SUMMARY OF REPORT:

This report provides an update in relation to Lord Keith Bradley’s independent review of the Crisis Care Concordat work in Greater Manchester. The review was commissioned by the Police and Crime Commissioner to identify both best practice and areas of focus for the future.

KEY MESSAGES:

The review acknowledges the good partnership work that has taken place in relation to crisis care over the course of the past 3 years, draws on good practice and identifies areas for development. In particular, the review highlights the innovative new integrated custody healthcare and wider liaison and diversion contract and the opportunities that this joint working affords, references the importance of joint training for staff and highlights the importance of strategic leadership in driving this agenda forwards.

PURPOSE OF REPORT:

The purpose of the report is to update members in relation to the outcomes of Lord Bradley’s independent review of the Greater Manchester Crisis Care Concordat partnership work.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:
• Note the contents of the report and comment on areas of significance, in particular the recommendations made in relation to leadership.

• Request that the recommendations are considered in the first instance by the Mental Health Strategic Partnership Board, which reserves the right to delegate responsibility for recommendation implementation to those working groups which already function within the Greater Manchester Mental Health strategic governance arrangements.

• Request feedback in relation to progress against recommendations, at a future meeting.

CONTACT OFFICERS:

Laura Mercer, Partnerships Manager (Office of the Police and Crime Commissioner)
Laura.mercer@gmpcc.org.uk
1.0 OVERVIEW

1.1 In 2014, a range of agencies in Greater Manchester signed up to the Crisis Care Concordat, a partnership agreement to work together to prevent crisis, ensure appropriate services were in place to intervene when need arises, and improve the long-term provision for people with mental health problems. Leading this work, Deputy PCC Jim Battle convened a Strategic Mental Health Partnership Board, with representation from a wide range of agencies. Sitting beneath this Strategic Board is the Crisis Care Concordat Working Group, chaired by GMP. The ambition of this group has been to act on the promises set out in the Concordat and work together to develop an offer for crisis care in GM which no organisation could achieve in isolation.

1.2 Lord Keith Bradley, by invitation of Police and Crime Commissioner and interim Mayor Tony Lloyd, has undertaken a brief independent review of the Crisis Care Concordat work, looking back on its key achievements from the last three years, and making recommendations about its future.

1.3 Methodology

1.3.1 In the course of his independent review, Lord Bradley interviewed chief officers, service managers, and frontline staff. He also visited a number of urgent care teams and police stations throughout Greater Manchester (a full list of meetings attached as Appendix 1).

1.3.2 The report is structured to follow the experience of service users moving through and between criminal justice and urgent care services. This pathway is the lens along which services are most likely to be understood from the perspective of people in crisis. A true map of relevant services and the pathways between them would, of course, be far more complex; people enter into services and divert between them along unique pathways depending on an endless range of factors.

1.3.3 The key moments in this journey are: early intervention and prevention; triage in the community; police custody; health-based places of safety; the criminal justice system; and onward trajectory and return to the community. A number of key themes cut across each of these sections. These include: the impacts of commissioning; partnership; information sharing and governance; empowerment through training; and leadership within the system.

2.0 REVIEW RECOMMENDATIONS

2.1 There are a number of health and social care related recommendations, which include references to each element of the pathway. A summary of the report recommendations can be found on page 62.

2.2 Prevention
2.2.1 In this section there is reference to the importance of the locality plans referencing mental health and suicide prevention. Lord Bradley also highlights the opportunities to access national funding in relation to children and young people’s mental health and the importance of shared principles when dealing with young people. The review also draws on best practice and uses the Trafford assertive outreach model as an exemplar.

2.3 Crisis

2.3.1 The importance of effective street triage is referenced here and the report draws on the joint investment that has recently been agreed between the OPCC and the 12 GM CCGs, regarding the control room triage model. Key to the success of this Bradley states will be the continued investment in street triage. The importance of the use of managing contract performance is also highlighted, as is the impact of joint training for practitioners.

2.4 Custody

2.4.1 Greater Manchester is the first police force area to jointly commission an integrated custody healthcare and liaison and diversion service. The review suggests that early indications are that this model is working well and already there has been positive feedback. The importance of shared data systems is a common theme that runs through the review, as is joint training to ensure that appropriately skilled staff are those which are employed in these high risk areas of work.

2.5 Places of Safety

2.5.1 Every police division, with the exception of Manchester has a dedicated section 136 suite—a place of safety where individuals who are detained by the police under section 136 of the Mental Health Act can be taken. Whilst there is a commitment from the new Greater Manchester Mental Health Service to establish a facility, it is important that this is based around the needs of both service users and the police and health staff. There is also a recommendation that suggests Greater Manchester should consider developing a similar bespoke facility for children.

2.6 Criminal Justice

2.6.1 This section highlights the significance of the liaison and diversion service working with the wider criminal justice system, including the courts and the whole system approach to women offenders. Again, reference is made to the inadequate information sharing systems and the need for this to be more joined up. Lord Bradley also references the need for a wider review of mental health across the whole criminal justice pathway—including community sentencing and prisons.

2.7 Leadership

2.7.1 There are a number of recommendations that are made within this section that rely on the continued commitment to this work, across a number of organisations and
levels. Specifically, the Partnership is asked to consider and comment on the recommendations made in this section of the review.

3.0 SUMMARY AND NEXT STEPS

3.1 This review provides partners with an overview in terms of what progress has been made and where gaps continue to exist. It is clear from the review that Greater Manchester has achieved a great deal, over the course of the past 4 years, since the establishment of the crisis care concordat. Key to this progress has been strong leadership, which is visible across all organisations and which is being led by the Health and Social Care Partnership arrangements. Fundamental to continued progress is this leadership and a commitment to address the recommendations highlighted within the review at both a strategic and operational level. The existing strategic governance arrangements which support the mental health work provide an excellent platform on which to build.

4.0 RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Note the contents of the report and comment on areas of significance, in particular the recommendations made in relation to leadership.

- Request that the recommendations are considered in the first instance by the Mental Health Strategic Partnership Board, which reserves the right to delegate responsibility for recommendation implementation to those working groups which already function within the Greater Manchester Mental Health strategic governance arrangements.

- Request feedback in relation to progress against recommendations, at a future meeting.
Appendix 1: Interview/visit schedule

<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>20/01/2017</td>
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<tr>
<td>10/03/17</td>
<td>Chief Officer, GM HSC Partnership</td>
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<tr>
<td>10/03/17</td>
<td>Chief Executive, Bolton Council</td>
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<td>16/03/17</td>
<td>Specialist Mental Health Nurse Practitioner/Former GMP Trafford Superintendent</td>
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<td>16/03/17</td>
<td>Chief Constable, GMP</td>
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<td>16/03/17</td>
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<td>17/03/17</td>
<td>Independent Chair, Mental Health Implementation Executive</td>
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<tr>
<td>17/03/17</td>
<td>Executive Director for Strategy and System Development, HSC Partnership</td>
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<tr>
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17/03/2017  Programme Lead, GM Integrated Liaison and Diversion
“Someone’s There”

Review of Crisis Care and Criminal Justice in Greater Manchester

The Rt. Hon. Lord Keith Bradley

April 2017

A review of partnership between mental health services and the police in Greater Manchester, with a view to taking stock of progress made around crisis care in recent years, and to identifying areas for development in the future.
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Foreword

It has been nearly a decade since the publication of my report on mental health and learning disabilities in the criminal justice system. In that time, tremendous steps have been taken on the national stage. NHS England currently commission liaison & diversion services over a footprint covering 53% of the population. By April 2018, this will have risen to over 75%\(^1\). At the same time, new interfaces between agencies and with the public have enabled better crisis management than ever.

I now turn my attention to Greater Manchester. It is well-understood that Greater Manchester, or ‘GM’, is unique. The near-simultaneous devolution of health, social care and parts of the Criminal Justice System has created an environment unlike any other in local government; one that doesn’t just facilitate innovation, but that could allow innovation to enlighten its core services in an unparalleled way. In 2014, GM leaders committed to a local agreement to match the national crisis care concordat, and in doing so, they pioneered a partnership approach that would go on to serve devolution. This report is the result of a request by Police and Crime Commissioner Tony Lloyd to review progress made since that commitment, and to help to steer the next era of crisis care in GM.

The recommendations in this report are founded on the belief that the key components are already in place to make GM a national leader in crisis care, and I hope that they will promote the best possible response to vulnerability. They are broad in scope, ranging from comments about how to overcome barriers to effective provision to strategic discussion of governance. Appropriately engaged with, these recommendations could support GM to reduce reoffending, improve the wellbeing of its residents, and prevent a significant number of mentally vulnerable individuals from unnecessarily entering the criminal justice system.

The quotations spread throughout this document are provided without attribution, but are all taken directly from the people I have spoken to in the course of the review. I hope that they hold a mirror up to the wider system. It is important to note that, particularly as a result of the short time span in which this piece of work has taken place, the specific services discussed in this review are exemplars only, and do not represent an exhaustive or complete picture of the system by any means. It has been disappointing that, given the time constraints of this review, I haven’t been able to visit more services. I hope to do so in the future.

Because this is a relatively focused report, completed at pace, I am particularly grateful to all those who made themselves available to me at such short notice. PCC Tony Lloyd and Deputy PCC Jim Battle have been generous in the parameters of the review and in their engagement with my observations. Laura Mercer and Chief Inspector Andrew Sidebotham have provided key strategic oversight. Alex Little has lent crucial thought to the review, served as a helpful sounding board, and prepared the substantial drafts of this document. I must also thank Rachael Storey, who has had the (not inconsiderable) task of co-ordinating dozens of hectic diaries, and who most ably organised my visits.

Most importantly, I must pay tribute to the frontline staff of GM, who took the time to discuss their work so thoughtfully and precisely. I cannot stress enough the reassurance I feel having met the women and men to whom we commit the task of safeguarding GM’s mentally vulnerable people in times of crisis. They are our greatest asset and our greatest potential.

About Lord Keith Bradley

Between 1987 and 2005, Rt. Hon. the Lord Bradley was Member of Parliament for Manchester Withington. During this time, he also served as Parliamentary Under Secretary of State for Social Security, Deputy Chief Whip (Treasurer of the Queen’s Household), Minister of State at the Home Office and a member of the Health Select Committee. He was appointed to the Privy Council in 2001 and was made a Life Peer of the House of Lords in 2006.

Lord Bradley is a non-executive Director at Pennine Care NHS Foundation Trust. He is non-executive Chair of the Manchester, Salford and Trafford NHS LIFT Company, as well as the Bury, Tameside and Glossop NHS LIFT Company. He is a member of the Government’s Advisory Board on Female Offenders and a Trustee of both the Centre for Mental Health and the Prison Reform Trust.

The Bradley Report on people with mental health problems and learning disabilities in the Criminal Justice System was published by the Department of Health in 2009.
Executive Summary

“There’s a huge swathe of people... who ricochet around the system. Ethically, morally, we thought... we must do something.”

Introduction

This short report merely provides a snapshot of Greater Manchester’s (GM) crisis care services. Completed over the course of 6 weeks, it is the culmination of an independent review commissioned by Police and Crime Commissioner Tony Lloyd, and reflects on GM’s progress in developing a strong safety net for individuals experiencing mental health crisis since the agreement of the Crisis Care Concordat in December 2014. It reviews achievements made since then, and seeks to take a step back from those achievements and appraise the current landscape, offering a range of next steps that partners should take to ensure clear pathways and consistency of provision across all ten localities in GM.

People in contact with the criminal justice system are far more likely to exhibit mental vulnerability than the general population. Adult offenders are three times more likely to have a mood disorder, thirteen times more likely to have a personality disorder, and sixteen times more likely to have psychosis. This disproportionate vulnerability is even greater for the population of women offenders. Viewed from the perspective of the demands placed on a modern Police Force, approximately 20% of incidents attended by the police are related to mental health. Partners within the criminal justice system have recognised the role that they have to play in supporting their mentally vulnerable cohort. They have an opportunity and a duty to protect the public by addressing vulnerability head-on.

The crisis care agenda has developed in a number of ways in the last three years. Partners from both health and social care and the criminal justice system have independently invested in a number of new initiatives, including mental health assertive outreach approaches and local phone services, designed to encourage effective engagement between mental health practitioners, the police and the community. GM’s

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commissioning bodies have also successfully come together to jointly develop interventions over the footprint of all ten localities, fostering collaborative partnership with the voluntary, community and social enterprise (VCSE) sector to drive a whole-person approach for women, developing non-statutory step-down services, and more recently making a joint commitment to introduce a co-designed, enhanced GM street triage offer. At the same time, existing core services have begun to be developed to meet the emerging picture of need, including urgent care provision and strengthened pathways between statutory services.

Frontline staff from the criminal justice system and health and social care system have each been highly supportive of the developing agenda around crisis care. There is now a broad recognition among GM’s police officers that mental health crisis is a reality of their role, in addition to a very apparent desire to support work on crisis care partnership wherever possible.

The structure of this report adheres to the structure of the pathway of mentally vulnerable people through the system. It is divided into sections on prevention; crisis intervention; police custody; health-based places of safety; and the wider criminal justice system; before finally looking at governance and partnership holistically. In reality, of course, crisis is not as straightforward as this linear pathway. In fact, a true test of crisis care systems is their ability to comprehend and engage with inherently chaotic situations; people present in crisis in an endless variety of ways, each with a specific complexion of need. A crucial distinction should be made between those who have offended and those who have not. While this report is representative of the experience of particular individuals, it makes recommendations designed to benefit all who flow through the system.

Prevention

Some of the most effective means by which to mitigate crisis are early intervention and prevention. Preventative work allows for services to engage service users or offenders outside of crisis, and therefore often at a point when they may be more receptive, and when more underlying need can be met.

Mental health assertive outreach was sufficiently successful to secure recurrent funding in Trafford, and continues to expand, with a strengthening substance misuse component. Dialogue on its wider take-up in other localities has proven complex, however, and progress has been patchy. The designation of a GM CCG lead for mental health has helped with consistent CCG representation among the wider partnership structures at conurbation level. At the same time, however, it would appear that CCG engagement at the locality level has been inconsistent, which has presented a barrier to greater progress. GM’s success or otherwise in replicating the mental health assertive outreach model and its principles in each locality, including the drugs and alcohol
component currently in development, will be contingent upon its ability to promote stronger engagement by clinical commissioners in all localities.

One way to secure this buy-in is via locality plans. Localities have developed these plans in part to give a schema to the use of transformation funding. They have largely focused on the sustainability and transformation of acute and community services, and mental health is often poorly represented. Partners developing GM’s suicide prevention strategy have scrutinised locality plans for reference to suicide prevention. Having developed a Greater Manchester Mental Health and Wellbeing Strategy, it is important to ensure continuity between the commitments in that strategy and the content of locality plans.

Importantly, partners are in the early stages of developing new prevention pathways for children and young people’s mental health based on ‘Thrive’, a mental health model which promotes early intervention. A core tenet of their work is to make support for young people available as early as possible, including early help services in the community and wellbeing initiatives in schools. In reviewing implementation for young people’s mental health, GM should not lose sight of new funding which central government has pledged. Partners must also develop principles for meeting crisis in children’s care homes, and hold care home providers accountable for their ability to live up to those principles.

**Crisis Intervention**

When mental health crisis does occur, it is important that it is identified as quickly as possible, and that all relevant services are involved promptly and efficiently. Key steps which partners have taken on this journey have been to explore effective communication between agencies at the point of first contact with an individual in crisis.

Properly supported, the enhanced GM street triage service could be a powerful tool in supporting swift decision making by the police. It is likely that it will enable the police to source advice from a mental health practitioner in all mental health cases they attend. It is less clear how it will support effective triaging of those in crisis without also ensuring there is a practitioner available at the scene. Rather than disinvest from their local service in response to the new GM provision (as would appear a current risk), clinical commissioners need to consider how the new service enables them to reallocate that funding to make even more robust services available in their locality – for example, by investigating the value of a ‘triage car’ approach in their community. Even if they do not pursue such options, they should wait for evidence about the new service to become available before they disinvest from their existing provision.
In order to be effective, the enhanced GM street triage model must be designed appropriately. It must be staffed by practitioners with appropriate qualification and experience in assessment and de-escalation. It must also be supported technologically, so that practitioners from street triage, custody healthcare, and locality urgent care teams all have a shared, jointly-developed understanding of service users. In order to support informed decisions, these practitioners should have up-to-date information about the availability of section 136 beds across GM. It is also crucial that, in promoting the new service, commissioners do not forget the necessity of keeping urgent care teams informed in advance about service users being conveyed by GMP or NWAS into A&E or a section 136 suite; another problem which may have a technological solution.

At the point of crisis, most service users still present to emergency services. It should be the long-term aspiration of the partnership to change this. For the police, this means having the best available access to mental health practitioners and advice at the scene of crisis. It also means having a range of resources for the police to draw on. These resources should be just as accessible as A&E, but more appropriate for the mentally vulnerable. There is still real progress to be made in this area, as hospitals remain a key focus of police activity.

**Custody**

If the decision is made that an individual should be detained to a custody suite, then it is important that it is possible to fully comprehend their vulnerability. It is important that assessment and early treatment is undertaken at the first opportunity. This way, information gathered can inform any subsequent decisions – including decisions about charging or referral.

The Integrated Custody Health Liaison and Diversion Partnership now rolling out services across a pan-GM footprint, will make it possible for mental health practitioners to reliably engage detainees on first arrival at a custody suite. This increased capability makes it significantly more likely that information will be gathered prior to a charging decision by the Crown Prosecution Service (CPS) or the attendance of the detainee in court. Importantly, the service also brings together new mental health provision with existing custody health provision, promoting the effective integration of physical and mental health under a single umbrella. Moving forwards, it would benefit police officers and mental health practitioners to attend joint training to build a shared understanding of mental health pathways in custody, and to enhance inter-agency relationship building. Information sharing is another key facet of liaison and diversion. At present, the partnership utilises an effective information sharing platform to ensure that practitioners in custody and court, as well as community support navigators within the probation service, each have a single view of the individual. The direction of travel must be towards greater integration with other services, and in particular with data held by the police. This would better support the needs of the service user.
A parallel strategy with relevance to liaison and diversion is the whole system approach to women. This approach was designed in part to fulfil the recommendations of the 2007 Corston Report on women offenders. The whole system approach should embrace the new L&D offer in GM’s custody suites and take account of how it can be used to better support the population of mentally vulnerable women.

Other particularly vulnerable groups include children and those with learning disabilities. Appropriate Adults services have received praise in some of GM’s localities for being professional and reliable. It is necessary to ensure that provision is equivalent in each locality.

The key drivers of change in the custody environment for the foreseeable future will be amended requirements to PACE and new legislative provisions in the Policing and Crime Act 2017. These two changes respectively place a limit of 24 hours on the duration for which an individual can be detained in custody without charge, or detained under sec. 136 of the MHA. Together, they amplify the pressure on custody suites to act quickly. It will be incumbent on partners from the police, mental health, and Local Authorities to work together to make sure that there is sufficient capacity among police, AMHPs, and approved clinicians.

**Places of Safety**

If the decision is made to take an individual in crisis to a health-based place of safety in GM, it is important to aim to provide an excellent minimum clinical offer for all service users. It is also important that practitioners be supported to help de-escalate crisis as effectively as possible.

The balance of section 136 detentions across most of GM would be influenced by the development of a section 136 suite at the Manchester Royal Infirmary. Although the development of such a suite in the City of Manchester is a complex issue, there is a clear necessity for Greater Manchester Mental Health Foundation Trust to establish it at that site, where it can relieve the greatest amount of demand on urgent care, as well as have the most positive effect on neighbouring localities particularly in the south of the conurbation.

Rather than simply fill the gap which existed previously in the centre of GM, Greater Manchester Mental Health, clinical commissioners in the city and their partners should also take the opportunity to think creatively about how a new service can best serve wider need. Establishment of a sec. 136 suite would be a basic essential in the City’s range of facilities in addressing mental health crisis. But a shrewder investment would look also at opportunities to further relieve pressure on the City’s wider urgent care services by establishing an expanded “Crisis Care Unit”. Such a facility would provide an...
ambulant assessment and treatment area for all individuals presenting in need; one
calmer and more appropriate than A&E, and not just for those sectioned under the MHA.

No other single action would have such an all-encompassing and positive effect on GM’s
entire crisis landscape. Rebalanced by such a provision, GM’s other localities would then
be enabled to consider the value of developing a similar expanded crisis care unit within
their own services. Creatively conceived, such resources could house a range of
alternatives to A&E.

**Criminal Justice**

By the point that those who have been charged arrive in court, they should have been
de-escalated from crisis, and mental health practitioners in the court setting should
have a thorough understanding of the nature of their mental vulnerability. This should
not only support informed sentencing decisions and prevent potentially harmful delays
while more information is gathered, but also allow for timely information about a
vulnerable individual to support them along their appropriate pathway.

Given that assessment and diversion should be undertaken in custody, the role of liaison
and diversion workers in court is to safeguard mentally vulnerable individuals and
ensure that relevant information is shared with, amongst others, lawyers and
magistrates. Before they can fulfil the first criteria, they need an adequate space in
which to undertake any additional work. Before they can fulfil the second, they need IT
platforms which can draw data from street triage, their own service in custody, GPs, and
the mental health trust based in that service user’s locality. This data must also follow
an offender if and when they are handed a custodial sentence. This should ensure
continuity of care in prison and on return to the community. These two features will
ensure magistrates make the most informed decision possible, and potentially avoid the
unnecessary remanding of mentally vulnerable offenders into custody.

Community support navigators within the new L&D model can deliver a good service,
but only if they have the capacity to undertake comprehensive activity which speaks to
other services; and particularly housing. Meanwhile, Women’s Centres provide excellent
support, but do need a more sustainable, long-term source of investment to become the
main means by which women offenders serve community-based sentences and receive
ongoing support.
Leadership

Since the signing of the Crisis Care Concordat, the crisis care agenda has been developed in GM by the Strategic Mental Health Partnership. There is scope to expand on the work of this group in future and create an environment which will deliver even better outcomes. To do so requires further development of the partnership’s governance structures.

Firstly, the partnership needs to develop the mechanisms by which it embeds its strategic priorities within the health and social care partnership, locality agendas, and the wider system. A more complete partnership would include representation from a wider set of agencies, such as the acute sector and the ambulance service. Its members would also more explicitly articulate their relationship with the partnership within their own organisations. And the forum would seek to better connect practitioners from neighbouring localities with one another, and give them a sense of shared identity as part of GM.

Secondly, localities and GM must work together to align and coordinate contracts more rationally and consistently. A key body in supporting this is the Joint Commissioning Board (JCB), whose role includes the development of common standards around commissioning. This process requires input from both commissioners and providers, and should allow commissioners to make joint decisions more effectively. It should also lead to services which are more efficient and coordinated.

Thirdly, all data-owning agencies should engage more fully with the opportunity presented by GM’s new information governance capability, GM Connect. A key first step is to appoint a senior information risk officer from within each agency’s leadership. Agencies who have done so can lay the groundwork for future engagement and co-design by jointly identifying service user cohorts for whom an information exchange would improve services.

“We’ve painted some nice pictures, but we don’t yet have a gallery.”

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Summary

My 2009 report on mental health, learning disabilities and the criminal justice system set a national direction of travel for the crisis care agenda. This review is more than a check-up on core priorities from that piece of work. It looks freshly at the conditions in which crises occur in GM and evaluates the whole system’s ability to respond. Unfortunately, the time afforded to this review did not allow for a comprehensive examination of all relevant services. Many of the recommendations in this report are anchored to particular examples, but are also about themes with a wider application. I hope, therefore, that partners see their own realities reflected in those depicted here.

There was good practice in 2013, but very little of it was properly shared, aligned, or critically reviewed. Success on crisis care has been made evident through the GM partnership’s ability to influence the service landscape, promote a pan-GM commissioning dialogue, and to host a developing interaction between localities and the centre.

As change occurs, be it in relation to this review or otherwise, the value of reliable monitoring and robust evaluation will continue to be clear. It will be vitally important for Greater Manchester to move towards a culture in which performance and analysis are used not as yardsticks or benchmarks to determine success or failure, but as a means of communication and understanding between commissioners and providers; services and leaders; localities and GM.

It has been of immense value to crisis care services that PCC Tony Lloyd has championed their significance, and that Deputy PCC Jim Battle has cultivated a collective commitment to partnership work around the agenda. There is no doubt that the newly elected Mayor and the new Deputy Mayor for Police and Crime Commissioning will continue to drive this forward.

I urge leaders to pursue a bold agenda for crisis care in GM. It has rightly received a significant degree of dedicated focus from GM’s leaders. Mental health crisis is a presenting characteristic in so much of the disparate need which presents in GM. As a programme, it is almost unique in its capacity to deliver immediate benefit to so many partners. Any drive towards effective public service transformation must serve the crisis care agenda. The opportunity exists for Greater Manchester to lead the agenda for crisis care provision nationally.

"Everybody wants the same thing: mitigate the risk to society; help the individual."
1. Introduction

Tony Lloyd, Police and Crime Commissioner and interim mayor for Greater Manchester, invited me to undertake this independent review of the partnership between mental health and policing for two reasons:

1. To look back on the landscape of these services during his time as interim Mayor and elected Police and Crime Commissioner; and
2. To look forwards on the next steps which will help the partnership to improve outcomes for people experiencing mental health crisis.

A clear benchmark against which to examine Greater Manchester is my 2009 review of people with mental health problems or learning disabilities in the criminal justice system⁵. That report, while broader in scope than this one, shares with it a holistic view of the individual. It also shares the goal of optimising our services to ensure that we all do what is best for people in crisis.

The Problem

Greater Manchester (GM) is an area which is at the same time home to a tremendous variation in need between neighbouring localities, and a specific profile all of its own. Among the general population, prevalence of violent crime, unemployment and homelessness are all high. For children, the picture is similar: rates of looked after children, children living in poverty and child protection orders are all higher than the England average⁶. Conditions and risk factors associated with mental health issues are heightened in GM, giving rise to significant need.

The impact of crisis manifests itself visibly in the demand placed on the police. Nearly 20% of all mental health incidents attended by the police result in conveyance by the police to accident and emergency departments⁷. In 2015-16, no police force outside of London experienced as many section 136 detentions as GM – and GM eclipsed even London’s use of the power for those under the age of 18⁸.

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⁷ Greater Manchester Police, 2016
In this context, and in recognition that police officers are increasingly the front line in addressing mental health crisis\(^9\), it is crucial that the collaboration of the police and mental health services be effective in diverting those in need to a safe place where they can be assessed, safeguarded, and above all, supported. It is also vital that those who remain on an offender pathway have their vulnerability considered at each critical juncture of the criminal justice system, whilst at the same time ensuring public protection.

**The Strategic Mental Health Partnership**

In July 2014, the GM Office of the Police and Crime Commissioner (GMPCC) convened a meeting of senior officers from Greater Manchester Police (GMP), the NHS, and a range of other public services. The purpose of the meeting was to agree terms of reference for a strategic partnership board with a focus on mental health. In doing so, GM would make binding its commitment to the principles of the Crisis Care Concordat, a national agreement between services and agencies involved in support of those experiencing mental health crisis. The Concordat “sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis”\(^10\). Convening the Strategic Mental Health Partnership (SMHP) was a first step in ensuring that the Concordat would be upheld.

One of the first steps of the SMHP was to develop an action plan. As it was developed, and the landscape of GM was examined, the partnership quickly identified that many of the items on the plan were a reflection of local innovation rather than strategic governance. It was felt important to record what was going on so that there was an opportunity to learn and replicate good practice across each of the ten localities in GM\(^11\).

Some of the good practice identified included:

- A new triage method being piloted in Oldham by Pennine Care and the GMPCC. This promoted the appropriate navigation of service users in crisis between services by giving frontline police a way to contact mental health professionals in an emergency;
- The commission of health workers in custody settings to promote the identification of mental health needs at the point of arrest;
- Offers in the voluntary, community and social enterprise sector for those exhibiting sub-threshold need; and

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\(^10\) HM Government, *op. cit*

\(^11\) Greater Manchester is a Combined Authority. As of May 8th, 2017, it will be led by an elected mayor. Within the boundaries of the GMCA, a number of public organisations operate. These include a police force, three mental health trusts, twelve clinical commissioning groups, twelve acute trusts, a health and social care partnership, and an ambulance service.
Mental health training provision for frontline workers in a range of criminal justice agencies to ensure that those practitioners, increasingly working with mentally vulnerable individuals, were better equipped to do so.

The work of the partnership in 2014 started by building on these foundations, and this review is designed to understand work undertaken following the identification of these areas of focus, and establish where there is scope to build more robust services.

In a statement issued in December 2014, the SMHP issued a formal declaration that its member organisations would “work together to prevent crises happening whenever possible, through intervening at an early stage... and meet the needs of vulnerable people in urgent situations.” The declaration included provision to promote parity of esteem between mental and physical health care through agreement of a shared care pathway and the improvement of individuals’ experience.

The word ‘partnership’ is used extensively throughout this review. Broadly, it is used to refer to the SMHP and its constituent organisations.

Methodology

In undertaking this review, I have sought the views of partners from across the spectrum of public services involved in treating mental health crisis, from the police, to mental health trusts and CCGs, to the voluntary, community and social enterprise (VCSE) sector; and from chief executives to staff on the front line. In addition to these one-to-one conversations, I have undertaken visits to crisis services across the length and breadth of GM.

This report is designed to function as a high-level appraisal, identifying the key issues and narratives from the rich wealth of information made available to me in the course of this review. I hope that it accurately reflects the experience of the stakeholders engaged, and combines each individual picture into a collage which illuminates the landscape of mental health and policing in GM.

The Structure of this Report

This report is structured to match the experience of service users moving through and between criminal justice and urgent care services. This pathway serves as the lens through which services can be understood from the perspective of people in crisis. A true map of relevant services and the pathways between them would, of course, be far more complex.
The key moments in this journey are: early intervention and prevention; triage in the community; police custody; places of safety; and onward passage through the wider criminal justice system. The chapters of this report will reflect this journey. However, a number of key themes feature in each of these chapters. These include: the impacts of commissioning; the strength of multi-agency partnership; information sharing and governance; empowerment through training; and leadership within the system. Recommendations within this review often reflect opportunities to protect the quality of each feature.

I have structured the sections of this report as follows.

Section 2 – Prevention
This section looks at the crucial efforts to move upstream of crisis, and prevent it from arising. It looks at the ways in which police and health services have taken the initiative in preventing mental health crisis in adults and children, and examines the scope to further prevent crisis among the population.

Section 3 – Crisis Intervention
This section looks at the immediate reaction of GM’s services in the first critical moments after a crisis. Its focus is defined by the places in which mental health crises occur – usually in the community. It explores the crucial role of policing in first identifying mental vulnerability and taking appropriate steps to involve mental health services. It also explores training available to the police to help them to more effectively support people in crisis.

Section 4 – Custody
This section looks at what happens when people in crisis are first removed into a service-based setting. It examines the entry-point into the criminal justice system, and reviews the range of activity that is triggered around the person. In doing so, it looks at how we can make sure people get the right support at the right time, and what can be done to protect vulnerable people in custody.

Section 5 – Places of Safety
This section explores the partnership of police officers and mental health practitioners when detainees are diverted into a health setting. This often occurs under section 136 of the Mental Health Act, and so this section affords an insight into the use of the power by GMP and how partners are working to ensure appropriate provision exists across the entirety of GM. It also examines the best deployment of step-down services before or after hospital.
Section 6 – Criminal Justice
This section looks at what happens when people with mental health needs travel through the criminal justice system. It has a particular focus on how guidance from mental health practitioners is made available to courts, both in immediate sentencing decisions and in the process of utilising wider rehabilitation pathways. Key to this is to ensure that treatment available on return to the community is available and appropriate – and that it breaks what is often a cycle of escalation and re-presentation.

Section 7 – Leadership
This section looks at the partnership environment and the place of crisis care in the wider reform and devolution programme. Comments and recommendations on governance and commissioning are made with regard to specific services throughout this review. This section takes a more holistic look at the design of the partnership and the way that system change can ensure effective strategic delivery in the future of GM.
2. Prevention

Greater Manchester has recognised its overarching need to focus on prevention work. Early intervention and prevention are two of the greatest driving forces of reform behind the health and social care agenda. It is broadly recognised that the earlier an investment to prevent crisis arising, the better the outcome for most service users. The crucial nature of prevention work extends to crisis care; to ensure that risk is captured as early as possible, and service user wellbeing is supported before, rather than after, a crisis has occurred.

Many service users who present in a state of crisis are considered sub-threshold for services. There is a large cohort whose need is not identified, or who disengage, or for whom provision is simply insufficient to fully support them. Tellingly two thirds of people who die as the result of suicide are not known to services at the point of their death.

"We have to see how people live their lives... The range of services and the pathways open to them..."

Introduction

The national Crisis Care Concordat says “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.”

Simplified, this statement is broken down into three components: prevention, de-escalation, and recovery. The promise to ensure that services ‘prevent crises happening’ is first and foremost in this statement, and correctly occupies a significant place in the Concordat. Culturally, Greater Manchester is giving greater and greater recognition to the importance of prevention in its services.

Assertive Outreach for Mental Health

A particular form of mental health assertive outreach was first developed in Trafford in recognition of the fact that ever-increasing mental health demand was being placed on the police, and inappropriate requests for police resources in support of mentally vulnerable individuals had been reported. Further, in the context of generally high demand levels, the crises of a relatively small number of individuals were the source of a tremendous and disproportionate demand on resources for all agencies. Compounding this problem was an identified lack of understanding between agencies about policies and protocols. The assertive outreach model was designed to give a dedicated resource to service users with the most demand-intensive need.

Mental Health Assertive Outreach

Taking steps to address a problematic landscape, partners successfully applied for Home Office Innovation Funding to support the secondment of a mental health practitioner into Stretford Police Station. The principal brief of this practitioner was to proactively engage with the most demand-intensive service users, aiming to develop an understanding of the underlying needs driving their problematic behaviour. To begin with, a cohort of 16 individuals was selected, with a view that this cohort could be refreshed if their underlying needs were successfully mitigated. This model is therefore both preventative, and a step-down option for individuals who have progressed through statutory services many times. Service users benefited from the engagement provided by the assertive outreach model. In the short term, the practitioner became an emergency point of contact. In the longer-term, the assertive outreach practitioner supported service users to build bridges into their community and to resolve the underlying issues keeping them from engaging with services.

Analysis showed successful demand reductions for all agencies, including a 58% reduction in hospital inpatient admissions, equivalent to 67 fewer bed days; a 42% reduction in attendances at A&E, equivalent to 122 fewer presentations; and a 15% reduction in police demand, equivalent 48 fewer police incidents. Independent evaluation demonstrated positive improvements in partnership at the front-line. Perhaps the most telling evidence of success is that, just over two years later, most of the original sixteen individuals have been stepped down to a minimal degree of community-based support, giving the assertive outreach practitioner scope to work with the next group of service users.
As an early test of commissioning on a Greater Manchester footprint, Trafford’s model of mental health assertive outreach has had mixed success. Salford CCG were quick to recognise that assertive outreach would make sense for their population because they were able to identify a similar cohort of small but costly service users. A short term programme is being reviewed for prospective introduction to the mainstream. Rochdale CCG have also developed a similar programme. But two years later, most CCGs in GM, including those from localities with some of the most intensive demand, do not have a programme of assertive outreach.

One cause of this may be some opaqueness about the cohort. Agencies can struggle to define a ‘frequent service user’ internally. For a partnership to jointly and systematically identify such a cohort is even more complicated. For Assertive Outreach in Trafford, prospective members of the cohort are first identified by the Public Protection Investigation Unit, a resource within GMP with a focus on complex public protection cases. These cases are then sent to the assertive outreach worker for comparison with NHS mental health data. This means that a service paid for by a clinical commissioner receives its caseload from the police. This model demonstrates boldness and creativity. But it is an arrangement which may be difficult to replicate with clinical commissioners who have a less direct relationship with GM or GMP. At the same time, “frequent service user” provisions in other localities may not replicate the same outcomes as Trafford’s model if they do not replicate the same identification methodology.

Historically, the term “dual diagnosis” has often been used to encapsulate the interrelationship between mental health problems and substance misuse. To this end, the ambition in Trafford is now to embed a drugs and alcohol worker within the core assertive outreach team, potentially creating significant benefits to a wider range of services.

**Recommendation 1:** GM should ensure that the mental health assertive outreach model be fully assessed in each locality, with a view to wider implementation.

**Recommendation 2:** GM should include the emerging substance misuse component of Trafford’s assertive outreach model in implementation plans in other localities.
Children and Young People

“There’s a big difference in mainstream provision [between] children and adults. There is no out-of-hours service for children. At 5pm the pathway shuts down.”

It is nationally recognised that children’s services have become strained in the last decade\(^\text{13}\) \(^\text{14}\) \(^\text{15}\). Funding for children's social services has been disproportionately affected in recent funding settlements. During the course of this review, it has been remarked that demand placed on mental health services by children and young people has risen almost in proportion with these reductions. Perhaps more than any other cohort, children are in a position to be positively influenced by early intervention and preventative support.

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**GM Thrive**

‘Thrive’ is an emergent, nationally-recognised framework for children and adolescents mental health services (CAMHS). The partnership have utilised the GM forum to develop a proposal for a GM-wide offer around improved mental health support for children and young people based on Thrive. Three of the four steps in in ‘Thrive’ are rooted in prevention:

- Getting Advice – which seeks to develop ‘highly accessible early warning services’ in a ‘range of mediums and settings’.
- Getting Help – which seeks to ‘ensure timely access to support for young people in distress’ (but not yet crisis).
- Getting More Help – follow up support in the form of ‘multi-agency care planning, improved access to interventions and increased delivery of help in community settings’.

The first stage of the Thrive model entails an offer of tele-health support as an interface with schools. A primary goal of this offer will be to support education and connect young people to supportive activity in their community. The second stage proposes a place-based offer. The third is a more intensive offer, which specifically describes the 24/7 co-location of ‘CAMHS Home Based Treatment Teams’ with adult mental health teams. The interventions within the proposal all move towards the integration of adults’ and children’s services.

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**GM Thrive**

Much of the work detailed in the Thrive proposal speaks to activity undertaken elsewhere within the GM mental health forum. For example, the proposal to ‘include trained tele-health coaches’ available across core hours may bare relevance to the enhanced GM offer around street triage. In developing the proposal, partners from the Children and Young People’s Mental Health Board (CYP Board), have liaised with the Crisis Care Concordat Working Group (CCCWG) and the independently-chaired implementation executive.

Yet there is still a risk that strategies like the GM Thrive approach are developed in a silo. Having developed groups like the CYP Board and the CCCWG, the partnership is in a position to exercise greater strategic control of the initiatives these groups produce to develop a whole-system approach to mental health. Cross-GM investment in mental health services should be encouraged and supported. It is essential that programmes are properly resourced and accessible to children and young people.

**Schools and Children’s Care Homes**

All children should be known to schools, and some of the most vulnerable live in care homes. These are therefore key organisations in delivering effective support to children and young people. Good work is being explored around peer support and dispelling mental health stigma. I regret that the scope of my review did not afford the opportunity to visit schools and speak with staff there; it is teachers, support staff, school nurses and safeguarding officers who are often closest to vulnerable young people, and who are best equipped to monitor their wellbeing. Central government has given strong indication that young people and schools in particular would be the focus of additional funding to be made available to support the mentally vulnerable16.

Care homes can be subject to more acute problems. Referral by care home staff to statutory services can be undermined by the lack of out-of-hours provision in some localities. This can result in care home staff resorting to emergency services. Mental health officers have suggested that pathways in some care homes can fail very quickly when confronted with crisis. It is incumbent on commissioners and providers to seek to resolve this issue. On one hand, it is important to ensure that care home staff have been trained to recognise crisis which can be handled without support from statutory services, and manage it appropriately. On the other hand, it is also important to ensure that children’s mental health provision is in place for more serious crisis so that care home staff are less likely to resort to emergency services.

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**Recommendation 3:** The partnership must ensure that they maximise the opportunity to access new funding for children and young people’s mental health. Commissioners must ensure this money is utilised for its intended purpose.

**Recommendation 4:** Providers and the wider partnership should develop agreed principles for crisis pathways in care homes and ensure accountability for their delivery.

**Suicide Prevention**

“*[On suicide] we want to be nationally leading.*”

There were 277 deaths from suicide in Greater Manchester in 2014. Yet only a third of all suicides occur in individuals who are known to mental health services. Partners, led by public health, necessarily take an approach to suicide prevention which focuses on population health rather than service design. Since 2015, a Suicide Prevention Executive (SPE) has been convened, reporting to the Strategic Mental Health Partnership, and including representatives from public health in all localities. Working with crucial input from Professor Louis Appleby, leader for the National Suicide Prevention Strategy, the SPE has developed a suicide prevention strategy for GM which outlines six broad objectives, and the steps necessary to meet them\(^{17}\).

These objectives include:

- the achievement of Suicide Safer Communities Accreditation for all ten localities by 2018;
- the elimination of suicides in inpatient and community mental care settings;
- the strengthening of impact and contribution of wider services;
- the offer of effective support for those affected by suicide;
- workforce development around assessment and support for suicide risk; and
- the better use of evidence, data and intelligence.

A key component of the suicide prevention strategy is an approach referred to as ‘assertive in-reach’. By working with people already engaged by services, rather than identified at risk in the community, the strategy seeks to identify a more receptive cohort.

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The primary means by which the GM forum on suicide can ensure localities take action is in their locality plans and through transformation funding. Having recognised the significance of these plans in ensuring compliance with the GM agenda, part of the work undertaken by the SPE has been to scrutinise those plans and evaluate the visibility of suicide. The suicide strategy has received approval from central and locality partners at the level of the Health and Social Care Strategic Partnership Board. For this approach to be successful, there must be adequate funding made available at the GM level. Despite national (and local) efforts towards parity of esteem, resources around mental health remain restrictive, particularly by comparison to the acute sector.

It is therefore important that strategic leads promote the suicide strategy and its funding allocation. The relationship between prevention work and the acute sector remains key to the movement of emphasis of health and social care away from inpatients and towards community-based provision. GM has a role to play in effectively communicating the relationship between the two, and ensuring that population-based mental health approaches are protected in locality planning.

**Recommendation 5:** GM should require that locality plans include specific reference to mental health, and suicide prevention in particular. This reference should be in line with the objectives agreed in the GM Mental Health Strategy.

**Summary**

Greater Manchester has put significant effort into enhancing its prevention offer. Though only a handful of exemplar services and initiatives have been discussed here, their common feature has been the fragility of their commissioning arrangements. The form of assertive outreach deployed in Trafford, Salford and Rochdale is strong, but has faltered at the point of transition into other localities. Care Homes are well linked-up to services functionally, but are not yet held fully accountable to the partnership. And the suicide prevention strategy will put to the test the ability of GM to guide localities to include content around mental health (and public health) in their locality planning.

Assertive outreach and the suicide prevention strategy in particular share a common attribute: they were both warmly welcomed within the GM forum. The fact that locality implementation has been a stumbling block for the former and poses a challenge for the latter suggests that there is a degree of relationship management still to be undertaken between GM and its constituent localities. This is a timely challenge.
3. Crisis Intervention

Mentally vulnerable people present to the police in a range of circumstances. In some cases, the police will have been called to an incident, and mental health will represent one aspect of a complex and potentially volatile situation. In other cases, the police will have been summoned after concerns have been expressed for the welfare of an individual. For example, a common factor associated with mental health crisis can be substance misuse, simultaneously generating erratic behaviour which may endanger the public, and concern for an individuals’ mental wellbeing.

There is always a need for a timely and effective response to ensure that the best outcomes are secured for the person in need. Mental vulnerability can be an underlying feature of crime. Effective intervention is the best means to reduce risk that crisis will occur again.

“...all roads lead to A&E....”

Introduction

Greater Manchester Police receive around 19,000 calls per year which they classify as relating in some way to mental health. Of these, nearly 4,000 incidents will result in some degree of liaison with health services. Around 1,300 incidents result in a detention under section 136 conditions — the ultimate power of the police to assert a duty of care over a mentally vulnerable person.

The police therefore rival the NHS as the first point of contact for people experiencing mental health crisis in the community. The haste with which they engage the wider suite of services available for support — and the breadth to which that partnership extends — is vital.

While it is the responsibility of police officers to decide how to proceed when they encounter an individual experiencing mental health crisis, they have several resources available to them. For example, at any given time there will be an Inspector with ‘custody silver’ status, given force-wide jurisdiction to manage detainee movements.

18 Greater Manchester Police, 2017
19 GMP Mental Health Performance Bulletin, 2016
20 National Police Chiefs Council, *op. cit.*
around custody units. On the other hand, beat officers will have street triage systems in place to ensure decisions are both informed (about a service user's situation) and effective (in de-escalating crisis). Following the Police and Crime Act 2017, it is now statutory that the police consult a mental health professional “where practicable to do so”\textsuperscript{21}. It should be carefully noted, though, that in the case of mentally vulnerable children and young people, detention into a police cell has been banned and support must be made available in the health and social care system\textsuperscript{22}.

Furthermore, the appropriate training of police officers will ensure that they are able to respond effectively to crisis. Police officers are not mental health practitioners, but are asked on an increasing basis to perform a role in mitigating crisis. Well trained officers will not only be better at recognising crisis – they will be better at handling it.

In making decisions about how to approach people in crisis, it is important that all diversion options are considered in proportion to the offence which has been (or is being) committed. It is not the role of the police, or other services, to divert people who have committed an offence away from the criminal justice system in totality. The decision to charge an individual will ultimately be taken by the Crown Prosecution Service (CPS). All decisions taken must ultimately achieve an outcome which best protects members of the public.

Nonetheless, any spell spent in police custody, in the company of other offenders, is unlikely to help de-escalate service users who may be disturbed, depressed, or suicidal. A pathway which sees mentally vulnerable people going to court only to be released back into the community without assessment and support also represents a missed opportunity to establish a firm care plan. This only heightens the risk that these service users will experience a second, third, or fourth crisis. It is the goal of partners not to criminalise mental health disturbance, nor to de-criminalise it, but to seek to treat it – potentially alongside, but never supplanted by, traditional offending pathways.

\textsuperscript{22} Ibid
Street Triage

“Sometimes people just need to hear a voice.”

Enhanced GM Street Triage

In 2013, GMPCC and the Royal Oldham Hospital piloted a 24/7 phone service for use by the police in handling mental health crisis. The service had three core purposes:

- to facilitate a person-to-person exchange of information about need;
- to give urgent care teams time to prepare for the arrival of a section 136 detainee. This makes for a more efficient handover and ensures that support is immediately available; and
- to support officers to triage by drawing on expertise from mental health practitioners.

Indicative evidence found that direct access to the Rapid Assessment, Interface and Discharge (RAID) urgent care team during the pilot significantly improved the amount of police time required to be allocated to dealing with mental health related calls. Feedback found that police officers involved in the pilot saw direct access to RAID as “important and significant in managing mental health crises in the community. Moreover, the pilot was found to contribute positively in helping to manage incidents of self-harm and threats of suicide. Greater Manchester’s CCGs opted to locally commission 24/7 phone services into each locality’s hospital-based mental health teams between June 2014 (in Salford) and March 2015 (in Manchester).

In late 2015, partners found some variation in the success of implementation. Phone triage was certainly effective where it was used. However, officers were accessing phone lines in fewer than one in five mental health incidents. Lines were operated by practitioners undertaking core duties, sometimes in the community. This meant they were often unavailable to immediately respond to a call, and it could take hours to secure a response, rendering the service impracticable.

In response, the Strategic Mental Health Partnership prioritised the delivery of a more robust street triage system in 2016. A business case has been developed for a centralised resource, staffed by dedicated practitioners whose core business will be to respond to urgent calls for triage support. This business case has secured support from the GMPCC and from clinical commissioners, with implementation from autumn 2017.
Enhanced GM Street Triage

A number of critical features will guide the success or failure of the enhanced model. First, while the police anticipate a more accessible service once the centralised model has been implemented, partners must monitor and report on its usage, and remain open-minded about optimising the service with varied or supplementary support. Secondly, the service will only achieve good outcomes for people in need if it is staffed by practitioners who are appropriately senior and experienced, and can therefore identify and de-escalate people in the midst of crisis. And thirdly, it is vital that information gathered by practitioners operating street triage is passed on to others practitioners at the point of disposal. This requires that data recorded by street triage practitioners should flow to custody healthcare professionals or urgent care teams in an acute setting. These three services may be operated by three separate providers in some localities, so in the long-term, these services must be organised by a clearer, more rational system of contract management. More immediately, partners must seek to equip services with a simple and well-supported technological capability to support the flow of information between them.

Specifically, there are two immediate issues which partners must address in designing the enhanced street triage service. First, it is crucial that mental health practitioners in locality urgent care teams such as RAID should be notified in advance when a person is taken to a health-based place of safety. Technology should be used to ensure that mental health teams are notified in advance about police conveyances into their service, even though they are no longer likely to be in receipt of the initial triage call. Secondly, the enhanced GM street triage service should have at their command a clear understanding of the availability of section 136 suites.

Recommendation 6: Enhanced GM street triage must be delivered by practitioners experienced in screening, treatment, and crisis de-escalation.

Recommendation 7: GMP must monitor and report on usage to ensure consistency of street triage support in all localities and help to refine local offers.

Recommendation 8: Technological investment must be made so that practitioners in enhanced street triage, custody healthcare, and locality urgent care teams have a shared, jointly-developed understanding of service users.

Recommendation 9: Practitioners operating enhanced GM street triage must have immediate access to information regarding the availability of section 136 beds across GM, and practitioners in urgent care should be notified in advance of a service user being transported into their service.
Local Phone Lines

Joint investment in a service with a GM footprint is seen by commissioners in some localities as an opportunity to step down investment in existing local systems. This is compounded by the fact that the GM system was developed in response to lack of usage of those pre-existing arrangements. GM and localities should not, however, be developing services in competition. Rather, they should be but working to ensure they maximise opportunities for place-based commissioning.

A point raised by practitioners in a number of localities has been about relationships. Street triage has worked best locally where good relationships have been cultivated amongst frontline personnel within police and mental health trusts. Reduced investment in local arrangements risks the sacrifice of months or even years of relationship-building. Local commissioners should view the GM street triage resource (and joint investments) as an opportunity to deploy resource in ways they could not have before. They should consider opportunities to develop the local response that complements and enhances the GM offer through, for example, a locality-based ‘triage car’.

Nationally, three broad models of street triage exist. One model sees practitioners operating as a deployable resource and working alongside police officers in a ‘triage car’ approach; a second model in which practitioners function as a centralised resource within a control room; and a third, synthesised model in which they are predominantly centralised but can travel to the scene of an incident. National comparison of models has found that no model is definitively more effective, but that the particulars of a given geography can define the most appropriate\(^23\). While the commission of a centralised resource in the form of enhanced GM street triage represents a success for the partnership, the local value of additional street triage in the community will become especially clear once the enhanced GM street triage model has been embedded.

In broad terms, a truly place-based response would encourage a balance between a standard street triage arrangement offered by the centre, and a bespoke arrangement made within the locality. They must respond to one another.

**Recommendation 10:** Clinical commissioners should not pre-emptively step down investment from local street triage systems.

\(^{23}\) University College London, *Street Triage – Report on the evaluation of nine pilot schemes in England*, 2016, (retrieved from [https://www.ucl.ac.uk/pais/research/cehp/research-groups/core/pdfs/street-triage](https://www.ucl.ac.uk/pais/research/cehp/research-groups/core/pdfs/street-triage))
Alternative Pathways to A&E

“We should always be looking for alternatives to A&E…”

On assessment, many individuals presenting to mental health services are found not to reach thresholds for clinical need. These individuals still require support, potentially to prevent escalation and crisis. In many cases, the police have few options other than to divert these individuals to A&E. This should be regarded as failed diversion, and one which the partnership has the ability to prevent. The Crisis Care Concordat states that access to emergency care for mental health crises should be “treated with as much urgency and respect as if it were a physical health emergency”. A&E is almost never an appropriate environment for individuals experiencing such crisis. In GM, more than twice as many individuals are conveyed to A&E by the police each year as are detained under section 136 conditions – over 2,60024.

A robust suite of sub-threshold options is needed to ensure that mental health crises are appropriately diverted from A&E. Given the opportunity to divert some individuals to settings other than A&E (a judgement best supported by street triage), police officers could dramatically reduce the time they need to spend with an individual, avert an unnecessary drain on resources at A&E, and simultaneously better protect a person in crisis. Partners in GM are live to the ever-present need to develop good alternatives to A&E. However, there is presently no comprehensive understanding of what options are available, nor a filter of that understanding to practitioners at the front line of service delivery.

Recommendation 11: Commissioners should ensure a wider range of alternative pathways into non-statutory or voluntary, community and social enterprise services. They should be clear with partners that these services are part of their commissioning framework.

For sub-threshold service users, alternatives to A&E are likely to take the form of VCSE services, which often provide a non-clinical environment in which to mitigate crisis. The Sanctuary service is one such environment. Clinical commissioners have found difficulty in proving the case that the Sanctuary acts as an alternative to A&E. The relatively small throughput of the Sanctuary service is a reflection of its apparent under-utilisation by the police. Self Help, the VCSE provider who operate the Sanctuary, believe that they have the capacity to serve a wider population.

24 New Economy, 2016
One option under consideration is the development of Sanctuary services in the acute setting, to exist as a direct part of the urgent care pathway rather than as a diversion option within the community. Located in such a setting, the Sanctuary would be likely to reduce the volume of A&E demand more effectively. However, it would no longer be a non-clinical community-based provision. Commissioners should be sensitive to the dual role of the Sanctuary in accepting demand both as an alternative to urgent care presentation and as a step-down from assessment. Performance data may reveal the most relevant configuration for a Sanctuary service in GM.

**Recommendation 12:** Commissioners must develop performance metrics linked to clinical outcomes in managing the contracts of commissioned VCSE services.

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**The Sanctuary**

The Sanctuary supports people to address immediate crisis, usually relating to anxiety, depression, suicidal thoughts, or self-harm. The majority of the Sanctuary’s clients self-refer, though Self Help, the provider of the Sanctuary, welcome service users appropriately carried to them by police officers and ambulance crews. Originally self-funded, the Sanctuary in the City of Manchester received a shared commission by the GMPCC and a number CCGs following the Crisis Care Concordat. The service, with remit to serve residents from a number of localities, is subject to a single contract between Self Help and a lead commissioner for GM. This simplified monitoring arrangement has set an important precedent for the empowerment of commissioners through partnership. Individual Sanctuary services were later commissioned in other localities.

Practically, the Sanctuary’s mission statement is to facilitate de-escalation from crisis. Staff at the Sanctuary usually have lived experience of mental health crisis, and are also trained to promote the use of personal toolkits to help people cope in moments of heightened depression or anxiety. ‘Clients’ leave the Sanctuary with an individualised support plan, and receive a check-up call from staff the following night if not an invitation to return.
Training

“The role of police officers in crisis is fluid. Circumstances can vary from a simple drop-off in a health-based setting to the more intensive protection of mental health practitioners during de-escalation. Competing pressures are placed on police officers. If a detained individual puts mental health practitioners at risk, then their support may be needed to undertake a more gradual handover into medical care. Some officers have expressed a frustration that they can be placed under pressure in these circumstances to leave the place of safety in order to undertake other essential duties. In circumstances which are already strained by crisis, it is important that staff in frontline roles are able to support one another.

Frontline staff from mental health and the police have each described the value of having a good understanding of how the wider system operates. Neither have access to training which helps them to understand the role of other services. One of the opportunities presented by a GM partnership is the development of training programmes not just for practitioners from a variety of agencies, but with a focus on the system those practitioners sit within.

In other partnerships nationally, some of the best training practice has emerged as a result of investment in programmes which train multiple agencies’ staff jointly, and which give them an opportunity to establish relationships with frontline practitioners from other organisations.

It would benefit the partnership to undertake the more systematic joint training of police officers and mental health practitioners most likely to interact across criminal justice and mental health services.

**Recommendation 13:** Police officers and mental health practitioners should be given joint training on mental wellbeing and their role within the wider crisis response system.
Summary

Given the scale of mental health demand met by the police, GMP need better support at their disposal than ever before. Empowering them to intervene successfully in crisis requires three components: good training, good advice, and good service options to choose from. Recent measures will ensure that a good standard of clinical advice is available to the police to further improve their decision-making.

There are a number of alternatives to A&E available across each of GM’s localities. To harness their potential, it is necessary to better embed those services within the pathway, and to make sure that they are utilised effectively.

Connect 5

Recognising the value of appropriate training, the GMPCC has invested in training for staff within the criminal justice system. Connect 5 is a training resource run from within Greater Manchester Mental Health Trust (GMMH). It aims to build capacity in trainees to promote and support mental wellbeing, and where required to be able to refer onto specialist mental health support. A dedicated resource is allocated to delivering this training to frontline staff from GMP, as well as the National Probation Service (NPS), Community Rehabilitation Company (CRC), third sector providers and others.

Connect 5 was initialised in 2015, and currently has capacity to deliver training to approximately 500 staff per year. It delivers a tiered programme, with varying degrees of intensity running from a 1-day course which instructs individuals in basic elements of mental wellbeing through to a 3-day course which trains staff to be able to support service users in developing plans for lifestyle change. There is also a ‘train-the-trainer’ option, which trains appropriately qualified staff to be able to deliver the course themselves within their own organisation. Feedback from staff who have been on the training has been positive, and a consistent theme has been its usefulness in helping offenders to better understand the emotional drivers for their criminal behaviour.

Based on the available evidence about Connect 5, it seems likely that while colleagues from probation services are well-represented on Connect 5 training, staff from the police are less likely to attend. Feedback from staff in custody suites suggests that they would value a more formal understanding of mental health crisis. While Connect 5 is a package which is not primarily concerned with crisis, it is helpful in its ability to quickly train staff in frontline roles about the vulnerabilities of service users in the criminal justice system.
4. Custody

There are a number of means by which individuals in crisis may end up in police custody. In some cases, the presence of vulnerability will have been evident from the beginning of a call-out. In others, it may have been revealed by triage on the scene. On many occasions, individuals can be arrested, and will only have vulnerability revealed at a police station. The common feature of all detentions to custody is the growing awareness that mentally vulnerable people need support which is timely and appropriate. The police custody environment has become a key component of the health and social care system, just as the health-based place of safety has become a key component of the criminal justice pathway.

“...depression was unheard of in cells. Nobody would self-harm. Now it's the norm. I don’t like to pass the buck...”

Introduction

If an individual has committed an offence, and the officer chooses to arrest them, then they will most likely be detained to custody. Custody suites are currently located at eight police stations throughout GM, and the flow of detentions to custody from neighbouring localities can be common. This section will explore how the police handle offender mental health, the current landscape of healthcare in custody, and how the wider system is wrapped around the mentally vulnerable individual.

Throughout the course of this review, police officers in GM’s custody suites have overwhelmingly recognised the importance of crisis care, and often been very thoughtful about their relationship with mental health. Officers are well aware that mental health vulnerability is now a core aspect of their working life. As soon as an individual has been detained, be it as the result of an arrest or under section 136 conditions, the police are subject to a code of conduct laid out in the Police and Criminal Evidence (PACE) Act 1984. These conditions stipulate that custody officers must “make sure a detainee receives appropriate clinical attention as soon as reasonably practicable if the person... appears to be suffering from a mental disorder.”25

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The Mental Health Act 1983 (MHA) stipulates that a detainee should have their mental health needs assessed as soon as possible. A key feature of custody healthcare is liaison & diversion (L&D). L&D services aim to identify vulnerabilities around mental health, learning disability and substance misuse when they first come into contact with the criminal justice system (CJS). The findings of their assessments will influence the pathway of the individual significantly. If they were detained under section 136 of the MHA, the assessment may trigger immediate clinical intervention. If they are an offender, the identification of mental health need will inform charging and sentencing decisions. Depending on the terms of their detention, it may even divert them from a criminal justice pathway and into mental health services. Therefore the findings of any screening or assessment which they undertake have tremendous impacts on a person’s life. If the partnership between criminal justice and health and social care has a focal point, it is L&D.

Recent legislation is also changing the landscape of custody healthcare. The previous 72 hour window in which an assessment should take place has now been reduced to 24 hours\(^{26}\). This puts incredible pressure on the practitioners in custody to screen and assess individuals as quickly as possible. Therefore the goal of all custody health systems must be to identify need in as timely a manner as possible.

More specific provision must also be considered in the case of children, young people, and those with learning disabilities. It is now illegal for individuals under the age of 18 to be detained under section 136 conditions in police custody\(^ {27}\). In advance of legislative change, GM has already successfully reduced the volume of mentally vulnerable young people detained in custody, reporting two such cases in 2015/16\(^ {28}\). Nonetheless, partners must still work to prioritise mentally vulnerable young people and the support they receive in a custody environment.

\(^{26}\) National Archive, op. cit.  
\(^{27}\) Ibid.  
\(^{28}\) National Police Chiefs Council, op. cit.
It is crucial that de-escalation by custody health providers be undertaken as quickly as possible in order to promote the best outcomes for the individual. It is equally important that screening and assessment of that individual for underlying mental vulnerability be undertaken at the first opportunity, to ensure that all subsequent decisions are made with an understanding of that vulnerability. Therefore, the defining attribute of an effective mental health liaison & diversion system is the swiftness of its response.

Previous L&D schemes in custody suites have only been operative for four hours per day, Monday to Friday. Though the quality of these services has been high, this limitation has constrained their accessibility. Under the previous system, a vulnerable individual detained at 8pm was likely to spend a night in a cell before being screened.
more than 12 hours later. Worse still, an individual arrested on Friday night was more likely to have been sent to court over the weekend before they could be seen by a practitioner at all. The new integrated model of liaison & diversion includes 24-hour provision during the week, with some coverage at weekends. Mental health practitioners and police officers have agreed that the service is more responsive.

The model supplements an existing system of practitioners delivering forensic interventions in custody for physical health needs. The new model has been able to achieve the scale of its support through the integration of this service with new staffing in the form of Band 6 mental health practitioners and Band 4 assistant practitioners. In time, the existing custody healthcare staff will be trained to be able to screen and assess for mental health need. This has the additional positive impact that individuals can be screened for physical and mental need without referral or delay.

The integrated approach extends beyond the co-delivery of physical and mental health needs, and includes joint training for practitioners to develop consistency and cohesion. It has been suggested that joint training of physical and mental health specialists could accommodate representatives from other agencies as appropriate. This is to be encouraged. Police officers in particular have suggested that they would benefit from a better formal understanding of mental health crisis.

A concern raised by some agency representatives in the course of the review was the availability of the liaison and diversion service to those attending police custody on a voluntary basis. GMP are undergoing a cultural shift in which voluntary attendance, rather than formal detention, is encouraged wherever possible. A recent inspection of police custody suites in GM remarked that the use of voluntary attendance has significantly increased\(^{29}\). It is important that L&D and the broader custody healthcare offer be extended to systematically include the cohort who voluntarily attend police custody.

**Recommendation 14:** GM should ensure that the development of liaison and diversion services in police custody is maintained and enhanced over the next twelve months.

**Recommendation 15:** Liaison & diversion services must be made available to screen and assess those who attend custody voluntarily.

**Recommendation 16:** Police officers and mental health practitioners working in the custody environment should receive and deliver joint training to promote effective integration.

Information Sharing for Liaison & Diversion

“I haven’t had a single one [opt-out] yet. They know it’s in their best interest.”

An important element of effective delivery is information governance. The Integrated Custody Health L&D Partnership uses SystmOne, a clinical IT platform designed to support a single view of the individual. This platform allows information gathered in the custody environment to flow quickly into court, and on to the community support navigator element of the service (discussed in section 6 of this report). While this is an effective means by which the elements of the service can share information with one another, it does not allow for information gathered by practitioners on the criminal justice pathway to interface with criminal justice agencies, nor with clinical information gathered outside of the criminal justice system.

Partners have previously proposed a solution which would see the federation of data from a range of partners, including GPs, broader mental health records, and importantly police data. This would allow for partners to agree together the information from each agency which it would be appropriate and necessary to disclose. This would make for the most effective form of liaison and diversion because it would allow for the fullest, best-contextualised picture of need to be clear to practitioners at each point of contact. Technologically, system integrators have been identified which would support this process.

Before further work can be pursued, it is necessary to secure agency agreement to the principles of information interface. An opportunity exists to build stronger links between criminal justice data and liaison and diversion data by designing GMP’s new IT platform to interface with SystmOne. This could enable appropriate sharing of data, based on consent, to better support partners should another crisis occur. It would also better inform the work of practitioners in custody. At present, these practitioners are unable to access relevant information around risk captured by the police. However, information sharing is a necessity to ensure the safety of the patient.

With regards consent, it is necessary to systematically offer mentally vulnerable offenders the opportunity to opt-in to information sharing protocols. When given the opportunity to consent, the experience to date has been positive. One representative has remarked that most offenders seem willing to engage.

Recommendation 17: In refreshing IT and data systems, GMP should ensure that it has the technical capability to share data with the SystmOne platform utilised by the integrated custody health L&D partnership.
Women in Custody

Services for women in the criminal justice system are poor nationally. Though women represent only 5% of the prison population, they account for 28% of self-harm incidents. 46% of women in prison have been victims of domestic abuse, and 31% were looked after children. Yet women are more than twice as likely as men to be sent to prison for a first offence; and once in prison, they are subject to heavier discipline. Since 2007, Baroness Corston has driven a national agenda around women in prison which explicitly references the importance of services with a specific role in diverting mentally vulnerable women from the criminal justice system. In GM, a whole-system approach to women in the CJS has been developed for some time. This approach has made positive steps towards providing better support for women across the CJS, from the first point of contact through to prison. Baroness Corston identified liaison & diversion services as a key element of addressing the specific needs of women, and an opportunity to rebalance the disproportionate vulnerability which women are likely to exhibit in custody. Work around women offenders in GM is well-built and continues to develop. This work should engage with the new integrated L&D model. This will maximise the impact that GM can deliver against Baroness Corston's recommendations about the appropriate use of community solutions for women offenders.

Recommendation 18: GM partners must ensure the appropriate integration of liaison & diversion with the whole system approach to women.

Appropriate Adults

Under PACE, if an officer suspects an individual detained into custody to be mentally vulnerable, it is necessary that they obtain the presence of an appropriate adult. The purpose of an appropriate adult is to act as an advocate of a detained individual who, because of their mental vulnerability or learning disability, has difficulty in understanding information given to them, in making informed decisions, or in accurately communicating that decision.

Historically, GMPCC hosted a volunteer service of appropriate adults. This has been replaced in Bolton, Wigan and Manchester by a professionalised service delivered by Child Action Northwest. This new service delivers full training to the appropriate adults who volunteer for the service, as well as expenses and nominal remuneration for attendance. Officers in custody in these localities have been complementary of the more

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professional culture which has developed as a result of engaging Child Action Northwest. They have remarked on reduced waiting times for appropriate adults to arrive in custody. As a result, officers feel better equipped to meet PACE guidance around vulnerability.

Staff in some custody suites have expressed concern about local variation which may arise following this recent transition. Without pan-GM co-ordination, they are unclear that the service available in their custody suite will meet their needs.

**Recommendation 19:** GM must ensure the availability of appropriate adult services in each locality.

**MHA Assessments in Custody**

“Keeping vulnerable people in cells is not the answer. But it is a safer option than pushing them out of the door.”

Approved Mental Health Professionals (AMHP) are responsible for the coordination of assessments under the Mental Health Act (MHA), and the execution of decisions made as a result of those assessments. Though they work with medical practitioners to undertake assessment, they are usually social workers, and as such their mandate to act is derived from the Local Authority. Ultimate responsibility for a mentally vulnerable person’s awareness of their rights and access to an advocate sits with an AMHP. Resource issues around AMHPs have been recognised nationally.

Without a readily available resource of AMHPs, delays in undertaking MHA assessments become problematic. Statutory restrictions can promote the release or charge of potentially vulnerable individuals without an assessment. Inappropriate release from custody as a result of ‘the clock running out’ on PACE can be as harmful as inappropriate detention. Given resourcing issues around AMHPs and approved clinicians, the partnership must review sectioning capacity. The question of AMHP resource can only be resolved nationally, but GM has the ability to review the availability of existing resources to ensure the appropriate deployment of AMHPs and approved clinicians.

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32 Community Care, ‘Patients face unacceptable waits of up to 48 hours for Mental Health Act Assessments’, 2013, (retrieved from http://www.communitycare.co.uk/2013/03/01/patients-face-unacceptable-waits-of-up-to-48-hours-for-mental-health-act-assessments/)
Recommendation 20: The partnership must review the capacity and availability of approved mental health practitioners and approved clinicians to ensure adequate and consistent resource exists. The partnership must consider integrated resourcing of these services.

Summary

Two changes to the landscape are likely to intensify mental health demand placed on custody suites:

1. Recent legislative change to PACE has reduced the time that the police can hold a person with mental health need to 24 hours; and
2. The reduction in the number of working custody suites within Greater Manchester.

The first factor means that transport, assessment, and other activity which occurs in the course of detention must be undertaken more quickly, with a particular requirement that AMHPs are readily available to coordinate MHA assessments. The second factor means that the police will lose dozens of cells available to them, and that the pressure to address mental health need will be competing more intensively with other police demand.

These are positive developments, as they reflect both the reduction in use of police custody as a place of safety and the attention which has been paid to L&D. In light of the changing landscape, it should always be ensured that the interests of the vulnerable person are protected and that appropriate support remains in place.

A key service now at the disposal of the criminal justice system is liaison & diversion. The additional resource recently devoted to liaison has been a positive marker of the need to integrate services effectively. Custody healthcare teams in police custody are now supported by L&D workers as part of an integrated pathway which includes support in court and back into the community. While such support is crucial to people in the CJS, it may require bolstering to ensure that it fulfils its second key function – diversion.
5. Places of Safety

The Mental Health Act 1983 recognised that custody cells were not an appropriate space for crisis. It authorised police officers to take people detained under section 136 to a ‘place of safety’ for a period of up to 72 hours. Importantly, it also authorised these officers to move people in crisis between places of safety. This gave acknowledgment to the fact that the first place into which many individuals are detained may not be the most appropriate. But irrespective of the crisis pathway, individuals in crisis should always ultimately be supported in a health-based place of safety.

Mental health crisis is best handled in a clinical environment. Even so, some individuals brought to health-based places of safety may have been temporarily diverted from a criminal justice pathway, with the intention to bring them back to the custody suite or court room. It is also in this setting that they can be placed on an appropriate care pathway to help mitigate the likelihood of future crisis.

"The system doesn't understand chaos. That's why the default is A&E."

Introduction

The statutory limitations of a section 136 still apply in a health-based place of safety. Practitioners have 24 hours in which to undertake a MHA assessment (if one has not already been undertaken) and to make a decision about whether to admit the individual to an inpatient psychiatric ward. In Greater Manchester, the volume of section 136 patients ‘converted’ into an admission is rising. This is a positive indicator of the more appropriate use of the power by the police. However, it is also the source of increasing strain on mental health services.

Up to 70% of mental health incidents attended to by Greater Manchester Police result in neither a section nor an arrest. These incidents (an estimated 2,700 per year) culminate in a voluntary attendance – a presentation at hospital which is either facilitated by or under escort by the police. Voluntary attendances almost always occur at A&E departments, and can involve a mix of presenting physical and mental health need. A&E is not a desirable environment in which to host crisis, and long waiting times can be highly draining for police capacity.
Most voluntary attendees for mental health will be seen by RAID teams. RAID teams are specialist, multidisciplinary mental health teams based in or near A&E. Presently, the largest volume of emergency mental health demand is placed on RAID teams, mental health liaison teams (MHLT), and other urgent care teams operating in GM’s hospitals. The lack of equivalent commissioning arrangements within each locality has created local variation in urgent care response. Many localities, such as Oldham, Tameside and Bolton have fully equipped RAID teams which are well-connected to section 136 and other formats of liaison with the police. Greater Manchester Mental Health has developed RAID to serve as a step-down service for those on wards to guide positive discharges from hospital. Wigan have a blue lights pathway including a blue lights assessment team which takes referrals from RAID. It is less clear that RAID, or its equivalent services, are well joined up with the police in all localities.

**Section 136 Suites**

There are section 136 suites in most of Greater Manchester’s localities. Generally based in close proximity to A&E, they are usually staffed by RAID or other mental health liaison teams, often as an additional service to the broader sweep of urgent care mental health support. There is a clear and specific referral pathway into the section 136 suite, designed for a specific set of circumstances. Only under temporary section by the police can an individual formally be accepted at a section 136 suite. They are therefore designed to provide the best environment for the de-escalation of crisis.

There are differing configurations of section 136 suite, but they share the function of protecting the individual in the hours of crisis, and allowing for observation and treatment. Most have observation windows, benign furniture, some form of bathroom, and locked doors. During the course of this review, visits were arranged at a number of section 136 suites from across the ‘patch’ of all three mental health providers operating within GM. The thought, care and dedication of the staff in these suites has been uniformly impressive. In a crisis, appropriately conveyed and suitably resourced, Greater Manchester’s residents are in safe hands.

In some respects, detention to section 136 suites represent a parallel pathway to the service received in custody. Detainees to a section 136 suite are by definition far more likely to present an immediate risk to themselves or the public as a result of their mental health.
"It’s not about a tick-box for Manchester. It’s about addressing the density of need...”

The section 136 power is deployed by police officers in all of GMP’s divisions, but not all divisions have a readily available disposal route to accept those sectioned. Historically, the most problematic gap has been in the City of Manchester. It generates around 370 section 136 detentions each year – about 30% of all such detentions in Greater Manchester. Without specialist section 136 suites, these individuals are largely diverted through A&E, which potentially reduces the presence of police officers from other essential duties in the community for a number of hours. This figure is rising, and indicative evidence suggests that more Manchester residents may be systematically diverted to other localities which do have urgent care suites to accept section 136 detainees – particularly Oldham and Salford.

Recognising this need, leaders in Greater Manchester Mental Health NHS Foundation Trust (GMMH) are developing plans for a section 136 suite in the City of Manchester as part of their acquisition of the former Manchester Mental Health and Social Care Trust (MMHSCT). There are four hospital sites in the City of Manchester which could potentially host a section 136 suite: Manchester Royal Infirmary (MRI); North Manchester General Hospital (NMG); Withington Community Hospital (WCH); and Wythenshawe Hospital.

In coordinating the development of a section 136 resource with clinical commissioners, GMMH are considering a number of factors concerning these sites; not least of which are demand, bed-space and the character of the estates.

Strategically, a centrally-based resource at MRI makes the most sense. Central Manchester is the source of the greatest volume of section 136 demand in the city. It would also be the most balanced location in supporting residents from the north and south of the city.

Placement of a section 136 suite in the north of the city makes the least sense strategically for a number of reasons, not least of which is that residents from the south of Manchester are already underserved, with no suite at either the MRI or Wythenshawe’s A&E departments, and Trafford’s section 136 provision only available between 8am and 8pm, when the urgent care centre at Trafford General Hospital is open. Residents from the north of Manchester, meanwhile, often present near to the border of Bury, Salford or Oldham, and are therefore already close to three existing section 136 suites.

33 New Economy, 2017
To put a sec. 136 suite in the north would be to ignore the role that a section 136 suite could have in relieving pressures on overburdened urgent care services elsewhere in the city. MRI has the busiest emergency department in Manchester, accounting for 45% of all the A&E attendances for mental health in the city – compared to 31% for UHSM and just 24% for NMG.\(^{34}\)

The location of a section 136 suite anywhere but in central Manchester would fail to address the volume of need presenting in the city centre. The needs of patients, particularly those in crisis, must dictate the composition of services, and not vice versa. The long-term location of a section 136 suite on that site could represent a particularly makeshift arrangement.\(^{35}\) Any further investment in crisis response in the north of the city would be wasteful of resource, fail to meet demand, and squander a key strategic opportunity.

**Recommendation 21:** A section 136 suite should be built at the Manchester Royal Infirmary. GMMH and clinical commissioners must address barriers to the location of a section 136 suite in the centre of Manchester.

### Expanded Crisis Care Suites

The national agenda around places of safety has moved beyond the focus on classical section 136 suites. For example, Birmingham and Solihull use a Psychiatric Decisions Unit (PDU), ‘an ambulant assessment area which provides a calming environment for the assessment and development of treatment plans for more complex service users who are in crisis and are accessing emergency services’.\(^{36}\) The PDU provides a bespoke environment for RAID to triage individuals who have voluntarily presented in crisis. In doing so, evidence from the PDU has demonstrated that it is possible to better support recovery while giving clinicians more time to manage the immediate crisis and ensure placement onto the right treatment pathway.

Bradford have developed a ‘First Response Model’ which offers urgent 24/7 access for all individuals experiencing crisis to mental health nurses and social workers based in partnership at the Bradford Royal Infirmary.\(^{37}\) This service works on a similar specification to A&E, endeavouring to support people within 4 hours of presentation and serving as gatekeepers to a range of step-down services. At the same time, the co-

\(^{34}\) New Economy, 2017


location of AMHPs with approved clinicians in this model ensures unaltering access to MHA assessment and, if necessary, sectioning.

The direction of travel in some of GM’s localities is already towards similar models. In Wigan, a bespoke mental health hospital at Atherleigh Park combines mental health inpatient wards with a section 136 suite, and began to take patients from March 2017. Though not integrated with this suite nor the A&E at the Royal Albert Edward Hospital, a bespoke ‘blue lights pathway’ also exists to provide an ambulant assessment area for the police to voluntarily refer mentally vulnerable individuals into. This pathway has demonstrated that these arrangements can relieve significant strain on the police.

At the Royal Bolton Hospital, transformation plans have included the holistic re-specification of the Rivington Unit into an A&E triage and mental health ambulant care area, with six beds and a direct link to A&E and section 136 suites. Bolton’s transformation of this unit should demonstrate that they can relieve significant strain on A&E by diverting people from an environment entirely inappropriate for their need.

Some expanded crisis care units include a Sanctuary-like service to provide a sub-threshold offer within the urgent care environment. A local example for this exists in the form of the Stockport Team for Early Management (STEM). STEM is a service trialled in Stockport by Self Help to offer overnight support to mentally vulnerable people visiting Stockport A&E department. The service, funded by Stockport CCG, “aims to reduce the number of admissions between 9pm and 9am, and provides a more appropriate level of support to patients who are in crisis and go to [hospital] due to self-harm, thoughts of suicide, or other mental health issues. This care pathway could represent an important non-clinical component in the expanded crisis care facility.

Localities like Birmingham and Bradford are becoming national leaders in mental health crisis. It is now time for other localities to follow this lead. By investing in a separate urgent care service for mental health crisis, GM’s localities would ensure effective response to mental health crisis which is vastly more likely to break the cycle of crisis.

The timing for a programme of strategic investment in expanded crisis care units is ideal. Providers and commissioners are contemplating mental health content in locality plans. The acquisition of MMHSCT by GMMH has begun a process of reviewing provision around mental health. And PCT is reviewing potential improvements to its place of safety provision, evident in five successful applications for national funding. Leaders from mental health trusts have expressed strong agreement that an expanded service would be of tremendous value, as have commissioners and, crucially, practitioners.

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38 Self Help, 2017
"That would be a wonderful thing to do."

“I think we should do that!”

“Absolutely! I couldn’t agree with you more!”

"That would be the ideal place”

“The lack of [this] is laughable. I’ve had calls about a 12 hour breach [in A&E]. It makes much more sense to have this. Birmingham is the go-to model!”

Recommendation 22: GMMH should develop plans for an expanded crisis care suite at the Manchester Royal Infirmary. This unit should include a section 136 suite and an ambulant assessment area for individuals in crisis.

Recommendation 23: GM should consider opportunities to develop expanded crisis care suites in other localities.
Urgent Care for Children and Young People

*GM Thrive*

Building on the brief Thrive section in the ‘Prevention’ chapter of this report, the fourth and final component of the emergent children and young people crisis care model is:

- **Intensive Help and Support** – A ‘flexible crisis response with access to risk assessment, advice and support 24/7 from a confident and well-train multi-agency workforce with access to appropriate hospital and community-based places of safety and/or intensive home treatment teams who can support young people in crisis in their own homes’⁴⁰.

In practice, this offer entails ensuring that CAMHS are well-represented in the emergent services being developed across the GM footprint. Implemented correctly, this would include a CAMHS component to RAID (on a GM-wide basis), the enhanced GM street triage service, and in community services such as Home-Based Treatment.

There is broad consensus about ‘all-age provision’ for mental health. The delineation between adult and children’s services has always been simplistic, leading to gaps in support where funding has not been equal. This does not reflect an approach which views the needs of the person as most important. All-age provision poses a particular information sharing challenge to services. GM-wide services will only make sense when they are supported by excellent platforms for information sharing between localities.

Information governance arrangements around adults’ mental health services are being explored. But information governance around children requires greater investment before practitioners will be able to deliver to the strategy outlined in the GM Thrive model. While digital capability will be addressed broadly in the final section of this report, it is a specific barrier to the effective delivery of services in this case.

*Children and Young People under Section 136*

There were 77 instances in 2015-16 of young people under the age of 18 being sectioned by the police to a health-based place of safety in Greater Manchester. There were two further instances in which young people were detained to police custody under section 136 conditions⁴¹. Police custody is an inappropriate environment for the detention of young people who have been sectioned.

Partners have considered their options around the reduction of these figures, and enjoyed some partial success. However, before significant reductions can take place, there is a need to better understand the problem. Given the numbers involved, an

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⁴¹ National Police Chiefs Council, op. cit.
intensive ‘deep dive’ has previously been proposed by the GMPCC, bringing together representatives from the police, urgent care teams, CAMHS, and potentially even the acute sector to build a complete understanding of the pathway followed by specific young people throughout crisis. This exercise received approval from the partnership, but has yet to be convened. A principal barrier has been information sharing. No standardised format exists for the aggregation of data from the NHS and police around a young person.

One longer-term option GM may choose to consider in the future is a section 136 facility specific to children. Given the scale of all-age provision proposed in the GM Thrive model, such a facility may represent a natural extension of that exercise. Such suites are being developed in other areas nationally, such as in Leeds42. Another option may be to embed an offer, without the need for additional capital investment, within the pathway already developed by the thrive model.

**Recommendation 24**: GM should consider and appraise the offer of bespoke section 136 provision within the all-age GM thrive model.

**Summary**

It was remarked by a senior officer in the partnership that the absence of a section 136 suite in the City of Manchester has, to an extent, obscured opportunities to aim higher and think more creatively about crisis care services. Now that GMMH are moving to fill the gap in Manchester, the timing is perfect to broaden the horizons of the conversation about what ‘places of safety’ mean to GM.

The best approach to take is one that is progressive. It must be remembered that services do not dictate demand. It is the needs of people that should dictate services. It would be ideal to see a section 136 suite and an expanded crisis care centre developed at the Manchester Royal Infirmary. Following this, patterns of demand will change. Through joint monitoring, it should become clear where else expanded crisis care units should be developed.

However, to specifically note, the provision of section 136 suites and expanded crisis care units should not be seen in isolation from the need for sufficient psychiatric inpatient beds across Greater Manchester.

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6. Criminal Justice

Mental vulnerability should have been identified before a service user progresses through the criminal justice system. For mentally vulnerable individuals on the criminal justice pathway, the offer should be designed to support the detainee. This should occur first in the court environment, where services can make sure that informed, effective decisions are made, with the effect of achieving better, timelier outcomes. The longer-lasting impact of this is to ensure that people continue to be served and supported appropriately in the long-term, whether that be on return to the community, detention to hospital, or a custodial sentence.

"I'm a nurse. When do you get to be part of that kind of opportunity?"

Introduction

In order to determine whether to begin criminal proceedings, the police will file a report with the Crown Prosecution Service (CPS). The CPS will consider any evidence presented to them in deciding whether a person should be charged, including the public interest in prosecution. If charged, the majority of criminal proceedings involving mentally vulnerable individuals will be undertaken in a magistrates’ court. The role of courts in responding to crisis has evolved as legislation and best practice have developed over time. Section 136 detainees are now almost exclusively conveyed to a health-based place of safety, and liaison & diversion activity is now undertaken in a custody setting. Therefore, the role of courts in the partnership should be to make informed and timely decisions about sentencing – not to instigate information gathering or assessment.

The offender population exhibits heightened levels of mental vulnerability. 39% of offenders have a current mental health condition, and even more have experienced a condition in their lifetime. Yet partners from the wider criminal justice system have not been directly involved in the crisis care agenda in GM. CJS partners are a broadly underrepresented set of agencies within the mental health partnership. Probation services are well aware of the overrepresentation of mental vulnerability among their cohort. The Cheshire and Greater Manchester CRC has regularly identified opportunities

43 Prison Reform Trust, op. cit.
to do more with mentally vulnerable offenders\textsuperscript{44}. The organisation’s involvement in the new Integrated Custody Health L&D Partnership is an important development in supporting the return of vulnerable offenders to the community. It should serve as a helpful foundation for additional work, and a more strategic role in the wider partnership, in the future.

While the focus of this review is on crisis care and its impact on the police, it should not be seen in isolation from the criminal justice system. The services discussed in this section are those linked to elements of crisis care which have been explored earlier in this report – and not a complete picture of services for mentally vulnerable individuals within the wider criminal justice system. In the time that was available for this review it was only possible to make a limited number of comments about these services. But in terms of the devolution of health, social care and justice, further consideration of these issues should be undertaken, including the provision of secure accommodation and supported housing in the community, and whether the further devolution of elements of the criminal justice system should be explored.

**Liaison & Diversion in Court**

<table>
<thead>
<tr>
<th><strong>L&amp;D in the Wider CJS</strong></th>
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<tbody>
<tr>
<td>The integrated custody health liaison &amp; diversion service includes a mental health practitioner with a role to support each of the magistrates’ courts in GM. These practitioners are in place to inform court decisions about the extent of the offender’s capacity, based on assessments undertaken earlier in custody. Factors taken into consideration in determining capacity include mental vulnerability, brain injury, dementia and learning disability. Following release from the criminal justice environment, the service provides mentally vulnerable individuals with a network of Community Support Navigators (CSN), tasked with ensuring that individuals with identified needs are able to access the support that they need in their local communities. This support is offered on step-down from custody or court.</td>
</tr>
</tbody>
</table>

The primary purposes of liaison & diversion in court should be to effectively communicate the detail of screening and assessment undertaken in custody, and to safeguard the mental health needs of the defendant during their time at court. If effective measures have been taken to undertake assessment prior to the initial arrival of an offender in court, then magistrates, lawyers, and other court professionals will be supported to make informed decisions. Particularly with regard learning disabilities, this allows for reasonable adjustments to be made which take account of capacity. If

\textsuperscript{44} Cheshire and Greater Manchester Community Rehabilitation Company, ‘Mental Health Week’ (retrieved from \url{http://cgm-probation.org.uk/news/mental-health-week/})
these measures are not in place, then the court may need to defer a sentencing decision until sufficient information has been gathered. This can create additional costs to the criminal justice system, such as the unnecessary commission of a psychiatric report or the remand of a mentally vulnerable individual to custody. If remanded, this can also increase the risk of harm; as expressed by one interviewee "at huge cost, for no benefit, but with a devastating effect on one individual".

To mitigate this, it is crucial that information flows directly from the police station into court. The integrated L&D service implemented in early 2017 includes an IT platform accessible to practitioners in both settings. This means that information gathered in custody is readily available on first appearance at court. It is unclear that a dedicated space will be made available for L&D in court. While the emphasis of L&D must be placed on custody, it is important that an appropriate space is made available in court to allow for additional assessment if required.

In very simple terms, a court decision will either result in an individual being released or sentenced. Sentences may be custodial or community-based. When a mentally vulnerable individual returns to the community, they will ideally be given support by a Community Support Navigator (CSN). These CSN expand on the ‘diversion’ remit of their service by identifying appropriate resources within the community which can be used to help support an individual’s mental wellbeing in the long-term. The role of the CSN is to identify the most appropriate services for each individual, and then assist them to overcome barriers they may face in accessing those services, including accompanying them to their first appointment or engagement. CSN also have some capacity to undertake brief case management for the most complex individuals, although this would usually be an interim measure.

In future, as probation services move towards place-based approaches to offender management, CSN may fulfil a wider brief by liaising more directly with other services. They could become an effective tool in relieving the pressures which give rise to crisis, such as debt or lack of suitable accommodation. Their initial contract is primarily for support between Monday and Friday. Given that many magistrates’ courts convene on Saturday, it would be wise to extend this provision to weekends.

**Recommendation 25:** Liaison & Diversion services must have access to a physical space in court.

**Recommendation 26:** The evaluation framework for L&D should give consideration to potential enhancement of the Community Support Navigator role; specifically with a view to engaging with elements of wider public service reform and the provision of additional capacity on weekends.
Services in the Wider System

"The starting point should be 'what are the needs of the individual and how do we meet them?"

Women’s Centres

Greater Manchester is fortunate to have a number of women’s centres; VCSE organisations which work to support the health and wellbeing of women living or working locally. The remit of women’s centres is broad, and they can work in partnership with a wide range of agencies, including partners from the health sector, housing, education and employment, as well as all components of the criminal justice system.

GM recently secured funding to build greater awareness of and referral routes into women’s centres. This funding has focused on women being prosecuted by non-CJS agencies for minor offences (such as TV licence evasion, public transport offences, and family and civil court offences). Evaluation undertaken as part of the whole system approach has also noted that women’s centres ‘are significantly different from one another in terms of physical space/layout’\textsuperscript{45}. The disparity in support between localities serves as a barrier to GM-wide policy on their use for community-based sentences.

Despite the significant progress of this programme, women’s centres remain an underutilised resource as referral centres for mentally vulnerable women offenders. At present, there is no systematic utilisation of women’s centres by statutory agencies for such purposes. Until a strategic national plan to support women in the community is launched, it is vital that GM concentrate on the use of women’s centres as a focal point in delivering step-down support, early intervention activity, and perhaps most significantly, as an integral component of delivering community-based sentences.

There are good foundations for delivering against the Corston Report’s recommendations about women offenders in GM. For example, WomenMATTA is a Women’s Centre supporting female offenders and women at risk of offending in Manchester and Trafford. In addition to case work and advocacy, longer-term support is provided to help women into training or employment. In addition to community-based activity, WomenMATTA go into prisons, magistrates’ courts and even police custody suites to provide support. This should be enhanced by a central GM commission. Women’s Centres should be better recognised as a substantive post-discharge step-

down option for mentally vulnerable women who have experienced crisis. They should also be empowered to serve as a key resource in hosting community orders for women.

**Recommendation 27:** The whole system approach to women offenders should continue to recognise the opportunity presented by women’s centres to support mentally vulnerable women in the community.

**Recommendation 28:** GM should ensure the long-term future of Women’s Centres through a GM-wide commission.

**Information sharing in prisons**

Recent evidence from the Centre for Mental Health has demonstrated that the risk of suicide in prison is being driven by the lack of adequate staffing. 2014 saw 89 prisoners commit suicide in England and Wales, the highest volume since 2007. The figure was matched in 2015.

Following its support of well-informed sentencing decisions, L&D’s further role is to make sure that a full understanding of need, supported by clinical screening and assessment, follows the offender through the criminal justice pathway and into prison.

An emergent dialogue between GM leaders, the Ministry of Justice, and the Department of Health is seeking to try to improve information sharing into prisons, including a new IT system. While this is a positive step, it will only support inmates if all relevant mental health providers are able to transmit data into prisons to support continuity of care, and if prisons are then able to transmit that data back out on release. In practice, this means ensuring that a strong interface exists between mental health trusts. Precedent for this has been set by the work on street triage, which has seen trusts sharing records to support operational work. The next step is for prisons to implement a similar, more systematic process.

**Recommendation 29:** GM should address the need for mental health providers to systematically share information about mentally vulnerable offenders as part of the criminal justice pathway.

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Summary

As mentally vulnerable individuals progress through the criminal justice system, a clear understanding of their needs should be shared between partners, whether in court, on return to the community, or in prison. This is the best way to ensure continuity of care and help prevent service users from re-presenting in crisis.

The services which have recently been initiated in GM are all promising, and should produce positive outcomes. Consideration should be given to making many of them accessible to a greater volume of service users. L&D should ideally be able to operate in a dedicated space within the court. Community support navigators in the integrated L&D programme should have the capacity to deliver a more comprehensive service. And there is a specific opportunity for existing work around the whole system approach for women to support mentally vulnerable women via women’s centres.

The priority for GM should be to ensure that informed sentencing decisions can be taken at the first opportunity, without the need to remand mentally vulnerable individuals while more screening and assessment is undertaken.

The relationship between mental health and criminal justice partners in GM should be more extensively reviewed, with a view to bringing agencies such as the CPS or probation service more directly into partnership in the future.

Recommendation 30: GM must undertake a review of mental health in the wider criminal justice system; specifically with regards probation, courts, community sentencing and prisons.

Recommendation 31: Criminal justice partners should be represented at the senior level on the strategic partnership board for health and social care.
7. Leadership

The opportunity exists for the criminal justice system and the health and social care system in GM to do things for crisis care that no-one else in the UK has done. Work undertaken since 2014 has seen significant progress in the interface between mental health and policing in GM, from better crisis management to more valuable strategy development. Enabled by an unprecedented set of devolved powers, the GM partnership could become national leaders on crisis care. But to do so, they will have to further develop the governance which has evolved over the last few years, and seek to embed crisis care more deeply into the agenda of all relevant GM agencies.

"While you're from health... you're actually there to represent the partnership. You have to be resilient. You have to challenge your own organisation."

Introduction

This review has followed offenders on a pathway through the criminal justice and health and social care systems. The recommendations made throughout this report have carried specific implications about commissioning, governance, and information sharing. This final section is designed to cast a more holistic eye over these cross-cutting issues, with a view to supporting the further development of leadership around crisis care in GM.

Identifying this leadership is not always easy, and never simple. Many of the officers who take a lead in GM have historically been seconded from posts within localities. Joint commissioning models around mental health have involved a single individual serving as lead commissioner on behalf of commissioning bodies in other localities. Partnership boards, executives and working groups have been chaired by representatives from a range of organisations, reporting back to governance groups chaired by individuals from other organisations, and with ever-evolving terms of reference.

The more extensive the work of the partnership, the more important clarity becomes. Transparency is a theme which is echoed throughout this section. Effective and well-timed communication is a tool which GM must use to marry together the agenda of
partners and help them to better understand the opportunities which GM has made available to them.

Localities and GM

"GM frightens me. We're scared that harmonisation will bring us down."

GM is a partnership comprised of all of the constituent agencies within its footprint. Those agencies have a dual identity: as parts of a whole and as entities in themselves. As parts of a whole, GM’s agencies have passed the significant hurdle of jointly commissioning services across a GM footprint. The next step, and in some respects the more challenging test for GM, is for localities in particular to respond to new GM-wide provision by redesigning their services and building a logical, systematic approach to the centre.

The presence of significant funding for transformation has been a driver of locality planning. Some locality-based organisations view GM as strategically significant mainly as a gatekeeper to this funding. Meanwhile, some agencies have a lesser degree of engagement with the GM mental health partnership than others – either because they have a different cultural perspective on funding (such as acute trusts) or because their priorities are less likely to be shaped by a GM dialogue (such as the ambulance service).

It is hoped that in time the nature of accountability in GM will be driven less by finance and more by culture. The view of GM as a funding gatekeeper will remain an ingredient of devolution until a clearer, more robust ‘GM voice’ emerges. There is certainly a risk of retreat from GM if a shared vision and identity is not entrenched before the bulk of transformation funding is allocated by 2020-21.

Some providers are reluctant to engage with GM because of a fear that standardisation will devalue their offer. GM must clearly communication that it recognises local variation. At the same time, strategic leaders have a responsibility to ensure that GM is well represented in their organisation’s vision; few organisations in GM have a strategy document outlining their view of GM or their relationship with its other agencies.

While strategy has an important role to play in setting the agenda, the best point for the cultivation of a non-transactional GM voice is on the frontline. Currently, many practitioners feel isolated from developments in GM. Service providers, practitioners and officers from many localities have expressed enthusiasm about the notion of a GM practitioners’ forum – an opportunity to convene frontline staff from multiple localities to develop a practitioner-led voice on transformation; build horizontal links between
practitioners in similar roles whose key relationships have primarily been within their own organisation; and instil a sense of shared identity as part of a GM-wide system.

**Recommendation 32:** GM should convene a practitioner’s forum to support the sharing of knowledge and good practice between frontline personnel.

**Recommendation 33:** GM must seek to build a more complete partnership around crisis care; specifically by taking a broad strategic view on agencies which are less engaged by the current partnership.

**Recommendation 34:** All organisations in the GM partnership should produce strategy documents which clarify their role in GM.

**Contract Management**

“*Change is constant, so staff leave. And why wouldn’t you? You’ve got nursery fees to pay, you need to know that you can afford them in six months.*”

As health and social care services are designed and re-designed, with some guidance from GM in the form of dialogue around locality planning, there is limited assurance that the design process will be coherent amongst localities. Commissioners of mental health have funded services in isolation, occasionally learning from the experience of partners but rarely aligning their commissioning patterns. Short, uncoordinated funding cycles have generated the cultural expectation in some services that re-tendering is inevitable.

GM organisations have encountered difficulty in rationalising pathways around shared GM-wide services because they have such variation locally. More pressingly, as localities have re-invested in existing provision, they have done so without re-calibrating the timescales or content of contracts to recognise what exists elsewhere across the partnership. Where GM services are designed as an enhancement or supplement to locality arrangements, such as street triage, this is a missed opportunity to re-invest in something new. But GM will find itself increasingly unable to articulate gaps in provision, and therefore constrained in its ability to coherently commission, if it is unable to meaningfully support localities to make the commissioning process more rational. The Joint Commissioning Board (JCB) is a body designed to promote GM standards around commissioning, and to support such an exercise.

It is totally undesirable to restrict organisations when making decisions about place-based commissioning. But without aligned contract horizons and clarity between
localities in what those contracts do, there will be less scope for innovation and effectiveness. A commissioning framework is designed at the GM level for mental health. But to be truly impactful, the framework requires significant buy-in from all commissioners and providers, Local Authorities and health and social care partners.

**Recommendation 35:** GM should ensure strategic leaders instigate a process of locality contract coordination.

**Information Governance**

“There’s massive variation. You just need to get the variations to agree with each other.”

In GM Connect, GM has a burgeoning but innovative information governance resource. GM Connect is a ‘transformational data sharing capability and governance structure’ which seeks to enable public bodies in GM to act within a single information governance ecosystem. Several projects involving GM Connect are already in train, including support for a prison IT interface and work seeking to align the GP data into a single framework. Both of these pieces of work would support recommendations in this report.

There are a number of other possible applications for GM Connect with regards crisis care. GM Connect could support street triage, for example, by facilitating an ‘attribute exchange’ between the police and mental health trusts. This would automatically give officers digital confirmation about whether a member of the public has been previously diagnosed with a relevant mental health condition. GM Connect could also support a data bridge between health providers in custody, urgent care, court, and in prisons.

GM is currently working to overcome barriers to such exercises. While some are technological, the most significant barriers are strategic. The Caldicott principles established in the 1998 Data Protection Act stipulate that support for direct care is the only justifiable usage of NHS data. This makes operational support for the police in responding to crisis problematic, not least because it would involve a transaction with an organisation outside of the health and social care system.

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47 GMCA, ‘Pioneering data service to connect Greater Manchester to improved services’, (retrieved from https://www.greatermanchester.ca.gov.uk/news/article/39/pioneering_data_service_to_connect_greater_manchester_to_improved_services)

48 The Caldicott Committee, op. cit.
Consent is a necessary enabler to overcome this barrier. GM Connect is working with communities to understand the best ways to help service users to opt-in to future interventions which will have a positive impact on their access to support. Both the police and mental health agencies have a need to engage with their service user community if they seek to develop a set of information sharing solutions. Agencies should identify cohorts of service user with whom they wish to engage in order to achieve consent. They should invite GM Connect to offer a view on the best practical approaches to communication with service users, and the best strategic approach to legal compliance around information sharing.

The success of GM Connect will take years to achieve. Leaders who may seek to pursue future use cases for GM Connect with specific application to their organisation should endorse and support its renewal and expansion.

**Recommendation 36**: All data-owning agencies should appoint a senior officer to act as ‘senior information risk officer’, enabling them to actively engage with GM Connect.

**Recommendation 37**: Agencies should identify a cohort of service users for whom an information sharing transaction would improve service delivery.

**Recommendation 38**: Partner agencies should endorse and support the renewal and expansion of GM Connect.
Summary – The Future of the Partnership

This review reflects on progress made to date by the strategic mental health partnership, led by the OPCC in GM. Its recommendations will have relevance for the new and developing partnership. It is important, therefore, that responsibility for the delivery of these recommendations be assigned to specific leaders and officers, with a view to ensuring delivery against the best range of crisis care services GM can offer. This review has attempted to engage with a range of services, but the full picture is still emerging. A fuller understanding of the organisations and services in each locality will support GM to approach strategy development with a more performance-driven approach.

To become a leader in crisis care, GM must move towards a more performance-driven culture to ensure the best outcomes. Historically, intelligence-gathering has often been driven by the need to develop investable propositions. In the longer-term, GM should move towards a culture where performance-as-a-driver becomes business-as-usual.

Moving forwards, there is an opportunity to take fuller advantage of the unique position in which GM now finds itself. Thanks to the joint devolution of both the justice and the health and social care systems, it can pursue crisis care strategy at the highest level. To this end, it is recommended that the criminal justice system continues to be represented within the health and social care governance structure.

There is no doubt that the newly elected Mayor will retain the ambition and drive so effectively demonstrated by interim Mayor and PCC Tony Lloyd with regards the crisis care agenda. Specifically, it would be valuable for the incoming Deputy Mayor for Police and Crime Commissioning to continue to represent the criminal justice system at the Strategic Partnership Board, and also to continue the valuable work of Deputy PCC Jim Battle in managing the interrelationship of mental health and criminal justice.

**Recommendation 39:** GM must identify a lead officer responsible for delivering each recommendation in this document.

**Recommendation 40:** GM must adopt a more performance-driven approach to strategy development around crisis care, with a view to ensuring consistency of provision between localities.

**Recommendation 41:** The Deputy Mayor for Police and Crime Commissioning should continue to represent the criminal justice system within the health and social care governance, while also overseeing strategy development around partnership between criminal justice and mental health.
8. Concluding Remarks

The GMCA should continue to have oversight of the crisis care agenda as it exercises a leadership role within the refreshed partnership. It is important that a specific environment for the development of mental health policy and strategy should be maintained. Likewise, there should be a clear forum for leadership on the joint work of criminal justice and mental health. There must be clarity about who owns the crisis care agenda, and there must be clarity about the governance structure through which progress is made.

The next steps are clear. First a section 136 suite should be built at Manchester Royal Infirmary. Secondly, an expanded crisis care suite should be developed alongside this provision and more widely across Greater Manchester. Thirdly, liaison and diversion services should be fully embedded across the criminal justice system with particular emphasis on joint mental health awareness training for all involved. Finally, information sharing and technological investment must be a priority to ensure that vulnerable people are supported in a timely way through health and justice pathways.

This has been a snapshot of crisis care in GM. If appropriately supported, many of the initiatives and services developed by the Strategic Mental Health Partnership since 2014 could become recognised as the gold standard for implementation across the country. The commitment and support by police officers in custody to the crisis care agenda has been consistently superb. Equally, it is has been a pleasure to speak with so many expert practitioners, and to witness the system affording them an opportunity to help many of GM’s most mentally vulnerable individuals. It is a testament to the leadership of the strategic mental health partnership that this is the landscape they have developed. There is now an opportunity to broker a fuller relationship between all of GM’s bodies; to ensure clear pathways, consistency of provision, and clarity of strategic priorities and objectives.

"There is a genuine and strong commitment to work together"
Annex A. Summary of Recommendations

Prevention

Mental Health Assertive Outreach

- **Recommendation 1:** GM should ensure that the mental health assertive outreach model be fully assessed in each locality, with a view to wider implementation.

- **Recommendation 2:** GM should include the emerging substance misuse component of Trafford’s assertive outreach model in implementation plans in other localities.

Children and Young People

- **Recommendation 3:** The partnership must ensure that they maximise the opportunity to access new funding for children and young people’s mental health. Commissioners must ensure this money is utilised for its intended purpose.

- **Recommendation 4:** Providers and the wider partnership should develop agreed principles for crisis pathways in care homes and ensure accountability for their delivery.

Suicide Prevention

- **Recommendation 5:** GM should require that locality plans include specific reference to mental health, and suicide prevention in particular. This reference should be in line with the objectives agreed in the GM Mental Health Strategy.
Crisis

• **Recommendation 6**: Enhanced GM street triage must be delivered by practitioners experienced in screening, treatment, and crisis de-escalation.

• **Recommendation 7**: GMP must monitor and report on usage to ensure consistency of street triage support in all localities and help to refine local offers.

• **Recommendation 8**: Technological investment must be made so that practitioners in enhanced street triage, custody healthcare, and locality urgent care teams have a shared, jointly-developed understanding of service users.

• **Recommendation 9**: Practitioners operating enhanced GM street triage must have immediate access to information regarding the availability of section 136 beds across GM, and practitioners in urgent care should be notified in advance of a service user being transported into their service.

• **Recommendation 10**: Clinical commissioners should not pre-emptively step down investment from local street triage systems.

• **Recommendation 11**: Commissioners should ensure a wider range of alternative pathways into non-statutory or voluntary, community and social enterprise services. They should be clear with partners that these services are part of their commissioning framework.

• **Recommendation 12**: Commissioners must use performance metrics, specifically with regards clinical outcomes, in managing the contracts of commissioned VCSE services.

• **Recommendation 13**: Police officers and mental health practitioners should be given joint training on mental wellbeing and their role within the wider crisis response system.
Custody

- **Recommendation 14:** GM should ensure that the development of liaison and diversion services in police custody is maintained and enhanced over the next twelve months.

- **Recommendation 15:** Liaison & diversion services must be made available to screen and assess those who attend custody voluntarily.

- **Recommendation 16:** Police officers and mental health practitioners working in the custody environment should receive and deliver joint training to promote effective integration.

- **Recommendation 17:** In refreshing IT and data systems, GMP should ensure that it has the technical capability to share data with the SystmOne platform utilised by the integrated custody health L&D partnership.

- **Recommendation 18:** GM partners must ensure the appropriate integration of liaison & diversion with the whole system approach to women.

- **Recommendation 19:** GM must ensure the availability of appropriate adult services in each locality.

- **Recommendation 20:** The partnership must review the capacity and availability of approved mental health practitioners and approved clinicians to ensure adequate and consistent resource exists. The partnership must consider integrated resourcing of these services.
**Places of Safety**

**Section 136**

- **Recommendation 21:** A section 136 suite should be built at the Manchester Royal Infirmary. GMMH and clinical commissioners must address barriers to the location of a section 136 suite in the centre of Manchester.

**Voluntary Attendances**

- **Recommendation 22:** GMMH should develop plans for an expanded crisis care suite at the Manchester Royal Infirmary. This unit should include a section 136 suite and an ambulant assessment area for individuals in crisis.

- **Recommendation 23:** GM should consider opportunities to develop expanded crisis care suites in other localities.

**Children and Young People**

- **Recommendation 24:** GM should consider and appraise the offer of bespoke section 136 provision within the all-age GM thrive model.
Criminal Justice

Liaison and Diversion in Court

- **Recommendation 25**: Liaison & Diversion services must have access to a physical space in court.

- **Recommendation 26**: The evaluation framework for L&D should give consideration to potential enhancement of the Community Support Navigator role; specifically with a view to engaging with elements of wider public service reform and the provision of additional capacity on weekends.

Services in the Wider System

- **Recommendation 27**: The whole system approach to women offenders should continue to recognise the opportunity presented by women's centres to support mentally vulnerable women in the community.

- **Recommendation 28**: GM should ensure the long-term future of Women’s Centres through a GM-wide commission.

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Mental Health and the CJS

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**Leadership**

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- **Recommendation 38:** Partner agencies should endorse and support the renewal and expansion of GM Connect.
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## Annex B. List of Meetings and Visits

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting</th>
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<tbody>
<tr>
<td>20/01/2017</td>
<td>MH Strategic Lead, GMP</td>
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<tr>
<td>10/02/2017</td>
<td>GMP Custody - Longsight</td>
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<td>10/02/2017</td>
<td>GMP Custody - Swinton</td>
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<tr>
<td>17/03/2017</td>
<td>Independent Chair, Mental Health Implementation Executive</td>
</tr>
<tr>
<td>17/03/2017</td>
<td>Executive Director for Strategy and System Development, HSC Partnership</td>
</tr>
<tr>
<td>17/03/2017</td>
<td>Atherleigh Park Mental Health Hospital, 5BP</td>
</tr>
<tr>
<td>17/03/2017</td>
<td>Programme Lead, GM Integrated Custody Health Liaison and Diversion</td>
</tr>
<tr>
<td>07/04/2017</td>
<td>Clinical Director, GM Integrated Custody Health Liaison and Diversion</td>
</tr>
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Annex C. Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>5BP</td>
<td>5 Boroughs Partnership NHS Foundation Trust</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Children’s and Adolescent’s Mental Health Services</td>
</tr>
<tr>
<td>CCCWG</td>
<td>Crisis Care Concordat Working Group</td>
</tr>
<tr>
<td>CSN</td>
<td>Community Support Navigators</td>
</tr>
<tr>
<td>CTO</td>
<td>Community Treatment Order</td>
</tr>
<tr>
<td>CYP Board</td>
<td>Children and Young People’s Mental Health Board</td>
</tr>
<tr>
<td>GM AGG</td>
<td>Greater Manchester Associated Governing Group of CCGs</td>
</tr>
<tr>
<td>GMMH</td>
<td>Greater Manchester Mental Health NHS Foundation Trust <em>(formed through the acquisition in 2016 of MMHSCT by GMW)</em></td>
</tr>
<tr>
<td>GMP</td>
<td>Greater Manchester Police</td>
</tr>
<tr>
<td>GMPCC</td>
<td>Greater Manchester Police and Crime Commissioner</td>
</tr>
<tr>
<td>GMW</td>
<td>Greater Manchester West NHS Foundation Trust <em>(former)</em></td>
</tr>
<tr>
<td>HSCP</td>
<td>Greater Manchester Health and Social Care Partnership</td>
</tr>
<tr>
<td>JCB</td>
<td>Joint Commissioning Board</td>
</tr>
<tr>
<td>L&amp;D</td>
<td>Liaison and Diversion Services</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act 1983</td>
</tr>
<tr>
<td>MHP</td>
<td>Mental Health Practitioner(s)</td>
</tr>
<tr>
<td>MMHSCT</td>
<td>Manchester Mental Health and Social Care Trust <em>(former)</em></td>
</tr>
<tr>
<td>MRI</td>
<td>Manchester Royal Infirmary</td>
</tr>
<tr>
<td>NMG</td>
<td>North Manchester General</td>
</tr>
<tr>
<td>OPCC</td>
<td>Office of the Police and Crime Commissioner</td>
</tr>
<tr>
<td>PACE</td>
<td>Police and Criminal Evidence Act 1984</td>
</tr>
<tr>
<td>PCC</td>
<td>Police and Crime Commissioner</td>
</tr>
<tr>
<td>PCT</td>
<td>Pennine Care Mental Health NHS Foundation Trust</td>
</tr>
<tr>
<td>SPE</td>
<td>Suicide Prevention Executive</td>
</tr>
<tr>
<td>SPOC</td>
<td>GMP Special point of contact for mental health</td>
</tr>
<tr>
<td>UHSM</td>
<td>University Hospital of South Manchester</td>
</tr>
<tr>
<td>WCH</td>
<td>Withington Community Hospital</td>
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</tbody>
</table>