Reference Number: *TBA unless document for review* **Version Number:** 2	**Date of Next Review:** *01/05/2028* **Previous Trust/LHB Reference Number:** *UHB 159*

Crisis Resolution Home Treatment Team Operational Policy

Policy Statement

Crisis resolution and home treatment teams (CRHT) are designed to provide people with a rapid response when they are experiencing an acute mental health crisis that would otherwise require an admission to an adult mental health inpatient unit. Elements of this crisis response are also set out to consider alternative packages of care which avoid or replace or shorten unnecessary hospital admissions as well as access specialist consultation in terms of managing mental health conditions or acute mental health crises.

The Crisis Resolution Home Treatment Team Operational Policy outlines the clinical/service aims and objectives that Cardiff and Vale University Health Board (the UHB) will deliver along with its responsibilities to those in receipt of care whilst receiving home treatment under the care of the Crisis Service.

Policy Commitment

We are committed to ensuring that the provision of Crisis Service assessment for admission avoidance and home treatment for the population of Cardiff and Vale UHB. Home treatment is offered where it has been assessed as safe to do so. Individuals receive care under the crisis team within their own homes as an alternative to hospital admission. If admission is required Crisis Service will arrange admissions to Hafan Y Coed inpatient unit as outlined in the Crisis Assessment Ward Policy. We will support staff within the service to provide assessments and home treatment by:

• Publishing this policy and keeping it updated in line with any service change/developments
• Providing training for staff on appropriate interventions and risk management
• Providing support to staff with managerial supervision

Supporting Procedures and Written Control Documents

This CRHT Team Operational Policy should be considered in conjunction with the below policy documents:

- Cedar Ward Operational Policy
- Crisis Recovery Unit Operational Policy
- Integrated CMHT Operational Policy
- Protocol for CRHTT and interface with WAST
- Section 136 Policy
- Clozapine Policy
- Putting things right process

Other supporting documents are:

- *Welsh Government 2015 Mental Health Crisis Care Concordat*
- *Welsh Government 2010 Mental Health Measure Wales*

Scope

This procedure applies to all healthcare professionals employed by the UHB within adult Mental Health's Crisis Services, including those on honorary contracts along with wider Community Mental Health/Inpatient/Liaison staff who will interact/refer into this service. It also applies to academics, healthcare support workers, students and locums working within this clinical area.

Equality Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has been completed and found there to be no impact and no key actions have been identified.*
Policy Approved by	Board/Committee/Sub Committee
Group with authority to approve procedures written to explain how this policy will be implemented	For example: Health System Management Board
Accountable Executive or Clinical Board Director	Dr Neil Jones Medical Director Mental Health Clinical Board

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	12/12/2012	31/03/2013	New policy
2	15/06/2023	20/06/2023	Review and update of Crisis Resolution Home Treatment Team Operational Policy 2012

Contents

1. Introduction

The Crisis Resolution Home Treatment Team will provide a flexible, responsive and integrated service to adult mental health clients and their carers, in the most appropriate setting.

The Crisis Resolution Team (CRT) is a multi-disciplinary community based mental health team which aims to provide a safe and effective home-based assessment and treatment service as an alternative to in-patient care. The service is available 24 hours a day, 365 days of the year for residents of Cardiff and Vale of Glamorgan with mental health difficulties who are experiencing an acute mental health crisis

The service has multi-disciplinary approach with staffing including; consultant psychiatrists, speciality grade psychiatrists, band 7 team leaders, community mental health nurses, social worker, occupational therapist, pharmacist and community support workers. There is psychology provision shared by the crisis service. The service also benefits from the Crisis Recovery Unit and Linden House (previously known as the crisis house appendix 1).

The CRHTT will promote continuity and consistency of care and intervention for individuals and their carers, offering a range of approaches and skills usually for no more than 8 weeks. If CRHTT input is indicated beyond this, weekly review meetings between CRHTT, the person, and the CMHT/GP should take place to ensure the right focus of care.

The CRHTT will treat each person as a unique individual who will receive non-judgemental care that sustains dignity, respect and privacy.

2. What is the Service Intending to Achieve?

2.1 People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Home treatment can be provided in a range of settings and offers an alternative to in-patient care. The Crisis Resolution Home Treatment service will:

- Act as a gateway to Mental Health in-patient services, rapidly assessing people with acute mental health problems and facilitating referrals to the most appropriate service if necessary.

- Provide rapid, responsive multidisciplinary, community-based treatment 24 hours per day, seven days a week, for people experiencing mental health problems.

- Ensure that people experiencing acute, severe mental health difficulties are treated in the least restrictive environment, as close to home as clinically possible.

- Provide intensive treatment in the community as an alternative to in-patient care.

- Remain involved with the person until the crisis has resolved and the person is linked to ongoing care if required.

- Be actively involved in discharge planning and provide intensive care at home or other appropriate location (for example Linden House) to facilitate early discharge, when in-patient care has been necessary.

- Provide psycho-education to reduce vulnerability to crisis and maximise the person's resilience.

2.2 The service is most appropriate for those with a serious mental disorder and/or are experiencing acute psychiatric mental health crisis that would otherwise lead to admission to an adult inpatient mental health bed. There is no blanket exclusion based on diagnosis alone; each individual client will be assessed on the basis of clinical presentation at the point of assessment.

2.3 The home treatment element of CRHTT expects to care for approximately 50 people at any one time, but the number of people receiving home treatment will be determined by capacity within the CRHT, the degree of risk/acuity of the person and the impact upon the carer.

3. Hours of Operation

The Crisis Resolution Home Treatment Team will operate 24 hours a day, 365 days per year. This will be achieved through shift work.

4. Catchment Population

4.1 The Crisis Resolution and Home Treatment Team will be responsible for people registered with GP Practices aligned with CMHT/Locality Teams in Cardiff and the Vale of Glamorgan.

4.2 If a GP cannot be identified or if the person is registered with the Safe Haven Practice or Cardiff and Vale Health Inclusion Service (CAVHIS), the person's address (including hostels) will be used to determine the responsible CMHT/Locality Team.

4.3 If a person's address cannot be identified or the person is not a Cardiff and Vale resident, the two CRHT's alternate the initial assessments for NFA or out of area assessments. If the patient is accepted for home treatment then it would go the team that assessed. If the patient gets admitted to Cedar ward then RC responsibility would be alternate between consultants, a record of this is held by team administration manager. If the patient subsequently needs transfer to a locality ward then consultant is identified via the NFA rota.

5. Referral Pathways

It is imperative that sufficient information is made available to the CRHTT to enable them to plan appropriate intervention with particular consideration to issues relating to risk assessment, gender preference and specific clinical information. If a full risk assessment has been undertaken it is imperative that this be available to the CRHTT. The CRHTT will make a decision on the appropriateness of the referral based on the information given. They may request further information before proceeding, they may signpost to other services or they may accept the referral as appropriate for an assessment.

The CRHTT accepts direct referrals from various sources including:

- Emergency Departments via Liaison Psychiatry
- Welsh Ambulance Service
- Police
- General Practitioners
- Rehabilitation and Recovery Teams
- Community Mental Health Teams
- Inpatient Units
- Adult Social Care
- Criminal Justice Liaison Service
- Homeless MDT
- Primary Care Liaison Team
- 111 MH team

5.1 In Hours

5.1.1 During the hours of 9.00am to 5.00pm the referral should ordinarily be via the CMHT. However it is acknowledged that other mental health services/professionals can directly refer, who in their professional judgement, require an admission assessment. In these circumstances the CRHTT will not require for the referral to be seen by the CMHT first, as long as a qualified mental health professional in the relevant team has seen the client within the last 24 hours. Good practice would suggest that the referrer discusses the possibility of a CRHTT referral with the CMHT, prior to making the referral.

5.1.2 New/urgent cases will have an initial screening assessment by the CMHT/ Locality team duty worker to determine whether the Crisis Resolution Home Treatment Team is required.

5.1.3 Any new referral from a CMHT/ Locality team must have been assessed face to face by the CMHT / Duty Worker / or significant other e.g. Responsible Clinician within the last 24 hours.

5.1.4 All referrals will be screened by the CRHTT Duty Worker and allocated to the most appropriate discipline to assess.

5.1.5 Health Care Providers based in Cardiff Bay police station can refer known service users directly to CRHTT for admission avoidance assessment, providing CRHTT involvement does not interfere with any judicial process.

5.1.6 In the event of a CMHT receiving an emergency referral after 4pm, it is unlikely that the CMHT will have the capacity to assess the same day. In these circumstances the CMHT worker will take the referral information and screen the referral as per usual practice. If an assessment is required the same day, the referral information will be passed to the relevant CRHTT to arrange an assessment with the referrer, this will not be screened further by the CRHTT.

5.1.7 In the event of a deterioration of a service user allocated service user to a CMHT where increased contact has been attempted over course of a week or more it may not be necessary to review on the day if referrer can demonstrate recent contact with mental state examination, outline current situation and potential risks.

5.2 Out of Hours

5.2.1 During the hours of 5.00pm and 9.00am the referral may be via the GP, a qualified mental health professional, Liaison Psychiatry, the Emergency Unit, WAST or the Police via section 136 pathway (see section 136 policy)

5.2.2. Waking night shifts are staffed by two members of the CRHTT based at Hafan y Coed. Please see Appendix 2 for Night Shift Protocol.5.2.4 In order to refer to the CRHTT, Out of Hours GPs will need to have reviewed the person within the last 24 hours in order to ensure, as far as possible, that the client is physically fit for a potential psychiatric admission.

5.3 24 hour services

5.3.1 In addition to referral routes identified some services (111 option 2, MH practitioners within WAST) can refer directly to the crisis service 24 hours a day if triage contact categorises the individual as very high risk to themselves or others, as per Colgate triage category (appendix 5). The triage must have been completed by a trusted assessor with requisite mental health experience and does not require face to face assessment for referral. Sufficient information must be provided to the crisis team in order to consider referral, offer appropriate interventions and manage any potential risks. Agreement will be made with referrer as to whether face to face assessment is offered at which point time/location to be agreed and communicated by referrer. Alternatively, in some instance's crisis team will accept responsibility for contacting the individual at which point options offered may include- advice to client, signposting/referral on to appropriate agencies or face to face assessment depending on presentation and knowledge of individual.

6. Assessment

6.1 The CRHTT will participate in all assessments, when admission to in patient setting is a possible outcome, and for all persons requiring a Mental Health Act assessment.

6.2 The CRHTT will provide a response to a request for an emergency assessment as soon as possible. The Welsh Assembly Government sets a CRHTT response time target of 4 hours.

6.3 The CRHTT will determine the safest place to undertake the assessment which may include the home, CMHT/Locality Team, EAS at Hafan y Coed, police station (if referred from custody, Safe Haven or A&E.

6.4 For people requiring a Mental Health Act assessment, the AMHP in the sector CMHT/ locality team will decide whether or not they can accommodate the MHA assessment, whether the person is known or unknown to services. If the CRHTT are not undertaking the AMHP function, a qualified member of staff from the CRHTT will attend the assessment with the CMHT AMHP, in order for the Home Treatment option to be considered. If the CRHTT are not able to attend a Mental Health Act assessment at the time planned by the CMHT, this will not delay the assessment for the person. The assessment will proceed without the CRHTT on the understanding that the assessing team will complete all relevant paperwork. If the assessment results in an admission, without the CRHTT having undertaken a gateway assessment, the admission ward will inform the CRHTT of the admission in order for the CRHTT to assess within 24 hours.

6.5 For the people requiring an assessment as a result of section 136 MHA, the CRHTT administrator/duty worker, in hours Monday to Friday, will be informed of the requirement for the assessment. The CRHTT administrator/duty worker would then contact the psychiatrist (duty consultant within hours) and locality AMHP manager. The locality AMHP manager will contact the duty AMHP to request further liaison with CRHTT and on-call psychiatrist. It is also important at this stage for the CRHTT to contact the shift coordinator for Hafan y Coed Unit of the potential for an inpatient admission. Once the assessment time is agreed, the CRHTT will attend the assessment. The CRHTT will complete an incident form if unable to attend due to clinical pressures/staffing issues, as per the non-attendance at mental health act procedure. If the person is subsequently without the CRHTT presence at the assessment, the CRHTT will attend the ward and assess for suitability for home treatment within 24 hours of the admission as per national CRHTT requirements.

6.6 The police may refer persons in their custody to the Forensic Medical Examiner (FME) or Diversion at Point of Arrest nurse (DAPA) or HCP, if they are concerned for their mental health. If the FME or DAPA nurse or HCP judges that the person may need an adult mental health admission, they will liaise with the CRHTT about the most appropriate venue for the assessment. If the criminal justice procedures are concluded, or the DAPA Nurse/ HCP has established the Index Offence and are satisfied that CRHTT will not interfere with the judicial process and there is no risk factor to prohibit this then the CRHTT may decide to assess the client at another venue such as the emergency assessment suite in Hafan y Coed. The CRHTT may feel the assessment requires medical input, in which case they will liaise with the consultant on call (SPR on call out of hours) to co-ordinate an assessment at Hafan y Coed as per GP referrals. Sometimes, however, the assessment will need to take place at the police station because the person is deemed too risky (in terms of their potential violence and aggression related to their mental health) to be released in which case a senior doctor would need to be involved in the assessment with the CRHTT. This will only apply to persons requiring an informal assessment. As per the Crisis Care Concordat, police custody is NOT defined as a Health Based Place of Safety and should not be used other than for circumstances agreed in the local protocol.

6.7 The assessment will, as a minimum, consider:

- The presenting problem (what has happened to precipitate action now)
- Risk issues
- Accommodation status
- Clinical signs and symptoms
- Unsafe or intolerable behaviour (this is most likely to cause community treatment breakdown)
- Carers and dependant children's needs including names and date of birth of all under 18 year olds as per 'Safeguarding Children Guidelines'.
- Interpersonal relationships

- Social support and needs
- Willingness to cooperate
- Safeguarding of Adults. It is the responsibility of all staff to ensure they identify and respond to concerns appropriately, completing any safeguarding referrals as necessary.

6.8 The assessment will actively involve the person, carer/family and all relevant others e.g. GP, Care Co-ordinator if possible and appropriate.

6.9 The assessment will be multidisciplinary where possible, and will identify the person's needs and levels of risk.

6.10 It should be recognised that risk cannot be eliminated; rather, the CRHTT assessment will aim to collaboratively co-produce risk mitigation plans, including the individual and relevant others where possible

The WARRN formulation tool will be used as a baseline risk assessment tool for all people in contact with the CRHTT.

6.11 Any physical health assessments will be carried out if relevant. It may be necessary to request the GP or advise A&E attendance, to review the physical health status of the person if outside of the remit/scope of the crisis team practitioners.

6.12 Once the CRHTT is involved in an assessment, they will remain involved and responsible for the immediate care needs of the person until a clinical decision is reached regarding the future management of care and, if required, a successful transfer has been carried out.

6.13 If CRHTT services are not required, but a referral to another service is, the CRHTT will make the appropriate referrals and ensure that the referrer is aware of any outstanding/unmet needs.

6.14 People assessed by CRHTT out of hours should not be referred to CMHT/Locality Teams as Urgent. If deemed to need urgent CMHT/Locality team review, CRHTT to provide support until able to hand over safely in hours.

6.15 For a CRHTT assessment to be concluded, one of the following options must have been achieved:

- A CRHTT intervention plan is in place.
- The person has been admitted to hospital or other appropriate agency.
- Acute intervention is not required but other appropriate support from other parts of the service is organised/will be organised.

- No further action or intervention is required from Secondary Mental Health Services.

6.16 If an assessment is required under the Mental Health Act, the AMHP has a responsibility, in line with the Code of Practice, to manage the process. As such the CRHTT will actively participate until they are no longer required.

6.17 If a known “relevant patient” is accepted by the CRHTT out of hours, the CRHTT will contact the care co-ordinator the next working day to agree a plan of care. Alternatively, an out of hours assessment may not require home treatment, but is suitable for further assessment at the CMHT. In this instance, the CRHTT will inform the CMHT as soon as practicable, detailing any further action or recommendations for follow-up.

6.18 CRHTT Administrators will fax a notification to the GP the next working day highlighting whether the person was admitted, detained or sent home.

7. In Patient Admission Criteria

The main indicators for hospital admission include but are not limited to the rationale that the person cannot be appropriately treated in a less intense level of care because of the need for:

• 24 hour availability of services for diagnosis, continuous monitoring and assessment of the person’s response to treatment
• availability of a physician 24 hours a day to make timely and necessary changes in the treatment plan
• the involvement of a psychiatrist in the development and management of the treatment program, and 24 hour availability of professional nursing care to implement the treatment plan and monitor/ assess the person’s condition and response to treatment
• 24 hour clinical management and supervision

In addition to the above the severity of the psychiatric illness presented by the person meets one or more of the following:

• The person poses a significant risk of harm to self or others
• The person’s judgment or functional capacity and capability has decreased to such a degree that self‐maintenance, occupational, or social functioning are severely threatened and this cannot be mitigated in any environment other than a psychiatric hospital
• The person requires treatment which may be medically unsafe if administered anywhere other than a psychiatric hospital

• There is an increase in the severity of symptoms such that continuation at a less intense level of care cannot offer an expectation of improvement or the prevention of deterioration, resulting in harm to self or others

7.1 People will be admitted when an application for compulsory admission has been completed.

7.2 When a Responsible Clinician (RC) intends to use powers of recall as per Community Treatment Order. Please see Appendix 5 for Recall of CTO protocol.

7.3 Should the person refuse the involvement of the CRHTT, admission will only be offered if clinically indicated. This would be discussed with the care co-ordinator at the earliest opportunity. Should the person's support network break down, the CRHTT will need to consider all other options first, such as Linden House.

8. Planning Care

8.1 If a period of Home Treatment is indicated, the Care Co-ordinator will retain responsibility for the client. The Care Co-ordinator will usually be a member of staff from a CMHT, however, care planning will be shared by the CRHTT and the Care Co-ordinator, if appointed.

8.2 If no Care Co-ordinator exists, and a person remains under the care of the CRHTT for a period of 2 weeks, a Care Co-ordinator will be allocated by the CRHTT. It will be clearly documented that the CRHTT are acting as interim Care Coordinator until handover of care within the Care and Treatment Plan. A Care and Treatment Plan will be commenced within 6 weeks.

8.3 The CMHTs will prioritise CRHTT clients, along with current in-patients, for allocation of a Care Co-ordinator as soon as possible.

8.4 Care planning of home treatment within the CRHTT will require a whole team discussion and agreement. This will be commenced at the point of the person being taken on by the CRHTT and an intervention plan will be completed. Intervention plans will:

- Include outcome to be achieved
- Reflect reason taken on for home treatment
- Interventions relevant to reason for home treatment
- Description of any interventions to be delivered
- Demonstrate service user involvement/perspective

8.5 Intervention plans will be reviewed as required, but no less than weekly at a designated CRHTT multidisciplinary team meeting and recorded as review meetings on Paris. CRHTT plans are accessible to care co-ordinators via Paris, however it is expected that the care co-ordinator will remain actively involved in care delivery whilst the person is under the care of the CRHTT. As a minimum this would include weekly liaison with the team and at least one formal review before discharge/handover from the CRHTT. There is evidence to suggest that joint working improves clinical outcomes for patients (Sesay 2008) therefore, joint visits where possible will inform care planning.

8.6 CRHT staff must complete a Consent to Share form with the person. Where consent is refused, information can still be provided to CRHTT by carers and relatives. Generic information regarding care provided by CRHTT can be given where risks are high and Consent to Share is refused; a discussion should take place within the MDT about the reasons for breaching confidentiality in cases of risk to life, and these discussions must be documented. People are to be informed that information is shared between professionals on a need to know basis.

9. Intervention

9.1 Services will be provided at the person's place of residence or when this is not a suitable location, they will be provided at Linden House for 24-hour support, or at the Crisis Recovery Unit for daytime support.

9.2 When a person is referred to CRHTT for Clozapine initiation, the CRHTT will request full information from the care co-ordinator (whether it is to treat residual symptoms or whether the person is relapsing, does the person live with any family or alone, are there any known cardiac problems, are they agreeable to attend the CRU for at least 10 days if it is possible to do community initiation) to ascertain whether community Clozapine initiation is feasible or inpatient initiation is required. CRHTT will make a joint decision with the person, Care Coordinator, RC and Clozapine nurse where possible and follow the Clinical Board's Clozapine guidelines.

10. Resolution

10.1 Planning for discharge from the CRHTT will begin early. The CRHTT will advise the person and their carers that the purpose of Home Treatment is to enable the person to return to their usual level of functioning as soon as possible.

10.2 Prior to discharge from the CRHTT, the team should ensure:

- There is a good shared understanding of why the crisis occurred and what is required to avoid a re-occurrence.
- Coping strategies have been explored with the person and their family/carer.
- A summary of input is provided to the referrer, including successful strategies to assist the Care Co-ordinator in developing a Crisis/Contingency Plan. For people discharged to the GP, the CRHTT will devise the Plan. In all cases, a discharge summary will be sent to the GP and recorded on Paris within 48 hours.
- If a person is being discharged to the GP and identified as not needing ongoing secondary mental health services. Eligibility to request assessment under part 3 of the mental health measure would apply. The person must be informed of their right to self-refer and the CRHTT will provide a part 3 letter on discharge.
- If ongoing care is provided by the Care Co-ordinator then a discharge planning meeting to confirm the details of on-going needs should take place prior to discontinuation of the CRHTT, attended by CRHTT, the Care Co-ordinator and all relevant professionals. The CRHTT will aim to confirm and communicate plans for CMHT follow up which will be completed within 3 days of discharge as per CMHT Operational Policy.
- The person and his/her family/carer have had an opportunity to comment on the service they received and contribute to service improvement.

11. Links with In Patient Services

11.1 All persons requiring admission to an inpatient setting will be admitted to the Crisis Assessment Ward at Hafan y Coed. The medical cover for the Crisis Assessment Ward is provided by the CRHTT psychiatrists. If it is felt that a person requires further assessment and treatment in an inpatient setting then the person will be transferred to a locality ward and care will be handed over to the sector consultant as described in the Assessment Ward Operational Policy.

11.2The CRHTT will work collaboratively with in patient staff at all stages of in-patient care as one of the core functions to facilitate Early Discharge.

11.3 Planning and implementing what is required for an in-patient to be discharged to less restrictive care is a priority and a responsibility shared by in-patient staff, Care Co-ordinators, Responsible Clinicians and CRHTT staff.

11.4 The CRHTT will identify all relevant reasons for admission and what needs to change during inpatient stay in order for home treatment to become a viable option. This will be identified on the CP1A Assessment Outcome box.

11.5 Progress towards discharge will be monitored through joint care review meetings between in patient and CRHTT staff. These meetings will focus on the reasons for admission and will identify a planned discharge date.

11.6 The CRHTT will support clients at home, who are subject to Section 17 Leave, if indicated.

12. Links with Perinatal Services

12.1 The CRHTT will assess people known to the Perinatal service in hours, if, after prior discussion with the Perinatal team it is felt safe and appropriate for home treatment to be considered. The Peri-atal Service will joint-work with the CRHTT throughout any spell of home treatment.

12.2 Out of hours, if an assessment is required, CRHTT will inform Perinatal Services of contact and outcome the next working day.

13. Links with Learning Difficulties Services

13.1 Learning disability should not act as a barrier to acceptance by the CRHTT as long as the CRHTT is best placed to meet the person's needs. Individuals with a learning disability will have equal access to crisis service assessments and if indicated admission. In cases where this is not immediately clear whether presenting problem is mental health or learning difficulty, assessments should be carried out jointly by representatives of both CRHT and Learning Disability Services in hours. Outside of normal operating hours, the CRHTT can access the Learning Disabilities on-call rota for advice regarding the on-going management of any person they assess who may fall into the remit of the Learning Disabilities Service.

14. Support to Forensic Clients Out of Hours

14.1 The CRHTT will assess people known to the Community Forensic Service out of hours only, i.e. weekends, bank holidays and evenings in the following circumstances:

- If the person is known to the Forensic Service, and is in police custody and is deemed to need a mental health assessment by the Forensic Medical Examiner the CRHTT will attend with the on-call psychiatrist.
- If the person is known to the Forensic Service, and is referred for an admission assessment by their GP or Mental Health Liaison Service, the CRHTT will undertake an admission assessment.

The CRHTT will not be required to assess people known to the Community Forensic Service in these circumstances:

- If the person is known to the Forensic Service and has committed a major crime eg murder, they will be assessed by the Caswell Clinic.
- If the person is known to the Forensic Service and has committed a serious crime e.g. arson, the police will access advice from The Forensic Team Leader or Court Liaison Nurse as the "Single Point of Contact" person. Should the "Single Point of Contact" feel a generic admission assessment is indicated, they will refer to the CRHTT to undertake an admission assessment.
- If the person is in prison and deemed to need transfer to a hospital bed, the Forensic Service will undertake this assessment. It is expected that this would only be facilitated in hours, however if needed out of hours this will be facilitated by the on-call Senior Psychiatrist.
- If a person, currently open to the Forensic Service needs extra support over the weekend they would be appropriately referred to the Weekend CPN Service.

14.2 The CRHTT will access PARIS records in order to undertake a safe assessment. The "risk alert" function within PARIS will be used by the Forensic Service to share concerns. There are occasions when specific details are not recorded on PARIS for legal reasons; this is classed as "privileged information" and may be recorded as "contact care co-ordinator" or "hidden information". Should the CRHTT be called to assess in these circumstances, they will ring the Forensic Team Leader or Court Liaison Nurse for further details.

14.3 It is most likely that, if a person known to the Forensic Service presents out of hours in a "crisis", the Service would have exhausted all other avenues already and admission is the safest outcome of the CRHTT assessment. However, there will be circumstances when the CRHTT feels that home treatment is an option, until the Forensic Service re-opens. In this circumstance, the assessment outcome should be discussed with senior on-call medical staff and the "Single Point of Contact".

15. Links with Weekend CPN Service

15.1 People known to CMHT currently requiring a higher level of support from a CMHT (but not at the point of needing admission) would usually be referred to the weekend CPN service.

15.2 If the Weekend CPN Service identifies that the client requires Admission, a referral to the CRHTT may be appropriate.

15.3 If a known person is assessed out of hours by the CRHTT, and is deemed to need extra support but not admission a referral to Weekend CPN may be appropriate.

16. Links with Physical Health wards at UHL/UHW

16.1 If a person on a physical health ward is assessed by CRHTT and felt to need a mental health inpatient bed, but an appropriate bed within Hafan y Coed is not identified, they will be reviewed after 72 hours by the CRHTT to re-assess need for admission.

17. Links with South Wales Police

17.1 As part of the Crisis Care Concordat, police officers are advised to contact CRHTT prior to detaining a person under a section 136, if it is practicable to do so. An informal assessment should be offered, if appropriate, to avoid the use of a section 136 detention.

17.2 For advice and guidance outside of 136 use police officers can access professional mental health triage nurses via the 111 option 2 service. Crisis team will be available to these triage nurses should they which to discuss further due to presenting acuity of person discussed, relates to a well known service user and if situation from triage conversation it appears to indicate potential for 136 use.

18. Links with Welsh Ambulance Service Trust

18.1 Welsh Ambulance Service Trust (WAST) paramedics are able to request a mental health assessment for people who are assessed by the Welsh Ambulance Service as an emergency (999) who have no evidence of physical complications that require attendance at the Emergency Unit (EU), but present with apparent mental health needs (Please refer to WAST Protocol).

18.2 Providing sufficient referral information has been provided WAST mental health triage practitioners can directly refer to the crisis service and assessment arranged with the team as an alternative to emergency department use.

19. Management

19.1 The day-to-day management of Nursing, Medical, Administrative and Social Work and psychology staff will be the responsibility of the Team Leader. This includes roster planning, annual leave and sickness monitoring. Occupational therapy staff are managed directly by the occupational therapy lead who attends weekly review meetings and allocates occupational therapy identified from this.

20. Concerns

20.1 The CRHTT aims to provide the very best care and treatment. However, there may be occasions where a concern is raised. Following any concerns raised, the CRHTT practitioner should attempt to address the concern immediately. If there is no immediate resolution to the concern, then escalation to the CRHTT Team Leader should take place, who will also aim to address the concern.

20.2 If the concern is unable to addressed at CRHTT level, the person raising the concern will be advised of the UHB concern procedure. Contact details of the UHB concerns team will need to be provided.

21. Patient Safety and Quality

21.1 CRHTT practice will be fully in accordance with clinical governance standards to deliver a high-quality service aiming towards constant service improvement.

21.2 CRHTT staff will be trained in appropriate risk assessment and management, equipping them with the necessary skills to undertake the role.

21.3 The CRHTT will be engaged with the Clinical Board patient safety and quality agenda and will follow all Adult Mental Health Directorate reporting procedures.

21.4 The CRHTT will participate in the joint Community/CRHTT Patient Safety and Quality Forum bi-monthly.

21.5 The CRHTT will, in accordance with the above meeting, hold a local CRHTT Patient Safety and Quality Forum.

22. Equality Statement

22.1 Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups. We have undertaken an Equality Health Impact Assessment, we wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

23. References

Department of Health (2007) Best Practice in Managing Risk - Principles and evidence for best practice and management of risk to self and others in mental health services"

Sesay B The Interface between a Crisis Resolution and Home Treatment Team and Community Mental Health Teams: an exploration of experiences and expectations of the working relationship Advancing Practice in Bedfordshire Volume 5: Number 2 (2008)

Appendix 1: Operational Policy Linden House (Previously known as the Crisis House)

1. Philosophy

Linden house will provide short term crisis accommodation for individuals with severe and enduring mental illness or who are experiencing crisis in their mental health. The project will seek to provide a holistic approach to aiding recovery. The service aims to prevent the possible stigmatization of hospital admission. The creation of a safe, comfortable and supportive environment that is responsive to individual need is essential to an individual's recovery. Linden House will provide a 24-hour service staffed by Support Workers employed by Platfform and will be supported by the Crisis Resolution & Home Treatment Teams (CRHTT).

Linden House will promote continuity of care between itself and community-based services, focusing on the psychosocial needs of service users usually for a period of 7 days but can be increased to 14 days as a maximum.

2. What is the project intending to achieve?

- Individuals experiencing severe mental health difficulties should be supported in the least restrictive environment with the minimum of disruption to their lives.
- Linden House will only be accessed via the CRHTT who will provide a gateway assessment to the service.
- Provide intensive support to individuals in Linden House as an alternative to inpatient care.
- To provide practical and emotional support to individuals who are experiencing an acute psychiatric crisis.
- Facilitate early discharge from hospital via the CRHTT
- Be actively involved in care planning to facilitate a return to the individual's home.

3. Criteria for admission to Linden House

Linden House will accept only those individuals currently under the care of the CRHTT. In order to focus services on those with the highest level of need, Linden House is less likely to offer intensive support to individuals suffering with:

- Mild anxiety disorders
- Primary diagnosis of alcohol or other substance misuse
- Brain damage or other organic disorders including dementia.
- Learning disabilities.
- Recent history of self-harm, but not suffering from a psychotic illness or severe depressive illness.
- A crisis related solely to relationship issues.

There is no blanket exclusion on these groups and each individual case will be considered on its merits and assessed by the CRHTT staff.

4. Hours of Operation

The project will be staffed 24 hours per day, with Platfform support workers covering both day and night-time shifts plus sleep-ins. The project management is cover is provided in hours and on an on-call basis out of hours. The project will aim to provide two members of staff on a twenty-four hours basis. Where this is not possible lone cover will take place during day-time hours with on-call support from both the regional office of Platfform for line management support and the CRHTT for clinical/medical support.

The project will seek to maintain a relief bank. This will include existing employees and others known to the organisation in an effort to maintain consistency and standard of care/support.

5. Referral

- Individuals will only be admitted to Linden House once they have been assessed and taken on by the CRHTT. The Crisis Resolution and Home Treatment team will remain involved throughout the period that Linden House accommodation is required.

- A verbal referral will be taken by Linden House Staff, accompanied by a current CPA 1a and risk assessment. Referral information sought by the project will include

-What is the crisis?
-Any changes in behaviour thoughts or feelings?
-Professional diagnosis
-Anticipated input from the CRHTT
-Does the individual /carer/relative agree to the referral to the house?
-Mental health related admissions
-Are there signs that indicate their mental health is deteriorating?
-Does the individual have a Care and Treatment Plan
-What do they need to support them through this crisis?
-Are there any cultural or religious needs relevant to using the service?
-Are there any physical or health needs relevant to using the service?
-Social issues e.g. homelessness

- The project is staffed via lone-waking cover between the hours of 11pm and 8am. Referrals made during these hours will only be accepted for service users previously known to Cardiff and Vale UHB mental health services.

- Where individuals are identified as experiencing significant health issues they will be supported in temporary registration with the local General Practitioner.

- Within twenty-four hours of intake a secondary assessment will be carried out in order to inform a support/action plan for the duration of the stay. Where an individual has an allocated Care coordinator and Care and Treatment plan a discussion will be held with the CRHTT and, where possible, the care co-ordinator in order to ensure consistent delivery of care and

support. This will also provide information on existing plans of care of the individuals return home.

- Individuals referred to the scheme will be residents of Cardiff and the Vale of Glamorgan. Where any individual referred is homeless or of no fixed abode this information will be provided at point of referral. Linden House staff will seek to engage other agencies in order to address housing need from the commencement of stay.

- Particular consideration will be given to issues relating to risk assessment, gender and current mental health issues.

6. Assessment

The Crisis Resolution & Home Treatment Teams will provide a gateway assessment to Linden house beds. All assessments will be undertaken by a qualified nurse, social worker or doctor based in the CRHTT. The assessment will, as a minimum, consider:

- The presenting problem
- Risk issues
- Accommodation status
- Clinical signs and symptoms
- Carer's and dependant children's needs
- Interpersonal relationships
- Social support and needs
- Willingness to engage with services

The assessment for the use of Linden House will actively involve where possible the individual their Carer/family, Linden House staff and all relevant others, e.g. GP, Care Co-ordinator if appropriate.

Risk assessment and management will form a key function of Linden House. In addition to an initial risk assessment provided at the point of referral, any concerns will be reviewed on a daily basis and information communicated at handover of shifts between Platfform support workers. Any change or new observation in relation to risk will be communicated to the CRHTT. Where significant observations are made indicating immediate risk to self or others, advice will be sought from the CRHTT and reported to line managers. If out of office hours, use will be made of both on-call within Platfform and CRHTT.

It will be the responsibility of the senior caseworker in conjunction with the Project Manager and CRHTT to regularly review mechanisms for the assessment and communication of risk.

7. Support Planning

Where an individual has a Care Co-ordinator they will retain overall responsibility for the individual and will usually be a member of staff from a Community Mental Health Team. Support plans will be shared by Platfform, Linden House, CRHTT and the Care Co-ordinator where appropriate.

It is anticipated that discussion of support to be provided by the will have been held between the individual and the CRHTT prior to referral to Linden house. At the earliest opportunity the individual will agree a support plan with Linden House staff. This will be reviewed regularly and discussed by Platfform Support Workers during hand-over of shifts. The support plan is intended to compliment the CRHTT plan of care promote recovery.

Linden House Staff will draw up a focused support plan detailing

(i) The Objectives to be met
(ii) The interventions offered to the individual detailing by whom, when and where the intervention will take place.
(iii) The support plan will require active involvement of the individual, taking account of the views, input and concerns of family/carers where appropriate
(iv) The support plan with identify priority areas to be addressed to aid individuals to return home or to longer term accommodation.
(v) Support planning will involve actively planning for the client to return home within 7/14 days days.

Support plans will be reviewed as required.

8. Record Keeping

It is anticipated that Platfform support workers will have “read only” access to the UHB’s record keeping system Paris. The CRHTT will ensure that as part of the assessment process Form 2a of the CPA (Consent to share information) has been agreed with the service user.

9. Move-on / Eviction

If an individual’s behaviour becomes incompatible with the ability to maintain the safety of staff and other residents. Platfform in conjunction with CRHTT have the right to ask the individual to leave, this will be a joint decision. If the behaviour is felt to be as a direct result of the individual’s mental health difficulties, an inpatient admission may be sought. Individuals will be advised of this as soon as possible after their arrival.

Individuals will be able to stay in Linden House for a period usually of seven days but up to a maximum of 14 days based upon clinical need. In cases likely to extend beyond seven days care and support will be reviewed jointly by Linden House and CRHTT staff. Following this, individuals will be expected to return to their home. If this is not possible the Local Authority will be approached to provide short-term accommodation. Linden House staff, CRHTT and Care Co-ordinator will be responsible for ensuring continuity of care throughout the move on period.

10. Alcohol / Substance Misuse

Alcohol or illegal substances will not be permitted in Linden House. Individuals will be asked to agree to a contract not to misuse alcohol or illegal substances whilst resident in Linden House. Should an individual exhibit behaviour which places others at risk, they will be asked to leave Linden House.

11. Medication

The CRHTT will assume responsibility for ensuring that the client has the necessary medication. Each bedroom will have a locked box to store individual medication. Medication will be supplied by the CRHTT and will either be administered by CRHTT staff or the individual themselves. It is not the responsibility of Platfform staff to administer medication.

12. Staff Support, Supervision and Management

Platfform staff at the project will receive regular supervision in line with Platfform policy and procedure. Direct supervision and day to day advice will be provided by the senior case worker with formal line management and supervision provided by the Project Manager.

13. Grievance and Complaints

Any grievances and complaints will be guided by Platfform Policy and Procedure. Copies of these policies will be available at all times to both staff and users of the service. Individuals will be made aware of complaints procedures on entry to the project.

14. Service User Involvement and Consultation

The views and needs of individuals will form a central consideration in the ongoing development and delivery of the Project. A variety of strategies will be employed to engage individuals including feedback questionnaires, and consultation with existing service user involvement groups.

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Appendix 2: CRHTT Night Shift Protocol

1. Handover from day staff takes place in the Crisis Team Duty Rooms at 8pm.

2. The taking of referrals is the responsibility of the CRHTT worker. This is to ensure the appropriate screening and consideration of workload can take place. If neither CRHTT worker is available, the patient details and referrer contact details can be taken by the Night Site Co-ordinator and the CRHTT will ring back when available to screen and accept the referral if appropriate..

3. The only safe places to undertake night-time assessments are the Emergency Assessment Suite at Hafan y Coed, A&E UHW, and in police custody. Should a Mental Health Act Assessment be required in the community, staff are to liaise with EDT who are responsible for its co-ordination.

4. Assessments which are referred to the team after 7pm may be delayed for the night staff to perform. Assessments referred after 6am will be delayed for the early shift to perform.

5. Should either CRHTT have more work than is possible to address, then it is expected that the workload is to be shared between both teams. Home Treatment needs should take priority in busy times, in order to maintain the 24 hour service to clients. It is also expected that wherever possible, both CRHTT workers will provide support to each other.

6. Breaks are in line with work time directives. CRHTT workers are to stagger their breaks, and the remaining worker is to hold the phones. Should “home treatment” calls be received in the hours’ break then the available member of staff is to respond and provide support on behalf of their colleague, if possible. If a referral is received in the hour’s break the available member of staff is to screen and take the referral.

7. Staff should remain on UHB premises throughout their shift unless at a person’s home or undertaking an assessment. When visiting people off-site, staff to comply with UHB’s Lone Worker Policy, visiting double-handed and informing the Night Site Co-ordinator of their intended destination and expected return time.

8. Any medication required from stock may be taken from the designated medication cupboard providing appropriate documentation is completed.

IN THE EVENT OF THERE BEING ONLY ONE CRHT WORKER AVAILABLE (SICKNESS, BEING REDEPLOYED OR WORK ELSEWHERE)….

1. The available worker is responsible for holding the other teams’ mobile phone, taking and screening their referrals and responding to calls from people on the “home treatment” caseload.

2. The CRHTT worker will undertake assessments for BOTH teams where possible.

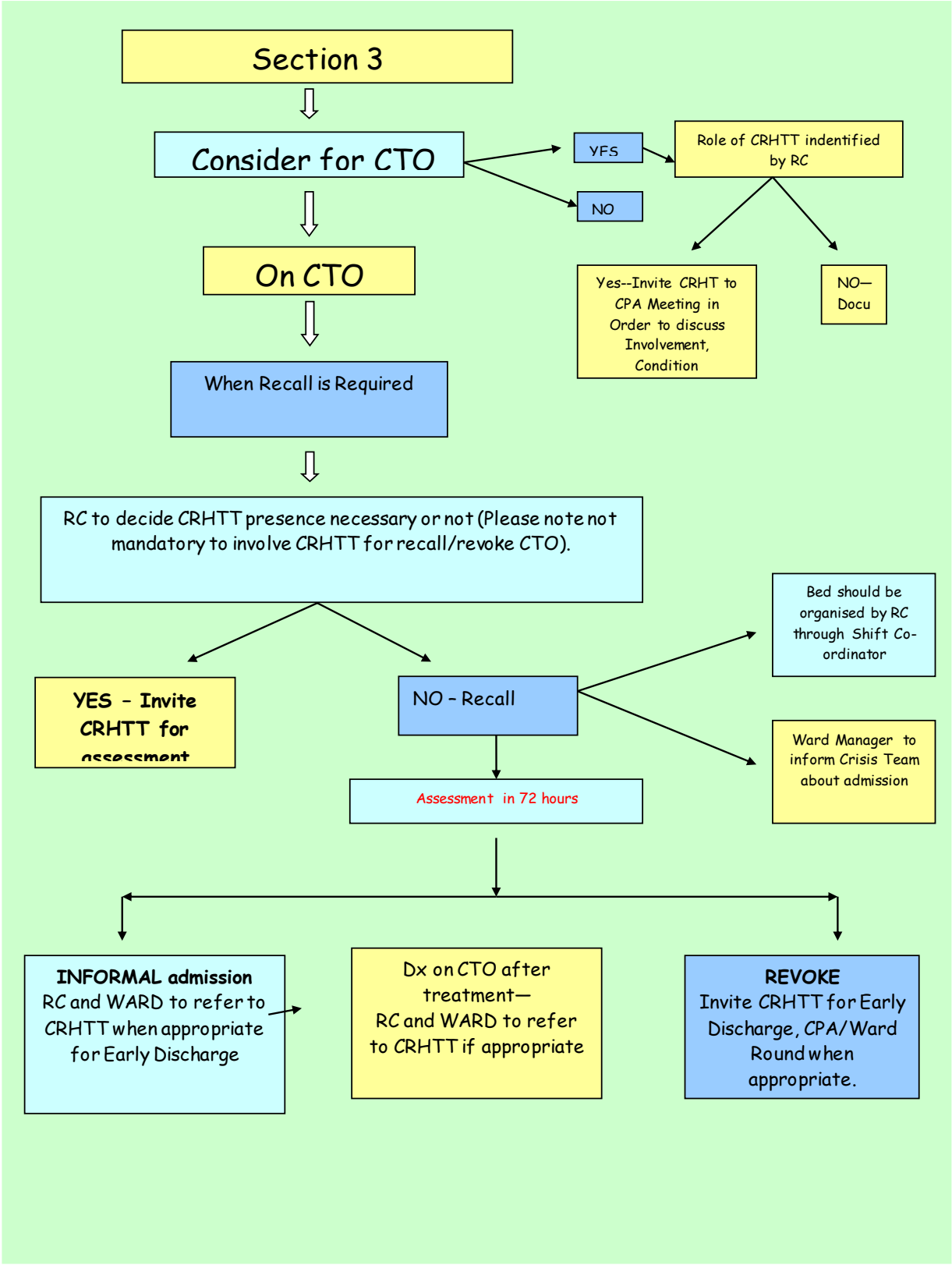
3. Should a “home treatment” visit be indicated CRHTT to approach the Night Site Co-ordinator for staff assistance.

4. If the CRHTT worker is engaged in other work when an assessment arrives at Hafan y Coed, it is appropriate for the Night Site Manager to receive the person , and explain the delay. In the event of more than one assessment having to take place, priority should be given to the first person to arrive, unless an emergency presentation needs to take precedence

5. There is not an expectation for CRHTT to cover liaison psychiatry between the hours of 1am – 3am when there is only 1 CRHTT worker.

6. Incident forms to be completed for each person who does not receive a gateway assessment, or each home treatment visit that cannot be facilitated.

Appendix 3: Recall CTO Process



Appendix 4: Colgate Triage Categories

UK Mental Health Triage Scale

Triage Code /description	Response type/ time to face-to-face contact	Typical presentations	Mental health service action/response	Additional actions to be considered
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice