

**OPERATIONAL POLICY  
CRISIS RESOLUTION AND HOME  
TREATMENT TEAMS (CRT)**  
SEPTEMBER 2014

This policy supersedes all previous policies for South Camden CRT, North Camden CRT and Islington CRT

<b>Policy title</b>	Operational Policy - Crisis Resolution and Home Treatment Teams (CRT)		
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<b>Membership of the policy development/ review team</b>	Debbie May, Interim Operational Services Manager; Aisling Clifford, Associate Director, All Crisis Resolution Team managers.		

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**Consultation**

All Crisis Team medical staff, Crisis House managers

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## 1. Introduction

1.1 The Crisis Resolution and Home Treatment Team (CRT) is a multi-disciplinary community based mental health team aiming to provide a safe and effective home-based assessment and treatment service as an alternative to in-patient care.

1.2 The service will be available 24 hours a day, 365 days of the year for residents of Camden and Islington with mental health difficulties who are in crisis.

1.3 The key features of the service are that, it will be mobile, provide a rapid response and act as gatekeeper to inpatient services.

## 2. Inputs/Main Functions of the Service

2.1 To provide a service to Camden and Islington residents experiencing a mental health crisis.

2.2 24 hour, 365 days of the year timely response to mental health crises.

- 2.3 To gatekeep all admissions to acute inpatient beds as per the guidance outlined in CQUIN (Commissioning for Quality and Innovation).
- 2.4 To take direct referrals from all inpatient wards and crisis houses if indicated. To facilitate early discharge from the inpatient mental health wards.
- 2.5 To attend reviews on an in-patient setting as appropriate and to consider whether their treatment can be transferred to a less restrictive environment, this could be a crisis house setting or to their home.
- 2.6 CRT will offer an assessment to all referrals from GPs.
- 2.7 Details of any referred service users from GPs who are assessed by CRT but not taken on, will be tabled for discussion at the CRT / GP Liaison meetings in order to reach a joint understanding of the functions of the service.
- 2.8 If, at the point of referral from a GP, it becomes clear that the service user requires an alternative CANDI service, then the CRT will take over the responsibility for making this onward referral from the GP i.e. the referral will not be “bounced” back to the GP.
- 2.9 All service users that CRT takes on for a treatment episode will be allocated a cluster as part of the Mental Health Tariff at the point of the initial assessment.
- 2.10 As part of the assessment process a full history and mental state examination will be undertaken by the service. During the course of this assessment the Crisis Team will consider if someone requires their treatment to be co-ordinated under CPA. If the team refers onto another Trust service then they will request, where appropriate, that that specialist team considers the individual’s suitability for CPA.
- 2.11 All service users that are taken on for treatment will be offered a review by a team psychiatrist.

- 2.12 For all service users that are taken on for treatment, a copy of their current medication will be obtained from their GP.
- 2.13 Gather collateral information from all relevant involved services & historical case notes.
- 2.14 All service users will have a risk assessment at the point of the initial assessment. This risk assessment will be updated as risk features change.
- 2.15 A care plan will be developed in conjunction with the service user in line with the needs identified; this will be documented within the progress notes and updated following each visit.
- 2.16 Service users taken on for treatment will receive a diagnostic coding.
- 2.17 CRT will consider the physical health and substance misuse needs of the service users in conjunction with our primary care partners.
- 2.18 Where indicated the service will arrange for a service user to have an Activity of Daily Living (ADL) assessment of needs.
- 2.19 All essential inputs will be recorded in the service user's electronic records system (RiO).
- 2.20 The service will make full use of all community resources; including the service user's own social system in any intervention.
- 2.21 The CRT will aim to involve and support the service user's support systems throughout the treatment episode.
- 2.22 The service will operate to the principles set out in the Safeguarding policies.
- 2.23 Where indicated the service will be able to carry out Capacity assessments.

### 3. Outputs/Outcomes

3.1 Output & Outcome measures from the CRT assessment will include the following:

- Taken on for home treatment / assessment
- Admit to assessment ward
- Refer for a Mental Health Act assessment
- Admit to treatment ward
- Admit to acute frail ward
- Admit to Crisis House
- Referred for physical investigations
- Not taken on for treatment / referred back to referrer with advice
- Safeguarding alert raised
- Feedback to referrer within 24 hours of assessment
- Discharge from ward to CRT
- Authorise and gatekeep all admissions to inpatient wards
- Following assessment all demographic and social information is recorded on RiO in the appropriate field

### 4. Interventions

4.1 Clear information about services available will be provided in order to promote choice. The team will produce safe, effective and regularly reviewed care plans that reflect the views and wishes of its clients.

#### 4.2 Biological

The service provides or ensures that, where indicated, the following is achieved:

- Drug Treatment
- Drug levels
- Drug checks/effects
- Medication reconciliation
- Routine blood screen tests/ECG/FBC/U&Es
- Phlebotomy

- Physical monitoring-TPR/BP/Weight/ Nutrition
- Alcohol/Drug misuse Treatment -Drug screens/breath tests/monitoring
- Wellbeing monitoring: diet/nutrition/weight/ exercise/ smoking cessation
- Specific drug monitoring-HDAT/LICO3/ Clozapine initiation & monitoring
- Prescribe for medical conditions
- Referral for ECT--physical checks/Anaesthesia
- Referral for additional tests-Brain scans/EEG/ Hormone profile/CXR etc

#### 4.3 **Psychological**

The service provides or ensures that, where indicated, the following is achieved:

- One-to-one review with a Clinical Psychologist
- Consent to RX/Capacity /Section 58 RX reviews
- Insight work - Peer led support / supervision
- CBT based interventions
- Solution focused interventions
- Behavioural based interventions
- Motivational Interviewing
- Supportive counselling
- Family psycho-education/social systems interventions
- Neuropsychometric tests as required
- Relapse prevention / Crisis planning
- Medication management and adherence

#### 4.4 **Social**

The service provides or ensures that, where indicated, the following is achieved:

- Benefits and Employment advice and support
- Carers assessment/ support
- Housing advice
- Full OT ADL assessment
- Review of risk/safety/ support requirements
- Practical support with ADLs



For all service users that are in treatment with CRT, the following will be monitored and reviewed daily:

- Risk
- Treatment plan
- Mental state
- Physical health
- Consent
- Capacity
- Living environment
- Suitability for discharge from the service
- Response to medication & side effects of treatment
- Collaborative care planning with service user and carer

## 5. Outcome Measures

### 5.1

- To inform the referrer of the outcome of the assessment within 24 hours
- Discharge notification to GP & referrer with 24 hours
- All service users to be requested to complete a feedback questionnaire for each treatment episode
- Appropriate aftercare arranged
- Shared crisis and contingency action plan agreed by service user and service – to include responses to identified relapse signatures

## 6. Who is the service for?

6.1 The team will prioritise the service for people suffering mental illness and who:

- Are in a mental health crisis
- Are being considered for admission to hospital
- Are already in an inpatient/crisis house facility
- Present a current risk to themselves or others

- Are resident in the catchment area.
  - Are aged between 16 and upwards
- 6.2 The service provided by the CRT is not primarily targeted at people whose primary need is drug or alcohol dependence, learning disability, brain damage or dementia.
- 6.3 The CRT will provide care for those over the age of 65 presenting with functional illnesses.

## 7. Operation of the CRT

7.1 The model used by the CRT is a bio-psychosocial one with an emphasis on social systems intervention. This requires a shift in perspective from the individual, to the system of which the individual is a part. This way of working enhances the collection of information, facilitates ownership of issues and generates solutions to identified problems and promotes a common understanding of the plan.

7.2 In their work with people in mental health crises the team uses the Social Systems Intervention model. The main tenets of this approach are to gather information about the person's social context; to elicit causes in their social world for the presentation; and through a process of group/family work, generate solutions.

7.3 The CRT will provide rapid help and treatment to people who are in a mental health crisis, involving their carers and social networks in order to resolve the crisis. As far as possible this will be provided in the person's own environment with as little disruption to their normal routines as can be managed.

7.4 The CRT will undertake a comprehensive assessment with a social systems interventions approach. The visiting team will include a doctor, who will be able to prescribe and advise on medication management. The team will be able to visit frequently, support the social network and stay involved until the crisis is resolved, at which point people will be handed on to on-going care if appropriate.

## 8. Hours of Operation

8.1 The team will provide a service 24 hours a day, 7 days a week. A two-shift system will operate from 0800 to 1600hrs and from 1300 to 2100hrs.

Between 2100 and 0800hrs one staff member will work and take telephone calls from known service users. They will also where necessary act as back up for the Mental Health Liaison teams via the three Accident and Emergency departments within the two boroughs.

## 9. Staffing and Skill Mix of the Team

9.1 A key element of any team is that of skills mix and competencies. A multidisciplinary team allows for a variety of approaches and interventions. The CRT includes the following professional disciplines:

- Team leader from any professional background
- Social workers,
- Band 6 and 5 mental health nurses
- Band 4 Assistant Practitioners
- Band 3 Clinical Support Workers
- Psychiatrists
- Psychologists
- Administrative staff

In order to understand the capacity of the team on a shift by shift basis, the current standard is that three clinical staff work per shift, two of whom should be registered nurse or social worker (Band 5 or 6) plus one Assistant Practitioner (Band 4, non-registered).

In Islington at present one additional staff member will operate and staff the incoming calls received via the pager.

9.2 All professional staff of all disciplines will have a common orientation and generic role with the service and will be fairly interchangeable in tasks performed.

9.3 Responsibility for the allocation of resources and duties in the team will lie with the team leader and these will be congruent with the skills and abilities of the professionals on the team.

9.4 All crisis teams aim to have a gender balance on each shift in order to provide choice to men and women in terms of assessments, home visits and other interventions. Some women using Trust services have requested to work with women and the Trust aims to meet this request. However, due to covering shifts a gender balance is not always possible. Managers are expected to take this into account when planning rotas and liaise with each other in terms of night cover.

If it is known that there will only be one gender on shift and there are service users who are known to find this difficult, they can be contacted by the previous shift or other services can offer support, such as the crisis houses and the acute day programmes in terms of telephone contact.

## 10. Communication

10.1 The CRT will provide written information for clients, outlining the services provided by the team and how to contact them. Identified team members will liaise with referrers and other service providers.

10.2 Referrers, GPs, CANDI staff and other will be provided with feedback within 24 hours of the initial CRT assessment.

10.3 CRT staff will carry mobile phones whilst on visits to enhance both safety and efficiency.

10.4 Due to the fact that the CRT spend most of the working day in the community, the telephone number will often divert to a paging service. This is also applicable when the volume of incoming calls becomes high.

In this case callers will be invited to leave a name and a contact number and the CRT will return your call as soon as possible. Any pager messages left

will be responded to *within an hour, but incoming messages will be triaged and prioritised and whenever possible will be responded to within 30 minutes*

This will also be the routine way in which the team is contacted between 2100 and 0800hrs.

10.5 All information will be entered on the RiO electronic record system.

10.6 An Assessment and Risk assessment will be recorded on RiO within 24 hours of the assessment.

## 11. Referrals

11.1 The CRT will receive referrals from a number of sources. All direct requests for admission to an inpatient unit will be referred automatically to the CRT for assessment,

11.2 For those service users that have already been admitted to hospital referrals are accepted from the in-patient units and the crisis houses as part of early discharge procedures. It is understood that these referrals will be for the purpose of reducing the time that the service user spends as an inpatient and to plan continuation of acute care in the home environment.

11.3 The CRT accepts direct referrals from the following sources:

- Assessment teams
- Recovery Teams
- Community Teams
- CANDI Crisis Houses
- General Practitioners
- Service Users that have been treated by the service previously
- Carers and families of services users that have been treated by the service previously
- A&E departments
- London Ambulance Service
- Police
- IAPT services

- Social services
- Non-statutory health and mental health organisations

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Elements to be monitored	Lead	How trust will monitor compliance	Frequency	Reporting arrangements  Which committee or group will the monitoring report go to?	Acting on recommendations and Lead(s)  Which committee or group will act on recommendations?	Change in practice and lessons to be shared  How will changes be implemented and lessons learnt/ shared?
					<i>Suggested wording</i>	<i>Suggested wording</i>
					Required actions will be identified and completed in a specified timeframe	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

## 12. Standards for response to referrals

12.1 When a referral is made both the urgency and the degree of risk for the service users and others in the situation will be discussed with the referring agent.

- 12.2 There is provision for the A&E Liaison Teams to decide whether further acute treatment needs to take place at home or in an inpatient setting. The A&E Liaison team will consult their CRT colleagues when they have made their decision. Ideally, the CRT and A&E Liaison Team will come to an agreement about the care pathway; reducing the need for CRT to carry out a duplicate assessment.
- 12.3 The preferred response would be for an assessment to be carried out by two members of the team one of which may be a psychiatrist.
- 12.4 An Assessment and Risk assessment will be completed and documented within 24 hours of the assessment.
- 12.5 After the service user has been assessed, the Crisis team will contact the referrer and GP to inform them of the outcome of the referral and any further plans. A copy of the complete assessment will be sent by fax, e-mail, or post to the referrer within 24 hours.
- 12.6 If the referrer works within the Trust then they will be informed of the outcome of the assessment in person or by phone and directed to view the full assessment on RiO.

### 13. Gatekeeping

- 13.1 The gatekeeping function of the CRT is essential – all admissions to an acute in-patient setting must be gatekept by the service. There is provision for the A&E Liaison Teams to decide whether further acute treatment needs to take place at home or in an inpatient setting. The A&E Liaison team will consult their CRT colleagues when they have made their decision. Ideally, the CRT and A&E Liaison Team will come to an agreement about the care pathway; reducing the need for CRT to carry out a duplicate assessment.



## 14. Assessment

- 14.1 The assessment will take place wherever the client is at that time, preferably at home, and will address the following areas:
- Needs assessment - including determining access to basic material supports such as food, shelter and finances
  - Mental state examination
  - Level of risk
  - Social systems

## 15. Planning Interventions

15.1 Following the assessment, if the service user requires CRT intervention, a treatment plan will include:

- The location where care will be provided
- The timing and the purposes of the visit
- Details of any medication to be given
- Expectations of the service user
- The role of the carers and /or social network
- Involvement of other specialist mental health services
- The role of the GP
- Details of how to contact the CRT in a crisis
- Support and practical help: e.g. finances, food, and daily living activities
- Medication
- Education and problem solving
- Psychological therapies
- Liaison with other practitioners and services

## 16. Quality and Monitoring

### Record Keeping

16.1 The CRT will keep records of every contact made with clients, their families/carers and other service providers, which must be entered onto the electronic record system RiO.

## 17. Complaints

17.1 Complaints will be dealt with according to the Trust Complaints Policy.

## 18. Evaluating the service

18.1 The service will be evaluated in the following ways:

- Twice daily handover meetings at which all service users will be discussed
- Service user interviews at point of discharge
- On-going evaluation of carer satisfaction.
- Key performance indicators and clinical audit
- Clinical risk management
- Continuing professional development for all staff
- Clinical & managerial supervision
- Participation in the Home Treatment Accreditation Scheme audited by the Royal College of Psychiatrists, CORE study.

## 19. Health and Safety

19.1. Staff will be based at one of three sites (The Highgate Mental Health Centre, 3 Daleham Gardens, St. Pancras Hospital) and will operate within guidance set out in Trust Policy.

19.2 At night staff members that do not drive can book a taxi to take them to Accident and Emergency departments which are not in their immediate vicinity (this could be either the Whittington Hospital, the Royal Free Hospital or UCLH) by faxing a booking form to the Transport department St. Pancras and quoting the relevant booking code (TASC no) for each team. Night staff from the transport department will organise the transport.

## Appendix 1

### **Did Not Attend Procedure (DNA)**

- **All service users must be seen face to face within 48 hours of initial assessment**
- **All service users must be seen face to face at time of discharge apart from in extenuating circumstances which have been discussed and planned as a team**

#### **Standard Operating Procedure for 'Did Not Attend' telephone calls.**

- If service user does not respond to a planned telephone call, leave a clear answer phone message if facility is available. Message should detail who is calling and leave a number on which the service user can contact the team.
- If not able to leave message, set a time during the next shift to attempt contact again. In the event that contact is still not made, consider an unannounced call at client's address.

#### **Standard Operating Procedure for 'Did Not Attend' appointments/ home visits.**

- If service user does not attend a planned appointment at the CRT premises, call them on available telephone number/s and rearrange. If no response follow procedure above.
- If service user is not home when attending a planned home visit, discretely leave a note on CRT headed paper to state the date and time attended and ask service user to contact team within certain time.
- Should service user not respond within stated time period, attempt telephone call and follow procedures detailed previously.

**In all cases a team discussion should take place taking into consideration risk factors and/ need for a police welfare check if appropriate**

- If the decision has been reached that the risk is sufficient that there are concerns for the welfare of the service user, staff will summon Police assistance. When confirmation of Police undertaking a welfare check have been received in the form of a CAD number, this will be documented in the service users progress notes and a time agreed of 6 hours after which if no contact has been received back from Police then CRT staff must follow this up with the Police.

## Appendix 2

### Night-Time Operational Procedures

**It is acknowledged that presently the CRT operates a limited service at night; there is one registered nurse/social worker on duty per borough. As a result they are unable to conduct any home visits.**

The service which is provided is as follows:

- Telephone support/counselling for Camden & Islington service users and their carers in mental health crisis.
- Gatekeeping.
- Assistance and back up to the three Mental Health Liaison teams within the two boroughs. Camden and Islington service users who may present to the three Accident and Emergency departments overnight will whenever feasible, receive a joint assessment/care planning from Liaison and CRT.

### Equality Impact Assessment Tool

	Yes/No	Comments
1. Does the policy/guidance affect one group less or more favourably than another on the basis of:	No	
Race	No	
Ethnic origins (including gypsies and travellers)	No	
Nationality	No	
Gender	No	
Culture	No	
Religion or belief	No	
Sexual orientation including lesbian, gay and bisexual people	No	
Age	No	
Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2. Is there any evidence that some groups are affected differently?	No	
3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4. Is the impact of the policy/guidance likely to be negative?	No	
5. If so can the impact be avoided?	No	
6. What alternatives are there to achieving the	No	

	Yes/No	Comments
policy/guidance without the impact?		
7. Can we reduce the impact by taking different action?	No	

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