Adult Social Care and Health
Overview and Scrutiny Panel

SCRUTINITY REVIEW: CARE OF PEOPLE WITH MENTAL HEALTH PROBLEMS IN TIMES OF CRISIS

February 2011
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task Group Foreword</td>
<td>3</td>
</tr>
<tr>
<td>Summary</td>
<td>4-6</td>
</tr>
<tr>
<td>Introduction</td>
<td>7</td>
</tr>
<tr>
<td>Terms of Reference</td>
<td>7</td>
</tr>
<tr>
<td>Methodology</td>
<td>8</td>
</tr>
<tr>
<td>Background</td>
<td>8-10</td>
</tr>
<tr>
<td>Mental Health Services in St Helens MBC</td>
<td>10-15</td>
</tr>
<tr>
<td>Findings</td>
<td>15-26</td>
</tr>
<tr>
<td>Conclusions</td>
<td>26-28</td>
</tr>
<tr>
<td>Recommendations</td>
<td>28-29</td>
</tr>
</tbody>
</table>
Task Group Foreword

The consequences of mental ill health touches us all every day whether we are aware of it or not and the effects on sufferers and their families can be devastating. We believe that as councillors we must support and safeguard good mental health and treat those affected by mental illness with respect.

This has been a wide-ranging and in-depth review of the care of those people with mental health issues in times of crisis. As part of its remit we have spoken at length with the different agencies, from the providers of mental health services to the voluntary and advocacy sector organisations in St Helens. We have also heard from the service users themselves and the carers of those service users whose needs are often over looked.

Whilst undertaking this review we found there was a great deal of excellent work carried out and a huge commitment amongst the statutory and voluntary agencies to make sure those who suffered a mental health crisis were given the best possible help available. However, whilst good work is being undertaken we recognise needs are changing. During the course of this review we noted a number of gaps in some of the services provided. This of course can be very upsetting for all involved and we have acknowledged this by highlighting those areas which we believe cause concern for mental health users and their carers. Our remit is to improve on good practice and identify any gaps and we hope that our recommendations will go some way towards achieving this.

We would like to thank all the people we spoke to during the review for their knowledge, expertise, input and honesty. We recognise that this is an extremely emotive subject and we would like to say an extra thank you to those service users and carers who came and spoke about their own, often painful experiences.

Finally we would like to thank John Edwards the Service Manager for Mental Health, Adult Social Care and Health, for his invaluable support throughout the review process.
Scrutiny Review of Care of People With Mental Health Issues in Times of Crisis

Summary

What we wanted to do:

Most of us have had some experience of mental health problems through family, community or work and because of this we wanted to look at how people who are suffering from mental health issues are helped in times of crisis.

We wanted to find out if crisis services were meeting the needs of the people and if they were easily accessible and effective.

Who did it?

The Adult, Social Care and Health Scrutiny Committee appointed a task and finish group to look at the topic

Councillors:
Suzanne Knight
Patricia Martinez-Williams
Janet Sheldon

Co-optees
Roman Babij – St Helens Local Involvement Network (LINk)

Officers from the Council who assisted the Task Group
Barry Fitzgerald – Assistant Director Care Management
John Edwards – Service Manager for Mental Health
Joanne Heron – Scrutiny Manager

<table>
<thead>
<tr>
<th>What we found out…</th>
<th>What we recommended…</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is still confusion as to individual definitions of crisis. Service users and carers have their own view of what they believe constitutes a crisis whilst the different agencies who deal with these can only work within their own definitions. Whilst we appreciate the complexity we believe that clearer explanations will go someway towards improving the</td>
<td>That access to mental health services via Open Mind be further promoted amongst relevant agencies and the possibility of developing a streamlined one point of call, which would be available both during working and out of office hours for those suffering a mental health crisis be investigated further.</td>
</tr>
</tbody>
</table>
Communication gap between service users and mental health services.

We heard that there was sometimes confusion and poor communication about how people get to where they want to be and access the right information. This was particularly noticeable in cases where a person was previously unknown to mental health services.

There appears to be confusion around people knowing where to get correct information from. A service user may self refer to the ‘Open Mind’ service. If a service user is not known to the team or not on their list, they do not always respond themselves and ask the person to contact either their GP or the police, depending on the severity of the situation. It was felt by some that those service userss who were ‘new’ to the crisis team tended to receive a less helpful service.

Information sharing between different agencies continues to be problematic. There are still issues with accessing the ‘Otter’ System by the Emergency Duty Team which makes information sharing between the Local Authority and 5 Boroughs more difficult.

That the difficulties associated with the sharing of appropriate and relevant mental health service users information via the Otter System and access to data between the 5 Borough’s Partnership Trust and other partner agencies be resolved as soon as possible.

It was acknowledged that some crisis episodes could be avoided by being managed more robustly by agencies picking up early warning signs and intervening and offering support at an earlier stage. There were gaps in services available for short-term mental health problems, such as those brought on by life-changing events i.e. bereavement, divorce, redundancy. These service userss tended to bounce around agencies as appropriate help was not always found in long-term mental health solutions. There appears to be a lack of support generally for families following a suicide or bereavement.

That all primary care agencies be encouraged to pick up early warning signs of impending crises and intervene promptly by offering support at an earlier stage and that GP’s ensure that increased support is offered to those families affected by suicide or bereavement and are directed to palliative care if required.
<table>
<thead>
<tr>
<th>Improvements to services for those with a dual diagnosis (mental disorder with a drug/alcohol programme are required.)</th>
<th>That those service users who have or may have a dual diagnosis be recognised and actively supported and treatment for their mental health problems not be compromised by the fact they may also suffer from drug or alcohol issues.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of people with dual diagnosis can be difficult because their needs are often complex and often long-term. Closer working is important because a lack of insight or awareness that there is a mental health problem and/or acceptance that there is a problem with alcohol or drugs can mean someone easily loses contact with services</td>
<td>That those service users who have or may have a dual diagnosis be recognised and actively supported and treatment for their mental health problems not be compromised by the fact they may also suffer from drug or alcohol issues.</td>
</tr>
<tr>
<td>We heard that not all service users were aware of what was on their care plan and had not had access to it. Everyone experiencing secondary care should have a care plan which should be signed as per the guidance.</td>
<td>That all mental health service users who already have a care plan and those who get one in the future be granted full access and be made aware of its contents.</td>
</tr>
<tr>
<td>To date there has been little consistent monitoring or auditing processes to ensure the appropriate use and evaluation of Section 136, however we were pleased to hear that this is now to be undertaken by Merseyside Police. Details of how often this would reported on and to whom was yet to be established.</td>
<td>That all agencies involved in the use of Section 135 of the Mental Health Act 2007 and Section 136 of the Mental Health Act 2007 agree a joint protocol on the use of this section and that the use of these Acts be monitored and audited to ensure appropriate usage.</td>
</tr>
<tr>
<td>Whilst there has been generic mental health awareness training among Merseyside Police, lack of awareness remains an issue.</td>
<td>That community support officers and police officers, including control room staff and firearm officers, link with local mental health services to develop joint training packages for mental health awareness issues.</td>
</tr>
<tr>
<td>We heard that there was a lack of consistency relating to the understanding of the Mental Capacity Act (2007) by partner organisations and were therefore pleased to hear that the PCT were currently in the process of rolling out joint awareness training around this Act for all relevant agencies.</td>
<td>That the possibility of developing the voluntary use of ‘Alert Cards’ for service users and their carers be investigated further.</td>
</tr>
<tr>
<td>The possibility of developing an ‘Alert Card’ containing contact details etc for mental health users was discussed. It was felt that this should be on a voluntary basis but could assist those agencies dealing with someone who presented themselves with a mental health</td>
<td>That the possibility of developing the voluntary use of ‘Alert Cards’ for service users and their carers be investigated further.</td>
</tr>
</tbody>
</table>
1. **Introduction**

1.1 During 2010 following several suggestions from the Scrutiny Annual Workshop and concerns from local councillors we carried out a scrutiny review to look at how people who are suffering from mental health issues are helped with in times of crisis.

1.2 Scrutiny agreed to review services for adults with mental health problems experiencing crisis and make recommendations for improvement in services where relevant. We did this by enlisting the help of John Edwards in the Adult Social Care and Health Department, 5 Boroughs Partnership, the Emergency Duty Team, PCT Commissioners and various service providers and a focus group of service users and carers. The task group’s work began in September 2010.

1.3 For the purpose of the review of task group focused on adults aged 18 to 65 living in the community and included people with functional mental health problems, e.g. depression, schizophrenia, etc but not people with organic conditions (e.g. dementia). We did not focus on adults residing in secure establishments.

1.4 Whilst undertaking the review, we were informed that the 5 Boroughs Partnership NHS Trust was reviewing how they deliver their service which could possibly result in a reorganisation of mental health services. To date, we were not aware of any future proposals.

2. **Terms of Reference**

- To interview and speak to staff and managers from key agencies including:
  - Primary Care Trust
  - 5 Boroughs Partnership NHS Foundation Trust
  - Knowsley and St Helens Hospital Trust
  - Community Health Services
  - Police
  - Adult Social Care

- To speak with service users and representative groups and voluntary organisations ie St Helens Mental Health Forum and Coalition for Disabled People.

- To interview and hold meetings with carers and representative groups i.e. St Helens Mental Health Carers Forum.

- To analyse records and performance information i.e. number of calls, speed of response etc and any associated strategy/research.

- To consider case studies from members own experiences.

- To consider mental health legislation and associated reports and guidance.
3. **Methodology**

- We met with John Heritage, Assistant Director, 5 Boroughs Trust and Julie Clarke, Business Manager, 5 Boroughs Trust and received a presentation about St Helens Crisis Resolution Home Treatment Team (CRHT).

- We visited the 5 Boroughs Peasley Cross Site and spoke with Julie Clarke, Bev Curtis (Crisis Team Manager), Ian Mountain (Modern Matron) and Mike Kenny (Assistant Director) from 5 Boroughs Partnership NHS Foundation Trust. We followed the meeting with a visit to the Section 136 Suite to observe the facilities available.

- We visited Heath Park Lodge and met with the Local Authority Social Inclusion Team, Making Space and the Coalition of Disabled People.

- We also spoke with the Lynne Hughes from Emergency Duty Team based at Widnes, and met with Lynne Marsden from the PCT.

- We held a focus group with St Helens Mental Health Carers Forum and a number of Service Users at the United Reform Church.

- We met with Hayley Sherwen the Mental Health Liaison Officer and Kirsten O’Brien, Public Protection Unit from Merseyside Police.

  We also examined the following key documents:

  - The Bradley Report
  - Policy Implementation Guidance (Crisis Resolution Home Treatment)
  - Mental Health Act 1983, 2007
  - Effective Care Co-ordination policy (5 Boroughs Partnership NHS Foundation Trust)
  - Department of Health - No Health Without Mental Health Strategy (Feb 2011)
  - CQC Patient Survey Report 2010

4. **Background**

4.1 The phrase ‘mental health problem’ is used in this review as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorder. Mental health problems may be more or less common, may be acute or longer lasting and may vary in severity. Some people object to the use of terms such as ‘mental health problems’ on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We are aware of these concerns and the stigma attached to mental ill health; however, there is no universally acceptable terminology that we can use as an alternative. A glossary including other frequently used terms is attached.

4.2 At any one time around one adult in six is experiencing symptoms of mental illness and one in four will experience mental illness during their lifetime. Mental illness is the largest single cause of disability in our society and costs the English economy at least £77 billion a year. (source)
4.3 Severe psychiatric illnesses are often episodic in nature, with stable periods of less intense symptoms interrupted by periods of crisis in which symptoms become intense. In recent years Crisis Resolution Home Treatment (CRHT) services have been developed to provide acute care for mental health service users living in the community and experiencing a severe crisis requiring emergency treatment. Previously, such treatment could only have been provided by admitting the service user to an inpatient psychiatric ward.

4.4 The introduction of CRHT services was one of the key elements in the 1999 National Service Framework for mental health; the NHS Plan (2000) made the provision of CRHT services a national priority; and the Department of Health’s (the Department’s) 2002 Public Service Agreement included targets both for the number of teams and the number of people treated. The main aim was to provide service users with the most appropriate and beneficial treatment possible. CRHT was also intended to reduce inpatient admissions and bed occupancy, support earlier discharge from inpatient wards and reduce out-of-area treatments (where a bed can only be found for a person in another locality).

4.5 Policy around mental health is continuing to evolve, in line with the Government’s emphasis on identifying what actually happens to the health of the patient - the outcome - as a result of the treatment and care they receive, as well as giving major importance to the voice of patients and service users, and handing GPs a key commissioning role. This is set out in the Department of Health new National Mental Health Strategy ‘No Health Without Mental Health’ (Feb 2011).

4.6 A consensus has emerged recently around broadening the focus of mental health from improving services to include public mental health and mental well-being. Mental health policy cannot be devised and implemented by any single government department or the NHS alone - it requires collaboration across central government, local government and the non-statutory sector.

4.7 Policy Context

4.8 We know that historically socially excluded groups are poor at accessing services, not least in engaging with primary care services which are in effect the gateway to secondary mental health services. The NHS has recognised this link and several recent initiatives focused strongly on addressing health inequalities in socially excluded groups. The White Paper ‘Our health, Our Care, Our say’ built on the foundations of ‘Choosing Health’ and identified issues affecting and arising from health inequalities.

4.9 The Mental Health Act 2007 has made several significant changes to the Mental Health Act 1983, which is the main legislation governing the care and treatment of people with mental disorders. Significantly, it provides the legislative framework for detaining people in hospital and for the assessment and treatment of their disorder against their wishes (Community Treatment Orders).

4.10 The Mental Health Act 2007 is more inclusive of all mental disorders and disposes of what was known as the ‘treatability test’. While clinical judgement remains paramount in decisions to detain and treat, the Act establishes the principle that personality disorder, as a mental disorder, is now a mainstream
condition requiring equal and appropriate consideration for assessment and treatment.

4.11 The Mental Capacity Act has been in force since 2007 and applies to England and Wales. The primary purpose of the Act is to promote and safeguard decision-making within a legal framework. It does this in two ways: by empowering people to make decisions for themselves wherever possible, and by protecting people who may lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process by allowing people to plan ahead for a time in the future when they might lack the capacity, for any number of reasons.

5.0 Mental health services in St Helens

What is a crisis?

5.1 In mental health terms, a crisis refers not necessarily to a traumatic situation or event, but to a person’s reaction to an event. One person might be deeply affected by an event, while another individual suffers little or no ill effects. It is not a 999 service. The questions the task group focused on throughout the review were as follows:

- What is the definition of a crisis as defined by 5 Boroughs Trust
- What is the professional view of a crisis according to the Policy Implementation Guidance.
- What is a service users/carers view of a crisis?

5.2 Mental Health Services in St Helens are provided by the PCT, 5 Boroughs Partnership NHS Foundation Trust (5BP) and the Local Authority.

5.3 At a primary care level (most depressions, anxiety, basic phobias, counselling services) services are delivered by GP’s and their surgeries and through the primary care team.

5.4 At a secondary care level (complex or resist depressions, severe and enduring mental illnesses, complex psychological issues) services are delivered in partnership between the 5BP NHS foundation Trust and St Helens Adult Social Care &Health department. Local Authority staff are seconded into the 5BP.

5.5 There is no separate social work team for mental health, social workers sit within the community mental health teams (EMI, North, South, Vista Rd, Assertive Outreach, Early Intervention, Crisis & Home Treatment) where they provide social care through the care programme approach. Services are delivered and Staff are managed within an amalgamated framework.

5.6 People within service are either on CPA (care programme approach) where they may have a care co-coordinator (Social Worker or CPN) as well as a Consultant Psychiatrist or they can be on Non-CPA where they might only have one worker usually a consultant psychiatrist.

5.7 Local Authority social workers have a number of statutory responsibilities including the approved Mental Health Practitioner (AMHP) who assess people
under the Mental Health Act 1983. In addition to this, the local authority provides support via:

- The Social Inclusion Team who work as part of the mental health network and the aim is to get people included in their own community;

- The Floating Support Team who work to support and maintain people independently in their own homes providing a lot of practical support and guidance.

5.8 St Helens services now follow a ‘Road to Recovery’ pathway and the initial access into services is via the Open Mind Service where referrals are made by GP’s, Primary Mental Health Team, Adult Social Care and Health other agencies or by individuals and carers. The team is made up of Practitioners, including Community Psychiatric Nurses and are based at Widnes. They will do an initial assessment and then refer on to the teams involved in that particular provision of service. They can also refer to the voluntary and independent sector.

5.9 The team covers both Halton and St Helens and operates from 9.00 a.m until 5.00 p.m. If help is needed outside these hours then contact is made via the Crisis Resolution Team (see below)

**Community Mental Health Teams**

5.10 St Helens currently has 3 Community Mental Health Teams that deal with around 400 people per team. The teams work hard to help reduce the need for further in-patient admission and treatment by working closely with GP’s and other healthcare professionals and providing care in the most comfortable and convenient way possible.

5.11 The service is for adults who have a severe and lasting illness such as schizophrenia and bi-polar disorder; people who need continued care and attention due to significant risks of self-harm or harm to others, e.g. acute depression or personality disorders; and people who have complex problems such as requiring support due to being subject to a section under the Mental Health Act (2007).

5.12 Together these people from both health and social care help deliver a co-ordinated care plan known as ‘integrated care’.

5.13 A community mental health team is central to the provision of treatment for individuals suffering from mental health conditions. There are several different members typically involved in forming a CMHT including a psychiatrist, community psychiatric nurse, social worker, clinical psychologist, occupational therapists, pharmacists as well as administration staff. The key benefit of this approach to treatment is that the patient's health problems may be tackled in a holistic manner as opposed to only receiving help for one area.

**St Helens Crisis Resolution Home Treatment Team (CRHT)**
5.14 St Helens Crisis team was set up following the NHS Plan (2001) as a team to provide crisis resolution by assessment, planning, intervention and resolution. St Helens Crisis Team stays intensively involved for as long as necessary for the immediate crisis to be resolved. The team also acts as the gatekeeper to the acute inpatient beds by assessing all people referred for hospital admission and facilitating early discharge.

5.15 The Team is based at Knowsley House in Peasley Cross Site, and provides multidisciplinary, community based services split into shifts working between the hours of 9 a.m. and 9 p.m. After 9pm, the team have on call arrangements 7 days a week, 9:00pm – 9.00 am

Pathway

5.16 Currently the pathway is for the service to respond to the following:-

- Referrals from Open mind service
- Contact from Local out-of-hours G.P. services for advice and signposting.
- Known service users open to community mental health teams
- Contact by the Senior Health Officers at A&E Departments where joint assessments are required for people who present there

5.17 The team provide a service for adults 16 years old and above with severe mental illness experiencing an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation may be necessary.
5.18 Following an initial assessment, individuals with the **following conditions are less likely to be offered home treatment** in order to focus our resources on those with the highest level of need.

- Mild anxiety disorders
- Generalised anxiety disorder,
- Panic attacks
- Physical Illness
- Brain damage
- Organic disorders
- Dementia.
- Learning disabilities. (Decided on the basis of individual needs)
- Hypochondrias
- Phobias
- Relationship issues.
- Obsessive-compulsive disorder
- Primary diagnosis of alcohol/drug or other substance misuse

5.19 Substance misuse and mental illness is very common and this is managed in times of crisis by accessing specialist help for some of the above where appropriate.

5.20 These are used as a guide. In urgent situations the decision to offer services is made in response to individual need.

5.21 There is an open referral system, including self-referral or referrals by other agencies, carers or families to ‘Open Mind’ and between Mondays to Friday 9am - 5pm. All referrals are screened and the Crisis Team is then contacted to provide an assessment based on need and risk. Access to the team during these hours is by professional referral only.

5.22 After 5pm and at weekends the CRHT receive referrals from service users open to services currently or out of hours GPs and Senior House Officers. (SHO’s). They can be contacted for advice and guidance, based on the outcome of this an assessment can be facilitated by the team.

(Appendix 3 sets out the Single Point of Access – Open Mind, referral process map)

**Emergency Duty Team (EDT)**

5.23 A joint Emergency Duty Team has been established for Halton and St Helens to ensure that statutory duties of the Local Authorities for both adults and children are met outside normal working hours. The service provides an emergency service for adults and children who are deemed vulnerable and are at immediate risk.

5.24 The service operates outside normal office hours at the following times:

- **Monday to Thursday**
  5.00 p.m. – 9.00 a.m.
- **Friday**
  4.00 p.m. – 9.00 a.m.
5.25 Professional independent and voluntary agencies, existing service-users, carers and anyone who is vulnerable and feels to be at immediate risk, can contact the EDT. The EDT staff will respond to emergency situations where the individual may need an assessment under the Mental Health Act 1983, 2007. They will ensure that the appropriate local policy and care assessment is used whilst maintaining awareness of the Mental Capacity Act 2007.

5.26 The EDT telephone line is staffed by Contact Centre advisors whose duty is to take initial details, including the telephone number of the caller and their specific concerns. This information will then be passed on to the Emergency Duty Social Worker who will decide on the appropriate course of action.

Heath Park Lodge

5.27 Heath Park Lodge is a resource centre in Thatto Heath for mental health support for people 18 and over who have experienced mental health problems and would like support to access educational and employment opportunities and voluntary leisure and social activities.

5.28 The teams based at Heath Park Lodge are:

- Social Inclusion Team – people accessing this have a care co-coordinator. The team help people to exercise choice and to plan thus developing confidence and self-esteem.

- Making Space Developing Options Service – This service encourages participation in socially inclusive activities including an allotment scheme.

- St Helens Mind – This is a voluntary organisation whose main service is a befriending scheme that puts those with mental ill health in contact with volunteer be-frienders who provide social support and encourage confidence and social networking. Mind also run a number of social groups, a successful allotment scheme and nationally they campaign for better mental health services.

Coalition for Disabled People

5.29 In 2000 the Coalition of Disabled people were commissioned to provide an Advocacy Service. The purpose of this service is to provide support, guidance representation and information for people who experience a Mental Health problem. This service is free, independent and confidential.

5.30 The aims of this service are to enable people with mental health problems to:

- Receive appropriate advice and support in order to raise concerns and make a complaint for themselves.
- Provide an advocacy service to assist with the signposting to other agencies.
- Progress concerns and complaints on behalf of service who are not able to fully participate in the process themselves
Merseyside Police

5.31 DC Hayley Sherwen is the Merseyside Police Mental Health Liaison Officer, which is jointly funded, by Merseyside Police and Merseycare NHS Trust. The role was established in 2002 and it continues to evolve. Hayley works with 5 Boroughs Partnership Foundation Trust, Cheshire and Wirral and Merseycare who jointly agree policies and procedures around information sharing, Section 136 and access and the promotion of mental health awareness training for police officers and the call centre.

6. Findings

6.1 We spoke to a number of organisations and individuals and looked at various national policy documents, whilst undertaking the review and felt that the best way to convey our findings was to group them into the following headings which discuss all the issues raised during all our interviews:

- Early Intervention
- Communication
- Mental Health Awareness Training for partner organisations.
- Dual Diagnosis
- Procedure for Self-Referrals
- Mental Health Act (Section 135 and 136)
- Individual Care Packages
- Out of Hours Services

6.2 Early Intervention

6.3 The “New Horizons” document outlined the incidence and outcomes of unidentified and untreated mental health problems in childhood and adolescence where the social and financial cost can be immense. Not getting help at the first sign of a problem can lead to emotional and behavioural disturbances at a great cost to the person, their families and society. This has now been superseded by the Department of Health Mental Health Strategy “No Health Without Mental Health” (Feb 2011)

6.4 Early interventions in severe mental illnesses such as schizophrenia and psychosis not only reduce the length and severity of the illness and disability but also are also very cost effective. Depression often originates in childhood and adolescence and earlier interventions to both prevent and treat depression in young people will also reduce the burden of mental illness in adult life. The sooner intervention takes place, the quicker the correct care package is identified.

6.5 In the examples we heard it was clear that in certain cases a crisis could have been avoided by being managed more robustly with agencies picking up early warning signs and intervening and offering support at an earlier stage. The crisis team could only deal with what they had been presented with.

6.6 Communications and Contacting the Crisis Team

6.7 Throughout the review it became clear that the definition of crisis could not be agreed by all— a person’s reaction to a situation will be different in each case
and therefore there are many ‘grey’ areas as to when services believe it is in their remit to intervene.

The 5 Borough’s Trust’s definition of what constitutes a crisis is:

Crisis Resolution and Home Treatment teams are part of a system for the response and assessment of a mental health crisis in the community with the possibility of offering comprehensive acute psychiatric care at home until the crisis is resolved, and usually without hospital admission.

Crisis teams provide an alternative to hospital admission for individuals with serious mental illness who are experiencing acute difficulties. In the moment of crisis involving mental illness, admission to hospital is not the only option. Intensive support can be delivered at home so as to maintain a focus on ordinary living, continue relationships with families, and allow the person to exercise choice and control over the type of help received.

Crisis Resolution/Home Treatment teams should be able to respond quickly to urgent referrals, for individuals with acute, severe mental health problems for whom home treatment would be appropriate, we provide community based treatment 24 hours a day, 7 days a week. We ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible.

Crisis teams remain involved with the service user until the crisis is resolved and the service user is linked to ongoing care.”

6.8 If a person feels that they are in a crisis the most important factor is to get help and support as soon as possible, regardless of whether or not this is the person's first mental health crisis or a relapse of an existing mental health condition. If the emergency happens in normal working hours then they should contact their GP, social worker or care coordinator involved.

6.9 When a person attends out of hours at the GP surgery or A&E, he or she will be seen by a doctor for an initial screening assessment of his/her mental health needs. From this, if it is assessed as appropriate, he/she will be referred by the doctor to the CR/HT Team for further assessment/treatment.

6.10 GP’s are the biggest referrers to Open Mind who assess the most appropriate level of intervention treatment. Open Mind was developed to help GP’s and they are tasked with deciding if a patient’s need is primary or secondary care. Open Mind receives around 40 – 70 referrals per day.

6.11 If a person is known to the Community Mental Health Team (CMHT) and the crisis is developing during normal office hours then the first point of contact would be the Care Coordinator or the Duty Worker. To assist this process, every patient open to 5 Boroughs services has an allocated Care Coordinator and a care plan. The care plan identifies the individual’s mental health needs and states interventions required to meet those needs. Within the care plan
there should also be a crisis/contingency plan which details signs that the individual is becoming unwell and what needs to be done to help that person. The CR/HT workers and Care Coordinators are frequently in touch to identify those patients who are becoming unwell and have a potential crisis which may require support outside of normal working hours. Therefore, the Care Coordinator is the key professional to ensure that patients are able to get additional help when and where they may need it.

6.12 Everyone receiving secondary mental health services would have access to or would have viewed their own care plan. However we were informed by services users and carers that this was not always the case. The Quality Care Commission’s Patient Survey Report 2010 highlighted this in their findings, however it must be pointed out that these findings relate to the 5 boroughs as a whole and not just St Helens.

Extracts below from Survey of people who use community mental health services 2010 (Care Quality Commission)

5 Boroughs Partnership NHS Foundation Trust

<table>
<thead>
<tr>
<th>Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been given (or offered) a written or printed copy of your care plan?</td>
</tr>
<tr>
<td>Do you understand what is in your care plan?</td>
</tr>
<tr>
<td>Do you think your views were taken into account when deciding what was in your care plan?</td>
</tr>
<tr>
<td>Does your care plan set out your goals?</td>
</tr>
<tr>
<td>Do the mental health services you receive help you to achieve these goals?</td>
</tr>
<tr>
<td>Does your care plan cover what you should do if you have a crisis (e.g. if you may need to be admitted to a mental health ward)?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crisis Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have the number of someone from your local NHS Mental Health Service that you can phone out of office hours?</td>
</tr>
<tr>
<td>The last time you called the number, how long did it take you to get through to someone?</td>
</tr>
<tr>
<td>The last time you called the number, did you get the help you wanted?</td>
</tr>
</tbody>
</table>

6.13 When speaking to a number of service providers and service users and carers, we heard of the confusion and problems that have occurred when the person in crisis is not known to the CMHT or if the crisis occurs outside office hours. In this case the first port of call would be the GP and if the surgery is closed there will be a recorded message stating an emergency contact. Alternatively contact can be made with the Emergency Duty Team.
6.14 Unfortunately some of the examples of case studies that were presented to us failed to show this joined-up approach.

**Extract from Patient Opinion Postings 2009 (5 Boroughs Partnership Trust)**

“I really do not understand access to the crisis team. I have a friend who has been in contact with mental health services for some time and has periods of crisis. We all know that crises don't just occur between 9 and 5. Yet whenever a crisis happens after 9 at night and this person asks to speak to someone, the answer is always 'you're not on the list so we can't contact them'. This happens even when there's a general knowledge that this person's having a few hard weeks. This isn't a one off event.

I can understand that they want to encourage people to get through crises themselves. And that one person's definition of a crisis isn't another's. But there must be a few people who members of staff have legitimate concerns about at any one time. Couldn't they have an additional list of people who aren't within the crisis team at that moment, but who might need quick access, or might not? Like a traffic light system - amber could go either way. Why does it seem like they don't want people to access their crisis service?”

**Extract from Patient Experience Survey (2010)**

“Not had many good experiences with my local crisis team in the past but I just wanted to comment on how well the service seems to be improving lately, there seems to be so much more consistency in what they say and do, the communication between them / other services and myself as a patient has got better and the overall service experience from a service users point has got a lot better.

I do want to thank them as well, I think people are aware that crisis team do get a bit of stick every now n then from peeps but they are really working hard given their case loads n staffing levels, and also a personal thank you from myself for the way I have felt treated by them recently, so supportive, non judgemental and overall professional about their work.

Keep up the good work!

Thanks St H Crisis Resolution Team.“

However, as the case study below indicates, improvements are being made and some service users are extremely satisfied with the service they received.

**Extract from Patient Opinion Posting 2010 (5 Borough’s Partnership Trust)**

“I have posted so far two negative posts regarding St Helens CRT, on behalf of friends.

I myself have also had my problems with the CRT in the past, and would usually refuse to let my care co-ordinator refer me to them when I was in crisis. However, not long ago I was referred into the CRT and was seen on a daily basis by the staff. I am pleased to say that my experience on the more recent occasion was much more positive than all my previous experiences.

I was listened to, had my feelings respected and every member of staff who I saw was caring, helpful and respectful. And with the care from the CRT being a more positive experience, I had more faith in them, I was more likely to call if I needed to, I was more able to be open about how I felt, and with their help I avoided a hospital admission. For the very first time, they made me feel better - which has definitely made me feel more positive about the team.
I am aware that other people are reluctant to feel the same as me... however, a friend of mine has also said that she has had a more positive experience with them within the past couple of months. I think it's important to highlight the positives, and not just to focus on the negatives... I also expressed my feelings to the CRT staff and their manager!

Thank you :)

6.15 In order to address this, we heard that the 5 Boroughs Trust were currently re-visiting all GP’s jointly with the Open Mind service and offering tailored training sessions for GP surgeries. It was felt that communicating with GP’s had always been problematic due to the number of them, the different approaches, their level of mental health understanding and expertise and the footprint of the borough itself. From the evidence gathered it became clear that there was an issue around the process and how well the different agencies understood this. A question put by the task group was “do all agencies really understand the process”? Information shared was not always understood.

6.16 In addition to the bespoke awareness session, communication issues were often discussed at the Mental Health Forum GP Forums which meet on a 1/4ly basis.

6.17 We heard that work was being undertaken on the Adult Social Care and Health web pages in order to direct people to the right service.

6.18 Dual Diagnosis

6.19 Dual diagnosis is a term commonly used to describe people who have a combination of mental health problems (such as schizophrenia, bipolar disorder or personality disorder) and alcohol or drug problems (also known as ‘substance misuse’)

6.20 It is not uncommon for someone with a mental health problem to also have problems with alcohol and drug use. Having a dual diagnosis usually involves more than the two issues of mental health and substance misuse. For example, issues can arise with physical health, social functioning, money and housing.

6.21 A psychiatrist makes the diagnosis of a mental health condition. It is important that during a mental health assessment the potential role of substance misuse is looked at. The symptoms of psychosis brought on by drug or alcohol use (‘drug-induced psychosis’) and psychotic illness can overlap and even mask each other making an accurate diagnosis difficult. If psychosis is an ongoing problem (rather than a one-off result of drug-use) it’s important to treat it, no matter what the cause.

6.22 How does dual diagnosis develop?

6.23 The relationship between mental health and substance misuse is complex and varies from individual to individual. The Department of Health has described four possible relationships:
A mental illness can lead to substance misuse. For example people using alcohol or drugs to ‘self-medicate’, because in the short-term they relieve symptoms eg hearing voices or help with side effects of medication.

The use of alcohol or drugs can make a mental health condition worse or alter its course. For example substance misuse may mask symptoms so when the use is reduced the mental health problem is revealed. This could have implications for treatment, as the sooner a mental health problem is treated the better the recovery/outcome.

Use of drugs or alcohol leads to psychological symptoms. For example alcohol is a depressant and can lead to low mood.

Substance use can trigger mental health problems. For example there is evidence that cannabis use increases the risk of developing a psychotic illness.

6.24 It is likely that a range of factors make some people more vulnerable to either or both mental health and substance misuse problems. This might include genetic factors, the impact of the environment someone grows up in or difficult or traumatic life events such as bereavement or abuse.

6.25 We heard that the Crisis Team would not carry out an assessment of mental health with someone who is intoxicated. Their intoxication makes it impossible to gain a suitable assessment. An assessment is not carried out until the person is sober. Breath tests similar to those for driving are given to establish the level of intoxication and there is a certain level the patient must come down to for assessment. If intoxicated patients leave before being assessed while sobering up the Crisis Team will follow them up for an interview. If the issue is due to drug or alcohol abuse history the Crisis Team will refer the individual to the appropriate agency and stop their involvement.

6.26 If someone is found by the Police to be displaying mental health symptoms or unusual behaviour the Police will take them into custody and escort them to the appropriate agency. However if an individual has physical injuries or issues the Police will take them to A&E to be treated for the physical issues before the mental health issues are addressed.

6.27 It is important to get the right medical assessment as soon as possible however difficult for professionals when presented with someone who under the influence of drugs/alcohol. The Department of Health guidance is clear that staff from mental health services should be equipped to treat and support service users with a dual diagnosis.

6.28 The Care Programme Approach (CPA) is the framework coordinating the care of people with complex mental health problems, including dual diagnosis. Guidance says that when a person’s care plan is drawn up detailing how their needs will be met, a risk management plan in relation to substance misuse should also be included. However this is further compounded for those with dual diagnosis as there is a current imbalance between resource provision for the treatment of alcohol and drugs, with much greater funding and provision being available for the latter.
6.29 Treatment of people with dual diagnosis can be difficult because their needs are complex and often long-term. An assertive approach is important because a lack of insight or awareness that there is a mental health problem and/or acceptance that there is a problem with alcohol or drugs can mean someone easily loses contact with services.

6.30 Procedure for Self-Referrals

6.31 Those in secondary care are given access to crisis services out of hours from 9am to 9pm and are provided with the numbers which are set out in Care Plans and Wellness and Recovery Action Plans (WRAP). Anyone known to the Crisis team are given access to a 24 hours service. Those not known to the Crisis team are referred to A&E. The Crisis Team cannot dictate to any GPs what to put on the answer messages for out of hours calls. Also the Crisis Team do not wish to make their number available on a GPs service to avoid becoming an emergency 999 service to anyone looking for a doctor in any distressing situation.

6.32 If a person presents themselves at A&E they will be triaged by the A&E nurses on duty. If it is felt that a psychiatric assessment is required then an on-call Senior House Officer (SHO) will attend. These officers cover both Knowsley and St Helens – a rough estimate of when they will be able to attend is given. SHO may have other service users to see so it could involve a wait. Usually if they are medically fit, according to the 5 Boroughs Partnership Trust around 90% of people are seen within an hour.

6.33 The crisis team undertake a joint assessment with the SHO and there are a number of options i.e. admission to the psychiatric ward, home treatment by the crisis team or signposted to another service.

6.34 The crisis team have changed their criteria and service users now need referring to the team rather than self-referring as was done in the past. Unfortunately there is still confusion with some GP’s, who still believe that anyone can ring and be referred the ‘old way’ There appears to be no straight path and confusion around people knowing where to get the correct information from. If a service users is not known to the team or not on their list, they do not always respond themselves and ask the person to contact either their GP or the police, depending on the severity of the situation. In other words it works well with known service users but there is sometimes an issue if a person is unknown to mental health services, especially out of hours. People can sometimes feel reluctant to go to their GP if their relationship with them had broken down.

6.35 Mental Health Act 1983 (As amended by Mental Health Act 2007) Sections 135 and 136 and Mental Capacity Act 2005

Section 135

6.36 Section 135 of the Mental Health Act 1983 allows an Approved Mental Health Practitioner to apply to a magistrate to issue a warrant authorising a police officer to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety.
Section 136

6.37 Part of the Mental Health Act 1983 (section 136) details removing a mentally ill person from a public place to a place of safety. It details police powers and the rights of someone in this position. There are occasions when the police may act if they think that someone is in need of immediate care or control. They have the power to remove someone to a ‘place of safety’ for their own protection, or the protection of others.

6.38 The task group found that the initial use of Section 136’s in St Helens was comparatively high, with only half of those initially sectioned being detained.

6.39 Section 136’s can tie up police officers for hours at a time, especially if the service users is under the influence of drugs/alcohol and needs to sober up. The use of Section 136 is a prime example of why the police and health services need to work so closely together. Once a person has been removed to a place of safety, the speed of assessment is further determined by the resources and willingness of local health and social services to attend within suitable time frames. We were informed that the police would like to develop an agreed protocol between all agencies on the use of this section to ensure waiting time is kept to a minimum.

6.40 Section 136 Suite

6.41 The Section 136 Suite is located in the 5 Boroughs Peasley Cross Site. It is only used when assessing people placed under at Section 136 by the Police and only in the St Helens area. There is a specific entrance and the police notify the unit when a person is on their way and is requiring an assessment as the suite may already be in use. Once there, a doctor and an approved mental health professional are requested to carry out a joint assessment.

6.42 Mental Capacity Act 2005

6.43 The Mental Capacity Act 2005 (MCA) provides a framework to protect vulnerable people over the age of 16 who are lacks capacity to make their own decisions. It makes it clear who can make decisions for people who are unable to themselves and in what situations decisions can be made. Capacity is assessed on a decision specific basis and the Act recognises that capacity is fluid concept.

6.44 For some people, symptoms during an episode of mental illness e.g. delusions, very high or very low mood, may mean they lose their ability to make decisions in a way they would when well. Prior to this Act, the law was complicated and out of date, but it now offers protection for people in a situation where they do not have the capacity to make certain decisions. It also offers legal protection for people who care for those lacking capacity.

6.45 We found that whilst a lot of training for the police, GP’s and other agencies had been undertaken, work still needed to be done to understand and effectively utilise both Acts and to facilitate a more effective joint agency approach. We heard that there was often resistance from both sets of professionals to fully utilise the Mental Capacity Act yet this was probably due to its complexity and the limited awareness of how it could be utilised.
Joint awareness training around the Mental Capacity Act for all the relevant agencies is currently being rolled out.

We heard that Merseyside Police regularly hold mental health liaison meetings whereby they meet with ward staff and unit managers. These meetings were extremely useful and good and bad practice is shared.

Out of Hours Service

The Emergency Duty Team (EDT) telephone number is a priority line and should always be answered within 30 seconds, even out of hours. All operators who take calls are aware of the remit of EDT and are trained to deal with callers in the first instance. The contact centre is run 24/7 every day of the year.

Sometimes a call may be manageable until the next working day and if so it will then be referred to other day time services.

Feedback from service users

The 5 Boroughs Partnership Trust works hard to get feedback from the users and carers and everyone using the service has an opportunity to be engaged. There is a Joint Service User Carer Forum held bi monthly attended by the Chief Executive and Directors who are available to answer any questions, however specific cases cannot be discussed in the open forum. These have recently been moved to monthly and venues will rotate around the Boroughs (2 x year for St Helens) In-house questionnaires are also distributed to all service users on wards and in community services yet no satisfaction surveys are carried out in respect of service from the crisis team.

The community mental health team have recently launched patient experience feedback. This service is well used and enables the trust to see what is happening in each of the areas. Issues raised here are fed into the Joint Service User Carer Forum and the Patient and Public Involvement Advisory Group. (PPIAG)

Whilst undertaking the review, the task group felt that it was extremely important to hear from those people who had had direct experience of how their own crisis had been dealt with or who had tried to help someone in crisis. The following are extracts from detailed case studies of examples submitted from St Helens Local Involvement Networks and the Mental Health Service Users and Carers Forum. We understand that there will be many people who are satisfied with the service they have received when in crisis and as a result have not felt the need to feedback to the various organisations.

Case Study 1 Monday 23rd August 2010 (LINks)

Got home, neighbour was stood at door, kids in street pointed out to me that she wanted me. Went over and she asks me in. Tells me that she’s really struggling mental health wise, and wants help, wants to be sectioned. I phone friend who says she will get me number of the ST Helens Crisis team. While waiting for friend to get me the number, neighbour tells me that she tried to cut her wrists and had thoughts about taking an overdose, (neighbour had been given a big bag of medication from her doctors, this bag was next to her), friend rings back with crisis team number. I
ring them, someone called S answers, I explain that neighbour is really struggling and having suicide thoughts, and I’m really out of my depth as to what should do.

Crisis team member says that they will not go out to visit without a referral from a doctor etc, as they would be being called out all the time. Neighbour tells me that someone from the Crisis team had been out to visit her a few weeks ago. I relay this back to CTM; he says that they would still need another referral to visit. I ask neighbour when the visit was – beginning of Aug, tell the CTM this and ask him to look for her on their system. He does and finds her record, says that the CTM who visited put a plan of action together for neighbour to sort out her Alcohol problems. I again explain about neighbour having suicide thoughts and I am really out of my depth. He explains that they can do nothing and the best plan is to wait till morning and take her to her doctors or if I am really worried take her to casualty. I really didn’t want to be on my own in car with neighbour whilst in this state, (neighbour has a history of attacking people).

Neighbour is still telling me things that have happened (death of sister, father dying, brother beating her up and the thoughts of wanting to be with her dead sister and wanting to be sectioned). I ask CTM to have a word with neighbour as I am now really struggling as to what to do, and pass phone over to her. She starts to explain what is wrong and how she is feeling, in the middle of the conversation the phone goes dead (either he has cut her off, or neighbour has managed to end the call).

The only thing I can then think of doing is ringing my doctors (we are both in the same surgery), explain to the receptionist, she goes away to get some advice, comes back and tells me to ring for an ambulance. Which I do.

In my opinion the Crisis Team are not a Crisis Team, this (again in my opinion) was a Crisis, someone having suicide thoughts, wanting to be sectioned etc, yet the CTM left a complete novice who said again and again that was out of their depth, to just deal with a neighbour who was obviously struggling.

Case Study 2 (Mental Health Carers and Service Users Forum)

C spoke about her son in crisis. Dr thought he had dementia. Her son wanted to be sectioned – he asked his mum. He begged his mum for tablets to end his life. The mum rang the crisis team at 4am in morning. She was told to ring another service. Asking if he was on the list – told her to contact GP emergency services. Dr asked her son if he was suicidal and ambulance was called to take him into hospital. Her son spoke to GP who asked if he had been drinking. They said because he was drunk, they could not see him. Her son was dead in next few days. Nobody contacted her son or his mum. The crisis team did not contact her at all. Her son was very ill, physically and mentally. He died in the caravan. She rang crisis team who said to call police and ambulance. She broke down the caravan door and her son was dead. He did have psychiatrist and CPN. She has together team now for support. She feels that there are not enough people in crisis team. But says there are good and bad people in crisis team. She wants now to help people so they do not go through same as her.

Case Study 3 (Mental Health Carers and Service Users Forum)

K – been under mental health services and felt that the crisis team were not consistent. She had taken overdose and ended up in hospital. Saw psychiatrist and
crisis team. The hospital said they would not admit her. No beds on iris ward. She went back to observation ward in Whiston and fell asleep. The tablets made her not know her legs were paralysed. She fell out of bed – broke her nose and jaw. She then went to Iris ward. She was physically aggressive and was released from hospital after 2 weeks still unwell. At home she said crisis team said she didn’t need them. She will now not ring the crisis team.

She now has support from ‘Together’. But cannot talk to her in a crisis. She is angry about this. She relies on D (from the carers group) to give her emotional support. She gets told there is nothing wrong with her (by the crisis team), but she is still on meds. Crisis team say she doesn’t need help and will not be given a CPN.

Case Study 4

Mr X was not known to mental health services. His wife was in the latter stages of a terminal illness and he was finding it difficult to cope and threatened suicide.

He was taken to the local A & E department by the Police (we understand under s136) but he absconded and returned home. The Police attended his home and because the Police and family were unable to gain support from the Crisis Team who were unable to help because he was unknown to services. The Crisis team did provide a Halton telephone number but when the call answered they were unable to help. He was then returned to A & E by the Police and a close family member also attended. Mr X waited for a number of hours in A & E with his family member and the Police. This situation was stressful especially due to issues related to his wife’s terminal illness and the amount of time they needed to wait. Despite requests for action and requested involvement of a Care Manager the involvement was of observation and not personal contact to assess any needs for Mr X and family member.

EDT (via St Helens Council) were contacted in the evening and they were helpful by telephoning A & E to ask for an update. The assessment was eventually co-ordinated and Mr X who by now was calmer, was admitted to hospital informally. Nevertheless, a distressed Mr X and his family waited in A&E unattended for a substantial period before being assessed. Mr X received support from in-patients and was discharged after a couple of weeks. Unfortunately although he seemed to be much better, shortly afterwards he did attempt suicide again and was re-admitted to hospital, this time under the Mental Health Act.

6.55 At the meeting with carers and services users it was stressed that the crisis team don’t always get involved when service users are admitted to the general wards for physical health problems whilst some staff on the general wards didn’t have experience of dealing with mental health problems. It was felt that the stress of admission with physical health issues onto a strange ward, could possibly result in mental health challenges. It was agreed that both the Crisis team and care coordinators needed to be more involved with the general wards.

6.56 It became clear that many service users relied on voluntary organisations and the peer support they got from attending groups. The Carers and Service Users Forum continues to ask 5 Boroughs to support / provide training /
provide a pathway for group leaders who are contacted by group members in a crisis. However to date, this has not occurred.

6.57 At a recent joint meeting of the 5 Boroughs Joint Service User Carers Forum it was confirmed that all people known to 5 Boroughs should receive an out of hours service. People not known, i.e. not on Otter, should still be assessed and screened with a next day referral into service if needed.

6.58 Concerns were also expressed around the crisis team complaints procedure, whilst everyone was aware there was one in existence many felt it was not useful in practice.

7.0 Conclusions

- There is still confusion as to individual definitions of crisis. Service users and carers have their own view of what they believe constitutes a crisis whilst the different agencies who deal with these can only work within their own definitions. Whilst we appreciate the complexity we believe that clearer explanations will go someway towards improving the communication gap between service users and mental health services.

- We heard that there was sometimes confusion and poor communication about how people get to where they want to be and access the right information. This was particularly noticeable in cases where a person was previously unknown to mental health services. We spoke to a number of agencies who themselves were unclear about the correct signposting routes and heard that a minority of GP’s didn’t always adhere to the agreed referral procedures. Many suggested that one set streamlined process/point of call should be available both during working and out of office hours. It was acknowledged in our meeting with 5 Boroughs that whilst awareness training had been undertaken with GP’s further work was required.

- Information sharing between different agencies continues to be problematic. There are still issues with accessing the Otter System which makes information sharing between the Local Authority and 5 Boroughs more difficult.

- In the examples we heard it was acknowledged that some crisis could be avoided by being managed more robustly by agencies picking up early warning signs and intervening and offering support at an earlier stage. The crisis team were only able to deal with what they had been presented with.

- There were gaps in services available for short-term mental health problems, such as those brought on by life-changing events i.e. bereavement, divorce, redundancy. These service userss tended to bounce around agencies as appropriate help was not always found in long-term mental health solutions. There appears to be a lack of support generally for families following a suicide or bereavement.

- We believe that crisis services should be more sensitive towards those people who consume alcohol or drugs as part of their self-medication. Throughout the review it became clear that despite the recognised high prevalence of dual diagnosis, mental health services cannot always meet these needs and can disadvantage those needing to access services for both
mental health and substance misuse/alcohol. Individuals needing both services have to access one service at a time, or even miss out on treatment altogether. This is further compounded for those with dual diagnosis as there is a current imbalance between resource provision for the treatment of alcohol and drugs, with much greater funding and provision being available for the latter.

- Treatment of people with dual diagnosis can be difficult because their needs are complex and often long-term. A more assertive approach is important because a lack of insight or awareness that there is a mental health problem and/or acceptance that there is a problem with alcohol or drugs can mean someone easily loses contact with services.

- There appears to be no straight path to referrals to mental health services and confusion around people knowing where to get the correct information from. A service user may self refer to the ‘Open Mind’ service. If a service user is not known to the crisis team or not on their ‘list’, they do not always respond themselves and ask the person to contact either their GP or the police, depending on the severity of the situation. In other words it works well with known service users but there is sometimes an issue if they are unknown to services, especially out of hours. We heard from the Mental Health Service Users and Carers Forum that people often feel reluctant to go to their GP.

- We heard that not all service users were aware of what was on their care plan and had not had access to it.

- Up to date there has been little consistent monitoring or auditing processes to ensure the appropriate use and evaluation of Section 136, however we were pleased to hear that this is now being undertaken by Merseyside Police.

- Whilst there has been generic mental health awareness training among Merseyside Police, lack of awareness remains an issue. Training should be cascaded across the force, particularly the control room staff that are often the first point of contact, and firearm officers.

- We heard that there was a lack of consistency relating to the understanding of the Mental Capacity Act by partner organisations and were therefore pleased to hear that joint awareness training around this Act for all relevant agencies was currently being rolled out.

- In order to share learning from previous experiences, we were informed that Merseyside Police regularly hold mental health liaison meetings whereby they meet with ward staff and unit managers.

- The possibility of developing an ‘Alert Card’ containing contact details etc for mental health users was discussed. It was felt that this should be on a voluntary basis but could assist those agencies dealing with someone who presented themselves with a mental health problem.

- During the review we heard about the experiences of carers and mental health service users and have highlighted a selection of these throughout the report. We feel very strongly that if the Crisis Resolution Team arranges an appointment with a service user/carer they should keep that appointment or if
this proves impossible, keep them informed and rearrange. To not turn up when there is a potential crisis situation is not acceptable. We have since been informed that in light of customer feedback new protocols to offer a window appointment have been implemented. This enables any urgent situations to be dealt with whilst still being able to maintain appointments. Staff are responsible for keeping this information updated.

- From these experiences a number of lessons can be learnt and we acknowledge the hard work which is being undertaken via the Patients Experience Survey to respond to comments/complaints and where possible act upon.

- We were particularly impressed with the facilities at the Section 136 suite at Peasley Cross and believed them to be a big improvement on previous arrangements.

8.0 Recommendations

Raising Awareness

1. That all primary care agencies be encouraged to pick up early warning signs of impending crises and intervene promptly by offering support at an earlier stage and that GP’s ensure that increased support is offered to those families affected by suicide or bereavement and are directed to palliative care if required.

2. That access to mental health services via Open Mind be further promoted amongst relevant agencies and the possibility of developing a streamlined one point of call, which would be available both during working and out of office hours for those suffering a mental health crisis be investigated further.

3. That community support officers and police officers, including control room staff and firearm officers, link with local mental health services to develop joint training packages for mental health awareness issues.

4. That both the Crisis Resolution Team and Care Coordinators be given the opportunity to raise their awareness by becoming more involved with the general wards

Communication

5. That the difficulties associated with the sharing of appropriate and relevant mental health service users information via the Otter System and access to data between the 5 Borough’s Partnership and other partner agencies, be resolved as soon as possible.

6. That all agencies involved in the use of Section 135 of the Mental Health Act 2007 and Section 136 of the Mental Health Act 2007 agree a joint protocol on the use of this section and that the use of these Acts be monitored and audited to ensure appropriate usage.
7. That all mental health service users who already have a care plan and those who get one in the future be granted full access and be made aware of its contents.

**Good Practice**

8. That those service users who have or may have a dual diagnosis be recognised and actively supported and treatment for their mental health problems not be compromised by the fact they may also suffer from drug or alcohol issues.

9. That the Crisis Resolution Team develop a Patients Experience System which allows mental health service users and carers to feedback their comments and experiences of the service and that these be used to further improve existing arrangements where appropriate.

10. That all appointments made by the Crisis Resolution Team be kept. If situations arise where this proves to be impossible, then service users are always informed of the cancellation and one is rearranged as quickly as possible.

11. That the possibility of developing the voluntary use of ‘Alert Cards’ for service users and their carers be investigated further.
Appendix 1

Glossary of Terms

**Advocate**
An advocate is a person who helps to support a service user or carer through their contact with all services.

**A&E - Accident and emergency**
A walk-in centre at hospitals for when urgent or immediate treatment is necessary.

**Approved Mental Health Practitioner**
A Social Worker specifically trained and approved by the local authority under the Mental Health Act 1983. Their role is to assess people who may require admission to hospital.

**Bipolar disorder (manic depression)**
A mood disorder consisting of very high and then very low changes in personality and behaviour.

**Care plan**
A signed written agreement setting out how care will be provided for people with more complex needs.

**Care programme approach (CPA)**
To assess the health and social (non clinical) care needs of people with mental illness and provide a package of care that ensures they get the full help and support they need.

**Carer**
A friend or relative who looks after an ill, disabled or older person on an informal, voluntary and long-term basis.

**Chronic condition**
A condition that develops slowly and/or lasts a long time.

**Service users**
Someone who uses health services. Some people use the terms patient or service user instead.

**Commissioning**
The purchase of specialist health services for a particular community or geographical area. Most mental health services are commissioned by primary care trusts.

**Community healthcare services**
NHS services provided outside of hospital.
Community mental health team (CMHT)
A team of workers from different health and social care professions who work together to help people recover from mental health problems.

Mental health difficulties can be caused by physical, mental or social conditions, and you may need help with different areas of your life, requiring lots of different skills. This is why different professionals work together in a CMHT.

Community psychiatric nurse (CPN)
Specialist nurses who work within local communities to assess needs as well as plan and evaluate programmes of care. They provide psychological treatments and support. CPNs also see how medication is working.

Crisis
A mental health crisis is a sudden and intense period of severe mental distress.

Crisis resolution team
Services to manage/limit the crises suffered by mental health service users and support people to remain at home.

Dual diagnosis
When two or more problems/disorders affect a person at the same time.

General practitioner (GP)
GPs are family doctors who provide general health services to a local community. They are usually based in a GP surgery or practice and are often The first place patients go to with a health concern.

Mental Health Act (1983)
The Mental Health Act is a law that allows for the compulsory detention of people in hospital for assessment and treatment of a mental illness. Read Mind's guide to the Mental Health Act (1983)

Mental health trust
A mental health trust provides treatment, care and advice for patients who are mentally ill. The services may be provided from a hospital or in the community.

Multi-disciplinary team
A team made up of both health and social care workers.

Organic illness
Illness affecting memory and other functions that is often associated with old age. Dementia, including Alzheimer's Disease, is an organic mental illness.

Otter
Electronic package that holds integrated care records for mental health service users.
Patient
Someone who uses health services. Some people use the terms service user or service users instead.

Primary care
Health services, which are first point of contact for patients, e.g. GP surgeries, pharmacists, local dentists, opticians etc.

Psychiatrist
A medical doctor specialising in the prevention, assessment, diagnosis, treatment, and rehabilitation of mental illness.

Psychologist
A mental health professional who specialises in psychological interventions.

Rehabilitation
A programme of therapy and re-enablement designed to restore independence and confidence and reduce disability.

The programme may include occupational therapy to help with domestic and vocational skills that people will need when they return to living independently.

Secondary care
Specialised treatment usually provided by a hospital.

Service user
This is someone who uses services. Some people use the terms patient or service users instead.

Social inclusion
Ensuring that vulnerable or disadvantaged groups are able to access all of the activities and benefits available to anyone living in the community.

Stigma
Society’s negative attitude to people, often caused by lack of understanding. Stigma is a major problem for people who experience mental ill health.
Appendix 2

Mental Health Act 1983 (As amended by Mental Health Act 2007) Sections 135 and 136 and Mental Capacity Act 2005

Section 135

This allows an approved mental health professional to apply to a magistrate for a warrant to have the police enter premises and if necessary, remove a mentally disordered individual to a 'place of safety' with a view to a further assessment under the Mental Health Act. It also allows for a police constable to apply for a warrant to enter premises where an existing patient is thought to be. In the former case, a place of safety may be a police station, hospital, care home or other suitable place, and the individual can be held for up to 72 hours.

Significant evidence is required for the approval of a warrant and it can only be used once. A decision has to be made if the service users needs to be removed to a place of safety so that they can be assessed in a more controlled environment. If there are concerns about a person’s physical health, A&E is utilised. A person needs to be medically fit and have the capacity to make a decision.

Section 136

This is a power for the police to apprehend a person appearing to them to be mentally disordered in a place to which the public have access and remove them to a place of safety for up to 72 hours. The place of safety is the hospital (Peasley Cross or A&E) but can be a police station and a person can be transferred between places of safety. The person can then be examined by a doctor and interviewed by an Approved Mental Health Practitioner (AMPH) and any necessary arrangements made or his or her treatment or care.
Process map for SPA referrals

Assessment function

- Screening and assessment functions supported by:
  - GPwSI
  - Clinical Psychologist
  - Advice for GPs via psychiatrist

Information and Reporting

- Tracking system for whole patient journey
- Circa 500 referrals per month

Screening and allocation function

- Multi Disciplinary therapeutic screening
- Flexible and needs led
- Referral to daily SPA meeting
- Critical
- Immediate high risk major MHP problems
- Substantial
- Significant risk MHP problems
- Moderate
- Some but not immediate risk MHP problems
- Low
- Limited/no risk
- Low risk
- Social Worker present
- Inpatient
- Other

Assessment take place in surgery/hospital?

SPA or other completed referral
- Log on to system
- Initial full assessment (IS)
- Initial full assessment (FC)
- Low intensity within Primary CA
- Mentally health promotion & well being SP
- Watchful waiting with GP
- Low impact IAPT staff
- Mental health promotion and Wellbeing SP
- Primary care MH Teams
- Councilors
- CBT Therapist
- Well being nurses
- High impact IAPT staff

Secondary Care

- Enhanced day therapies
- Community mental health team
- Early intervention
- Older people
- Forensic/Criminal justice liaison
- Assertive outreach

Appendix B