HM Government

Mental Health Crisis Care Concordat

Improving outcomes for people experiencing mental health crisis

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Mental Health Crisis Care Concordat: the joint statement

"We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped 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 prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery.

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

Signatories to the Concordat

Association of Ambulance Chief Executives
Association of Chief Police Officers
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Association of Police and Crime Commissioners
British Transport Police
Care Quality Commission
College of Emergency Medicine
College of Policing
The College of Social Work
Department of Health
Health Education England
Home Office
Local Government Association
Mind
NHS Confederation
NHS England
Public Health England
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists

The national organisations that are signatories to this Concordat have made a commitment to work together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England.

In addition, a number of third sector and voluntary organisations have agreed to be identified formally as **supporters** of the Concordat.

The list of supporter organisations is available at www.gov.uk

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1. Concordat statement: The vision

This Concordat is about how we, as signatories, can work together to deliver a high quality response when people – of all ages – with mental health problems urgently need help. Mental illness is a challenge for all of us. When a person's mental state leads to a crisis episode, this can be very difficult to manage, for the person in crisis, for family and friends, and for the services that respond. All may have to deal with suicidal behaviour or intention, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control, or irrational and likely to endanger the person or others.

Every day, people in mental health crisis situations find that our public services are there when they need them – the police officers who respond quickly to protect people and keep them safe; the paramedics who provide initial assessment and care; the mental health nurses and doctors who assess them and arrange for appropriate care; and the Approved Mental Health Professionals, such as social workers, who coordinate assessments and make contact with families.

These services save lives. There is much to be proud of. But we must also recognise that in too many cases people find that the same services do not respond so well. There have long been concerns about the way in which health services, social care services and police forces work together in response to mental health crises.

Where there are problems, they are often as a result of what happens at the points where these services meet, about the support that different professionals give one another, particularly at those moments when people need to transfer from one service to another.

This is a very serious issue – in the worst cases people with mental health problems who have reached a crisis point have been injured or have died when responses have been wrong. In other cases, patients have had to travel long distances when acute beds have been unavailable.

There are also particular barriers to achieving better outcomes for people in black and minority ethnic (BME) communities, such as the higher levels of detention under the Mental Health Act 1983 and the higher rates of admission to hospital that people from some BME groups experience. Where a particular group or section of society is reaching crisis point at a disproportionate rate, or accessing mental health services through involvement with the criminal justice system at a high rate, this needs to be identified and addressed by commissioners.

This Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur.

The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

This Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.

We believe this Concordat serves as an important joint statement of intent and common purpose, and of agreement and understanding about the roles and responsibilities of each service. This will help to make sure people who need immediate mental health support at a time of crisis get the right services when they need them, and get the help they need to move on and stay well.

2. "When I need urgent help… "

What people who use services should expect

What should I expect if I, or the people who depend on me, need help in a mental health crisis?

The following statements were developed by Mind, the mental health charity, with service users, families and carers in a consultation carried out for the Concordat.

- **Access to support before crisis point**

When I need urgent help to avert a crisis I, and people close to me, know who to contact at any time, 24 hours a day, seven days a week. People take me seriously and trust my judgement when I say I am close to crisis, and I get fast access to people who help me get better.

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

If I need emergency help for my mental health, this is treated with as much urgency and respect as if it were a physical health emergency. If the problems cannot be resolved where I am, I am supported to travel safely, in suitable transport, to where the right help is available.

I am seen by a mental health professional quickly. If I have to wait, it is in a place where I feel safe. I then get the right service for my needs, quickly and easily.

Every effort is made to understand and communicate with me. Staff check any relevant information that services have about me and, as far as possible, they follow my wishes and any plan that I have voluntarily agreed to.

I feel safe and am treated kindly, with respect, and in accordance with my legal rights.

If I have to be held physically (restrained), this is done safely, supportively and lawfully, by people who understand I am ill and know what they are doing.

Those closest to me are informed about my whereabouts and anyone at school, college or work who needs to know is told that I am ill. I am able to see or talk to friends, family or other people who are important to me if I so wish. I am confident that timely arrangements are made to look after any people or animals that depend on me.

- **Quality of treatment and care when in crisis**

I am treated with respect and care at all times.

I get support and treatment from people who have the right skills and who focus on my recovery, in a setting which suits me and my needs. I see the same staff members as far as possible, and if I need another service this is arranged without unnecessary assessments. If I need longer term support this is arranged.

I have support to speak for myself and make decisions about my treatment and care. My rights are clearly explained to me and I am able to have an advocate or support from family and friends if I so wish. If I do not have capacity to make decisions about my treatment and care, any wishes or preferences I express will be respected and any advance statements or decisions that I have made are checked and respected. If my expressed wishes or previously agreed plan are not followed, the reasons for this are clearly explained to me.

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

I am given information about, and referrals to, services that will support my process of recovery and help me to stay well.

I, and people close to me, have an opportunity to reflect on the crisis, and to find better ways to manage my mental health in the future, that take account of other support I may need, around substance misuse or housing for example. I am supported to develop a plan for how I wish to be treated if I experience a crisis in the future and there is an agreed strategy for how this will be carried out.

I am offered an opportunity to feed back to services my views on my crisis experience, to help improve services for myself and others.

3. Aim, purpose and scope

Aim and purpose

This Concordat is a joint statement, written and agreed by its signatories, that describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs.

It is about how these different services can best work together, and it establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements. All the bodies and organisations that have signed up to the Concordat agree that improvements need to be made and sustained.

The Concordat has also been informed by engagement with people who have needed these services in the past and who were willing to share their experiences. This engagement has been led by voluntary organisations, principally Mind and Black Mental Health UK. With these contributions, the Concordat outlines an approach to improving services that reflects what people say they need - whether they are existing service users, carers, or other people seeking access to help, care or treatment.

The Concordat also contains an action plan. This brings together the initial commitments made by the signatories to undertake work that supports the Concordat and helps to bring about its success. Much of this work is already underway. An annual Concordat Summit will be held by signatories to review progress and hold each other to account on the delivery of this action plan.

Making it happen – local Mental Health Crisis Declarations.

The Concordat has been agreed by a partnership of national organisations and representative bodies. But real change can only be delivered locally. The most important ambition of the Concordat is that localities all over England adopt its principles.

The signatories of the Concordat therefore expect that local partnerships between the NHS, local authorities, and criminal justice system work to embed these principles into service planning and delivery.

Just as the Concordat establishes a national agreement of principles, the ambition is for every local area to commit to agreeing and delivering their own Mental Health Crisis Declaration. This should include:

- A jointly agreed local declaration across the key agencies that mirrors the key principles of the national Concordat – establishing a commitment for local agencies to work together to continuously improve the experience of people in mental health crisis in their locality
- Development of a shared action plan and a commitment to review, monitor and track improvements
- A commitment to reduce the use of police stations as places of safety, by setting

an ambition for a fast-track assessment process for individuals whenever a police cell is used; and

- Evidence of sound local governance arrangements

The Department of Health and the Home Office, with the Concordat signatories and other partners, are planning practical ways to support and promote the development of these local agreements.

Scope and context

This Concordat focuses on people who experience acute mental health crisis. It spans the health, social care and criminal justice systems, but is also relevant to other partners such as housing providers.

It defines the service responses expected for people of all ages suffering mental health crises. It takes into account the factors that can lead to a crisis, such as physical, psychological, spiritual, educational or social problems.

Although the Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention.

Where the Concordat uses the term 'criminal justice system', this includes the youth justice system.

The Concordat builds on and does not replace existing guidance. Current service provision should continue while the improvements envisaged in this document are put in place.

The role of the NHS – parity of esteem

The Government has put mental health at the centre of its programme of health reform. It has therefore included a specific objective for the NHS, in the Mandate from the Government to NHS England[1], to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole".

The Mandate for 2014-15 also establishes specific objectives for the NHS to improve mental health crisis. The government expects:

- NHS England to make rapid progress, working with clinical commissioning groups (CCGs) and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services.

- NHS England to ensure there are adequate liaison psychiatry services in Emergency Departments.

- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in this Concordat

NHS England is responsible for deciding the best way to achieve these ambitions, and the others contained in the Mandate. This Concordat supports this work by setting out ways that local health commissioners, working with their partners, can make sure that people experiencing a mental health crisis get as responsive an emergency service as people needing urgent and emergency care for physical health conditions.

[1] Department of Health. The Mandate; a mandate from the Government to NHS England: April 2014 to March 2015. Department of Health, November 2013. https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

We recognise that there is relatively limited information available to assess current service provision. NHS England will work with partners to carry out a robust gap analysis of current demand for these services against available service provision. The availability of psychiatric beds will form part of this analysis. This information will be used to support clinical commissioning groups to understand their baseline position, as they develop plans based on local needs and circumstances to move toward the Concordat's vision, and deliver this part of the Government's mandate to the commissioning system. NHS area teams will assure these plans, and are expected to pay particular attention to parity of esteem between mental and physical heath, including that sufficient crisis services are being planned by CCGs.

The immediate commitments made by NHS England are contained in the Action Plan of this Concordat.

NHS England is also currently carrying out a full review of urgent and emergency care services. The review recognises that the NHS urgent and emergency care system must be responsive to the needs of the most vulnerable people in society who rely on it, and this includes people suffering mental health crises.

Public Health England

In 2012, the Government published the mental health strategy *No health without mental health*[2]. The strategy's implementation framework[3] includes a commitment for Public Health England to work to reduce mental health problems by promoting improvements in mental health and wellbeing. The work led by Public Health England will seek to develop the resilience of the population throughout people's lives by addressing the individual, community and societal factors that can lead to a crisis, such as environmental, psychological, emotional or social problems. This is because what will help to reduce mental health crises in the future will be making sure people have good housing, decent income and good health. Local government now has a statutory responsibility for improving the health of their populations, and Public Health England will support them in this endeavour.

The case for change

There is growing evidence[4 5] that it makes sense, both for the health of the population and in terms of economics, to intervene early when people may have an issue with their mental health, in order to reduce the chances of them going on to develop more serious and enduring mental health problems which are worse for the individual and harder and more expensive for the NHS to treat.

2 Department of Health. No health without mental health; a cross-government mental health outcomes strategy for people of all ages. Department of Health, February 2011. https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

3 Department of Health. No health without mental health; implementation framework. Department of Health, July 2012. https://www.gov.uk/government/publications/mental-health-implementation-framework

4 NHS Confederation, Mental Health Network. Early intervention in psychosis services. Briefing 219. NHS Confederation, May 2011 http://www.nhsconfed.org/Publications/Documents/early_interventionbriefing180511.pdf

5 Knapp, Martin, McDaid, David and Parsonage, Michael. Mental health promotion and mental illness prevention: the economic case. Department of Health, 2011 http://eprints.lse.ac.uk/32311/

An independent inquiry by Mind[6] found that access to crisis care services varies widely across the country – in the types of crisis care available, in staffing levels, and in the range of options available for those who need a safe place to go that is not a hospital. It found that in some areas the lack of community-based options, including those that support the discharge of people who have finished their hospital treatment, meant that beds were not always available for those who needed them urgently. This had meant that some patients in need of urgent care were sent to hospitals many miles from their family and community. In particular, the inquiry found there was insufficient 24 hour mental health care provision in some areas, and criticised what it identified as a decreasing number of inpatient psychiatric beds.

Primary care teams and Emergency Departments experience wide variations across England in access to specialist mental health services.

A Criminal Use of Police Cells, the joint review by Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons and the Care Quality Commission[7], highlighted the issue of people in crisis being detained by police officers and taken to police stations, sometimes because mental health crisis services are unable to respond, often because of a lack of capacity in the system. Although the numbers reduced in 2012/13[8], it still happens far too often.

The Independent Commission on Mental Health and Policing[9] made recommendations to the Metropolitan Police and forces nationally on how to prevent serious injury and deaths when officers respond to incidents involving people with mental health conditions. It concluded that mental health was part of the core business for the police, who should be trained to be aware of the vulnerabilities people may have, because mental health issues are common in the population. The report was clear that the support of other agencies is essential because the police "cannot and indeed are not expected to deal with vulnerable groups on their own".

Other identified issues include a lack of clarity about which service should do what and when, and the continued high levels of detention of people from BME communities, and their over-representation on inpatient wards[10].

This Concordat addresses these issues, by bringing together the national leadership of those services that need to work together effectively to respond to people in mental health crisis in a coordinated and timely way.

6 Mind. Listening to experience: an independent inquiry into acute and crisis mental healthcare. Mind. 2011. http://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

7 Her Majesty's Inspectorate of Constabulary, Care Quality Commission, Her Majesty's Inspectorate of Prisons, and Healthcare Inspectorate Wales. A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs. HMIC, CQC, HMIP, HIW June,2013 http://www.hmic.gov.uk/media/a-criminal-use-of-police-cells-20130620.pdf

8 Information Centre for Health and Social Care. Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, Annual figures, England, 2012/13. October 2013 http://www.hscic.gov.uk/catalogue/PUB12503

9 Independent Commission on Mental Health and Policing report. May 2013. http://www.wazoku.com/independent-commission-on-mental-health-and-policing-report/

10 Information Centre for Health and Social Care. Mental Health Bulletin: Annual report from MHMDS returns – England, 2011-12, further analysis and organisation-level data. February 2013 http://www.hscic.gov.uk/catalogue/PUB10347

4. Effective commissioning

Developing an effective local system that anticipates, and where possible prevents, crisis, and which ensures timely and supportive crisis care, is first and foremost a commissioning responsibility. It is at heart a leadership challenge for commissioners. Commissioners should have as their standard that they commission crisis care services that they would be content for their family or friends to use if they needed it. Local commissioners have a clear responsibility to put sufficient services in place to make sure there is 24/7 provision sufficient to meet local need.

Excellence in commissioning requires a mature multi-agency approach. Health and wellbeing boards will support this by bringing together health and social care commissioners, the local community and wider partners. Through the board, these partners will work together to develop a joint understanding of the local population's health and wellbeing needs and a shared strategy for meeting them. Central to this is the Joint Strategic Needs Assessment (JSNA) process, and the development of a Joint Health and Wellbeing Strategy (JHWS) to set out a shared set of priorities to address the identified need.

JSNAs and JHWSs together therefore provide a framework for developing the shared local understanding that each locality needs to have of the current and future health and care needs, and the partnership working to deliver it. This should include people experiencing mental health crisis.

Depending on local circumstances and the evidence in JSNAs, health and wellbeing boards might choose to review:

- Whether there are effective care pathways from police custody suites and courts to make sure individuals with co-existing mental health and drug and alcohol issues can effectively access appropriate substance misuse services.

- Whether sufficient resources are available within the crisis care pathway to ensure patient safety, enable service user and patient choice and to make sure individuals can be treated as close to home wherever possible. This could also consider the transient population that may create an otherwise hidden demand in particular areas. This might include homeless people and those vulnerable people who come to notice on the rail transport network.

- The needs of children and young people with mental health conditions, such as self-harm, suicidality, disturbed behaviour, depression or acute psychoses.

Local health and social care commissioners will also be expected to develop their own commissioning plans in line with any relevant JSNA or JHWS, and must be able to justify any parts of their plans which are not consistent with these.

Clinical commissioning groups are required, under the Crime and Disorder Act 1998[11], to work in partnership with the police and other local responsible authorities in Community Safety Partnerships. These partnerships make strategic assessments of crime and disorder, anti-social behaviour, and drug and alcohol misuse and develop local strategies to deal with these issues.

Excellence in commissioning also requires a clear understanding of effective service responses as described and evidenced by the National Institute for Health and Clinical Excellence (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. This will ensure that service providers collect, analyse and act on a range of agreed outcomes, including patient and carer experience and satisfaction data. Commissioners will want to ensure that they have effective local safeguarding arrangements in place to prevent or reduce the risk of significant harm to people whose circumstances make them vulnerable.

Addressing these questions will enable local commissioners to realise the ambitions set out in this Concordat.

Effective commissioning ensures that the support and services reflect:

- The needs of people of all ages and all ethnic backgrounds, reflecting the diversity of local communities
- An equal relationship between physical and mental health
- The contribution of primary, community and hospital care, as well as other partners
- The inclusion of seldom-heard groups, or those that need improved early intervention and prevention.

This can be achieved through service user and carer involvement in all elements of the commissioning cycle, strategic direction, and monitoring of crisis care standards.

The next section sets out the elements of an effective system which will support local areas to plan the changes needed to strengthen and improve responses in order to best address local circumstances. It is not the role of the Concordat to set out exactly how this will be translated at the local level. There can be no single national blueprint, as local circumstances will differ.

What we can do at national level is support, inform and equip the commissioning arrangements locally. We have set out a number of interventions for strengthening the commissioning system for mental health services, including crisis care. This includes:

– The establishment of the Mental Health Information Network in 2014 to ensure that commissioners have the best possible information about the state of mental health and wellbeing in every area. This will help them make good decisions about what works in making real improvements in local services, including advice about the level and types of services needed
– Working with the Association of Directors of Adult Social Services (ADASS), the Association of Directors of Children's Services (ADCS), and the Chief Social Worker to strengthen the social care contribution to commissioning
– Support from NHS England to improve specialist leadership skills among CCGs

[11] Crime and Disorder Act 1998. The Stationery Office. http://www.legislation.gov.uk/ukpga/1998/37/contents

– Working with those areas which have been selected to be pioneers in the integration of health care services for mental health to demonstrate best practice and evaluate models of care.

In the NHS, mental health crisis care spans local commissioning led by CCGs, and primary care and specialised commissioning – led by NHS England.

NHS England, as part of its Parity of Esteem programme, will be producing a range of tools and resources to support effective commissioning of mental health services, including crisis services.

There are important roles, both for local Healthwatch organisations and local Overview and Scrutiny Committees, to hold local commissioners to account for performance in respect of crisis care services.

It is clearly important that commissioners have the opportunity to exchange experiences and practice. NHS England will facilitate this through their Commissioning Assembly and other groups.

The National Quality Board's recent guide to nursing, midwifery and care staffing capacity and capability[12] states that appropriate levels of staffing need to be sustained 24 hours a day, 7 days a week, to maintain patient care and protect patient safety. The guide is for providers and commissioners of mental health services, NHS acute services, maternity, learning disabilities and community services.

In addition, NICE announced in November 2013[13] that it will produce definitive guidance on safe and efficient staffing levels in a range of NHS settings, including mental health inpatient and community units.

Agencies, such as police and local government also have a key role. Close partnership between all the local commissioners and the NHS England area teams is needed to translate the models of urgent and emergency care developed by NHS England into local solutions that work for the demographic needs of their areas. In doing this, they will need to draw in contributions from other disciplines, such as housing and wider criminal justice.

Local commissioners also need to make sure primary care practitioners are fully involved in developing local plans, working in partnership with NHS England's area teams to secure this involvement. Partnership working is best supported by services working within catchment areas which are as co-terminus as possible, for example within the same area covered by local Emergency Departments and ambulance services.

[12] National Quality Board. How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability. NQB. 2013. http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

[13] National Institute for Health and Care Excellence. NICE to produce guidance on safe NHS staffing levels. NICE. November 2013. Press release. http://www.nice.org.uk/newsroom/news/NICEToProduceGuidanceSafeNHSStaffingLevels.jsp

Case Study

A new vision for Urgent Mental Health Care in North West London

Shaping Healthier Lives is North West London's mental health transformation strategy, 2012-15. It involves collaborative work between eight clinical commissioning croups and two mental health trusts.

The aim is to improve the experience of, and outcomes from, mental health urgent assessment and care. It provides the framework for improving mental health services across North West London, including increasing the management of the health and wellbeing of people with mental health problems in primary care. There is a need for rapid access to assessment and care for those in crisis, to be provided when and where the service user most needs it.

Initial approaches to improve crisis assessment and care include:

- Roll out and embedding of a common access and care standards policy
- A review of the local skills mix, competency and training needs of staff
- Progress to align mental health services to those in primary care- covering the period 8am – 8pm as a minimum. Extension of home visiting for crisis resolution work, providing 24/7 cover every day of the year
- Simplification of the 'way in', with a single telephone number, available 24/7 every day of the year.

Glen Monks
NWL Mental Health Programme Lead

5. Core principles and outcomes

This section sets out the principles and statutory requirements that all services involved in responding to mental health crises should follow.

It also describes improvements in services that can benefit people who depend on this support.

People seeking urgent help with mental health conditions, and friends and family close to them, will approach a range of different services – including their GP, helplines or voluntary sector groups, Emergency Departments, social services, schools, colleges, mental health trusts, and the police.

The complexity of crises may mean that individuals need support for several aspects of their crisis. This means having their mental health issues understood within the context of their family, cultural or community setting and other urgent needs, such as self-harm, alcohol or drug misuse, or pregnancy.

For there to be an effective emergency mental health response system, there should be detailed coordination arrangements in place between all the agencies regularly contacted by people in mental distress. People should be able to expect a whole system response.

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

A. Access to support before crisis point

A1 Early intervention – protecting people whose circumstances make them vulnerable

Mental health services need to intervene early to prevent distress from escalating into crisis. People with mental health problems, or their families or carers, are often aware that they are approaching crisis and may know what they need to do to avert it. They need to know who to contact in these circumstances. Services, in turn, need to trust the judgement of these 'experts by experience' and respond swiftly.

Early interventions can include:

- The development of a single point of access to a multi-disciplinary mental health team. These teams include staff from different professions, such as social workers and psychiatrists, and have been shown[14] to simplify and improve access. This access point should be available to agencies across the statutory and voluntary sectors

[14] West M, Alimo-Metcalfe B, Dawson J, El Ansari W, Glasby J, Hardy G et al. Effectiveness of multi professional team working in mental health care. Final report. NIRH Service Delivery and Organisation Programme. 2012. http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1819-215_V01.pdf

- A joined-up response from services, for people of all ages who find themselves in crisis, with strong links between agencies, for example social care teams and substance misuse services
- Help at home services, including early intervention or crisis resolution/home treatment services
- Respite away from home or a short stay in hospital as a voluntary patient
- Peer support, including access to crisis houses or other safe places where people can receive attention and help
- Access to liaison and diversion services for people with mental health problems who have been arrested for a criminal offence, and are in police custody or going through court proceedings.

Each local area will need to decide the combination of services that best serves the particular needs of their population.

Care planning, including joint crisis care planning, for people with mental health problems is a crucial element of the preventative approach to crisis management.

Primary care, working in effective multidisciplinary teams and in partnership with a range of organisations, has an important role in supporting people experiencing mental distress or crisis.

Early intervention should be appropriate for people from vulnerable groups, including BME communities, people with learning difficulties, people with physical health conditions, people with dementia and children and young people, so they can find and stay engaged with services which keep them safe, improve their mental health and prevent further crises. People from these vulnerable groups are also at a high risk of going missing, with an estimated four out of five adults who go missing experiencing a mental health problem at the time they disappear.[15]

Early intervention work can include suicide prevention. The Mandate from the Government to the NHS states that, "It is… important for the NHS to take action to identify those groups known to be at higher risk of suicide than the general population, such as people in the care of mental health services and criminal justice services".

B. Urgent and emergency access to crisis care

B1 People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery

The NHS Mandate for 2014-15 contains an objective for the NHS to make sure that every community develops plans, based on the principles set out in this Concordat, that mean no one in crisis will be turned away.

People in mental distress should be kept safe. They should be able to find the support they need – whatever the circumstances in which they first need help, and from whoever they turn to first. As part of this, local mental health services need to be available 24 hours a day, 7 days a week.

The Concordat signatories believe responses to people in crisis should be the most community-based, closest to home, least restrictive option available, and should be the most appropriate to the particular needs of the individual.

[15] Missing children and adults: A cross government strategy. Home Office, 2001. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117793/missing-persons-strategy.pdf

B2. Equal access

Commissioners and providers should be aware that the Equality Act 2010[16] applies to mental health services, and requires that people should have equal, appropriate access. The Health and Social Care Act 2012 also introduced new legal duties regarding health inequalities for NHS England, stating that inequality of access to services and inequality of outcomes from them must both be reduced.

Equality is a key policy objective within England's cross government strategy for mental health, *No health without mental health*.

For some people from BME communities in particular, there is evidence that poor previous experience of services leads to a reluctance to have further engagement. There is also evidence that a lack of access contributes to situations where a crisis has to be reached, often involving contact with the police or child protection services, before a person seeks or receives support.

This Concordat supports the guidance produced by Mind on commissioning crisis care services for BME communities[17]. It recommends that commissioners:

- Consult and engage with BME groups early on when commissioning services – this may include the voluntary agencies that represent and support service users from BME communities
- Make sure staff are delivering person-centred care that takes cultural differences and needs into account
- Commission a range of care options that meet a diverse range of needs
- Empower people from BME groups by providing appropriate information, access to advocacy services, and ensure that they are engaged in and have control over their care and treatment.

B3 Access and new models of working for children and young people

Children and young people with mental health problems, including children in care, care leavers, and those leaving custody in the youth justice system, should feel supported and protected at all times as they are especially vulnerable. In particular, this group should have access to mental health crisis care.

For those cases where children and young people need to be admitted to hospital for mental health treatment, the Mental Health Act 2007[18] introduced new provisions, that took effect in April 2010, to help ensure that patients under the age of 18 are accommodated in an environment that is suitable for their age – that is, not on an adult ward, unless their particular needs made it absolutely necessary.

For young people in the 16 to 18 years age group, who are making transitions between services and need continuity of care, there is a risk of additional distress when they first come into contact with adult services. Adult systems and processes may not offer the level of support and care that adolescents are used to. It is important that all staff who

16 Equality Act 2010. The Stationery Office. http://www.legislation.gov.uk/ukpga/2010/15/contents

17 Mind. Mental health crisis care: commissioning excellence for Black and minority ethnic groups: a briefing for Clinical Commissioning Groups. Mind. 2013 http://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf

18 Mental Health Act 2007. The Stationery Office http://www.legislation.gov.uk/ukpga/2007/12/contents

work to support these young people should have the appropriate skills, experience and resources to support them effectively.

Parents who have been very closely involved in the care and support of their child can also face difficulties once their child is considered to be an adult. Parents can find themselves excluded from information relating to the young person's care unless there is consent. The need for early intervention and clarity about the role of parents in the young person's care plan is critical. Staff should be willing to take the views of parents into account, as well as those of other people who are close to the young person.

To help facilitate access, there needs to be robust partnership working and communication between organisations that offer primary care to children and young people and specialist secondary care services. The focus on the interface between specialist children and adolescent mental health services (CAMHS) and primary care therefore needs to remain a central policy issue in CAMHS planning.

Other partners, such as schools and youth services, should also be fully involved in developing crisis strategies for children and young people as they may well be the first to identify the problems that a young person is facing. The best interests of the child or young person should always be a significant consideration when services respond to their needs. Children and young people should be kept informed about their care and treatment, in the same ways that adults are.

B4 All staff should have the right skills and training to respond to mental health crises appropriately

Staff whose role requires increased mental health awareness should improve their response to people in mental health distress through training and clear line management advice and support.

Because individuals experiencing a mental health crisis often present with co-existing drug and alcohol problems, it is important that all staff are sufficiently aware of local mental health and substance misuse services and know how to engage these services appropriately.

Local shared training policies and approaches should describe and identify who needs to do what and how local systems fit together. Local agencies should all understand each other's roles in responding to mental health crises.

Each statutory agency should review its training arrangements on a regional basis and agree priority areas for joint training modules between NHS, social care and criminal justice organisations. Although it is desirable that representatives of different agencies be trained together, it is not essential. It is more important that the training ensures that staff, from all agencies, receive consistent messages about locally agreed roles and responsibilities.

B5 People in crisis should expect an appropriate response and support when they need it

People in mental health crisis who need help, need to receive it promptly.

NICE quality standards are designed to help service providers quickly and easily examine the performance of their organisation and assess improvement in standards of care they provide. They also help commissioners assess whether the services they are purchasing are high quality and cost effective and focussed on driving up quality.

Service commissioners and providers should work towards NICE quality standard QS14,

Quality standard for service user experience in adult mental health, Quality Statement 6, Access to services[19].

This quality standard recommends people in crisis referred to mental health secondary care services are assessed face to face within 4 hours in a community location that best suits them; service users and GPs have access to a local 24-hour helpline staffed by mental health and social care professionals; and crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, regardless of diagnosis.

In addition:

- Hospital, step-down and community services should be commissioned at a level that allows for beds to be readily and locally available in response to a person in urgent need, as required by statute[20].
- Accommodation and facilities, including community based solutions, designed to be suitable for patients younger than 18 years must be commissioned at a level that ensures local provision in response to a young person in urgent need.
- If people are already known to mental health services, their crisis plan and any advance statements should be available and followed where possible. Considerations regarding data sharing are covered in **section B8**.

B6 People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the police must be supported by health services, including mental health services, ambulance services, and Emergency Departments.

The police have a power, under section 136 of the Mental Health Act,[21] to remove from a public place any person an officer believes is suffering from mental disorder and who may cause harm to themselves or another and take them to a designated place of safety for assessment under the Act.

NHS commissioners are required by the Mental Health Act to commission health based places of safety for this purpose. These should be provided at a level that allows for around the clock availability, and that meets the needs of the local population. Arrangements should be in place to handle multiple cases.

Police officers should not have to consider using police custody as an alternative just because there is a lack of local mental health provision, or unavailability at certain times of the day or night. To support this aim, it is essential that NHS places of safety are available and equipped to meet the demand in their area. The signatories of the Concordat will work together to achieve a significant reduction in the inappropriate use of police custody suites as places of safety.

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

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19 National Institute for Health and Care Excellence. Quality standard for service user experience in adult mental health: Quality statement 6, access to services. NICE. December 2011. http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14/quality-statement-6-access-to-services

20 Mental Health Act 1983, s. 140. The Stationery Office http://www.legislation.gov.uk/ukpga/1983/20/contents

21 Mental Health Act 1983, s. 136. The Stationery Office http://www.legislation.gov.uk/ukpga/1983/20/contents

Street triage pilots

The Department of Health is funding pilot schemes, managed by nine police forces, in partnership with local NHS organisations. Some other forces already have schemes in operation, including Leicestershire Police, as described in the case study below. In these schemes, mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health problems. This advice can include an opinion on a person's condition, or appropriate information sharing about a person's health history. The aim is, where possible, to help police officers make appropriate decisions, based on a clear understanding of the background to these situations. This should lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of section 136. An evaluation is planned for 2014.

Case Study

British Transport Police and NHS London – Operation Partner

In February 2013 British Transport Police (BTP) and NHS London launched a pilot scheme bringing together Psychiatric Nurses to work alongside Public Protection officers and staff. Their remit was to apply a multi-agency approach to the vulnerable people who come to the BTP's notice on the railway network, often in suicidal circumstances. The overall aim is to provide a managed, risk based approach that effectively moves people from crisis to care.

This is achieved through a joint assessment of all cases over the preceding 24 hours and the formulation of a joint plan to reducing the risk of harm and to engage relevant care pathways. The NHS staff have access to health information systems and provide a telephone service to officers on the ground, giving information and advice so that more informed decisions can be made in the best interests of the individual concerned. At the time of writing, 689 cases have been jointly reviewed.

Mark Smith
British Transport Police

Police officers may find it helpful to follow the guidance on responding to people with mental ill health or learning disabilities[22]. Police officers should undertake appropriate training, to enable them to recognise risk and vulnerability and identify the need for health care. This training will support the police to decide whether individuals should be detained under section 136, or whether they can be helped in some other way. Training should also cover the roles and responsibilities of partner agencies.

As part of local Mental Health Crisis Declarations, local areas will each be expected to make a commitment to improve performance in this area – by reducing the number of such uses, and by setting

[22] Guidance on responding to people with mental ill health or learning disabilities. Association of Chief Police Officers, National Policing Improvement Agency, 2010.

an ambition for a fast-track process that either provides an assessment or arranges transfer to a health based place of safety for individuals whenever a police cell is used.

Commissioners and providers should make sure there is accurate and detailed data showing why and how often police cells are used as places of safety. Local partners should also review each individual case where a police cell has been used, to make sure the use was appropriate and to see whether there are lessons to be learned for the future.

The Department of Health will monitor the national figures on the use of section 136 and expects to see the use of police cells as places of safety falling rapidly, dropping below 50% of the 2011/12 figure by 2014/15.

Local protocols

Every area should have a local protocol[23] in place, agreed by NHS commissioners, the police force, the ambulance service, and social services. This should describe the approach to be taken when a police officer uses powers under the Mental Health Act.

These local protocols should ensure that:

- When the police make contact with health services because they have identified a person in need of emergency mental health assessment, mental health professionals take responsibility for arranging that assessment.

- Individuals in mental health crisis are taken to a health based place of safety rather than a police station. The Mental Health Act Code of Practice states that "a police station should be used as a place of safety only on an exceptional basis". Local protocols should set out an agreement about what constitutes a truly exceptional basis, for example seriously disturbed or aggressive behaviour. Local Mental Health Crisis Declarations should include local ambitions to reduce the use of police cells as places of safety.

- Particular reference is made to the needs of children and young people. Unless there are specific arrangements in place with Children and Adolescent Mental Health Services, a local place of safety should be used, and the fact of any such unit being attached to an adult ward should not preclude its use for this purpose, Protocols should help to ensure that police custody is never used as a place of safety for this group, except in very exceptional circumstances where a police officer makes the decision that the immediate safety of a child or young person requires it. Even in cases where police stations are used, the use of cells should be avoided, and alternatives considered wherever possible

- NHS staff, including ambulance staff, should take responsibility for the person as soon as possible, thereby allowing the officer to leave, so long as the situation is agreed to be safe for the patient and healthcare staff. There should not be an expectation that the police will remain until the assessment is completed

- Assessments under the Act are made in good time (see section B7).

- Partner organisations are clear about respective roles and responsibilities in order that responses to people in crisis are

[23] Department of Health. Code of Practice: Mental Health Act 1983. Chapter 10. The Stationery Office. 2008 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf

risk based, personalised, proportionate and safe, and that a guiding principle is to choose the least restrictive option, for example not choosing to detain someone when there is a viable alternative option.

- Arrangements are in place for escalation to more senior staff in case of disagreement.

B7 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

Commissioners and providers should ensure that people who are in distress owing to their mental health condition, and who are in need of formal assessment under the Mental Health Act, receive a prompt response from section 12 approved doctors and Approved

Case Study

THE STREET TRIAGE CAR IN LEICESTERSHIRE

"Our street triage car has reduced the section 136 detention rate by 33% on the level prior to the introduction of the car" – Leicestershire Constabulary.

Since January 2013, Leicestershire Police and Leicestershire Partnership Trust (LPT) have jointly operated a mental health triage car, which is driven by a police officer and contains a mental health nurse from the crisis service operated by LPT.

It aims to improve the service provided to the people who police encounter who may be experiencing difficulties with their mental health or learning disability; responding at the earliest opportunity and then directing people to the most appropriate service available. The car provides an initial point of contact for police officers on the beat who encounter incidents which have a mental health element, before exercising their police powers.

The mental health nurse provides the training, experience and legal powers of a registered nurse, can conduct a mental health assessment, has mobile access to mental health services and information systems, and has experience of working practices and procedures in the NHS and in particular mental health services.

The police officer provides the training, experience and legal powers of a constable. These include powers under criminal law, the Mental Health Act and the Mental Capacity Act, has mobile access to criminal justice information systems, experience of working practices and procedures within the criminal justice system. The officer has been trained in public order and methods for gaining entry to locked or barricaded premises, and is qualified to higher driving standards, enabling emergency response if required.

The approach in Leicestershire appears to have led to a reduction in section 136 detentions of 33% of the level prior to the introduction of the car. The average time to help people when they are detained is now five hours and the car deals with 120 cases per month.

Peter Jackson
Leicestershire Police

Mental Health Professionals (AMHPs) so that arrangements for their care, support and treatment are put in place in a timely way.

Timescales should reflect the best practice set out in the Royal College of Psychiatrists guidance on commissioning services for section 136[24], which states that the Approved Mental Health Professional and doctor approved under section 12(2) of the Mental Health Act[25] should attend within three hours in all cases where there are no clinical grounds to delay assessment.

In the case of children and young people, the assessment should be made by a child and adolescent mental health services (CAMHS) consultant, or an AMHP with knowledge of the needs of this age group.

There should be no circumstances under which mental health professionals will not carry out assessments because beds are unavailable. Section 140 of the Mental Health Act states: Local health commissioners must keep those local authorities whose areas overlap informed of the hospital or hospitals where arrangements are in force to allow the reception of patients in cases of special urgency, so that AMHPs know where beds are available. Similarly, provision of dedicated AMHPs should be sufficient to meet needs, especially in out of hours periods.

When deciding upon any course of action, all professional staff should act in accordance with the Mental Health Act's principle of least restriction and to ensure that the services impose the least restriction on the person's liberty. This includes avoiding the stigmatising appearance that a mental health crisis is a crime, for example, police forces should consider using unmarked cars to travel to a property to enforce a warrant under section135 of the Act.

B8 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 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[26]. This may include:

- The name, address/contact details of the person (or a description if these cannot be ascertained)
- Details of any relative(s)/friend(s) or carer who can be contacted and, for children, family and school details
- Gender/age
- Language spoken (if not English) and any communication needs e.g. sign language
- Description of current behaviour/ presentation
- Whether likely to be affected by drink or drugs
- Physical impairments and any prescribed medicines or dietary requirements
- Whether the person is already engaged with his/her GP and/or mental health

[24] Royal College of Psychiatrists. Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983, Position Statement PS2/2013. April 2013 http://www.rcpsych.ac.uk/pdf/PS02_2013.pdf

[25] Mental Health Act 1983, s. 12(2). The Stationery Office http://www.legislation.gov.uk/ukpga/1983/20/contents

[26] Department of Health. Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services Ref 11929, Department of Health. 2009

Case Study

THE DEDICATED 136 NUMBER IN LINCOLNSHIRE

"Our central number for police has helped reduce the waiting time for people in crisis who need urgent health interventions"
– Lincolnshire Partnership Foundation Trust.

In March 2012 the section 136 working group for Lincolnshire , made up of police, Lincolnshire Partnership Foundation Trust (LPFT), the ambulance service, Approved Mental Health Professionals (AMHPs) and the Local Authority, created a joint mental health process which fully outlined operational protocols and responsibilities. Essential to this protocol was the use of a central 136 number for the police to use to enable them to access information and support from mental health professionals.

The 136 number connects officers to the mental health duty nurse at the Lincolnshire place of safety. The police expect an immediate response and advice on incidents involving an individual having a mental health crisis. The nurse is able to offer a rapid referral to healthcare services. This supports the police and ambulance services to engage with the individual in crisis with greater understanding and confidence. Section 136 is only used when necessary, because appropriate alternatives are fully considered.

The point of contact becomes the section 136 suite duty nurse once this number has been dialled and a clear data sharing process comes into play. The information is shared allowing for quicker decisions about what happens next.

Mary Quint
The Lincolnshire Partnership Foundation Trust

services and the name of the team and any involved professional

- Whether they have a mental health 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)
- Any relevant health information – such as the person being diabetic
- Children, dependents, pets or other factors to take into account when planning the most appropriate response

Information on patients should, through appropriate sharing protocols, follow them through the system and make sure 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 this is happening, and how to support that person appropriately to secure the best outcome. This may include identifying whether the individual is already in treatment

Case Study

INFORMATION SHARING AND POLICE TRAINING ON VULNERABLE PEOPLE IN LONDON

"Since the Metropolitan Police Service (MPS) introduced the recording of vulnerable adult information in April 2013, there have been in excess of 20,000 reports, which show that there has been an unmet demand for a mechanism to record information on vulnerable adults" – Metropolitan Police Detective Inspector, Mental Health Team.

The MPS has been working with a range of partners to adopt a fresh approach to the way in which information is collected and shared with partners to support better outcomes for all vulnerable adults, including individuals with mental ill health. The MPS wants to reduce the incidents of crisis interventions by police and mental health services, which arise in a complex city that tends to draw vulnerable people in from across the country.

Through delivering training and guidance to all newly trained police recruits, and all front line officers and staff, the MPS is working to change the way in which vulnerable people are identified and how that information is then shared. Concerns raised as a result can then be shared with partners, through processes such as the multi-agency safeguarding hub process, with public protection units and the community multi agency risk assessment conferences (which share information to increase the safety, health and wellbeing of all, for possible further assessment or support to be offered).

All front line officers will be trained by April 2014.

Find out more about the approach being developed by the MPS from **frankie.westoby@met.pnn.police.uk**

Find out more about the psychiatric public emergency assessment tool originally developed in the University of Central Lancashire by **Ivan McGlen, IMcglen@uclan.ac.uk**

and/or is known to services, their GP or other community-based mental health services.

B9 People in crisis who need to be supported in a health based place of safety will not be excluded

Irrespective of other factors, such as intoxication, or a previous history of offending or violence, individuals suffering a mental health crisis and urgently needing to be detained while waiting for a mental health assessment should expect to be supported in a health based place of safety.

When a decision is made by a police officer to use their power under section 136, it is essential that the person in crisis is screened by a healthcare professional as soon as possible. In the majority of cases it will be the ambulance service that will screen the person to exclude medical causes or complicating factors and advise on the local healthcare setting to which the person should be taken.

Intoxicated people, of whatever degree, where their mental state is in question, must have an adequate mental and physical clinical assessment to determine and manage the cause of their problem. People presenting

with behaviour leading to use of section 136 but complicated by alcohol ingestion are best managed in a healthcare setting – either the locally designated place of safety or, if the level of intoxication appears to pose a medical risk, the Emergency Department. Either facility requires staff skilled to make mental health and physical health assessments, diagnosis and continued clinical monitoring, with access to investigation including scans.

When dealing with a person who is intoxicated, the paramount consideration should be to ensure their safety and the safety of others. No presumption should be made in regard to the cause of apparent intoxication until the person is in a safe environment for an adequate clinical assessment to be completed. Intoxication should not be used as a basis for exclusion from places of safety, except in locally defined and agreed circumstances, where there may be too high a risk to the safety of the individual or staff.

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

Currently, exclusion may also occur because local services cannot respond to the needs of people with personality disorder because of their diagnosis, gender or because they have self-harmed. Local commissioners should work towards the commissioning of local provision in line with current NICE guidance[27] with the aim of preventing the escalation of risk and reducing the need for crisis management by primary care, Emergency Departments or the police.

B10 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 in mental distress often seek help from Emergency Departments – sometimes directly, if 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 if the person requires urgent medical attention – this may be voluntarily, under arrest for an offence, or through a detention under section 136.

Whatever the circumstances of their arrival, people in mental health crisis should expect Emergency Departments to provide a place for their immediate care and adequate liaison psychiatry services to ensure that they obtain the necessary and on-going support required in a timely way.

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 to ensure that people receive treatment on a par with standards for physical health.

The 2014-15 Mandate to the NHS contains a requirement for NHS England to ensure there are adequate liaison psychiatry services. Clinical commissioning groups should therefore ensure that there are effective liaison psychiatry services in place, to make the links between Emergency Departments and mental health services.

[27] NICE Pathways. Personality disorder overview. http://pathways.nice.org.uk/pathways/personality-disorders

Case Study

Liaison psychiatry at Department of Psychological Medicine, Hull Royal Infirmary

The A&E mental health liaison team operates seven days a week from 8am until 10pm.

It is a multidisciplinary team which includes a range of professionals who focus on people who deliberately self-harm and/or who have mental health problems within the acute care pathway.

This team therefore sees patients who have self-harmed in A&E and on the Hull Royal Infirmary and Castle Hill sites. The team will also arrange to see patients who are initially seen within the minor injuries units which are spread throughout Hull and East Yorkshire. The latter patients are usually seen within 24 hours.

The team provide an AGELESS service to patients who have self-harmed. They offer specialist psycho-social assessment, follow up where appropriate and limited outpatient work of a more psychotherapeutic nature where there is an identified need.

From: Liaison psychiatry in the modern NHS, Centre for Mental Health and NHS Confederation Mental Health Network, 2012 http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf

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 crisis, who are exhibiting suicidal behaviour, or who are self-harming, 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 staff are equipped to identify and intervene with people who are at risk of suicide, through on-going training in accordance with 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 always actively followed up
- Emergency Department staff should treat people who have self-harmed in line with the NICE guidance and work towards the NICE quality standard[28]. 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 and their need for referral for appropriate psychological therapies and follow up
- Commissioners work with hospital providers to ensure that Emergency Departments, police and ambulance services agree appropriate protocols and arrangements about the security responsibilities of the hospital and the safe operation of restraint procedures on NHS premises. Emergency Departments

[28] National Institute for Health and Care Excellence. Quality Standard for self harm. QS 34. June 2013. http://publications.nice.org.uk/quality-standard-for-selfharm-qs34

should have facilities to allow for rapid tranquilisation of people in mental health crisis, if necessary, and clear protocols to safeguard the patient. This should be in accordance with NICE Guidelines[29]. (http://www.nice.org.uk/nicemedia/live/10964/29718/29718.pdf)"

B11 People in crisis who access the NHS via the 999 system can expect their need to be met appropriately

The experience of people in mental health crisis accessing the NHS via the 999 system could be further improved by commissioning:

- The provision of 24/7 advice from mental health professionals, either to or within the clinical support infrastructure in each 999 ambulance control room. This would assist with the initial assessment of mental health patients and help ensure a timely and appropriate response.
- Enhanced 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
- Ambulance trusts to work flexibly across boundaries by exercising judgements in individual cases to ensure that an individual's safety and treatment is not compromised.

B12 People in crisis who need routine transport between NHS facilities, or from the community to an NHS facility, will be conveyed in a safe, appropriate and timely way

In the case of routine transfers of mental health patients, not all contracts are operated by NHS ambulance services - there are many private sector providers of routine patient transport services.

Commissioners will need to make sure that the transfer arrangements put in place by mental health trusts and acute trusts provide appropriate timely transport for these patients. For example, police vehicles should not be used to transfer patients between units within a hospital. Caged vehicles should not be routinely used.

B13 People in crisis who are detained under section 136 powers can expect that they will be conveyed by emergency transport from the community to a health based place of safety in a safe, timely and appropriate way

Where a police officer or an Approved Mental Health Professional (AMHP) requests NHS transport for a person in mental health crisis under their section 135 and 136 powers for conveyance to a health based place of safety or an Emergency Department, the vehicle should arrive within the agreed response time.

The NHS ambulance services in England are planning to introduce a single national protocol for the transportation of section 136 patients, which will provide agreed response times and a standard specification for use by clinical commissioning groups.

Police vehicles should not be used unless in exceptional circumstances, such as in cases of extreme urgency, or where there is a risk of violence. As mentioned above, caged vehicles should not be used.

[29] NICE Clinical Guideline 25. Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments http://www.nice.org.uk/nicemedia/live/10964/29718/29718.pdf

Case Study

AN AMBULANCE SERVICE and POLICE CONVEYANCING POLICY IN THE NORTH WEST

"The policy has brought clarity to a very complex area of service. It has dispelled a few myths and unrealistic expectations held between agencies and placed the vulnerable person at the centre of day to day responses to mental ill health" – Greater Manchester Police

The North West Ambulance Service NHS Trust (NWAS) and North West Regional Police Forces, under the authority of the North West Regional Mental Health Forum, have agreed a policy which provides guidance for ambulance service personnel, medical and/or other healthcare practitioners, Approved Mental Health Professionals (AMHPs) and police officers to ensure that patients with mental ill health are conveyed in a manner "which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people", in accordance with the Mental Health Act.

The conveyance policy sets out the roles and responsibilities of each agency including the NHS trusts, the ambulance service, the police and local authorities both in and out of working hours. All parties involved in the creation of the policy use their multi-agency experience to agree effective processes and clear care pathways.

A person-centred approach is taken with the aim of ensuring that vulnerable people receive appropriate and timely care, minimising the role of the police and the use of police vehicles in the conveyance of people experiencing mental ill health. In practical terms, the policy explains that police assistance should only be sought if there is evidence of risk of either resistance (active), aggression, violence (to self or others) or escape. The policy determines that patients are conveyed to hospital in the most humane and least threatening way, consistent with ensuring that no harm comes to the patient or to others. In order to facilitate better multi-agency working, it provides relevant telephone numbers to enable faster referrals to take place, as well as specifying the response times NWAS aim to meet when requested to assist with a mental health related incident.

The policy has brought clarity to a very complex area of service. Professionals involved now 'Think Ambulance First'. It has also enabled senior police officers to challenge requests for police involvement in conveyance when the circumstances are not appropriate and emphasised to all agencies that each has responsibilities, inside and outside of working hours, for vulnerable people.

Adele Owen
Greater Manchester Police

C. Quality of treatment and care when in crisis

C1 People in crisis should expect local mental health services to meet their needs appropriately at all times

Responses to mental health crises should be on a par with responses to physical health crises. 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, every day of the year.

The dignity of any person in mental health crisis should be respected and taken into to account.

C2 People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting

The Care Quality Commission (CQC) monitors and inspects many of the care services that provide a response to people experiencing a mental health crisis including acute and mental health hospitals, community based mental health services, GPs and primary medical services, NHS and independent ambulance providers and prison healthcare services. How these services respond to people experiencing a mental health crisis will form part of the regulatory judgement that leads to a rating.

The CQC is introducing changes to the way it monitors, inspects and regulates different care services, including developing a new approach which focuses on whether services are safe, effective, caring, responsive and well-led. For specialist mental health services, the CQC will put a greater emphasis on inspecting and monitoring the care that people with mental health problems receive in the community, including during a crisis.

It will develop tools and methods to ensure that consideration is given to the key issues for people experiencing a mental health crisis in the future as part of the new regulatory approach. This development work will be informed by emerging concerns relating to the quality of mental health crisis care such as:

- The accessibility and responsiveness of services to support people through crisis and prevent admission to hospital, and
- The number of people who are admitted to hospital far away from their home area because of pressures on their local acute or admission wards.

The CQC also has specific responsibilities to monitor the use of the Mental Health Act and to protect the interests of people whose rights are restricted under the Act. This will include making sure the powers of the Mental Health Act are properly used by the range of professionals involved in its operation, including AMHPs and the police. The CQC will take account of this Concordat when inspecting and monitoring the support people receive from these agencies in response to their crisis, including inter-agency working at key points in the care pathway. They will also ensure that there is evidence that the least restrictive care has been provided and that mental health legislation and codes of practice have been complied with.

In addition, service providers have the responsibility for monitoring the quality of their responses to people in crisis.

Where specific concerns are raised that relate to the criminal justice system the criminal justice inspectorates will have regard to these in developing their joint inspection programme.

C3. When restraint has to be used in health and care services it is appropriate.

Once a person is in a mental health setting, the Code of Practice requires the organisation to make sure staff are properly trained in the restraint of patients. The Code also requires adequate staffing levels.

There should be a clear local protocol about the circumstances when, very exceptionally, police may be called to manage patient behaviour within a health or care setting. In these cases, mental health professionals continue to be responsible for the health and safety of the person. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological well-being.

The Department of Health and other partners are working on a programme to ensure the use of appropriate and effective restraint in health and care services.

C4. Quality and treatment and care for children and young people in crisis

There should be clearly stated standards relating to how each service involves and informs children and young people about their care, including medication and diagnosis, to make sure it is age appropriate.

Each service should explain how they seek and respond to the views of children and young people, and how they are supported if they wish to make a complaint. It can be beneficial for children and young people who have experienced mental health services to take part in shaping services to meet their needs.

Children and young people should have access to an advocate. Mental health professionals should advise them if their circumstances give them this right, for example if they are sectioned, and make the necessary arrangements. Young people should also be supported in maintaining contact with their families where appropriate.

If a child or young person needs treatment, the first principle should be to treat at home or in the community if possible. If treatment is needed in an inpatient bed, local accessibility is important, so that the young person is close to home, friends and school, so long as none of these is contributing to the crisis. Young people need easily accessible and age appropriate information about the facilities available on the inpatient unit, geared towards their specific needs. This includes information on their rights and how to complain. They require extra support to settle in from a single key worker who remains the same throughout their stay where possible. They should be able to phone their families and friends. The units need to be safe, warm and decorated at an appropriate age level, and not appear to be an institution. Families should have regular meetings with the ward staff.

D. Recovery and staying well / preventing future crises

As stated in **A1 Early intervention**, care planning is a key element of prevention and recovery. Following a crisis, NICE recommends[30] that people using mental health services who may be at risk are offered a crisis plan. This should contain:

- Possible early warning signs of a crisis and coping strategies
- Support available to help prevent hospitalisation

[30] National Institute for Health and Care Excellence. Quality Standard on crisis planning. http://www.nice.org.uk/guidance/qualitystandards/service-user-experience-in-adult-mental-health/CrisisPlanning.jsp

- Where the person would like to be admitted in the event of hospitalisation
- The practical needs of the service user if they are admitted to hospital, for example, childcare or the care of other dependants, including pets
- Details of advance statements and advance decisions made by the person to say how they would like to be treated in the event of a mental health crisis, or to explain the arrangements that are in place for them
- Whether and the degree to which families or carers are involved
- Information about 24-hour access to services
- Named contacts.

A person's transitions between primary and secondary care must be appropriately addressed. Commissioners should expect clear criteria for entry and discharge from acute care. This should include fast track access back to specialist care for people who may need this in the future, and clear protocols for how people not eligible for the Care Programme Approach (CPA) can access preventative specialist health and social care when they need it. The CPA is a particular way of assessing, planning and reviewing someone's mental health care needs.

The principles of integration of care are valuable in this respect, in making sure the pathway of services is comprehensive and is organised around the patient, particularly during transition from acute to community teams.

Meeting the needs of individuals with co-existing mental health and substance misuse problems requires an integrated and coordinated approach across the range of health, social care and criminal justice agencies.

In terms of local leadership, directors of public health, clinical commissioning groups, NHS England and police and crime commissioners all have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways to meet the needs of people with co-existing mental health and substance misuse problems. Health and wellbeing boards offer a forum for joining up local services and could coordinate the commissioning of services for people with multiple needs.

Clinical commissioning groups and local authority commissioners should ensure that service specifications include a clear requirement for alcohol and drug services to respond flexibly and speedily where an individual in crisis presents in a state of intoxication or in need of urgent clinical intervention. Workforce development has an important role to play in ensuring that staff receive the necessary training and support to work effectively and confidently. This should be reflected in the commissioning intentions of both substance misuse and mental health services.

Joined-up support is particularly important in criminal justice settings and it is critical that the development of liaison and diversion schemes is closely tied in with existing custody based interventions, such as those for drug misusing offenders to maximise their impact on this client group.

6. Next steps – enabling improvements in crisis care to happen

Actions to enable delivery of shared goals

This Concordat sets out the principles under which statutory agencies should work together to refine and improve the services that support people with mental health problems when they need urgent help.

As a first step towards making sure that these principles are translated into improvements across the health and justice systems, the Concordat signatories have all made specific commitments, which are contained in the following annex.

These commitments cover all of the areas that this Concordat seeks to address - effective commissioning, access to support before crisis point, urgent and emergency access to crisis care, the quality of treatment and care when in crisis, and preventing future crises.

These actions represent a vital part of this Concordat. An annual Concordat Summit will be held by signatories to review progress and hold each other to account on the delivery of this action plan.

Mental Health Crisis Declarations

The local dimension is critical to success, and central to this ambition is the expectation that local areas commit to delivering their own Mental Health Crisis Declaration.

The drive to achieve this will be supported by the national Concordat signatory organisations from spring 2014, through the use of existing networks and partnerships. In particular, the Department of Health will promote a number of road show events across England that will provide health and police partners in local areas with an opportunity to come together to review local practice and agree their Declaration.

A programme to support implementation is being developed, including:

- The opportunity to register local declarations online
- An independent evaluation of the support programme. This will include convening a national steering group to oversee and assess the implementation of the Concordat and its effectiveness
- Regional events across the England and an annual summit to assess progress, the first to be hosted by the Royal College of Psychiatrists.

Annex 1
Mental Health Crisis Care Concordat – Actions to enable delivery of shared goals

1. Commissioning to allow earlier intervention and responsive crisis services

No	Action	Timescale	Led By	Outcomes
Matching local need with a suitable range of services				
1.1	Share good practice on the development of JSNAs, local health plans and local commissioning plans, with a focus on establishing the local need for mental health and substance misuse services, working with local partners, and signposting to safe, effective and evidence-based local alternatives to hospital admission.	Within annual commissioning cycle (review and update).	LGA.	Least restrictive, most local and effective response to crises. Reduction in out of area placements because of urgent need.
1.2	A toolkit will be developed with police forces to capture and articulate data which quantifies the demand for responses for people in mental health crisis, including local monitoring arrangements for MHA S135/136 to ensure needs related to mental disorder and intoxication.	Scoping work beginning April 2014.	Home Office, with policing partners and PHE.	Clearer evidence on which to base local commissioning.
1.3	Support, develop and improve Mental Health Clinical leads' knowledge and experience of commissioning for crisis care and physical health of people with severe mental illness.	By April 2016.	Royal College of General Practitioners.	Improved commissioning of mental health services.

No	Action	Timescale	Led By	Outcomes
Improving mental health crisis services				
1.4	Review of the availability, quality and gaps in the information needed to assess the level of local need for crisis care, develop baseline assessment of current provision and the gap analysis and monitor the effectiveness of responses to people who experience a mental health crisis including those who are assessed and detained under the Mental Health Act.	NHS England is developing its mental health intelligence programme and, from April 2014, when the data is routinely available, commissioners and providers will be able to review capacity in line with local need and agreed model.	NHS England Information Strategy and Mental Health Intelligence Network (NHS England, PHE HSCIC, CQC, NHS Benchmarking club, NHS clinical informatics network and AHSNs).	Improved national data to inform commissioning decisions.
1.5	Analysis of gap between current provision and concordat vision to inform actions.	From April 2014.	NHS England/ DH/PHE.	Focus commissioning support programmes on areas needing improvement.
1.6	Programme of support to CCGs to improve mental health crisis care commissioning.	From April 2014.	NHS England.	Commissioning Development Assembly working group to consider issues around commissioning mental health services.
1.7	Consider forming an improvement collaborative to share learning and transform services.	During 2014.	NHS England to lead with partners, including PHE.	Transformation of local services.

No	Action	Timescale	Led By	Outcomes
1.8	To develop bespoke guidance and model service specifications to support commissioners in delivering an integrated and responsive approach to meeting the needs of individuals experiencing mental health crisis where there are also co-existing substance misuse issues.	By September 2014.	PHE/NHS England/RC Psych/RCGP.	To provide clear, updated guidance to promote commissioning practice in line with concordat expectations.
Ensuring the right numbers of high quality staff				
1.9	HEE will set up a Mental Health Advisory Group to advise on policies, strategy and planning of the future workforce for mental health. This will enable HEE to: Ensure sufficient numbers of psychiatrists, other clinicians and care staff are trained to meet service needs. Review and set out future requirements for workforce training as outlined in HEE Mandate, in particular, by rolling out the Improving Access to Psychological Therapies and dementia programmes. Ensure agreement on the policy, funding and implementation plan for improvements to GP training including compulsory work-based training modules in child health, and mental health, including dementia and also include understanding of working in multi- disciplinary teams to deliver good integrated care.	From April 2014.	Health Education England and partners.	Staff are equipped to treat mental and physical conditions with equal priority.

No	Action	Timescale	Led By	Outcomes
Improved partnership working at a local level				
1.10	Development of a web portal to enable exchange of effective practice for police/health service/local authority partnerships.	Early 2014.	Home Office/ national police leads.	Spread of good practice.
1.11	NHS England mental health partnerships website, launched to support its strategic clinical networks (SCNs) to establish with partners examples of what good looks like, including in crisis services.	Mid 2014.	NHS England.	Spread of evidence based good practice.
1.12	Develop a programme of support, including online tools, to support local areas to develop their own 'Local Crisis Declarations' driven by local circumstances.	Spring 2014.	Department of Health/NHS England/Home Office.	Spread of good practice and evaluation of impact of the Concordat.

2. Access to support before crisis point

No	Action	Timescale	Led By	Outcomes
Improve access to support via primary care				
2.1	Develop a programme of work to support primary care to work collaboratively with other services, facilitating and co-ordinating access to specialist expertise and to a range of secondary care services including crisis care mental health and substance misuse services as required.	Ongoing.	Royal College of General Practitioners (with CCG Mental Health Network).	Prevention of avoidable crises.
2.2	Support, develop and improve GPs knowledge and experience of management of severe mental illness including physical health and crisis care through the RCGP Curriculum statement for mental health and the appointment of an RCGP Mental Health Clinical Lead.	April 2015.	Royal College of General Practitioners.	Prevention of avoidable crises.
Improve access to and experience of mental health services				
2.3	DH to work with voluntary sector organisations to understand and respond to inequalities in access to mental health services, particularly for black and minority ethnic communities.	Development work before March 2014	DH.	Improved outcomes and experiences of black and minority ethnic communities involved with mental health services.
2.4	Work with voluntary sector providers to assess any additional gaps in provision which are specific to the needs of LGBT people and those from 'seldom heard' groups experiencing mental health crises.	Development work before March 2014.	DH/NHS England/PHE/ HO.	Ensure services take account of the needs of diverse local populations when improvements are made.

3. Urgent and emergency access to crisis care

No	Action	Timescale	Led By	Outcomes
Improve NHS emergency response to mental health crisis				
3.1	Complete a Review of Urgent and Emergency Care, including specific reference to models of care that work for people in mental health crisis.	By October 2014.	NHS England.	Description of models and commissioning guidance by Oct 2014.
3.2	Planning process to deliver mental health crisis care objectives in 2014-15 Mandate.	Started November 2013.	NHS England.	
3.3	Audit and Review Emergency Department access to specialist mental health services across England and report back findings to NHS England and CCG networks.	September 2014	Royal College of Psychiatrists, College of Emergency Medicine	Establish baseline for parity of urgent access standards for people experiencing mental health crises
3.4	Following NHS England Urgent and Emergency Care review, develop best clinical practice around mental health crisis.	September 2014	Royal College of Psychiatrists (with partner agencies)	Improved commissioning of good clinical practice/quality services
3.5	Audit of mental health assessment rooms in Emergency Departments.	During 2014.	College of Emergency Medicine, through the PLAN accreditation network.	Service users experience a safe and improved environment and staff safety is improved.

No	Action	Timescale	Led By	Outcomes
Social services' contribution to mental health crisis services				
3.6	Support local social services to review their arrangements for out of hours AMHP provision: • 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 • explore potential for better integration of AMHP and EDT services with out of hours crisis provision of health and other partners • 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 (with LGA and College of Social Work).	Reduction in delays experienced by service users awaiting an AMHP assessment.

No	Action	Timescale	Led By	Outcomes
3.7	Support local social services to review and plan contribution to local mental health crisis services including: • representation in local senior operational and strategic forums overseeing and developing crisis services • in collaboration with local partners to have a system of ongoing review to ensure AMHP workforce is sufficient and capable to address local needs.	By April 2014.	ADASS (and LGA with College of Social Work).	Reduction in delays experienced by service users.
3.8	CQC and DH to review effectiveness of current approach to monitoring AMHP provision and whether the Care Quality Commission requires additional powers to regulate AMHP services.	April 2014.	DH and CQC.	Service users experience improved timeliness and quality of service.
Improved quality of response when people are detained under section 135 and 136 of the Mental Health Act 1983				
3.9	Update guidance, first published in Jan 2013, on the use of section 136 for commissioners and providers.	September 2014.	Royal College of Psychiatrists (with partner agencies).	Improved data collection and monitoring to inform commissioning standards.

No	Action	Timescale	Led By	Outcomes
3.10	CQC to carry out a review of health based places of safety including coverage, capacity, inclusion and exclusion criteria, staffing, arrangements for governance and multi-agency working including police support. Develop this approach to monitoring the quality of health based places of safety as part of future inspections.	Survey completed by April 2014; monitoring approach developed by September 2014.	CQC.	Improved information made public on the availability and quality of health based places of safety.
3.11	The NHS ambulance services in England will introduce a single national protocol for the transportation of S136 patients, which provides agreed response times and a standard specification for use by clinical commissioning groups.	April 2014.	Association of Ambulance Chief Executives (AACE).	Consistent responses to S136 conveyance experienced by service users.
3.12	Model for more effective joint agency arrangements to address the safeguarding and needs of vulnerable people with complex need, including personality disorders, addictions or dependencies, who turn to emergency services for help at times of crises and are at risk of exclusion from mental health services.	By September 2014.	Royal College of Psychiatry and College of Emergency Medicine.	Reduction in repeated crises experienced by people with complex needs.
3.13	The Department of Health will monitor the national figures on the use of section 136.	By November 2015.	DH.	An expectation to see the use of police cells as places of safety falling rapidly, dropping below 50% of the 2011/12 figure by 2014/15.

No	Action	Timescale	Led By	Outcomes
3.14	Review and update local Mental Health Act protocols on mental disorder and intoxication from alcohol or drugs to include guidance for emergency services, so that: • People who appear to be mentally disordered and so intoxicated as to represent an immediate physical health risk to themselves will be medically assessed in an Emergency Department • People intoxicated as a result of alcohol or drug misuse who have been assessed as mentally disordered or are currently being treated by a mental health service will be accepted into the designated health based place of safety • People intoxicated as a result of alcohol or drug misuse who do not appear to be mentally disordered or who are not known a mental health service will be dealt with by the police through criminal justice processes.	From January 2014.	DH through updating Mental Health Act Code of Practice Chapter 10, and Royal College of Psychiatry Interagency group.	People are dealt with by the service most able to respond to their immediate needs.

No	Action	Timescale	Led By	Outcomes
Improve information and advice available to front line staff to enable better response to individuals				
3.15	Support agencies sharing key information about a person, in line with current guidance – Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services Ref 11929, DH 2009.	Summer 2014.	DH through local partnership board arrangements and through Caldicott and data protection officers.	Improved management experienced by the person in crisis.
3.16	Support local mental health service providers to develop arrangements which provide real time advice and support to the police when assessing the mental health needs of a vulnerable person.	April 2014.	National Policing Lead for Mental Health /NHS Confederation Mental Health Network to provide a joint Briefing paper including examples of current best practice.	Improved quality of assessments and experience by vulnerable people with mental health needs.
3.17	Street triage pilots in nine police forces will be conducted. The Department of Health and Home Office will share the evaluation and lessons learned from the pilots widely as they progress to benefit all other triage approaches being used.	1 year pilot programme: Autumn 2013 to Autumn 2014.	Department of Health/Home Office.	New initiatives to improve the efficiency of responses and collaboration between health partners and the police are evaluated for the benefit of other areas.

No	Action	Timescale	Led By	Outcomes
Improved training and guidance for police officers				
3.18	Review of curriculum available to police forces to enable officers to undertake sufficient training on mental health. The review will also survey the 'take-up' of, and adherence to, the available training, leading to recommendations for improvements to the police curriculum.	Summer 2014.	College of Policing (supported by the Home Office).	All police forces in England can realistically be able to ensure that all frontline officers (and others) who may deal with people with mental health problems, can receive sufficient training with minimal disruption to normal business.
3.19	Review of 2010 *Guidance on Responding to People With Mental Ill Health or Learning Disabilities*.	Commence in 2014.	College of Policing.	Police guidance is updated and easier to use, transferred into Authorised Professional Practice – and available to the public.
Improved services for those with co-existing mental health and substance misuse issues				
3.20	Nationally: Public Health England, NHS England and the LGA will work together to develop resources that will support LAs and CCGs in the development of an effective framework for the commissioning of services that will meet the needs of those in mental health crisis.	April 2014.	PHE / LGA.	To drive improved service provision and encourage a consistent approach to commissioning services to individuals in crisis who present with co-existing mental health and substance misuse issues.

4. Quality of treatment and care when in crisis

No	Action	Timescale	Led By	Outcomes
Review police powers and use of places of safety under the Mental Health Act 1983 and CQC monitoring of operation				
4.1	Review of Mental Health Act 1983 Code of Practice.	Updated Code of Practice published October 2014.	DH.	Response to recommendations of HMIC/CQC report on use of police cells for s136.
4.2	Review of legislative framework for sections 135 and 136.	Spring 2014.	DH and HO.	Recommendation for any change to primary legislation to support principles of Concordat.
4.3	Carry out a thematic review of the quality, safety and responsiveness of care provided to people experiencing a mental health crisis by regulated providers and providers/ agencies with responsibility for operating the Mental Health Act 1983.	October 2013 – September 2014.	CQC.	Focused assessment of regulated providers and localities in relation to mental health crisis response; inspection of multi-agency responses within a sample of localities, particularly where concerns are identified; local and national reporting to inform improvement.

No	Action	Timescale	Led By	Outcomes
4.4	Based on the learning from CQC's thematic review, develop the approach to monitoring and inspecting providers that respond to people experiencing a mental health crisis and who are regulated by CQC so that key issues are routinely considered within the new model for regulation.	September 2013 – April 2015.	CQC.	Strengthened regulation of providers that respond to mental health crises to promote improvement in the experience and outcomes for people who use these services.
Patient safety and safeguarding				
4.5	Positive and safe campaign on restraint practices.	Guidance published for consultation, December 2013.	RCN for DH.	Part of a wider programme to reduce the use of physical restraint in mental health services.

No	Action	Timescale	Led By	Outcomes
4.6	Develop resources to support safeguarding boards, specific to the circumstances and needs of, and responses to, people experiencing mental health crisis.	During 2014.	LGA/ADASS.	Ensure effective planning, monitoring and review of local safeguarding arrangements. Support safeguarding boards to take oversight of the safeguarding implications of current arrangements between local organisations and how these might be strengthened. Support safeguarding boards approach to monitoring the effectiveness of safeguarding arrangements for people experiencing mental health crisis. Support the development of strategic plans (in advance of statutory requirement) that include the very specific needs of people experiencing mental health crisis.

No	Action	Timescale	Led By	Outcomes
Primary care response				
4.7	Improve GP Trainees' understanding of the management of severe mental illness including physical health and crisis care in the community (through the extended training proposals).	April 2015.	Royal College of General Practitioners, Health Education England.	Improve primary care response to mental health crisis.

5. Recovery and staying well / preventing future crises

No	Action	Timescale	Led By	Outcomes
Joint planning for prevention of crises				
5.1	Information and good practice guidance about prevention and early intervention produced and disseminated.	From April 2014.	PHE.	Service users experience more appropriate and consistent responses, disseminating latest best practice evidence and disseminating emerging case studies.
5.2	Set standards for the use of Crisis Care plans, in line with Care Programme approach guidance (DH publication 2010) and NICE Clinical Guidance CG 136 (Service User Experience of adult Mental Health Services NICE 2013).	Date to be agreed.	NHS England.	Service users jointly produce contingency plans in case of relapse or crisis.
5.3	Bring to attention of Health and Social Care services vulnerable people identified in the course of day to day policing in order to contribute to management plans and develop role of Neighbourhood Policing in helping to protect vulnerable people.	Ongoing.	Police national leads.	Prevention of crises due to relapse in poor mental health experienced by a vulnerable person.

No	Action	Timescale	Led By	Outcomes
5.4	Commission services so that Liaison and Diversion Services and Street Triage refer individuals with co-existing mental health and substance misuse problems to services which can address their needs.	April 2014.	PHE/NHS England.	The needs of service users with co-existing mental health and substance misuse needs are better addressed in the development of services.