I refer to your Freedom of Information Act Request acknowledged by ourselves on 15th October 2015. I apologise for the delay in responding. Your request sought information relating to the following:

(1) Please provide the current Operational Policy (or equivalent document) for the Crisis Resolution and Home Treatment Team

Please find attached.

(2) Please provide activity data for this team in terms of number of new patients / clients seen (a) who are subject to part 2 and/or 3 of the Mental Health Measure (b) who are not subject to part 2 or 3 of the Measure. If possible please provide this data on a monthly basis for the last 12 months, broken down by geographical site. If that level of information is not available, please provide the most similar summary data that is available.

Please note that the figures below are all subject to the Part 2/3 Mental Health measure. The health board does not record those that are not subject to part 2/3 of the Mental Health measure.

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(3) What proportion of first / new contacts (or new referrals) to the Crisis Team occurs or originates outside the standard opening hours of the Community Mental Health Teams?

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<tr>
<td>Number of new contacts</td>
<td>297</td>
<td>274</td>
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<td>Number outside CRHT Hours (9am-9pm)</td>
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<td>23</td>
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<tr>
<td>Percentage outside CRHT Hours</td>
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I hope this information is helpful. If you require anything further please contact us at FOIA.Requests@wales.nhs.uk.

Under the terms of the Health Board’s Freedom of Information policy, individuals seeking access to recorded information held by the Health Board are entitled to request internal review of the handling of their requests. If you would like to complain about the Health Board’s handling of your request please contact me directly at the address below or register your complaint via FOIA.Requests@wales.nhs.uk.

If after Internal Review you remain dissatisfied you are also entitled to refer the matter to the information commissioner at the Information Commissioner’s Office (Wales), 2nd Floor, Churchill House, Churchill Way, Cardiff, CF10 2HH. Telephone Number: 029 2067 8400.

Yours sincerely,

Steve Combe
Board Secretary
MENTAL HEALTH DIRECTORATE POLICY

OPERATIONAL POLICY FOR
Crisis Resolution Home Treatment

Disclaimer

When using this document please ensure that the version you are using is the most up to date either by checking on the Trust database for any new versions or if the review date has passed please contact the author.

Originator: Team Manager, CRHTT/Swansea

Team Manager, CRHTT/Neath Port Talbot

Team Manager, CRHTT/Bridgend

Date: 03/04/2014

Date of Review:
1. **Philosophy**

The Crisis Resolution Home Treatment Team will provide a flexible, responsive and integrated service to adult clients and their carers in the most appropriate setting e.g. their own home, respite facility.

The Crisis Resolution Home Treatment Team (CRHTT) aims to provide a service for adults who are experiencing acute mental health crisis. The CRHTT will provide a service promoting a multidisciplinary approach whilst focusing on psychosocial needs of service users and their carers.

The CRHTT will promote continuity and consistency of care and intervention for service users and carers, offering a range of approaches and skills for a maximum of 6 to 8 weeks.

The impact of mental health difficulties on individual sufferers and significant others is diverse, and the need for mental health services in specific communities varies.

An appropriate pattern of services for any community is dependent on local circumstances, the individual needs of clients and the availability of health and social care resources within the community.

Mental health services should be dedicated to the provision of needs-led, comprehensive care, which is facilitated by locally based staff. Such services should enable choice and easy access. Care plans should reflect team members’ respect for client individuality and autonomy. Whereas, inpatient facilities are an important community resource, we believe that mental health care is most appropriately delivered to people in or near their homes (wherever possible).
Clients and carers have the right to be involved in their plan of care, the planning of services, and in service development.

2. What is the Service Intending to Achieve?

People experiencing acute mental health crisis should be treated in the least restrictive environment, with the minimum of disruption to their lives. Home treatment can be provided in a range of settings and offers an alternative to inpatient care. The Crisis Resolution Home Treatment Team service will:

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

- Provide immediate multidisciplinary, community based treatment 12 hours a day, seven days a week, for individuals experiencing mental health problems.

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

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

- Remain involved with the client until the crisis has resolved and the client is linked to ongoing care.
• Be actively involved in discharge planning and provide intensive care at home to facilitate early discharge, when inpatient care has been necessary.

• Provide psycho-education to reduce client vulnerability to crisis and maximise their resilience.

Who is Eligible for the Service?

3. Eligibility and Catchment Population

3.1 Eligibility Criteria

As per WHC (2005) 048 “Policy Implementation Guidance on the development of Crisis Resolution / Home Treatment (CRHT) services in Wales”, the following client groups will be eligible for CRHT services.

CRHT services should be targeted at adults from the age of 17 years and 9 months with acute mental distress, who are experiencing a crisis of such severity that without the involvement of CRHT hospitalisation would be necessary. There is no upper age limit although joint working between Older People Services is encouraged.

CRHT services will also be for people who are ready to leave hospital, but require intensive support to facilitate safe discharge.

Upon discharge service users that are admitted to acute inpatient services due to suicidal ideation will be offered 7 day follow-up by the CRHTT service. This will include a minimum of one face to face contact and two telephone calls; this is in response to the national confidential enquiry into suicide.
Beyond initial assessment, this service is not usually appropriate for individuals with the primary following conditions:

- Mild anxiety disorders.
- Primary diagnosis of alcohol or other substance misuse.
- Brain damage or other organic disorders including dementia.
- Learning disabilities.

In order to focus CRHTT services on those with the highest level of need, the CRHTT is less likely to be able to offer intensive support for the above conditions because of the priority given to serious mental illness, which could otherwise lead to admission to hospital.

There is no blanket exclusion on these groups and each individual case will be considered on its merits. The crisis assessment function of the team will provide responsive support to anyone who appears to be experiencing acute mental health crisis, at least until an assessment has been completed and a clear care pathway is agreed or alternative arrangements have been put into place. Where ambiguity exists around the appropriateness of home treatment it is better to err on the side of caution and offer home treatment for a period of 48 – 72 hours maximum for assessment during the period of crisis.

3.2 Catchment Population

The Crisis Resolution Home Treatment Teams will be responsible for clients residing within their geographical area.
4. Referral Pathways

CRHTT services are part of Secondary Mental Health Services and are subject to the code of Practice Parts 2 & 3 of the Mental Health Measures 2010.

An initial assessment should involve identification of current presenting problems and the rational/need for CRHTT intervention following the initial assessment. Referral details should include an MSE, risk factors and any relevant information.

It is imperative that sufficient information is made available to plan appropriate intervention, with particular consideration to issues relating to risk assessment, gender preference and specific clinical information.

5. Hours of Operation

The Crisis Resolution Home Treatment Teams (CRHTT) in Bridgend and Neath & Port Talbot operate 12 hours a day (9.00-21.00 hrs), 365 days per year.

The CRHTT in Swansea operate 14 hrs a day (7.00-21.00) 7 days a week 365 days per year.

5.1 In Hours

5.1.1 During the hours of 9.00 – 5.00 All referral should be via the CMHT duty system (Swansea) or urgent referral system NPT & Bridgend. Direct gate keeping referrals are accepted by the liaison service and psychiatrists in CMHT’s (primary care service users)

5.1.2 Any new referral from a CMHT must have been assessed face to face by the GP / Care Coordinator / or significant other.
5.1.3 Clients on general wards will require assessment by the liaison nurse/medic. Should the assessment indicate that admission may be necessary; the CRHTT will complete a gatekeeping assessment to determine whether the client requires admission to inpatient services or can be treated at home by the CRHTT.

5.1.4 Clients in A&E will, if appropriate, be assessed by the nurse practitioner/medic. Should further assessment be required, the CRHTT will assess the client.

5.1.5 Clients in Police custody will require an initial assessment by the custody liaison nurse or police surgeon, prior to referral to the CRHTT.

5.2 Out of Hours

5.2.1 All clients currently under the care of CMHT’s and their relevant carers will have access to the Crisis Resolution Home Treatment Team without a preliminary external medical assessment by the GP, provided that this has been identified as part of the clients care plan and previously agreed with the CRHTT. All CMHT clients and carers will have been provided (as part of their contingency plan) with relevant phone numbers, to enable them to contact the CRHTT by their care co-ordinator, along with guidance on when it might be appropriate to do so.

5.2.2 Clients in A&E or the general wards will require a medical assessment prior to referral to the CRHTT.

5.2.3 Clients in police custody who are not under secondary care and not subject to 136 of the Mental Health Act, will require assessment by the police surgeon, out of hours GP or a medic/nurse practitioner in the A&E dept, prior to referral to the CRHTT.

5.2.4 All new referrals should have been assessed for any physical health problems prior to referral.
6. Assessment

6.1 The CRHTT will participate in all assessments as part of their gatekeeping role when admission to inpatient care is a possible outcome, and for all clients where appropriate requiring a Mental Health Act assessment who are aligned to CMHTs.

6.2 Individuals requiring a mental health act assessment, it is the responsibility of the AMHP in the sector CMHT to arrange the assessment. They should contact the CRHTT as part of the gatekeeping process (out of hours this role is undertaken by EDT).

6.3 The CRHTT will provide a response to a request for an emergency assessment within 2 hours and will offer to conduct an assessment within 4 hours if appropriate.

6.4 Wherever possible the assessment will be provided at the client’s home or wherever the crisis is occurring, however, risk management will determine priority. The hospital or CMHT may be used to ensure safety especially where the client is not known or poses a risk to staff.

6.5 All initial assessments will be undertaken by qualified CRHTT staff.

6.6 Assessments will be carried out in line with the mental health measures Care Programme Approach (CPA) Recovery and Risk Assessment.

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

6.8 Any physical health assessments will be carried out if relevant. It may be necessary to request the GP to review the physical health status of the client.
6.9 Once the CRHTT is involved in an assessment, they will remain involved and responsible for the immediate care needs of the client until a clinical decision is reached regarding the future management and care and, if required, a successful transfer has been carried out.

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

6.10.1 The client has been admitted to hospital or other appropriate agency or accepted for home treatment.

6.10.2 Acute intervention is not required but other appropriate support from other parts of the service is organised/will be organised.

6.10.3 No further action or intervention is required from specialist Mental Health service.

6.11 If an assessment is required under the Mental Health Act, the AHMP has a responsibility, in line with the Code of Practice, to manage the process. As such they can request CRHTT to attend if agreed that it is appropriate to do so or as part of the gate keeping process.

6.12 If an out of hours referral is made but does not result in ongoing CRHTT input, the appropriate individuals (i.e. GP, referrer, Care Co-ordinator and RMO if required) will be notified by the CRHTT as soon as practicable, detailing any further action or recommendations for follow up (usually within 24 hrs for urgent action).

6.13 The assessing team will fax a letter to the GP the next working day/or within 24 hrs detailing the outcome of the assessment and any action required.
6.14 Where ambiguity exists around the validity of CRHTT input, it is better to err on the side of caution and offer CRHTT input for a short duration to further assess.

7. Inpatient Admission Criteria

7.1 Where it is deemed not possible to safely manage a service user at home due to risk or clinical concerns an assessment by the CRHTT to facilitate inpatient admission should be sought.

8. Care Planning

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

If no Care Co-ordinator exists, the CRHTT will appoint a care coordinator and have clinical responsibilities whilst actively seeking the appointment of a Care Co-ordinator from the CMHT should ongoing care be identified? The CRHTT will regularly communicate progress to inform CMHT discussions regarding future needs.

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

An initial crisis care plan will be conducted by the assessing CRHTT staff/team members. A multi disciplinary review of the crisis care plan with is ongoing during the teams' intervention. The outcome will be a focused plan detailing the objectives to be met:-
• Number and frequency of visits including medical assessments/reviews.
• This needs to be flexible enough to respond rapidly to changes in the clinical situation.
• Crisis Care planning will require the active involvement of the client, taking account of the views, input and concerns of family/carers.
• Clients and carers will be provided with contact numbers and advised how to access the CRHTT urgently.
• Crisis Care planning involves actively planning for the discharge from the CRHTT at an early stage in the process.
• Crisis Care plans will be reviewed as required, but no less than weekly at a designated CRHTT multidisciplinary team meeting attended by the consultant psychiatrist or their deputy.

9. Intervention

9.1 Anyone who requires CRHTT input will receive practical intervention in all areas identified as necessary to achieve the resolution of the current crisis. These will include meeting the range of needs identified in the individualised crisis intervention plan/case notes.

9.2 The active ongoing involvement of the appointed Care Co-ordinator throughout the period of CRHTT.

9.3 Services will be provided at the client’s home/Crisis Recovery Unit or a suitable location, health or social care facility.
10. Resolution

10.1 Planning for discharge from the CRHTT will begin at the earliest opportunity and should be a component of the assessment process.

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

- There is a good understanding why the crisis occurred and what is required to minimise a re-occurrence.
- Coping strategies have been explored with the client and their family/carer.
- A Relapse and Recovery plan is in place and is understood by relevant others e.g. Care Co-ordinator, family, GP.
- If ongoing care is provided by the Care Co-ordinator then a discharge planning meeting to confirm the details of the Care Package should take place prior to discontinuation of the CRHTT, attended by CRHTT, the Care Co-ordinator and all relevant professionals.
- The client and his/ her family/carer have had an opportunity to comment on the service they received and contribute to service improvement.
- The Client and their family understand their rights under the Mental Health Measures Part 3 and pathways for future advice assistance and assessment.

11. Links with In Patient Services

11.1 The CRHTT will work collaboratively with in patient staff at all stages of inpatient care as one of their core functions.
11.2 Multi disciplinary planning is required for inpatients to be discharged to less restrictive care is a priority and a responsibility shared by inpatient staff, care co-ordinators, consultant psychiatrist and CRHTT staff.

11.3 Teams will examine what is required to achieve discharge and who will be responsible for these tasks. Progress towards discharge will be monitored through joint care review meetings between inpatient and CRHTT staff. This includes weekly discharge planning meetings.

11.4 The CRHTT will support clients at home who are subject to Section 17 leave. However, informal service users should be considered for discharge in the first instance when considering leave.

12. Management

12.1 The day-to-day management of the CRHT service and staff will be the responsibility of the Team Manager/or a designated deputy. This will include ensuring appropriate professional supervision systems are in place.

13. Record Keeping

13.1 During periods of CRHTT intervention, the responsibility for maintaining clients’ records rests with the CRHTT (including inpatient wards, CMHT in secondary care).

13.2 On discharge from the CRHTT, a summary of the intervention and recommendations for follow up will be forwarded to the CMHT and GP.
14. Clinical Governance

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

14.2 All CRHTT staff to ensure compliance with mandatory training including additional training on risk assessment. All staff have a personal and collective responsibility to ensure that supervision, PDR’s and appropriate levels of training and education are maintained to ensure registration compliance, safe and high quality delivery of service.