Mental Health Crisis Care: The Five Year Forward View

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Overview

Parity of esteem

What are the challenges for people in crisis in 2015?

What is the model we are aiming for in line with the Crisis Care Concordat and Urgent and Emergency Care review?

What metrics do we have to measure the baseline and progress?

Where are the examples of routine good practice, innovation and transformation across the country?

What are the challenges for us, working with people in crisis in 2015?
Parity of esteem
<table>
<thead>
<tr>
<th>If I have a physical health crisis I ring 999 or 111 and get expert help</th>
<th>If I am in mental health crisis, I don't know what number to ring or where I should go to get help</th>
<th>If I have a physical health crisis and I go to my GP or A&amp;E, staff are trained to manage me well</th>
<th>If I go to my GP or A&amp;E in a mental health crisis, I have a 1:3 chance of being assessed and treated in line with NICE guidelines</th>
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<tbody>
<tr>
<td>I keep on getting assessed but no one offers me treatment</td>
<td>I may be brought to a police cell for a mental health assessment rather than a hospital</td>
<td>If I go to A&amp;E I have only a 45% chance or being assessed by staff trained to do mental health assessments</td>
<td>I am more likely to keep having to come back to A&amp;E in crisis when I don't get a meaningful response</td>
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<tr>
<td>I may end up in any of 14 different places to get help in crisis including police cells, transport police, duty systems in mental health and acute care, A&amp;E, home care.</td>
<td>If I am seen by a crisis home treatment team they are so busy that they can give me and my family less support than I need</td>
<td>If I need admission to a mental health bed in a crisis, I may have to travel hundreds of miles</td>
<td>If I am from the BME community my crisis is likely to be responded to by police, not healthcare</td>
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A glimmer of hope?

- Political commitment
- Mental Health in the 5YFV
- Crisis Care Concordat has brokered new collaborations across the country
  - Leaders
  - Coproduction
  - Information & Intelligence
  - What good looks like
  - Communicating a compelling narrative
Transforming urgent and emergency care services in England
Update on the Urgent and Emergency Care Review

Mental health crisis care: commissioning excellence
A briefing for Clinical Commissioning Groups
November 2012
mind.org.uk/crisiscare
The Mandate established specific objectives for the NHS to improve mental health crisis care. The government expects:

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

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

- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in this Concordat.
- Access to support before crisis point
- Emergency and urgent access to crisis care
- Quality of treatment of crisis care
- Recovery and staying well
The case for change for mental health crisis care: key summary

The clinical case:
- In physical health a person in crisis can ring 999 or 111
- In mental health we often do not have a single access number and there are 14 different confusing access points which include GP, police stations, mental health community and hospital based services, A&E
- There are evidence-based safe, effective service models & RCPsych peer accreditation standards
- The problem is not the lack of evidence:
  - there is major variation in commissioning and provision
- The mental health crisis demand is rising as fast as A&E demand, and needs to be included in System Resilience programmes
- We are now seeing a decommissioning of best care services, rising suicide rates & greater A&E demand
- The patient experience is less good than it should be

Good news: There are robust well established standards and evaluated improvement programmes we can put in place over the next 5 years to drive transformational improvement with an economic impact
The case for change for mental health crisis care: key summary

The economic case

- The lack of a clear accessible evidence based crisis pathway for mental health is costing lives, but also providing poor value
- The poor economic outcomes are
  - People with mental health problems use hospital emergency services x5 more than other patients
  - They use ambulance services more
  - They are frequent repeat attenders to A&E
  - They have high rates of admission to acute trust beds
  - They have high rates of admission to care homes

- LSE have undertaken economic modeling and there is a compelling case for change in the case of
  - Tele triage services, crisis home treatment teams, liaison psychiatry in A&E and acute trusts
What is the NHS England model for mental health crisis care?

agreed in line with Crisis Concordat & the Keogh Urgent & Emergency Care review
1. **Prevention - focus of all agencies**
   - Identification of the causes of MH crises & prevention
   - PH, Health & Wellbeing Boards, CCGs, transport, police, housing, social care

2. **Single point of access**
   - Single telephone number to ring? **111**
   - All agency response, GPs, social care, NHS

3. **Tele-triage and tele-health well trained staff**
   - May reduce face to face need by 40%
   - Responds to police & other referrers

4. **S136 places of safety**
   - Street triage

5. **Crisis Home Treatment Teams**
   - reduce admissions and length of stay

6. **Liaison psychiatry**
   - in A&E & acute trusts
   - reduce admissions and length of stay

7. **Crisis houses & day care** as alternatives to admission

8. **Adequate acute beds when needed**
Mental health has no data to help commission locally appropriate services NOT TRUE

Mental Health Intelligence Network
http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data
<table>
<thead>
<tr>
<th>CCG/ LA area local characteristics</th>
<th>City/urban/rural/deprivation characteristics</th>
<th>Hot spots for crisis events, e.g. suicides, transport hub, mobile populations</th>
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<tbody>
<tr>
<td>Governance</td>
<td>Crisis Concordat multi agency programme board established</td>
<td>System resilience Board: MH lead on it</td>
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<tr>
<td>Do you have in place:</td>
<td></td>
<td>Urgent care networks: MH lead?</td>
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<tr>
<td>Concordat action plan developed</td>
<td>Have you agreed local standards</td>
<td>Have you waiting times in line with national standards</td>
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<tr>
<td>Access standards agreed</td>
<td>What has each agency committed to in the Action plan</td>
<td></td>
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<tr>
<td>Directory of Services</td>
<td>Have you got a DOS with the key Local Govt, 3rd sector, NHS &amp; other CQC registered services: helplines, psychological therapies, bereavement, relationship in and out of hours Benchmark in and out of hours the reasons for the crisis calls &amp; response in place</td>
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<tr>
<td>111 / Single point of access</td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>Tele triage &amp; tele health Service with trained workforce</td>
<td>Yes/No: Does your single point of access include:</td>
<td>GP in &amp; out of hours MH crisis response</td>
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<td></td>
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<td>Social care, Housing, Carer crisis response</td>
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<td></td>
<td></td>
<td>Street triage police and/or Transport hub triage services</td>
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<td></td>
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<td>Ambulance hub triage</td>
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<td></td>
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<td>Liaison &amp; diversion triage for custody</td>
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<td></td>
<td></td>
<td>Alcohol and drug services</td>
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<tr>
<td>Crisis Home Treatment team</td>
<td>Is the team commissioned in line with local need</td>
<td>Does the team operate to the ‘Fidelity’ criteria</td>
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<tr>
<td>Liaison Psychiatry</td>
<td>Is the team Core, Core Plus, enhanced, comprehensive</td>
<td>Was the person a 4 hour breach</td>
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<td>What is the team’s RCPsych peer accreditation PLAN network standard</td>
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<td>Crisis houses / day</td>
<td>Yes/No</td>
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<tr>
<td>Inpatient</td>
<td>Bed occupancy</td>
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Summary of progress to date and the route map

The care of people in mental health crisis

Geraldine Strathdee

What is the current baseline in England

– We have the data and need to now produce CCG by CCG reports
– We need as a priority a ‘State of England’ mental health acute care pathway and crisis care
– Economic remodelling tools as were used in London
– Evaluate the current front runner case studies - NTW, NWL, South West

What are the Big Transformation ideas that can deliver at pace

– Implement spend to save liaison psychiatry to reduce admissions, OPC attendances,
– Implement spend to save Crisis home treatment teams to reduce admissions, LOS.

What is NHSE doing in 2014/5 to expedite

– We have been working on plans in the SCNs, and AHSNs, and with DH/MIND concordat programmes
  with 25 community agencies engaged

Where could the financing come from

– Maximise +++ prevention of crises which is possible with work with police, fire chiefs, housing LGA,
  tele triage
– A great deal is spend to save reengineering, estate sales, bed and OPC reductions with money into
  CCG commissioned care

What do we need to do to commission

– We have a draft expert commissioning pack that needs a governance process
– We will be providing commissioning training to 200 CCG MH leaders
– We need NHSE revised MH governance process and a MH crisis care SRO
Prevention

Tackling causes

Building health literacy

Employers: ‘win win’
Family friendly, productive positive employer practice
Increases productivity & reduces sickness absence

Schools: 4 Rs Reading, writing, arithmetic & Resilience
Building resilience, addressing dyslexia & learning styles
Training school nurses & form tutors, engaging school governors

College students:
Building resilience & physical & mental health literacy

Parenting programmes; ‘the statin of mental health’

Transport
Preventing isolation in older people
Reducing avoidable suicides & Reducing transport hub detentions

Fire chiefs
70% of avoidable fires due to untreated mental illness

Police commissioners
Safer neighborhoods
Alcohol: serious strategy needed
Direct access & tele triage and tele health

Evidence of best value for commissioners

Tele triage by skilled trained staff person centered and economic benefits:

- Access rates and times
- Provides care to a person in their home
- Especially effective in rural areas
- Reduces the need for face to face contact by 30-40% if there is a well kept up to date Directory of Services
- Enables reengineering of estate
- Is more eco friendly reducing carbon footprint through travel

Best Practice Case examples:
- Northumberland, Tyne and Wear has band 4 tele triage staff sitting alongside band 6 tele health trained staff
- North West London Urgent Advice lines
Crisis Resolution and Home Treatment teams

- CRHTs are rapid response teams operating 24/7 when commissioned & provided well

- These are the backbone of mental health and why we have been such a successful leading sector in closing hospital beds until HSC act and recession challenges changed the incentives

- The evidence base for CRHTs is robust

- But 37% are not commissioned 24/7

NHS England governance

CRHTs need to be included in the Seven Day Working and Urgent & Emergency Care programmes
### Liaison psychiatry for acute trusts

<table>
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<tr>
<th>Baseline Key facts summary</th>
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<tr>
<td>• Liaison psychiatry teams have an expanding evidence base demonstrating clinical and cost effectiveness</td>
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<tr>
<td>• 45% of acute trusts now have a liaison psychiatry service</td>
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<tr>
<td>• There are clear standards and ‘fidelity’ criteria for optimal safe, effective care and commissioning value &amp; an accreditation network</td>
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<tr>
<td>• Benefits through reduced readmissions and length of stay</td>
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<tr>
<td>• As well as the crisis care pathway they accrue benefits in other areas – LTC, MUS</td>
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<tr>
<th>2014/15</th>
<th>Announcements that can be made:</th>
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<tr>
<td>• Liaison psychiatry to be included in the NHSE 7 day service review</td>
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<tr>
<td>• <em>Liaison psychiatry teams have been commissioned or capacity increased as part of the Better Care Fund and winter pressures monies and System Resilience funds</em></td>
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<tr>
<td>• £40 million access funds includes commissioning of more liaison psychiatry teams &amp; a workforce development programme</td>
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Sometimes a crisis does require a bed

The NHS England Beds Time Series shows that

- From 1988-2010 there has been a reduction in beds from
  - 67122 in 1987/88 to
  - 25503 in 2009/10
- The bed number continues to reduce and in
  - Q1 2010: there were 23,515 beds (April to June that year).
  - By Q4 2011: there were 22,268 available beds
  - Reduction of 1247

In 2012/2013, demand for acute beds rose for the first time in 10 years
Sometimes a crisis does require a bed

The Commission on Acute Adult Psychiatric Care – Royal College of Psychiatrists

- The number of patients in England travelling out of their local area for emergency mental health treatment more than doubled in two years from 1301 in 2011/12 to 3024 in 2013/14. One person was sent 300 miles, from Devon to West Yorkshire.

- A 2014 analysis of English coroners’ reports found that seven suicides and one homicide were linked to a psychiatric bed not being available between 2012-2014.

- In Wales, psychiatric wards have been operating at above the RCPsych’s recommended figure of 85% occupancy every year since 2010/11.

- In a 2014 survey of UK psychiatric trainees, 24% said that a bed manager had told them that a patient would only get a bed if they were sectioned under mental health legislation.
An effective pathway to improve crisis care responses

**Access to support before crisis point**
- Tele triage and tele health
- Early Intervention Services
- Suicide prevention
- Personalised care budget
- Helplines
- Peer Support
- Help at Home
- Supported Housing
- Adult placement

**Urgent and emergency access to crisis care**
- ‘Parity’ between responses to physical or Mental Health emergencies
- Single point of access to specialist mental health services 24/7
- Crisis Home Treatment team
- Crisis and respite house
- Hospital Admission
- Effective Bed Management Pathway

**Quality of treatment and care when in crisis**
- Physical assessment and treatment
- Mental state assessment
- Safe, competent treatment at home wherever possible
- Timely ambulance transport to appropriate NHS Facility
- Access to Liaison & Diversion from police custody or Court

**Recovery and staying well / preventing future crises**
- Crisis Plan (NICE)
- Self management and family involved crisis plan
- All utilities working, food in house, debts and benefits sorted
- Transition to GP led care (with ‘fast track’ access back)
- Care and treatment (inc MHA, MCA, CPA)
What is it like to be a person in crisis in England in 2020?

**Access to support before crisis point**

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

**Urgent and emergency access to crisis care**

- If I am in mental health crisis this is treated as an emergency, with as much urgency as if it were a physical health problem.
- If I have to be taken somewhere, it is done safely and supportively in suitable transport.
- I am seen by a mental health professional quickly and do not have to wait in conditions that make my mental health worse.
- I then get the right service for my needs, quickly and easily.
- Every effort is made to understand and communicate with me, to check any relevant information that services have about me, and to follow my wishes and any previously agreed plan.
- I am safe and treated kindly, with respect, and in accordance with my legal rights. If I have to be held, this is done safely, supportively and lawfully, by people who know what they are doing.
- Anyone at home, school or work who needs to know where I am has been informed and I am confident that arrangements are made to look after anyone who depends on me.

**Treatment and care when in crisis**

- I get support and treatment from people who have the right skills and who focus on my recovery, in a setting that is suited to my needs.
- I have support to speak for myself & make decisions about my treatment & care.
- If I do not have capacity to make decisions about my treatment & care, any statements of wishes, or decisions, that I made in advance are checked & respected, & I am able to have an advocate.

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

- I, and/or people close to me, have an opportunity to reflect on the crisis, and to find ways to manage my mental health in the future, with support if needed. We have an agreed strategy for how I will be supported if my mental health gets worse in the future.
Challenges for 2020

- Money
- Technology
- Outcomes
- Patient experience
- Workforce development
Thank you for listening

www.cnwl.nhs.uk/liaison-psychiatry