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People's experiences of help, care and support during a mental health crisis

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can



CQC supports the Time to Change **Get the Picture** campaign to change the way mental health stories are illustrated in the media. Images from the campaign are used throughout the report.

www.time-to-change.org.uk/getthepicture

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Forewords

Dr Paul Lelliott

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The work that this report describes is part of a wider movement spanning six decades to improve the care for people who experience mental ill health. In the 1950s, pioneers campaigned for mental health legislation that was based on human rights. Between the 1960s and the 1990s, the asylums that segregated people with mental health problems from society, were closed to be replaced by an integrated system to care for people living in the wider community. More recently, the 'Time to Change' campaign has worked tirelessly to reduce the stigma, discrimination and disadvantage experienced by people with mental health problems.

We can see public attitudes to mental ill health are shifting. There is growing recognition and acceptance that it can affect anybody and that experiencing mental ill health does not and cannot stop you from working and participating fully in our society. Also, it is now widely accepted that people with mental illness have the same right to high-quality care as people with physical ill health.

This review explored the lived experience of people who experience a mental health crisis and the response they received when they reached out to services for help and support. It paints a picture of variation and inconsistency in the quality of care given and while some of the evidence it draws on is new, some of the key messages are not. During the course of this work, we found that many of the concerns identified over the years are still there.

It has been over 10 years since NICE (the National Institute for Health and Care Excellence) introduced clinical guidelines for the care of people who self-harm, but many services are still failing to provide a caring, empathetic response when presented with

a person who may have harmed themselves. Carers still feel they are not being listened to and struggle to get useful advice and support despite widespread recognition of the role they play in identifying crisis triggers early and preventing a crisis from escalating. In light of this, improvement is needed to make sure that everyone can get the right help at the right time. We know what best practice looks like – failing to deliver it is no longer acceptable.

If there is a reason to be confident then it may be found in the Crisis Care Concordat. Launched in February 2014, it focuses on how services respond to help people with mental illness at the time of their greatest need. It has been a remarkable initiative. An extraordinary range of public services and other bodies have acknowledged their responsibilities and all over the country groups have come together to develop local action plans to improve mental health care.

With the momentum built by the Concordat, it is now the time for health and care leaders to act decisively. They need to tackle the long-standing issues that result in the most vulnerable people in society being abandoned at a time of crisis. Organisations must look carefully at when, where and why a person in crisis comes into contact with a local service and how they can work collaboratively to challenge unacceptable responses. CQC recognises the part it will play in this and will be developing its approach to inspection and monitoring to ensure that the care and treatment of people with mental health problems is given due consideration.

This report flags up some beacons of good practice and innovation; such as the pilot street triage services that divert people with mental illness from the criminal justice system to the help that they

need. However, it also shows that services across England still vary greatly in their ability to provide a timely and high-quality response to people experiencing a mental health crisis. It demonstrates that too many people in this situation are unable to access the help they need, when they need it, and are dissatisfied with the help they have been given.

The report highlights some key lessons for the wider system, including commissioning services to meet local need, and the different agencies involved in crisis care taking a more joined-up approach. Local Crisis Care Concordat Groups have a major role in making sure that pathways for crisis care provide the right care to people in crisis, when they need it.

It also points the way forward for CQC. As set out in our business plan for 2015/16, *Shaping the Future*, the way we operate contributes to the way health and social care is, and needs to be, changing. We want to more actively look at the quality of care not just in a provider, but also across pathways.

Thanks to the work of this review, we are now far better placed to inspect the health and social care services that interact with people experiencing a mental health crisis, to understand what good looks like and to encourage services to improve.

Lucy Seren

Expert by Experience

As with the findings of this report, my experiences of care when I have been in crisis have been very mixed. Sometimes I have received the help I need to get better. At other times I most definitely have not.

I am fortunate that I have great support from my GP and community psychiatric nurse (CPN). My CPN in particular is great as she knows me and knows when I need extra help or am able to manage on my own. I have also found that, on the whole, staff in my local liaison psychiatry service are responsive to my needs.

However, this is not the case across all specialist mental health services. As other people who have experienced a crisis have described in the report, of all the services that I have come into contact with, I have found that the response of the crisis teams to be the least helpful. I often feel that they don't have enough resources as they are keen to get people 'off their books' as quickly as possible. On occasion, I have not felt listened to and felt that I have been discharged too early.

Like many others, when I have experienced a crisis I have often ended up going to A&E as I don't feel that I have anywhere else to turn. I've never used the crisis helpline in my local area as I've only heard bad things about it, like being put through to a call centre, being cut-off after 20 minutes or just being referred to A&E in the first place.

How people speak to me and treat me when I have a crisis has a big impact. On the whole, the staff in A&E have been kind and treated me with respect. But sometimes when I have gone there for help I have often felt sidelined, and that people with physical health needs have been given priority over me. Being able to access the help you need when you need it and being treated with respect and compassion are so important during a crisis.

I welcome this report and the recommendations CQC has made. Commissioners need to listen to the people in their local areas to make sure that they are providing the right services, with kind and compassionate staff, and that are open at the times people experiencing a crisis need them the most.

Summary

Attitudes to mental health are changing fast. In the last four years it is estimated that two million people have developed a more positive attitude towards mental illness.

However, there is still a long way to go until a person experiencing a mental health crisis receives the same response as someone with a physical health emergency.

In February 2014, the Coalition Government announced the launch of a new agreement called the Crisis Care Concordat. This is a challenge to those responsible for commissioning, providing and delivering the services to commit to a set of core principles around crisis care, to make sure that people get the help they need when they are having a mental health crisis. The Concordat has been signed by more than 25 national bodies, including CQC.

As part of our commitment, we agreed to review the quality, safety and effectiveness of care provided to those experiencing a mental health crisis. Throughout we have put people at the heart of the issue and sought to understand whether people were being offered the right care, at the right time, and if they were being given the information they needed, as well as what they felt about the attitudes of those providing help, care and support.

Our findings show that there are clear variations in the help, care and support available to people in crisis and that a person's experience depends not only on where they live, but what part of the system they come into contact with.

We found many examples of good crisis care, but our work has also shown that far too many people in crisis have poor experiences due to service responses that fail to meet their needs and lack basic respect, warmth and compassion. This is unsafe, unfair and completely unacceptable.

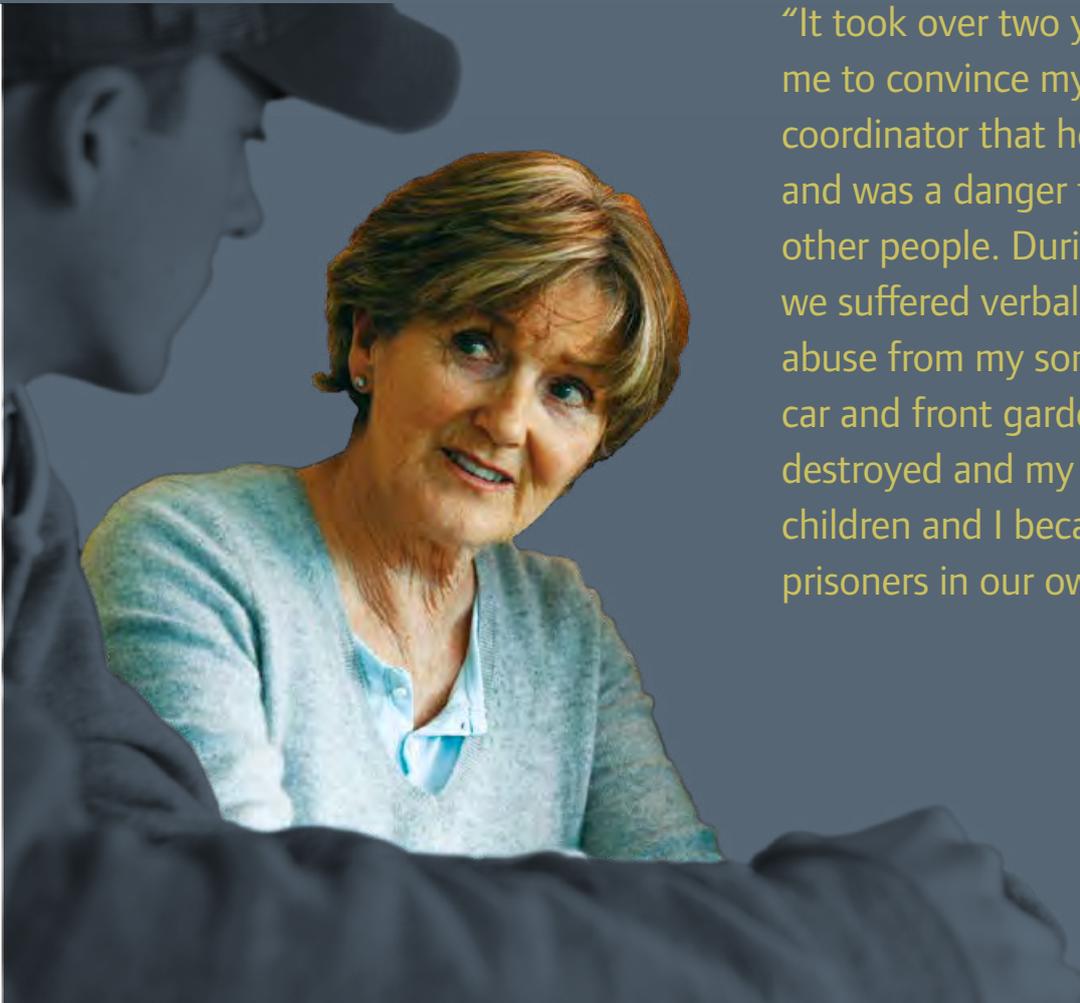
We asked people to share their experiences with us. What they told us presents a challenge for everyone responsible for ensuring people in crisis receive the best possible help, care and support. Commissioners, providers and those delivering services must all recognise the role they have to play in providing the right kind of services and making sure that they are accessible at the times when people need them.

The consequences of poor crisis care

“My GP initially referred me to the early intervention in psychosis team which didn’t help since they weren’t the right team for me. I eventually went to A&E since I became suicidal and tried to kill myself...”

“It was approximately seven hours before I got crisis support and that was only a call not a visit, which would have been more useful. As my crisis worsened I took a small overdose as I was not coping or getting any immediate help.”

“It took over two years for me to convince my son’s care coordinator that he needed help and was a danger to himself and other people. During this time we suffered verbal and physical abuse from my son. My house, car and front garden were destroyed and my two younger children and I became almost prisoners in our own home.”



There is a distinct gap between people’s perceptions of how they are treated by staff working in accident and emergency (A&E) departments and specialist mental health services compared to other services. We asked people whether they felt listened to and taken seriously, whether they were treated with warmth and compassion and if they felt judged. Fewer than four in 10 respondents gave a positive response about their experience in A&E for any of these statements. Those coming into contact with specialist mental health services were only slightly more positive.

In comparison GP, ambulances and the police were all perceived as being more successful in providing caring and empathetic responses to people in crisis. It may be less of a surprise that volunteers and charities received the most positive responses from those who come into contact with them but the gap between the voluntary and statutory sectors is substantial (table 1).

Table 1
Individual survey: I received help in a timely way, felt listened to, treated with compassion and not judged *

Local Service	I felt...				Average number of respondents
	I received the help I needed in a timely way	My concerns were taken seriously and listened to	I was treated with warmth and compassion	I was not judged for what I had done or how I felt	
Volunteers or a charity	74%	86%	88%	84%	97
GP	52%	64%	65%	66%	538
Telephone helpline	50%	62%	63%	64%	112
NHS ambulance	63%	61%	63%	53%	156
Police (encountered in a public place)	65%	54%		50%	104
Crisis resolution home treatment team	41%	44%	46%	47%	317
Community mental health team	38%	48%	52%	54%	431
Accident and emergency	35%	37%	34%	33%	316

Source: CQC’s call for evidence 2014: number of respondents

Irrespective of location or which services people came into contact with, 56% (449 people) told us that the care they received helped to resolve their crisis or was partially helpful, but 42% (339 people) said it did not help (figure 1). A health and care system where over four in 10 respondents feel their crisis was not resolved raises serious questions about the fairness and safety of service responses.

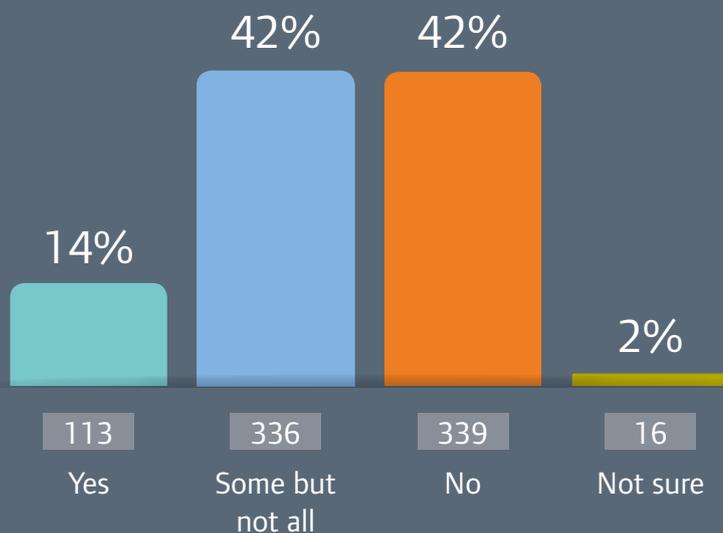
This variation is unfair. The principle of parity of esteem between mental and physical healthcare is built into the NHS Mandate. Providers must recognise that the risks from emotional harm are just as real, and potentially life-threatening, as those from a physical injury. Feedback from our call for evidence highlights poor staff attitudes to injuries caused by self-harm. These attitudes cannot be tolerated and show that work is still needed to embed parity of esteem across organisations.

This report makes an important contribution to the conversation around crisis care at a national and local level. It gives a strong evidence-base for recommendations to local Concordat groups, and identifies a series of areas where we encourage commissioners, providers and services to make improvements.



Figure 1

Individual survey: Do you feel that the care you received provided the right response and helped to resolve your mental health crisis?



Source: CQC's call for evidence 2014: number of respondents

What we found

Overall, we found that:

- The quality of care experienced by a person in crisis varied depending on where they lived and when they sought help.
- Many people have experienced problems in accessing help at the time they need it and in getting the right help when they have a mental health crisis. We found this reflected in:
 - The attitudes of staff towards people when they were in crisis. For example, staff judging people in crisis, not treating them with respect or compassion, or not taking the time to listen to carers' concerns.
 - The accessibility and availability of care at all times. This includes people being able to access the service they need at any time of day and night.
- The quality of services that are offered, and their responsiveness to people's needs. For example, whether services are following evidence-based models of good practice and are set-up to meet the needs of their local population.
- The implications for safety, particularly in risks associated with self-harm. For example, making sure that people are treated quickly and compassionately to prevent the crisis from getting worse or prevent them from hurting themselves or others.
- Across the country local services are developing innovative approaches to the challenge of providing a high-quality response to people in crisis. More can be achieved where these innovations work in partnership and services are integrated around the needs of the person in crisis.

Help, care and support in the community

Many people with a mental health condition will be seen mainly by their GP and will only have limited, if any, contact with more specialist mental health

* For more information on respondent numbers please see table 2 on pg23 and figure 5 on pg25.

services. We know that at any given time, an average of one in four patients of a full time GP requires treatment for a mental health condition. To put this into context, there were nearly three million adults on local GP registers for depression in 2013/14, and nearly 500,000 people on GP registers for a serious mental illness.

It is positive that the majority of people said they felt that their GP listened to them, and treated them with compassion. However, almost one in four said they did not feel they could get help they needed. GPs have a vital role in identifying mental health issues. When they do not feel they can provide the required care they must refer people to specialist services, such as talking therapies.

In 2013/14, over one and a half million people were in contact with NHS trusts providing specialist mental health services, the vast majority of who were supported by community-based mental health teams. The role of these teams is to support people with more complex mental health problems, and help those at risk from a crisis to stay well. Making sure that people feel involved in their care, and that they know who to contact in a crisis is essential.

While 57% of people who responded to the 2014 Community Mental Health Survey felt as involved as they wanted to be in their care planning, it is clear that there is significant room for improvement with a substantial minority (6%) feeling they were not involved at all. In addition, 23% said that they had not agreed the care they received. Over three in 10 (32%) people also said that they were unsure who to contact in a crisis.

Problems have been identified with Crisis Resolution Home Treatment Teams, with teams struggling to offer an adequate home treatment function. In particular, lack of frequent visits, inconsistency of staff and lack of support was a major frustration of people who use services.

One person told us:

“Perhaps the worst thing is all the different faces you meet. I wish they could adjust their rotas to minimise this, as seeing fewer people would be easier.”

While ideally a crisis will be managed to prevent it from escalating, we recognise that there are times when a person will need to be admitted to hospital. However, accessing inpatient beds when they are needed is becoming increasingly difficult. This can lead to the person being placed a long way from home, which can in turn make a crisis worse. Local commissioners need to make sure that the services they are commissioning are able to meet the needs of people in crisis in their local area. This includes services that can intervene early and prevent crises from happening, as well as making sure that there is a bed available locally when someone needs to be admitted to hospital.

Going to A&E

Around 5% of all A&E attendances are recorded as relating to mental health problems. There are many reasons why people go to accident and emergency (A&E) at a time of crisis. For example due to self-harm, referral from a GP or because they feel that there is nowhere else to go.

“I feel that GPs dismissed my concerns and my experiences and made me feel that I could not turn to them.”

Not being able to access the right help at the right time is unsafe and unacceptable. This can cause a crisis to escalate, leading to greater mental distress or physical harm.

We found that the rate of people admitted to acute hospital via A&E for a mental health condition varied across the country. In 2012/13, over 4,000 people had attended A&E multiple times (on average at least once a month) in the five years before being admitted. The rate and frequency of attendance at A&E is likely to be a sign that local services are not working well together and that people are not getting the specialist help they need.

Figure 2

Peak hours for acute admission via A&E



Source: HSCIC Hospital Episode Statistics

The Crisis Care Concordat is clear that people experiencing a mental health crisis should have access to the help and support they need 24 hours a day, seven days a week. This is crucial to achieving parity with physical health care. Except for people with dementia, most people with a mental health condition are admitted to hospital via A&E in the evenings (outside of 9am and 5pm). In particular, the peak hours for self-harm admissions are between 11pm and 5am when it accounts for 6% of all people admitted via A&E (figure 2). This may indicate that there are problems with other services providing support out of hours, so that people turn to A&E for help because other support is not available.

Key national and local organisations have signed up to the commitments in the Crisis Care Concordat. Our findings challenge those organisations to look at whether they are delivering their commitments and doing enough for people who experience a mental health crisis. There is no silver bullet, but it is clear that some systems and organisations are already meeting the needs of people in crisis. By learning from those organisations, we can secure a programme of continuous improvement.

We found that access to, and the quality of, services after 5pm was not good enough. Commissioners and providers should make sure that they have the most appropriate services with the staff that have the right skills working at the times when people with mental health needs are more likely to access them.

To address this, many acute hospitals have introduced liaison psychiatry teams. These teams provide patients who are in distress in hospital with assessment and short-term care, and link with the follow-up support they need. They are designed to help bridge the gap between mental and physical health care, and enable organisations to deliver a more joined-up approach. However, findings from a national survey by the Royal College of Psychiatrists have deemed that many liaison psychiatry services are not good enough and were providing an inadequate response to people who need their service.

At a time when the NHS is under financial pressure, it is vital that commissioners take an active role in commissioning adequate and effective liaison psychiatry services across acute settings that deliver value for money, alongside improving outcomes for people who come into contact with them.

Experiences of being detained

People don't choose when or where to have a crisis. As a result, the police, in particular, frequently find themselves involved in responding to people in mental health crisis. For example, they may be called to attend someone acting in a way that may be a danger to themselves and others. In these situations, the police have the power to detain the person under section 136 of the Mental Health Act. In 2013/14, this power was used by the police over 24,000 times.

We carried out some experimental analysis on the use of section 136. The analysis suggested that there were wide variations across the country in how often people were admitted to hospital after being subject to the power. We also found that just under 13% of section 136 detentions in 2012/13 were of people who had been detained under the Act in the last 90 days. Repeated use of section 136 for the same person may be a sign that people are not receiving appropriate support from local services after being discharged from hospital. NHS trusts that provide mental health services should make sure that people receive the support they need after they have been assessed or, if admitted, once discharged from hospital to prevent further crises.

Feedback from people who came into contact with the police showed the service in a more positive light than many of the specialist mental health services. It is encouraging that a professional working outside of specialist services can get it right and this should act as a challenge to those working in the health service to do the same.

“[I had] brilliant support from the police who gave me good advice and agencies to contact.”

To make sure that people have access to the right support from the beginning of the detention, a number of local authority areas are piloting street triage schemes. In these schemes, mental health nurses accompany officers to incidents where police believe people need immediate mental health support. Nurses assess and intervene where needed to make sure that people receive the most appropriate help. Initial results are positive with pilots appearing to show a substantial reduction in the use of section 136.

People should receive transport quickly and that is appropriate to their needs. Ambulance trusts have implemented a voluntary target of responding to requests from police within 30 minutes, and data from the first three-quarters of 2014 shows that most trusts met this target on over two-thirds of requests.

However, on arrival at the health-based place of safety people are often being turned away or forced to wait for long periods because they are already full or there are staffing problems. This is neither fair nor acceptable. We would not expect someone with a broken leg to be turned away from A&E or to have to wait in police custody until they could be seen by a health professional.

In 2013, only 44% of the places of safety that returned information said that their assessment room was never inaccessible because it was already occupied. While there has been a significant reduction in the use of police custody as a place of safety for people in crisis, in some areas we found that there were still problems with people under 18 being able to access a suitable place of safety. In 2013/14, 31% of people under 18 who were detained were taken into police custody.

We welcome Home Secretary Theresa May's announcement, in May 2015, of £15 million for the delivery of health-based places of safety so that no-one ends up in a police cell due to a lack of suitable alternatives.

Once in a place of safety, most services are conducting assessments under the Mental Health Act within three hours of arrival. Where we found delays, the most common reason was a lack of specialist mental health (section 12) doctors or approved mental health practitioners (AMHPs).

Local authorities are reminded that they are responsible for ensuring that there are enough AMHPs to meet local need.

Conclusions and recommendations

Our findings suggest a health and care landscape that is struggling to provide the appropriate levels and quality of responses and support across the system. We looked at three different pathways of care and at the services with which people in crisis most often come into contact and found poor experiences and considerable variation across England at almost every point in the process.

Local providers and commissioners have to ask serious questions about whether the services they provide are safe. It is not just about making sure that people are physically safe, it is about preventing unnecessary mental distress to people when they are vulnerable. The level of variation also presents a challenge about whether services are fair, and whether people are receiving unacceptable responses because of where they live or when they try to access it.

There is also cause for optimism as through our review we have found some examples of very good practice. However, there is still too much variation across the country, and even variation within the same local authority areas. The Crisis Care Concordat has called on the different agencies that help people in crisis to work together to provide a better, more joined-up approach to mental health care. To this end, we have outlined a number of specific recommendations that we expect primary care teams, acute trusts and those involved in section 136 detentions to action.

When asked for their view on the quality of services, our findings point to people in crisis having a much more positive experience of voluntary sector services compared with

services provided by the statutory health sector. This should act as a challenge to providers who must take responsibility for making sure staff have the appropriate skills to meet the needs of people in crisis. Commissioners should look towards the role the voluntary sector could play in providing local area responses to people in crisis.

We urge local providers and commissioners to recognise the issues relating to individual pathways and that only they, working in partnership with those who use and deliver services, are in a position to understand how this might impact on their local area and the solutions necessary to resolve them.

We recommend that representatives of local Crisis Care Concordat groups:

- Ensure that all ways into crisis care are focused on providing accessible and available help, care and support for all those who require it at the time they need it.
- Hold commissioners to account for commissioning crisis services that deliver a quality of care based on evidence-based good practice and that is in line with the Concordat key principles.
- Engage with local, regional and national partners to make sure that innovative approaches to improving the experiences of those in crisis are shared within, and across, local areas.

Background

What is a mental health crisis?

A mental health crisis can be unpredictable. A person in crisis may need support at any time of day or night. They may seek help from a GP, or medical attention from a local hospital, or the crisis may result in an intervention by the police. It is estimated that one in four people who use primary care services will need treatment for mental health problems at some point in their lives. In 2013/14 specialist crisis teams recorded more than 1.8 million contacts with people who were referred to their service.

Whatever the circumstances, someone experiencing an urgent mental health problem should be able to expect the same quality of response – be it safe, effective, responsive or caring – that anyone with a health emergency would want to receive.

The NHS Mandate for 2014 to 2015 refers to the parity of esteem principle. It states that organisations should “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”.² This recognises that it is not only specialist mental health services that have a responsibility to provide high-quality, accessible care to people with mental health needs.

In February 2014, the publication of the Crisis Care Concordat placed mental health crisis care under the national spotlight. The Concordat committed its signatories to working together to improve the system of care and support, so that people in crisis are kept safe and are helped to find the support they need.

A mental health crisis is defined in Mind’s report *Listening to experience* as when someone “is in a mental or emotional state where they need urgent help”.¹

A person may find their crisis is the result of a sudden deterioration of an existing mental health problem or it may be the first time that they have sought help, care or support for what they are experiencing. Signs of a crisis can include feelings of anxiety, agitation, desperation or depression.

Raising the profile of crisis care

In recent years, organisations across the voluntary, community and statutory sectors have raised awareness about the quality of crisis care and the roles and responsibilities of the different agencies involved.

- **Mind** has been championing the voice of people who use services. Their 2011 report, *Listening to experience*, brought together the views of people with experience of acute and crisis care, and their friends and family members, with those of individual staff members, advocates and organisations. This has been vital in establishing person-centred understanding of crisis care issues.
- **Black Mental Health UK** has highlighted the disproportionate number of people from African Caribbean communities with mental health needs who come into contact with police, and their experiences of care when they enter the mental health system.
- **Healthwatch England** has used its special inquiry powers to explore the issue of unsafe discharge from hospitals, care homes and mental health units, with a particular focus on people with mental health conditions.
- **The All Party Parliamentary Group on Mental Health** published its report *Parity in Progress* in March 2015. In reference to the quality of mental health emergency care, it concluded that, while progress has been made, “more must be done to clarify roles and responsibilities in this area, and ensure that mental health crisis care services are of a comparable quality to physical emergency care”.⁴
- **The Home Affairs Committee** published its report into policing and mental health in February 2015. This acknowledged the important role that the police have in working with those with mental health problems. It also recognised that, for many people experiencing a crisis, a police officer is not the professional best placed to help them, and it does not make best use of police officer time and skills.

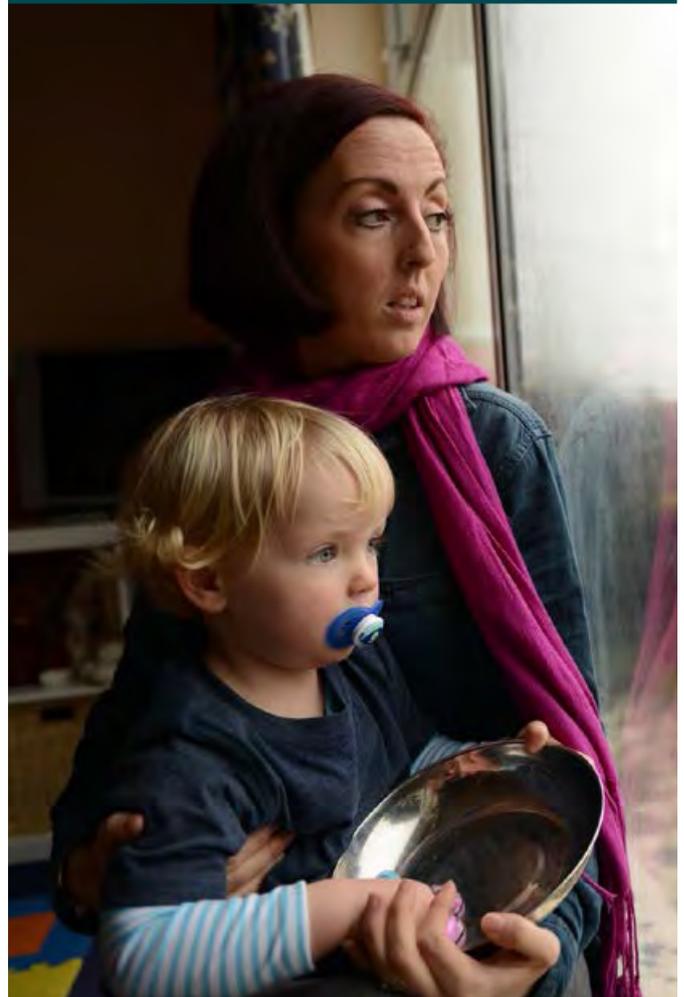
Crisis Care Concordat

The Crisis Care Concordat is built around four key principles:

- 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

It also recognises the vital role that **effective commissioning** must play in improving outcomes.³

The Concordat reflects a way of looking at service delivery that is meaningful to those who have experienced crisis and will help local organisations work together to provide effective responses.



Changes to crisis care and support

Developments in the last few years, that are aimed at improving how services respond to people in crisis, include:

- Crisis Care Concordat Local Area Declarations. Every local area in England has approved action plans that commit local area partners to deliver specific, timed, agreed actions.*
- Revisions to the Mental Health Act Code of Practice. These reflect changes in legislation, policy and professional practice. Developed in close consultation with people with lived experience and other key partners, the Code provides important information on how police and ambulance services should support people in crisis.
- A review of the operation of sections 135 and 136 of the Mental Health Act. The aim of this is to improve access to mental health services, and reduce their association with criminality.
- Greater support through strategic clinical networks for commissioners looking to ensure appropriate provision of crisis care services in their local area.
- An expectation that, by April 2016, more than 50% of people experiencing their first episode of psychosis will access a NICE approved package of care within two weeks.
- An expectation that, by April 2016, more than 75% of adults referred to the Improved Access to Psychological Therapies programme will be treated within six weeks of referral, and 95% will be treated within 18 weeks of referral. This standard applies to adults.
- £30m targeted investment (in 2015/16) on effective models of liaison psychiatry in a greater number of acute hospitals.
- Development of a national police monitoring form for section 135/136 encounters.
- Review of the use of emergency departments for people detained under section 136.
- Opportunities for providers to express an interest to join NHS England's Urgent and Emergency Care Vanguard by focusing on people with urgent care needs. This may include providing those experiencing a mental health crisis with highly responsive services that deliver care as close to home as possible, and minimise disruption and inconvenience for patients and their families.

About our review

As a signatory to the Concordat, CQC committed to providing a national overview on crisis care using our powers under section 48 of the Health Social Care Act 2008. We agreed to carry out "a thematic review of the quality, safety and effectiveness 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".⁵

CQC is uniquely placed to carry this out because of our responsibilities to inspect and regulate many of the care services that help people experiencing a mental health crisis. This includes acute and mental health hospitals, community-based mental health services, GPs and primary medical services, and ambulance providers.

We also have specific responsibilities to monitor the use of the Mental Health Act (MHA) and to protect the interests of people whose rights are restricted under the Act. For example, the use of section 136 by the police, and assessments carried out under the MHA by approved mental health professionals (AMHPs) and section 12 approved doctors.

* 152 (out of 152) local areas had agreed action plans by May 2015.
www.crisiscareconcordat.org.uk/explore-the-map

Our aims

We wanted to find out whether:

- Responses to people experiencing a mental health crisis varied across the country.
- The quality of the response people received was a matter of concern.
- A lack of joined-up working between different agencies was putting people at risk.

The project looked at three ways in which people are likely to come into contact with services in their local area during a crisis, and explored the pathways of care for each of these groups. Taking this approach meant that we could focus on the experiences and outcomes for people as they move between service providers in their local area. This helped make sure that we always looked at how a person in crisis experiences services rather than the response of individual services.

We focused on people who experience a mental health crisis and:

- Require access to and support from specialist mental health services.
- Present to accident and emergency departments (with a particular focus on people who self-harm).
- Are detained under section 136 of the Mental Health Act.

It is important to remember that these care pathways do not exist in isolation. We recognise that people may come into contact with more than one of these pathways during their crisis, and that problems in one care pathway may have an impact on another.

For example, we know that people may go to accident and emergency (A&E) during a crisis for a number of reasons. They may have been told to go there by their doctor or by following advice received from NHS 111, or they may have tried to access a local crisis service only to be turned away. In some cases, they may actively avoid what may be considered more appropriate routes because of previous experiences of poor care.

Section 48: CQC's Special Review Powers

Section 48 of the Health and Social Care Act gives CQC the freedom to explore issues that are wider than the regulations that underpin our regular inspection activity. Using these powers, we can explore local area commissioning arrangements and look at how organisations are working together to develop pathways of care that put people who use services at their heart.

The purpose of this thematic work is to use our position in the health and care system to encourage improvement in the quality of joined-up, person-centred care. This includes models of integrated care, the quality of care pathways, and the quality of services in a local health and care economy.

Our work on crisis care is the first of a series of thematic projects which look at health and care provision across a local area, and that focus on how well services are integrated. It will be followed by projects that look nationally at the delivery of end-of-life care and the provision of integrated care for older people.

Our activities

We worked with people with lived experience of a mental health crisis, voluntary and statutory sector colleagues, and professional and provider organisations to develop the approach for our review, which consisted of four main activities.

1. National data review

We carried out a major review of available national data to paint a picture of mental health crisis care across England. We then looked more closely at this information at a local level to help us select areas for inspection and to answer our key questions about variation between different areas.

We published the analysis on our website in November 2014. It allows people to search by local authority to see how their area compares to the national average across a range of indicators. We encourage stakeholders to use these data to inform their crisis concordat local area declarations and action plans. We also believe that it can help people to hold local services to account.*

2. Call for evidence

To better understand the concerns of people with experience of a mental health crisis, and how they interact with services at a local level when they are in crisis, we asked people across the country to share their experiences with us.

The call for evidence ran for six weeks in spring 2014, and we received more than 1,750 responses. The information we received was used to help inform our local area inspections. It has also been used to provide the voice of the individual in this report.

3. Survey and map of health-based places of safety

In January 2014, we surveyed every NHS mental health trust and two community interest companies to find out more about their provision of health-based places of safety. Using the information we collected, we produced an online map that people can use to find health-based places of safety in England. This includes information on their opening times, capacity, and age restrictions. In October 2014, we published the findings and key recommendations from the survey in *A safer place to be*.⁶

4. Local area inspections

Following pilots in two local authority areas, we carried out 15 local area inspections in winter 2014/15. These inspections looked at the health and care services within a local area, and focused on how these services work in partnership to deliver help, care and support to people in crisis rather than on the activity of a single provider. For the inspections we developed specific methods and tools to assess issues relating to the quality of care and effectiveness of care pathways for people in crisis. The reports from these local area inspections are published alongside this report.†

* www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review

† We are publishing 12 of the 15 local area inspection reports. It was agreed that the pilot inspection reports would not be published and the Northamptonshire findings were considered as part of the comprehensive inspection of Northamptonshire Healthcare NHS Foundation Trust.

‡ In September 2014, following an expansion in scope, the Mental Health Learning Disability Data Set (MHLDDS) replaced the Mental Health Minimum Data Set (MHMDS).

Data quality and the development of an evidence base

The national data underpinning our findings broadly spans a three-year period (2011 to 2014). During this time a much greater focus has been placed on crisis care through the development of the Concordat. As a result, we recognise that many local areas have made substantial changes to their services and that local partners may have already begun to make improvements through the development and implementation of their local Concordat action plans. However, we feel that our evidence-based data findings can still be used as a baseline from which the success of changes to local crisis care provision can be measured.

Our analysis includes some experimental indicators, including indicators drawn from linking two national datasets, Hospital Episode Statistics (HES) and Mental Health Learning Disability Data Set (MHLDDS)[‡]. These indicators require further consultation and testing before being used for ongoing monitoring. There were also other measures that we would have liked to have developed for this review but for which the data were either not readily available or of poor quality. The table below summarises these indicators by potential data source and highlights the issues we identified.

Without good quality data it will be difficult for local areas to pinpoint areas where improvement is needed and to monitor progress. We therefore encourage providers and other relevant partners to make sure that any data quality issues are addressed at a local level to improve their understanding of local need, and help generate a national evidence-base around crisis care. We are also committed to working with other national organisations with responsibility for mental health intelligence (such as the Mental Health Information Network) to develop indicators to ensure people’s experience and outcomes of a mental health crisis can be monitored along the care pathway, and that any data quality issues are identified.

Sector/data source	Indicator/measure	Issue
Primary care: The Quality and Outcomes Framework (QOF)	We wanted to look at the numbers of people recorded on local GP registers for mental health conditions and compare this with the estimated numbers of people that have these mental health conditions within a local area to ascertain how well mental health problems are being identified within primary care.	The GP registers are cumulative and for mental health conditions often count more people than are estimated as having the condition. In view of this, we could not compare estimated prevalence to those ‘diagnosed’ and on the register as a way of measuring identification of ill health in primary care.

Table continues overleaf

Sector/data source	Indicator/measure	Issue
<p>Specialist mental health services: The Mental Health Learning Disability Data Set (MHLDDS (previously the Mental Health Minimum Data Set (MHMDS))</p>	<p>There were several measures we wanted to generate, including:</p> <p>The time people waited between being referred to a specialist mental health service and being seen for an assessment</p> <p>The number of people admitted as an emergency to a mental health hospital out of their local area</p> <p>The proportion of people on the Care Programme Approach (CPA) who had a crisis care plan in place</p> <p>We have included analysis of the use of Section 136 (S136) based on MHLDDS, KP90 and Association of Chief Police Officers (ACPO) data but it is apparent that use of S136 is often under recorded in MHLDDS in comparison with both KP90 and ACPO data.</p>	<p>MHLDDS is not currently structured to support the measurement of waits for individual referrals, but the dataset is being amended to support the calculation of waiting times in mental health in future. The methods for doing so, for individual services, are in development.</p> <p>Although we were not able to generate an indicator on out of area transfers, we have included information in this report on the Health and Social Care Information Centre’s (HSCIC) experimental analysis on distance between admission to mental health hospital from where the person lived and our own experimental analysis looking at whether or not people were admitted as an emergency to a hospital usually commissioned by the person’s local clinical commissioning group. However, these are both proxy measures of out of area transfers.</p> <p>When we tried to generate this indicator we identified significant variation in recording and a lack of completeness in capturing this information by providers. However, since the introduction of a recommended quality and outcome measure for crisis plans, and regular reporting in monthly MHLDDS currency and pricing reports, there is a greater focus on this issue and more recent data suggests that quality is improving.</p> <p>There is a particular issue in relation to the recording of S136 in MHLDDS in that this would only generally include counts of people taken to mental health based place of safety, so will not reflect people taken to an A&E in an acute hospital where this is the designated health based place of safety or where people are taken to a police cell and may not capture the use of S136 of the MHA for younger people. Even within this context, HSCIC’s comparison of the use of S136 as recorded in MHLDDS compared with KP90 suggests that some providers are still under recording S136 use in MHLDDS which is a concern in view of plans to phase out the KP90 data collection over the next few years.</p> <p>For this review we wanted to explore a number of issues relating to section 136 detentions, namely, how many people are subsequently admitted to hospital and how many are detained again under section 136 within 90 days of their previous detention. MHLDDS was the only available source of data that could be used for this analysis. However, we acknowledge that the incomplete recording of section 136 information in MHLDDS may have affected the validity of this analysis.</p>
<p>Hospital Episode Statistics (HES) A&E data</p>	<p>We explored options for measuring the numbers of people who attend A&E due to mental health problem, including as a result of self-harm.</p>	<p>We were advised that the recording of presenting conditions was not sufficiently complete or consistent to ensure that we could accurately reflect the numbers of people who had a mental health condition as the main reason for attending A&E.</p>

Personal experiences of crisis care

What do you feel was most important to you in the care you received?

“Kindness, and no judgement given. Treating me like any other patient and listening to me. Also just normal human contact and making me feel welcome. Offering me a coffee or telling me a story.”



What we found

- Only 14% of people who have experienced a crisis felt the care received provided the right response and helped to resolve their crisis. A health and care system where such a low proportion of people think they get the urgent help they need is one that is unsafe and inherently unfair.
- 65% of local organisations felt that out-of-hours care was not of an equal standard to care provided at other times of day. It is unacceptable that people are not able to access the services they need when they need them.
- Almost half of the respondents did not feel confident they would receive a timely or helpful response if they experienced a future crisis. This raises serious questions about the fairness and safety of service response.
- On average people told us they came into contact with three services during their crisis, but 12% encountered between six and ten.
- Services need to improve how they listen, respect and provide compassionate responses to people in crisis.

I felt... statements

To capture the breadth of people's experiences during a crisis, we designed six statements to tell us how they felt about the individual services they may have come into contact with.

I felt...



... respected



... I was listened to and my concerns were taken seriously



... I was treated with warmth and compassion



... I wasn't being judged for how I felt or what I had done



... the advice and support I was given was right for me



... the help I received was given to me in a timely way

Background

We wanted to put people at the heart of our approach. To do this, we recognised that we had to improve our understanding of people's experiences of crisis care. Mind's report *Listening to experience* (2011) was an important starting point, but there have been major transformations to the health and care landscape since its publication. Changes include a new system of commissioning and local councils becoming responsible for public health. Continuing financial pressures have also put pressure on local services to think innovatively if they are to deliver services that meet people's expectations.

As a result, we wanted to look again at people's experiences and find out more about how well they felt organisations responded to them. In particular, we wanted to understand which organisations people came into contact with at the point of crisis, and whether they saw multiple services. We also wanted to know if people were being offered the right care at the right time, were given the information they needed, and what they felt about the attitudes of those providing the help, care and support.

Between February and April 2014 we asked people to tell us about their experiences. We asked people to tell us about what happened during a specific crisis event, rather than more general feedback about crisis care in their local area. Since we knew that many people may have experienced more than one crisis, and have had varying experiences, people were able to tell us about more than one crisis event if they wished to.*

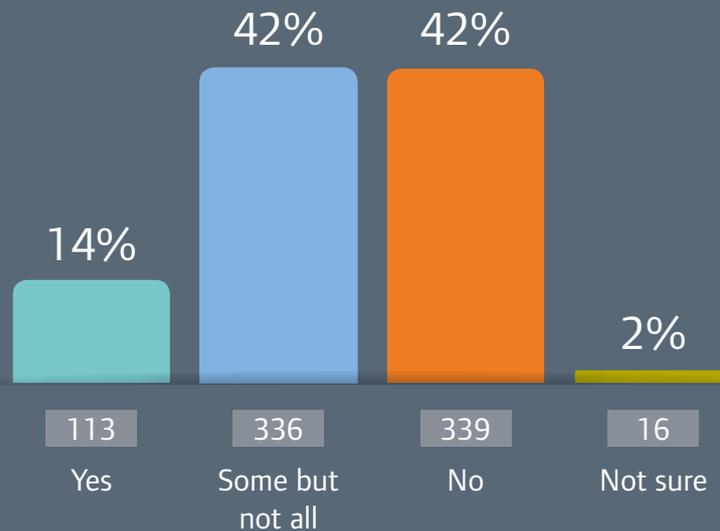
In total we received 1,756 responses: 985 came from people who had experienced a crisis, 545 were from people who had cared for someone during a crisis, and 226 were from groups who told us about crisis care services in their local area. We developed tailored questionnaires for each group to make sure that the questions reflected their circumstances.

We also commissioned the Race Equality Foundation to carry out a series of interviews and focus groups across England. These were held in areas that represented high and low levels of ethnic diversity to help improve our understanding of the views of black and minority ethnic people who have experienced a mental health crisis. The discussions from these meetings will be published by the Race Equality Foundation alongside this report.⁷



Figure 3

Individual survey: Do you feel that the care you received provided the right response and helped to resolve your mental health crisis?



Source: CQC's call for evidence 2014: number of respondents

What we found

Receiving the right response that helps to resolve their crisis is central to a person's experience of care during a crisis event. However, responses to our call for evidence show that only 14% of respondents felt that the care they received helped to resolve their crisis, while 84% felt it was either not, or only partially, helpful (figure 3).

* The call for evidence was delivered as an open consultation and respondents were self-selecting volunteers. Given the challenges of identifying a robust sample of people who have experienced a crisis, this method was more appropriate than using surveying or sampling tools. It should be noted that this method was the best available in the timeframe. However, it should be noted that the resulting findings may over-represent individuals who have strong opinions. We promoted the call for evidence through a range of organisations to encourage a wide range of viewpoints.

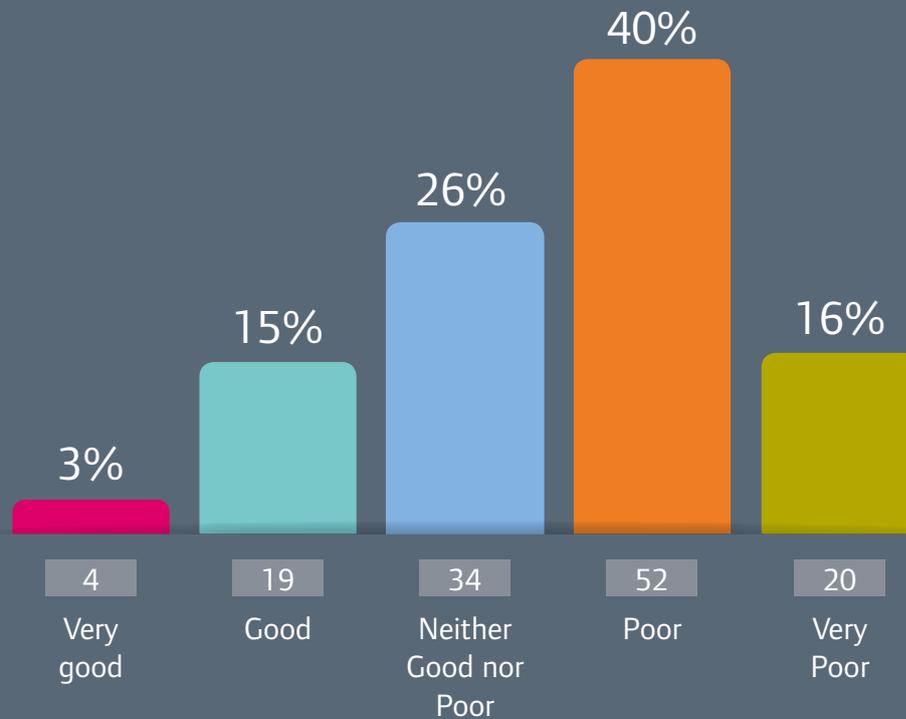
It is very concerning that, for every 10 people who experienced a mental health crisis and responded to our survey, at least eight received a response they felt did not fully meet their needs. This kind of feedback would be unthinkable for physical health emergencies and it should also be seen as unacceptable for people with mental health emergencies. While we recognise that it may not be possible to fully resolve every crisis event, these results suggest that local organisations are not consistently meeting the needs of people in crisis.

The difficulty in helping people to stay well can be seen in the fact that nearly five times as many responses we received were about a recurrence of a crisis event rather than the first one experienced. People who had experienced more than one crisis were more likely to say that the response was not at all helpful (45% compared to 30% for those who were experiencing a crisis for the first time).



Figure 4

Group survey: Please could you give us your overall impression of the quality and effectiveness of services in responding to crisis within the area you are telling us about?



Source: CQC's call for evidence 2014: number of respondents

Feedback from local groups reinforced the view that local services are struggling to provide high-quality, effective care for people in crisis. In total, 56% of groups said that they felt services in their local area offered poor or very poor care, while 18% felt they offered good or very good care (figure 4).

We asked local groups whether they felt that the level of support 'out of hours' was equal to that available between 9am and 5pm. Only 10% of 121 groups felt that the support available was equal out of hours, whereas 65% said that it was not. This strongly suggests it is more likely that people experiencing a crisis outside 9am to 5pm will not receive a response from local services that meets their needs.

I can access the right service when I need it

We wanted to find out which services people came into contact with when trying to access support in a crisis. We asked people to tell us about all the different organisations they saw during the crisis event they were telling us about. We found that more people accessed GP services (573 – 58% of all responses) than any other single service. This potentially reflects that GPs remain the initial point of contact for a health need for many people.

However, 334 responses (34%) said that they came into contact with A&E. While we recognise that there will be times when this is entirely appropriate – for example when someone has harmed themselves and

Table 2

Individual survey: I felt statements *

Service	I felt...								Average number of respondents
	I received the help I needed in a timely way		My concerns were taken seriously and listened to		I was treated with warmth and compassion		I was not judged for what I had done or how I felt		
	Yes	No	Yes	No	Yes	No	Yes	No	
Volunteers or a charity	74%	17%	86%	9%	88%	8%	84%	8%	97
GP	52%	38%	64%	28%	65%	26%	66%	23%	538
Telephone helpline	50%	38%	62%	30%	63%	29%	64%	26%	112
NHS ambulance	63%	25%	61%	23%	63%	23%	53%	29%	156
Police (encountered in a public place)	65%	31%	54%	34%			50%	37%	104
Crisis resolution home treatment team	41%	48%	44%	48%	46%	43%	47%	41%	317
Community-based mental health team	38%	55%	48%	43%	52%	39%	54%	34%	431
Accident and emergency department	35%	56%	37%	49%	34%	53%	33%	52%	316

Source: CQC's call for evidence 2014: number of respondents

needs to be assessed and treated for their physical health needs – the evidence also indicates that people are turning to A&E because they do not feel they can access the help they need elsewhere, or because they have been told to go there by another service. For instance, one local group told us that “people are no longer receiving the level of support in the community that they used to. Out-of-hours people often have to resort to presenting at A&E.”

Table 2 shows that just over half of those who came into contact with a GP felt they received a timely response. While this is one of the better responses for services providing support in a crisis, it is still

* Respondents to CQC's call for evidence were asked to identify the service they came into contact with and so the number of responses varies between services. Respondents were not provided with the statement “I felt I was treated with warmth and compassion” in relation to interactions with police services. All respondents were provided with a ‘not sure’ option to the “I felt” statements. These responses have not been included in this table. The table only includes services that were selected by at least 10% of respondents to the call for evidence.

concerning because of the implications it may have for the other services in the system. If more than one in three people do not feel they can get help from their GP when they need it, they may choose to use another route, such as accessing support from liaison services based at acute hospitals. Alternatively, they may not access any services until the crisis reaches a point where the police have to intervene.

Services that are likely to be provided by NHS mental health trusts were perceived as particularly poor for offering a timely service. The most positive response was for telephone helplines and they were seen to only provide help in a timely way 50% of the time. The results also show the variation in people's experiences, with each service having a substantial minority of respondents whose opinion was the reverse of the majority.

In contrast, 74% of respondents felt that access to volunteers and charities was timely. However, only 99 respondents told us that they used this as a way to get help during a crisis, suggesting there may be a disconnect between what is being commissioned

at a local level and what services people would find useful, or that people are not aware of the services available in their local area.

Our call for evidence shows that timely access to services is very important to people. Analysis of individual free-text comments showed that there were over five times more negative comments relating to access to services and waiting times than positive comments.

Inevitably people's experiences will vary, even in the same local area, with some having very positive experiences, and others feeling that the services helped to contribute to the escalation of a crisis. The following examples, taken from the same local area, demonstrate this:

“Within 10 minutes of returning home from the GP appointment, we were contacted by the Crisis Response Team... after the GP made my referral to them after we left the surgery, and an assessment appointment took place the same day.”

“I wish I had a place to go when I was feeling like self-harming that I could talk to someone... and have my feelings validated. Once I was discharged it took several days to get a phone call from a community mental health team, making me feel even worse.”



However, it is worrying that people do not appear to be confident that things are beginning to move in the right direction. Almost half (48%) of the 787 individual respondents stated they were “not at all” confident that, if they experienced a crisis again, that the response from local services would be timely and helpful next time.

I am treated compassionately, my concerns are listened to and I feel respected

The culture of services and attitude of staff towards people when they may be at their most vulnerable has been highlighted as a recurring theme in national investigations into major care failures.

However, it is difficult to learn about staff attitude using traditional methods. Knowing how many staff received mental health awareness training does not tell us what happens when someone in crisis approaches them for support. As a result, we felt it was essential to ask people who have looked for help about how they felt they were treated, particularly whether they were respected, listened to and treated with warmth and compassion.

In the individual survey, just under half of all the comments we analysed related to staff care and attitudes, showing how important it is to people. However, the responses were not all negative – 120 of the 153 positive comments we analysed related to the attitude and care of staff (table 2).

Just how central it is to someone's overall experience are highlighted in the examples below:

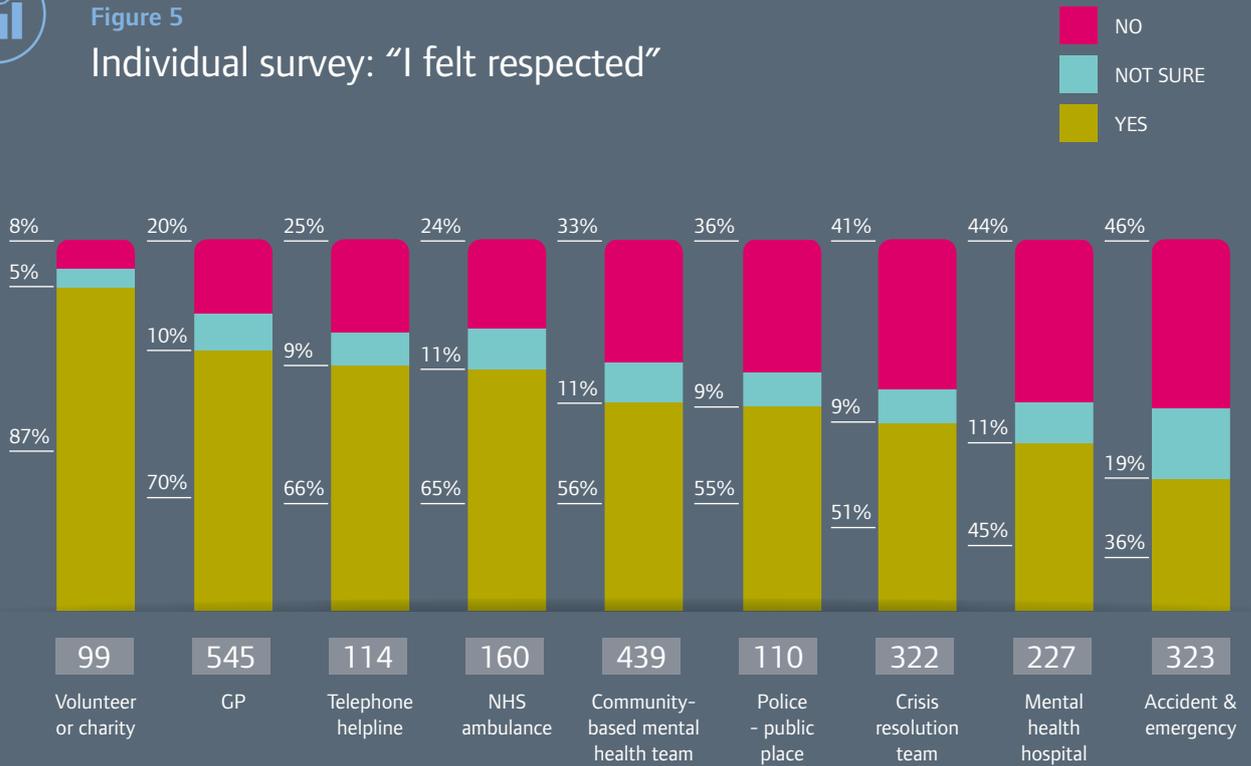
“My GP listened and did not judge me, he believed what I was saying and agreed I needed help.”

“The most important factor that helped me was the members of staff who listened to me, who cared about me and who treat me with respect.”

“When I did eventually call, three days later, I spoke to the same receptionist and she was great. It was as if she knew I was struggling and took the time to listen.”



Figure 5
Individual survey: "I felt respected"



Source: CQC's call for evidence 2014: number of respondents. Due to rounding percentages may not total 100%

I felt respected and that I wasn't being judged

We asked people to tell us if they felt respected by the services they encountered during a crisis. In general, people said that they did feel respected. Voluntary organisations scored notably higher than all other services, with 87% of respondents feeling they were respected. GPs also scored highly compared to other services, with 70% of respondents feeling respected. However one in five people who saw a GP said they did not feel respected by their doctor (figure 5).

"I feel that GPs dismissed my concerns and my experiences and made me feel that I could not turn to them."

We also asked people if they felt they were judged for what they had done or how they felt. As with the question of feeling respected, the voluntary sector (84%) and GPs (66%) scored higher than other groups. A&E was highlighted as the place where most people felt they had been judged (52%, 11 percentage points higher than the next service). In addition, people scored it lowest for taking their concerns seriously and treating them with warmth and compassion.

It is concerning that people's experiences of specialist mental health services were also varied. Although 44% of people who came into contact with crisis resolution home treatment teams during their crisis felt their concerns were listened to, 48% did not. Similarly, 46% felt they were treated with warmth and compassion, while 43% felt they were not. Community mental health teams

received slightly more positive scores, but 43% of respondents still felt that they did not consistently listen to people or take their concerns seriously. These results reinforce the impression that people are likely to receive a varying response when accessing help, care and support during a crisis. In many cases it appears that it is almost a 50:50 chance that someone will receive a service they value.

Participants in the focus groups held by the Race Equality Foundation highlighted issues that suggest people still feel that discrimination on the basis of race takes place throughout the system. They talked about the perceived stigma in statutory services, with one respondent saying that her son had been arrested many times, despite being mentally ill, because he was black. It was also suggested that a person's appearance could influence how you are treated. For example one person said that "because I was dressed in dossy clothes (it was cold) I think he looked at me as if to say 'she's just another scum off the street' and he wasn't listening to what I was telling him".

However, feedback from people who came into contact with police in a public place during their crisis shows that the service is also seen in a more positive light than many of the specialist health services. Some of the comments we received praised the police for their response.

"Brilliant support from the police who gave me good advice and agencies to contact."

"The police responded swiftly, were informative and dealt with my son, who was attempting suicide with a knife, in a calm and compassionate way; they treated him with dignity."

We think it is very positive that a professional working outside of specialist services can get it right and is a challenge to those working in the health service to do the same.

I felt I was treated with warmth and compassion

By asking about warmth and compassion, we wanted to distinguish between the ability to be respectful and the ability to show empathy to someone in distress. We looked at whether someone in crisis felt that the people they saw treated them in a way they would hope to be treated themselves.

Voluntary services and GPs again scored highly, with 88% of people who came into contact with voluntary organisations, and 65% of people who saw a GP, stating that they felt they were treated with warmth and compassion. However, a substantial minority (over one in four) of people who saw a GP did not feel this way, highlighting that people's experiences of accessing primary care are varied.

As with the question about respect, people did not feel that A&E was a service that demonstrated empathy. While 34% of respondents said they were treated with warmth and compassion, over half (52%) said they were not. People shared a number of concerning experiences with us, but there does not appear to be one single factor to explain why the experiences of people in crisis in A&E are so poor.

As well as our own call for evidence, we also looked at the results of CQC's annual A&E survey. This does not ask people directly about how they felt, but it does demonstrate the gap between the experiences of people with a self-reported mental health condition, and those without. While we do not know if these include crisis attendees, we can see that people with a self-reported mental health condition were significantly less likely to feel that staff helped to reassure them when feeling distressed (table 3).

Table 3

Extract from NHS A&E Patient Survey 2014

Q22: If you were feeling distressed while you were in the A&E department, did a member of staff help to reassure you? (Broken down by self-reported mental health condition) ⁷

	No mental health condition	A mental health condition
Yes, definitely	50%*	37%
Yes, to some extent	29%	30%
No	21%	33%*
Number of respondents	14,062	1,416

* Asterisk indicates statistically significant difference between those with and without a mental health condition. Asterisk shown in the column with the larger proportion.

On the whole, responses for specialist mental health services – including community-based and crisis resolution home treatment teams – show an even split between people who felt they were treated with warm and compassion and those who had more negative experiences. However, it is concerning that services whose primary function is to interact with people at a point of crisis, or to help in their recovery, do not appear to be meeting their expectations of warm and compassionate care. Warmth and compassion should not be seen as optional extras, but a core part of starting a person on the road to recovery.

Is it caring?
A key question for CQC’s inspection model

Under our new approach we inspect against five key questions. One of these looks specifically at whether a service is ‘caring’. In every inspection we carry out we will ask services to provide evidence that they are treating people who use the service treated with kindness, dignity, respect, compassion and empathy.

I felt listened to and my concerns were taken seriously

A mental health crisis may be difficult to recognise initially as it may not have an obvious physical symptom, and there may not be an outward sign of distress. However, people who have experienced a crisis before may recognise the trigger signs and look for help from medical professionals. It is crucial that their knowledge and understanding of what works for them are taken into account.

Sometimes it is the small things that can make a big difference. The following example shows that recognising a person’s concerns can have a positive impact on their experience:

“I felt the paramedics were amazing. I have a phobia of men I don’t know, so [the] hospital sent two women. They were kind and gentle, and helped me feel a bit better and less nervous and frightened”.

It is notable that people perceived ambulance and police staff as more likely to take a person’s concerns seriously than most specialist medical professionals.

Almost half the responses from people who came into contact with crisis resolution home treatment teams or accident and emergency departments felt their concerns were not taken seriously. In contrast only 23% of responses about ambulances, and 34% of those about those who met the police in a public place said they felt this way.

However, across the board (excluding voluntary and charity organisations) people said they did not feel listened to. Almost three in 10 people (28%) said that they did not feel listened to by their GP. This is vastly different to the 2015 GP Patient Survey which showed that only 3.6% of respondents said GPs were poor or very poor at listening to them. The results cannot be directly compared with findings from the call for evidence, but it is suggestive of variation between how the general population and people in crisis perceive the GP services they use.*

The picture was even worse in specialist mental health services, with 49% of people in contact with a mental health hospital, and 48% of those accessing crisis resolution services, saying they were not listened to.

Another area of concern is that respondents who indicated that they had experienced a mental health crisis before said they were less likely to feel listened to or their concerns taken seriously. This is in line with Mackay and Barrowclough's investigation from 2005 which showed that A&E staff were less willing to help following repeated self-harm attendances.⁸ In addition, a Royal College of Psychiatrists' report from 2011 showed that respondents were dissatisfied with how some medical and care professionals dealt with those who had repeatedly harmed themselves.⁹

Caring for a person in crisis

Carers are a vital, and often unsung, part of the health and care system. While people known to specialist mental health services may have regular visits from community mental health teams, they might also have a carer that provides day-to-day support. Often carers are responsible for helping a person to access help when it is needed. As a result, we wanted to find out what they thought about how local areas are responding to people in crisis and how, as carers, they feel they are treated by health and care professionals.

Carers' knowledge of when events might escalate into a crisis should be a vital part of the prevention process. Although they are not healthcare professionals, they should be seen as a valuable resource for mental health services. However, the general response we received from carers can be summed up by the following statement:

"It's very hard to say, as a carer, what I felt about the service provided during my son's most recent crisis as I was almost totally excluded from it."

Services must recognise carers' frustrations that they do not feel listened to. Despite the fact that carers provide regular, ongoing support for people at risk of crisis, and so are well placed to recognise when a crisis may escalate, less than 35% of respondents who were carers felt that mental health services and telephone helplines listened to them. Fewer felt that these services provided either timely help or advice and support that was right for the situation (table 4).

* <http://gp-survey-production.s3.amazonaws.com/archive/2015/January/January%202015%20National%20Summary%20Report.pdf>; pg25. 856,712 people responded to this question in the January 2015 GP Patient Survey

† All respondents were provided with a 'not sure' option to the 'I Felt' statements. These responses have not been included in this table. The table only includes services that were selected by at least 10% of respondents to the call for evidence.

Table 4

Carer survey responses [†]

Carer survey responses	I felt...						Average number of respondents
	They listened to me and responded to my concerns as a carer		I was given advice and support that was right for my situation		I was given help in a timely way		
	Yes	No	Yes	No	Yes	No	
Volunteers or a charity	81%	15%	66%	26%	62%	33%	50
NHS ambulance	78%	11%	65%	20%	70%	21%	86
Police	65%	27%	56%	36%	62%	30%	127
GP	59%	31%	37%	49%	38%	55%	229
Accident and emergency department	41%	49%	32%	58%	27%	65%	152
Telephone helpline	35%	57%	26%	64%	29%	68%	89
Mental health hospital	32%	61%	27%	64%	29%	66%	165
Community-based mental health team	31%	61%	21%	71%	21%	73%	255
Social services	28%	63%	14%	74%	15%	76%	76

Source: CQC's call for evidence 2014: number of respondents

It is clear that more needs to be done to integrate carers into the recovery process. Carers can provide a valuable perspective on the person's home environment that can help tailor care plans to an individual's circumstances. It is also important that their own needs are taken into account when the person they are caring for experiences a crisis, and that local services make carers aware of their rights. Commissioners and providers must recognise that powers under the Care Act 2014 give carers the right to an assessment of their needs, regardless of their income, finances or overall level of need. The assessment should also consider the risks for the person providing care to a person in crisis and provide tailored support in strategies for crisis prevention and management.



Case study

It took over two years for me to convince my son's care coordinator that he needed help and was a danger to himself and other people. During this time we suffered verbal and physical abuse from my son. My house, car and front garden were destroyed and my two younger children and I became almost prisoners in our own home. All this time, the only response I got was "We cannot do anything until [he] does something really bad!"

Eventually he did and was sectioned for six months, but it took four days to organise the section. During this time his care coordinator, two psychiatrists and two police officers had visited and left him in a very agitated state. After they left [he] went out and assaulted a police officer, which then led to him being arrested and transferred to a mental health ward."



I am given advice and support that is right for me

Empowering people to take decisions about their care is central to developing a system that is built around preventing a crisis from occurring, intervening early when it does and focusing on helping the person to recover and stay well. This may be done in a structured way, through the development of a crisis plan, or an informal way by providing them with leaflets about relevant local services or numbers to call in a crisis.

The Crisis Care Concordat reflects this need to be flexible when it states, "Each local area will need to decide the combination of services that best serves the particular needs of their population."¹⁰ However, it is also clear that "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."¹¹ This shows how vital it is that local services can provide the right advice and support for the person.

As voluntary services are seen positively by many people, it is important that statutory services understand and appreciate the role the sector can play in providing help, care and support to people who may be mentally distressed, but who might not qualify for support from specialist services. That more could be done in some areas is highlighted by a comment from one local group who told us, "There is also a lack of knowledge or a lack of willingness to support people to access other voluntary sector services which are more accessible – for example, people will come to A&E be discharged in distress but not told about local helplines or support groups."

Figure 6 highlights the fact that people consistently feel that services are not providing appropriate information and support. It is particularly concerning that half of all respondents who came into contact with a community-based mental health team felt that the advice and support they received was not right for them. While no-one expects a service to be all things to all people, as a key function of community-based mental health services is to provide ongoing support to people with an identified mental health need, it is concerning that 50% of people do not feel they are given the right information. This suggests there is a major gap between what is being offered and what people feel they need.

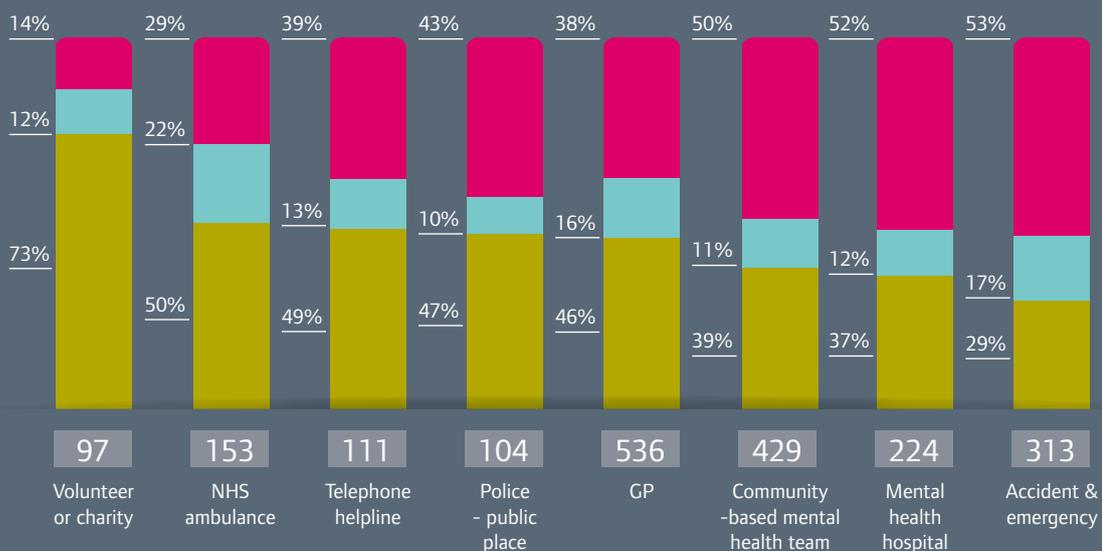
Participants from minority ethnic communities did not feel that the advice and information available was relevant to people from all backgrounds. The Race Equality Foundation found that people felt there was a lack of understanding about faith in the mental health system. This extended to both actively asking someone about their faith, and how people were treated when they were open about their faith. Person-centred care planning must account for differences in people’s cultural identities, and services must try to be responsive to the challenges of working in communities with diverse beliefs.

To understand whether people thought services are preparing them on how to deal with the possibility of another crisis, we asked if people felt they would know what to do next time they experienced a crisis. This is a central element of the Concordat’s drive towards preventing crises before they begin.



Figure 6

Individual survey: “I felt the advice and support I was given was right for me”

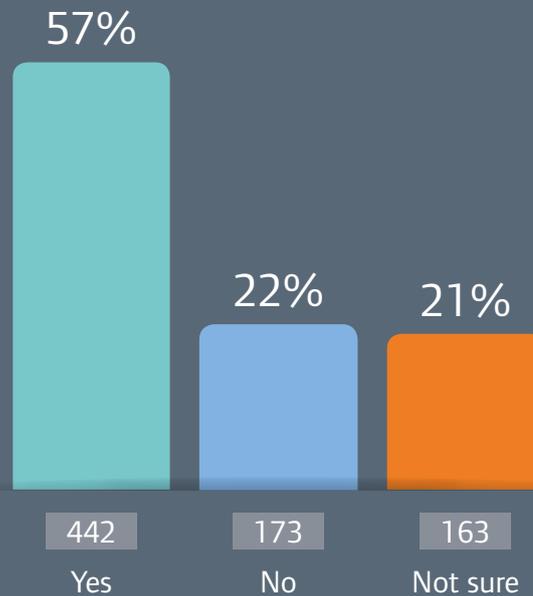


Source: CQC’s call for evidence 2014: number of respondents. Due to rounding percentages may not total 100%



Figure 7

Individual survey: If you experienced a crisis in the future do you think you would know what to do?



Source: CQC's call for evidence 2014: number of respondents

Over half of respondents (57%) said that they felt they would know what to do in the event of a crisis (figure 7). Those who would not know what to do and those who were not sure are almost equally split (22% and 21%). Again, this demonstrates that people's confidence in knowing what they would do during future crises varied.

Feedback from the Race Equality Foundation suggested that information about crisis services is often shared within the community through informal mechanisms, such as family members. There was widespread feeling that mental health support services were not well known about in other organisations, and that often people in the voluntary and community sector were not told about changes in statutory services. This lack of information sharing can mean that people are given outdated information, which can in turn decrease their chances of receiving a timely, effective response when they are in crisis.

It was felt that mental health services could do more to understand the culture of minority groups. Participants spoke about issues relating to specific cultural norms, such as how mental health remains a taboo subject within some Asian communities, and that doctors should be more aware of how difficult this can make it for people to access appropriate services.

The Concordat states that people "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".¹² From a user perspective, it is frustrating and potentially distressing to be moved unnecessarily between multiple services.

We recognise that there will always be times, particularly in complex situations, when something may not be resolved at the first point of contact. However, this only makes it more important to make sure that people are seen by as few agencies as possible.

On average, we found that respondents came into contact with three different services during their crisis event. However, 12% of respondents said they had come into contact with between six and 10 services. No matter how complex the event, it should not require that many services to resolve the crisis and suggests that there may be a lack of joined-up working in the local area. It is crucial that local organisations take on board the Concordat's suggestion that "local agencies should all understand each other's roles in responding to mental health crises".¹³

Suicide deaths

In the most extreme cases, a mental health crisis may end in a person taking their own life. Every suicide will be triggered by a series of factors that will be unique and personal to their situation. However, it is vital that we reflect that a mental health crisis can end in the most tragic of circumstances.

It was estimated that there were 4,727 suicide deaths in 2013. This is an increase of 214 compared with 2012. Suicide is three times more common in males as it is in females (13.8 per 100,000 compared to 4.0 per 100,000).¹⁴ We do not suggest that each one of these events was the result of, or triggered by, a mental health crisis, but it is important that we recognise that the availability and accessibility of appropriate help, care and support to a person who is distressed could be a factor in helping them to stay well.

In relation to people who are in contact with specialist NHS mental health services, we looked at the numbers of people who took their own lives while in contact with a service or who had been discharged within the previous month. Our analysis of MHLDDS data showed that in 2012/13, there were 241 suicide deaths that occurred under these circumstances in England.

We also note that crisis resolution home treatment teams play a key role in keeping people in crisis safe.

Between 2003 and 2011, the number of suicide deaths per year increased from 71 to 185 among people seen by crisis resolution home treatment teams, and decreased from 183 to 83 among mental health inpatients.¹⁵ This may reflect wider trends towards seeing people in the community and prioritising increased safety in inpatient settings. Despite an increase in the total number of suicides, the suicide rate in all mental health settings has declined. However, it remains higher among crisis resolution home treatment teams than other mental health settings (14.6 per 10,000 compared to 8.8 per 10,000 for inpatients, and 7.8 per 10,000 in contact with other mental health services while receiving care in the community).¹⁶ The decline in the rate of suicide suggests that teams have strengthened measures to reduce risk. The fact it remains higher among crisis teams means it is vitally important that work to manage people with suicidal symptoms continues.

There will be times when, despite the help, care and support of families, friends and the involvement of local services, a person will take their own life. However, the recent introduction of zero suicide aspirations in three areas of the country acts as an important reminder that this should not mean that local areas do not aspire to achieving this. With greater numbers of people being seen by community-based teams, rather than inpatient services, it is vital that crisis resolution home treatment teams have protocols that make sure people identified as being at risk of suicide know how to access professional expertise that is available when they need it, and that intensive support is provided to meet the immediate risk.

Variation in every direction

For every service we looked at, we found that the experiences of respondents varied greatly. We heard from people who praised their GP and criticised their mental health team, but we also heard from people who found the support they needed with a specialist team after feeling let down by their doctor.

“[My] GP was amazing. She may not be an expert in mental health but I feel she is so much better than my CMHT”,

“[I] went to my GP who was useless, told me I was either being silly or that I should go on anti-depressants (even though I was not depressed and actually psychotic). It was only until I demanded to be put in contact with the mental health team that I received real help”.

A person’s experience can also be determined by variation and change within a service team, which means their first point of contact may change. For example we were told, “My GP has now retired and other doctors in the practice are all new and show absolutely no interest in my mental health problems. Don’t even bother to read my notes. This is very worrying.”

The strongest message from the call for evidence is that there is no uniform experience for people needing help, care and support during a crisis. Some people feel that they will have a worse experience in A&E than the voluntary sector, but we can also find examples where people have praised the support received from A&E staff. Primary care appears to be performing well, but we must recognise that around a quarter of respondents did not feel this was the case. This variation may even extend to experiences within the same surgery so that two people in the same town would tell us two different stories.

It is crucial that services recognise their responsibility towards shaping the experiences of those in crisis, and make efforts to explore what they can do to help a person through a very distressing time.

Help, care and support in the community

“I wouldn’t have gone through so much pain if I had known what to do about my illness and who to go to, where I could get support. Maybe then I could have stayed in work.”

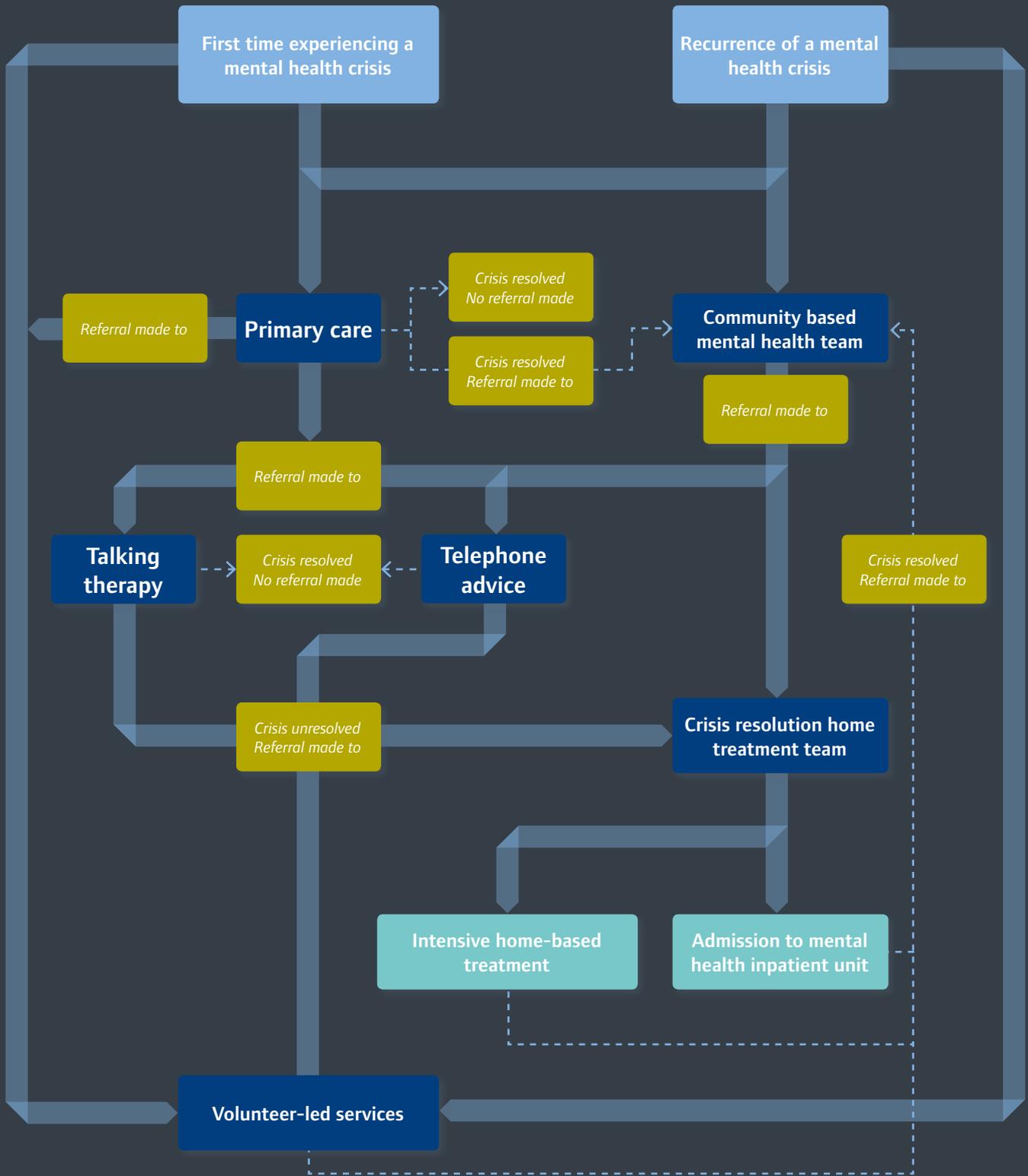


What we found

- The majority of people who visited their GP during a mental health crisis were satisfied with the help, care and support they received. However, a substantial minority reported a less positive experience.
- Contacting mental health teams and telephone support lines outside of regular working hours can be very difficult. Not being able to access the right help at the right time is unacceptable and can cause a crisis to escalate, leading to greater mental distress or physical harm.
- The role and function of crisis resolution home treatment teams appears to be becoming less defined, with some teams struggling to offer an adequate home treatment function. It also raises serious questions about safety and whether these teams have processes in place to manage people at specific risk of suicide.
- Community mental health teams involved people in care planning and providing advice on what to do in a crisis, but many of those using services felt they could be more involved.
- People are being placed outside of their local area when their crisis escalates to a point where they require a hospital bed.



Figure 8
Possible routes through local services for people experiencing a mental health crisis



Background

For the majority of people the route to accessing healthcare is clear. In the first instance they will contact their local GP or, if they are already in regular contact with a specialist mental health service, they may get in touch with the person responsible for coordinating their care in the community mental health team (figure 8).

It is estimated that one in four patients of a full-time GP will need treatment for mental health problems, and many of those will rarely come into regular contact with more specialist services.¹⁷ In 2013/14, there were nearly half a million people on the GP register for people with a serious mental illness, and close to three million people on the GP register for adults with depression. These figures demonstrate that while GPs do not need to be mental health specialists, it is vital they recognise that “mental health problems should be managed mainly in primary care by the primary health care team working collaboratively with other services”.¹⁸

New models of care are changing how a primary care setting is understood and co-located services are a mechanism for bringing specialist expertise into primary care environments. We know that innovative approaches are needed to meet future challenges and CQC’s *Shaping the future* outlines our commitment towards taking an adaptable approach to regulating new models.*

GPs must be confident about identifying potential mental health conditions and be knowledgeable about referral routes that have a “clear focus on prevention and early intervention” to minimise the risk of a crisis occurring.¹⁹ This means making appropriate referrals to talking therapies and mental health teams, so that a person can receive a direct intervention and contact from specialist support when they need it. GPs also need to have knowledge of local support services – operating across sectors – so that they can signpost people effectively.

Increasingly people are turning to NHS 111, or local telephone helplines, when looking for help during a crisis. The advantage of a tele-triage system is that they may be well placed to signpost people to information when the most appropriate form of support is through a voluntary or community agency. They can make it easier to access up-to-date information, about a wide range of voluntary sector support organisations, or provide a direct referral to a more appropriate agency.

For many people a mental health crisis will not be a new experience. They will have experienced a crisis event in the past and possibly many times. As a result, a significant number of people will already be known to specialist mental health services in their local area. Even if they are not directly in contact with services at the time they enter crisis, they still should know how to access appropriate, timely support.

The number of people who require more specialised support is not a small proportion of the population. In 2013/14, over 1.7 million people were in contact with NHS trusts providing mental health services, and over 105,000 spent some time as an inpatient during the year. Of these, 68,811 admissions were to acute mental health wards – the majority of which were classed as emergency admissions.

The Concordat is clear that a preventative approach to crisis management is through “care planning, including joint crisis care planning, for people with mental health problems”.²⁰ This should be agreed with the person and contain specific actions tailored to their needs about what they should do in the event of a crisis. If the individual agrees, this plan should be easily accessible by any service involved in providing crisis support.

Specialist mental health services may take many forms and will often have been set up to meet local needs, or the demands of a local area. However, it is likely that in the event of a crisis there will be a crisis resolution home treatment team that will provide specialist interventions and prevent admissions to mental health acute inpatient beds. Regular support from mental health services will be provided through other community-based teams.

* CQC. *Shaping the future*. March 2015.

Crisis teams should be available at all times. However, we know that many areas will have a telephone support line that operates outside of regular working hours to provide a point of access to those who may need advice and support. Crisis houses or drop-in centres also provide people with alternative options of where to go if they feel a crisis is escalating.

People with a known mental health history can place additional pressure on the local health and care system through attending A&E multiple times. It is important that this is not seen as the responsibility of the individual, but as a potential symptom of a local system not working effectively.

It can suggest that primary care and specialist mental health services do not have a joined-up approach to those at risk of crisis, and raises questions about whether services are focusing resources on the early identification and prevention of mental health crisis events.

Early identification and prevention: the role of the GP

The 2003 National Survey of NHS Patients highlighted the central role that primary care plays in providing help, care and support to people in a crisis. It found “approximately 91% of people with a

mental health problem will be treated in the primary care system”.²¹ The important role of primary care is reinforced by findings that suggest 45% of individuals consulted with their GP in the month before their suicide.²²

This means that, like a person with a physical health need, someone worried about their mental health is likely to see their GP in the first instance. As a result, it is crucial that a GP is able to provide advice and expertise when it is needed to prevent a crisis escalating unnecessarily.

In our call for evidence, we asked people to tell us about the service they received from their local GP. As table 5 shows, the majority of people scored GPs highly, with the most positive responses relating to issues of staff attitude – people feeling listened to, treated with compassion and not judged. While these results are better than those for other health services, it is concerning that around a quarter of patients are not satisfied, and that almost 40% felt the advice and support they were given was not suitable. This suggests there is a substantial minority of people who are not getting the help, care and support they need when they are in crisis.

Building mental health into the training of GPs
The Concordat is clear that “all staff should have the right skills and training to respond to mental health crises appropriately”.²³ With estimates that “around

Table 5
Individual survey: access, support and attitude of GPs

I felt...	Yes	No	Not sure	Total respondents
I was able to access help in a timely way	52%	38%	10%	533
I was listened to and my concerns were taken seriously	64%	28%	8%	545
I was treated with warmth and compassion	65%	26%	9%	536
I was not judged for what I had done or how I felt	66%	23%	11%	537
The advice and support I was given was right for me	46%	38%	16%	536

Source: CQC’s call for evidence 2014: number of respondents

300 in every 1,000 people experience mental health problems every year, [of which] 230 will visit a GP”, this principle applies as much to primary care as it does to other elements of the health and care system.²⁴

All doctors in training, including GPs, undertake a period of two years foundation training. We support Health Education England’s target for 45% of foundation year doctors to undertake a psychiatry post from 2014/15 onwards.²⁵ This will make sure that many more doctors entering GP training will have spent time in a mental health post.

We support the recommendation made in the Annual Report of the Chief Medical Officer 2013 that there “should be a period of specific mental health training in GP training”.²⁶ Providing specialist training for GPs will help them to respond better to mental health crises. It will also help them to identify underlying mental health issues at the first point of contact, and enable a deeper understanding of the relationship between physical and mental health conditions.

However, it is important that the training needs of practice nurses are also taken into account. A January 2014 survey of practice nurses found that nearly half (42%) reported having had no training in mental health and wellbeing. It also showed that 81.5% think that they are carrying out mental health and wellbeing responsibilities without relevant training.²⁷

Approximately two-thirds of respondent CCG leads felt that nurses should be trained to carry out annual reviews for people with dementia, behaviour change, alcohol and drug abuse, or who self-harm. Yet 15% of respondent GPs felt that courses were often too expensive and only 53% would offer protected time to complete e-learning courses.²⁸

Supporting people at risk of a crisis

One of the most important preventative tools in mental health crisis care is providing people who have a known mental health condition with a care plan that includes guidance on what to do in a crisis. These plans should be accurate, easily understood, reviewed annually and discussed with the individual and those close to them.

It is estimated that up to half of people with a serious mental illness are only seen in a primary care setting, highlighting the important role primary care plays in providing long-term support. It is vital that GPs have a leading role in developing a care plan that outlines what will happen in the event of a crisis. This is recognised in the Quality Outcome Framework† (QOF) indicator (MH002) that measures the percentage of people with a serious mental illness who have an agreed care plan documented in their primary record in the last 12 months.

In 2013/14, achievement against this indicator was just under 75%. This suggests that, generally, GPs are making sure that those at risk of a crisis have some form of documented plan in place. However, this is still well below the average achievement score across all QOF mental health indicators (90.4%).²⁹ This means that around one in four people with a serious mental illness do not have a care plan in their primary care record.

Good practice dictates that information and current care arrangements are shared between primary and secondary care. Local areas should make sure that care plans are shared between agencies – with the permission of the individual – rather than creating a duplicate plan for secondary mental health services. This would reduce bureaucracy and create a more seamless service for the individual that stops people having to undergo multiple assessments.

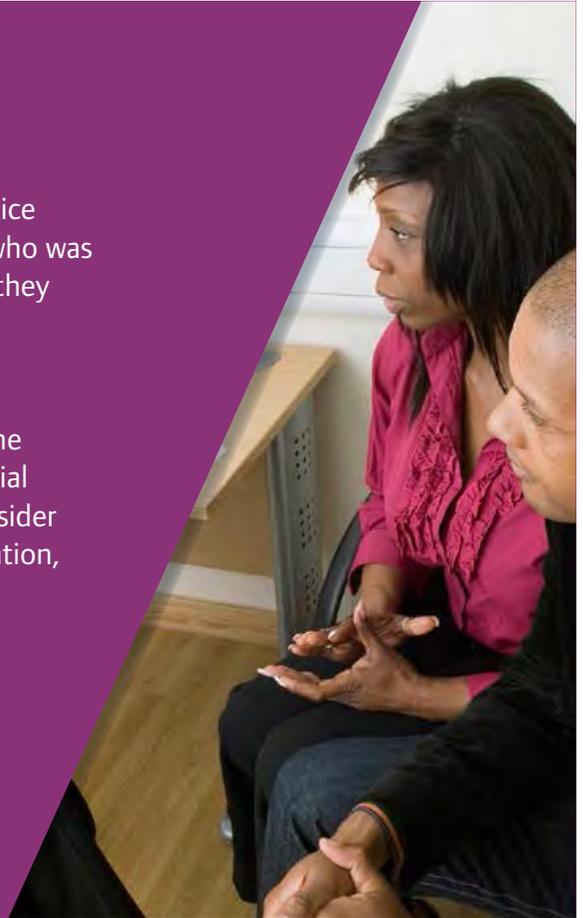
† The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme that rewards practices for the provision of ‘quality care’ and helps to fund further improvements in the delivery of clinical care

Case study: Knowing what to do and who to speak to

During a local area inspection we asked how staff at a GP practice would respond to a 44-year old man with learning disabilities who was experiencing a mental health crisis. The reception staff told us they would immediately refer the person to the GP.

The GP was able to explain the options available to the person, including urgent referral to the crisis team, who may come to the surgery if the patient was suicidal. They discussed other potential avenues of information available, and said that they would consider contacting the patient's carers to try and find out more information, and if there were other agencies involved.

The crisis team confirmed that they would go and see the person at the surgery or at the person's home if they were able to go home. They said they could contact the Intensive Support Team (Learning Disability) for a joint assessment and were confident that this could be arranged.



It is also important that primary care services make sure that vulnerable people or those who find it more difficult to access services are not forgotten. While QOF indicators allow for exception reporting (for example, if patients do not attend for a review), local areas should recognise that people at risk of crisis may be more likely to be classified as a QOF exception.

National data for 2013/14 demonstrates that the average exception rate across relevant indicators is 4.1%, but the clinical group with the largest number of exceptions is mental health and neurology (14.4%).³⁰ Local areas showing significantly higher than average numbers of exceptions should examine the reasons behind this and make sure that services are designed to be accessible by all those in their local area.

IAPT targets to be achieved by April 2016

- 75% of people referred for talking therapies for treatment of common mental health problems like depression and anxiety will start their treatment within six weeks.
- 95% of people referred for a common mental health problem will be treated within 18 weeks of referral.

Providing the right advice first time

For many people their local GP surgery is the first place to go for help. This is supported by findings from our call for evidence, which showed that 39% of people who were experiencing their first crisis, and 31% who had experienced a previous mental health crisis, went to their GP for help first. Twelve per cent of respondents said that they received the treatment they needed from their GP, and a further 48% said they were referred to a specialist mental health service.

This means that over half of the respondents (60%) saw a GP that knew how to meet their needs, or knew how to refer to a specialist service. However, this still means that almost one in four felt they did not receive the help their crisis required.

Having your needs recognised by the first person you come into contact with is a vital part of reducing the number of unnecessary contacts. People seeking help and support have told us that they ended up being bounced around the system – this is not just frustrating, but also risks causing their crisis to escalate.

Referring to appropriate specialist services

If someone working in primary care identifies a mental health need but does not feel that it can be treated within their service, they must refer the person on for appropriate help.

Since the launch of the Improving Access to Psychological Therapies (IAPT) model in 2010, ‘talking therapies’ have become an increasingly important part of early intervention and pre-crisis support programmes. Initially, IAPT was rolled out to all adults of working age, but in 2011 it was announced that it would be expanded to include children and younger people, and people with long-term physical conditions or severe mental illness.

The introduction of specific waiting time standards for IAPT services was then announced in 2014. This is a major step towards embedding parity between mental and physical health services, and creates targets against which local services can be held to account.

The number of people being referred to IAPT services is increasing. In 2013/14 almost a million people (947,640) were referred, an increase of more than 180,000 from 2012/13. There was also a substantial increase in the number of referrals that led to people entering treatment; 709,117 referrals entered treatment in 2013/14, an increase of 63% on the number of referrals that entered treatment in 2012/13 (434,247). This suggests that there is an increasing awareness of, and access to, the IAPT programme, and that the number of appropriate referrals has also improved.³¹

We can see there is variation in the types of people being referred to IAPT services. For example, women account for 63% of referrals, and people aged between 25 and 29 were almost twice as likely to access the service (3,384 per 100,000 compared to 1,759 for all ages). When looking at the rates of access to IAPT, people whose ethnicity is recorded as “any other mixed background” (4,434 per 100,000) and “any other ethnic group” (3,537 per 100,000) have the highest IAPT referral rates. These compare to 1,726 per 100,000 from White British, and 2,170 per 100,000 from Black-Caribbean. Bangladeshi (859) and Chinese (465) are the only ethnic groups to record referral rates of less than 1,000 per 100,000.³²

Local areas need to make sure that services are reaching the population groups that need them, and that certain groups are not under-represented. This may involve undertaking work to remove barriers to access and raising awareness among the community to ensure that all who could benefit from talking therapies are able to access them.

Alongside variation in who is being referred to IAPT services, where someone lives may also influence whether they are referred. While higher referral rates do not necessarily mean more appropriate referrals, where referral rates are very low it may suggest that more could be done to raise awareness of IAPT among local partners, or that commissioners are not making sure that there is enough provision of IAPT services in the first place (figures 9 and 10, overleaf).



Figure 9

IAPT: New referrals received by clinical commissioning group, 2013/14

Source: HSCIC Improving Access to Psychological Therapies dataset, Table 1c, ONS 2013 Clinical Commissioning Groups (England) April 2013 Boundaries.

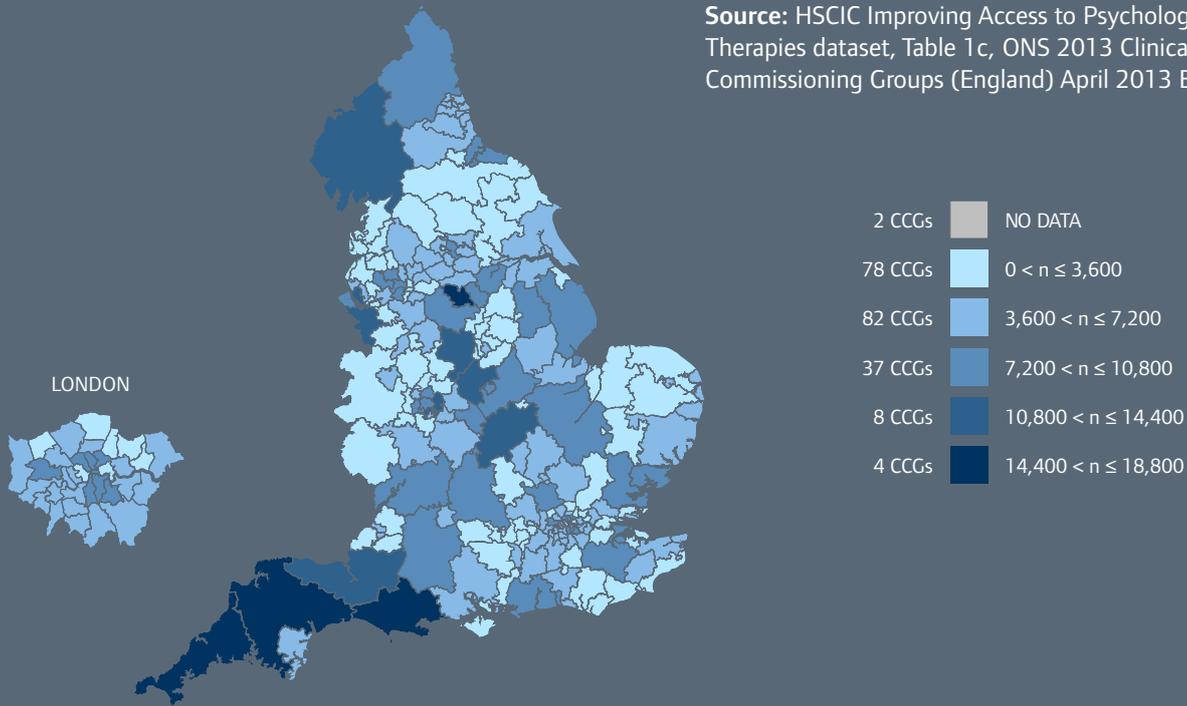
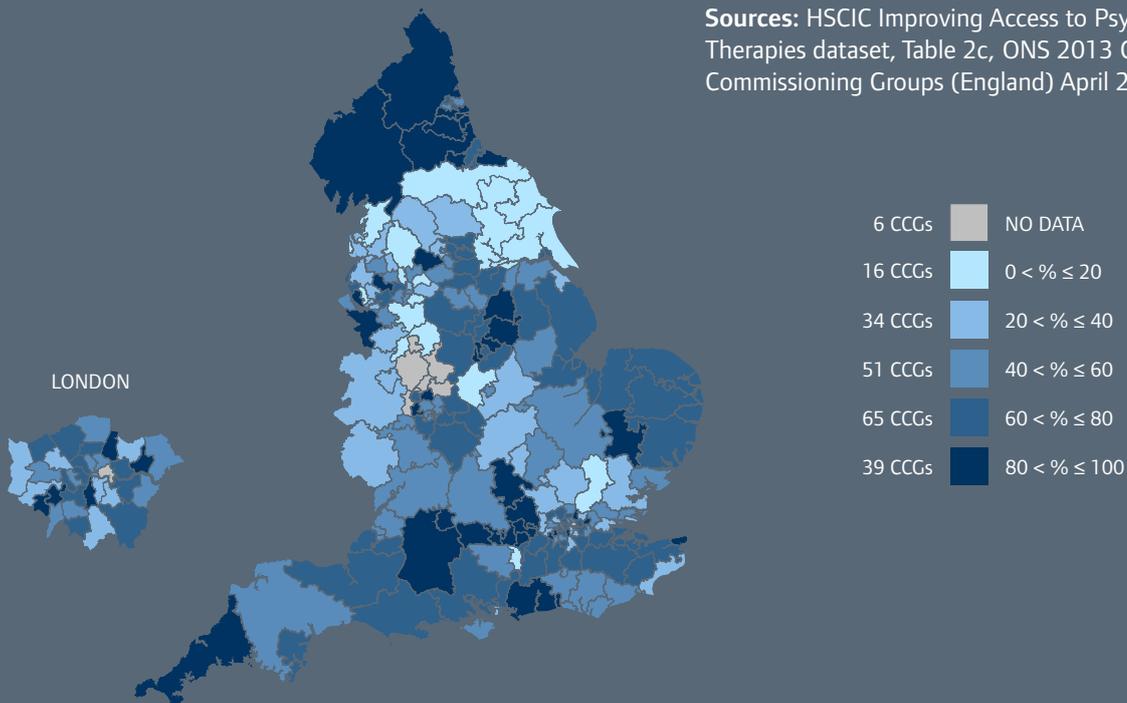


Figure 10

IAPT: Referrals entering treatment within 28 days as a proportion of all referrals entering treatment by clinical commissioning group, 2013/14

Sources: HSCIC Improving Access to Psychological Therapies dataset, Table 2c, ONS 2013 Clinical Commissioning Groups (England) April 2013 Boundaries



CQC encourages:

- GPs to improve achievement against the Quality and Outcomes Framework indicator MH10, so that all appropriate individuals on a GP register have a comprehensive care plan in their primary care record.
- Providers and commissioners to review local referral arrangements for talking therapies so that all patients are seen within the planned waiting time standards, and consideration is given to introducing stretch targets to encourage improved performance.
- Commissioners of primary care mental health services to ensure specifications for primary care mental health outreach services recognise the needs of those who find it difficult to access primary care services to ensure safer follow up and monitoring.

Making sure that people working in primary care are aware of referral routes to IAPT is only half the picture; it is also vital that people are able to access therapy when they need it. Data submitted to the Health and Social Care Information Centre (HSCIC) shows that parts of the country are already achieving the target for 75% of referrals being seen within six weeks.

We would also note the recommendation to commissioners in *No Health Without Mental Health* that talking therapies are offered through Any Qualified Provider to ensure that there is equal accessibility across all equality groups.³³

Developing person-centred care plans: the roles of the community mental health team

In most instances, people who do not need to be admitted as an inpatient but are assessed as requiring care from specialist services are likely to be supported by a community mental health team rather than a crisis team.

The role of the community mental health team is to provide support for more complex mental health problems that a GP may not be able to provide. Working through multidisciplinary teams, they are responsible for a variety of treatment and care options. For people at risk of a crisis, ensuring recovery from a crisis event and helping the person to stay well is an important function of the team.

Involving people in their care planning

Everyone who uses services should be considered as partners in the care planning process, and be active participants in decisions about their care. The Concordat is clear that “care planning, including joint crisis care planning, [...] is a crucial element of the preventative approach to crisis management”.³⁴

CQC’s Community Mental Health Survey 2014, which asks people who use community mental health services to comment on their experiences, gives a valuable insight into how involved people feel in decisions about their care.³⁵

* IAPT dataset, Table 1c and 2c, ONS 2013 Clinical Commissioning Groups (England) April 2013 Boundaries

Almost a quarter (23%) of the 13,198 respondents told us they had not agreed what care they would receive, and a further 34% had only agreed it “to some extent”. We also know that, while 57% (of 9,793 respondents) felt as involved as they wanted to be, a substantial minority told us they wanted to be more involved in their care, either feeling they were not involved at all (6%) or only to some extent (37%).

These findings are reinforced by a very similar proportion of people who felt that their personal circumstances were only taken into account to an extent (33% of 9,699 respondents), and 6% who felt that their circumstances were not taken into account at all.

Once a care plan is agreed it is important that it is a living document. It should respond to changes in a person’s circumstances and reflect their particular needs at that particular time.

Knowing who to contact and being able to access support when it is needed

The Concordat recognises that a crucial part of effective care planning is making sure that a person knows who is responsible for organising their care:

“People with mental health problems, or their families or carers, are often aware that they are approaching crisis...they need to know who to contact in these circumstances.”³⁶

Seventy-seven per cent of 11,335 respondents in the Community Mental Health Survey (8,728 respondents) told us that they could remember being told who was in charge of their care and services, but this did not mean that they knew who to contact for help outside of regular working hours.³⁷ Over three in 10 people (32% of 11,860 respondents) suggested that they did not know who to contact out of hours if they had a crisis.³⁸

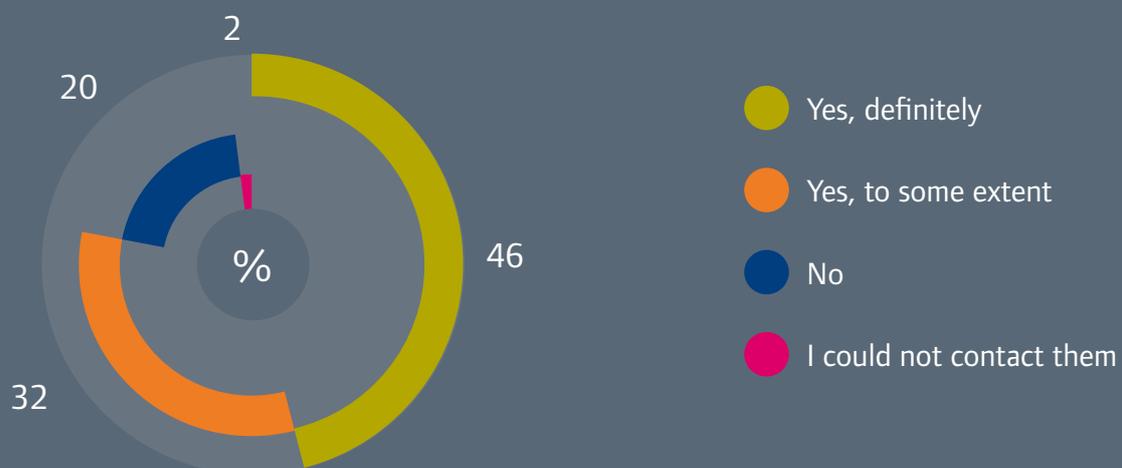
* This question was answered by people who knew who to contact out of office hours in the event of a crisis, and who had tried to contact this person or team in the last 12 months

† Total number of responses to this question = 3,008



Figure 11

Community Mental Health Survey 2014: Q23 When you tried to contact them, did you get the help you needed? †



Case study: Remembering who your service is for

In one of our local area inspections we found that people trying to access services via telephone support were presented with a series of paths required for the person to navigate through.

At a time of vulnerability this would be difficult for people who were required to be patient as they listened to the options, had to select telephone options, write down different numbers only to find specialist support services were unavailable outside working hours and weekends.



The findings from the survey also highlighted that there was a lot of variation between those on the Care Programme Approach (CPA) and those who were either not on it, or whose status was unknown. In total, 79% of those on CPA felt like they knew who to contact if they had a crisis, but this fell to 62% among other respondents. No matter what the approach to providing care for a person with a mental health need, they should know how to access support at any time.

Figure 11 also shows a mixed picture when people tried to make contact during a crisis. While almost half of the respondents to the Community Mental Health survey felt they definitely received the help they need, one in five did not.³⁹ This demonstrates the variability people in crisis experience, even when they have identified routes for accessing specialist help and support.*

During our call for evidence people told us they were concerned about the effectiveness of telephone support lines. Issues included an abrupt and uncaring response to individuals, and the effectiveness and accessibility of out-of-hours crisis telephone services lines.

Whether provided in-house or contracted externally, it is important that providers assure the quality of their operation of telephone helplines. They must be accessible to those in crisis, and operated with appropriate sensitivity to the needs of the person accessing the service.

People accessing voluntary sector organisations tended to regard them as extremely valuable. This may be

because they are often seen as offering services where there is nowhere else to turn, and are accessible at any time. The Leeds Survivor Led Crisis Service, an award-winning voluntary sector organisation that has been running since 1999, captured the necessity of making sure that there is somewhere for people to turn:

“It is nonsensical that most mental health services operate Monday to Friday, nine to five. This is about the needs of staff who work in services, not people who use them. If you are in crisis, the worst times are night times and weekends. This is why Leeds Survivor Led Crisis Services are all out of hours - we are open when everything else is closed.”

CQC encourages:

- Community mental health teams to make sure that people are supported to develop a crisis care plan, in line with expectations set out in the Crisis Care Concordat. This must involve people in decisions about their care, be clear about appropriate local support options and contain agreed actions on what to do in the event of a crisis.

Specialist support when it is needed: the role of the crisis team

“People can access mental health services when they need them... crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, regardless of diagnosis.”

[NICE Quality Standard 14, Quality Statement 6]

Delivering a service in line with best practice

The concept of a specialised team to respond to people in crisis was first outlined in the 1960s but only really developed in England following the publication of the National Service Framework for Mental Health (1999).⁴⁰

We know that mental health trusts across the country set up their services in different ways. This is entirely appropriate providing they meet local needs. We recognise that the crisis function of a trust in a densely populated, highly diverse inner-city area may need to be very different to a service in a sparsely populated, rural area that services a predominately white older population.

However, we would expect that any crisis team is designed to deliver the core functions of the service. We are concerned that evidence suggests that crisis resolution home treatment teams (CRHT) are failing to meet core service expectations and are not keeping fidelity with the model outlined in the Mental Health Policy Implementation guide.⁴¹

For this part of the review we looked at the CORE (Crisis resolution team Optimisation and Relapse prevention) study. This was undertaken by University College London between June 2013 and April 2014. It analysed the work of approximately a third of all crisis teams in England to measure the extent that they were meeting expected best practice. Teams were assessed on a five point scale, in which a score of ‘four’ or higher was benchmarked as good.*

Table 6
UCL CORE Fidelity Study: mean scores of crisis teams by themed area, June 2013 to April 2014

Themed area	Mean score (out of 5)
Referrals and access	3.40
Content and delivery of care	2.86
Staffing and team procedures	3.25
Location and timing of help	1.85

Key functions of a crisis resolution home treatment team ⁴²

- Act as a 'gatekeeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service.
- For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multidisciplinary, community-based treatment 24 hours a day, seven days a week.
- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible.
- Remain involved with the client until the crisis has resolved and the service user is linked into ongoing care.
- If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge.
- Reduce service users' vulnerability to crisis and maximise their resilience.

Table 6 shows the mean scores in four separate areas. It demonstrates that there was not a single themed area where the average performance, across CRHT teams surveyed, was scored at the level of good in relation to best practice.

Teams followed the best practice model most closely in the area of 'referrals and access'. It is commendable that they are working well with people who would otherwise be admitted to an adult acute psychiatric ward, and in making sure that their service is easily accessible to anyone who is eligible. However, it is concerning that there is a mixed picture around whether teams provide a

24/7 service and offer a distinct service of crisis assessment with only brief home treatment. This suggests that CRHT teams are struggling to deliver a service that is aligned with best practice.

* Developed by Brynmor Lloyd-Evans, Sonia Johnson and the CORE Research Group* www.ucl.ac.uk/core-study

The CORE CRT Fidelity Scale constitutes independent research funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research programme (Reference Number: RP-PG-0109-10078). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

Table 7

Referral and access to crisis resolution teams (CRTs)

Item	Percentage of CRTs by assigned score (scores of 4 or above are 'good')					Median score
	5	4	3	2	1	
The CRT responds quickly to new referrals	3%	19%	13%	31%	35%	2
The CRT is easily accessible to all eligible referrers	43%	23%	31%	4%	0%	4
The CRT accepts referrals from all sources	27%	16%	24%	13%	20%	3
The CRT will consider working with anyone who would otherwise be admitted to adult acute psychiatric hospital	43%	31%	22%	1%	0%	4
The CRT provides a 24-hour, seven day a week service	40%	15%	20%	3%	23%	4
The CRT is a distinct service which only provides crisis assessment and brief home treatment	27%	39%	21%	9%	4%	4

Source: UCL Core Fidelity Study

It is concerning that whether teams accept referrals from all sources varies widely. While over a quarter (27%) scored top marks, one in five (20%) were placed in the lowest band. This may mean that where someone lives determines how easily they can access the crisis team (table 7).

The teams that were surveyed performed most poorly against the item assessing whether they could 'respond quickly to new referrals'. Only 3% of teams scored the full five marks for responding quickly to new referrals. In total, only 22% scored good or above, while 34% teams were given a score of '1'.

A comment from our call for evidence offers a powerful reminder of what could happen if people in crisis are not given support quickly enough:

"The crisis team seems to be overstretched and cannot respond quickly enough. It was approximately seven hours before I got crisis support and that was only a call not a visit, which would have been more useful. As my crisis worsened I took a small overdose as I was not coping or getting any immediate help."

The potential for tragic consequences is reinforced by the number of suicides of those seen by CRHT teams. In 2014, it was estimated that there were 180 deaths reported as suicide of people in contact with CRHT teams.⁴³ There has been a continuing shift away from treating people in inpatient settings, leading to more people who may be at risk being supported in community settings. NHS providers of specialist mental health services must, as a priority, make sure that crisis teams have effective risk assessment processes in place.

This may involve ensuring new referrals are responded to promptly so that an early assessment can be made on the level of risk that an individual in crisis faces. A reduction in suicidal behaviour was noted when repeated follow-up contacts were used as a preventative measure⁴⁴, and it is concerning that frequency of visits was one of the lowest scoring indicators in the CORE study of CRHT teams.

Gatekeeping

A key role for crisis teams is to provide an effective gatekeeping function to local inpatient mental health services. In our analysis, teams scored better for gatekeeping than for other core functions. One reason for this may be that the quality of data about gatekeeping has improved since it became a specific point of focus in the Mental Health Community Teams Activity data returns in 2010/11.

Clinical need may dictate that a person in crisis needs to be admitted as an inpatient but, where possible, alternatives should be explored. If it is decided that the person should receive home treatment, it is vital that the team stays involved with the individual until the acute need is resolved. At the same time, the team needs to plan for the discharge of care to an appropriate local service.

When home treatment is not an appropriate response, the crisis team should act as a gatekeeper to admissions. In 2013/14, the Mental Health Community Teams Activity data returns showed that 98.3% of admissions to acute wards came through CRHT teams.

Supporting long-term recovery

While gatekeeping is operating at near 100%, it is not such a positive picture elsewhere. Being able to access a service 24/7 is a key function of the CRHT teams, but results of the CORE survey showed that less than half the teams surveyed were evaluated as 'good' for providing a 24/7 service. This suggests a lack of appreciation of when a crisis event may be likely to occur. This is concerning: if people are not able to access a crisis service, it increases the likelihood that they will end up seeking support from people less equipped to deal with the specialist nature of a crisis – for example, either through attending A&E, or by coming into contact with the police.

The CORE study also showed that the majority of teams (53%) achieved a top score for adequate staffing levels, which means they have enough staff to provide a basic level of service to meet demand. However, the median score was only 2 out of 5 for their ability to provide a full multidisciplinary team. This suggests that while teams have enough staff to run critical aspects of the service, they are unable to resource more rounded support for people in crisis.

They were also unable to provide consistency of staff and support, with more than one in five teams failing to meet any of the criteria. Lack of continuity of care was raised in both our call for evidence and in all the areas that the Race Equality Foundation carried out engagement exercises. One person told us:

“Perhaps the worst thing is all the different faces you meet. I wish they could adjust their rotas to minimise this as seeing fewer people would be easier.”

It was a regularly voiced source of frustration, particularly as people were often able to see that the staff themselves were trying as hard as they could to offer a caring and responsive service.

“... it was a big team and I often spoke to or saw a different person each time which I found difficult. Having said that most of the people I came into contact with were very supportive and kind and offered reassurance.”

Possibly as a result of not having a full multidisciplinary team, less than a third of teams were scored as good in the CORE study for areas that might be seen as outside of a core service delivery, even if they are important for providing long-term support and recovery. This included low scores against measures for whether teams addressed physical health needs and involved those close to the person.

A major function of a CRHT team is to enable alternatives to hospital admission. It is vital that the people providing day-to-day support to someone at risk of crisis are given specific guidance and access to advice on how to do this. It is particularly concerning that not a single team achieved a top score, and that

80% of teams failed to meet any of the assessment criteria for planning for future crises. Building a person's future resilience should be a core function of a CRHT team and the principle of working towards recovery and staying well is central to the Concordat.

Location and timing of help was assessed against three indicators. Teams were scored against the frequency of visits, the range of accessible alternatives to hospital admission, and whether the team could conduct assessments and support people in their own home. These are vital aspects of a CRHT team's ability to ensure that a person is given a level of service that helps to prevent a crisis event from escalating to the point that it requires admission to hospital.

This was the area that teams demonstrated least fidelity to the best practice model, with the mean score being 1.87 out of a possible 5. While 96% of teams received the top score of 5 against supporting people in their own home, the median score fell to 2 for frequency of visits, and 1 for alternatives to hospital admission. Over half (56%) of the teams surveyed failed to meet any of the criteria for alternatives to hospital admission.⁴⁵

It is concerning that crisis teams are struggling to offer appropriate alternatives to hospital admission, and are finding that they are unable to offer frequent visits. Making sure that people in crisis receive help and support in the least restrictive environment should be a core function of a crisis team.

During our local area inspections, some people told us their crisis team saw them up to three times a day when necessary, and that this engagement helped with their recovery. This demonstrates that, even in a tough financial environment, it is possible to develop a service that is focused on intensive support to help people stay out of hospital.

While providers must make sure that services are set-up to meet local needs within the context of evidence-based good practice models, commissioners must also take responsibility for what is commissioned and hold providers to account if they are failing to provide effective and efficient services that put the individual at their heart.

CQC encourages:

- > NHS providers of specialist mental health services to make sure that:
 - a. Crisis resolution home treatment (CRHT) teams fulfil the core functions described in the policy implementation guidance.
 - b. Crisis telephone helplines – whether provided in-house or through external providers – are accessible when they are most needed and meet expected service standards.
- > Commissioners to make sure that CRHT teams are resourced so they can respond to people's need at any time through home treatment visits, where the option is appropriate to the person in crisis.

Case study: Putting the person first

“The care that I received during my crisis was amazing. My care coordinator responded appropriately and helpfully in calling the crisis and home treatment team who I was already known to having had several crises over the last few years.

They saw me within the expected time frame and were able to offer me the help and support I needed. The day after I saw them I knew I could not remain in my own home so some friends offered for me stay with them. When I rang the crisis team to say this would be happening and would they be able to support me there, the immediate answer was yes and that is what they did.

The care the team provided was first class. They tried to keep the number of people working with me as small as possible and to people who knew me from previously. The staff treated me with respect, allowed me the time I needed to talk through what was happening, helped me look at ways to manage it and also tried to look at reasons why this particular crisis which was way beyond anything I had experienced before may have come about. They were unrushed and were in no way judgmental.

I felt that I was really important to them and not just a number. I particularly valued one of the team who I knew the best taking me back to my house to pick up my phone charger that I had left behind and then taking me to a local cafe where we were able to talk through the whole crisis and explore why it happened. It really helped my understanding of what had happened.”



Since 2014, CQC has been working to embed a new approach to inspecting trusts that provide mental health services. As part of this new approach, we have defined 11 core services that we will always inspect when we provide a comprehensive rating for the mental health trust. One of these is ‘mental health crisis services and health-based places of safety’. This means that the ratings that we give will be based on our judgements following inspection of health-based places of safety and any teams that are defined as being CHRT teams.

While we have not been able directly compare the findings of the CORE study and our inspections, where we have provided ratings of these services we have found a similarly mixed picture and have rated services as good, requires improvement and inadequate, with no outstanding provision found.

Entering hospitals: a bed available in the local area

Bed availability

One of the key concerns flagged in our call for evidence was that inpatient beds were becoming increasingly difficult to secure when they were needed. While ideally a crisis will be managed to prevent it from escalating, it is also necessary to make sure that when a crisis occurs a person can access inpatient care if it is needed.

*“John has been hospitalised several times. He says that each time it has become ‘harder and harder’ to be admitted to hospital. The local general mental health unit was closed and replaced by a secure unit, which means being hospitalised outside the area. He felt that the emphasis is on saving money first and dealing with the patient second.” **

Nationally, it is recommended that bed occupancy levels for acute inpatient wards are 85% or less. Figure 12 shows that, on average, occupancy of consultant-led mental health beds exceeds this level. It also shows bed occupancy varies between trusts providing mental health services, with occupancy averaging 97% among the 10% of providers with the highest levels of occupancy.†

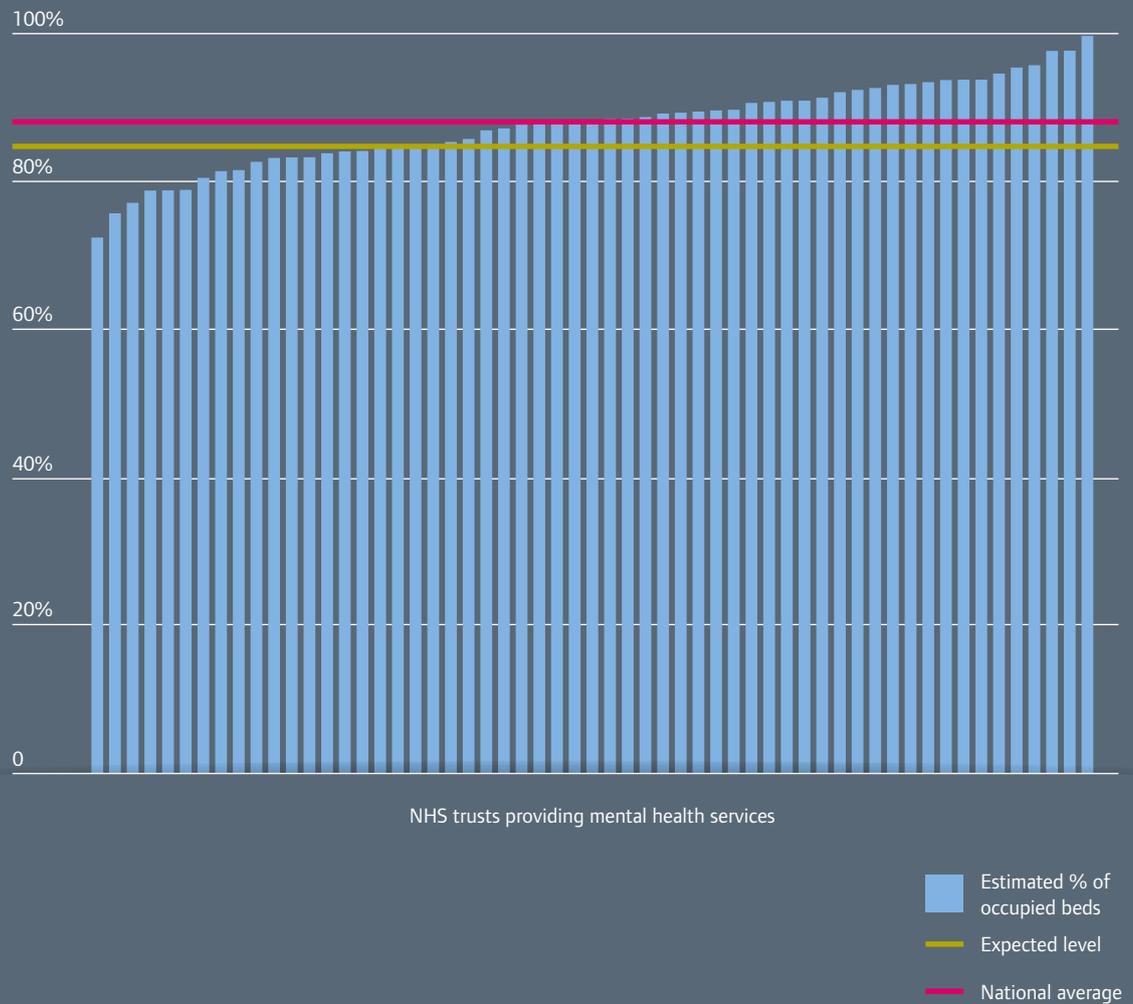
Royal College of Psychiatrists’ trainees’ survey

- In June 2014, the Royal College of Psychiatrists’ carried out a survey of trainees.⁴⁶ The responses (576 returns, of which 493 were based in England) highlight the concerns of medical professionals about the availability of beds for people in crisis.
- 70% had experienced difficulty in finding an appropriate bed at least once, and this increases to 83% when talking about access to beds for children and young people.
- Of even greater concern, professionals were using their knowledge of the system to ensure bed access. Overall, 37% said a colleague had used the Mental Health Act to detain a patient knowing it might make provision more likely, while 24% reported bed managers had told them unless a patient had been sectioned they would not get a bed.
- 20% have admitted a patient to a bed belonging to a patient who has been sent home on a period of trial leave.



Figure 12

Estimated overnight mental health bed occupancy 2012/13



Source: NHS England: KH03 bed availability and occupancy data collection 2012/13

* Race Equality Foundation consultation, name has been changed.

† It should be noted that some of the trusts included in the analysis do not only provide mental health care, but care for people with learning difficulties as well as community health services.

Out-of-area placements

The Concordat recognises the impact on those who end up being placed miles from friends and family, and is very clear that "... responses to people in crisis should be the most community-based, closest to home, least restrictive option available".⁴⁷

Given the emotional cost to the person and the financial cost to local areas, it is surprisingly difficult to access data on out-of-area placements. As the Mental Health and Learning Disabilities Data Set (MHLDDS)* does not capture this information, we are unable to gather a national picture on the issue.

In January 2015, the Health and Social Care Information Centre (HSCIC) published experimental data that showed (where distance from residence could be calculated) that 410 people had been placed in acute beds more than 50km from their home address. This was 4.9% of the 8,284 people in acute beds at the end of October 2014 where distance from residence could be calculated (figure 13).⁴⁸

In total, 296 (72.2%) of people in beds more than 50km from their home were receiving care that was not from their local clinical commissioning group's normal provider. There may be mitigating factors for this, such as people experiencing a crisis while on holiday, or because some mental health trusts span large geographic areas, but all local areas have a responsibility for developing systems that make sure people are not placed a long way from home.

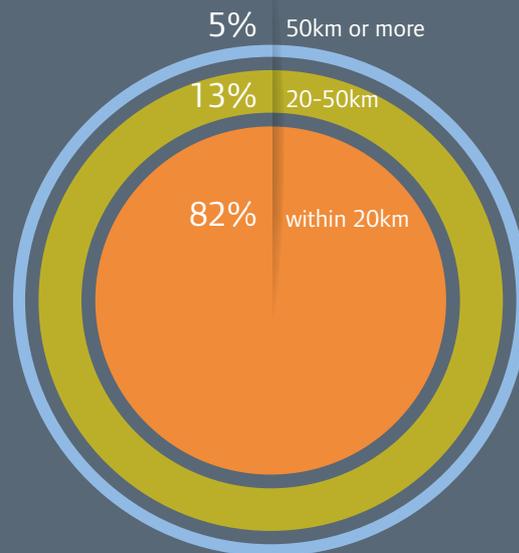
As part of our data review, we developed an experimental indicator to look at cases where people over 18 were admitted as an emergency to a mental health inpatient unit to see whether it was one of the main providers[†] of the service commissioned by their local clinical commissioning group or not. The implication is that where a service is not one of the main providers commissioned by a CCG, it may be further away. Our results suggest that, nationally, 4.4% of placements in 2012/13 were potentially out of area, which reinforces the HSCIC findings (figure 13).



Figure 13

Distance to treatment for people in acute mental health beds, HSCIC October 2014

- 82% of those in hospital were within 20km of residence
- 13% of those in hospital were between 20km and 50km from their residence
- 5% of those in hospital were 50km or more from their residence



This analysis does not include people in specialist beds (forensic services, rehabilitation, eating disorder, mother & baby and learning disability beds).

Other information sources also hint at the strain being felt across the country. The Royal College of Psychiatrists' trainee survey found that 80% of respondents had been forced to send someone outside the local area for a bed, and 15% had been doing this more frequently than once a month. These results suggest the issue is neither limited to a small number of areas nor the result of one-off pressures.⁴⁹

This is reinforced by a survey of Approved Mental Health Professionals (AMHPs) carried out by the College of Social Work in 2013. At the time, 90% of respondents reported that an individual receiving treatment had to travel beyond their local area on at least one occasion in the previous six months because of a shortage of beds locally, and over 60% stated this had happened at least five times.⁵⁰

However, these findings do not fully reflect the impact on the person in crisis. This impact becomes clearer when we consider that 37% of respondents to the Royal College of Psychiatrists' survey had sent someone over 100 miles away from their local area, and 22% of respondents who worked in child and adolescent mental health services (CAMHS) had placed a child 200 miles away from their family.⁵¹ This is the equivalent of placing an adult living in London in a bed in Gloucester, or a child living in Manchester being sent to the south coast in order to access a CAMHS bed.

There is a clear emotional cost to those involved, and placing someone outside of their local area is also likely to be a more expensive option for commissioners. A freedom of information request from *Community Care* magazine showed that out-of-area placement costs (from 23 trusts) increased from £21.1 million in 2011/12 to £38.3 million in 2013/14.⁵²

Local organisations must recognise the negative impact this has on a person's experience of crisis. Being driven across the country in order to find a bed is not the way to de-escalate a crisis, and will make it harder for many people to begin the recovery process if they are far from their home and any established support networks.

The Joint Commissioning Panel for Mental Health state that commissioners should commission "acute care services they would recommend to their family and friends".[†] Those with responsibility for commissioning services should reflect this in their local areas and consider if current provision follows best practice guidance.

It is also vital that out-of-area placements are addressed at a national level through the development of a measure that allows for routine and robust analysis of where people are placed.

CQC encourages:

- > Commissioners to make sure the services they commission are in line with guidance from the Joint-Commissioning Panel for Mental Health and offer value for money outcomes across the local area.

* In September 2014, following an expansion in scope, the mental health minimum data set (MHMDS) was replaced by the mental health learning disability data set (MHLDDS).

† A mental health service was defined as a 'main' provider if it accounted for at least 10% of a CCG's emergency mental health admissions.

‡ 10 Key Messages on commissioning acute care – inpatient and crisis home treatment services, Joint Commissioning Panel for Mental Health.

Going to A&E for help and support

“My GP initially referred me to the Early Intervention in Psychosis team which didn’t help since they weren’t the right team for me. I eventually went to A&E since I became suicidal and tried to kill myself... and was given the number for the crisis team... when I rang the crisis team they called me a “bad person” for hallucinating which triggered me to self-harm for the first time, and they just told me to go back to A&E who told me to call the crisis team - it was all a circle of blame shifting and avoiding the problem.”



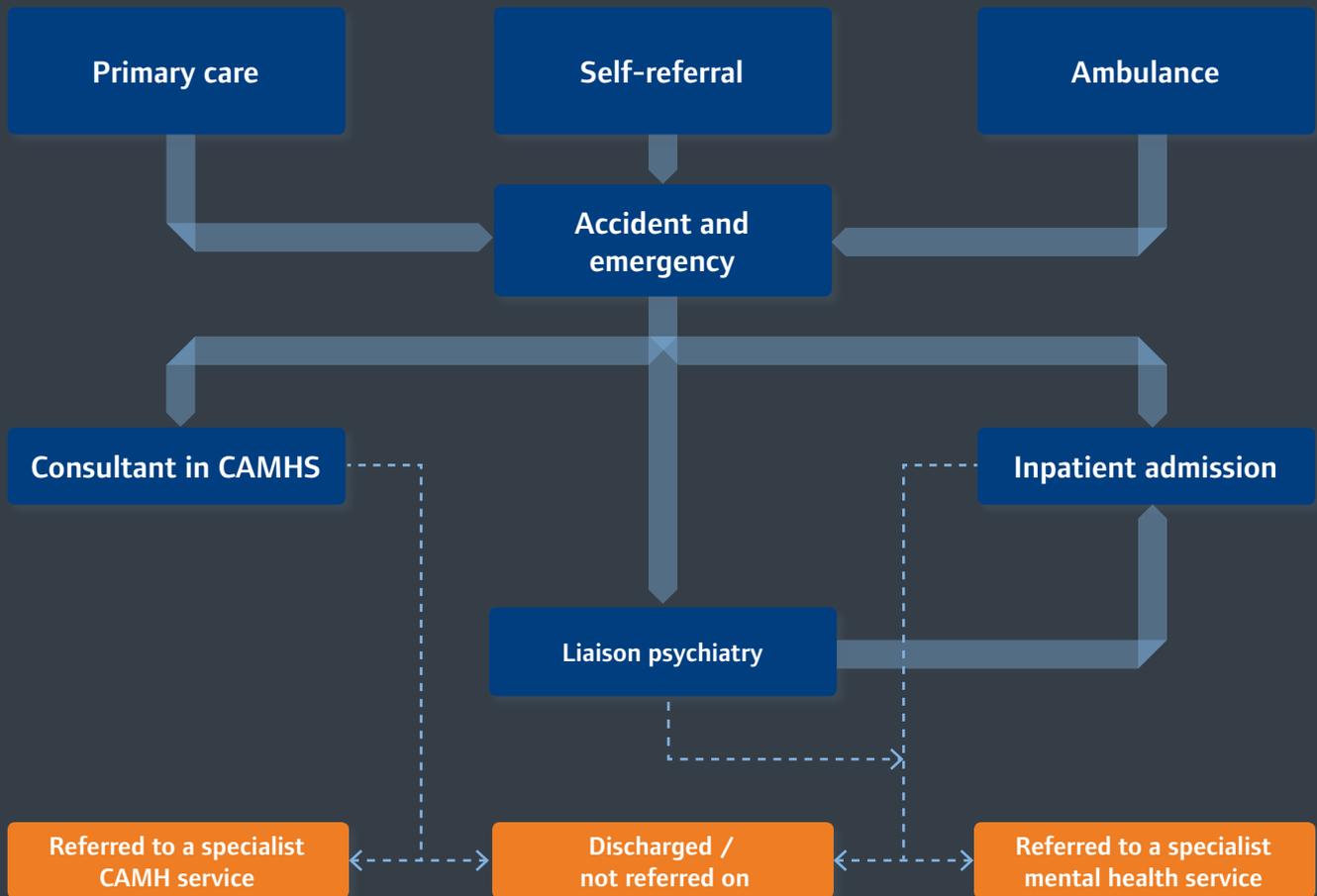
What we found

- How people with a mental health condition use accident and emergency departments varies across the country. This can be seen in the proportion of people with a known mental history who attend hospital multiple times, and the number of people admitted for a mental health condition, discharged and then need to return to A&E within 30 days. The rate and frequency of attendance at A&E is likely to be a sign that local services are not working well together and that people are not getting the specialist help they need.
- Over half of liaison psychiatry services may be ‘unlikely to... offer a reliable quality of care or outcome’.⁵³ This raises serious questions about the fairness of the response that these services are able to provide.
- The peak hours for self-harm admissions via A&E are between 11pm and 5am when it accounts for 6% of all admissions. Across England admissions via A&E for self-harm during these hours vary from below 3% of total admissions in the areas with the lowest admission rates to above 10% in areas with the highest admission rates.
- Presentations at A&E for all mental health conditions (other than dementia) are highest outside of regular working hours.



Figure 14

Possible routes when going to A&E for help in a mental health crisis



Background

There are all kinds of reasons why people go to accident and emergency (A&E) in a time of crisis. For some it may be the place to go when there doesn't seem anywhere else to turn, for others it

may be the first place they go. They may not have experienced a crisis before and so are not aware of options available to them, they may find it difficult to arrange an appointment with a GP, or cultural sensitivities may mean they do not feel it is possible to approach a specialist service.

For other people it is the only possible route into healthcare, as they may be excluded from other services due to a history of violence or they may be an overseas visitor who does not realise they are able to register with a local GP.

An estimated 5% of all A&E attendances are related to mental health problems.⁵⁴ The incomplete and inconsistent recording of presenting conditions in A&E means that it is hard to be accurate, but if this estimate is correct, this would equate to over one million attendances at A&E for a mental health problem.

We know that A&E departments are under great pressure. We do not expect all frontline A&E staff to be mental health professionals, but helping to minimise mental distress is a crucial function of a good A&E service. Feedback from our call for evidence indicates that, in many places, A&E staff could do more to listen to people and provide them with empathy and understanding.

People who deliver emergency care recognise the need to improve responses to those in crisis. The Academy of Royal Medical Colleges has made recommendations to help A&E departments minimise the impact of waiting in A&E on someone whose crisis may be at risk of escalating. This includes giving staff the necessary tools to provide a caring and effective response at any time, and to make sure “the same standard of urgent assessment, diagnosis and intervention should be provided for mental health care as is expected for physical health care”.⁵⁵ The Royal College of Emergency Medicine has developed a toolkit that provides a quick guide to resources and best practice that emergency departments can use to improve a person’s experience of their service.⁵⁶

Increasingly, liaison psychiatry teams are being seen as essential in providing an effective pathway of care. A close relationship between a liaison service and the A&E department can provide people in crisis with a quicker and more effective assessment. They can also provide frontline staff with basic mental health awareness training. This may help to reduce the number of times that a person’s mental health needs may be overshadowed by the presentation of a physical health need, and lead to more confidence in staff interacting with those in crisis.

Understanding who goes to A&E at a time of crisis

Admissions to hospital after going to A&E

To provide effective, timely responses to people who may visit A&E at a time of crisis, it is crucial to understand the scale of the issue. A core aspect of our work has been to build an evidence-base around national indicators that may relate to people in crisis. We have used Hospital Episode Statistics (HES) and Mental Health and Learning Disabilities Data Set (MHLDDS) to develop our understanding. Where possible, we have presented this information at a local authority area level to show whether care varies across the country.

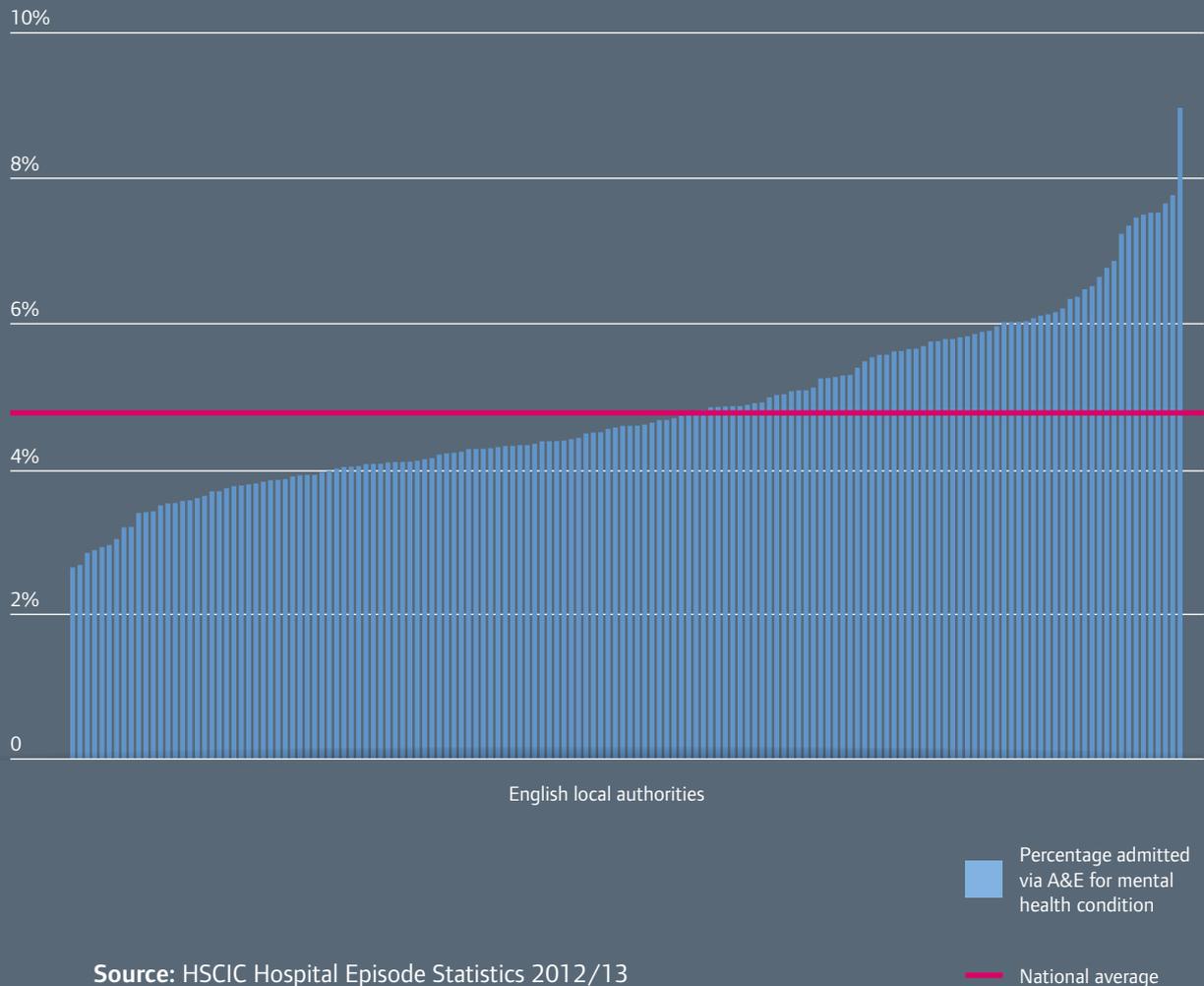
Not everyone who presents to A&E will subsequently be admitted to hospital. In 2012/13, over 2.5 million people were admitted to acute hospital via A&E. We found that just under 5% of these were admitted for a mental health-related behaviour or condition (125,404 people).

People who were admitted via A&E for these conditions varied between 3% and 7% comparing the top and bottom 10% of local authority areas (figure 15). This variation might suggest that differences in local structures have an impact on the ability of some local systems to prevent acute hospital admissions that could have been avoided.



Figure 15

Percentage of admissions to acute hospitals via A&E that were for a mental health condition 2012/13



Source: HSCIC Hospital Episode Statistics 2012/13

We looked at the specific mental health conditions that would be relevant to admissions related to a mental health crisis. This was so that we could understand the impact that people who were presenting in a mental health crisis had on overall acute admissions via A&E.

Of the nine conditions or behaviours included in our analysis, over 60% of all mental health crisis-

related admissions to acute hospitals via A&E in 2012/13 were attributed to self-harm or injury of undetermined intent. This means that there were approximately 105,000 admissions for self-harm or injuries of undetermined in 2012/13 alone. This is equivalent to 2.8% of all admissions to acute hospitals via A&E. The next highest proportion was for mental health conditions resulting from use of alcohol at 0.9% (table 8, overleaf).

Table 8

Percentage of admissions to acute hospital by mental health condition

Selected mental health condition/behaviour by HES classifications	Percentage of all admissions to acute hospitals via A&E in 2012/13	Percentage of selected mental health related admissions to acute hospital via A&E in 2012/13
Self-harm and undetermined injury	2.8%	62.4%
Mental and behavioural disorders due to substance use - alcohol	0.9%	19.9%
Alzheimer's	0.2%	4.9%
Organic mental disorders, excluding Alzheimer's	0.2%	3.7%
Neurotic, stress-related and somatoform disorders	0.2%	3.7%
Mood disorders	0.1%	2.6%
Schizophrenia, schizotypal and delusional disorders	0.1%	1.4%
Mental and behavioural disorders due to substance use – other psychoactive substances	0.0%	1.0%
Behavioural syndromes	0.0%	0.3%

Source: HSCIC Hospital Episode Statistics 2012/13

It is important that hospitals recognise that self-harm is the most likely mental health related condition that staff in A&E will encounter. Providers must make sure that frontline staff are fully equipped, through appropriate training, tools and work environment, to respond effectively to people who present at A&E.

However, the responsibility does not lie solely with the acute service provider. People presenting at A&E with self-harm or undetermined injuries may be a symptom of problems in the wider system. These may relate to the ability of primary care to refer people at risk of crisis to appropriate services, or wider pressures on specialist mental health services that mean they are not able to provide the community support that people require.

It is important that local services monitor the profile of people admitted via A&E for self-harm related injuries, to make sure that services are meeting local needs. If the admissions for self-harm related injuries in a local area appear significantly higher than the national average, key partners should work together to identify any wider factors that could be contributing to the higher rates of injury.

Re-attendance at A&E following discharge

Re-attendance at A&E shortly after a previous hospital admission via A&E for a mental health condition may suggest local services are not working together effectively. An effective service will provide a seamless transition for the individual so that they receive appropriate specialist help when they are discharged from hospital. Going back to A&E suggests that they cannot get the support they

need in the community and that A&E is seen as somewhere they will be able to go for help. We reviewed the data for people with a previous history of contact with either mental health or acute hospital services because of a mental health problem who had been admitted via A&E to an acute hospital in 2012/13 for a mental health condition. This was to see what proportion returned to A&E within 30 days for any reason.*

We found that, on a quarter of occasions where there was a known mental health history, the person involved went back to A&E within 30 days of being discharged. In total this equates to more than 18,000 attendances at A&E across England.

We cannot be sure that people's re-attendance at A&E was because of mental ill health, or that their re-attendance was not part of a planned follow-up. However we do know that, nationally, planned follow-ups at A&E account for less than 2% of A&E attendances.

Re-attendance rates varied significantly across local authority areas. In the 10% of local authority areas with the highest proportion of re-attendance, the average was one in three people. Among the 10% with the lowest proportion of re-attendance it was fewer than one in five. It is also notable that there was a significantly lower rate of re-attendance within 30 days of discharge for people with no prior known mental health history (table 9).

Table 9

Re-attendance at A&E within 30 days of discharge

	Re-attendance at A&E within 30 days of discharge			
	Total number of re-attendances	Re-attendances as percentage of admissions	Average of 10% of local authorities with highest proportion of re-attendance	Average of 10% of local authorities with lowest proportion of re-attendance
Re-attendance of people with known mental health history following admission via A&E to an acute hospital for a mental health condition	18,186	24.9%	33%	19%
Re-attendance of people with no prior known mental health history following admission via A&E to an acute hospital for a mental health condition	7079	13.5%	20%	9%
Re- attendance of people following any admission via A&E	690143	19.2%		

Source: HSCIC Hospital Episode Statistics 2012/13

* A history of contact with secondary services for mental health related issues was defined in our analysis as a service user having one or more of the following: a prior spell in MHLDDS that closed within six months of the acute hospital admission in 2012/13, a currently open spell in MHLDDS, or an acute hospital admission for mental health conditions in the past five years.

We do not know why people re-attend A&E following discharge from hospital, or why the proportion of those re-attending is so much lower for those with no prior known mental health history. However in the call for evidence people who had previously experienced a mental health crisis said they were less confident about what to do if they had a future crisis. Looking at this alongside higher re-attendance rates, it may suggest that people become disillusioned with the local service response, and see A&E as a route to accessing professional medical expertise if their needs are not being met elsewhere.

Demographics of acute admissions via A&E for mental health related conditions

Evidence shows us that where someone lives may have an impact on the response they receive during a crisis. However, we are also aware of anecdotal information that suggests factors such as age, ethnicity, sexual identity or whether a person has a physical or learning disability can also have an impact.

We looked at data related to gender, ethnicity, age and deprivation. However data quality issues has meant that the depth of our analysis against all equality characteristics remains limited. We factored in a past history of contact with specialist mental health services or prior acute admission for mental health related conditions.

There is no one factor that makes people more likely to be admitted to hospital via A&E for a mental health related condition, although the data does show variation between different demographic groups. It is important to recognise that this variation may be related to a wide range of factors, such as differences in predisposition towards particular forms of mental illness or socio-cultural barriers in accessing services or support.

While these factors may make providing services more challenging, they should never be an excuse for allowing a person's experience to be determined by them.

Frequent attenders at A&E

Attending A&E frequently may also be a sign that people who should be known to local mental health services are not being referred to or being provided with appropriate information on who to contact in the event of a crisis. International research has suggested that recurrent attenders account for 8% of all emergency department attendances and that the most common reason for frequent attendance is an untreated mental health issue.⁵⁷

The 2014 A&E Patient Survey reinforces these findings. It shows that just under half of all people with a mental health condition had been to A&E before about the same condition or something related to it, compared to 31% of people without a mental health condition (figure 16, page 64). This difference is statistically significant and, while we do not know whether people were attending due to a physical or mental health concern, it shows a clear difference between those with or without a long-term mental health condition, and reinforces concerns around parity.⁵⁸

Demographics of people presenting at A&E for mental health-related conditions

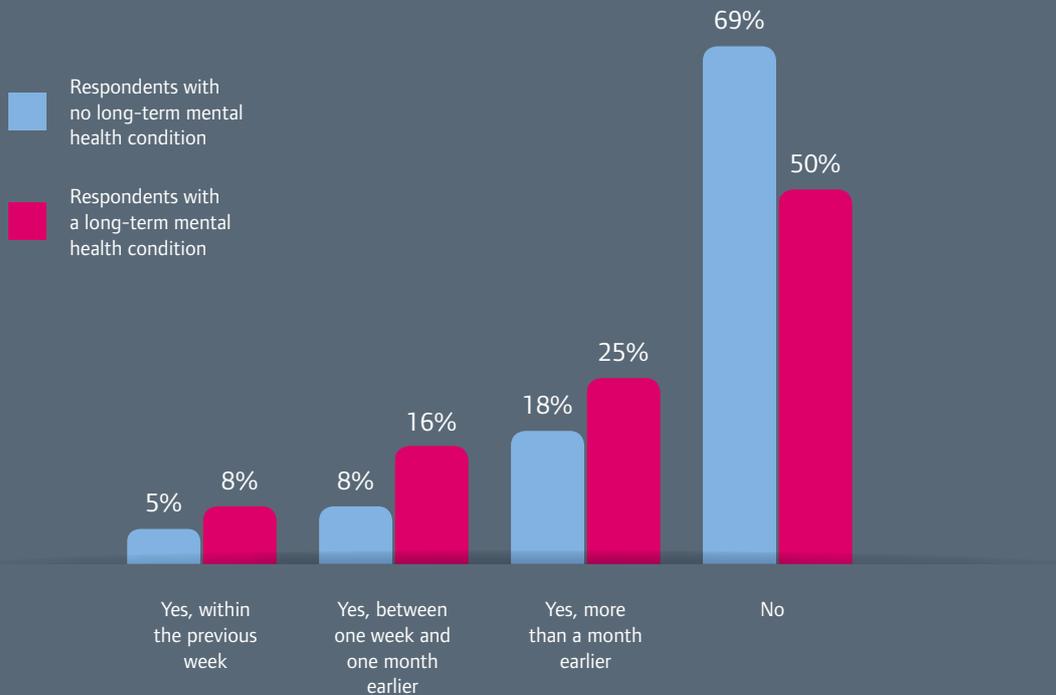
- Admission via A&E for mental health related conditions made up a higher proportion of all people admitted via A&E aged 15 to 19 (15.7%) than for any other age group.
- The ethnicity groups that had the highest percentages of people admitted via A&E for mental health related conditions were White British (5.0%) or those of a mixed White and Black Caribbean heritage (5.0%). People from Pakistani (2.0%) or Bangladeshi (2.0%) groups had the lowest proportion of admissions groups.
- Breaking down mental health conditions further, it can be seen that black and minority ethnic groups had reduced odds of admission via A&E for self-harm and substance-use related mental health conditions, and increased odds for schizophrenia-related admissions.
- While there was little difference between men and women for A&E admissions for a mental health related condition; men were more likely to be admitted for substance-use related conditions, whilst women had higher odds of being admitted for self-harm and neurotic disorders
- As levels of deprivation increased so did the proportion of people admitted via A&E for mental health related conditions.*

* The Indices of Multiple Deprivation have been used to define deprivation levels at a local authority level.



Figure 16

2014 A&E survey: Before your most recent visit to A&E, had you previously been to this A&E about the same condition or something related to it?



We found that 4,355 (3.5%) people admitted via A&E for a mental health condition in 2012/13 had attended A&E on multiple occasions (over 60 times) in the five years before the admission. Again, this varied between local authority areas across England. In some areas less than 2% of people admitted via A&E to an acute hospital for a mental health condition had previously attended A&E multiple times. This increased to 7% in the 10% of local authority areas with the highest proportions of people admitted that were multiple attenders.

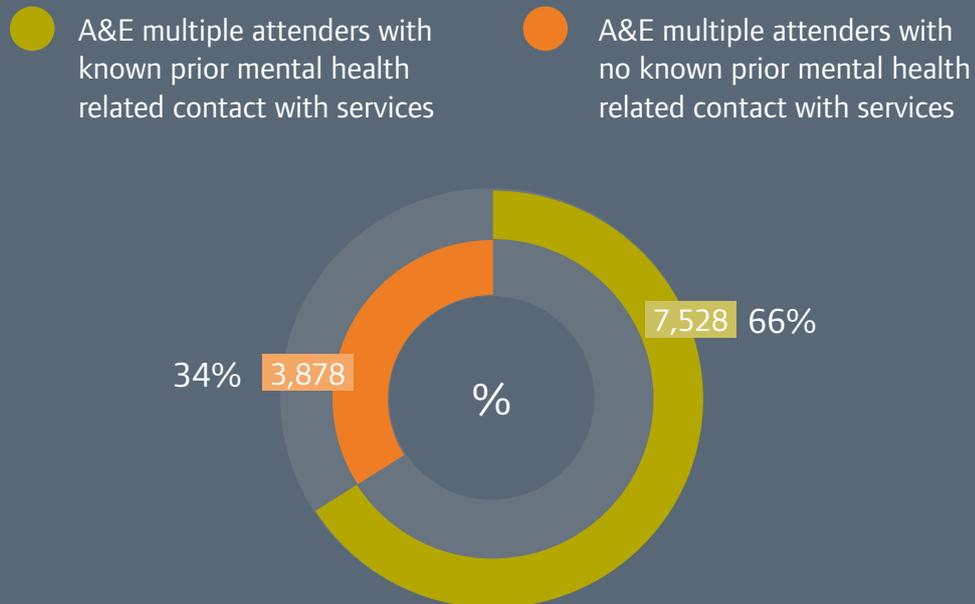
We also found that two-thirds of people attending A&E multiple times for any reason will have had previous contact with specialist mental health services, or have previously been admitted to an acute hospital for a mental health condition (figure 17). In practice this means that a substantial number of people who go to A&E multiple times should already be known to mental health services.

Yet again this figure varies across England. In the 10% of authorities who recorded the lowest proportion of multiple attenders, people with a known mental health history accounted for just under half (48.5%), while in the 10% with the highest proportions the average was 82.5%.



Figure 17

Among patients who attended A&E multiple times prior to admission, how many had prior contact with mental health services or admission to acute hospital for a mental health related condition? †



Source: HSCIC Hospital Episode Statistics linked with MHLDDS 2012/13. Numbers in this figure refer to number of people.

We recognise that specialist mental health services will not be able to stop people turning to A&E for help on every occasion, but these figures support findings from our call for evidence that people are struggling to get the support they need. For example, one person told us, “the only way to get help is through A&E in larger hospitals with psych teams”. Others reported that when they tried to get help out of hours, the response was often that they should go to A&E.

If people are frequently attending at A&E because they do not feel they can access help elsewhere, questions should be raised about whether the right services are being commissioned locally. This is

reinforced by anecdotal feedback that people are finding it increasingly difficult to access specialist mental health services.

One local group responding to the call for evidence told us that services “seem quite restrictive in what they consider ‘mental illness’ and often if the service deems something ‘social’ or ‘emotional’ then mental health crisis services won’t see them. Often people end up going to A&E as they do not have anywhere else to go or don’t know what else to do and then report staff seeming confused or annoyed that they are there”.

† Definition of multiple attenders is a person who had attended A&E at least 60 times in the five years before being admitted in 2012/13.

The Concordat is clear that mental health care should be moving more towards early identification and prevention. This is an opportunity for commissioners to reconsider provision in their local areas. Frequent attenders may represent a significant cost to providers, and it may also be an opportunity to engage the voluntary sector in providing appropriate services for those who may be mentally distressed, but whose distress has not yet escalated into a full crisis.

CQC encourages:

- Local Crisis Care Concordat partners to prioritise assessment of the level of, and reasons behind, frequent attendances at A&E departments, and to using a system-wide approach commission/provide alternative options for people identified as being at high-risk of attending frequently.
- NHS trusts providing acute hospital and specialist mental health services within a local area to work together to review the process for people accessing support following attendance at A&E and/or discharge from acute hospital to decrease the number of people re-attending at A&E within 30 days.

In the local authorities where four out of five frequent attenders at A&E had a known history of mental ill health, it suggests that local strategic working arrangements are failing to understand how people are accessing services. Organisations that respond to people in crisis need to look at their data to understand the pathways that people are using to access care and make changes to ease pressures on the system.

People's experiences of acute hospitals at a time of crisis

What people told us

One of the clearest findings from our call for evidence was that people are not satisfied with how A&E departments respond to people in crisis. A&E departments received the lowest score of any service*, with less than 40% of individuals giving a positive response against each of the 'I felt' statements (table 10).

Only 36% of people who went to A&E during a crisis felt respected by the service, with 46% stating that they did not. While we recognise the pressure that A&E departments are under, it does not excuse the fact that this figure remains unacceptably low.

Often the personal stories that people shared with us suggest that there are some A&E staff who view people with mental ill health as a burden that get in the way of dealing with other patients.

"I have a clinical illness. It's not my fault my brain chemistry fluctuated. [...] To be treated as a drunk, an inconvenience and with visible contempt only makes it worse."

This is not just about the provision of services, but is more fundamentally an issue about how all staff – including non-clinical staff like A&E receptionists and security guards – speak and act around people in crisis. It is about recognising that the needs for mental ill health may be different to physical ill health, but every bit as important.

Table 10

Individual survey: A&E responses to people in crisis

I felt...	Yes	No	Not sure	Total respondents
I felt respected	36%	46%	19%	323
I was able to access help in a timely way	35%	56%	9%	314
I was listened to and my concerns were taken seriously	37%	49%	13%	318
I was treated with warmth and compassion	34%	53%	14%	316
I was not judged for what I had done or how I felt	33%	52%	15%	314
The advice and support I was given was right for me	29%	53%	17%	313

Source: CQC's call for evidence 2014

Responses to people who may have self-harmed

As noted earlier, 2.8% of all admissions via A&E to acute hospitals were classed as self-harm undetermined injury in 2012/13. Alongside this we are aware of perceptions that there are negative attitudes towards people in crisis, particularly those who self-harmed.

The Royal College of Psychiatrists have published a working paper that states that psychiatrists "have expressed dissatisfaction with the expertise of some members of their own profession and with other staff (nurses, doctors, social workers, paediatricians, police and prison staff) in dealing with and in undertaking assessments for people who have harmed themselves (particularly those repeatedly harming themselves) or who are suicidal."⁵⁹

One of the key issues we wanted to test was how staff at A&E respond to people who present with injuries related to self-harm. We wanted to understand whether staff are following the NICE guideline on self-harm which states, "People who have self-harmed are cared for with the compassion and the same respect and dignity as any service user."⁶⁰

People's experiences in A&E were almost universally negative, and in many ways mirror the findings of the Royal College of Psychiatrists.

"A&E was horrible. I felt like I was being judged for inflicting injuries on myself and that certain staff actively didn't want to treat me."

"There was a long wait in hospital A&E to see a team of people (two turned up) who didn't want to help. I was clearly in a bad way having just had internal and external stitches up my arms so I would have thought they'd help but all they did was tell me to ring a number and talk to someone next time."

Nevertheless, during our local area inspections, we did discover some examples of excellent practice in relation to self-harm. We found instances of staff providing caring and effective responses to people, which is not something that we were told about when we asked those people with experience of crisis to share their experiences with us.

* Of services that were indicated as being accessed by more than 10% of respondents to the Individual survey

Two stories of self-harm

Gina told us about two of her experiences at A&E – one good, one bad. The huge differences tell us a lot about variation a person can receive even when you know the system. It also demonstrates how a single event in a person's pathway of care can have a significant negative impact on the rest of their experience and affect how they interact with other services.

Positive experience:

When booking in at the A&E reception I was allowed to write down the details of my self-harm injuries rather than give the information verbally which could be overheard by other people.

This helped me to feel less humiliated and ashamed and therefore better able to manage the situation as sometimes I feel that everybody is staring at me and talking about me.

Negative experience:

I had not been taken seriously at triage. I had explained how distressed I was feeling as I had also been assaulted and how badly I was bleeding. I explained that if I lay down the bleeding was much less severe. The triage nurse was very dismissive and said there were no cubicles free and that I would have a long wait. She told me I would have to lie on the floor of the toilets if I needed to lie down that badly.

They accused me of self-harm while I was in the toilets, which was not the case. I was terrified, humiliated and upset, and could not calm myself down or trust anybody for the rest of my admission leading to disturbance and distress for other patients.

I felt completely humiliated and was unable to trust the psychiatric staff and home treatment team that attempted to help me afterwards. I was unable to attend outpatient appointments as I felt so humiliated by my experiences and so ashamed.

- Name has been changed upon request

CQC encourages:

- Acute hospital trusts to focus on improving the experiences of people in crisis when they present to A&E for help, care and support through:
 - Enabling staff working in A&E to attend joint-training sessions run by members of the liaison psychiatry service. Training should incorporate people using mental health services and carers to emphasise how attitudes can impact on a person’s personal experience.
 - Making sure that the environment of A&E departments, and the response of those that work there, offers warmth, compassion and empathy to those presenting with self-harm related injuries at any time.

Getting the right help at the right time

The Concordat clearly states that “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, seven days a week”.⁶¹

An analysis of peak acute admission times via A&E for different types of mental health condition shows the importance of making sure that services for people with mental health needs are available at all times. Figure 18 shows that dementia – a mental health condition most likely to be associated with older people – is the only one to peak during a period that includes the ‘regular working hours’ of 9am to 5pm.

Figure 18

Peak hours for acute admission via A&E



Source: HSCIC Hospital Episode Statistics

In 2012/13, 6% of all people admitted to acute hospitals via A&E between 11pm and 4.59am were admitted for self-harm or injuries of undetermined intent. This varied across local authority areas; in the 10% of areas with the highest proportions of people admitted via A&E it accounted for nearly one in 10 people admitted during these hours, while across the 10% of areas with the lowest proportions the average was less than 3%.

The provision of appropriate round-the-clock support for people in crisis at A&E is crucial for achieving a parity of response. Acute hospitals must recognise that responding to people who self-harm is an important part of their core business, and that acute admission rates via A&E change over the course of a day, peaking outside 9am to 5pm. As a result, they should look to ensure they have right staff with the right skills working at the times when presentations are more common.

It is also important that providers assess whether the liaison psychiatry provision is meeting local needs. If the service has not been set up to provide comprehensive 24-hour coverage, then out-of-hours on-call responses need to be sufficient to meet demand. Lack of capacity may result in people having to wait for longer periods in A&E until they can be seen by a mental health professional.

It is important that those responsible for commissioning services take into account a whole system approach, and recognise that people may be presenting at A&E because they are unable to access more appropriate crisis services. In our call for evidence, we found that people were frustrated about the quality of service out of hours across the health and care system. This was reflected in the responses from local groups, with 65% telling us that there was not an equal level of support available to people out of hours.

Those responsible for commissioning services across a local area should use available data to make sure that access to and the availability of crisis services are aligned to when demand is highest. They should recognise that the nature of a crisis means that these services cannot fit within the traditional mould of 9am to 5pm.

Quality and availability of liaison psychiatry services

Increasingly, liaison psychiatry is seen as an essential element of the care pathway for people who have presented to A&E during a mental health crisis. The Concordat states that “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”.⁶²

NHS England has also recognised the important role that liaison psychiatry plays in resolving longstanding concerns about people’s experiences of A&E during a crisis. It has announced an investment of “£30 million in developing liaison psychiatry services... [so]that all acute hospitals should have a liaison psychiatry service which is appropriate to the size and scale of the hospital.”⁶³ This investment will not deliver comprehensive liaison mental health services nationwide. It is important that providers and commissioners recognise the expectation set out in *Achieving better access to mental health services by 2020* that “by 2020, all acute trusts will have in place liaison mental health services for ages appropriate to the size, acuity and speciality of the hospital”.⁶⁴

Liaison psychiatry services help to bridge the gap between mental and physical health and enable organisations to deliver a more holistic approach to care. Developing a close working relationship with staff in A&E means that those attending who report, or display signs of, a mental health need can be seen by mental health professionals in a timely way.

The need for this kind of service is reinforced by the UCL Partners study of four A&Es across London. They found that people presenting with a mental health issue were 6.5 times more likely to have to wait more than four hours to be seen than people presenting with a physical need. While it is a small sample, it is reinforced by the 2014 Accident and Emergency Patient Survey, which found that people with a reported long-term mental health condition were twice as likely to wait more than four hours before being examined by a doctor or a nurse.

Table 11 shows the results of the First Annual Survey of Liaison Psychiatry in England. This was a survey of liaison psychiatry services located in hospitals with an emergency department carried out between December 2013 and January 2014. It shows that there was not enough investment in liaison psychiatry in England to be sure that patients will have a good experience of services wherever or whenever they need them.

In the survey, services were categorised as Inadequate, Core, Core 24, Enhanced 24 or Comprehensive. Core was considered to be the minimum level of provision likely to derive a demonstrable benefit.⁶⁵ Adequate services were “recognised as paying for themselves several times over by reducing length of stay and readmissions to general hospital”.⁶⁶ The RAID (Rapid, Assessment, Interface and Discharge) model, and a study of Optimal Liaison Psychiatry in North West London, indicated that every £1 invested derives an approximate benefit value of £4.

The survey suggests that 39% of liaison psychiatry services are likely to be paying for themselves, with the picture less clear for the remaining less-resourced services. While we cannot make a judgement on whether they delivering value for money, professionals in the field have observed the less well-resourced services “seemed unlikely to... offer a reliable quality of care or outcome”.⁶⁷ With the existence of a clear evidence base, commissioners should question the purpose of continuing to commission services that may not be offering value for money or reliable care outcomes for those who use it.

In order to drive up standards the Royal College of Psychiatrists has developed the Psychiatric Liaison Accreditation Network (PLAN). This is a subscription-based peer review scheme that means accredited member organisations are assessed as achieving a series of minimum standards for their service.

As of October 2014, 39 organisations had received PLAN accreditation for their liaison psychiatry function. However, it is concerning that even accredited organisations are not providing dedicated all hours support. Across 37 PLAN accredited organisations, we found that 30% of members offer round-the clock 24/7 service provision, while the largest proportion (46%) only operate a Monday to Friday, 9-to-5 (or 6) service and will be reliant on other on-call or emergency cover or alternatively have no specific provision outside of this time.

Table 11
Liaison psychiatry services in England
December 2013 to January 2014⁶⁸

Grading	Total	% of total
Comprehensive	3	2%
Enhanced 24	6	4%
Core 24	14	8%
Core	42	25%
Inadequate	105	62%

Case study: One service for adults, another for children

Through our local area inspections on people presenting to A&E in crisis, we found that there were clear differences in the quality of care experienced by those under 16 compared to those over 18 years old.

The liaison psychiatry service met specifications set out in the RAID model. Adults were seen promptly and there were clear pathways through to community services. People aged 16 or 17 would be seen and assessed by the RAID team with support from CAMHS, while those under 16 were referred directly to the child and adolescent mental health service (CAMHS). This may be an appropriate referral route, but in practice it meant that if a CAMHS referral was made after 12.00 noon, the child would not be seen until the following day or potentially after the weekend, as the CAMHS team did not offer out-of-hours service.

This led to a clear variation in the quality of care that was purely determined by the age of the person looking for help and support.



CQC encourages:

- Commissioners in a local area to commission services that deliver parity in the quality of service received by people that are experiencing a crisis outside of 9am to 5pm.
- Those responsible for commissioning liaison psychiatry services – and other services relevant to the A&E pathway – to consider the needs across local population groups and the times those at risk of crisis are likely to present when ensuring there is adequate and effective service provision.

Experiences of detention under section 136 of the Mental Health Act

“The relationship between the police and the mental health team is much improved since the start of meetings held every two to three months between us to iron out any issues and ensure small matters do not become big ones. Learning and development points are raised and best practise highlighted and encouraged.”



What we found

- How many times section 136 powers are being used, and how often people subject to the power are subsequently admitted to hospital, varies significantly across the country. It is unfair and unacceptable that where a person lives has such an impact on the care they receive when they are in crisis.
- There has been a marked reduction in the use of police custody as a place of safety for people in crisis, but there are still problems with accessing suitable provision for those under 18 in some areas. We recognise changes are being made, but it is totally unacceptable that people in crisis are continuing to be held in police cells, due to a lack of appropriate alternatives.
- Delays in achieving local targets for carrying out Mental Health Act assessments are often the result of a lack of available section 12 doctors or approved mental health professionals.
- Following the introduction of a new voluntary national protocol, ambulances attending section 136 incidents are arriving within 30 minutes on over two-thirds of occasions.

Background

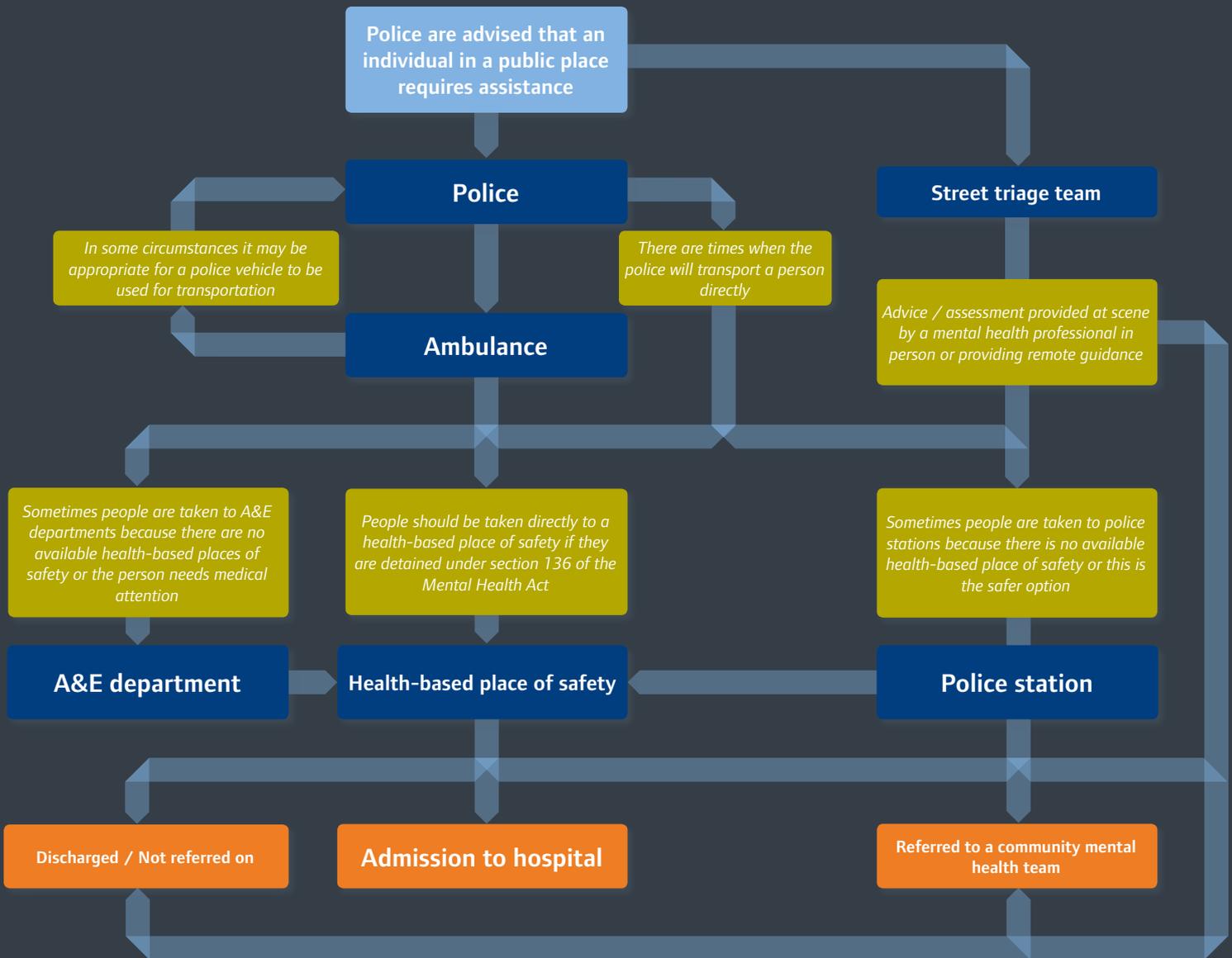
People do not choose when or where to have a crisis. As a result the police, in particular, often become involved in issues related to mental health. They come into contact with the public every day and are the service that people are likely to call if they someone acting in a way that suggests that they

may be a danger to themselves and others. In her evidence to the All Party Parliamentary Group on Mental Health, Commander Christine Jones of the Metropolitan Police estimated that “40 per cent of policing time was currently being devoted to dealing with people who are vulnerable as a result of mental ill health”.⁶⁹



Figure 19

Likely pathway of care for people detained under section 136



The introduction of triage schemes across an increasing number of areas is a sign that local agencies are starting to work together to find innovative solutions that bring the expertise of mental health professionals to those who first come into contact with people in crisis (see page 78). Anecdotal feedback from the local area inspections suggests the schemes have been welcomed where they have been introduced. However, it is important that a full evaluation is carried out to understand their effectiveness across pilot areas.

In 2013/14, according to police data the section 136 power was used more than 24,000 times, an increase of over 10% from 2012/13.⁷⁰ This increase may be due to improvements in data recording. It may also reflect a better understanding of mental health and more appropriate decisions to use the powers. Alternatively, it could reflect problems in the local health and care landscape that mean people are

not able to access the care they need through more appropriate channels.

CQC's commitment to ensuring the quality of services to people in crisis has seen health-based places of safety form part of our comprehensive inspection process. We also wanted to build a more detailed picture about national provision and so we surveyed all NHS mental health trusts and two community interest groups. The findings of the survey were published in our report *A safer place to be* in October 2014. This shone a spotlight on the accessibility and availability of health-based places of safety, as well as the arrangements of local organisations for their safe and responsive operation. Findings from our report are outlined in the box below. We also developed specific tools to look at the section 136 care pathway in our local area inspections.

What is a section 136 detention?

- Section 136 of the Mental Health Act 1983 allows police officers to detain someone who is in a public place and take them to a place of safety, if it appears that the individual is suffering from mental disorder and is in immediate need of care or control, and it is in the interests of that person or for the protection of others. Once section 136 has been applied, a person should receive transportation via an appropriate vehicle, most likely an NHS ambulance but on occasion private vehicles may have been commissioned. In some circumstances conveyance in a police vehicle may be required.
- A person should be taken to a health-based place of safety. Police stations can be a place of safety, but it is not seen as an appropriate location for people experiencing a mental health crisis, and should only ever be used under exceptional circumstances.
- Once at a place of safety, an assessment under the Mental Health Act must take place within 72 hours (although detention in a police station under section 136 should not exceed 24 hours).

A safer place to be: CQC comments on health-based places of safety

- Places of safety are turning people away or requiring people to wait for long periods with the police, because they are already full or because there are staffing problems. This raises questions about provision and capacity.
- Many providers operate policies that exclude young people, people who are intoxicated, and people with disturbed behaviour from all of their places of safety.
- Commissioners are not adequately fulfilling their responsibilities for maintaining an oversight of the section 136 pathway.
- Providers are not appropriately monitoring their own service provision. Many places of safety could not give us basic information about the use of their service or how often people were turned away, or excluded, and the reasons for this.

For more information on *A safer place to be*, including the recommendations we made to key agencies the full report is available on CQC's website at www.cqc.org.uk/content/safer-place-be.

* The HSCIC's experimental Mental Health Act statistics for 2012/13 counts 9,739 section 136 detentions in 2012/13 based only on NHS providers and including any section 136 episode that started in the year. Our analysis included all providers and only counted section 136 episodes that started and ended in the year.

† We calculated admissions to hospital for people subject to section 136 Detentions are deemed to have been admitted to hospital if there was a hospital spell which started during the period of section S136 detention and which ended at least 1 day after the section 136 S136 detention. The figures here are much lower than the uses of section 136 recorded in KP90 and even accounting for differences in coverage, the MHMDS figures represent an under recording of the uses of this power.

Variation in outcomes following use of section 136

Analysis of national data on the use of section 136 suggests that the outcomes for people subject to the power can vary greatly between areas.

Our experimental analysis of data from the Mental Health and Learning Disabilities Data Set (MHLDDS) was based on 9,626 detentions under section 136 in 2012/13*, around 35% of which resulted in an individual subsequently being admitted to hospital.† In the 10% of local authority areas that had the highest admission rates following use of section 136, on average 77% of detainees were admitted to hospital. In contrast, the 10% of local authorities with the lowest admission rates saw an average of just 13%.

Looking at this against the total section 136 detentions recorded in MHLDDS, the 10% of local authority with the lowest admission rates had more than four times as many section 136 detentions compared to the 10% of areas with the highest admission rates.

We recognise that these findings are based on experimental analysis and that the results may be affected by the completeness of data recording. Despite this, it is important to highlight the suggestion that there are parts of the country where people are far more likely to find themselves admitted to hospital if they happen to be subject to section 136, as this reflects the variation we have consistently found across other indicators related to crisis care.

Variability in outcomes following use of section 136 may be the result of several factors, and the reason may differ depending on the local area and the incidence of mental ill health. In some areas a lower proportion of admissions may mean that an area has commissioned suitable alternatives to inpatient treatment, and has greater capacity to provide appropriate community support. However, low rates of admission should also raise questions about the understanding and application of the power and may reflect a lack of alternative options for the police,



Comprehensive recording of the use of section 136

Recording about the use of section 136 is variable. While figures are reported nationally by health services through KP90 and MHLDDS data returns, these are not consistent with those collected by the police and may not reflect fully the use of the power, particularly where people are subject to section 136 but not taken to a health based place of safety.

Against this backdrop, the Home Office has developed a mental health monitoring form in consultation with key stakeholders, including CQC. This form encourages police officers to collect information on:

- The initial encounter and what action was taken.
- Whether the person had been detained under a section 136 previously.
- Whether the person need to be taken to A&E for illness or injury what action was taken.
- Details of the method of conveyance and the type of place of safety.
- Outcomes for the individual.

particularly as this is the only power the police have when a person is considered to need “immediate care or control”.

When a power enables a person who is not a mental health professional to detain a person using mental health legislation, it is vital that how it is applied is clear and easy to understand. It ensures that the human rights of individuals are not being infringed through inappropriate uses of the power, and it provides a mechanism for ensuring that frontline police officers can have confidence that they are making the same decisions as their colleagues across the country.

Our understanding is limited by the lack of a standardised process for recording how the power is being applied by police officers. We support the development of a monitoring form that is being rolled out across the country and may lead to improved monitoring of the use of section 136.

Triage pilots

Between 2013 and 2015, the Department of Health funded nine police forces to run triage pilot schemes. All pilots were based around the principle of a mental health nurse working directly with police officers to support people in crisis face-to-face, or provide support for officers in person or by phone.

The pilot period has now ended, with all schemes providing evaluations to the Department of Health. In addition, NHS England have commissioned University College London to provide an evaluation of the pilots, which started in February 2015. At the time of publication, funding is ongoing in nine areas, with at least 17 other force areas running their own schemes – around 26 out of 39 forces in England.

Feedback from local stakeholders in our local area inspections suggested that the scheme provides a positive outcome for all parties. The person receives support from a professional, the police are provided with access to expert advice, and the mental health trust can feel confident that people who are arriving at their health-based place of safety are likely to be those most in need. This aligns with the Mental Health Act 1983 Code of Practice that states, “When deciding that detention may be necessary, the police

may also benefit from seeking advice before using section 136 powers in cases where they are unsure that the circumstances are sufficiently serious for using these powers.”⁷¹

The triage schemes help to foster a spirit of closer working between the police and the mental health trust, and help to save costs through decreasing inappropriate uses of section 136. By partners working together it also embeds information-sharing across agencies. While the pilots have not been in place long enough to provide any data, early feedback from stakeholders is positive, with improved working between local partners for people in crisis.

We have seen evidence that models have been adapted to fit local need. For example, in Lambeth, where the trust covers a wide area, a mental health nurse is on hand to provide 24-hour telephone advice for police officers or face-to-face assessments at certain times of day. This means that if the person is known to the service the nurse can advise police.

In an period of financial pressure, it is important that evidence-based services are commissioned locally. Triage schemes should be subject to a full evaluation on completion to make sure that they offer improved outcomes for those coming into contact with the service, while providing local partners a solution that offers value for money.

Re-detentions under section 136

If a person detained under section 136 has been assessed as requiring further treatment, specialist mental health services need to meet their care requirements. As part of their recovery they are likely to be moved from an inpatient unit to the care and support of a community-based mental health team. It also makes it easier to integrate with any existing support networks.

This period is very important in helping a person to eventually stay well. As a result, it is critical that they have access to timely care that prevents their symptoms escalating if they feel they may be at risk of slipping back into crisis. Repeated use of section 136 for the same person may be a sign that local services do not have the right support mechanisms in place after discharge.

From our experimental analysis we found that in 2012/13, 12.6% of detentions under section 136 recorded in MHLDDS were followed by another detention under section 136 for the same person within 90 days. This reflects 1,216 instances where a person has been detained under section within 90 days of a previous detention.

Such detentions varied across the country. While some of this variation may be the result of inconsistent recording, the data suggests that in approximately a third (46) of local authorities no-one was subject to re-detention under section 136 within 90 days. However, it is concerning that across 10% of local authorities an average of one in five detentions was linked to another detention under section 136 for the same individual within 90 days of a previous detention (figure 20, page 80). Higher rates of repeat detentions may suggest that services are not effective in preventing further crises through appropriate assessments, follow up or support post-discharge to people.

Finding local solutions

Having been an early adopter of innovative approaches to improve the experience of people detained under section 136, key partners along the south coast have built on their early experiences to find tailored solutions that can work locally. These includes the use of a street triage scheme on the Isle of Wight and an alternate, dedicated transport options for people detained under section 136 in Hampshire.

On the Isle of Wight:

- Monthly usage of the section 136 power has fallen from 16 to 6.
- No person has been detained under section 136 in police custody since Sept 2013.
- All frontline staff have benefited from specialist mental health response training.
- 75% of sections 136 detentions have resulted in admission to a mental health hospital.

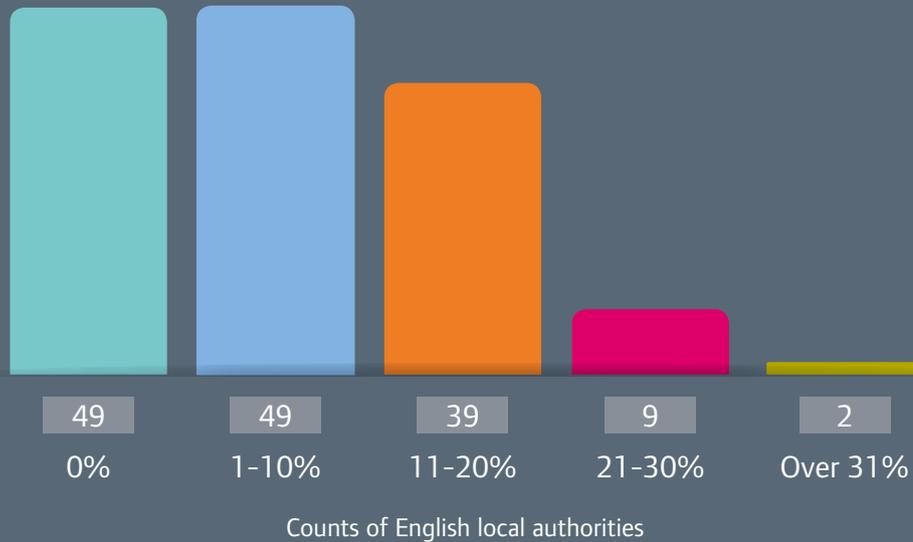
In Hampshire:

- A private ambulance service (Medisec) that specialises in the transport and care of those who have a mental health need is now used to look after people from the point they are detained under section 136 and throughout any time they require transportation or supervision whilst on the s136 pathway.
- Police officers are usually back on patrol within 30 minutes of arriving at an incident. A Medisec ambulance attends immediately and once a handover form is completed Police do not need to be involved further in the process, and are not involved in escorting a person to hospital.
- Medisec have transported over 500 people in the last year with no adverse incidents.
- People who may require expert help from a health professional can access it from the point of their detention.



Figure 20

Proportion of re-detentions under s136 within 90 days of previous s136 detention



Sources: MHLDDS 2012/13

CQC encourages:

- > Police forces to actively support the roll-out of the Mental Health Monitoring form and that information captured is used to help review the effectiveness of the local section 136 pathway.
- > A full evaluation of triage pilot schemes to determine whether they are appropriate and cost-effective option for improving the section 136 pathway.

People being taken to health-based places of safety

The NHS Mandate is very clear on the issue of parity between mental and physical health services. The issue of whether there is sufficient provision of health-based places of safety goes to the very heart of this debate. A key finding we reported in *A safer place to be* was that people were being turned away, or forced to wait for long periods with the police, because appropriate facilities were already at capacity or not available due to staffing problems.

In total, almost a quarter (24%) of mental health trusts did not feel there was sufficient provision in their local area. This was matched by findings that a quarter of all health-based places of safety were not accessible because the place of assessment was already occupied. Only 44% of places of safety could demonstrate that in 2013 their assessment room was never inaccessible due to it already being occupied. These figures raise serious questions over the provision and capacity of appropriate facilities to support people in crisis.

Linked to the issue of provision is whether people end up being taken to police stations instead of more appropriate locations.

“The police on the whole are sympathetic but I would like to be able to attend a hospital rather than a police station.”

Across the health and social care landscape, there has been a real push to reduce the number of people who end up in police custody. Data collected by the National Police Chiefs Council suggests that there has been a significant reduction in 2013/14. In 2013/14, just under a quarter (24.6%, 6,028) of section 136 detentions resulted in a person being taken into police custody (table 12, page 84). While this figure is still far too high, it is important to note that it represents a decrease in the number of times police custody was used of approximately 24% on the previous year (7,881).

Although we cannot provide year-on-year figures for reductions across all police force areas, we can see significant variation between police forces in the 2013/14 data. There were two areas where less than one in 100 people detained under section 136 ended up in police custody, whereas in another nine out of 10 people detained under section 136 were recorded as being taken to a police cell rather than a health-based place of safety (figure 21, page 82).

Ensuring adequate and appropriate capacity to meet local need

A 17-year-old was placed under section 136 and was not admitted to the child and adolescent mental health (CAMHS) section 136 suite as there were not enough staff to receive the young person. Another section 136 facility was persuaded to accept the young person after several hours in transportation. On arrival they found the suite was occupied and the young person was then transported to a another facility where they waited outside in the police car for four hours. Eventually they were admitted.

The decrease in the use of police custody may not mean that people are more likely to be detained under section 136 in dedicated places of safety based in mental health services. It may be that a desire to avoid using police custody has moved the pressure to elsewhere in the local system. In October 2014, the College of Emergency Medicine published a report examining the use of emergency departments to hold people detained under a section 136.* Over half of the emergency departments in England and Wales responded to the survey, which showed that 51% routinely received patients who

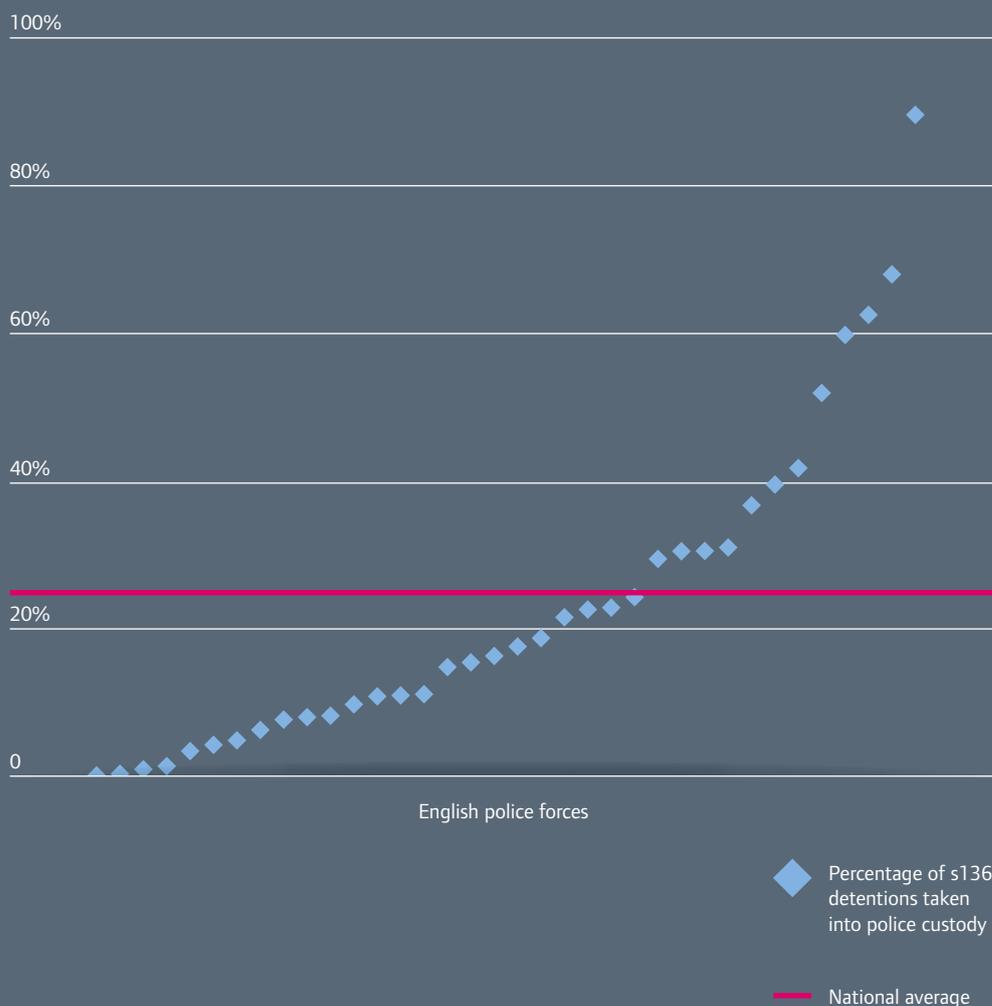
were detained under section 136 but did not have a physical health need. The findings also revealed that 14.4% of respondents said there was no dedicated section 136 suite in their area.†

Long-term solutions, and decisions around where detainees under section 136 are taken, must focus on the needs of the individual rather than the system. Routinely using A&E is not an appropriate alternative to the lack of a dedicated health-based place of safety.



Figure 21

Section 136 detentions taken into police custody in 2013/14



Sources: HSCIC and ACPO 2013/14

The following example from our call for evidence shows that, without a clear, agreed pathway for those in crisis, this can cause confusion among frontline staff who are attempting to implement what they believe is the correct policy:

“The lady police officer who helped me was amazing, she had my best interests at heart. However the A&E staff seemed to have a different understanding of whether hospital was a place of safety. There was also a lack of communication between the two services. In the end the police and nurse got into an argument in front of me.”

The revised Mental Health Act Code of Practice suggests that, when a dedicated place of safety is not available, there is nothing to preclude other areas of a psychiatric hospital (such as a ward) being used as a temporary place of safety. This temporary location must have a suitable environment for a person in crisis and be appropriate in the specific circumstances of the individual.⁷² This may be a preferable arrangement to the use of A&E departments.

In *A safer place to be* we reported that acute trusts are not represented on over a third of section 136 multi-agency groups across England. Without representation on local strategic groups that make decisions about the operation of section 136, it is possible that these concerns are not being raised at an appropriate level.

*† An investigation into care of people detained under Section 136 of the Mental Health Act who are brought to Emergency Departments in England and Wales, College of Emergency Medicine, October 2014.

§ CQC defines a ligature point as anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

Case study: The use of A&E as a place of last resort

During a local area inspection we were told that a health-based place of safety at the mental health hospital had been closed on a number of occasions. Staff were based on acute mental health inpatient wards and when there was staffing shortages on the wards, the section 136 was closed and people detained under a section 136 were taken to the local A&E unit. While the acute hospital had made the best use of the resources they had, it was not an appropriate location as it was not a designated place of safety and was not suitable for vulnerable patients due to the area containing free standing equipment, cords and a number of ligature points.§



Table 12

Number of section 136 detentions taken to police custody and health-based places of safety in 2012/13 and 2013/14 ^{*,†}

	2012/13	2013/14
Total s136 detentions in police custody	7,881 ^r	6,028
– s136 detentions for under 18s taken to police custody	263 ^e	236
Total s136 detentions in health-based places of safety	15,073 ^e	18,461 ^e
– s136 detentions for under 18s in health-based places of safety	317 ^{eu}	517 ^e

Source: HSCIC and ACPO 2013/14

We also had concerns about the provision of appropriate places of safety for children and younger people. We found that too many providers had policies that excluded young people from all their places of safety.⁷³ These restrictions created untenable situations where people under 18 were one and a half times more likely to end up in police custody.

However, there has been a major drive to reduce the number of children and young people in police custody. Between 2012/13 and 2013/14, the percentage of under 18s detained in police custody fell from approximately 45% to around 31% (table 12). This is a positive achievement, but it still means that nearly one in three people under 18 ended up in police custody rather than somewhere they could receive appropriate treatment.

Inappropriate use of police custody for adults is falling faster than it is for younger people. This means that, in 2013/14, the proportion of under 18s out of the total of all detentions who ended up in police custody actually rose. We welcome the Government's continued focus on resolving this long-standing issue, and Home Secretary Theresa May's announcement in May 2015 of new legislation to ban the use of police cells for children with mental health problems. The Government also announced £15 million to deliver health-based places of safety so that no person ends up in a police cell due to a lack of suitable alternatives.

* These experimental figures are expected to be an undercount. However, significant improvements have been made to local collection methodologies. For more details please see the reports and data quality statements for each release: www.hscic.gov.uk/pubs/inpatientdetmha1314 (2013/14) and www.hscic.gov.uk/pubs/inpatientdetmha1213 (2012/13).

† 'r' denotes revised figure to include an estimated 120 uses by the British Transport Police, which provided data for the 2013/14 collection but not 2012/13. Revised figures for other 2012/13 counts were not available and do not include figures for British Transport Police.

'e' denotes an estimated figure.

'u' denotes an unreliable figure (due to figures being unavailable for several forces).

**‘An event that will never happen’:
How the Pan-London Mental Health
Partnership Board is tackling the use
of police cells to hold people in mental
distress**

London is a fluid and transitory city. Alongside an estimated population of over eight million, it welcomes millions of temporary visitors every year, from tourists on vacation to commuters going to work. Its position as an international hub, and an arrival destination for many people from around the country, creates a unique set of pressures on its police and health service.

In this context it is remarkable that last year the Metropolitan Police recorded that no-one under the age of 18, and only 22 adults, with mental health needs were held in police custody, rather than be taken to a health-based place of safety.

The London Ambulance Service, along with three police forces (Metropolitan Police, City of London Police and British Transport Police) operate across the capital, but the same geographic area is covered by multiple mental health trusts and local authorities. Nevertheless a shared understanding has been developed that the use of police cells should be thought of as an ‘event that will never happen’. There is also a protocol for handling section 136 detentions.

The Pan-London Mental Health Partnership is driving this development, which is supported by the development of the London Strategic Clinical Network’s Mental Health Commissioning Guide. This guide outlines the standards required for commissioning appropriate services to people in crisis, which are in line with the Concordat. It also makes it absolutely clear that there should be contingency plans in place to manage times when there are multiple section 136 detentions.

CQC encourages:

- Local Crisis Care Concordat groups to make sure that data are collected on children and young people who are subject to a section 136 detention and that a review takes place when a child or younger person is placed in a location other than an appropriate health-based place of safety.
- Providers and commissioners to revisit the key findings from *A safer place to be* to make sure that they are planning sufficient provision to meet the needs of the local population, and that local organisations place a commitment to ensuring sufficient provision at any time, accessible to all, as part of their Concordat local area action planning.

Appropriate transport

“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”

(Concordat, pg316)

It is important that a person in crisis receives transport that is appropriate to their needs and arrives quickly. The assumption is that this will be through the NHS ambulance service, although private ambulance providers have been commissioned in some instances. We recognise that a person may need to be transported in a police vehicle where that is deemed appropriate.

Whatever form of transport is used, providers need to recognise that they are responsible for making sure that local arrangements preserve a person’s “dignity and privacy consistent with managing any risk to their health and safety or to other people”, as set out in the Mental Health Act Code of Practice.⁷⁴

In order to meet the spirit of the Code of Practice and reinforce the principles set out in the Concordat, ambulance trusts have developed special arrangements for section 136 incidents with the aim of responding within 30 minutes of receiving a request from the police to attend. Data collected from ambulance trusts for the first three quarters of 2014 demonstrate that this target was achieved in 67% of requests (figure 22).

The worst performing ambulance trust achieved this target in 30% of requests (22 percentage points below the next lowest performer). However, it should be noted that they also reported the second lowest number of response requests. Three of the four trusts with the highest numbers of police-only section 136 requests had above average performance. This may suggest that the more ambulance services attend section 136 requests, the more likely it is they may have considered how to optimise their responses.

We recognise that, without formal guidelines, existing clinical priorities will dictate response times, and that there will be occasions when an ambulance cannot attend within 30 minutes because they need to attend high priority emergency cases. Having it as a commissioned activity would help to ambulance trusts to configure their services to meet demand, alongside existing clinical need.

It is important that the data only records when ambulances have been requested by the police. Anecdotal feedback is that ambulance trusts are not always called to provide transport support. This may be because private providers are commissioned or in some cases because the police are using their own transport as a default option.

A 2014/15 project piloting the use of a new mental health data toolkit, which involved Thames Valley Police, Metropolitan Police and British Transport Police, recorded how people detained under a section 136 were transported. Out of 324 instances where the mode of transport was recorded, an ambulance was used less than half the time (42%) (table 13, page 88). While the pilot demonstrates improved data monitoring, and that organisations are working together to improve outcomes, it also suggests that police vehicles are routinely used to transport a person in crisis to a place of safety.

* This data covers 8 out of 10 ambulance trusts. Data was not available for two ambulance trusts. One trust included in the analysis returned data for only one quarter of 2014/15.



Figure 22

Ambulance trusts – proportion of police only s136 requests (Q1-Q3 2014/15) responded to within 30 mins



Sources: Association of Ambulance Chief Executives, quarter 1 to quarter, 3 2014/15

Table 13

Home Office Mental Health Toolkit Pilot, August to September 2014

Mental Health Toolkit Pilot – mode of transportation for s136s and reasons for using police vehicles

		s136 detentions	% (excluding blanks)
Transportation	Transported by ambulance	137	42%
	Transported by police vehicle	185	57%
	Not requested	2	1%
	Blank	79	-
Reasons for using a police vehicle	Ambulance refused to take	3	2%
	Ambulance not available in timescale	79	45%
	Risk assessment – client behaviour	52	30%
	Already at the place of safety	1	1%
	Other	40	23%
	Blank	11	-

The most common reason recorded for the use of a police vehicle was that an ambulance was not available within the timescale (45% of responses where a reason was provided). This suggests that once an estimated timescale is given, a judgement call is made by the attending officer about whether it would be more appropriate to transport the person in a timely or an appropriate way.

In 30% of cases where a reason had been given, the individual's behaviour was listed as a reason for transport in a police vehicle. There is not an established baseline that sets expectations for how frequently a police vehicle is likely to be required due to behavioural or other risk issues. We note that the Code of Practice states "If the patient's behaviour is likely to be violent or dangerous, the

police should be asked to assist in accordance with locally agreed arrangements. Where practicable, given the risk involved, an ambulance service (or similar) vehicle should be used even where the police are assisting."⁷⁵

During our local area inspections, we found that the transport of people in crisis appeared to vary between local authority areas. For example, in one area, an agreement had been put in place that the police would always request an ambulance to assist in the transport of a person detained under a section 136. However, in another area covered by the same ambulance trust, it was far more common for the police to use their own vehicles to transport people to a place of safety.

These variations may be the result of specific working relationships that have developed between the respective police forces and ambulance providers over time. It is important that local partners revisit processes to ensure that they maximise the privacy and dignity of the individual, while recognising other potential risks, and are aligned to the spirit of the Concordat.

In another inspection we heard that arrangements for transporting patients to places of safety were routinely monitored and issues discussed during multi-agency meetings. This was to help improve patient outcomes and make sure that transport arrangements were appropriate. We would hope that other local areas have similar protocols in place.

CQC encourages:

- > Agreement to be reached on a national data source for ambulance response times to section 136 requests. As requests received through the computer-aided dispatch system are logged electronically this may be the most appropriate source.

Mental Health Act assessments

The Mental Health Act states that “the maximum period a person may be detained under section 136 is 72 hours”, but the expectation is that “in practice, detentions should not need to be this long”.⁷⁶ It is worth remembering that only adhering to the 72-hour timeframe means that a person will be detained in severe mental distress for three times longer than a person accused of a crime is legally allowed to be held without charge in police custody.

This legal limit is very rarely breached, but organisations with statutory responsibilities for ensuring safe crisis care need to make every effort to make sure that assessments are carried out well within this timeframe. This is longer than timescales permitted under equivalent legislation in most other European countries and is something recognised in the Code of Practice’s proposal to reduce the timeframe of mental health act assessments to 24 hours.*

It is positive that 72% of places of safety have a target of less than three hours to begin an assessment. Although the majority of delays in beginning assessments outside of target times happened in the areas with shorter target times, it does still mean that the place of safety is attempting to operate well inside the statutory limit.

More concerning is that 9% of locations indicated they did not have a target, or operated within the maximum legal limit. Even if these areas are operating a highly efficient service, it suggests that they will not have stretch targets that encourage improvement towards the most responsive service to people in crisis. It also raises the question of whether the multi-agency group was providing effective oversight arrangements.

Reasons for delay

We recognise that delays in initiating Mental Health Act assessments may often be outside the direct control of the trust. Over 90% of places of safety said that section 12 doctors or approved mental health professionals (AMHPs) not being available were the reason behind their for delay.

If trusts have concerns over whether there are enough professional experts required to carry out Mental Health Act assessments within locally set timescales, they should bring this to the attention of representatives on the multi-agency groups.

* The Code of Practice already states that if it becomes necessary to take a person to police custody as a place of safety then “wherever practicable, detention in a police station under section 136 should not exceed a maximum period of 24 hours” (16.40, pg146)

Local authorities are responsible for ensuring that there are enough AMHPs to meet local need. Since local authorities are represented on 95% of section 136 multi-agency groups, it is vital that these meetings are used to raise awareness of pressures in the system.⁷⁷

Understanding the provision of approved mental health professionals across England

As part of the commitments made to the Concordat action plan, CQC and the Department of Health have been carrying out a review to the effectiveness of the current approach to national monitoring of approved mental health professionals (AMHPs). Stakeholder feedback identified that while data are collected locally, there is no requirement to report nationally and no standard approach to data collection. This contributes to the difficulty in producing a national picture on the provision of AMHPs.

The next stage of the review will look at whether the regulation of AMHP services could improve guidance and standardise approaches to monitoring and data, collection, helping to drive improvements for those requiring AMHP services.

A further concern is the lack of mental health bed availability. This has reached a point where pressure is being felt elsewhere in the system. CQC's *Monitoring the Mental Health Act 2013/14* annual report stated that the "mental health inpatient system was once again running over capacity. The number of available mental health NHS beds in Q4 2013/14 had decreased by almost 8% since Q1 2010/11."* This pressure may well be affecting those in crisis. In *A safer place to be* we found that 76% of places of safety indicated there were delays in completing assessments because there was no bed available, while 61% reported that AMHPs refused to start assessments until a bed was available.⁷⁸

Understanding the service

Providers reported that they have embedded mechanisms for monitoring equality information. While 98% of providers did so for age and gender, this fell to 83% for ethnicity monitoring and only 34% for information on disabilities.⁷⁹ Given the specific issues faced by equality groups, and considering the equality duty set out in the Equality Act 2010, all local areas should have mechanisms for collecting this information as a matter of course.

Collecting information might help the multi-agency group understand how the health-based place of safety fits within the local area, and how other local pressures may impact on the quality of its service delivery.

Table 14 outlines the percentage of providers collecting information about specific aspects of the place of safety's operation. The type of data collected does not indicate in itself whether a trust is well integrated into the local area. However, if trusts collect information, for example, on employment status, alcohol and drug usage or whether a person had responsibilities for children or vulnerable people, they will have a far richer picture of a person in crisis. They will be better placed to meet their needs and bring in appropriate services from across sectors.

* Infographic: Mental Health Act Annual Report 2013/14, CQC

Mapping health-based places of safety

In October 2014, CQC launched an online map of health-based places of safety. For the first time it was possible to see geographical coverage across England, along with important information about when they were open, what their capacity was and whether there were any access restrictions. The tool can be used in a number of ways:

- To help frontline police and ambulance staff find the nearest location that will accept a person in crisis.
- To enable providers and commissioners to better understand coverage in their region.
- To allow members of the public to find out about the availability and accessibility of services in their local area.

The online map of health-based places of safety is available at: www.cqc.org.uk/content/map-health-based-places-safety-0

CQC encourages:

- > Section 136 multi-agency groups to bring together local data from ambulance, police, local authority and mental health trust partners to build an end-to-end view of the operation of the section 136 pathway in order to identify service improvements.

Table 14

CQC health-based places of safety survey February 2014:
data collected by providers

Is data collected on:	% of providers
The outcome of the assessment carried out in the place of safety?	100%
Delays in initiating a MHA assessment for people brought to the place of safety?	88%
The number of people who are transferred between places of safety?	71%
How many times people are turned away from the place of safety?	50%
The reason people are turned away from the place of safety?	47%
Other protected characteristic(s)?	19%

Strategic working and commissioning of services

“I felt like an object, not a person. I was passed from person to person, organisation to organisation. Spoken about, not to. It took years and years of crisis admissions, section 136 sections, and endangering my life situations before I finally got the help I required.”

Background

Throughout the report we have highlighted the importance of local systems providing joined-up, integrated care that meets people’s expectations, and the key role of the Crisis Care Concordat in driving this change, both at a national and local level.

The Concordat makes clear that tackling mental health successfully is not something that can be achieved in isolation. Health services, social care services, police forces and the voluntary sector, along with other local partner agencies must work together to provide an effective person-centred response.

Commissioners need to commission evidence-based models of good practice that take into account the demography of the local area and the needs of the local population. They should use national strategies to make sure commissioning arrangements are aligned with national objectives, and make full use of commissioning guidance to inform their decision-making process.

Despite mental illness accounting for nearly a quarter of the total burden of disease, it is estimated that it accounts for only 13% of the total NHS budget. Research has also suggested that mental health trusts have seen an 8% real decline in their budgets over the last five years.⁸⁰

As it is likely that the pressure on health services will continue, it is vital that organisations work together to do more with less. Commissioners must take responsibility to make sure that providers are delivering the services that are being commissioned, and that these services are of a standard “they would be content for their family or friends to use if they needed it”.⁸¹

In this section findings from our local area inspections are used to look at how local areas are commissioning joined-up care, working towards a joint-strategic vision and an understanding of where improvements could be made.

Case study: Supporting people in crisis through closer working in Greater Manchester ⁸²

As part of a commitment towards more integrated working, a specialist mental health practitioner (supplied by the mental health trust) has been co-located with Greater Manchester Police. Their role is work with police and council staff to triage emerging risk, engage with individuals who are presenting demands on services and supporting the development of multi-agency care plans.

An evaluation of the first seven months of the programme have identified several benefits that can be realised as cost savings to individual services, alongside improved user experience through a reduction in the amount of interactions with local services. Among the individuals engaged in the programme there has been a:

- 15% reduction in volume of calls leading to a reduction in police demand.
- 20% reduction in the number of 999 calls to the North West Ambulance Service.
- 42% reduction in number of attendances at the local emergency department.
- 58% reduction in number of 'bed-days' for hospital in-patient admission.
- 50% reduction in call volume to the local crisis resolution home treatment team.



Shared vision and strategy

Using the Crisis Care Concordat as a driver for change

To encourage local services to work better together to provide effective, joined-up responses to people in crisis, the Concordat challenged key stakeholders to agree local area declarations by the end of 2014, and to work towards creating jointly-agreed action plans.

At the time of our local areas inspections, we found that all areas were developing Concordat action plans. Local Concordat groups had been set up and actions plans with clear dates for completion of objectives across partner agencies were in the process of being agreed.

We found local areas that had embedded oversight of the Concordat into senior programme boards to ensure that action plans were integrated into service delivery. In these areas inspectors reported that there was a “strong focus on multi-agency working” and that there were systems in place to make sure that “quality and progress along agreed action plans” was maintained. They also found that both staff and senior management understood the strategies in place.

All of the 152 local areas have developed publicly available plans, which commit local partners to specific actions to improve the quality of care. For example in Salford, Greater Manchester Police’s Safer Neighbourhood Team will work with mental health professionals to identify early interventions

for people with a mental health need, and learning from this will be rolled out across the whole of Greater Manchester. In Gloucester, housing and accommodation needs will be reviewed as part of the crisis pathway.*

The role of commissioners

Effective commissioning

Commissioners play a key leadership role in making sure people in crisis receive care quickly. Commissioners and providers must recognise their responsibilities towards delivering the Concordat, which expects that they “commission crisis care services that they would be content for their family and friends to use if needed”.⁸³

We recognise that agreeing systemic changes with local partners is difficult. However, we were pleased to see in our inspections that some areas understood and were aware of national strategies, and others were aware of national projects such as the street triage pilots, which they were using to inform the commissioning of their services.

We found a number of areas were moving towards a commissioning strategy focused around early intervention and prevention. This is in line with the core principles of the Concordat and demonstrates local areas taking a longer-term view of supporting people at the risk of crisis. However, it is important that organisations retain an appropriate number of beds that can be accessed in crisis in order to avoid the use of out-of-area placements. We heard concerns in some areas that were moving towards prevention about whether there were enough crisis beds.

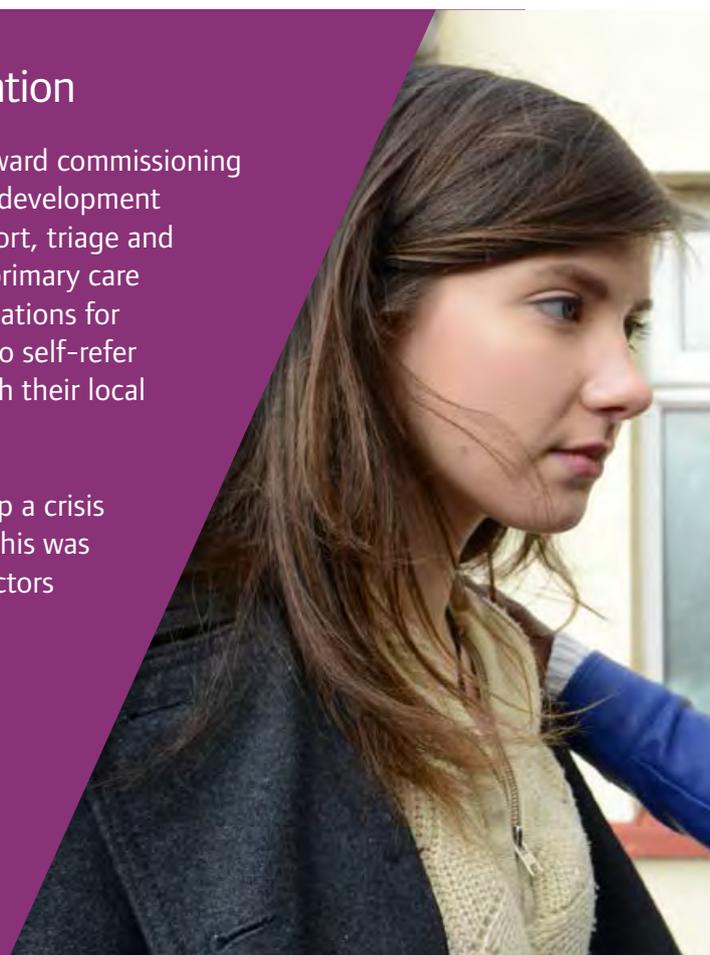
* Action plans, <http://www.crisiscareconcordat.org.uk/explore-the-map/>

Case study: Moving towards prevention

During one inspection we were told that a move toward commissioning preventative services was being driven through the development of a ‘hub service’. This sought to provide peer support, triage and housing advice services, which included referral to primary care services, social care services and voluntary organisations for specific support. From April 2015, people are able to self-refer themselves to the service, or can be referred through their local GP (with over 50% of GPs engaged in the service).

Commissioners were also in the process of setting up a crisis house, which would provide additional crisis beds. This was in response to concerns from colleagues in other sectors who felt that there were not enough beds available.

As well as developing a joined-up approach that focuses on identifying and preventing crisis events, this service also recognises the importance of making sure that there are enough crisis beds available for those who need it.



It is appropriate that commissioners explore transformative options that centre on the provision of community services, such as crisis houses. It is important that an evidence-based understanding of population need underpins the decision-making process, and recognition that meeting the Concordat principle of preventing a future crisis must not come at the expense of the availability and accessibility of the quality care when in crisis.

While we found that commissioners were aware of the Concordat and the key principles, we also heard about barriers that might impact on a person's experience of crisis. For example, local stakeholders may still think in terms dictated by their organisation's geographic boundaries. This can impact on the ability to deliver joined-up care in a way that considers the person at the heart of process.

In one area we found that the local acute and mental health trusts delivered services in two different local authority areas, but the commissioners had not talked to each other about the needs of the local community as a whole. They had not carried out a formal analysis of demand to look at how and where people accessed services, but had commissioned services based on the organisations' boundaries. It demonstrates a situation where commissioning may rightly be focused on meeting local population needs, but may not be offering services in the way that people would choose to access them.

Meeting local needs

During our inspections, we looked at whether commissioners understood the objectives of national strategies and if they had commissioned services based on the needs of their local population. Our findings present a mixed picture of commissioning arrangements, but it is difficult to comment on whether these services are truly representative of local needs as we heard very little about how commissioners are engaging people who use services in the development of local strategies.

We found evidence that services were being commissioned to meet the needs of people in crisis, and these took account of challenges specific to the local area's population profile. For example, in one area that contained a garrison, commissioners recognised "the challenges of meeting the needs of military and ex-military personnel", while in other areas we found that commissioners were aware of the challenges presented by "a growing population, and the needs of the Black and minority ethnic populations".

In general, the needs of the most vulnerable people were met, but where we identified gaps these often related to services for children and young people. For example, two areas we inspected had clear pathways of care for adults, but had issues with accessibility for children. In one area they could be "waiting for some time before a suitable place becomes available", while in another the child and adolescent mental health service (CAMHS) was "not able to see anyone after 11am".

In a number of areas, local stakeholders identified CAMHS as needing development. Examples given included 16 and 17-year-olds being admitted to adult wards, and one CAMHS lead stating that crisis services for young people had "never been commissioned comprehensively".

These examples highlight the concerns about accessibility and availability of services for children and young people, and reinforce the findings from our survey of health-based places of safety about whether there is appropriate provision for those under 18. They also suggest that there are still problems with some areas delivering of the same level of care for adults and children.

Alongside specific concerns around the commissioning of CAMHS, we also found that access to specialist support was more difficult out of hours in some areas due to the availability of staff. This had a particular impact on people with a learning disability, older people with cognitive impairments, and children and younger people.

More could be done to ensure that the needs of people from groups at risk of being vulnerable are taken into account. For instance in one area the local trust was reviewing its performance in relation to “people with characteristics protected by the Equality Act 2010”, but it was not clear how they were actively capturing the views and experiences of people from groups who may be vulnerable.

This was reinforced by feedback to the Race Equality Foundation which suggested that people from Black and minority ethnic communities felt that cuts to mental health services had left them feeling that “black mental health is no longer a priority”. On occasion, the provision and quality of service was reported as being down to one particular staff member or tied to a particular initiative, such as the Delivering Race Equality Programme. This means that when a funding stream or a person is made redundant then people who use the service could feel like they “were left high and dry”.

During our inspections, local areas provided evidence of their developed Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategy. This demonstrates that local authorities and clinical commissioning groups are meeting statutory duties. However, as they should form the backbone of evidence-led local commissioning, it is concerning that stakeholders made little reference to the role of these documents in the commissioning process when we spoke to them during our local area inspections.

The Concordat states the documents should provide a “framework for developing 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”.⁸⁴ It is important that commissioners recognise their potential for improving provision to meet the needs of the whole community.

Interagency working and coordination

Driving strategy through multi-agency working

Multi-agency working at a local level is at the heart of the Concordat’s vision. It sets an expectation 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”.⁸⁵

In the majority of areas we visited, we found a strong commitment to multi-agency working. We also found evidence that these groups were considering issues with local care pathways for people in crisis. For example, one area had a local forum that included representation from the Crown Prosecution Service (CPS), public health, police, ambulance and mental health services. These services worked together to map pathways and identify gaps in provision. In another area, multi-agency working had led to the development of parallel mental and physical health assessments in A&E to reduce length of stay, and a protocol with the prison service to ensure continuity of care.

In some aspects of crisis care these arrangements will already be in place, such as through the multi-agency groups with oversight of the operation of section 136. However, feedback from our local area inspections suggests there is some way to go before this approach is embedded in all aspects of crisis care in a local area.

During the local area inspections we held engagement events that invited key crisis stakeholders to discuss local service provision across organisations. Feedback from attendees suggests these events were welcomed, but in some areas stakeholders told inspectors it had been the first time they had been involved in such discussions. Following the development of local crisis care concordat groups we hope they will meet with more regularity in the future, and that all partners in the crisis pathway are encouraged to attend so they are able to take ownership of changes to local crisis provision.

Sharing information to keep people safe

The Independent Information Governance Oversight Panel's annual report recognised that changes to local health structures, introduced by the Health and Social Care Act 2012, led to "the loss of centres of expertise in information governance".⁸⁶ Having good information sharing protocols in place is an essential element in keeping people safe, and information about known risks to people who may be at risk of self-harm or suicide must be shared with relevant partner agencies.

During our local area inspections we found a mixed picture about organisations' abilities to share information. For example in one area, the RAID (Rapid, Assessment, Interface and Discharge) team could access information from both the acute hospital and mental health trust. This meant it was easier to find out about a person's medical history. In A&E, where electronic notes were not available, a risk assessment was filed in the A&E record.

However, in the same area we discovered that the CAMHS system was standalone. This meant that staff were unable to access records out of hours and led to assessments having to be carried out without access to all relevant information. Again, this highlights that crisis care for children and younger people varies. It also shows that even within a local area the quality of response is not of an equal level for those under 18.

NHS trusts that provide specialist mental health services are large, complex organisations and it is important that information sharing processes are maintained even as services are reshaped to meet the challenges presented by responding to the Concordat priorities within a tough financial climate. Through our call for evidence we were told that "community and crisis teams used to be part of the same team but now are separate entities, and frequently information gets lost or misinterpreted between them".

Healthwatch England special inquiry

The first Healthwatch England special inquiry found worrying instances when the lack of appropriate information sharing led to tragic outcomes.

They reported that, "[We] spoke to people experiencing mental health problems who were known to have engaged in self-harming and suicidal behaviour previously (and had usually been admitted for this reason). This information had been recorded on their notes, but on discharge were only offered a crisis support phone number, which proved to be an inadequate safeguard when they returned to their home. In a number of cases this led to a substantial escalation of crisis and in a couple of cases resulted in death."⁸⁷

CQC and information governance

CQC has a statutory duty to monitor the information governance practice of those we regulate. Our National Information Governance Committee provides expert advice on how we could embed this in our inspection activity. On the recommendation of the committee, we have developed a key line of enquiry surrounding information governance, which means it will be assessed in all inspections of health providers. This move has been welcomed by the Independent Information Governance Panel and the next challenge will be to demonstrate that our new monitoring arrangements lead to improvements in practice.

While information-sharing is vital to keeping people safe, it is also a key part of how local services should work together to provide a person-centred response. Continually having to repeat their personal history to new services was a common frustration for people in crisis. People may feel embarrassed by their circumstances or not feel comfortable talking about their feelings with someone they do not know.

The failure to share information was raised a number of times in the call for evidence. One person said that there should be “greater communication between crisis team and people who see/treat me regularly (i.e. my GP, support worker, therapist)”.

While a medical professional may need to ask some questions to ensure the person’s immediate safety, local partners should wherever possible – and always after gaining the consent of the individual – look to share information with relevant services so that they do not have to go through a detailed assessment on each occasion.

Local areas should have a standardised practice in place for sharing care plans with relevant local agencies to ensure that everyone involved in a person’s care is aware of what should be done in the event of a crisis.

Case study: Achieving ‘perfect care’ in Mersey

Mersey Care have a programme in place to provide ‘perfect care’ in order to reach the target of zero suicides by 2018. To do this, they have put in place a multi-stranded programme that realigns the trust’s focus on the issue. They are creating a dedicated ‘Safe from Suicide’ team that will be drawn from across the organisation and will enable advice, support and monitoring to be shared across teams.

They are also looking to upskill their staff with improved training in the most appropriate areas, such as the clinical skills needed to work with patients and those close to them in order to develop a ‘safety plan’. An essential part of the plan will be to identify clear ways that a person can receive help at any time of night or day.

Critical to the success of the plan will be to work with other providers and stakeholders in the local area. This is not just statutory bodies, but also voluntary sector organisations with significant expertise around talking to those at risk of suicide – such as CALM or Samaritans – and sharing best practice knowledge across key partners.



The importance of joined-up working in preventing suicide

This report has focused on how services interact with people in crisis. Suicide is an area where a person, who may or may not have been known to local health services, may have experienced a crisis that has escalated to its most tragic point.

Three areas in England have recently pledged to a 'zero suicide' ambition. It is an attempt to create an aspirational culture that challenges preconceived notions that suicides are inevitable events, while retaining a strong message to staff that it is not to be considered a failure of care. Each area is tailoring their actions to meet local need, but they share the vision of making suicide prevention everyone's business.

For example, in the South West this means:

"... [the trust] working closely with A&E to better identify and support people who present with suicidal thoughts or attempts [and exploring] ways of providing better mental health support for people once they've been discharged, regardless of which NHS service they've been in contact with."

While in the East of England there will be training provided:

"... to give police, paramedics, midwives and GPs greater confidence in talking to people who are in distress and help provide the care needed to keep them safe."



Conclusions

This report has shown that while there are key concerns with the quality of care that people experience during a mental health crisis, there is also room for optimism.

Through our local area inspections we found examples of staff who were committed to finding ways of working to make sure that people in crisis received help, care and support that was of the highest quality. We also found that local areas were breaking down the traditional barriers and were looking to provide joined-up, effective care.

At all levels there is a realisation that things have to change and agreement that the Concordat is the

framework that will enable the system to do so. Nationally, organisations like CQC have committed to working across the health and care system to embed the Concordat's principles and make it a reality for everyone, no matter where they live or how they try to access services.

We have already taken a number of steps towards ensuring that our inspection processes take into account the experiences of people in crisis, not just within traditional mental health setting but across all the providers we have responsibility for regulating and monitoring. However, we know there is still work to do and have identified a number of areas for change in 2015/16.

CQC has

- Selected crisis resolution home treatment teams and health-based places of safety as core services that will always be inspected as part of our comprehensive inspection activity for specialist mental health services.
- Introduced a specific focus on liaison mental health services and the provision of specialist emergency areas in A&E departments during the comprehensive inspection process for acute hospitals.
- Produced tools and guidance that will support inspections when problems in crisis care can be identified.
- Developed tools that enable assessment of the pathway of care and testing of multi-agency stakeholder meetings as an element of the evidence collection process.
- Published and consulted on a set of measures that could be used to monitor the effectiveness of crisis care and associated pathways of care.
- Shared analysis from the review with comprehensive review inspection teams for forthcoming inspections.

CQC will

- Evaluate the tools and methods developed for the review with a view to identifying their added value.
- Clarify our position on whether we should inspect a crisis service when it does not fall under CQC's definition of a core service and develop guidance and tools as relevant.
- Explore options for ensuring our inspections consider the issues of people who need specialist mental health care while in acute hospitals.
- Provide training for inspection staff on key review findings to increase knowledge, understanding and awareness across the organisations.
- Determine how and when a local area's Crisis Care Concordat declaration and action plan informs our inspection of providers.

We repeat our call for local providers and commissioners to take this opportunity to identify areas where they could deliver change that has a real impact for people who use their services at a time when they are at their most vulnerable.

All areas of England have now agreed local area action plans, which can be used to hold agencies to account. These action plans are central to changing the way that local agencies work together. If they are to be successful they require an agreed, shared vision and strategy that embraces the Concordat's key principles. They also need to be aligned to effective commissioning plans that recognise the needs of the local population.

All organisations interested in improving care should reflect on the key findings that have emerged from this report and the recommendations we make for representatives of local Concordat groups:

- The quality of care experienced by a person in crisis varied depending on where they lived and when they sought help.
- Many people have experienced problems in accessing help at the time they need it and in getting the right help when they have a mental health crisis. We found this reflected in:
 - The attitudes of staff towards people when they were in crisis. For example, staff judging people in crisis, not treating them with respect or compassion, or not taking the time to listen to carers' concerns.
 - The accessibility and availability of care at all times. This includes people being able to access the service they need at any time of day and night.

- The quality of services that are offered, and their responsiveness to people's needs. For example, whether services are following evidence-based models of good practice and are set-up to meet the needs of their local population.
- The implications for safety, particularly in risks associated with self-harm. For example, making sure that people are treated quickly and compassionately to prevent the crisis from getting worse or prevent them from hurting themselves or others.
- Across the country local services are developing innovative approaches to the challenge of providing a high-quality response to people in crisis. More can be achieved where these innovations work in partnership and services are integrated around the needs of the person in crisis.

We recommend that representatives of local Crisis Care Concordat groups:

- Ensure that pathways for crisis care are focused on providing accessible and available help, care and support for all those who require it at the time they need it.
- Hold commissioners to account for commissioning crisis services that deliver a quality of care based on evidence-based good practice and that is in line with the Concordat key principles.
- Engage with local, regional and national partners to make sure that innovative approaches to improving the experiences of those in crisis are shared within, and across, local areas.

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