Services for people experiencing a mental health crisis situation: across IIMHL countries

“I needed a safe place – somewhere I could not seriously harm myself until I recovered emotionally. I also needed to feel that someone actually cared about me…” (p.2)

Introduction

All IIMHL countries have a service that works alongside adults who experience a mental health crisis situation. England, for example, has undertaken a significant body of work to improve peoples’ experiences of support when in a crisis situation (see the section on England). [http://www.crisiscareconcordat.org.uk/about/](http://www.crisiscareconcordat.org.uk/about/)


The authors note four interesting concepts that have arisen from this quick scan:

1. The growing promotion of peers in crisis work
2. The growing use of technology to better services for people who need them

1 [https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf](https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf)
3. It is interesting to note how most countries separate mental health “crisis” from a drug and/or alcohol “crisis” whereas they may be very connected.

4. Also, while this report does not cover children and youth, this appears to be a fruitful area for exploration as it appears much less information is available for these groups?

5. In addition, within one small country (e.g. New Zealand) there are a range of names for crisis services. Would one consistent, widely publicised name be easier for the public?

The information in this current report was obtained via two main strategies: through IIMHL contacts but mainly through a brief website search. This search assumes that all websites are up-to-date.

Please note it is not a definitive literature search, but rather a quick snapshot of some national or state resources and activities. While it also includes some information on suicide as it relates to people using crisis services, it does not focus on suicide per se.

If there is a major policy document missing we are happy to include it.

We hope you find it helpful.

Janet Peters and Fran Silvestri

Defining a “mental health crisis”

Over the years, there have been many attempts to define what is meant by a “mental health crisis”.

Self Definition:

“Crisis is defined by the person, as a fundamental part of that person owning the experience and the recovery. Crisis is based on the individual’s description of the way the world is at the time (p.11).


One concept shows a crisis can be described as a change in mental wellbeing that is likely to lead to an unstable or dangerous situation for the individual concerned.

“A crisis is a perception or experience of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms…” (p. 9)

Rosen (1997) identifies three types of crisis as:

- **Developmental**: those crises experienced at key developmental or psychodynamic life stages;
- **Situational**: reactive crises, for example, following loss of job or bereavement; and
- **Complex**: referring to severe trauma following disasters, or complex mental illness” (p.11).


Mind defines ‘mental health crisis’ as:

> “when a person is in a mental or emotional state where they need urgent help”

Crisis is different for different people: a person may be highly agitated, in despair, experiencing suicidal impulses or the need to self-harm, immobilised by depression, or frightened within the changed reality of psychosis. [https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf](https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf)

### Defining a crisis response

In a change from past practice, all models examined across countries agree with the Scottish work in that:

> “Crisis models should be informed by and developed around the needs of service users. The meaningful participation of service users and their carers should be central to all considerations and at all stages”. (p.47)

The Scottish National Standards (2008) state that in an attempt to design services appropriately, others have looked more specifically at the services itself and have attempted to categorise the functions that a crisis service can offer. The literature outlined on page 12 of the Standards provides an understanding of these functions.

Segal (1990) outlines three categories of help/intervention that can be offered to individuals in crisis:

- **Supportive**: appropriate at early stages, aiming to enhance the individual’s own capacity to resolve the problems;
- **Supplemental**: offers additional aids and resources; and
- **Substitutive**: helps take the individual out of their environment and may temporarily “take over”.

Wakeling (1999) identifies two models of service response to crisis:

- “Assessment and disposal: short term, and may amount to little more than ‘holding’ the individual for a short time; and,
• Crisis resolution: can involve implementing a care plan to stabilise the crisis and help the individual cope in the future, this support may last several weeks”.


(Note: The authors take issue with using the word “disposal” in this context).

A wider view is taken by Zero Suicide:

To incorporate the use of crisis services, health and behavioral health organizations should:

• Make formal agreements or subcontract with crisis centers to provide follow-up services for their patients
• Provide written information with the crisis center phone number to every patient with suicide risk as part of a formal safety plan
• Provide every patient with crisis center information upon discharge from treatment
• Explain the purpose, utility, and services offered by the crisis center to every patient and his or her family, both at the start of treatment as well as at discharge
• Obtain patient consent prior to discharge from inpatient or emergency department care for a crisis center to provide follow-up support in the form of phone calls.

http://zerosuicide.sprc.org/toolkit/transition/using-crisis-services-augment-care

Names of crisis services

In the US Zero Suicide has been established. “The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge”.

http://zerosuicide.sprc.org/about

This agency outlined the following services each of which may be applicable for people in crisis:

• Telephone, text services
• Mobile crisis teams
• Walk-in crisis clinics
• Hospital-based psychiatric emergency services
• Peer-based crisis services
• Care coordination services, which have the potential to lower readmission rates for high-utilizing patients (National Suicide Prevention Lifeline, 2013)
• Other programs designed to provide assessment, crisis stabilization, and referral to an appropriate level of ongoing care

Crisis centers can also serve as a connection with the patient between outpatient visits. These services can be particularly helpful for patients with barriers to accessing outpatient mental health services. Providing a full range of crisis services can reduce involuntary
hospitalizations and suicides when paired with mental health follow-up care (National Suicide Prevention Lifeline, 2013).

Communities should offer a full continuum of services designed to provide the right care at the right time and support an individual’s ability to cope with suicidal thoughts or feelings. http://zerosuicide.sprc.org/toolkit/transition/using-crisis-services-augment-care

International agencies

Organization for Economic Co-operation and Development (OECD)


“Emergency departments are the front line of health care systems and play a critical role in ensuring an efficient and high-quality response for patients in stress or crisis situations. A growing demand for emergency care might however reduce patients’ satisfaction (through waiting times), increase health provider workload and adversely affect quality of care. This working paper begins with an overview of the trends in the volume of emergency department visits across 21 OECD countries. It then explores the main drivers of emergency department visits in hospital settings, paying attention to both demand and supply side determinants. Thereafter, national approaches instituted by countries to reduce the demand for emergency care and to guarantee a more efficient use of emergency resources are presented”.(p. 4)

While this paper is focused on services in ED it also talks about people who utilise ED for psychiatric reasons. For some countries this appears acceptable, for others it may not be – see below, for example:

<table>
<thead>
<tr>
<th>Belgium</th>
<th>Portugal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency visits are considered appropriate when the patient is referred by a GP or by the emergency helplines; when the patient is admitted to the hospital at the end of the episode; when the plaster room is used; when the patient dies on the same day; when it is a psychiatric emergency; or when child delivery is expected in the coming three months.</td>
<td>An ED visit is considered appropriate if it results in patient hospitalisation; if death occurs in the ED; if the patient is transferred to another hospital; or according to explicit criteria based on specific diagnostic tests or treatment performed. A visit is appropriate if it requires imaging studies such as MRI, ultra-sonographic studies, CT scan, and if treatment requires intravenous fluids, oxygen, prescription medications administered in the ED, transfusion of blood products, orthopaedic treatments, wound management (other than cleaning or bandaging minor</td>
</tr>
</tbody>
</table>

Visits are considered inappropriate for all other situations.
abrasions), and removal of foreign bodies (in eyes, and digestive or respiratory tract).

Visits are considered inappropriate for all other situations. (p.14)


World Health Organisation (WHO)

Mental health policy, planning & service development

The Optimal Mix of Services for Mental Health

Source: Integrating Mental Health into Primary Care: A global perspective. WHO & WONCA (2008)

“Mobile Crisis Teams” are described by WHO as being part of recommended community mental health services along with a range of other community services (p.2).
Also recommended is integration with primary health care.
http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf?ua=1

IIMHL Leadership Exchange match in 2015

New Zealand leaders who attended the 2015 Leadership Exchange did a summary of the information obtained via matches. Page 8 describes an approach to crisis services in Vancouver, Canada. An excerpt (from Janet Peters) is below:

Match: Community Crisis Response and the Crisis Pathway
(Downtown East Side - DTES - Vancouver)

Key Points

- DTES has a population of poor, aging peoples, with significant drug-taking and homelessness is common, and people with co-existing physical and mental health problems common; and a significant indigenous population. The overall aim of Vancouver City (our equivalent of a City Council) and all agencies is to ensure the best possible care for people who experience mental health/homelessness and physical health problems by diverting people from Police and Justice systems into Health by having clear policy about the interactions between Health, Police and Justice.

Three programmes that involve Health, Police and Justice and supported by the City of Vancouver:

1. Mental Health Emergency Services/Car 87/Car 88 Program ("MHES/Car 87")
   MHES/Car 87 is a program that has been in operation for over 30 years, in which a mental health nurse and a police officer together respond to calls to assess individuals in crisis for mental illness, and to provide referrals, follow-up and emergency intervention where required.

2. Assertive Community Treatment (ACT) Teams
   ACT is a program that has been in operation since 2011 in which VPD and VCH have partnered to provide community-based assessment and treatment services to individuals within the community who have serious mental illnesses and/or substance abuse disorders.

   Unlike the emergency-based MHES/Car 87 program, ACT teams have a set caseload of clients. VCH staff provide health care and treatment, while VPD officers assist VCH staff in carrying out the care plan, ensuring safety of staff and clients, and assisting clients with navigating the criminal justice system where necessary (e.g. helping a client to deal with outstanding warrants). Note: After the programmes first year of operation, ACT clients had a 70-per-cent reduction in emergency department visits, a 61-per-cent reduction in criminal justice involvement and a 23-per-cent reduction in incidents of victimisation,
according to the Ministry of Health. The teams, which each cost about $1.6-million annually, can take on a total caseload of 420 people.

3. **Assertive Outreach Team (AOT).**
AOT is a new partnership between PHC, VCH and VPD designed to provide intensive case management for individuals within the community who have serious mental illnesses and/or substance abuse disorders. The AOT teams work on a similar model as the ACT teams, but with a focus on short-term stabilisation and risk mitigation. The programme is also similar to MHES in that VPD and health care staff are paired in a police car, and VCH/PHC staff may be able to view a client’s information in PRIME on the car’s laptop. Information sharing will work similarly to the MHES/Car 87 model, in that information-sharing requirements are driven by crisis intervention rather than a fixed caseload of clients, and therefore will relate primarily to staff and public safety.

We were impressed with how strongly people were diverted from Police and Justice to Health and Housing and the training that Police received.


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**AUSTRALIA**

**National policy**

**The Australian Government**

**Mental Health Services in Australia: The Australian Institute of Health and Welfare**

The Australian Government and all state and territory governments share responsibility for mental health policy and the provision of support services for Australians living with a mental disorder. State and territory governments are responsible for the funding and provision of state and territory public specialised mental health services and associated psychosocial support services. The Australian Government has primarily taken the lead in national mental health reform initiatives but also funds a range of services for people living with mental health difficulties.

Mental health services in Australia provides a picture of the national response of the health and welfare service system to the mental health care needs of Australians.

Mental illness comprises a wide range of disorders and varies in its severity. The effect of mental illness can be severe on the individuals and families concerned and its influence is far-reaching for society as a whole. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity and homelessness. Those with mental illness often experience problems such as isolation, discrimination and stigma.


In looking at this website I found little specifically on crisis mental health services that work in the community.

There is a good overview of mental health services in general:

And some information on mental health services provided in emergency departments as below:

**Mental health services provided in emergency departments**

**Key points**

- There were an estimated 276,300 ED occasions of service with a mental health-related principal diagnosis in 2012–13, that is about 3% of all ED occasions of service reported in public hospitals (about 8 million occasions of service).
- Four categories of principal diagnosis comprised almost 4 out of 5 (79%) of mental health-related ED occasions of service. These were: neurotic, stress-related and somatoform disorders; mental and behavioural disorders due to psychoactive substance use; mood (affective) disorders; and schizophrenia, schizotypal and delusional disorders.
- More than 4 in 5 (82%) mental health-related ED occasions of service were classified as either semi-urgent (patient should be seen within 60 minutes) or urgent (patient should be seen within 30 minutes). Just over 1 in 9 (12%) were emergency (patients should be seen in less than 10 minutes) and about 1 in 100 (1%) required resuscitation (patient requires immediate care).
- Three in five (60%) mental health-related ED occasions of service were recorded as being resolved without the need for admission or referral. Most of the remaining mental health-related occasions of service (32%) were admitted to hospital.
- Mental health-related ED occasions of service were more likely to result in an urgent admission when compared to all ED occasions of service (47% and 34% respectively).

National Mental Health Commission

A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention

This publication is the second of an annual series of the National Report Card on Mental Health and Suicide Prevention. This Report Card is accompanied by a technical document that provides detailed commentary on the data it contains, a supporting document that provides a detailed Report Back against our 2012 Recommendations and a set of literature reviews. These documents can be downloaded from the website www.mentalhealthcommission.gov.au

The Turnbull Government releases its response to the National Mental Health Commission’s 700-page Review of Mental Health Programme and Services. The response sets out a bold reform package that will put the individual needs of patients at the centre of our mental health system.

Of note, the Commission reports that it costs on average $10,000 to treat one person for nine days in hospital, and the same amount to support someone to stay well in the community for an entire year.


Fact sheets were published to support the actions:

Fact Sheet 1
- What this means for people, families, carers and communities (WORD – 214KB) / (PDF – 157KB)
  - “improving emergency access to telephone and internet based forms of crisis support, and linking crisis support services to ongoing forms of information/education, monitoring and clinical interventions; and”

Fact sheet 10
- What this means for access according to need - stepped care (WORD – 401KB) / (PDF – 364KB)

The stepped care fact sheet assumes that crisis services would fit into the right hand half of the figure below.

Examples of State or Territory activities
Examples of the crisis mental health work of two states are outlined below.

New South Wales

New South Wales Government

The NSW Health web page notes:

Contact a Service
Emergency Contact Numbers
Mental Health - 24 Hour Contact
Drug and Alcohol Service Intake Numbers
Interstate Health Contact Details
Other Relevant Numbers

Emergency Contact Numbers

In an emergency, please call 000 or go to a hospital emergency department, where they may refer you to a mental health and/or drug and alcohol service.
Mental Health - 24 Hour Contact

The Mental Health Line is a 24-hour telephone service operating seven days a week across NSW.


NSW Mental Health Reform 2014-2024

The NSW Government is undertaking a decade-long whole-of-government enhancement of mental health care.

The reforms come in response to the Mental Health Commission of NSW’s Living Well report, a framework for reform, which puts people - not processes - at the centre of the mental health care system.

Hospital care will always be an important option for those needing higher level care. However, evidence shows that mental health care should be recovery-focused.

Care should be provided in the least restrictive setting, close to home where possible, with minimal disruption to a person’s family, community supports, networks and relationships.

The Government wants to improve mental health services and the wellbeing of the community in partnership with non-government organisations (NGOs), consumers and carers to deliver better lives for people with mental illness, their families and carers.

To strengthen mental health care in NSW, the Government will focus on:

- A greater focus on community-based care
- Strengthening prevention and early intervention
- Developing a more responsive system
- Working together to deliver person-centred care
- Building a better system


Call Handling Guidelines for Mental Health Telephone Triage Services

This is a policy guideline for staff at the call centre manning the phones.

The Mental Health Commission of New South Wales


In the Strategic Plan it states:

“The Strategic Plan sets out directions for reform of the mental health system in NSW over the next 10 years. These directions build on those extraordinary strengths we find in individuals, families and communities and hope to supplement them, when requested, with services which respect people and offer them support in ways they find helpful and that fit well with their lives.

It maps a demanding agenda for change that puts people – not processes – at the heart of its thinking.

It insists on principles of social equity: that at any stage of life, whatever our culture, wherever we live and no matter what other health or social difficulties may complicate our lives, we are equal citizens who should expect to find high quality, timely mental health support in our community when we need it.

It demands that we not wait for a crisis. Plenty of strong evidence tells us it is possible to promote good mental health in our community and prevent much mental illness, particularly in young people. And if the signs of distress are already apparent, the course of illness can be improved if we get in early to offer support before people’s lives are badly affected”.


Some relevant excerpts from the Plan are:

**Priority 1: Improving the community-based mental health response**

NSW has relied heavily on hospitals to support people with persistent or acute mental illness. While there will always be an essential role for hospitals to care for people when they are experiencing a crisis, research evidence clearly shows people recover better when they are supported with appropriate and adequate services in their own homes and communities. This is a 2015-18 priority because:

- Many people with severe mental illness – some of the most vulnerable in our community – continue to experience extreme distress as a consequence of being separated from their families, friends, work and regular activities. As a matter of justice, we need urgently to do better by them.
- By investing more strongly in community-based mental health services, we will be able to make a positive difference in the lives of more people, while taking the pressure off hospitals. This will make it more likely that people experiencing an acute episode of mental illness can find a hospital bed when they need it.

4.4 Responding to trauma

Many people do not connect their current problems and behaviours with past traumatic experiences – and nor do those who provide services. Even when trauma is identified, many services do not give the person the support they need.

We need a service system that understands trauma and responds appropriately. Such a system would focus on ensuring services do not re-traumatise or blame people for their efforts to manage their traumatic reactions but understand a person’s behaviour in the context of their life experiences and attempts to cope.

http://nswmentalhealthcommission.com.au/node/2066#putting

5.1 A better community-based system

An effective community system wraps services and support around people living with severe mental illness. This includes assertive outreach, with mobile treatment and crisis resolution teams and whole-of-person support services, a variety of residential alternatives to hospital, and less reliance on involuntary treatment orders.

It also requires strong integration and partnership among clinicians in hospitals and in the community, such as general practitioners, private psychiatrists and other care providers”


5.2 Commitment, resources and collaboration

Developing a contemporary, community-focused, integrated mental health care system will require commitment, human and financial resources, and co-operation and collaboration at the community and state level. We need a system that directs energy and resources towards services outside hospital, delivered close to home.

The community mental health service must include step-up and step-down care as an alternative to inpatient admission or to provide support after an acute episode of illness. For community-based care to be effective, we must ensure:

- easy access and availability of services
- co-ordination and continuity of care
- early detection and intervention
- evidence-based medical and psychological treatments
- safety and risk management
- acute and emergency interventions
- rehabilitation approaches that support social inclusion
- opportunities for learning, employment, housing and social relationships.

This is the 224-page Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (Plan), which has been developed by the Mental Health Commission, the former Drug and Alcohol Office and the Department of Health. [http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/The_Plan_81215_1.sflb.ashx](http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/The_Plan_81215_1.sflb.ashx)

A first of its kind for the State, the Plan sets a bold agenda to create a more connected, high quality and person-centred system focused on the provision of holistic care and support. It provides a targeted and phased approach to investment over the next 10 years to deliver the optimal mix and level of services to meet the needs of the current and future population.

This includes an increase in hospital beds and specialist care, a shift towards the provision of more services in the community and enhanced programs and strategies that prevent mental illness, reduce drug and alcohol-related harm, and that intervene early to reduce the development of serious illness. [http://www.mentalhealth.wa.gov.au/ThePlan.aspx](http://www.mentalhealth.wa.gov.au/ThePlan.aspx)

Aboriginal people have a diverse culture with a rich and compelling history. The impact of colonisation, legislation and the stolen generation created significant hardships for Aboriginal Australians. These problems continue today and impact on Aboriginal people and their mental health. [http://www.mentalhealth.wa.gov.au/mental_illness_and_health/mh_aboriginal.aspx](http://www.mentalhealth.wa.gov.au/mental_illness_and_health/mh_aboriginal.aspx)

**Mental Health Commission**

**Mental Health Emergency Response Line (MHERL) - background information**

If someone in the community experiences a mental health emergency, the Department of Health will provide an emergency response through two new integrated services:

- Mental Health Emergency Response Line
- Community Emergency Response Teams

*How does this differ from the Psychiatric Emergency Team (PET)?*

The primary difference between the services is that there are seven Community Emergency Response Teams, whereas there was just one response team for the PET.

Also, the Community Emergency Response Teams are geographically located across the metropolitan area rather than concentrated in a central location. This allows a more rapid response to mental health emergencies across the Perth metropolitan area.
The PET was a standalone service, whereas the Community Emergency Response Teams are part of the local community mental health service. This brings continuity of care by staff with local knowledge of services.

RuralLink

A specialist after-hours mental health telephone service for the rural communities of Western Australia.

Free call 1800 552 002 – TTY 1800 720 101

Examples of agencies and activities

Mental Health Online (formerly Anxiety Online)

This is an internet-based treatment clinic for people with mental health problems. It is an initiative of the National eTherapy Centre (NeTC) at Swinburne University of Technology and funded by the Federal Department of Health and Ageing.
https://www.mentalhealthonline.org.au/pages/about-us

It has information online about other agencies that work in the crisis area.
https://www.mentalhealthonline.org.au/pages/useful-resources/crisis-services

Each state has a 24/7 telephone line with Western Australia also having a “Rural Support Line” (i.e. specialist after-hours mental health telephone service for rural communities).
https://www.mentalhealthonline.org.au/pages/useful-resources/crisis-services

Beyond Blue

This well-known, nationwide agency has several ways of assisting a person in a crisis situation and an extensive range of resources and chatlines covering all ages, ethnicities, and mental health problems.
3 million Australians are living with depression or anxiety. beyondblue provides information and support to help everyone in Australia achieve their best possible mental health, whatever their age and wherever they live. [https://www.beyondblue.org.au/](https://www.beyondblue.org.au/)

Several avenues for crisis support are outlined both online, by phone and email.

**beyondblue SupportService**
Support. Advice. Action  1300 22 4636

If you are in an emergency, or at immediate risk of harm to yourself or others, please contact emergency services on 000.

To talk to someone now call

**Suicide Call Back Service**
1300 659 467

**Lifeline**
13 11 14


There is also a safety app:
**BeyondNow – Your suicide safety planning app**

*What is safety planning?*

If you or someone close to you is experiencing suicidal thoughts or feelings, safety planning can help you get through the tough moments.

It involves creating a structured plan – ideally with support from your health professional or someone you trust – that you work through when you’re experiencing suicidal thoughts, feelings, distress or crisis.

Your safety plan starts with things you can do by yourself, such as thinking about your reasons to live and distracting yourself with enjoyable activities. It then moves on to coping strategies and people you can contact for support – your friends, family and health professionals.

While everyone’s plan will be unique to them, the process and structure are the same – it prompts you to work through the steps until you feel safe.

*What is BeyondNow?*

Convenient and confidential, the BeyondNow app puts your safety plan in your pocket so you can access and edit it at any time. You can also email a copy to trusted friends, family or your health professional so they can support you when you’re experiencing suicidal thoughts or heading towards a suicidal crisis.


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**SANE Australia**

How to help when someone experiences a mental health crisis

When caring for someone with a mental illness, there may be times when their health deteriorates to a point that immediate support is required. This may be because they have developed suicidal thoughts or are perhaps so agitated that they may be a risk to others.

When this occurs, it is best to contact a specialist service that is able to assess the situation and help you to decide on the best course of action. If the person you are caring for agrees, you can attend the emergency department of your local hospital.

However, there are times when the person affected might not agree there is any risk, or might not be willing to reach out for help.

When this occurs you can contact the local Crisis Assessment and Treatment Team (CATT) through the closest major public hospital. In some parts of Australia they are called Psychiatric Emergency Teams (PET). The CATT/PET is a multi-disciplinary team with Psychologists, Psychiatrists, Social workers and Nurses who provide assessment and support for people who are in crisis with mental illness.

Their phone lines are staffed 24 hours a day. Your local team will conduct an initial phone assessment and may get in contact with other treating practitioners.

From this assessment they will decide how to best support the person in crisis. This may involve a home visit as their aim is to treat people in the community where possible.
However, they may decide that hospitalisation is necessary to ensure the best care. If you have any questions or concerns, you are welcome to contact the SANE Help Centre.

To find your local CATT or PET team, ring your closest major public hospital.

Sane Australia also has:

“Helpline, online forums, chat and email services available to help you right now.”


**Mental Health Coordinating Council**

The Mental Health Coordinating Council (MHCC) is the peak body for community mental health organisations in New South Wales. MHCC has been supporting community based organisations to deliver services to people with mental health issues, their families and carers since 1983. We strive to raise the profile of mental health through our projects, submissions and by promoting partnership development. MHCC is currently accredited under Australian Council on Healthcare Standards (ACHS).


The MHCC has published the following Manual:

**MENTAL HEALTH RIGHTS MANUAL: An online guide to the legal and human rights of people navigating the mental health and human service systems in NSW**, 2015.

The Manual incorporates the latest legislative reform and describes the mental health and human services environment.

A key objective of this Manual is to provide a resource which covers many of the areas which may at some time or other be of concern to people with mental health conditions, their carers and families, and the workforce that supports them that they can access in one place.

http://mhrm.mhcc.org.au/home/

**mindhealthconnect**

What is mindhealthconnect?

mindhealthconnect is the easy way to find mental health and wellbeing information, support and services from Australia’s leading health providers, together in one place.

Supported by the Australian Government, mindhealthconnect helps you to find information you can trust. Start now with the Guided search or Mental Health A-Z.

64 trusted resources for Crises
Examples are below:

*Indigenous - The Trauma and Grief Network (TGN)*

Australia’s First Peoples are resilient and resourceful. We have survived through adversities; some in the past, but many of these adversities are ongoing.


More from Australian Child and Adolescent Trauma, Loss and Grief Network (ACATLGN)

*Emergency Help*

If you are feeling suicidal there are people who can help. If you live in Australia please call: and tell the person answering your call that you are thinking about suicide.


More from e-hub Mental Health - Australian National University (ANU)

*Mental Health Services*

Find support with a practitioner or through a health service by using one of the directories below. Alternatively you can find Emergency and Crisis Helplines or disorder specific helplines and online

*About ‘care plans’*

Many parents experiencing mental illness find there are periods where they’re well, and then some periods of ‘crisis’ when they may be unable to cope and need extra sup …


More from COPMI – Children of Parents with a Mental Illness
Information and helplines, resources and services - COPE

Below are a range of agencies that provide free telephone support, information resources and services to assist you to access further information, support and care.

cope.org.au/get-help/types-treatment/

More from COPE - Centre of Perinatal Excellence


Celebrating more than 50 years of service to the community, the Australian Drug Foundation is one of Australia’s leading bodies committed to preventing alcohol and other drug problems in communities around the nation.

The Foundation reaches millions of Australians in local communities through sporting clubs, workplaces, health care settings and schools, offering educational information, drug and alcohol prevention programs and advocating for strong and healthy communities.


A search for “crisis services” yielded 52 results – more related to information than to a service per se.

http://www.adf.org.au/component/search/?searchword=crisis%20services&searchphrase=all&Itemid=2
National policy

Government of Canada

The Minister of Health is responsible for maintaining and improving the health of Canadians. This is supported by the Health Portfolio, which comprises Health Canada, the Public Health Agency of Canada, the Canadian Institutes of Health Research, the Patented Medicine Prices Review Board and the Canadian Food Inspection Agency.

The two agencies involved in mental health are:

**Health Canada**
Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances.

**Public Health Agency of Canada**
The Public Health Agency of Canada has been created to deliver on the Government of Canada's commitment to help protect the health and safety of all Canadians. Its activities focus on preventing chronic diseases, like cancer and heart disease, preventing injuries and responding to public health emergencies and infectious disease outbreaks.


**Inequalities**

Canadians, in general, enjoy very good health, but some Canadians are not as healthy as others. Major health disparities persist between various groups in Canadian society. Key health inequalities are associated with factors such as socioeconomic status, Aboriginal heritage, gender and geographic location. For example, when compared to Canadians more generally, First Nations and Inuit peoples have a life expectancy of 5 - 10 years less. Many of the consequences of these health inequalities are avoidable, including preventable early death, disease and disability, and are costly for the health system and society in general.


In Canada, the planning and delivery of mental health services is an area in which the provincial and territorial governments have primary jurisdiction. The federal government (chiefly through Health Canada) collaborates with the provinces and territories in a variety of ways as they seek to develop responsive, coordinated and efficient mental health service systems. The Public Health Agency of Canada's Centre for Chronic Disease Prevention and Control contributes through surveillance activities.

First Nation and Inuit Health

First Nations Mental Wellness Continuum Model

A full spectrum of culturally competent supports and services is necessary to support mental wellness. This continuum includes:

- Health Promotion, Prevention, Community Development, and Education
- Early Identification and Intervention
- Crisis Response
- Coordination of Care and Care Planning
- Detox
- Trauma-Informed Treatment
- Support and Aftercare

Still First Nation and Inuit:

The Non-Insured Health Benefits (NIHB) Program's Mental Health Counselling (MHC) benefit is intended to provide coverage for mental health counselling to address crisis situations when no other mental health services are available and/or being provided. This benefit is intended to support the provision of immediate psychological and emotional care to individuals in significant distress to stabilize their condition, minimize potential trauma from an acute life event, and, as appropriate, transition them to other mental health supports.

If you or someone you know is in immediate danger, call 9-1-1 or the number for emergency services in your community.

What is covered?

The MHC benefit provides up to a maximum of 15 one-hour sessions per mental health crisis over a 20 week period. Eligible billable services under the MHC benefit may include:

- Initial assessment (maximum of 2 one hour sessions) performed by an enrolled provider; and
- Counselling sessions on a fee-for-service basis as per Prior Approval Form (e.g. individual, family, or group counselling).

Mental Health Commission of Canada
**Mental Health Strategy for Canada**

*Changing Directions, Changing Lives*, released in May 2012, is the first mental health strategy for Canada. It aims to help improve the mental health and well-being of all people living in Canada, and to create a mental health system that can truly meet the needs of people living with mental health problems and illnesses and their families.

**Guidelines for the Practice and Training of Peer Support**

In this MHCC document crisis peer support is seen as important:

Figure 1: Spectrum of Types of Peer Support

<table>
<thead>
<tr>
<th>Type of Peer Support</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FORMALIZED/INTENTIONAL PEER SUPPORT</strong></td>
<td>Consumer run peer support services within community settings (either group or one-to-one) focusing on issues such as education, employment, MH systems navigation, systemic/individual advocacy, housing, food security, internet, transportation, recovery education, anti-discrimination work, etc.</td>
</tr>
<tr>
<td><strong>WORKPLACE PEER SUPPORT</strong></td>
<td>Workplace-based programs where employees with lived experience are selected and prepared to provide peer support to other employees within their workplace</td>
</tr>
<tr>
<td><strong>COMMUNITY CLINICAL SETTING PEER SUPPORT</strong></td>
<td>Peer support workers are selected to provide support to patients/clients that utilize clinical services, e.g., Outpatient, A.C.T teams, Case Management, Counselling</td>
</tr>
<tr>
<td><strong>CLINICAL/CONVENTIONAL MH SYSTEM-BASED PEER SUPPORT</strong></td>
<td>Clinical setting, inpatient/outpatient, institutional peer support, multidisciplinary groups, recovery centres, or Rehabilitation Centres. Crisis response, Crisis Management, Emergency Rooms, Acute Wards.</td>
</tr>
</tbody>
</table>


**An example of Canadian State activities**

**Alberta**

**Alberta Health Services**
Alberta Health Services (AHS) is Canada’s first and largest province-wide, fully-integrated health system, responsible for delivering health services to the over four million people living in Alberta, as well as to some residents of Saskatchewan, B.C. and the Northwest Territories. Alberta is the fastest-growing province in Canada. In 2014, Alberta’s population growth rate more than doubled the national average (2.9 per cent and 1.1 per cent, respectively). Programs and services are offered at over 650 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities and community health sites. The province also has an extensive network of community-based services designed to assist Albertans maintain and/or improve health status. http://www.albertahealthservices.ca/about/about.aspx

This agency also has the following:

**Mental Health Help Line**

Provides:

- confidential, anonymous service
- crisis intervention
- information about mental health programs and services
- referrals to other agencies if needed
- Service Access

Call 1-877-303-2642 (toll free within Alberta) for mental health advice. https://myhealth.alberta.ca/find-health-care/services/Pages/profile.aspx?SERVICEID=6810

It is interesting to note that the website has estimated waiting times for people to note. Could this be done for mental health crisis services?

**Emergency Department Wait Times**

The estimated waiting time to see a physician in Emergency is approximate and is for informational purposes only. Please remember, we provide care to the most critical cases first. Estimated wait times are updated every 2 minutes (see the disclaimer). http://www.albertahealthservices.ca/waittimes/waittimes.aspx


**Agencies and activities**

**Canadian Mental Health Association (CMHA)**
An example of innovation in crisis services is the following in Ontario:

**The Mental Health & Addictions Crisis Centre is open 24/7 for walk in crisis assessment and support.**

The Crisis Centre provides 24/7 walk in support for individuals experiencing a mental health and/or addictions crisis that do not require hospital or emergency service interventions. Located at 648 Huron St., London, the Crisis Centre houses the Crisis Assessment Team, Crisis Mobile Team and can provide access to 5 off-site crisis stabilization beds. The building is a warm, welcoming environment that will be open for walk in self-referrals and community referrals 24 hours a day, 7 days a week. [http://cmhamiddlesex.ca/crisis-services/crisis-centre-faqs/](http://cmhamiddlesex.ca/crisis-services/crisis-centre-faqs/)

*(Note: the Crisis Stabilization Beds will continue to be located off site until building renovations are completed later in 2016)*

If you, a family member or friend (over the age of 16) are experiencing:

- a serious mental health or addictions problem
- a situational crisis
- psychosis
- risk of self-harm or harm to others
- emotional trauma
- agitation and sleeplessness
- severe depression or anxiety
- symptoms of substance use withdrawal and needing support
- suicidal thoughts
- Crisis resulting from a gaming/internet disorder or problem gambling

Walk through our doors at **648 Huron St., London, ON** to receive immediate crisis assessment, intervention, stabilization and links to community resources. For more information, call 519-434-9191.
CMHA British Columbia Division

This agency shows a wide range of options in a crisis situation. https://www.cmha.bc.ca/get-informed/crisis-information

An example is:

**Prevention and preparation**

The best way to handle a crisis or emergency is to prevent it in the first place. Prevention might include:

- Following your individual treatment plan
- Monitoring your symptoms for any changes
- Learning stress-management and problem-solving skills that work for you
- Planning ahead for stressful events you know are coming
- Maintaining a balanced, healthy lifestyle
- Going to your doctor or mental health professional as soon as you notice a change in the way you feel.

Unfortunately, working to prevent your symptoms from getting worse or coming back doesn’t guarantee that you’ll never feel unwell. So it’s important to think about what you want to do if you start to feel unwell again. Then you can take action right away and help control the crisis.
or emergency. Your action plan also tells others what to do if you can’t express your needs and wishes to them.

An action plan might be a formal agreement you sign with your health care provider, or it might be an informal plan between you and your loved ones. It might include:

**Signs that show you aren’t feeling well**

- At what point you want outside help: As soon as you notice warning signs? When you can no longer manage symptoms on your own?
- Where to go for help or who to contact in an emergency situation
- What treatments you’d prefer
- A list of your current medications and any other treatments (including alternative treatments)
- Contact information for your health professional, the nearest emergency room, and contact information for the loved ones you want notified

An action plan may also include steps your loved ones agree to take. For example, a loved one may contact your doctor or mental health provider, inform your employer that you aren’t well and help keep everything in order (such as rent or bill payments) if you need to stay in hospital. Whether your action plan is a formal agreement or an informal plan among loved ones, it’s best to put everything in writing so everyone knows what they need to do.

You might not want to think about feeling unwell when you’re feeling well, but planning ahead may actually help you feel better. Many people who recover from a mental illness worry about what will happen if their symptoms come back (a relapse) or become worse. An action plan may reduce some of the worry because you know that you have a back-up plan if you need it.

If your plan or agreement involves the care of your children, access to your financial information or other important matters, it’s best to talk with a lawyer about your options. [https://www.cmha.bc.ca/get-informed/crisis-information/emergencies](https://www.cmha.bc.ca/get-informed/crisis-information/emergencies)

**CMHA Alberta**

Crisis Intervention
CMHA Alberta South offers a number of crisis intervention services. Read more below.
Community Mental Health Crisis Beds
24-Hour Community Stabilization Program for Individuals in Crisis.

Distress Line of South Western Alberta
A 24-Hour Phone Support for Individuals Experiencing a Crisis.

Mental Health Crisis Intervention Team
Partners for Mental Health

In November 2010, Partners for Mental Health became an independent registered charity in Canada.

Through partnerships, public engagement and strategic initiatives, Partners for Mental Health seeks to transform the way Canadians think about, act towards and support mental health and people living with a mental illness.

A national charity accredited by Imagine Canada’s Standards Program, Partners for Mental Health aims to improve mental health in Canada by mobilizing and engaging Canadians to drive fundamental changes that result in:

- increased awareness and attention toward one’s own mental health
- greater understanding, acceptance and support for people living with a mental health problem or illness
- increased access to mental health services, treatment and support
- better workplace policies
- more funding for programs and services

http://www.partnersformh.ca/about-us/who-we-are/

Crisis centres across Canada

Calling a crisis centre is the right thing to do if you or someone you know is in crisis. Making the call is an important first step that can save a life. Crisis centres are located across Canada in communities of all sizes. Many offer telephone support 24 hours a day, and most are associated with professional counselors.

Click the links below to find a list of crisis centres in your area. Or, you can call your local clinic, mental health centre, hospital, doctor or emergency number and ask for assistance in connecting to a crisis centre.

http://www.partnersformh.ca/resources/find-help/crisis-centres-across-canada/

Ottawa

The service below looks like an NGO.

The Mental Health Crisis Service

Our professionally trained Crisis Line Responders are there to answer your call 24 hours a day, seven days a week.
A crisis can include difficulty dealing with stress, overwhelming feelings, symptoms of depression, anxiety or psychosis, suicidal thoughts, or any concerns regarding your mental health or that of your loved ones.

There are two components to the Mental Health Crisis Service:

**Mental Health Crisis Line**

- Is the first point of public access to the mental health crisis response system.
- Serves people 16 years of age and over.
- Provides toll-free telephone access in both French and English, 24 hours/7 days a week.
- Is staffed by trained volunteer Crisis Line Responders, supported by professional staff.
- Provides screening, assessment, referrals, and support in a crisis, suicide intervention and transfer to the Local Crisis Team or to emergency services when advisable.

**Local Crisis Team**

- The Local Crisis Team can generally respond within minutes to phone calls and within 24 hours to see someone face-to-face.
- The Local Crisis Team works closely with emergency services such as hospital emergency departments, police, doctors and other community agencies to ensure a safe and comprehensive response.
- Services include crisis intervention, assessment, consultation and links to community supports in a least intrusive approach to enable individuals in crisis to receive services in their own environment.
- Consultation and advice can be provided to family members.
- Follow-up and support services can be provided to help resolve the crisis.
- The Local Crisis Team includes registered nurses, social workers, crisis counselors and other health professionals.

**To Reach the Crisis Line**

The Crisis Line can be reached 24/7 by calling 613-722-6914 or toll-free 1-866-996-0991.

Your call will be answered as quickly as possible. On average, clients will have their call answered within 2 minutes, and will wait no longer than 10 minutes. The Volunteer Crisis Line Responder will offer support and if required, can make a direct transfer to the Local Crisis Team with your consent, which includes providing your name and phone number.

**When speaking with the Crisis Line Responder, you will be asked to provide all relevant information about the crisis:**

- What caused the current crisis? Is there one particular event?
- What triggered your current emotions or feelings?
- Are you alone or with others?
- Are you currently injured?
- Is this a situation that can be worked on over the phone?
- Provide names of friends or family as available.
- Facts
  http://www.crisisline.ca/english/faq/faq.html

Online Lifeline

This service offers a nation-wide crisis line.
http://www.yourlifecounts.org/need-help/crisis-lines?field_country_value=Canada&field_province_value=All

ENGLAND

National policy

Department of Health and National Health Service

Closing the gap: priorities for essential change in mental health


No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.


Report - Five Year Forward View, 2014

“The independent Mental Health Taskforce has brought together health and care leaders, people using services and experts in the field to create a Five Year Forward View for Mental Health for the NHS in England. This national strategy, which covers care and support for all ages, was published in February 2016 and signifies the first time there has been a strategic
approach to improving mental health outcomes across the health and care system, in partnership with the health arm’s length bodies."

One recommendation was:

- “Proper funding and integration of mental health crisis services, including liaison psychiatry.
- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.
- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible” (p. 22).


**Five Year Forward View for Mental Health (Feb 2016)**

The Care Quality Commission (CQC) found that just half of Community Mental Health Teams (CMHTs) are able to offer a 24/7 crisis service today. By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme. Out of area placements for acute care should be reduced and eliminated as quickly as possible.

Good liaison mental health care is also needed in acute hospitals across the country, providing a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients to acute hospitals. Only a minority of A&E departments have 24/7 liaison mental health services that reach minimum quality standards, even though peak hours for people presenting to A&E with mental health crises are 11pm-7am. By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the ‘core 24’ service standard as a minimum. (p. 12)

**Vision by 2021:**

There will be a 7 day NHS providing urgent and emergency mental health crisis care 24 hours a day, as there is for physical health, delivering 24/7 intensive home treatment and not just crisis assessment. Police cells will be used only in exceptional circumstances for people detained under the Mental Health Act. Good quality liaison mental health services will be available more widely across the country. (p. 31)

Particularly recommendations 17 and 18:

Recommendation 17: By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are
adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme.

Recommendation 18: By 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the ‘core 24’ service standard as a minimum. (p. 34)

NHS England

NHS England will be publishing more detailed tools in due course but the following resources may be useful in terms of the core crisis services above which will form part of the focus for the next few years in England:

- Psychiatric liaison services in acute hospitals:
  http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/liaisonpsychiatry/plan.aspx
- UCL Crisis resolution team Optimisation and RElapse prevention (CORE) Study:
  https://www.ucl.ac.uk/core-study

Report - Achieving Better Access to Mental Health Services by 2020

In No Health Without Mental Health and Closing the Gap, the Government set out its commitment to achieving parity of esteem for mental health. Timely access to services and then for treatment is one of the most obvious gaps in parity – whilst there are waiting time standards for physical health services, for mental health services, these standards simply don’t exist.

This plan sets out the immediate actions we will take this year and next to end this disparity and achieve better access to mental health services and our vision for further progress by 2020.

Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis

The National Institute for Health and Care Excellence (NICE) guidelines for adult mental health state the assessment and referral procedures for urgent and crisis mental health
should include alternatives to emergency departments such as 24 hour helplines, 24 hour accessible crisis resolution and home treatment teams and the ability to self-refer.

In March 2014, the All Party Parliamentary Group for mental health launched an inquiry into crisis mental health and emergency care.

A national survey was circulated among service users, carers, families, health and social care professionals and the police which revealed that there are major inconsistencies in access to services, standards and models of service delivery. Negative experiences included overstretched and fragmented services, unclear routes into care, place of safety not within an appropriate setting (at police stations or emergency department), long waiting times, a postcode lottery regarding access, advice and services, no clear access route into services and repeated ‘bouncing’ between services.

Evidence given by the range of stakeholders clearly showed how current mental health crisis provision is characterised by lack of access and poor emergency departments care leading to poor and unacceptable outcomes for patients, so highlighting the immediate need for change. http://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/11/mh-urgent-commiss-doc-102014.pdf

http://www.crisiscareconcordat.org.uk/about/

This 2014 document was published by the Department of Health and Concordat signatories (a range of government, health, primary care, police, clinical, ambulance and third sector agencies)

**Mental Health Crisis Care Concordat: the joint statement**

"We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first. We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery. Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England."

The document sets out the principles and good practice that should be followed by health staff, police officers and approved mental health professionals when working together to help people in a mental health crisis.
It follows the refreshed Mandate for NHS England, which includes a new requirement for the NHS that “every community has plans to ensure no one in mental health crisis will be turned away from health services”.

“The NHS Mandate is structured around 5 main areas where the government expects NHS England to make improvements:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring that people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm

The Mandate reaffirms the government’s commitment to an NHS that remains available to all, based on clinical need and not ability to pay - and that is able to meet patients’ needs and expectations now and in the future”.


In the press release it was noted:

The Crisis Care Concordat challenges local areas to make sure that:

- Health-based places of safety and beds are available 24/7 in case someone experiences a mental health crisis
- Police custody should not be used because mental health services are not available and police vehicles should also not be used to transfer patients. We want to see the number of occasions police cells are used as a place of safety for people in mental health crisis halved compared 2011/12
- Timescales are put in place so police responding to mental health crisis know how long they have to wait for a response from health and social care workers. This will make sure patients get suitable care as soon as possible
- People in crisis should expect that services will share essential ‘need to know’ information about them so they can receive the best care possible. This may include any history of physical violence, self-harm or drink or drug history
- Figures suggest some black and minority ethnic groups are detained more frequently under the Mental Health Act. Where this is the case, it must be addressed by local services working with local communities so that the standards set out in the Concordat are met
- A 24-hour helpline should be available for people with mental health problems and the crisis resolution team should be accessible 24 hours a day, 7 days a week


In the Crisis Concordat examples of new practice are given as “case studies”.

Some of these are described below to illustrate the change in thinking and practice.
Case Study THE STREET TRIAGE CAR IN LEICESTERSHIRE

“Our street triage car has reduced the section 136 detention rate by 33% on the level prior to the introduction of the car” – Leicestershire Constabulary. Since January 2013, Leicestershire Police and Leicestershire Partnership Trust (LPT) have jointly operated a mental health triage car, which is driven by a police officer and contains a mental health nurse from the crisis service operated by LPT. It aims to improve the service provided to the people who police encounter who may be experiencing difficulties with their mental health or learning disability; responding at the earliest opportunity and then directing people to the most appropriate service available. The car provides an initial point of contact for police officers on the beat who encounter incidents which have a mental health element, before exercising their police powers.

The mental health nurse provides the training, experience and legal powers of a registered nurse, can conduct a mental health assessment, has mobile access to mental health services and information systems, and has experience of working practices and procedures in the NHS and in particular mental health services. The police officer provides the training, experience and legal powers of a constable. These include powers under criminal law, the Mental Health Act and the Mental Capacity Act, has mobile access to criminal justice information systems, experience of working practices and procedures within the criminal justice system. The officer has been trained in public order and methods for gaining entry to locked or barricaded premises, and is qualified to higher driving standards, enabling emergency response if required. The approach in Leicestershire appears to have led to a reduction in section 136 detentions of 33% of the level prior to the introduction of the car. The average time to help people when they are detained is now five hours and the car deals with 120 cases per month. Peter Jackson Leicestershire Police. P. 25

Case Study AN AMBULANCE SERVICE and POLICE CONVEYANCING POLICY IN THE NORTH WEST

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

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

The conveyance policy sets out the roles and responsibilities of each agency including the NHS trusts, the ambulance service, the police and local authorities both in and out of working hours. All parties involved in the creation of the policy use their multi-agency experience to agree effective processes and clear care pathways. A person-centred approach is taken with the aim of ensuring that vulnerable people receive appropriate and timely care, minimising the role of the police and the use of police vehicles in the conveyance of people experiencing mental ill health. In practical terms, the policy explains that police assistance should only be sought if there is evidence of risk of either resistance (active), aggression, violence (to self or others) or escape.

The policy determines that patients are conveyed to hospital in the most humane and least threatening way, consistent with ensuring that no harm comes to the patient or to others. In order to facilitate better multiagency working, it provides relevant telephone numbers to enable faster referrals to take place, as well as specifying the response times NWAS aim to meet when requested to assist with a mental health related incident. The policy has brought clarity to a very complex area of service. Professionals involved now ‘Think Ambulance First’. It has also enabled senior police officers to challenge requests for police involvement in conveyance when the circumstances are not appropriate and emphasised to all agencies that each has responsibilities, inside and outside of working hours, for vulnerable people. Adele Owen Greater Manchester Police. P.32
An appendix describes actions, timeframes, leadership and roles, for example:

**Improve access to support via primary care**

<table>
<thead>
<tr>
<th>No.</th>
<th>Action</th>
<th>Timescale</th>
<th>Led by</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Develop a programme of work to support primary care to work collaboratively with other services, facilitating and co-ordinating access to specialist expertise and to a range of secondary care services including crisis care mental health and substance misuse services as required.</td>
<td>Ongoing</td>
<td>Royal College of General Practitioners (with CCG Mental Health Network).</td>
<td>Prevention of avoidable crises</td>
</tr>
<tr>
<td>2.2</td>
<td>Support, develop and improve GPs knowledge and experience of management of severe mental illness including physical health and crisis care through the RCGP Curriculum statement for mental health and the appointment of an RCGP Mental Health Clinical Lead</td>
<td>April 2015</td>
<td>Royal College of General Practitioners.</td>
<td>Prevention of avoidable crises</td>
</tr>
</tbody>
</table>


As described in an OECD publication:

The mental health Crisis Care Concordat was agreed between over 20 national organisations from health and policing and launched in February. It aims to improve the responses that people in mental health crisis situations receive from services, and in particular, to keep people in mental distress, who have committed no crime, out of police cells.

Since February 2014 there have been a number of achievements:

- Health, policing and local authority colleagues working together in every locality in England to develop their joint Local Crisis Declarations. The amount of activity from local leads on mental health and policing is unprecedented, and people are set on finding local solutions and agreements through joint action planning.
- The use of police cells as places of safety for people detained under the Mental Health Act reduce by 24%. (There were 7,881 cases in 2012/13, down to 6,028 cases in 2013/14) The Department is working closely with the Police to monitor further progress this year.
- Ambulance Trusts accept a new protocol for rapid response to people in mental health crisis. Previously, some Trusts did not treat these cases as emergencies, now all have signed up to provide initial clinical assessments within 30 minutes.
• The Care Quality Commission undertake a survey and mapping exercise of all hospital based places of safety, and begin to inspect mental health crisis services against many of the service standards set out in the Concordat.

• DH funded street triage schemes show that nurses advising police officers on people in mental health crisis can reduce detentions (data to August showed a reduction of s136 detentions of 25%) and keep these people out of police cells. The nine DH funded schemes have been joined by around 15 schemes funded by police, NHS and local authorities this year.

• The Royal College of Psychiatrists survey the provision of liaison psychiatry services in Emergency Departments and NHS England use this information as the basis for GBP 30m investment to be targeted in 2015/16 on the development of effective models of liaison mental health services in acute hospitals.


Resources


• Evaluation of the Crisis Care Concordat Implementation Final Report
  Prepared by the McPin Foundation for Mind, January 2016. Download (PDF, 1MB)

• Evaluation of the Crisis Care Concordat Implementation Final Report Summary
  Prepared by the McPin Foundation for Mind, January 2016. Download (PDF, 3MB)

• Evaluation of the Crisis Care Concordat Implementation Final Report Infographic
  Prepared by the McPin Foundation for Mind, January 2016. Download (PDF, 436kB)

• Local Progress Report – Guide

• NHS 111 and the Crisis Care Concordat
  This briefing on NHS 111 is for local areas.

• Evaluation of the Crisis Care Concordat implementation Interim Report
  Prepared by the McPin Foundation for Mind, January 2015. Download (Word document, 188kB)

http://www.crisiscareconcordat.org.uk/resources/

Public Health England’s National Mental Health Intelligence Network (NMHIN) published its crisis care data catalogue on 19 May 2016

This lists all the metrics and datasets relevant to mental health crisis care, and includes links to data sources and details regarding availability of data and the geography at which the data is published. It can be used by commissioners; policy makers, planners, and service providers to identify available data on crisis care, and to inform their work to ensure there are adequate
and effective mental health crisis care services in England. The aim is for the data catalogue to support the planning and implementation of local Crisis Care Concordat action plans. PHE will be seeking feedback on the data catalogue so that it can improve and meet needs as much as possible. A feedback form is provided on the website, or alternatively contact mhdnin@phe.gov.uk with comments and suggestions.

Click here to link to the crisis care data catalogue and further information on the Public Health England website.

Events related to the Concordat
http://www.crisiscareconcordat.org.uk/events/

National Institute for Health & Care Excellence (NICE)

Assessment and referral in crisis

Crisis resolution and home treatment teams

Health and social care providers should ensure that crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, and available to service users in crisis regardless of their diagnosis.

Crisis assessment

If assessment in the service user's home environment is not possible, or if they do not want an assessment at home, take full consideration of their preferences when selecting a place for assessment.

Assessment in crisis should be undertaken by experienced health and social care professionals competent in crisis working, and should include an assessment of the service user's relationships, social and living circumstances and level of functioning, as well as their symptoms, behaviour, diagnosis and current treatment.

Immediately before assessing a service user who has been referred in crisis, find out if they have had experience of acute or non-acute mental health services, and consult their crisis plan and advance statements or advance decisions if they have made them. Find out if they have an advocate and contact them if the service user wishes. Ask if the service user has a preference for a male or female health or social care professional to conduct the assessment, and comply with their wishes wherever possible.

When undertaking a crisis assessment:

- address and engage service users in a supportive and respectful way
• provide clear information about the process and its possible outcomes, addressing the individual needs of the service user, as set out in the recommendations on assessment in this pathway
• take extra care to understand and emotionally support the service user in crisis, considering their level of distress and associated fear, especially if they have never been in contact with services before, or if their prior experience of services has been difficult and/or they have had compulsory treatment under the Mental Health Act (1983; amended 1995 and 2007).

Supporting service users in a crisis

To avoid admission, aim to:

• explore with the service user what support systems they have, including family, carers and friends
• support a service user in crisis in their home environment
• make early plans to help the service user maintain their day-to-day activities, including work, education, voluntary work, and other occupations such as caring for dependants and leisure activities, wherever possible.

At the end of a crisis assessment, ensure that the decision to start home treatment depends not on the diagnosis but on:

• the level of distress
• the severity of the problems
• the vulnerability of the service user
• issues of safety and support at home
• the person's cooperation with treatment

When a person is referred in crisis they should be seen by specialist mental health secondary care services within 4 hours of referral.

Health and social care providers should support direct self-referral to mental health services as an alternative to accessing urgent assessment via the emergency department. Health and social care providers should provide local 24-hour helplines, staffed by mental health and social care professionals, and ensure that all GPs in the area know the telephone number.

Consider the support and care needs of families or carers of service users in crisis. Where needs are identified, ensure they are met when it is safe and practicable to do so.

Quality standards

The following quality statements are relevant to this part of the pathway.

6 Access to services    10 Assessment in a crisis
Resources
The following implementation tools are relevant to this part of the pathway.

Service user experience in adult mental health – assessment and referral in a crisis: clinical audit tool


NHS London Strategic Clinical Networks: London mental health crisis commissioning standards

Click here to download London mental health crisis commissioning standards and recommendations

The Mental Health Strategic Clinical Network has produced a set of standards and recommendations for commissioning mental health crisis services across London. To develop the standards, the network has analysed existing mental health crisis provision, reviewed literature, cross referenced against other guidance such as that produced by NICE, identified case studies and consulted people with lived crisis experience. The commissioning standards therefore were devised to reflect what people should expect from London’s mental health crisis services.

They are embedded within twelve subject areas, mirroring the Crisis Concordat approach including:

- Access to crisis care support
- Emergency and urgent access to crisis care
- Quality of treatment of crisis care
- Recovery and staying well

The following standards are to be refreshed in the future and are our first initial step to improving mental health crisis.

Click here to download London mental health crisis commissioning: Case studies.

This document describes 32 examples of crisis services for different areas and populations.

Click here to download London mental health crisis commissioning guide.

“This document, which has been compiled following extensive analysis and consultation, contains standards for the future commissioning of crisis services and covers twelve key areas of service delivery. The aim therefore is to ensure the consistent delivery of high quality, responsive crisis care, which reflects and meets the needs of all service users and their carers. The standards build on work already on going regionally and nationally, and in addition, reflect best practice identified across the world”. (p.5)

The commissioning standards therefore were devised to reflect what people should expect
from London’s mental health crisis services. They are embedded within twelve subject areas, mirroring the Crisis Concordat approach including:

- Access to crisis care support
- Emergency and urgent access to crisis care
- Quality of treatment of crisis care
- Recovery and staying well

The following standards are to be refreshed in the future and are our first initial step to improving mental health crisis.

**Access to crisis care support**

1. Crisis telephone helplines » A local mental health crisis helpline should be available 24 hours a day, 7 days a week, 365 days a year with links to out of hours’ alternatives and other services including NHS 111

2. Self-referral » People have access to all the information they need to make decisions regarding crisis management including self-referral

3. Third sector organisations » Commissioners should facilitate and foster strong relationships with local mental health services including local authorities and the third sector

4. GP support and shared learning » Training should be provided for GPs, practice nurses and other community staff regarding mental health crisis assessment and management.

**Emergency and urgent access to crisis care**

5. Emergency departments » Emergency departments should have a dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis

6. Liaison Psychiatry » People should expect all emergency departments to have access to on-site liaison psychiatry services 24 hours a day, 7 days a week, 365 days a year

7. Mental Health Act Assessments and AMHPs » Arrangements should be in place to ensure that when Mental Health Act assessments are required they take place promptly and reflect the needs of the individual concerned

8. Section 136, police and mental health professionals » Police and mental health providers should follow the London Mental Health Partnership Board section 136 Protocol and adhere to the pan London section 136 standards

**Quality of treatment of crisis care**

9. Crisis housing » Commissioners should ensure that crisis and recovery houses are in place as a standard component of the acute crisis care pathway and people should be
offered access to these as an alternative to admission or when home treatment is not appropriate

10. Crisis resolution teams/ Home treatment teams » People should expect that mental health provider organisations provide crisis and home treatment teams, which are accessible and available 24 hours a day, 7 days a week, 365 days a year Recovering and staying well

11. Crisis care and recovery plans » All people under the care of secondary mental health services and subject to the Care Programme Approach (CPA) and people who have required crisis support in the past should have a documented crisis plan

12. Integrated care » Services should adopt a holistic approach to the management of people presenting in crisis. This includes consideration of possible socioeconomic factors such as housing, relationships, employment and benefits (p.6,7)


NHS Choices

Crisis
If you, a family member or friend require urgent care but it is not life threatening, you could call NHS 111. You should call NHS 111 in the following circumstances:

- if a person with an existing mental health problem is suffering a relapse in their symptoms
- if a person is experiencing a mental health problem for the first time
- if someone has self-harmed in a way that clearly does not immediately threaten their life, or is talking about wanting to self-harm
- if a person shows signs of onset of dementia
- if a young person leaves care
- if a person is experiencing domestic violence or physical, sexual or emotional abuse

However, if you’ve already been given a Crisis Line number by your GP or local CCG, you should call them instead.

If you are under the care of a mental health team and have a specific care plan that states who to contact when you need urgent care, you should follow this plan.

If you have urgent concerns about someone’s social circumstances, such as children and young people, vulnerable adults or people with learning difficulties, it may be more appropriate to call social services. Local government services such as housing services and social care services often run out-of-hours duty provision. Search for your local council and find out how your social care service deals with emergencies out of office hours.

Social care services may also be involved in the assessment of people in crisis through the legislation of the Mental Health Act.

http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/accessing%20services.aspx

http://www.nhs.uk/Conditions/online-mental-health-services/Pages/introduction.aspx
Excerpt:

**The role and functioning of Crisis Resolution and Home Treatment teams**

All Trusts use Home Treatment teams (HTT) or Crisis Resolution and Home Treatment teams (CRHT) as “gatekeepers” for inpatient care, seeking to provide alternative care outside hospital wherever possible. Some Trusts the Commission visited, however, make CRHTs absolutely central to their whole service with in some areas the same team responsible for admissions and discharges.

As noted in the first Chapter, there are risks to patients, carers and the public if patients are treated by CRHT teams which are not able to provide adequate, intensive support. Decisions about admission and discharge need to be made with knowledge of the strength and capability of the whole system locally.

It is clearly essential that the composition and capability of CRHTs should reflect the intensive and specialised nature of the role. This requirement is, however, not being met across the country. A recent review of 75 CRHTs measured their performance against best practice and found that average team performance was lower than “good” in all areas measured. 33% of teams scored less than “good” in the item on adequate staffing, and 73% scored less than “good” in relation to providing a full multi-disciplinary team.

The Commission also notes that there is an extensive study currently underway on how well CRHTs adhere to their intended model of operation and how this impacts service user outcomes.

There are no simple solutions here. North East London NHS Foundation Trust (NELFT) which now has the highest ratio of acute home treatment to inpatient care and the lowest acute bed base across London began the redesign of its services in 2008 and has continued development with the same leadership ever since. It serves a population of about 1 million in some of the most deprived communities in London. Its acute bed numbers have fallen from 17 per 100k in 2008 to 10 in 2013. Similarly, older people’s bed numbers have fallen from 12 in 2008 to 5 per 100k in 2013. It has a low suicide rate and has not transferred any patients out of its area since commencing the programme in 2008 (p.26).

**Philosophy:**

The philosophy of the model is based on a simple premise:

> “What can we do today to make a difference tomorrow?”

P.27

An example of a recommendation:
The Commission recommends that:

“Commissioners, providers and Strategic Clinical Networks in each area together undertake a service capacity assessment and improvement programme to ensure that they have an appropriate number of beds as well as sufficient resources in their Crisis Resolution and Home Treatment teams to meet the need for rapid access to high quality care by October 2017”.
http://media.wix.com/ugd/0e662e_6f7ebeffbf5e45dbbefacd0f0dcffb71.pdf

Agencies & activities & research

Examples of charities who assist with crisis situations are:

Mind

Report: Listening to Experience: An independent inquiry into acute and crisis mental healthcare.

Mind commissioned an independent panel to carry out an inquiry into acute and crisis mental health care. We ran a call for evidence, held hearings and visited a range of services. We asked:

• What do people in mental health crisis need?
• What is good about existing acute and crisis services – what would you like to protect or have more of?
• What are the problems in acute and crisis care?
• If services in your area are being reorganised, what impact is this having on acute and crisis care (if you know)?
• What changes in acute and crisis care do you want this campaign to achieve?

This report outlines its methods and findings but is perhaps best summarised by the vision described:

“Our vision for acute and crisis care is of one that is built on humanity, embodying a culture of service and hospitality, where people are treated with kindness, respect and courtesy, have someone to talk to and feel safe.

We believe there should be a stronger voice for the person in crisis, with healthcare professionals acknowledging people’s own experience and trusting in their knowledge of when they are going into crisis and what helps. Jointly produced crisis and safety plans, that are signed off by the person whose care it is and followed through by healthcare teams, should be standard practice. When people are detained, their views should still be taken
seriously and they must experience the same standards of hospitality and humanity as anyone else.

Prevention and management of violence should be based on human values, and restraint and seclusion made a thing of the past. We want to see everyone who needs help receiving it in a timely way and the crisis (or ‘pre-crisis’) response becoming the start of recovery. There should be more options for people in crisis – more gateways into help and more kinds of help so that the requirements of all groups and communities can be satisfied. People should be understood in the context of their own lives, and friends and family members be supported. Compulsion should be reduced and those from black and minority ethnic communities no longer over-represented in compulsory care and coercive interventions.

We believe provider organisations should be run on human principles, expressed not only in care for those receiving services, but also for staff and the care/working environment. Staff should be supported and developed, especially in positive risk-taking and through reflective practice. The complementary skills and capabilities of peer workers, healthcare professionals, support staff and volunteers should all be used to best effect. We believe psychiatrists should be valued as part of the team or as consultants, but not always be seen as ‘in charge’.

“We would like to see the defining concept of residential acute care shift from that of the medical ward towards that of a retreat; providing humane, respectful, personalised care in a comfortable environment.

Our vision is of acute and crisis services that are well known in communities as people and places that provide healing and recovery and which welcome their local communities into them. A vision of services that are always ready to involve and learn from other organisations and sectors – from education to leisure and hospitality.

To realise this vision we have to work together, to recognise and learn from those services which work well and to raise the level of those which are failing people” (p.5).

https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

Rethink Mental Illness

Getting help in a crisis

- Overview
- What is crisis
- Getting help
- Mental Health Act
- Problems getting help
- Support

If your relative has a mental illness, you may find that there are times when their mental illness gets worse. This section aims to give you information on who to contact if you feel that the situation has reached crisis and they need urgent help.
In these pages, we refer to the person you know or care for as your relative, though we understand that you may not be related.

- A mental health crisis can mean different things, but is generally when someone’s health worsens to the point where they need urgent help from professional services.
- You and your relative may notice early warning signs that their mental health is getting worse. It can be useful to try and get help at this stage to try and stop a possible mental health crisis.
- Different services can help if your relative is having a mental health crisis, such as the Community Mental Health Team (CMHT) or crisis team.
- In some circumstances, it may be appropriate to use the Mental Health Act. The ‘nearest relative’ can ask social services to think about doing an assessment under the Mental Health Act for your relative.

Find local support

Find services and support groups near you We provide a range of services nationally, including advocacy, carer support, crisis services and more. Click here to find groups and services in your area

SANE

Crisis

If you feel you are in crisis, you might like to know about some options for help and support in addition to the free help available from SANE.

General crisis support:

- Ring or text a friend or family member.
- Ring SANEline, a specialist mental health helpline -0300 304 7000 between 6pm and 11pm each evening.
- You can ring Samaritans any time - 116 123 – they offer a listening service.
- Ring NHS 111 by dialing 111.
- Go to your local Accident and Emergency department if you are feeling suicidal or if you have self-harmed and are concerned about it.

If you already have contact with mental health services:

- Contact your local Community Mental Health Team (CMHT)
- Contact your crisis team if you have one.

If you have had no contact with mental health services, e.g. it may be the first time you, or someone else, has been in crisis:
• Contact your out-of-hours GP service. Google ‘Out of hours GP in x’ (give your location).
• Alternatively, your GP surgery will usually provide an answer phone message advising you of who to contact in an emergency, together with other useful telephone numbers.
• Make an appointment with your regular GP, as this is usually the first point of contact for anyone concerned about mental health issues.

http://www.sane.org.uk/what_we_do/support/crisis/

**Benefits of online mental health help**

You don’t need a lot of experience with computers or the internet to use online mental health services. They are available around the clock and are easily accessible via a computer, tablet or smartphone, wherever you are. Other advantages include:

• suitable for anyone who doesn’t want to work face to face with a therapist
• helpful for people who find it difficult to leave home because of agoraphobia or social anxiety
• shorter waiting times for NHS referrals
• no need to travel to a particular location
• discreet and confidential

If you need help with getting online, your local UK Online centre can help.

The following online mental health services are examples of those that have all been approved for use by the NHS.

**Big White Wall**

Big White Wall is an anonymous digital service that supports people experiencing common mental health problems such as depression and anxiety. It’s available around the clock and is staffed by trained "Wall Guides" who make sure that the community is safe and supportive. Big White Wall is available on the NHS in some areas, or you can join by paying a subscription of £25 per month.

See more about Big White Wall

**Buddy**

Buddy is a mobile phone app that allows you to keep a daily diary of your thoughts, feelings and behaviours via text messaging. It’s designed to be used alongside face-to-face sessions with a therapist rather than being a mental health treatment in its own right.

The app prompts you to text what you are doing and how you are feeling each day. Reading through your text messages helps you to spot patterns in your behaviour and make connections between what you do each day and how you feel. It also helps you to plan your next therapy session.

See more about Buddy
Leso digital health

Leso digital health offers live, confidential one-to-one cognitive behavioural therapy (CBT) with a therapist via secure instant messaging. It’s available to anyone with common mental health problems such as depression, anxiety, pain management, obsessive-compulsive disorder (OCD), phobias and stress management.

Leso is available to NHS patients in some areas. You can also buy private CBT sessions directly through Thinkwell, Leso’s website for paying clients.

See more about Leso digital health

Research

Crisis intervention for people with severe mental illnesses
Suzanne M Murphy et al, 2015

In keeping with the original ethos of earlier crisis-intervention models, the models used for people with serious mental illnesses usually, but not always, require a multidisciplinary team of specifically trained staff. These teams may be available 24 hours a day. They advocate prompt detection of exacerbation of serious mental illness followed by swift, time-limited, intense treatment delivered in a community setting.

Since their initial introduction several 'crisis' programmes have emerged, all designed to offer intensive crisis-oriented treatment to mentally ill people in a variety of community settings. These include programmes such as mobile crisis teams, crisis units in hospitals, crisis day treatment centres and crisis residential programs.

This expansion of crisis-intervention programs has been dramatic. In countries such as Australia and in North America it is now the central method of treatment used in community mental health programmes (Finch 1991; Weisman 1989). In the UK, government policy mandated that crisis resolution home teams (CRHTs) be established throughout England (Department of Health 2000).

The objectives of this Cochrane Study were to review the effects of crisis-intervention models for anyone with serious mental illness experiencing an acute episode compared to the standard care they would normally receive.


- The reviewers found no new studies to include since their previous update in 2010
- 8 studies were included in this review, and were of variable quality. Only one was rated high quality
- 1,144 patients data in total
- Six of these studies were more than 20 years old, one was published fifty years ago. Only two were published in last ten years
- Pooling of data was not possible beyond mental state, but this suggested mental state did not appear improved (MD -4.03, 95% CI -8.18 to 0.12)
Data from single studies indicated:

- Reduced hospital readmissions at 6 months (RR 0.75, 95% CI 0.50 to 1.13)
- Those in crisis groups appeared more satisfied with care (MD 5.40, 95% CI 3.91 to 6.89)
- Family burden was not reduced at 6 months (RR 0.34, 95% CI 0.20 to 0.59)

Authors conclusions

Care based on crisis-intervention principles, with or without ongoing home care packages, appears viable and acceptable way of treating people with serious mental illnesses.

However, only eight small studies with unclear blinding, reporting and attrition bias could be included and evidence for the main outcomes of interest is low to moderate quality. If this approach is to be widely implemented it would seem that more evaluative studies are needed.


IRELAND

National policy

Department of Health

The groups for which most social care supports are provided currently are those of disability, older people and mental health. The common thread running through all of these groups is the need to provide a service, which holds the individual care recipient at its centre. We need to foster innovation and ensure that a service exists that will maximise independence and achieve value for the resources invested.


Mental Health

In 2015 the Minister for Primary Care, Social Care & Mental Health have published the priorities for the Department of Health for 2015. The mental health ones included:
• Publish National Framework for Suicide Prevention
• Publish review of the Mental Health Act 2001
• Update Vision for Change Policy with a focus on implementation of key initiatives

Each year, the Department of Health allocates funding to the Health Service Executive (HSE). Each HSE Area then makes decisions about how they will distribute available resources to the agencies in their area.

Health Services Executive (HSE)

Most people with mental health problems can be treated by their GP, and are referred to HSE Mental Health Services when necessary. The HSE provides a wide range of community and hospital based mental health services in Ireland, and these services have seen dramatic changes and developments over the past twenty years.

These changes continue, as we move from the hospital model to providing more care in communities and in clients’ own homes.
http://www.hse.ie/portal/eng/services/list/4/Mental_Health_Services/

HSE: National Service Plan, 2015

One part of this is a significant shift of resources into the community.

HSE webpage for people in crisis
http://www.yourmentalhealth.ie/Mind-Yourself-Support-Others/In-crisis/

Healthy Ireland in the Health Services National Implementation Plan 2015 – 2017

An excerpt:

Chronic or non-communicable diseases are illnesses that affect people over a long period of time and cause a burden of illness, pain, disability and premature death to those who experience them and to their families. Chronic diseases include diabetes, cancer, heart and lung diseases and mental health problems. Chronic diseases are predicted to increase by up to 40% by 2020.

• 1 in 5 of all of us will experience mental health problems in our lifetime
• Levels of depression and admissions to psychiatric hospitals are higher among less affluent socio-economic groups
The vision for mental health services is to support the population to achieve their optimal mental health and the Mental Health Division aims to do this through the implementation of the recommendations of the Report of the Expert Group on Mental Health Policy – A Vision for Change (2006), and in the context of the publication of Connecting for Life Ireland’s National Strategy to Reduce Suicide (2015-2020).

The vision is recovery focussed, service user-centred, flexible and community based. It spans the spectrum of services provided by the Division which extends from promoting positive mental health through to supporting those experiencing severe and disabling mental illness. Resources and materials to support this programme are available at [www.hse.ie/wellbeing](http://www.hse.ie/wellbeing)

**ACTIONs 96–105**

- Continue roll out of SCAN (Suicide Crisis Assessment Nurse)
- Continue implementation of the Clinical Programmes for Self Harm
- Collaborate with Health and Wellbeing teams and programmes to accelerate the development of programmes for early intervention and prevention
- Improved service user and carer/family engagement in the design and delivery of mental health and wellbeing services
- Develop an increased focus on the health and wellbeing of our population in the delivery of recovery oriented services
- Provide continuous professional development to all staff
- Deliver health promotion and improvement programmes aimed specifically at supporting the wellbeing of staff working in mental health services
- Implement Connecting for Life Ireland’s National Strategy to Reduce Suicide (2015-2020)
- Develop a programme to train staff in intensive cessation supports to enable them to assist clients who smoke to quit
- Further develop psychology services within primary care to support and empower clients and service users to manage their mental health and promote wellbeing


**Advancing Community Mental Health Services In Ireland: Guidance Papers**

Excerpts from this 2012 document are quoted as the author saw fit.

The past 6 years have seen Mental Health Services grapple with the challenge of re-orientating from a hospital and bed based focus to developing the structures and processes required for community based services in line with national policy as laid out in *A Vision for Change*.

Targets for change are:

1. Establishment of professionally complete community mental health teams
2. Rapid access to emergency assessment in the community and prompt access to routine assessment
3. Availability of day hospital care and treatment on a seven day week basis
4. Improved effectiveness and efficiency of care and treatment through the implementation of the clinical programmes in mental health
5. Significant reduction in acute inpatient admissions
6. Significant reduction in length of stay for acute inpatient admissions

Table 2 details the functions of the different components of acute community-based secondary mental health care. As highlighted above, the needs of service users/carers will only be met to the extent that these service elements work in an integrated manner.

| 1 CMHT | Provide and co-ordinate a range of interventions in a variety of locations (e.g., out-patient clinics, home-based intervention, day hospital, crisis house, day centre) and interact with and liaise with other services. |
| 2 Assertive outreach team | Provide a form of specialised mobile outreach treatment for those with more severe and enduring mental health presentations. |
| 3 Crisis resolution and homecare team | Offer immediate, short-term, intensive treatment and support during a crisis period. |
| 4 Day hospital | Provide a range of interventions for those in acute phase of illness including alternative to in-patient admission for a proportion of service users |
| 5 Crisis house | Provide a community based short term alternative to hospital care in a safe, supportive and, family-like environment for service users in crisis. |
| 6 Respite house | Provide a planned period of residential care, the aim of which is to prevent or delay hospitalisation while additionally providing relief for service users’ carers. |

Chapter 5 in this document is: Crisis Resolution And Home Treatment Teams

As quoted:

“Crisis resolution and home treatment (CRHT) teams were established to offer immediate support to people with severe mental health problems in a crisis. They aim to provide an alternative to in-patient admission and to ‘gate keep’ admissions to hospital (Dublin West South West Mental Health Services, 2009).

They give short-term, intensive treatment and support during the crisis period to those who are not admitted to hospital’ (Boardman & Parsonage, 2007, p.31-32). In a crisis resolution context, a 'crisis' is defined as the breakdown of an individual's normal coping mechanisms.

Crises may vary in form – they may be developmental, situational, or a result of severe trauma (SCMH, 2001). The benefits of home treatment can include the maintenance of family systems and the support of members of social systems.
It is seen as more acceptable and therefore less intrusive and traumatic to service users and carers. It is also less likely to lead to institutionalisation (McGlynn & Flowers, 2006)” (p.26).

Table 5. Aims and objectives of different home treatment teams.

- Provide immediate assessment and intervention 24 hours a day, 7 days a week to individuals experiencing a mental health crisis. In view of the acute nature of their difficulties, service users/carers need someone they can turn to should a difficulty arise, especially in the middle of the night when people feel most alone. If they know they can get immediate help at any time of the day or night, they will be more willing to accept home treatment.
- Provide a service in service users’ own environment with minimal disruption to their normal routine. There are some who will not come to a clinic or a Centre or an Accident and Emergency department, despite efforts to get them there, because they do not believe they need help, or they do not want help.
- Engaging people in their own environment allows them to behave more naturally, more of their social network is likely to be involved, and staff can evaluate the circumstances in which intervention is to take place.
- Provide a service that accepts that mental health difficulties cannot be isolated from an individual’s social system. Therefore their social system needs to be part of the assessment, intervention and ongoing care. ‘The network can give important information about the client that the client does not disclose…CRHT teams in turn should inform, advise, educate and generally support the social network’.
- Provide an alternative to hospital admission for individuals experiencing acute mental health difficulties.
- Ensure inter-disciplinary assessment and decision making at the point of referral for hospital admission. The value of this approach is in broadening the scope of the assessment and the provision of a range of crisis interventions. However, this may necessitate a change in work practices for a number of disciplines.
- Act as gatekeeper to hospital beds by ensuring that every individual referred for in-patient admission receives a comprehensive inter-disciplinary assessment before a decision is made about intervention location.
- If intensive support is available to service users in the community, discharge from hospital can occur at an earlier stage than had previously been possible Having resolved a particular crisis, these teams need to ensure that service users/carers are, where necessary, linked into ongoing care and that they have access to further assistance, on a 24-hour basis, if required (p.27).

Table 6. Interventions provided by home treatment teams

- Rapid response following referral
- Time-limited and intensive intervention and support with sufficient flexibility to respond to different service user/carer needs.
- A range of therapeutic interventions including medication management, cognitive and behavioural interventions, and evidence-based family interventions.
- Active involvement of service user/carers, and liaison with multiple stakeholders (e.g., General Practitioners, and voluntary and community services).
• Short-term respite accommodation i.e. crisis houses may be offered if the home environment becomes too stressful. They can provide alternatives to hospitalisation as well as respite for service users and their carers/families

**Staffing**

The required size for a CRHT team depends on variables including population size and degree of unmet clinical need in a catchment area, the level of hospital admissions for that area and the profile of in-patient stays. Allowing for periods of leave and sickness, a team needs to have the capacity to maintain an adequate service provision rota and to ensure strong intra-team communication as well as external communication with other services.

In urban areas, the most appropriate model may be a discrete crisis resolution team that exists alongside other services such as mainstream CMHTs, AOTs and acute in-patient units. In rural areas or less densely populated areas, where a discrete crisis resolution service may not be cost effective, crisis resolution workers may be included within another appropriate service. For example, one or more generic CMHTs might provide a crisis resolution service through either dedicated specialists within the team and/or a rota of staff.

**Impact**

The quickest way to demonstrate the impact of a CRHT service is via reduced admissions and bed use. Such data collection is both straightforward and resource neutral. However, CRHT teams need to collect data on a broader range of performance indicators so that they can monitor their progress, identify blockages and plan for the future:

- Number of admissions: by consultant psychiatrist/sector
- Average length of stay: by consultant psychiatrist
- Number of referrals from the in-patient units: by consultant psychiatrist/sector
- Number of these referrals accepted for early discharge
- Early discharge cases – proportion of CRHT team workload.

(Author note: Consumer feedback should be in here)

**Table 7. How crisis resolution differs from assertive outreach (p.29).**

<table>
<thead>
<tr>
<th></th>
<th>CRISIS RESOLUTION</th>
<th>ASSERTIVE OUTREACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of involvement</td>
<td>Short term, usually 2-3 weeks</td>
<td>Longer term, frequently several years</td>
</tr>
<tr>
<td>Service users</td>
<td>May have no previous contact with psychiatric services</td>
<td>Established mental health history</td>
</tr>
<tr>
<td>Referrals</td>
<td>Accepted from GPs, A&amp;E department and service users themselves (if already known)</td>
<td>Usually require referral from secondary service</td>
</tr>
<tr>
<td>Hours of operation</td>
<td>Always 24 hour</td>
<td>Usually more limited</td>
</tr>
<tr>
<td>Service delivery</td>
<td>Rapid response – usually within one hour</td>
<td>Longer response time, especially for service users not previously known to service</td>
</tr>
<tr>
<td>Other</td>
<td>Act as gatekeepers to in-patient beds</td>
<td>Usually no gatekeeping role</td>
</tr>
</tbody>
</table>
Chapter 7: Crisis And Respite Houses

Crisis houses

A crisis 2 house is an ordinary community residence where mental health professionals and support staff provide 24 hour care for those experiencing acute mental health difficulties (WHO, 2010). Such services cater primarily for those service users who otherwise may require in-patient care. However, crisis houses do not seek to replicate, or provide a ‘watereddown’ version of hospital care. Rather, a key objective is the provision of a safer, less stigmatising alternative to hospital care that provides a more communal, family-like environment.

Given that they are ultimately designed to provide a more cost-efficient alternative to hospital care, cost-effectiveness tends to be a key dimension on which crisis houses are measured. However, dimensions of healthcare like acceptability and accessibility are as equally important. With regard to the former, it is important that crisis houses provide an adequately safe and supportive environment. A combination of qualitative measures and quantitative measures (e.g. the Ward Atmosphere Scale; Moos & Houts, 1968) may be required. With regard to the accessibility dimension, key performance indicators related to the referral process may be analysed to ensure that service users can efficiently access the service in their time of crisis.

Respite houses

Crisis houses aim to meet the immediate needs of individuals in an acute phase of mental health distress. In contrast, respite houses provide a more planned period of residential care, the aim of which is to prevent or delay institutionalisation while additionally providing relief for service users’ carers.

http://www.hse.ie/eng/services/publications/Mentalhealth/vfcguidance.pdf

The Department of Children and Youth Affairs

The Department of Children and Youth Affairs focuses on harmonising policy issues that affect children in areas such as early childhood care and education, youth justice, child welfare and protection, children and young people’s participation, research on children and young people, youth work and cross-cutting initiatives for children.


One in 4 people in Ireland will suffer from mental health problems at some stage in their life and 75% of the first onset of poor mental health occurs under the age of 25.
This Policy Framework has adopted an outcomes approach, based on five national outcomes for children and young people. These outcomes are that they:

1. Are active and healthy, with positive physical and mental wellbeing.
2. Are achieving their full potential in all areas of learning and development.
3. Are safe and protected from harm.
4. Have economic security and opportunity.
5. Are connected, respected and contributing to their world.

The outcomes approach adopted here will underpin all subsequent interrelated strategies.

“Prevention and early intervention means intervening at a young age, or early in the onset of difficulties, or at points of known increased vulnerability, such as school transitions, adolescence and parenthood. Universal services are the main providers of prevention and early intervention. Prevention and early intervention is cost-effective. The Government is committed to rebalancing resources to place a greater emphasis on prevention and earlier intervention, the aim of which is to gradually transfer resources over time from crisis to earlier points of intervention” (p. 8).

“Mental health is defined as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Children and young people’s mental health is the most important aspect of their social and cognitive development. Good mental health is a necessity if they are going to reach their full potential and truly live a life that is filled with positive experiences.

The recent rise in demand for mental health services and the incidence of self-harm and suicide among children and young people is of significant concern” (p.53).

Examples of Government commitments are:

- “Implement a Vision for Change as it relates to children and young people, in particular to improve access to early intervention youth mental health services and coordination of service supports, with a focus on improving mental health literacy and reducing incidents of self-harm and suicide.
- Ensure there is equity of access to child and adolescent mental health services for all children, in particular those aged 16 and 17 years”(p.57).
- Enable hard-to-reach groups to access services by making health services (including mental health services) available in youth-friendly, accessible and inclusive environments(p.58)

Mental health and well-being services

“Primary care practitioners provide care for children and adolescents with less severe mental health problems, supported where necessary by psychology services or where more specialised help is required, by community-based Child and Adolescent Mental Health Services (CAMHS). CAMHS have been established throughout the country and are the source of referral for children needing assessment or with complex or more severe needs (p.72).”

The Mental Health Commission

The main vehicle for the implementation of the provisions of the Mental Health Act, 2001 is the Mental Health Commission, which was established in April 2002. It is an independent statutory body, whose primary function is to promote and foster high standards and good practices in the delivery of mental health services and to ensure that the interests of detained persons are protected.
http://www.mhcirl.ie/

Strategic plan

Agencies and activities

Two interesting models for nursing are outlined.

Report - Research Evaluation of the “Suicide Crisis Assessment Nurse” (SCAN) Service, 2012

A General Practitioner or Primary Care Team is frequently the first point of contact for a distressed person seeking assistance. While sometimes their needs are health related, others may be situational and require a wider response. In a busy Primary Care practice it can be difficult to contain the crisis and keep the individual safe.

The Suicide Crisis Assessment Nurse (SCAN) approach is to anticipate these needs and be in a position to respond to many of these immediate presentations. Built on a clear evidence
base, the SCAN model brings confidence to health practitioners in choosing a care and support pathway for the individual in crisis.

“SCAN is a responsive service model, rooted within the community, the persons own natural habitat, which can introduce helpful services and coordinate practical measures” (p.2)

The results found that GPs valued the service and “There is plausible evidence in both Wexford and Cluain Mhuire that the decline in inpatient admissions since 2008 is related, at least in part, to the introduction of the SCAN service” (p.10).

“Self-harm nurse” Galway and Roscommon Health Service, 2014

“In January 2014, Galway/Roscommon Mental Health Services launched the first of three self harm nurse posts in this area. Two further posts are approved for this year, and will be located in Roscommon General Hospital and in Portiuncula Hospital Ballinasloe respectively. This is part of a national plan to appoint over thirty nurses under the Clinical Programmed for Management of Self harm in Emergency Departments, which is also in line with Vision for Change.

The Self Harm Nurse Service will be based in University Hospital Galway, and will take direct referrals from the Emergency Department and from the Psychiatric Liaison Team. The primary role of the Self Harm Nurse will be to engage with the person following a self harm episode, carrying out a detailed mental health assessment and risk assessment. This involves an in depth bio psychosocial assessment, identifying the causes of the crisis, the context of the self harm, the current level of risk, the primary stressors and triggers, and a formulation of a management and safety plan. Following this the self harm nurse may see the person for structured sessions to begin educative and therapeutic work around reduction and management of self harm behaviours. Interventions may in certain instances, be less formal and take the form of telephone support and advice or guidance. ….the person may be referred on to other more medium-to-long term counselling within the primary care and nonstatutory sectors.

The service also offers an outreach service to patients in their own homes if appropriate. If it becomes clear that the person has a more serious mental health concern, the Self Harm Nurse can arrange an outpatient appointment for the person to see a psychiatrist, or arrange for a hospital admission for assessment and treatment”.


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This report by Chambers D and Murphy F is relevant in that young people may turn to online help in a crisis situation.

Chapter nine is entitled: Crisis response and escalation protocols

Crisis response procedure (online)

It notes: “Virtually every organisation which provides mental health information or support online could be the recipient of crisis communication which indicates a risk to life situation. Ranging from synchronous counselling to services contactable by email, online mental health resources should be prepared to respond to such communication”(p.31).

The report outlines a policy for such distress cals and a template for responding to people in crisis.
http://www.hse.ie/eng/services/list/4/Mental_Health_Services/NOSP/Resources/goodpracticeonline.pdf
Mental Health Reform

Established in 2006, Mental Health Reform is the national coalition of 55 agencies promoting improved mental health services and social inclusion of people with mental health conditions. “We work towards achieving a system of good health and social care that is available to everyone no matter where they live or what their income is”.

http://mentalhelp.ie/

This organisation has a web page for getting help in a crisis:

http://mentalhelp.ie/crisis-support-2/

Organisations

Samaritans
Established in Ireland in 1962, there are now 20 Samaritans branches across Ireland with 2,400 active volunteers.

Aware

Aware’s purpose is to provide information, education and support for people who experience depression or related mood disorders and their concerned family members and friends. As well as our educational programmes; Life Skills, Wellness@Work and Beat the Blues, Aware offers three core support services: Support Line, Support Mail and Support Groups.
http://www.aware.ie/help/support/aware-support-services/

Pieta House

This agency provides a free, therapeutic approach to people who are in suicidal distress and those who engage in self-harm. It has nine sites across Ireland.
http://www.pieta.ie/
The New Zealand Health Strategy sets the direction of health services to improve the health of people and communities.

The 2016 New Zealand Health Strategy refreshes the previous strategy, developed in 2000. It was developed with the help of sector leaders, independent reports, extensive public consultation, and was informed by other government programmes and initiatives.

The Strategy has two parts:

- New Zealand Health Strategy: Future direction
- New Zealand Health Strategy: Roadmap of actions 2016

The information below on crisis services is provided by the Ministry of Health website.

**Mental health services**

Most people will be referred to mental health services through their GP or family doctor. On this page you can find out what to do in an emergency, read a list of helplines, and access other resources to help you find services.

**What to do in an emergency**

If you're seriously concerned about someone's immediate safety:

- call 111 or take them to the Accident and Emergency Department (A&E) at your nearest hospital
- phone your nearest hospital, or your district health board’s psychiatric emergency service or mental health [crisis assessment team](http://www.health.govt.nz/publication/new-zealand-health-strategy-2016)
- remain with them until support arrives
- remove any obvious means of suicide (eg, guns, medication, cars, knives, rope).

**Helplines**

- The Depression Helpline (0800 111 757)
- Healthline (0800 611 116)
- Lifeline (0800 543 354)
• Samaritans (0800 726 666)
• Youthline (0800 376 633)
• Alcohol Drug Helpline (0800 787 797)


Mental health crisis services (for emergencies only).

The Ministry has a webpage outlining all the crisis teams in New Zealand by District Health Board, by area covered and by phone number and operating hours.

It appears that most teams operate 24/7 though this is sometimes unstated in some regions. http://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services/crisis-assessment-teams

Example of information from a crisis mental health team:

Capital and Coast District Health Board

Crisis Assessment & Treatment Team
Telephone 0800 745 477

The CAT team provide 24 hour, 7 days a week assessment and short-term treatment services for people experiencing a serious mental health crisis and for whom there are urgent safety issues.

CATT provides after-hours crisis contact for clients of all C&CDHB Mental Health, Addictions & Intellectual Disability Directorate (MHAID) services, general practitioners, community and consumer groups and other health professionals.

You may contact the crisis service by:

• Phoning the team yourself - 04 494 9169
• Referral by GP, or another community provider
• Asking your whanau/family or friend to contact us

We may provide crisis assessment following phone discussion. The venue for your assessment may be at a clinic, in your home or another agreed venue. Assessment and treatment options will be discussed with you. The CAT team may also consult with your whanau/family and others involved in the crisis situation.

Treatment planning (up to 6 weeks)

Following assessment we will work with you to develop a plan that will help you to engage with appropriate supports. We provide information about:
• Mental illness and Addictions
• Mental Health (CAT) Act 1992
• Other services available in the community

We also provide:

• Referral to other mental health services where appropriate
• Crisis Respite
• Links to Maori Mental Health and Health Pasifika
• Consultation and liaison to health services in the community
• Home Based Treatment
• Day Hospital

We are located at Kenepuru Hospital, Raiha Street, P O Box 50-215, Porirua (8.00am to
5.00pm)”

Data collected on crisis services

Mark Smith from Te Pou^2 noted:

“The Ministry uses information on crisis mental health by collecting data on activity code T01
- Mental health crisis attendance. However there is some issue with this being collected
consistently across the different DHBs I understand. This information gets pulled for
organisations like the Police”.

Resources for use in a mental health crisis

Examples of written and online information are:
“Having suicidal thoughts?”

“Everyday people and mental illness”

Examples of websites are:

The Lowdown
Helping young people understand and deal with depression. Video, stories, guides, music,
chat.
https://thelowdown.co.nz/

Depression website
How to recognise depression, find a way through and stay well. Includes e-therapy tool The
Journal, guided by Sir John Kirwan (an ex-All Black)
http://www.depression.org.nz/
Working to prevent suicide

The Ministry of Health website notes:

“Suicide is a serious concern for New Zealand communities. Every year, around 500 New Zealanders die by suicide, with many more attempting suicide. This has a tragic impact on the lives of many others – families, whānau, friends, and workmates, communities and society as a whole”.

The Ministry has a webpage which highlights some of the current initiatives led by government that are contributing to preventing suicide by enhancing protective factors or reducing risk factors – many of these are led by agencies in the community; including Maori, Pacific and Asian communities.

Cross-government programmes contributing to preventing suicide

The Ministry supports many work programmes that also feed in to suicide prevention.

Initiatives in the New Zealand Suicide Prevention Strategy and Action Plan sit alongside other work programmes across government that share a focus on the risk and protective factors for suicide.

These include work on vulnerable children, crime, education, drugs, gangs, mental health and family violence.

Suicide Prevention Information New Zealand  http://www.spinz.org.nz/page/5-home

Managed by the Mental Health Foundation this website has a wide range of resources, including: Responding to People at Risk of Suicide

Health & Disability Commissioner (H&DC)

Open All Hours

In an older document led by one of the current authors, (Peters, 2001) for the Mental Health Commission of New Zealand) it was found there was no standard name for a crisis service in New Zealand. Names appear to have been chosen to reflect the local service context.

In 2016 many teams have the same name. Below shows the variation in service names and acronyms used around the country.
Examples of crisis service names

CAT: Community Assessment Team (the most common name used)
MCT: Mobile Community Team
PEHTT: Psychiatric Emergency and Home Treatment Team
SMET: Southland Mental Health Emergency Team
CATT: Community Assessment and Treatment Team
MHEAT: Mental Health Emergency Assessment Team
PES: Psychiatric Emergency Service
TACT: Timaru Assessment Crisis Team (p.13)

http://www.hdc.org.nz/media/200431/open%20all%20hours-%20review%20of%20crisis%20mental%20health%20services.pdf

Since this report was done there are now also new names, for example:

Community Acute Team

Crisis Resolution (CR)

Health Passport

In a crisis mental health situation the “Health Passport” could be useful.

The H&DC and the Ministry of Health promote the Health Passport, which is:

“a booklet you can carry with you when you go to hospital or when you use other health and disability services, such as your GP or a new carer. It contains the information you want people to know about how to communicate with you and support you”.

The Health and Disability Commissioner is working with hospitals around the country to introduce the Health Passport. Visit their website to order a copy of the Health Passport or download one to print.
http://www.hdc.org.nz/publications/resources-to-order/health-passport
Te Pou o Te Whakaaro Nui is a national centre of evidence based workforce development for the mental health, addiction and disability sectors in New Zealand. We work with a range of organisations and people including service providers (DHB and NGO), training and education providers, researchers and international experts. Organisations can use Te Pou’s resources, tools and support to improve their services. Te Pou includes Matua Raki (addiction workforce development) and Disability Workforce Development. We’re funded by the Ministry of Health. [http://www.tepou.co.nz/about](http://www.tepou.co.nz/about)

Te Pou undertakes a wide range of work, and while there is not a specific focus on crisis services per se, many of the initiatives contain work that assists this area. [http://www.tepou.co.nz/initiatives](http://www.tepou.co.nz/initiatives)

Three examples are:

**Early intervention in psychosis services** are set up to provide intensive support, as early as possible, for people who may be experiencing psychosis for the first time. Early intervention clinicians aim to provide recovery centred, collaborative support which may range from talking therapy, group work, medication, psychoeducation and family work. The research suggests that people who receive this type of specialist service recover faster, experience more complete recovery, and have lower rates of relapse and hospital admissions. [http://www.tepou.co.nz/initiatives/early-intervention-in-psychosis-/164](http://www.tepou.co.nz/initiatives/early-intervention-in-psychosis-/164)

**Reducing seclusion and restraint**

Seclusion and restraint are traumatising experiences for people receiving services and staff delivering services.

Evidence based tools are available to support in-patient services to reduce seclusion and restraint, developed by Te Pou with support from the Ministry of Health. There are also resources in the area of sensory modulation.

Reducing and working to eliminate seclusion and restraint is highlighted as a priority action in *Rising to the Challenge*. Currently New Zealand has made good progress towards reducing seclusion and restraint and Te Pou will support DHBs to continue that work. [http://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102](http://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102)

**On Track: Knowing where we are going**

This report is intended to serve as a road map for Mental Health and Addiction (MH&A) non-government organisation (NGO) providers as they work to achieve this transformation. It has been written from the perspective of NGOs, with the principal aim of helping providers to make changes in their models of service delivery.

One of the key ways that NGOs has improved service delivery is in the area of crisis respite care. [http://www.tepou.co.nz/uploads/files/resource-assets/on-track-knowing-where-we-are-going.pdf](http://www.tepou.co.nz/uploads/files/resource-assets/on-track-knowing-where-we-are-going.pdf)
Agencies and activities

Mental Health Foundation of New Zealand

This national agency is the most well-known mental health agency in New Zealand.

“Our work is diverse and expansive, with campaigns and services that cover all aspects of mental health and wellbeing. We take a holistic approach to mental health, promoting what we know makes and keeps people mentally well.

We provide free information and training, and advocate for policies and services that support people with experience of mental illness, and also their families/whānau and friends. Established in 1977 from the proceeds of a telethon, the Mental Health Foundation (MHF) is a charitable trust, with a governing board. Board members are experts in their fields – they are professionals who collectively guide our direction.

Te Tiriti o Waitangi and The Ottawa Charter are the core documents from which our principles and values are based, and the board is committed to directing our work to reflect this. We value the expertise of mental health consumers/tangata whaiora and incorporate these perspectives into all the work we do. Our work is funded through donations, grants and contract income”.

http://www.mentalhealth.org.nz/home/about/

Do you need immediate help?

1. If this is an emergency and you feel you or someone else is at risk of harm - phone 111
2. Go to your nearest hospital emergency department (ED)
3. Phone your local DHB Mental Health Crisis Team (CATT team). See contact numbers below or ring Healthline 0800 611 116.

Below is the example of crisis services in Auckland only (phone numbers for the whole country is covered on this webpage)

<table>
<thead>
<tr>
<th>DHB</th>
<th>AREA COVERED</th>
<th>PHONE</th>
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<tbody>
<tr>
<td>Northland</td>
<td>Topuni to North Cape</td>
<td>Whangarei 09 430 4101 ext 3501 After hours 0800 223 371</td>
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<tr>
<td></td>
<td></td>
<td>After hours 0800 223 371</td>
</tr>
<tr>
<td>Waitemata</td>
<td>Wellsford to North Shore</td>
<td>West Swanson, Piha &amp; Titirangi 09 822 8500 After hours 09 822 8500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Henderson 09 822 8500 After hours 09 822 8500</td>
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SCOTLAND

National strategy

The Scottish Government

Our work on mental health is divided into five main areas:

- Work to promote good mental health and improve mental health services is set out in the Mental Health Strategy
- Work to improve services for people living with dementia, their families and carers is set out in the Dementia Strategy
- Work to reduce suicide and self harm is set out in the Reducing Suicide and Self Harm section of the website
- Responsibility for, and development of mental health law. Information about mental health law and development of updated legislation is available on the Mental Health Law section of the website
- Supporting Scottish Ministers statutory role in respect of Restricted patients

http://www.gov.scot/Topics/Health/Services/Mental-Health/Strategy/MHDT
Mental Health Strategy for Scotland: 2012-2015

The current legislative and policy framework for mental health service provision is multifaceted, and involves a wide range of different Acts, national policies and initiatives. The current key policy for mental health in Scotland is the Mental Health Strategy for Scotland 2012–2015. This documents a number of key areas of focus and makes 36 commitments to further Scotland's mental health.


An excerpt from the Strategy (p.8):

“Key Change Area 3: Community, Inpatient and Crisis Services

A well functioning mental health system has a range of community; inpatient and crisis mental health services that support people with severe and enduring mental illness. There has been considerable redesign of mental health services across Scotland, continuing the long-term trend of moving from largely inpatient services to services where care and treatment is delivered mostly in the community. Within the broad direction of change towards developing more services based in the community, we know that there are wide variations in pace of change, delivery, and models of services.

As information about mental health services has been developed over the past few years, there is increasing scope to use data - across teams, services, local areas and internationally - to understand variation and use the information to plan and implement change. There are examples across Scotland of NHS Boards using such data to improve the quality of care and treatment, improve the efficiency and effectiveness of services, and to make strategic decisions about how services should be configured. We intend to develop our understanding of how service structure and design produce better outcomes.

Intensive Home Treatment Services and Crisis Prevention Approaches

Some mental health problems can be episodic in nature, with people experiencing stable periods with few symptoms, and periods of crisis with intense symptoms. A number of NHS Boards have developed home treatment services to care for people in their own homes during the acute phases of severe mental illness. Two reports, The Scottish Crisis Resolution/Home Treatment Network Service Mapping Report and A Review of Crisis Resolution Home Treatment Services in Scotland, highlight the range of models that have been developed in Scotland but also indicate the difficulty in making comparisons across the models to understand which deliver the best outcomes”........

http://www.gov.scot/Publications/2012/08/9714/8

The HEAT Target

The national target is to reduce the suicide rate between 2002 and 2013 by 20 per cent. The NHS is supporting this by ensuring 50 per cent of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010.
Why is this HEAT target important?

Suicide prevention is a major public health challenge in Scotland.

Many people who are feeling suicidal give an indication of their intent, whether verbally or through behavioural change. This is where training to increase the knowledge and skills of key frontline staff in the NHS forms a vital role. The more staff who feel confident and willing to explore possible signs of suicide risk and provide support and help, the higher the potential for saving lives. The Suicide Prevention HEAT target therefore aims to increase the number of people being trained in suicide prevention skills, to ensure that people most likely to be in contact with those feeling suicidal will be trained in the necessary skills to help.

http://www.gov.scot/About/scotPerforms/partnerstories/NHSScotlandperformance/suicideprevention

NHS Health Scotland is a national Health Board working with public, private and third sectors to reduce health inequalities and improve health. Details of related programmes of work being taken forward by NHS Health Scotland and our partners.


Briefing to Scottish Parliament, May 2014

Organisation of mental health services

Mental health services are delivered primarily through the NHS and local authorities, in partnership with the voluntary and independent sectors (e.g. charities and other not-for-profit organisations). NHS Boards are responsible for the treatment of those with mental health problems either in community or acute settings, whilst local authorities are responsible for securing social care and support services (e.g. housing, day care services etc.) in the community, as well as providing a range of mainstream services to support recovery. The principle behind delivery is that care should be organised through a partnership approach to ensure that the needs of the whole person are met, and not just their medical requirements.

Third sector organisations

The third sector, which includes charities, voluntary and other not-for-profit organisations, plays an important role in the provision of services, support and information for people with mental health conditions.


Quality

There are three Quality Ambitions for Scotland, that dictate that health and care must be safe, person-centred and effective.

Targets

There are currently two national HEAT targets regarding aspects of mental health service provision. These are to reduce the waiting times for referral to treatment in both CAMHS and psychological therapies to 18 weeks by the end of December 2014 (Scottish Government online).
Mental Health in Scotland: National Standards for Crisis Service Services Practice Toolkit, 2008

The aim of this resource is to provide clear guidance which can be used by services to help them to operationalise the vision laid out in the National Standards. The insights gained from the work of the Learning Network have helped to shape this resource; ensuring that it takes account of the reality of being in crisis and of providing support to people in distress.

This resource is for:

- Crisis practitioners to evaluate their own individual practice and to share learning across teams;
- Service users and their carers to develop understanding of what they can expect from crisis services;
- Service managers to evaluate the implementation of the National Standards for Crisis services across services and to inform service improvement activities;
- NHS Boards to measure progress of services towards implementation of the National Standards for Crisis services; and
- Joint planning groups which bring together a range of partners to steer crisis service development and improvements.

STANDARD 1   Access and Availability
STANDARD 2   Planning and Delivering Support
STANDARD 3   Promoting Equality and Respecting Diversity
STANDARD 4   Resolution and Discharge
STANDARD 5   Service User Involvement
STANDARD 6   Supporting and Involving Carers
STANDARD 7   Training/Workforce Development
STANDARD 8   Working with Communities

Process and outcomes

Although this resource mainly takes an outcomes-based approach to evaluation, it also recognises the importance of putting in place the right processes to achieve these outcomes.

Therefore this resource seeks to combine outcome methods of evaluation with the identification and evidencing of the process undertaken. By combining outcome measurement with process indicators the Workbook aims to enable services to capture the quality of the experience of service users and their carers, the learning of practitioners as well as measuring the impact of the service in terms of the benefits to service users and carers. http://www.gov.scot/resource/doc/924/0072211.pdf

NHS 24 - Scotland's national Telehealth and Telecare organisation

Call us free on 111 if you are ill and it can't wait until your regular NHS service reopens http://www.nhs24.com/
NHS 24 (the Board) is a Special Health Board responsible to Scottish Ministers through the Scottish Government Health and Social Care Directorates.  
http://www.nhs24.com/aboutus/

An example of a NHS website from one area:

**NHS Greater Glasgow and Clyde**

<table>
<thead>
<tr>
<th>Mental Health</th>
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<tbody>
<tr>
<td>If you feel you are:</td>
</tr>
<tr>
<td>• NOT COPING WITH LIFE</td>
</tr>
<tr>
<td>• DEPRESSED</td>
</tr>
<tr>
<td>• SUICIDAL</td>
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</tbody>
</table>

Access to urgent mental health services is available over 24 hours, including public holidays, through the Community Mental Health Team and Crisis Service. Call NHS 24 on 111.

Many people throughout their lives will have periods where they feel stress. In the majority of cases this is perfectly normal given the pressures that many of us have to face in everyday life. There will be times however, when stress becomes unbearable and some people who suffer from existing mental health issues such as severe depression or psychosis they may require to access urgent help.

The appropriate and rapid access to emergency mental health services is by contacting your GP who may put you in touch with your local Community Mental Health Team (CMHT) who if appropriate can see you the same day.

Crisis Intervention Teams work closely with local teams to ensure that people who are at significant risk have access to a Mental Health Practitioner 24 hours a day, 365 days a year. Crisis Teams are specifically there to support people who are experiencing a mental health crisis and who require rapid intervention and can be accessed via your GP or through NHS 24 out of working hours.

http://www.nhsggc.org.uk/patients-and-visitors/know-who-to-turn-to/mental-health/

**A Review of Crisis Resolution Home Treatment Services in Scotland, 2011**

This report is intended to help NHS Tayside in the planning and development of a Crisis Resolution Home Treatment Service. It draws on all of the main available research evidence from the UK, and more importantly upon the experience of nine other services in Scotland. Some of these have been operating some form of a Crisis Resolution Home Treatment Service for several years now. These clearly have had a positive impact on acute mental health care.

“Of the different models reviewed – especially the differences between the stand alone and partially integrated approaches - it is not possible to determine which one is best at delivering the benefits of a CRHT – reduced admissions. While the structure and organisation of the services is important, so are the philosophy, attitude and outlook regarding the acute patient pathway”(P iv).

The research evidence overall does not provide an absolute indication of what factors are the most important, but it is possible to list some of the factors in addition to overall funding that were highlighted as impinging upon delivery of the intended outcomes:
1. The extent to which the CRHT team was the gatekeeper to admission (i.e. there were no other pathways to admission)
2. Staffing out of hours/weekends
3. Liaison between CRHT teams and inpatient services (which particularly affected the level of early discharges)
4. Input from consultant psychiatrists – either in terms of the time input from consultants or whether they were integrated with the CRHT team.
5. Inappropriate referrals because of referrers not understanding the purpose of the CRHT team.


Agencies and activities

Why Mental Health Matters to Scotland’s Future, Briefing Paper, 4th March 2016

Much of this paper is quoted in order to get the full picture.

In a briefing paper published this month, the Scottish Mental Health Partnership (SMHP) is calling for a radical shift in Scotland’s approach to mental health.

The 14 member organisations all have a national remit undertaking a variety of roles. These include health and social care provision; public health, social justice and advocacy roles as well as the representation of people affected by mental health issues.

The Partnership came together as a result of a growing collective sense that Scotland needs to recommit to mental health, as a critical health, socioeconomic and political issue for our times. Member organisations bring different perspectives, and there is healthy debate. We are united in the belief that Scotland must take a world leading position in innovation, vision and action in mental health.

We aim to:

- Increase awareness of the prevalence and consequences of poor mental health in Scotland and influence public attitudes towards people experiencing mental health issues.
- Improve the provision, accessibility and quality of mental health services and supports in Scotland, which are person centred, rights based and empowering.
- Take a positive approach to considering the potential for systems level and transformational change in support of improved mental health.
- Promote parity of esteem between mental and physical health provision and ensure that mental health is considered across policies.
For all

We need to prevent the distress that leads to isolation, discrimination and, too often, an early grave. For most, that will mean creating opportunities to thrive in work, as parents, as learners or as citizens building our resilience and ability to cope with adversity and to know when and where to seek support when we need it. This means recognising the role mental health plays in achieving Scotland’s agreed national outcomes across the board. Continuing to back early years provision, preserving key resources like libraries and leisure facilities, and creating opportunities for safe and affordable housing and employment all help build wellbeing across the population.

For people most at risk

Inequality in mental health means the unequal distribution of and exposure to protective factors that promote positive mental health and risk factors that are known to be detrimental to mental health. Our unequal society and the cost of this to mental health should be a central concern for us all; it leads to an unequal distribution across population groups of mental health conditions and illness and in people’s ability to recover and lead fulfilling lives. If we want a fairer and more just society, we need to address the chronic stress that having less power, status and control brings, and to work with people to build strong communities and empowering services. For many people who are most disadvantaged in society, who experience inequality, exclusion and other life challenges, addressing mental health means acting early to educate about the importance of looking after mental wellbeing, to prevent distress, to encourage and to nurture. This is key for people who have experienced trauma, or have been affected by bullying or other risk factors. It is critical for groups like refugees and asylum seekers, care leavers, LGBTI people, offenders and other marginalised populations, who are at increased risk of mental ill health.

For people living with mental health conditions

An increased focus on population mental health and wellbeing must be complemented by a continued focus on addressing mental health conditions when they arise. Many people experiencing mental ill health are finding it increasingly hard to access the sort of timely and effective help and support that can aid longer-term recovery and too often the people who are able to get help and support report negative experiences. These include a lack of compassion, choice, an over-medicalised approach and difficulty in raising concerns. For people living with mental health conditions, ‘prevention’ means support to live a fulfilled life, as free as possible from the disabling effects of ongoing mental ill health. This requires flexible, equitable access to health and social care services that act early, hold hope, and focus on the creating the circumstances for a person to thrive, not merely exist. That in turn is critical for avoiding the economic and social impact of health inequalities that can lower life expectancy by 20 years.

We are calling on the Scottish Government to make an immediate commitment to:

- Adopt a rights based approach to the development of the next Mental Health Strategy, as recommended by the Mental Welfare Commission and the Scottish Human Rights Commission.
• Operationalise the Christie Commission recommendation to ensure that all public services assume a responsibility to address inequalities first, by recognising the complex bidirectional relationship which sees inequality drive down mental health, and poor mental health drive-up inequality. Mental health inequality should be considered explicitly in all equality impact assessments, and in all future strategy development.

• Ensure that the process of delivering primary care reform and health and social care integration has due regard for mental health, both in terms of the public mental health agenda and the equal status of mental health in health and social care funding and access.

• Support a shift towards services and supports which are focused on evidence-informed prevention and early intervention, self-management and peer support. The approach to this should be co-produced by a wide range of stakeholders, including the diversity of people in Scotland who experience mental health conditions. One route might be an innovation process or processes that tested promising concepts at scale, with robust evaluation against key output, process and impact outcomes. It is critical that pilot projects which show promise find support for scale development that includes the reallocation of resources where necessary. It is highly likely that to achieve this, additional investment in the development of lived experience leadership, research, and development will be necessary.


The members of the Scottish Mental Health Partnership (SMHP) are:

• Action on Depression
• Bipolar Scotland
• British Psychological Society
• Mental Health Foundation
• Penumbra
• Royal College of GPs
• Royal College of Psychiatrists in Scotland
• Samaritans
• Scottish Association for Mental Health (SAMH)
• Scottish Independent Advocacy Alliance (SIAA)
• Scottish Recovery Network (SRN)
• See Me
• Support in Mind Scotland
• Voices Of eXperience (VOX)

http://www.samaritans.org/news/rethinking-mental-health-scotland

Two examples of NGO services:

Voices of Experience

VOX is a National Mental Health Service User Led organisation, we work in partnership with mental health and related services to ensure that service users get every opportunity to contribute positively to changes in the services that serve them and wider society.
VOX sits on a range of groups whereby collaborative working helps to ensure that those who have or have had mental health problems are central to service developments.

We are involved in the Mental Health Cross Party Group, the Royal College of Psychiatrists, the Independent Living In Scotland Project Development Steering Group, The Mental Welfare Commissions Practice Network and the Peer Support Development Group. read more

http://www.voxscotland.org.uk/about/our-work/improving-services

The Scottish Association for Mental Health

An excerpt:

Crisis Support
SAMH Crisis Support is part of services offered to people in the Scottish Borders area experiencing mental health crisis. We are a team of support workers, who support people through periods of mental health crisis. The service offers an alternative to in-patient admissions during times of crisis, where this is appropriate.

What do we do?
SAMH Crisis Support provides support to people in their own homes. The service focuses on out of hours support, ensuring that people are able to access the service in the evenings and at weekends. We offer a rapid response to referrals, and can offer an intensive level of support where this is needed (i.e. two or more contacts each day).


Mental Health Foundation, Scotland

In Scotland, we focus on social justice and inequality in mental health, raising awareness of mental health with the public and working in partnership with community organisations, policy makers and researchers.

Today, the Mental Health Foundation has published a review of Mental Health Services in Scotland in partnership with Voices of Experience (Vox) and supported by Healthcare Improvement Scotland.

Commissioned by the Scottish Government as Commitment One of the Mental Health Strategy for Scotland 2012 - 2015, the report reflects on the successes and challenges of the current mental health system in Scotland. Collating the experiences of people using services, families and carers, practitioners, commissioners and stakeholders, it makes a number of practical recommendations to build on progress already made. The review follow news that the Scottish Government is investing an additional £54 million in mental health services over the next four years with a focus on expanding provision for children and young people and improving the availability of psychological therapies to all.

Isabella Goldie, Director of Development and Delivery at the Mental Health Foundation said:
"Focused on the experience of people with living with mental health problems, their family, carers, and relevant healthcare professionals we hope this report guides and influences the development of mental health services in Scotland in the coming years.

"The direction of travel has been positive with much change for the better. But clearly there is more that needs to be done to ensure that people in Scotland have access to the mental health services they need and deserve. To this end the report sets out a number of practical recommendations to build on progress already made, which we look forward to being seen delivered in the near future."
https://www.mentalhealth.org.uk/news/mental-health-foundation-publishes-review-mental-health-services-scotland

A Review of Mental Health Services in Scotland: Perspectives and Experiences of Service Users, Carers and Professionals, Jan 2016

Report for Commitment One of the Mental Health Strategy for Scotland: 2012 - 2015

An excerpt:

Experiences of accessing inpatient care

With the shift from hospital-based to community-based mental health care, there was a perception among service users that accessing hospital services has become more difficult but that there has not been a corresponding increase in community care capacity. Therefore, people are now more ill on admission to hospital:

'It's more and more hard for people to get into hospital, especially those who have personality disorders and it almost seems to be a national statement to say that all the evidence is that if you have a personality disorder, you shouldn't go into hospital without providing any alternative.'

- Expert Interview (p.69)

This view differed from some members of staff in some of the services visited. They recognised this perception amongst some of their longer terms service users who had lived through the movement towards more community-based mental health care. However, they felt that home treatment, crisis teams and community services represented progress in that they now allowed for people to be supported in their own homes for longer than previously possible:

'We try to treat people at home unless it becomes unavoidable and they have to be admitted. They are then sent home to be supported and treated there.'

- Staff, Panel Inquiry Area

A reoccurring theme that emerged from the review, raised by a range of participants including GPs, CAMHS staff teams and voluntary sector organisations, was the view that some of the demand on CAMH services was due to a gap in provision around crisis care and in
prevention/early intervention. Despite this, one area highlighted good practice around training of teachers and those who work with young people to identify distress, in particular self-harm, and provide them with the skills to help young people manage this.

“We are coming across more and more complex cases now, but we don’t have the number [of cases] to sustain a crisis team.’

- Staff, Panel Inquiry Visit (p.77)


USA

National policy

SAMHSA

Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018

This document outlines how SAMHSA will focus its work efficiently to increase awareness and understanding of mental and substance use disorders, promote emotional health and wellness, address the prevention of substance use disorders and mental illness, increase access to effective treatment, and support recovery. In this plan, SAMHSA outlines six Strategic Initiatives and the links between these initiatives and SAMHSA’s policy, programmatic, and financial planning.

STRATEGIC INITIATIVES:
1. Prevention of Substance Abuse and Mental Illness
2. Health Care and Health Systems Integration
3. Trauma and Justice
4. Recovery Support
Goal 4.1: Improve the physical and behavioral health of individuals with mental illness and/or substance use disorders and their families.

Objective 4.1.4: Expand the adoption of comprehensive community-based crisis response systems (for example: mobile outreach, respite programs) for individuals with mental illness and/or substance use disorders.

Increase core health outcomes for at least 60% of individuals served by SAMHSA’s discretionary grant programs.

5. Health Information Technology
6. Workforce Development

At its core, this plan supports a framework for cross-collaboration and organization of SAMHSA’s work to achieve its priority objectives. This plan demonstrates how SAMHSA will leverage these initiatives, and the knowledge, experience, and expertise within the agency, to advance behavioral health nationwide.

Moving forward, SAMHSA is furthering its commitment to addressing the challenges of today and the future. Leading Change 2.0 capitalizes on SAMHSA’s strengths and leverages its strong relationships with federal partners, key stakeholders, and the people served by the agency to demonstrate that behavioral health is essential to health, prevention works, treatment is effective, and people recover.

http://store.samhsa.gov/shin/content/PEP14-LEADCHANGE2/PEP14-LEADCHANGE2.pdf

National Strategy for Suicide Prevention

On September 10, 2012 the Action Alliance, along with the US Surgeon General Dr Regina Benjamin, released the revised National Strategy for Suicide Prevention (NSSP). The revised strategy emphasizes the role every American can play in protecting their friends, family members, and colleagues from suicide. It also provides guidance for schools, businesses, health systems, clinicians and many other sectors that takes into account nearly a decade of research and other advancements in the field since the last strategy was published.

The NSSP features 13 goals and 60 objectives with the themes that suicide prevention should:

- Foster positive public dialogue; counter shame, prejudice, and silence; and build public support for suicide prevention;
- Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities;
- Be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
- Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems;
- Bring together public health and behavioral health;
- Promote efforts to reduce access to lethal means among individuals with identified suicide risks;
- Apply the most up-to-date knowledge base for suicide prevention.
The revised NSSP is the work product of the National Strategy for Suicide Prevention task force, co-led by Dr. Regina Benjamin, U.S. Surgeon General, and Dr. Jerry Reed, Director of the Suicide Prevention Resource Center.

**SAMHSA-supported resource: Webinar**


This is a good resource talking about the ‘Open Dialogue’ process in a crisis situation.

Christopher Gordon and Keith Scott, Advocates, Inc.

Through education, training, and resources the Recovery to Practice (RTP) program supports the expansion and integration of recovery-oriented behavioral health care delivered in multiple service settings.

For more on resources: [http://www.samhsa.gov/](http://www.samhsa.gov/)

**National Association of State Mental Health Program Directors (NASMHPD)**

Wellness, resiliency and recovery are the overall goals and certain fundamental values guide NASMHPD in its mission:

- Human rights and health equity
- Health and wellness
- Recovery-oriented and person-centered system
- Empowerment
- Community education
- Least restrictive and most integrated setting
- **Zero suicide**
- Working collaboratively
- Effective and efficient management and accountability
- Culturally and linguistically responsive
- High quality workforce capacity

[http://www.nasmhpd.org/content/about-us](http://www.nasmhpd.org/content/about-us)
Other Agencies and activities

The Annapolis Coalition

The Annapolis Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field. As part of this effort, we seek to strengthen the workforce role of persons in recovery and family members in caring for themselves and each other, as well as improving the capacity of all health and human services personnel to respond to the behavioral health needs of the individuals they serve. http://annapoliscoalition.org/who-we-are/

National Action Alliance for Suicide Prevention: Crisis Services Task Force

From the revised NSSP, the Action Alliance has selected priorities that, when accomplished, will help the group reach its goal of saving 20,000 lives in the next five years. The priorities were chosen because of their potential to produce the systems-level change necessary to substantially lower the burden of suicide in our nation. The priorities chosen are:

1. Transform health care systems to significantly reduce suicide.
2. Change the public conversation around suicide and suicide prevention.

Crisis Now: Transforming Services is Within Our Reach, 2016-04-24

“Foundational elements of an improved mental health system are in place with mental health parity, coverage expansion, the launch of the Certified Community Behavioral Health Clinics and the Excellence in Mental Health Act, and the national implementation of first episode psychosis programs. Our nation’s political leaders recognize the work is not done, and for the first time in many years, there are several robust legislative proposals that focus on “fixing the broken mental health system.” Now is the time to get it right. Therefore, comprehensive crisis care must be included in mental health reform. Yet systematic improvements in crisis care, which could save lives and reduce fragmentation, are not included in current leading reform proposals. Now is the time to establish comprehensive crisis care as a foundational, transformative, life-saving core element of behavioral health care and of suicide prevention.

After reviewing approaches to crisis care across the United States, the Crisis Services Task Force (hereafter “Task Force”) of the National Action Alliance for Suicide Prevention (Action Alliance) believes now is the time for crisis care to change. The Task Force, established to advance objective 8.2 of the National Strategy for Suicide Prevention (NSSP), comprises many experts (see Task Force and Support Team Participants in the Appendix), including leaders who have built and who operate many of the most acclaimed crisis programs in the
nation. After reviewing the literature and model programs, we offer this report to suggest what can be done, galvanize interest, and provide a road map for change.

Our comprehensive review finds that now is the time for crisis services to expand because of a confluence of factors and forces, including:

1. Crisis care often being the preferred and most efficient care for people in crisis
2. The absence of core elements of successful crisis care in many communities
3. Mental health reform proposals that are on the table but fail to seize the opportunity to improve crisis care
4. Mental health parity legislation and coverage expansion

The challenge EDs face addressing behavioral emergencies The Task Force has studied elements of successful programs and reviewed their effectiveness. While some communities are crisis-ready, there are very few communities where all key elements of crisis care are in place, and many where even the “parts” of crisis care that exist are inadequate. In short, core elements of crisis care include:

1. Regional or statewide crisis call centers coordinating in real time
2. Centrally deployed, 24/7 mobile crisis
3. Short-term, “sub-acute” residential crisis stabilization programs
4. Essential crisis care principles and practices“(p.2,3)


National Council for Behavioral Health

In March 2015, the National Council for Behavioral Health asked its 2,300 members to participate in a critical and time-sensitive survey of crisis programs.

The survey had two main goals:

1. To collect information and learn more about the crisis services provided in the United States; and
2. To learn about the needs of the community mental health center programs that provide crisis services.

What did members report? Check out the Summary of Findings for the scope of services offered and the barriers that challenge the success of crisis services programs.
Crisis to Recovery: The National Council for Behavioral Health

National Council Magazine • 2016, Issue 1

This magazine is dedicated to crisis service innovations and best practice. It also includes some information on child & youth services.

A key focus is the need for peer solutions in the future.

Linda Rosenberg, President and CEO, National Council for Behavioral Health

Excerpt:

“Far too many people in crisis still wind up in the wrong places with inadequate care and little follow-up, or get no care at all with disastrous consequences. So it is crucial we educate the public to understand, first, that “crisis” in the context of an addiction or a mental illness does not mean “over in an instant.” As we know, it can mean intense work with a patient over weeks and months. And, second, we must convince people that these crises should be treated with the same urgency and get the same kind of effective response as, say, emergency care for a physical ailment like a broken leg.

We’d be horrified to think someone with a broken bone or a deep gash wouldn’t get appropriate treatment quickly. Yet people rarely think about all the people with mental illness or addictions who continue to fall through the cracks of our imperfect systems. There’s one crucial difference, though, between dressing a physical wound and treating a behavioral one: The extensive follow-up with counseling, therapy and other assistance that the severe mental illness or addiction requires, often involving social workers, psychiatrists and even job counselors.
That’s a far more expensive proposition than sewing up a cut and sending the patient home with some antibiotics” (p.4,5).

David W. Covington CEO & President, RI International and Michael Hogan, Independent Advisor and Consultant, Hogan Health Solutions. Co-leads, Crisis Services Task Force, National Action Alliance for Suicide Prevention

Excerpt:

A new approach to crisis care:

THEN Absence of data and coordination on emergency department wait times, access, outcomes and crisis bed availability.

- **NOW Publically available data in real-time dashboards.**

“Cold” referrals to mental health care are rarely followed up and people slip through the cracks.

- **NOW Direct connections and 24/7 scheduling.**

THEN Emergency departments are the default mental health crisis center.

- **NOW Mobile crisis provides a non-law enforcement response that often avoids emergency department use and institutionalization.**

THEN Crisis service settings have more in common with jails.

- **NOW Crisis service settings—the urgent care units for mental health—look more like home settings.**

THEN Despair and isolation worsened by trying to navigate the mental health maze.

- **NOW Crisis care with support and trust: what you want and need, where you want and need it (p.6)**

Kana Enomoto Acting Administrator, Substance Abuse and Mental Health Services Administration.

Excerpt:

In five to 10 years, what will every behavioral health crisis system include?

“Crisis systems must strive to be comprehensive, to have a unified approach, to adequately share patient information and to ensure continuity of care through all stages of treatment and referrals.

We released a paper a couple of years ago, Crisis Services: Effectiveness, CostEffectiveness
and Funding Strategies (available at http://store.samhsa.gov), that outlines the core crisis services once a crisis occurred (23-hour crisis stabilization, short-term residential, warm lines, peer crisis services, etc.).

Systems need to include activities oriented to prevention, early intervention, stabilization and postvention. All are important components”.

Vijay Ganju, Behavioral Health Knowledge Management

Excerpt:

<table>
<thead>
<tr>
<th>EXISTING SYSTEM</th>
<th>FUTURE SYSTEM</th>
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<tbody>
<tr>
<td>Crisis defined by system perspective</td>
<td>Crisis defined by consumer or family perspective</td>
</tr>
<tr>
<td>“To” or “for” consumer</td>
<td>“With” consumer</td>
</tr>
<tr>
<td>Crisis Service Directed, coercive</td>
<td>Crisis Continuum</td>
</tr>
<tr>
<td>Reduce danger to self or others</td>
<td>Recovery-oriented, trauma-informed Support</td>
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<tr>
<td>Fragmented, multiple agency response</td>
<td>and safety Coordinated partnerships</td>
</tr>
<tr>
<td>Behavioral health/law enforcement</td>
<td>Health/behavioral health (p. 14)</td>
</tr>
</tbody>
</table>

Eduardo Vega, CEO, Mental Health Association of San Francisco Bay Area
Overcoming a Crisis of Confidence: Increasing Peer Involvement in Crisis Services

Excerpt:

“What we need are programs that are able to support people at their most difficult moments and help them through crisis with understanding. For people experiencing crisis, community-based alternatives that treat a client’s unique experience as something to work with, rather than against, have greater capacity to support personal learning, healing and growth.

Those of us who have been there can be excellent resources to others at their hardest moments. Peers can relate in different ways to offer messages of hope and recovery and work to self-manage, coach and collaborate with providers in unique ways” (p.32).
http://www.thenationalcouncil.org/consulting-best-practices/magazine/

Zero Suicide

As noted earlier, Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.
A key document is:

**ZERO SUICIDE: An International Declaration for Better Healthcare. March 2016**

The introduction to this document notes:

“Every 40 seconds a person dies by suicide somewhere in the world. Over 800 000 people die due to suicide every year and it is the second leading cause of death in 15-29-year-olds. There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide. Suicides are preventable… Health-care services need to incorporate suicide prevention as a core component (World Health Organization, Preventing suicide: A global imperative, 2014) Suicide is a complex, multifaceted biological, sociological, psychological, and societal problem with few resources for prevention.

As a major international health problem, it is estimated that it will contribute more than 2% to the global burden of disease by 2020. Suicide deaths impose a huge unrecognized and unmeasured economic global hardship in terms of potential years of life lost (YPLL), medical costs incurred, and work time lost by mourners. The stigma associated with mental illness works against prevention by keeping persons at risk from seeking lifesaving help while the stigma associated with suicide deaths seriously inhibits surviving family members from regaining meaningful lives. In the UK, twice as many people die from suicide than from road accidents every year. Whilst in the US, suicide is the tenth leading cause of all deaths and the second such cause for young people aged 15-24 years, and claims 40,000 lives annually, more than from homicide.

While many lives are saved in healthcare by clinicians and other staff, many lives are also lost by individuals receiving mental health services. Until now, a central focus on suicide prevention in healthcare settings has been largely missing. Yet many people experiencing suicidal ideation are in healthcare or in contact with healthcare: recent mental health contacts by about 30% of those who die, recent primary care contacts by about 45% (70% among older men), emergency department contacts by about 10%. Furthermore, there is great risk among people treated in/discharged from psychiatric inpatient and/or crisis facilities after a prior attempt.

We can do something to change all of this”. (P.1)

For health care systems, this approach represents a commitment:

- To patient safety, the most fundamental responsibility of health care
- To the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. A systematic approach to quality improvement in these settings is both available and necessary.
The challenge and implementation of a Zero Suicide approach cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and close gaps.

**Essential Elements of Suicide Care**

After researching successful approaches to suicide reduction, the Action Alliance’s Clinical Care and Intervention Task Force identified seven essential elements of suicide care for health and behavioral health care systems to adopt:

1. **Lead** – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
2. **Train** – Develop a competent, confident, and caring workforce.
3. **Identify** – Systematically identify and assess suicide risk among people receiving care.
4. **Engage** – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. **Treat** – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
6. **Transition** – Provide continuous contact and support, especially after acute care.
7. **Improve** – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Zero Suicide is a call to relentlessly pursue a reduction in suicide and improve the care for those who seek help. [http://zerosuicide.sprc.org/about](http://zerosuicide.sprc.org/about)

**New York City**

**ThriveNYC: A Mental Health Roadmap for All.**

“For so long, our city has not done enough to support the emotional wellbeing of its residents. Too many New Yorkers have not gotten the help they needed for any number of reasons. Perhaps they were afraid to reveal their pain, the help they needed was hard to access, they couldn’t find someone who understood their culture, they didn’t think it would help, or they simply couldn’t afford it. All told, 41% of adult New Yorkers with a serious mental illness (SMI) said they needed treatment at some point in the past year but did not receive it or delayed getting it.

Clearly, mental illness isn’t just disrupting the lives of individual New Yorkers—it is exacting a terrible social, financial, and emotional cost on our city. What is needed—and what New York City currently lacks—is a major commitment to mental health, one that is backed up by resources that are commensurate to the challenge. Tackling a problem that directly affects 20% of New Yorkers—in addition to all of the people in their lives— requires a population-
wide response. And to be successful, that response must assertively support and promote mental health in addition to addressing mental illness.

The World Health Organization defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” In other words, our ability to thrive—as human beings and as a city—is closely tied to our mental health. At the most basic level, this new commitment is about thinking big and thinking differently. A public health solution must include all the following elements: prevention of illness, promotion of mental health, early detection of problems, and treatment.

By themselves, mental health professionals cannot stem the tide of one of our society’s most difficult and pervasive health challenges. To achieve lasting success, we must treat not only the individual, but also the conditions in our society that threaten mental health. We must identify when people are at greater risk and why, while paying close attention to the range of factors—both individual and social—that can either make us more vulnerable or prevent the onset or worsening of mental illness.” (p.10)

**Actions relating to strengthening crisis services are:**

6) **Police Crisis Intervention Team Program and Training (NYPD, DOHMH)** NYPD and DOHMH are partnering to implement a NYC Crisis Intervention Team (CIT) Program. CIT includes three key components: police training, drop-off options for officers, and community involvement.

A total of 5,500 officers will participate in a four-day training to help them recognize the behaviors and symptoms of mental illness and substance misuse. They will also learn techniques for engaging people in respectful, non-stigmatizing interactions that de-escalate crisis situations. This initiative is part of the Behavioral Health Task Force action plan.

7) **Public Health Drop-Off Centers (DOHMH, NYPD)** DOHMH will open two new Public Health Drop-Off Centers, which will provide NYPD with a new treatment-based option for people they encounter who show signs of mental illness and/or substance misuse and would benefit from diversion to an alternative to hospitalization or the criminal justice system.

The Centers will operate 24/7/365 with a no-refusal policy for persons brought in by the police. Our goal is to create more Centers and ultimately provide citywide coverage. In selecting clients for the Centers, we will be careful to ensure that we are advancing mental health while protecting public safety (p.47).

**Crisis/Suicide Counseling:**

- NYC Support will include a 24/7 hotline that will provide crisis intervention, suicide prevention, and resource referral services. Highrisk callers will receive more comprehensive follow-up services;
- NYC Support will provide phone-based and text-based crisis counseling;
- NYC Support will have the capacity to activate mobile crisis teams citywide (p.62)