Crisis Care Concordat
Mental Health

# 2014 National Summit Post-Summit Report

## Crisis Care Concordat Aim

The central ambition of the Crisis Care Concordat is that local health, local authority, youth and criminal justice systems and service users and their representatives across England commit to working together to review, monitor and continuously improve the experience of people in mental health crisis in each and every locality. The Crisis Care Concordat was launched in February 2014. 22 national organisations signed the concordat, committing to assist through a series of national actions. By the end of 2014, all 152 localities across England had in place a declaration signed by local organisations, forming a partnerships and commitment to work together to improve crisis services.

## Crisis Care Concordat National Summit

The Crisis Care Concordat inaugural National Summit took place on 27th November 2014 at the Connaught rooms, London. It consisted of plenary speakers, seminars and an opening address From Rt Hon Norman Lamb MP, Minister of State for Care and a closing address from Rt Hon Mike Penning MP Minister of State for Policing, Criminal Justice and Victims Support. The summit was a full day programme celebrating progress and improvement to practice since the launch of the Crisis Care Concordat in February 2014. There were 11 plenary speakers from a variety of fields. In addition to the plenary speakers five expert panel discussion and seminar sessions were held. Each seminar was delivered twice, once in the morning session and once in the afternoon session. All summit delegates were invited to attend and participate in two different seminars. The seminars covered a broad range of topics, selected to correspond with themes of the Concordat. The seminars were facilitated by experts in their fields. The seminars included a presentation to introduce the topic followed by facilitated discussion with all those in attendance. The full programme for the day can be viewed at [insert link]

## This report

This report summarises the topics of discussion covered in each of the 5 seminars. This report collates the notes taken in each seminar by the expert facilitators. It is intended to serve as a summary of the issues raised, discussion held and conclusion and solutions proposed through the discussion. With the intention of informing future work and further discussions to progress practice. The notes taken are not comprehensive minutes of all discussions which took place and have been presented in bullet point format. This report contains the following headings and sub-headings

1. **Training**
    - Issues raised
    - Good practice ideas and observations
    - Conclusions
2. **Information Sharing**
    - Issues raised
    - Approaches to consider
    - Conclusions
3. **Intoxication**
    - Issues raised
    - Conclusions
4. **Quality of treatment and Care when in Crisis**
    - Approach and context
    - Outcomes and successes
    - Conclusions and lessons learnt about successful implementation
5. **Recovery and Staying Well**
    - Issues and questions raised
    - Conclusions

# 1. Training

The theme of training for professionals in mental health crisis care pathways was explored and facilitated by; Inspector Michael Brown, Mental Health Coordinator for the College of Policing; Claire Barcham, Professional Practice Development Coordinator for the College of Social Work and Anna Akerman, Policing Practice Developer for the College of Policing.

## Issues raised

Within the training seminar a number of issues were raised and questions explored through discussion, including training of different professions, legality of protocols, expectations, limitations and ongoing management of arising issues. These issues have been summarised in bullet points below:

### Across all professions

- Entrenched attitudes and stigma are still prevalent issues among both psychiatric/mental health care professionals, A&E professionals and the police
- The requirement for legal training for professionals 'Legal literacy' in each agency is well accepted, however, the level of detail that is necessary and appropriate is the subject of debate.
- Training and encouraging ambulance staff to use restraint, when they are under resourced carries a significant risk and the 8 minute time target for incident response for ambulances exacerbates this problem. This risk impacts upon the safety of paramedics, and ultimately the police will be required to step in, regardless of local protocols or training.
- The Mental Health Act is in many ways an outdated law that does not provide adequate tools for modern Crisis Care service requirements (for the Police or Mental Health professionals).
- The vocabulary, training and understanding of intoxication related issues that include Acute Behavioural Disturbance and Excited Delirium must be made consistent between services to aid joint working and prevent tensions/disagreement that is detrimental to service provision.
- The management and handling of individuals with personality disorders is a specialist issue that needs separate consideration. This is a particular concern when it results in repeat call outs of the police and health/social care efforts to use 'pathways to care' which prove ineffectual, alternative CJ options might be more effective in some cases.

### In relation to the Police

- Training has been delivered within some police forces by 'generalist' trainers who do not have any subject matter expertise or experience which has led to inaccuracies in the information provided and a lack of credibility, creating risk and potentially hampering effectiveness.
- There is anecdotal evidence that police officers who have received highly detailed legal and procedural training in a single day's training input have been overwhelmed and not absorbed the content sufficiently.
- There is a risk that by providing police officers with too much medical and symptom focused training they will begin to inadvertently clinically assess an individual when they have insufficient knowledge and expertise. Linked to this, a concern was raised that a focus on procedural, framework based interactions would be detrimental to the natural human reaction and empathy that should be encouraged between professionals and service users in crisis.
- The intervening presence of police officers at the scene of a service user in crisis can either be an aggravating factor (be perceived as threatening or frightening) or can have a calming influence.
- Police officers are prevented from adhering to legal and procedural obligations where 24/7 access to MH advice and services are not available locally.

**In relation to Social Workers / AMPS**

- Social workers are currently not considered by the NHS to be 'allied professionals' which is restricting their access to, and funding for appropriate training.
- AMHP response times for assessment (of typically 4 hours) are causing unnecessary delay for service users, wasting police resources and creating risks.
- Access to NHS medical information and Social Care databases are seen as the central and key levers for improvement to risk assessment by the police. This can be achieved via Street Triage but may also be achieved via alternative information sharing arrangements.
- There is a tension within MH trust care services between staffing Crisis response teams to attend people in crisis, and managing the resourcing of wards/units. Often this means a choice of one or the other service because staff are shared.
- A question was raised, is reasonable or appropriate to say that there is a 'crisis team, or crisis response team' when the service will only handle pre-booked appointments?

## Good Practice ideas and observations

Following the discussion identifying issues, further debate took place to highlight good practice ideas and strong existing practice. Observations and ideas have been summarised in bullet points below:

**Training models**

- The National Decision Model (NDM) can aid joined up working, decision making and communication between services and health and social care professionals.
- A system of 'Champions' for MH within the police/health and social care services, who receive additional (which might mean sufficiently detailed) training may be a cost effective and efficient use of training resources and may help diffuse the 'de-stigmatisation' message.
- A good practice example of 'champions' for mental health exists in Hampshire police, in which 5% of front line police officers have received detailed training with contextualisation via work with MH Units and service user input. These officers are then preferentially deployed to MH Crisis incidents similarly to the American CIT (Crisis Intervention Team) model.
- American CIT (Crisis Intervention Team) model should be explored and considered for use
- American 'Emotional CPR' training model could be used to assist the Police and Mental Healthcare staff with additional de-escalation and diffusion training

**Additional training**

- The use of a scenario based training approach (using 6 most common scenarios with real case data and outcomes) has proved successful for MH professionals and could be replicated. Some forces have already developed videos that could be used more widely.
- All front line police officers, AMHPs and paramedics should have a basic level of MH training, this may be delivered via the relevant 'initial' learning programmes (or pre-registration learning requirements) but also requires refreshing throughout a career and existing staff must receive appropriate training.
- All services would benefit from experience gained working directly with other agencies, although this may be impractical for all staff, it may be beneficial for a small proportion (as per the CIT model).
- There is an expectation that Police Officers should know and have a thorough understanding of MH law and how it is applied, this includes relevant case law.
- Training in skills associated with emotional awareness and empathy are equally necessary and appropriate for all emergency response services.
- Initial encounter ('meet and greet') training that includes an assessment of vulnerability aspect is appropriate and necessary for all emergency response services.

- Multi-disciplinary teams working closely together over an extended period of time develop trust, understanding and expertise jointly. This approach provides the optimum potential for effective information sharing which results in improved care and results for service users.
- The police service may benefit from risk management training that more closely reflects the Healthcare approach, i.e. not risk adverse, but one that accepts and is obliged to accept and tolerate more uncertainty. If a mentally ill service user makes a decision not to co-operate, but is not in mortal danger, is lucid and there are no doubts about mental capacity, an officer may need to learn to accept that they have fully discharged their duty of care and no additional police intervention is required.
- Police officers must receive training that allows them to make effective decisions within their local areas, to do this training must include an element of 'understanding local arrangements and procedures'.

## Conclusions

Through discussion the following conclusions were raised:

- The primary challenge for all front line response training is providing sufficient detail and value in the time available. There are limitations to abstraction time to train all sectors particularly for police officers and ambulance staff. Ambulance staff have been attending training on their own rest days.
- National standards should be based upon a set of baseline legal obligations, expectations and principles available for all services/partner agencies. These standards should be linked to local procedures and protocols wherever possible and there should be an established level of 'legal literacy' for all professionals.
- Having professionals work alongside each other helps to break down unhelpful pre-conceptions.
- Respect and dignity should be central to all training for MH.
- Service user perspectives/input must be applied to training and should influence all training for every agency.
- Poor availability of health based POS beds will always hamper the quality of service, and presents a limitation to the effectiveness of Police, Health and Social Care/AMHP training. The benefits of training can only be realised if adequate HB POS are made available.
- There is an inconsistency and challenge in developing and/or enhancing legally and morally robust multi-agency joint working protocols that stand up to local working realities and provision of services and resources. To be useful the agreements must be achievable, legally sound and in the spirit of the CCC, however this is often impossible given practical limitations.

## Useful links on Training

Safety in Mind Training film

## 2. Information Sharing

The theme of information sharing across professionals, organisations and pathways within the field of mental health crisis care was explored and facilitated by; Seamus Watson, National Programme Manager for Wellbeing and Mental Health at Public Health England and Detective Inspector Frankie Westoby from the Association of Chief Police Officers. A link to the presentation slides used to introduce topics for discussion are here

### Issues raised

Within the information sharing seminar a number of issues were raised and questions explored through discussion, including cultural issues, clarity required and other barriers such as transient populations and IT systems. These issues have been summarised in bullet points below:

- There is a cultural issue of perceived resistance by health / social care towards information sharing
- Greater clarity is required around why information should be disclosed
- Clarity should be sought around when a client has and has not given consent to information sharing
- Many service users don't appear to have an issue with sharing information or believe that it is the wrong thing to do because they thought this was being done already.
- There is a different understanding of confidentiality across agencies.
- Transient populations are an added complexity. Where there is a transient population, sometimes found in parts of larger cities this can cause issues with ISAs.
- Additional barriers such as IT systems need to be explored and resolved. Some Section 75 agreements address this.

**Approaches to consider**

A number of different approaches, ideas and solutions were discussed to tackle issues raised, these have been summarised in bullet points below:

- Intervention upstream is needed to avoid crisis when working with the most needy / challenged individuals and families across agencies. There needs to be 'contingency / crisis' care plans in place before a crisis occurs, especially for people who regularly present in crisis.
- There is a need for national clarification, particularly on how legislation interacts with each other and what this allows in relation to information. We shouldn't have each area trying to make sense of legislation by itself (waste of effort and will lead to greater inconsistency)
- Consideration should be given to the use of National Decision Making Model, currently used by the Police
- Peer support is very valuable in times of crisis, so peers should be provided with information to assist them.
- Information sharing agreements have to include information beyond that held by mental health organisations
- Information needed may be in primary or secondary care ( GP's, Health Visiting, School Nursing )
- Highlight practical examples of strong practice and where things are working well.
- Strong examples of Information Sharing Agreements are:
    - South Wales, achieved through a task and finish group.
    - Rotherham & York, Emergency Services and Mental Health Services.

## Conclusions

Through the discussion the following conclusions were raised:

- Professional's fear to share information in relation to protecting people's privacy and rights could be tackled by changing attitudes towards a safeguarding view of 'what will happen if we don't share information?'
- Best practice should be captured and held in an easily accessed place to inform progress
- We need to ensure that the data held is accurate, so we must continue to work with service users
- It is very important that the right information is gathered and available to share, which is contingent upon asking the right questions in the first place
- Agreement should be reached about what common information can be shared i.e.
    - If known to Police or mental health services
    - If have a care plan
    - If have children
    - Care plans can be shared but not necessarily share diagnosis
- There is a need to clarify the purpose for which information is to be used.
- Timeliness of information sharing is critical as it is often needed immediately or at least within 2 or 3 hours
- Care plans should include
    - how service users can take control i.e. 'my health locker'
    - What information is shared when they are well?
- Information needs to be shared quickly when someone is in crisis i.e. less complex information and details about early intervention in crisis.
- Service users have to be involved in their care plans
- Professionals need to make clear what their role is when dealing with the service user
- Mutual understanding around what confidentiality mean is needed across different organisations
- Interpretation of information sharing is very important, there needs to be a consistent understanding of what is shared.
- There has to be leadership and involvement of executives in lead organisations: to form executive partnerships with local lead organisations, to formally commit to information sharing and provide governance oversight. Caldicott guardian has to be included as well.

## Useful links on Information Sharing

Carers and confidentially in Mental Health
Triangle of Care
Information Commissioners Office
Mental Health Cop


confidentialitytoolkit_full.pdf

## 3. Intoxication

The theme of intoxication within mental health crisis care pathways and services was explored and facilitated by; Ian Hulatt Mental Health Advisor for the Royal College of Nursing; Dr Michael Kelleher Consultant Psychiatrist and Clinical lead for Lambeth addictions, South London and Maudsley NHS and JP Nolan Emergency Care Advisor for the Royal College of Nursing.

### Issues raised

Emerging issues and themes raised within the information sharing seminar included impact of the tendering process on services, information sharing and a safe environment. These have been summarised in the below bullet points:

- The location and skill set needed for providing a safe environment, what is it and how can it be provided?
- There is often a view that people who are intoxicated are often "unsafe" and vulnerable, both in their behaviour, the risks from others and their internal functioning physically
- There is a need for a 'fourth place' for people who are intoxicated, which is neither physical health, police nor mental health focused i.e. alcohol welfare centres or "drunk tanks", the advantages are evident and allow a safe containment and also escalation if necessary.
- There is concern regarding information sharing, in particular access to information when police have detained an individual who could may mental health issues and be already known to secondary services.
- Commissioning can be fragmented with addiction services being provided by local authorities and also the third sector.
- Repeated tendering exercises are unhelpful

### Conclusions

Through the discussion the following conclusions were raised:

- A closer relationship between health services, local authorities and the third sector would be beneficial to future tendering processes and commissioning
- The assessment care and welfare of people who are in a state of "intoxication….plus" is of paramount importance
- The overriding challenge is to attend and determine the nature of the "plus" and see it as a legitimate concern of health, police and social care.

### Useful links on Intoxication

Mental Health Act Code of Practice
Guidance for Commissioners
Best Interests Decision study
Dual Diagnosis: Good Practice Handbook
Dual Diagnosis (Drug Abuse with Other Psychiatric Conditions)
Detention under the Mental Health Act
Assessing capacity to give consent
Alcohol misuse

Intoxication Test for
Mental Health Asses

## 4. Quality of Treatment and Care when in Crisis

The theme of quality and treatment of care when in crisis was explored and facilitated by; Dr Rahul Bhattacharya Associate Clinical Director at East London NHS Trust; Saffron Cordery Director of Policy and Strategy at NHS Providers and Cassandra Cameron Policy Advisor at NHS Providers. A link to the presentation slides used to introduce topics for discussion are here

### Approach and context:

A presentation explored and opened for discussion Home Treatment Teams (HTT) and Crisis Houses (CH)

- Home Treatment Team (HTT) and Crisis House (CH) program have been running in Tower Hamlets for 5 years
- Tower Hamlets is a challenged local area for mental health care – highly transient population, high immigrant, deprived area – lack of stability for treatment and less key social support structures to facilitate recovery and resilience
- HTT and CH are available to a wide range of service users – all ages and types of Mental Health conditions including Older Adults and LD. Though there is service level agreement to work with 16-18 year olds from local CAMHS services there has not been much demand for this.
- Crisis House is embedded in the HTT and admission to crisis house are gate-kept by HTT (HTT workers deliver treatment in community at the service user's home, or during their residency at the Crisis House)
- HTT has a clear place in the care pathway in mental healthcare and it can work across care delivery
- Crisis House service in Tower Hamlets is run by third sector through an integrated partnership approach involving cooperation and consultation about admissions and management of patients

### Outcomes and successes:

Through the presentation and discussion the following outcomes and successes were touched upon:

- HTT improves quality - 1) clinical effectiveness (provides a true alternative to Hospital admission) 2) patients generally prefer it over inpatient care, and 3) improved safety in care
- CH preferred to inpatient approach by both clinicians and patients because is more effective in facilitating recovery, offering continuity of care pre- and post-discharge
- Benefits also flow onto other aspects of care delivered by the Trust – i.e.; lower bed occupancy on acute inpatient wards in Tower Hamlets to below 85%; reduced length of stay; and (potentially) improved staff and patient satisfaction
- HTT doesn't reduce rates of detention under the Mental Health Act (MHA) as the treatment approach involves service user / patient to agree and allow access to professionals and a degree of acceptance of their mental illness- On the other hand service users detained under MHA are often detained due to their unwillingness to accept their illness and (along with) risks associated that warrant over-riding their wish.
- It is hard to measurably assess and determine the whole-system impact of HTT and CH approach but the evidence suggests the positive impact extends across the system – however, there is evidence on suicide reduction by approx. 2 completed suicides / 10 000 / year in areas where there was a 24 hour Crisis and Home treatment team.
- In partnership with academia and royal colleges, the team is taking a more structured approach to measuring quality improvement. The TH HTT and Crisis House has been benchmarked and validated through national benchmarking exercises and the services have engaged in innovation (e.g. clozapine titration (medication initiation that usually warrants hospital admission) at crisis house) and developing evidence base in the field of Crisis and Home Treatment Team.

- TH HTT is keen to engage in obtaining outcome data gathering within their clinical practice and have piloted Clinician rated outcome measures (CROM) as well as Patient Experience Measures (PREM). TH HTT is currently piloting Patient Reported Outcome Measures (PROM). In future the teams expect outcome data gathering to be embedded in their practice.
- It takes about 18-24 months to observe measurable improvement in efficacy of the TH HTT / CH model of care.

## Conclusions and Lessons about successful implementation:

Through the discussion the following conclusions and lessons about successful implementation were reached:

- Need to keep caseload management and patient inflow under control of HTT to maintain high quality outcomes
- The treatment model needs to be cohesive - HTT and CH care benefits from a clear, defined strategy and ambitions for outcomes in the local population
- Involvement of third sector in management of HTT and CH is feasible and beneficial as long as it involves an integrated approach that has clear accountability and governance, along with a shared understanding of desired goals and outcomes
- Communication with care coordinators is critical for continuity of care for service users that have care coordinators. Involvement of all professionals involved in care of the service user is key in developing holistic care plan and crisis and contingency plans.
- Readmission are sometimes a reflection of the impact of decisions made in other parts of the social system – about housing, social support. There is scope for improving data capture to facilitate greater information sharing and learning between local partnerships in mental health care, to identify linkages between various social factors that are correlated with poor mental health in the local population.
- CH is not a solution to acute inpatient demand and flow problems as this often involves multiple systems such as mental health care in the community, health and social care in general, inpatient psychiatric bed management, culture of the organisations and teams and patients and carers' choice and expectations.
- Length of Stay in CH is in part determined by other factors including impact on a service user's social benefits, autonomy and independence – averages out at about 3 weeks, but try to keep in under 4 weeks unless exceptional circumstances. 3-4 weeks also reflect closely to average length of stay in acute psychiatric ward (and it is to note that TH CH and HTT are aiming to offer a viable alternative to such an acute psychiatric inpatient admission.
- HTT has some applicability to in-home dementia care for crisis episodes but is generally not suitable as it is not a long-term treatment approach.
- Service users and patients can be beneficially included in benchmarking and sustainability planning.
- Family and carers can be involved but only providing that this will not be in conflict with the patient's needs or treatment (i.e. against their wishes, or otherwise inappropriate). Benchmarking exercises (often) involve user and carer feedback obtained through 3rd parties.

## Useful links on Quality of Treatment and Care when in Crisis

Mental Health in Emergency Departments

## 5. Recovery and Staying Well

The theme of Recovery and Staying Well within mental health crisis care pathways and services was explored and facilitated by; Thomas Farebrother Team Leader of Crisis Point at Turning Point; Colin Marsh Divisional Manager of Learning Disabilities and Mental Health of Sandwell Council for the Association of Directors of Adult Social Services and Amanda Reynolds Director at Blend Associates Ltd for the Association of Directors of Adult Social Service. A link to the presentation slides used to introduce topics for discussion are here and here

### Issues and questions raised

Emerging issues and themes raised within discussions around recovery and staying well included personal budgets, demand for crisis services and challenges for commissioning have been summarised in the below bullet points:

- It is important to recognise that no one service can meet all crisis needs
- Personal budgets are great but staff (care coordinators and councils) need info and training to support them
- Councils and the NHS have different thresholds for support
- It is a challenge for commissioners to change the range of services to adapt to people who use non-traditional support in the recovery process
- Austerity has resulted in cuts to 'support services', increasing the use of crisis services
- Personal budgets are a good concept but not well implemented.
- How do we build partnerships across system to make sure the support people want and need is in place?
- How can something be a crisis service when there is a waiting list?
- Demand is stopping crisis teams responding quickly
- Crisis houses are very good, however, crisis teams do not have capacity to support in community.
- Touch down and safe spaces including talking 'when in crisis' is beneficial to avoid hospital admission

### Conclusions

Through the discussion the following conclusions were raised:

- Teams and organisations need to work together. A good example of this is the Manchester crisis Forum
- Use of peer support is beneficial when people are beyond crisis
- Personal budgets need to be built into a Care Programme Approach
- Crisis houses should not be mixed sex
- There is a need for more prevention approaches to avoid crisis in Tier 1, Tier 2, Tier 3, then crisis and eventually in Tier 4 (GP's, A&E, schools all know about crisis coming) so can aid prevention approaches

### Useful links on Recovery and Staying Well

Making Recovery a Reality
Implementing Recovery
Implementing Recovery through Organisation Change