

Supporting People in Crisis

**People's experiences of using services
in North Tyneside when experiencing a
mental health crisis**

November 2018

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Acknowledgments

We would like to thank the steering group, which was attended by a number of service users, carers and mental health staff who gave invaluable input throughout the process.

We would also like to thank the commissioners, NHS Trusts, service providers and a range of voluntary sector organisations who helped to ensure the project was collaborative and promoted the opportunity for people to participate widely across the borough.

Most importantly, we would like to thank everyone who took the time to share their feedback and experiences with us.

Healthwatch North Tyneside

Healthwatch is the independent consumer champion in health and care. We gather and represent the views of people who use health and care services. We feedback this information to the people responsible for commissioning and providing services so that they can take action to address people's concerns and improve the services in their area.

Local Healthwatch have been set up in each local authority area in England, creating a national network to make sure the voices of people who use health and social care services are heard at the highest level.

1. Background

In 2017 our report 'People's experiences of mental health services in North Tyneside' considered the views of 272 service users. We made recommendations to commissioners and providers and received responses. We worked with North Tyneside Council (NTC) and North Tyneside Clinical Commissioning Group (CCG) to include the recommendations of the report into the North Tyneside Mental Wellbeing Strategy. Since then, we have continued to prioritise mental health as a key area impacting the lives of people in North Tyneside. A significant area people told us about was access to support when they were experiencing a mental health crisis. Therefore, we decided to carry out a piece of work looking in greater depth at this aspect of mental health support.

The CCG are currently reviewing the mental health crisis pathway in North Tyneside. This focused piece of work on people's experiences of mental health crisis will be fed into this pathway review and our findings utilised in the development of an action plan addressing any gaps identified during the pathway review.

2. National context

Mental health is a growing concern nationally with almost two-thirds of people saying that they have experienced a mental health problem¹. Therefore it is vitally important that we clearly understand how best to support people experiencing mental ill health. This is especially important when people feel they need urgent support in a mental health crisis.

In 2015, the Care Quality Commission (CQC) released a national report highlighting people's experiences of help, care and support during a mental health crisis. This report illustrated that there is a significant variation in support and care people receive and highlighted some of the barriers people face to accessing crisis support in a timely manner.

What should mental health crisis support look like?

The Mental Health Crisis Care Concordat was established in 2014. The Concordat brought together services involved in providing mental health crisis support with a focus on access to support before crisis point; urgent and emergency access to crisis care; quality of treatment and care when in crisis and recovery and staying well. The Crisis Concordat Joint Statement commits to:

“work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need - whatever the circumstances in which they first need help - and from whichever service they turn to first”²

The key NICE Guidelines (2011)³ in relation to adult mental health services are outlined below:

¹ www.mentalhealth.org.uk/publications/surviving-or-thriving-state-uks-mental-health

² www.crisiscareconcordat.org.uk/about/#the-joint-statement

³ www.nice.org.uk/guidance/cg136

- **“crisis and home resolution teams should be accessible 24 hours a day, 7 days a week regardless of diagnosis”** (QS14 Statement 6)
- **“people at risk of crisis should be offered a crisis plan”** (QS14 Statement 9)
- **“people using mental health services, and their families or carers should feel optimistic that care will be effective”** (QS14 Statement 1)

We will consider aims of the Concordat and the NICE Guidelines throughout the report to understand what good practice looks like in terms of supporting someone who is experiencing a mental health crisis.

3. Local context

The population who report having a long-term mental health condition in North Tyneside is not significantly different to the rates in England⁴. However, in North Tyneside there are increased rates of self-reported depression and anxiety and a lower rate of “serious mental illness” which is known to GPs.

The North Tyneside Joint Health and Wellbeing Strategy identifies “Improving Mental Health and Emotional Wellbeing” as a key priority for the borough with a focus on positive mental health promotion and recovery through a range of services and community support. These priorities are reflected in the North Tyneside Joint Mental Health and Wellbeing Strategy 2016-2021 which not only hopes to reduce mental health inequalities across the borough, but also to improve identification and intervention before people reach the point of mental health crisis.

⁴ North Tyneside Joint Mental Health and Wellbeing Strategy 2016-2021
Healthwatch North Tyneside 2018

4. Service mapping of mental health services

In order to understand what provision looks like and how it operates within the borough we met with a number of local stakeholders before the design of the project to ensure that our methodology was informed and appropriate to the local area and the services it delivers. This included meeting with commissioners, service providers and front-line staff.

We identified the key services that people may interact with when experiencing a mental health crisis. The majority of mental health services within North Tyneside are delivered by Northumberland, Tyne and Wear Foundation Trust (NTW). However, it is important to note that people may engage with a range of different services when they experience a crisis, not solely NHS mental health services. The range of services we have identified are mapped out below:

- Crisis Resolution and Home Treatment Team (NTW)
- Psychiatric Liaison Team (NTW)
- A & E
- Emergency Services (including Northumbria Police and North East Ambulance Services)
- NHS 111 Helpline
- Street Triage (NTW and Northumbria Police)
- Community Treatment Team (NTW/NTC)
- Talking Therapies (Northumbria Healthcare)
- GPs
- A range of voluntary sector organisations and peer support groups

5. Methodology

5.1 Aim

To identify common themes in service experience for people who are in need of mental health services during crisis which reflect the views of service users, carers and staff. We will work alongside commissioners and providers to identify gaps in service provision and highlight areas for improvement as part of the Crisis Pathway Review being conducted by North Tyneside CCG.

5.2 Approach

In order to ensure service users voices are central to the research and it is relevant to providers and commissioners, we adopted a co-production approach. Therefore, the research design, collection and analysis were directed by the project steering group which met at the beginning, mid-point and end of the research process. Each steering group was attended by a number of representatives including; service users, carers, provider staff and commissioners. The steering group consulted on the draft proposal, assisted with the analysis of the research and helped to craft recommendations based on the findings developed.

Prior to beginning the data collection process, we met with a number of stakeholders from across the borough to discuss their experiences and thoughts on the current service provision and what areas our research should focus on. This included commissioners from both the CCG and the local authority; staff from both Northumbria and NTW trusts; and a range of local voluntary sector organisations. We offered them the opportunity to share any information they thought could be useful to the process and to consult on the draft proposal and data collection tools.

5.3 Methods

We employed a range of methods to engage with a wide range of local people and understand their diverse experiences of accessing, receiving and (where appropriate) leaving mental health services when experiencing a mental health crisis.

- We produced **three surveys (available online and offline) aimed at service users, carers and staff** to complete. This enabled us to reach a wide audience and included open and closed questions to gather both qualitative and quantitative information. The survey provided the opportunity for people to discuss general experiences and 'map out' their journey through services. The carers survey also included questions related to how they were supported as a carer and included in the decision-making processes around the person they cared for. The staff survey included additional questions around how they found the process of referring and transferring service users and how staffs training needs were met - as identified as key topics in the steering group.

- We conducted **5 focus groups** with local people which were facilitated through existing mental health service user groups meetings and forums. We scheduled these across a period of a month and at various times of the day to maximise accessibility for those who wanted to take part.
- We utilised the feedback we have collected through **HWNT general engagement** from February 2017 to February 2018 to ensure people's recent experiences were included and therefore relevant to the current service provision and delivery. This included feedback we had received at our 'talk to us' events, via our online feedback centre and through social media.
- We used our **statutory 'enter and view' powers** to talk to people who have experienced crisis following discharge from the Crisis Resolution and Home Treatment Team and the Psychiatric Liaison Team. This involved both services distributing consent forms to people using their service, which asked for consent to share details with HWNT. Services handed forms out for approximately 4 weeks, we collected forms on a regular basis and contacted those who had consented to ask if they would like to participate in a **telephone interview** about their experiences. Following an in-depth training day, our volunteers then conducted the telephone interviews with service users to gather real-time feedback about their most recent experience of services when experiencing a mental health crisis.

5.4 Sample

We used purposive sampling to engage with those who have accessed or experienced Crisis services within North Tyneside. We ensured that we reached a wide demographic spread by focusing engagement, focus groups and distribution of surveys across the borough and promoting the survey via our enews and social media.

As we were focusing on adult crisis services, we engaged with adults (over 18 years and those in transition to adult services) and those who care for an adult. This allowed the research to be more focused, however we acknowledge that young people and older people also face barriers when in crisis, this was not within our scope for this project.

We also collected feedback from professionals who work within mental health services. This helped us to understand what barriers staff may face when working with a person in crisis and how services in the pathway currently interact to provide support to service users.

	Number of respondents:			
Method of gathering feedback:	Service users	Carers	Staff	Unknown
Online and Offline survey	56	36	37	0
Focus groups	33	0	6	0
E & V Telephone interviews	4	0	0	0
General engagement (including social media interactions and our Feedback Centre)	30	7	0	6
Total:	123	43	43	6

In total we received feedback from **215** service users⁵, carers and staff⁶.

Although we utilised various methods to reach a wide range of people, with a particular focus on seldom heard groups, we heard significantly more views from females and people of White British ethnicity. This may be reflected in some of our findings. To see demographic information about the survey respondents, refer to appendix 1.

5.5 Analysis

We co-produced a number of the key themes at our mid-point steering group. The themes identified during this process were then used to develop our coding framework, which was utilised throughout the analysis process. We used NVivo software to code qualitative data thematically.

Quantitative data and pathway mapping was analysed using excel spreadsheets and survey monkey analysis tools. We involved the final steering group in the process to craft potential recommendations, where appropriate.

5.6 Dissemination and impact

The findings from the final research report will be fed into the CCG Crisis Pathway Review. We will work collaboratively with commissioners to ensure the feedback we have received is considered and incorporated into the pathway review and action plan. We will also share our findings with Northumberland, Tyne and Wear

⁵ Service Users includes people with mental health needs who have attempted to access services as well as those who have experienced using mental health services in North Tyneside.

⁶ However, respondents may have potentially contributed via one or more methods of engagement.

NHS Foundation Trust and other service providers to share good practice and highlight areas in need of improvement.

The final report will be available on our website and circulated through social media. Printed versions will be provided on request to the general public and respondents will have the opportunity to receive a copy of the report. We will also develop a summary document highlighting the key findings from the report in an accessible format.

The report will be sent to key stakeholders and Healthwatch England to feed into their national analysis of service user feedback.

We also took the opportunity to present the key findings from this at the Northumberland, Tyne and Wear Research Conference in May 2018.

5.7 Ethical considerations

Due to the nature of this research we ensured ethical considerations were at the centre of our decision making and research process. The key actions we implemented to ensure our project was ethical are outlined below:

- Ensuring participation consent was fully informed and clearly explained to those who chose to take part in the project. This was via consent forms, participant information sheets and verbally.
- Ensuring all data collected was anonymised and personal, identifiable information removed from any outputs from the project. Keeping the raw data confidential and stored in a secure location in line with data protection guidelines.
- Ensuring our volunteers and staff members were trained in mental health and crisis support prior to involvement in the project, with opportunity to debrief following interviews.

Overall, it was important that service users and carers were involved throughout so that the research was appropriate, accessible and valuable to those with lived experience of mental health crisis.

6. Findings

The key themes outlined below were identified when considering what people had told us about experiencing crisis. As the primary objective of this project was to understand people's individual journeys through services, thematic findings have been grouped in relation to the journey through services:

- How do people define a mental health crisis?
- Accessing support
- Receiving support
- Leaving support
- Cross cutting factors

6.1 How do people define a mental health crisis?

From our engagement with stakeholders it became apparent that there was no clear definition of crisis within mental health service provision that was agreed by all services. Mind's (2011) definition of a mental health crisis states that a crisis is when:

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

Therefore to understand people's experiences of support, we first explored how people may define or understand the term 'mental health crisis'. We used responses from the survey and focus groups to develop a working definition which we adopted for this project.

“An overwhelming experience of extreme mental ill health, which impacts a person's ability to cope and stay safe”

This definition incorporates a range of aspects that service users, carers and staff deemed important when defining a crisis which are explored in further detail below. Each of these aspects can be an indicator of a mental health crisis, however not every aspect was common to all respondents.

Risk to self

In the survey, respondents identified the key aspects that described, personally, what a mental health crisis meant to them. The most common aspect was in relation to risk of harm and suicidal thoughts, with 63 service users, carers and staff discussing this:

“Thoughts of ending life” (Service User)

“When the person I care for has no way of being able to make themselves feel safe” (Carer)

“Suicidal thoughts, plans or actions. Self-harming desires” (Staff)

The majority of respondents discussed this in relation to harm to self but, a number (10) also noted the potential of harm to those around them.

“Someone whose mental health may have deteriorated to the point that they are at imminent risk of harming themselves or someone else” (Staff)

Therefore, the element of risk or harm was identified as a main element of defining crisis.

The need for immediate intervention

Another area that was identified was the need for immediate response and urgent support. This was discussed by 27 respondents.

“There is need for a fast response” (Carer)

“...requires urgent intervention as opposed to planned care” (Staff)

Respondents also noted that they would be unable to cope independently without an intervention at the point of crisis.

“A mental health emergency which directly threatens someone’s life or drastically reduces their quality of life, and is usually beyond their capacity to mitigate or deal with” (Service User)

“A code word for in need of intervention” (Service User)

A ‘can’t cope’ situation

A frequent way of describing crisis was in relation to “a ‘can’t cope’ situation” or a feeling of being overwhelmed. 25 respondents discussed the notion of being overwhelmed by their mental health condition or current situation when asked to define a mental health crisis. This was equally recognised amongst service users, carers and staff as a key element of experiencing a crisis.

“When I’m totally overwhelmed by my depression” (Service User)

“Severely distressed. Not coping” (Carer)

“Overwhelming strong negative feelings, sometimes suicidal. Unable to apply coping strategies” (Staff)

This characteristic was also identified in relation to not being able to carry out daily tasks or function in a way that was ‘normal’ to the individual experiencing the crisis.

Rapid deterioration

It was noted by 13 respondents that crisis was often characterised by a rapid deterioration and worsening in a person’s mental health condition or a significant behavioural change as a result of this.

“Different or marked change in behaviour outside of a person’s normal behaviour range” (Service User)

“Acute and rapid worsening of bipolar symptoms” (Carer)

“A person who is having an acute severe behavioural change” (Staff)

However, it is important to note that this was deemed as relative to the person experiencing the crisis and behaviour change may not always present as a worsening in mental health i.e. when a person is in crisis during mania they may feel ‘a moment of enlightenment’.

Individual to the person experiencing the crisis

The final aspect respondents stated, when defining a mental health crisis, was the personal nature of a crisis. Respondents frequently discussed how differently crisis can be experienced by others and stressed the importance of a crisis being self-defined by the person experiencing it.

“Different for different people” (Service User)

“Mental health crisis is individual to the person experiencing it. To define it would exclude people who need help, care and support” (Staff)

There were parallels between the way in which service users, carers and staff defined a mental health crisis and the complexity of a definition was evident throughout the responses we received. When speaking with stakeholders it was noted that often people may present to services with a ‘life crisis’ (i.e. divorce, unemployment) rather than a ‘mental health crisis’ which meant that treatment through their service may not be appropriate. However, it is important to note that there is a correlation between socio-economic factors such as unemployment, austerity and social deprivation and poor mental health (Knapp, 2012)⁷. Therefore, often a ‘life crisis’ may lead to be simultaneous to a worsening in a person’s mental health.

Crisis and service criteria

Although there were no significant differences between how service users, carers and staff defined a mental health crisis in the responses we received, respondents continued to discuss the difficulties of experiencing a crisis and being turned down by services due to not meeting the criteria for treatment or support.

“Because I don’t know how the crisis team class as a crisis, so I never know if its ok for me to call or not. It’s not clear what service is for what” (Service User)

“Being clear about how they class as a crisis- where to go when. Because I get it wrong e.g. I said i felt like hurting myself, so they said we aren’t emergency call ambulance or police. So then next time I did not tell that just say I feel bad, so they said it’s not a crisis call CPN tomorrow” (Service User)

“I am very, very confused what service is for when and I really want crisis team to 1, explain how they class as a crisis 2, explain what words I should say so they will help” (Service User)

“I rang the crisis team for support. My plea for help was declined due to being told my partner was not in a serious state, after a lengthy telephone discussion with a member of their team where I was desperately seeking some support” (Carer)

“the criteria that services work to regarding what is defined as a ‘crisis’ is not widely known and definitely not known by the public. I have supported clients who have been suicidal or have reported suicidal idealisation however the crisis team will not speak to them or support them which

⁷ www.ebmh.bmj.com/content/15/3/54

leaves clients no immediate services other than A&E which is inappropriate” (Staff)

This confusion about service users experiencing a crisis but either being turned away due to needing emergency services or lower level services was a significant issue described by many respondents. In addition, when we asked respondents what was helpful about the support they received, 24 people said “nothing” was helpful. This was largely related to people feeling they had not been given any support when trying to access services, rather than the quality of support received from services.

Respondents also discussed the need for additional support to be in place when they are unable to access support from the CRHT but are experiencing a mental health crisis. They discussed alternative approaches that may be useful such as having a ‘safe space’ they could go to in this event or a ‘crisis line’ in place to call. Mental health staff also discussed issues arising due to service users not meeting the threshold for crisis support and the need for an alternative.

“Lack of access to statutory services, more and more people are not meeting the threshold to access statutory services which then drives them further into crisis. In addition to this there is far less community support now available in North Tyneside which again results in people ending up in crisis when preventative input could have helped avoid this” (Staff)

Suggested actions:

- **One stop shop and trusted assessment** – CCG to develop a one-stop shop for people in need of support to access different services from a single contact. The one stop shop conduct a trusted assessment so that different mental health services are confident that a referral has come to the right place.
- **Low-level crisis support** – CCG to develop a lower level crisis support service for those who feel they are experiencing a crisis but do not meet the threshold for Crisis Resolution and Home Treatment Team. Other areas have good examples of CCGs and voluntary sector organisations coming together to deliver this. e.g. Together in a Crisis.

6.2 Accessing support

This section will explore the feedback we received about people’s experiences of accessing support. The key areas we have identified are:

- Contact with services prior to a crisis
- Planning prior to a crisis
- Knowing where to go in a crisis
- Access for people with additional needs
- Waiting times
- Prior negative experiences

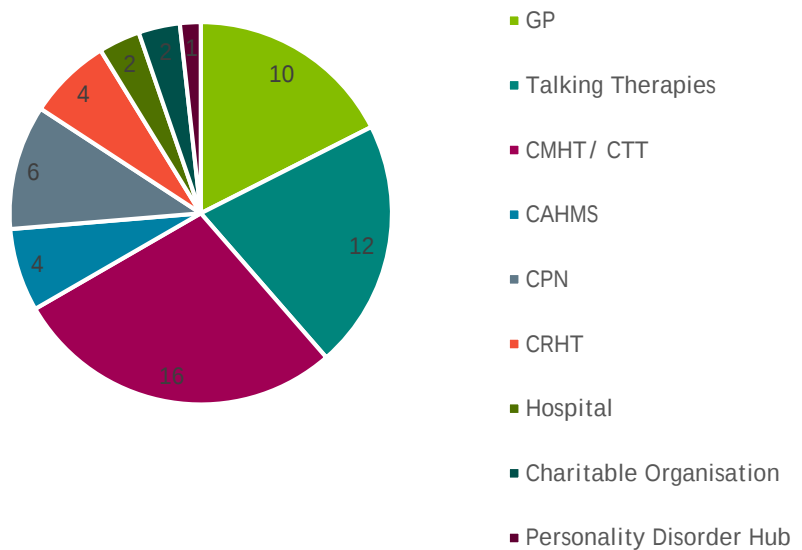
- Access for older people

Contact with services prior to a crisis

We asked service users and carers if they were in contact with a service prior to their most recent crisis. Of those who responded, 65% had been or were in contact with a service themselves or of the person they cared for.

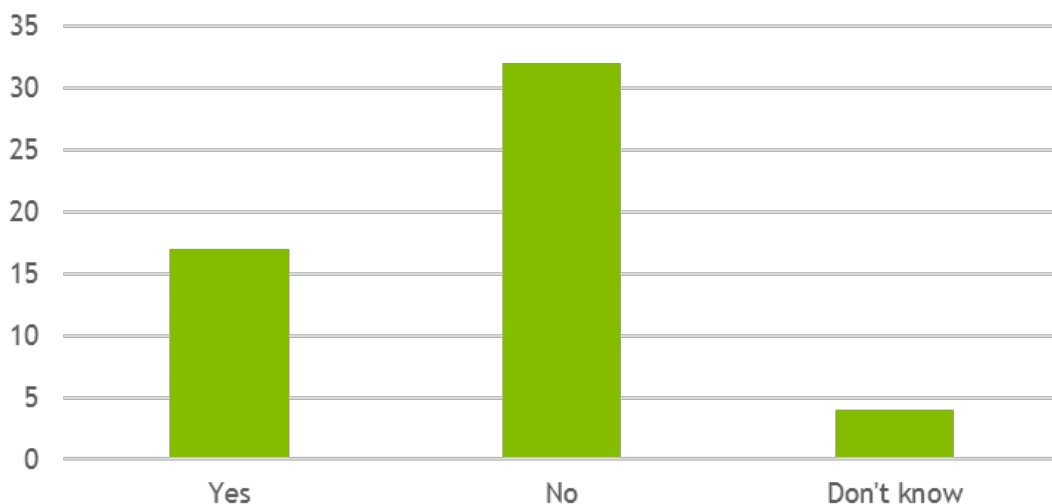
Of those respondents who were in contact with services prior to their crisis. The most common services that they were in contact with was the CTT, Talking Therapies and their GP. Overall, 19% had been in contact with the CMHT/CTT, 15% with Talking Therapies and 12% their GP.

Who were people in contact with prior to their crisis?



Planning prior to crisis

Did you have a plan in place for when you are experiencing crisis?



We asked service users if they had a plan in place for when they are experiencing a mental health crisis. 32% of respondents stated they had a plan in place, with the majority (68%) stating that they did not, or they were unsure if they did. As a high number of respondents were currently or had previously been in contact with mental health services, it is a concern that most people we talked to did not have a plan in place.

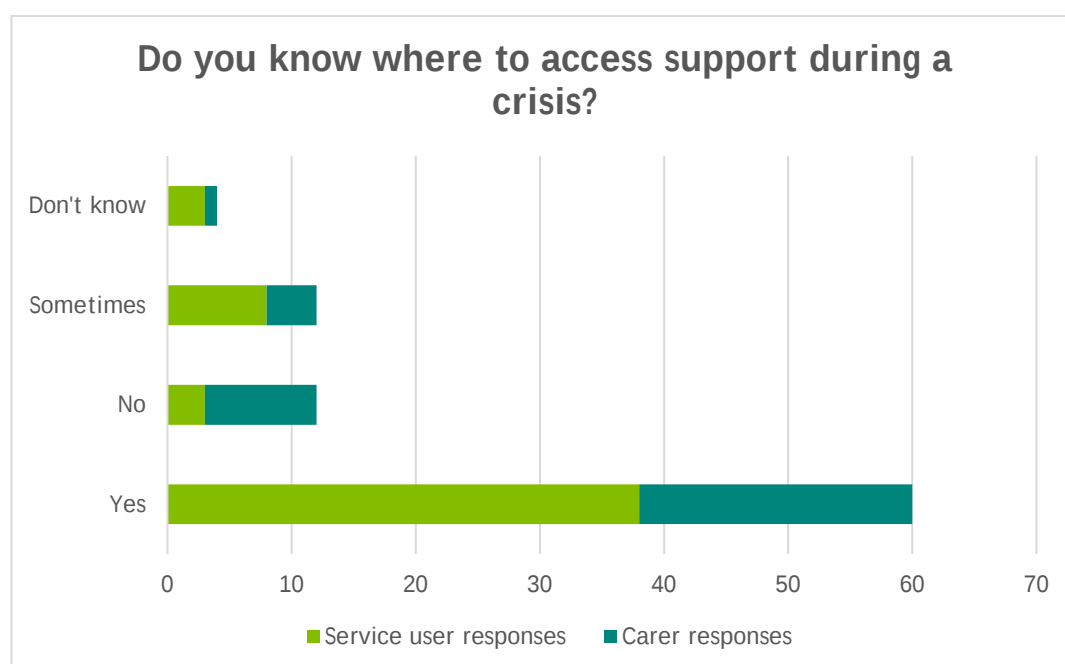
Of those who did have a plan in place, plans were often developed through their CPN or through Voluntary Organisations. However, a few respondents also described being given phone numbers. People also told us about the difficulties in following the plan they had developed when experiencing a crisis.

“Tried to follow but found it difficult, was helpful for others to use to help me the best they could” (Service User)

Suggested action:

- **Crisis planning** – Service Providers to review information given to service users and carers about what to do if they experience a mental health crisis.

Knowing where to go in a crisis



We also asked service users and carers if they knew where to go when experiencing a mental health crisis. The majority (68%) of respondents stated that they did. Of those who described where they accessed support, the top three responses were:

- Ringing telephone numbers/helplines that they had received
- Contacting the Crisis Resolution and Home Treatment Team
- Contacting their local GP

Although respondents discussed knowing where to go in a crisis, Issues were raised about being able to access the support from services. This was due to a number of factors such as the changing nature of support offered.

“Where to go changes quite often. (As do services provided by mental health services!)” (Service User)

Access for people with additional needs

This was specifically raised in relation to people who have a dual diagnosis or have issues with alcohol or substance misuse.

“When you ring crisis assessment team if you’re an alcoholic they won’t help other than sending you to A and E” (Service User)

Staff also noted the difficulties in referring people to services when they also experience substance misuse.

“Crisis team will not engage with emergency services and will not engage with patient with alcohol even if the person is not under the influence. The first mention of alcohol halts the pathway of care” (Staff)

Suggested action:

- **Access and additional needs:** Commissioners and providers to develop a multi-disciplinary approach to support people with multiple needs, particularly when people are using alcohol and drugs.

Waiting times

49 respondents talked to us about the waiting times to access services. 18% of the feedback we received was about positive experiences of timely access to services.

“I was in crisis and they were there with help and support in less than 24 hours” (Service User)

“They really are a day and night service’ - You can ring anytime day or night” (Service User)

82% of this feedback was about people feeling that there were long waiting times to access a range of services including:

- waiting for return calls from the crisis team
- awaiting referrals and assessments to a number of services
- waiting to access talking therapies
- waiting for GP appointments

These issues were described by a number of respondents:

“She said someone would ring me back. After 4 hours! no-one had” (Service User)

“It was 2 hours before someone was able to phone me back and talk to me about how I was feeling” (Service User)

“I was waiting for help from GP and during that period I attempted to end my own life” (Service User)

Suggested action:

- **Waiting Times** – Service providers to be clear with service users and carers about expected waiting times and apologise if times are delayed. Understand that the pressures on services will change with the development of a lower level crisis support and a one stop shop.

Prior negative experiences

Another issue that respondents noted was prior negative experiences of using services acting as a deterrent to them reaching out to the service again. This was largely in relation to phone calls with the Crisis Resolution and Home Treatment team leading to inappropriate support being given or long waiting times to be contacted back.

“I know to call the crisis team but never would as don’t find them helpful” (Service User)

“I had two attempts at contacting the crisis team, both by telephone. On both occasions the call was answered, and I was told they were busy and they would call me back, which they never did” (Service User)

Access for older people

10 respondents talked about the lack of services for over 65s when experiencing crisis. This was especially emphasised by mental health professionals who described difficulty in supporting older people with the limited resources.

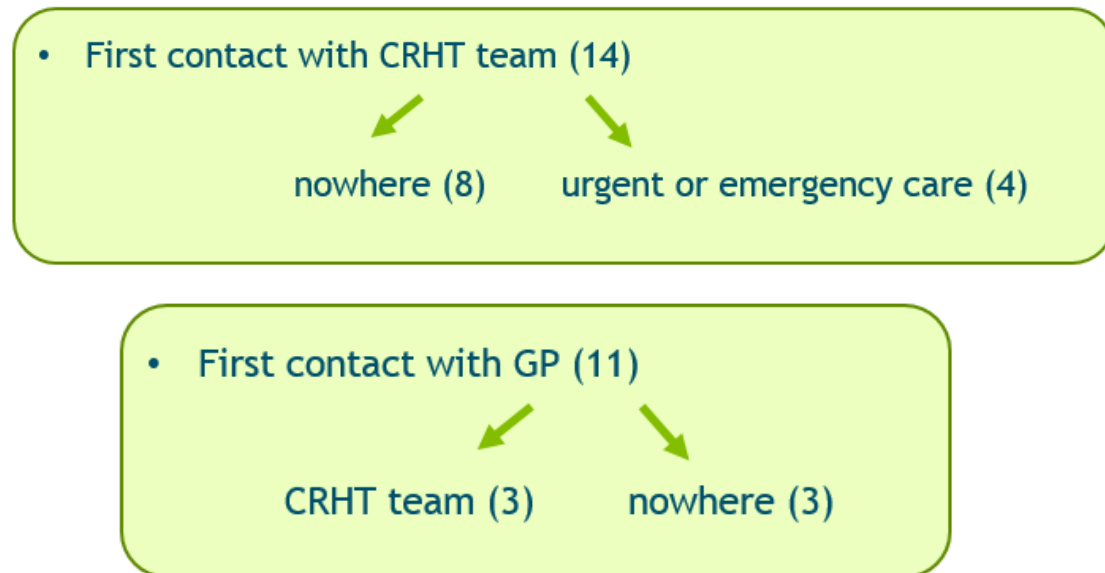
“Our service does not provide out of hours support and the Crisis Team will not see patients over 65 years of age. There are limited resources available to over 65 patients” (Staff)

Suggested action:

- **Older people** - Mental Health Integration Board to review the support for older people experiencing a mental health crisis.

Where do people go when experiencing a crisis?

We asked respondents to 'map out' their most recent experience of accessing support in a crisis⁸. The two most common pathways people told us about are illustrated below:



The two most common points of access people described were the CRHT and their GP. It is positive to see that GPs were directing people to CRHT when experiencing crisis, although a number of people also ended up going 'nowhere' in both instances. This raises concerns about how people are signposted or referred for further support when they are deemed as unsuitable for the initial service they engage with.

Accessing support by service

Through mapping out journeys we were able to estimate the typical access rate into services respondents told us about. We used the two most common points of access⁹. From those who sought help with their GP, we found there was a 69% chance you would receive support. From those who sought help from the Crisis Resolution and Home Treatment Team, we found there was a 39% chance you would receive support in a crisis.

⁸ A limited number of respondents engaged with this section of the survey.

⁹ Access rates of other services were deemed as not high enough levels of feedback to calculate percentages from.

6.3 Receiving support

What works well?

Of those who had received support from a service when experiencing a crisis, they were largely positive about the treatment that they had received. This was in relation to quality of care, being listened to and services supporting family and carers as well.

“Family and carers were offered support as well. Seen by lots of different staff (but this was a good thing) including a doctor, nurses, support workers and an OT” (Service User)

“reassured the person and talked to her parents to explain symptoms and medication. They felt empowered” (Service User)

All four interviewees who were currently receiving support from the CRHT were ‘very satisfied’ with the treatment and would recommend the service to someone experiencing a similar issue.

Interviewees discussed feeling involved in decisions about their treatment and talked about receiving intensive support for their needs on a regular basis. Other examples of good practice were noted such as the CRHT arranging support to be transferred to another service whilst a person was out of the area for the festive period. Another person discussed the support family members received, explaining that their relative could ‘call on the CRHT anytime’.

What needs to improve?

Respondents discussed issues arising from lack of resources and increased need, this linked to the decommissioning of local ‘crisis beds’.

“Crisis house was closed with no notification” (Staff)

“Needs to be more respite beds” (Service User)

Staff told us that not having crisis beds has impacted the support for those in crisis.

Suggested action:

- **Crisis beds** - NTC to investigate the impact of decommissioning of crisis bed provision on the current support available to people in crisis.

We asked carers specifically about how involved and appropriately supported they felt when engaging with crisis services, 26 carers responded. 31% of those who responded discussed feeling positively supported by a range of services including voluntary sector organisations, their GP, the police and the Crisis Resolution and Home Treatment Team. However, the majority (69%) of carers described feeling unsupported and involved by mental health services.

“Left to fend for self during the months that followed. Little or no support” (Carer)

“Not at all. Still have no help on how to deal with things. I have had to do some major research myself to educate myself and family of his difficulties. No help for our family whatsoever” (Carer)

Suggested actions:

- **Carer support** – Commissioners and Service Providers to review how carers are supported to ensure that their own support needs are identified and met as set out by The Care Act (2014) and the new Carers Partnership Board.
- **Carer involvement** – Service Providers to review how carers can be involved and/or informed about the support available to the person they care for.

6.4 Transitions and discharge

In terms of leaving support, 36 respondents told us about experiences of being discharged from crisis and non-crisis mental health services and transferred between a range of services.

What works well?

7 people told us about positive experiences of being discharged and/ or transitioned.

“I was well informed in advance of my discharge that although the sessions were finished in could contact them anytime and was given telephone number” (Service User)

Positive experiences were largely characterised by service users and carers being involved in the process and being clearly informed.

What needs to improve?

29 people told us about negative experiences of being discharged or transitioned.

“Received no help and support once discharged from A&E” (Service User)

8 people talked about being left with no support at all following discharge. Others talked about the process being ‘disjointed’, self-led and the follow up support following discharge being very short-term. A number of people mentioned issues around transitioning between a range of different services.

“Disjointed and poorly managed, no communication, forgotten, no definitive plan” (Service User)

“I was discharged to care of my husband and left to follow up myself” (Service User)

Staff respondents also talked about referring service users to other services, they noted difficulties due to waiting lists and lack of resources. However, it is important to note that steps have been made between Northumbria and NTW services towards working together to ensure referrals are now more fluid.

Suggested actions:

- **Bridging gaps** – Service Providers to continue to work together towards planning, referral and streamlining transition process to ensure people do not fall into gaps in between services.
- **Early identification** – Service Providers to Identify when a person might need additional support to access follow up services following discharge.

6.5 Cross cutting factors

Staffing

A key element respondents told us about when sharing their experiences of mental health crisis was the impact that the staff they engaged with had on their overall experience. Overall, 98 respondents discussed their experiences of staff.

What works well?

Service users and carers told us about their experiences of being supported by a range of professionals during their crisis. Of those who did 20 people told us about positive experiences in relation to support from their GP, CRHT, CAHMS and the voluntary sector.

“Positive consistent and supportive GP” (Carer)

“I was contacted by the crisis team. They helped immediately. Nurse (name omitted) saved my life” (Service User)

What needs to improve?

However, 78 people told us about negative experiences they had encountered with staff from a range of services. This included feedback about a range of aspects of staffing:

- Attitude (32)
“Rude nurses answer the phone and make you feel like you are a hassle from the outset” (Service User)
- GP knowledge, support and understanding of MH (24)
“The GP was useless - total lack of understanding on mental health issues” (Carer)

Suggested action:

- **GP and primary care support** - CCG to work with primary care services to increase Mental Health awareness, knowledge of services available and referral mechanisms since Primary Care Services are often the first point of contact for people with mental health needs.

- Levels of staffing and continuity of staff (14)
“There is no continuity of care. I have to explain my difficulties from the beginning every time” (Service User)
- Training received by staff (8)
“encourage crisis staff to treat those in crisis as 'people with problems', rather than 'problem people'” (Service User)

Staff also told us about a range of experiences of training within their role from high level clinical training to very minimal training received which was solely “learnt on the job”. Therefore, there was a significant disparity between the levels of training the staff who responded had received.

Suggested action:

- **Staff training** – Service Providers to ensure mental health awareness training is provided for non-specialist staff and mental health professionals are consistently trained in relation to tackling stigma and handling crisis.

NICE Quality Standard QS14 Statement 2 states that “people using mental health services should feel they are treated with empathy dignity and respect”. We continue to hear service users and carers tell us about negative experiences of engaging with staff about their mental health needs.

Suggested actions:

- **Issues around staffing** – Commissioners and Service Providers to continue to work with their staff to ensure that people feel they are being heard and respected.
- **Feedback** – Services should devise and/or review mechanisms they use regularly to ask for anonymous feedback from service users and carers about the services they receive including how they feel they are treated by staff.

7. Overview of suggested actions

See below for the full list of suggested actions included in the report:

1. **One stop shop and trusted assessment** - Develop a one-stop shop for people in need of support to access different services from a single contact. The one stop shop conduct a trusted assessment so that different mental health services are confident that a referral has come to the right place.
2. **Low-level crisis support** - Develop a lower level crisis support service for those who feel they are experiencing a crisis but do not meet the threshold for Crisis Resolution and Home Treatment Team. Other areas have good examples of CCGs and voluntary sector organisations coming together to deliver this. i.e. Together in a Crisis.
3. **Crisis planning** – Service Providers to review information given to service users and carers about what to do if they experience a mental health crisis.
4. **Access and additional needs** - Develop a multi-disciplinary approach to support people with multiple needs, particularly when people are using alcohol and drugs.
5. **Waiting times** - Be clear with service users and carers about expected waiting times and apologise if times are delayed. Understand that the pressures on services will change with the development of a lower level crisis support and a one stop shop.
6. **Older people** - Mental Health Integration Board to review the support for older people experiencing a mental health crisis.
7. **Crisis beds** – NTC to investigate the impact of decommissioning of crisis bed provision on the current support available to people in crisis.
8. **Carer support** – Commissioners and Service Providers to review how carers are supported to ensure that their own support needs are identified and met as set out by The Care Act (2014) and the new Carers Partnership Board.
9. **Carer involvement** – Service Providers to review how carers can be involved and/or informed about the support available to the person they care for.
10. **Bridging gaps** – Service Providers to continue to work together towards planning, referral and streamlining transition process to ensure people do not fall into gaps in between services.
11. **Early identification** – Service providers to identify when a person might need additional support to access follow up services following discharge.

12. **GP and primary care support** - CCG to work with primary care services to increase mental health awareness, knowledge of services available and referral mechanisms since primary care services are often the first point of contact for people with mental health needs.
13. **Staff training** – Service providers to ensure mental health awareness training is provided for non-specialist staff and mental health professionals are consistently trained in relation to tackling stigma and handling crisis.
14. **Issues around staffing** – Commissioners and service providers to continue to work with their staff to ensure that people feel they are being heard and respected.
15. **Feedback** – Services should devise and/or review mechanisms they use regularly to ask for anonymous feedback from service users and carers about the services they receive including how they feel they are treated by staff.

These actions reflect what we have heard from engaging with service users, carers and a range of mental health professionals over the last year. However, a significant number of these actions reflect recommendations from our previous report 'People's experience of mental health services in North Tyneside'¹⁰ which considered feedback received in 2015. Although, progress has been made, it is evident that people accessing mental health support continue to encounter similar difficulties. Therefore, we would like to reiterate the previous recommendations for our earlier report below:

1. Create a single point of access for all community-based services (including those which are not commissioned by the statutory sector) which complies with NICE Standards.
2. Reduce waiting times to bring them into line with NICE standards by:
 - Setting standards for waiting times across commissioned services and publishing information about compliance.
 - Develop a network of support for people on any waiting list such as a support group or online forum.
3. Develop and implement a clear support pathway, including out of hours, for people who feel that they want to end their lives, harm themselves or who are experiencing a crisis. This should include support pathways for people who already access services and those who do not.
4. Support staff in a variety of settings to better meet the needs of people with mental health problems:
 - Provide mental health awareness training for non- specialist staff, for example in A&E, GPs, receptionists and Care Navigators.

¹⁰ www.healthwatchnorthtyneside.co.uk/wp-content/uploads/2017/07/HWNTmentalhealthreport2017.pdf
Healthwatch North Tyneside 2018

- Provide training for mental health professionals in relation to handling crisis, tackling stigma, listening skills, service availability and managing stress.

8. What happened next?

We shared this report with key stakeholders and it was well received by North Tyneside Clinical Commissioning Group, Northumberland, Tyne and Wear NHS Foundation Trust and North Tyneside Council. We have agreed that The Mental Health Integration Board will review this report and take responsibility for implementing the suggested actions. The Health and Wellbeing Board will be updated regularly, and Healthwatch North Tyneside will review progress in 12 months' time. We will be presenting this report to the Board of NTW later this year.

A summary version of this report will be released to share with stakeholders and most importantly to relay the findings in a more accessible format to those people who contributed their experiences into this project.

We have also released a 20-minute film of service users' experiences of mental health services which was premiered at the Service User and Survivor Forum. We will be showing this film to the NTW board later this year and it will be available to view on our website.

We will continue to talk to local people about their experiences of mental health services across the borough and work closely with commissioners and providers to ensure local people's voices are heard.

Appendix 1 - Demographics

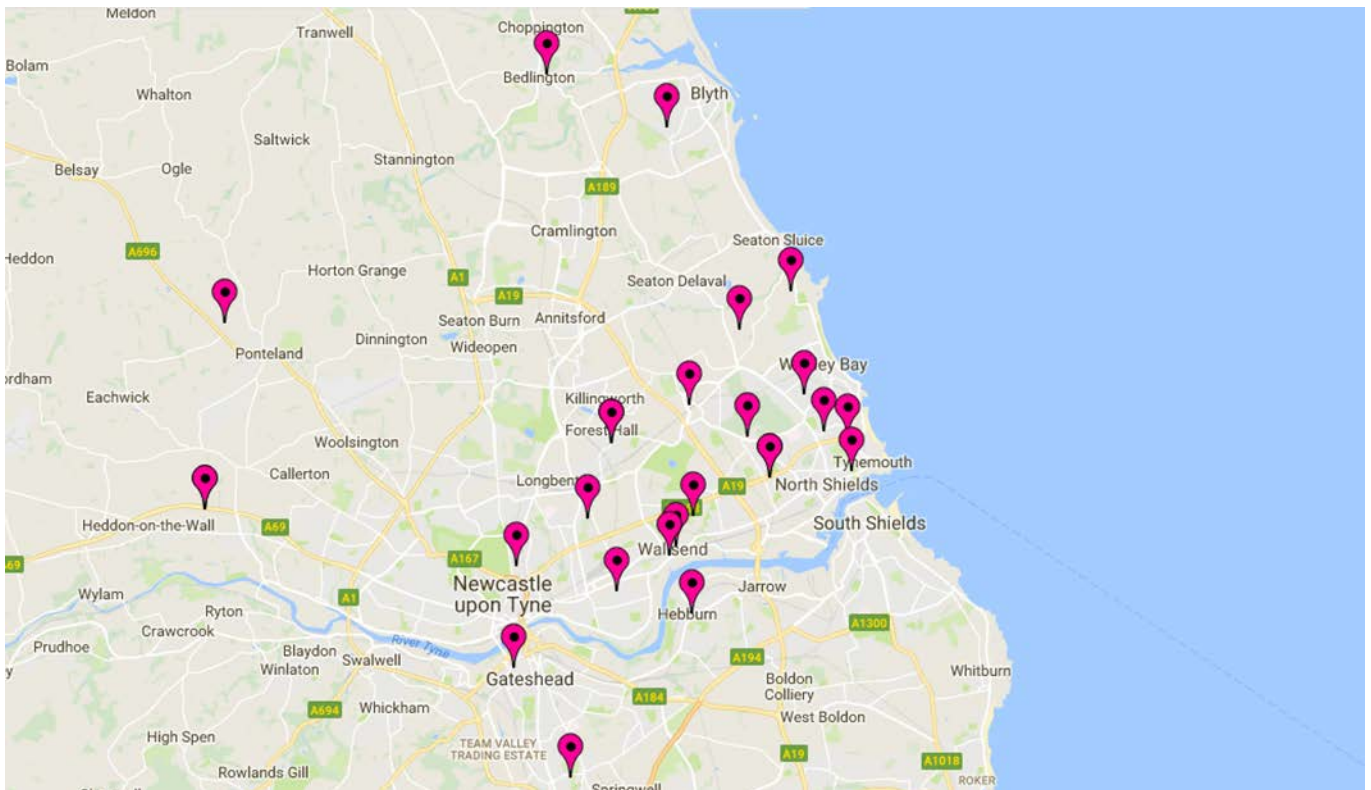


Figure 1. Postcodes of survey respondents

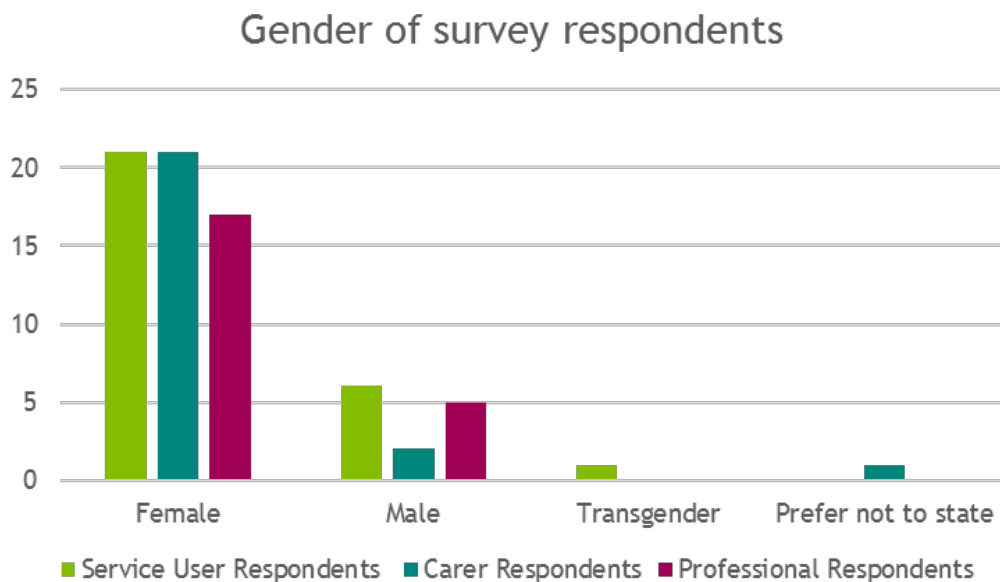


Figure 2. Gender of survey respondents

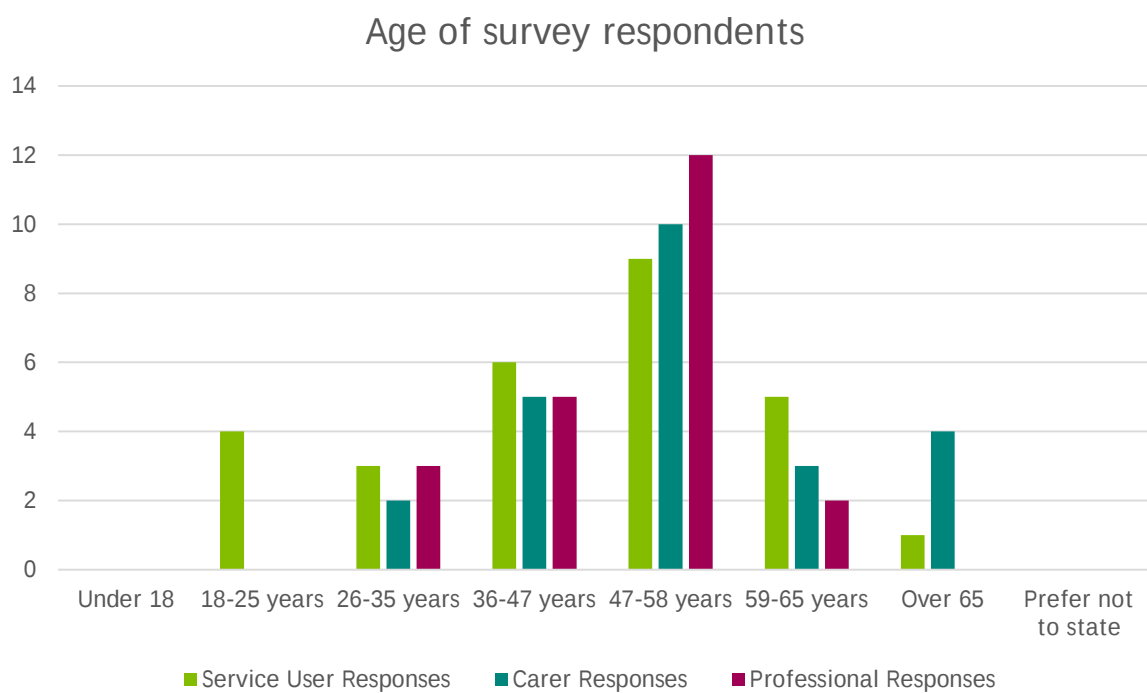


Figure 3. Age of survey respondents

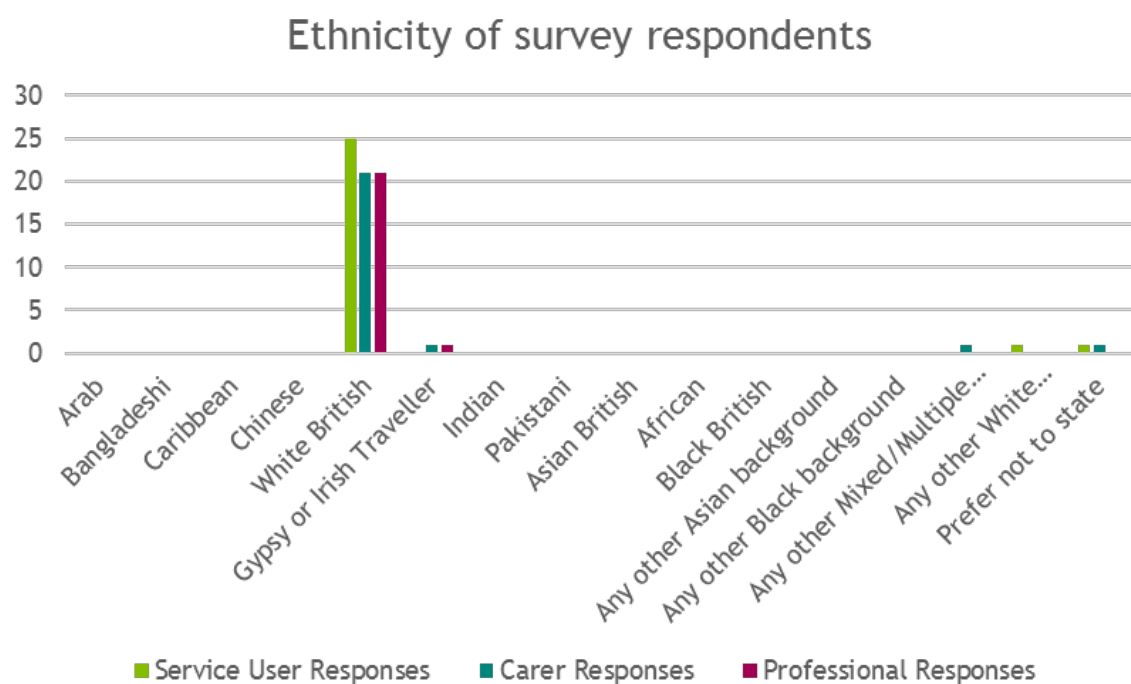


Figure 4. Ethnicity of survey respondents



Figure 5. Crisis occurrence of survey respondents

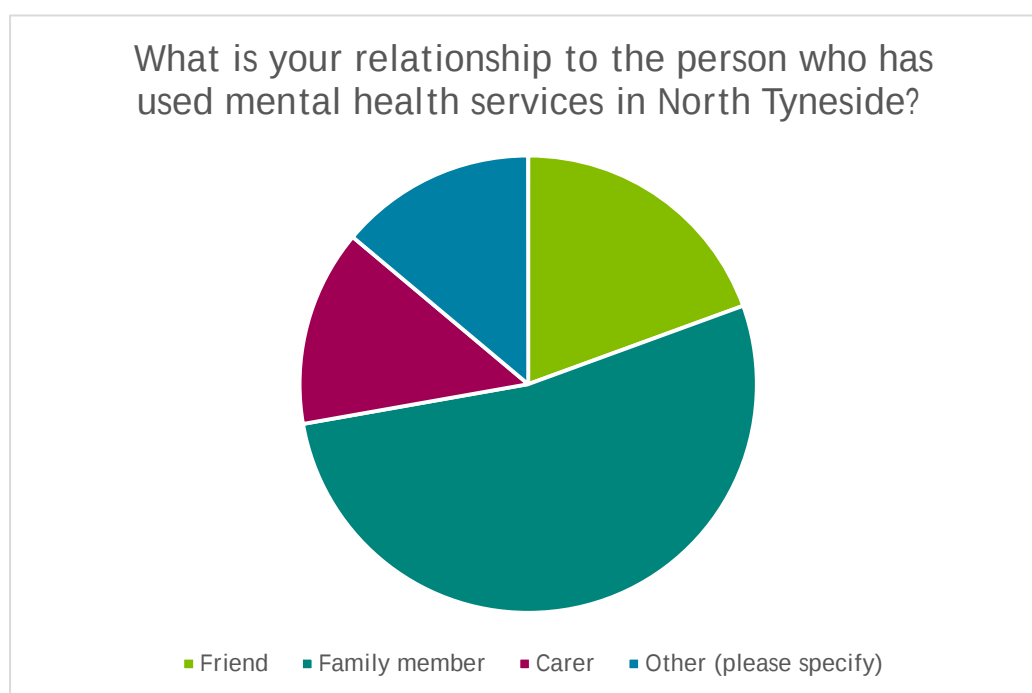


Figure 6. Carer responses to relationship with person who experienced crisis

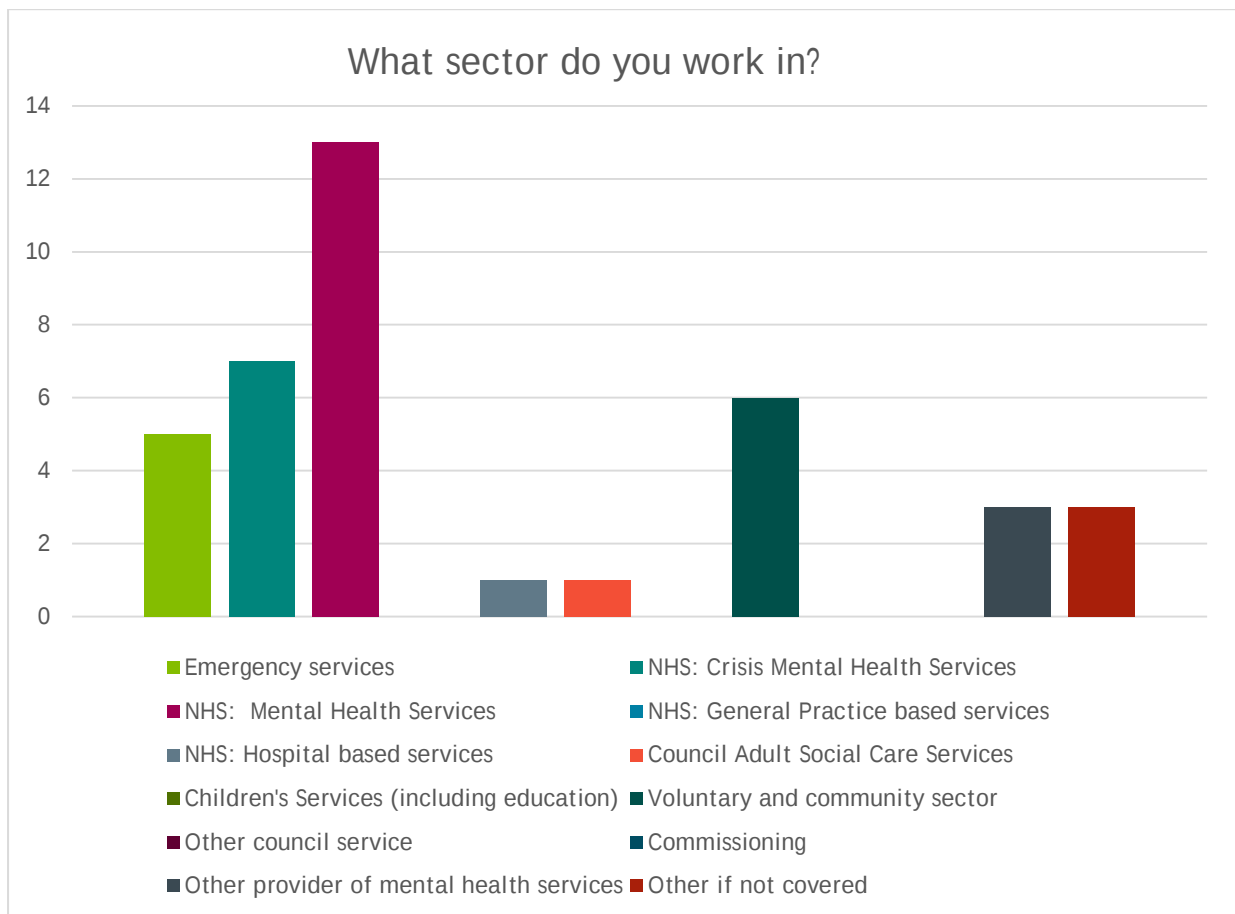


Figure 7. Staff responses to which sector they work in



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