



*National Institute for
Mental Health in England*

NIMHE West Midlands

CRISIS RESOLUTION & HOME TREATMENT

mental health questions? ask NIMHE

mental health questions? ask NIMHE

EDITOR

Marcellino Smyth

Visiting Professor of Social & Community Psychiatry, Faculty of Health, UCE
Birmingham
NIMHE West Midlands Fellow Research & Development

ASSISTANT EDITOR

Kevin Heffernan

Programme Lead Crisis Resolution NIMHE West Midlands

PRODUCTION SUPPORT

Alan Rowland

Service User Consultant

NIMHE West Midlands would like to gratefully acknowledge and thank the West Midlands Crisis Resolution and Home Treatment Network, Carers in Partnership, UCE Birmingham Faculty of Health and the following for their support and contributions towards this publication.

Dr Ian McPherson

Alastair McIntyre

Amanda Rose

Carol Childs

Sean Clee

Clare Nightingale

Dr John Houlst

Prof Antony Sheehan

Lawrence Moulin

Nick Adams

Danni Jutla

Sainsbury Centre for Mental Health

Mervyn Morris

CR/HT Team's

Handsworth

Ladywood

Kingstanding

Sparkbrook

Small Heath

Sutton

Wolverhampton

Yardley

Carers in Partnership

Pauline Arksey

Pat Fleetwood-Walker

Simon Foster

Ann Williams

PUBLICATION



This document is published by NIMH (E) in conjunction with the Centre for Community Mental Health, UCE Birmingham

mental health questions? ask NIMHE

mental health questions? ask NIMHE

Introduction

The intention of this publication is to provide expanded guidelines surrounding the implementation of Crisis Resolution / Home Treatment based on the Department of Health Mental Health Policy Implementation Guide (March 2001).

These guidelines provided a framework for one of the most significant developments in acute mental health care, complementing inpatient care and offering choice to service users, carers and clinicians. Crisis Resolution/ Home Treatment is a Recovery oriented approach which offers a more personalized approach to mental health care both in theory and reality.

As Crisis Resolution/ Home Treatment teams developed, the possibilities for this model began to be realised and the issues surrounding best fit and local implementation within an integrated community care system, also emerged. Many services had different starting points and priorities for development, and the interface issues between community mental health teams and inpatient units in particular (along with developing Assertive Outreach and Early Intervention teams) were important.

The facilitatory work of NIMHE West Midlands was supported and informed by the West Midlands Crisis Resolution/ Home Treatment Network, with one common theme – the enthusiasm of experienced practitioners, managers, service users and carers, to contribute time and effort towards assisting others at different stages of local development. From the beginning, there was a critical mass of established and emerging teams in Birmingham, Coventry and Wolverhampton to support a meaningful Network. This publication draws heavily on that shared experience and also detailed research in North Birmingham which examined the model in operational practice. Continued development in more rural areas across the West Midlands is gathering pace and experience gained from this is hoped to be included in a supplemental publication.

It is hoped that this contribution provides a timely source of useful information to support continued implementation of Crisis Resolution/ Home Treatment.

Marcellino Smyth, Editor

mental health questions? ask NIMHE

CONTENTS

Foreword	1
1. Vision & Values for Mental Health Service Users	3
2. Defining Crisis Resolution/Home Treatment	7
3. Who is the Service For?	9
4. What is the Service Intended to Achieve	11
5. Background of Crisis and Home Treatment	15
6. Types of Crisis and Evidence Base	19
7. What is the Rationale for Targeting the Service	23
8. Advantages of Crisis Resolution/Home Treatment	27
9. Phases	31
10. Model of Service Delivery	35
11. The Decision to Admit	37
12. Crisis Resolution/Home Treatment Teams and Inpatient Units	39
13. Joint Working Between Home Treatment Teams and Community Mental Health Teams	43
14. Frequently Asked Questions	47
15. Setting Up a New Team	49
16. Staffing & Professional Roles	51
17. Joint Working with Assertive Outreach Teams	57
18. Fidelity in Home Treatment/Crisis Resolution	61
19. Respite Services and Crisis Resolution/Home Treatment	71
20. Training	75
21. The Service User Perspective	79
22. Carers' Views (Carers in Partnership)	83
23. Audit & Evaluation	101
24. Network	103

mental health questions? ask NIMHE

Foreword

I am delighted to welcome this expanded guide aimed at informing and supporting the implementation of Crisis resolution/Home treatment in line with the National Plan. Starting with the value base behind this choice of service, the guide offers further detail to assist project managers, local implementation groups, clinicians in multidisciplinary teams, service users and carers to reference the issues that may be faced in different localities in moving forward this agenda. Particularly useful is the repeated focus on CR/HT as one element of an integrated comprehensive community service, within which interface and coordination aspects are important to achieving the full potential of these teams. We hope that the experience reflected in the document which has been gained from the work of NIMHE West Midlands' collaboration and support for promotion of new team development and networks including service evolution in established initiatives, offer a helpful contribution.

Dr Ian McPherson
Director NIMHE West Midlands

1. VISION AND VALUES FOR MENTAL HEALTH SERVICES

How are the vision and values for mental health services reflected in Crisis Resolution/Home Treatment?

I. FOCUS ON RECOVERY AND INCLUSION

“In future mental health systems, service users will be responsible for their own recovery”.

While use of the term “Recovery” amongst Mental Health Services influences attitudes towards an optimistic view of the prospects of people experiencing mental distress, it should be understood that “recovery” is a process that is unique to each person. It is not just a state of personal “well being” but is the actual development of each individual's coping strategies in order that they can assume the fullest control of their own life – the rate of recovery is therefore unique to each individual. To recover is a verb, in the same sense as ‘improvement’ or ‘being’ in recovery.

The process of recovery is the goal of all treatment which must enhance each individual's personal strengths, abilities and the support they receive from their family and peer networks. Each person's control of their life will be maximised by promoting availability of choice, including the type and intensity of service they require for successful living and supporting each person's ability to make choices.

Crisis Resolution/Home Treatment can offer a different perspective and set of personal meanings attached to the experience of severe mental illness. These meaning or attribution systems are very powerful and tackling them a central task of recovery. The process of recovery involves a reorientation towards individual strengths, coping strategies and meaning systems, which do not give illness a dominant or privileged position. Retaining personal control during illness and breaking the cycle of expectation that hospital admission is always required, can invite a fresh synthesis of the meanings attached to difficult phases. Determination to overcome the battle of illness can be greater in the knowledge and experience of a more autonomous and practical process of recovery from the acute episode in which disruption and dependency are minimised.

“Include people into their own community, not into the service system”

A cornerstone of inclusion within one's community is full access to the same opportunities and resources as all other citizens, both for support and for the opportunity to contribute meaningfully. This significantly contributes to the process of recovery by reinforcing a self-identity as “other than disabled” and reduces the feeling of “otherness” that so often results from the stigmatisation of those experiencing mental illness.

Crisis Resolution/Home Treatment can impact on the stigma associated with psychiatric hospital admission. The emphasis on community integration involves a broader focus than treatment outcomes, including life satisfaction, social networks, immediate housing and living problems, and assistance with benefits and finances. Preparatory work around further education and employment opportunities, and identification of specific social exclusion factors which contribute to an individual's marginalisation should be integral elements of the approach.

II. SUPPORT FOR FAMILY AND PEER NETWORKS

“The informal carer has a crucial role in the overall system and their needs must be taken into account when developing services.”

The care received from one's own family and peers is an essential part of the natural framework of support – particularly during recovery. Each framework is unique to each person and is made up of the people that the service user considers as their family or peers. These may not be just relatives (many people do not have a family at hand) but can be friends and neighbours who may meet at home or via local community centres or self help groups.

The inclusion and participation of the social network should be led and directed by the service user. A service user in distress will signpost you, they know and understand the significance of people 'they can trust'.

It is incredibly powerful for carers to directly participate in the process. To interact, to share the highs and lows, to feel themselves a sense of worth, and 'to tell their story'.

Crisis Resolution/Home Treatment

Work takes place in the individual's own community, aiming to preserve the strengths of family support and the support of local social networks. Having the support of family around can be reassuring and practically helpful during the acute phase of mental health difficulties. Separation from family can add to the distress of acute mental health problems. Sometimes after admission to hospital, restoring relationships and contact with one's community is a difficult task, made more problematic by the stigma attached to psychiatric hospitalisation. Crisis resolution work emphasises active collaboration with families and carers, who should be active partners in the decision making and arrangements of the support planning. Acute mental illness presents a significant burden to families and carers. Worry anxiety, uncertainty and disruption of daily routines are all understandable consequences of supporting a family member through crisis.

Carers are often more willing to help with the reassurance that immediate access to a supporting team is at hand. Burden and practical difficulties for families can be addressed directly, in the context of a partnership approach towards resolution of crisis.

III. USER DIRECTED SERVICES

Through greater understanding of service user experiences (of disability, recovery and of the services they receive), mental health services will be able to promote more effective psychosocial rehabilitation and recovery. This requires positive efforts to hear their experiences and to balance the control of services between professionals and service users – and their families and peers- by working jointly in planning and implementation at all levels. This ranges from service design, development and delivery to evaluation and training.

Crisis Resolution/Home Treatment revolves around the individual service user's needs, placing these needs centre stage, rather than the system of care. When offered a choice, most people would prefer to be treated in the security and familiarity of their own environment, able to continue where possible to live their lives with familiar routine, and having the same freedom to come and go as they please in their own local community. The planning of visits and treatment interventions are discussed and negotiated so as to fit in with the person's life and demands of living. Interventions are flexibly responsive to the individual's needs and personally tailored to a degree which is harder to achieve in hospital. The person has access 24 hours, 7 days a week to the team. Crisis resolution/Home treatment staff are guests in peoples' homes, promoting a good understanding of their lives and life situations, in which illness is only one aspect.

IV. BEST PRACTICE

“The differences that exists between service and education providers and service users are matters of perspectives and experiences, not innate intelligence, abilities or talents” experiences perspectives and experiences, not innate intelligence, abilities or talents.”

A core value of Community Mental Health systems is the continuous improvement of knowledge, skills and values as a basis for effective practices, which emphasise well-being, prevention and rapidly responsive crisis support. The full set of needs of each person must be considered, including; health, social, occupation, finances, accommodation and education. There should be capacity to respond to particular needs such as criminal behaviour, substance abuse, homelessness and general health care. This multi agency care requires high quality management and liaison between mental health systems, primary care teams, voluntary and community organisations in order to provide seamless care. Services should be completely non-discriminatory in all of their decisions and activities, and must value and support the diversity of all people. Full account is to be taken of people's ethnicity, religion, class, gender, sexuality, culture and their levels of physical and educational ability. Each person will have a personally tailored plan developed by the individual, their family and peers and the practitioner, based on strengths, needs and goals.

Service users will be treated with genuine dignity and respect for their independence, self-determination, ability to manage risks, and their privacy – intruding no more than is necessary to achieve the agreed goals.

Finally, the delivery of best practice is only as effective as the abilities of well trained staff; therefore, it is critical that local Community Mental Health systems have sets of competencies that reflect best practice and a capacity for recruiting, training and retaining practitioners.

Crisis Resolution/Home Treatment Teams should be accessible and responsive and integrated with local inpatient and community mental health team services. This approach is one which can challenge the skills and perspectives of professional staff in providing safe, intensive and effective alternative acute care which for success needs to continually adapt to individuals, their families, living situations and social circumstances. The model is one in which the place for an objective or technological understanding of individuals and mental health problems is less helpful, and there is a distinct opportunity for a dialogue based on common subjectivity and more reflective practice to emerge.

Training and education in competencies is needed to unite professionals in a common approach which borrows less on previous distinct professional training.

Crisis Resolution/Home Treatment can directly accommodate the needs of individuals from diverse ethnic backgrounds. CR/HT can progressively learn about and respond to the range of important different cultural perspectives and work with the strengths of local community social and religious supports in providing help.

The importance of values could be expressed by looking at specific outcomes. Clinical and organisational audit may not capture a value-based orientation. Examining satisfaction, relationship and recovery orientation might be more direct ways to stress the importance of values in the delivery of service. CR/HT is a service that provides a particular opportunity to adapt practice to the questions we all ask daily about the philosophy of mental health care.

2. DEFINING CRISIS RESOLUTION / HOME TREATMENT

What is Crisis Resolution/Home Treatment?

‘As a definition of a service

Crisis Resolution/ Home Treatment refers to a system for the rapid response and assessment of mental health crisis in the community with the possibility of offering comprehensive acute psychiatric care at home until the crisis is resolved, and usually without hospital admission. Acute care is delivered by a specialist team so as to provide an alternative to hospital admission for individuals with serious mental illness who are experiencing acute difficulties.

‘As a definition of a choice

In the moment of crisis involving mental illness, admission to hospital is not the only option. Intensive support can be delivered at home so as to maintain a focus on ordinary living, continue relationships with families, and allow the person to exercise choice and control over the type of help received.

‘As a definition of an opportunity...

This service offers an opportunity to move beyond the psychiatric and/or service definition of a crisis, towards an understanding which allows more possibilities, personal ownership and more open discussion of the service elements themselves. The moment when a person in crisis receives attention, can be seen as the point of greatest simplification (Dell’Acqua 1988). The individual has probably already been simplified or summarised with the complexity of suffering reduced to a set of symptoms to which psychiatric services are assumed to be the best equipped to respond. If personal suffering is incorrectly translated into a mental illness framework, this can lead to further crystallisation and chronicity (Asioli 1984).

Psychiatric services may be the best and most appropriate response after initial assessment, but with CR/HT there is an opportunity to protect individuals from unnecessary classification within mental illness frameworks, and equal attention to issues in the individual’s environment.

The Department of Health Programme Implementation Guide describes

“Who is the service for?”

and

“What is the service intended to achieve?”

These are described in the following sections.

3. WHO IS THE SERVICE FOR?

Who is the service for?

Commonly adults (16 to 65 years old) with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder) with an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary. In every locality there should be flexibility to decide to treat those who fall outside this age group where appropriate.

Beyond initial assessment, this service is not usually appropriate for individuals with the following conditions. In order to focus services on those with the highest level of need, **CRISIS RESOLUTION/HOME TREATMENT** teams are less likely to be able to offer intensive support for the following conditions because of the priority given to serious mental illness, which would otherwise lead to admission to hospital.

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

Are these conditions to be read as exclusion criteria?

Where ambiguity exists around the appropriateness of home treatment it is better on the side of caution and offer the service for a short while during a period of crisis.

These are not to be read as exclusion criteria but are offered to assist targeting Crisis Resolution/Home Treatment services to service users in greatest need. It is recognised that CR/HT will be assessing a wide variety of conditions in emergency situations and the decision to offer services will be made in response to individual need.

MILD ANXIETY DISORDERS

Hospital admission would not normally be considered for the treatment of neurotic conditions such as generalised anxiety disorder, panic attacks, hypochondriasis, phobias and obsessive compulsive disorder. Severe depression can sometimes complicate these conditions and lead to consideration for more intensive treatment.

PRIMARY DIAGNOSIS OF ALCOHOL OR OTHER SUBSTANCE MISUSE

Detoxification from alcohol or substance abuse is arranged in a variety of ways, according to the availability of local specialist addiction services. Admission for alcohol detoxification uncomplicated by mental illness is not unusual in general psychiatric units. Crisis Resolution/Home Treatment teams would not usually involve the function of detoxification for primary substance abuse or primary alcohol

problems. Co-morbidity of alcohol or substance abuse problems with mental illness is very common. This can be managed by Crisis resolution/Home treatment teams (accessing specialist help where appropriate) in the context of managing crisis and relapse of illness in the community. Local operational team policies should contain clarity after local discussion, as to the circumstances or degree to which teams undertake these functions. (Please see Frequently Asked Questions –“Should Crisis Resolution/Home Treatment teams undertake detoxification from alcohol?”).

BRAIN DAMAGE OR OTHER ORGANIC DISORDERS INCLUDING DEMENTIA

These conditions require more specialist approaches than can be provided by Crisis Resolution/Home Treatment teams.

PHYSICAL ILLNESS / MEDICAL CONDITIONS

Although Crisis Resolution/Home Treatment teams consider physical/organic illness at assessment and arrange basic medical investigations, further assessment and management of mental illness with physical illness is often a reason to consider hospital admission.

LEARNING DISABILITIES

These conditions require more specialist approaches than can be provided by Crisis Resolution/Home Treatment teams. The extent of local service provision will influence the degree of Crisis resolution/Home treatment teams in managing crisis.

EXCLUSIVE DIAGNOSIS OF PERSONALITY DISORDER

This should be decided on the basis of individual needs. Crisis Resolution/Home Treatment support can be a useful short-term support and access point in the face of repeated crisis, especially as an alternative to arranging hospital admission.

RECENT HISTORY OF SELF-HARM BUT NOT SUFFERING FROM A PSYCHOTIC ILLNESS OR SEVERE DEPRESSIVE ILLNESS

Only a small proportion of cases with deliberate self-harm would usually be considered as requiring inpatient admission or other intensive support. (Please see Frequently Asked Questions – “How do Crisis Resolution /Home Treatment teams work with local A&E and Psychiatric Liaison Services?”)

CRISIS RELATED SOLELY TO RELATIONSHIP ISSUES

The role for specialist mental health services in relationship issues in general such as breakdown, separation and loss, is not pronounced.

4. WHAT IS THE SERVICE INTENDED TO ACHIEVE?

“People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives.”

“Crisis Resolution/Home Treatment can be provided in a range of settings and offers an alternative to inpatient care.”

“The majority of service users and carers prefer community-based treatment, and research in the UK and elsewhere has shown that clinical and social outcomes achieved by community-based treatment are at least as good as those achieved in hospital.”

Crisis Resolution/Home Treatment service will offer:

GATEKEEPING AND RAPID RESPONSE

“Act as a ‘gatekeeper’ to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service.”

Crisis Resolution/Home Treatment teams perform two gatekeeping roles:

The first involves screening for the presence of mental health problems which would benefit from involvement of specialist mental health services.

Not all crisis referrals will involve mental health problems which require specialist psychiatric help, and direction to other more appropriate agencies can follow assessment. The importance of directing people to the right service should not be underestimated.

The second gatekeeping role refers to the function of screening possible hospital admissions, so as to minimise these by the provision of Crisis Resolution/Home Treatment team support. If acute psychiatric emergencies are being admitted to hospital without the knowledge or involvement of the team, this bypassing will limit the effectiveness of the team.

Crisis Resolution/Home Treatment teams should be able to respond quickly to urgent referrals, both during working hours, and outside of them. Rapid reliable response is reassuring to the referrer, clients and carers, and may stem escalation of crisis so as to increase the likelihood of providing help in the community. Rapid response is not only essential to assessments but also in the need to respond to the clinical caseload.

ASSESSMENT AND TREATMENT

“For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week.”

Comprehensive multidisciplinary assessment is improved by attendance at home or wherever the crisis is occurring. Most commonly, the assessment would be performed by nursing and medical staff.

LEAST RESTRICTIVE CARE

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

Options include treatment at home, at family accommodation or in respite facilities.

SUSTAINED CRISIS INVOLVEMENT AND LIAISON WITH FURTHER CARE

“Remain involved with the client until the crisis is resolved and the service user is linked to ongoing care.”

Teams will remain involved until the crisis has resolved, whether this is a matter of days, weeks or months. The support from the team is time limited, but this is according to need, rather than according to any circumscribed timeframes. Before discharge from crisis support, the necessary links between individuals and community mental health teams will be restored (established cases) or arranged (for new cases).

INTEGRATED ACUTE CARE WITH INPATIENT UNITS

“If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge.”

When hospitalisation is necessary, teams will be actively involved in the arrangements for admission and linking with acute inpatient units in offering joint ongoing care in which the best balance and staging of inpatient and community care is coordinated. Before discharge, teams can support leave from hospital, working with inpatient and community mental health team staff to respond to ongoing need. Crisis Resolution /Home Treatment teams are commonly able to facilitate earlier discharge because intensive acute support can continue in the home setting once the pressing or immediate requirements for admission are no longer exerting such an influence. Good structured communication, active and early joint involvement in discharge planning is a routine task towards achieving this, and smoothing the transition between the different elements of the acute service. Throughout this collaboration the service user and their family should be fully consulted and involved in discussing options.

RELAPSE PREVENTION AND RECOVERY

“Reduce service users’ vulnerability to crisis and maximise resilience.”

Recovery from crisis is an important opportunity to understand why the crisis may have happened, and how to try and prevent further crisis happening either at all, or to the same stage, so that help can be accessed earlier. Life stresses and illness are not easily predictable, but involvement of the individual in preparing a crisis plan is both a practical and reassuring process which can reduce vulnerability to further crisis and maximise resilience in the journey towards recovery. Crisis plans can anticipate as far as possible the stages and process of arranging early help, and also include the additional choice of acute care which intensive treatment at home offers.

PRINCIPLES OF CARE

Experience indicates that the following principles of care are important:

- Access to a 24 hour, 7 day a week service
- Rapid response following referral
- Intensive intervention and support in the early stages of the crisis
- Active involvement of the service user, family and carers
- Minimising disruption and maintaining natural social supports
- Flexible visiting
- Maintaining a bio-psycho-social perspective
- Providing practical support and assistance with problems of daily living
- A style based on partnership and negotiation, aiming to offer choice and uphold service users autonomy
- Sensitivity to particular ethnic and cultural issues (24 hour access to translation services should be available)
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs
- Learning from the crisis
- Recovery planning

5. BACKGROUND OF CRISIS AND HOME TREATMENT

How did Crisis Resolution / Home Treatment Develop?

There are three main sources in tracing the development of Crisis Resolution / Home Treatment

1) Home Treatment as part of early Assertive Outreach work

2) Generic Community Mental Health Teams adopting a crisis response role and offering more community support

3) Specific Crisis Services (often using Crisis Theory Approaches)

1) As psychiatric care expanded into the community, a number of initiatives focused on those with severe mental illness. The prevention of admission to hospitals was a clear aim of early community psychiatric initiatives, as the de-institutionalisation movement gathered momentum. Institutionalisation was seen as harmful and perpetuating disability and social stigma was attached to admission. Efforts developed to assist individuals to regain a normal life outside of institutional care, to maintain community living and to reduce relapse and readmission to hospital. As intensive long-term support was being provided in the community through programmes like Assertive Community Treatment, the capacity to provide similar short-term support for those in acute need was also recognised.

Home Treatment teams developed in the UK, North America and Australia whose focus was on the provision of alternative short term and intensive care at home, rather than arranging psychiatric admission if this could be avoided.

2) Most generic community mental teams were increasingly taking on a similar role, although the capacity to do so and the provision of 24-hour support could not be offered to the same extent as dedicated Home Treatment teams. The community mental health team responded to referrals from general hospital accident and emergency departments, social services, general practitioners, the police and other agencies involved with emergency presentations (including some crisis services not directly connected with mainstream psychiatric services). Community mental health teams were responding to this need for urgent assessment alongside their role of more planned assessments from primary care and the ongoing care of severe mental illness in the community. Specialist home treatment teams began to develop out of community mental health teams, working alongside them and with inpatient units as part of an integrated system.

3) Crisis services developed in Europe and America in the 1960's as a drive towards preventative psychiatry. In the context of mental health, a crisis has been defined as a breakdown in a person's normal coping mechanisms in response to (usually severe) stress. Lindemann in 1944 wrote about working with the terrible grief of relatives after a devastating fire in a night club in Boston with the loss of 49 young lives. Following Caplan in 1964, a set of theories about the process of undergoing a crisis developed. The types of crisis involved were connected to stressful life events which were understandable responses to life transitions, or exposure to unpredictable traumas. These theories suggested distinct phases in the face of crisis, involving recoil, dis-equilibrium, and recovery of equilibrium or further psychological decompensation. By intervening and supporting during a crisis, workers could steer the individual towards recovery. Crises in people's lives are understandable in response to relationship breakdowns, bereavement, employment difficulties, physical illness, accidents and other traumatic events.

Crisis theory and approaches deriving from it were not based on people with established mental illness. The approach sought to prevent mental illness occurring after stressful life events. Caplan saw most crisis as self-limiting, and also potentially as an opportunity for growth and change. The majority of crisis experiences involve people who are not suffering from mental illness, and seldom lead to mental illness requiring treatment.

Primary care GP services in the UK provide, alongside with social support networks, most of the help required for psychological distress during stressful circumstances. Primary care practitioners are usually the first to recognise the possibility of more serious mental health difficulties arising, which may require specialist additional help.

Alongside GP's, a very wide range of crisis services have been developed such as telephone help lines, crisis counselling, crisis homes and walk-in centres. Some crisis services try to help a wide range of problems and others serve particular needs or groups. There is a lot of variability between the extent to which different crisis services work alongside, separate or from within NHS mental health services. The range of crisis services in different countries is very different and depends to a large extent on how much psychiatry is organised around an integrated system. The following list shows the range of ways in which crisis can be responded to:

Telephone Help Lines

These do not usually involve face-to-face contact. Many offer anonymity. Some telephone helplines are for particular groups or problems (e.g. The Samaritans)

Walk- In Crisis Services

These involve face-to-face contact and differ in the extent to which the service considers itself psychiatric. For instance some walk-in services will focus on psychosocial crisis, whereas others will be more orientated to severe mental illness and psychiatric emergencies.

Crisis Wards/Centres

There have been many initiatives of this kind in European cities, with overnight facilities. They vary according to whether the remit is more the 'crisis' or 'psychiatric emergency' end of the spectrum.

Mental Health Crisis

Individuals with mental health problems can be more vulnerable to life crises and illness itself can lead to crisis directly. The impact of crisis, rather than being self limiting, maybe profound and enduring. Crisis Resolution services within mental health usually involve a different approach to some other services, with less of an emphasis on 'crisis theory'. Crisis resolution/Home Treatment involves the combination of mental health crisis responses with the capacity and adaptation for delivery at home or in the community.

Mobile Outreach Crisis Services

These are usually still crisis services (not offering intensive home treatment) where workers will visit at home. However many were forerunners of Crisis Resolution/Home Treatment involving psychiatrists and/or social workers who were prepared to travel (usually in urban settings) and to assess all types of psychiatric emergency. In the USA there were many mobile crisis teams set up in this way in response to developments in community psychiatry. Data on their effectiveness is not comprehensive and they differ in how they were organised, in what they offered, and in the relationship to other components of the service. They involve a higher proportion of relatives or other agencies contacting them, as against the individual themselves.

6. TYPES OF CRISIS and THE EVIDENCE BASE

Phelan (1996) has categorised problems according to the following broad groups:

1) Newly identified psychosocial crisis involving people who have not had previous contact with specialist services. Many may not suffer from a formal mental illness.

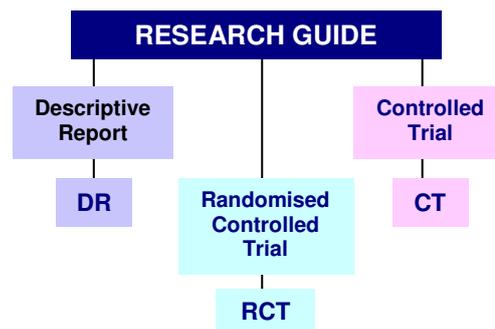
2) Recurring psycho- social crisis for people with mild or moderate mental health problems, drug or alcohol problems and/or personality problems.

3) Problems related to a long-standing disorder, probably involving psychosis. These may involve symptomatic relapse and/or social difficulties with potentially catastrophic consequences.

Crisis Resolution/Home Treatment services may be involved in assessing and screening all the above types of scenario. The focus of work after screening is largely the third group, in the experience of established teams. However the distinction between these groups is not so clear in actual practice and especially at the point of urgent assessment and the early phase of intervention. (Please see 'What is the Rationale for Targeting the Service').

THE EVIDENCE BASE FOR CRISIS RESOLUTION/HOME TREATMENT

The evidence base for Crisis Resolution/Home Treatment involves many centres both in the UK and abroad, and research going back over 30 years. In the chronological list that follows, there is an attempt to classify the type of report (for instance descriptive account or randomised controlled clinical trial) and also briefly describe which type of service is being evaluated. After the list of individual reports, other useful articles which have summarized or reviewed the evidence follow at the end.



1930's

Querido (1968) developed a 24 hour, emergency psychiatric domiciliary service in Amsterdam in the late 1930's. He estimated that about 50% of the acute presenting cases could continue to live in the community.

DR

1950's

Carse (1958) developed outpatient and home services reducing admissions by 40% to Greylingwell hospital in Worthing.

DR

1960's

Friedman (1964) in Boston delivered an alternative to acute admission through home treatment.

RCT

Pasamanick (1967) in Toronto studied the effectiveness of home care compared to hospitalisation in schizophrenia.

CT

Langsley (1969) in Denver used Family Crisis Therapy as an alternative to admission.

RCT

1970's

Goodacre (1975) started the Vancouver Home Treatment project comparing admission to home treatment at home for acute presentations.

RCT

Polak (1976) in Denver used crisis intervention, social systems engagement and additional respite in Family Sponsor Homes, to compare hospital and community treatment over 18 months.

CT

Fenton (1979) in Montreal compared acute home treatment with hospital treatment in a densely populated urban area.

RCT

1980's

Scott (1980) in Barnet, London, described the impact of a community crisis service which he estimated was avoiding 270 admissions to Napsbury hospital per year.

DR

Stein & Test (1980) in Madison, Wisconsin researched an intensive community treatment programme for severe mental illness over 18 months. The 'Total Community Living' project was aimed at significantly reducing admissions through assertive community support. Guidelines for when admission was the best option were also developed.

RCT

Hoult & Reynolds (1983) in Sydney offered 24 hour intensive home treatment for emergency presentations to hospital involving severe mental illness. Sixty percent of the home treated cases were managed in the community (at home and with respite).

RCT

Dean & Gadd (1989) in Birmingham offered intensive 24-hour home treatment in a deprived urban area. They also studied the social factors that predicted the feasibility and success of this model.

DR

1990's

Reynolds (1990) looked at the crisis response function of community home treatment in New South Wales. The Ryde Hunters Hill crisis team was studied in relation to the impact on admissions to Macquarie State Hospital.

DR

Punukollu (1991) presented a 4-year follow up of the West Huddersfield Crisis Intervention Team.

DR

Sashidharan & Smyth (1992) presented results on a 2-year evaluation of the West Birmingham Home Treatment service in Ladywood.

DR

Muijen (1992) in South Southwark in London presented results of the 'Daily Living Project', based on the Madison approach, with 24-hour access for crisis resolution at home or in hospital, and assertive community follow up.

RCT

Burns (1993) in suburban London compared home and hospital based acute psychiatric services. No direct attempt was made to reduce hospital care, although it was significantly less with the more flexible community service.

RCT

Dean & Phillips (1993) continued their evaluation of the Birmingham Sparkbrook home treatment service in the form of a prospective controlled trial over 12 months

CT

Marks et al (1994) presented final findings from the London Maudsley study. These results now included an extended phase when inpatient care of the Daily Living Project (Home Treatment) group had been transferred back to standard teams.

RCT

Merson (1992) looked at an early intervention community service for psychiatric emergencies, compared to conventional hospital based care (inpatient and outpatient care).

CT

Beer et al (1995) reported on the work of an inner city Crisis Intervention Service in Lewisham, in London.

DR

Minghella et al (1998) reported on a case control study of the East Birmingham Psychiatric Emergency Team, compared to the Erdington area (before Home Treatment services had been developed there).

CT

Brimblecombe & O'Sullivan presented results on the community home treatment team in Hertfordshire.

DR

Bracken & Thomas (1999) published a report about the Bradford Home Treatment service.

DR

Whittle & Mitchell (1997) published a report about the community based acute psychiatric team in Torbay in South Devon.

DR

Summaries and Reviews of the Evidence Base

Braun P, Kochansky G, et al (1981) Overview: Deinstitutionalisation Of Psychiatric Patients, A Critical Review Of Outcome Studies. American Journal Of Psychiatry 138, 736-749

Joy CB, Adams CE, Rice K (1999) Crisis Intervention for people with severe mental illnesses. In The Cochrane Library 1. Oxford: Update Software.

Kliuter H (1997) Inpatient treatment and care arrangements to replace or avoid it: – searching for an evidence based balance. Current Opinion in Psychiatry 10, 160-167

Smyth MG & Hoult J. (2000) The Home Treatment Enigma. British Medical Journal 320: 305-307

Szmukler G (1990) Alternatives to Hospital Treatment. Current Opinion in Psychiatry 3, 273-277

Tantam D (1985) Alternatives to Psychiatric Hospitalisation. British Journal of Psychiatry 146, 1-4

Implementation Articles

Kennedy P, Smyth M Out of Bounds Health Service Journal 2002

Northern Centre NIMHE Discussion paper CR/HT 2003

Smyth M CR/HT and inpatient care. Psychiatric bulletin 2003.27 :44-47

7. WHAT IS THE RATIONALE FOR TARGETING THE SERVICE?

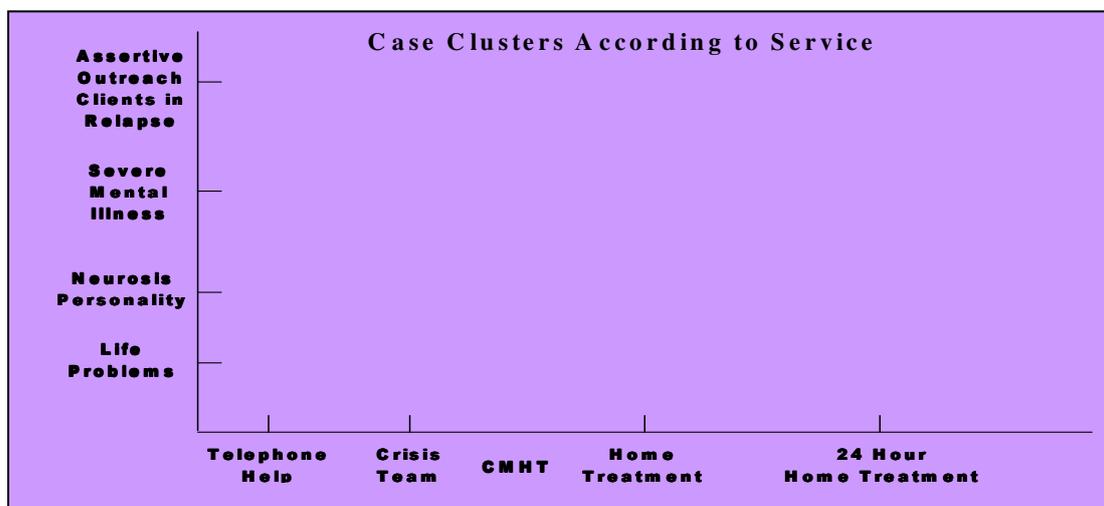
RATIONALE

In order to be efficient and effective, Crisis Resolution/Home Treatment teams need to target those who might otherwise be admitted. The needs of those with severe mental illness in crisis are such that in the absence of an alternative, admission to a psychiatric hospital is a more likely outcome than in those without severe mental illness. The consequence of crisis for such individuals can be profound and enduring, and there is a lot at stake. If teams are not targeted, the team's capacity, resources and expertise will be compromised in the management of this type of crisis. There would be less impact on reducing admissions and those who could avoid admission and benefit from alternative home treatment will miss out. If teams focused on those with severe mental illness but who were not at risk of admission, or on individuals who did not have severe mental illness, capacity to impact on admissions would be limited. Team efforts and resources would be spread more widely but also more thinly, and would overlap with or replicate other service elements who would normally provide care for those with different sets of problems.

Dilution of response reduces the threshold for positive risk taking and therefore reduces the potential for negotiation around risk. It impacts on the flexibility of the team, which is crucial to responding to daily changes of need and expectation. In either of these circumstances, the resource justification for providing the service would be compromised.

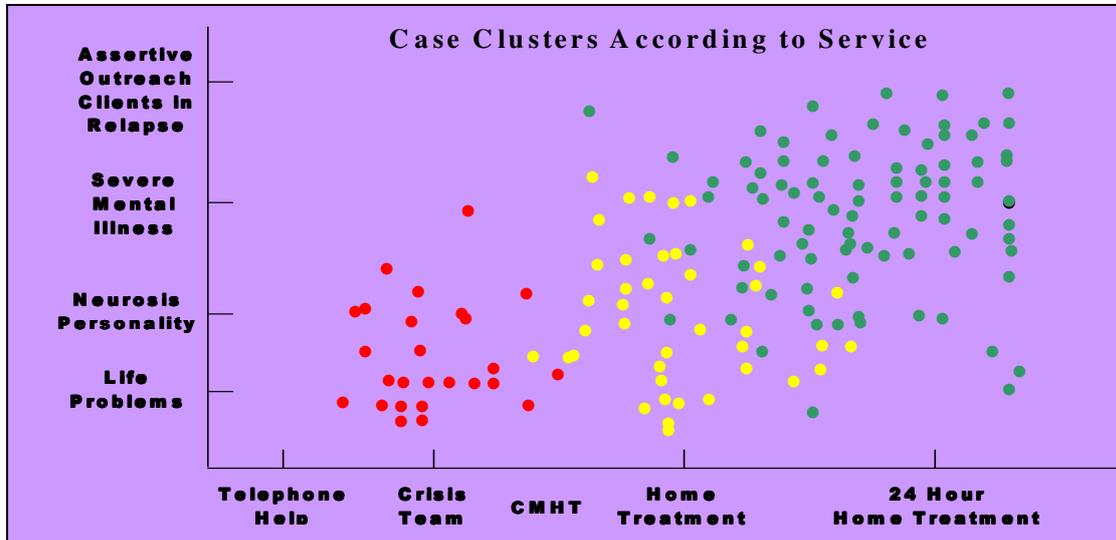
In the following explanatory chart, degrees of problem complexity and degrees of service response complexity are plotted together. On the vertical axis, there is a range of problems from problems of life not involving mental disorder, up to relapse of severe mental illness in an Assertive Outreach client. On the horizontal axis, a range of crisis response services includes telephone help lines, community mental health teams and home treatment teams with increasing capacity up to 24-hour home treatment teams.

CHART 1



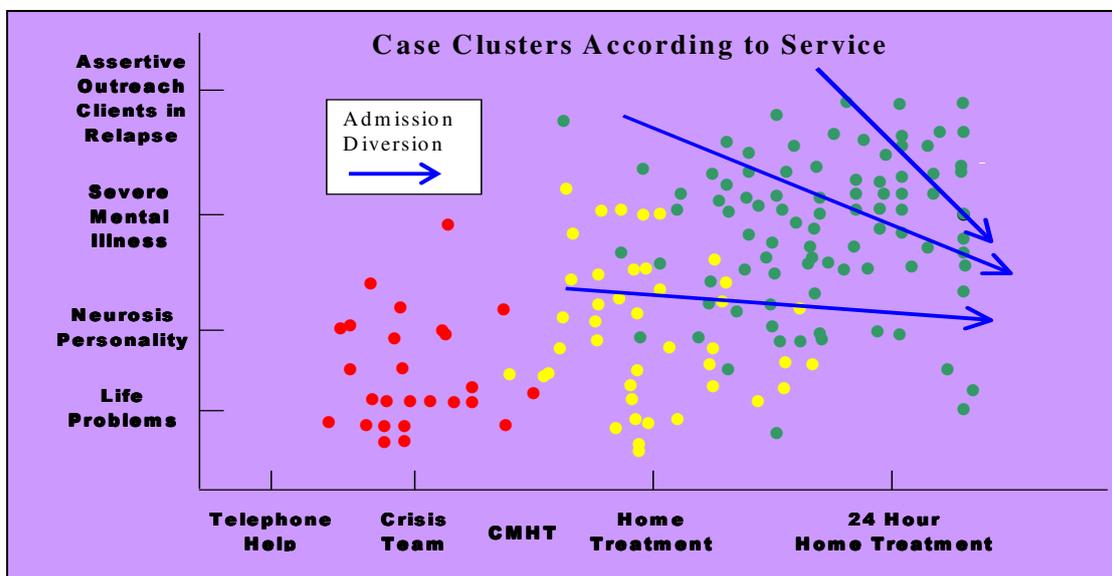
If we plot clusters of cases according to which type of service is seeing which type of problem, we would see 24-hour home treatment services involved mainly with severe mental illness and more so than community mental health services or other crisis services.

CHART 2



If we consider to what extent admissions are reduced by different kinds of crisis services, the impact will be steeper in the right upper area of the chart (because these kinds of cases are more likely to be considered for hospital admission).

CHART 3



So even though some crisis services may be excellent, others may not be reducing hospital admissions significantly because they are not seeing admission destined cases (which pass them by), or because they do not have the capacity to offer intensive acute support in the community. This was the experience in the USA where hundreds of crisis teams were set up in the context of a national policy initiative, but evidence as to their impact on diversion from hospital was disappointing (Geller 1988).

Team expertise, risk management and other operational policies need to develop in the context of providing safe, alternative care for the target group. It is important in crisis assessment work to have some parameters of suitability for the home treatment option, the admission option, and for those with different kinds of problem, to be able to safely liaise with other components of the service with clear boundaries of responsibility.

8. ADVANTAGES OF CRISIS RESOLUTION/HOME TREATMENT

1. RAPID RESPONSE

With rapid response capability, teams can commence assessment and treatment quickly after referral. Prompt action not only alleviates suffering, it also stems the clinical deterioration and the social escalation of a crisis which commonly dictates admission. GP's who attend psychiatric emergencies have the options of requesting an urgent domiciliary visit or asking Social Services for a Mental Health Act assessment. A domiciliary visit may take hours or days, and if occurring after-hours or weekends may be undertaken by an on-call psychiatrist whose decision making may reflect lack of further responsibility for the patient with a lower threshold for admission. The process of assessment under the Mental Health Act (apart from taking a few hours to organise) introduces a degree of formality and legality which raises the expectation that if mental illness is present, admission is a likely outcome. The restricted choice of admission or non-admission is often influenced by the clinician's anxiety about the compliance with and supervision of frequently changing medication regimes, with the support of the family and community psychiatric nurses. Guaranteed administration of medication and close clinical supervision and feedback from a visiting team is an option that would reassure many clinicians who have to admit in order to err on the side of safety.

2. INTENSIVE MONITORING AND SUPERVISION

This can be provided in the patient's own home flexibly in response to the clinical situation. It is often necessary to establish a rapport with the patient before medication is introduced. This can proceed safely over the first 24-hours without insistence on immediate compliance to medication. Once patients realise that medication is only one aspect of the support offered, they are often more amenable.

3. SUPPORT FOR CARERS AND THE PATIENT

Carers are more willing to help the patient at home and avoid the disruption and trauma of admission, when they know that immediate help is at hand. Both patients and carers appreciate the exclusivity and personal tailoring of intervention which is possible on home treatment. Home treatment is in an ideal position to advise on initiatives aimed at addressing the National Service Frameworks standard around carers independent assessments. The comprehensive nature of Home Treatment allows greater understanding of the needs and difficulties faced as well as being in a position to react and intervene immediately.

4. EXPLANATION AND ADVICE

With treatment at home, patients and carers have to be given on-going explanation and advice. Carers witness at first hand the interaction of staff and patients and are better informed about the disorder and the management of eventualities and the rationale for different therapeutic agents. In hospital, carers may never see the medical or nursing staff directly work with the patient.

5. ADDRESSING SOCIAL PROBLEMS

Home treatment teams have to confront immediate social problems. This can range from food, cooking and electricity to debts and inter-personal problems. With daily visits most social difficulties are accurately uncovered. Conflicts and tension with significant others can be witnessed at first hand and the effect on symptoms and behaviour addressed.

This contrasts with the situation in hospital where social problems are 'out there', where delay often is involved in their recognition, where the benefits of addressing them need to be translated to the 'in vivo' living situation (with trial leave), and where the heat is often taken out of relationship difficulties only to re-materialise after discharge. The focus in hospital can involve a translation to symptoms and behavioural conformity. By targeting social problems at the outset, home treatment is more efficient and faster in resolving acute presentations. Hospital treatment can also involve a certain inertia related to the process of 'weekly' ward rounds and slower clinical decision-making.

6. AVOIDANCE OF STIGMA

Mental patients are still defined by the public as those who have been admitted to a psychiatric hospital. Stigma is lessened by the avoidance of admission. The inclusive nature of CR/HT in engaging and participating with local communities can be a powerful educational process.

7. AVOIDANCE OF ADMISSION

Patients and relatives in general do not want admission. The process of admission is not without difficulties. Scott (1973) discussed the 'treatment barrier,' invoking the archetype of the admitted hospital patient and cultural distance created by admission to the institution. Admission to a psychiatric hospital could establish a deep and sometimes unbridgeable gulf between the patient and others outside. In the setting of crisis and suffering, increasing tension and pain led in his view to 'closure' or protective emotional withdrawal. This closure involves personal relationships which he believed to be 'dehumanised' as closure occurred. The psychiatrist became an official perpetuator of the 'rift of dehumanisation' as sanctioned by society. With the majority of admissions occurring in crisis situations, he found it remarkable how often patients would not know the reason why they had been admitted (apart from loss of insight).

With the patient role came difficulties of abnegating personal responsibility and illness behaviour which could be difficult to penetrate. In outlining the 'crisis of admission', Polak described the complete lack of correlation between factors listed as causing admission, when the different views of staff, patients, and their relatives were solicited.

It is hard to ignore the problems which have been described in relation to psychiatric hospitalisation. Reynolds & Hault (1984) described how hospitalisation was a negative upsetting and unhelpful experience because of the rules, restrictions, patient mix and lack of communication which applied. Other themes are well known such as deprivation of liberty, lack of autonomy, unsatisfactory surroundings, lack of status and recognition, an emphasis on behavioural conformity, oppression, medicalisation of social disharmony and removal from family.

In the avoidance of admission CR/HT teams build significant relationships with other community based alternatives (crisis houses, family sponsor homes, hostels etc). CR/HT should not be viewed as the last lone outpost. The teams can become the catalysts for exploration of many community alternatives which address issues such as gender and cultural need.

8. BREAKS THE CYCLE OF ADMISSION

A history of previous psychiatric admission remains a robust determinant in predicting further admission. At worst this leads to the 'revolving door syndrome', of treatment, discharge and relapse with re-admission. Home treatment can interrupt this cycle and modify the sense of inevitability of admission in carers and clinicians which characterised previous breakdowns.

9. ALLOWING EARLIER DISCHARGE FOR ADMITTED PATIENTS

Even when patients are admitted, CR/HT facilitates early discharge and further acute treatment after the pressing reasons for admission are less relevant (often a matter of 24 or 48 hours).

10. REDUCES HOSPITAL ADMISSIONS

The natural consequence of offering choice and alternatives has led to CR/HT being associated with on average a 50% reduction in admissions. This allows for redeployment of resources in the community setting.

11. REDUCED LENGTH OF STAY

Where admissions do occur, Crisis resolution/Home treatment has the capacity for early discharge with team support. In London (Audini et al 1994) this resulted in an 80% reduction in mean length of stay.

12. BETTER SERVICE RETENTION

Higher satisfaction and preference of alternative acute care by service users, translates into higher rates of ongoing engagement with mental health services (Dean et al 1993, Joy et al 1998). CR/HT can help to diffuse future potential crisis. Clients who previously had home treatment support may access services earlier due to newly discovered knowledge and experience of how crisis affects them and how services respond. This can give real confidence that even very difficult situations can be dealt with in the least restrictive way.

13. CULTURAL SENSITIVITY

The high prevalence of diagnosed psychosis in certain cultural groups emphasises the importance of developing a culturally competent service. Home treatment has the potential to develop and adapt approaches to individual problems within the context of different cultural and ethnic minority backgrounds. The immediate impact of cultural issues may be identified more accurately with home visits. It is easier to incorporate understanding of particular cultural issues of relevance into a treatment plan which is designed for a person and their family, than in a hospital setting where necessity approaches need to be more standardised. Continued engagement with local ethnic minority community resources is easier to sustain with treatment at home

The teams use a pool of skills, knowledge and experience, which allows a corporate approach to focus expertise. An individualised treatment approach allows language and cultural barriers to be overcome more effectively. The full participation of extended families in 'in vivo' meetings can be more reflective of how they would wish to support a loved one.

Crisis assessment can also be taken much more into context.

14. HIGH SERVICE USER AND FAMILY SATISFACTION

Studies have demonstrated that service users and their families significantly prefer this type of service.

The active participation in the recovery process can strengthen relationship bonds.

9. PHASES

WHAT DOES THE SERVICE DO?

There are four phases to crisis resolution – assessment, planning, intervention and resolution. The diagrams and tables below discuss each of these phases in detail.

ASSESSMENT

Information Gathering

Although urgent referrals are by their nature rushed, it is important to have basic referral information standards. The example given is tailored to crisis intervention/home treatment work and is by design over-inclusive. Teams will often need to decide the balance between delaying a response until further background information is obtained. A few extra phone calls can yield a lot of important additional information that can help the assessors make a sound plan. For referral of new cases, involvement and assessment by a general practitioner beforehand is very important.

Setting Up The Assessment (Where, When and Whom)

Most crisis assessments will take place either in the individual's home or wherever the crisis is occurring (Friends' or Relatives' House, Accident & Emergency Department, Police Custody, etc.) Involvement of family and carers in the assessment is highly desirable both in terms of improving the accuracy of the assessment and agreeing a support plan for appropriate cases which meets with the agreement of family and carers.

Usually two team members and a psychiatrist will undertake the assessment, coordinating a joint visit.

ASSESSMENT HEADINGS

- What is the nature of the crisis or presenting problems?
- Who is going to be there? Can family/carers be involved? Are there any particular relationship tensions that need to be considered in organising the assessment?
- Are there any immediate social stressors?
- Does the individual and family/carers know about the assessment and are they willing to co-operate? What has been said/explained to them so far?
- Who is being affected by the crisis? For whom is this a crisis?
- Is there a previous psychiatric history?
- Are there mental health issues? How serious are these?
- If mental illness is involved, what are the clinical signs and symptoms?
- Is severe mental illness involved?
- Are there any physical health problems to consider?
- What practical problems of living need to be addressed?
- Risk Screening and Assessment

ASSESSMENT OUTCOME

There are 5 possible outcomes after assessment:

- i) Acceptance onto Crisis resolution/Home treatment (Assessment and Treatment at Home)
- ii) Acceptance onto Crisis resolution/Home treatment (Treatment at Respite Facility)
- iii) Arrangement of Hospital Admission
- iv) No Direct Intervention - Liaison with Other Parts of Local Psychiatric services (e.g. Community Mental Health Team, Assertive Outreach Team)
- v) No Direct Intervention – Inappropriate for Mental Health Services

PLANNING

- Produce a focused care plan identifying short and medium term objectives
- Decide on medication as well as number of visits in initial phase and level of input
- Begin thinking about 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

INTERVENTION

- A 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 with acceptance of named worker and aware of how to contact him/her
- Intensive support and Frequent contact (based on home visits) throughout crisis
- Ongoing risk assessment
- Ongoing 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
- 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
- Staff need training in storage and use of medication
- 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

PRACTICAL HELP WITH BASICS OF DAILY LIVING

- Help with benefits, housing, childcare etc
- Empowering service users to maintain independence
- Service user/family/carers must be involved in all decision making
- 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
- 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 and there is considerable variation between service users.
- Development of individualised plans can be effective in reducing the severity of relapse
- 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

RESPIRE

- 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 in-patient services
- If hospitalisation required, regular, formal joint (inpatient staff and CR/HT staff) review of patients should take place to ensure that the service user is transferred to the 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

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 views about the service and contribute to service improvement.

10. MODEL OF SERVICE DELIVERY

INTRODUCTION

With local demographics, finite resources and staffing, different areas at different starting points, will discuss the advantages that investment in a specialist Crisis resolution/home treatment offers. This section looks at the advantages of supporting a specialist team.

MODEL OF SERVICE DELIVERY

Crisis resolution/home treatment services are best provided by a discrete, specialist team that has:

- Staff members whose sole (or main) responsibility is the management of people with severe mental health problems in crisis
- Adequate skill mix within the team to provide all the interventions listed above
- Strong links with other mental health services and a good general knowledge of local resources

ADVANTAGES OF A SPECIALIST TEAM

The main advantage of a specialist team configuration, is that this is the most reliable and consistent way of delivering the overall advantages of the Crisis resolution/Home treatment approach.

A single point of referral, 24-hour access and rapid response is easier to co-ordinate.

A team based responsibility for gatekeeping is more cohesive.

Responsibility for the management of crisis and coordination of support is clearly delineated within the service.

Team member's responsibilities are limited to Crisis resolution/Home treatment working.

A team based approach allows for greater flexibility in meeting the fluctuating and intensive clinical demands of acute cases while combined with the pressure of responding to other urgent referrals.

Team staff develop specialist skills and competence in safe assessment and management of acute crisis in the community.

Teams develop specialist risk management strategies for the demands of this style of work.

Clinical decision making around admission is multidisciplinary, shared and team based.

Specialist teams can develop a style and culture of practice which is recovery oriented.

Staff training, continued professional development and mutual support is facilitated through a team approach.

Team operational policies for integration with other components of the service, joint working and maintaining continuity of care can be developed.

11. THE DECISION TO ADMIT?

ADMISSION

Obviously Crisis resolution/ Home treatment teams strive to maintain individuals in crisis in the community. Consideration of hospital admission is a clear indication for referral to assessment by the team, and the issue of whether hospital treatment still needs to be considered in the best interests of the individual and their family, is a question that teams will address after every assessment.

Psychiatric practice is not definitive regarding the criteria which determine hospital admission. Research on the factors which lead to admission is not conclusive, involves broad generalisations and also references the complexities of different clinicians, with different experience, different resources of support at their disposal, and the pressure of doing what they believe to be ultimately in the best interest of the service user in that place at that particular time. Mental health legislation combines the protection of service users from harm and the issue of possible harm to others in the setting of mental disorder of a nature and degree sufficient to warrant involuntary hospital treatment.

Because the nature of the cases taken on by teams will have most commonly involved consideration of admission, this consideration may continue to apply during care delivery. This means that it is not uncommon for Crisis Resolution /Home treatment teams to start treatment, but at some stage during that treatment to arrange admission.

Circumstances may change, such as the clinical condition, an inadequate response to treatment and intervention, access to the home, the wishes of the service user, concern about burden on relatives, or the need for more intensive monitoring.

It is difficult to generate guidelines around this area because each individual and their circumstances need to be taken on their own merits. However the following sets of circumstances, alone or in combination, repeatedly lead to more active consideration of admission from home treatment assessment:

- Accommodation instability
- Housing problems
- Lack of regular access to client
- Frequent moves of client

Risk to others related to mental disorder which requires inpatient containment or management

Risk to self (arising from self neglect or self harm) which is considered significant or unstable, requiring inpatient assessment, safety and management

- Complicating or co-existing physical illness
- Strong client preference for admission
- Strong carer preference for admission

- Lack of adequate family/carers support
- Alcohol or substance abuse problems

- Co-existing and/or complicating
 - Particular tensions with significant others in the home
 - Particular tensions with neighbours or within local community

IN PRACTICE

Admission from assessment will be arranged when “It is not possible to adequately and safely meet the needs identified in the assessment”

Admission during an active phase of treatment will be arranged when “It is no longer possible to adequately and safely meet the needs identified by the team during the treatment phase”.

Admission will also be arranged if an application for compulsory admission has been completed.

CONTINUING ROLE AFTER ADMISSION

Gatekeeping by Crisis Resolution/Home Treatment teams should involve them in the vast majority if not all admissions. The team is ideally placed to have an understanding of the factors which lead to admission in each circumstance, and to ask, in a continuous and systematic way during inpatient care in conjunction with inpatient staff, whether those factors still apply. The role of Crisis Resolution/Home Treatment teams continues after admission as an active liaison and joint working role in alliance with inpatient staff in terms of discharge planning.

Often, the social or clinical circumstance which led to admission are no longer so compelling, while the need for active acute intensive support is still required. In such scenarios, early discharge from hospital to Crisis Resolution/ Home Treatment is a feasible option. In other circumstances discharge from inpatient care is not directly dependant on Crisis Resolution/Home Treatment support (e.g. accommodation issues). Not all discharge planning will involve a phase of Crisis Resolution/Home Treatment acute care.

The joint working of Crisis Resolution/Home Treatment teams and inpatient care is described more fully in Section CR/HT and Inpatient care.

12. CRISIS RESOLUTION/HOME TREATMENT TEAMS AND INPATIENT UNITS

INTRODUCTION

Both Crisis resolution /Home treatment teams and inpatient teams have a common purpose and overlapping functions in the assessment and management of acute severe mental illness. It is important that good communication, working relationships and agreed operational policies cover the interface between both phases and types of acute care.

“Assessment, care delivery and discharge planning should include crisis intervention/home treatment teams where appropriate, e.g. where admission follows a period of home treatment input. With increasing gate-keeping of acute presentations by crisis/home treatment teams the potential for collaborative acute work even after admission has occurred needs to be recognised. Further joint working during inpatient phases, can support leave and facilitate early discharge”

“The National Inpatient Programme Guidance”

“Each NHS Trust must establish an Acute Care Forum, with links across the elements of the acute care system (to include intensive care) and with involvement of service users and carers to agree and regularly review the operation and co-ordination of the range of acute care services”.

“The National Inpatient Programme Guidance”

AREAS OF PARTICULAR CO-OPERATION INCLUDE:

Inpatient policies may require that the Crisis Resolution/Home Treatment team has screened all admissions. Efficient gatekeeping requires that cases are not admitted direct to inpatient care without Crisis resolution/Home treatment team involvement or knowledge. Usually the Crisis resolution / Home treatment team would assess all potential admissions, although there will be occasions when treatment at home is not a feasible option, and this is agreed beforehand. If cases are bypassing the team and being admitted, the team manager should examine why this is occurring and arrange more robust systems of communication (especially out of hours).

SCREENING

After admission to hospital, often the pressing reasons for admission are not so compelling within 1 or 2 days, and the clinical situation has improved to a point where treatment at home becomes a viable option. Crisis resolution/Home treatment teams should have arrangements in place to routinely screen inpatients for the possibility of

early discharge to support and treatment at home. This could be arranged by having particular link days with the ward for screening, or having a designated link nurse on the team who visits the ward daily and is a point of contact for the inpatient unit to discuss progress and planning around earlier discharges.

JOINT WORKING

Home treatment and inpatient teams can actively joint work in combining assessment skills in different settings, and in supporting social functioning, community re-integration and leave to the community at an earlier phase than might usually be possible without the availability and support of a home treatment team.

FACILITATING EARLY DISCHARGE

Home treatment facilitates early discharge and further acute treatment after the pressing reasons for admission are less relevant (often a matter of 24 or 48 hours).

ACHIEVING INTEGRATION

Ways to promote this could include:

- Structuring linkages between CR/HT and IC from the beginning (rather than trying to establish them later on). Operational policies ward rounds, routine screening for early discharge, joint acute care reviews, supported leave arrangements etc. While policy after policy is one way to achieve this, it may prove mechanistic or even institutional. Far more preferable is the emergence of linkages through a shared value base and mutuality. Joint working is easier if teams share the same base location. The more natural collaboration that follows from one consultant having responsibility for acute care in both settings, contrasts with the logistic difficulties of achieving repeated sets of linkages across a series of consultant teams. In North Birmingham, ease of collaboration was inversely proportional to the number of consultants linked to each CR/HT team and ward.
- Improving inpatient facilities, staffing and practice according to the recommendations of the National Inpatient Strategy Group
- Preserving model integrity of CR/HT teams in terms of a sustained focus on severe mental illness. If these teams are by their availability and responsiveness, seeing a high quota of inappropriate referrals involving crisis but not mental illness, this will detract from their efficiency in managing acute illness in the community.
- The contractual possibilities for acute care workers operating in both settings flexibly, and according to demand is worth considering (and has training implications)

“With the advent of new community acute treatment options there are local opportunities to improve service coherence and co-ordination by the creation of acute care nursing posts that work in both the inpatient and community treatment teams and that facilitate creation of better graded and higher status nursing posts.”

“The National Inpatient Programme Guidance”

The development of Acute Care Forums will be critical towards the local integration of Inpatient and Crisis Resolution/Home Treatment.

13. JOINT WORKING BETWEEN HOME TREATMENT TEAMS AND COMMUNITY MENTAL HEALTH TEAMS

Even with the development of new functionalised teams including Crisis Resolution/Home Treatment, Assertive Outreach, and Early Intervention for Psychosis teams, Community Mental Health Teams remain the cornerstone of community psychiatric care. The Policy Implementation Guidelines for Community Mental Health Teams acknowledge this role.

“Community Mental Health Teams will continue to be the mainstay of the system. CMHT’s have an important, indeed integral role to play in supporting service users and families in community settings. They should provide the core round which newer service elements are developed.”

THE FUNCTIONS OF THE CMHT INVOLVE:

“Giving advice on the management of mental health problems by other professionals – in particular advice to primary care and a triage function enabling appropriate referral.”

“Providing treatment and care for those with time-limited disorders who can benefit from specialist interventions.”

“Providing treatment and care for those with more complex and enduring needs.”

The majority of Case Management work under the Care Programme Approach. This involves short term and long term input.

Crisis assessment, screening, and more intensive intervention (according to capacity, availability, developmental stage and local relationships with Crisis Resolution/Home Treatment.

In line with these functions, CMHTs undertake:

- The majority of assessments from Primary Care referrals.
- Arranging more intensive intervention (Crisis Resolution/Home Treatment and Inpatient Care).
- Joint discharge planning and support for individuals during acute care phases.

ADVANTAGES OF CRISIS RESOLUTION/HOME TREATMENT FOR THE CMHT

Given the wide range of functions of the CMHT, the CHMT has some natural limitations on its flexibility and adaptability, particularly in the setting of impending or established crisis. CMHT workers will have booked commitments for assessment, direct sessional work in Primary Care settings, and structured case management responsibilities in the community. Out of hours capacity is very limited. How can Crisis Resolution/Home Treatment support and complement this service ?

Areas in which cooperation and support might be suggested are:

- Offering a more intensive and flexibly responsive service during crisis (both in hours and extending to out of hours) i.e. formal Crisis Resolution/Home Treatment team work.
- Supporting the additional CMHT input which is often required to maintain functioning in the community during difficult times. This can involve assessment or formal Crisis Resolution/Home Treatment input.
- Responding to urgent referrals directly or after preliminary screening by the CMHT.

It makes sense for the CMHT and Crisis Resolution/Home Treatment team to work closely together and having representatives of the Crisis Resolution/Home Treatment team regularly attend the CMHT weekly team meeting can be very productive.

Even a 20 minute routine exchange of overview information can be very useful. The need for further detailed sharing of information and planning joint visits emerges naturally.

Case coordinators in the CMHT can alert Crisis Resolution/Home Treatment staff of concerns about individuals (prior to crisis). Routinely the CMHT adjusts input and strategies to offer additional support so as to prevent crisis developing. This may or may not be successful depending on the nature of the problems, clinical issues and changing situations – deciding the kind of situation where additional input from the Crisis Resolution/Home Treatment team comes from the experience of collaborative practice. With a well established relationship, the large majority of referrals from the CMHT to Crisis Resolution/Home Treatment would lead directly to Crisis Resolution/Home Treatment support (indeed more than from any other referral source).

Even when a crisis occurs out of hours, which the CMHT has not completely predicted, foreknowledge of concern helps the Crisis Resolution/Home Treatment in their assessment and care planning.

The regular meeting keeps both teams informed, and makes for easier liaison with care coordinators around arranging joint visits during the phase of acute care. These joint visits maintain continuity of case coordinator input, is reassuring to service users, and allows the process of discharge planning and fine tuning crisis relapse prevention plans to be better informed.

The CMHT can also be alerted by Crisis Resolution/Home Treatment that they have started work with a new individual to the service and that further ongoing input from the CMHT is required. This advance planning from both teams can allow time for appropriate and considered allocation of case coordinators from within the CMHT.

OTHER ADVANTAGES

The CMHT is now better placed to review its relationship with Primary Care. The interface between primary and secondary care can be re-examined so as to maximise efficiency with easier access, and more streamlined care planning. Because of the presence of Crisis Resolution/Home Treatment, the CMHT is less concerned with fire-fighting all problems while trying to maintain a focus on severe mental illness. Staff in the CMHT can more fully deliver a range of therapies and support in a planned way, including direct work and liaison in the GP surgery. Delivering specific interventions like cognitive behavioural therapy needs time and structure in the workload planning of CMHT workers. This can lead to better relationships between GPs and their mental health colleagues.

14. FREQUENTLY ASKED QUESTIONS

SHOULD CRISIS RESOLUTION / HOME TREATMENT TEAMS PROVIDE DIRECT DETOXIFICATION FROM ALCOHOL IN THE COMMUNITY?

The decision of whether to provide direct alcohol detoxification through home treatment will be influenced by the availability of other, including specialised resources within an area to provide this. Supervised withdrawal from alcohol can be provided in general hospitals, general and specialist psychiatric inpatient units, and in the community (for instance by community alcohol teams). Local custom and tradition often determines the balance between detoxification in general hospitals or local general psychiatric facilities. This choice is also often determined by the acuteness and place of presentation, and the clinical spectrum of withdrawal problems which can involve psychological and physical components.

The medium to longer-term efficacy (in terms of lapse prevention) is better for specialist units and specialist community teams where there is ongoing structured specialist support following the period of supervised withdrawal.

Where supervised withdrawal in the community is feasible (no history of withdrawal fits, no complicating physical illness, and high motivation).

Crisis Resolution/Home Treatment teams may be considered as an additional or alternative resource to provide this service. Local decisions will have to be made and translated into operational policies to cover this.

There are a number of considerations which have generally influenced established teams towards caution in providing this service.

These are:

- Team members may not have specialist training in this area
- There are logistic difficulties in supplying and supervising withdrawal medication three or four times a day, which can limit the capacity of the team to deliver acute psychiatric care for other psychiatric emergencies
- There are well recognised clinical risks involved in leaving withdrawal medication (high dose anticonvulsants and/or benzodiazepines) with individuals who might drink excessive alcohol unpredictably, with dangerous interactions
- Assessment of whether an individual is under the influence of alcohol, and the clinical decision to supply or withhold further medication, can be a difficult judgement in practice
- Crisis which involve combined alcohol problems and mental illness may be very appropriate for the team to monitor and support in the community, for instance where it is not anticipated that withdrawal problems are likely.

HOW DO CRISIS RESOLUTION / HOME TREATMENT TEAMS RELATE TO GENERAL HOSPITAL ACCIDENT AND EMERGENCY DEPARTMENTS?

A&E departments are a major source of urgent psychiatric referrals. Crisis resolution /Home treatment teams should be able respond to requests for assessment for A&E departments in order to gatekeep acute psychiatric admissions and see if acute psychiatric treatment at home is appropriate. It is more efficient if initial psychiatric screening has already occurred, leading to the conclusion that either acute inpatient or home treatment care is required. Initial screening by local liaison services is important, because most presentations to A&E departments of those with mental health difficulties (Deliberate self harm, Overdoses) would not usually require intensive acute intervention in the form of inpatient or Crisis Resolution/Home Treatment care.

The use of Crisis Resolution/Home Treatment teams as the main liaison service to A&E departments results in a high proportion of inappropriate assessments, involving a multidisciplinary response, and detracts from the team's capacity to undertake its core functions.

15. SETTING UP A NEW TEAM

INTRODUCTION

The setting up of a new team involves both a series of steps and principles. Successful implementation is accelerated when there is a widespread commitment to the initiative from all stakeholders and levels of the organisation. The involvement of key representatives from the whole system allows different perspectives and implications to be anticipated and considered. It is to be expected that there will be different enthusiasm, agendas, anxieties and starting points from different representatives (Professional Groups, Managers, Service User and Carers, Inpatients and Community Mental Health Team staff and Primary Care and Social Services).

The formation of a Project Steering Group which stresses involvement and which is committed to realising the choice and advantages which Crisis Resolution/Home Treatment can offer within an integrated system is an approach which has a lot to recommend it. Successful development relies heavily on this wide commitment in principle and then a culture and process of development which allows different views to be respected, thoroughly discussed and thought through in each area. The ideas behind Crisis Resolution/Home Treatment need to be repeatedly articulated and explored in different settings, so that people are involved and aware of the rationale, the purpose, and implications. The role of a Project Manager is discussed below.

SUGGESTED STEPS IN SETTING UP A NEW TEAM ARE:

1. Local geography and population needs assessment
2. Estimating workload and caseload
3. Staffing
4. Training
5. Location
6. Audit and Evaluation
 - An audit of pathways of care, current service provision and local epidemiology should be undertaken initially. Information from this audit should then be used to develop an implementation plan. A needs assessment needs to be undertaken prior to the formation of a crisis resolution/home treatment team to calculate likely service usage
 - Factors to take into consideration include:
 - Geography of the area
 - Demography and epidemiology
 - Health and Social Service boundaries
 - Primary care referral patterns and needs
 - Acute care demand historically (Inpatient admissions, length of stay, Mental Health Act patterns) existing facilities map (Statutory and Voluntary Sector)
 - Strengths and weaknesses of current provision
 - Phased development and impact of other teams (Assertive Outreach, Early Intervention)

THE EMPLOYMENT OF A PROJECT MANAGER TO OVERSEE THE FORMATION OF A CRISIS RESOLUTION/HOME TREATMENT TEAM SHOULD BE CONSIDERED

Tasks of the Project manager

- Establishing the framework for the operational policy
- Work with steering groups to agree development plans and policies
- Explain to statutory and non-statutory agencies how the service will work
- Identify and link with local community resources
- Recruit staff and organise training
- Identifying the team operational base

ESTIMATING WORKLOAD AND CASELOAD

Each team is likely to cover a population of approximately 150,000 and have a caseload of 20 to 30 service users at any one time. The size of population covered will vary according to the demographics of the area. For instance inner city teams may cover populations of 40 – 60,000, while teams in less deprived areas could cover a population of 200,000. As a guide, the area/population that could be served by a team might approximate to the area/population served by an inpatient ward (before the development of Assertive Outreach and Crisis Resolution/Home Treatment). Workload includes not only the active caseload, but also the requirement to respond rapidly to urgent assessments (not all of which will receive Crisis Resolution/Home Treatment after assessment), and the requirement to liaise actively with inpatient wards for early discharge joint planning.

16. STAFFING AND PROFESSIONAL ROLES

Teams staffing requirements usually reflect the need to maintain a rota which offers availability around the clock. Most teams operate two shifts during the daytime (early, late) with two staff (at least one of whom is qualified) from the late shift going on to provide on-call. The early shift could be 8.00 am to 4.00 pm (6 staff). (At weekends this could be 2 staff). The numbers of staff per shift will vary according to clinical pressures and workload.

The late shift could be 1.00 pm to 9.00 pm (2 staff). The on-call hours extend from 9.00 pm to 8.00 am (usually the 2 late shift staff)

A team size of 12 is the usual minimum complement required to provide a 24-hour rota (allowing for annual and study leave). With 12 in the team, staff are on-call 4/6 times each 4 week period.

Designated named workers include:

- CPNs
- ASW
- OT
- Psychologists
- Support workers including service users

The mix of trained staff, professional groups and support workers is optional. Because of the skills of monitoring and administering medication, community psychiatric nurses will normally be significantly the most represented profession. An appropriate mix of staff is needed to ensure that all the interventions listed can be provided within the team. Recruiting 'designated named workers' allows flexibility in the recruitment process, so that the best local balance of skills is sourced in the setting up of the team.

Designated named workers/ Key skills:

- High energy level
- Team player
- Ability creatively to engage service users
- Understanding of needs of service users, including specific needs related to cultural background/age/gender etc
- Able to co-ordinate care and provide broad range of interventions

A typical team structure is given below:

- 1 - Team Manager (I Grade Nurse or equivalent)
- 7 - Community Psychiatric Nurses (3 G Grade, 3 F Grade, 1 E Grade)
- 2 - B Grade Health Care Assistants/Support Workers
- 2 - Approved Social Workers
- 0.5 - Administrative/Clerical Staff

Medical staff

Active members of the team.

24-hour access to senior psychiatrists able to do home visits is vital.

Involvement from both consultant and middle grade psychiatrists.

Level of psychiatric input to be determined by local need and service configuration.

MEDICAL ARRANGEMENTS TO SUPPORT HOME TREATMENT TEAMS

The full involvement of Psychiatrists is fundamental to the operation of this model. In the development phase, it is very useful if a Consultant Psychiatrist is supporting the development and a member of the Project Steering Group.

In the operation of this service Psychiatric medical staff are actively involved in all assessments, all decisions following assessment as to the most appropriate service, and throughout the management of crisis with the team.

Psychiatrists can be integrated with Crisis resolution/Home treatment teams in different ways. The examples given below include both 'in hours' and 'out of hours' arrangements. The choice as to which arrangements suit a particular team will depend on the area and population covered by the team and local Consultants, local service arrangements and psychiatric medical staff resources available.

OPTION A (IN HOURS)

One Consultant Psychiatrist (usually supported by middle grade and/or junior doctor) is responsible for all cases managed by the Crisis resolution /Home treatment team.

ADVANTAGES

In the developmental phase, there are advantages to this approach in that there is a lead consultant involved with the team during the training phase, setting up operational policies, liaising with other components of the service and preparing the team for going operational.

A single consultant can provide consistency in approach in looking at the threshold of referrals, clinical team meetings, organizing medical availability for assessments and reviews, and deciding on admission to hospital care if clinical deterioration despite home treatment or other considerations towards admission apply. Accessibility, consistency and leadership are the main advantages of this approach. Sometimes it will suit local teams to continue this arrangement beyond the developmental phase so as to make it the conventional arrangement for that team.

Integrated working of the Crisis Resolution/Home Treatment team and Inpatient units is easier to achieve with a single consultant, providing ease of communication, awareness of clinical progress and consistency in approach.

A possible disadvantage to this solution is the lack of continuity of medical staff in the individual's life at a very difficult time. Another disadvantage is the referral systems and procedures that need to be developed between different consultants and medical teams when managing acute presentations, which require more intensive help in the form of home treatment or admission.

OPTION B (IN HOURS)

Different medical teams interface with the Crisis resolution/Home treatment teams according to catchment area.

ADVANTAGES

This option has the advantage of maintaining continuity of medical staff during the acute care period. Medical involvement before, during and after crisis is consistent, much as happens with conventional hospital care.

One problem with this arrangement is that Crisis resolution/Home treatment teams which are linking with a range of medical teams, are presented with logistic difficulties in arranging sets of meetings for joint clinical review, liaison with inpatients and ward rounds, and also different community mental health teams. Immediate availability of medical staff for urgent assessments during working hours can be difficult to organize with this model, because doctors may be tied up in outpatient clinics or other community work.

Teams relating to a number of Consultant Psychiatrists may find it more difficult to establish and maintain consistency in operational practice, having to adapt to different styles and traditions.

OPTION C (IN HOURS)

Option B above, but with dedicated senior non-consultant medical time to support the Crisis resolution/Home treatment team (e.g. Senior Clinical Medical Officers). This model preserves the advantages of continuity of Option B, but also provides direct and reliable medical access to the team, especially during working hours in response to urgent referrals.

OUT OF HOURS

Crisis resolution/Home treatment teams need to access medical staff for out of hours assessments and to assist with clinical problems that may arise with established cases. As these teams are involved in a complex level of urgent assessment and clinical decision (usually involving serious mental illness), the grade of doctor required is senior (for instance consultant, or non-consultant senior doctor, senior clinical medical officer). Involvement of primarily junior doctors with limited psychiatric training is not the ideal. See McGlynn P, Smyth M (1998) 'The Home Treatment Team: Making it Happen' (in) Developing Home Treatment and Assertive Outreach. London: Sainsbury Centre for Mental Health.

SOCIAL WORKERS

There are natural advantages to Approved Social Workers being core members of the Crisis Resolution/Home Treatment team. Teams without Social Workers need to develop good working links with local Social Services.

Social Workers often have considerable experience of emergency assessments involving mental health issues. They have a good understanding of the way in which social pressures can impact on psychological health. Part of a Crisis Resolution/Home Treatment team's role is to avoid the translation of life and social

stresses into illness frameworks and Social Workers are very skilled in this area and can develop this culture within the team. Social workers have an orientation towards social and community support, working with and considering the needs of families and carer.

They have experience in accessing local resources, benefit entitlements, accommodation and also particular expertise in areas of risk management such as Child Protection issues if required. If Mental Health Act assessment is required, having an Approved Social Worker within the team is very valuable in terms of decision making, safety, efficiency and maintaining a relationship and ongoing assessment of need, including when admission is required.

However it cannot be assumed that all Mental Health Act assessments will involve an Approved Social Worker within the team. Social Workers will be operating within the multidisciplinary team as team members in the first instance, with a caseload for which they are named workers, on call responsibilities, and responding to urgent referrals like other team members.

PSYCHOLOGISTS

Teams, which have access to psychology sessional support, find this very valuable. Access to Clinical Psychology assessment can be valuable with complex presentations and in care planning.

Delivery of more specific interventions such as Cognitive Behavioural Therapy may be difficult for psychologists to deliver within the timeframe of acute care, and within of their own sessional commitments. However identification of specific need and planning of more ongoing psychological support can be facilitated. Some teams will have other core staff (often nurses) with specialist skills such as Cognitive Behavioural Therapy.

OCCUPATIONAL THERAPY

Occupational Therapists can offer additional strengths to Home Treatment teams. Individuals in psychiatric crisis who are experiencing difficulties with activities of daily living can feel that they have little control over their lives, adding to their sense of helplessness. Holistic assessments by Occupational Therapists, looking for the potential for change can highlight additional areas of need and strategies toward recovery. Skilled planning of person specific graded activities towards identified goals can enhance skills, knowledge and attitudes. Skills in self care, productivity and leisure can maintain or restore more balance and structured life roles. Motivation to use abilities and strengths and regain control is fundamental to the Occupational Therapists approach.

The involvement of the Occupational Therapists in the individuals home is a more natural and immediate setting, even in the acute phase, to deliver these benefits of approach.

SUPPORT WORKERS

These are people with health, social care or appropriate life experience or personal experience of mental health problems/ treatment. The provision of support during crisis is a fundamental task which runs in parallel with more specific interventions. Support workers are often free from the institutional constraints from which other team members might be moving away. They can relate to people in crisis as individuals and look in very practical terms at what help is required, while also providing emotional support.

Support workers offer an additional way to reflect the demography of the local population.

PROGRAMME SUPPORT

1 wte administrative assistant.
IT, audit and evaluation support may also be needed.

IT access to CPA records and Risk Assessments can be very helpful to Crisis Resolution/ Home Treatment staff undertaking assessments out of hours, for individuals known to specialist mental health services.

17. JOINT WORKING WITH ASSERTIVE OUTREACH TEAMS

JOINT WORKING BETWEEN HOME TREATMENT TEAMS AND ASSERTIVE OUTREACH TEAMS

The Programme Implementation Guidelines for both Assertive Outreach and Crisis resolution/Home Treatment incorporate joint working. In the case of Assertive Outreach, Crisis Resolution/Home treatment Teams can be a support in the management of crisis and in trying to avoid admission.

“The Crisis resolution/Home treatment team can provide crisis care out of hours”

“If acute care is required, joint assessment should take place between the Assertive Outreach team and the Crisis Resolution/Home Treatment team, so that the least restrictive care setting is arranged”

IN THE CASE OF CRISIS RESOLUTION/HOME TREATMENT:

A key function of Crisis Resolution/Home Treatment is to provide out of hours support and intervention where Assertive Outreach does not provide this.”

“Links should be established in terms of

- *Handovers and referrals being easily made*
- *Crises are anticipated and contingency plans known to all involved in care*
- *Assertive Outreach service users are aware of who to contact out of hours*
- *Staff from the Assertive Outreach team could participate in the Crisis Resolution/Home Treatment rota.”*

DEVELOPMENTAL LINKAGES

There is a strong developmental linkage between Assertive Outreach and Crisis Resolution/Home Treatment. The early development of assertive community treatment involved attempts to reduce hospital admission during crisis. Efforts focused on providing alternative intensive community support. These initiatives then extended that support to beyond the crisis stage into a sustained service. Some Assertive Outreach teams included a mobile crisis response as an integral component, however over time the development of separate crisis teams become more the established pattern.

While there are differences between Assertive Outreach and Crisis Resolution/Home Treatment, there are important similarities. Both involve a dedicated team approach to community engagement which embraces social, interpersonal and illness perspectives.

WORKING RELATIONSHIPS IN PRACTICE

In the set up phase and the development of working relationships between these teams it is essential to map out the common ground. This should include an attempt to develop a shared value base. Both teams can benefit from being honest and explicit about potential interface issues right from the beginning.

The caseload of Assertive Outreach by nature suggests that difficult, complex and often fragile 'crisis situations' will arise and Crisis Resolution/Home Treatment need to acknowledge the long-term commitment made by staff to support clients. This can be extremely rewarding but equally demanding and this needs to be understood in reflecting on responses. Crisis Resolution/Home

Treatment teams may have a different perspective around admission in acute phases, than may apply with Assertive Outreach who are aware that the respite gained for client and clinician gained during an admission may prove very beneficial in the long term relationship building. (If this is acknowledged as being a potential clinical issue both teams can work creatively to identify other alternatives to an acute inpatient unit during these times of need).

Professional credibility and integrity can lead to tensions around Crisis Resolution/Home Treatment's role of 'Gatekeeping'. A keyworker who has a well-established working knowledge of a client can be annoyed to hear a clinician from another team saying they don't think the individual needs to be admitted. Local agreement is important to harmonise the additional potential of CR/HT, while not second-guessing the safe clinical practice of Assertive Outreach teams.

Gatekeeping may mean a face to face assessment may not be required but more an exploration team to team to ensure all possible avenues have been explored prior to admission.

The point at which you request additional support from another team can be critical.

As most Assertive Outreach teams like to manage their own treatment crisis very often the referral to Crisis Resolution/Home Team can be when hospital admission *is* the most likely outcome. Both teams need to work on the 'extension theory' i.e. CR /HT are viewed as an extension of AOR and not as a separate specialist service. Collaboration can happen even if crisis is not an issue. If CR/HT view their working in the context of service need the boundaries they set for referral and assessment need to be flexible. When other teams are working with individuals long term, and they anticipate crisis unless additional input is available, CR/HT should be receptive to this.

The teams should work together on the system of contact and joint working. Simple strategies such as identifying team members as links who mutually attend each other's team meetings for updates and exchanges of information are worth considering. It could also be helpful to develop a continuum of clinical presentation, which flags an immediate discussion with CR/HT, which can work on two levels.

The continuum may be categorising each AOR client into current clinical presentation.

This may mean CR/HT teams are invited into the planning process when someone enters a potentially critical phase. As all clients are reviewed daily by AOR and CR/HTT it becomes a very proactive exercise.

It can allow information to be exchanged that prepares CR/HT teams for crisis which may soon occur, so teams may choose to hold current care plan and direction from AOR teams on how to proceed should this crop up out of hours. It can spark an immediate joint working plan which prevents escalation into the scenarios where CR/HT are contacted when it is 'too late'. This may include CR/HT visiting evenings and at weekends as a 'top up' but should always include some provision for joint visiting, which not only reinforces the collaborative working to the client but also allows the teams to understand each other and constantly address issues of continuity and positive risk thresholds. In this way CR/HT teams also 'get to know' the AOR caseload which can be so helpful to clients and professionals when they may meet out of hours in crisis situations.

18. FIDELITY IN HOME TREATMENT/CRISIS RESOLUTION

FIDELITY ISSUES AND CRISIS RESOLUTION/HOME TREATMENT

Why is it important to measure programme implementation ?

It is normal in any responsible programme of reform to look at the extent of improved services that become available and at their quality. Looking at implementation allows those involved to:

- Have an assurance that the intended service was implemented
- Indicate to others to what exact kind of service emerging research/evidence applies
- Identify necessary management controls
- Identify the strengths and weaknesses of 'usual care'
- Test theories about effectiveness
- Look at maturation and further refinement / local adaptation

I. FIDELITY AND CRISIS RESOLUTION/HOME TREATMENT

In the case of Assertive Outreach approaches there is a methodology and literature surrounding how these teams work best, examining their components and styles of working, and considering how best the benefits of the approach translate in different countries and between urban and other settings. The notion of 'Fidelity' refers to the extent to which a new team adheres to the model of working. Closer adherence to the described model was found to lead to similar positive outcomes. The more variant a new team (with lower fidelity), despite the best intentions of all concerned, the more likely that the expected benefits of establishment and impact would fail to materialise. Naturally, with the hope of improved services, the dedication of staff, resources and training to new teams, service planners and the staff themselves are interested in the details of configuration and the lessons learned from other sites, so as to have maximum impact and success. With financial pressures, there is a risk that new teams become compromised with team composition and ways of working less than desired. This risk then extends to other parts of the mental health system. Access to specialist care suffers for service users and primary care referral sources, community mental health teams will continue to try to do 'everything' including crisis care, and the benefits for inpatient services of reduced admissions and greater acute care flexibility is lost.

If a new team is closely modelled on the original configuration and has high fidelity, but struggles to deliver the expected outcomes, then we may ask different questions about the degree of fit in that setting, for instance results in the UK as compared to the USA, or urban and rural settings. It is important to acknowledge that fidelity is a very important aspect, but also not the only reason why a new team might have different outcomes than were expected.

There is just as much interest and commitment to success in the case of Crisis Resolution/Home Treatment as there is with Assertive Outreach. However the history is different with Crisis Resolution/Home Treatment and the background described

above, cannot be said so easily about Crisis Resolution/Home Treatment. This difference is for a number of reasons:

- Agreed research defined fidelity criteria have not been yet developed (Published). There is not a set of research derived fidelity criteria, which have been put to the test in practice with new teams. (The Durham criteria are discussed below).
- The historical legacy of Crisis Resolution/Home Treatment is more complicated than Assertive Outreach, not being so clearly traced to the one source. We recognize the influences of Crisis theory and Crisis initiatives, Community Mental Health teams expanding to cover crisis work and more treatment at home, and the influence of Assertive Outreach in the development of Crisis Resolution/Home Treatment.

NIMHE and FIDELITY AND FLEXIBILITY

The models of service specified in the Mental Health Policy Implementation Guide (MHPIG) were based on published evidence of effectiveness and on known examples of good practice. As local economies have begun to implement the NHS Plan, an increasing number have asked questions about whether it is mandatory to conform with the MHPIG in every detail, and what scope there is for flexibility, given that that the Guide does also talk about tailoring services to local needs. There have been lively dialogues about its applicability in rural areas with dispersed populations.

NIMHE is preparing a document on Fidelity and Flexibility which will address these issues and provide guidance as to the parameters and processes for Local Implementation Teams in conjunction with Strategic Health Authorities and NIMHE Development Centres.

II. THE DURHAM CRITERIA

The following criteria have been employed for the measurement of implementation of CR/HT:

Durham criteria

- A Multidisciplinary team
- Offering 24 hour /7 day a week cover
- Frequent contact (per shift)
- Intensive contact over short period
- Staff stay involved until problem resolved

With further experience of development, can other/additional criteria be suggested which also look towards fidelity? Based on the working practices of established CR/HT teams in the West Midlands, the following criteria are also useful in measuring fidelity to the MHPIG:

- **CR/HT target group of 75 % and over, having severe and enduring mental illness**

Background: Having a distinct and measurable focus on severe and enduring mental illness suggests that the CR/HT is targeting those who might otherwise be admitted. This suggests that people with severe and enduring mental illness are able to be assessed and in many cases be offered acute treatment at home. This is one of the key aims of CR/HT provision.

•Having an Assessment load/Treatment load ratio

Background: Having a distinct and measurable ratio between the number of assessments that a team is undertaking and the number who go on to have the active support of CR/HT is a useful monitoring tool. If a team is assessing a very high proportion of individuals who then do not meet the criteria, there may be problems with the referral pathways and the team can become frustrated through not being able to offer help to the majority of those whom they assess in crisis. CR/HT offers a triage function, but this is not their only remit. A high assessment load may also detract from the teams' ability to deliver safe and coordinated acute home care to those who need it because they have to respond urgently to so many assessments. If a team is taking on the majority of cases which they assess, it can suggest targeted referral pathways, but also alternately suggest a team that is not targeted, trying to cope with all types of referral. Many established teams would be offering the CR/HT service after assessment to around 50% of referrals –focusing on those who have severe and enduring mental illness and who are at risk of hospital admission.

•Community Mental Health team accounting for the majority of referrals (e.g. >75%)

Background: In a well integrated system, the local Community Mental Health Team will be working closely with the CR/HT team and accounting for the majority of referrals, especially in working hours. The Community Mental Health Team will already have established links with Primary Care and work routinely with individuals who are at higher risk of acute relapse. A high proportion of referrals coming from sources other than the local Community Mental Health Team suggests a crisis service working independently from the rest of the service and also having less of an impact in the overall service.

•Rate of hospital admission diversion > 30%

Background: This target is anticipated in the National Plan.

•Rate of early discharge from hospital to CR/HT

Background: This provides a focus on the capacity for CR/HT to offer early discharge after the pressing reasons for admission are less of a concern and acute care can safely continue at home with the support of CR/HT. Length of hospital stay is important to individuals and their families. If CR/HT is not offering early discharge, there is a lost opportunity and the suggestion that the CR/HT team is not joint working with the local inpatient facility.

•**Strongly integrated with Inpatient Care (structure/working practices)**

Background: The National Inpatient Care guidelines emphasise the close integration of acute services. Flexible tailoring of the best balance of Inpatient care and CR/HT in the community requires partnership working on a day to day basis. Active inreaching to the inpatient unit is a basic standard of CR/HT practice.

NORTH BIRMINGHAM COMPONENTS OF CRISIS RESOLUTION/HOME TREATMENT

(This study was conducted by Smyth M, Heffernan K, and Hoult J)

In 2001, six well established Crisis Resolution/Home Treatment teams were surveyed to examine the components of this model of acute psychiatric care. The overall results of this exercise are offered to other centres in the hope of providing detail of the ingredients of this model in practice. All the teams involved were operating in an urban context, although including affluent to inner city deprived areas. No rural areas were served by these teams. Within North Birmingham, the results were useful in generating a Trust Operational Policy for this service, and in highlighting differences in practice which were usually the result of different staffing composition and locality specific ways of working (e.g. some teams had a single lead consultant, some teams had social workers as integral team members, some teams worked closely with Assertive Outreach, and the agreements between teams and Community Mental Health teams regarding processing of urgent referrals varied between localities).

Crisis Resolution/Home Treatment in North Birmingham had been evaluated by the Sainsburys Centre for Mental Health (Open All Hours – Minghella et al 1998) and had also been referred to as an example of good practice in the National Service Framework for Mental Health.

The methodology involved developing a questionnaire looking at the components of Crisis Resolution/Home Treatment working. The questionnaire was refined after a pilot exercise in which the initial schedule was administered with space for comments and suggestions from practitioners. The revised questionnaire was then administered to all staff working in six Crisis Resolution/Home Treatment teams, who had at least 12 months experience of this way of working. The respondents included nurses, doctors, healthcare assistants and social workers. At the time of administration, service users, psychologists and occupational therapists were not working directly with these teams and could not be surveyed.

Suggested components were scored according to how they were judged to be critical to the way of Crisis Resolution/Home Treatment working i.e. strongly agree, agree, neutral, disagree or strongly disagree. Statistical analysis involved the use of the McNemars/Binomial distribution test on each component to see whether there was a statistically significant difference in the collected views of the respondents i.e. that was unlikely to have arisen by chance.

The questionnaire examined the following groups of components:

- **Team structure**
- **In hours working**
- **Out of hours working**
- **Organisational issues**
- **Treatment**
- **Skills, values and principles**

Team Structure

SIGNIFICANT AGREEMENT (COMPONENTS)

- The team should have enough staff to provide 24 hour cover
- Team is multidisciplinary
- The team should include social workers
- The team should have one identified consultant psychiatrist (i.e. with responsibility for all cases managed by the team)
- The team should have a dedicated non-consultant doctor (working across all patches covered)
- Team members responsibility is limited to home treatment (not other parts of service)
- All team members participate in on-call roster
- Team composition should reflect cultural diversity of area
- Team composition should aim towards a balanced gender mix
- The team leader should be clinically active

Team Structure

SIGNIFICANT DISAGREEMENT (NOT COMPONENTS)

- The team should include those with specialist training in alcohol/substance abuse
- The team should include employed service users
- Team members should rotate to/from inpatient wards

Organisational

SIGNIFICANT AGREEMENT (COMPONENTS)

- The caseload needs to be manageable
- There should be a team based approach to management of cases. Clients & families (on CR/HT) should have direct access to team (24/7)
- A named worker system is important in case management.
- The team should have quality standards regarding review meetings (frequency, participation, structure)
- The team should have quality standards regarding identification of treatment targets/evaluating interventions

- CR/HT should act as a gatekeeper for all potential admissions
- The team should be present at all Mental Health Act Assessments
- CR/HT should be gatekeeper for Assertive Outreach arranged admissions
- CMHT should be first point of contact/screen for all urgent referrals before CR/HT
- CR/HT should act as gatekeeper 24/7
- The team should take on any people with Severe Mental Illness
- The team should take on any people with mental health problems likely to be admitted
- The team should operate fixed age boundaries for response (e.g. 16-65)
- The team should routinely visit ward & screen admitted cases for early discharge possibility
- The team should attend ward rounds (for instance one representative)
- The team should manage some discharges for a short period
- CR/HT should be a time limited intervention that has sufficient flexibility to respond to different user needs
- The team should have an assertive approach to engagement
- The team should have access to (non-hospital) respite facilities

Organisational

SIGNIFICANT DISAGREEMENT (NOT COMPONENTS)

- The team should operate a ceiling on the numbers of active cases
- The team should take on any people in crisis, or any people with Mental Health problems
- The team should manage all discharges for at least a short period

In Hours Operations

SIGNIFICANT AGREEMENT (COMPONENTS)

CR/HT Teams should accept direct referrals from the following:

- GPs
- Social Services
- A&E Departments
- Police Custody
- Psychiatric medical staff (not exclusively working with CR/HT should be routinely involved in the decision to refer cases to CR/HT)
- Teams should remain involved until the crisis is resolved
- Wherever possible assessment should take place in the clients home
- Referral details should be taken/processed by only qualified clinical staff
- Assessment should always involve medical staff (but not necessarily at the same time)

- Assessments should involve a minimum of two CR/HT staff (not including medical staff)
- CR/HT Team should assume full clinical responsibility during community CR/HT
- CR/HT should assume responsibility for risk assessment and management during community CR/HT
- CR/HT Teams should be clear about different areas of responsibility during CR/HT phases (i.e. between the team and other parts of the service)
- Following resolution of Crisis/CR/HT Teams should transfer/restore clinical responsibility/management as soon as it is feasible and appropriate to do so.
- CR/HT Teams should communicate about cases not taken on with the referrer

In Hours Operations

SIGNIFICANT DISAGREEMENT (NOT COMPONENTS)

- CR/HT Teams should accept direct referrals from ex-clients of CR/HT
- CR/HT Teams should take responsibility (for cases not taken on at assessment) until appropriate follow-up is secured

CR/HT Teams should accept direct referrals from the following:

- Families/Carers
- Voluntary Agencies
- Addiction Services

Out of Hours Operations

SIGNIFICANT AGREEMENT (COMPONENTS)

CR/HT Teams should accept direct referrals from the following:

- GPs
- Social Services
- A&E Departments
- Police Custody
- Assessments should always be undertaken with medical staff present
- Wherever possible assessments should take place in the clients home
- CR/HT Teams should retain responsibility until appropriate follow-up is secured
- CR/HT Teams should liaise/communicate for cases not taken on

Out of Hours Operations

SIGNIFICANT DISAGREEMENT (NOT COMPONENTS)

CR/HT Teams should accept direct referrals from the following

- Previous CR/HT clients
- Families/carers
- Voluntary Agencies
- Addiction Services
- NHS Direct
- Clients 'involved' with Mental Health services

Treatment

SIGNIFICANT AGREEMENT (COMPONENTS)

CR/HT should involve the following:

- Management of medication
- Targeting symptoms
- Rapid restoration of functioning
- Establishing diagnosis
- As little disruption as possible to the clients life
- Explaining diagnosis
- Education about mental illness and crisis
- Individualising treatment packages
- Identifying and discussing the factors contributing to the crisis
- Advocacy
- Care designed to improve compliance with medication
- Service user involved in decision making
- Ongoing explanation to individual
- Ongoing explanation to family/carers
- Needs led intervention
- Brief supportive counselling by the team
- Arranging external counselling
- Practical problem solving
- Stress Management
- Practical help with basics of daily living
- Arranging respite to address carers burden where appropriate (not involving admission)
- Arranging respite for the individual (not involving admission)
- Offering direct counselling for carers
- Developing a crisis plan (who to contact etc.)
- Developing a relapse prevention plan
- Flexible care plan to respond to change rapidly in the clinical situation

Ways of Working

SIGNIFICANT AGREEMENT (COMPONENTS)

- Should be able to attend a crisis call when necessary within one hour of receiving the call “in cities and large towns”
- Should have the capability of spending lengthy periods at the initial interview with the client
- Should have the capability of spending long periods with the client at subsequent interviews
- Should have the capability of frequent visiting (that is, several times daily to clients and their social network where necessary)
- Should have as a priority the involvement of members of the clients social network during the assessment, planning and treatment phases of a client’s care
- Should keep relevant members of the social network informed of the progress during the course of treatment
- Should use a bio-psycho-social framework in the care of the client
- Teams should pay particular attention to the assessment of a client’s basic needs (e.g. housing finances, benefits during the initial assessment)
- If home assessment is not possible, assessment should take place where the crisis is occurring
- Clinical reviews should be at the clients home

Skills, Values and Principles

SIGNIFICANT AGREEMENT (COMPONENTS)

- Avoidance of hospital admission if possible
- Minimisation of hospital stay is a desirable target
- Crisis and relapse is a positive opportunity to change the future course of severe mental illness
- Crisis and relapse is a positive opportunity to discuss previous involvement and service experience of psychiatry
- Crisis management at home requires a different more informal, personal approach to that in hospital
- Targeting individual treatment staff can lead to more successful engagement in certain cases
- CR/HT aims to preserve client autonomy

SIGNIFICANT DISAGREEMENT (NOT COMPONENTS)

Initial admission to hospital is not too much of an issue, because of the CR/HT early discharge facility

As a background to the North Birmingham Components Study, data is available for admissions for the East Locality CR/HT team which was the same team evaluated by the Sainsburys Centre for Mental Health (Open All Hours –Minghella et al 1998). A study of admissions was conducted from 1991 to 2001 (4 years before and 6 years after the establishment of the team)

**Analysis of Hospital Admission Trends for the East Locality CR/HT Team
(This study was conducted by Smyth M and Hoult J)**

The total annual numbers of admissions for east locality from 1991 to 2001 is shown in Table A. The mean number of admissions for the years 1991 to 1994 (before Home Treatment) was 334.5 (standard deviation 17.5, SEM 8.7) compared to the mean for the years 1996 to 2001 (after Home treatment) which was 171.8 (standard deviation 19.2, SEM 7.8). The year 1995 was excluded from analysis because it involved a part effect with an admission rate of 226 (the team commencing in July 1995 for 3 electoral wards, expanding to cover the whole locality in October 1995).

The admission rates according to electoral wards were also examined. There was no statistical difference in the pattern of Home Treatment impact according to electoral ward (or by implication different Consultant medical teams in the Locality).

The impact of Home Treatment accounted for a mean reduction in admission rates of 48.7 %. The pattern of admission reduction commencing from the part year effect at the introduction of the service in 1995 was sustained for the next 6 years.

Admission Figures

Year – number of admissions for the electoral area of East Birmingham

Year	Admission
1991	337
1992	345
1993	347
1994	309
1995	226
1996	178
1997	176
1998	192
1999	177
2000	153
2001	155

19. RESPITE SERVICES AND CRISIS RESOLUTION/HOME TREATMENT

Respite facilities offer further potential to Crisis Resolution/Home Treatment teams to support individuals in crisis in the community. For years, voluntary sector and mainstream services have provided crisis house accommodation and support as an alternative to hospital admission. With the development of Crisis Resolution/Home treatment, the potential for close working and further support has added to the capacity of these initiatives. Respite offers a further alternative when there is a need for more support than can be provided at home, yet the intensive needs of inpatient care may not be indicated.

The request for more flexible community support coming from service users was stressed in the Audit Commission's report 'Finding a Place'. A Mental Health Foundation survey of 400 people and crisis care, showed a preference for places of safety that can be accessed quickly, enabling people to avoid hospital admission. The National Service Framework emphasises the need for improved crisis care. There is an often better fit between the wishes of peoples in crisis to have more control, and the nature and flexibility of respite support to facilitate a more individualised style of coping in crisis.

Common situations where respite care may be considered are:

- Remaining at home during the crisis is not in the best interests of the individual and/or family, but the indications for intensive inpatient care are not present.
- The individual expresses preference for respite care over either staying at home, or being admitted to hospital.
- Social or situational stress at home or in one's neighbourhood.
- The need for a break from home or immediate social network because of tensions.
- The temporary or permanent absence of family/carer support, and individuals living alone.
- Temporary accommodation problems.
- As a step down from inpatient admission prior to returning home, with Crisis Resolution/Home Treatment and Respite offering an early discharge facility.

TYPES OF RESPITE

There is a very wide range of arrangements to provide respite. Facilities may be crisis houses operated by service users themselves or recovery guides, partial or full residential staffing, and safe houses with telephone access. Some facilities offer respite to particular vulnerable groups such as women and ethnic minorities. Another

scheme involves Family Sponsor Homes where ordinary families and individuals take people experiencing crisis into their own homes. The length of stay is also variable as is the inter-relationship with statutory social and mental health services. The principles involve the provision of a safe environment, care planning which emphasises personal understanding, strengths and resources, coping strategies and risk management. The key component is the setting of a safe environment in which people in crisis and distress can have someone to talk to them with respect and caring. Access may be through self referral, Social Services, Voluntary Organisations or may be through Crisis Resolution/Home Treatment and Assertive Outreach and Community Mental Health teams.

Setting up a crisis house

The report 'Being There in a Crisis' explores the experience of eight innovative, community-based crisis projects in England, which were set up to provide support to people experiencing a mental health crisis as an alternative and complement to inpatient hospital care. The report:

traces the services from inception through establishment to active experience, discussing both difficulties and achievements, as identified through project evaluation. The projects demonstrate the value of these types of services in helping to meet the needs of people in crisis and the unique, but complementary role they play. The projects also show the benefits of user-led services or services with extensive user involvement, which also ensure good working relationships with mainstream services.

Published by The Mental Health Foundation in association with The Sainsbury Centre for Mental Health.

This publication is sold by The Mental Health Foundation, and can be ordered from www.mentalhealth.org.uk

CRISIS RESOLUTION/HOME TREATMENT AND RESPITE

III. OPERATIONAL CONSIDERATIONS AT THE INTERFACE

- Referral Procedures.
- Referral and Admission Policy (from the community and from inpatient care, supporting early discharge).
- Therapeutic Aims (incorporating the strengths of combined and complementary approaches and philosophies).
- Confidentiality.
- Is access to the Respite House always through the Crisis Resolution/Home Treatment team?
- What are the guidelines for assessment of suitability, risk and safety?
- Self Harm policies and procedures.

- Substance Abuse policies and procedures
- What are the joint agency care planning arrangements?
- How does the Crisis Resolution/Home Treatment team liaise with the Respite House (communication protocols, visiting frequency, review etc.)?
- Is clinical responsibility with the Crisis Resolution/Home Treatment team provided in partnership with another agency?
- Who takes responsibility for storage and administration of medication?
- What arrangements exist for emergency medical care?
- Staff and Resident Safety.
- Accident / Incident Reporting.
- Joint Training

20. TRAINING

This section describes areas of training for new Crisis Resolution/Home treatment teams.

Ideally training should be offered from a 'Shared perspective', that is Clients and Staff devising and delivering together. Training should not just be induction programmes but opportunities to work on 'whole systems'. It is recommended that a minimum of 15 days training should be set aside and that the training should be pulsed. It should incorporate initial preparation for operational issues and also developmental and evaluation of this newly emerging service.

It is important that some of the days are exclusive for the team but others should be opened up to explore the issues relating to Home Treatments impact on a whole system, i.e. Assertive Outreach, Inpatients, Day Services and Community Mental Health teams, Users and Carers coming together to work in a focused collective sense. The contact between the teams during this initial stage can inform and educate so that each area has understanding and clear expectations of each others roles. It can be an important time to dispel myths and focus on each team's role and individual strengths.

It has been useful for some teams to consider the emerging Home Treatment team as an 'extension' of the existing teams.

The Induction process can generate as many questions as answers. Staff will need to re-explore critical issues after they begin to build their clinical expertise from direct practice experiences. Therefore all training programmes require time to evaluate and reflect so that learning and development are already built in prior to going operational. This can be very important as demands and expectations on the team will undoubtedly be high once they begin clinical work. Planning and offering protected time in advance would be a distinct advantage for all staff involved.

Networking should be considered critical in the continued development of the team, utilising and capitalising on existing skills and experiences from Regional and National forums should be encouraged.

Individual training needs should run in parallel and compliment initial team training. Each member of the team should have defined training needs assessed. This section describes areas of training for new Crisis Resolution/Home Treatment teams

Orientation

- Local area - geography, history, and socio-demographic profile.
- Local Community resource directory
- Range and organisation of local mental health statutory and voluntary providers
- Primary Care Organisations and Resources

Team Building and Identity

- Team Values and Vision
- Communication
- Skill Mix
- Role definition
- Understanding different team roles
- Nursing staff
- Social work staff
- Support worker staff
- Medical staff
- Occupational therapy staff
- Psychology staff
- Service user support staff
- Working positively within boundaries

The Model of Crisis resolution/Home treatment

- History of development
- Social and medical illness models
- Crisis theories and services
- Home treatment principles and services
- Evidence base

Service Delivery in Practice

- Operational policies
- Care planning
- Care Programme Approach
- Record keeping and documentation
- Named worker system
- Target Group
- Referral pathways
- Assessment and treatment phases
- Caseload management
- Structured reviews
- Interventions
- Clinical practice
- In hours and out of hours working
- Discharge planning

Skills

- Situational role plays
- Assessment skills
- Strategies for working with severe mental illness in the community
- Social, psychological and medical interventions
- Counselling
- Anxiety and Stress management
- Practical problem solving
- Family work
- Medication management and supervision
- Personal narratives

Integration and Interface Issues

- The gatekeeping role
- Understanding tensions across interfaces
- Constructive solutions and building alliances
- Structured communication
- Community mental health team
 - Assertive outreach team
- Early intervention team
- Substance misuse services

Inpatient and Crisis resolution/Home treatment collaboration

- Admission decisions and processes
- Joint working during acute inpatient care
- Maintaining connections with individuals and families/carers
- Link staff and processes
- Involvement in ward rounds
- Supporting leave arrangements
- Facilitating early discharge
- Joint risk assessment and management

Risk assessment and management

- Risk thresholds
- Risk assessment
- The use of risk instruments
- Working positively with risk
- Mental Health Legislation

Quality and Governance

- Audit
- Outcome measurement
- Standards
- Supervision
- Staff development and training

Personal Safety

- Personal and team safety issues
- Assessment procedures
- Visit procedures

Community Networks

- Culture and Diversity
- Acute Care Forums
- Links with local community

21. THE SERVICE USER PERSPECTIVE

The importance of both rapid access and choice has been repeatedly echoed by service users. This service does offer a rapid response, and a realistic opportunity for alternative acute care. This has been another factor in the drive to develop this service. The team also realistically provides access once support starts on a 24 hour/7 day a week basis. As stated in the Section on values and principles, **Crisis Resolution/Home treatment** revolves around the individual service users needs, placing these needs centre stage, rather than the system of care. When offered a choice, most people would prefer to be treated in the security and familiarity of their own environment, able to continue where possible to live their lives with familiar routine, and having the same freedom to come and go as they please in their own local community. The planning of visits and treatment interventions are discussed and negotiated so as to fit in with the person's life and demands of living. Interventions are flexibly responsive to the individual's needs and personally tailored to a degree which is harder to achieve in hospital. Crisis resolution/Home treatment staff are guests in peoples' homes, promoting a good understanding of their lives and life situations, in which illness is only one aspect.

SATISFACTION WITH CRISIS RESOLUTION/HOME TREATMENT

Study after study has revealed higher service user satisfaction for this model when compared to conventional hospital care. How can these findings be explained? It is likely that there are positive aspects to do with the Crisis resolution/Home treatment service itself and also reflection on unsatisfactory aspects of inpatient care. However, it needs to be recognised that most of the older research comparing new Crisis Resolution/Home Treatment initiatives to inpatient care were based on relatively neglected inpatient settings within an institutional era. If service users found that the inpatient experience was more beneficial, adequately staffed, pleasant and therapeutic, it's questionable whether the same strength of opinion would have emerged. Also it needs to be recognised that even with this service available, admission will still occur and that both components need to match expectations. Even with the choice of Crisis resolution/Home Treatment, a number of service users will prefer inpatient care, either generally, or in response to particular sets of difficulties and different types of crisis.

POSITIVE COMMENTS ON CRISIS RESOLUTION/HOME TREATMENT

- **Client (service user) view**

In the following section Alan Rowland (Client) describes his experience of working alongside a Crisis Resolution team

“After my recovery and whilst working on a client (service user) support project I was fortunate enough to be based with an established Home Treatment team. My observations are as follows”:

My experience of home visits with a Home Treatment Team is one where daily issues are dealt with in a relaxed way, such as, have you had a drink of tea this morning? Have you eaten today? Do you have any food in the house? Many of the simple humanity issues were resolved allowing the more substantial issues to be approached and tackled. People felt understood and valued, trust is built on open non-judgmental discussions. Genuine empowerment and involvement was offered at every stage. Honesty and sensitivity seems to give the person and the team confidence in each other. Extended visits when necessary encourage a fuller, deeper and more meaningful communications to occur.

The building of relationships appears to be the cornerstone of the treatment process.

For Clients, the main positive points that I have observed are:

Education, normalisation of a crisis, choice, trust, support, exploration of medication issues, negotiation, being seen as a whole person, relaxed approach, empowerment and enablement through involvement in ones own recovery, planning and exploring old and new coping strategies for the future. Carers are offered a central role of value; support from the team reduces isolation and the potential of distance. The team will often quickly understand the dynamics and tensions of the relationships, allowing the steady building of confidence between all involved including the team. Stigma is often reduced through the normalisation of the crisis and knowing a response is only a phone call away.

For Carers, the main positive points that I have observed are;

- Not feeling alone.
- Being understood.
- Education being a three way process.
- Active Involvement in seeking solutions.
- Having the potential to be supported by other carers
- Enabling choice to become an option, less anxiety about the outcome and understanding the process of crisis.
- Being given hope of a speedy resolution of the crisis.

As A Team the main positive points that I have observed are;

The whole team approach to crisis resolution, discussions, options, creative thinking, allows positive risk taking to occur more frequently. Knowledge and use of the range of existing services available in the community also influences choices and options of the team. The team make a special effort to liaise with the full directory of local community resources in their area. This is important because not everyone assessed will require actual Crisis Resolution/Home Treatment intervention, and those that do, have further support. This all allows for a more consistent approach by the team, and the person receiving the service feels the confidence of the team and in turn is reassured. Seeking solutions to patterns of behaviour is complex and sometimes tiring, resolution is both rewarding and energising for individual team members and for the team as a whole.

With closer relationships within the team, genuine multi-disciplinary team working becomes a continuous process of education between all of the professions. The confidence of the 'whole team approach' influences the manner and depth of daily contact with other teams. Over time, this produces a more cohesive locality service,

especially when other teams see Crisis Resolution/Home Treatment Teams as an extension of their own teams.

Home Treatment is most often the choice of clients (service users) and carers who have experienced the service, why?

Because it allows:

- Quality time
- Undisrupted one to one contact
- Discussions able to conclude
- Quality experience (client and professional)

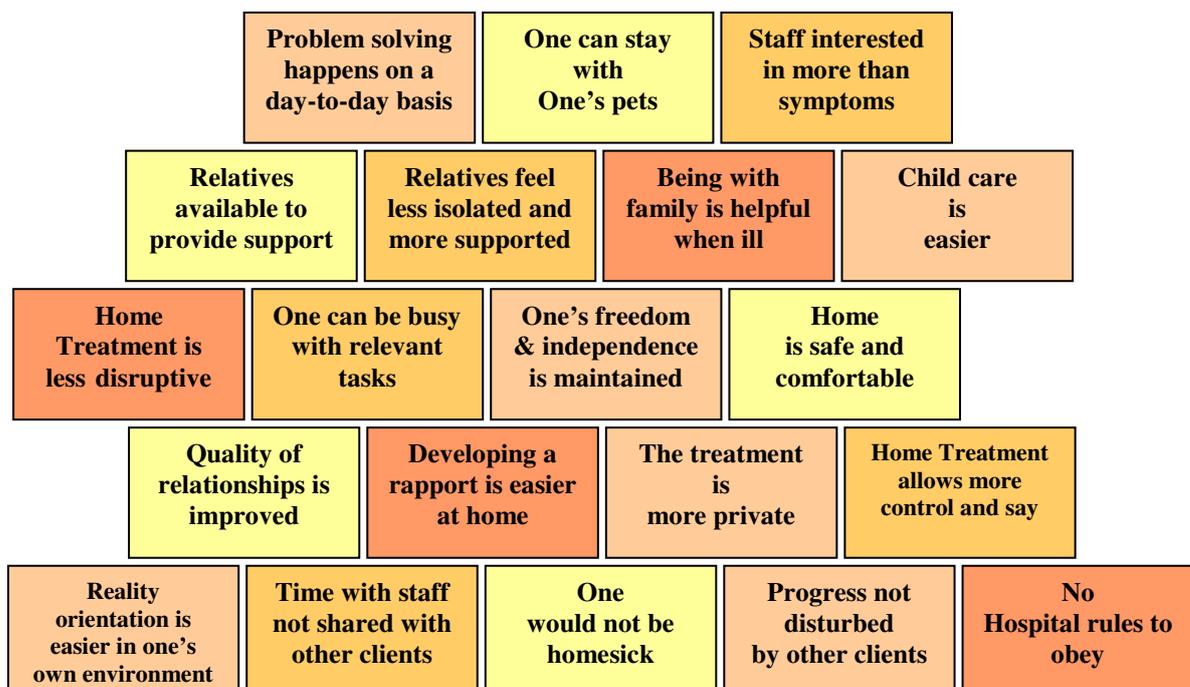
NEGATIVE COMMENTS ON CRISIS RESOLUTION/HOME TREATMENT

Service users want to define crisis for themselves, rather than professionals deciding for them, what is a crisis that needs more acute support.

This service involves new staff with whom the service user is unlikely to be familiar. This is not easy to deal with if you are in crisis.

The nature of the team staffing and 24 hour cover means that different staff can be involved in repeat visiting. This can be stressful at the beginning of assessment and treatment before more clearly named workers are more consistently involved.

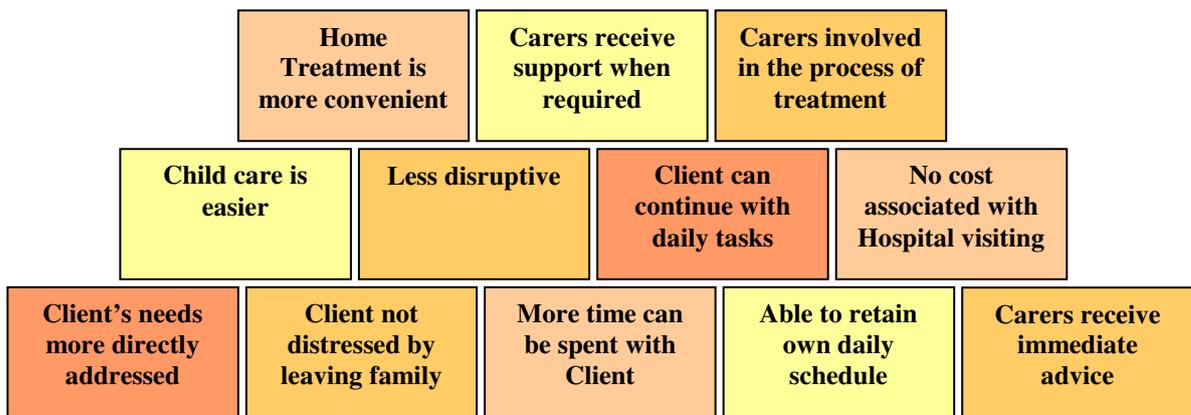
Advantages of Home Treatment Identified by Clients



These are comments are from a survey of Crisis Resolution/Home Treatment conducted by Marcellino Smyth with the Ladywood Crisis Resolution team in West Birmingham (40 participants)

These advantages for Clients and Carers become the foundation blocks for successful therapeutic engagement

Advantages of Home Treatment Identified by Carers



These are comments are from a survey of Crisis Resolution/Home Treatment conducted by Marcellino Smyth with the Ladywood Crisis Resolution team in West Birmingham (40 participants)

These advantages for Clients and Carers become the foundation blocks for successful therapeutic engagement.

22. CARERS VIEWS (Carers in Partnership)

CARERS IN PARTNERSHIP

Carers in Partnership produced a Guidance Paper on Crisis Resolution/Home Treatment. The members of the working group who researched and wrote this paper are:

Pauline Arksey
Pat Fleetwood-Walker
Simon Foster
Ann Williams

The West Midlands Development Centre is grateful to Carers in Partnership for the work involved in developing this guidance and for permission to include it within this document. Information about Carers in Partnership is provided after the guidance.

About Carers in Partnership

Carers in Partnership gives carers a way to work together regionally to influence the planning, implementation and delivery of mental health services in the region.

Carers in Partnership is a carer-led initiative. Our members include professional carers and support workers from all disciplines, both statutory and voluntary services, and service-users. A majority of members are carers – the families and friends of people who experience mental health problems.

Carers in Partnership is part of the West Midlands Partnership for Mental Health.

For many years the families and friends of people with mental health problems have been struggling to make their voices heard in the care of their loved ones. In a set of illnesses where the person who is experiencing mental ill health may deny there is anything wrong, it is often the carer who first identifies the problem, and seeks help. It is also the carer who tends to spot the early signs of relapse, and in enduring cases of mental illness, the carer may provide much of the day-in, day-out support that helps the individual take steps towards recovery.

For more details about Carers in Partnership, please contact:

Simon Foster, Project Officer, Carers in Partnership
Rooms 11 Ruskin Chambers
191 Corporation Street
Birmingham B4 6RP
0121 233 1631
cip@rethink.org

CIP views on HT/CR

Home Treatment (also known as Crisis Resolution) is a new type of mental health service being introduced across the country. By providing more intensive treatment at home, Home Treatment aims to avoid hospitalisation and sectioning. Home Treatment teams typically take clients from 4-8 weeks and may provide daily visits from a nurse, staff on duty 24 hours a day, and a rapid response if the situation deteriorates.

Carers in Partnership is the West Midlands forum which gives carers a voice in the development of mental health services. This paper is Carers in Partnership's response to Home Treatment outlined in the Department of Health's Mental Health Policy Implementation Guide.

In this paper we put forward comments on the model, from the carer's perspective, which we hope will be useful to Home Treatment Team members, those who set up such teams, and those who train team members. We also outline some of our concerns about the model.

The Department of Health's guide for how Home Treatment should look is to be found in the Mental Health Policy Implementation Guide. This was published in March 2001 to 'support the delivery of adult mental health policy locally'. Issued as a 'guide not a prescription', it outlines specifications for new models of service such as assertive outreach and home treatment, while allowing local services flexibility within these guidelines in order to meet local need.

You can view it at www.doh.gov.uk/mentalhealth/implementationguide.htm

Carers in Partnership is pleased that new models of care such as home treatment and assertive outreach will be made more widely available. Alongside these, the new, fuller right to carers' assessments should enable carers to have some choice in how they participate in care, and it should empower them to care and cope more effectively – to make carers more truly partners in caring and achieving recovery. But it can also put a heavy burden on the shoulders of carers, which may be too great for some families at some times to bear. It must be recognised that there will be some times when treatment at home is not an option because of the needs of others in that home.

Most service users prefer to be supported at home where the surroundings are familiar. This often means that they are being treated in the same home where family members are present. For the family, crisis care at home may be the last straw. They will probably have been coping with minimum professional support with a difficult and frightening pre-crisis situation, and they may well experience hospital admission as a breathing space and a much-needed chance to recharge their batteries. When an assessment for home treatment is made it is important that the physical and emotional health of the family is fully considered and that no attempt is made to persuade them to accept crisis treatment in their home, if they have realistic doubts as to whether they can cope.

Where Home Treatment/Crisis resolution is used family members will often be coping with a person who would otherwise be in an acute hospital. They will find themselves dealing with an even more difficult situation than they would have before. They will inevitably be drawn into a number of roles, which will take time, effort, money, emotional energy and probably sleepless nights.

It is essential that they are involved and consulted in what is happening. Carers have a unique view of the situation, offering a range of perspectives not available to the professional. The carer will know what the individual was like before the onset of the illness, what s/he is like at all stages of the illness (professionals specialising in community or acute care will not have seen all these stages), and will be familiar with early signs of relapse.

Where a carer is not living in the same home they may still be on hand and in touch regularly. Again, the carer can provide valuable support and encouragement and should be engaged by the services. Carers and Disabled Children's Act guidance recognises that carers do not necessarily live at the home of the person they care for – services have a duty to recognise these carers too.

CARERS IN PARTNERSHIP'S RESPONSE

This section shows our response to chapter 3 of the Department of Health's *Mental Health Policy Implementation*

Guide, 'Crisis Resolution/Home Treatment Teams'.

Carers in Partnership welcomes much that is contained in the model. The document identifies that carers should be involved throughout the process. We believe that Home Treatment/Crisis Resolution offers many advantages.

The *Mental Health Policy Implementation Guide* describes in detail components of the service. The table is reproduced in full overleaf with an additional column, which includes our comment

Key Component

AGE, CULTURE DISABILITY AND GENDER SENSITIVE SERVICE

Key Element

Comments

- 24 hour access to translation
- Single sex accommodation and gender sensitive services should be provided if needed.

- The high prevalence of diagnosed psychosis in certain cultural groups emphasises the importance of developing a culturally competent service
- services should be available
- Needs of different groups should be explored and services adapted appropriately

CiP's Response

- **Age, culture, disability and gender issues affect carers as well as those with mental ill health.**
- **Carer's needs, understanding and expectations may vary because of these factors.**
- **Services have to engage carers in the model of care they are using and the outcomes they are working towards.**

Key Component

ASSESSMENT

Key Element

- 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, multi-service user's needs and level of risk
- Assessment should actively involve the service user, carers/family and all relevant others e.g. GP

Comments

- Rapid-available within one hour of referral
- Assessment to take place in service user's home wherever possible
- Problem solving approach

CiP's Response

Carers should be told of the assessment process: what it is, what the aims are; how it works; how to participate; how it is used. Carers – and the person with the illness – should receive copies of the care plan as they all work towards its aims. Carers should be told of their own right to assessment at this time. If they have received an assessment previously, they should be offered a review as this is a particularly difficult time. Goals from assessment may be to help all members of the family to understand the illness and how to cope. Also to help each family member to find a useful role during this time so that the pressure does not just fall on – for example – the mother's shoulders. Input from a male member of staff may help to engage the men in the family.

Key Component

PLANNING

Key Element

Comments

<ul style="list-style-type: none">• Produce a focused care plan• Decide on number of visits and level of input• Begin discharge planning at an early stage	<ul style="list-style-type: none">• 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
--	--

CiP's Response

- **In order to engage family members properly all mental health professionals need to be trained in carer/family awareness.**
- **Carers in Partnership see this as essential if home treatment is to succeed.**

Key Component: Interventions- the following interventions should be available

DESIGNATED NAMED WORKER

Key Element

Comments

- 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

CiP's Response

- **Carers may also want an independent source of information and support and this can often be obtained from local voluntary services, carers groups etc.**
- **Carers and users will build up relationships with specific staff members and will want to know when they are on or off duty.**

Key Component

INTENSIVE SUPPORT

Key Element

- Frequent contact (including home visits) throughout crisis
- Ongoing risk and needs assessment
- Service must have the capacity to follow service user throughout crisis

Comments

- In the early phase, several visits a day may be needed

CiP's Response

- **Some of this support and contact should be targeted at the family/ carer who will need support and can offer a fuller picture.**
- **Carers should have a say in when visits take place.**
- **A separate worker may be needed to support carer.**

Key Component

MEDICATION

Key Element

Comments

- 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

CiP's Response

- **Even in Home Treatment carers are relied upon to see that medication is taken. Where this happens it should be agreed in the home treatment care plan in advance. Workers should be aware that this practice can give carers an 'adversarial' role and can lead carers to focus on medication as the solution to the problem. Workers should be willing to relieve carers of managing medication if necessary so that family members can support in different ways.**

Key Component

PRACTICAL HELP WITH DAILY LIVING

Key Element

- Help with benefits, housing, childcare etc

Comments

- Empowering service users and respecting their independence is crucial
- Service user/family/carers must be involved in all decision making

CiP's Response

- **Carers should be encouraged to believe in recovery and to consider what is possible and worth pursuing.**
- **Promoting independence is a goal which everyone can sign up to.**

Key Component

FAMILY/CARER SUPPORT

Key Element

- Ongoing explanation to family/carers
- Education about the crisis and the service user's illness
- Arrange practical help as needed.

Comments

- Involvement of carers/family and provision of support during crisis are key components of recovery

CiP's Response

- **Carers need information, support, education, respite and involvement in planning and providing care.**
- **Good practice – Rethinks Carers Education and Support Programme (CESP) a ten session course in caring is invaluable in building carers knowledge, skills and confidence.**
- **Carers need staff time with and without the ill person. Workers need to be sensitive to which sort of support is appropriate when. The service needs to be seen as supporting the whole family.**
- **Support to carers should be flexible, imaginative and practical. Carers and Disabled Children's Act has good guidance for planners and practitioners.**
- **Good Practice – a consultant in Solihull runs a carers clinic: any carer in the borough can access a 15 minute appointment to discuss their concerns in confidence**

Key Component

INTERVENTIONS AIMED AT INCREASING RESILENCE

Key Element

Comments

<ul style="list-style-type: none">• 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	
---	--

CiP's Response

• Carers need to be given information, support and training in order to provide a supportive environment that promotes recovery.
Good Practice: the West Midlands' Meriden Project has equipped many workers with family work skills so that they can encourage effective communication and problem solving with families on their caseload. While the family may not be able to learn new skills during a crisis, HT/CR staff can be introducing the idea as recovery begins.

Key Component

RELAPSE PREVENTION

Key Element

- 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

Comments

- 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

CiP's Response

- **Carers (and users) are often experts in identifying early warning signs of relapse and families' observations must be taken seriously.**
- **All families would prefer crisis prevention to crisis resolution.**
- **Good Practice – some Home Treatment teams allow direct access from carers of people they have previously treated.**

Key Component

CRISIS PLAN

Key Element

Comments

- 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

- Families should be actively encouraged to use 24 hour contact.

CiP's Response

- **Far from being pushy many families are nervous of contacting services. It helps if the worker contacts the family by phone to set a precedent.**
- **Easy access should not mean using general switchboards. The person picking up the phone should be expecting a call to home treatment service.**

Key Component

RESPITE

Key Element

- Access to respite facilities preferably in non hospital surroundings e.g. cluster homes, community hostels etc.
- Access to day care facilities

Comments

- 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

CiP's Response

- **The type of respite most appropriate in this context is not a planned break but as brief, unplanned stay (possibly for as little as 2-3 days) in staffed, residential accommodation, such as a crisis house, which is likely to give a break to all concerned.**
- **Introducing a home treatment model without decent respite facilities must be avoided. For families who have struggled with a crisis for a long time some kind of respite is essential. It is widely recognised that hospital admissions are sometimes only when the family can no longer cope. Home Treatment in this context will not work.**
- **Good Practice Rethinks *FocusLine* service in Nottingham (a carer-user planned service) is a helpline linked to a 2-bed support house and a night service. This range of support helps to prevent crisis and empowers users and carers to tackle problems before they get out of control.**

Key Component

LINKS WITH IN PATIENT SERVICES

Key Element

Comments

- 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

CiP's Response

- **Continuing contact with family during inpatient stay is important. Carers continue to care - actively - and experience stress during inpatient stays.**
- **Carers may themselves have requested an in-patient service and must not be allowed to feel guilty for doing so.**

Key Component

RESOLUTION

Key Element

- 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 but could include transfer of care to:
 - Primary care
 - Assertive outreach team
 - Early intervention team
 - Continuing care
 - Other mental health services

Comments

- 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/carers have had an opportunity to express their views about the service and contribute to service improvement.

CiP's Response

- **Discharge is critical. Carers repeatedly experience discharge from hospital as one of the weak points of the mental health system. Discharge from Home Treatment can be similar. Carers will always need to know when discharge is planned, what contact to expect and how to plan themselves for the discharge.**
- **Many carers are surprised by how long a discharged patient is left before the first community visit is made.**

CARERS COMMENTS:

Carers in Partnership collected the following views from carers on the advantages and risks of Home Treatment/Crisis Resolution from the family's perspective:

Risks:

- Over-reliance on medication because other therapies are not available.
- Service-user could become isolated from meeting others and 'institutionalised within the home'
- Service-user could become more dependent on the family
- Family does not meet other families – an interaction which could be useful
- Family is drawn in more than with hospital treatment and loses time for work and leisure
- Family feels increased responsibility and worry
- Family frightened and/or put at risk (especially children)
- Staff not trained in family/carer issues might fail to see this as a 'whole-family' intervention, which it has to be to work
- Families feeling guilty when they feel they can't cope or don't cope well enough
- Children – especially young carers – experience stress and isolation, and can fall behind in school and lose friendships

Advantages:

- Can act as **crisis prevention** rather than **crisis resolution**
- The family has easier access to staff than in hospital and other community settings
- The family (including the service user) get to understand the illness and know how to cope
- The family (including the service user) are valued by professionals and seen as part of the team
- The family (including the service user) is helped to stay together: relationships are not disrupted
- The whole family can be engaged instead of just main carer
- The family can learn skills from watching professionals at work
- Staff come to terms with their understanding of confidentiality because they have to co-operate with the family (information sharing and use of confidentiality still causes problems for many carers)
- It may be easier for mental health workers to identify and cope with other family members' needs
- The consultant and other staff working with the service-user sees the 'bigger picture' in the home environment
- Stigma of mental illness reduced
- Easier to negotiate care plan with all parties and to accept each other's needs

23. AUDIT AND EVALUATION

INTRODUCTION

This section outlines a range of audit and evaluation areas to consider in setting up Crisis Resolution/ Home Treatment Teams.

REFERRALS

- Recording of information
- Source
- Time (in/out hours)
- Frequency
- Social and Demographic details

ASSESSMENT

- Place
- Staff involved
- Family/Carer involvement
- Needs identified
- Mental Health Act assessments
- Outcomes:
 1. Acceptance onto Crisis resolution/Home treatment (Assessment and Treatment at Home)
 2. Acceptance onto Crisis resolution/Home treatment (Treatment at Respite Facility)
 3. Arrangement of Hospital Admission
 4. No Direct Intervention - Liaison with Other Parts of Local Psychiatric services (e.g. Community Mental Health Team, Assertive Outreach Team)
 5. No Direct Intervention – Inappropriate for Mental Health Services

INPATIENT LINKAGE

- Joint working initiatives
- Admission Patterns
- Occupied Bed Days
- Early Discharge from Inpatients to Crisis Resolution/Home Treatment
- Screening for Joint Working/Early Discharge
- Supported leave
- Ward Round attendance

TREATMENT

- Client Episodes
- Episode Length
- Pattern of Supported Respite
- Caseload patterns

OTHER CLINICAL GOVERNANCE MONITORING

- Risk Assessment and Management
- Mental Health Act patterns
- Joint working with housing, voluntary organisations
- Recovery management

VALUES

- Philosophy of care and interventions
- Client and Carer satisfaction
- Recovery orientation

24. NETWORK

NIMHE WEST MIDLANDS CR/HT Network

Aims

- Forum and mechanism for sharing best practice
- A network of development support and expertise
- Maximising training opportunities and identifying ongoing training needs/workforce issues
- Creative collaboration, improving and refining the model of CR/HT in different service contexts
- Articulation of value base and vision of more flexible and responsive acute practice
- Supporting integration of CR/HT with other functional teams (including IP care)
- Identifying research priorities
- Communication forum with other mental health national work programmes

The network is currently facilitated by NIMHE West Midlands and is held bi-monthly



***To support the development of
services that could be used with
confidence by our families,
our friends, and ourselves***

NIMHE West Midlands
Osprey House
Albert Street
Redditch
Worcestershire B97 4DE

Tel. 01527 587622/5
Fax. 01527 587503
E mail: contact@nimhe.wmids.nhs.uk

www.nimhewm.org.uk