

CRISIS RESOLUTION & HOME TREATMENT TEAM

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Aims and Objectives

- What is Crisis Resolution Home Treatment?
- Explore the term “crisis”
- Examine the pathway from referral to assessment to employing appropriate treatment
- CRHT Staffing structure
- What is risk and risk management?
- Brief look at Mental Health Problems
- Dual Diagnosis and where CRHT fit in the pathway
- Questions?
- Case Summary Discussion

Government Policy

- The National Service Framework for Mental Health (1999) called for mental health services to be available 24 hours a day, 7 days a week in the community for people in mental health crisis.
- The NHS Plan (2000) stated the Government's intention to modernise mental health services, including the introduction of Crisis Resolution Teams.
- Darzi Report (2008) extending services in the community, continued quality and improvement (cquin).
- New Horizons (2009) CRHT and acute care pathways, gate keeping and the *Acute Care Declaration*.

What is a crisis?

- *‘person experiencing acute distress, and is presenting with significant risk of self harm, deterioration/neglect or harm to others which requires treatment and support more intensive than that which can be offered by CMHT or other non-acute service’*
- *‘the person would require hospitalisation if they were not seen by the team’*
- *‘the person needs to be seen within 24 hours’*

Emergency Service?

- CRHT is not an emergency service, the service aims to assess within a 4 hour period, however there may be occasions when this may have to be extended
- Emergency can be defined as ‘ a life threatening situation demanding an immediate response’, should there be an immediate risk to an individual or to others, Emergency Services should be contacted via 999
- Difficult boundary between emergency and crisis, take a pragmatic approach – if there is an urgent mental health need for professional intervention which meets the CRHT criteria give us a call.

Crisis Resolution and Home Treatment (CRHT)

CRHT is the first point of access for service users who present in a crisis.

CRHT provides assessment (if appropriate) and access to mental health services for Leeds residents between the ages of 18 - 65 within statutory and voluntary sector

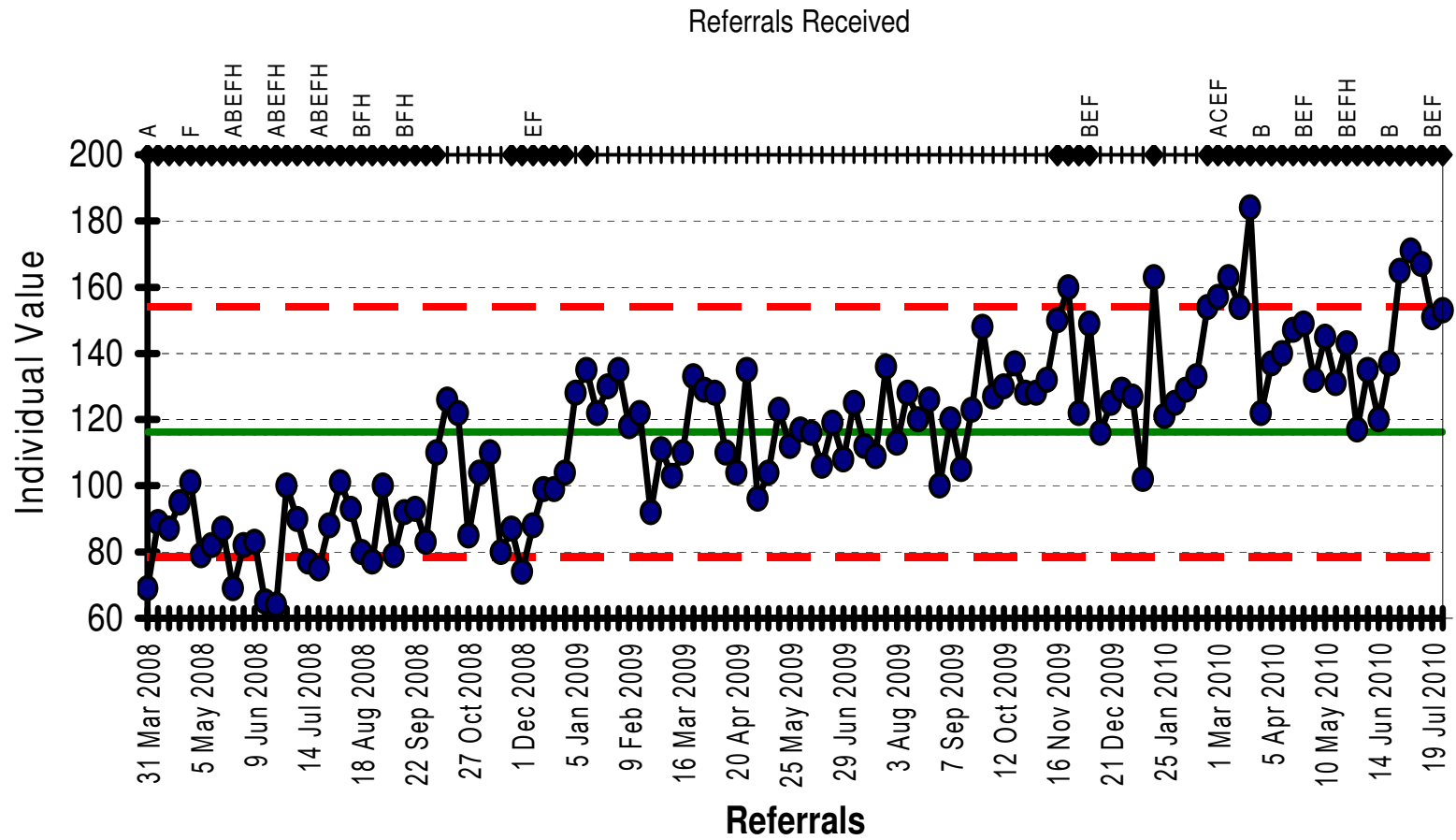
Roles of CRHT

- Provide assessment of acute mental health needs
- Gate keep acute mental health services
- Provide intensive community based support
- Signpost to appropriate services
- Provide support, education, advice to relatives and carers
- Facilitate early discharge from inpatient services
- Facilitate assessments under Section 136 and MHA, (1983)
- OAT's initiative – overnight suite

Additional information

- Not total Gate keeping, CRHT are responsible for around 50-60%
- 40-50% come from Mental Health Act Assessments, or direct referrals into hospital from A&E liaison and Acute Community Services (ASC).
- Referrals to the service fluctuate daily, CRHT triage the referrals, within a 24 hour period we have been known to assess up to 12 individuals and on other days as little as 1.
- Section 136 Assessments can also fluctuate from 0 to over 10 in a 24hr period.

CRISIS RESOLUTION



Home Treatment Structure

- CRHT operate a zoning system to reflect the level of risk and required support for all patients on home treatment.
- RED – seen daily and often if their need reflects it more than once i.e. Medication compliance.
- Amber – seen every other day, sometimes there may be longer periods between face to face contact, support calls offered between face to face contact.
- Green – This indicates that the patient is ready for transfer and planning has occurred with care co-ordinators.
- There is no maximum for Home Treatment and the service has supported in excess of 30 individuals.

Section 136 Service

- Local Inter-agency Commissioned, but lies within accepted national guidelines.
- Partners - Leeds PFT, Leeds Teaching Hospitals, West Yorkshire Police, British Transport Police, Leeds PCT, Yorkshire Ambulance Service and Leeds City Council Social Service Department.
- Police detention, individual considered to be suffering from a mental disorder and to be in need of care, they may be at risk or present a risk to others can be removed to a place of safety for max of 72hrs for assessment.

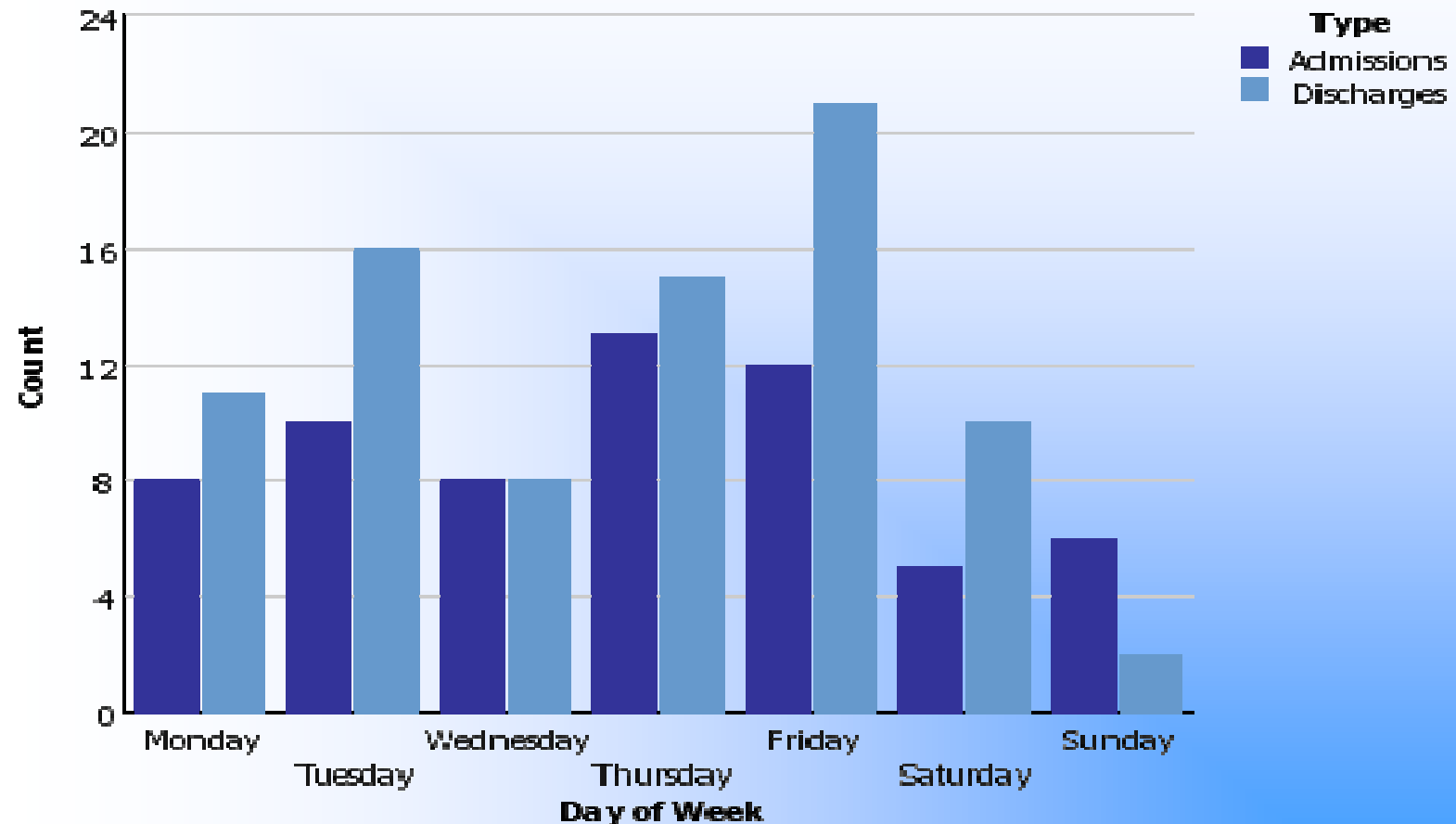
S136 Service (figures)

- It was suggested as the service was developed (2005) that there would be around 500-600 referrals a yr.
- 2007 – 565 (10 month figure)
- 2008 – 641
- 2009 – 822
- 2010 – 475 (6 months) est. 950+
- Example of average months referrals, (June,2010):
89 detentions s136, 84 of which were related to risk of self injury.
36 were referred back to GP, 5 to addiction services and the rest into mental health services (many already involved with services).
15 were admitted into mental health inpatient care.

Over Night Suite

- Will open on 7th September 2010.
- Designed to help alleviate capacity pressures within acute inpatient care.
- Will operate 17.00 through to 9.00 the following morning. Designed to stop out of area admissions.
- 4 beds for out of hours admissions if no vacant bed exists already within the inpatient structure.
- Mixed ward. Transfer to main ward will occur 08.30.
- Zoning system will operate on the wards to indicate who is most suitable for transfer to another area of the acute care pathway.
- Patient and family will be involved throughout the discussion to enable best care provision.
- System wide approach with all services monitoring capacity and providing appropriate transfer. i.e. CMHT discharge to primary care.

Becklin Centre Admissions and Discharges by Weekday: July 2010



Acute Community Services

- 5 ACS different regions and CMHT specific.
- South, east, west, north-east and northwest.
- Open from 8.00-20.00 m-f and 10.00-18.00 w/e.
- Additional support with CRHT - access to care line or even arranged home visits.
- Shared care with inpatient service – patients go for a day and return to ward.
- Offers psychosocial interventions, group work, 1-1 time and regular medical reviews - Consultant cover via CMHT.

Who can refer?

- Community Mental Health Teams
- A+E Liaison Psychiatry/Self Harm Team/Duty SHO
- GP's & Primary Mental Care Practitioners
- Social Services
- Police
- NHS Direct
- Other Mental Health Service Providers (statutory/Non Statutory)
- Self-Referral, By prior agreement

Prompts For Triage

- **What is the reason for the referral?**
- **Do they have any history with mental health services?**
- **What are the main risks currently & historically?**
- **To self -**
- **To others -**
- **Current Presentation –**
 - **Mood,**
 - **Sleep,**
 - **Appetite,**
 - **Concentration,**
 - **Behaviour,**
 - **Energy Levels & Motivation,**
 - **Anxiety, agitation, anger,**
 - **Thought disorder**
 - **Hallucinations**
 - **Delusions (Grandeur, & Persecutory / Paranoid)**

Cont.d

- Do they have a diagnosis?
- Are the risks Acute or Chronic?
- When did you see them?
- How urgently do they need to be seen?
- Do they know they have been referred?
- Are they happy to see us?
- What have you tried to address these risks?
- What is their current medication regime?
- Has medication been reviewed recently?
- Are there any physical problems?
- Do they use Alcohol & Drugs?
- Does the referrer have any information they could fax over to CRHT?
- Do they have a Care Co-ordinator? Have you spoke with them?
Can a Joint Assessment take place?
- Is it safe to see them at home?

Exclusions?

- Moderate – severe learning disability
- Organic brain disease
- **Primary drug and alcohol use**
- Mild to moderate mental health problems
- PTSD
- High level of presenting dangerousness
- In situations where specialist skills/services are required

Outcome of assessment

Most appropriate outcome for the service user, '*at that time*':

Admission to inpatient services

Intensive community based support

Engagement with ACS

Referral to CMHT

Signposting to statutory/non statutory services i.e.
Counselling, addiction services

Signposted to GP

Staff Structure

- Acute Services Manager
- Operations Manager
- 2 Consultant Psychiatrists
- 1 Specialist Registrar
- 1 Educational Staff Grade
- 2 Junior Doctors
- 1 Clinical Team Manager
- 5 Band 7 Clinical Lead Practitioners
- 18 Band 6 Nurses
- 11 Band 5 Nurses
- 4 AMHP's (Approved Mental Health Practitioners))
- 6 Community Support Workers

Shift Cover: 24/7

- Day shift 8.30-21:00 – 8 practitioners
- Night shift 20.30-9:00 – 6 practitioners + AMHP until 01:00
- Monday – Friday (09:00 – 17:00) : medical cover.
- Throughout the shifts a number of students from various disciplines

Risk

Demographic factors

- Increasing age
- Low socio-economic status
- Unmarried, separated, widowed
- Living alone
- Unemployed

Background history

- DSH (with high suicide intent)
- Childhood adversity
- Family history of suicide
- Family history of mental illness

Best practice in Risk
Management –DoH 2007

Risk

Clinical history

- ▶ Mental illness diagnosis (depression, bipolar disorder, schizophrenia)
- ▶ Personality disorder diagnosis
- ▶ Physical illness
- ▶ Recent contact with psychiatric services
- ▶ Recent discharge from inpatient facility

Psychological and psychosocial factors

- Hopelessness
- Impulsiveness
- Low self esteem
- Relationship instability
- Lack of social support

Best practice in Risk Management DoH 2007

Risk

Current 'context'

- Suicidal ideation
- Suicide plans
- Availability of means
- Lethality of means

If in doubt seek further
advice

Best Practice in Risk
Management DoH 2007

- **Twelve Points to a Safer Service**

- In this report and in *Safer Services* we have presented a series of recommendations that address policy and practice in mental health. Below we list what we consider to be the most important clinical recommendations from both reports. This is intended as a checklist for local services.

- _ Staff training in the management of risk – both suicide and violence –every 3 years
- _ All patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care
- _ Individual care plans to specify action to be taken if patient is noncompliant or fails to attend
- _ **Prompt access to services for people in crisis and for their families**
- _ Assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients
- _ Atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with “typical” drugs because of side-effects
- _ **Strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service**
- _ In-patient wards to remove or cover all likely ligature points, including all non-collapsible curtain rails
- _ Follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months
- _ Patients with a history of self-harm in the last 3 months to receive supplies of medication covering no more than 2 weeks
- _ Local arrangements for information-sharing with criminal justice agencies
- _ Policy ensuring post-incident multi-disciplinary case review and information to be given to families of involved patients

- http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058243.pdf

Mental Health Problems

- 1 in 4 people will experience some form of mental health problem
- Varying degrees of mental illness
- Various interventions
- Mainly managed within society or primary care

Self Harm

- Quite common 5–10% of population
- Various methods, varying severity.
- Various reasons – e.g. symptomatic relief, suicide attempt
- Reasons often unclear
- Often with alcohol
- Often repeat.
- Increases risk of suicide (50 – 100 times)
- Safety (assessment)
- Engage with the person involved
- Prompt treatment
- Clear about role (limitations)
- Consent and capacity

Suicide

- 11-20 per 100,000 each year, depending on source of data.
- All ages
- 25% contact with MH services within the year
- Hanging / Strangulation and Self poisoning most common.
- Assessment of risk is a specialist area

*National Suicide Prevention
Strategy for England –DoH
2007*

Personality Disorders

- Various types
- Mainly involved with Emotionally Unstable Personality Disorder and Borderline types.
- Difficulties with relationships
- Perceptual abnormalities
- Self harm
- Labile mood
- Substance misuse
- Risk taking behaviour / impulsivity

Psychosis

- Schizophrenia (1% pop)
 - Very often paranoid.
 - Variable presentation.
- “Psychotic” symptoms
 - Hallucinations, delusions, thought disorder
 - Mood / affect abnormalities
 - Behavioural disturbance
- Bipolar Affective Disorder (BPAD, 1% pop)
 - Episodic
 - Mood symptoms

Anxiety and Depressive Illness

- Very common
- Very variable in presentation
- Mainly treated in primary care (?)
- Tends to be chronic / recurrent
- Associated with: alcohol, irritability, substance misuse, physical health problems, Social situations etc.

Dual Diagnosis

- Substance misuse in diagnosed psychotic illnesses is around 20-40%.
- Upto 50% of all individuals with mental health problems may misuse alcohol or drugs.
- CRHT work closely with all partners within the dual diagnosis network.
- Primary concern should be mental health related, referrals from addiction services tend to be connected to risk – CRHT can assess and support but cannot intervene with existing treatment or commence opiate treatments.
- Triage can facilitate support to callers and where fitting advise on appropriate care pathways.
- Alcohol detoxifications can be provided if the service user is in acute care, being treated for mental health related disorders.

Useful numbers

- CRHT triage 01 13 3056690 (professional referral line only)
- CRHT office 01 13 3056683 (9-5 mon to fri)
- Email: adrian.elsworth@leedspft.nhs.uk

**Thanks for
listening
Any
Questions**

Case Summary

- Female, aged 18.
- Lives with boyfriend
- Parents involved however client is ambivalent concerning their input.
- Good childhood – no significant markers – relationship with mother described as best friends while growing up. Born and remained in London till age 11.
- Never knew biological father, mother remarried when client aged 8.
- Went to dance school at early age (17) in Dundee – plan was to start at 18 in London – while in Dundee was sexually assaulted.
- Left college and returned to Leeds (mothers address) regular trips to Dundee for court preparation.
- First seen in September 2009, 4 months post assault – no identified mental health needs – had argued with mother and left. Stayed in hostel accommodation then with her boyfriend.
- Relationship dynamics present.
- No identified risk when first assessed. No alcohol or illicit drug use reported.
- Asthmatic
- Enjoyed dancing – contemporary and ballet. Had been teaching hip-hop dancing.
- Assessment concluded support through STAR only.

- Mother had her own mental health needs and the assault appeared to have surfaced an incident that the mother had been involved in as a young woman.
- Services involved with mother, frequent assessments occurred with identified need as psychological – ref accepted by psychotherapy.
- Occasional referral would occur for the mother each time this was associated with relationship dynamics with the client.

- New referral for the client august 2010 – referral request from mother. Client contacted who did not feel the need for an assessment.
- Mother unhappy and complaint sent in.
- Mother also self referred her daughter to detox 5. Currently reported to be using £10-£30 heroin daily, undisclosed crack cocaine and alcohol. With previous reported use of amphetamines and Mkat. This had been occurring since beginning of 2010.
- The client's mother who appears to have been attempting to support her believed her daughters problems were similar to her own and was using substances to “block-out” her emotions. She was reported to be suffering from PTSD.

- Detox 5 requested follow-up before admission to their unit. It was suggested to the GP that a referral to CMHT would be beneficial – no communication was suggested with addiction services.
- CRHT were asked to arrange an acute bed for her post detox, this was refused.
- Frustrations increased in the mother with increase calls to various services.
- Mental Health Act Assessment conducted, formulation –
- 19 year old girl presenting with poly substance abuse and possible Heroin dependence. She is due to attend detox and rehab from tomorrow (but this looks precarious after today's events). There are very complex dynamics with her mother. She is very vulnerable and the risk of abuse and exploitation is high given her drug use but there is no evidence of severe and enduring mental illness currently in terms of psychosis or significant depression.

- **Questions?**
- **What is the appropriate care pathway?**
- **What is the primary diagnosis?**

References

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