrals must be assessed initially at primary care level on direct contact with the patient. It is inappropriate to refer patients solely on the basis of third party information (such as a telephone call from a neighbour or relative).

6.4 **Inappropriate Referrals**

All referrals will be screened using the Trust screening process to identify referrals that are inappropriate, the service user and referring agent will be given an explanation regarding the decision and alternative suggestions will be offered.
Any unresolved issues relating to the appropriateness of the referrals will be passed on to the Team Co-ordinator of the CRHT, their Team Leader or the Senior Manager on call.

6.5 **Crisis Alerts**

Local Community Mental Health Teams or other mental health professionals should alert the CRHT Service of impending difficulties. This would not constitute a referral, but would alert the service that an individual may contact the service direct as part of their CPA crisis plan, which must be fully completed. All information regarding the individual including the crisis plan and relapse signatures must be forwarded to the Triage Co-ordinator with appropriate alert form. The individual will be kept on ‘alert’ for one week unless otherwise notified by person initiating ‘alert’.

7. **OPERATIONAL MANAGEMENT**

The overall managerial arrangement for the service will be determined by the Lincolnshire Partnership NHS Foundation Trust at Divisional level. The Team Leader will manage the team in conjunction with other Division mental health services. The day-to-day clinical responsibilities; staff management; ensuring sufficient resources are available to efficiently meet the service demands; will be undertaken by the CRHT Team Co-ordinator and in their absence, the Senior CRHT practitioner on duty.

The team will be multidisciplinary in accordance with the Department of Health Policy Implementation Guidance (PIG) and will be made up of the following staff:

- Team Leader
- Senior crisis resolution practitioners. (Nurses or Social Workers)
- Crisis resolution practitioners. (Nurses or Social Workers)
- Support Time Recovery Workers.
- Administrative support.
- Medical cover.
- Clinical Psychologist input
- Senior Occupational Therapist input.

Individuals not previously known to mental health services remain the medical responsibility of the GP unless following a full psychiatric assessment the Consultant Psychiatrist agrees to take on this responsibility.

8. **WORKING ARRANGEMENTS**

The CRHT provides a 24 hour a day, 7 days a week service.

**Hours of Service**

8.00 am to 10.00 pm during which emergency assessment and home treatment will be carried out.

10.00 pm – 8.00 am is covered by a Triage Co-ordinator, on duty, and a member of staff on-call, if a home visit is required. This will apply to Boston and Lincoln only.
10.00 pm – 8.00 am in Grantham and Louth is covered b a Triage Co-ordinator who is on-call.

9. ASSESSMENT PROCESS

The assessment pathway will follow that of LPFT’s policy and procedure for CPA. The formal assessment begins at the point of direct contact between the CRHT Service and the service user and extends through to the time when a comprehensive care plan is developed for the service user.

The assessment should be conducted in a way that maximizes the co-operation and involvement of the user, carer, family and significant others, and meets the needs of the situation. The consent of the client (and guardian where appropriate) should be sought regarding their involvement and the disclosure of information, so that questions of breach of confidentiality do not arise.

Where the service user does not consent to disclosure, others should only be told information in general terms or in accordance with recognised Care Programme Approach and medical practice.

The CRHT Worker must be thorough in the assessment of people with apparent psychiatric disturbances, recognising that signs and symptoms of mental health disturbance may be presenting features of a psychiatric, neurological or medical problem.

A comprehensive assessment procedure includes direct discussion with the service user and relevant carer/family members, contact with treating clinicians if appropriate and available, mental state examination, physical assessment, social and environmental circumstances. Service users must be given the opportunity to contribute information on their history and current situation. However, details must be verified and relevant and necessary information must be obtained from significant others.

Risk assessment should include significant people in the service user’s environment, without the user being present.

Components of a comprehensive assessment include identification of:

- presenting problem
- risk of suicide and/or self harm
- risk to others
- risk of neglect
- psychiatric history
- physical state and medical history
- mental state
- personal and social history
- family details
- protective factors
- strengths/coping strategies

Where it is established through the formal assessment process that the user is not suitable for ongoing CRHT service because they do not meet the intake criteria, then the assessment will be concluded and the individual referred to another appropriate service
or back to the referee. However, the needs of the service user and family/carer will always be a primary consideration.

Assessments will be documented in line with CPA requirements and the approved Integrated Care Pathway for Acute Care and records maintained according to LPFT’s Records Management Policy.

10. WORKER SAFETY

The following principles form the basis for safe practice:

- All workers will follow the Lone Working Policy
- Workers will be trained and experienced in assessing and managing risk, and retain the right not to enter dangerous situations without adequate support.
- The safety of workers is enhanced by comprehensive information gathering and the application of worker safety practices such as the carrying of mobile phones and regular contact with the CRHT Service office.
- No worker will operate alone in an unfamiliar and threatening situation.
- All workers will withdraw their interventions if at anytime they believe that it is unsafe to proceed. This will be reported to the Triage Co-ordinator who will arrange appropriate action to be taken.
- Assessments conducted by the CRHT Service will aim to have two CRHT Workers to undertake the assessment, taking into account the location and safety of workers. During 2200 – 0800 hrs, if the environment is considered relatively safe, i.e. A&E Dept; Police or GP are present; CRHT practitioners may assess without an accompanying worker. A/E departments will have been risk assessed utilising LPFT’s risk assessment processes and local protocols for assessment used.
- The Triage Coordinator is responsible for ascertaining at the time of the referral all possible risks to the service user, or to others, from the referring agent. Any past psychiatric history must be checked before an assessment is undertaken.

11. SERVICE DELIVERY

Intensive Community Based Treatment and Support

11.1 Service User Contact

Most CRHT service users receive intensive community based treatment and support, this being the primary role of the CRHT service.

Service User contact is short term, generally spanning a period comprising a number of weeks (maximum). Frequent and intensive contact is provided on an outreach basis during the period of mental health crisis, with Care Coordinator and Consultant Psychiatrist continuing with active involvement for the benefit of the service user, if the service user is already known to the Trust.
11.2 Medical Treatment

Treatment with medication is a significant role of a CRHT service; CRHT practitioners are frequently required to supervise users regarding the taking of medication and in some situations, may administer medication. The CRHT service role in relation to supervision of medication may at times require multiple daily contacts with service users. Medication review is a role, which is performed by CRHT service medical practitioners at regular intervals during a service user’s involvement with the CRHT service.

The CRHT Consultant Psychiatrists will review their patients receiving home treatment. Regular liaison as required, will take place with other Consultant Psychiatrists and SHO’s.

CRHT staff will attend the in-patient multi-disciplinary meetings to facilitate early discharge.

11.3 Medication Management

Interim operational policy for CRHT medication management

CHRT teams will have access to a range of common medications available for CRHT service users for emergencies only. The existing Medicine Management Policy (OPR/17) and the NMC Guidelines for the administration of medicines inform all issues of prescribing, dispensing, supplying, administering and storing CRHT medications.). This includes the agreed protocols for access, storage, ordering and risk management. Local protocols will be in place and will be agreed with the Trusts Chief Pharmacist. Additionally, patient group directives will be considered to be utilised in the exceptional circumstances of individual user prescriptions not being available and immediate access to CRHT medications being required.

11.4 Carrying Medication

Protocols will be in place in each CRHT base to cover the issue of access and storage of medication. These will be in line with the Trusts policy OPR/17.

The transport medication this will be via a locked briefcase and in line with the appropriate policy.

11.5 Crisis Intervention

A crisis response will be delivered by the CRHT. All available rostered staff are expected to assume responsibilities with clients as required and to change their work schedule in response to crisis demands.

The Senior CRHT practitioner on duty will set and review priorities on a daily basis in relation to all work demands, taking into account the urgency of crisis demands.

Crisis intervention by a CRHT practitioner may involve telephone or face-to-face crisis intervention, arranging urgent medical assessment/review or treatment,
negotiating with family members/carers or friends regarding problems and liaison with other agencies or service providers.

11.6 **Support for Carers**

The CRHT service will follow LPFT CPA policy guidance in relation to working with users and their carers. The needs of the service-user often relate not just to their own lives, but also to the lives of their carers and family. Under Carers' (Recognition and Services) Act 1995 and the Carer and Disabled Children Act 2000, all carers are eligible for general support and can ask for an assessment of their caring needs. Under the Mental Health National Service Framework, all individuals who provide 'regular and substantial' care for a person with mental health problems should be offered:

- an assessment of their caring, physical and mental health needs which should be repeated on at least an annual basis
- a written care plan which is agreed with the carer and covers their caring, physical and mental health needs. Younger carers particularly need to be identified and their needs, including their educational and welfare needs, assessed. Younger carers need consideration for referral to appropriate services.
- The care plan should be reviewed on an annual basis.

Subject to the consent of the service-user, carers should receive information about the help available to them and the services provided for the person for whom they are caring. This should include medication details, other care and treatment, what to do and who to contact in a crisis.

It is the responsibility of the CMHT, in particular the Care Co-ordinator, to ensure that carers are offered an assessment of their needs and provided with a care plan to meet those needs and to co-ordinate the care plan. This carers care plan should be located in the service users clinical or practice notes.

11.7 **Information and Education**

CRHT service clinicians play an important educational role by providing timely information to the client and family members/carers on the nature of the mental illness, treatment options, medication effects, side effects and service options.

The needs of dependent and adult children in relation to information about their parent's illness must be responded to in a manner, which is age-appropriate and recognises the fears and misconceptions, which may be experienced by children.

The service user's or guardian's consent to disclosure of information to family members/carers should always be sought and where consent is refused, information can only be provided in general terms on the service user's condition or in accordance with the recognised customs of medical practice.

11.8 **Monitoring**
CRHT practitioners must regularly monitor the situation of service users, including changes in physical and mental state, risk level, family situation and social situation.

Service Users who are a high risk to themselves or others whose situations are subject to frequent change may need to be monitored more often than those whose situation is relatively stable.

11.9 Review

Following completion of the assessment process and documentation of the assessment report, CRHT practitioners will continue over time to seek information for assessment and review purposes. Routine verbal reviews will be undertaken at each handover for every CRHT service client who is receiving ongoing treatment and support.

Formal review processes must be established by the Clinical Team Co-ordinator or a Senior CRHT practitioner, for high risk and difficult to manage service users. The formal review should be undertaken at regular intervals, not exceeding one week, and a written record of all decisions must be maintained.

The review will consider the progress, condition and needs of CRHT service users and carers, in order to determine whether the appropriate intervention is being undertaken and to clarify the immediate and longer-term needs.

Whilst much of the immediate CRHT service intervention targets symptom relief and achievement of goals, CRHT service clinical staff must also focus on physical and social matters, which have an impact on the service user’s ability to manage in the community. It is important to consider the protection of others.

11.10 CRHT Transfer Planning

Formal processes should be established in each service to ensure that transfer from the CRHT service is well managed. Strong links will be developed with Community Teams and inpatient areas to define responsibilities for treatment and care coordination. Clear protocols will be developed for transferring people in to and out of the CRHT service to ensure continuity of care.

CRHT care transfer plans will identify the current treatment and care needs of the service user, ongoing interventions required, to support the client and carers, and expectations established with the care coordinator, GP and other significant people.

12. EMERGENCY RESPITE ACCOMMODATION

This service is not currently available within Lincolnshire, however, it is hoped that in the future, CRHT services will directly manage access to emergency respite accommodation. This would be used for short-term stays only and any ongoing needs identified and communicated to the Care Coordinator, GP or other agencies involved.

Referrals that would be considered inappropriate for Emergency respite accommodation:
Individuals who are homeless;
Individuals who are dependent on alcohol or illicit substances;
Individuals who are at risk to self or others.

Unless there is clear evidence of significant mental health problems.

13. LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST – ADULT ACUTE SERVICES

13.1 Admission

CRHT services and mental health acute inpatient services will have established agreed methods of working to ensure that a home treatment service is provided as an alternative to admission, wherever possible.

The Team Co-ordinator and Senior CRHT practitioners must develop systems to identify and monitor acute inpatient service admissions.

13.2 Inpatient Liaison

Inpatient liaison will be provided by a Care Coordinator. Where CRHT services will be maintaining ongoing involvement they are responsible for liaison with inpatient service staff and the Care Coordinator on matters relating to the service user’s inpatient treatment.

Responsibility for inpatient liaison for ‘out of area’ service users will be negotiated between the inpatient service and the mental health services in the area to which the service user will be discharged.

13.3 Inpatient Discharge Planning

Care Managers are responsible for ensuring that discharge plans are developed for all service users of acute services. CRHT practitioners are responsible for contributing the components of the discharge plan which relate to CRHT service involvement and must be an active participant in discharge planning for all service users who require CRHT service follow up on discharge from inpatient services.

In these circumstances the Senior CRHT practitioner, or another CRHT practitioner, will assess the viability of managing the service user in the community in the immediate future.

Discharge planning requires an assessment of the service user’s progress, assessment of the impact of discharge on family/carers and their ability to provide necessary support and identification of the level of service needed from the CRHT service and other agencies to sustain treatment and support in the community. Discharge plans involving the CRHT service will be agreed with the Senior CRHT practitioner on duty and CRHT medical input as appropriate.

13.4 Out of Hours Backup
There will be one Crisis Resolution practitioner, acting as Triage Coordinator, on-call or available during the following times:
10 pm – 8 am, 7 days a week.

Consultant Psychiatrist

Where Consultant Psychiatrist expertise is required after hours by CRHT practitioners, the on-call Consultant Psychiatrist should be contacted in the first instance according to local arrangements.

Junior Doctors

Generally, the Junior Doctor on call would be the first contact regarding medical issues during ‘out of hours’ and working hours, unless the GP is already involved with prescribing.

13.5 Inappropriate Referrals

The Triage coordinator is responsible for deciding whether the referral is appropriate and what action should be taken as a consequence.

Where the referral is deemed inappropriate, the Triage coordinator is responsible for providing information or advice on referral to alternative services. In some circumstances in order to satisfy a duty of care, this may require active assistance in contacting alternative services. People may be referred on to other services in situations where:

- There are no indicators of mental illness and the person is not experiencing a psychiatric crisis.
- Community management is possible with general support and home treatment is not being considered.
- The referred person is the subject of a court order, request from a magistrate or judge for a psychiatric assessment report to assist sentencing.
- The referred person is in police custody serving a sentence or on remand.

If there is doubt about whether the referral should be accepted, an assessment will be undertaken by the CRHT service to determine suitability.

14. INITIAL RISK ASSESSMENT

14.1 Risk to the service user or Others

The Triage Co-ordinator is responsible for ascertaining at the time of referral whether there is any indication of risk to the service user, other people or property and ensuring that risk factors are taken into account when deciding how the assessment should be managed.

In situations where there are indications of significant risk to the service user or other people, an initial risk assessment and action taken must be clearly documented on the client record.
Police may already be involved, but if not, their involvement must be considered in situations of high risk.

14.2 **Risk to staff**

It is the responsibility of the triage coordinator to seek information on staff safety factors and to assess the risks involved in direct contact with the referred person and others in the immediate environment.

Staff must, **at all times**, follow the Lone Working Policy.

Factors which need to be considered are:

- level of agitation;
- explicit acts or threats of violence;
- past history of violence;
- attitude of person to the referral;
- psychiatric history;
- presence of other people, including dependent children;
- role of other people (threatening or supportive);
- physical location of referred person;
- gender issues.

In situations where there is indication of a significant risk to staff safety, the assessment plan must be discussed with the CRHT Clinical Team Leader or the Consultant Psychiatrist. The details regarding the initial risk assessment and action taken must be clearly documented on the service user record.

14.3 **Staff Safety**

The following principles form the basis for safe practice:

- Workers are expected to be trained and experienced in assessing and managing risk, and retain the right not to enter dangerous situations without adequate support.
- The safety of a worker is enhanced by comprehensive information gathering and the application of worker safety practices such as the carrying of mobile phones and regular contact with the CRHT service office.
- No worker should be expected to operate alone in an unfamiliar and threatening situation.
- Workers have the right to suspend their activities and withdraw from direct involvement if at any time during their intervention they believe that it is unsafe to proceed. Where a worker withdraws from a situation appropriate alternative action or referral must occur e.g. involvement of police.

In high-risk situations where face-to-face contact with the service user is not possible, CRHT service clinicians can still make an important contribution to ensuring the best outcomes for the service user.

Police involvement must be considered in situations of high risk.
14.4 **Risk to Children**

CRHT staff are required to consider the risk to children in their initial assessment. In situations where it is believed that children or adolescents up to the age of seventeen years are at risk of actual or potential harm from physical abuse, sexual abuse, emotional abuse or neglect, CRHT service clinicians are required to comply with guidelines established in the Lincolnshire Health Trust Child Protection Policy.

CRHT staff will undertake training in child protection issues.

15. **INTERFACE WITH LEARNING DISABILITY SERVICES AND CHILD & FAMILY SERVICES**

(a) **Policy in relation to Learning Disability Services**

15.1 **Background**

As part of the establishment of a county-wide Crisis Resolution and Home Treatment Service (CRHT) for adults with Mental Health problems the project team have considered the role of the CRHT team in supporting people in crisis who also have Learning Disabilities.

It is estimated that the volume of clients who may require a crisis service is in the region of c24 episode per year (6 per Consultant).

In determining this role the project team have adopted the following principles:

- The Mental Health NSF covers all adults and therefore includes people with learning disabilities (Source: Green Light for Mental Health)
- Staff in mental health and learning disability services need to work together to make it easy for people with learning disabilities to use ordinary mental health services. (Source: Valuing People)

15.2 **Service Scope**

It is assumed that most people with severe learning disabilities will be looked after in some form of residential care facility and as such will continue to utilise existing arrangements for “crisis situations” where specific LD skills are required.

The CRHT will respond to calls for crisis support for all adults with mental health problems including those where the service user also has mild/moderate learning disabilities.

Where the service user has mild/moderate learning disabilities the CRHT will:

- Respond to the crisis call and undertake an assessment of the service user
- Determine the most appropriate course of action to resolve the immediate crisis
- Contact the service user’s designated Care worker and/or Consultant (where known to the LD service) at the earliest opportunity to discuss and agree a care plan to support the service user through the crisis period.
Where the person in crisis is not known to the LD service an appointment will be made with the local LD Consultant as soon as possible for further assessment.

Continue to provide /home treatment in accordance with the agreed care plan

Agree the handover arrangements to ensure the involvement of the CRHT is time-limited

15.3 Training Issues

It is recognised that CRHT staff would benefit from some additional LD specific training. The project team (supported by the LD service) will seek to incorporate this into the training programme for CRHT staff. This will focus primarily on how the LD service works and how to undertake assessments.

In the longer term it is felt that inclusion of staff with LD experience into the CRHT team would be beneficial

15.4 Operational Issues

The LD service will provide:

- Crisis alerts to the CRHT if it is felt that a service user may be on the verge of a crisis
- A contact list of key LD personnel in each area to whom the CRHT can refer to for advice and guidance

In order to ensure that the role of the CRHT is time-limited there is a need to identify what other additional support may be required from the Trust's adult services. It is felt that the involvement of the Assertive Outreach team may be appropriate for this client group. Further discussions need to be held to address this issue.

(b) Policy in relation to Child & Family Services

15.5 Background

As part of the provision of a county-wide Crisis Resolution and Home Treatment Service (CRHT) for adults with Mental Health problems consideration has been given to the role of the CRHT team in supporting people who meet the following criteria:

- Aged 16 and 17 years
- Suffering from a serious mental illness

CRHT will undertake initial assessment at any time during the day. A young person’s educational status is not relevant.

Where the assessment outcome is unclear the needs of the user will be assessed in consultation with C&FS professionals to ensure the safe resolution of the potential crisis.

- Out of hours – contact on-call C&FS Consultant
15.6 Service Scope

Where the service user meets the criteria outlined above the Crisis Team will:

- Respond to the crisis call and undertake an assessment of the service user
- Determine the most appropriate course of action to resolve the immediate crisis
- If admission to hospital is required this will usually be to an adult ward. However consideration will be given to admitting to Ash Villa if the service user is no older than 16½ yrs and this is agreed with the Child & Family Services.
- Contact the service user’s designated Care worker and/or Consultant at the earliest opportunity to agree the way forward.
- Provide out of hours support to the service user if required until he/she can be handed over to the Child & Family Services team. It is expected that handover will take place at the earliest opportunity – i.e. next working day.
- To work with Child & Family Services professionals in providing a care package to complex cases where a multi professional approach is needed.

15.7 Training Issues

There are no specific training issues related to the crisis support for Child & Family Service clients

16. TRAINING AND DEVELOPMENT

An initial induction and training programme is to be initiated and co-ordinated by the Clinical Team Leader in post. All team members will be required to undergo the programme.

All subsequent staff recruited to the team must undergo training before commencing active duty. This will orient them to their key roles and responsibilities, operational issues and resources available.

Ongoing team and individual training and development needs will be identified through the Trust Staff Development and Performance Review.

Particular attention will be given to risk assessment skills, managing risk, and brief therapeutic interventions, with an emphasis on a whole systems approach to supporting individuals in crisis.