London mental health crisis commissioning guide

NHS

**London
Strategic Clinical Networks**

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ACKNOWLEDGEMENTS

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PREFACE

In setting up London's Mental Health Strategic Clinical Network it was clear that something different was needed; something that represented more directly the different narratives that exist around mental health and illness. The response to individuals in crisis has always been critical – when your mental health breaks down the pain is every bit as real as when you break your leg – and it is our responsibility as health and care professionals to respond as quickly.

Dr Geraldine Strathdee, national clinical director for mental health, always reminds us that the best crisis is a crisis averted – and we can all think of cases where things could so easily have been prevented. But we will never eliminate every case and we must be prepared.

Indeed we are, in many ways, at a moment of real possibility in relation to mental health. Increasingly, a body of ideas is being shared that together represent a coherent direction of travel. Care and support moving further out of hospital towards home; moving from prescription to partnership in working with empowered citizens and patients; seeing the development of resilience and health promoting communities as key ingredients for real population health; and working towards holistic approaches that bridge the mind-body divide that we have artificially created.

I am grateful to all who have contributed to this work, particularly those people who have lived this experience which grounds us in why it is so important. As one participant reminded us, "I actually say you're never out of crisis; everybody's in crisis it's just how you cope with your life -- and everyone's different, everybody copes differently."

There is much in this guide and the manual that goes along with it to provoke us all to rethink our response to crisis, and a clear mandate from those who use our services to make some changes. We hope it provides inspiration to you all.

Dr Matthew Patrick
Clinical Director, London Mental Health Strategic Clinical Network
Chief Executive, South London and the Maudsley NHS Trust

PREFACE

Whilst the aim should always be to prevent individuals experiencing mental health crisis, the nature of mental disorders is such that, from time to time, and in response to the stresses that individuals can experience people will experience a crisis. When this happens it is clearly essential that appropriate support and treatment is readily available. The Government's commitment to parity of esteem should ensure that crisis services available for those with mental health difficulties, are comparable to the services available for individuals presenting with acute medical and surgical problems. This, unfortunately, is not the case.

Across London in recent years we have seen a number of innovative services develop, and examples of high quality care. In addition, the relationship between the capital's secondary mental health providers and primary care has undoubtedly improved. Practice, however, remains variable and the variety of crisis services currently being delivered has resulted in a landscape for service users and their carers which is often difficult to navigate.

This document, which has been compiled following extensive analysis and consultation, contains standards for the future commissioning of crisis services and covers twelve key areas of service delivery. The aim therefore is to ensure the consistent delivery of high quality, responsive crisis care which reflects and meets the needs of all service users and their carers. The standards build on work already on going regionally and nationally, and in addition, reflect best practice identified across the world.

London is committed to ensuring that the recommendations outlined in the Crisis Concordat are acted upon in order to deliver better crisis services. The standards we advocate form part of the London's comprehensive response to the Concordat.

Dr Nick Broughton
Chair of Urgent and Crisis Care, London Mental Health Strategic Clinical Network and
Medical Director, West London Mental Health NHS Trust

EXECUTIVE SUMMARY

The Mental Health Strategic Clinical Network has produced a set of standards and recommendations for commissioning mental health crisis services across London. To develop the standards, the network has analysed existing mental health crisis provision, reviewed literature, cross referenced against other guidance such as that produced by NICE, identified case studies and consulted people with lived crisis experience. The commissioning standards therefore were devised to reflect what people should expect from London's mental health crisis services. They are embedded within twelve subject areas, mirroring the Crisis Concordat approach including;

» Access to crisis care support
» Emergency and urgent access to crisis care
» Quality of treatment of crisis care
» Recovery and staying well

The following standards are to be refreshed in the future and are our first initial step to improving mental health crisis.

Access to crisis care support

1. Crisis telephone helplines	» A local mental health crisis helpline should be available 24 hours a day, 7 days a week, 365 days a year with links to out of hour's alternatives and other services including NHS 111
2. Self-referral	» People have access to all the information they need to make decisions regarding crisis management including self-referral
3. Third sector organisations	» Commissioners should facilitate and foster strong relationships with local mental health services including local authorities and the third sector
4. GP support and shared learning	» Training should be provided for GPs, practice nurses and other community staff regarding mental health crisis assessment and management

EXECUTIVE SUMMARY

Emergency and urgent access to crisis care

5. Emergency departments	» Emergency departments should have a dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis
6. Liaison Psychiatry	» People should expect all emergency departments to have access to on-site liaison psychiatry services 24 hours a day, 7 days a week, 365 days a year
7. Mental Health Act Assessments and AMHPs	» Arrangements should be in place to ensure that when Mental Health Act assessments are required they take place promptly and reflect the needs of the individual concerned
8. Section 136, police and mental health professionals	» Police and mental health providers should follow the London Mental Health Partnership Board section 136 Protocol and adhere to the pan London section 136 standards

Quality of treatment of crisis care

9. Crisis housing	» Commissioners should ensure that crisis and recovery houses are in place as a standard component of the acute crisis care pathway and people should be offered access to these as an alternative to admission or when home treatment is not appropriate
10. Crisis resolution teams/ Home treatment teams	» People should expect that mental health provider organisations provide crisis and home treatment teams, which are accessible and available 24 hours a day, 7 days a week, 365 days a year

Recovering and staying well

11. Crisis care and recovery plans	» All people under the care of secondary mental health services and subject to the Care Programme Approach (CPA) and people who have required crisis support in the past should have a documented crisis plan
12. Integrated care	» Services should adopt a holistic approach to the management of people presenting in crisis. This includes consideration of possible socioeconomic factors such as housing, relationships, employment and benefits

INTRODUCTION

Individuals with mental health difficulties, particularly those who experience serious mental illnesses such as schizophrenia and personality disorders, may experience crises requiring urgent and at times emergency mental healthcare.

It has long been recognised that there is considerable variation in terms of the quality and accessibility of services. In addition it is recognised that services typically compare unfavourably to similar services for those requiring urgent and emergency care for physical health problems, and this is an important area to tackle if we are to achieve parity of esteem.

Mental health crisis care encompasses a wide variety of services including primary care, secondary care, emergency and social services as well as services provided by the third sector.

With such an array of services, a systemic and integrated approach is required to improve crisis provision. This must be provided in combination with high quality "planned" mental healthcare, (aimed at preventing individuals experiencing crisis) together with a comprehensive programme of public mental health promotion (aimed at building resilient communities).

A whole systems approach such as this requires an integrated commissioning strategy that extends to social care, housing and employment support as well as substance misuse interventions. Whilst the best care is undoubtedly planned care, the aim should be to prevent individuals experiencing crises.

The nature of mental health, however, means that there will be a continuing need for high quality and responsive crisis services.

Defining mental health crisis

Over the years, there have been many attempts to define what is meant by "mental health crisis".

A crisis can be described as a change in mental wellbeing that is likely to lead to an unstable or dangerous situation for the individual concerned. Terms such as 'emergency care', 'urgent care', 'crisis care', 'unplanned care' and 'unscheduled care' have been used to describe the services developed to support and treat those presenting in crisis. Varied terminology alongside differing interpretations of the terms has frequently led to confusion amongst providers, commissioners, service users and carers. Previous Department of Health guidance[1] on telephone access to out of hour's services clarified terms as:

» **Emergency care** - An immediate response to time critical healthcare need
» **Urgent care** - The response before the next in hours or routine (primary care) service is available
» **Unscheduled care** - Involves services that are available for the public to access without prior arrangement where there is an urgent actual or perceived need for intervention by a health or social care professional

The definition for urgent and emergency response is often different for mental health conditions compared to physical health conditions. Mental health response services need to be commissioned as part of urgent and emergency care pathways to both ensure quality of care for mental health problems and to address the significant number of crisis mental health presentations in primary and acute secondary care[2].

> "…crisis is a perception or experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms..."[4]

Mind defines 'mental health crisis' when a person is in a mental or emotional state where they need urgent help[3].

Key challenges to designing crisis mental health services which incorporate a service user and carer perspective is that each person's perception of what constitutes a crisis is individual reflecting their history and social support network[5]. People will respond differently to clinical situations which objectively appear similar, some finding the situation to be manageable, others finding it overwhelming.

INTRODUCTION

Challenges facing mental health crisis services

The mental health crisis and urgent care pathway is often complex, characterised by multiple entry and exit points, and different mental health conditions being addressed by different teams and agencies. Problems often arise at the point where services meet in relation to transfers and communication. People experiencing mental health crisis may need to navigate their way through numerous services in attempt to find help. Navigation can be made unnecessarily difficult with differing names and roles of mental health teams depending on the locality.

> "When someone is experiencing a mental health crisis, it is essential that they feel able to access the help they need and quickly... Without help, people may be at risk of causing harm to themselves and those around them... They often end up in police cells – completely inappropriately. They may even commit suicide... I hear tragic cases of suicide after someone has repeatedly been unable to access mental health crisis support."
>
> - Norman Lamb, MP
> 21 February 2014[6]

The need for equality and non-discrimination in regards to proportionality in the delivery of crisis care also applies to different cultures, religions and diverse groups.

There are barriers to achieving better outcomes for black and minority ethnic groups. For example, there are higher levels of detention and higher admission rates to hospital. Black Mental Health UK state that there are higher use of control and restraint among UK's African Caribbean population.

Members of this patient group are also given higher doses of anti-psychotic medication than their white counterparts and are less likely to be offered psychotherapy as the primary form of treatment[7]. The Crisis Care Concordat[8], 2014 highlights the need for commissioners to focus on particular groups or sections of society which are reaching crisis point at a disproportionate rate, or accessing mental health services through the criminal justice system at a high rate.

Many people are unclear on what services are provided locally and how to access them. Information and awareness of services varies by geography, organisation, the specific service and the individual's experience and knowledge. Service users can be misdirected and told to go to emergency departments when in fact another more appropriate service was available.

Analysis has revealed that referral to emergency departments from primary care is too often the default position in response to a crisis.

The reasons for this include:
» self-referral not accepted
» slow or no response from the appropriate service
» no alternative services made available
» a failure to provide a safe space out of hours (nowhere else to go)
» lack of knowledge of mental health services in primary care
» inadequate crisis plans in CPA documentation
» historical attitudes that emergency department is the default service for all crises
» limited capacity and availability of crisis services (under staffed, lack of resources)

Initial analysis of research carried out by University College London regarding crisis teams has revealed that across the country, only 39 per cent of teams provide a 24-hour service seven days per week. In addition, only 55.5 per cent of teams accept self-referrals from known clients and 21 per cent from unknown clients[9].

Emergency departments are not the best place for people presenting in mental health crisis.

> "I know I shouldn't have gone to A&E, but I felt there was no alternative… I wish there was somewhere to go where there isn't the fear of being judged, and that it's acceptable to be there… Or if it's OK to go to the A&E department for there to be more awareness about this."[3]

INTRODUCTION

Whilst emergency department capacity and ability to manage mental health crisis has increased significantly in recent years with the development of liaison psychiatry services there is undoubtedly still a strong argument that such departments remain far from ideal environments for the assessment and management of those presenting in acute psychological distress.

The National Institute for Health and Care Excellence (NICE) guidelines for adult mental health[10] state the assessment and referral procedures for urgent and crisis mental health should include alternatives to emergency departments such as 24 hour helplines, 24 hour accessible crisis resolution and home treatment teams and the ability to self-refer.

In March 2014, the All Party Parliamentary Group for mental health[11] launched an inquiry into crisis mental health and emergency care.

A national survey was circulated among service users, carers, families, health and social care professionals and the police which revealed that there are major inconsistencies in access to services, standards and models of service delivery. Negative experiences included overstretched and fragmented services, unclear routes into care, place of safety not within an appropriate setting (at police stations or emergency department), long waiting times, a postcode lottery regarding access, advice and services, no clear access route into services and repeated 'bouncing' between services.

Evidence given by the range of stakeholders clearly showed how current mental health crisis provision is characterised by lack of access and poor emergency departments care leading to poor and unacceptable outcomes for patients, so highlighting the immediate need for change.

Although there are many challenges facing mental health crisis services there are examples of excellent crisis and emergency mental health care. It is important to capture good practice and share the benefits and impact of these services, interventions and studies.

COMMISSIONING MENTAL HEALTH

The process of 'commissioning' includes the evaluation, funding, planning and delivery of mental health services in a local area.

Local commissioners have a responsibility to provide high quality and responsive mental health crisis services which are well suited to meet local population needs.

Commissioners should have well established links with other agencies to enable an effective and integrated approach to a mental health crisis and urgent care. Various strategies are devised locally to ensure CCGs are engaged with wider partners and therefore able to offer a seamless service across the whole patient journey.

Commissioning partners include other parts of the health sector (providers), the police force, ambulance service, criminal justice system, social care and local authorities. An example of this is the development of the Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) which have been devised to align priorities based on local need[12]. The CCG's commissioning intentions and strategic plans should incorporate the JSNAs and JHWS into their planning process.

Issues such as staffing capacity, alternative options to inpatient hospital care together with the availability and accessibility of services especially in relation to minority ethnic groups should be addressed. Services should be designed to serve the needs of all ages, ethnic backgrounds and cultures.

Parity of esteem should be reflected in how services are commissioned as well as the contribution of primary, secondary, community and inpatient hospital care.

Evidence from NICE and other guidelines should also be considered. Commissioning decisions have traditionally been steered by 'evidence based practice' which has relied on scientific and research evidence however the views of people who have lived experience have equal weight and should therefore be included in every stage of the commissioning cycle[13]. Co-production and service user engagement should be included to promote values based commissioning and take into account the patient and carer perspectives and values.

There are three main commissioning principles which the Mental Health Strategic Clinical Network (SCN) has adopted in the development of this mental health crisis commissioning guide and the commissioning standards. The principles combined contribute to delivering a whole system approach to ensure individuals who experience a mental health crisis receive a high quality, effective and seamless service.

Commissioning principles

1. **Anticipation and where possible prevention of a mental health crisis**
Efforts should be taken to reduce the number of crisis incidents through preventative measures including resilience interventions and early diagnosis. Support should be accessible and available pre-crisis.

2. **In the event of a mental health crisis, provide a timely and effective response**
Effective crisis management and control of a mental health crisis should be taken to prevent further escalation. Individuals should be in a safe environment, respected and receive high quality treatment and care.

3. **Achieve the best patient experience and outcomes**
Individuals who have experienced a mental health crisis should feel reassured and content with the way the crisis was handled. Individuals should be given support following the incident, equipping them with recovery and self-management tools. This is best achieved through co-producing care packages which are integrated with their local community services.

Policy context

Mental health crisis care is commonly cited as a healthcare challenge which requires urgent attention. The NHS Mandate[14] 2014/15 highlights the need to improve mental health crisis to ensure services are accessible, responsive and of as high a quality as other health emergency services. Crisis mental health also features in NHS England's business plan[15] which has made parity of esteem (valuing mental and physical health equally) a key objective, this includes improving crisis care and waiting times.

The need to improve outcomes for people experiencing mental health crisis was highlighted in the mental health Crisis Care Concordat[8] published in February 2014. Twenty two signatories, representing key stakeholders involved in the delivery of crisis care, have committed to taking action to improve the system of care and support for those in crisis. This policy context means it is timely to address the mental health pathway for patients presenting in crisis across London.

NHS England aims to support the delivery of the Crisis Concordat to ensure there is access to appropriate crisis services. This supports previous goals around assisting CCGs to understand and tackle unwarranted variation in mental health crisis provision.

Standardising crisis mental health

A uniform and standardised approach will produce less variability, enable service delivery comparison and ensure good practice is communicated and shared.

Stakeholders, partners and engagement

Clinical commissioners, mental health providers, social care, third sector, police representatives and service users have been consulted throughout the development of the mental health crisis guide. The SCN is ideally positioned to share resources, information and connect to other improvement boards and wider agencies and share best practice. The London Mental Health SCN has engaged with Concordat co-ordinators as well as NHS England colleagues in commissioning assurance, health in the justice system and other London transformation teams. The guide has been informed by engagement with people who have needed crisis mental health services in the past coordinated by Mind.

Excellence in commissioning requires a clear understanding of effective service responses as described and evidenced by the NICE and the Social Care Institute for Excellence (SCIE), with a focus on recovery which is demonstrated by measuring outcomes and clearly shown in service specifications. National guidance and recommendations have been researched to support the guide.

> "Support the delivery of the crisis concordat so that we are working towards ensuring the access to crisis services, for an individual, are at all times as accessible, responsive and as high quality as other health emergency services. This includes ensuring the provision of adequate liaison psychiatry services in emergency departments and developing and implementing an access/waiting time standard for mental health services."
>
> - Putting Patients First
> NHS England Business Plan
> 2014/15 - 2016/17

Methodology

From March 2014, London-wide data was collated to explore current mental health crisis provision and understand the barriers to improvement. The guide provides a brief outline of London's crisis and urgent care provision as well as identifying what good looks like for urgent care and crisis emergency pathways using a whole system approach. Tasks have included:

» London Mental Health Trust website scoping exercise Reviewing basic public information on services, teams, referrals, definition of a mental health crisis, public instruction and carer support.
» London Mental Health Trusts crisis questionnaires* Scoping if there are trust policies/standards, procedures in crisis care (including out of hours), criteria of teams (emergency departments, walk in centres, crisis houses etc), confirmation of transformational programmes in operation and views on best practice.
» London CCG mental health crisis commissioning questionnaires* Determining GP responses to patients presenting in mental health crisis, out of hours procedures, teams for referral, views on the 'perfect' crisis care, barriers to change and awareness of best practice models.
» Literature review Researching models of best practice in crisis mental health internationally, nationally and regionally. Examining cost effectiveness of models and impact on patient outcomes.
» Mapping of NICE guidance and other existing national standards in place
» Mental health service/referral mapping

Understanding the patient pathway, team composition, referral routes from entry to discharge per London region in an attempt to determine variation of London services
» Hosting a crisis service user engagement event Consulting and engaging with people with lived mental health crisis experience from within London. To discuss draft standards, incorporate view points and real life experiences and to capture which aspects of the crisis pathway are good which are poor and where improvements are required.

To view questionnaire data see Manual report.

To note
» Nine of the ten mental health trusts were surveyed and all nine responded.
» Twenty three CCGs mental health leads responded to the CCG questionnaire
» Answers provided to questions may be subjective as it is likely one person or one team would have completed the questionnaires and returned them based on their knowledge. There also may be variation in terms of 'interpretation' of the questions, as the questionnaires were circulated via email and not structured interviews etc.

Implementation

From the 'scoping' tasks, the variation and gaps in London's local service provision became evident. This evidence alongside service user experience, led to a set of recommendations. The commissioning standards are embedded within twelve subject areas, mirroring the Crisis Concordat approach ensuring:
» Access to crisis care support
» Emergency and urgent access to crisis care
» Quality of treatment of crisis care
» Recovery and staying well

The Crisis Concordat expects that in every locality, a local partnership of health, criminal justice and local authority agency agrees and commits to local mental health crisis declarations and an action plan outlining services that meet the principles of the national Crisis Concordat will be delivered.

In response to this initiative, the London Mental Health SCN has developed this guide with pan London standards and recommendations which we hope will assist and direct commissioners in designing and shaping crisis mental health services.

AREA 1: CRISIS TELEPHONE HELPLINES

Commissioning standards and recommendations

A local mental health crisis helpline should be available 24 hours a day, 7 days a week, 365 days a year with links to out of hour's alternatives and other services including NHS 111

Crisis helplines should be staffed by qualified, competent and compassionate mental health professionals who are appropriately trained, supervised and supported

Crisis helplines should be well publicised among people with mental health problems, carers, health and social care professionals, emergency services and the wider public

Crisis helplines should be profiled within the Directory of Services and enabled to receive referrals from NHS 111 including electronic referrals where appropriate

Feedback provided within 24 hours to all relevant agencies following assessment or following a decision being made not to assess

People should expect to have a single crisis helpline telephone number across London in the future

Single point of access is a departure from the traditional arrangement of GP referral to individual specialists.

The idea behind the service is to avoid inefficiencies created by multiple assessments, referral forms and client records. This type of service has been used by other medical disciplines, as well as psychiatry including primary care and emergency care. For single point of access to practically work, practitioners need to have confidence in the process and have good communication systems in place as well as a clear understanding of each other's roles and skills.

A single point of access to mental health care usually starts with a single telephone number. Crisis telephone lines offer a first point of contact for individuals experiencing a crisis or distress and requiring urgent or emergency support. According to the All Party Parliamentary Group for mental health[11] many individuals have found them useful for immediate help, advice and signposting to the right mental health specialist support. Crisis lines have also been identified as a way of reducing emergency department admissions.

Mental Health Direct – 24 hour mental health support and crisis line (Case study 1)

Mental Health Direct (MHD) evolved out of discussions with service users, carer groups, GPs and commissioner consultations following complaints about lack of out of hour's provision. It was also highlighted that mental health services were difficult for non-professionals to navigate, leading to inappropriately high use of A&E. The service was incorporated into the existing switchboard and clinical support supplied by Access and Assessment Teams, clinical lead and in out of hours the home treatment team. MHD is available 24 hours to anyone who requires it. The biggest challenge was managing demand with an increase by 33 per cent in calls from 2012-2013. Benefits of the service include one recognisable number for all, reduction in unplanned A&E attendance and robust out of hour's service. This is also a service which works closely with service users to deliver local needs.

"Talking can help reassure you and the helpline does a great job."[11]

"I want someone to be compassionate and kind, who cares about me."
- Event participant

Sunderland and South of Tyne Initial Response team (Case study 2)

Northumberland, Tyne and Wear (NTW) trust designed a service to manage mental health crisis using the Sunderland and South of Tyne Initial Response Team. The team offers an efficient 24/7 response to urgent telephone requests for help from people of all ages and conditions and offer triage and routing/signposting to appropriate services within the region. The phone line is available 24 hours a day and calls are managed by trained handlers. The team is the first point of contact for the public, service users, carers and referrers.

Early evaluations indicate:
» Improved response times (average 30 minutes from call to door)
» Improved telephone access (average nine second pick-up)
» Equality of access to urgent mental health services
» Improved service user, carer and referrer experiences
» Reduced avoidable harm - no "bounced referrals" (routed to the appropriate service)
» Reduced assistance required from emergency services
» Positive staff and service user feedback

> "100 per cent of service users would recommend the service to a friend in need of similar help."
> - Sunderland and South of Tyne IRT

> "Staff are polite, show kindness and empathy and behave in a professional manner."
> - Sunderland and South of Tyne IRT

References to case studies and contacts
» Mental Health Direct – 24 hour mental health support and crisis line (Case study 1)
» Sunderland and South of Tyne Initial Response team (Case study 2)
» Northumberland, Tyne and Wear Initial Response service (Case study 3)
» North west London's mental health transformation strategy 2012-15 (Case study 4)
» Integration of CAMHS into a single point of access for children (Case study 5)

AREA 2: SELF REFERRALS

Commissioning standards and recommendations

People have access to all the information they need to make decisions regarding crisis management including self-referral

A range of self-referral options should be available for people in mental health crisis

Mental health crisis services provide information in various formats, detailing opening hours, referral procedures and eligibility criteria

Mental health crisis information should be available in different languages and take into account different cultures and religious beliefs

Mental health crisis information should be available and easy to obtain via provider trust websites; this should be accurate and up to date

> "A GP must make a referral to the crisis team first and then aim to see you in four hours after that referral... impossible for me at the time. I couldn't leave the house. People need to be able to self-refer."[11]

> "People wanted their own definition of being in crisis respected as the first step in getting help and exercising choice and control."[3]

Access to services is known as to be one of the biggest concerns for those in crisis.

There are many accounts of individuals being turned away from services unable to access help for not being ill enough or not meeting the service criteria[3].

Self-referral offers advantages for improved access to services for those who would not otherwise receive services. More self-referral options could reduce the use of compulsory treatment if people are able to get timely support rather than crises escalating[16]. It can open up pathways to care enabling people to access services of their choice.

In a time of distress, self-referral can also offer an easier option for people who do not know where to go especially out of hours. It also means that people who have used services would not have unnecessary repeat assessments, with the potential to escalate their mental health problem.

This includes having the correct information when it is needed, the right support in being referred and some control at a time when they may not be able to exercise choice.

A sense of control and choice at the point of crisis may help prevent the crisis escalating further. *(This is linked with crisis care plans, see Area 8.)*

Language, culture and health beliefs can be barriers to accessing appropriate care. Different cultures, health beliefs or a limited understanding of mental health may mean that mental health services are not seen as being relevant or helpful.

Mind[17] recommend that commissioners empower people from black and minority ethnic groups by providing appropriate information, access to advocacy services and ensure that they are engaged and have control over their care and treatment.

See Area 9 regarding information on the two crisis houses in Camden. Any adult resident in Camden who believes themselves to be at risk of being admitted to hospital due to a mental health problem can be referred by a crisis team, or can call and refer themselves during normal office hours. Further details at http://www.candi.nhs.uk/services/services/rivers-crisis-house/

References to case studies and contacts for further information
» Big White Wall digital mental health service (Case study 6)
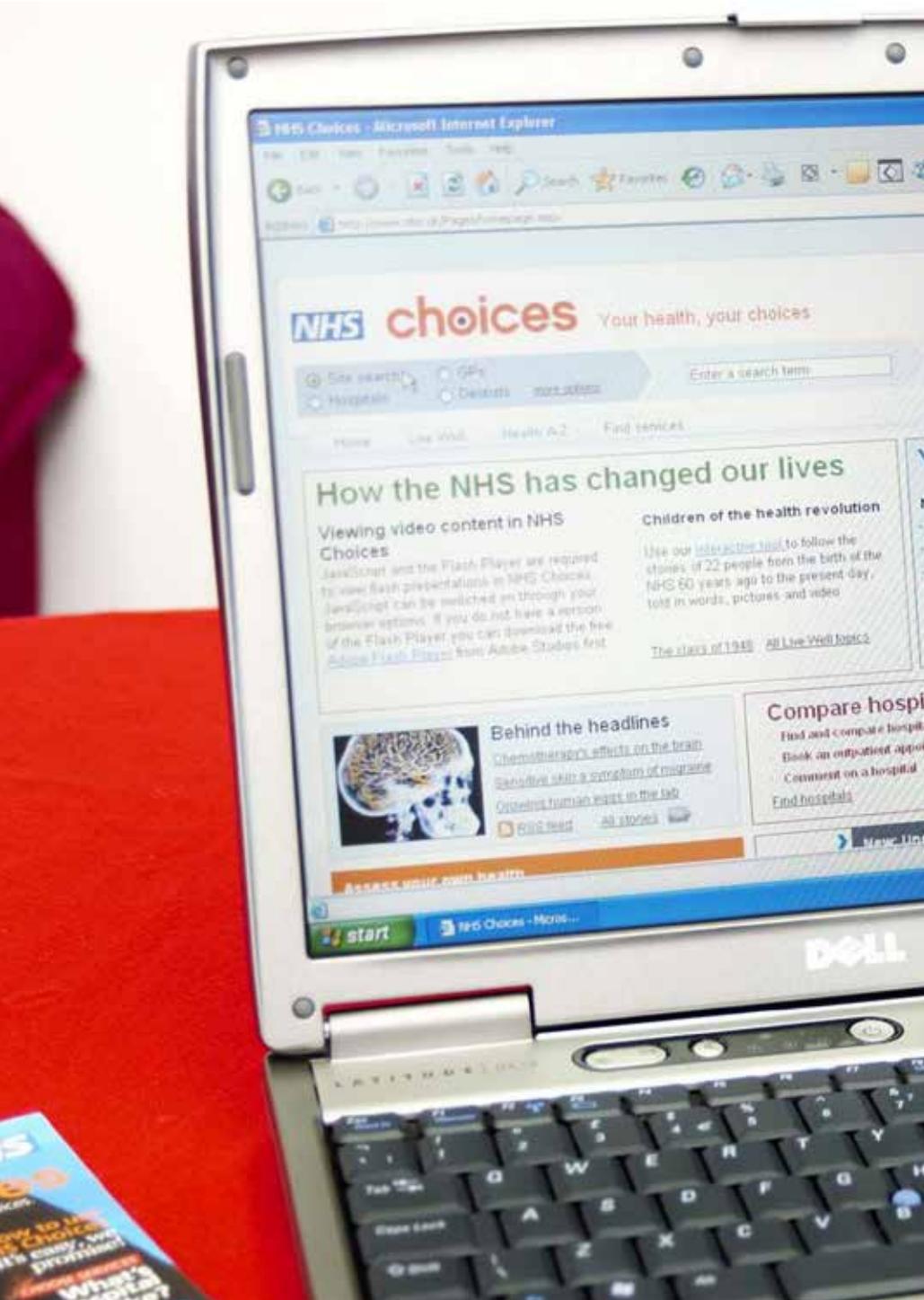
Big White Wall digital mental health service (Case study 6)

The digital mental health service, Big White Wall, is offered on a self-referral basis to all adults in Southwark.

With the aim that this will increase access to mental health services, particularly for people who are unwilling or unable to access other options. The service offers instant access, 24 hours a day crisis support from trained counsellors through the 'Ask a Wall Guide' function, safe and moderated peer support, and self-management materials. The service is fully anonymous, meaning that it is more acceptable to people who are unwilling to access support due to stigma. Members are protected through clear house rules and real-time moderation. Big White Wall members frequently make use of the network at times of distress, to resist urges to self-harm or to cope with suicidal thoughts – many then continue to use it for support with longer-term issues.

AREA 3: THIRD SECTOR ORGANISATIONS

Commissioning standards and recommendations

Commissioners should facilitate and foster strong relationships with local mental health services including local authorities and the third sector

Commissioners should work with organisations representing black and minority ethnic groups to ensure that all services are delivered in a culturally appropriate manner

The involvement of the third sector should be routinely considered in service design Local third sector services should be mapped relevant to the management and support of those in crisis and ensure that mental health crisis teams are aware of these

An accurate and up to date database of local services should be available to people with mental health problems and their carers

Commissioners should ensure that third sector organisations are appropriately profiled within the NHS 111 Directory of Services

> "If it wasn't for the staff in Mind or my family, I wouldn't be here today."
>
> - Event participant

Organisations such as Mind, Rethink Mental Illness and the service user led network, National Survivor User Network (NSUN) strive to empower and support people with mental health conditions, and offer services which compliment and support the activities of the statutory services.

Voluntary bodies such as these are valuable in helping individuals get through a mental health crisis by providing advice, navigating and signposting people to services, offering up to date information and also provide services locally. They can advise or recommend NHS services and also direct patients to use voluntary sector services[18]. Their roles are varied and they can provide a number of interventions in mental health from counselling, support and activities. Some are also involved in mental health crisis helpline provision as well as providing alternatives to admission to hospital, such as crisis houses.

Telephone helplines are a useful resource for immediate support. There are a number of national charities for certain mental health problems which operate phone lines out of hours for example, the Samaritans, No Panic (for panic and anxiety) and Beat (for eating disorders). Rethink Mental Illness and Mind provide mental health services including housing, crisis helplines, employment training, counselling and befriending schemes.

Local Mind offices provide drop in centres, day services as well as acute day hospital services – some of these (not all) are set up to help people to manage crisis.

Staff from a recognised voluntary organisation can access services more easily than an individual can alone. Staff are acquainted with mental health professionals making communication on behalf of the individual much easier and quicker.

Online support can also be useful for crisis support including NHS Choices, Mind and Rethink Mental Illness, providing high quality advice and up to date information and links to support services including those created and maintained by people with mental health problems.

The voluntary sector also have an important role in supporting commissioners and providers to develop services in partnership with people who use services, to ensure services are as effective at meeting the needs of those they serve as possible.

NSUN have developed National Involvement Standards framed in terms of the principles and purpose for involvement. The standards also address the processes of involvement across health and social care at strategic, operational and individual levels and, for it to be meaningful, the impact of involvement. The 4PI framework can support people to make decisions about the care they need, which is vital in times of crisis and indeed may prevent it[19].

References to case studies and contacts
» "Evolve" – A navigator service (Case study 7)
» Leeds survivor led crisis service (Case study 8)
» Solidarity in a crisis (Case study 9)

Supporting information
» Refer to NSUN's values based commissioning reference/standards (May 2014): http://bit.ly/nsun-vbc
» Refer to NSUN's service user and carer involvement standards (2013): http://bit.ly/nsun-involve

ACCESS TO CRISIS CARE SUPPORT

"Evolve" - A navigator service (Case study 7)

'Evolve' is part of CREST, a local voluntary sector charity in Waltham Forest, and provides navigators to establish the nature of the crisis, whether social or medical, and works with the individual to decide on the appropriate course of action to minimise risks to a mental health relapse.

Initial outcomes of the pilot have shown that the Evolve team has contributed to an overall reduction in the number of individuals having a crisis where regular contact with a navigator is maintained, as well as a reduction in the duration of a crisis episode through quicker access to intervention and treatment.

Leeds survivor led crisis service (Case study 8)

The Leeds survivor led crisis service is governed and managed by people with direct experience of mental health problems. The service is funded by three Leeds NHS CCGs, Leeds City Council and Leeds Personality Disorder Clinical Network and receives small amounts of charitable trust funding occasionally.

Whilst working in partnership with local statutory services the service remains outside mainstream mental health services. It has been successful in providing a viable alternative to the medical model of care for people in acute mental health crisis. "It can be cheaper to locate crisis services in the voluntary sector, than it is to provide statutory services, including inpatient services. It is also a more positive experience to be in a community based homely environment."

Solidarity in a crisis (Case study 9)

Solidarity in a crisis is a peer support service which is co-designed and co-delivered by service users and carers in Lambeth.

Crisis support is offered over the phone or in person out of hours during the weekends. It is an alternative service to NHS services or hospital. The aims of the service are to reduce isolation, support people using empathy and knowledge gained through experience and to help the person before reaching crisis point. Peer supporters are trained and have regular supervision. They provide advice in a non-judgmental manner and give people reassurance, a sense of belonging and hope to those who are in distress. The service accepts referrals from community mental health teams, inpatient wards, GPs, voluntary agencies and self-referrals.

> "The peace and quiet was a nice change from the noisy, hectic crazy ward."
>
> - Service user, Leeds survivor led crisis service

> "I was so low I was having thoughts of not wanting to live anymore. The peer support from NSUN was vital to me finding my voice in distress and just knowing I could share it with people who had been in a similar position. It reminded me that I was part of something bigger."
>
> - NSUN service user

AREA 4: GP SUPPORT AND SHARED LEARNING

Commissioning standards and recommendations

Training should be provided for GPs, practice nurses and other community staff regarding mental health crisis assessment and management

GPs should be aware of mental health crisis services within the locality

Ensure out of hours services know referral routes for those in mental health crisis

Commissioners should take steps to further develop the skills of CCG mental health leads in the commissioning of mental health crisis services

Training delivered to primary care staff should ensure that staff from all agencies receive consistent messages about locally agreed roles and responsibilities

GPs should be routinely consulted and involved in investigations following serious untoward incidents related to crisis presentations to ensure that learning is embedded systemically

GPs and other community staff should receive training regarding the potential precipitants for crises, including the role of substance misuse and social factors, in order to ensure early identification and intervention when possible

> "I am lucky to have a great doctor who understands me."[11]

GPs are often the first point of referral into mental health services. With the onset of a crisis, GPs can be a valuable source of support. GPs are in an ideal position to prevent the escalation of a crisis with an established relationship with their patients. They can play an important role in recognising a mental health problem at an early stage or identify any worsening of a mental health issue.

GPs can also help with the management of a crisis to support self-management techniques that may have proven to work in the past, including any personal coping strategies. The GP can also recommend and refer the most appropriate service for the individual taking into account of all of their needs and preferences. The GP also may already be aware of their personal circumstances including housing, employment and any personal matters that could play a part in the escalation of a crisis. Giving advice on wider lifestyle factors which may be affecting the person's mental health, such as diet and exercise, can be effective.

As individuals experiencing a mental health crisis can present with co-existing drug and alcohol problems, it is important that all staff are aware of local mental health and substance misuse services and know how to engage with them8. GPs may also consider prescribing medication for symptoms in the short term while investigating the underlying causes of a crisis.

This should include all primary care professionals who have a responsibility to try to prevent crisis by understanding individual stressors, encouraging compliance with medication where appropriate and supporting carers and families.

An increased focus on training has been suggested, and may form part of the new four-year training regime being developed by the RCGP and Health Education England. Chief Medical Officer, Dame Sally Davies said specific training is needed to raise awareness of the consequences of violence on mental health throughout a patient's life20. The Mental Health Foundation21 suggests widening the scope of mental health education and training to include all primary care staff including GPs, practice nurses, administrative staff. Although undergraduate training for doctors includes a mandatory psychiatry element "the RCGP curriculum for mental health makes no mention of continuing training or development".

References to case studies and contacts
» City and Hackney CCG mental health training (Case study 10)
» Kingston CCG advanced diploma in mental health (Case study 11)
» Bespoke mental health training for practice nurses (Case study 12)
» Time to Change: mental health training for GPs (Case study 13)

ACCESS TO CRISIS CARE SUPPORT

City and Hackney CCG mental health training (Case study 10)

City and Hackney CCG have just launched a programme of training for all primary care staff offering free Mental Health First Aid Lite courses to all GP reception staff.

The next phase of the programme will be to offer a two day course to those reception staff who would like further training. Practice nurses, district nurses and health care assistants are encouraged to attend the UCLPartner's mental health and wellbeing training package for practice nurses (Case Study 12). This includes face to face and e-learning which ensure that nurses have a thorough and wide understanding of mental health in primary care including crisis management. For GPs, educational sessions and workshops continue to run. Mental health training has also been incorporated into this year's locally enhanced service (LES).

GP practices are required to ensure that all reception staff have children and adolescent mental health crisis training to be able to respond better to young people who need urgent access to primary care. City and Hackney have been awarded a grant to develop a community mental health education and training hub which will promote good mental health training across professions in the borough. Joint training opportunities between schools, workplaces, health, police and the local authority will be arranged and a virtual shared calendar of training will be set up. This will help to build a strong sense of community resilience so that more people are empowered to help people in crisis.

Kingston CCG advanced diploma in mental health (Case study 11)

Kingston CCG has been awarded funding to provide training to advanced diploma level in mental health to 20 Kingston GPs. The programme is accredited by RCGP and to be delivered by PRIMHE, from autumn 2014 to summer 2015. There will also be training for nurses to follow and awareness training for all interested other GPs and their practice staff. The overall aim is that there will be enough GPs trained to this level to assist and support the delivery of mental health care in primary care across Kingston. There are 27 practices and this would mean 'buddying up' for some. Overall, each trained GP practitioner will cover a population of roughly 10,000 registered patients.

> "I can't believe how much of this stuff really works."
>
> - GP, Sandwell

> "Feeling heard and having your wishes considered by your GP is the most important thing."[11]

AREA 5: EMERGENCY DEPARTMENTS

Commissioning standards and recommendations

Emergency departments should have a dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis

Dedicated areas should be designed to facilitate a calm environment while also meeting the standards for the safe delivery of care

Resources should be in place to ensure that people experiencing a mental health crisis can be continuously observed in emergency departments when appropriate

All emergency departments' frontline staff should be trained in the assessment and management of mental health crisis

Emergency departments and local mental health providers should work closely to ensure safe effective care pathways between services

Systems should be in place to ensure that people who regularly present to emergency departments in crisis are identified and their care plans appropriately reviewed

Arrangements should be put in place to ensure that crisis plans are accessible to emergency departments and ambulance staff

Emergency departments should have immediate access to psychotropic medications routinely used in the management of mental crises including intramuscular preparations

Although an intervention of last resort, intramuscular tranquilisation, when necessary, should be administered in emergency departments in accordance with accepted guidance

Mental Health Act assessments undertaken in emergency departments should be completed within four hours of the person's presentation to the emergency department in order to ensure parity of esteem

A large proportion of crisis and urgent mental health problems present to emergency departments. Primary mental health presentations account for around five per cent of emergency department attendances[22]. Thirteen-twenty per cent of admissions are associated with alcohol related problems, and self-harm is the most common reason for acute medical admissions. Self-harm is one of the top five reasons for admission to hospital for emergency medical treatment, accounting for up to 170,000 admissions in the UK each year[22].

Lack of urgent care mental health services mean people default to emergency departments. Often such cases are not appropriate or eligible for secondary care home treatment teams[2]. Research has shown that people with mental health conditions attend emergency department services more frequently than the average. Mental health problems are common in frequent attenders with a significant proportion being linked to psychosocial exacerbations of underlying conditions. The prevalence of mental illness among people with physical health conditions is two to three times higher than in the rest of the population. People with depression are twice as likely to use emergency services as those with long term conditions without depression[2].

There have been many accounts of individuals presenting at emergency departments in distress, waiting for hours for assessment and treatment as there is no mental health professional available. Long waits in a chaotic, busy and unsettling setting such as emergency departments can lead to

> "There should be dedicated, trained mental health nurses in all A&E departments, who have access to my current care plan."
>
> - Event participant

more distress and unnecessarily escalate a mental health crisis or lead to the individual absconding. Individuals experiencing a mental health emergency need the same immediate medical attention as they would for a physical health problem. The All Party Parliamentary Group on mental health[11] asked service users about mental health services at A&E and if appropriate care was provided their responses included:

"Put separate emergency rooms in A&E departments for psychiatric patients staffed by consultants not junior doctors with very little experience of mental health."

"Encourage mental health care providers to have their own mental health A&E departments."

"I voluntarily took myself to A&E because I was afraid I would hurt myself. As soon as I arrived at reception I was immediately dismissed and told that I would have to wait, there are people with more serious problems here. I waited until 3am before I met with members of the crisis team. They were unhelpful and dismissive. I was sent home at 5am and told to just contact my GP."

References to case studies and contacts

Whittington integrated liaison assessment team (Case Study 14)

The integrated liaison assessment team has the following features:

Consultant/specialty trainee follow-up clinic -The consultant and specialty trainee offer a follow-up clinic during the week for patients seen in the emergency department. This clinic is for cases where there are diagnostic difficulties or medication issues.

Liaison follow-up clinic - The team provides a follow-up clinic seven days a week. This is typically offered to those who do not require admission or crisis team follow-up and who do not have easy access to community follow-up. This clinic may also be helpful for 'new' core trainee doctors, particularly on call at night, who are not yet confident with their management plan and would like a second opinion. The patients are seen in an interview room in emergency departments. This clinic is available to patients from any area regardless of whether they are already under the care of one of the community teams, and is not a replacement, but a support, to existing services.

Direct referrals -The team has developed an initiative to identify patients who are more appropriately referred directly to psychiatry from the triage nurse using an agreed protocol. This is a joint agreement between A&E and the team. Direct referrals take place 9am to 8pm, 7 days per week.

Parallel assessments - To reduce waiting times in the A&E and improve patient management, the team can carry out assessments in parallel with emergency staff before a patient is deemed 'medically fit'. The key issue will remain whether an individual's mental state is accessible. Parallel referrals can be made as soon as possible after the patient arrives.

AREA 6: LIAISON PSYCHIATRY

Commissioning standards and recommendations

People should expect all emergency departments to have access to on-site liaison psychiatry services 24 hours a day, 7 days a week, 365 days a year

Liaison psychiatry services should see service users within 1 hour of emergency department referral to ensure a timely assessment and minimise risk

Clinicians in the emergency department should have rapid access to advice from a senior clinician following emergency department crisis assessments

> "Only 40 per cent of general hospitals have a psychiatric liaison service."[3]

> "Locally we majorly need an investment in liaison services and for commissioners to support the work under way."[25]

Liaison psychiatry addresses the mental health needs of people attending the general hospital in emergency departments, inpatient and outpatient settings.

People with acute mental health problems commonly present to emergency departments therefore liaison psychiatry has a key role to support those in crisis. For many, an assessment in emergency department will be their first experience of mental health services.

Timeliness is also a necessity as emergency departments have a performance target requiring all patients to be discharged within four hours. Effective liaison psychiatry services should therefore be located in general hospitals, able to respond quickly to emergency situations, and well integrated with community mental health services and social care.

Mind's *Listening to Experience* report[3], demonstrates that people who use services want to see liaison services in every emergency department.

According to liaison psychiatry guidance[23] there are six main patient groups who attend emergency or unplanned care at acute hospitals who stand to benefit from liaison psychiatry services.
» People who self-harm
» People with physical and psychological consequences of alcohol and substance misuse
» Frail older people
» People with known severe mental illness when in relapse
» People admitted with primarily physical symptoms which upon assessment have psychological or social causation

» Vulnerable groups such as the homeless, people with personality disorders, victims of domestic violence and abuse, children and young people at risk

Liaison psychiatry services in a general hospital could generate savings of up to £5 million a year by improving the care offered to people in hospitals who have a mental health condition[24].

According to the liaison psychiatry guidance commissioned by the South West Dementia, Mental Health and Neurological Conditions Strategic Clinical Network there is evidence that for every £1 invested in liaison psychiatry services, up to £4 of value is returned to the local economy[23]. There remains however wide variation around the country both in the availability of liaison psychiatry services in general hospitals and in models of service delivery[24].

Rapid assessment, interface and discharge (RAID) has been recognised nationally for its innovative approach to liaison psychiatry.

Evaluations of the RAID model has shown to reduce admission, length of hospital stay, costs and revealed clinical benefits to service users[26].

References to case studies and contacts
» Liaison psychiatry in north west London (Case study 15)
» Hull and East Yorkshire Hospitals Trust: The mental health team (Case study 16)
» Birmingham Rapid Assessment, Interface and Discharge (RAID) (Case study 17)

Liaison psychiatry in North West London (Case study 15)

Central and North West London NHS Foundation Trust and West London Mental Health NHS Trust, worked in partnership to establish pilot services at four acute trusts: North West London Hospitals NHS Trust (Northwick Park and Central Middlesex hospitals), Hillingdon Hospital NHS Trust, Ealing Hospital NHS Trust, and West Middlesex University Hospital NHS Trust. A working group involving mental health providers, acute trust staff, commissioners and service users developed an 'optimal standard' model for a hospital of 500 beds that provided an integrated multidisciplinary service with 24 hour input to emergency department and inpatient populations. There have been improvements in mental health diagnosis, treatment and care of patients in acute hospitals with co-morbid physical and mental health problems and a reduction in the overall lengths of stay for the same group.

Hull and East Yorkshire Hospitals Trust: The mental health team (Case study 16)

The team is a multi-disciplinary team which assesses patients with a range of mental health problems including acute mental illness; self-harm; attempted suicide; or extreme distress. Dependent upon the nature of the referral the response rates are 30 minutes the same working day or within 24 hours. A further aim is to educate staff within the acute trust to enable them to recognise mental health problems early and refer appropriately.

Birmingham Rapid Assessment, Interface and Discharge (RAID) (Case study 17)

The Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service operating in City Hospital, Birmingham operates 24 hours a day, 7 days a week and emphasises rapid response, with a target time of one hour to assess referred patients who present to A&E and 24 hours for seeing patients on the wards. An independent economic evaluation of the service reported that RAID saves 44 beds per day in a 600 bed hospital which equates to about £4 million per year.

> "The team has expanded to integrate older people's liaison service."
>
> - HMHT Hull and East Yorkshire

AREA 7: MENTAL HEALTH ACT ASSESSMENTS AND AMHPs

Commissioning standards and recommendations

Arrangements should be in place to ensure that when Mental Health Act assessments are required they take place promptly and reflect the needs of the individual concerned

An urgent assessment in the community, not necessitating police intervention, should be completed within a maximum of four hours from referral whenever possible

Assessments should not be delayed due to uncertainty regarding the availability of a suitable bed. To assist in this it is recommended that a pan-London protocol for the management of psychiatric beds is developed

To ensure the prompt attendance of AMHPs and section 12 approved doctors at Mental Health Act assessments, particularly out of hours, sector wide rotas should be developed

The provision of AMHPs across London should be increased in order to ensure that Mental Health Act assessments are completed within the agreed timeframe

Assessing doctors and AMHPs should have up to date knowledge of what local alternatives to admission to hospital (eg crisis houses) are available, these should be considered as part of the assessment

Assessments should consider the individual's crisis plan when available including any advanced directives

For Mental Health Act assessments of children and young people arrangements should be in place to ensure that at least one of the assessing doctors has CAMHS expertise or that the assessing AMHP has expert knowledge of this age group

According to the Mental Health Act 1983, if a person has a "mental disorder" (any disorder or disability of the mind), they can be admitted to hospital voluntarily as an informal patient or be admitted to hospital against their wishes as a formal patient[27].

The Act gives an approved mental health professional (AMHP) the power to make an application to admit a person to hospital under a section of the Act if they consider it necessary to ensure the best care and treatment for that person[28].

An AMHP is often a specially trained social care worker, community mental health nurse, occupational therapist or psychologist who has been approved by the local services authority to administer functions under the Act. The Act gives the nearest relative the right to request that an AMHP considers application for admission to hospital. The nearest relative is determined by section 26 of the Act and is usually the spouse or co-habitee[29]. The police maybe called to assist in some cases when detaining an individual is particularly problematic.

"About a quarter of people are in hospital without their agreement."[28]

Although local arrangements may differ, every borough should have a single point of contact where an AMHP can make contact with police to request help with mental health assessments. The reasons for police assistance include to manage risks and to promote cooperation. The Metropolitan Mental Health and Policing Briefing sheet[30] describes the common pitfalls around the implications of attending mental health assessments both with and without a warrant.

Use of the Mental Health Act

The following must be considered by the AMHP when undertaking the Act:

» Age and physical health
» Wishes and views of the individuals needs including past wishes expressed by the patient
» Cultural background
» Social and family circumstances
» Impact of further deterioration or lack of improvement on children, carers, family and the individual

In the case when a person belongs to a particular patient group, such as under 18 or has a learning disability, at least one of the professionals involved in the assessment should have expertise in this area.

References to case studies and contacts
» Hackney 24 hour AMHP service (Case study 18)

Hackney 24 hour AMHP service (Case study 18)

The London Borough of Hackney and East London Foundation Trust out of hours AMHP service aims to respond to requests for Mental Health Act assessments which arise outside usual working hours (5pm-9am week days and 9am to 9am on bank holidays and weekends).

The service aims to provide consistency and continuity of care to people requiring this intervention. Since July 2013, it undertakes approximately twenty five assessments out of hours per month. There has been improvement in response times with 100 per cent compliance with the four hour response target. Discussions with referrers has suggested that the service is more accessible and responsive than the previous emergency duty team arrangement and has also been able to undertake some planned assessments out of hours when circumstances are appropriate. There is now a single 24 hour phone number. The service operating costs are less than previously.

"AMHPs reported delays of four to five hours in getting a bed were not uncommon."[31]
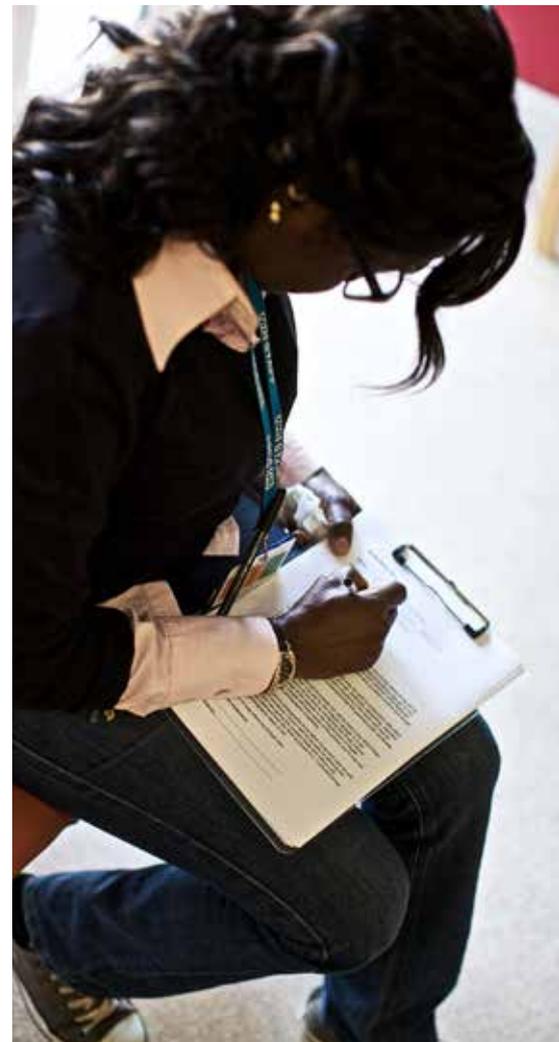
Area 8: Section 136: Police and mental health professionals

Commissioning standards and recommendations

Police and mental health providers should follow the London Mental Health Partnership Board section 136 Protocol and adhere to the pan London section 136 standards

The police should be provided with a single number to access mental health professionals for advice and they should ideally use this facility before using their section 136 powers

When people are detained under section 136 they should be taken to a NHS place of safety. If under any circumstances police custody is used as an alternative, arrangements should be made to understand why this has happened and a full partnership review should take place to avoid further incidents of this nature occurring

Organisations commissioned to provide places of safety should have dedicated 24 hours, 7 days a week, 365 days a year telephone numbers in place. The police or any other service transporting people should always use these numbers to phone ahead prior to arrival at any place of safety

People should expect appropriate contingency plans to be in place in the event of multiple section 136 assessments. If a trust has no immediately available designated places of safety for a section 136 assessment arrangements should be in place to access an alternative within the trust or by arrangement with a neighbouring organisation

Follow up should be arranged for people in their area of residence when they are not admitted to hospital following a section 136 assessment and their GP informed in writing regarding the crisis presentation and the outcome

> "On average across London, 42 percent of respondents reported that where a patient is denied access to a place of safety, a principal reason for doing so is that the place of safety is already in use."[33]

Safety in Mind DVD

The Vulnerability Assessment Framework has been adopted by a number of partners in London already. A partnership training DVD called 'Safety in mind' uses the assessment framework. The DVD has been jointly developed by South London and Maudsley Mental Health Trust, Metropolitan Police Service and London Ambulance Service and was launched on 03 October 2014.
More information:
http://bit.ly/slam-film

The interface that exists between crisis services and emergency services (such as the police, ambulance, fire brigade and emergency departments) is critical to the delivery and management of crisis support. In many cases, these services are the first point of contact for someone experiencing a mental health crisis and are responsible for their transition to more specialised mental health support.

Over the past decade, police involvement in mental health crisis has been recognised. Police officers act as gatekeepers making critical and difficult decisions within local communities.

Police teams have powers under section 136 of the Mental Health Act to take someone to a place of safety for a mental health assessment. According to the Act, if the individual's behavior is violent or aggressive, police should be asked to assist and they should be taken to a place of safety by ambulance (or similar) even where police are assisting[27].

Individuals should be transported in a safe manner as agreed locally between police, approved mental health practitioners and health services. Where police vehicles are used due to the risk involved it may be necessary for the highest qualified member of an ambulance crew to ride with the patient. In this situation the ambulance should follow directly behind to provide assistance. Where the person has a physical injury, illness or condition (including intoxication) that requires medical attention they should be taken to an emergency department.

Only after the injury or medical requirement has been resolved should the person be taken to the designated health based place of safety. Police involvement is sometimes appropriate and necessary "especially where a crisis could not be foreseen or prevented, but often they act as a default where mental health services fail."[32]

It is frequently reported that the place of safety is police custody which should be used only in exceptional circumstances. Despite many accounts of compassionate police officers, police cells are not appropriate[11] and officers do not have the right training or expertise to manage a mental health crisis. In some cases, the police cannot access or locate an available place of safety and lack support from other services. The role and responsibility of the police, emergency departments and ambulance services need to be closely examined especially in relation to their interaction with mental health teams.

The London Mental Health Partnership Board action plan[33] explores a number of solutions and recommendations regarding section 136 including around access to places of safety, police response, the role of section 12 doctors and training.

Multi-agency approaches are now being considered between the police and the NHS. Street triage aims to respond to crisis at the earliest opportunity with a mental health nurse available for assessment before police officers potentially exercise their powers under section 136. With mental health professionals giving ap-

propriate advice, police officers are equipped to make the necessary decisions. This would then led to people receiving care more quickly and reduce the use of section 136.

References to case studies and contacts
» Vulnerability Assessment Framework training tool (Case study 19)
» London street triage pilot (Case study 20)
» Integrated mental health team based within police headquarters (Case study 21)
» British Transport Police (BTP) suicide prevention project (Case study 22)

Vulnerability Assessment Framework training tool (Case study 19)

The Vulnerability Assessment Framework provides a simple tool for Metropolitan police officers to use to identify those that are vulnerable and possibly in need of further help. The tool was developed by the University of Central Lancashire, originally called the Public Psychiatric Emergency Assessment Tool. Since this system went live over 55,000 reports have been completed, enabling the police and partners to identify individuals that are becoming vulnerable far earlier and enabling early intervention.

London street triage pilot (Case study 20)

NHS England (London Region) together with the Mayor's Office for Police and Crime (MOPAC) have commissioned a Street Triage Project in London, piloted in the boroughs of Lambeth, Lewisham, Croydon and Southwark. The triage service consists of mental health practitioners accompanying police officers to mental health related call outs and/or providing dedicated telephone support to officers on the ground who are responding to people in crises. The mental health practitioners are deployed specifically to help officers decide on the best option for individuals in crisis by offering professional, on the spot advice and assessment, accessing health information systems and liaising with other care services to identify the pathways for those individuals in need of support. The project aims to reduce the use of section 136 of the Mental Health Act amongst the police and reduce the amount of time that officers spend dealing with people who are in crisis due to mental health problems.

> "In 36 per cent of cases those detained under section 136 of the Mental Health Act 1983 were held in police cells rather than health-based places of safety."[11]

AREA 9: CRISIS HOUSES AND OTHER RESIDENTIAL ALTERNATIVES

Commissioning standards and recommendations

Commissioners should ensure that crisis and recovery houses should be in place as a standard component of the acute crisis care pathway and people should be offered access to these as an alternative to admission or when home treatment is not appropriate

Crisis houses should be considered as an alternative to early discharge from wards

Crisis houses should be appropriately staffed and supported; this should include regular psychiatric input and out of hours cover

> "There is no single model for crisis houses."[3]

> "One of the world's great mysteries is why we don't have more [crisis houses]."[3]

Crisis houses and residential alternatives are non-clinical areas, often smaller and less medically focused when compared to an inpatient ward that can meet the needs of people in mental health crisis who need short term support away from home.

Alternatives to inpatient admissions have been used in the UK and worldwide. They may be provided within the NHS or the voluntary sector. There is no single model and they can vary as to how they are accessed and staffed[3]. Alternative approaches are strongly supported by people using services and crisis houses have often been set up in direct response to demand from local mental health service users as a preferred alternative to hospital treatment[34].

Crisis houses enable people to recover in a community based, safe and therapeutic environment, which allows them to continue with their day to day routine but in the knowledge that emotional and practical support is available to help them recover from crisis and prevent relapse upon discharge.

People using crisis houses are able to influence and provide feedback about how the houses are run through weekly house meetings, they are encouraged to state what could be changed or improved (more activities, group therapies) and are supported to develop and participate in peer led initiatives.

The main focus is on ensuring people leave the crisis house with a range of personal wellbeing strategies and tools, coping mechanisms and have access to support networks in the community to ensure they build up resilience to reduce the likelihood of a future mental health crisis.

References to case studies and contacts
» Highbury Grove crisis house (Case study 23)
» Camden crisis houses (Case study 24)
» West of Dorset recovery house (Case study 25)
» Hertfordshire Partnership NHS University Foundation Trust: Host Families scheme (Case study 26)

Highbury Grove crisis house (Case study 23)

Highbury Grove in Islington provides an alternative service to hospital admission for people experiencing mental health crisis in a community setting. The service consists of three components including a twelve bed residential service; a crisis phone line provided seven days a week 5pm to 6am and the crisis night centre. The crisis night service is available seven days a week to provide a safe place for service users to meet and socialise therefore minimising social isolation, while providing support where necessary. Referrals to all three services can be made by acute mental health services, housing providers, GP's, drug and alcohol services, recovery and rehabilitation teams, and service users can self -refer. The service also offers support with developing independent living skills, working towards achieving a full and healthy lifestyle, accessing social and community facilities, training, education and social development, accessing other specialist support and accessing local support groups.

"The centre acts for me a great safety network to create a pleasant quality of life. I feel the environment is safe and very pleasant staff of which I am very grateful."
– Service user, Highbury Grove Crisis House

Camden crisis houses (Case study 24)

Two crisis houses were established in Camden to provide an alternative to acute inpatient hospital admissions based on a person-centred recovery model. The Camden crisis house model includes a crisis team who support people in their homes and act as gate-keeper for admissions and a structured acute day treatment programme, where service users are encouraged to participate in therapeutic groups. A robust range of treatment and support is provided which can safely meet the needs of people experiencing a crisis, flexibility and responsiveness to individual needs and resources to enable people to manage their own crisis in a community setting where possible. People are admitted to the houses at the height of acute crises for brief stays of on average two to ten days. Most people (74-78 per cent) are discharged to their own homes.

AREA 10: CRISIS RESOLUTION TEAMS / HOME TREATMENT TEAMS

Commissioning standards and recommendations

People should expect that mental health provider organisations provide crisis and home treatment teams, which are accessible and available 24 hours a day, 7 days a week, 365 days a year

Assessment by the mental health team following a crisis referral should take place within:
» 4 hours in an emergency
» 24 hours if urgent

In extreme circumstances, when the risks are immediate, flexible and responsive services will be required

The eligibility criteria for crisis teams should be readily accessible and shared with referrers to ensure referrals are appropriate; this should include guidance as to what constitutes an emergency referral

Information regarding alternative services (including for example how primary care can better support the individual) should be provided when a person is assessed as not meeting eligibility criteria for a crisis team

Feedback should be provided to service users and referrers regarding the rationale in the event of a service user not meeting the eligibility criteria for a crisis team

Initial assessment must be undertaken by suitably trained and supervised mental health clinician

A summary should be sent to the referrer within 24 hours of assessment completion which should include detail of all actions to be taken

Mental health crisis teams should use the CORE Crisis Resolution Team Fidelity Scale criteria for benchmarking best practice

Crisis resolution teams work within mental health services providing short term, intensive home treatment for people experiencing mental health crisis[35].

The teams treat patients at home when they would otherwise be considered for admission to acute psychiatric wards.

The multidisciplinary teams consist of doctors, nurses, psychologists, occupational therapists and social workers. Terminology used in relation to such teams varies, often being referred to as intensive home treatment teams, mobile treatment teams (in the USA), home-based crisis services, crisis services, rapid response team etc.

The common factor is that these teams deliver treatment both in and out of office hours in patients' homes. The level of cover can vary, some teams are accessible for home visits 24 hours a day, others have other service input when visits are not available. These teams aim to minimise bed use by acting as gatekeepers - preventing hospital admissions where possible and supporting people after a crisis as they plan to leave hospital.

Research shows they are effective in reducing admissions to hospital and increasing the acceptability of crisis care[35].

> "Only 40 per cent of CRTs provide a full 24/7 service while 85 per cent provide some cover 24/7."
>
> – Mental Health Today Group [115a]

Supporting information
» Use CORE CRT fidelity scale and scoring guide for producing CORE CRT fidelity review. Resource packs: www.ucl.ac.uk/core-study
» Refer to the North England SCN CRT commissioning standards http://www.nescn.nhs.uk/networks/mental-health-dementia-and-neurological-conditions-network/

In practice, crisis resolution teams have a patchy gatekeeping role with involvement from trusts and communities differing. Only 35 per cent of teams have access to non-hospital beds[35]. Not all are readily available, staff report high caseloads, understaffing and a variable approach to delivering the gatekeeping role.

Variation in role can also dilute their ability to focus on crisis home treatment, with some teams expected to fulfil other functions such as running psychiatric liaison services from emergency departments. Confusion over role boundaries and variability in job functions are understandable when these teams are designed to work in partnership with other mental health care services. In certain areas there are concerns about how well the teams are integrated with other services[35].

References to case studies and contacts
» Redbridge home treatment team (Case study 27)
» South Tyneside crisis resolution and home treatment team

Redbridge home treatment team (Case study 27)

North East London Foundation Trust provides multi-disciplinary home treatment as an alternative to admission which enables wards to target those who require an inpatient stay. The team consists of social care staff, psychologists and occupational therapists. All referrals to acute services are initially assessed by a mental health practitioner - referring teams are guaranteed an immediate telephone response and physical assessment when needed within two hours. The teams have a 100 per cent gate-keeping role to their wards and are also 100 per cent involved in inpatients discharge: arranging same day home visits for service users discharged from hospital and daily follow up until the end of the acute phase to ensure patients are well-supported in their home environments which better facilitates recovery. The home treatment team works closely with acute wards identifying outstanding practical issues, including service users who are not ready to be discharged at that point. The co-location of the team within the wards at one central base facilitates this integrated way of working.

South Tyneside crisis resolution and home treatment team (Case study 28)

Northumberland Tyne and Wear NHS Foundation Trust provides a crisis resolution home treatment team with the capacity to visit service users up to three times daily, providing a range of psychological and physical interventions including support and psycho-education for carers and families. The team works extensively with the inpatient units, gatekeeping all admissions and providing early discharge planning. The team provides a 24 hour mobile workforce inclusive of nurses, doctors and support workers with access to specialist clinical advice. The mobile team has improved performance in record keeping and reduced time spent completing documentation by using digital dictation via mobile phones, sending records to a transcription service. Access to the team is via the South of Tyne initial response service, which provides 24 hour telephone access for all referrers who require urgent mental health support. Positive outcomes include;
» collaboration with service users to provide robust packages of care working within a recovery based model
» a reduction in clinical administrative workload; providing a more timely response to referrals and allows the clinical staff to focus more on clinical interventions
» the initial response service manages telephone referrals this team provide the face to face response; avoiding disruption to care and providing improved access for referrers
» maintaining an individual's care in the community, reducing the adverse effects of hospital admission,
» a significant reduction in hospital admissions and bed usage and improved financial efficiency

AREA 11: CRISIS CARE AND RECOVERY PLANS

Commissioning standards and recommendations

All people under the care of secondary mental health services and subject to the Care Programme Approach (CPA) and people who have required crisis support in the past should have a documented crisis plan

Those people not on CPA should have a crisis plan as part of their primary care local care plans for vulnerable people where appropriate

Arrangements should be put in place to ensure that crisis plans are accessible to GPOOHs and NHS 111 teams

Crisis care plans should be co-produced by the person with mental health problem, his/her carer(s) and the mental health professional(s)

Mental health professionals should understand the use and purpose of crisis care plans and be trained in their design

Crisis care plans should:
» include information regarding the 24 hour help line and how to access crisis care services out of hours
» be accessible to health professionals immediately when a service user presents in a crisis (including GPs, ED Staff, LAS, NHS 111, GP OOHs)
» focus on individual strengths, networks of support and service user defined recovery outcomes
» be reviewed regularly and kept up to date, particularly following any crisis presentation, admission or significant change in an individual's circumstances
» identify factors which potentially could precipitate a crisis and what steps can be taken to reduce the likelihood of a crisis in such circumstances

The care programme approach is the national framework which ensures that individuals with mental health problems under the care of specialist mental health services have their needs assessed and an appropriate plan of care then formulated in response. This should then be regularly reviewed and updated as circumstances change. The care plan should include a detailed crisis plan outlining the interventions necessary to prevent and manage potential crises.

The Crisis Concordat[8] highlights care planning as an essential component of recovery, as well as key in the prevention and management of a mental health crisis. Planning can be used to help plan treatment and used effectively can play an important role in preventing a crisis escalating.

The term 'crisis plan' is used to refer to multiple plans including joint care plans, crisis cards, treatment plans, wellness recovery action plans, and psychiatric advance directives. Advance directives reflect a person's preference for treatment should they lose capacity to make decisions in the future e.g. when they are in the midst of a mental health crisis.

The Mental Health Capacity Act entitles adults who have capacity to do so, to make advanced decisions to inform their care plan when unwell including how they wish to be cared for in times of crisis. Advanced directives have the potential to improve clinical outcomes through an increase in provision of preferred services during crises and improved service user engagement[36].

A joint crisis plan aims to empower service users while facilitating early detection and treatment of relapse[37, 38].

Joint crisis plans are an application of the shared decision making model[36], developed after widespread consultation with service user groups[38]. The joint crisis plan is formulated by the individual in collaboration with staff and aims to increase their level of involvement. It is kept by the individual and allows them to express their treatment preferences for any future crisis, when he or she may be less able to express clear views[39].

Crisis cards contain key information from an individual's crisis plan including who they would want to be contacted in an emergency. Good crisis planning, including active involvement and service user engagement reduces the frequency of relapse and the likelihood of crisis admission[40].

References to case studies and contacts
» What makes a good crisis plan? Case study (29)

What makes a good crisis plan? (Case study 29)

In 2013/14, one of South West London and St George's Mental Health Trust's CQUIN targets was to review the crisis plans of people on care programme approach and implement a programme to improve the quality of crisis planning. The first action has been to co-produce what is considered to be an exemplar crisis plan and good practice standards for the crisis planning process. A three-stage process was used. Stage one, a literature review, stage two a workshop with service users, carers, friends, families and professionals to identify what makes a good crisis plan and stage three a Delphi exercise to identify areas of consensus. 78 out of 94 statements reached positive consensus within the Delphi exercise. 10 per cent of service users and 25 per cent of carers and families in comparison with 49 per cent of mental health professionals disagreed or strongly disagreed with the statement that crisis plans will not work because services will not honour them. The process for coproducing an exemplar crisis plan and good practice standards appears to have worked well.

"Every service user should have a crisis management plan, shared with GP, social worker etc. and triggers should be recorded."

– Event participant

"Advanced directives give [service users] control in times of vulnerability."[36]

Area 12: Integrated care

Commissioning standards and recommendations

Services should adopt a holistic approach to the management of people presenting in crisis. This includes consideration of possible socioeconomic factors such as housing, relationships, employment and benefits

Provider trusts should work closely with local authority partners

Bridging support should be provided between crisis services and wider community services e.g. mentoring, befriending, mediation and advocacy

Provider trusts should work with partner agencies to compile and maintain a directory of local services which can provide support for service users in crisis e.g. women's aid, drug and alcohol services and welfare advice services

Integrated care, for the purposes of this guide, is defined as joined up mental health care, adopting a coordinated approach between health and social care, ensuring all the individual's needs are considered. It describes the coordinated commissioning and delivery of mental health services to support those in crisis or those who have experienced a crisis, maximising their independence, health and wellbeing[41].

The wider, holistic model embedded within social prescribing, has an emphasis on personal experiences, relationships and social circumstances can be more consistent with lay concepts of mental wellbeing and mental distress than a medical model[43].

Social prescribing, normally delivered in primary care, links individuals to sources of support within the local community. This can include promoting or recommending opportunities for arts and creative activities, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems[44].

This approach is reliant on frontline health professionals having access to information about local services and possessing good links and contacts which extend beyond the health sector, and to be aware of the influence social, economic and cultural factors can have on mental health outcomes.

A holistic approach takes into account an individual's background including housing, income, employment, status and welfare.

Welfare rights problems are a major cause of stress which can precipitate a mental health crisis or worsen diagnosable mental health conditions. People with severe mental illnesses are at higher risk of experiencing a wide range of welfare issues. They are at a much higher risk of homelessness and in some cases this is preventable. Severe mental illness and low income can result in social isolation where an individual can cut themselves off from friends and family which can be source of help and support. People with poor mental health living on low incomes or who are unemployed are more likely to run into financial or housing difficulties and may have less capacity to cope or deal with these problems. In particular, those who are not employed depend on state benefits and if advice is not provided there is risk of financial problems including the accumulation of debts and arrears. One problem can aggravate the other leading to a downward spiral into mental health crisis[46]. Engagement with advice services and local partners is therefore crucial if people are to access wider advice and support.

References to case studies and contacts
» Ways to wellness: social prescribing for people with LTCs (Case study 30)
» The Sandwell Esteem Team (Case study 31)
» Manashanthy: CBT for Tamil people in south west London (Case study 32)

Ways to wellness: Social prescribing for people with long term conditions in Newcastle West CCG (Case study 30)

This project developed a single cohesive approach to social prescribing in primary care to improve the quality of life for adults with a range of long term conditions and mental health issues. This includes link workers to provide focused support to help patients identify and access community activities and where necessary specialist advice to help improve their wellbeing. GPs refer and encourage people to take up activities instead or alongside medical prescription. This approach recognises the wider determinants to bring about long term behaviour change increasing social networks and promote staying well.

"Unmanageable debt is a risk factor for self-harm."[45]

"Around half of all people with debts have a mental health problem."[42]

The Sandwell Esteem Team (Case study 31)

The aim of the esteem team is to support people with mild to moderate mental health conditions and complex social needs at an early stage to prevent deterioration and admission to secondary care services. It aims to empower patients to take control of their own lives by offering guided therapies and tools for self-help. The esteem team is part of an integrated primary care and wellbeing model, developed to work in close partnership with statutory agencies to offer a seamless primary care service without barriers. The team works closely with welfare rights, talking therapies, advocacy, to ensure clients get the right services and help to access services. The team consists of gateway and link workers who act as care coordinators and navigators for those with complex needs. The service provides support, improves and maintains wellbeing.

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APPENDIX A - GLOSSARY

APPG	All Party Parliamentary Group
AMHP	Approved Mental Health Practitioner
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CPA	Care Programme Approach
CRT	Crisis Resolution Team
ED	Emergency Department
EDT	Emergency Duty Team
HTT	Home Treatment Team
JHWS	Joint Health and Wellbeing Strategies
JSNA `	Joint Strategic Needs Assessment
NICE	National Institute for Health and Clinical Excellence
PES	Psychiatric emergency service
RCGP	Royal College of General Practitioners
SCN	Strategic Clinical Network
SCIE	Social Care Institute for Excellence

CASE STUDY DIRECTORY

LONDON-WIDE AND NATIONAL CASE STUDIES - *Compiled by the London Mental Health Strategic Clinical Network*					
No	Title	Description	Location	Contact name(s)	Contact details
1	Mental Health Direct – 24 hour mental health support and crisis line	Mental health direct offers 24 hour mental health support via a single recognizable crisis telephone number. The switchboard element is operated by non-clinical staff who apply an algorithm process to callers to ensure they are directed to the appropriate service or given the correct advice. The service ensures earlier intervention for people in crisis and aims to reduce unplanned A&E admissions.	North East London Foundation Trust	Gavin Mess, Mental Health Direct Manager,	gavin.mess@nelft.nhs.uk
2	Sunderland and South of Tyne Initial Response team	A single point of access for urgent mental health requests including signposting to relevant services. Objectives are to offer a 24/7 response to telephone requests for help for all ages and conditions; offer triage and routing to services including local services. Call handlers and clinical triage provide rapid response and advice on care and treatment. Team works alongside the crisis team and service specialties.	Northumberland, Tyne and Wear NHS Foundation Trust	Denise Pickersgill, Service Manager Access and Treatment Service, NTW	Denise.pickersgill@ntw.nhs.uk
3	Northumberland, Tyne and Wear Initial Response service	Initial Response Service (IRS) is a key development within the Principal Community Pathways (PCP) programme. The service provides a single point of access to NTW to ensure service users (urgent and routine) are referred to the right service and placed on the right pathway without delay, keeping them fully informed of this process. If service user needs cannot be met by one of the services they and their referrer are signposted to the appropriate service elsewhere, with an informative explanation.	Northumberland, Tyne and Wear NHS Foundation Trust	Denise Pickersgill, Service Manager Access and Treatment Service, NTW	Denise.pickersgill@ntw.nhs.uk
4	North west London's mental health transformation strategy 2012-15	The aim of the transformation programme is to improve the experience of, and outcomes from, mental health urgent assessment and care across North West London, including increasing the management of the health and wellbeing of people with mental health problems in primary care. Improvements include: a access and care standards policy; review of the local skill mix, competency and training needs of staff; extension of home visiting for crisis resolution work, providing 24/7 cover every day of the year and a single point of access available 24/7 every day of the year.	North west London	Glen Monks, Mental Health Programme Director, North West London Michael Doyle, Head of Urgent Care Programme, North West London	glen.monks@lucent.org.uk Michael.doyle4@nhs.net
5	Integration of CAMHS into a single point of access for children	To develop the existing single point of access to improve assessment and triage so that appropriate referral is made to Tier 2 Primary Mental Health Services, Tier 3 services or redirected to Tier 1 services. The new service will have a single access point for all children's emotional and behavioural services. The child will reach the most appropriate service first time around reducing waiting time.	Richmond CCG	Dr Brinda Paramothayan, Children's Clinical Lead, Richmond CCG	brinda.paramothayan@nhs.net

CASE STUDY DIRECTORY

No	Title	Description	Location	Contact name(s)	Contact details
LONDON-WIDE AND NATIONAL CASE STUDIES - *Compiled by the London Mental Health Strategic Clinical Network*					
6	Big White Wall digital mental health service	The digital mental health service, Big White Wall, is offered on a self-referral basis to all adults in Southwark. The service offers instant access, 24 hours a day crisis support from trained counsellors through the 'Ask a Wall Guide' function, safe and moderated peer support, and self-management materials. The service is fully anonymous, meaning that it is more acceptable to people who are unwilling to access support due to stigma. Big White Wall members frequently make use of the network at times of distress, to resist urges to self-harm or to cope with suicidal thoughts – many then continue to use it for support with longer-term issues.	Southwark CCG	Carol-Ann Murray, Senior Mental Health Commissioner, NHS Southwark Clinical Commissioning Group	carol-ann.murray@nhs.net
7	'Evolve'- a navigator service	'Evolve' is part of CREST, a local voluntary sector charity in Waltham Forest, and provides navigators to establish the nature of the crisis, whether social or medical, and works with the individual to decide on the appropriate course of action to minimise risks to a mental health relapse. Initial outcomes of the pilot have shown that the Evolve team has contributed to an overall reduction in the number of individuals having a crisis where regular contact with navigator is maintained, as well as a reduction in the duration of a crisis episode through quicker access to intervention and treatment.	Waltham Forest	Chris O'Sullivan, Evolve Team Leader, CREST Waltham Forest	chris.osullivan@crestwf.org.uk
8	Leeds survivor led crisis service	The Leeds survivor led crisis service is governed and managed by people with direct experience of mental health problems. It runs a telephone helpline Connect, offers a place of sanctuary for people in acute mental health crisis called Dial House and provides person centred group work. It has been successful in providing a viable alternative to the medical model of care for people in acute mental health crisis.	Leeds	Fiona Venner, Service Manager, Leeds survivor led crisis service	Fiona.venner@lslcs.org.uk
9	Solidarity in a crisis	Solidarity in a crisis is a peer support service which is co-designed and co-delivered by service users and carers in Lambeth. Crisis support is offered over the phone or in person out of hours during the weekends. It is an alternative service to NHS services or hospital. The aims of the service are to reduce isolation, support people using empathy and knowledge gained through experience and to help the person before reaching crisis point.	Lambeth	Patrick Nyikavaranda, Peer Involvement Coordinator, Certitude	PNyika@certitude.org.uk

CASE STUDY DIRECTORY

LONDON-WIDE AND NATIONAL CASE STUDIES - *Compiled by the London Mental Health Strategic Clinical Network*					
No	Title	Description	Location	Contact name(s)	Contact details
10	City and Hackney CCG mental health training	City and Hackney CCG have just launched a programme of training for all primary care staff offering free Mental Health First Aid Lite courses to all GP reception staff. The next phase of the programme will be to offer a two day course to those reception staff who would like further training. Practice nurses, district nurses and health care assistants are encouraged to attend the UCLPartner's mental health and wellbeing training package for practice nurses (Case Study 12). For GPs, educational sessions and workshops continue to run. Mental health training has also been incorporated into this year's locally enhanced service (LES).	City and Hackney CCG	Rhiannon England, GP Mental health lead, City and Hackney CCG	rhiannon.england@nhs.net
11	Kingston CCG advanced diploma in mental health	Kingston CCG has been awarded funding to provide training to advanced diploma level in mental health to 20 Kingston GPs. The programme is accredited by RCGP and to be delivered by PRIMHE, from in autumn 2014 to summer 2015. There will also be training for nurses to follow and awareness training for all interested other GPs and their practice staff. The overall aim is that there will be enough GPs trained to this level to assist and support the delivery of mental health care in primary care across Kingston.	Kingston CCG	Phil Moore, GP Lead clinical commissioner for mental health, Kingston CCG	Phil@philmoore.org
12	Bespoke mental health training for practice nurses	The project was funded by the Health Education North Central East London (HENCEL) to establish a sustainable network of nurse educators, develop a 10 module training and train the trainer programme and educate practice nurses in the region. A bespoke mental health and wellbeing package for practice nurses has been developed. The practice nurses are taught to understand the patients' mental, physical, emotional, spiritual and social needs. This has the potential to prevent crisis and when a crisis occurs, increase recognition with appropriate and effective response.	North east and north central London	Sheila Hardy, Education Fellow, UCL Partners	Sheila.hardy@uclpartners.com
13	Time to Change: mental health training for GPs	The BIG Lottery funded a focused training programme for GPs and primary care staff. This funding was awarded to create an opportunity to learn from the Education Not Discrimination (END) targeted training element of Time to Change phase 1 (Sept 2007 – Sept 2011) and seek to develop a training model that is targeted and aligned with the needs of GPs and primary care staff, as well as meet the objectives of the new commissioning framework. This project was designed to try and improve attitudes and behaviours in GP practices towards people with mental health problems through improving knowledge.	London	Leigh Wallbank, Mental Health Promotion Manager, Rethink Mental Illness	training@rethink.org

CASE STUDY DIRECTORY

		LONDON-WIDE AND NATIONAL CASE STUDIES - *Compiled by the London Mental Health Strategic Clinical Network*			
No	Title	Description	Location	Contact name(s)	Contact details
14	Whittington integrated liaison assessment team	The integrated liaison assessment team has the following features: consultant/specialty trainee follow-up clinic for cases where there are diagnostic difficulties or medication issues; liaison follow-up clinic typically offered to those who do not require admission or crisis team follow-up and who do not have easy access to community follow-up; direct referrals - the team has developed an initiative to identify patients who are more appropriately referred directly to psychiatry from the triage nurse using an agreed protocol.	North central London	Stuart Shepherd,	carol-ann.murray@nhs.net
15	Liaison psychiatry in north west London	Central and North West London NHS Foundation Trust and West London Mental Health NHS Trust, worked in partnership to establish pilot services at four acute trusts: North West London Hospitals NHS Trust (Northwick Park and Central Middlesex hospitals), Hillingdon Hospital NHS Trust, Ealing Hospital NHS Trust, and West Middlesex University Hospital NHS Trust. An 'optimal standard' model was developed for a hospital of 500 beds that provided an integrated multidisciplinary service with 24 hour input to ED an inpatient populations. There have been improvements in mental health diagnosis, treatment and care of patients in acute hospitals with co-morbid physical and mental health problems and a reduction in the overall lengths of stay for the same group.	North west London	Dr Steven Reid, Consultant Liaison Psychiatrist and Clinical Director, Central and North West London NHS Foundation Trust	steve.reid@nhs.net
16	Hull and East Yorkshire Hospitals Trust: The mental health team	The team is a multi-disciplinary team which assesses patients with a range of mental health problems including acute mental illness; self-harm; attempted suicide; or extreme distress. Dependent upon the nature of the referral the response rates are 30 minutes the same working day or within 24 hours. A further aim is to educate staff within the acute trust to enable them to recognise mental health problems early and refer appropriately.	Hull	Dr Stella Morris, Consultant in Liaison Psychiatry, Hull and East Yorkshire Hospitals Trust	Stella.morris@humber.nhs.uk
17	Birmingham and Solihull Mental Health NHS FT: Rapid Assessment Interface and Discharge (RAID)	The service aims to meet the mental health needs of all patients over the age of 16 including those who self-harm, have substance misuse issues or mental health difficulties commonly associated with old age including dementia. With an emphasis on rapid response, it has a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on the wards. The service puts an emphasis on diversion and discharge from A&E and on the facilitation of early but effective discharge from general admission wards.	Birmingham	Michael Preece, RAID Operational Lead, Birmingham and Solihull Mental Health Foundation Trust	Michael.preece@bsmhft.nhs.uk

CASE STUDY DIRECTORY

No	Title	Description	Location	Contact name(s)	Contact details
LONDON-WIDE AND NATIONAL CASE STUDIES - *Compiled by the London Mental Health Strategic Clinical Network*					
18	Hackney 24 hour AMHP service	The London Borough of Hackney and East London Foundation Trust out of hours AMHP service aims to respond to requests for Mental Health Act assessments which arise outside usual working hours. There has been improvement in response times with 100 per cent compliance with the four hour response target. There is now a single 24 hour phone number. The service operating costs are less than previously.	Hackney	Gill Williams, City and Hackney Centre for Mental Health, East Lonodn Foundation Trust	gill.williams@eastlondon.nhs.uk
19	Vulnerability Assessment Framework training tool	The Vulnerability Assessment Framework provides a simple tool for Metropolitan police officers to use to identify those that are vulnerable and possibly in need of further help. The tool was developed by the University of Central Lancashire, originally called the Public Psychiatric Emergency Assessment Tool. Since this system went live over 55,000 reports have been completed, enabling the police and partners to identify individuals that are becoming vulnerable far earlier and enabling early intervention.	London	DI Frankie Westoby, National Mental Health Policing Portfolio Staff Officer to Commander Jones and Metropolitan Police Service Central Mental Health Team	frankie.westoby@met.pnn.police.uk
20	London street triage pilot	NHS England, London Region together with the Mayor's Office for Police and Crime (MOPAC) commissioned a Street Triage Project in London, piloted in the boroughs of Lambeth, Lewisham, Croydon and Southwark. The triage service consists of mental health practitioners accompanying police officers to mental health related call outs and/or providing dedicated telephone support to officers on the ground who are responding to people in crises. The project aims to reduce the use of section 136 of the Mental Health Act amongst the police and reduce the amount of time that officers spend dealing with people who are in crisis due to mental health problems.	London	Sinéad Dervin, Commissioning Manager, Health in the Justice System, NHS England	s.dervin@nhs.net
21	Integrated mental health team based in police headquarters	The aim of the project is to have an integrated mental health team based within the control room at police headquarters in Norfolk in order to improve safeguarding for those suffering from mental ill health and introduce and provide early access to services for those with mental health issues before they reach crisis point.	Norfolk	Terri Cooper-Barnes, Lead mental health Nurse, NSFT Amanda Ellis, Chief Inspector, Norfolk Police	terri.cooper-barnes@nsft.nhs.uk ellisam@norfolk.pnn.police.uk

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22	British Transport Police (BTP) suicide prevention project	In February 2013 a suicide prevention project (Operation Partner) was set up between BTP, NHS London and 2 London mental health trusts. This involved BTP staff and community psychiatric nurses working together to implement and review suicide prevention plans for people at risk. During 2013/14 631 people received life-saving interventions on the railway. During Operation Avert 1 and 2 the daily life saving intervention rate doubled and the numbers of fatal and injury suicide events reduced.	London	Mark Smith, Head of Suicide Prevention and Mental Health, British Transport Police	mark.smith2@btp.pnn.police.uk
23	Highbury Grove crisis house	Highbury Grove in Islington provides an alternative service to hospital admission for people experiencing mental health crisis in a community setting. The service consists of three components including a twelve bed residential service; a crisis phone line provided seven days a week 5pm to 6am and the crisis night centre. The crisis night service is available seven days a week to provide a safe place for service users to meet and socialise therefore minimising social isolation, while providing support where necessary.	Islington	Sara Kelly, Team Manager, One Housing Group	skelly@onehousinggroup.co.uk
24	Camden crisis houses	Two crisis houses were established in Camden to provide an alternative to acute inpatient hospital admissions based on a person-centred recovery model. The Camden crisis house model includes a crisis team who support people in their homes and act as gate-keeper for admissions and a structured acute day treatment programme, where service users are encouraged to participate in therapeutic groups. People are admitted to the houses at the height of acute crises for brief stays of on average two to ten days. Most people (74-78 per cent) are discharged to their own homes.	Camden	Kate Clayton, Operational Manager, Camden and Islington Mental Health Trust	katie.clayton@candi.nhs.uk
25	West of Dorset recovery house	The service provides an alternative to acute psychiatric inpatient admission, which allows care and support to be delivered in a safe environment that promotes recovery. The crisis and home treatment team offer a stay at the recovery house to people whose needs can be safely and effectively met there and who would otherwise require hospital admission.	West Dorset	Deborah Rodin, Services Manager, Rethink Mental Illness	deborah.rodin@rethink.org

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26	Hertfordshire Partnership NHS University Foundation Trust (HPFT): Host Families scheme	The Host Families scheme is an alternative to hospital admission or follows on from inpatient care and aims to offer intensive intervention and support to service users in a crisis. The scheme is an integral part of the Crisis Assessment and Treatment Team providing a supportive, therapeutic alternative to inpatient care. Host families are recruited to offer a supportive family environment to mental health service users.	Hertfordshire	Sarah Biggs, Hertfordshire Partnership University Foundation Trust	sarah.biggs@hpft.nhs.uk
27	Redbridge home treatment team	North East London Foundation Trust provides multi-disciplinary home treatment as an alternative to admission which enables wards to target those who require an inpatient stay. The team consists of social care staff, psychologists and occupational therapists. The teams have a 100 per cent gate-keeping role to their wards and are also 100 per cent involved in inpatients discharge.	North east London	Pete Williams, Assistant Director NELFT MHS Acute Services Lead	pete.williams@nelft.nhs.uk
28	South Tyneside crisis resolution and home treatment team	Northumberland Tyne and Wear NHS Foundation Trust provides a crisis resolution home treatment team with the capacity to visit service users up to three times daily, providing a range of psychological and physical interventions including support and psycho-education for carers and families. The team works extensively with the inpatient units, gatekeeping all admissions and providing early discharge planning. The team provides a 24 hour mobile workforce inclusive of nurses, doctors and support workers with access to specialist clinical advice.	Northumberland	Emma Bailey, Team Manager, CRHT Sunderland and South Tyneside	emma.bailey@ntw.nhs.uk
29	What makes a good crisis plan?	In 2013/14, one of South West London and St Georges mental health trust's CQUIN targets was to review the crisis plans of people on care programme approach and implement a programme to improve the quality of crisis planning. The first action has been to co-produce what is considered to be an exemplar crisis plan and good practice standards for the crisis planning process	London	Miles Rinaldi, Head of Recovery and Social Inclusion, SW London and St Georges Mental Health Trust	Miles.Rinaldi@swlstg-tr.nhs.uk
30	Ways to Wellness: social prescribing for people with long term conditions in Newcastle West CCG	This project developed a single cohesive approach to social prescribing in primary care to improve the quality of life for adults with a range of long term conditions and mental health issues. This includes link workers to provide focused support to help patients identify and access community activities and where necessary specialist advice to help improve their wellbeing. GPs refer and encourage people to take up activities instead or alongside medical prescription. This approach recognises the wider determinants to bring about long term behaviour change increasing social networks and promote staying well.	Newcastle West CCG	Sandra King, Project Director Ways to Wellness	sandra.king@vonne.org.uk

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31	The Sandwell Esteem Team	The aim of the esteem team is to support people with mild to moderate mental health conditions and complex social needs at an early stage to prevent deterioration and admission to secondary care services. It aims to empower patients to take control of their own lives by offering guided therapies and tools for self-help. The esteem team is part of an integrated primary care and wellbeing model, developed to work in close partnership with statutory agencies to offer a seamless primary care service without barriers.	Sandwell and Birmingham	Ian Walton, IAPT lead, Sandwell and Birmingham CCG	ianwalton@btinternet.com
32	Manashanthy: Cognitive Behavioural Therapy (CBT) for Tamil people in south west London	The aims of this project were to identify needs in the Tamil community, raise awareness of existing IAPT services and offer interventions to meet their needs. A culturally adapted CBT model has been established: Tamil speaking CBT therapists were employed and trained to provide workshops at the Wimbledon Shree Ganapathy temple to the Tamil community, as well as via other local temples and churches.	South west London	Meera Bahu, Psychological Therapies and Wellbeing Service, South West London and St Georges Trust	meera.bahu@swlstg-tr.nhs.uk

About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders
-- providers, commissioners and patients -- together to create
alignment around programmes of transformational work that will
improve care.

The networks play a key role in the new commissioning system by
providing clinical advice and leadership to support local decision
making. Working across the boundaries of commissioning and
provision, they provide a vehicle for improvement where a single
organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major
healthcare challenge where a whole system, integrated approach
is required: Cardiovascular (including cardiac, stroke, renal and
diabetes); Maternity and Children's Services; and Mental Health,
Dementia and Neuroscience.