Crisis Resolution Home Treatment Team Standard Operational Procedure

SOP NUMBER	AUC05	
VERSION NO & DATE	3	**Date:** June 2024
SOP LEAD	Clinical Director – Acute Care	
SOP AUTHOR	Operational Manager – Acute & Urgent Care	
APPROVED VIA:	Acute Care Clinical Governance Committee	
ANTICIPATED REVIEW DATE:	January 2025	

The purpose of the Crisis Resolution Home Treatment Standard Operational Procedure (SOP) is to set out a framework which ensures that the Trust provides a clear, consistent, and fair approach to service user care over a 24-hour period for the Trust's service users who require crisis intervention and/or home treatment.

1. Executive Summary

The Crisis Resolution Home Treatment (CRHT) team provides timely and accessible help to persons experiencing psychiatric and psychosocial crises by providing intensive treatment in the patient's home. The service will provide a flexible, responsive, proactive, coordinated, integrated, safe and supportive alternative to hospital admission for individuals with serious and enduring mental illness (such as schizophrenia, bipolar affective disorder, severe depressive disorder) who are experiencing an acute episode of mental health deterioration.

Through providing this service, the CRHT team aims to provide an alternative to hospital admission for individuals with serious mental illness, facilitate more rapid discharge from a psychiatric acute care setting, and offer respite to carers from the demands of caring.

2. Scope

This Standard Operational Procedure (SOP) is designed to provide clear operational guidance for CRHT as to how the service operates for all stakeholders.

The following SOP does not seek to define every eventuality or tell clinicians/managers what decisions to make. It is expected that individual CRHT teams will be working to define micro level activities and good practice initiatives to ensure that timely and accessible help by CRHT teams is given to those experiencing psychiatric and psychosocial crises.

3. CRHT Service Overview

CRHT is a treatment service which operates and is accessible 24 hours a day, 7 days a week – this consists of a core service in hours and a reduced urgent service (urgent calls and Mental Health Act assessments) overnight. Access to the service is via referral only and suitability for the service will be assessed as part of the referral screening process.

The service will support adults (25 years and above in Birmingham and 18 years and above in Solihull) registered with a GP within Birmingham and Solihull or resident within Birmingham and Solihull but with no GP registration.

CRHT teams consist of specialist mental health professionals who can respond to acute mental health problems by providing intense home-based therapies and support as a safe alternative to a psychiatric inpatient admission.

Through CRHT input, the risk of deterioration and harm to self and others can be reduced and this period is an ideal time to develop positive resolutions to distress. CRHT teams will work alongside the service user / carer to develop a care plan to meet their individual needs.

The CRHT team will continue to remain involved in the service users' care and treatment until the crisis has sufficiently resolved and the required/identified treatment outcomes have been achieved. The team may engage with some individuals for a day/s up to 4 to 6 weeks.

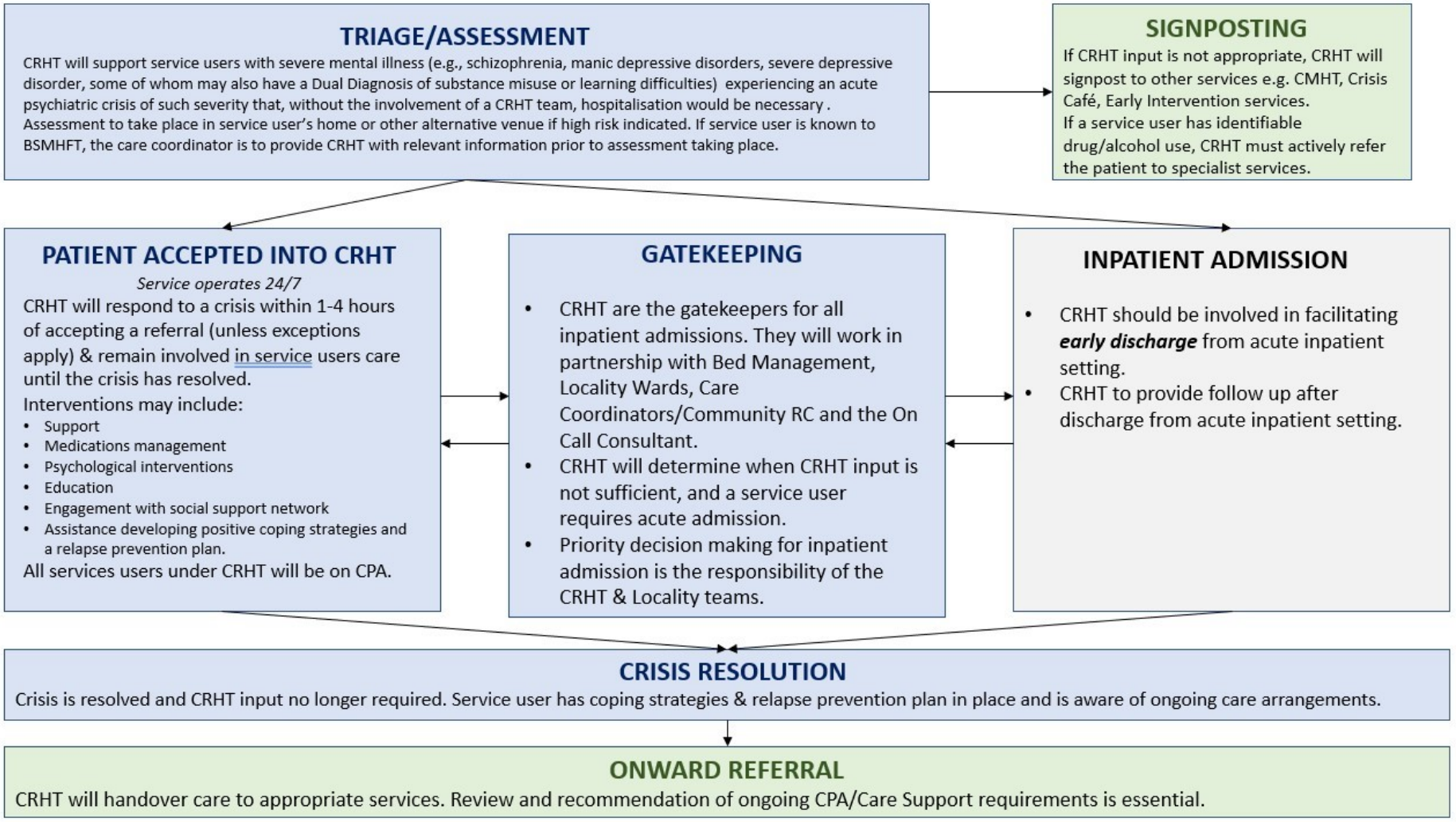
Service users and their carers who are on a CRHT caseload will have direct access to the relevant CRHT teams.

The CRHT service will:

- Develop creative ways of working that are appropriate to service user needs.

- Ensure the service is flexible and responsive to disability, gender, sexual orientation, age, ethnic, spiritual, cultural, religious, physical, and sensory needs and ensuring that anti-discriminatory practice underpins the service.
- Ensure that a multi-disciplinary team is involved in assessing risk and developing an appropriate treatment/care, risk management and discharge plan which considers the views of the service user and relevant carers.
- Perform a 'gatekeeping' function for acute hospital mental health admissions.
- Minimise the length of hospital admission by proactively targeting early discharge cases from the acute inpatient wards.
- Ensure a high standard of treatment and care is provided, primarily provided within an individual's home environment, providing regular contact and the capacity and competency to work with individuals and those who may care for them within an intensive and therapeutic outcome focused manner.
- Actively involve service users and their family/carer as appropriate to reduce their vulnerability to crisis and to maximise their strengths.
- Remain involved in service user care until a crisis has been sufficiently resolved and their mental health has improved to the point that their ability to self-manage has improved. At this point, service users are referred to appropriate onward services.
- Work in a coordinated manner with other services that can form part of a service user's pathway e.g., acute inpatient settings, urgent care, Community Mental Health Teams (CMHT), GPs and third/voluntary sector.

An overview of the CRHT function and pathway is outlined below:


TRIAGE/ASSESSMENT
CRHT will support service users with severe mental illness (e.g., schizophrenia, manic depressive disorders, severe depressive disorder, some of whom may also have a Dual Diagnosis of substance misuse or learning difficulties) experiencing an acute psychiatric crisis of such severity that, without the involvement of a CRHT team, hospitalisation would be necessary . Assessment to take place in service user's home or other alternative venue if high risk indicated. If service user is known to BSMHFT, the care coordinator is to provide CRHT with relevant information prior to assessment taking place.
SIGNPOSTING
If CRHT input is not appropriate, CRHT will signpost to other services e.g. CMHT, Crisis Café, Early Intervention services.
If a service user has identifiable drug/alcohol use, CRHT must actively refer the patient to specialist services.
PATIENT ACCEPTED INTO CRHT
Service operates 24/7
CRHT will respond to a crisis within 1-4 hours of accepting a referral (unless exceptions apply) & remain involved in service users care until the crisis has resolved.
Interventions may include:
• Support
• Medications management
• Psychological interventions
• Education
• Engagement with social support network
• Assistance developing positive coping strategies and a relapse prevention plan.
All services users under CRHT will be on CPA.
GATEKEEPING
• CRHT are the gatekeepers for all inpatient admissions. They will work in partnership with Bed Management, Locality Wards, Care Coordinators/Community RC and the On Call Consultant.
• CRHT will determine when CRHT input is not sufficient, and a service user requires acute admission.
• Priority decision making for inpatient admission is the responsibility of the CRHT & Locality teams.
INPATIENT ADMISSION
• CRHT should be involved in facilitating early discharge from acute inpatient setting.
• CRHT to provide follow up after discharge from acute inpatient setting.
CRISIS RESOLUTION
Crisis is resolved and CRHT input no longer required. Service user has coping strategies & relapse prevention plan in place and is aware of ongoing care arrangements.
ONWARD REFERRAL
CRHT will handover care to appropriate services. Review and recommendation of ongoing CPA/Care Support requirements is essential.

4. CRHT Referral and Access pathway

4.1 Referral criteria and acceptance threshold

CRHT will support service users with Severe Mental Illness e.g., schizophrenia, manic depressive disorders, severe depressive disorder, some of whom may also have a Dual Diagnosis (of substance misuse or learning difficulties), experiencing an acute psychiatric crisis of such severity that, without the involvement of a CRHT team, hospitalisation would be necessary. CRHT therefore provide gatekeeping for acute inpatient settings.

As per Triage Codes B and C of the *UK Mental Health Triage Scale,* typical presentations which require CRHT input include:

Risk	Typical Presentations
High risk of harm to self or others and/or high distress, especially in absence of capable supports. Urgent mental health contact and response within 24 hours.	• Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent • Rapidly increasing symptoms of psychosis and/or severe mood disorder • Wandering at night • Vulnerable isolation or abuse • Overt/unprovoked aggression in care home or hospital ward setting • High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control
Very high risk of imminent harm to self or to others. Very urgent mental health response within 4 hours.	• 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

CRHT is not appropriate for all, and so service users will be signposted to more appropriate services where necessary. Beyond initial assessment, this service is not usually appropriate for individuals with the following conditions, as they are more likely to benefit from other mental health services:

- Mild anxiety disorders.
- Primary diagnosis of alcohol or other substance misuse with active use.
- Brain damage or other organic disorders including dementia.
- Learning disabilities.
- New episode of self-harm where there is no chronic history, but not suffering from a psychotic illness or severe depressive illness.
- A crisis related solely to relationship issues.
- Exclusive diagnosis of Personality Disorder.
  Personality disorder is an important factor in many admissions and crisis services should seek to serve these users as clinically appropriate. This work can include short periods of

home treatment, and this should be provided as an overall care plan that supports and enhances joint working between CRHT teams and CMHTs.

These are not to be read as exclusion criteria but are offered to assist in providing CRHT to service users in greatest need.

4.2 Referral & Allocation Process

Referrals to CRHT teams must be through a point of contact and referral details must be taken by a senior clinician (Band 6 or above) within CRHT teams. Referrals must be made via email to the generic inbox for the relevant CRHT, and then followed up with a phone call. During this phone call, a qualified, registered clinician-to-clinician conversation must take place in which receipt of the referral and its urgency are acknowledged. The names of the clinicians involved in this conversation must be documented on Rio by both parties.

When a service user is being referred from another BSMHFT service (e.g., CMHT) it is the responsibility of the referring service to ensure that all clinical records are up to date at the point of the referral being made. This will enable the CRHT team to triage the referral and determine whether CRHT input is appropriate. Service users should not be informed that they will be followed up by CRHT until the referral is accepted. If following triage, a referral to CRHT is not appropriate, then the rationale for this decision will be clearly documented and communicated to the referrer, including any suggestions for referring to alternative pathways as required.

For referrals to CRHT from GPs, GPs should complete a BSMHFT SPOA form (Single Point of Access) and follow this up with a telephone call to the duty worker within the relevant CRHT. The relevant CRHT team will then triage the referral to determine if it is appropriate for CRHT input or not.

When a referral is made as a crisis call to the point of contact, it must then be referred on to the appropriate CRHT team and it is the responsibility of the receiving CRHT team to follow up with the service user. Following this, an email must be sent to notify the service users team of the contact. A follow up call must be made the following morning to ensure the email has been received and noted.

Assessment of known service users will be allocated to CRHT teams based on the geographical location of their registered GP. If travelling distances are deemed too high or impractical by the host CRHT teams then care will be provided from another CRHT team (e.g., where a service user's registered GP is not local to their current residential address). These arrangements must be agreed by the two CRHT teams and the relevant consultant psychiatrists. However, unless agreed, it remains the responsibility of the host CRHT team to provide medical responsibility. If the service user's GP is not known, then the CRHT team that covers the GP closest to the service user's permanent postcode will provide care.

An overview of referral and allocation pathways is outlined in Appendix 2.

For all the pathways outlined in Appendix 2, there will be a daily on-take rota for those referred
with No Fixed Abode (NFA) and outliers. NFA referrals will be accepted by CRHT or a request for an inpatient bed will be made.

4.3 Response times

CRHT teams will ensure rapid response to a referral by providing intervention and support in the early stages of a crisis. It is anticipated that the initial response (first assessment) from the team for very urgent referrals (see Table in 4.1) will be completed within 1 to 4 hours of

receiving the referral. Urgent referrals (see Table in 4.1) should be seen within 24 hours. Any cases not seen within this time frame should have a clearly documented rationale.

Where a referral is received and deemed as high risk, meaning an assessment is required within 4 hours, the RC must be notified immediately after this risk level is determined.

4.4 Escalation Process if a service user does not respond

There may be circumstances in which a service user does not respond to a contact/visit from a CRHT team, following a referral. In this instance, the following escalation process should be used:

1) Put a note through a service user's door to state CRHT has tried to visit, provide contact details & request a call back.
2) Attempt to contact the service user again (within the same 24-hour period). *CRHT teams must ensure they hand over the requirement to do this to colleagues working the next shift.*
3) If referral states the service user was suicidal/had previously attempted suicide, contact police to request a Safe & Well check.
4) Contact GP to obtain next of kin details (if not already in possession) and confirm with the referrer whether they have any information regarding the service user's whereabouts.
5) Contact the next of kin to determine if they know the service user's whereabouts. When a service user is missing, this can be done without the service user's consent.
6) Contact other services that the service user may be known by e.g., pharmacy (for methadone script), Mother & Baby groups, local shops/facilities.
7) Contact the Police and report Service User as a missing person.

The risk associated with a referral should be considered throughout and clinicians should progress through this escalation process as they deem appropriate.

All attempts to contact the service user should be documented in the patient's notes on Rio.

5. CRHT Assessment

CRHT assessment will take place in the most appropriate setting, with the emphasis on reducing the stigma involved in accessing mental health care, to assist with engagement. Where higher risk is indicated, an alternative venue than the service user's home might be required. To achieve this, the service must retain flexibility around visiting – duration, frequency and intensity of visiting is a key requirement to successfully deliver an alternative to hospital admission.

For known service users, the care coordinator will provide relevant information to the CRHT teams prior to any assessment taking place. The care coordinator will be actively involved in the information sharing and decision making that are part of the assessment to ensure adequate continuity and effective assessment as well as minimising the need for the service user to have to repeat their histories unnecessarily.

CRHT teams within working hours should take responsibility for sourcing collateral information from other areas. When attempts at this have not been successful, this should form part of the handover process.

When the CRHT assesses a service user outside normal working hours and the care coordinator cannot be part of the assessment then the CRHT will inform the care coordinator of the outcome of the assessment on the next working day.

Initial assessments will be undertaken by qualified practitioners (e.g Band 6 and above clinician) and accompanied by either a doctor or Advanced Clinical Practitioner. The decision as to whether a medical assessor must be present is decided through a discussion between Senior Nurses, Advanced Clinical Practitioners, and the medical team wherein they consider reasons for referral and risk (current and historical). If this information suggests an admission may be indicated, a doctor must attend the initial assessment. This clinical decision should not be changed due to operational pressures without escalation (in MDT and/or the Grand Huddle) and appropriate agreement and mitigation.

A longitudinal risk assessment should be carried out as part of this initial assessment. The team must ensure that the patient and their family/carers understand the purpose of the assessment, as well as the parameters of what CRHT can provide (e.g., timescales, possible interventions).

When a service user is referred by a consultant who has seen the service user in last 24 hours then the CRHT will accept the service user on to the CRHT caseload.

During an assessment, the CRHT will focus on the strengths and interests of the service user, emphasising the benefits of being in contact with the service and contribute to the service user's engagement. Sustained engagement with the service user and their family/carers is a key component of the service model and will allow the CRHT to perform a comprehensive and in-depth assessment and provide evidenced based interventions.

Where an interpreter is required, CRHT teams should request these via the usual BSMHFT process and in line with the Trust's *Accessible Information and Communication for Service Users and Carers Policy.*

5.1 Assessment Outcomes

After the assessment, the multi-disciplinary team will make a decision as to how and where the service user's needs may best be met. Possible outcomes following CRHT assessments include:

- **CRHT episode:** Service users accepted onto CRHT will be medically reviewed by a CRHT doctor or Advanced Clinical Practitioner the next working day. The decision as to whether a medical assessor must be present is decided through a discussion between Senior Nurses, Advanced Clinical Practitioners, and the medical team wherein they consider reasons for referral and risk (current and historical).
  Where ambiguity exists around the appropriateness of CRHT it is better to err on the side of caution and offer CRHT for a maximum period of 48-72 hours, for ongoing assessment during the period of crisis.

- **Hospital admission**
  The admission must be undertaken ensuring minimal disruption to service user, carer, and family and in a least restrictive manner and the service user must be informed of the reasons why home treatment was not appropriate. The process for prioritising admission securing a bed and implementing admission is stated in Section 7 of this SOP.

- **Referred to and accepted by another mental health service**

- **Referred to specialist community services**
  Where a service user has identifiable alcohol or drug use, CRHT should refer the patient to appropriate specialist community services for advice, support, and treatment.

- **No further follow-up from specialist mental health services**

If following an assessment, CRHT is not indicated then it is the responsibility of the CRHT staff to inform the referring individual of the outcome and any recommendations/interventions necessary for follow-up the next working day. If a service user is not accepted on to CRHT following an assessment, then the CRHT team will write to the referring agency outlining the outcome of the assessment and any recommendations.

Failure to engage with the CRHT service will not necessarily lead to case closure; the CRHT team will work with family and significant others to try to promote engagement. Continued and persistent failure to engage will lead to multi-disciplinary clinical review. Persistent failure to engage will result in an inter team case conference and a plan of action will be identified.

6. CRHT treatment and interventions

CRHT interventions may include support, medication management, education, social support, assistance to develop positive coping strategies and a relapse prevention plan to address any deterioration in mental health in the future. The range of interventions provided by CRHT to a service user will depend upon clinical need and clinical response, with the service user and carer needs and views also being considered. In deciding which interventions or what input is appropriate, consideration should be given to what has caused the service user's crisis and what keeps the crisis presentation going.

Appropriate interventions could include the following (although this list is not exhaustive):

- Crisis assessment and management, including intensive support & frequent contact throughout crisis.
- Ongoing risk and needs assessment.
- Individualised recovery planning with goals and milestones.
- Medication (prescribe, administer, monitor & review).
- Low intensity psychological intervention to help resolve crisis and increase resilience (e.g., anxiety management, Cognitive Behavioural Therapy).
- Highly specialist Psychologist formulation and intervention to help resolve crisis.
- Strategies aimed at maintaining/improving social networks & practical help/support (budgeting, shopping, work).
- Family support/intervention, including Carers Assessments where appropriate.
- Access to Respite / Crisis House / Day Care or other facilities.

There are several specialist services available to BSMHFT service users (e.g., NHS Veteran's Mental Health Transition, Intervention and Liaison Service, Deaf Mental Health services, Eating Disorders) which CRHT teams should consider liaising with to ensure that the most appropriate interventions are being offered to service users.

To ensure continuity in treatment, each CRHT team should complete a daily handover, with this handover being documented in each service user's 'Progress Notes' on Rio.

6.1 Care planning

If a period of home treatment is indicated the service user will be on Care Plan Approach (CPA) and all staff must adhere to the principles of CPA, as outlined in the Trust's '*Care Management & CPA/Care Support Policy'*. When existing service users are referred to CRHT, all relevant CPA documentation should be in place. For new service users, joint care plans should be written in consultation with the referrer.

As per CPA process, review and evaluation of the service user's care plan should be ongoing and a multidisciplinary process between the service user, carer, and any relevant professionals. As a minimum standard, all existing Home Treatment service users will be medically reviewed by their Care Coordinator, RC, other CRHT doctor or Advanced Clinical Practitioner on a regular basis, as guided by the weekly MDT discussion – care plans and risk assessment should be updated on Rio in line with this.

As per the Trust's *'Advance Statements and Advance Decisions'* policy, individuals should be encouraged to develop advance statements with the assistance of staff wherever possible. If the individual does not wish to set advance statements this should be documented in service user notes.

6.2 Allocation of Care Coordinator

When a service user who is not previously known to services does not have an allocated care coordinator and is receiving CRHT, the assessing CRHT professional will be deemed the identified Care Coordinator. Following CRHT, if CMHT input is required, CRHT will request a care coordinator from the CMHT.

6.3 Service user and carer engagement

It is essential to ensure active involvement of the service user, carer(s), family, and the wider social network at the earliest opportunity to optimise the benefits of CRHT team treatment and interventions. The immediate family and carer support network will be mapped out at first assessment and recorded accordingly. They will be engaged in any assessment, treatment, and support planning as appropriate and in a proactive way.

6.3.1 Service user engagement and consent

If a service user attempts to disengage by declining the next visit/contact or deviates from the treatment plan there will be an immediate review with the clinical team of the care plan which incorporates risk factors, and the next course of action will be formulated. The outcome must be clearly recorded, the care plan amended accordingly, and all individuals involved in the care informed as soon as possible by the CRHT.

6.3.2 Family / Carer Engagement and Support

During an initial assessment it is the responsibility of the CRHT clinician to identify and document the needs of the service users' main carer(s) and family, their relationship and how to contact them. Consideration should be given as to whether the carer(s) and/or family should be referred to the Family Liaison Worker and this should be discussed in MDT.

CRHT should also:

- Make sure the carer knows how to contact the care coordinator.
- Communicate with carer/s on a regular basis.

- Be tactful where service users do not accept involvement of their families but recognise that conflict should not be a barrier to carer involvement; carers still need information and other services in these situations. Provide education and information about the illness, treatment, and care plan.

6.4 Medical/ACP Reviews

Weekly medical reviews will be offered as a minimum standard to all service users on a CRHT caseload. Qualified Advanced Clinical Practitioners (ACPs) are able to undertake these reviews under the direction and supervision of the Consultant Psychiatrist and in parallel to MDT reviews and team decision making.

6.5 Physical Health Monitoring

A diagnosis of severe and enduring mental health disorder can render people more vulnerable to co-morbid complaints and long-term conditions. Upon initial presentation to a CRHT, safety and crisis management is of paramount concern but, as soon as it is clinically feasible and consent is obtained, physical health concerns should be addressed. Treating clinicians should consider the physical health of service users as part of their assessment and management at the point of first referral.

The service user's GP should be the first point of contact for all physical health issues, and they should ideally hold primary responsibility for the service user's physical health. Direct liaison with secondary care (e.g., referral to a cardiologist) should not be entered into unless in exceptional circumstances. If this is done, the GP should be made fully aware of the contact.

There may be certain cases (such as when a drug prescribed by a clinician may directly impact upon health) when the treating team will need to have greater involvement in physical health monitoring. It may be appropriate for the treating clinician to conduct physical examinations, order blood tests or other investigations independently. As far as possible, the results of these should be shared with the GP. In any case, the prescribing clinician must be satisfied that the service user is receiving physical health care appropriate to the medication they are taking.

It may also be appropriate for other clinical staff to give general advice about physical health and collect basic information (such as height, weight, BMI etc). The needs of the service user, the degree of involvement of primary care and the treating team and any actions required should all be noted in the care plan and reviewed as part of the CPA process.

6.6 Access to Means

Where a service user has access to means, this must be escalated to the Team Manager and/or Lead Clinician and/or via MDT for consideration. Where appropriate, this should also be discussed at local safety huddles. Clinical decision making should be used to determine whether carers should be informed that an access to means exists.

7. CRHT Gatekeeping Function

CRHT teams will act in a 'gatekeeping' role meaning they will assess all service users before admission to acute inpatient psychiatric wards and decide whether they are suitable for CRHT. This function is outlined in the *Acute & Urgent Care Locality & Gatekeeping SOP.*

7.1 Inpatient Admissions

CRHT teams rapidly assess individuals with serious and enduring mental illness and refer them to the most appropriate service. If an inpatient admission is deemed necessary, CRHT will act as a gatekeeper to all hospital admissions, in line with the *Acute & Urgent Care Locality & Gatekeeping SOP* and will work with the BSMHFT Bed Management Team to coordinate inpatient admissions, using the principles outlined below:

- Priority decision making is the responsibility of the clinical CRHT and locality teams.
- Priority is based on meeting the access criteria and current level of need.
- Where appropriate and possible, family / carers must be fully involved in the service user's treatment plan and, if a bed is not available, then clarification of next steps and additional support required must be conveyed.
- An individual's eligibility to the admission criteria may fluctuate. It is therefore essential that the referring MDT and the Bed Management team have continual dialogue to monitor any clinical changes.

Valid exceptions to CRHT being the gatekeeper are:

- Section 136 in Place of Safety: when a service user is under a Section 136 in Place of Safety, there is no requirement for a CRHT review before the service user is added to the bed list.
- AOT: AOT have allocated beds which they can admit service users into, without the requirement for CRHT input.
  CRHT may provide additional clinical crisis support to AOT out of hours (8pm-8am) where AOT are struggling for resource. This should only be in exceptional circumstances and, when this occurs, it should be escalated to the Senior Manager on call.
- Repatriation from an out of area provider: The Bed Management team would coordinate this.

Service users' will be admitted to hospital when:

- It is beyond the resources of the team to meet the needs of the service user adequately, safely, and effectively in the community.
- Where the level of observation, supervision, and support provided by the team and carers is unlikely to prevent psychological trauma to others or there is a serious risk to the service user by self/others because of their mental state.

CRHT teams must be central, in collaboration with the multi-disciplinary team, to the decision-making process around inpatient admission. Face to face contact should be utilised unless it can be demonstrated that face to face contact was not appropriate or possible. For each case where face to face contact does not occur, documented clinical rationale should be provided.

If a bed is not available within the respective CRHT teams allocated bed base, the escalation process as outlined in Section 3.3.2 of the *Acute & Urgent Care Locality & Gatekeepong SOP*, must be followed.

7.3 Section 17 Leave

Where CRHT team support is required for Section 17 leave, the CRHT team should be involved in the planning process. Where necessary, the CRHT will provide nursing and

social care support while the service user is on short term Section 17 leave. Where there are separate consultants for inpatients and CRHT, the consultant for inpatient will retain RC status until the service user's care is formally transferred to CRHT.

7.4 Community Treatment Order (CTO)

7.4.1 Placing a service user on CTO

As per the Trust's *Section 17 Leave of Absence* Policy, a CTO should be considered for all service users who are on Section 17 leave for longer than 2-4 weeks. The RC of the CRHT and CMHT teams will initiate the process for placing the service user on a CTO. The AMHP & RC inpatient who was involved in the assessment, planning and management of service user during the acute phase of treatment, is best placed to organize the CTO. If the care-coordinator in the CMHT is an AMHP, then they will organise the CTO.

The service user, carer (if appropriate), independent mental health advocate, care-coordinator, AMHP and CRHT consultant are expected to attend the CTO meeting. The RC from CMHT should be invited to attend the CTO meeting but, if this is not feasible, a telephone consultation should take place before the service user is placed on the CTO. The RC transfer form will be completed at the time of transfer of service user from CRHT to CMHT.

A second opinion should be obtained within 28 days for all service users on a CTO. If the service user is likely to remain under the care of CRHT for 28 days after they are placed on the CTO, the CRHT consultant will request the second opinion. If the service user is transferred to the CMHT immediately after being placed on the CTO, the CMHT consultant will request the second opinion. If the service user fails to attend the first appointment with the SOAD, then they will be re-referred to CRHT to facilitate the second opinion assessment as failure to attend will be a breach of CTO, necessitating recall to hospital. Alternatively, the CRHT consultant could remain as RC until the second opinion is completed, even if the service users' care has been transferred to the CMHT.

7.4.2 Recall of service user on CTO

If the RC decides that a service user on CTO needs to be recalled to hospital, the respective RC should transfer the RC responsibility immediately to the consultant in CRHT. An urgent assessment will be carried out by the CRHT and if it is deemed that the service user needs immediate hospitalisation, the consultant in CRHT will complete the CTO recall form.

7.5 Absent from Ward without Leave (AWOL)

7.5.1 Informal Service Users

If an informal service user is AWOL and refuses to return to the ward the nurse in charge, in consultation with a doctor (team or on-call), will decide if the service user needs assessment in the community. If urgent assessment is deemed necessary, the ward will refer the service user to CRHT for an assessment.

7.5.2 Formal Service Users

If a detained service user is AWOL the nurse in charge, in consultation with a doctor (team or on-call), will decide if the service user should return to the ward immediately. If the decision is made that the service user should return immediately, the nurse in charge will activate the Trust's *Missing Patient Policy*. If the service user does not need to return to the ward immediately, they will be referred to CRHT for community support and monitoring.

7.6 Discharge planning from Inpatients

A care plan, with objectives and outcomes written in language that the service user can understand, will be formulated within the first 72 hours of admission to an inpatient setting. These objectives underpin the reason for the service user's admission. Progress towards these objectives is progress towards their discharge, therefore discharge planning starts within the first 72 hours of admission.

The CRHT team will work closely with the inpatient unit to systematically review whether the reasons for admission continue to exist, and what needs to happen prior to the individual being discharged.

Following discharge from hospital, CRHT should contact the service user within 24 hours via telephone, to ensure that there is an appropriate level of support. A face-to-face follow-up contact should be provided within 48 hours of discharge, and then a further review should take place within 72 hours of discharge. The frequency and nature of follow ups after this initial 72-hour period should be determined based on the clinical need and risk of the service user. The whole follow-up process must include an assessment of how the service user is coping with the discharge and return to the stressors of life, a mental health and risk assessment and any concerns related to engagement, concordance with treatment and capacity. These assessments would usually involve more than one team or individual worker and should be documented in Progress Notes on Rio. These follow ups should include an assessment of how the service user is coping with the discharge.

Where face to face contact is not possible, a valid reason must be documented.

The follow up contacts for service users who are discharged on a Friday and are considered to need a 48-hour follow up, must be planned with, and provided by the appropriate CRHT, or other team providing service users support at the weekend.

Where a service user is discharged from to a CRHT team outside of the Trust, the local BSMHFT CRHT team who has been involved in the service user's care should seek assurance before the patient is discharged from an inpatient setting that we have handed over to the local CRHT, and that they have accepted follow up responsibilities for the service user.

7.7 Early discharge from Inpatients

Early discharge means discharge at an earlier time than if intensive CRHT was not available and is still part of an acute episode of care. Facilitating early discharge from the acute inpatient unit will be a core function of the work of the CRHT team and teams will need to develop a systematic approach to providing this.

The proactive approach of working together should and must ensure early discharge cases are targeted and the CRHT team focus on 'early discharge' and do not become the discharge service, which would dilute their potential to divert cases heading for hospital.

Early discharge may include supporting the individual to return home or for an appropriate spell in a respite facility as a stepped approach to returning home. When service users are identified for CRHT to facilitate an early discharge, consideration should be given to the increased risk of suicide post discharge from hospital.

It is imperative that each CRHT maintains daily contact with their respective inpatient units to facilitate early discharge and thus reduce length of stay.

7.8 Section 117 Aftercare Plan

It is good practice to arrange a pre-discharge meeting 2 weeks prior to a Section 117 meeting. The Section 117 meeting should be arranged as soon as possible when the service user is in hospital, as part of early discharge planning. The CRHT RC remains as RC until the Section 117 meeting is completed.

8. Interface between CRHT and other Clinical Teams

The CRHT team must ensure they work within a 'whole system' approach and therefore need to ensure they establish good and effective working relationships with other teams to provide an integrated service. This includes with inpatient services, locality-based services, and other specialist community services.

When working with any other team / service, the CRHT will demonstrate the ability to:

- Hold regular interface meetings.
- Ensure the direct handover of care – as required for the transition of service users between teams.
- Ensuring joint working protocols are in place during periods of transition.

When any service user receives treatment from CRHT, the care coordinator will continue to provide face-to-face contact at a regular interval during CRHT episode. If there are exceptions, then they should be recorded in the notes. As appropriate, the care coordinator or nominated person will maintain contact with the service users' family / carers.

This weekly contact between care coordinator and "Named Worker" (CRHT) may include but is not confined to formal care planning/review meetings or ward round meetings.

All circumstances where it is deemed appropriate not to have face-to-face contact with the service user should be considered as exceptional and the reasons for each exception should be reported to the appropriate Team Manager and be documented by the care coordinator or nominated person in the service users' clinical record.

Where it is recognised that a crisis is likely to occur for service users supported by a CMHT, the host CMHT will be expected to work with CRHT to develop a joint care plan with clearly identified roles for both teams and the point at which the respective roles will be enacted.

9. Discharge from CRHT team

Prior to discharge the team should ensure that:

- The MDT team have agreed that the service user is suitable for discharge from CRHT services.
- There is good understanding by the service user, their family, carers, and relevant others of why the crisis occurred and how it may be avoided in the future.
- Coping strategies have been explored with the service user and family/carer.
- A relapse prevention plan is in place.
- Service users and their family/carers have had opportunity to provide feedback and express their views about the services to help us improve.

- The decision to discharge from the CRHT should be made through consultation between the relevant clinical teams, the Care Coordinator (where one is allocated), the service user, and carer.
- CRHT will actively review the service user's CPA/Care Support and make recommendations for ongoing care. This will be documented in the service user's care record.
- There will be a full and complete handover, and all relevant documents, letters to GPs and care records will be completed in accordance with Trust policies. Clinician to clinician conversations between CRHT and the service providing ongoing care should take place to support this handover process.
- Where appropriate, joint visits should be utilised to ensure the safe transition of the service user between services and to provide the opportunity to build relationships with service users.
- Clear discharge plan needs to be given to the patient & other relevant parties within 48 hours of discharge. Plan should include:
    - Ongoing care in the community/aftercare arrangements. There should not be an assumption that a service user is automatically referred back to the service they were referred to CRHT from. Instead ongoing care should be an active referral, to a broad range of available services, and have a clear rationale for how this will support ongoing care.
    - Crisis and contingency arrangements including details of who to contact.
    - Medication, including monitoring arrangements. ○ When, where and who will follow up with the patient as appropriate. ○ For service users with a diagnosis of Personality Disorder, the guidance outlined in Appendix 3 should be followed.

10. Risk management

10.1 Safeguarding

All staff should consider and adhere to the Trust's *'Safeguarding Adults'* Policy as part of the risk management process.

10.2 Risk Huddles

Risk huddles are short weekly meetings to proactively manage risk and improve the quality of risk formulations so that CRHT teams are enabled to review ongoing issues and to raise any concerns. One service user will be the focus of each risk huddle and a risk formulation (using the 5 P's, as outlined in Appendix 4), and risk management plan will be created. All the MDT are invited and expected to attend where possible.

10.3 Lone Working

All staff should consider and adhere to the Trust's *'Lone Working'* Policy as part of the risk management process. This policy outlines that, where teams are undertaking visits to community locations and the homes of service users, the risks of undertaking these visits should be regularly reviewed by the team. Where significant risks are identified, a risk mitigation plan should be established and, where there is a history of violence from a service user and/or the location is high risk, consideration should be given as to whether visits can take place at a neutral location e.g., a Trust premises.

All CRHT staff are provided with lone working devices, and it is a compulsory requirement that these are fully utilised for all work-related tasks where there is a potential risk to safety.

If a staff member still has concerns about their safety despite risk mitigation plans being created and enacted, they should escalate their concerns to their Team Manager or Clinical Service Manager (in hours) or to the On Call Manager (out of hours).

11. Governance arrangements

The Trust's *'Care Records Management'* Policy should be adhered to at all times. Documentation is completed via Rio. It is essential that each contact is documented and communicated to relevant team members. Whenever there is a change in the service user's contact details and/or clinical presentation, all core documentation must reflect this.

12. Relevant Documents:

- UK Mental Health Triage Scale, Microsoft Word - UK Mental Health Triage Scale_June13-15.docx (wordpress.com)
- BSMHFT Accessible Information and Communication for Service Users and Carers Policy (C32, August 2019)
- BSMHFT Care Management & CPA/Care Support Policy (C01, April 2019)
- BSMHFT Advance Statements and Advance Decisions Policy (MHL03, June 2022)
- BSMHFT Section 17 Leave of Absence Policy (C56, March 2021)
- BSMHFT A&UC Locality Gatekeeping SOP (AUC02, April 2024)
- BSMHFT Missing Patient Policy (C37, April 2022)
- BSMHFT Adult Safeguarding Policy (R&S 26, February 2022)
- BSMHFT Lone Working Policy (RS04, June 2022)
- BSMHFT Care Records Management Policy (C12, May 2022)

13. Appendices 13.1 Appendix 1 – Equality

Screening Assessment

Equality Analysis Screening Form

Title of Proposal	Crisis Resolution Home Treatment Team SOP		
Person Completing this proposal	XXXX	**Role or title**	Operational Manager – Acute & Urgent Care
Division	Acute & Urgent Care	**Service Area**	CRHT
Date Started	15/09/21	**Date completed**	15/09/21
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
The purpose of this SOP is to set out a framework which ensures that the Trust provides a clear, consistent, and fair approach to service user care over a 24-hour period for the Trust's service users who require crisis intervention and/or home treatment.			
Who will benefit from the proposal?			
All staff and service users who deliver/use/interact with Crisis Resolution Home Treatment.			
Impacts on different Personal Protected Characteristics – *Helpful Questions:*			
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*		*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*	
Please click in the relevant impact box or leave blank if you feel there is no particular impact.			

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**

Age				
Including chil988en and people over 65				

Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability				
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender				
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships				
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity				
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity				
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief				

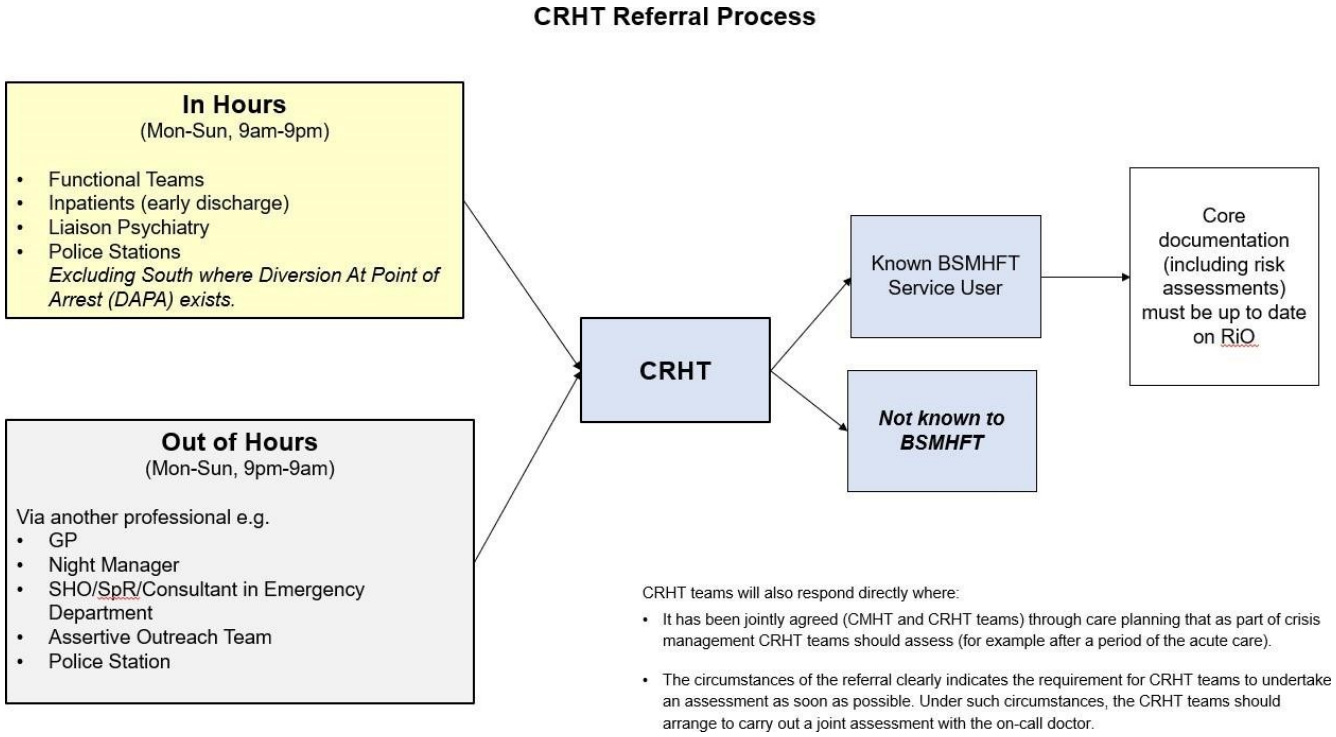
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation				
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				

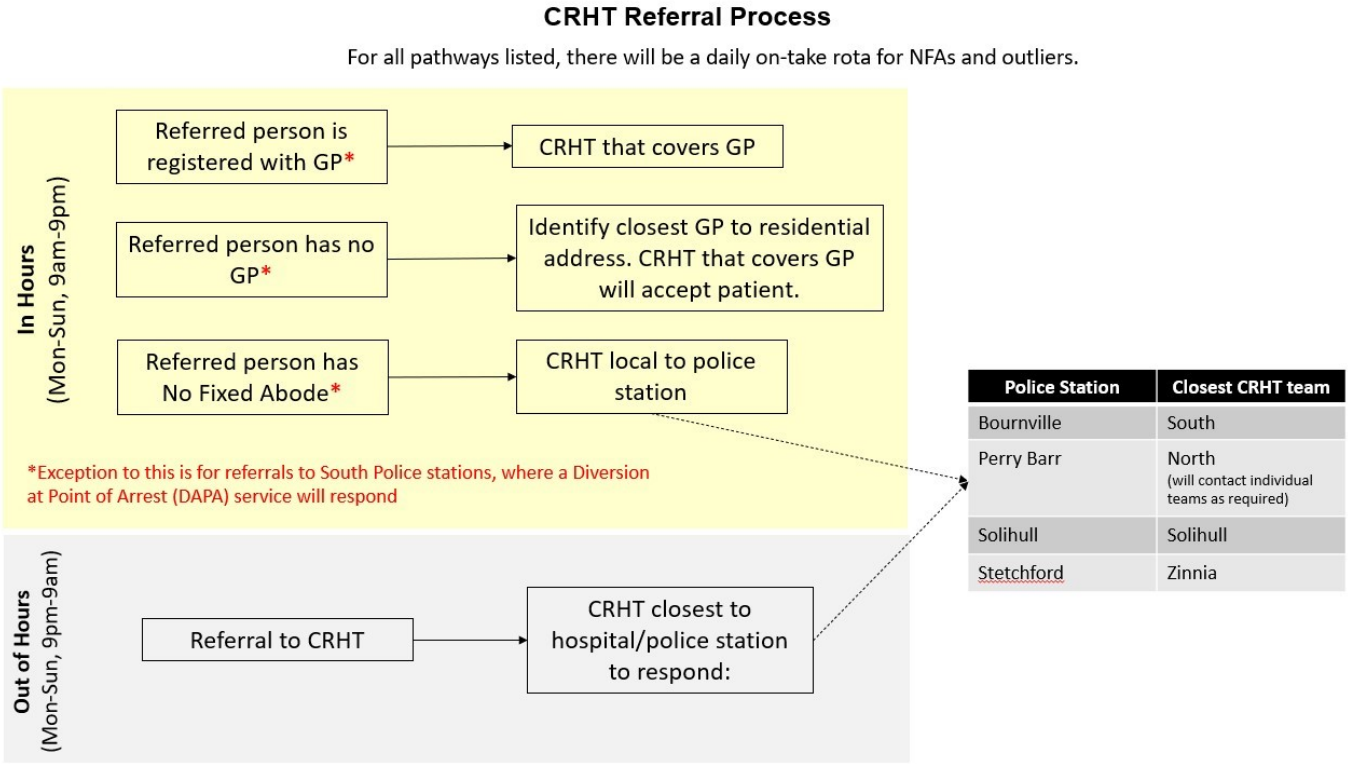
Transgender or Gender Reassignment				
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights				
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
N/A
How will any impact or planned actions be monitored and reviewed?

N/A
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
N/A
Please save and keep one copy and then send a copy with a copy of the proposal to the Equality and Diversity Lead Bina Saini. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

13.2 Appendix 2 – Referral Pathways to CRHT





13.3 Appendix 3

Transition from HTT to CMHT for people with a diagnosis of personality disorder.

The importance of these clinical guidelines when considering transfers of care are as follows:

- Transitions between care teams can be a time of increased risk and anxiety for any service user, but particularly for individuals where relationship difficulties can be a key part of their experience.
- Service users will hopefully form attachments with practitioners and services at a time when support is crucial to their well-being therefore the ending of these need to be considered in a way that limits the disruption to recovery.
- Transitions between teams is an opportunity to work through challenging times, distressing emotions and can help to teach service users about the natural course of relationships. Times of transition are going to cause difficult emotions for the service user and this is an opportunity to sit with the emotions and work through them without avoiding. Although difficult for clinicians, this could be seen as a therapeutic opportunity.
- With people who can experience extremely high levels of mental distress/anguish, the thought of being left alone with this causes additional stress and worry.
- Any change to arrangements is likely to cause anxiety and a sense of isolation and loneliness. It may also cause thoughts of abandonment and hopelessness.
- Self-harm and suicide attempts often occur at times of change and increased distress and therefore are likely to be more prevalent at transition points.
- The pressure on boundaries of relationships and services can increase at transition. Working together as a whole pathway will improve these transition points. Transitions can be stressful for staff too and boundaries will aid a better relationship with the service user.
- Being able to helpfully navigate a transition between services is a crucial part of our role.

For all these reasons, transitions need to be carefully considered. Transitions need to be managed with honesty, clarity, transparency and sensitivity with the aim of avoiding retraumatisation. It is acknowledged that services may be impacted by staffing and logistical pressures which may make following these guidelines more difficult however, this should also be dealt with in a similar transparency so that services users can learn about boundaries and expectations.

Guidance regarding transition from Crisis resolution Home Treatment Teams (typically known as HTT) to CMHT is already outlined in BSMHFT Personality Disorder Care Pathway: Clinical Guidance and the following will summarise and expand on this guidance. The transition/discharge protocols as set out in the HHT SOP are equally relevant for this client group and should also be followed.

Transition to HTT from CMHT:

When referring to a HTT, the goals / aims of the episode of care with the team should be clear at the point of referral, documented and be clearly communicated and agreed with the service user. If there is no improvement or progress on the difficulties identified at referral in a short time frame, for example, a week, then the home treatment team should consider working towards a transition plan back to CMHT.

If referring to HTT to access another service, for example, respite / crisis house / day service, it is important the service user is supported with their expectations until there is certainty that the service would be available for the service user. If a service is not available and the service user was expecting to access it, assume this will cause feelings of rejection, abandonment and / or hopelessness. Discussing the understandable disappointment and having an alternative plan is important.

If a person has a care coordinator or is actively seeing a psychological therapist in the CMHT, they should continue to offer face to face contacts at regular intervals during the HTT episode. If there are exceptions, the rationale should be discussed with HTT, recorded in the notes and any change to their usual CMHT's care should be explained to the service user by their care coordinator/psychological therapist. Integrating services is important to establish clear pathways for transitions between services and agencies, and facilitating well organised services, care and support.

The HTT / CMHT must ensure they work within a 'whole system' approach and therefore need to ensure they establish good and effective working relationships with the other team to provide an integrated service. This would include holding regular interface meetings, ensuring the direct handover of care and ensuring joint working protocols are in place. It is important that contact with the service users' family is also maintained through the crisis episode by the CMHT.

Transition back to CMHT from CRHT:

The decision to transfer care should be made through consultation between all relevant clinicians involved, the service user and carer. This consultation should also include consideration for other relevant life circumstances for example the ending of other key relationships and these should be discussed with transparency. Attempts to do this need to be documented accordingly. This transition may feel difficult for a service user, regardless of whether they have engaged with the service or not. Discussing their concerns about transition will be important and validating their feelings about it. Working closely with their CMHT should help support them in this period of change.

Discuss a transfer of care in advance and develop a structured and phased plan acceptable to the service user, that gives them a greater sense of control and reduces associated anxiety.

A clear individualised transition plan should then be followed which has been agreed between teams and the service user. If the plan needs to change at any point it will be important to involve the service user and ensure they feel heard and supported, as unexpected change at a time of transition may lead to a service user feeling more anxious.

Joint visits must be utilised to ensure the safe transition of the service user between services and to provide the opportunity to build or re-establish relationships with service users.

It will be important to ensure there is good, shared understanding with the service user, their family, carers, and relevant others of why the crisis occurred, for example chronic social factors, and how it may be managed in the future. Feeling overwhelmed by emotions can lead people to feeling they have no ways to manage on their own, but this understanding and a good crisis plan can help. Although our aim should be that a crisis plan is in place that is co-produced with the service user and their support network (where appropriate), it is important to recognise that this may not be possible. It is important the development and reviewing of a crisis plan is continually considered.

13.4 Appendix 4

5 P's Risk Formulation

Risk formulations have clinical utility and are fluid. They should be updated once a week, at all reviews and when there is change of presentation or care. Formulations and plans should be communicated verbally to transferring teams. Receiving teams should also check the formulation and plan detailed in the level 1 risk assessment. Formulations **should not** be deleted but instead expanded upon and reviewed / changed- this will help to consider whether the risk has changed. There should not be more than one risk formulation featured on the level 1 risk assessment.

Presenting

What risks is the person presenting with? All current risks of level 1 risk assessment should feature).
should be described (anything indicated as a yes at the top

If self-harm, how do they self-harm, if suicidal ideation, how have they acted on suicidal thoughts in the past? As much detail as known.

Predisposing

Historic factors that made the person vulnerable to developing the presenting problem(s).
E.g. early experiences, abuse, bullying, biological predisposition etc.

Precipitating

What triggers the risk behaviour? E.g. stress, conflict in relationships, rejection, abandonment, financial stress etc.

Perpetuating

What maintains the risk behaviour/what keeps the problem going? E.g. lack of insight, poor coping skills, drugs and alcohol, low self-esteem etc.

Protective

What makes the person less likely to act on urges to carry out the risk behaviour?

E.g. seeking support/willing to engage, future oriented, hobbies/responsibilities, evidence of some positive coping strategies? Be very thoughtful about including children.

REMEMBER: Protective factors can become precipitants – e.g. if a person loses a significant role or relationship.

Check whether protective factors are current

Individualised Risk Management Plan

- Formulations and plans could be put together by individual clinicians following assessment or by teams within risk huddles.
- The plan must link to the risk formulation. It should not be a general plan. ➨ It should be a biopsychosocial plan.
- If information is missing from the 5 P's formulation, part of the plan should be to collect the information.
- Signposting and liaising with other services should be detailed.
- Risk Management plans should ensure that short and long term risks, are considered.
- Contingency plans should be considered including what telephone numbers given, safety plans and relapse plans.

Short term Risk Planning

- How are the team and the service user managing presenting risk? E.g getting rid of the means, giving crisis numbers etc.
- How is the team going to manage the precipitants (trigger)?
- Protective- how are we making use of the protective factors present and how are we bolstering protective factors.
- Detail services to liaise with and for what purposes.
- Consider what can be focused on in contacts with patients.

Long term Risk Planning

- Perpetuating factors-how can the perpetuating risk be managed?
- If the service users needs go beyond what can be offered at home treatment, what referrals need to be considered?
- Consider future risks and consider how these are going to be mitigated eg transfers of care, future destabilisers.
- How is the risk going to be managed longer term / in different services.

Reviewing the Risk Management Plan

- Formulations and plans must be reviewed once a week in either MDT and / or medical reviews. The main features of a risk management plan should feature on MDT review plans and care plans.

- As tasks have been completed in the risk management plan, this should be clearly documented and the formulation / plan updated accordingly.
- If a patients care is transferred to another team with outstanding actions, it should be clearly recorded and handed over what is outstanding.