Concordat – Improving outcomes for people experiencing mental health crisis

We, the undersigned, commit to work together to improve the system of care and support so that people in crisis as a result of a mental health condition can be kept safe and helped by us to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.

We will work together, and with local organisations, to stop crises arising whenever possible through prevention and early intervention. We will seek to ensure vulnerable peoples' needs are met when urgent situations arise. We will strive to ensure that all relevant public services support any person who appears to have a mental health problem to move towards Recovery.

Jointly, we hold ourselves to be accountable for enabling this commitment to be delivered across England."

Draft – v4.0; 16th September

Contents

1. Concordat statement: The Vision

We recognise that people experiencing mental health crisis are among the most vulnerable in our society. They should be able to expect a timely and appropriate response from the services we represent which is effective in meeting their needs.

We acknowledge that this is not always the experience of people with these needs and so together we are committed to ensuring action is taken to make this the norm across England.

We are committed to work together to achieve Parity of Esteem for people experiencing mental health crisis, ensuring they get the same level of service at all times as people needing urgent and emergency care for physical health conditions.

We can achieve this by working together to anticipate and prevent mental health crises; to improve crisis care for people who need it; and to make sure that there is an effective emergency response system established, in which each agency involved will support the others, in the best interests of the people that need us..

Our intention is that people in mental health crisis will be treated with respect, compassion and dignity, they will be kept safe and their needs will be addressed appropriately and in a timely way to achieve the best outcome and experience possible for the individual.

We are committed to ensuring that people in mental health crisis can expect the following outcomes at different points in their experience:

- **Access to support before crisis point**

When I need urgent help to avert a crisis I, and/or people close to me, know who to contact 24/7. People take me seriously and trust my judgement, and I get speedy access to a service that helps me get better.

- **Urgent and emergency access to crisis care**

If I am in mental health crisis this is treated as an emergency, with as much urgency as if it were a physical health problem. If I have to be taken somewhere, it is done safely and supportively in suitable transport.

I am seen by a mental health professional quickly and do not have to wait in conditions that make my mental health worse. I then get the right service for my needs, quickly and easily.

Every effort is made to understand and communicate with me, to check any relevant information that services have about me, and to follow my wishes and any previously agreed plan.

I am safe and treated kindly, with respect, and in accordance with my legal rights. If I have to be held, this is done safely, supportively and lawfully, by people who know what they are doing.

Anyone at home, school or work who needs to know where I am has been informed and I am confident that arrangements are made to look after anyone who depends on me.

- **Treatment and care when in crisis**

I get support and treatment from people who have the right skills and who focus on my recovery, in a setting that is suited to my needs.

I have support to speak for myself and make decisions about my treatment and care. If I do not have capacity to make decisions about my treatment and care, any statements of wishes, or decisions, that I made in advance are checked and respected, and I am able to have an advocate.

- **Recovery and staying well / preventing future crises**

I, and/or people close to me, have an opportunity to reflect on the crisis, and to find ways to manage my mental health in the future, with support if needed. We have an agreed strategy for how I will be supported if my mental health gets worse in the future.

This Concordat will have succeeded when local health, social care, criminal justice systems and service users across England have embraced and committed to the principles and outcomes it sets out, and are working together to review, monitor and continuously improve the experience of people in mental health crisis in each locality. For that reason we have included within the Concordat a pledge that will allow local partnerships and individual organisations to commit to ensure higher standards of care in their areas [to be drafted].

At a national level, the following organisations are **signatories [indicative list, not yet complete or definitive**] to this Concordat, committing to work together to support local systems to achieve systematic and continuous improvements for crisis care for people with mental health issues across England:

Department of Health

Home Office

Children and Young People's Outcomes Forum

Association of Ambulance Chief Executives

[Association of Chief Police Officers - check correct term for National Policing Lead]

Association of Directors of Adult Social Services

Association of Police and Crime Commissioners

Care Quality Commission

Clinical Commissioning Groups Mental Health Network

College of Emergency Medicine

College of Policing

College of Social Work
Health Education England
HM Inspectorate of Constabulary
Criminal Justice Joint Inspectorate
Local Government Association
NHS England
Public Health England
NHS Confederation
Royal College of Psychiatrists
Royal College of General Practitioners
Royal College of Nursing

2. Introduction

Aim and purpose

This Concordat sets out the agreement between the signatories of the:

- Vision for the outcomes that people in mental health crisis should expect
- Actions which each party has committed to in enabling the delivery of this vision across England
- Shared and collaborative accountability framework through which each signatory will continue to work with its Concordat partners to monitor progress in delivering these commitments [DN: Do we need to say more about this and if so, does it go in the main body or as annex?]

The main body of the document sets out the vision and outcomes that people in mental health crisis should expect. These guiding principles are described from the service user's perspective framed by a proxy mental health crisis pathway as follows:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Treatment and care when in crisis
- Recovery and staying well / preventing future crises

The document provides further details, for each of these elements, of the outcomes which people experiencing mental health crises should expect, illustrated by case studies from across the country illustrating examples of positive practice in each area. The annexes contain the actions committed to by each party, which are also structured in the above format, and also include a dissemination and communications plan.

An annual Concordat Summit will be held by signatories to review progress, refresh the direction of travel and put results in the public domain in order to build public confidence in mental health crises services.

Scope

The scope of the Concordat spans the health, social care and criminal justice systems. It defines the outcomes expected for people of all ages and mental health crises in the broadest sense, including physical health related needs, including:

- Suicidal behaviours
- Clinical depression
- Dementia
- Personality disorder
- Alcohol and drug dependence
- Adults with self-harm events
- Psychosis relapse
- Children's crisis conditions

- Social crisis such as homelessness or bereavement resulting in mental health trauma
- The physical health emergencies which have arisen as a result of a mental health condition e.g. overdose

The case for change

Individuals suffering from mental ill health may come into contact with a range of emergency and urgent services. This can lead to:

- Inappropriate emergency responses;
- Lack of clarity about which service should do what and when;
- Disruption to providing continuity of care for those with long-term mental health conditions;
- Tensions between agencies on the ground based on a lack of clarity about the most appropriate response

A series of recent publications [add references - Mind report, Adebowale report, NHS England Urgent & Emergency Care Review, CQC Crisis Review, Crisis Resolution Fidelity Report] have highlighted the fact that despite many examples of good practice, mental health crises services often fall short in providing effective care and treatment for people who are among the most vulnerable in our society. Moreover, the outcomes and experience for people in mental health crises are disproportionately poorer than the general population.

Detentions under the Mental Health Act are on the rise, which is placing more pressure on statutory services to ensure that they are working together as efficiently as possible to provide an effective response within available resources.

3. Key Commissioning Responsibilities

The legal and policy framework is summarised at annex 4.

The NHS Mandate

'By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence based services.' [HMG, NHS Mandate]

The NHS Mandate sets out the Government's priorities for the spending of NHS resources from 2013 to 2015. It will establish the improvements that will be made to mental health services and show where improvements to mental health services can improve the performance of the NHS as a whole. Specifically, this includes '*supporting people with multiple long-term physical and mental health long-term conditions…delivering a service that values mental and physical health equally*'. [HMG, NHS Mandate]

Delivery of these commitments related to parity of esteem is central to the NHS's work to improve mental health services and will provide the impetus for driving improvements to mental health crisis care linked to the NHS Urgent and Emergency Care Review.

Commissioner responsibilities

Health and social care commissioners should ensure that sufficient resources to meet their statutory duties are made available within the acute care pathway to ensure patient safety, enable service user and patient choice and for individuals to be treated at or close to home.

Commissioners will want to have a strategic focus on prevention, wellbeing and community services alongside suicide and self-harm prevention programmes which respond to local needs. They will ensure a range of service provision which is timely, accessible, offers choice and appropriate care, including NICE approved interventions. The acute pathway should be effective in response to local needs:

"An effective pathway is one where all those involved in providing the service share aims, priorities and values as well as operational policies. The relationships between the component parts are as important as the properties of the parts themselves. There need to be clear arrangements in place for the cohesive overall management of a locality's acute care services and its workforce" [Mental Health Joint Commissioning Panel].

An effective response to mental health crises requires a range of services which meet local need. The characteristics of effective crisis services are described in Section 5.

Clinical Commissioning Groups, as commissioners of health services, will undertake statutory assessments of need and commission services with partner local commissioners in social care and others. Services should be commissioned at a level that ensures that people should never be turned away from mental health

services because S 136 rooms or wards are full, or because staff are unavailable, or because they are not currently resident in a particular area.

Police and Crime Commissioners [Home Office to draft]

Provider responsibilities

NHS commissioned providers are responsible for ensuring that people have positive experiences of the care they receive. This will include effective levels of access to, and waiting times for, mental health services. NHS England are mandated to consider new access standards, including the financial implications of any improvement in quality standards [HMG, NHS Mandate, 2013, pages 18-19].

In an emergency, immediate access to an effective crisis response is critical – particularly where this involves a Mental Health Act assessment. Providers have a duty to report on quality standards, including service user experience feedback.

The focus on patient safety in the NHS sets an expectation that people with mental health problems will be cared for in a safe environment and protected from avoidable harm: *'(NHS England) will need to work with Clinical Commissioning Groups to ensure providers of mental health services take all reasonable steps to reduce the number of suicides and incident of self-harm or harm to others, including effective crisis response.'* [HMG, NHS Mandate,].

The role of regulators

[CQC to add]

The role of police forces

[National Policing Lead to add]

4. Core principles and outcomes

This section sets-out the principles and the outcomes which mental health crisis services should provide from a service user perspective. It also forms the approach to the structure of the Action Plan at annex 1. The structure is summarised in the boxes below:

Access to support before crisis point

When I am beginning to experience the early signs of crisis, I will get the help I need from health and social care professionals in the community when I need it to address my needs and prevent my from experiencing a crisis episode

Urgent and emergency access to crisis care

When I recognise that I am beginning to experience a crisis, I will be able to contact Crisis Services on a 24/7 basis and get the right help and support I need to deal with the problem and to prevent it getting worse.

When I am experiencing a crisis, emergency services will respond quickly and ensure that I am kept safe. Rapid decisions will be taken about the service that is most appropriate to my needs. If I cannot be supported at home, I will be transported to an appropriate service in a safe and supportive way. All the professionals involved in this process will work together in my best interests to manage my care safely and effectively.

Treatment and care when in crisis

When I am in crisis and need to attend health service facilities, my physical and mental health needs will be assessed and treated promptly and effectively in the most appropriate care settings to meet my needs. Services will ensure my safety and begin to work towards helping me to move to Recovery.

Recovery and staying well / preventing future crises

People should expect a whole system approach

People needing urgent help with their mental illness, or friends and family close to them, may seek help from a number of different sources – including their GP, helplines or voluntary sector groups, emergency departments, social services, mental health trusts, or the police.

For there to be an effective emergency mental health response system, there should be detailed local planning, commissioning and coordination arrangements in place between all the agencies that are regularly contacted by people in mental distress

People needing help should be treated with respect, compassion and dignity by the professionals that they turn to.

1. Access to support before crisis point

1.1 People vulnerable to mental health crises should expect early intervention by services to address their needs focusing on prevention

First and foremost, people in mental distress should be kept safe. Mental health services, whether NHS, local authority or voluntary sector need to intervene early to prevent distress from escalating into crisis.

Early interventions include help at home services, specifically Early Intervention or Crisis Resolution/Home Treatment services, and peer support including access to crisis houses or other safe places where people can receive attention and help.

Early intervention and crisis services should be appropriate and acceptable for the range of protected characteristics, so that people from BME communities, people with learning difficulties, physical health conditions, people with dementia and children and young people can find and stay engaged with services which keep them safe, improve their mental health and prevent further crises.

Action for groups of people who are experiencing discrimination or inequality.

2. Urgent and emergency access to crisis care

2.1 People in crisis are amongst the most vulnerable in our society and must be kept safe, have their needs met appropriately and be helped to achieve recovery

People experiencing mental distress should be able to find the support they need - whatever the circumstances in which they first need help, and from whomever they turned to first.

All agencies supporting this Concordat believe that responses to people in crisis should be the most community-based, least restrictive options most appropriate to

the needs of the individual. Community based alternatives should be used in accordance with locally agreed access standards and protocols.

For BME communities in particular there is evidence of poor experience of services and lack of access contributing to a vicious circle where support is only sought and offered once crisis is reached, often as a result of contact with the police or child protection services.

2.2 People in crisis should expect all staff to have the right skills and training to respond to their needs appropriately

Local shared training policies and approaches should be in place which describe and identify 'who needs to do what and how does it all fit together' to ensure the safety of and continuity of treatment and support for a person with mental health problems. Each statutory agency should review its mandatory training arrangements on a regional basis and agree priority areas for joint training modules between NHS, social care and criminal justice organisations.

Staff (for example, Emergency Departments and hospital security staff) whose role requires increased mental health awareness should expect to be prepared for this through training and clear line management advice.

2.3 People in crisis should expect parity of esteem and an appropriate response and support when they need it

People in mental health crisis who need help need to receive it promptly. This means that:

• Standards of access for emergency mental health care should be in line with equivalent service standards in Emergency Departments

• Mental health services should be capable of providing high quality and safe care at the time it is needed - seven days a week and overnight

• Hospital, step-down and community services should be commissioned at a level that allows for beds or alternatives to hospital admission to be immediately available in response to a person in urgent need

• If people are already known to mental health services, their crisis plan and any advance statements should be available and respected.

2.4 People in crisis who need to be supported in an NHS Place of Safety will not be excluded

NHS places of safety should operate at a level that ensures that staff and facilities are available to manage and support the vulnerable individuals that need them. Intoxication alone should not be used as a basis for exclusion, although in very exceptional circumstances, and in accordance with agreed risk protocols, there may

be too high a risk that the NHS would be unable to keep either the individual and staff safe.

A previous history of violence should not in itself lead to exclusion and only in exceptional circumstances, in accordance with agreed risk management protocols, should a police custody suite be used to manage disturbed behaviour.

The overall aim should be to reduce substantially the inappropriate use of police custody suites which is likely to result in a poorer experience and outcomes for vulnerable people.

2.5 People in crisis should expect that statutory services share essential 'need to know' information about their needs

All agencies (including police or ambulance staff) have a duty to share essential 'need to know' information for the good of the patient, so that the professionals or service dealing with a crisis know what is needed for managing a crisis and any associated risks to the distressed person or to others.

Information on patients should, in practice and through appropriate sharing protocols, follow them through the system and ensure that people known to services get the treatment they need quickly and where applicable the services are aware of their crisis plan and any advanced statements – no matter at what point they re-enter the mental health system.

Within the requirements of the data protection legislation, a common sense and joint working approach should guide individual professional judgements. If the same person presents to police, ambulance or emergency departments repeatedly, all agencies should have an interest in seeking to understand why and how to deal with that person appropriately to secure the best outcome. This may include identifying whether the individual is already in treatment and/or is known to services, their GP or other community-based mental health services.

2.6 People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help and to be supported by mental health services in taking the appropriate steps to meet the needs of the individual and to maintain community safety

Police officers responding to people in mental health crisis should expect response from health and social care colleagues within locally agreed timescales, so that the individuals receive the care they need at the earliest opportunity.

Police officers should recognise, through appropriate awareness training, that people with vulnerabilities related to their poor mental health will be a key aspect of their work, and that partnership working and good communication with health colleagues will therefore be essential to meet the mental health needs of vulnerable people in

crisis, and the small number of mentally disordered offenders, whose behaviour poses a risk of danger to themselves or to others.

Police officers should have the training, capacity, and support to decide how best to help vulnerable people, whether they should be assessed under Section 136 of the Mental Health Act 1983, or whether they can be helped in some other way.

Street Triage pilots: these mental health nurses, as part of the crisis home treatment response services, will be able to provide on the spot advice on mental health and substance misuse, and also check on people's health history, to help police officers make good decisions based on a clear understanding of situations. We will be testing whether this means that people reach the services they need more quickly and with a better outcome.

Local protocols should be developed to ensure that when a police officer makes contact with health services because he or she has identified a person in need of emergency mental health support, an NHS coordinator should take responsibility for arranging that support. When the police officer and the vulnerable person arrive at the hospital (Emergency department, mental health unit or hospital based place of safety) NHS staff should take responsibility for the person, thereby allowing the officer to leave, so long as the situation is agreed to be safe. As a guide, hospital staff should not be expecting police officers to stay for longer than one hour after bringing a mentally ill person to a hospital. Locally agreed protocols will cover circumstances where they may need to stay longer, for example when based on an assessment of risk and with the support of a police supervisor. Local protocols should provide for include escalation to more senior staff in case of disagreement.

• NHS England regions are obliged by the Mental Health Act 1983 to commission health based places of safety. These should be staffed at a level that allows for 24/7 availability, with agreed arrangements in place to handle multiple referrals.

• Local agreements should guide professional judgements on when it is appropriate for police custody to be used as a place of safety due to seriously disturbed or aggressive behaviour. Local Mental Health Partnership Boards should also review each individual case circumstance when this has occurred to ensure it was appropriate and whether there are any lessons to be learnt for the future.

• In cases where police custody is used as a place of safety, the aim should be to transfer the patient as soon as possible to appropriate health services. If this cannot be arranged then they should be transferred to a health based place of safety at the earliest opportunity.

• Police vehicles should not be used to transfer patients between units within a hospital.

• All police staff should have training in de-escalation/safer restraint as part of mental health awareness training

2.7 When people in crisis appear (to health or social care professionals or to the police) to need urgent assessment, the process should be prompt, efficiently organised, and carried out with respect.

When deciding upon any course of action, all professional staff should have regard to the Mental Health Act principle of least restriction and ensure that the services impose the least restriction on the person's liberty.

• Clinical Commissioning Groups, local authorities and mental health service providers should ensure that approved section 12 doctors and Approved Mental Health Professionals (AMHPs) are available to carry out assessments of people in mental health distress, within locally agreed timescales of their arrival at a designated place of safety, or other appropriate setting.

• There should not be circumstances under which mental health professionals will not carry out assessments because no beds are available

2.8 People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right ongoing support

People with mental distress often seek help from Emergency Departments – sometimes directly, or because they have harmed themselves, or are experiencing a physical or mental health crisis. They may also be brought in by others because they have attempted suicide or taken a substance which has altered their mental state. They may be brought in by the police, either voluntarily or on a section 136.

Clear responsibilities and protocols should be in place between emergency departments and other agencies and parts of the acute and mental health and substance misuse service.

There should be a local forum (such as a Local Mental Health Partnership Board) for agreement of protocols and escalation of issues, ensuring that :

• People experiencing mental health crises, self-harming or suicidal behaviour are treated safely, appropriately and with respect by Emergency Department staff

• Clinical staff identify mental health problems in people presenting with a physical health problem and refer them to a GP or specialist help where necessary

• Clinical Commissioning Groups give priority to establishing effective liaison psychiatry services in place for people of all ages of a similar standard to the RAID model [see Box X]

• Clinical staff are equipped to identify and intervene with people who are at risk of suicide through training such as ASIST, through induction and on-going training in the application of the relevant NICE guidelines, statutory and legal requirements under the Mental Health legislation and communicate with other services so that people who are at risk are actively followed up.

• Emergency department staff treat people who have self-harmed in line with the NICE guidance and quality standard. All people who have self-harmed should be offered a preliminary psychosocial screening at triage. Screening should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

• Emergency departments are able to cope with and keep safe mentally ill people who present in states of intoxication or who display violent behaviour. There should be explicit protocols agreed between the police and mental health trusts on the handling of people who are intoxicated or violent, including escalation procedures for managing disagreements between professionals.

• Clinical Commissioning Groups should ensure that Emergency departments, Police and Ambulance services agree protocols and arrangements regarding the security responsibilities of the hospital. They should also agree with police a protocol regarding the safe operation of restraint procedures on NHS premises. Emergency departments should have facilities to allow for rapid tranquilisation of people in mental health crisis who need it.

2.9 People in crisis who access the NHS via the 999 system can expect their need to be met appropriately

The experience of mental health patients accessing the NHS via the 999 system could be further improved by Commissioning Ambulance services to:

- provide 24/7 mental health professionals within the clinical support infrastructure in each 999 control room. This would assist with the initial assessment of mental health patients and help ensure a timely and appropriate response.
- to enhance the levels of training for ambulance staff on the management of mental health patients. This could include the ability to provide more multi-agency training with other professionals to ensure a truly joined up approach
- to be able to work flexibly, including across borders by exercising judgments in individual cases which they can be confident their commissioners will support; or, outside the usual contract scope, to ensure that an individual's safety [and treatment] is not compromised. There may be occasions in large geographical areas where an ambulance from "across the border" is better placed to respond than one from within the local area.

2.10 People in crisis who need routine transport between NHS facilities or from the community to an NHS facility will be conveyed in a safe, timely and appropriate way

In the case of routine transfers of mental health patients it should be noted that there are multiple providers of routine patient transport services and such contracts are no longer always operated by NHS ambulance services.

Commissioners will need to ensure that the transfer arrangements put in place by Mental Health Trusts and Acute Trusts provide appropriate timely transport for these patients.

2.11 People in crisis who are detained under S136 powers can expect that they will be conveyed by emergency transport from the community to an NHS facility/Place of Safety in a safe, timely and appropriate way

Where a police officer or an AMHP requests NHS transport for a person in mental health crisis under their Section 136 powers for conveyance to an Emergency Department or NHS Place of Safety (or in exceptional circumstances, to police custody suite), the patient should be conveyed in a safe and timely way.

3. Treatment and care when in crisis

3.1 People in crisis should expect local mental health services to meet their needs appropriately at all times

Response to mental health crisis should be on a similar basis to physical health {“parity of esteem between mental and physical health”). This means that health and social care services should be equipped to deal safely and responsively with emergencies that occur at all times of day and night, seven days a week, 365 days a year., .

4. Recovery and staying well / preventing future crises

4.1 People in crisis should be able to expect that the services and quality of care they receive are subject to systematic review, regulation and reporting

The Care Quality Commission will inspect the whole system pathway, regulating acute health trusts and mental health and primary care and social care providers, talking account of this Concordat when looking at the support mentally ill receive in response to their physical health, mental health, substance misuse and other relevant crisis situations. They will also ensure that, across the care pathway, there is evidence that the least restrictive care has been provided and that mental health legislation (and codes of Practice) is complied with.

5. Characteristics of effective mental health crisis services

The signatories to the Concordat have identified and agreed that effective local mental health crises services include the following characteristics:

- Evidence based early interventions commissioned from agencies to prevent escalation from mental health need to crisis
- All partners including Health, Social Care, Criminal Justice and Voluntary Sector, independent sector and local community leaders should be involved in assessing local needs within the Joint Strategic Needs Assessment (JSNA), sharing relevant data in order to understand the pattern of need and inform commissioning and planning of the primary care, social care, specialist mental health, substance misuse and other relevant services to meet local needs
- Telephone help lines or on-line services, including computer-based self-help
- Crisis houses and recovery house provision for people who cannot be treated at home but who do not need to be admitted to hospital
- Other domiciliary or non-residential alternatives to hospital admission (including respite for those with a long term mental health conditions
- Supported housing
- Direct payment schemes
- Early intervention mental health services
- Psychiatric liaison mental health services to Emergency Departments,
- Access to telemedicine or telepsychiatry
- Community mental health teams
- Psychology and specialist mental health services
- NHS Place (s) of safety
- Peer support
- Day hospital places/ inpatient beds in a safe and therapeutic settings [2].
- Plans for extending access to Improving Access to Psychological Therapies (IAPT) and other services which provide clinical and economic evidence based interventions for people with mental ill health, thus reducing mental ill health and escalation to crisis
- A 24/7 single point of access to specialist mental health response, giving rapid access to appropriate integrated assessment of physical, mental health and substance misuse presentations and provision of care and support, wherever it is needed 24/7
- Services with access thresholds that respond effectively to early signs of mental distress, including when combined with other needs, providing a response which prevents escalation to crisis point
- Good communication between voluntary sector services (for example The Samaritans) and health services, including consideration of when self-referral to services may be helpful
- Emergency Departments that provide the right help to people in mental distress and ensure they get appropriate care for both their physical and mental health and substance misuse conditions
- Mental health professionals who respond promptly and effectively to GP and police referrals
- Good quality health based places of safety which are available 24/7 and effectively coordinated with local police, emergency departments, ambulance

services and mental health services, particularly Approved Mental Health Professionals (AMHPs) and Section 12 doctors
- The use of police cells as a place of safety only in exceptional circumstances
- A range of community based alternative services which can respond to mental health crises in the community, for example help at home services, crisis houses, and other safe places where people can receive attention, support, care and/or therapy
- Ambulance services are appropriately trained to recognise mental health crises and substance misuse crises as emergencies and respond appropriately
- Appropriate and clear protocols on the minimal use of restraint in crisis situations – to protect the distressed person, staff and the public. Effectively monitored protocols for police and health service staff that use restraint will provide clear explanations of the circumstances and situations that warrant the use of restraint, and will set out where the responsibility lies in each case [this is linked to wider guidance on the use of restraint in health and social care settings]

We also recognise that the exact way in which services are delivered will depend in part on demography and geography.

Annex 1. Concordat Action Plan

1. Access to support before crisis point

No	Action	Timescale	Led By	Outcomes
1.1	Consider the types of services provided and how the range of options can be expanded in line with local leads and preferences including crisis houses, non-residential crisis services, host families, retreats, hotels, and peer-survivor services	Annually through the Joint Strategic Needs Assessment (JSNA) process	NHS England/ Clinical Commissioning Groups	Service users have their needs met appropriately with increased choice and control
1.2	Set standards for the use of Crisis Care plans, in line with Care Programme approach guidance (DH publication 2010)	April 2014	Clinical Commissioning Groups	Service users jointly produce contingency plans in case of relapse or crisis

2. Urgent and emergency access to crisis care

No	Action	Timescale	Led By	Outcomes
2.1	Local social services should review their arrangements for out of hours AMHP provision and consider the implementation of a scheme that employs sessional AMHPs in addition to existing resources to ensure they are able to respond in a timely manner	By April 2014	ADASS and LGA (with College of Social Work)	Reduction in delays experienced by service users awaiting an AMHP assessment
2.2	As part of AMHP service reviews, authorities who have combined the services with children's safeguarding should satisfy themselves, in consultation with the police and mental health providers, that AMHPs can be available within locally agreed response times	By April 2014	ADASS and LGA (with College of Social Work)	Reduction in delays experienced by service users awaiting an AMHP assessment
2.3	The Department of Health will review with the Care Quality Commission whether additional powers are required for them to monitor AMHP services	By April 2014	DH and CQC	Service users experience an improved quality of service
2.4	Make available a map of the location of all health based Places of Safety in England	October 2013	Department of Health	Service users experience more appropriate NHS provision and the use of police custody suites is avoided
2.5	Themed inspections of the quality of all Health Based Places of Safety in England. This should include information about the number of beds, opening hours and staffing	April 2014	Care Quality Commission	Service users experiences improved access and quality of NHS services

	levels. Include the national stakeholders in the scoping of this work.			
2.6	Information sharing and communications: All agencies have a duty to share information for the good of the patient, so that the professional or service dealing with a crisis (including police or ambulance staff) knows key information. (see note)	Current	All agencies through Caldicott and data protection officers (DN How to account for actions led by all)	Improved management experienced by the person in crisis
2.7	The NHS ambulance services in England will introduce a single national protocol for the transportation of S136 patients, which provide agreed response times and a standard specification for use by Clinical Commissioning Groups. (see note)			
	Placeholder: Police training – College of Policing leading work on the syllabus.			
	Is there an action on looking at provision of appropriate adults for people with MH problems (in the exceptional event they end up in custody)?			
	Identify and monitor indicator of improved emergency responses for people with MH problems arising from the duty to collaborate between the police and ambulance services arising from the Policing Bill?			

3. Treatment and care when in crisis

No	Action	Timescale	Led By	Outcomes

4. Recovery and staying well / preventing future crises

No	Action	Timescale	Led By	Outcomes
4.1	Good practice booklet produced and disseminated nationally drawing from local areas	November 2013	Home Office	Service users experience more appropriate and consistent responses

Notes

Note 2.6:
Information sharing and communications: All agencies have a duty to share information for the good of the patient, so that the professional or service dealing with a crisis (including police or ambulance staff) knows the following key information.

- The name, address/contact details of the person (or a description if mute)
- Details of any relative(s)/friend(s) or carer who can be contacted
- Gender/Age
- Language spoken (if not English) and any communication needs e.g. sign language
- Description of current behaviour/presentation
- Are likely to be effected by drink or drugs
- Physical illnesses and any prescribed medicines or dietary requirements
- Whether the person is already engaged with his/ her GP and / or mental health services and the name of the team and any involved professional
- Whether they have a crisis plan or other advance statements
- Any clinical information e.g. prescribed medication, psychological therapy
- Any presenting risk factors (for example, self-harm, suicide, physical aggression, confusion, impaired judgement, self-neglect, missing from home)
- Children, dependents, pets or other factors to take into account in planning the most appropriate response

Note 2.7:
The **NHS ambulance services** in England will introduce a single national protocol for the transportation of S136 patients, which provides the following:

- An 8 minute response time to any such patient that presents with a life threatening illness or injury or who is being actively restrained.
- A 30 minute response time with a clinician who can make a face to face assessment of any S136 patient who does not have a life threatening illness or injury and who is not being actively retrained. This initial clinical assessment may be provided by a clinician in a rapid response vehicle and where this is the case a supporting transporting resource will also need to be provided in an appropriate timescale.
- Clinical commissioning groups will commission services that ensure ambulance trusts are able to meet the terms of this protocol

APPENDICES TO BE WORKED ON

NHS England Urgent and Emergency Care Review - System design objectives

1. Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice.
2. Increase my or my family/carer's awareness of early detection and options for self-care and support me to manage my acute or long term physical or mental condition.
3. Increase my or my family/carer's awareness of and publicise the benefits of 'phone before you go'.
4. If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.
5. Improve my care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway.
6. Wherever appropriate, manage me where I present (including at home and over the telephone).
7. If it's not appropriate to manage me where I present (including at home and over the telephone), take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to a highly specialist centre if needed.
8. Ensure all urgent and emergency care facilities are capable of transferring me urgently and that the mode of transport is capable, appropriate and authorised.
9. Information, critical for my care, is available to all those treating me.
10. Where I need wider support for my mental, physical and social needs ensure it is available.
11. Each of my clinical experiences should be part of a programme to develop and train the clinical staff and ensure their competence and the future quality of the service is constantly developed.
12. The quality of my care should be measured in a way that reflects the urgency and complexity of my illness.

Appendix: NICE standards of care

NICE clinical standards of care

CG 16: short term management of people who have self-harmed

CG 133: Longer-term management of people who have self harmed

CG Depression (replaced by CG90) and CG Anxiety

CG 82: Schizophrenia 2009,

CG 44: BPAD, 2006, & BAP 2009

CG Treatment of Psychosis in Substance Misuse (March 2011

CG 100: Alcohol dependence & harmful alcohol use,

2010 CG 51: Drug Misuse: psychosocial guidelines

CG 76: Medication Adherence – involving patients in decisions about prescribed medicines and supporting adherence, 2009

CG Borderline PD (BPD)

CG Antisocial personality disorder

CG Violence

CG ADHD

CG Autism spectrum disorders in children & young people

SCIE standards of care

Homeless

Home care and personalised budgets

Annex 4: The legal framework, existing standards and policy overview

The legal framework which governs the experience of a person experiencing a mental health crisis is set by the ***European Convention on Human rights (ECHR)***, in particular:

- Article 3 (the prohibition of torture or degrading treatment);
- Article 5 (the right to liberty);
- Article 8 (the right to respect for a person's private and family life, which includes the right to moral and physical integrity); and
- Article 14 (the prohibition of discrimination)

Additionally, the *Equalities Act 2010* may be applied to the impacts of differing levels or variations in service provision. A range of international law and conventions adopted by the UK guide interpretations of rights and responsibilities in the management of mental health crises (see Annex DN: ref: UN convention on the rights of the disabled person) – notably UNCRDP Article 25 'the right to parity of physical and mental healthcare', which is further promoted as a key policy objective within England's cross government strategy for mental health 'No health without mental health' (HMG 2011).

The *NHS Constitution* (REF) sets out further statements of rights and pledges – in particular the right of every patient to be treated with dignity and respect, a right to drugs and treatment recommended by the National Institute for Clinical excellence (NICE) when these are recommended by a doctor – though at present few (DN: no) NICE guidelines are applicable in the case of mental health crises presentations.

The first points of access to NHS services, unrestricted by nationality or immigration status are GP services. GPs are prohibited from refusing to register a patient on grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. The National Health Service (General Medical services Contracts) Regulations 2004 require GPs to provide medical services for the management of registered patients and temporary patients who are, or who believe themselves to be, ill. The regulations also require GPs to provide services for "immediately necessary treatment" for up to 14 days for anyone who needs it, including those who are not registered with a GP in the area. Medical services should be delivered "in the manner determined by the practice in discussion with the patient", providing for a degree of choice and control by service users. Health service providers are subject to part 3 of the Equalities Act 2010 which means that, when planning service provision, they have a duty to consider in advance what reasonable adjustment they should make to ensure that a person with any disability should not be at a substantial disadvantaged in their access to services and treatments. This includes commissioners planning services that can identify and respond to the needs of people in distress as a result of a mental health crisis. NHS Trusts should publish the arrangements they have in place to ensure that a level of healthcare is in place and available when it is needed.

If a person seeks help as a result of mental health distress, their first point of contact should be their primary healthcare team or GP. Article 25 of the UNCRPD (which guides the interpretation of the law) states the need for early identification and intervention by services designed to minimise and prevent further disability. Thus

Standard 2 of England's National Service Framework for Mental Health (DH 2001) states that any person who contacts a primary healthcare team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments including referral to specialist services for further treatment or care if necessary.

Very many people present to services in a mental health crisis related to some aspect of social care. Their needs can be met through Local Authority powers and duties e.g. care packages, accommodation, social work support and the provision of Approved Mental Health Profession services under the Mental Health Act 1983. The National Health Services and Community Care Act 1990 S47 (1) imposes a duty on the Local Authority to assess a person who appears to them to be in need of community care services, although considerable discretion is allowed for in the exercise of this duty. Further duties to assess health or housing need and provide services, which include people with a mental disorder, are set out within the Chronically Sick and Disabled Person's Act 1970.

In 2011, 104,000 people using specialist mental health services were admitted to an inpatient hospital bed. Of these 16,647 people were detained in hospital under the provisions of the Mental Health Act 1983. Hospitals are one part of the crisis care system, but effective responses require alternatives including crisis resolution teams, home treatments (including detoxification) and a range of evidence based alternatives to admission.

People with long term mental health conditions are more likely to have poor physical health than the general population and may present in urgent situations to their GP or to Emergency Departments. The Equalities Act 2010 and Disability Discrimination Acts of 1995 and 2004 require, firstly, that people with mental health disabilities are given access to health services on an equal basis to other patients and, secondly, that where necessary reasonable adjustments should be made to take account of the impacts of their disability. Specific responsibilities that providers should take into account are set out in NICE Guidance (for Schizophrenia, Bi-polar Disorder, Depression in children and young people).

Mental health is the only area of NHS care to be governed by additional legislation providing for compulsory medical treatment. The civil and criminal provisions of the Mental Health Act 1983 are wide ranging. Within the context of this Concordat is the principle that the "least restrictive alternatives" should be applied. Police powers of arrest under Section 136, and Ambulance Service duties to convey patients are further interpreted within the Code of Practice and subsequent standards and Guidance documents (DN : to cite/Ref), alongside the responsibilities of Local Social Services Authorities to provide an Approved Mental Health Professionals service and the powers and duties which relate to the NHS. Where mentally disordered people are help in Police custody for any reason, the Police and Criminal Justice Act 1984 (including the need for 'Appropriate Adults') will apply alongside the provisions of the Criminal Justice Act comes into effect. Where a criminal offence may have been committed, the Police may consider charging a mentally disordered person with an offence in order that a prosecution can be taken forward by the Crown Prosecution Service. Extensive Guidance on the prosecution of Mentally Disordered Offenders is available.

Local Authorities commission:

• tobacco control and smoking cessation services
• alcohol and substance misuse
• public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
• the National Child Measurement Programme
• Interventions to tackle obesity such as community lifestyle and weight management services
• locally-led nutrition initiatives
• increasing levels of physical activity in the local population
• NHS Health Check assessments
• public mental health services
• dental public health services
• accidental injury prevention
• population level interventions to reduce and prevent birth defects
• behavioural and lifestyle campaigns to prevent cancer and long-term conditions
• local initiatives on workplace health
• supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
• comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
• local initiatives to reduce excess deaths as a result of seasonal mortality
• the local authority role in dealing with health protection incidents, outbreaks and emergencies
• public health aspects of promotion of community safety, violence prevention and response
• public health aspects of local initiatives to tackle social exclusion
• local initiatives that reduce public health impacts of environmental risks.

Reference material/sources of evidence quoted