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1 Background

The Crisis Care Concordat, launched in February 2014, is an England-wide national agreement between the different agencies and services involved in the care of people experiencing, or at risk of experiencing, a mental health crisis. The focus of the Concordat is on improving the quality and availability of help and support, with a focus on acute mental health crises, although it also recognises the importance of prevention and recovery. The four main aims of the Concordat are:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously;
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency;
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment;
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

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

Twenty-seven national bodies have signed up to the Concordat, representing health, the police, social care, housing, national and local government (including the Home Office, Department of Health and the Ministry of Defence) and voluntary and community sector organisations, among others. However, implementation is very much at local level with local areas responsible for building partnerships to work together to develop and implement the Concordat aims.

In May, 2014, Mind commissioned The McPin Foundation to complete an evaluation of the work being undertaken to implement the national Crisis Care Concordat statement. The evaluation is guided by the core values within the concordat and aims to:

1. Assess the progress and impact of rolling out the local crisis declarations;
2. Begin to understand the success factors for local areas to sign up and embed agreements made through Local Crisis Declarations into their working practices and protocols, as well as the major challenges and obstacles;
3. Produce learning and recommendations for how local partners can effectively work together to improve the experience of people in mental health crisis in each and every locality.

2 Outline of Methodology

2.1 Methods

The evaluation used a mixed methods approach, with data collection and analysis consisting of the following:

a) An analysis of a sample of local area action plans from across England
b) Observations in four local areas
c) Interviews with key stakeholders in the four areas
d) Interviews with members of the National Steering Group
e) Surveys of the experiences and views of service users and carers (baseline and follow up)

The action plan analysis and observations of local area meetings helped to develop an understanding of the way in which local areas responded to the Concordat in the initial stages of the work. Through the action plan analysis we were able to give an account of the positioning of the Concordat in local contexts. The observations provided an insight into the nature of the work involved in developing the action plans, including the implications for partnership working. This was then explored further in interviews with the key stakeholders in those areas, and with the members of the National Steering Group. The interviews were also used to gather views on the future of the Concordat and of mental health crisis care. The surveys allowed us to examine the extent of any changes in the experience of crisis care over a 12 month period, contributing to an overall picture of crisis care in England, and the directions in which it has been developing.

More details of the specific methodologies are given in the relevant sections of the analysis below. We begin with the analysis of the local area action plans, before moving on to the observations. We then present an analysis of the local area and National Steering Group interviews. Finally, this is followed by the analysis of the service user and carer experiences survey data.
2.2 Limitations

Since the main focus of this evaluation was progress at the level of local implementation, there are a number of important areas of Concordat working that have not been included in our data collection and analysis. While we have interviewed a number of members of the National Steering Group, we have not considered the following in any detail:

- Changes to the national framework
- National signatory actions, for example
  - The role of NHS England in driving improved commissioning of crisis services
  - The work of the Care Quality Commission in establishing a new approach to inspecting the full crisis care pathways in localities
  - The contribution of Mind working across the country to encourage take up

The survey data analysis provides some insights into changes in service user and carer experiences of accessing and receiving support. However, this data has a number of limitations. Firstly it is not possible to determine the extent to which any changes are a direct result of the work of the Crisis Care Concordat, and secondly, it is with a small, self-selecting sample of people, and so cannot be seen as representative of service user and carer experiences within England on the whole.

It is also important to note that the impact of the Concordat is expected to extend well beyond this time period and so there will be further changes that we have been unable to capture at this point in the evaluation.

2.3 Routine data analysis

In addition to the methods outlined in section 2.1, we also intended to include an analysis of routine data available from the Mental Health Dementia and Neurology Intelligence Network and the Health and Social Care Information Centre. We planned to examine baseline data in local areas prior to the work of the Concordat, and the most recent available data towards the end of the project, to demonstrate any change, for example, in the use of section 136 and places of safety. In 2014, as part of its thematic review of mental health crisis care, the Care Quality Commission published a detailed analysis of data describing crisis care at a local authority level. Using a pathways approach, they looked at data in relation to presentations at Accident and Emergency Departments (A&E), support from specialist
mental health teams and section 136 detentions. The data covers the period from April 2012 to March 2013 and so provided a valuable baseline for our evaluation. It was included in our interim report, and is available here; however, we were unable to conduct a follow-up analysis as no equivalent data were available for 2014/15. Some discussion of the limitations of routine data currently collected is included in Section 5.2.4 (interview data) and is also addressed in our discussion and recommendations (Section 7).

3 Action plan analysis

3.1 Introduction

The purpose of this part of the analysis was to provide an overview of local responses to the Crisis Care Concordat at the stage of submitting the initial action plan. The analysis is therefore a snapshot of a particular point in the process, giving a picture of the work required to begin to realise the Concordat vision, as this has been interpreted and enacted at local level. In this respect the action plans represent an articulation of what the national Concordat means for service development and delivery in local areas. Given the different local contexts, it is not surprising that there was variation in terms of the starting points and focus for the work. Thus, while some of this work was already in progress at this point, in other cases the action plans are just that; planning for the future of crisis care.

Following their submission, all of the action plans were scrutinised at national level and feedback provided to the local areas; in our analysis therefore, instead of focussing on gaps in provision or mismatch between local area action plans and the national agreement, we have attempted to provide an understanding of the implementation of the Concordat as it is expressed through a cross-section of action plans. Although we do draw attention to particular areas of service development, rather than simply describing the range of services and activities included in the action plans, or concentrating on specific examples of partnership working as ‘good practice’ (for some examples see http://www.crisiscareconcordat.org.uk/local-inspirations/), we have reported on key aspects of the ways in which partnership working is represented in the action plans across different aspects of crisis care.
3.2 Methodology

Action plans were randomly selected from a total of 96 for analysis. Thirty two plans were included in the analysis at which point saturation was reached (i.e. no new or relevant information was emerging from the data). Seven plans were from the London area, 10 from the Midlands and East of England, 10 from the North of England and 5 from the South of England. The number of plans from the South of England reflects the lower number in this category, with action plans for London placed in a separate group.

We used a modified Framework Method of analysis, in which data were extracted and organised into initial categories before being analysed for underlying themes. This resulted in the identification of four main themes that capture the substance of the local implementation of the Crisis Care Concordat. The first theme ‘Sharing information and expertise’ begins by looking at the importance of information sharing and access to mental health expertise for service users, carers and professional and lay people involved in crisis care. Within the second theme ‘Accessing quality care in a crisis’, we look at some predominant examples of partnership and multi-agency working that support urgent/emergency access to and quality of care in a crisis. Under the heading ‘The community in crisis care’, we then look at the broader range of services and service providers involved in prevention and recovery. Finally, under the theme of ‘Inclusion in crisis care’, we look at the ways in which the needs of vulnerable and excluded groups are addressed in the action plans, as well as the involvement of service users and carers in developing and implementing the action plans.

3.3 Themes

3.3.1 Theme 1: Sharing information and expertise

Across all aspects of service development and delivery, the importance of communication and information sharing, and the sharing of expertise, was apparent. To begin with, a substantial part of the Concordat work has focused on mapping and reviewing current services in local areas in order to establish a baseline and to identify where improvements need to be made, and this is clearly reflected in the local action plans. Beyond this, the theme incorporates three main aspects.
Access to information and advice for service users and carers featured in most of the action plans. This included improving and publicising options for self-referral, for example use of the ‘Big White Wall’, and improved signposting for service users and carers. The use of crisis and mental health helplines was also evident in a number of action plans, including 24/7 provision and the promotion of voluntary sector helplines such as the Samaritans and the Rethink Self Harm helpline, which in one local area was to be promoted through workshops in schools. Additional actions included reviewing information available to the public through GP surgeries and other locations, and on websites and flyers. One local area intended to procure a one stop shop to provide information, advice and guidance. Specific areas of information provision included developing an information pack for carers and families of people with psychosis, increasing awareness of personal health budgets and providing information on mental health advocacy.

A number of action plans included the development of a ‘single point of access’ to services and to information and advice. In one local area, this meant having a single point of access “providing expert advice and support for all external agencies, users and carers, and with direct access to known patient records and ability to book an initial emergency, urgent or routine or assessment”. The use of a single point of access incorporated not only information and support for service users and carers, including access to self-help, but also for professionals including ambulance staff and police, to provide expert advice and access to assessment teams. In one area the model of a single point of access was also used to provide primary care and other professionals with access to support available for service users within the voluntary sector.

Access to information and expertise for non-mental health professionals was also provided through crisis and mental health helplines, or through direct access to mental health clinicians. For example, two local areas were piloting a ‘111 clinical floor walker’ to help improve NHS 111 responses to people in crisis.

Sharing information about service users

As well as access to advice and information about services, and the provision of mental health expertise, information sharing about service users was also addressed. Specific plans for improved information sharing included developing systems for providing feedback between Mental Health Trusts and primary care, and for cross agency access to care plans.
Other approaches included reviewing and extending IT systems, for example adapting the ambulance service system, ERISS (Electronic Referral Information Sharing System), and establishing a county-wide web portal. In other areas the focus was on Information Sharing Agreements (ISAs) between different agencies, for example Mental Health Trusts and the police, or on a Shared Care Records approach. Some action plans sounded a note of caution with regard to information sharing, noting governance issues, and the need to ensure a balance between access to information and confidentiality.

**Sharing expertise through training**

The theme of sharing of expertise also incorporates training, in particular multi-agency training, with the aim of developing an informed and skilled workforce. While some action plans made more detailed commitments than others, across local areas as a whole, the range of training and development was comprehensive, recognising the wide range of professional and lay people involved in supporting people in crisis or in the prevention of and recovery from crisis. Those identified as having training needs included health care professionals such as GPs and others working in primary care, A&E staff and those working in a Place of Safety (POS), ambulance and NHS 111 staff. It also included training in mental health commissioning for CCGs. Other professionals identified as having training needs were those working in social services, including Approved Mental Health Professionals (AMHPs), and probation services, police and other professionals working in police custody and in criminal justice, as well as non-statutory and community organisations. For example, one action plan aimed to provide Mental Health First Aid training for both local authority staff and non-specialist community organisations such as BME organisations.

Further specific areas of training included training on autism for police officers, suicide awareness and suicide prevention training, including ASIST and training on self-harm for A&E staff and raising awareness of the links between substance misuse and self-harming behaviour as well as working with dual diagnosis more generally. Other training for A&E staff included working with the mental health needs of physical health patients. In addition, training in the use of restraint procedures was evident in a number of action plans, including for psychiatric liaison staff. Other areas identified were criminal justice training for mental health professionals as well as multi-agency training on mental health legislation and the Mental Capacity Act.
Some action plans referred to particular methods for delivering training such as developing a GP network to share best practice, using GP mental health champions to support education for GPs, blended training and online delivery, for example a section 136 e-learning resource, and action learning.

3.3.2 Theme 2: Accessing quality care in a crisis: multi-agency and partnership working

When a person is experiencing a mental health crisis, they require urgent access to treatment from a mental health professional. However, when a person is in crisis, it is often the case that their first point of contact will be with non-mental health services, particularly out of hours. In particular, the police service may be called to attend, or the person may present to A&E. Meeting the requirement to treat people in a mental health crisis with dignity and respect therefore requires careful attention to multi-agency and partnership working at the point of responding to a person in crisis. Multi-agency working was evident in all stages of the development and implementation of the local action plans, and across the full range of services. In this section we point to three prominent areas of partnership working between health and emergency services aimed at improving access to and quality of urgent care in a mental health crisis.

Street triage

At the time of the publication of the Crisis Care Concordat, the Department of Health was funding Street Triage pilot schemes managed by nine police forces, in partnership with local NHS organisations, with some other forces already having schemes in operation. Of the action plans analysed, almost half of the local areas were piloting and evaluating and in some cases extending existing schemes, with another six areas considering such schemes.

Places of Safety

In treating the person with dignity and respect, it is vital that they are not made to feel that they have committed a crime. Another important area identified in the Crisis Care Concordat was use of police cells as a POS, and the need to provide alternatives so that cells are used only in exceptional circumstances. Here the Concordat included a specific target, with the aim of reducing the 2011/2012 figure by more than 50% by 2014/2015 It is not surprising therefore that the majority of the action plans addressed this directly, for example, by monitoring and improving access to and standards of section 136 suites and Places of Safety, including recording and reporting the use of police cells. In some areas a
commitment was made to ‘zero tolerance’ of people to be held in custody as an alternative to a POS, including under-18s, or a commitment to reducing the use of police cells and to developing clear definitions of exceptional circumstances for use of police cells (see here for data regarding the success of the Concordat in achieving this target). Related to this, most of the action plans paid attention to transportation for people in a crisis, for example through the use of an appropriate vehicle and meeting targets for response times.

*Psychiatric liaison services*

Where a person experiencing a mental health crisis presents at A&E, staff require access to specialist support. As such, the importance of psychiatric liaison services was also widely recognised, appearing in over three-quarters of the action plans. Within this, some plans referred to enhanced Psychiatric Liaison Services, including 24/7 provision and the use of the RAID model (Rapid Assessment, Interface and Discharge).

**3.3.3 Theme 3: The community in crisis care: prevention and recovery**

When someone is in crisis, it is essential that they are provided with urgent access to specialist services that are adequately resourced. However, included in crisis care are prevention and recovery, and here a picture of the role of the community and the requirement for a more extensive response to the needs of services users emerges. The wider range of services and individuals involved in supporting a person who is recovering from or is at risk of a mental health crisis reflects a holistic approach to crisis care and this was apparent, albeit to a greater or lesser extent, in the action plans analysed.

Further, the action plans made apparent not only the role of statutory services in prevention and recovery but also the importance of the involvement of the voluntary sector as well as family and the wider community.

**Strengthening the role of statutory services in prevention and recovery**

Where statutory services are concerned, across local areas the need for prevention and recovery was for the most part addressed through improvements to primary care. For example, as we describe in more detail above (‘Sharing information and expertise’) one approach was to increase access to specialist mental health expertise within primary care, either by ensuring GPs had access to mental health advice and information, or by creating specialist mental health roles within practices, such as mental health workers or GP Mental
Health Leads. One area included a coordinated care project to improve multi-disciplinary working in primary care.

In addition, commitments were made to improving access to and the capacity of Community Mental Health Teams (CMHTs), which in one area was given specific responsibility for enhancing recovery, and Crisis Resolution Home Treatment Teams (CRHTTs), with some localities making an explicit commitment to provide 24/7 access. Increasing availability of IAPT and CBT services was included in a small number of plans. The use of social prescribing in prevention and recovery was also included in a small number of plans, while others aimed to increase awareness and use of personal health budgets and the use of care plans and the Care Programme Approach.

Housing and employment support were also included as aspects of prevention and recovery and two local areas made specific mention of mental health promotion in the workplace, for example by signing up to a mindful employer initiative.

Working with voluntary and community organisations

As well as statutory services, the role of the voluntary and community sector was very much in evidence here, and more so than in other areas of service development and delivery. Thus while the role of the voluntary sector is included across the provision of care, and with a number of areas making a commitment to reviewing and strengthening links with the voluntary sector and involving the voluntary sector in service development, it is clear from the action plans that it is viewed as having an especially important role to play in prevention and recovery. It is perhaps indicative of the strength of the voluntary sector in providing for local needs and working at a grassroots level that it does play such a central role in building a holistic and responsive approach to crisis care. For example, as well as promoting and linking in with voluntary sector helplines and campaigns such as Mind’s Time to Change, and increasing awareness of services such as mental health advocacy, a number of plans included provision for alternatives to hospital admission, for example respite services and crisis houses, or an out of hours’ crisis sanctuary.

Other areas of provision focused on self-help and peer support, for example through the use of Wellness Recovery Action Planning, or ‘WRAP’, developing the use of the Recovery College model, including service user led ‘Expert by Experience’ programmes, developing
and sustaining self-help community groups and peer support programmes and community engagement programmes focusing on resilience and self-care.

**Supporting carers in prevention and recovery**

Support for carers was also considered as part of this theme, with some local areas including a commitment to improving access to support for carers and the promotion of a carer’s emergency card or carer’s contingency card. One local area included training for carers on managing challenging behaviour. Two local areas referred to the provision of a Carer’s Assessment, under the terms of the Care Act.

Further examples of voluntary, carer and service user involvement are provided in the final theme ‘Inclusion in crisis care’.

### 3.3.4 Theme 4: Inclusion in crisis care

We also looked at the action plans for the ways in which inclusion was addressed. This incorporates the inclusion of vulnerable and excluded groups, including children and young people (CYP), who have in the past not been provided with the same level of mental health provision as adults, including crisis services.

**Extending crisis care for children and young people**

All of the action plans analysed included some reference to CYP provision, covering early intervention and support before a crisis as well as access to and quality of care in a crisis and in recovery, although this varied in detail and scope. In addition to reviewing Child and Adolescent Mental Health Services (CAMHS) outreach services, in many cases, the planned actions took the form of the extension of existing adult services, for example early intervention and developing an early detection service to support young people at risk of developing psychosis, out of hours services and the extension of Crisis and Home Treatment services. Hospital services for CYP were also addressed, for example access to beds, commissioning Places of Safety or separate areas for mental health assessments, appointing a Liaison Health Visitor to review needs in A&E and extending Psychiatric Liaison services. With regard to prevention and recovery, action plans included the provision of care plans and advance care plans for CYP, implementing a CAMHS recovery plan and inclusion of children and young people in suicide prevention strategies. In some areas Street Triage schemes were to be extended to include people under the age of 18.
Also included were the development of services to address self-harm, improvements to transition arrangements from CYP to adult services and the provision of emergency specialist foster care arrangements. One local area planned to work with voluntary and community organisations to review the accessibility of services for young men in a mental health crisis.

Working with dual diagnosis

Another area of working with people who are vulnerable that featured in many of the action plans was dual diagnosis and substance misuse, and working with people who are intoxicated. Here there was again a focus on inter-agency working, in particular referral to and working with or improving services for substance misuse. Specific actions included reviewing the need for a specialist crisis drug and alcohol team, developing substance misuse diversion services to divert service users away from acute services towards drug and alcohol services and providing liaison services for people presenting in A&E (as part of a wider service to include people with learning disabilities, older people and people who self-harm). In one area there was to be a ‘street pastors’ scheme to support people recovering from a night out. Other services for people with learning disabilities included the use of crisis care contingency plans.

Crisis care and the criminal justice system

Related to this were services designed to support vulnerable people involved in the criminal justice system, including those with a dual diagnosis as well as people with learning difficulties, for example through criminal justice liaison services and liaison and diversion services. In addition, action plans included the use of WRAP within liaison services, improved access to an appropriate adult, prison in-reach, employment of a learning disabilities nurse onto the criminal justice pathway and provision for victims of crimes who have mental health problems. One action plan included a non-exclusion policy for access to a POS due to intoxication, or previous history of offending or violence. Another area was tracking a cohort of offenders with regard to physical and mental health. Provision also included a CAMHS consultation clinic for Youth Offending Service and Foundations.

Addressing the needs of BME (black and minority ethnic) and faith groups

Although addressed with less frequency than the above, provision for BME and faith groups was also evident in a number of action plans, for example, commissioning a Community
Access service, providing Mental Health First Aid training for BME community groups, implementing Mind guidance on commissioning crisis care services for BME communities, developing a base in the community for BME communities to access the CRHTT and extending the outreach of the CRHTT (for example through mosques). As in the ‘Prevention and Recovery’ theme, the role of the voluntary and community sector was acknowledged here.

*Crisis care, elderly care and other vulnerable groups*

Elderly services, including dementia, were also evident in some action plans, for example the use of advance care plans, and improving out of hours’ services and community response, a hospital-based Dementia Liaison post and considering an alternative POS for people with dementia.

Other services for vulnerable and excluded people included in a small number of action plans were ante- and post-natal services, services for asylum seekers and refugees, services for veterans and children of forces personnel, support for children who are carers, support for vulnerable homeless people, services for people with physical health needs, awareness of vulnerability and needs of the transgender community and crisis care for LGBT communities.

In addition to these specific actions, some plans made reference to ‘vulnerable’ or ‘marginalised’ people and the need to take their needs into account, or consulting with and reviewing service access data for people with ‘protected characteristics’ in order to provide them with appropriate person-centred care.

*Service user and carer involvement: co-production*

Under ‘inclusion’ we also looked for the involvement of service users and carers in the development of the action plan. This was more evident in some plans than others, but where there was evidence of service user and carer involvement this was facilitated through the organisation of events and systems for feedback, co-production events, focus groups, involvement in a communications plan and membership of groups responsible for the development and/or delivery of the plan, such as a Task and Finish group or a multi-agency group or through specific service user groups, or groups including service user and carer representation. In some cases representation was via input from voluntary sector organisations. We explore this further in the analysis of the interview data below.
In addition, some action plans included the involvement of carers and service users in the development of services, primarily through evaluation and feedback. Specific examples of the use of feedback to develop services included the development of a best-practice tool, producing information and advice, and through the co-production of services. One action plan stated the intention to commission research into the needs of service users.

Co-production was also included in relation to care plans, along with service user and carer involvement in crisis planning and advance directives, and the involvement of children and young people, together with their family and carers, in transition planning. Finally, as mentioned above in Theme 3, service users and carers were also directly involved in service provision through peer support.

4 Local Area Observations

4.1 Introduction

The local area observations provided valuable data in ascertaining some of the challenges discussed in relation to implementing the Crisis Care Concordat, the participation of different organisations and the approaches being taken. Since each area had successfully established regular meetings, which continued after this element of the evaluation had been completed, as with the action plan analysis, these observations should be viewed as a snapshot of a particular point in the process. As well as providing an understanding of the way in which the different individuals and agencies in local areas came together to put the aims of the Concordat into practice, the observations were a valuable exercise in identifying key themes to be explored in interviews with key people in each local area.

Observations took place in four local areas. The process of site selection took longer than envisaged. While one area was quite advanced and eager to participate, other sites were more cautious. Four sites were selected by late summer 2014. The sites provide a good geographical mix (one from the east of England, one from the South West, one from the North West and London) and a good mix of rural and urban sites (one densely urban, one rural, and two mixed). The sites also, as far as possible, represent different levels of progress with implementation. One site, Gloucestershire, was chosen because it was already advanced in developing a declaration and action plan. Other sites were still starting
this work when the evaluation was beginning. Table 1 gives an outline of the observations completed.

Table 1: Details of observations completed by the evaluation team

<table>
<thead>
<tr>
<th>Local area</th>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gloucestershire</td>
<td>Task and finish meeting</td>
<td>22\textsuperscript{nd} July, 2014</td>
</tr>
<tr>
<td>Cambridgeshire</td>
<td>CCC regional event – South East Mental health concordat declaration group Concordat workshop</td>
<td>4\textsuperscript{th} July, 2014 27\textsuperscript{th} August, 2014 8\textsuperscript{th} October, 2014</td>
</tr>
<tr>
<td>The Wirral</td>
<td>CCC regional event – Cheshire &amp; Merseyside Mental Health and Social Care Board</td>
<td>7\textsuperscript{th} July, 2014 20\textsuperscript{th} October, 2014</td>
</tr>
<tr>
<td>London</td>
<td>London mental health partnership board CCC regional event – London</td>
<td>8\textsuperscript{th} October, 2014 27\textsuperscript{th} October, 2014</td>
</tr>
</tbody>
</table>

The intention was to complete two observations for each site, however Gloucestershire was already at their last Task and Finish group meeting by the time the evaluation started. An additional observation was therefore completed in Cambridgeshire instead. In each site, except Gloucestershire, the observations included at least one local meeting in which implementation was being discussed, and one regional Crisis Care Concordat event.

4.2 Themes

4.2.1 Theme 1: Leadership

The organisations taking a lead varied across the four regions observed. In one site, the Task and Finish group was co-chaired by a CCG representative and someone with personal experience of a mental health crisis. In a second, co-chairs were from the CCG and the local police force, with considerable drive from the Police and Crime Commissioner’s office. In a third, leadership was through the police with CCGs leading action planning for their areas. In the fourth region – London – leadership was still under discussion at the events observed, with several existing groups potentially well-placed to drive the Concordat work forward.
In the interviews, we explore this further under the theme ‘Local implementation of the national agreement’, where we also consider the way in which members of the National Steering Group were able to provide leadership to local areas.

4.2.2 Theme 2: Partnership working

The Crisis Care Concordat explicitly requires different agencies to work together in producing a declaration and action plan that contains commitments from a number of different organisations. At the meetings we observed, representatives attended from the following organisations:

- Local constabulary
- Office of the Police and Crime Commissioner
- Local Clinical Commissioning Groups
- Local Mental Health Trusts
- Local Ambulance Trusts
- Local authorities
- Accident and Emergency departments
- British Transport Police
- Prisons
- Third sector providers
- Probation
- Crown Prosecution Service

The history of partnership working varied from area to area. In one site, for example, a board including partners from virtually all of the key organisations for the Concordat had been in existence for three to four years and had been addressing issues related to crisis care during this time. This meant that there was a solid base for continued partnership working, and excellent existing relationships at this management level. In other sites, this way of working appeared to be much newer. In one area, attendees commented on the benefits of having an opportunity – apparently not there previously – to discuss provision of care and services across these different agencies. At several points, it became clear that new information was being revealed about the way other agencies worked, the pressures on their systems and the data they managed. One basic aspect was the frequency with
which specialist terms and acronyms had to be explained to colleagues from other organisations, highlighting how far the language used was different.

While it clearly opened up some fantastic opportunities, there were also suggestions that tensions existed in the early stages of such partnership working. Incentives to change the systems and release pressure for some partners were not there for others. In the interviews, we explore further how these partnerships worked, what the challenges were and how and the extent to which they were overcome.

4.2.3 Theme 3: Regional boundaries

One of the apparent challenges to partnership working is the lack of co-terminosity for different agencies. The key partners – police, mental health trusts, local authorities and CCGs – all have different geographic boundaries. One effect of this is that some agencies – for example the larger police forces – had to be involved in a number of Crisis Care Concordats. Equally, it required all CCGs in a given region to engage in the process while managing different local pressures and contexts. In London, as an extreme example, the Concordat declaration was signed by two police forces, six mental health trusts, 33 CCGs and London Councils on behalf of 32 local authorities and the City of London. This contributed considerably to challenges around who should take responsibility for the Concordat work and at what level. Subsequently, each London CCG later produced its own action plan.

In one site, a further issue was raised about those things that were in local control and things that were decided at a national level, including legal requirements and aspects such as GP training.

In some areas, the regional variation was also an issue that arose in implementation meetings. Some of the sites are large and contain diverse populations and needs. The need to understand these variations across the area through good quality data was raised in observed meetings.

4.2.4 Theme 4: Competing priorities

Again linking to partnership working challenges, various agencies faced different pressures – both relating to crisis care and to broader care delivery issues. A major theme that arose frequently in the observed meetings was the challenge of resource. Many of the agencies involved have been under considerable financial pressure. In some sites, particular financial
issues were pressing in the concerns discussed. This meant that while some agencies were
talking about investment in new ways to improve crisis care, others were warning of the
potential for further cuts in services.

These competing priorities emerged in a number of ways. First, in some sites there were
agencies who did not feel that this was the right time to focus on changes in crisis care, or
that they had the time to work on it alongside other pressures. Second, and linked to the
theme of regional boundaries, where multiple agencies delivering the same services were
involved in a single declaration, concerns sometimes arose about how changes in crisis
care delivery might increase demands on some agencies and not others.

Related to priorities were the different cultures of the organisations involved. These were
observed, though not generally discussed explicitly at local meetings. In regional events,
however, these sometimes came to the fore in relation to the different approaches from
health services and from the police. Several of the police at regional events voiced the view
that health services appeared to be less mandated by national policy than they felt they
were themselves. Related to this, police often felt that they were spending more time in
crisis related activities than they should be because of a lack of capacity in the health
system.

These issues are explored further in the interview analysis, with respect to partnership
working and the future of crisis care.

4.2.5 Theme 5: Co-production

This theme was identified early in the evaluation as an issue of particular interest to Mind.
Co-production refers to the extent to which people receiving (or potentially receiving) mental
health crisis care were involved in the local work being done to implement the Concordat.

In fact, this theme did not arise much through the observations, though it was raised by
people at several of the regional events where it was felt to be very important. One notable
exception in the local groups was the co-chairing of the Gloucestershire Task and Finish
group by someone who had used local crisis care services in the past. This model was not
repeated elsewhere, however. There was some discussion in one of the other sites about
how people using mental health services might be consulted about plans to improve crisis
care.
The extent to which service user and carer involvement is evident in the local area action plans is outlined above, and the question of how far and in what ways service users and carers have been involved in the implementation of the Concordat was followed-up in the local and national interviews, forming one of the themes reported on below.

5 Local Area and National Steering Group interviews

5.1 Introduction

Local area interviews were undertaken with 12 stakeholders, three from each of the local study areas, between July and the beginning of November 2015. These were people identified as having played a key role in the development and implementation of the local action plan and include representation from health, policing and consultancy/management backgrounds. Interviews with members of the National Steering Group were carried out during November 2015. Four participants were interviewed, including representatives from police, the Royal College of Psychiatrists, the Royal College of Emergency Medicine and the Care Quality Commission.

The interview schedules were informed by the evaluation aims and the themes identified through the observations of local areas. While some of the themes arising from the observations were very much in evidence in the interviews, in other cases (e.g. ‘Regional boundaries’) they were not discussed to any substantial degree, suggesting perhaps that these issues had been overcome. Conversely, where service user and carer involvement was notable in the observations by virtue of a lack of evidence, this was explored in interviews, both in terms of the extent to which this was achieved and with regard to some of the obstacles experienced and need for further engagement.

Semi-structured interviews were carried out by telephone. Interview data were analysed thematically, with the local area and national interviews analysed together: in presenting the themes, we have indicated where relevant whether the findings are from local or national stakeholders. Four themes were identified: ‘Partnership working’; ‘Local implementation of the national agreement’; ‘Service user and carer experience’; and ‘The future of crisis care’. ‘Partnership working’ looks at the experience of partnership working in the development and delivery of local area action plans and at the achievements and the obstacles experienced in working with a number of different statutory and non-statutory agencies.
‘Local implementation of the national agreement’ considers the experience of implementing a national agreement at local level, including issues relating to leadership and management of the process. ‘Service user and carer experience’ describes approaches and attitudes towards service user and carer involvement in the delivery of the Concordat, and the mechanisms for this involvement, particularly in the development of the local action plans, but also in terms of involvement at national level. Finally, ‘The future of crisis care’ looks at participants’ views on what needs to happen next in order for the Concordat work to have lasting impact, and their hopes and fears for the future of crisis care. It also elicits some areas for wider consideration and debate concerning what is meant by ‘crisis care’ and its scope and purpose.

Where we have quoted directly from interviews, participant identifiers are used. The initials ‘A’ to ‘D’ followed by a number indicate a local area interview; the initials ‘SG’ followed by a number indicate a National Steering Group interview.

5.2 Themes

5.2.1 Theme 1: Partnership working

A number of achievements were identified with regard to partnership working, and overall this had been a positive and productive experience. Although in some areas the Concordat work was building on existing initiatives, it is clear that the scope of partnership working has been extended through the development and implementation of action plans.

In line with the analysis of local area action plans reported on above, partnership working was credited with the development and delivery of specific services, with Street Triage schemes being a prime example, together with initiatives such as 24/7 psychiatric liaison. Also included were achievements around section 136 and the use of police cells as a POS, which was reported as having been substantially reduced. However, there was also what one interviewee referred to as the “less tangible benefits” (A3). One area of achievement in this respect was being able to get different organisations “into the room” or “around the table” together. In some cases this was the first time that certain organisations had worked together. Learning about crisis care from different perspectives and angles allowed partners to develop a better understanding of the roles of different agencies and the pressures that they are under and enabled partners to better describe the “landscape of demand” on all
public services. A key achievement of partnership working was therefore increased knowledge and understanding across the system.

Partnership working also provided some challenges. At a local level, there were difficulties engaging particular groups, which varied across areas. For example while in general the work of the ambulance service was commented on very favourably, in one area they had been difficult to engage. In other areas, difficulties involving GPs, the probation service and acute medicine were mentioned. Explanations were given in terms of internal issues affecting some services/organisations and demands on time and resources. One area felt it might be missing relevant service provision, due to agencies doing relevant work not being involved in the Concordat; in this area a need to increase involvement of voluntary organisations in the implementation and further development of action plans was also identified. At a national level there were concerns that vulnerable groups were not represented, particularly perspectives from those working in CAMHS:

“Unfortunately, however much we say children are important we do tend to get round to them second” (SG2)

However, partners also acknowledged that if all relevant stakeholders were required to attend Concordat meetings the work could become “too big and unwieldy”, meaning that less would be achieved. This is also reported on under the theme ‘Service user and carer experience’.

In some areas cultural differences, particularly between the police and health were noted, for example with regard to chains of command, and the structure of organisations:

“I do find the health service structure quite a difficult one to understand” (SG1)

Partnership working was also seen as exacerbating the complexity of the funding and policy landscape, particularly where partners were working across non-coterminous boundaries, although this issue was less evident in the interviews than it had appeared to be during the local area observations. There were also some concerns over continued commitment of all partners, with concern in one area that health services would be left to take on the bulk of the work. At both a national and local level, there were differing views regarding who was ultimately responsible for crisis care:
“A big challenge is getting people who don’t work in mental health services to recognise that mental health is everyone’s responsibility” (SG2)

In some cases, however, the challenges that partnership working involved was also seen as a strength. Partnership working allowed organisations to come together and discuss disagreements and take steps to address these challenges:

“We don’t agree about everything and that’s really healthy, but it doesn’t mean that we don’t look for better ways of doing things and progress things, and that, for me, is actually what a partnership should be” (SG1)

Different organisations had worked hard to find a common language and to find a way of working together that is both challenging and constructive. Partnership working was also seen as important in both holding each other to account and supporting each other in the implementation of actions:

“We’ve all been there when everyone agrees all sorts of wonderful policies and everyone then walks away and deals with whatever the priority is … one of the strengths of the Concordat is that there’s been lots and lots of follow-up and making sure that, yeah you’ve agreed to it so what are you doing about it?” (D1)

A number of participants felt the skills and knowledge of their partners played a central role in driving the work of the Concordat. Partners valued those who had been working in the field for some time, who brought with them important learning from previous initiatives and a real commitment to the work. Key facilitators of partnership working also included strong leadership and a “forward thinking” attitude, which meant individuals were prepared to challenge their own perspectives:

“It’s not what you do, it’s the way that you do it that keeps a concordat running…for a true partnership what you need is an enabling leader who can keep everybody at the table” (SG2)

5.2.2 Theme 2: Local implementation of the national agreement

As a national agreement, the Concordat was seen as facilitative at local level in the sense of giving the work “some teeth” and as a “policy enabler”. It was credited with helping to secure funding, providing a focus on action, and providing a means of accountability. In some of the local areas there were initiatives that preceded the Concordat, including those
involving partnership working, particularly between mental health services and the police; here the Concordat was seen as building on existing work and helping to give it a focus and visibility. For example, one interviewee, when talking about work to reduce the use of police cells as a POS said that

“We were doing it before the Concordat … if the Concordat hadn’t happened we’d still be doing it … but you might say that it justified our continued work in this area, and the fact that we keep going and we’re now going to extend our work into section 135” (D3)

National partners spoke of the successful implementation of the Concordat at a local level and the importance of this:

“[It is] a rare example of a national initiative that has resulted in local action” (SG4)

Some felt that national leaders had taken positive action to support implementation through local symposiums, and a key achievement of the Concordat work identified by national partners was its strong public profile:

“Most people in the sector do know what it is and think it’s delivering something positive” (SG2)

Partners believed national campaigning around the work of the Concordat had raised awareness of the challenges of crisis care, and Places of Safety in particular, leading to a change in attitudes across the sector around how mental health is viewed and how people experiencing a mental health crisis should be supported:

“The biggest achievement so far at a national level has got to be that kind of almost world recognition that mental ill health is deserving of professional care in a health environment and not being thrown into the back of a police van and taken to a police cell” (SG1)

One concrete example given of an action at national level having an impact on the local delivery of crisis care is the development and implementation of an inspection pathway by the CQC.

Other partners, however, felt more could have been done at a national level to set clear standards around “what good looks like” in the commissioning of local crisis services. National members recognised that there are likely to be a diverse range of barriers to local implementation across different areas, particularly because health inequalities are far
greater in some areas compared to others, and because services are likely to be at various stages of development across the country. They felt it was important to get feedback “from the ground” about what was working and what wasn’t, but also said this could be difficult to consider during busy National Steering Group meetings.

In terms of implementation, in a number of interviews, the importance of having the right people involved in the Concordat work at a local level was regarded as essential to its success, with broad agreement about what constitutes the ‘right kind of person’ – that is, people who are committed to the work, are knowledgeable, and have sufficient authority within their organisations to make things happen.

“I always think there’s an issue about … people who have an interest and commitment and understand the subject versus people that have the formal seniority and authority within their organisation … and ideally you want those two things to combine … but sometimes that doesn’t happen” (A2)

On the whole, however, it seems that this was achieved, albeit that it in some cases the right people were not identified immediately; in one area this was put down to the complexity of the organisational structure of the NHS which meant that even internally there were difficulties identifying those who were best placed to take the work forward. Similarly, in one area there had been some initial problems in continuity of attendance at meetings, which was felt to have hindered progress with the work. However, this had been overcome by the time of the interview, with the same representatives attending successive meetings.

With regard to the challenges involved in implementation, a primary concern was the demand on resources as a limiting factor in the development and implementation of action plans. In one area, the view was also expressed that there was still work to be done in ensuring that the principles of the Concordat are reaching those responsible for service delivery, where it was felt that there was a tendency for the ethos of the Concordat to be lost in the journey to the frontline of delivery.

5.2.3 Theme 3: Service user and carer experience

The importance of keeping in mind service user and carer experiences, and remembering that this is at the core of crisis care, was reiterated in a number of interviews; in one local area this was addressed in part through the appointment of a co-chair with lived experience
to the Task and Finish group and a number of service user and carer representatives formed part of the National Steering Group.

National partners felt the involvement of people with lived experience was essential and ensured that the National Steering Group held the practical implications of their work in mind, as well as some of the most complex and difficult issues in relation to crisis care:

“We need to hear the messages that are hardest to hear” (SG1)

One member commented that it was sometimes difficult to allow enough time to consider lived experience perspectives whilst also addressing the other items to be covered during meetings, and felt it may have been beneficial to have a smaller lived experience working group. At both a national and local level partners considered the meaning of the term ‘lived experience’ and what the meaningful involvement of ‘lived experience’ should look like. They discussed the range of perspectives that ‘lived experience’ could cover and the challenges of ensuring that these views are represented throughout the work of the concordat:

“How do you get lived experience that is representative of lived experience? Because lived experience is so diverse” (SG2)

At a local level, there were a number of different ways in which service users and carers were engaged, for example through a series of qualitative interviews; engagement events; through service user and carer organisations and through voluntary and community organisations.

While all local areas had involved service users and carers in the development of their action plans, this appeared to vary in extent, and there was discussion of how this might be extended further, not just in terms of the numbers of people involved, but reaching a wider population. With regard to service user involvement, one participant felt that this was limited by on the one hand, service users being too ill to be involved, and on the other hand, not wanting to be involved when they were feeling well. At the same time, in one area they had been unable to involve all of the voluntary agencies wanting to take part, with one organisation making a complaint. However, it was felt that meaningful engagement required a limit on the number of organisations involved. One interviewee felt that continuing to engage service users in the implementation of the action plans was vital to their success, and something that needed more attention.
5.2.4 Theme 4: The future of crisis care

One issue that was raised a number of times at local and national level was the need to maintain momentum and importance of follow-up to the work that has been done so far. There was a shared view that getting areas and organisations to sign up to the Declaration and develop action plans is only the beginning of the work, which needs to be looked at as a longer term project. Concerns in this respect include questions over continued resourcing and uncertainty about the future policy landscape, including the impact of further cuts to services:

“The biggest challenge is the money to do what needs to be done” (B2)

Related to this, there was a fear that crisis care might be victim to “the next fashionable thing” (SG4)

In steering group interviews there were concerns that future progress would be limited by the quality of data available, which may not accurately describe the demand on services:

“the data sets that were used to come to the conclusions around strategic priorities, in my view, missed the richer picture to demonstrate quite what the service demand for mental ill health crisis and pre crisis services are” (SG1)

Participants felt that in the future, data from a range of organisations, such as housing associations, GPs and the police should be combined to give a more complete picture of demand, which would “support and assist” the work of the Concordat. Participants also noted the importance of having accurate data at a local level, which was particularly important given the diverse range of challenges in the delivery of crisis care experienced in different local contexts.

This was also reflected at local level, where having good data was seen as one of the strengths of the work that had been undertaken as a result of signing up to the Concordat, as well as an area requiring further attention, particularly with regard to measuring impact:

“We’ve got the data narrative [on lack of resources in the community] … it’s not just me going on about it, we know for a fact that this is an issue” (D3)

“Is this having an impact? … We need to be looking at the data. We need to move away from anecdote to more of the data … the number of patients being brought into the ED, the number of
patients that are being diverted via Street Triage, and what are the outcomes for those patients?”

(C3)

Another issue emerging from the data is the need for cultural changes in order to implement some actions – for example, a shift to provision for young people in Crisis Teams. Work towards increasing CYP crisis care, and the need for further extensive work in this area, was included in several interviews. The message appears to be that while some progress has been made, far more is needed to address the lack of crisis services for children and young people, for example with regard to local availability of appropriate in-patient care. Further, this depends on a model of crisis care that does not take adult care as the standard model, but begins with the needs of children and young people who are in crisis or at risk of crisis.

“I just didn’t feel very comfortable that we were doing the best by children generally … it just struck me that there was piece of work to do … that that was the next big challenge” (A1)

One question that arose from the interviews was around the understanding of what is meant by crisis care. At a national level, partners recognised that a very wide range of services could be considered ‘crisis services’ and felt there was a need for clear boundaries around what is and what isn’t considered to be crisis care. In one local area there had been an attempt to move away from reliance on a clinical or psychiatric diagnosis to determine whether someone is eligible for crisis care, to an understanding that if someone thinks they are in crisis then they are in crisis; it was noted however that some partners had been quicker to take this on board than others.

Another question that arose was around the inclusion of prevention and recovery in the work of the Concordat. Most felt that this was appropriate, for example in the following extract stating that crisis care is not just about

“how we pick people up off the street, it’s about how we make sure that they don’t get ill in the first place or that they stay well” (A1)

Another interviewee put this in terms of a need to focus on stopping or reducing demand – a “Prevention Concordat” (D3) – with too many people at present turning up in crisis as their way into the mental health system. However, in one interview, concern was expressed that the shift to prevention and early intervention was a move away from what crisis care is or ought to be, that is, an appropriate 24/7 response when in need of urgent care:
“The Crisis Care Concordat is actually about crisis. And it is about … the right care, at the right time, in the right place, the first time of asking for someone that’s suffering a mental health crisis. So it was then about, let’s identify how a person in crisis would touch each partner” (B2)

How we are to understand crisis care also includes an understanding of the appropriate delivery of crisis care. The role of A&E in the delivery of crisis care was discussed in a number of interviews, including whether it should be considered a POS:

“Is it a Place of Safety or is it not a place of safety? And I don’t think there’s common agreement” (D1)

One interviewee expressed very strongly the view that parity of esteem means that people in a mental health crisis and requiring urgent care ought to be able to access that care through A&E in the same way that they would for a physical health crisis:

“It’s not parity to say that people with mental health problems shouldn’t go to A&E … If I’ve got a mental health problem and I’m in crisis I should feel as welcome at my A&E as anyone else” (D3)

At national level, one of the questions raised was the future of the Crisis Care Concordat itself, with a suggestion that it might be that at some point it will be time for it to “put itself out of business” (SG4) with a good handover.

6 Survey of crisis care experiences

6.1 Introduction

We developed an online survey in order to understand the experience of crisis care from the perspectives of service users and carers, and examine any change in their experiences over time. The survey consisted of a number of tick box questions, asking about the nature of contacts with services, experiences of accessing support, staff knowledge, skills and attitudes and access to advocacy. Open ended questions were used to elicit service user and carer views on positive aspects of their experiences, as well as areas for improvement.

The survey was developed alongside three people with experience of using mental health crisis services – two as people with mental health problems themselves and one as a family
carer. The topics and question wording were developed and agreed across these peer advisors and the researchers. The questionnaire was then presented to a user-led group in Gloucestershire to gather feedback.

The survey was administered at two time points; during October and November 2014 (Time 1) and November and December 2015 (Time 2) to capture any change in participants’ experiences of crisis services over one year, and was primarily available online.

At Time 1 (T1) the survey was promoted through online networks, including Mind’s and McPin’s twitter and facebook pages, as well as those of other third sector organisations. It was included in various newsletters and email distributions. In the four local study areas, we identified as many local voluntary sector networks as possible and asked them to promote the survey. In only one site (Gloucestershire) were we able to engage with a local voluntary sector organisation to actively support people to complete the survey. Since NHS ethics approvals were not sought for this study, we were not able to go through NHS services or distribution lists.

At Time 2 (T2) a modified version of survey was sent to people who participated at T1 and indicated that they would be willing to take part in a follow-up survey. Participants who had experienced a crisis, or who had cared for someone who had experienced a crisis in the previous 12 months were asked the same series of questions about their experience of crisis care as in the T1 survey, together with some additional questions about their awareness of and any involvement in the Concordat work in their local area. Those who had not experienced crisis care in the previous 12 months were only asked the questions about their awareness of and involvement in the Concordat work.

This section presents the T1 survey data, which constitutes a cross sectional survey of people’s experiences of crisis care at the end of 2014, followed by a comparison of T1 and T2 data, which investigates any changes in people’s experiences of crisis care between 2014-2015. In graphs and results tables, the number of people completing each question is given as ‘n’.
6.2 Results: A cross-sectional survey of experiences of crisis care (T1)

For our initial survey (T1), a total of 732 survey entries were received. Of these, 129 had to be removed because they contained insufficient data for inclusion\(^1\), giving a total sample size of 603. Of this sample, 399 were people with personal experience of a mental health crisis, 153 were family or other carers of someone with experience of a mental health crisis, and 51 were people with a mental health condition who had not experienced a mental health crisis. Where participants indicated that they had a mental health condition but had not experienced a mental health crisis in which they needed urgent help, they were asked only 3 questions since the majority of the survey was not relevant to them.

Table 2: Demographic profile of survey respondents at T1

<table>
<thead>
<tr>
<th></th>
<th>People with personal experience of crisis care</th>
<th>People with experience of crisis care – family responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>(n=391) 75 (19%)</td>
<td>(n=150) 77 (51%)</td>
</tr>
<tr>
<td>Female</td>
<td>313 (80%)</td>
<td>73 (49%)</td>
</tr>
<tr>
<td>Transgender</td>
<td>1 (0.3%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-25</td>
<td>(n=385) 52 (14%)</td>
<td>(n=146) 38 (26%)</td>
</tr>
<tr>
<td>26-35</td>
<td>86 (22%)</td>
<td>38 (26%)</td>
</tr>
<tr>
<td>36-45</td>
<td>113 (29%)</td>
<td>22 (15%)</td>
</tr>
<tr>
<td>46-55</td>
<td>83 (22%)</td>
<td>28 (19%)</td>
</tr>
<tr>
<td>56-65</td>
<td>43 (11%)</td>
<td>11 (8%)</td>
</tr>
<tr>
<td>Over 65</td>
<td>5 (1%)</td>
<td>7 (5%)</td>
</tr>
<tr>
<td>Rather not say</td>
<td>3 (1%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>(n=385) 233 (61%)</td>
<td>(n=145) 90 (62%)</td>
</tr>
<tr>
<td>White other</td>
<td>5 (1%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>White (not specified)</td>
<td>43 (11%)</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>British (not specified)</td>
<td>37 (10%)</td>
<td>18 (12%)</td>
</tr>
<tr>
<td>Irish</td>
<td>7 (2%)</td>
<td>1 (1%)</td>
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<td>Asian/British Asian</td>
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<td>3 (2%)</td>
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<td>0</td>
</tr>
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<td>Black/Black British</td>
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<td>1 (1%)</td>
</tr>
<tr>
<td>Mixed</td>
<td>5 (1%)</td>
<td>0</td>
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<tr>
<td>Rather not say</td>
<td>37 (10%)</td>
<td>22 (15%)</td>
</tr>
<tr>
<td><strong>Fluent English speaker?</strong></td>
<td>(n=389) 385 (99%)</td>
<td>(n=149) 145 (97%)</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>No</td>
<td>1 (0.3%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Rather not say</td>
<td>3 (1%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td><strong>Physical disability or long-term health condition?</strong></td>
<td>(n=390) 195 (50%)</td>
<td>(n=145) 61 (42%)</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>179 (46%)</td>
<td>78 (54%)</td>
</tr>
<tr>
<td>Rather not say</td>
<td>16 (4%)</td>
<td>6 (4%)</td>
</tr>
<tr>
<td><strong>Carer’s relationship to the person they support</strong></td>
<td>NA</td>
<td>(n=150) 11 (7%)</td>
</tr>
</tbody>
</table>

\(^1\) Data was insufficient if no responses were given to any items rating the experience, and no qualitative data was given.
The demographic profile of T1 survey participants are outlined in Table 2. Respondents with personal experience were overwhelmingly female (80%), while the people family carers responded about were evenly split by gender. The median age of people responding about their own crisis experience was 36–45, with a normal distribution across the age categories. Family responses were skewed to the younger age group, with a median age of 26–35. This probably reflects the large proportion of parents who responded about their son or daughter (49%).

Participants were asked to describe their ethnicity. Sixty-one percent described themselves as White British, a further 11% as White, and a further 10% as British. Only 5% of people with personal experience of a mental health crisis described themselves as a non-White ethnicity, and only 3% of family participants.

There was also a difference in the pattern of diagnoses between people with personal experience and family participants. The proportion with a diagnosis of schizophrenia or schizoaffective disorder was higher among the family participants (26% compared to 8%), and the same was true for psychosis (20% compared to 15%). In contrast, higher proportions of anxiety, depression, bipolar disorder and personality disorder were reported by people with personal experience of a crisis. This was anticipated, since people who are living with diagnoses of severe mental illness such as schizophrenia or psychosis – particularly those with recent experience of a crisis – were felt to be less likely to respond to a survey themselves.
Family participants were asked to specify their relationship to the person about whom they were responding. Nearly half were parents and around a fifth were partners or spouses. The other category included grandparents, nieces and nephews and other relations.

In the section below, responses from people with personal experience and from carers are reported separately. The text compares the two groups to highlight similar patterns or substantial variations. Unless otherwise stated, the numbers refer to numbers of participants, not percentages.

6.2.1 How long ago was the experience of crisis?

Our survey gave the following definition of a crisis: “A mental health crisis is when you need urgent help because of a mental or emotional state. It might include times of being, or feeling, out of control of your body, mind or behaviour, or being at risk of hurting yourself.” We asked participants to answer only about their most recent experience of a mental health crisis.

![Length of time since most recent crisis experience (n=399)](image-url)
Of people with personal experience, 65% had experienced a crisis within the last year, and 90% had experienced a crisis in the last 5 years. A similar pattern was reported by family, with 67% supporting someone who experienced a crisis in the last year, and 93% supporting someone who had experienced a crisis in the last 5 years.

6.2.2 Initial contact with services in a crisis
For both personal and family responses, the most common first point of contact was the person’s GP or a mental health professional who was already involved in their mental health care. In a sizeable minority of cases, people had initial contact with A&E (SUs - 12%; family – 11%) or with police (12%; family - 11%). The specified other categories included voluntary sector organisations, housing support, child and young people’s services and individually named centres or services.

6.2.3 Result of the mental health crisis: hospital admissions

- No hospital admission: 17%
- Voluntary hospital admission: 24%
- Admission under a section of the MHA: 59%
Among people with personal experience of care in a crisis, the majority of participants’ most recent mental health crises did not result in a hospital admission. Of the 41% that did, 60% were voluntarily admitted (24% of the whole sample) and 40% were admitted under a section of the Mental Health Act (17% of the whole sample). Family respondents reported that the person they care for was admitted to hospital in roughly half of cases, with 36% of those being admitted voluntarily (18% of the whole sample) and 64% being admitted under a section of the Mental Health Act (32% of the whole sample). This is a sizeable difference across the two samples and may reflect a greater severity among the people being supported by family and carers, compared with people responding about their own experiences.
6.2.4 Experiences of care in a crisis

We asked participants to rate how far they agreed with a number of statements about their experience of care in a crisis. These statements were adapted from the ‘I statements’ developed by Mind and included in the Crisis Care Concordat. People with personal experience and family and carers gave a similar pattern of responses, though family and carers were less likely to agree that they were able to access an appropriate service or

<table>
<thead>
<tr>
<th>Experience of care in a crisis</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was able to access an appropriate service or professional as quickly as I needed (n=397)</td>
<td>64</td>
<td>106</td>
<td>96</td>
<td>120</td>
<td>11</td>
</tr>
<tr>
<td>They knew what to do to give me the help I needed (n=392)</td>
<td>63</td>
<td>96</td>
<td>100</td>
<td>122</td>
<td>11</td>
</tr>
<tr>
<td>They took me seriously and treated me with respect (n=393)</td>
<td>91</td>
<td>114</td>
<td>81</td>
<td>97</td>
<td>10</td>
</tr>
<tr>
<td>I was offered the chance to have a friend, family member or advocate there if I wanted one (n=389)</td>
<td>64</td>
<td>89</td>
<td>88</td>
<td>105</td>
<td>43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience of care in a crisis - family responses</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>They were able to access an appropriate service or professional as quickly as they needed (n=153)</td>
<td>19</td>
<td>33</td>
<td>38</td>
<td>60</td>
<td>3</td>
</tr>
<tr>
<td>They knew what to do to give the person I care for the help they needed (n=152)</td>
<td>27</td>
<td>37</td>
<td>47</td>
<td>35</td>
<td>6</td>
</tr>
<tr>
<td>They took the person I care for seriously and treated them with respect (n=152)</td>
<td>38</td>
<td>52</td>
<td>27</td>
<td>26</td>
<td>9</td>
</tr>
<tr>
<td>They were offered the chance to have a friend, family member or advocate there if they wanted one (n=151)</td>
<td>29</td>
<td>56</td>
<td>23</td>
<td>21</td>
<td>22</td>
</tr>
</tbody>
</table>
professional as quickly as needed (34% compared with 43%). Family and carer respondents were more likely to agree that the person had been offered the chance to have a friend, family member or advocate present (56% compared with 39%). This may reflect the sample, in that family respondents may be more likely to openly identify as carers and be actively involved in the person’s care. If so, professionals may be more likely to include, or offer to include them than other family members and friends.

Further insight into respondents’ experiences of care were provided in response to open questions, where service users and carers were asked to give details of both positive aspects of their experience and areas for improvement. Among the areas of improvement, service users identified barriers to accessing services which included not knowing who to contact or not being able to contact appropriate services, and experiencing distressing delays:

“It would have been easier for the crisis team to assess me initially but the only way to do that is to go to A&E which is distressing and unnecessary”

“To know where to go in times of crisis - I was never given this information by mental health services or a GP. To have someone I could have called on quickly to get help immediately”

“I had been seeking help for weeks before local mental health services would see me. By the time they did I was very unsafe”

This was also reflected in carers’ experiences:

“Crisis teams should be available 24 hours, as crises are just as, if not more likely to happen at night. Mental Health crises should not be left to A&E. Past experience of crisis teams is that they are fairly ineffectual, even when they are available.”
Others reported more positive experiences:

“As soon as I was admitted to hospital following being sent via ambulance and an overnight stay, I received help from a number of professionals who I hadn't been able to get help from otherwise, which lead to a very quick diagnoses of OCD, and treatment both in and out of hospital.”

With regard to the quality of the treatment received, and the attitudes of staff, again there were mixed experiences. Service users and carers described good quality care delivered in a way that was respectful of the person:

“The nurse in A&E was kindness itself. She let us wait in a quiet room away from the evening drunks and chaos that is A&E. She kept in touch and kept us informed, even if that was only 'We are still waiting for the duty psychiatrist'.”

“The doctor who assessed my son’s mental health at A/E treated him with respect and understood his feelings and fear.”

“The crisis team were expert in their field and gave me time and opportunity to explain my feelings and issues.”

“The GP was great. She didn't judge me or tell me to pull myself together. She listened to me, suggested things and told me to see her again”

Again, however, there were a number of reports of unsatisfactory care:

“I received telephone support via crisis team, but was not well enough to talk.”

“I was made to feel like I was wasting their time and exaggerating the emotions I was experiencing.”

“Bullish and impersonal staff at the psychiatric hospital. I felt like I was being treated as herded animal.”
While the majority of responses concerned engagement with health professionals, some referred to other services, including police. In the case of carers, these experiences had generally been positive:

“The police are often much more knowledgeable than the psychiatrists who cannot understand that a frightened man with mental health problems needs a strong sympathetic man for company and not anyone else, so the support workers are usually females.”

“Can honestly say the only positive help received came from the police!”

In the case of service users, the experience was more likely to be negative, although in a minority of cases their involvement had been experienced as supportive:

“The police on section 136 were disgusting they treated me roughly like a criminal, I felt violated … I was not violent at any time.”

“I often end up being sectioned in a police cell for my own safety. This makes me feel really unsafe … I really need to feel safe not to feel so scared that I want to self harm badly.”

“Somewhere other than a police cell to be assessed and understanding, not being treated as a drunken low life they perceive me to be.”

“More Police Officers need more training in Mental Health and I don’t mean only just one day. They need to actually work alongside health professionals and deal with the acutely ill when training.”

“I was treated like a criminal and aggressively manhandled by the police even though I was known by the police and they knew I had PTSD. My experience has left me with flashbacks and increased my PTSD symptoms.”

“The police were amazing and really supportive.”

“Kindness and respect was what came across from the police officer.”
6.2.5 Overall quality of crisis care

Sadly, 50% of participants rated their overall experience of care received in a crisis as ‘not very good’ or ‘poor’. Only 30% rated their experience as ‘excellent’ or ‘good’.

Due to an error in the online survey set-up, only family members who said that the person they cared for had been admitted into hospital were asked to rate the care they received. This means that these responses are not comparable with those from people with personal experience. Nonetheless, 54% of these family respondents rated the experience as ‘not very good’ or ‘poor’.
Again, responses to the open questions suggest some areas where services were thought to require improvement. For service users this included a perceived lack of resourcing of services and failures of communication between agencies:

“The community crisis team is so appalling that if they had been properly staffed to actually visit me and be more understanding to me then I probably wouldn’t have reached the crisis point that I did.”

“I think those people I came into contact with this time did want to help and were kind but the resources just weren’t there for them to provide things that would have been more helpful.”

“Phone calls were not returned as promised, psychiatrist thought I was under crisis team but crisis team did not, thus I slipped through a net.”

“The [crisis] team were not informed of my hospital discharge and so I had no support (that had been agreed by the hospital consultant at ward round), for several days, until my carer contacted the crisis team and ward, to find out why not.”

Among aspects of services that those receiving care valued were choice and service user involvement in treatment, continuity of care and access to peer and voluntary sector support. In one case efficient and respectful care had led to non-admittance and a quick return to wellness:

“The GP, single point of access service and crisis team enabled me to get back on track very quickly so I could return to work and my normal functioning. I was treated with respect and understanding. My needs were assessed well and I got appointments within 24hrs of being assessed by each service plus telephone support in between appointments so I didn’t need to be admitted to the ward.”
Carers sometimes experienced services as inefficient, again pointing to demands on resources, and to improvements needed in the involvement of carers:

“Ambulance services are kind and they are there, but can do nothing, but take my partner to sit in A&E in a highly stressed and apparently suicidal state for four hours while she waits for a psychiatric nurse to tell her she is ill and advise her to call her mental health team.”

“My daughter's care coordinator is so overworked! We couldn't get hold of her for days. Then all she could do was to hand my daughter over to the crisis team. She did her best to give them the information they needed but she couldn't stay for the handover and in practice my daughter was assessed again from scratch. The crisis team were useless and just sent my daughter straight into hospital.”

“We were not listened to. And in fact told that our opinions didn't make any difference because it was a mental health issue and that the mental health service now became the responsible agent for our son and not us.”
6.2.6 Support to avoid a crisis

We asked participants to tell us whether they had received support to prevent another crisis in the future. Forty-five percent of participants agreed or strongly agreed that they had this support, while 49% disagreed or strongly disagreed. Family respondents were less likely to agree with this statement with 34% agreeing or strongly agreeing, and 56% disagreeing or strongly disagreeing.

![Bar chart showing received support to prevent a future crisis (n=392)](chart1)

![Bar chart showing received support to prevent a future crisis - family responses (n=149)](chart2)
6.2.7 Future contact in a crisis

We asked participants whether they would know who to contact, at any time of day or night, if they needed urgent help in a crisis again in the future. A little over half (52%) of participants with personal experience of care in a crisis agreed or strongly agreed that they would know who to contact in a future crisis. Forty-three percent disagreed or strongly disagreed. For family respondents, slightly fewer agreed (47%) and the same number disagreed.

![Graph showing the distribution of responses](image)

This question was also asked of people with personal experience of living with a mental health condition but who had not needed urgent help in a crisis. The pattern is slightly...
different for this group, with people more likely to disagree than strongly disagree. However, the combined proportions who agreed and strongly agreed were similar (52%).

This group of participants were also asked how confident they were that they would receive appropriate support if they ever experienced a mental health crisis in the future. Participants were asked how far they agreed that they felt confident they could access appropriate help as quickly as they needed it, and that they felt confident that services would know how to help.
This suggests that people were more concerned about appropriate access than they were about the quality of care in a crisis.

6.2.8 Exploring the data further

For the following section, we combined data from people with personal experience of a mental health crisis with data from family and friends. This provides a combined sample size of 552 participants.

*Changing experiences of crisis over time*

The data in the four graphs below suggest that experiences may have improved over time, with more people agreeing with the statements in relation to the last 5 years than before that. However, these differences are generally small and the number of people responding for the earlier period is much lower (more than 6 years = 51 participants; fewer than 6 years = 499). The small numbers in the earlier categories suggest caution should be taken, as they may be less typical of people experiencing a crisis in that period. There does, however, consistently appear to have been a worsening of the experience of crisis care in the last year compared to 1-5 years ago.
In the last year
Between 1 and 5 years ago
Between 6 and 10 years ago
More than 10 years ago
Grand Total

Able to access an appropriate service or professional as quickly as needed (n=550)

Able to access an appropriate service or professional as quickly as needed
Agree/strongly agree: 59%
Agree/strongly disagree: 47%
Disagree/strongly disagree: 50%
Not sure: 3%

They knew what to do to give me the help needed (n=544)

They knew what to do to give me the help needed
Agree/strongly agree: 60%
Agree/strongly disagree: 37%
Disagree/strongly disagree: 33%
Not sure: 3%
In the last year
Between 1 and 5 years ago
Between 6 and 10 years ago
More than 10 years ago
Grand Total

Agree/strongly agree
disagree/strongly disagree
Not sure

Offered the chance to have a friend, family member or advocate there if wanted (n=540)

Agree/strongly agree
disagree/strongly disagree
Not sure
This pattern was also reflected in the overall experience of care in a crisis. In general, experiences appeared to be better in the more recent time categories than in the earlier ones. Again, experiences seemed to have worsened slightly in the last year.

![Bar chart: Overall rating of care in a crisis (n=471)]

**Experiences in different areas**

We were particularly interested in responses from the four local areas where further evaluation of the Crisis Care Concordat was taking place. We therefore asked people to tell us if they had experienced their crisis in one of these areas. The numbers responding from each area are low, however: Cambridgeshire, 34; Gloucestershire, 12; London, 55; the Wirral, 11. We would therefore be hesitant about drawing conclusions from these findings. Nonetheless, the data available suggests that more people reported excellent or good experiences in Cambridgeshire compared to the average, while fewer people in the Wirral and Gloucestershire reported excellent/ good experiences. Cambridgeshire was the only area in which more people reported good experiences than poor ones.

Note that this data is incomplete for family and friends due to an error in the online questionnaire.
Admitted to hospital

Overall, experiences of care in a crisis appear to have been more positive when the crisis resulted in an admission to hospital. Thirty-two percent of those who were admitted rated their overall experience as excellent or good, compared to 26% of those who were not admitted. This may reflect a view that hospital admission is the desired, or appropriate, response to a mental health crisis. However, those who were admitted under a section, rated the experience as less positive (28% rating excellent/good, compared to 37% of those voluntarily admitted).
Demographics

We compared overall rating of care in a crisis across age groups, gender and diagnosis. There were insufficient numbers of non-White British to compare by ethnicity. Ratings
appeared to be worse among the younger and older age groups. The pattern among men and women was very similar, though women were slightly more likely to rate their care as OK, and men more likely to rate it as poor.
The pattern across the six most commonly reported diagnoses is similar, though fewer people with schizophrenia and bipolar disorder rated their experience as poor compared to the other diagnoses. These differences are small however.

6.3 Results: Comparison of T1 and T2 survey data

The T2 survey was sent to 401 participants who responded at T1, and had indicated they would like to be contacted for the second survey. Of this sample 245 returned a survey at T2, 36 were deleted because of insufficient data leaving a total of 209 responses. Of this sample, 140 were people with personal experience of a mental health crisis (84 of whom had experienced a crisis in the last 12 months; Table 3), 55 were family or other carers of someone with experience of a mental health crisis (34 of whom had experienced a crisis in the last 12 months), and 14 were people with a mental health condition who had not experienced a mental health crisis. Because this survey aimed to investigate any change in experience of crisis care since T1, people who had not experienced a crisis, or cared for someone who had experienced a crisis, in the last year were only asked the questions reported in sections 6.3.7 and 6.3.8.

6.3.1 Overview of statistical tests used

We used the Wilcoxon signed rank sum test to determine whether there was any change in participants responses between the 2014 survey (T1) and the 2015 survey (T2). Below, the results of this test are indicated by the symbol “p”. The p-value indicates whether, or not, a
change in participants' response is statistically significant. A statistically significant result means it is unlikely that the change in score happened by chance. For this data, a \( p \)-value lower than 0.01 indicates a significant result, and means there is a less than 1% probability that a change in score happened by chance.

### 6.3.2 Demographic profile of respondents

The demographic profile of people who responded to the survey at T2 are displayed in Table 3, and, on the whole, is similar to the larger cohort of people who took part in the survey at T1. Carers were asked about the characteristics of the person they were caring for, rather than themselves. All results reported in this section were from this group of people.

<p>| Table 3: Demographic profile of people who responded to both the T1 and T2 survey |
|------------------|------------------|------------------|
|                  | People with personal experience of crisis care | People with experience of crisis care – family responses |
| <strong>Gender</strong>       |                  |                  |
| Male             | (n=140) 107 (76%) | (n=55) 24 (44%)  |
| Female           | 32 (23%)        | 31 (56%)        |
| <strong>Age</strong>         |                  |                  |
| 16-25            | (n=139) 22 (16%) | (n=53) 11 (21%)  |
| 26-35            | 30 (22%)        | 13 (25%)        |
| 36-45            | 46 (33%)        | 6 (11%)         |
| 46-55            | 29 (21%)        | 14 (26%)        |
| 56-65            | 11 (8%)         | 6 (11%)         |
| Over 65          | 1 (1%)          | 3 (6%)          |
| <strong>Ethnicity</strong>    |                  |                  |
| White British    | (n=130) 114 (88%) | (n=49) 47 (96%)  |
| White European   | 4 (3%)          | 0 (0%)          |
| Irish            | 5 (4%)          | 2 (4%)          |
| Scottish         | 2 (2%)          | 0 (0%)          |
| Asian/British Asian | 2 (2%)   | 0 (0%)          |
| Mixed            | 3 (2%)          | 0 (0%)          |
| <strong>Location</strong>     |                  |                  |
| London           | (n=137) 21 (15%) | (n=54) 4 (7%)    |
| The Wirral       | 2 (1%)          | 3 (6%)          |
| Gloucestershire  | 4 (3%)          | 4 (7%)          |
| Cambridgeshire   | 14 (10%)        | 3 (6%)          |
| Elsewhere in England | 96 (69%) | 40 (73%) |
| <strong>Fluent English speaker?</strong> | (n=139) 139 (100%) | (n=49) 54 (98%) |
| Yes              | 139 (100%)      | 54 (98%)        |
| No               | 0 (0%)          | 1 (2%)          |
| <strong>Physical disability or long-term health condition?</strong> | (n=140) 74 (53%) | (n=53) 25 (47%) |
| Yes              | 74 (53%)        | 25 (47%)        |
| No               | 64 (46%)        | 27 (53%)        |
| Rather not say   | 2 (1%)          | 0 (0%)          |
| <strong>Carer’s relationship to the person they support</strong> | NA | (n=55) |
| Son/daughter     | NA              | 3 (5%)          |
| Friend/neighbour |                | 5 (9%)          |</p>
<table>
<thead>
<tr>
<th>Relationship</th>
<th>T1</th>
<th>T2</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>27</td>
<td>1</td>
<td>(49%)</td>
<td>(2%)</td>
</tr>
<tr>
<td>Sibling</td>
<td>1</td>
<td>15</td>
<td>(27%)</td>
<td>(7%)</td>
</tr>
<tr>
<td>Spouse/partner</td>
<td>15</td>
<td>4</td>
<td>(27%)</td>
<td>(7%)</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1</td>
<td>(7%)</td>
<td>(2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>T1</th>
<th>T2</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia or schizoaffective disorder</td>
<td>8</td>
<td>12</td>
<td>(5%)</td>
<td>(26%)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>23</td>
<td>12</td>
<td>(17%)</td>
<td>(20%)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>66</td>
<td>18</td>
<td>(48%)</td>
<td>(39%)</td>
</tr>
<tr>
<td>Depression</td>
<td>87</td>
<td>19</td>
<td>(64%)</td>
<td>(41%)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>39</td>
<td>10</td>
<td>(28%)</td>
<td>(20%)</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>3</td>
<td>2</td>
<td>(2%)</td>
<td>(6%)</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>42</td>
<td>8</td>
<td>(31%)</td>
<td>(15%)</td>
</tr>
<tr>
<td>PTSD</td>
<td>5</td>
<td>3</td>
<td>(4%)</td>
<td>(4%)</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>2</td>
<td>0</td>
<td>(1%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>2</td>
<td>0</td>
<td>(1%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>2</td>
<td>0</td>
<td>(1%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>Rather not say</td>
<td>3</td>
<td>0</td>
<td>(2%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

**T1 survey: When did the crisis happen?**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>T1</th>
<th>T2</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last year</td>
<td>84</td>
<td>34</td>
<td>(60%)</td>
<td>(62%)</td>
</tr>
<tr>
<td>1-5 years ago</td>
<td>43</td>
<td>15</td>
<td>(31%)</td>
<td>(27%)</td>
</tr>
<tr>
<td>6-10 years ago</td>
<td>8</td>
<td>4</td>
<td>(6%)</td>
<td>(7%)</td>
</tr>
<tr>
<td>10+ years ago</td>
<td>5</td>
<td>2</td>
<td>(4%)</td>
<td>(4%)</td>
</tr>
</tbody>
</table>

1. Four people were caring for someone different at T2
2. Participants could tick multiple options for diagnosis, reflecting multiple diagnoses received. Percentages stated are of participants who responded to the question
3. T2 responses reported below are in relation to a crisis experienced during 2015

### 6.3.3 Initial contact with services in a crisis

We asked participants to tell us which professional they first had contact with when they, or the person they cared for, experienced a mental health crisis. A total of 106 people completed this question at both time points. Table 4 shows their responses.

**Table 4: First contact with professionals during a mental health crisis**

<table>
<thead>
<tr>
<th>Professional</th>
<th>Frequency</th>
<th>T1</th>
<th>T2</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>21</td>
<td>20</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Casualty / A&amp;E</td>
<td>10</td>
<td>8</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>19</td>
<td>11</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Mental health professional involved in care</td>
<td>32</td>
<td>41</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Mental health professional not involved in care</td>
<td>7</td>
<td>8</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Ambulance / paramedics</td>
<td>6</td>
<td>5</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>NHS 111</td>
<td>1</td>
<td>2</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>11</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows that in 2015 a lower number of respondents were first in contact with the police during a mental health crisis, and a higher number first came in contact with a mental health professional who was involved in their care, compared with 2014.
6.3.4 Experiences of care in a crisis

In each survey, participants were asked to rate their agreement with a number of statements related to their experiences of care. We used the Wilcoxon signed rank sum test to determine whether there was any significant change in participant’s responses (see section 6.3.1 for an explanation of this test). Table 5 shows the results of this analysis.

Table 5: Wilcoxon signed rank sum test of change in participants’ response to questions about their experiences of crisis care between T1 and T2

<table>
<thead>
<tr>
<th></th>
<th>Service user</th>
<th>Carer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>sig (p)</td>
</tr>
<tr>
<td>I was able to access an appropriate service or professional as quickly as I needed</td>
<td>72</td>
<td>0.027*</td>
</tr>
<tr>
<td>They knew what to do to give me the help I needed</td>
<td>72</td>
<td>0.001*</td>
</tr>
<tr>
<td>They took me seriously and treated me with respect</td>
<td>71</td>
<td>0.002*</td>
</tr>
<tr>
<td>I was offered the chance to have a friend, family member or advocate there if I wanted one</td>
<td>69</td>
<td>0.121</td>
</tr>
<tr>
<td>As a carer I felt I was appropriately involved in decisions concerning crisis care for the person I support T1</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>As a carer I felt I was appropriately valued and respected by services and professionals during this crisis period T1</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*There was a significant change in participant’s responses to this question between T1 (2014) and T2 (2015) at the p<0.01 significance level.

There were no significant differences in carers’ responses, suggesting that their experiences of crisis care between T1 and T2 had not changed, however we did find some significant differences in responses from people who had used crisis services themselves.
At T2 there was more agreement with the statement “I was able to access an appropriate service or professional as quickly as I needed” compared with T1, suggesting that participants’ experiences of accessing crisis care during 2015 had improved since they last needed to access crisis services.

![Graph showing responses to the statement](image)

In response to the open question about positive aspects of care, one service user said that:

“The support had certainly exceeded my expectations based on past events particularly focussing on the crisis team and how helpful they were to me this time around. They actually seemed to take me seriously which helped enable my recovery.”
Compared to T1 there was also more agreement with the statement “They knew what to do to give me the help I needed” at T2, suggesting that participants felt staff had a better understanding of how best to support them when they had a crisis during 2015 (T2), compared with their previous experiences of crisis services.

![Bar chart showing responses to the statement “They knew what to do to give me the help I needed” at T1 and T2.](image-url)
Finally, at T1 there was more agreement with the statement “They took me seriously and treated me with respect” compared with T2, suggesting that participants had experienced more positive attitudes amongst staff during their crisis in 2015 compared to crisis care they had accessed previously.

![Chart showing responses to the statement about being taken seriously and treated with respect.](image)

Again in answer to the open question about positive aspects of care, one service user told us that:

“Everyone I came into contact with (Police and mental health) treated me with respect and kept me informed about what was happening all the time”
6.3.5 Overall quality of crisis care

Participants were asked to rate the quality of crisis care and whilst there were no differences in ratings provided by carers at T2 compared with T1, there were statistically significant differences in responses from service users (Table 6).

Table 6: Wilcoxon signed rank sum test of change in participants’ ratings of the quality of crisis care between T1 and T2

<table>
<thead>
<tr>
<th>Service user</th>
<th>Carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>n Sig (p)</td>
<td>n Sig (p)</td>
</tr>
<tr>
<td>Overall how would you rate the support and response you received from services and professionals during this crisis care experience</td>
<td>73 0.001*</td>
</tr>
</tbody>
</table>

*There was a significant change in participant's responses to this question between T1 (2014) and T2 (2015) at the p<0.01 significance level.

At T2 there were higher numbers of people rating the quality of their care as ‘Excellent’; and ‘Good’, compared with T1 and correspondingly, lower numbers of people who rated the quality of their care as ‘Poor’, suggesting that the quality of crisis care had improved in 2015.

The following is a concrete example of one area of improvement:

“I was not placed in a police cell like it used to be. Instead [I was placed in] a witness room completely separate from the custody suite.”
6.3.6 Support to avoid a crisis

Participants were asked to indicate their level of agreement with statements about the support they, or the person they were caring for, were given to help them to prevent a future crisis. There was no statistically significant change in participants’ responses to these questions between T1 and T2 (Table 7).

Table 7: Wilcoxon signed rank sum test of change in participants’ experiences of support to avoid a crisis between T1 and T2

<table>
<thead>
<tr>
<th></th>
<th>Service user</th>
<th>Carer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>sig (p)</td>
</tr>
<tr>
<td>After my MH crisis, I was offered the services and support I needed to help me prevent another future crisis</td>
<td>73</td>
<td>0.5</td>
</tr>
<tr>
<td>If, in the future, I needed urgent help in a crisis, I know who to contact at any time of day or night</td>
<td>74</td>
<td>0.6</td>
</tr>
</tbody>
</table>

6.3.7 Future contact in a crisis

Thirteen people who had experienced mental health problems, but had not accessed support for a mental health crisis were asked to indicate their level of agreement with statements about their knowledge of, and confidence in, crisis services. There was no change in their responses to these questions between T1 and T2 (Table 8).

Table 8: Wilcoxon signed rank sum test of change in participants’ knowledge of, and confidence in, crisis services between T1 and T2

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>sig (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If, in the future, I needed urgent help in a crisis, I know who to contact anytime day or night</td>
<td>13</td>
<td>0.6</td>
</tr>
<tr>
<td>If, in the future, I needed urgent help in a crisis, I feel confident that I would be able to access an appropriate service or professional as quickly as I needed them</td>
<td>13</td>
<td>0.3</td>
</tr>
<tr>
<td>If, in the future, I needed urgent help in a crisis, I feel confident that services and professionals would know what to do to give me the help I needed</td>
<td>13</td>
<td>1.0</td>
</tr>
</tbody>
</table>
6.3.8 Perceived impact and awareness of the work of the concordat

In the final part of the survey participants were asked whether or not they were aware of the work of the Concordat, and if they felt that crisis care in their area had improved in the previous 12 months.

Table 9: Agreement with the statement: “In the last 12 months, crisis care in my area has improved” amongst all participants

<table>
<thead>
<tr>
<th></th>
<th>n (total = 105)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>Disagree</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>Not sure</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>Agree</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Surprisingly, the majority of participants did not feel there had been any improvement in local crisis care services (Table 9), in contrast with the results reported above, which indicate that service users’ experiences of crisis care had improved. One explanation for this disparity might be that respondents were unaware of any improvements in terms of the availability or extent of services, as opposed to improvements in their experiences of receiving care.

Around 20% of respondents were aware of Crisis Care Concordat work in their area (Table 10).

Table 10: Participants responses to the question: Have you been aware of the Crisis Care Concordat work in your local area?

<table>
<thead>
<tr>
<th></th>
<th>n (total = 103)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>No</td>
<td>84</td>
<td>79</td>
</tr>
</tbody>
</table>
Respondents who indicated that they were aware of the Crisis Care Concordat in their area were then asked 2 further open questions asking about any opportunities they had had to be involved in the Concordat, and any further comments on the Concordat work.

The degree of involvement varied, ranging from “none” to extensive involvement as a carer representative working with the clinical commissioner and Trust employees on an equal footing “to implement the Concordat for the best possible safety, care, effectiveness and responsiveness to the needs of service users and their carers”. Other involvement included as a voluntary sector representative, as a Healthwatch representative, as part of a LEAP (Lived Experience Advisory Panel) project and as a member of a local action learning set. Respondents were also aware of and had attended involvement events. However, some respondents expressed frustration at not having had opportunities to be involved:

“None, not as a carer or as an employee of a local Mind association. In my paid role I contacted local services about the Crisis Care Concordat but we did not have the opportunity to get involved. As far as I am aware neither service users or carers were involved in this work.”

“None. I would have loved to have been included and raised concerns that whilst I support the initiative I am concerned about how the outcomes will be measured effectively.”

To some extent, attitudes towards the Concordat reflect the findings in other parts of this evaluation. For example, respondents expressed concerns about resourcing:

“I feel that on paper the recommendations are very positive and beneficial but have serious concerns and doubts about its implementation, due to cuts and lack of funding.”

“A tick box exercise. No real changes to improve care. Tried a street triage pilot, excellent evaluation, but not commissioned as CCG had no money to fund it. CCG priority for mental health is extremely low, useless.”

While one respondent felt that it hadn’t made any practical difference, another referred to improvements, albeit with some caution:

“The open telephone line [which] leads one to a triage system is working really well.”

“Has improved things slightly - though need to have more experienced (and qualified!) staff manning the phones and support networks.”
Finally, one respondent expressed concerns about the limits to service user inclusion:

“I think that the 'system' fails to reach the most vulnerable service users and very pertinent people are being excluded from making any valuable input. If we challenge the system we are labelled as 'trouble' and the system just shuts down on us.”

7 Discussion and recommendations

The Crisis Care Concordat aims to provide a set of principles underlying the ways in which agencies are expected to work together to provide the quality of care that people experiencing a mental health crisis, or who are at risk of a crisis, need in order to receive the same level of response they would expect in a physical health crisis, and the same respect for their dignity and rights.

Based on the analysis of a sample of local area action plans, observations and interviews in 4 local areas, interviews with members of the National Steering Group and a baseline and follow-up survey, we have provided an evaluation of the work undertaken to implement the Concordat at local level, and its impact to date. In this section we discuss our findings, and provide some recommendations based on the learning from the evaluation.

7.1 Implementing the Concordat at local level

Beginning with the action plan analysis and observations, we have been able to provide an understanding of the ways in which local areas responded to the Crisis Care Concordat vision and some of the demands and opportunities this presented to partners signing up to the Declaration. While it was clear from the action plans and from the local area observations that different areas were starting from different points in terms of crisis care provision and partnership working, the sign up of all local areas across England to the Concordat is an achievement in itself and indicative of the impact of the initiative.

Some of the themes that emerged from the observations were followed up in more detail in the local area and National Steering Group interviews, allowing us to reach a fuller understanding of the achievements and challenges involved in implementing the Concordat at local level, of the impact it has had to date, and of the work required to continue to strengthen and improve crisis care.
The Concordat was credited with enabling local areas to build on existing work, for example by giving the work visibility and helping to secure funding. While co-terminosity of boundaries appeared as a challenge in the observations, this was not raised as a substantial issue in the local area interviews, suggesting that any difficulties arising from this had either not been as problematic as anticipated, or had been overcome.

It is clear that the Concordat has achieved considerable success in initiating and sustaining multi-agency working across a range of partners. In addition to improving service development and delivery, with particular achievements in the area of reducing the use of police cells as a POS, partnership working was credited with increasing knowledge and understanding of the delivery of crisis care across services. In both the observations and interviews it was evident that the work of the Concordat at local level had provided partners in some areas with an opportunity not previously available to sit in a room together and talk. While there were challenges involved in this – from finding a shared language to understanding and negotiating the different cultures in different sectors – it was also invaluable in facilitating learning from and understanding of other services involved in the delivery of crisis care.

While there were some challenges early in the process in engaging specific agencies, these had been overcome to a large extent. There were also some challenges associated with cultural or organisational differences evident in both the observations and in the interviews, in particular between health services and the police. From the perspective of the police, these included the complexity of chains of command in the NHS, which were felt to impact on the implementation of actions, as well as, again in the case of the NHS, the perceived difficulty in identifying the right people to involve in the Concordat, leading to delays and lack of continuity of attendance at meetings at least at the beginning of the process.

Another area of particular interest was service user and carer involvement, both in the process of development and implementation of the action plans, and the development and delivery of crisis care more generally. It was clear from the action plan analysis that, in some areas at least, there were mechanisms in place for the inclusion of lived experience perspectives, as well as commitments to co-production across different aspects of the process. Further, while the observations had indicated limits to service user and carer involvement, it was clear from the interviews that this had been achieved to some extent in all 4 of the local areas, as well as at the level of the National Steering Group. It was clear,
however, that there had been some challenges to this involvement, and in this respect findings from the T2 survey suggest that awareness of and involvement in the Concordat work among service users and carers was limited. Some of the challenges to service user and carer involvement that were identified in the interviews concerned the necessity to limit the number of individuals and organisations involved, difficulties in ensuring a diversity of perspectives, and the need to ensure that involvement is meaningful, which might require placing boundaries around service user and carer contributions.

Inclusivity was also evident in the provision of services, with a number of services for vulnerable and excluded groups included in action plans, again with a focus on partnership working to meet a diversity of needs. This includes the development of crisis care for children and young people. This was widely recognised as an area requiring attention in order to meet the Concordat aims. While all of the action plans included provision of and improvements to services for CYP, it was evident from both the local area and National Steering Group interviews that it is recognised that there is still a great deal of work to be done in order to provide the same level of service for children and young people experiencing or at risk of a mental health crisis as adult service users.

7.2 Service user and carer experience of crisis care

Our baseline (T1) and follow-up (T2) surveys of service user and carer experiences of crisis care show that, among our sample at least, there have been some significant changes in the last 12 months indicating improvements in the experience of accessing and receiving care in a crisis. That is, there was significantly more agreement with the statements “I was able to access an appropriate service or professional as quickly as I needed”; “They knew what to do to give me the help I needed” and “They took me seriously and treated me with respect”. Further, among service users, there was a statistically significant difference in how they rated services overall, with more respondents giving a rating of ‘Excellent’ or ‘Good’, and fewer giving a rating of ‘Poor’. While caution should be exercised given the size of the sample, this is an encouraging result at this stage of the Concordat work in terms of its impact on service user and carer experiences.

7.3 Looking to the future

The local area and National Steering Group interviews allowed us to identify a number of areas that will be of importance in determining the future of crisis care. At both local and
national level it was recognised that it was essential to maintain the momentum provided by the Concordat, with the work only just beginning on what needs to be a longer term project. In this respect, concerns about funding and resources, also identified in the observations, come to the fore. While the Concordat was credited with attracting funding, there remained concerns about resourcing, including questions of where responsibility for funding initiatives involving partners from different agencies would lie, and the impact of anticipated cuts.

The need to maintain momentum extends beyond resourcing, however, with some concerns around the future of partnership working and the continued engagement of all partners. In one of the local area interviews the view was also expressed that there was more work to be done in ensuring that the principles of the Concordat were reaching those working on the frontline of service delivery. This leads to question about responsibility for crisis care, both in terms of leadership and delivery, with a concern that it is seen as everyone’s responsibility, not just those working in the health service. Indeed, even within the health services there appears to be an ongoing debate regarding responsibility for crisis care, including the role of emergency medicine in achieving parity for mental health and physical health services.

Finally, the need for good quality data was evident in the action plans, the observations and in interviews. While some of this work has been done, it is evident that there is more to do in this respect in order to understand and respond to the needs of service users.
7.4 Recommendations

Quality and availability of data:

1. There is a further need for combined data sets from the range of organisations involved in the crisis care pathway, including police, housing, social services, general practice, as well as statutory mental health services.
2. There is also a need for all data to be available at local level; this is particularly important given the variations in delivery of services and in level and range of need between different local areas.

Inclusion:

3. Consider whether the use of lived experience working groups would be a more meaningful and effective way to facilitate the contribution of service user and carer perspectives, including ensuring diversity of views.
4. Build on the work already in place to consider the specific needs of vulnerable and excluded groups, for example people with dual diagnosis, people involved in the criminal justice system and people with learning difficulties.
5. Address the lack of parity in crisis services for children and young people, including looking at ways to move beyond a model of extending existing adult services to one that addresses the specific needs of children and young people who are experiencing or at risk of a mental health crisis.

Maintaining momentum:

6. Embed partnership working into routine practice at local level, providing leadership and ensuring accountability, as well as a clear understanding of where responsibility lies to sustain the delivery of the Concordat vision.
7. Agree mechanisms and responsibilities at national level for embedding mental health crisis care in current and future policy and funding landscapes, and for continuing to improve service user and carer experience.
About the McPin Foundation

The McPin Foundation is a specialist mental health research charity based in London but working across England. We exist to transform mental health research by placing lived experience at the heart of research activities and the research agenda.

Our work includes:

• Guidance and expert support on public and patient involvement in mental health research
• Collaborative research studies in partnership with organisations interested in user focused mental health research
• Campaign and policy work to raise the profile of mental health research and improve access to evidenced based information

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