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Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Parc Cathays
Caerdydd CF10 3NQ

Cathays Park
Cardiff CF10 3NQ

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Title: Policy Implementation Guidance on the development of Crisis Resolution/Home Treatment (CR/HT) services in Wales.

For Action by: NHS Trust and Local Health Board Chief Executives	**Action required: Cascade as appropriate**

For Information to: See attached distribution list at Annex 3

Sender: Peter Lawler, Policy Lead. Mental Health Branch, Health and Social Care Department

National Assembly contact(s) : Peter Martin 029 2080 1470

Tel: 029 20825111 GTN: 1208
Llinell union/Direct line: 029 2080 1470
Ffacs/Fax: 029 206331
http://howis.wales.nhs.uk/whcirculars.cfm

The development of Crisis Resolution/Home Treatment (CR/HT) Services in Wales

Policy Implementation Guidance

1. Purpose of the guidance

The development of mental health Crisis Resolution/Home Treatment (CR/HT) services is a health priority for Wales. This guidance describes the functions and operational requirements of CR/HT services, and can be used as a tool to help implement SAFF[1] target 17 for the NHS in Wales, which requires such a service to be established by 31st March 2006. It can also be used to support implementing Key Actions 23 and 24 of the adult Mental Health National Service Framework[2] (NSF).

2. Introduction

The modernisation agenda for adult mental health services in Wales is driven by the Mental Health Strategy[3], the NSF and the recommendations made in the reform of health and social care in Wales (the Wanless Review[4]). Modernisation will also need to ensure that services are able to meet the challenges that may arise from any reform of the Mental Health Act.

The Welsh Assembly Government considers the establishment of CR/HT services to be a core service component that is necessary to implement this modernisation agenda. The CR/HT service model is not new and has been in existence in areas of the United States, Australia and other parts of the UK since the 1980's[5].

There is growing evidence and support for the impact that CR/HT services are having, and this positive impact is not only perceived as beneficial for service users and their carers but for mental health services as a whole[6] [7]. Research has found that service users and carers generally prefer community-based care and treatment and that CR/HT services are as effective both clinically and socially as inpatient care.[8]

Research also shows that home treatment services can reduce the length of inpatient stay, particularly if the teams make regular home visits and provision is for both social and health care[9] [10]. For the service to be effective and offer service users and carers a real alternative to hospital admission, it needs to act as a gatekeeper to acute inpatient facilities.

This will allow for the most appropriate use of inpatient beds by means of assessment and examination of alternatives. Control of the admissions process through the application of clear and agreed criteria, requires close liaison and co-operation between CR/HT staff and other professionals including medical and nursing staff.

The needs of people with a mental illness are often diverse and complex, and are best met through a whole systems approach to care developed through an analysis of local need. Annex 1 of this guidance provides referral routes and liaison links, and shows the functions of CR/HT as part of an integral mental health service, and as the gatekeeper to inpatient services.

3. What is a Crisis Resolution Home Treatment Service?

CR/HT offers a rapid response in the form of assessment and where appropriate support and treatment to adults for a brief period who are experiencing a mental health crisis, as an alternative to hospital admission[11]. It offers people experiencing severe mental health difficulties the opportunity to be treated in the least restrictive environment with increased choice in the management of their mental health problems.

There is no set structure for a CR/HT service, however, it is essential that services adhere to the key elements outlined in this guidance in order to meet service delivery objectives. The design of the service can be adapted to meet local need and circumstances[12].

Within urban areas the most appropriate model may be a discrete specialist CR/HT team working alongside other services such as mainstream Community Mental Health Teams (CMHTs), day hospitals and acute inpatient units. In less densely populated or rural areas there may not be the need for a discrete CR/HT team, or it may not be a cost-effective option.

In these circumstances it may be more appropriate for crisis resolution staff to be included within another service team. For example, one or more generic CMHTs may provide a crisis resolution service either through dedicated specialists within the team and/or a rota of staff[9]. It may be necessary to undertake an in-depth audit of current service provision, care pathways and local epidemiology to identify and assess local need in order to inform the model of service developed.

The CR/HT service should work as an integral part of the mental health system aiming to provide a safe and effective home based assessment and treatment service as an alternative to inpatient care, working in conjunction with other service elements. It is essential that the service acts as a bridge between community and inpatient care and not perceived as a “bolt on” but as an integral part of the whole system approach to mental health care in Wales.

4. Key principles to underpin service model

The Welsh Assembly Government supports the following principles identified by the Sainsbury Centre for Mental Health: [12]

- Crisis management is a process of working through the crisis to the point of resolution;
- Successful client engagement is paramount. The formation of a therapeutic alliance with the client is essential before any interventions can be successful;
- Services take a holistic approach, looking at all the factors involved in the crisis, including biological, psychological and social issues, and using a range of interventions to address these;
- The individual's social network has a powerful effect on the person's mental health and treatment must directly address these significant social issues;

- Crisis staff should approach work with users from a 'strengths' rather than an 'illness' model, and draw on the innate strengths of service users in order to support them;

- Educating service users will comprise a significant part of the crisis work and should help clients learn behaviours to improve and maintain their mental health. The approach should be one of collaborating with the user or their family by 'doing work with them', rather than 'doing work on them', so as to promote their 'ownership' of the crisis.

5. A CR/HT service should as a minimum:

- Be multidisciplinary with input either as a core part of the CR/HT service or access to: medical; nursing; occupational therapy; psychology; support workers; approved social workers/social workers;

- Be multi-agency, i.e. health and social care services and others where appropriate, including non statutory sector providers;

- Be available to respond to psychiatric emergencies 24 hour a day 7 days a week 365 days a year;

- Provide a core service that is available as a minimum from 0900 to 2100, with an on-call service available throughout the night;

- Provide intensive contact with service users and where appropriate carers for a short duration of up to six weeks;

- Act as a 'gatekeeper' to acute inpatient services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service;

- Ensure that individuals experiencing acute and severe mental health difficulties are treated in the least restrictive environment and as close to home as clinically possible;

- Remain involved with the client until the crisis has resolved and the service user is linked into on-going care;

- Ensure where hospitalisation is necessary, active involvement in discharge planning;

- Be involved in care planning through the Care Programme Approach (CPA)

- Plan interventions that cover social, financial, housing as well as treatment needs;

- Provide support and education to carers/ family where appropriate

6. Who is the Service For?

CR/HT services should be targeted at working age adults with severe mental illness who are experiencing an acute episode or who are in crisis to such an extent that admission to hospital would be required without such intervention. It should also be for people who are ready to leave hospital but require intensive support to facilitate safe discharge.

Targeting should be on the basis of need and risk rather than solely on diagnosis although the service will not usually be appropriate for individuals who present with:

- Primary diagnosis of alcohol or other substance misuse;
- Crisis related solely to relationship issues;
- Mild anxiety disorders;
- Exclusive diagnosis of Learning disability;
- Exclusive diagnosis of Personality Disorder;
- Brain damage or other organic disorder including dementia;
- Recent history of self-harm but not suffering from a psychotic illness or severe depressive illness.

7. Whole systems working and CRHT services

CR/HT services need to form an integral part of the mental health whole system, receiving referrals from either primary or secondary care services. In either case the CR/HT service must be fully integrated into a system that provides a fast response to primary care, and a gate-keeping function to secondary inpatient care. It must work in close consultation, agreement and in liaison with CMHTs, and not work in isolation, and there should be clear and agreed protocols between CR/HT services and other community services such as supported accommodation, day hospitals, and day services.

8. Language, culture and diversity

In developing CR/HT services consideration must be given to meeting the needs of the diverse range of cultures within the local population. Specific attention should be paid to providing a service that meets the needs of people whose first language is Welsh, to meet the needs of people from black and minority ethnic communities, and to meet the needs of people from the culturally deaf community.

9. What are the benefits of CR/HT services?

The recognised benefits of implementing CR/HT services include:

- More choice for service users and carers;
- Potential to reduce compulsory admission rates;
- Reduce both rates of admission to acute inpatient facilities and reduce length of stay;
- Reduce the need for out of area placements;
- Increased access for less urgent referrals.

10. What can service users expect from the service?

The service will offer advice, assessment and support where appropriate. When a referral is accepted the team will work with the person for a brief period to manage and resolve the crisis. Longer-term intervention will be provided by the appropriate service e.g. CMHT, day hospital, day care, etc.

Service users and families/carers should be provided with the following information:

- Description of the service, range of interventions and what to expect;
- Name and contact details of care co-ordinator and other relevant parties;
- Contact details for out of hours advice and help;
- Care plan and comprehensive information about medication;
- Relapse prevention and crisis plan;
- Discharge plan;
- How to give their views on the service.

11. Lessons from service development

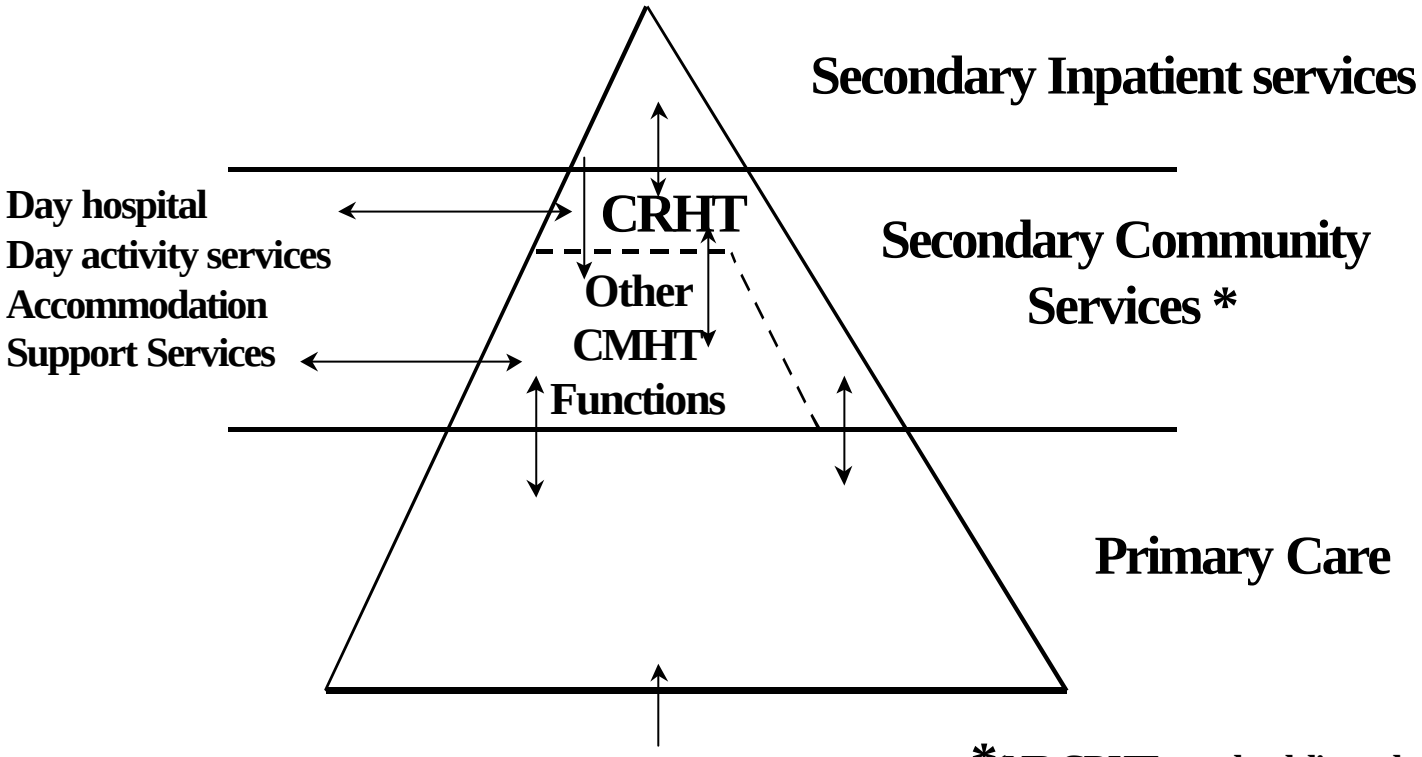
Experience from other areas indicates that the following principles of care are important:

- A 24 hour a day, 7 day a week service;
- Rapid response following referral (DH guidelines for England specify 1 hour[8]);
- Intensive intervention and support in the early stages of the crisis;
- Active involvement of the service user, family and carers;
- Assertive approach to engagement;
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs;
- Learning from the crisis.

12. What does the service do?

Mental Health Policy Implementation Guidance developed in England[8] identified 4 phases to crisis resolution. The Welsh Assembly Government supports this approach and this guidance is reproduced in Annex 2.

CRHT Referral & Liaison Links



*(NB CRHT may be delivered by a free standing team or as a component part of a CMHT)

What does the service do?

Key Component	Key Elements	Comments
1. ASSESSMENT	➢ Initial screening to ensure service is appropriate for the patient ➢ If inappropriate, make referral to other services and ensure adequate continuity of care ➢ Physical health assessment where appropriate ➢ If appropriate, multidisciplinary assessment of service user's needs and level of risk ➢ Assessment should actively involve the service user, carers/family and all relevant others, e.g. GP.	➢ Rapid – available within one hour of referral ➢ Assessment to take place in service user's home wherever possible ➢ Problem solving approach
2. PLANNING	➢ Produce a focused care plan ➢ Decide on number of visits and level of input ➢ Begin discharge planning at an early stage	➢ Team approach and team decision making ➢ Active involvement of the service user. Include input from family/carers ➢ Care plan must be flexible enough to respond rapidly to changes in the clinical situation

3. INTERVENTION – the following interventions should be available:		
Key Component	**Key Elements**	**Comments**
Designated named worker	➢ Responsible for co-ordinating the service user's care ➢ Provides continuity of care and ensures effective communication within the team	➢ Service user and family/carers involved in selecting named worker and aware of how to contact him/her
Intensive support	➢ Frequent contact (including home visits) throughout crisis ➢ Ongoing risk and needs assessment ➢ Service must have the capacity to follow service user throughout the crisis	➢ In the early phase, several visits a day may be needed
Medication	➢ Immediate, 24 hour access to medication ➢ Delivery and administration of medication to service users who require intensive monitoring ➢ Care designed to improve concordance (co-operation with treatment) ➢ Service user involved in decision making and monitoring effects of medication ➢ Standard side effect monitoring tools to be used regularly by service user and staff	➢ Staff need training in storage and use of medication as well as concordance training ➢ Links with hospital and local pharmacies required to ensure continued supply ➢ Careful attention to avoiding/reducing side effects vital if engagement and concordance are to be maintained

Key Component	Key Elements	Comments
Practical help with basics of daily living	➢ Help with benefits, housing, childcare etc	➢ Empowering service users and respecting their independence is crucial ➢ Service user/family/carers must be involved in all decision making
Family/carer support	➢ Ongoing explanation to family/carers ➢ Education about the crisis and the service user's illness ➢ Arrange practical help as needed	➢ Involvement of carers/family and provision of support during crisis are key components of recovery.
Interventions aimed at increasing resilience	➢ Range of therapies for both service user and family/carers should be available including: ➢ Problem solving ➢ Stress management ➢ Brief supportive counselling ➢ Interventions aimed at maintaining and improving social networks	

Key Component	Key Elements	Comments
Relapse prevention	➢ Individualised early warning signs plan developed and on file ➢ Plan to be shared with primary care, GP and others as appropriate ➢ Relapse prevention plan agreed with service user and family/carers ➢ Effort made to identify and reduce conditions that leave the service user vulnerable to relapse	➢ Changes in thought, feelings and behaviours precede the onset of relapse but there is considerable variation between service users. Development of individualised plans can be effective in reducing the severity of relapse
Crisis plan	➢ Service user and family understanding of when to call for help ➢ 24 hour contact number supplied to client, family, carers	➢ Easy access to help 24 hours a day

Key Component	Key Elements	Comments
Respite	➢ Access to respite facilities preferably in non hospital surroundings e.g. cluster homes, community hostels etc ➢ Access to day care facilities	➢ Community residential care should be in small family style accommodation that emphasises 'normal living' and has an 'open door' policy ➢ Day care can be very effective in helping both service user and family/carer cope with crisis and recover
Links with inpatient services	➢ If hospitalisation required, regular, formal joint (inpatient staff and home treatment staff) review of patients should take place to ensure that the service user is transferred to the lowest stigma/least restrictive environment as soon as clinically possible ➢ Home treatment team to be involved in discharge planning process ➢ Service user/family/carers to be actively involved in discharge planning process	➢ Primary care and other services to be involved as appropriate and kept informed of discharge plans

Key Component	Key Elements	Comments
4. RESOLUTION	➢ Discharge planning should begin early ➢ Information about the crisis, interventions and ongoing care should be exchanged with relevant others (GP, CMHT) ➢ Discharge possibilities will be dependant on clinical situation and local service provision but could include transfer of care to: ➢ Primary care ➢ Assertive outreach team ➢ Early intervention team ➢ Continuing care ➢ Other mental health services	➢ Prior to discharge the team should ensure that: ➢ There is good understanding (service users, family, carers, relevant others) of why the crisis occurred and how it could be avoided in future ➢ Coping strategies have been explored with the service user and family/carers ➢ Relapse prevention plan is in place ➢ Service user/family/carer have had an opportunity to express their view about the service and contribute to service improvement

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Annex 3

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