Early Review of the Mental Health Crisis Care Concordat

Krayer, Anne; Robinson, Catherine

Published: 29/06/2017

Publisher's PDF, also known as Version of record

Early Review of the Mental Health Crisis Care Concordat

Anne Krayer & Catherine A. Robinson

Centre for Mental Health and Society, Bangor University

Ariennir gan **Lywodraeth Cymru**
Funded by **Welsh Government**

Foreword

Excellent care for people in mental health crisis is possible. After a year-long independent inquiry, Mind's 2011 'Listening to Experience' report into crisis care in Wales and England found that good, compassionate and effective care does exist but that for many provision is too little, too late or non-existent.

The harrowing experiences shared with the enquiry proved galvanising. In 2015 the Welsh Government published the 'Mental Health Crisis Care Concordat,' a powerful statement of intent by 24 of the organisations most involved in this area to work together to turn things around.

But we were determined that this needed to be more than warm words. Our Task and Finish Board enabled open, honest and focused planning and learning. We deliberately started with a fairly narrow and specific focus so as to be able to make tangible progress. We were also clear about the importance of learning from what didn't work as well as what did. From the start, we wanted to be in a position to examine the evidence, to identify what needed to happen next and to create a culture where it was safe to express frustrations and acknowledge difficulties.

I would like to thank all fellow Board members for their commitment, energy and honesty and the Welsh Government for supporting this work. All of us in the Wales Alliance for Mental Health hear good and bad accounts of crisis care every day. We know there is a long way to go and we are there all the way.

The evaluation is very welcomed and needed. The recommendations can only add to the work of local partnerships. I would like to thank Professor Catherine Robinson and Dr Anne Krayer for their independent and objective work and thank colleagues in all sectors for their contributions to this study.

Sara Moseley

Chair, Wales Alliance for Mental Health and the Mental Health Crisis Care Task and Finish Board

Summary

Background

The Welsh Mental Health Crisis Care Concordat (MHCCC) was published in December 2015. The focus of the concordat is on improving the quality and availability of services, with an emphasis on people in acute mental health crisis. Its main objective is to prevent the criminalisation of people who present with mental health problems. A National Task and Finish Group (NTFG) Board has guided the development of the MHCCC and the local implementation plans in Wales. These plans will now be implemented over the coming months.

What the evaluation is about

We explored the experiences of people involved in developing the Mental Health Crisis Care Concordat implementation plans across Wales in this early and brief evaluation. The aim was to identify opportunities and gaps that have emerged and to provide learning to inform the rollout of the MHCCC.

What we did

We looked at all the local implementation plans and talked to 21 representatives from statutory services and third sector organisations about: their role in the planning, development and implementation of the concordat; their understanding about how the concordat will operate and the expected benefits/challenges arising from the concordat.

Summary of findings

- Stakeholders report the NTFG as a great success as it provided a forum for discussion and knowledge exchange.
- Opportunities to move away from silo thinking and working to provide a service that matters to people was seen as important.
- Local delivery plans include innovative ideas and areas of good practice
- Details need to be agreed on how the plans will be delivered.
- Challenges include agreeing priorities, working within financial constraints and maintaining momentum.
- Crisis care pathways need to be supported by clear decision-making arrangements and real time clinical advice where appropriate.

- Care should be based on recovery principles and professionals should treat people with compassion and dignity.
- Providing services for people who are intoxicated and/or moderately violent and the development and provision of a range of Alternative Places of Safety (APoS) were perceived as challenging and may benefit from further work at national level and additional resources.
- Decisions need to be made about what data to collect, how it is collected and how it is shared.
- Data collected needs to include experiences of people using the services and professionals providing it.
- Including people who use services and carers is very beneficial and can ensure that services provided meet people's needs

This brief and early evaluation of the implementation of the Mental Health Crisis Care Concordat and the experiences of people involved in the National Task and Finish Group highlights some successes and illustrates examples of good practice and innovation. There is cause for optimism and excitement looking ahead to the actual implementation of the MHCCC. However, the work is only just beginning and this brief evaluation has identified a number of areas that will be important in the future of crisis care.

Our findings and the literature around comprehensive person-centred mental health service provision, suggest that conceptualising mental health crisis responses as occurring in a system of services rather than independent sectors is critical. Developing and implementing care pathways collaboratively is crucial. Ensuring that all key partners are familiar with these pathways is equally important. Taking forward joint working principles and learning from the development phase will be key to making the implementation of the MHCCC a success. Providing opportunities to share learning and experiences are essential and examples are joint training and co-location (for example in the control room). Distinct visions of care and service provision that guide specific practice need to be made transparent. A system approach underscored by principles of joint working will facilitate working through challenging issues such as conveyancing or providing services to people who are intoxicated and/or moderately violent or. Areas need to make sure that they develop mechanisms to sustain collaboration and work

towards embedding change in their organisations. Situating the MHCCC in the wider policy and practice context such as the unscheduled care framework would support this.

Recommendations

- **Continue developing and strengthening joint working foundations whilst moving from a task-focused to a systems thinking approach:** This will facilitate dealing with complex issues, including commissioning and running Alternative Places of Safety and working with people who are intoxicated and/or moderately violent.
- **Consider overall data needs to be able to document change and compare service provision across Wales**: in addition, meaningful qualitative data should be collected and ways established so it can be fed back into the system to enable learning.
- **Continue enabling meaningful involvement for people who use services and their carers at all stages of the implementation:** This would support the shift from a medical, problem-focused model of service delivery to a recovery-based one.

Wider questions

It became clear during the interviews and the analysis of the data that there are some wider issues linked to the implementation of the MHCCC, which need to be considered. The following two issues seemed to be the most pertinent:

- **What is the role of the police in mental health crisis?** Some commentators in the literature suggest that this is linked to the wider question of the future of policing in the 21st century. Additionally, there are debates about the police taking more of a public health role.[1, 2]
- **What are the definitions of mental illness, distress and crisis and our expectations of appropriate responses from services and communities?** There are a number of interpretations and expectations that people and professionals hold implicitly. These need to be articulated and made transparent.

Contents

Introduction

The Welsh Mental Health Crisis Care Concordat (MHCCC) was published in December 2015. The focus of the concordat is on improving the quality and availability of services, with an emphasis on acute mental health crisis. Its main objective is to prevent the criminalisation of people who present with mental health problems.

The Mental Health Crisis Care Concordat is designed to support policymaking; investment in services; in anticipating and preventing crisis; and in making sure effective emergency response systems operate in localities when a serious crisis occurs. [3]

The Mental Health Crisis Care Concordat is structured around four key areas:

- Access to support before crisis point
- Urgent and emergency access to crisis care by both face-to-face and 'hear and treat' services.
- Quality treatment and care when in crisis
- Recovery from crisis and staying well in the future.

Senior leaders from different agencies and services, including all Health Boards, Welsh Police Forces, Welsh Fire Services and the Youth Justice Board amongst others have endorsed the MHCCC as a sign of a shared commitment to provide support in a mental health crisis.

A National Task and Finish Group Board (NTFG) had been convened, comprising partners and wider stakeholders to oversee the early phase of the delivery of the Concordat. This involved an agreement of a collective statement of intent and the drafting and signing off regional delivery plans with clear stated outcomes and timescales. The delivery plans focus on improving the care and support for people experiencing or at risk of mental health crisis in respect of Section 135/136 (s135/136) of the Mental Health Act 1983[4].

The police have powers under the Mental Health Act to arrest and detain people for the purposes of assessment within a designated place of safety. There have been longstanding issues with appropriate places of safety, timing of assessments and partnership working[5,6,7]. Recent figures released by the National Police Chief Council[8] in September 2016 show that efforts are making a difference with a 57% reduction of the

use of police cells in Wales as places of safety under s136 from the previous year. In the period from April 2015 to March 2016, police cells were used as a Place of Safety for 336 adults and eight young people (aged under 18). In total, 1,252 people were taken to Health-Based Places of Safety (HBPoS).

The regional delivery plans are expected to address the outcomes specified in the concordat:

- Better training for Police
- Better liaison between Police and Mental Health practitioners
- Suitable alternatives to the use of legal powers by Police at crisis point
- Availability of Health based places of safety
- Dynamic joint review process
- Developing an outline specification for a commissioned evaluation study
- Communication strategy

This brief and early evaluation explored the experiences of people involved in developing the Mental Health Crisis Care Concordat implementation plans across Wales and aimed to identify opportunities and gaps that have emerged during plan development and implementation and to provide learning to inform the rollout of the MHCCC.

What we did

Specifically, we aimed to …

- begin to assess the progress and impact of rolling out the area Mental Health and Criminal Justice Partnership action plans.
- begin to understand the success factors for local areas as well as the major challenges and obstacles.
- produce learning and recommendations for how local partners can effectively work together to improve the experience of people in mental health crisis.
- identify gaps in the early stages of service planning and make recommendations for further improvement activity.

To do this, we looked at all the local implementation plans and talked to 21 representatives from statutory services and third sector organisations about their role in the planning, development and implementation of the concordat; their understanding about how the concordat will operate and expected benefits/challenges (further details in the Appendix).

Background Mental Health and Crisis Care

Why does mental health crisis care need to be addressed?

- Mind raised the awareness of Crisis Care with their 2011 report, *Listening to experience*[9], which highlighted variations in crisis care provision across the UK and underscored the importance of providing person-centred mental health crisis care.
- A review by HMIC[10] in 2013 highlighted the high use of police cells as places of safety even though this should only happen in exceptional circumstances. A further inspection[11] published in 2015, emphasised that a number of vulnerable people were in custody cells inappropriately, including people experiencing mental health problems. The review concluded that this is likely to have a negative impact on people's health and well-being.
- A report by the Home Affairs Committee[12] published in 2015 documented that police officers play a key role for people in mental health crisis. The Committee questioned however, if a police officer is the best-placed professional to work with people in mental health crisis.

The importance of partnership working to deliver person-centred services to people in mental health crisis has been highlighted by all these reports. In addition, the recent passing of the Policing and Crime Bill to become an Act[13] of Parliament in January 2017 has a number of implications for policing and mental health. Restrictions of detentions of adults and children in police stations under s135/s136 are amongst the changes.

Policy Landscape

A number of Welsh policies and strategies recognise the importance of crisis care. Increasingly, there is an emphasis on partnership working and joint care planning to ensure that people receive the right care when they need it.

- The importance of partnerships when responding to people in in mental health crisis was highlighted in the *Together for Mental Health Strategy* published in 2012 by the Welsh Government[14]. Since then, a number of policy implementation guides have been published which link to the strategy. These include: criminal justice liaison services[15], mental health services for veterans in prison[16], children or young people

at risk of becoming involved in, or in, the youth justice system[17], treatment of people with co-occurring mental health and substance misuse problems[18]

- Responses to mental health crisis and the use of powers under the Mental Health Act are covered in the Mental Health Act 1983 Code of Practice for Wales[19], which outlines the duties and requirements on partners.
- The Well-being of Future Generations (Wales) Act (2015) [20] puts an onus on organisations to think long-term, work better with people and each other, look to prevent problems, and take a more joint approach. Public Services Boards should be established and local Well-being plans developed.
- A legal framework for improving the well-being of people who need care and support, and for transforming social services in Wales is provided by the Social Services and Well-being (Wales) Act 2014[21]. Apart from the focus on joint working and co-operation of organisations, it also emphasizes increased engagement of people who need care and support and their carers and promotes a focus on well-being.

Approaches to mental health crisis

There has been a focus on the development of community-based alternatives to hospital care in the UK since the 1983 Mental Health Act[22]. This went hand-in hand with the reduction of inpatient beds and the introduction of the care programme approach in the 90s[23]. Consequently, Crisis Resolution/Home Treatment teams (CRHT) rose to prominence in England and Wales. Their aim is to provide a realistic and safe alternative to hospital treatment[24]. Although crisis services have formed a part of Welsh Mental Health policy and planning[25, 26], implementation has been inconsistent[24]. Since then, there has been a growing recognition that some of the CRHT models did not work in all areas and that increased local flexibility was needed. In fact, Gilburt and colleagues[22] suggest that, access criteria for traditional CRHTs have become more restricted with teams focusing on existing patients. Very few teams provide 24hr care and assertive outreach staff have often been absorbed by community mental health teams. A recent review of Crisis Resolution teams by Hubbeling and Bertram[27] suggests that although CRHT can reduce admission and average bed use, it is unclear whether they are the only option to achieve these outcomes. They suggest that there are other alternatives such as day hospitals and

crisis houses, which may be equally effective. In common with others, they identified a lack of research evidence to draw firm conclusions.

Gilburt and colleagues[22] (p.9) argue that we are now in a phase of development and innovation to meet emerging needs and agendas, partly driven by:

- the impact of social movements and voices for change
- growing therapeutic optimism
- innovations in service delivery
- case management and care co-ordination
- changing professional roles and cultures
- financial models.

This is an exciting time with the MHCCC providing opportunities for innovate practice and the development of collaboratively commissioned models of care.

There are a number of reviews and papers, which focus on mental health crisis care provision. The following section highlights recent ones that are particularly relevant:

- A rapid evidence synthesis by Paton and colleagues[28] on improving outcomes for people in mental health crisis concluded that there is a lack of available evidence. Findings were inconclusive concerning which services were best for improving emergency access to crisis care in A&E and for helping the police with their responsibilities under the Mental Health Act 1983. However, they found that crisis teams worked well but that there are a number of different service types, which makes comparison more difficult. They also identified crisis houses and acute day hospitals as important alternatives to inpatient treatment. They concluded that a range of services are needed, including those supporting recovery, and helping with issues such as employment.
- A recent report[29], evaluating nine street triage schemes in England, identified a number of functions associated with better outcomes. These include: joint ownership of the scheme and agreed protocols; on ongoing process to review joint working arrangements; clarity about the population to be served; information provision of referral pathways to health and community services; joint training programmes; and co-location of staff or dedicated phone lines.
- A study by Lea and colleagues[30] looked at the management of people with moderate to severe mental health needs who come into contact with the police. The

study reviewed a person's journey through services, analysed costs of the journey, and consulted local stakeholders. The authors concluded that there is a need for joint protocols and training to improve information sharing and people's experiences with services.

- An evaluation of an Alternative Place of Safety Pilot in West Sussex[31] concluded that this was an effective alternative. The report provides a number of useful recommendations including the importance of collaborative commissioning and having onwards pathways to local agencies offering support with issues such as housing, employment and debt.
- Lancaster[32] provides a review of mobile crisis teams, which provide joint responses by the police and mental health services. He brings together and reflects on evidence supporting the use of mobile crisis teams and provides some useful implications for practice including that mobile crisis teams can lead to better outcomes, reduce the provisions of the MH Act and lead to fewer hospital admissions but that further evidence is needed to establish effectiveness.

What we found

We report the findings by the two phases: a *development* and an *implementation* phase. The development phase has already taken place and participants talked about their experiences with the NTFG and the development of the local delivery plans within the context of joint working. The second phase is about rolling out the MHCCC delivery plans and the themes reported here capture participants' thoughts on and expectations of what might happen.

All this sits in a wider context, which influences the delivery of the MHCCC.

Context

All participants highlighted the importance of the context in which the MHCCC delivery plans were situated. This included:

- Existing policies and strategies at local and national level, some creating competing demands on partners.
- Different starting points in terms of crisis care provision – not all areas have an outreach service or a crisis resolution team.
- Varied histories of partnership working and a high rate of staff turn-over in some areas.
- Challenges and opportunities linked to service delivery in rural and urban areas. For example, services are spread further apart and travel times are longer in rural areas. Police officers taking someone for an assessment tend to be tied up for hours and people experiencing a mental health crisis are likely waiting longer for an assessment. Models of alternative crisis care that might work in a city such as a sanctuary house are unlikely to be feasible in a rural area.

The following are some examples of the influence of policies and strategies to illustrate the complexity and range of influences. For example, the MHCCC delivery plans sit within the wider *Mental Health (Wales) Measure (2010)*[33] and some of the participants referred to this and in particular the role of the Care and Treatment Plan for people receiving secondary health services. This plan should include agreed arrangements to help prevent crisis but also agreed actions of what should happen once people are in crisis to assist their recovery.

The *Together for Mental Health Strategy* Delivery Plans[34] put the onus on local health boards to put in place local multi-agency partnership arrangements to develop local

delivery strategies. The comprehensiveness of the mental health strategies varied in the five areas due to different reasons. For example, the Hywel Dda University Health Board is currently reviewing their mental health service provision through the *Transforming Mental Health Services* Consultation[35]. This has an impact on their MHCCC delivery plan as they need to await the outcomes of the consultation.

Finally, some participants felt that the *Social Services and Well-being (Wales) Act 2014*[21] puts competing demands on Health Boards.

> *But I do think there has been a knock-on effect from the Social Services and Wellbeing act. And I think that knock-on effect means that some of the, hm, I need to carefully word this, time, focus has shifted […]. (CC 20)*

These differences, in the context of the MHCCC mean that areas have different starting points and challenges to face.

Phase 1: Development of the MHCCC

Partnerships and collaborative working were at the heart of these developments. This included the NTFG, with an independent third sector Chair and Welsh Government secretariat, and the development of local delivery plans via the Mental Health and Criminal Justice Partnership Boards.

Everyone involved has experienced the NTFG in a positive way. They reported that it provided a forum for discussion, sharing concerns and knowledge exchange:

- Opened-up discussions and dialogue and provided the opportunity to develop and work towards a shared vision across Wales
- Provided space for partners to come together to better understand each other's' backgrounds, influences and approaches
- Developed trust and built relationships
- Highlighted the importance of flexible services according to what matters to people
- Created opportunities for moving away from silo thinking and working

> *The Crisis Concordat brings the need for partnerships to the fore, as mental health is increasingly an issue for all partners (…). It also provides space for partners to better understand each other's' approaches and work. (CC 10)*
>
> *The concordat provides an opportunity to look at the whole system, not just isolated pockets (Joint interview CC 4)*

The Crisis Concordat work was perceived as very timely and an opportunity for partners to focus their on-going work. Several participants talked about how existing Mental Health and Criminal Justice groups have been the springboard for taking the MHCCC work forward and the value of being able to build on existing relationships.

The MHCCC concentrates on issues around s135/136 in order to keep it *manageable, focused* and *achievable* within existing capacities.

> *In the short term, the focus for the next year has to be on reducing the overall numbers of arrest and detention using those powers because there is just too many of them. […] In the medium and long-term, which hopefully the plans, the delivery plans all capture, focus needs to be much more on prevention. (CC 19)*

This was perceived as positive overall but some participants wished the MHCCC had been more ambitious.

All the local plans address the outcomes set-out in the MHCCC but there were regional differences. The ability to implement a national MHCCC according to local needs has been perceived as very positive. However, some participants pointed out that a balance needs to be struck between providing a national consistent service and allowing for local flexibility to accommodate local needs and resources. People experiencing a crisis should be able to expect consistency in services wherever they are and too much local variation can make comparability difficult.

Plans include innovative ideas and areas of good practice including:

- Development of a mobile app to support decision-making for police officers (see case study below).
- Pilot of a sanctuary (APoS), based on learning from visits to existing projects across the UK.

- Participation of people who use services in the development of the MHCCC delivery plan.
- Development of area Vulnerability and Risk Management Multi-Agency Panels.

Case Study: Development of a Mental Health APP

South Wales Police (SWP) and the Police and Crime Commissioners Office identified concerns regarding high levels of the use of S136 of the Mental Health Act. Having completed 2 years of research, a report on Early Interventions for People in Mental Health Crisis was produced and a number of recommendations stated. One of these recommendations was to utilise the emerging mobile technology that SWP had invested in to aid officers in making better decisions and recording the use of S136. This development is supported by the Police and Crime Commissioner.

The app is the first of its kind in the UK, allowing officers to record in real-time their actions and observations around their use of S136. This offers a unique opportunity provide officers with evidence-based **accountability** as well as guidance around some of the issues they may encounter when using S136. Use of the app is intended to support officers make defensible decisions about their use of S136, therefore giving them greater confidence to use the appropriate response to a person in mental health crisis.

It is hoped that the app will play a vital role in evidencing the commitment SWP has to openness and transparency in its procedures as well as demonstrating procedural **fairness** and the incorporation of **collaborative decision-making.**

It is expect that the app will help to reinforce the Human Rights based approach to policing.

The aim of the mental health APP is to provide officers with real-time capability to record the use of S136 and evidence their decision-making.

Helen Bennett – SWP Mental Health Consultant
Jenny Phillips – Mental Health project support officer

Phase 2: The implementation of the MHCCC

Participants identified the following themes as relevant for the next phase: going forward, delivering person-centred care, data considerations, and inclusion of people who use services and cares.

Going forward

Participants perceived that the main challenges are to: *implement the local plans* consistently and *keep the momentum*.

> *Need to make sure that the concordat lives and breathes at 3.00 o'clock the same it does on a Monday morning at 10.00 o'clock. (Joint interview CC 14)*

Implementation: Participants emphasised the importance of making sure that the *right people* were coming together to be part of the local implementation activity. It is not only about having representation from all the relevant partners but also about having strategic staff representation to enable decisions to be made and acted upon. Providing opportunities for operational staff to make their voices heard was described as essential and good practice.

Anticipating work in the near future, participants talked about the need for more details of how the plans will be delivered and implemented. The need for further local negotiations were indicated such as agreements about shared priorities, commissioning, governance, accountability and resources. Partners need to further develop an understanding of each other's roles and responsibility, and relationships build on trust. Participants pointed out that there will be challenges around agreeing priorities and working within financial constraints.

For example, one area has used the delivery of multi-agency training to create opportunities for a better understanding between partners and building of relationships and trust. The training was developed based on local need and involved people who used services. Importantly, outcomes were agreed at the end of the training, ensuring that positive developments from the training are taken forward in the implementation process (see Case Study below). One of the challenges of joint training highlighted by participants was the need to accommodate certain training packages nominated by an organisation and written for a particular profession, whilst at the same time considering local relevance and delivering knowledge of interest to partners. An example is the Mental Health Training Package developed by the College of Policing[36] (2016).

Case Study: Mental Health – Working Together Awareness Raising Events in Powys

Under the auspices of the Powys Mental Health Planning and Development Partnership, the s136 Criminal Justice sub group arranged five **multi-agency training sessions** during 2016/17 focusing on:

- Respective roles and responsibilities
- Mental health presenting behaviours,
- Wales Mental Health Crisis in Care Concordat
- Powys Section 136 protocol
- Views of a person using services regarding their experience of the process.

The quality assured training included presentations from a range of contributors from Health, Social Care and Police followed by detailed discussion around a challenging case study.

Over 100 police officers from Powys plus 70 members of staff from agencies in both the statutory and third sector attended the sessions including from Psychiatry and CMHTs, AMHPs and specialist nurses, the Crisis Resolution Home Treatment Team, Ward staff, CAMHS, Welsh Ambulance Service Trust, and Third Sector.

Feedback included:

- That the message was consistent
- That training focused on the individual and acting in theirs, and others, best interest
- Having more confidence identifying and working with partnership agencies and in adhering to agreed procedures.

Whilst the package can be replicated elsewhere, it accounts for local challenges of operating in a large rural county, with only one place of safety being within its borders as well as other complex arrangements.

Evaluation highlights **positive feedback** from attendees, most notably in respect of the input from psychiatry and the person using services. She recounted her personal experiences, both past and present, highlighting the massive impact decision-making has on an individual and the encouraging difference she has seen more recently in terms of the understanding and support she has received at time of crisis because of multi-agency working.

Louisa Kerr, Mental Health Partnership and Project Manager, Powys Teaching Health Board Inspector Brian Jones with responsibilities for Mental Health, Dyfed Powys Police Force

Partners need to respect each other's expertise and provide support where applicable. An example that will create challenges for commissioning and governance are the development of Alternative Places of Safety.

> *I think the Alternative Places of Safety absolutely need a commitment from the third sector, and support of the third sector from the health board and Local Authorities (…) And I think for me that is going to be very very challenging. Because, how do we commission those settings? How do we support the third sector? (CC 17)*

Participants highlighted that questions and issues around how change can be embedded within and across organisations needed to be addressed. Change of attitudes and thinking were seen as essential, as were strong relationships.

> *It is not just about changing the model but about changing people's thinking. (Joint interview CC 4)*

Ensuring momentum to continue to make progress was seen as a challenge by participants. The delivery plans were described as only the start and now work needed to evolve and endure. Most areas were going to form sub-groups to focus on various work strands. Sub-group chairs are expected to report back to the regional Mental Health and Criminal Justice Partnership Boards Task and Finish group.

Participants emphasised the importance of the chairs' commitment and leadership in taking the work forward. Co-chairing was seen as a way of ensuring buy-in from different organisations. Other ways of ensuring momentum mentioned were:

- Further opportunities for sharing and learning from other areas
- On-going support and steer from Welsh Government
- For Welsh Government to make financial resources available
- Situating the MHCCC in the wider policy and practice context such as the unscheduled care framework

Although a communication strategy is part of the local delivery plans, participants emphasised the importance of generally raising awareness of the MHCCC – in particular with frontline staff and members of the public.

Delivering person-centred care

The importance of person-centred crisis care is reflected in the core principles of the MHCCC and participants commented on this. *Seamless care pathways* and *quality of care and recovery* were identified as important elements of person-centred care.

Seamless care pathways: participants felt that joint development and management of care pathways were essential in delivering quality care. This was highlighted in the delivery plans, for example, one of the overall outcomes of one of the plans was:

> *To improve multi-agency working at the point of crisis through the establishment of clear referral pathways and pathways of care. (Plan 2)*

Care pathways need to be supported by clear decision-making arrangements and real time clinical advice where appropriate. A number of different models (also called triage models) have been proposed in the plans or already piloted, including a single access point, clinicians in the control room or direct access to mental health services 24/7.

A particular issue when talking about care pathways is conveyance to HBPoS and APoS.

> *To go back to the earlier issue of the ambulance availability – teaching officers that if you find a person with s136 issues you call an ambulance, don't put the person in a police car anymore. If they tell you that they are creaking and can't send you one, then you are covered to take that person to hospital. (CC 14 joint interview)*

All delivery plans mention the need to review, agree or revisit conveyance arrangements. At the heart of the debate is the pressure on emergency (999) vehicles and one plan mentions the need to develop novel joint provision models (Plan 1). The following case study highlights an example of best practice.

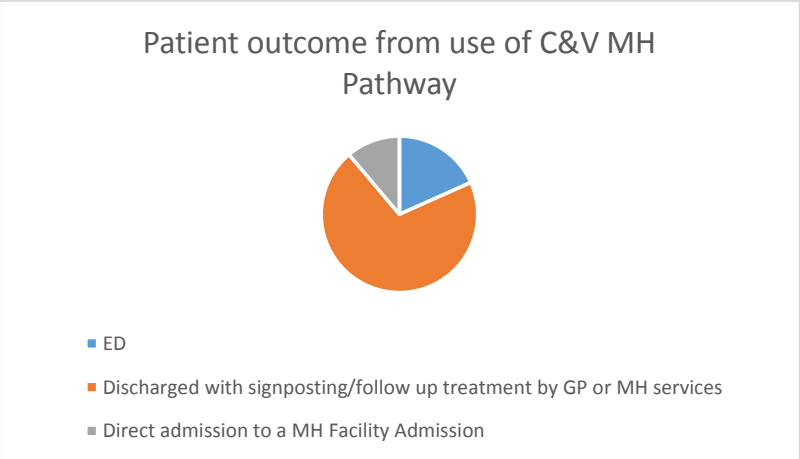
Case study: Protocol for Cardiff and Vale Crisis & Home Treatment Teams (CRHTT) and the Interface with Welsh Ambulance Services.

Patients in a mental health crisis tend to access the Welsh Ambulance Service via 999. If there is no Mental Health Pathway these patients will often end up being conveyed to an inappropriate health surrounding, namely an emergency department (ED).

An alternative pathway, the Cardiff & Vale Mental Health Pathway (C&V MH Pathway) was developed and piloted to allow patients to **be referred directly to the Crisis Team** for an assessment of their mental health needs. On receiving the 999 call, the Ambulance Staff will assess the patient looking at acute mental health needs. If Ambulance staff decide that the patient has acute mental health needs but might be well enough to be assessed outside of ED, they can telephone CRHTT for advice. A **shared decision** is made on whether patients can be safely discharged and managed in the community or a mental health assessment is needed.

What is the impact upon patient outcomes and experiences?

Patients in need of urgent help are now receiving a safe and more efficient service appropriate for their need. About 80% of calls are safe to be discharged at home with signposting or follow up treatment arranged. Audit of patients accessing the pathway show excellent benefits to patients and both organisations.



Two-hundred and fifty-one referrals made by Paramedics to C&V MH Pathway since going live have resulted in:

- 28 patients taken direct to Mental Health facility
- 177 patients discharged on scene for follow up by mental health services or primary care
- 46 conveyed to ED on advice

Of the 71% of patients discharged at scene, no adverse incidents have been recorded. The Social Care Institute of Excellence has recognised this pathway as an example of best practice.

Greg Lloyd Head of Clinical Operations WAST

Participants highlighted that seamless care pathways needed to be flexible and able to accommodate different groups of people. The two groups highlighted most often were children and young people and people who are intoxicated and/or moderately violent. Planning for and delivering services for children and young people is in early development but there are examples of good practices such as the negotiation of spaces for children and young people for assessment on a paediatric wards.

> *It is an area where the pathway is not as clear for children as it is for adults. […] We have basically commissioned beds but they are not necessarily available when we need them. (CC 20)*

There were strong feelings about crisis service provision for people who are intoxicated and/or moderately violent. Views about what could be considered to be best practice varied considerately. Some participants suggested that the issues would benefit from a consistent national approach. Intoxication may be an expression of distress and people may be at their most vulnerable and at risk when intoxicated:

> *When someone is intoxicated, they are at more risk* (CC 11)

Quality of care and recovery principles: Several participants emphasised that services should be based on recovery principles and that professionals should be compassionate and treat people with dignity. This was linked to seeing a person rather than a diagnosis or problem:

There is this whole issue of dignity and treating people as human being and having a person-centred approach, and not just to crisis care but to recovery-bit issues (Joint interview CC 8)

Focusing on a person and their needs would also help recognise that not all crises are mental illness related but that there may be issues around for example, debt or bereavement. Being able to draw on a range of options and choosing the least restrictive appropriate one (HBPoS or APoS) is then important to keep people out of the health or criminal justice system.

An example is the planned pilot of a sanctuary in one of the areas, which would also offer follow-up appointments such as bereavement counselling, coping with depression sessions, and referrals for housing, debts or substance use advice.

The therapeutic environment is so important; so there is something about the approach and the service delivery that will feel very different to a statutory service trying to assess you or tell you what happens next (CC12)

The following case study provides an example of how close partnership working can prevent people entering into crisis.

Case study: Better liaison between police officers and mental health practitioners to prevent, and at the point of crisis - the Vulnerability and Risk Management Panel (VARM) pilot

The VARM Panel is a multi-agency case management forum designed to plan services more effectively for individuals repeatedly coming to the attention of services:

- Those service users who do not fit the criteria for MAPPA (Multi-Agency Protection Arrangements)
- Relevant patients under the Mental Health Measure (MHM), but who may be displaying complicating factors, which are causing increasing concern that fall outside of the MHM risk management plan.
- Repeat demand cases with regard to s136 detention who are cause for concern and who require multi-agency risk management.
- Repeat demand cases where the vulnerability of the individuals is increasing, and impacting on the ability of agencies to provide service to others.

Thirty cases have been referred to VARM since its inception in September 2016. In all cases a joint management plan has been created resulting in reduced vulnerability and risk. Alongside this there has been an associated reduction in demand for urgent and unscheduled responses for all agencies.

The panels have been attended by Police, Mental Health, Local Authority, Housing, Probation, CAMHS North Wales Fire and Rescue, Victim Support & WAST. Membership is currently growing and the panel have co-opted attendees such as GP's where necessary.

The benefit for citizens and **services are a more co-ordinated** and coherent service provision in their area focussed on the most vulnerable members of the community. A reduction in demand on emergency services means that resources are more focussed on their primary function. Improved outcomes for people are derived from **earlier identification and intervention** and a clearly coordinated response to their needs. We envisage that continued collaborative working will improve inter agency relationships and knowledge across the sector.

Example cases

Case 1	7 incidents in 2016	No incidents following discussion at January 17 VARM	Male was suffering from acute MH issues. Actions for CMHT and Early Intervention Team (EIT) officer to visit and assess. Treatment programme provided and has now returned to full time work.
Case 2	7 incidents of concern 2017	Nil incidents since discussed at March 17 meeting	Female is now working with EIT officer. MH issues and a hoarder, work has been undertaken with NW Fire Service and a house clearance package has taken place.

David Brennan, Strategic Protecting Vulnerable People Unit, North Wales Police
Sam Watson, Clinical Network Manager, Betsi Cadwaladr University Health Board
DCI Andrew Williams, North Wales Police
James Cook, North Wales Police

Data considerations

The concordat provides an opportunity to look at what is currently collected and decide on common data sets that should be consistently collected across Wales. These would allow for comparability and ensure accountability.

There is a lack of clarity and agreement on the type of data to collect, how to collect it and what to share (CC 3)

Several participants emphasised the importance of collecting more than quantitative information such as people's experiences with services, and what difference the contact with a service has made. Some also emphasised the importance of collecting feedback from staff to understand what staff are struggling with and what they find helpful.

> *If you consider the Police data, which is one of the key success or failure factors in this particular process, there is a lag in that data being provided, and in any case […] that data doesn't provide any kind of insight into the effectiveness of the whole system (Joint interview CC 8)*

Reducing the number of s135/136 is a useful indicator; ultimately, however, it is important to be able to understand what happens longer-term and where people are ending-up:

> *Last year, X said to me we have reduced s136. And I said so what happens to these people? But nobody knows. And I said: What the hell have you done that for? (CC 21)*

This would also start to pave the way towards long-term thinking around prevention and staying well.

Inclusion of people who use services and carers

Including people who use services and carers in the development and delivery of the MHCCC is essential.

> *The service user voices have galvanised us. There is power in sharing experiences. How do we want our services to work? How do we want to support people? (Joint interview CC 4)*

Engagement of people who use services and their carers should go beyond consultation and move towards giving people a voice and including them at all stages of the implementation of the MHCCC.

Feedback indicated that having an independent 3rd sector representative chairing the NTFG, facilitated a focus on the experience of individuals going through crisis as well as a reflection of the wider partnerships needed in this context.

The level of involvement of people who use services and their carers in the development and the intended delivery of the plans varied across areas but there were a number of good practice examples (see Case study below). For example, in one area people who

use services and carer representatives participated in a number of workshops with other representatives of services to develop the local delivery plans.

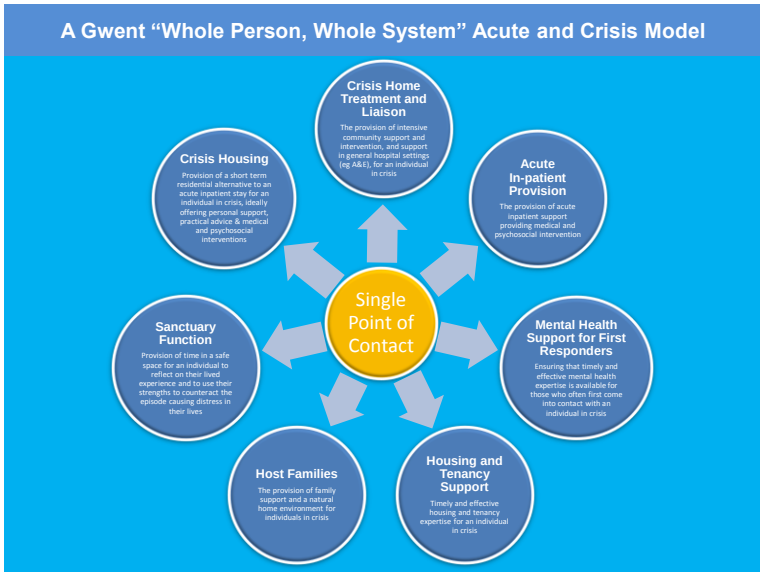
Some participants highlighted that experiences of people who use services not only needed to be captured but also fed-back into the dynamic joint review processes. An example of how this might work is the intention in one area to use an independent panel of people who use services to review cases in order to provide a perspective on what worked well, did not work well and what could be improved.

Case study: Working in Partnership to Develop a "Whole Person, Whole System" Acute and Crisis Model for the Population of Gwent

With the support of the International Mental Health Collaborative Network (IMHCN) in 2016 the Gwent Mental Health and Learning Disability Partnership Board established a multi-agency Action Learning Set (ALS) with the aim of improving outcomes for those with a mental health need who present in crisis and their carers.

Members of the ALS included service users, carers and staff from a range of statutory (e.g. Health Board, Local Authorities and Gwent Police) and third sector organisations and met over 6 full days. The ALS provided members with the opportunity to consider how individuals are currently supported and learn together via a variety of mechanisms including sharing and discussion of service user/carer/staff stories, learning from others both nationally and internationally, analysis of local data and consideration of evidence based practice.

One of the key pieces of work undertaken has been to develop a "Whole Person, Whole System" Acute and Crisis model for the population of Gwent:



It will take us a number of years to fully implement all elements of the model and we are now establishing work streams to take forward our key priorities.

Key progress to date includes;

- The introduction of a Mental Health Practitioner within the Gwent Police Control Room providing **timely advice and support** for police officers supporting individuals in crisis.
- The development of a **pathway** to enable Welsh Ambulance Service NHS Trust colleagues to access advice and direct support for individuals from the CRHTT.
- The approval of a business case to change the way individuals **access transport** when in crisis.
- A **commitment** from all partners to implementing the model and the development of a Crisis Care Community of Practice to ensure interested parties can continue to work together on this agenda.

We have only started this journey and there will be many challenges for us as we move forward. However, we are confident that by working in true partnership with those who use services, carers, and staff within statutory and third sector organisations we will meet our ambition of significantly improving outcomes, experience and support for individuals and their families.
Dr Chris O'Connor, Divisional Director for Mental Health and Learning Disabilities, Aneurin Bevan University Health Board
Sarah Paxton, Group Manager, Torfaen County Borough Council
Superintendent Nick McLain, Gwent Police

Findings in context

This brief and early evaluation of the implementation of the Mental Health Crisis Care Concordat and the experiences of people involved in the National Task and Finish Group highlights some successes and illustrates examples of good practice and innovation. There is cause for optimism and excitement looking ahead to the actual implementation of the MHCCC. Challenges identified in the work are not new, and are in line with previous work[37,38].

Summary of findings

- Stakeholders experienced the NTFG as a great success as it provided a forum for discussion and knowledge exchange.
- Opportunities to move away from silo thinking and working to provide a service that matters to people was seen as a feature.
- Local delivery plans include innovative ideas and areas of good practice
- Details need to be agreed on how the plans will be delivered.
- Challenges include agreeing priorities, working within financial constraints and maintaining momentum.
- Crisis care pathways need to be supported by clear decision-making arrangements and real time clinical advice where appropriate.
- Care should be based on recovery principles and professionals should treat people with compassion and dignity.
- Providing services for people who are intoxicated and/or moderately violent and the development and provision of a range of Alternative Places of Safety were perceived as likely to be challenging and may benefit from further work at national level and additional resources.
- Decisions need to be made about what data to collect, how it is collected and how it is shared.
- Data collected needs to include experiences of people using the services and professionals providing it.
- Including people who use services and carers is very beneficial and can ensure that services provided meet people's needs.

Concluding thoughts

Our findings and the literature around comprehensive person-centred mental health service provision, suggest that conceptualising mental health crisis responses as occurring in a system of services rather than independent sectors is critical. Developing and implementing care pathways collaboratively is crucial. Ensuring that all key partners are familiar with these pathways is equally important. Taking forward joint working principles and learning from the development phase will be key to make the implementation of the MHCCC a success.

Systems thinking focuses on how things are connected to each other. It aims to improve:

- the quality
- the interactions

of the whole and its parts.[39]

Providing opportunities to share learning and experiences are essential and examples are joint training and co-location (for example in the control room). Distinct visions of care and service provision that guide specific practice need to be made transparent. This includes perceptions of risk. A system approach underscored by principles of joint working will facilitate working through challenging issues such as providing services to people who are intoxicated and/or moderately violent or conveyancing. Areas need to make sure that they develop mechanisms to sustain collaboration and work towards embedding change in their organisations. Situating the MHCCC in the wider policy and practice context such as the unscheduled care framework would support this. The current short-term focus is on reducing the use of s135/136 where appropriate and the provision of meaningful alternatives. Work towards continuing and strengthening crisis care should be on-going and there is a need to look to the future and move towards a stronger focus on prevention.

The signing up of all areas in Wales to the Concordat and the development of local implementation plans, focusing on care and support for people experiencing or at risk of mental health crisis in respect of s135/136 of the Mental Health Act, is a major achievement. The specific plans are the starting points for system-focused work. However, the work is only just beginning and this brief evaluation has identified a number of areas that will be important in the future of crisis care.

Recommendations

- **Continue developing and strengthening joint working foundations whilst moving from a task-focused to a systems thinking approach:** This will facilitate dealing with complex issues, including commissioning and running Alternative Places of Safety and working with people who are intoxicated and/or moderately violent.
- **Consider overall data needs to be able to document change and compare service provision across Wales**: in addition, meaningful qualitative data should be collected and ways established so it can be fed back into the system to enable learning.
- **Continue enabling meaningful involvement for people who use services and their carers at all stages of the implementation:** This would support the shift from a medical, problem-focused model of service delivery to a recovery-based one.

Wider questions

It became clear during the interviews and the analysis of the data that there are some wider issues linked to the implementation of the MHCCC, which need to be considered. The following two issues seemed to be the most pertinent:

- **What is the role of the police in mental health crisis?** Some commentators in the literature suggest that this is linked to the wider question of the future of policing in the 21st century. Additionally, there are debates about the police taking more of a public health role.[1, 2]
- **What are the definitions of mental illness, distress and crisis and our expectations of appropriate responses from services and communities?** There are a number of interpretations and expectations that people and professionals hold implicitly. These need to be articulated and made transparent.

Appendices

What we did – further details

Data collection

We collected copies of the five local implementation plans from the different areas. The Table below shows which Police Force and Health Board areas are coterminous.

Table 1: Coterminous Police Force and Health Board areas

Police Force	Health Board
North Wales Police	• Betsi Cadwaladr University Health Board
South Wales Police	• Cardiff & Vale University Health Board • Abertawe Bro Morgannwg University Health Board • Cwm Taf Health Board
Gwent Police	• Aneurin Bevan Health Board
Dyfed Powys Police	• Hywel Dda Health Board • Powys teaching Health Board

South Wales Police covers a geographical area with three Health Boards and Dyfed Powys Police Force with two Health Boards. The two Health Boards covered by Dyfed Powys Police, Powys Teaching Health Board and Hywel Dda Health Board decided to produce two separate MHCCC implementation plans. This decision was based on the specific arrangements of the delivery of adult mental health services for the Powys Teaching Health Board. Until recently, three neighbouring Health Boards including Betsi Cadwaladr University Health Board (BCUHB), Abertawe, Bro Morgannwg University Health Board (ABMUHB) and Aneurin Bevan Health Board (ABHB) provided adult mental health services. However, Management arrangements transferred back into Powys Teaching Health Board for BCUHB and ABMUHB in December 2016.

In terms of the interviews, key stakeholders were identified by the team who commissioned the evaluation. They approached potential participants with information about the project on our behalf. We then send an information pack including a consent form to potential participants. Interviews were arranged at a convenient date and time when we received a consent form. We spoke to 21 people (five joint and 11 single interviews). Interviews lasted between 20 – 60 minutes. We recorded interviews where participants provided consent and otherwise took notes (two interviews).

Table 2: Interview Participants

Organisation	Participants
Police	8
NHS	8
Third Sector	3
Government	2
Total	21

We analysed the data looking for themes and patterns[40]. We coded data focusing on experiences of delivering the MHCCC, barriers and facilitators to the implementation and gaps. Themes were further compared and contrasted to look for communalities and differences. NVivo 10, a qualitative data analysis software package, was used to code the data and to support the analysis process.

This evaluation received ethical approval from the Ethics Committee of the College of Business, Law, Education and Social Sciences, Bangor University.

Abbreviations

APoS – Alternative Places of Safety

HBPoS – Health Based Places of Safety

NTFG – National Task and Finish Group

MHCCC – Mental Health Crisis Care Concordat

s136 – Section 136 under the Mental Health Act 1983

References

1. Public Health England (2016) *Police and Public Health Innovation in practice: An overview of collaboration across England. A paper to support the October 2016 summit: Creating a shared purpose for policing and health.* Available at: https://www.gov.uk/government/publications/police-and-public-health-collaboration-across-england.
2. Wood, J.D. & Watson, A.C. (2017) Improving police interventions during mental health-related encounters: past, present and future. *Policing and Society*, 27, 289-299.
3. Welsh Government and Partners (2015) *Mental Health Crisis Care Concordat. Improving the care and support for people experiencing or at risk of mental health crisis and who are likely to be detained under section 135 or section 136 of the Mental Health Act 1983.* Welsh Government. Available at: http://gov.wales/docs/dhss/publications/161109concordaten.pdf
4. Great Britain. *Mental Health Act 1983*. Available at: http://www.legislation.gov.uk/ukpga/1983/20/contents
5. Lord Bradley (2009) *The Bradley Report. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.
6. Durcan, G., Saunders, A., Gadsby, B. & Hazard, A. (2014) The Bradley Report five years on. *An independent review of progress to date and priorities for further development.* Centre for Mental Health. Available at: https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=33874f52-53cb-4a40-b8a7-db8d34d7b583
7. Gregory, M.J. & Thompson, A. (2013) From here to recovery: one service user's journey through a mental health crisis: some reflections on experience, policy and practice. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community*, 27, 455-470.
8. National Police Chief's Council (9 September 2016) *Use of police cells for those in mental health crisis more than halves.* Press release. Available at: https://news.npcc.police.uk/releases/use-of-police-cells-for-those-in-mental-health-crisis-more-than-halves.
9. Mind (2011) *Listening to experience. An independent inquiry into acute and crisis mental health care*. Available at: https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf
10. HMIC (2013) *A criminal use of police cells? A joint review by Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons, the Care Quality Commission and Healthcare Inspectorate Wales to examine the extent to which police custody is used as a place of safety under section 136 of the Mental Health Act 1983.* Available at: https://www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf
11. HMIC (2015) *The welfare of vulnerable people in police custody*. Available at: http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/the-welfare-of-vulnerable-people-in-police-custody.pdf

12. Home Affairs Committee (2015) *Policing and Mental Health*. Eleventh Report of Session 2014–15 Report, together with formal minutes. Ordered by the House of Commons to be printed 3 February 2015. HC 202 [Incorporating HC 908, 2013–14]. Published on 6 February 2015 by authority of the House of Commons London: The Stationery Office Limited. Available at: https://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf
13. Great Britain. *Policing and Crime Act 2016*. Available at: http://services.parliament.uk/bills/2015-16/policingandcrime.html
14. Welsh Government (2012) *Together for Mental Health. A strategy for mental health and wellbeing in Wales.* Available at: http://gov.wales/docs/dhss/publications/121031tmhfinalen.pdf
15. Welsh Government (2013) *Criminal justice liaison services. Policy Implementation Guide*. Available at: http://gov.wales/docs/dhss/publications/131010criminalen.pdf
16. Welsh Government & NHS Wales (2013) *Veteran informed prisons. A guide to improving the health and wellbeing of prisoners in Wales who are veterans*. http://gov.wales/topics/health/publications/health/guidance/prison/?lang=en
17. Welsh Government (2014) *Children and young people first. Welsh Government & Youth Justice Board joint strategy to improve services for young people from Wales at risk of becoming involved in, or in, the youth justice system.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/374572/Youth_Justice_Strategy_English.PDF
18. Welsh Government (2015) *Service framework for the treatment of people with a co-occurring mental health and substance misuse problem*. Available at: http://gov.wales/docs/dhss/publications/150909reporten.pdf
19. Welsh Government (2016) *Mental Health Act 1983 Code of practice for Wales review*. Available at: http://gov.wales/docs/dhss/publications/160920mentalacten.pdf
20. Welsh Government. *Well-being of Future Generations (Wales) Act* 2015. Available at: http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
21. Welsh Government. *Social Services and Well-being Wales Act (2014).* Available at: http://gov.wales/topics/health/socialcare/act/?lang=en
22. Gilburt, H., Peck, E. with Ashton, B, Edwards, N. & Naylor, C. (2014) *Service Transformation. Lessons from mental health*. Kings Fund. Available at: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/ service-transformation-lessons-mental-health-4-feb-2014.pdf
23. Great Britain. *NHS Community Care Act 1990*. Available at: http://www.legislation.gov.uk/ukpga/1990/19/contents
24. Jones, R. & Jordan, S. (2010) *The implementation of crisis resolution home treatment teams in Wales: Results of the National Survey 2007-2008*. Open Nursing Journal, 4, 9–19.
25. Welsh Assembly Government (2004) *Annual priorities and planning guidance for the service and financial framework 2005- 2006.* WHC (2004) 083. Cardiff.

26. Welsh Assembly Government (2005) *Policy implementation guidance on the development of crisis resolution/home treatment (cr/ht) services in Wales*. WHC (2005) 048. Cardiff. Available at: http://www.wales.nhs.uk/sites3/documents/776/Welsh%20CRHT%20PIG.pdf
27. Hubbeling, D. & Bertram, R. (2012) Crisis resolution teams in the UK and elsewhere. *Journal of Mental Health*, 21(3), 285-295.
28. Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., Simpson, A., Webber, M. & Meader, N. (2016) Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. *Health Technology Assessment*, 20(3).
29. Reveruzzi, B. & Pilling, S. (2016*) Street Triage Report on the evaluation of nine pilot schemes in England*. UCL. Available at: https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/pdfs/ street-triage
30. Lea, S., Callaghan, L., Eick, S., Heslin, M., Morgan, J. et al. (2015) The management of individuals with enduring moderate to severe mental health needs: a participatory evaluation of client journeys and the interface of mental health services with the criminal justice system in Cornwall. *Health Services and Delivery Research*, 3, 15. Available at: https://njl-admin.nihr.ac.uk/document/download/2003861
31. Home Office and Partners (2015) *Alternative place of safety evaluation. The West Sussex Pilot Evaluation. Available at:* http://16878-presscdn-0-18.pagely.netdna-cdn.com/wp-content/uploads/2016/04/ 176336mh_ report _APOS_v7.doc.pdf
32. Lancaster, A. (2016) Evidence for joint police and MH response for people in MH crisis. *Mental Health Practice*, 19, 20-26.
33. Welsh Government. Mental Health (Wales) Measure 2010. Available at: http://www.legislation.gov.uk/mwa/2010/7/contents/enacted
34. Welsh Government (2012, 2016) *Together for Mental Health Strategy Delivery plans* (2012-16 & 2016-2019). Available at: http://gov.wales/topics/health/nhswales/plans/mental-health/?lang=en
35. Hywel Dda University Health Board, WWAMH & Community Health Council (2015) *Transforming mental health services*. Available at: http://gov.wales/docs/dhss/publications/121203planen.pdf
36. College of Policing (October 2016) *Mental Health Training Package*. Available at: https://www.app.college.police.uk/app-content/mental-health/
37. Bennett, H. & Phillips, J. (2015) *Final Report – Early intervention to prevent individuals with mental health and/or learning disabilities in crisis entering the Criminal Justice System.* Police and Crime Commissioner & Cardiff & Vale University Health Board.
38. Gibson, S., Hamilton, S & James, K. (2016) *Evaluation of the Crisis Care Concordat implementation. Final Report*. McPin Foundation. Available at: http://mcpin.org/wp-content/uploads/CCC-Evaluation_Report.pdf
39. Peters, D.H. (2014) The application of systems thinking in health. Why use systems thinking? Health Research Policy and Systems, 12:51.
40. Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Early Review of the Mental Health Crisis Care Concordat

Anne Krayer & Catherine A. Robinson

Centre for Mental Health and Society, Bangor University

For further information: a.krayer@bangor.ac.uk

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government