



**Delivering for Health:
Delivering for Mental Health
National Standards for Crisis Services
November 2006**

“National standards will be developed and published for crisis services and out of hours work, based on the crisis pilots funded by the Executive.”

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Crisis response and resolution services to reduce hospital admissions and repeat admissions

The crisis function of any NHS, local authority (LA), Voluntary Sector or joint service is to address prevention, intervention and recovery through the management of individuals during periods of acute illness, relapse or mental distress.

In all cases and for all arrangements crisis services should link with longer term mental health agencies who should retain lead responsibility for individual care from completion of acute episode or resolution of crisis and discharge to recovery.

Crisis response may be delivered in a number of ways, reflecting the needs of local areas and settings and will include, but not be restricted to, specialist crisis teams, community mental health teams, outreach teams and other services.

1. OBJECTIVES

- 1.1 To provide an alternative to unnecessary admission/alternative to unnecessary statutory referral for people experiencing an acute mental health crisis.
- 1.2 To provide assessment, intensive home treatment or other relevant crisis resolution input.
- 1.3 To ensure people experiencing severe mental health difficulties are treated and/or assisted in the least restrictive environment.
- 1.4 (Where the function is from a separate team); to provide short-term management of an individual's care during a period of acute relapse.
- 1.5 (Where crisis services are provided out with the community mental health team); to work in conjunction with (and transfer lead care at the appropriate point) to the community mental health team key worker.

2. ELIGIBILITY CRITERIA

- 2.1 People with first onset of severe mental illness.
- 2.2 People with severe mental illness and/or psychotic relapse undergoing a period of acute crisis or relapse.
- 2.3 People experiencing a crisis that without professional or crisis service intervention might require hospital stay.
- 2.4 People who may benefit from short term intervention to prevent longer term reliance on mental health services.

3. OUTLINE QUALITY OBJECTIVES

- 3.1 Response time from approach to intervention **no more than 4 hours**.
- 3.2 Overall contact (receiving crisis intervention or support from a specialist service or a CMHT or other linked service) should be **no longer than 21 calendar days** unless exceptional circumstances apply.

4. WORKFORCE INTERVENTIONS

- 4.1 NHS Boards will lead on the following core specialist functions. Consistent with the needs of individuals in crisis, (high risk/dynamic and intensive) this will include:
- Risk assessment;
 - Medication management;
 - Managing challenging behaviour;
 - Managing process from crisis to resolution;
 - Successful client engagement;
 - Holistic approaches; and
 - A focus on client strengths (as opposed to illness model).
- 4.2 Social Work Departments will have cross cutting interest in joint working and will lead on:
- Screening, assessment and care management;
 - Social care, either directly provided by LA or commissioned/purchased from other providers;
 - Mental Health Officer services; and
 - Work with service users and informal carers to reduce the likelihood of a crisis occurring or recurring. This includes giving information, and/or arranging relevant services or supports.
- 4.3 Some functions will apply to specific professions and a multidisciplinary skill mix will be required to protect this capacity.

5. ROLES AND INTERFACE

- 5.1 The NHS has lead responsibility for overview, gatekeeping, care co-ordination and referral to inpatient beds.
- 5.2 The long-term care and case management responsibilities will remain with the generic community function or team who will maintain standard levels of engagement.
- 5.3 There should be clear guidelines and agreed protocols for Consultant and Senior House Officer responsibilities across all community team interfaces (i.e. who, what, when and where) as part of the Psychiatric Emergency Plan for each NHS Board area.
- 5.4 Where age consideration applies protocols should be agreed for referrals and supported transitions to child, adolescent and old age psychiatry services.
- 5.5 Those areas without crisis services will require all specialist teams to include crisis response within their protocols.

- 5.6 Long-term management is the lead responsibility of the community team. Day to day care management lead will be held by the crisis service, where one exists.
- 5.7 All staff directly or indirectly involved in crisis prevention, response or resolution should have appropriate (and ongoing) training and skills development.
- 5.8 Crisis services should form part of a stepped care system in the Community Health Partnership ranging from community support to primary care interventions to specialist secondary care intervention in the community and acute in-patient care.
- 5.9 Levels of need should be matched to the level and duration of intervention. Interventions should be delivered in response to need by the most appropriate agency.
- 5.10 Where no dedicated out of hours service is provided support should be available through NHS Accident and Emergency and Social Work standby services.

6. OUTCOMES

- Reduce hospital admission rates by 10% (by end December 2009).
- Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% (by end December 2009).

There will also be qualitative measures which will incorporate the following:

- Acceptable locations for and quality of care to service users.
- Improvement of service user experience in management of episodes of crisis care; and
- Increase/improve social inclusion.

Work is being taken forward as part of the Mental Health Delivery Plan on the development of a Scotland wide tool to assess the values, ethos and principles of all mental health services. This will provide a basis for assessing qualitative measures in crisis services.

7. TIMETABLE

Delivering for Mental Health (December 2006) confirms the expectation that local agencies and partners work together to deliver crisis services and responses in line with the standards set out in this document **by end December 2009**.

Approaches to Delivery

Wider quality of service and service user outcome considerations must apply over and above delivering on the target outcomes listed, which in themselves are quality based. In organising crisis prevention, intervention, recovery services and approaches agency partners are invited to consider and adopt the following minimum functions

Mental Health Crisis Services should:

1. Be predominantly community based;
2. Consider referrals from all sources, including self referrals, those from the Police, Social Work, Community Psychiatric Nurse, GP etc;
3. Have prompt access (including direct referrals) to inpatient NHS care when required;
4. Address health and social support needs including medication management;
5. Offer safe alternatives to hospital admission;
6. Have partnership links with all other services: within the NHS, (including A&E); Local Authority (Social Work and housing); Private and Voluntary Sector agencies; the Police; and other relevant services;
7. Have agreed protocols specifying conditions/situations where referral to the crisis service would be inappropriate;
8. Provide a responsive service 24/7; (alternatively operate accessible, safe out of hours arrangements perhaps linking with an access and signposting service such as NHS/24;
9. Incorporate a telephone helpline, walk-in services, outreach and overnight care where appropriate;
10. Have operational, delivery and outcome links with the local Psychiatric Emergency Plan;
11. Provide information and support for carers for individuals in crisis. This should include information on services provided by the NHS Board and partners for carers; and
12. Have agreed protocols for information sharing and feedback.



Standards

All approaches and delivery of crisis services in Scotland should comply with the following standards, which set the minimum expectations.

1. Access and Availability

Standard	Delivery Objectives	Operational Criteria
<p><i>“Crisis services should provide community based accessible, appropriate and immediate interventions which aim to prevent or reduce the impact of a crisis. Prompt and timely support should be offered to those in crisis at hours when they are most needed.”</i></p>	<p>The aspiration should always be toward 24/7 cover. For those services not operating 24/7, accessible alternatives should be provided out with the core hours of operation, (e.g. out of hours helpline, links to other services, NHS 24 etc).</p> <p>In designing a care response account should be taken of service users and carer’s own assessment of the crisis. If the service is not placed to meet the assessed needs, information should be given on alternative options and services.</p> <p>Unavoidable delays should be communicated to service users, their carers and/or referring organisations, with an anticipated response time.</p>	<p>Operational protocols agreed (who, what, where over the 24-hour period) in partnership with all relevant services and agencies;</p> <p>Minimum target for response times agreed based on available resources including staffing levels;</p> <p>Arrangements in place to ensure immediate 24-hour access to medication support, including administration of medication, monitoring of side effects and information on medication/side effects;</p> <p>Referral protocol agreed and in place to ensure timely supported transitions;</p> <p>Current information and advice provided to service user and/or carer on alternative support organisations;</p> <p>Complaints procedures in place;</p> <p>Literature and information available on crisis service organisation and values with contact details throughout the 24-hour period;</p> <p>Procedures in place to record and feedback on referral outcomes to service users, carers and referring agencies;</p> <p>Protocols in place for links with NHS 24 and other out of hours telephone response services.</p>

2. Planning and Delivering Support

Standard	Delivery Objectives	Operational Criteria
<p><i>“Assessment and planning processes promote recovery and take account of the service users’ own resources and support structures”.</i></p>	<p>Assessment procedures need to actively engage the individual and their carers or other support organisations, as appropriate, to learn about the nature of the difficulties and what would help most.</p> <p>There should be a focus on the individual’s strengths underpinned by the principles of recovery. Approaches should support the individual toward self-awareness, to consider own resources and support systems and focus on solutions.</p>	<p><i>Assessments should:</i></p> <p>Take account of current medication, including effectiveness, side effects, need for access to information or support regarding medication or dosage;</p> <p>Focus on the individual’s strengths and on recovery;</p> <p>Are a collaboration between the service user and their carer;</p> <p>Take account of all aspects, including physical health and social environmental factors including relationships, housing and employment status;</p> <p>Ensure alcohol or drug misuse does not compromise planned service response; and</p> <p>Address childcare and needs of other dependants.</p>

	<p>Planning and agreeing support should be a collaborative process at all levels of intervention, including those where risk is identified. Where this is not possible advance statement or crisis plans should be identified to establish the wishes of the service user concerned. Limitations may arise where there is a high level of risk and where compulsory interventions may be necessary.</p> <p>Risk should be openly and honestly discussed by all parties and arrangements for managing risk should be clearly and comprehensively set out. Advance statements and crisis plans should be accessed if available.</p> <p>To engender ownership planned interventions should be agreed (wherever possible) with the service user and their carer.</p>	<p><i>Interventions should:</i></p> <p>Take account of the strengths, coping strategies and support networks of the service user and focus on sustained recovery and social inclusion;</p> <p>Support service users to maintain contact with family and community networks;</p> <p>Provide opportunities for service user and carer to explore strategies for preventing recurrence and managing crisis;</p> <p>Be specified within service plans, including the level and duration of planned intervention.</p> <p><i>Risk assessments</i></p> <p>Protocols in place covering Risk Management based on principles of least restrictive alternative and which:</p> <ul style="list-style-type: none"> • Outline the therapeutic value of risk; • Ensure all aspects of safety priority; • Anticipate scenarios where disparity of views arises on care options.
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	<p>Where possible, interventions should be delivered at the first level of service available and referred to services with more specialist skills as required.</p> <p>Wherever possible, interventions should build on service user's own coping strategies and support networks and promote social inclusion.</p>	<p><i>Protocols in place:</i></p> <ul style="list-style-type: none"> • on meaningful involvement of service users/carers; • to ensure advance statements, where they exist, are considered and implemented; • on child protection policies and procedures with arrangements for links/referrals to child and family support services as required; • to support individuals who self harm (including substance misuse); • to link service users with longer-term support to address physical health issues, (e.g. self harm, alcohol and drug misuse services); • Referral criteria agreed that ensures self-harm (including substance misuse) is not a barrier to appropriate service response; • Structures in place for contact with specialist pharmacological services.
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3. Promoting Equality and Respecting Diversity

Standard	Delivery Objectives	Operational Criteria
<p><i>“Service responds to diverse needs and carries out its functions in a manner which encourages equal opportunity”</i></p>	<p>The diversity of the individual should be a recognised factor in determining a successful outcome to all contacts. Assessments, interventions and ongoing support.</p> <p>Every effort should be made to anticipate and remove all physical and other barriers, (perceived or otherwise) for those seeking support. This will involve links to interpreting services, addressing the built environment for suitability/accessibility and addressing any workforce needs.</p>	<p>Equality and Diversity policies and procedures in full compliance with current legislation;</p> <p>Annual Equality Impact Assessments carried out and findings implemented;</p> <p>Structures in place to ensure regular communication and consultation with equality groups, on all aspects of the service with an equality impact;</p> <p>Monitoring and Review processes in place to take account of the experience and quality of diverse communities contact with service;</p> <p>All service information and approaches take account of diversity issues (literacy, translation, alternative formats).</p>

4. Resolution and Discharge

Standard	Delivery Objectives	Operational Criteria
<p><i>“Crisis services negotiate and develop discharge and follow up plans collaboratively with service users, incorporating the views of their carers and relevant services (where reasonable and applicable) providing opportunities for reflection”</i></p>	<p>Ongoing planning for supported transition to other services should form part of the assessment and other engagement. That consideration should also have a retrospective dimension for reflection of what interventions helped resolve the crisis.</p> <p>Agreement on timely transfer of lead responsibility is critical to helping service users and their carers make informed choices and ensuring that they experience a smooth transition from the crisis service to wider mainstream support.</p>	<p>Plans are developed in collaboration with and (where reasonable and applicable) incorporate the views of services users and their carers.</p> <p>Longer-term support needs are identified.</p> <p>Structures are in place to link with other services to provide support during the transition from crisis services (mentoring, befriending, mediation and advocacy services).</p> <p>Information is provided to service users and their carers on transition support following transfer from crisis to mainstream services.</p> <p>Information is provided regarding the crisis, interventions accessed and plans for longer-term support, which can be exchanged with community support services.</p> <p>Information is exchanged in observance with relevant legislation, policies and procedures e.g. confidentiality policies.</p>

5. Service User Involvement

Standard	Delivery Objectives	Operational Criteria
<p><i>“Service users are supported to actively and positively participate in decision-making within individual support plans, and have opportunities to contribute to the planning and development of the service”.</i></p>	<p>Crisis models should be informed by and developed around the needs of service users. The meaningful participation of service users and their carers should be central to all considerations and at all stages.</p> <p>Service users may require support to participate in planning, and the role of collective advocacy organisations and user led organisations in supporting participation should be considered, as should skills training and mentoring approaches.</p> <p>All staff should understand their responsibilities to involve service users and carers.</p>	<p>Service users supported to participate in assessment, intervention planning and transition planning processes;</p> <p>Staff training needs and performance addressed to ensure meaningful user involvement;</p> <p>Service users provided with a copy of assessment (including risk) and planning documentation;</p> <p>Service users and others provided with the opportunity to feedback on the service and support offered at all stages;</p> <p>Service users are supported to reflect on the risk management strategies adopted;</p> <p>Risk management valued as a therapeutic process and assessments are carried out collaboratively between services and service users, providing opportunities for service users to identify risks and potential coping strategies for managing risk;</p> <p>Service users linked with local collective advocacy organisations;</p>

		<p>Working partnerships established with service user led organisations for input on practice and/or policy developments; and have</p> <p>Access provided to independent advocates for information, advice and support including assistance with advance statements.</p>
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6. Supporting and Involving Carers

Standard	Delivery Objectives	Operational Criteria
<p><i>“Carers views are incorporated in support plans (where reasonable and practicable, and carers have opportunities to contribute to the planning and development of the service”</i></p>	<p>All relevant legislation and rights to confidentiality must be observed in delivering this standard.</p> <p>Carers own support and information needs should be considered and addressed to ensure that their own health is not at risk and that are supported to link with services, particularly in terms of their role in the ongoing aspect of care.</p>	<p>Carers views (where appropriate, reasonable and practicable) and consideration of their capacity to cope are taken into account, always in observance of the service user rights to confidentiality and their wishes.</p> <p>Carer involvement policies and procedures are in place which:</p> <ul style="list-style-type: none"> • Take account of the carer’s own needs and capacity to cope; • Support carers to participate within service planning and development; and have • Outline arrangements to link with carer organisations. <p>Carers are provided with access to information on medication and potential side effects where appropriate; and</p> <p>Structures are in place to link carers with organisations that provides carers with support, information and/or training.</p>

7. Training/Workforce Development

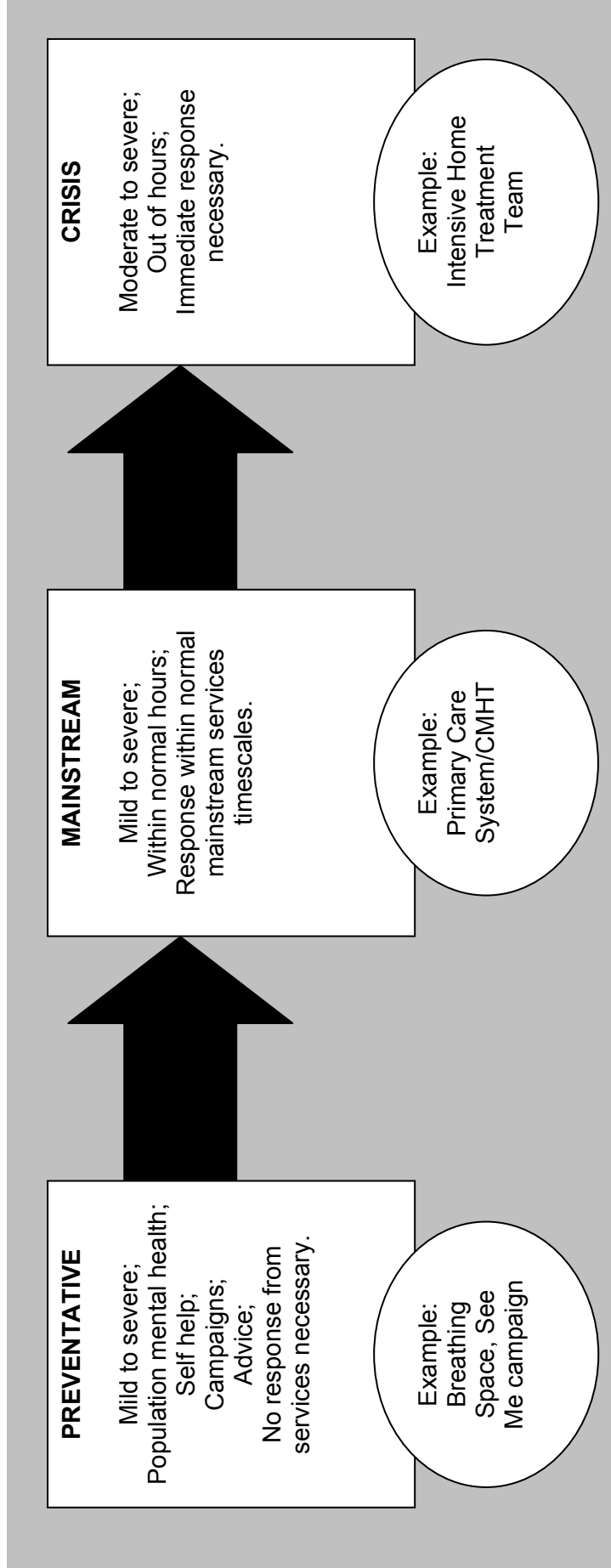
Standard	Delivery Objective	Operational Criteria
<p><i>“A local training framework is in place, ensuring crisis services are provided by staff trained and skilled in managing risk, delivering strengths based mental health interventions that compliment and value existing support mechanisms”</i></p>	<p>Mental health crisis services should feel confident in their ability to deliver appropriate interventions and manage risk.</p> <p>Agency training frameworks Joint training (wherever possible) should ensure that all interventions and approaches support the principles of recovery, social inclusion, equality and recognise diverse needs. The user and carer experience should be recognised within training strategies.</p> <p>Mental health crisis services should work with partner agencies to promote awareness and best practice.</p>	<p>All staff with direct contact with service users and carers have received training on the following (as a minimum):</p> <ul style="list-style-type: none"> • suicide prevention • basic counselling skills • best practice in relation to self-harm. • promoting recovery safety and therapeutic risk management • alcohol and drug misuse • equality and diversity. <p>All training is monitored, reviewed and evaluated regularly.</p> <p>All staff have personal training plans with access to local and national training.</p> <p>Clinical staff have access to psychopharmacology training.</p> <p>Service users and carers have opportunities to contribute to staff training.</p> <p>Service users and carers engaged in the development of the service provided with appropriate training.</p>

8. Working with Communities

Standard	Delivery Objectives	Operational Criteria
<p><i>“Crisis services work in partnership with other mental health services and wider community organisations, to ensure that service developments are accessible, responsive to community needs and complement existing services”</i></p>	<p>Crisis services should be an integral part of local service provision providing smooth transitions for service users between services and providing opportunities for practice development, sharing of skills, knowledge and specialist experience across services.</p> <p>Crisis services should forge partnerships, and work alongside and complement existing services. Joint working will ensure best use of available resources.</p> <p>Accessible up-to-date information on available services will increase awareness for services, users of services and carers on support and the role of the crisis service.</p>	<p>Protocols in place which:</p> <ul style="list-style-type: none"> • Outline roles and responsibilities between the crisis service, and services which most often form the first point of contact e.g., Help Lines, GP’s, Police and A&E departments; • Ensure safe and supported transitions for the services user, including referral arrangements, sharing of information, and arrangements for transfers and follow up; • Provide bridging support between the crisis service and the wider community, such as mentoring, befriending, mediation and advocacy services; • Support service users to link with wider community resources, which provide physical healthcare support;

		<ul style="list-style-type: none"> • -Where shared referral and assessment processes are not in place, arrangements in place to communicate information across services; • Information exchange established by partner agencies covering referral criteria, hours of operation and contact details; • Shared approach adopted for referral and assessment processes; • Joint working with wider health and community organisations, through community partnership arrangements is promoted; and • Attention given to anticipatory support (Woman's aid, drugs and alcohol services, welfare advice services etc).
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CRISIS SERVICE FUNCTION IN MAINSTREAM SERVICE CONTEXT



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This document is also available on the Scottish Executive website:
www.scotland.gov.uk