Mental Health Network
NHS CONFEDERATION

Is mental health crisis care in crisis?

Key points

- Anecdotally, MHN members inform us that there are occasions when there are no routine acute mental health assessment beds available across the country.

- There is concern that committed government funding for mental health is failing to reach the front line of care.

- There are further concerns that the sustainability element of STP (sustainability and transformation plans) funding has largely been apportioned to the acute sector.

- People with a mental health problem are three times more likely to attend A&E.

- Suicide by service users under community crisis teams is increasing.

- Peak hours for mental health presentations to A&E are between 11pm and 7am.

- Good practice examples from MHN members show how local areas can operate as a whole system to benefit individuals and the wider system of care.

- Mental health crisis care needs to be a priority area for transformation.

Introduction

Mental Health Network (MHN) members have told us that mental health crisis services are under immense pressure, and there are occasions when no acute mental health assessment beds are available across the country. This is a national scandal and is leading MHN to ask 'is mental health crisis care in crisis?'

Despite the clear policy direction and pledged government investment, funding has not reached the front line of care and significant challenges remain for providers to meet demand and for individuals to get the help they need.[1,2] This briefing explores the gap between the policy rhetoric around mental health crisis care and reporting on the ground.

The level of work required with different agencies demonstrates the complexity of the problem and the scale of the challenge. Building on our previous publication *Mental health and policing*[3], the case studies in this briefing show that by operating as a whole system, local areas are developing new ways of working. These systems are not perfect but, with commitment and a shared vision, providers and their local health and care partners are improving mental health crisis care for individuals, as well as working towards making wider system changes and alleviating the pressure on A&E departments and police services.

We make the case for mental health to be part of the current reorganisation of services and sustainability and transformation plans. Failing to embed mental healthcare more deeply within the wider healthcare system will be a missed trick. Not only will it fail vulnerable individuals, their families and carers, but it will seriously challenge the government's ambitions for mental health to achieve parity of esteem with physical health.

Policy context

A number of reports have raised a level of concern around mental health crisis care.[4,5,6] Cost pressures are, some say, driving a trend in the creation of generic crisis care services.[7] This has led to a strong policy narrative about employing strategic approaches to build capacity in the community based on population need. These are advocated in the Crisis Care Concordat[8] and the Lord Crisp review of acute adult psychiatric care.[9] This policy narrative was restated with renewed vigour in the recent *Five Year Forward View for Mental Health*[10] and includes associated funding to support implementation by 2020/21.[11]

Crisis resolution and home treatment teams (CRHTTs) across England are expected to expand to ensure that 'a 24/7 community-based mental health crisis response is available in all areas', and that these teams are 'adequately resourced' to offer an alternative to an acute inpatient admission.[12] There are also recommendations to eliminate the use of non-specialist out-of-area treatments and increase the number of health-based places of safety relevant to local need.

These recommendations echo the standards from the *National Service Framework for Mental Health* published over a decade ago.[13] More recently they build on the work of the Crisis Care Concordat launched in 2014. As well as highlighting key areas for action, the Concordat has successfully brought together all agencies with a role to play in mental health crisis and asked agencies to look at the system as a whole, from prevention and access through to recovery and staying well. Good collaborative partnerships have been developed at national and local level but there is more to do.

"Good collaborative partnerships have been developed at national and local level but there is more to do."

Is crisis care hanging in the balance?

There is a question as to how the work of the Concordat will continue beyond October, when the implementation support provided by Mind, the mental health charity, will cease. NHS England are yet to communicate plans of how their ongoing work and implementation guidance will continue to support this agenda.

How existing crisis care work will fit into the current reorganisation of services is not clear. At the NHS Confederation conference in Manchester in June this year, Simon Stevens, chief executive of NHS England, talked about using sustainability and transformation plans (STPs) to provide the opportunity to address some of the 'big ticket items' and making 'this the right time' to resolve challenging issues. With a focus on place-based systems of care, STPs are ideally placed to help resolve systemic issues across localities – such as mental health crisis care.

Mental health is included as one of the nine 'must dos' for every local area in England in 2016/17, and there is an expectation from NHS England that mental health should form an intrinsic part of STP plans. Yet £1.8 billion of the £2.1 billion available to invest from the STP funding has been allocated to the sustainability element of the fund. Concerns have been raised that this funding will largely be apportioned to the acute sector.[14]

There needs to be full consideration of how STPs will fundamentally improve and sustain the crisis care pathway to ensure that people get the care that they need in their local area. Otherwise the political rhetoric around mental health crisis care will continue to get lost in translation between Whitehall and the front line of care.

Under pressure

26 per cent of adults report having ever been diagnosed with at least one mental health problem.[15] By 2030 it is estimated that there will be approximately two million more adults in the UK with mental health problems than there were in 2013.[16] Demand is rising and needs are not being met. Data shows that:

- Almost two million people (1,835,996) were in contact with mental health and learning disability

Key issues for crisis care

services at some point in 2014/15, an increase of 89,298 (5.1 per cent) on the previous year. (Amounting to approximately one person in 28).[17]

- NHS hospitals recorded 117,115 cases of self-harm and 14,827 cases of stress and anxiety for 2013/14, measured by the number of finished admission episodes. For self-harm, this was up from 107,451 in 2012/13 and for stress and anxiety, up from 14,230.[18]

- Only half of community teams offer an adequate 24/7 crisis service.[19]

- Peak hours for mental health presentations to A&E are between 11pm and 7am.[20]

- People have reported contact with at least three different services when they had a mental health crisis. 12 per cent said that they had come in to contact with between six and ten services.[21]

- Suicide rates in men aged 45-54 in the general population have risen by 37 per cent since 2006, and by 29 per cent in men aged 55-64.[22]

- There are now three times as many patient suicides under CRHTTs care as in inpatient care.[23]

- There were 58,400 cases of people being detained under the Act in 2014/15 – a 9.8 per cent rise on the previous year.[24]

- A survey by the *Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults* found that 91 per cent of wards were operating above the Royal College of Psychiatrists recommended 85 per cent occupancy rate.[25]

The Quality Watch report, *Mental ill health and hospital use*, found that in 2013/14, people with mental ill health[26] were:

- 3.2 times more likely to attend A&E

- 4.9 more likely to be an emergency inpatient admission than someone without mental ill health.

- 3.6 times more likely to have a potentially preventable emergency admissions than those without mental ill health.

Investment

There was a £600 million real-term fall in NHS mental health funding (8.25 per cent) over the course of the last parliament.[27] 45.6 per cent of NHS mental health providers reported a deficit by 30 September 2015.[28] A recent survey by NHS Providers and the Healthcare Financial Management Association shows that 90 per cent of mental health trusts and 60 per cent of commissioners do not feel confident £1 billion additional taskforce investment will be enough to meet mental health service challenges.[29]

In August this year, NHS England pledged £3.97 billion of planned investment in mental health services by 2020/21, and set out how regulators, commissioners and providers will meet the recommendations of the Mental Health Taskforce.[30] Former Mental Health Network chief executive Stephen Dalton – currently chief executive of the NHS Confederation – told HSJ that "transparency is absolutely essential. Otherwise commissioners will claim they have invested, providers will say they haven't had the money and NHS England will say they have done their bit."[31]

There needs to be clarity about where the money is coming from to address key elements of the crisis care system.

Data

In recognition of the lack of quality of mental health monitoring and outcome data, work is underway to develop robust and regular data. The new Clinical Commissioning Group Improvement and Assessment Framework (CCGIAF) will helpfully support transparency around service outcomes and specifically addresses improvements to NHS crisis care.

However, the framework in itself will not necessarily lead to service transformation. Members tell us that, despite best efforts, the collection of data becomes detached from the core purpose of delivery and that data needs to support decision-making across agencies in real time, as this will lead to system improvement. Developing the right data, set rooted in clinical reality, will inform policy development, regulation, commissioning as well as support service

user choice. The vanguard work referred in the West Yorkshire case study (see page 9) has seen this as a priority.

Legislation changes
The Police and Crime Bill currently going through parliament will ban use of police custody as a place of safety for under-18s from April 2017. Guidance is expected in early 2017 to support implementation of the new law.

In our briefing to the House of Lords, we are clear that the significant resource and capacity issues need to be resolved in order to ensure that the bill's aims can be implemented effectively without any unintended or adverse consequences for service users or mental health providers.[32]

Workforce
There needs to be greater clarity on workforce requirements to address recruitment and retention and service delivery. The recently published *Implementing the Five Year Forward View for Mental Health* set significant ambitions to increase the workforce to ensure effective service model works can be effectively resourced.

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Solutions

Building capacity in community crisis services
Acute inpatient beds, psychiatric intensive care units, specialist community teams, street triage, 24/7 access to support and alternatives to admissions, are all key components to building a robust crisis care system. Shape and form may vary according to population need but it is clear that a pathway system of crisis care can deliver care closer to home in the least restrictive settings.

24/7 community crisis care – improving access and early intervention
Many people who attend A&E departments could potentially have their needs addressed in community settings or could be supported to avoid a health crisis altogether. In response to the recognition that the peak hours for mental health presentations to A&E are between 11pm and 7am, a number of our members with local partners have established out-of-hours services. These services are, however, patchy and variable across the country.

The safe havens in Surrey and North East Hampshire and the Haven in Bradford are good examples of community crisis support. Both services sit within a wider crisis care system. For example, Bradford First Response service is a telephone service open 24/7 to anyone in mental health crisis or concerned about someone in crisis. Crisis coaching may be offered over the phone by experienced staff. Urgent requests are referred to a 'first responder', a mental health nurse or social worker, who will then arrange a visit at a time and place convenient to the caller. Referrals can also be made to the Haven.

Leeds and York Partnership NHS Foundation Trust operates a city-wide acute mental health service for people 18 years and over and who require an assessment that day or within the next 72 hours. Leeds crisis care acute assessment service (CAS) is open 24/7 and offers a more extended assessment for individuals with complex needs, preventing unnecessary hospital admissions where possible. Assessment rooms and overnight facilities for up to six people in single sex accommodation areas are provided. Referrals are accepted from other mental health staff and partner agencies, primary care, A&E departments, adult social care, paramedics, the police and people experiencing a mental health crisis and their carers.

Crisis and home treatment teams (CRHTTs)

The 2015 report of the National Confidential Inquiry into suicide and homicide by people with mental illness[33] found that, while numbers of suicides by inpatients have been falling in England, the number of suicides by service users under the care of CRHTTs is increasing and there are now three times as many suicides under CRHTT care as in inpatient care.

In 37 per cent of cases, the service user had been under the care of the CRHTT for less than a week. This puts great importance on ensuring that CRHTTs are able to operate effectively as intensive specialist community-based alternatives to inpatient care and not simply as generic crisis services.

Capacity of the Home Based Treatment team in Greater Manchester West NHS Foundation Trust was increased through additional investment to support the principle of home-based care and enabled service users to receive multiple daily visits where clinically indicated.

The Centre for Mental Health report states that, once CRHTTs are fully funded and operating effectively, CCGs will be able to cash savings from reduced mental health inpatient activity through elimination of spend on acute out-of-area placements and bed reductions.[34]

Health-based places of safety

NHS commissioners are required by the Mental Health Act to commission health-based places of safety so that any person a police officer believes is suffering from mental disorder, and who may cause harm to themselves or others, can be taken to a designated place of safety for assessment.

A 2014 review of the sections 135 and 136 of the Mental Health Act found people were being detained in police cells because of a lack of available health-based places of safety, whether this was due to capacity issues, staffing levels or opening hours. However, recent data released by the National Police Chiefs' Council (NPCC)[35] shows more cases are being referred straight to health-based places of safety than ever before (26,171) in England and Wales.

The comparative data for England for 2014/15[36] and 2015/16 shows that:

- use of a police cell as a place of safety fell by more than 50 per cent from 3,996 to 1,764

- 35 children under-18 were detained under S136 and ended up in a police cell. This represents a reduction of 75 per cent from last year's data (when 145 children were detained in police custody).

In August, the government awarded funding of £6.1 million (from a total of £15 million committed funding) to 15 NHS trusts and partnership organisations covering ten police force areas[37] to create new places of safety or refurbish existing sites.

Alternative places of safety

The Mental Health Act states that a place of safety may include 'a local authority care home, an NHS or private hospital, an independent care home' or 'any other suitable place the occupier of which is willing temporarily to receive the patient'. However, this option is rarely explored.

In 2015, local agencies in Sussex participated in a Home Office funded alternative place of safety (APoS) pilot in partnership with the Richmond Fellowship. A residential care home was available for 60 hours each weekend for 12 weeks.[38] Although the parallel implementation of a street triage scheme in West Sussex meant that use of the APoS was lower than anticipated, the pilot concluded that the APoS was considered a suitable alternative by agencies involved in the pilot. The Home Office report encourages local agencies to explore opportunities to commission and provide APoS.

"There are now three times as many suicides under CRHTT care as in inpatient care."

Bed availability and out-of-area treatment placements (OATs)

It will only ever be clinically appropriate and economically viable to deliver some types of specialist services at a regional or national level. However, it is also the case that sometimes out-of-area services are used not because of a particular specialist need, but because of a lack of service options one might reasonably expect to be available in a local area. Sometimes this can be as a result of a lack of integration with other services, such as supported housing. There are concerns that non-specialist OATs negatively impact on patient experience and make care planning more difficult.

Community care data[39] obtained from 42 of England's 56 NHS mental health trusts under the Freedom of Information Act revealed 5,411 patients were sent to out-of-area hospitals in 2015/16, up 13 per cent from 4,093 in 2014/15. Figures from trusts that recorded admission reasons showed more than 90 per cent of out-of-area placements last year were due to local bed shortage, rather than for appropriate specialist units, such as eating disorder units. Some patients were reported to travel over 300 miles away from their local area.

The number of suicides after discharge from a non-local unit has increased in recent years, from 68 between 2003 and 2007 to 109 between 2008 and 2012, leading the National Confidential Inquiry into suicide and homicide by people with mental illness to call for an end to acute admissions out of area.[40]

National bodies are working to develop the first national definition of OATs alongside a new national data collection that will enable accurate measurement and analysis, including placement type, reason, duration and cost. In 2016/17, all localities should put in place plans to ensure robust monitoring of OATs for all bed types, with the aim of delivering a demonstrable reduction in acute OATs by March 2017.

Bradford Care NHS Foundation Trust has eliminated all use of OATs over a three-year period. Costs have been reduced from nearly £2 million in 2014/15, where over 100 placements were out of area, to none as of April 2016.

Working across the system

Liaison psychiatry
The Taskforce report stated that comprehensive liaison mental health services are currently available in only one in six (16 per cent) of England's 179 acute hospitals. Yet all acute hospital must have an all-age mental health liaison services in emergency departments and inpatient wards by 2020/21, and at least 50 per cent of acute hospitals should be meeting the 'core 24' service standard as a minimum.

The West Yorkshire urgent and emergency care vanguard is seeing liaison services across the locality reduce people with mental health problems attending A&E, acute hospital readmissions and lengths of stay on physical wards since their introduction. Liaison services can therefore play an important role in creating better solutions for people and the right package of care.

Ambulance conveyance
The Code of Practice for the Mental Health Act requires that people taken to a health-based place of safety should be transported there by an ambulance or other health transport arranged by the police. The Crisis Care Concordat states that police cars or vans should be used only in exceptional circumstances.

Ambulance provision to convey people to a place of safety can vary significantly. In 2013/14, 75 per cent of those detained under S136 in the West Midlands were carried in an ambulance, whereas in London it was 30 per cent, Thames Valley 10 per cent, and Lancashire 5 per cent. For many parts of the country, no data is available.[41]

Improved data collection is necessary, however, the government's review of the use of S136 found polarised responses to the issue of transportation. The majority of respondents who were paramedics or ambulance staff said ambulances should not be used, while the majority of police respondents said police vehicles should not be used suggesting clarity is needed.[42]

MHN viewpoint

Triage services

Triage services are partnerships between NHS organisations and the police and vary in format according to local circumstances. Mental health advice is provided by a mental health practitioner, either based in the control room (giving advice over the telephone), or where the mental health practitioner is able to attend the incident.

Where triage services are in place, there appear to be reductions in the use of mental health act assessments and they have also led to significant reduction in use of S136 and use of police cells in some areas.[43]

As part of a Greater Manchester wide commitment to the Crisis Care Concordat, Greater Manchester West NHS Foundation Trust has implemented a triage telephone line for police officers to support the principle of a person seeing the right person at the right time with the right skills. This also includes supporting the appropriate use of the Mental Health Act by police colleagues. Mental health awareness training has also been delivered in order to support more positive experiences for people the police come into contact with who may have mental health problems.

The fact that our members have told us that there are occasions when there are no acute mental health assessment beds for people in crisis, indicates that local care systems are not working, creating a national problem. This suggests that despite political rhetoric, mental health is not yet taken seriously as a priority. This is further evidenced by government funding for mental health failing to reach the front line of mental health services.[44] There are concerns that the sustainability element of STP funding was largely apportioned to the acute sector, not mental health. Many providers are therefore still managing the urgent rather than being able to address the important – developing systemic solutions to build a system of crisis care.

Improving mental health crisis care pathways can and does play a central role in achieving government ambitions to improve mental and physical healthcare and to save lives. The case studies demonstrate that with strategic planning and investment, the mental health sector, with partners, holds real potential to make an important contribution to the health and care economy, including reducing pressures in the wider acute system and police services.

The 44 leadership groups currently working to submit final STPs by the end of October need to address whether mental health crisis care is one of the 'big ticket items' in their footprint. These next few months are critical and, if mental health crisis care is not to be a priority area for transformation, we will be asking, if not now, when?

"The sustainability element of STP funding was largely apportioned to the acute sector, not mental health. Many providers are therefore still managing the urgent rather than being able to address the important."

Case studies

Surrey and Borders Partnership NHS Foundation Trust (SABP) – building a coherent response to mental health crises

Surrey and Borders Partnership NHS Foundation Trust (SABP), Surrey County Council, Surrey Fire and Rescue Service, Surrey Police, the county's six CCGs and South East Coast Ambulance have joined forces with the county's 11 boroughs and districts and the voluntary sector to improve mental health crisis care.

This partnership, with people who use services and carers, forms the Crisis Concordat Delivery Group, which was set up in 2014. It is developing a multi-faceted, coherent response to mental health crises with the aim of making parity of esteem for mental health a reality on the ground. Key elements of crisis work include, home treatment teams, crisis line, police call centre support, places of safety and liaison psychiatry services in all acute trusts across the county.

Safe havens
Central to the new SABP crisis care system was the development of safe havens. Opened following consultation and co-design with people who use services, they offer a less formal and stigmatising venue than A&E. They operate in the evenings and weekends, with trained staff able to provide a mental health assessment and peer workers offering additional support. Service manager, Stanley Masawi, said: "They are places where people can be seen immediately with no long wait, keeping them out of A&E, acute care and the criminal justice system."

The first safe haven started in Aldershot as a pilot in April 2014 and opens every day of the year. It is run by SABP and the local charities Catalyst and MCCH, with funding from North East Hampshire and Farnham CCG. The model has now been extended with five further safe havens across Surrey and plans for others in Hampshire. The service won the HSJ Value in Healthcare award in February 2016 and has featured on the BBC One Show and other national media.

Single point of access (SPA)
SABP is currently developing a SPA in partnership with other statutory agencies to coordinate a fast response to support anyone experiencing a mental health crisis. This is due to go live in April 2017 and will include the ability for self-referrals so people not already known to services can receive immediate support.

Emerging outcomes
SABP reports that positive partnership working is reaping benefits for individuals and the wider system. Some emerging outcomes include:

1. **Improved access and experience**. Feedback from people who use the safe havens has been extremely positive, with some describing the facility as a 'life saver'. They are well known and recommended by local GPs, acute hospitals, the police and ambulance service.
2. **Reducing attendance at A&E**. With growing attendance at safe havens, they are proving to be a diversion from A&E, reducing pressure on the acute sector. Last year, 758 people attended the safe haven as an alternative to A&E and between January and February of this year 261 attended.
3. **Reducing inpatient admission**. An independent survey highlighted how secondary care hospital admissions owing to mental ill health reduced by a third in the Aldershot safe haven catchment area. The havens are thought to be hugely influential in improving mental health crisis care. However, SABP is clear that each part of the crisis service makes a valuable contribution to ensure that people receive timely care in the right place.
4. **Care closer to home**. There has been a steady reduction in the use of non-specialist out of area placements since 2014.
5. **Reducing use of police cells as a place of safety**. Since the Crisis Care Concordat was established, no one under 18 years of age in mental health crisis has been detained in a police cell in the country. Use of police cells has fallen from 19 per cent of all S136s in 2013/14 to 3 per cent in 2015/16. Police use the places of safety or, if an individual is consenting and willing to be supported, the safe havens.

Children and young people
SABP is also developing a new integrated partnership model of care, and launched Mindsight Surrey CAMHS in April 2016. The new model will improve access to crisis care for children and young people, and is enabling SABP to reach many more children and families than the more traditional tier 3 CAMHS approach.

Find out more at **www.sabp.nhs.uk**

West Yorkshire urgent and emergency care vanguard (UEC)

West Yorkshire are aiming to develop a shared outcomes model for mental health services across West Yorkshire as part of a UEC vanguard programme that aligns with work underway in the urgent care network and West Yorkshire's sustainability and transformation plan.

The model aims to reduce complexity and fragmentation and move towards population-based outcomes that support integrated pathways and aligned system incentives, enabling a joined-up approach to contracting for services across West Yorkshire. There is a focus to reduce local variation in the quality of services, provide consistent care pathways and achieve efficiencies through economies of scale, ensuring that services provide best quality and best value.

The model works collaboratively across mental providers (Leeds, Bradford and South West Yorkshire), West Yorkshire Police, West Yorkshire Fire and Rescue Service, Yorkshire Ambulance Services, the six local authorities and other partners (e.g. voluntary services, Mind and Cellar Project).

The models of care include:

First Response in Bradford
First Response developed in February 2014 following feedback from people using mental health services, carers and the trust's partners. It is an integrated crisis service managed and operated by the trust in partnership with City of Bradford Metropolitan District Council.

The service is available 24/7 and self-referral is encouraged. There is one number with dedicated call handlers and triage staff who triage urgent requests and provide crisis coaching or referring on to first responders as required.

The service has led to improved discharge planning and zero reliance on out of area placements. It also forms part of a stepped approach to care which also includes: A&E liaison, health-based place of safety, intensive home treatment, and a mental health nurse in police hub and diversion from custody.

The Haven
Bradford District Care Foundation Trust, The Cellar Trust and Bradford Metropolitan District Council have been working in partnership to open the new specialised space as a safe, supportive place in the local community for those in mental distress. The Haven service will play a vital role in identifying crisis triggers early and preventing a crisis from escalating. People in the local area, when they reach out to services for help and support, will receive the right help, with kind and compassionate staff at the times when they need them most, without having to attend A&E.

Nick Smith, a governor at Bradford District Care NHS Foundation Trust has lived experience of mental health crisis has welcomed the opening of the Haven, based at The Cellar Trust in Shipley:

"The service is available seven days a week, and when you're in crisis, you phone First Response and they can refer you to the Haven. It is manned by staff and also volunteers that have experienced mental health problems. It's also a non-clinical environment where you can just escape. They will be offering relaxation sessions, mindfulness sessions, peer support groups and other therapies, as well as signposting to services and making people realise they are not on their own."

The Haven builds on the success of the First Response mental health crisis service, which has resulted in people being cared for closer to home, with no out-of-area placements in the last year and has been cited as best practice in the national five-year strategy Mental Health Taskforce report.

The First Response service has been running alongside the Sanctuary, a night-time mental health service, which is open from 6pm-1pm, based at Mind in Bradford. People attending the Sanctuary will also have the opportunity to be referred to the Haven where appropriate for their wellness action plan. The model has been progressed through the mental health liaison urgent and emergency care vanguard in West Yorkshire, and there are now plans in the pipeline to roll out the model across the region.

People in crisis can now access the Haven via The First Response Service (telephone: 01274 221181).

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