

# Listening to experience

An independent inquiry into acute  
and crisis mental healthcare

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

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# Methodology

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

## Call for evidence

The call for evidence was hosted on Mind's website and promoted through Mind's networks and other contacts. Hardcopy responses were also welcomed. It ran from 30 September to 17 November 2010 and was re-opened in April and May 2011 to seek more responses from black and minority ethnic communities.

We asked:

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

There were about 350 responses, the majority from people with experience of acute and crisis care or friends and family members, and also from individual staff members – including nurses, social workers, managers and advocates, and organisations.

## Hearings, meetings and visits

The panel held its first meeting in November 2010. Between January and April 2011 we held five hearings in which panel members were able to discuss issues in greater depth with invited experts, with a further meeting in August 2011. Witnesses, or guests, included experts by experience, individual crisis team staff and other individuals, and representatives of organisations. Between March and June 2011 panel members and Mind staff visited a range of groups, services and individual experts. Please see the acknowledgements for details of the organisations that gave evidence or hosted a visit.

The panel developed their views in discussion with each other, based on this evidence, background briefings based on the literature and their own knowledge.

# Forewords

The experiences of people with mental health problems who need acute and crisis care are central to the whole of the mental health community. Over 100,000 people a year spent time as an inpatient last year. We wanted to hear from people about their experiences, and to ask an independent panel of experts to report on what they found. We are grateful to Paul Grey and his colleagues on the inquiry for their hard work and careful consideration, and for creating a clear vision based on what they heard.

They found some excellent care. The hard work and dedication of staff and managers up and down the country should be applauded. Often it's a relatively small thing that makes a positive difference to your stay as an inpatient, and that's down to the work of staff and managers inside units.

But equally the panel found that some people's experiences were poor – or worse than poor. The details make harrowing reading.

There is wide consensus among staff, service users and managers about what good care looks like: being treated as a human being, respected, cared for, and being helped to recover are themes the panel heard many times. The changes required are both bottom up and top down. As the health service changes, as commissioning becomes more localised we need to be clear as a society what level of service we expect for people with mental health problems in crisis. And we need to be clear what falls below an acceptable level.

Excellent acute and crisis services are possible – the evidence is in this report. We need to see the quality of the best become the standard. This shift can only be achieved by all working together across the NHS. If we can do that, we will make it happen.

**Paul Farmer**

Chief Executive of Mind

When a person is in crisis or needs acute care, what would they experience in England and Wales? Staff who are patient and kind, encouraged to take positive risks and who are constantly learning? They drive through the remote Welsh valleys to meet a need, sometimes taking up to half a day to make the round trip. Why – because one person is important.

Or a psychiatrist who is part of a team – not above anyone else but who has equal power and influence, and who adds value by listening to every word, bringing solace to a beautiful mind. They are touched by their fellow human being's needs and the first prescription is that of hope.

Or would you experience a foul mouth in a foul environment? When we think of acute care, do we think of locked wards or someone being held face down? Or is this practice stopped and filed in the archives of history?

What the people called for in this report is for humanity – for care to be humane. I believe people can deliver this and more because we are each other's keepers. Inquiry team, you have delivered a great vision; thank you contributors. Thank you for your bravery, skills and will.

**Paul Grey**

Chair of the Inquiry Panel

# Vision

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

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

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

We believe provider organisations should be run on human principles, expressed not only in care for those receiving services, but also for staff and the care/working environment. Staff should be supported and developed, especially in positive risk-taking and through reflective practice.

The complementary skills and capabilities of peer workers, healthcare professionals, support staff and volunteers should all be used to best effect. We believe psychiatrists should be valued as part of the team or as consultants, but not always be seen as 'in charge'.

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

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

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

# Executive summary

Crisis and acute mental health services are a crucial part of mental healthcare, providing for people when they are most unwell and vulnerable. For example, people may be highly agitated, in despair, experiencing suicidal impulses or the need to self-harm, immobilised by depression or frightened within the changed reality of psychosis. There is an urgent need for help. How people are treated in these circumstances makes a huge impact on their recovery and willingness to seek help should they need it again.

Between Autumn 2010 and Summer 2011, the independent inquiry panel heard evidence in relation to acute mental healthcare in England and Wales, including inpatient wards, emergency departments, crisis resolution and home treatment teams and other community services. We heard from people with experience of receiving crisis and acute care, family members, individual staff and representatives of professional, provider and community organisations. We visited some of the services and settings where care is provided.

There is no doubt that good acute and crisis care is achievable. We heard about good examples of care, courteous and helpful staff and well designed environments. There were staff teams with a can-do spirit and approach, getting on and making improvements and positive efforts to help people in crisis and their families. There were some voluntary sector projects providing a different kind of response from the NHS that was more directly accessible.

However, many people told us about poor, even traumatic mental health experiences. We should not, as a society, be leaving people with urgent mental health needs isolated, frightened and unsupported in impersonal hospital settings. We should not be traumatising those who use these services to such an extent that they would do anything not to return.

Our services should not be giving people a sense of abandonment when they try to use them. We heard of people being put “on hold” or

having their crisis calls unanswered, or being told they were not ill enough to qualify for help, or waiting for hours in A&E minded by security guards. We should not be ‘managing’ those with acute care needs in some of the worst hospital environments in the NHS.

Our services should not be discriminatory, treating some groups more neglectfully or coercively than others as still appears to be the case for some black and minority ethnic communities. In the 21st century, mental health services in one of the most developed countries should be doing much better.

We identified four key areas where work should be focused in order to raise all services to the level of the best. Our aim is for acute mental health services that are responsive, effective, appropriate and that promote recovery.

## Humanity

What people overwhelmingly want is to be treated in a warm, caring, respectful way irrespective of the circumstances in which they come into contact with services. In other words, all of us would like to be treated with humanity. Some do this but many of the experiences the panel heard suggested that mental health services have lost touch with basic humane principles when dealing with people in crisis – as shown by dirty wards, lack of human contact, a lack of respect often bordering on rudeness by staff, and a reliance on force. This does not produce the relationships and conditions that help people recover.

Action is needed to ensure that acute care is built on humane values and embodies a culture of service and hospitality – not least for the large percentage of inpatients who are in hospital against their will. This will require organisational commitment and a rethinking of ‘professional boundaries’ so that staff can interact naturally with the people they are caring for without losing their professionalism. There should be continual checking back with those

receiving the service about their experience, staff support and development, and an openness to ideas from outside the service.

Training in the prevention, de-escalation and management of disturbed behaviour must also be based in humane values. We should re-evaluate the need for and the reliance on 'control and restraint' procedures which appear to be used far too often in crisis situations. Aspects of current restraint procedures such as face-down restraint can be dangerous and potentially life threatening. Such interventions are dehumanising and we should reappraise the reliance on them in managing crisis. The use of face-down restraint should be ended and we would like to see acute services work towards eliminating seclusion and restraint altogether.

## Commissioning for people's needs

While there are common needs for care, safety, respect and someone to talk to, everyone's crisis is different. People's needs and home circumstances are different. Service delivery, in form and content, must reflect this diversity of needs. Different service models may be needed in rural and urban areas. It is important that services meet the requirements of BME communities, given the fact that ethnic inequalities are still entrenched. This means ensuring access to clinical mediation and advocacy, involving specialist community organisations in mainstream care provisions and forging genuine partnerships with those communities.

Commissioners and local health boards should not assume that one model will fit all. One particular configuration of services for acute care may not be appropriate in all communities and settings. Commissioners of acute and crisis care and local health boards should encourage flexibility and creativity in providing personalised and community-specific solutions. They must demand accountability from providers, over reasonable timeframes, with service user satisfaction measures that demonstrate they are

providing high-quality and humane care to all who need it. There must be evidence that services are effective, based on a clear set of values, and that they are appropriate to the needs of the local community.

## Choice and control

Access to help was one of the biggest problems people told us about, both for those in crisis and those who knew their mental health patterns and felt they could anticipate the need for more intensive help to prevent a crisis or suggest ways to support them through it. Often, people were told they were not ill enough or were too ill to meet the criteria for particular services. People wanted their own definition of being in crisis respected as the first step in getting help and exercising choice and control.

We urgently need more direct access options. This means that people can self-refer, and there should be an explicit acknowledgement that individuals know what they need. People should have more say over what happens at a time when they may not be able to exercise choice directly. Crisis plans that are jointly developed in an independently facilitated process have been shown to reduce the use of statutory powers to detain and treat people against their will.

## Reducing the medical emphasis in acute care

The needs people described – care, safety, someone to listen, something to do – did not require a medically dominant response. People told us about the value of different people who have supported them from across the range of mental health professions as well as non-professional help. While some emphasised 'trained professionals', many people would prefer more peer support from people who have themselves experienced mental health problems.

In one of the most valued services we heard about, the Leeds Survivor-Led Crisis Service, staff had experience of mental health crisis;

another, the Maytree sanctuary, recruited staff for their people and listening skills, not specific qualifications. In the NHS we heard about the value of team decision-making, and nurse-led teams.

We accept that doctors play a valuable role but this does not mean that they should head a hierarchy of professions. Psychiatrists are likely to be more effective and their contribution more valued by service users if they contribute as part of a team or are available to teams for consultancy rather than always 'in charge' or wholly 'responsible' for care.

In the current economic climate, services – already struggling to meet demand – are under particular strain. It is essential that this sector of care and the people who provide it are recognised as important and their work is protected (as much as possible). It is equally important to ensure that money is being spent on appropriate, acceptable and effective services.

The aim of this report and campaign is to focus attention on what really matters to people in crisis and help create a sea-change in the approach to acute and crisis care across England and Wales.

## Summary of recommendations

### For commissioners and local health boards:

Review how far acute services are meeting local people's requirements, and consult with black and minority ethnic communities in this process.

Set clear standards for values-based services in the procurement or planning process and hold providers to account using measures that include service user/carer satisfaction.

Expand the range of options to meet different needs; for example, crisis houses, host families and services provided by people with experience of mental health problems, and self-referral options.

### For provider organisations:

Consider 'inpatients' as 'guests' as well as recipients of care. Review the standards of hospitality that are being offered and ask the guests for their feedback.

Commit to working without violence and reappraise control and restraint methods, in particular ending face-down holds.

### For staff teams:

Carry out jointly negotiated crisis planning with people who may need to access acute care in future.

Plan and perform your work in the knowledge that people using services value time with staff and that empathy, kindness and respect go a long way.

### For professional education providers:

Market mental health professions and recruit on the basis of candidates' values and personal qualities as well as skills.

Re-evaluate how professional boundaries are taught so that staff are encouraged to be themselves with the people in their care.

See pp.42–47 for the full recommendations.

# Introduction

Acute and crisis mental health services provide for people at their most unwell and vulnerable, when needs are particularly urgent. The quality and effectiveness of the crisis response makes a huge impact on people's recovery and their willingness to seek help should they need it again.

Over the life of the National Service Framework for Mental Health in England (1999 to 2009) specialist teams were set up to help people avoid admission to mental health hospitals or to return home sooner, and there have been several initiatives to improve inpatient care, some of which are still thriving. The current Government strategy, *No health without mental health* (Department of Health, 2011), focuses on outcomes and includes work on the acute care pathway. The Welsh Government mental health strategy also introduced targets for specialist teams or functions, and for developing improved models of care in hospital.

Yet there continue to be major problems with acute care, with people describing difficulties getting help when they need it and wards that are not safe or therapeutic. Rates of detention under the Mental Health Act have continued to increase. In particular, and despite a five-year plan to deliver race equality in England, some black and minority ethnic (BME) groups are still significantly over-represented in compulsory detention and coercive treatment in England and Wales.

Inpatient care (particularly secure care) is the most expensive part of mental health services. At a time of financial constraint, when efficiency savings are being sought, these services are vulnerable to cuts and service reviews.

## Mind's panel

To look at the whole question of what was happening in acute and crisis care, Mind brought together an independent set of experts and commissioned them to conduct an inquiry into the state of acute care in England and Wales. Their task was to investigate services,

create a vision for the treatment, care and support of adults with acute mental health needs that is fit for our times, and make recommendations for how to bring it about.

We called for evidence in Autumn 2010 and between January and August 2011 panel members held hearings, made visits and met with a range of experts. They heard from people with experience of mental health crisis and using services, family members, individual staff, provider organisations in the NHS and voluntary sector, national policy leads/advisers, advocates, lawyers and researchers.

They heard about some excellent practices and services, as well as appalling experiences. They heard of solid programmes for improvement and inspirational lobbying for change. There were staff working through the challenges of delivering what they knew was needed with limited resources. There were 'why isn't there one of these everywhere?' moments. And there were many suggestions of small changes that could make a big difference.

This report reflects the findings of the panel and forms the basis for Mind's campaign on acute and crisis care.

We learned a huge amount from people who gave evidence and we are very grateful for it. While the overall lessons are summarised in this report it was not possible to include everything. Mind will continue to draw on the full evidence as we take this campaign forward.

Unless stated otherwise, quotes in this report are from responses to the call for evidence. In most cases they are from people with direct personal experience of using or receiving acute mental health services.

It is not just about changes to systems, service reconfigurations and legislative programmes – it is more fundamental than that. It is about:

- ensuring humanity in services
- reducing the medical emphasis in acute care

- commissioning for personal and community needs
- increasing choice and control for people using acute care.

We believe this represents both a lasting vision and an immediate call to action. During 2012 we will be mobilising support and working with the sector to bring these recommendations about.

## Acute and crisis services: a glossary

**Acute wards** – reserved for those who are most unwell, many of whom are detained under the Mental Health Act. Admission is determined by crisis resolution and home treatment teams (CRHTs) and is influenced by safety considerations, bed availability and what social support the person has. Wards may be locked, even though not all patients are detained. People who are deemed to need closer supervision for their own or others' safety may be admitted to a psychiatric intensive care unit (PICU).

**Advance statements or advance directives** – these are documents drawn up by individuals when well to express their wishes about future care and medical treatment, when they may be unable to express those wishes themselves. They may include **advance decisions** which are legally binding refusals of treatment. An advance decision does not normally have to be written down.

**Crisis houses** – smaller and less medical than a ward, these may be provided within the NHS or the voluntary sector. There is no single model, and they vary as to how they are accessed and how they are staffed.

**Crisis resolution and home treatment teams (CRHTs)** – the role of these specialist NHS teams is to respond to major mental health crisis

and provide intensive support at home to people who would otherwise be admitted to hospital. They carry out assessments and decide whether people can be treated at home or in another community setting or if they should be admitted to hospital. They can also support people when they are discharged from hospital. These teams are part of the secondary services and people have to be referred by the GP or another health care professional, unless they are already using specialist mental health services.

**Detained or sectioned under the Mental Health Act** – the Mental Health Act 1983 provides for people with a mental disorder to be detained in hospital for assessment or treatment in the interests of their own health or safety, or with a view to the protection of others. It also provides for people to be discharged on to a community treatment order.

**Emergency departments (A&E)** – used by people who have harmed themselves and need urgent physical healthcare, and others who have immediate mental health needs. People who have barriers to other healthcare, such as homeless people and vulnerable migrants are more likely to go to emergency departments. Many, but not all, emergency departments have psychiatric liaison services to assess mental health needs, provide short-term treatment and support and link people into longer-term care if needed.

**Forensic mental health services** – these are specialist, secure services that work with people in the criminal justice system.

**Other community services** – from the Samaritans listening service to respite care, there is a range of support that people can access themselves or which crisis resolution and home treatment teams or other health professionals can mobilise on their behalf.

## Acute care in numbers

### England

- Over 1.25 million people used NHS specialist mental health services in 2009–10, an increase of 4% on the previous year which continues a rising trend (Health and Social Care Information Centre, 2011b).
- 107,765 people spent time as an inpatient in 2009/10, which was 8.5% of all those using specialist mental health services and the first increase since 2003/04 (Health and Social Care Information Centre, 2011b).
- There were 16,647 people detained in hospital at 31 March 2011, an increase of 0.2% on the previous year (Health and Social Care Information Centre, 2011a).
- 39.4% of those who spent time in hospital in 2009/10 were detained under the Mental Health Act – an increase of 7.6% on the previous year (Health and Social Care Information Centre, 2011b).
- 66% of black people who spent time in hospital in 2009/10 were detained compared with 54% the previous year (Health and Social Care Information Centre, 2011b).
- Total investment in adult mental health services in 2009/10 was £5.3 billion, an increase of 5.3% on the previous year, of which £253m was spent on crisis resolution and home treatment, and £585m on acute wards (Department of Health, 2010).
- £244 million is the annual amount of national gross savings that could be made by 2014/15 by improving the acute care pathway and reducing inpatient bed usage in areas where it is high (Department of Health, 2011).

### Wales

- There were 1,820 mental health inpatients in Wales at 31 March 2010 (Welsh Government, 2010).
- There were 596 people detained in hospital at 31 March 2010 (33% of patients) compared with 468 (22%) in 2000 (Welsh Government, 2010).
- 38% of refugees living in Wales said that their mental health had deteriorated since coming to the UK (Crawley and Crimes, 2009).

# Crisis and acute needs

## What is a crisis?

“...the mind is at melting point and everything is frightening, even the affected person’s loved ones.”

“...I get very paranoid, and think of myself as a horrid burden to my family.”

Crisis is different for different people: a person may be highly agitated, in despair, experiencing suicidal impulses or the need to self-harm, immobilised by depression, or frightened within the changed reality of psychosis.

Mental health crisis means that a person is in a mental or emotional state where they need urgent help. Mental health crises may take the following forms:

- suicidal behaviour or intention
- panic attacks/extreme anxiety
- psychotic episodes (loss of sense of reality, hallucinations, hearing voices)
- other behaviour that seems out of control or irrational and that is likely to endanger the self or others (Mind, 2010).

“People describe being in crisis as an overwhelming experience; something that is more than the person can deal with and not one’s normality. It can mean having nowhere to turn or having exhausted all one’s coping strategies.”

Leeds Survivor Led Crisis Service website

Crisis is often where people start in the mental health system. Their problems may have arisen very suddenly or they may not have sought or received more timely help for an emerging problem. Not all acute treatment needs are crisis situations and our inquiry covered the full range of acute care. However, we had a particular interest in what happens in those initial stages of crisis because of its impact on how people progress and recover, and their willingness to seek help in the future should they need to do so.

## What do people need in crisis?

In our call for evidence we asked what people need in a mental health crisis.

“Safety – caring and compassionate staff with the correct skills and expertise. A safe environment that is of a high standard of comfort, privacy and access to personal space – be it in one’s own home, family home or residential facility. Guidance and engagement in determining the level and sort of help/treatment provided. Support for friends/carers/family as appropriate. Regard for any previously completed plans/preferences/advance directives.”

NHS manager

“The support I need to ward off a full-blown crisis is fairly simple and straightforward and definitely cheaper than hospitalisation. I need emotional space to talk to someone outside of my everyday life about what is going on for me... I can identify what does help, but at times of crisis lose sight of these things and literally just need someone to be calm, available to connect to and to remind me of these strategies.”

There were common, interconnected themes across many responses.

## Attitudes and values

“Reassurance; stability; understanding; response which is simple, kind, calm, human, non-judgmental; sufficient expertise.”

Many of the comments about what is needed in a mental health crisis focused on the nature and quality of the human interaction involved. These included:

- respect, and being taken seriously
- a warm, caring, compassionate response
- understanding.

The stories we heard show that these attitudes can be lifesaving and provide a basis for

recovery. People who talked to us spelled out the importance of caring, respect for the person's own knowledge of their needs, and the emotional component of care.

## Someone to talk to, and time to talk

“While I was still in distress when I left, I think they [Samaritans drop-in] saved my life that night simply by the virtue of knowing that I wasn't going to be rejected or disregarded, but that someone would listen and was available.”

Having someone to talk to was fundamental. People wanted time to talk and “someone who is able to tell when I can't get the words out”.

## Safety

“To get myself into hospital so I would be safe from what the voices told me to do – for example, jump out first-storey windows.”

“I needed a safe place – somewhere where I could not seriously harm myself until I recovered emotionally. I also needed to feel that someone actually cared about me so that I would not leave hospital in the state of mind where I still wanted to harm myself because I felt that no one cared about me.”

Different people described different kinds of safety. It was often about a place to go, for example when at risk of hurting themselves or of other risky behaviour during a manic phase. For some people this meant a hospital, while for others it was definitely not.

Feeling and being safe whatever the environment was important – at both an emotional and physical level – and help to work out what was needed so as to feel safe. Sometimes it was about having someone with you – both “sanctuary and company”. Some people wanted to be safe from compulsory or forced treatment. Others placed great importance on being able to trust that care would be there for them when needed – a safety net.

## Case study

Hannah, an ex-RAF worker, has been admitted to hospital more than 20 times since she experienced her first episode of bipolar disorder 15 years ago.

“Personally, I need admission as my manic highs need urgent dealing with. Home Treatment is not an option for me as I stay up all night and [home treatment] intervention happens during the day. I need a place of safety and respite from my highs.”

Hannah's first admission on a mixed sex ward was “a horrific experience,” however, she has seen real improvements in standards of care. Recently, she has been treated in a small local unit:

“The unit only has seven beds, however has two members of staff on duty. The staff have been great – they're always available to speak to, arrange discussion groups and activities daily and instil a positive atmosphere.”

But NHS reorganisation means the unit has closed and her community psychiatric nurse has been taken away.

“There is now nowhere for people like me to go. There is a night-time phonenumber run by the locked ward, but frequently there is no one to answer it. Equally, if you don't need a locked ward, but do need night support, there is nowhere to turn.

“People in crisis need fast access to services. However, as budgets are cut and staff become stretched, service users are left to fend for themselves and many people just do not get access to their support.”

A safety concern that was raised by staff in particular was access to information about the person in crisis, so that staff could respond to them safely and appropriately.

## Access to a timely, effective response

“To know there was help readily available without having to jump through hoops. People in crisis do not have the capacity to make appointments, phone calls, take long journeys or communicate what they need.”

Counsellor and friend/relative

People wanted 24/7 services that respond quickly and are effective in helping prevent further deterioration or escalation of the crisis. The help needed to be adequate to the situation, whether that meant staff being physically present (rather than on the phone), recognition of how serious the situation was, sufficiently knowledgeable or experienced staff, or continuity and consistency of care.

Some people said they wanted other people with personal experience of mental health crisis to be involved in their care. Gaining access to crisis help – or preferably help before reaching crisis point – was a very strong theme and this included different options to meet different needs.

## A place to go

“Somewhere to go and sit, and blurt out your mind, that you can leave afterwards. Somewhere away from home and family, and somewhere you can get to at any hour if you don't own a car.”

Whether for safety, respite or for other reasons, a lot of people wanted a place to go. Being supported to stay at home throughout the crisis

was not always the desired option. Sometimes people needed to get away from their home situation or did not have the support of friends or family nearby. ‘Calm’ was often what people were looking for from this place.

## Families, friends and communities

People wanted support for families and friends and for their knowledge and needs to be considered. They did not want to have to go far away from friends and family. People also wanted to know what help was available; this suggests a need for community-wide information about mental health and acute care.

## Choice and control

Some people emphasised wanting someone else to take control in crisis, while others focused on ways to maintain some control over what happened to them. People wanted their wishes about how they were treated to be respected; for example, through advance directives, agreed care plans, or the involvement of a trusted family member or friend. People wanted to be listened to and to be able to access the kind of help they knew they needed at the point when they asked for it.

People talked about particular types of services, professionals and therapies as well. However, the characteristics described above allow us to see what it is that makes an acute service helpful or not. They are very human needs that people described to us – about being treated with respect and humanity and provided with a decent level of service.

The following section looks at what we learned about acute care and how far services are providing these.

# How does reality match up?

“Access at a time of your choosing to a service you can trust is hard to find.”

## Policy and research context

### Crisis resolution and home treatment

Acute mental health needs have been traditionally managed by acute inpatient wards. In the late 1980s home-based crisis resolution and home treatment was pioneered with good results both in terms of clinical outcomes and service user and carer preference. The aim was to provide care in the least restrictive environment and work with the person in the context of their life, enabling them where possible to maintain their family and community connections and avoid the dislocation and sometimes trauma of hospital admission. From a resource point of view it enabled more cost-effective care, reducing hospital admissions and length of stay.

Developed in line with national policy in both England and Wales, these teams have been set up as a standard part of the system of care, and a key part of their role is to gatekeep access to inpatient care. This gatekeeping is part of what mental health trusts are assessed on. However, although the Government's *No health without mental health* strategy for England advocates comprehensive use of crisis resolution and home treatment services to improve the acute care pathway, the end of central policy direction in England means that it is open to commissioners and trusts to organise these and other acute services as they choose.

A review of research into service user satisfaction with crisis resolution and home treatment (CRHT) teams (Winness et al., 2010) found that easy access and rapid response were rated as positive qualities, in particular 24/7 availability, opportunities for telephone contact and flexible referral procedures. Simply knowing that a team could be easily accessed made some people feel safer.

Dealing with crises in the context of the person's everyday life could help to normalise crises and strengthen people's coping strategies. People were able to return to their day-to-day activities more quickly. Although satisfaction was significantly higher for CRHT teams than inpatient services, there were still huge gaps connected with discontinuity in services, short follow-up care, staff shortages, long waiting times for care and a lack of information on an individual's mental health condition and/or medication.

### Inpatient services

Acute inpatient care is now reserved for those who are most vulnerable and seriously ill and who would not benefit from alternative treatment at home. It aims to keep service users safe, assess and treat their mental health problems and also tries to resolve other life problems that people may have (Bowers et al., 2005). Bed availability plays a large role in the decision to admit, as do the social support and other services available to the prospective patient (Bowers et al., 2009).

The number of inpatient beds is decreasing and, worryingly, an increasing number and proportion of people in hospital are detained under the Mental Health Act. Overall this is 39 per cent of inpatients, but in some hospitals (particularly those in urban areas) it can be very much higher at 80 to 90 per cent. “This suggests that NHS psychiatric hospitals are increasingly used to care for and contain people who are seriously mentally ill and who are considered to pose a risk to themselves or others.” (Health and Social Care Information Centre, 2011b). Inpatient environments are increasingly custodial and most acute wards are locked (Care Quality Commission, 2010).

The Count Me In census, carried out annually over the five years of the Delivering Race Equality programme, has continued to show disproportionately high rates of admission for black and minority ethnic (BME) groups, especially in forensic services and compulsory

treatment/admission, and with particular over-representation of people of African origin and mixed heritage (Care Quality Commission, 2011).

This disproportionality is also evident in the use of compulsory treatment in the community. The most recent *Mental Health Bulletin* showed that while the number of black and black British people using specialist mental health services had stopped increasing; there had been a decrease in voluntary admissions and an increase in compulsory admissions. There was also a continuing steady increase in Asian and Asian British people using services. Increase in the use of services was most marked for the mixed heritage group (Health and Social Care Information Centre, 2011b).

The official review of the Delivering Race Equality programme, which ended in 2010, reports similar levels of satisfaction between white and BME community service users, but does not present data for inpatients and states that “some of the evidence from the Community Engagement reports shows that patients from some BME communities do fear services – particularly those with experience of mental health services.” (NMHDU, 2010)

Mixed sex wards are a long-standing concern, and all NHS organisations are now required to eliminate mixed sex accommodation except where it is in the overall best interests of the patient or reflects their personal choice. This means that men and women should not have to share sleeping accommodation or toilet and bathroom facilities. In mental health units, female patients should have access to day spaces that are for women only.

Irrespective of where patients are, staff should always take the utmost care to respect their privacy and dignity. In addition, patients should not need to pass through opposite-sex areas to access their own facilities. Trusts are required to report breaches of this policy and may be penalised.

Problems with inpatient environments – often overcrowded, noisy, unsafe and with limited

therapeutic input – have been identified over the last 10 years or more (Department of Health, 2002; Care Quality Commission, 2009) and addressed by a number of initiatives and approaches.

These include:

- Refocusing – a project management approach to making positive changes in working practice that benefit staff (its starting point is the job strain created in acute units) and patients (Dodds and Bowles, 2001; Bowles and Dodds, 2001).
- Productive Ward: Releasing Time to Care – an NHS initiative across all kinds of wards whereby staff improve ward processes to allow for more time for direct patient care.
- Star Wards – an initiative to inspire and encourage best practice in mental health wards, mainly through activity, creativity and interactions that improve inpatient experience and outcomes. Some 550 wards are signed up.
- Acute Care Programme – the National Mental Health Development Unit in England (closed March 2011) and its predecessor body, ran a programme promoting best practice. Its web resource, Virtual Ward, is now hosted by the Royal College of Nursing.
- AIMS (Accreditation of Inpatient Mental Health Services) – an accreditation scheme run by the Royal College of Psychiatrists whereby wards are reviewed against a set of detailed national standards. In 2010 a set of recommendations for improving services for BME patients was developed to inform these standards (Royal College of Psychiatrists, 2010).

However, the outgoing president of the Royal College of Psychiatrists, Dinesh Bhugra, was still able to tell the *Guardian* in 2011 that, “widespread failures in inpatient care for mentally ill people meant many hospital wards did not meet acceptable standards and discharged back into society sick people who

remained a risk to themselves and others” (Hill, 2011). He attributed this at least in part to the shortage of psychiatrists. The College produced a list of 10 standards for how to judge a ward (Royal College of Psychiatrists, 2011).

## Emergency departments (A&E)

Only 40 per cent of general hospitals have a psychiatric liaison service. This is a very significant gap in provision as many people in general hospital care have mental health needs – including people who go to emergency departments in crisis. These teams provide assessment, short-term treatment and support, and link people into longer-term care when needed. The Psychiatric Liaison Accreditation Network (Dupin et al., 2011) helps services share good practice, recognises achievement, and identifies areas for improvement.

## Crisis houses and other ‘alternatives’

Crisis houses have often been set up in direct response to demand from mental health service users as a preferred alternative to hospital treatment (Faulkner, 2002). However, non-hospital crisis services do not necessarily have to be residential (see p.30).

A series of research articles published in a *British Journal of Psychiatry* supplement showed greater service user satisfaction in residential ‘alternatives’ than with inpatient care. Service user experiences of alternative, non-hospital services appeared to be more positive overall, with reports of this type of care offering minimal coercion, maximum freedom and autonomy, safety and opportunities for peer support (Gilbert et al., 2010). Service users also reported less anger and aggression in alternative services (Osborn et al., 2010). There is no significant difference in costs (Howard et al., 2010).

## Quality and efficiency

The NHS is currently making efficiency savings. The Quality, Innovation, Productivity and Prevention (QIPP) programme includes work on the acute care pathway.

Audit Commission evidence (cited in Naylor and Bell, 2010) suggests wide variations between trusts in their use of inpatient services, after adjusting for population characteristics:

- a 20-fold variation in total bed days
- a six-fold variation in admission rates
- a 15-fold variation in average length of stay.

The Kings Fund and Centre for Mental Health recommend that unnecessary or over-long stays are reduced by:

- strengthening crisis resolution and home treatment
- integrating acute care teams
- developing alternatives to admission, such as crisis houses
- targeting groups at high risk of being in hospital unnecessarily or too long, such as some minority ethnic groups and some people with personality disorders (Naylor and Bell, 2010).

The Government considers that improvements to the acute care pathway that reduce bed use could yield national gross savings of £244 million a year in England by 2014/15 (Department of Health, 2011).

## National strategies

NHS reform in England and the mental health strategies in England and Wales set the context for making service improvements. The strategy in England, *No health without mental health* (Department of Health, 2010), is based on delivering outcomes that include recovery, a positive experience of care and support, and a reduction in avoidable harm.

The Welsh Government has committed to a new mental health strategy and is working collaboratively to develop it. The new Mental Health (Wales) Measure should impact on the experience of acute care. Its provisions include access to advocacy for everyone in mental health hospitals and direct access to secondary mental health services for those who have used them previously.

With this background in mind, we listened to what people had to tell us about their experience of acute and crisis care, what they were doing as providers and professionals, and how care could be improved.

## What people told us about using and providing acute and crisis care

Across the whole spectrum of care we found that there was good practice in individual services and some excellent experiences of care. However, the overwhelming weight of comments suggested that this was not the general experience. It is possible that people were more likely to contact us about bad experiences than good ones, but a worrying number of people had nothing good to say about acute care.

*“It feels like I literally have to have one foot off the bridge before I can access services.”*

Access was a key issue and people talked about being “batted away” or “deflected”. While some people wanted to get into hospital but could not, others were desperate to stay out. Many people criticised crisis resolution and home treatment services. There were people who had had traumatic experiences of hospital. We also heard from people with a loved one who had taken their own life while in, or trying to access, the care of mental health services.

What people wanted was better access to care, more say in their treatment, more time with staff, better information about what was available, better access to psychological therapies, and better information and support for friends and family members. While there were some very good experiences of staff care, negative staff attitudes were a very big issue for many people who gave evidence.

## Services

This section looks first at the evidence about different types of services and then some underpinning issues.

### Crisis resolution and home treatment teams

*“Support the crisis teams – if they are in crisis themselves they can’t help us!”*

*“I went to the GP in a very bad state – I was impressed how quickly I was seen by the mental health crisis team. They kept seeing me three times a day at home and left it as long as they could till I needed to be taken into the [inpatient unit]. The crisis team were friendly and caring.”*

*“The crisis intervention team when working properly can be fantastic, but in the majority of areas it is grossly underfunded and not just ineffective, but dangerous.”*

While there were some very positive experiences of CRHTs, there were also major frustrations and problems to do with the capacity of teams, their responsiveness, the effectiveness of their help and their role in gatekeeping acute hospital admissions. To some extent problems were attributed to under-staffing, but the threshold at which they accept people into their own or hospital care is another critical factor.

## Making contact

A frequent concern was difficulty getting through to someone on the telephone or having a long wait for a call back after leaving a message, or a long wait for someone to come out. Some people commented that the person they spoke to was unhelpful, and one recommended that calls should be recorded so that if people needed to complain it would not be the word of the patient against the professional. This person also pointed out that there are specific skills and qualifications in providing personal support by telephone and questioned whether crisis team staff had these.

Some people were not able to use the telephone and wanted other contact options, such as text lines. People also talked about different barriers that might stop them making a call:

- It is hard to express yourself in crisis.
- It is harder to express yourself if you are calling out of hours and are aware that there may be another caller in crisis waiting.
- There is a risk that you might get through to someone you find unhelpful.
- It can be hard to wait for a call back especially if you fear it will be an unhelpful response.
- There is a risk that you feel rejected by the outcome of the call.

Numerous people cited the advice to have a bath, hot drink or go for a walk as being completely inadequate to the situation of someone who has come to the end of their resources. In particular, those who are experienced in self-management will have exhausted any such strategies. These pieces of advice may be experienced as rejection – replacing the visit or other direct help that the person wants or needs. The absence of direct help and feelings of rejection are both a risk to people who may be on the verge of self-harm. In some cases the advice itself may be risky – such as going for a walk in the middle of the night.

It is very worrying that people can have such difficulties obtaining help and experience a service that is there to help as a source of potential harm.

## Case study

Ryan has used exemplary mental health services in Brighton since developing bipolar disorder at 16, with effective hospital care and a crisis team who understood the fluctuations in his mental health.

“The team really responded to little changes in my mental health, and prevented things from getting worse. If it all got too much, I went to the local hospital, which was seamless. The staff were professional and took an interest – they really knew what they were doing. It was a place where I could get genuine help which put my family and friends’ minds at rest.”

However, Ryan recently moved to a different NHS Trust, where the lack of support meant he deteriorated to crisis point and lost his job.

“I was used to having crisis services, and here there is nothing. I was on the road to recovery, and then I just got left.

“My previously well balanced medication stopped being monitored, the crisis team keep losing my details and send me letters with blank gaps in. Inevitably I had a breakdown which the crisis team missed and that culminated in a major suicide attempt. Even after that, I received no support.

“I’ve tried the crisis helpline but they are always engaged. Only once did someone answer, but it was equivalent to talking to somebody flicking through a magazine. I’ve turned up at A&E and been sent home, and no crisis team ever came out.

“My GP is tearing his hair out because he can’t get me the crisis network we both agree I need to live my life.”

## Thresholds and the role of CRHTs

We heard from someone who had helped develop CRHTs that teams needed to gatekeep hospital admissions (and be 24/7) to be successful. It was not only about reducing admissions, but ensuring an equitable service for people who need intensive help. However, some people who responded to our call for evidence who wanted to go into hospital, or to go in sooner than they did, saw the CRHTs as an obstruction. People commented on the high thresholds for access to hospital and the CRHTs' own services.

The NHS Confederation told us about an interesting flexibility in the way the Bristol CRHT controlled admissions for some people. Their custom-built crisis management plans (see p.21) were developed with a group of people who had used the CRHT and acute wards the most. These personalised plans allowed for a lower threshold for admission to hospital where it was felt to be necessary.

Crisis staff themselves told us about the strain on the service caused by having to assess increasing numbers of people. One urban team had 1,000 referrals a year when they started a few years ago and now have 1,500 to 1,600. They do not take on any more people than before, but having so many assessments makes it difficult for them to deliver on their promise of home treatment to those they do take on. It seems as though there is either a problem with the capacity and resourcing of teams (although that particular team was well resourced) or with the expectations placed on them.

Are people being referred to CRHTs when they should be offered help elsewhere? And if so, where should they receive support? We were told that teams have been filling gaps (for example, in primary care and emergency departments), and that not everyone who is having suicidal thoughts needs to be referred to a CRHT. Other teams and clinicians should be able to respond; for example, by offering more intensive support for a time. There are

crisis support services in the voluntary sector as well.

A key element in a new London-wide approach to commissioning for people in mental health crisis is about commissioning a range of services for people who do not need an immediate medical/psychiatric response, and making available information about them. This would provide a “systematic, co-ordinated response to crises, which is not currently widely available and encompasses the wider network of crisis support available” (London Health Programmes, 2011).

We think that this is a good approach and that there need to be more gateways into care. Expanding the range of options for people in crisis has to be part of the solution. Although we were still troubled about the lack of voice for the person in crisis trying to secure help.

## Continuity and consistency

Another major complaint is the number of people and assessments that could be involved in crisis resolution. To some extent the problem of not seeing the same people is inherent in 24/7 services, but we heard of different ways to mitigate this, such as providing the individual with information about the team. Consistency of approach could be improved through team-working and making sure that information about the person in crisis is passed among staff.

People working in services stressed the importance of information-sharing and access to records out of hours: “I have recently had someone turned away from crisis intervention in the middle of the night because the doc decided she was drunk, when in fact she was hypomanic. She ended up being admitted hours later in a very traumatic way.”

Multiple assessments are particularly hard on a person in crisis who has to keep demonstrating their need for help. They can also waste time. Some crisis staff felt there were times when they were effectively rubber-stamping other people's assessments. We are aware that some

trusts are working on this. However services are organised, the systems need to be built around the person they are there to help.

### Rural areas

The CRHT model was developed in cities and there are very different challenges and needs in rural areas. A city usually has a greater need

(for example, one team reported 12 to 14 referrals in a two-hour period) but the distances involved in rural areas can mean that one home visit takes three to four hours out of the staff member's day. Where city teams can visit the same person two or three times in a day, rural teams can only visit once – staff told us this was unfair to service users. One approach was to

## Examples of crisis resolution and home treatment teams

### Dorset Healthcare University NHS Foundation Trust

The CRHT uses an award-winning zoning policy which enables staff to communicate quickly with each other about each service user's overall need for care, to ensure their safety. This allows staff to make fast and accurate decisions in response to changing clinical circumstances and to avoid unwanted hospital admissions.

### Avon and Wiltshire Mental Health Partnership NHS Trust

Bristol's CRHT identified the 20 people who had used their service and/or acute wards most in the previous year. Working with a service user development worker and a range of other staff, it reviewed whether existing services were effective for them. In the first instance the group were mostly women diagnosed with borderline personality disorder.

Personalised crisis management plans were developed by the care co-ordinator, service user and carer, based on an analysis of the problems leading to crisis and solutions to them. Where it was agreed to be beneficial, a short admission followed by facilitated early discharge home was noted in the plan even though this might be at a lower threshold for

admission than teams were used to. Some service users agreed to relatives overriding their views when in a crisis. Though negotiated and agreed with the service user, the plans were largely written for staff – explaining what to do and what not to do, with a brief description of the person's usual level of functioning.

Service users have responded very positively to the approach. And there has been less demand for hospital admission since it was made an option at an earlier point.

### Cheshire and Wirral Partnership NHS Foundation Trust

The CRHT in Wirral prioritises attendance at all community multidisciplinary team meetings which ensure effective and good network communication. At the acute care (CRHT and inpatient) meeting, all potential early discharges are identified enabling the team to free up beds on a regular basis. The clinical leadership spans both inpatient and crisis teams, which means there is a real alternative to admission. Acute care consultants spend more time with service users in their homes, and support staff provide both practical and emotional support to service users and carers.

Source: Mental Health Network of the NHS Confederation

have a main base and a satellite that staff work from for part of the week. Alternatively, rather than setting up a new service, nurses in the community team could work flexibly, providing support over a weekend if need be and taking back the time.

We believe there needs to be the flexibility to develop models that work in context for the communities' needs. For example, Gwynedd's advocacy service has employed more staff on fewer hours and they work as a dispersed team over a large area. This is another model that could be considered for working with people in mental health crisis.

### Inpatient wards

Numerous people referred to good hospital care. Where they elaborated, they talked about the qualities of staff, for instance "supportive, kind, gentle, tenacious" and "fantastic, non-judgmental, easy to talk to" and being treated with respect. Other things that were good were having enough staff, smaller wards, private rooms, single sex wards, occupational therapy, good food, and efforts to make the ward homely and relaxing.

However, the majority of comments about hospitals were negative, some very much so, with several people saying in the strongest terms that they would not go back.

"Quality of life on the ward was terrible, it was a violent place to be. I was repeatedly hit and had things stolen but most of the nurses did not care. The hospital was filthy and the staff stressed and over-worked, access to different therapies was non-existent. They moved my bed eight times in four weeks! Mostly without my knowledge till I tried to find my bed and belongings."

### Structure and organised activity

"On the ward, my care was a knock on the door at 10am to go and get my meds, and a knock every few days to see the psychiatrist.

I had no one-to-one conversations with any nurses or support workers except one when I spent a day on eyesight obs.\* I felt extremely safe on the ward, and benefited from speaking to others with mental health problems. I got more 'therapy' from them than I did any of the staff."

"All staff time and resources are spent to stop bad things happening but not make good things happen."

Structure and activity were important to people who contacted us, and were a big problem when lacking. People felt that nothing was being done to support them to recover. Some said there was a holding or containing function but that it did not get to the root cause of problems. People wanted access to psychological therapies. Boredom leads to frustration which, when acted out, can get people labelled as violent. Lack of structure also made people with learning disabilities particularly anxious.

One ward we visited in Bassetlaw had responded to people's desire for more activity with a ward-based activities organiser, bringing in outside volunteers and instructors with such specialist areas as relaxation, arts and crafts, thinking skills, complementary therapies and tai chi. The ward has groups on recovery, staying well and personal development. It provides group information and support sessions about medication and diagnosis, there is a ward community meeting and Mind volunteers facilitate a social group.

The Star Wards initiative promotes practical ideas for inpatient wards and disseminates and celebrates member wards' best practice. The experience of a mental health NHS trust which integrated Star Wards and the Productive Ward programme shows how the innovations introduced by these initiatives can be embedded as everyday

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\* Special observation is a way of keeping patients safe (for example, when at risk of self-harm) by providing extra care and attention. There are different levels, one of which is where the patient should be kept within sight at all times.

## Case study

Elizabeth was in her first term of ballet school, yet despite fulfilling her dream began to feel depressed. Knowing she wasn't just homesick, she quit college and returned home, where her GP prescribed antidepressants. Elizabeth felt little improvement and, after suffering a major set back, went to a private hospital for intensive support.

"It was brilliant. There were treatments and things to do every day, and in the evenings you were free to plan your own time, and spend time with other patients. The staff were fantastic."

Elizabeth's private care ended, and her depression deepened. Desperate for help and suicidal, she went to A&E.

"I was sent home and told the home treatment team would come round the next day. Nobody turned up. The day after that, still no one came. I couldn't cope with this – I told them I was suicidal, but no help had come. My GP chased it up but even then it was another two days... and then they only came by for 10 minutes."

Weeks later Elizabeth was back in A&E, and this time agreed to be admitted to hospital – which proved rather different to her private care.

"It was disturbing how little was done for the patients. You were left all day and all night to

wander around the ward, unsupervised. There were no staff, nobody to talk to. I thought there would be some treatment, a therapy session, just something – there was nothing. Nobody made an effort to make anyone better."

Elizabeth was kept shut in, refused access to outside space and was so upset by her environment she didn't eat a single hospital meal. After three days, a doctor finally arrived for assessment.

"He said: 'you've got no reason to be depressed. There hasn't been a death in the family'."

Elizabeth was left to 'think' and after a week without treatment or staff contact, was convinced hospital was making her worse. She requested to leave and once back home, the home treatment team visited, again for just 10 minutes. After two visits, they stopped coming.

"I realised that I was going to have to work on my depression myself, without the NHS. After the failed home treatment visits, I got myself a private therapist. I am a student and only work part time, but that's what I needed to do to get myself better."

After her experiences of crisis care in her local area, Elizabeth is adamant she will never seek NHS crisis services again.

"I feel... sort of a little scarred by the whole experience. However bad it gets, I will never, ever take myself to A&E again."

practice (Kemp, 2011). As well as increasing direct therapeutic interactions between nursing staff and patients, wards developed a range of other Star Wards objectives including a ward library, a gardening group, a ward-based internet café, and the running of regular movie nights. During the project the number of recorded incidents such as aggression and absconding declined from an average of 30 to 13 per month.

The Mental Health Network of the NHS Confederation also provided examples of trusts that were improving the quality of experience for people in inpatient services: Birmingham and Solihull Trust was expanding its therapeutic and leisure activities, and there were service user involvement projects in Central and North West London.

### Staff attitudes and engagement with patients

These were very significant issues especially given the importance of having someone to talk to. We were told about the “heaviness” of the atmosphere on some acute wards and a feeling of apathy that affected staff and patients alike. In some cases people commented on staff being over-worked and stressed, and the impact this had on their manner and availability. This lack of availability, whether through busyness or being in the office, was probably the biggest issue. Some said that attention was focused on the loudest or angry patients not the quiet ones. However, there were also references to lack of care and taunting, derogatory comments, even brutality.

A recent report highlighted issues in dynamics between staff and patients, particularly African Caribbean men, on a London ward (Social Action for Health, 2010). The men tended to stay longer on wards and were less included in ward life. The involvement of lay people acting as ‘health guides’ made a big impact, simply through relating to the men in an ordinary way, and taking an interest in their health and wellbeing. We heard from Awetu, a Welsh BME mental health organisation, about how simple some of the everyday things were that were lacking, such as varied meals. Members of the African Caribbean service user group Maat Probe (see p.25) talked about staff mentality needing to change and a lack of respect.

Several of the people we talked to spoke of the big impact of small kindnesses – an encouraging word or celebrating birthdays.

A ward manager told us about the success of their ‘protected time’ initiative and how staff wanted to continue monitoring one-to-ones with patients beyond the benchmarking period because this was something they were proud of. It was good to hear that staff as well as patients valued this one-to-one contact. People we talked with in more depth said that good staff were caring and open; we were told that

*The trick of being ordinary* (Brandon, 1982) was “all you need to read actually”. Boundaries are important, but we think staff can be both professional and themselves in how they relate to the people in their care. Basic human values were becoming central to the story we were hearing.

We were very concerned at the lack of basic humanity and respect that many people described to us and the organisational cultures that could allow the kinds of attitudes and behaviour that we heard about.

### Lack of safety

“Hospital wards are generally terrible – I truly think the two main dangers are having mixed wards (where patients are at a huge risk of violence and sexual assault) and staff being overstretched.”

Lack of safety was understandably one of the most strongly expressed concerns and it was experienced in different ways. There were numerous calls for single sex wards and accounts of violence on wards including:

- sexual abuse and assault in mixed sex environments
- coercive treatment including restraint
- insecurity of belongings
- not feeling safe to complain.

We were particularly inspired by Maat Probe Group’s approach to influencing practice and by Recovery Innovations, which showed how practice can improve when the decision is made to start from a position of respect. Another technique that one panel member had found helpful for de-escalating situations and reducing everyone’s anxiety was to offer the person a phone call before using physical restraint. We believe that the use of control and restraint needs urgent reappraisal and that the use of face-down restraint should be ended. Ultimately we would like to see the end of restraint and seclusion, which is another form of coercion.

We think that making the commitment to work towards eliminating restraint and seclusion is a good first step, and that respect-based training is a key part of getting there.

#### Other aspects of quality of life on wards

People commented on other aspects of the quality of life on wards that hinder recovery; for example, the lack of peace, with banging doors and clanging keys, and overcrowding that raises tensions. Some spoke of a lack of cleanliness,

not having access to any outside space and unhealthy food. One person described the quality of life on the ward as not being good, despite fantastic surroundings. Another spoke of sleep deprivation from night-time observations. One referred to inadequate communication with the outside world – one phone call a day – and distance from home and family was a problem for many people. The smoking ban was a big issue for some people, with restrictions on smoking creating stress and tensions. In some

## What people told us about control and restraint

We heard about restraint from the Sheffield-based African Caribbean service user Maat Probe Group, several individuals who responded to the call for evidence, the Centre for Mental Health, and the Care Quality Commission.

This is a critical issue in terms of both safety and dignity. It was the inquiry into David (Rocky) Bennett's death from restraint that prompted the last government's Delivering Race Equality programme.

When Maat Probe Group carried out a monitoring exercise in 2009 to investigate black people's experiences of mental health services, they found that 46 per cent of the people they interviewed had been restrained by mental health staff. Of these, 79 per cent felt it was aggressive and 34 per cent were physically injured. People talked about being pinned to the floor, having a knee on the back of the neck, feeling violated, "Go in for recovery... come out injured." As a result, the group's top priority was for an alternative to control and restraint to be used in resolving difficult situations on the ward – methods taught in programmes such as Respect, SCIP or Studio III Training. They have since lobbied successfully for the trust in Sheffield to adopt Respect training.

Members of Maat Probe Group told us about the importance of communication between staff and service users in preventing and dealing with difficult situations – for example, to listen and respond to people's fears about medication. If some form of physical holding was ultimately needed, then it was much safer and humane to be held facing and not face-down. People wanted everyone to be safe, and to feel that staff had service users' best interests at heart. Respect, they said, would be "the best tool they've got".

One individual from another area described what happened when staff were unable to de-escalate a situation and police were called in, "storming the car-park, alarming visitors and patients". Patients were locked in for their safety. The individual who contacted us was a patient on the same ward. They heard staff making accusations to the service user (which did nothing to defuse things) and police mocking the whole situation.

We also heard from a woman about being restrained by male staff, with the risk of triggering further distress, and the experience of being restrained and injured by security staff in A&E.

cases smoking breaks were at prescribed times, making for an institutionalised atmosphere.

The National Service User Network told us about a much-valued, off-ward space in Kent that was available for recreation and meeting ‘outsiders’ including visitors.

### Capacity

A recurrent theme was the number of beds and high occupancy rates, which we were told were not always accurately reflected in statistics. As well as making it harder to access inpatient care, the impact on individuals included overcrowding, being moved from ward to ward or having their belongings put into black bags while on short-term leave.

One psychiatrist told us he had seen about 10 avoidable suicides in recent years due to severely depressed people at risk of suicide being denied hospital admission due to lack of beds and current policies. At the same time we heard that being in hospital was not necessarily safe.

Service reviews may include bed reductions, but we were told that reducing bed numbers only made savings if a whole ward was closed. We consider that the capacity of acute care needs to be addressed at a system-wide level, especially given the impact of increased diversion of people from the criminal justice system.

### Community links

“...wards need to be more permeable so that people can come and go and talk about ordinary things like the football or weather. Put simply, the wards need to open up.”

Bayliss, 2010

Some people talked about the impact of stigma and the unhelpfully negative public view of mental health hospitals. The Sussex Partnership NHS Foundation Trust’s Langley Green hospital (an attractively designed new build) has a café that is open to the public as well as service

users and staff, and local Muslim women used one of its sacred spaces for prayer. They and other providers told us about the relationship-building they did with local communities.

Some of the negative experiences people shared with us made us ask whether organisations with an ethos of service and hospitality would treat people in this way. What difference might it make if people were thought of as being guests as well as being recipients of care? And what was happening in organisations if their culture allowed poor care to go unchallenged?

### Emergency departments (A&E)

“My experiences have been mixed, but the last time I visited, it was after I’d cut myself very badly and I was dealt with by staff who treated me with respect and kindness which made an enormous difference to me. They had a lasting impact.”

“Walking into an A&E department and asking to speak to the duty on-call psychiatrist or community psychiatric nurse and then having to wait in a crowded noisy waiting room for hours is enough to push me over the edge.”

There were mixed experiences of emergency departments. Some people were treated very well and there were very positive comments about some psychiatric liaison staff. It was helpful simply to know that it was possible to turn up and speak to them.

However, one hospital was said to “hate mental health patients,” refusing anaesthetic when stitching self-harm wounds. Other people talked about judgmental staff, or lack of knowledge or understanding about mental health – of being told angrily to keep still when shaking with fear and lithium tremor (a side effect of medication). People often felt that the emergency department was the wrong place to be in a mental health crisis, especially because of long waits often in a busy area.

There was also uncertainty about the role of emergency departments. One person described going there one weekend when she was desperate and suicidal and her other options were unavailable, unhelpful or unacceptable. She received “fantastic” support and care from the receptionist, nurses and security guard.

“I know I shouldn’t have gone to A&E, but I felt there was no alternative. ...I wish there was somewhere to go where there isn’t the fear of being judged, and that it’s acceptable to be there... Or if it’s okay to go to the A&E department for there to be more awareness about this and for the standard of care I received to be rolled out in other A&E departments across the country.”

Only 40 per cent of general hospitals have psychiatric liaison services, which assess mental health needs, provide short-term treatment and support, and link people into longer term care if needed. Several people responding to our call for evidence wanted liaison services in every emergency department. Where they exist they seem to be highly valued by service users and general hospital staff but to have very limited resources (Dupin et al., 2011). For example, one service was working out of a Portakabin, and another’s emergency department had a separate suite for people with emergency mental health needs to wait, but not enough staff to make it safe to run. Loss of social work staff through local authority cuts would limit the scope of the help they could offer.

Some people described problems where cover was provided by crisis teams instead of liaison services. We were told that CRHT clients generally have different needs from those going to emergency departments and so a distinct service is more helpful, especially as crisis team nurses might have to drop other visits to see someone who might be in less need.

Some people we spoke to also questioned whether the crisis team should have to assess someone referred by the liaison team for them to access a bed – as well as being distressing

for the person concerned, for the crisis team it could effectively mean rubber-stamping other people’s assessments.

We were shocked by some of the worst experiences we heard about, which suggest that some very negative attitudes towards people with mental health problems persist in parts of the emergency service. Some areas are clearly able to provide a respectful, helpful service and psychiatric liaison teams play a significant part in this.

However, even with good teams, the environment and overall demands of emergency departments can make it hard to provide appropriate care. One liaison service wanted to be able to create an appropriate space and have time for people to settle and reframe their problems, where the team could mobilise support for them.

While some people need to attend because of physical injuries, others may go to the emergency department because it is the only option available to them. If there were other out-of-hours walk-in options available, would these better meet the needs of some people in mental health crisis?

### Crisis houses and other ‘alternatives’

“One of the world’s great mysteries is why we don’t have more [crisis houses].”

“[I] like the idea of a safe space where things can be talked about – this makes sense to me and I feel it would be more beneficial to me [than hospital].”

There were many positive comments about crisis houses – from those who had used them, those who wished there was one in their area, and those who had not heard of them but thought they sounded like a good idea. They can “give the breath of fresh air a person may need”.

Some people commented that their area did not have a crisis house despite pressure from service users and there were one or two references to provision having been closed.

## Host families

One of our witnesses with lived experience of crisis suggested that individual families and households in the community might take a person into their home from time to time and build up a relationship with them. She saw it as helping neighbours and the community understand mental health problems as part of life as well as enabling the individual to have respite and care while remaining in the context of their everyday life.

We then heard from Hertfordshire Partnership NHS Foundation Trust which was developing a host family scheme and recruiting their first family. Its initiative was inspired by services elsewhere in the world including Lille in France. The service in Lille aims to prevent crisis and hospital admission and is founded on the recognition of the importance of relationships for recovery. There are about 10 families involved and people stay for 17 to 21 days. The host family provides a place to develop, unload when times are hard and see how others cope with problems. What people say they have gained from it include being part of a “balanced” family; being seen as a “real person”; being part of everyday life – its pleasures and chores; and “to forget that I am ill”. (Hertfordshire Partnership NHS FT, 2011)

Hertfordshire Partnership NHS Foundation Trust described its new scheme:

“The host family scheme in Hertfordshire aims to provide an alternative to hospital for people who are going through a period of mental ill health. The hosts will provide a caring, family environment which focuses on

home, family and the community. A host family will not be required to provide professional support; this will be provided by professional staff from the Trust’s Crisis Assessment and Treatment teams who will initially visit daily and respond when requested by the host family.

Hosting is envisaged to last between three and 12 weeks at a time. Guests will be encouraged to participate in family routine and will be fully involved in the daily running of the household. Guests will be encouraged to look after themselves and maintain a sense of personal responsibility.

Host families will not suit everyone’s needs and matching hosts and guests is an important part of getting this innovation right. We do not envisage having a large number of families on the scheme (in Lille the scheme has been running over three years and they have 10 families) but the evidence we have seen is that for some people this provides a real alternative to a hospital admission and a real chance of speeding, facilitating and maintaining recovery.

Remuneration will be paid while a family has a guest and a small retainer will be paid when the family is available but not currently allocated a guest. This is considerably less than the cost of an inpatient stay, for which the reference cost is just over £2,000 per week and the evidence from overseas is that service users both prefer the experience of being hosted to an acute inpatient stay and gain greater benefit from it.”

There is no single model for a crisis house and in some cases the service might be described as a safe haven or sanctuary. Some are fully within the NHS, others run by voluntary organisations with or without funding from the statutory sector. The only crisis house in Wales is run by the voluntary organisation, Gofal, and access is controlled by the crisis resolution and home treatment team. A service may be peer led or have various mixes of mental health support and professional staff. Some may allow the person to have their child or children with them. Some are specific to a particular group; for example, women- or, less commonly, men-only services.

People liked the fact that crisis houses were smaller, calmer and more personal than an inpatient unit. And they valued having someone to talk to, and peer support as well as self-referral options where available. For one of our witnesses, being in a crisis house meant she could still go to work, visit the friend who supports her, go to the shops, the gym – keep up the routines that are important to her and stop her mental health deteriorating. For a person who lives on her own, it also meant she was safe and this was reassuring to her friend. Another person said it was good that she had been able to have her daughter with her in a crisis house and had help to look after her.

Gofal pointed out that the higher staff-to-patient ratio (1:2) and very different social environment in a crisis house creates a different kind of engagement from that on hospital wards where people can become bored and frustrated.

There were very few negative comments about crisis houses. One person was critical of their

service for not taking self-referrals. There were some references to inadequate support or inappropriate use of crisis houses. One person said they had no help from their crisis team once they were referred to the crisis house. Another had mixed feelings because they had been left alone when they needed some social interaction to help them begin to talk things through (while for someone else, being left to their own devices was exactly right). Another person felt there should be more extended emotional support on leaving a crisis house after such intensive help.

These comments provide important pointers for how to improve crisis house provision and they are a reminder that the form of service provision is no guarantee of quality or suitability for the individual. However, it was striking that the idea and reality of crisis houses were regarded so positively.

Crisis houses are not the only possibility for people who need to get away from home in mental health crisis. Crisis support can be provided to people in supported accommodation, staying with a host family (see p.28) or in a hotel. There is scope for 'green' options such as rural community retreats or 'care farms'.

Not everyone needs an overnight stay. Leeds Survivor Led Crisis Service is a highly valued service that provides sanctuary in the evenings until late, in addition to a helpline and group work. A Samaritans drop-in clinic that is open late into the evening was also commended, and within the NHS there are acute day services and resource centres.

## Examples of voluntary sector crisis provision

### Leeds Survivor Led Crisis Service

Leeds Survivor Led Crisis Service was set up 11 years ago by a group of campaigning service users out of complete dissatisfaction with services. The service exists as an alternative to hospitalisation though a lot of people use it as a complement to statutory services. It comprises Dial House, a helpline and groups run by those using the service.

Dial House offers sanctuary during the evenings up to 2am, in a homely environment with one-to-one support to help de-escalate the crisis. They can work with eight to 10 people a night, and are mainly used by people at risk of self-injury and suicide. They are usually able to de-escalate a crisis, but on the rare occasions that a person is not safe to go home (by taxi) when they close, they would refer back to the crisis resolution team.

Staff all have experience of crisis themselves, as well as substantial experience of working with crisis. They work to the therapeutic, person-centred approach and their philosophy is that “each individual has their own experience of crisis. The causes and impact of crisis will be different for each person. We believe that people are expert in knowing their own situations and with the right kind of attention and support can find their own solutions.” Tight confidentiality guidelines also help define them as an alternative to statutory services.

Despite being highly valued by people who use and commission their services, publicly recognised and much visited, this model has not been replicated elsewhere in the country. Funding may be a barrier, but survivor organisations also have to work harder to gain credibility.

“I have called them for support on numerous occasions and it has always helped. Sometimes just 15 minutes is enough to get me through to the next day. Their approach includes compassion, acceptance and unconditional positive regard. They also let you define if you’re in crisis, you don’t have to fit specific definitions or referral criteria.”

### Crisis Point, Manchester

Crisis Point is a crisis intervention centre offering emotional and practical support to individuals who are in a crisis. It is run by Turning Point, a health and social care organisation that provides services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

The service has worked with residents of Manchester for over 13 years and has become integral to crisis provision in the city. Crisis Point offers a rapid response to individuals and is accessible 365 days a year between 8am and midnight. Intensive support is offered over a period of 10 days, with structured one-to-one sessions offered daily and informal time spent with each individual. Initial referrals can be made by anyone. Staff give service users control over their support, helping them to make decisions, be in control and move forward with life. Staff listen to, and learn about what people want from their lives and look to develop an empathic and non-judgemental relationship.

Crisis Point takes a multidisciplinary approach and works with other organisations in the city. Each staff member has an area of responsibility for improving and driving the service and the service user involvement plan includes a service user group that gives

feedback, makes suggestions and helps with open days and awareness events.

## The Maytree Respite Centre, London

Maytree is a four-bed house in a residential street providing befriending and sanctuary to people in suicidal despair. People can refer themselves and stay up to four nights (five days), once only. Paid staff spend one-to-one time with guests while volunteers befriend guests, prepare and share meals and stay overnight. This care from volunteers plays a big part in helping guests feel accepted and valued.

A stay at the house is a very intensive time and can be transformative. Maytree cannot help those under the age of 18, or people who are actively using drugs and/or alcohol and guests need to be open to exploring the issues that have led them to the point of suicide. Maytree is not for everyone, and sometimes the team will decide that a stay is not appropriate. Endings are marked carefully with proper good-byes and a personal good-bye letter from a staff member, and people can be signposted to other help.

“My time at Maytree was the most transformative period I have ever had, in terms of how I manage my depression. I have never experienced such warmth and such effective help – and it’s so simple – just intensive talking therapy (with trained counsellors and with befrienders too) over five days. In a very normalising, ‘home’ type environment (house, own bedroom, big kitchen, free to do what you want).

“I had such a sense of belonging and calm – and perversely enough I developed such a strong sense that I was perfectly ‘normal’ and not some crazy patient. Just a normal person who happened to be experiencing a terrible, terrible crisis, but one that could be talked through. We need more Maytrees. I truly believe that this place saves lives.”

## Stockport Mind

Stockport Mind’s crisis accommodation and home support service provides practical support that is not always part of a crisis service. They offer different levels of support to help people help themselves out of a crisis, including problem solving, crisis resolution, practical and emotional support, housing-related support and alternative accommodation when needed, recovery action planning, recovery-focused peer support, and alternative and complementary interventions.

## Norwich and Central Norfolk Mind’s Omnia project

Provides a residential rehabilitation programme to assist people in their recovery. A six-month stay enables people to develop confidence, identity and new relationships; to have new experiences and engagement with the local community that build resilience to stress and promote citizenship and independence; and to develop and test out of ways to better self-manage health and wellbeing. Following the programme there is a further 12 months’ access to the project’s support including a residential stay if needed.

Crisis houses and other community crisis options are clearly in demand. We consider that they provide the responsiveness, emotional and personalised care that we are looking for and that they expand and improve the mix of available options. Exactly what kinds of service and support are provided should be planned with local communities and with individuals in personalised care planning – there will be different needs and priorities and may be better ideas.

We question whether a ward should be considered the default setting for acute care with everything else an alternative. Other kinds of service should be judged on equal terms as to whether they are meeting people's acute and crisis needs.

In fact we question whether environments for acute and crisis care should look like a medical ward at all. Some of the benefits experienced in crisis houses and related services – such as accommodating employment and childcare needs – could be provided by wards, especially if they were conceived in a less medical way. While people want access to appropriate skills, expertise and therapy, does this need to be in a medical ward? That isn't the kind of environment people generally described as being what they needed. In the light of this we were concerned about the trend in Wales to locate mental health units in general hospitals, especially as it was the same earlier policy in England that led to so many of the clinical, sterile environments that people criticised in our inquiry.

We were interested in the approach taken by the original York Retreat when it opened in 1796 before becoming a more typically medical asylum. It was a pioneer of humane mental health treatment and was based on benevolence, personalised attention and a comfortable living environment encouraging reflection. These are the kinds of values we want to see back at the forefront of services today.

## Underpinning issues

### Equalities

In this inquiry our main equalities focus was on black and minority ethnic communities because of the limited progress there has been on shifting pronounced inequalities in the acute sector of care. The themes raised by BME respondents were similar to those in the response as a whole with an additional emphasis on:

- information about how services work and the help available
- confidentiality and trust
- access to talking therapies in different languages
- communication with staff and availability of interpreters
- culturally appropriate services.

Again there were good experiences among this group but also long waits, especially for talking therapies, lack of diversity among staff, lack of respite facilities, and some serious problems with quality of life on wards. There was criticism of how black men are disproportionately diagnosed with schizophrenia and of the prevalence of community treatment orders among BME groups. The Maat Probe Group told us about negative experiences of treatment on wards (see p.25).

We were told about the extreme needs of people who are destitute, having been refused asylum, and who have acute mental health problems. These were exacerbated by lack of entitlement to secondary mental health services.

Some of our witnesses told us about how they were addressing BME communities' needs. For example, one organisation whose location made it inaccessible to BME groups, was planning to offer a service from a BME partner organisation's premises.

Despite some good initiatives we did not get a strong sense from mental health services overall of a strategic drive to overcome ethnic inequalities.

However, we were very encouraged to hear of 'reverse commissioning', an initiative from the NHS BME Network that is proposed by the network's transitional lead, Dr Vivienne Lyfar-Cissé. This is a commissioning procedure that aims to ensure that BME communities are effectively engaged in the health commissioning process and that ethnic inequalities are reduced. It starts with an analysis of the data held by provider organisations to determine how far BME communities are using existing services. This information is used to ask the communities about their needs, which in turn are fed back to health professionals. This separate engagement of providers and communities and the feedback it generates is then used to bring them together and forge genuine partnerships.

This approach is just being developed so we do not know how effective it is yet, but it is a tool that is entirely consistent with what we are proposing – community consultation and engagement in commissioning, and clear outcomes.

We were not able to focus in depth on other equalities issues, but we heard about women's lack of safety on wards and men's lack of access to respite facilities. We were told that black men stayed longer in hospital. People's physical access needs were not always accommodated and it could be difficult for people with learning disabilities to get an appropriate service. We heard about homophobic abuse and people being assumed to be heterosexual. We were made aware of the barriers to care faced by

## BME communities

### Hertfordshire Partnership NHS Foundation Trust

The Trust had recently undertaken three initiatives:

#### Trailblazers Cultural Awareness programme

BME service users and carers are trained alongside equality workers to deliver awareness-raising sessions to staff within their own services. It was primarily developed for inpatient services and is being rolled out across all community services.

#### Talk About It

A DVD about emotional health and wellbeing in 12 languages including British Sign Language, that shows people sharing their experiences. It was developed in response to research with Asian Women in Watford which found that the women wanted better types of resources and media than leaflets and posters.

### Cultural Audit

A cultural audit of inpatient mental health and learning disability services was carried out through staff questions and interviews with BME service users. It was followed up with an action plan to improve patient experience with respect to culturally appropriate services.

### Awetu

Awetu, now part of Diverse Cymru, acts as gateway, bridge, support and advocate for people with mental health needs receiving or trying to access mental health services. We heard how they advised both service users and staff. For example, they provided awareness training to student nurses, advocated for people in hospital, and worked with refugees and asylum-seekers, providing support with the Home Office and tribunals, as well as their mental health and day-to-day survival needs. They also build capacity in other organisations to help them accommodate people's mental health needs.

people with multiple needs and exclusions. We heard about people with dual diagnosis being excluded from both mental health and alcohol services.

Another particular concern was age discrimination. The Faculty of the Psychiatry of Old Age at the Royal College of Psychiatrists emphasised the importance of ending age discrimination in crisis care. As with other care this meant ensuring that services were both non-discriminatory and age-appropriate – not just opening up younger adults’ services, but ensuring their specific needs were met.

Enabling older people to stay at home was especially important as older people are more likely to suffer adverse consequences of admission to hospital. We heard from Lancashire Care Foundation Trust that they had removed upper age limits on eligibility for the crisis team service some years ago and that this model worked well. We are concerned that all older people should get equal, age-appropriate help in crisis as the law requires.

We believe that mental health service providers need to make equality and human rights central to the ethos of their organisations. This needs to be made practically meaningful as, for example, Mersey Care NHS Trust did with the publication of a booklet on human rights developed by and for people with learning disabilities.

We also think that community engagement, personalised care and greater choice and control for the people concerned will help end inequality.

### Choice and control

“On an important note, the team that supports me believes fully that I have the right to decide the treatment I need and this extends to crisis. This allows me to work collaboratively with them and I trust them.”

“I’ve had psychotic episodes since I was 19 and I’m now 45 – I’m beginning to get the hang of it so it’s really important that people

pay attention when I say things are getting bad.”

Two of our witnesses spoke in depth about the kind of relationship they wanted to have with health professionals, where their own knowledge was fully used and there was genuine collaboration, with the service user directing or supervising the professional involved in their care.

Other witnesses described the benefits of joint crisis planning from both a personal and clinical research point of view (see p.35; also Bristol’s CRHT, p.21).

Others discussed the value of quick re-access to secondary mental health services when needed, rather than having routine appointments while well. This is something that the Mental Health (Wales) Measure includes (to be operational by June 2012).

There were comments in written evidence about wanting more say, but also of the need sometimes for someone else to take control, or the burden of being expected to make decisions in the midst of crisis rather than having the opportunity to do so in a pre- or post-crisis situation.

In our view the point of choice and control is that people can participate as fully as they wish in decisions about their care. We consider that shared decision-making (Deegan et al., 2006; Nunes et al., 2009) should be adopted in the interests of both autonomy and finding the most effective help, and that joint crisis planning is a good, evidence-based way of making this a reality in acute and crisis care. Providing more direct access options should result in more timely help and better use of resources, with people feeling more confident to live with less support in the knowledge they can access it when needed.

## Joint crisis plans

One witness told us how a jointly agreed crisis care plan was one of the things that had helped her avoid hospital admission over the last four years.

“Having a crisis care plan pre-written (if crises can be predicted) saves going over the same ground again and again, the nurses can quickly see what does and doesn’t work for you, and you (or someone close to you likely to be around at crisis point) can keep a copy so wherever you end up being assessed, and whoever by, the information is there.

The plan immediately cuts out the things that aren’t helpful and makes it possible to articulate things that you cannot articulate when in crisis. The plan was put together with the help of the community psychiatric nurse, crisis-team nurse, and a close friend.

“We all sat down and said what has worked for me, what hasn’t worked for me. And there were times when they would say things like, ‘You did this and we don’t understand why.’ And I would say, ‘Oh, I remember...’”

Professor George Szmukler told us that joint crisis plans reduced the use of compulsion for people with psychosis. The initial research pilot (Flood et al., 2006; Henderson et al., 2004), which found this, has now been

extended into a larger trial due to complete this year. In this programme, a joint crisis plan is a voluntary, negotiated agreement between patient and clinical team, with the patient having the final say. An independent facilitator ensures that the patient has their full say, while the involvement of both care co-ordinator and senior clinician ensures buy-in from the team.

There is a menu of items; for example, what the person would like done when they first become unwell, preferred treatment, advance refusals of treatment, who should get a copy of the plan, and the circumstances under which the person wants to be admitted. The plan is made after discharge from hospital so that the person does not feel under pressure to comply.

In the initial study, compulsion was halved – 13 per cent of those with a joint crisis plan were admitted under section compared with 27 per cent of the control group. The larger study will also look at the impact on black African and black Caribbean people, and consider service user views.

Professor Szmukler’s main message was a plea for joint crisis-planning as a structured and disciplined clinical activity that looks at both what has worked in the past and at patient preferences.

## Support for family and friends

“My partner’s GP is prepared to discuss my partner’s needs (ie, support and help I can give) without breaching his medical confidentiality, so I can understand what I can do. This means I don’t feel excluded. After all I live with my partner so I have to deal with any crisis or bad patches. Excluding me makes things worse.”

“I needed someone to physically be with me and my partner, to deal with the immediate issues. I had a serious incident, where a panic attack developed into a full-blown hallucination and episode of self-harm. My husband needed to get me help and called our out-of-hours GP who told him I was attention seeking and refused to come out, the crisis team told him they would speak to me but not visit, even though they had visited previously. They

ultimately left my poor husband with me in a chaotic situation without any way to help or defuse the situation.”

Numerous people talked about lack of support for carers or their lack of involvement, both carers themselves and people with mental health problems. A major current initiative is the Triangle of Care, an approach developed by carers and staff to improve carer engagement in acute inpatient and home treatment services under the auspices of the Princess Royal Trust for Carers and the National Mental Health Development Unit.

Northumberland, Tyne and Wear NHS Foundation Trust told us about a carers’ charter it had developed, that was written by carers for carers working with a range of local organisations. The published charter sets out what the Trust commits to do to recognise, value, inform and advise, and involve carers.

Nottinghamshire Healthcare NHS Trust told us that it provided interventions or direct care to family and friends and had family work champions.

The importance of family and friends was a strong theme in the evidence and it was distressing for the person in crisis as well as those closest to them when they were not listened to or supported. People were worried that service reorganisations would result in having longer distances to travel to receive care and being isolated from their families and support networks. A number of people also talked about how hard it was not to have the support of family or friends.

A personalised approach needs to respond to the home circumstances of the individual and their important relationships. Promoting better understanding and awareness of mental health and the help available generally in the community will also help families know how to provide support.

## Staff mix and roles

“It was important for me to know that I was being looked after by trained professionals who I felt understood what I was going through and could give appropriate help and advice.”

“...encourage more social and interactive activities run by ex-inpatients. Because it brings hope and solidarity when you see people who have been in the same situation facilitating creative activities in the hospital.”

Afiya Trust/Catch-A-Fiya Network

“User-led services and services shaped by real, proper, user involvement are much more likely to get it right. People who have not had personal experience of mental health problems often see patients through a lens of diagnosis, their professional training, role and a whole host of other influences which stop them seeing the person and taking a basic human approach. User led services don’t have this barrier to overcome – they come from a place of understanding and empathy. User involvement can help to overcome these barriers if it’s done well and the user voice is properly respected.”

In our discussions there was a recurring theme of having the right people doing the right things. While some people specified the need for ‘trained professionals’, there are many aspects of care and support that do not require professional skills or a specific professional approach.

One person described a stay in a crisis house that was staffed by support workers with crisis nurses coming in to do assessment and monitoring, crisis planning and making recommendations for medication. A doctor prescribed medication and the support workers provided day-to-day support. The support work required training and experience but not necessarily a qualified professional. “...if you’re distressed over the fact that you can see someone in your room that’s not there...”

if you just need to talk to someone or you need someone to do crosswords with you, that doesn't need to be a qualified nurse. Because they still know about distraction therapies and all that sort of stuff."

We heard about the importance of having quick access to medical input when needed, but not necessarily having doctors in charge. There were different ways of organising teams and it was suggested that nurse-led and consultant-led teams might operate in different ways. In one

case, a nurse-led crisis team was thought to be more flexible and make decisions more quickly, tending to discharge a person back to their regular care as soon as the crisis was resolved, whereas the staff in a consultant-led team tended to wait for the consultant, as the most senior person, to sanction decisions.

Another witness from the nursing profession wanted to encourage clinical nurse leadership and said that clarity about who is leading the team was important to encourage nurses'

## Peer support

### Hertfordshire Partnership NHS Foundation Trust

The Trust told us about their peer support programme. "Peer support is founded on the principle that people who share a similar life experience have something to offer each other, which cannot be provided by professionals. The peer-support worker is a person living well with a mental illness, who is employed to share their experience to assist other people with a mental illness, helping them to discover their own strengths and resilience, supporting them in getting what they want and need in developing autonomy and independence."

Nineteen people graduated from their training in November 2010, having learned about helping others alongside self-understanding, reflection and staying well. A number of them went on to be employed or volunteer in the self-directed support team and plans were underway to introduce them to the acute day-treatment service.

### Nottinghamshire Healthcare NHS Trust

We also heard from staff in Bassetlaw about the introduction of 10 peer support workers to

community and acute services across Nottinghamshire county services. They will focus particularly on the transition between community and hospital. They will also help demystify admission and acclimatise people; they see themselves as pioneers, agents of change.

This was the first programme to also provide dedicated peer support workers for carers.

## Sussex

The National Service User Network told us about the CAPITAL project in Sussex which has launched an inpatient peer support service at Meadowfield Hospital in Worthing, in which three peer workers (one per ward) provide one-to-one and group support, with a view to expanding the project to other services.

We think there is a strong case for extending peer support programmes, with good training and support, and ensuring that these reflect all communities. We would like to see less medical emphasis within acute care and a more collaborative, shared approach in bringing about healing and recovery. Within this, all roles and professions would be valued for their own skills and strengths, with the inclusion of carers and primary focus on the wishes of the person who is being cared for.

responsibility and avoid dominance by consultants.

There were several calls for a less medically dominant approach and a strong interest in seeing more peer support and survivor-led services in acute care.

### Staff development, care and support

“After working on a mental health ward myself, I realise many of the nurses are not looked after by the NHS properly – not enough supervision and not enough support. If wards spend more time looking after staff and have more regular training such as in interpersonal skills and the Carl Rogers person-centred approach, also more incentives, I feel that this would greatly improve the care people receive on the wards.”

We heard from different witnesses about the importance of staff support especially given the high demands of acute work. The refocusing initiative starts from the understanding of job strain in acute care (Bowles et al., 2002). We were told that mental health is a people-based system – staff need good organisations, management and support, especially in tough times. It is a high risk field – it is important to recognise staff’s distress when things go wrong and for them to know that they will not be left alone to have the finger pointed at them in a media scandal. There were several calls in our evidence for services to work in less risk-averse ways (see p.39), which in turn demands good leadership, processes and support.

Engaging leadership is a leadership style that has been found to enhance productivity (Alimo-Metcalfe et al., 2008) in research that was done with crisis resolution and home treatment teams. This leadership style emphasises service to others and shared decision-making; it involves stakeholder engagement at the outset, collective

vision of a good service, non-hierarchical teams, supportive culture and successful change management. We think this is a style that should be adopted and encouraged.

We were impressed by the levels of staff support provided by Leeds Survivor Led Crisis Service. In addition to supervision, staff have a monthly reflective practice group, where they can discuss individuals or issues, and an individual wellbeing budget they can spend on external supervision, counselling or complementary therapies. There is experiential, reflective training through the year.

The manager told us they had a good record on progression of volunteers to paid work and that staff satisfaction is high. As an organisation with a person-centred approach they consider that staff “can’t be warm and empathic and compassionate and loving to us, our visitors and callers if they’re not receiving those conditions themselves”. We were told that staff turnover is low and that staff say it is the support and training that enables them to continue doing intense crisis work in the middle of the night.

We were encouraged to hear about a nurse leadership programme that recognises the importance of values and personal qualities. This two-year course in Wales for band five newly qualified nurses prepares them as Leaders for the Future. Selection is from all over the country, with a two-stage interview process that looks at team working, key skills, underpinning values, professionalism, warmth and humanity. During this rotational course they are supported by training, education, action learning sets based on equality and human rights principles, mentoring, supervision and support.

These are the kinds of approaches to management and training that we believe humanise organisations and help them to help people recover.

## Working with risk, promoting safety

Several witnesses were concerned about services working in ways that were risk-averse and wanted to see this change. Mat Kinton from the Care Quality Commission set out the dilemma for staff in acute services. They are told to use the least restrictive alternative, making sure people retain their autonomy, while at the same time they are told “whatever you do, don’t make a mistake”. He said there was a pressure on services not to allow people the freedom to make a mistake, which made positive risk taking very difficult, “and I think that’s so dangerous”.

Fiona Venner, who manages Leeds Survivor Led Crisis Service, told us that because of the high demand on their service they prioritise people at high risk of suicide and self-injury. She said they had a very good record on working with risk (there had been no violence against others and no death on the premises) and that they work in a less risk-averse way – “I think that culture of fear of blame and defensiveness has infected us less than it’s infected inpatient units and statutory providers.” They allow people to self-injure on the premises, but because the service respects self-injury as a coping strategy, which some staff have also used, it can be discussed openly and people very rarely feel the need to do it.

The Maytree provides short, intensive stays for people in suicidal despair. They do not do

formal risk assessments, apart from a daily 0–5 scale assessment to establish where the suicide risk is, but rather have processes for thinking about risk. Guests and staff assess risk when they arrive and risk assessment is an ongoing process throughout a guest’s stay. Staff and guests develop a relationship based on trust, and there is a high staff-to-guest ratio. There is a great deal of trust involved and staff will tell a guest if they are worried about them.

These themes were picked up in evidence from someone with personal and professional experience who emphasised the importance of respect, understanding and boundaries in keeping people safe. She advocated that harm minimisation should be mandatory for all those working with self-injury in mental health services and that nurses and other staff should be trained so as not to be ignorant or afraid of self-injury.

The Wales Applied Risk Research Network aims to improve standards of risk assessment and management through research and training.

A forthcoming publication by Rachel Perkins, a panel member, advocates approaching risk in a recovery-oriented way, where the emphasis is on understanding the perspective of the person concerned as well as others, and the co-production of plans that promote safety for everyone.

## Changing services in challenging times

Many people who responded to our call for evidence were concerned about what changes in the NHS would mean for acute care, especially given the major savings required within the NHS. As early as Autumn 2010 people were talking about frozen posts and bed reductions. A particular concern was that centralisation of services would mean people

having to receive care a long way from home, making them more isolated from their support networks. Reconfiguration could mean amalgamating teams and potentially diluting the function of crisis resolution and home treatment teams.

People were concerned with the loss of lower level social support and the voluntary sector infrastructure as these helped people stay well.

The loss of social work posts affected the scope and effectiveness of what mental health teams could offer. Several times a service was commended in the evidence, and then the comment added: “but it is closed now”. People felt that mental health was an “easy target” for budget reductions.

One psychiatrist told us that resource restrictions had started to bite and there was no more overlap between services or capacity for staff to go the extra mile. There were more disputes at service boundaries and people argued over who had the duty of care; for example, in escorting someone from an emergency department to a mental health unit.

At the same time, change can provide an opportunity for improvement. Some of the people we heard from talked about how they were planning, monitoring and developing services to improve their quality. A number of trusts were participating in Implementing Recovery Organisational Change (IMROC), a change programme being run by the NHS Confederation and Centre for Mental Health.

For example, a ward in Bassetlaw, Nottinghamshire, had done a recovery benchmarking exercise and from that developed a strategy that encompassed a range of improvements. Discussing how they worked

and what was successful about it, management and staff said that they shared issues, owned them and sorted them out; everyone owns what they do and is accountable.

The National Service User Network told us that East London and the City Mental Health NHS Trust commissioned local independent user groups to audit services, and their reviews feed into performance management through the trust’s acute care forum.

Northumberland, Tyne and Wear NHS Foundation Trust told us about the 12 design principles for urgent care services written by service users and carers. They include valuing the expertise of the individual, an empathetic workforce, monitoring quality, and respectful ward environments – “respecting the need for privacy and kindness”.

Change does not have to start with the provider or commissioner. Some individuals told us how they had influenced trusts through making complaints or suggestions for improvement. Maat Probe Group had worked collectively to influence their trust, having been inspired to campaign by meeting other groups and seeing how things worked elsewhere. The reverse commissioning process described earlier (p.33) proposes a way for BME communities to be effectively involved in commissioning.

# Conclusion

In the course of the inquiry we learned from people who responded to our call for evidence, from existing research, services we visited and experts we invited to talk to us. The scope of our inquiry was potentially huge and there are many issues that we could have explored in greater depth; for example, the specific needs of older people or of those with dual diagnosis, eating disorders or personality disorders.

However, the messages we received were primarily about the fundamentals of what was being offered and the 'terms of engagement' between those using and those providing services.

And while we heard about the pros and cons of different ways of organising services, we did not try to create a blueprint. We think this is for local communities and organisations to negotiate, learning from best practice. We think individuals should be offered personalised options not just a prescribed list.

Much of what we learned was about how people were being treated – with respect and kindness, or without – and the difference that made. This led us to base our vision and recommendations around values and humanising services for all involved. This is something for commissioners as well as mental health provider organisations and their staff to address.

We learned about people's difficulties accessing help, or the kind of help they found useful, and this also drives our recommendations for commissioning and for strengthening the choice and control people can exercise over how their acute mental health needs are met.

Many of the problems we heard about arise from the working practices, culture and

dynamics of crisis and inpatient teams. Lack of humanity, depersonalised care, treating the illness or managing the crisis rather than supporting or healing the individual, and emphasising risk rather than needs, were all themes that arose.

To some extent these reflect the way that priority may be given to the medical management of acute mental health needs, while the other things that can help are devalued. While medical approaches such as diagnosis and medication have their place, we think that there should be a better balance. One way to do this is through a more collaborative and inclusive approach that emphasises the human side of healing and support.

There was also a sense of uncertainty about what to do in a mental health crisis. People need to know what acute and crisis services there are, what they do and how to access them. The better services link with their communities, the more likely they are to be trusted. If this is based on a wider understanding of mental health and improved early intervention, this should help prevent crises arising.

We are very conscious of the economic climate and the drive to make savings in the NHS. This may put valued services at risk and further reduce the capacity of services to respond to urgent needs. Mental health services, including the acute sector, need to be protected as far as possible, and – in keeping with the 'parity of esteem' set out in *No health without mental health* (Department of Health, 2011) – they should be treated no less favourably than physical health services in the allocation of resources.

# Recommendations

Over the course of our inquiry we found evidence that acute and crisis care can be and is being done well, but we were discouraged by how often people are not getting the support they need when they need it and the numbers of poor, even traumatising, experiences.

But we firmly believe, and the evidence we read and have heard confirms this belief, that acute and crisis care can be made excellent and fit for the 21st century. To do this we need a paradigm shift in the way acute services are conceived and delivered, focusing on four main areas:

- Humanity.
- Commissioning for people's needs.
- Choice and control.
- Reducing the medical emphasis within acute care and facilitating a more collaborative, person-centred approach in bringing about healing and recovery.

This chapter sets out the steps we believe need to be taken to make our vision reality (see p.5 for the vision statement). They build on the good practices we have seen and the ideas we have heard.

While some changes require planning, investment or organisational or Government commitment, there are many things that can be done now at team and individual level without any need for a new service or policy – they include small changes that can make a big difference.

## Recommendations for mental health provider organisations

### Humanity

- Think of people using hospital and other building-based services as guests as well as recipients of care. What standard of hospitality are you offering – in terms of welcome, comfort, cleanliness, atmosphere and food? Invest in the care and working environments as needed.
- Ensure that services offered are appropriate and effective and tailored to meet individual needs, and that they promote wellbeing and recovery.
- Adopt and encourage a style of leadership that is engaging – with a focus on serving, enabling and including people.
- Make equality and human rights central to the organisation's ethos and practice and make this meaningful in practice; for example, in how performance is assessed and through patient information.
- Recruit and develop staff on the basis of their values and personal qualities as well as their skills.
- Encourage and support staff through regular supervision, reflective practice, adoption of easy wins and celebration of good work. Reinforce boundaries that allow for warmth and ordinary social interaction as well as professionalism.
- Motivate and develop staff through planned rotations; the advantage of this for ward staff includes seeing people in the context of their day-to-day lives and when they are less unwell.
- Support teams where there has been a serious incident and ensure there is effective learning for the whole organisation as well as accountability.
- Take robust action in the cases of staff whose behaviour is detrimental to the recovery, wellbeing and human rights of those in their care.
- Commit to working without violence and, in England, consider training in approaches such as Respect and Studio III. The All Wales NHS Violence and Aggression Training Passport and Information Scheme already teaches face-to-face safe holding where a hands on intervention is required.
- Ensure that mixed sex accommodation (see p.16) is eliminated and that safety and privacy are prioritised. Where possible offer the option of exclusively single-sex wards.

- Continually check how you are doing through feedback from people using the service. Use a range of mechanisms to ensure that all are enabled to take part; for example, exit interviews and independently facilitated group feedback. Mind can advise you on this.
- Ensure outcome measurements are used routinely including service user satisfaction.

### Commissioning for people's needs

- Consider the types of service provided and how you can expand the range of options in line with local needs and preferences – these may include crisis houses, non-residential crisis services, host families, retreats, hotels, peer/survivor-led services.

### Choice and control

- Carry out joint crisis planning with people who may need to access acute care again in future. Ensure it is negotiated in a structured way that empowers the person whose care it is and allows them final sign off. Involve any friend, family member or other supporter the person wishes to include and ensure buy-in from the whole care team.
- Approach risk assessment, or safety planning, in a similar recovery-oriented way that sets out to understand the person's own perspective on what they need in order to be and feel safe.
- Provide for more direct access into secondary mental health services for those who have previously been service users (this will be mandated in Wales under the Mental Health Measure).
- Allocate funds for teams to spend in flexible, personalised ways for those service users who do not choose the full personal budget or direct payment route.
- Support and equip staff teams in positive risk-taking.
- Ensure that service users moving into more secure provision have a care co-ordinator

they trust, who can support them through this transition and back into non-custodial care when possible.

- Agree to a change of consultant when requested, unless there is a good reason not to do so

### A shared approach to healing and recovery

- Consider the mix of staff and how they are used – where specific healthcare professionals are needed, where support workers could be more helpful, where direct lived experience of mental health problems will be of particular value.
- Consider ways of strengthening community links; for example, through well planned visits, or involving people such as educators, artists, health trainers and volunteers in wards and other services.
- Develop the role of peer supporters and recruit from BME groups.
- Support the leadership of non-medical clinicians and team managers.
- Ensure maximum availability of psychiatrists for the decisions and input for which they are needed.
- Develop support roles (peer or otherwise) for people who need sustained social contact during their crisis.

### Recommendations for staff teams

- Share something of yourself in interactions with people using your service – not all your problems, but enough of your life to engage on an ordinary human level.
- Know who people are, acknowledge them by name, and ask them how they are.
- Provide introductory information about the crisis team members who are most likely to visit a person at home.
- Try and ensure continuity of contact – not different people visiting individuals at home.

- Provide different means for people to contact your team – for example, telephone, text for a call-back, email, ring and walk-in between certain hours of the day.
- Make proactive contact with the people you are worried about.
- Make commitments – such as going for a walk with someone or having a one-to-one – that you can keep.
- When someone comes into hospital in an emergency, unless it is really impossible, let them pack a bag.
- Make sure you can provide toiletries and a change of clothes for those who need them.
- Check everyone is getting good and varied food they can enjoy.
- Celebrate birthdays and personalise care – tap any sources you can for presents.
- Take inpatients' concerns about security of belongings seriously.
- Review how inpatients' things are looked after while they are on short-term leave and someone else is in their room.
- Test your practice against standards based on recovery and service user feedback.
- Commit to working in non-violent ways and use de-escalation techniques first.
- Help look after the care/working environment so that people feel cared for too.

### Commissioning for people's needs

- Investigate reverse commissioning (see p.33).
- Look beyond the mainstream service for community resources that might help you better meet the needs of the people you are working with.

### Choice and control

- Proactively tell service users about advocacy and encourage them to access it.
- Trust what people tell you they need.
- Ensure the people you work with have copies of their own care plans and that what they most want healthcare staff to know is at the top.

### Recommendation for voluntary sector organisations not engaged with acute and crisis care

- Consider offering services that contribute to crisis prevention, support or after-care, and making your services accessible to people using acute and crisis care. These could include crisis houses or other crisis support services; advocacy, involvement projects and social inclusion initiatives based in NHS acute care; brokering personal budget planning that include crisis care; or residential alternatives for after the acute phase.

### Recommendations for commissioners and local health boards

#### Humanity

- Include an organisation's value base as a criterion in awarding contracts or funds and in the assessment of performance.

#### Commissioning for people's needs

- Review the extent to which services are meeting people's acute and crisis mental health needs – are they fit for purpose, are people satisfied with them, and do they provide value for money?
- Prioritise a review of commissioning for the needs of people from BME communities and develop models of commissioning in which

communities can genuinely participate and define their needs and priorities; for example, using the reverse commissioning approach (see p.33).

- Commission services from a range of providers including specialist BME providers.
- Commission services for a substantial period (for example, five years) but with a genuine commitment to re-tendering where a service underperforms.
- Set clear standards, including value base, in the procurement process and conduct regular, effective performance reviews including service user satisfaction measures.
- Expand the range of options so that crisis houses and sanctuaries, survivor-led crisis services, host families, use of retreats and hotels become widely available. But plan this with communities so that different needs and priorities are reflected in the choices made – and any better ideas are captured.
- In commissioning advocacy services include those tailored to the needs of BME communities and, in England, ensure advocacy is not limited to the statutory schemes.\* Provide clinical mediation if necessary through third-party agencies.
- Set standards for the use of crisis care plans.
- Ensure the range of services includes sufficient options for those who may not need a full statutory acute care response. This may require primary care services and community mental health teams to consider how they can support people more intensively during difficult periods rather than automatically referring to CRHTs.
- Consider what service models are most appropriate for rural communities and make adjustments where necessary. Host families may be a good rural solution for some people; a larger team of dispersed staff working

shorter hours may serve a large rural area better than a team operating out of a single location; spot purchasing from a trusted bank of staff may provide more flexibility.

- Facilitate providers making flexible provision that can deliver personalised care and adjust for people's circumstances; for example, to help people stay in employment during a crisis or to care for their children.
- Ensure that the needs of friends and families are catered for. For example, engage with the Triangle of Care programme (Worthington et al., 2010), require carer involvement in contracts and commission family support teams.
- Ensure commissioning meets the needs of marginalised groups such as vulnerable migrants, and people with multiple exclusions such as homelessness, substance misuse and contact with the criminal justice system (Mind, 2009; Page et al., 2011).
- Ensure that a wide range of effective psychological therapies are available to all including people in acute and crisis mental health services. This should include brief interventions for those who do not need in-depth work.
- Ensure that an appropriate therapy is available within 28 days of requesting referral.
- Provide for psychiatric liaison services (teams) in all general hospitals and emergency departments, with resources to provide an appropriate response.
- Move away from the medical ward as the defining concept of acute care and consider basing services around other concepts, such as 'retreat'.
- End the move to locate mental health units in Wales on general hospital sites.

### Choice and control

- Commission and/or provide more self-referral options and a wider range of options from

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\* In Wales the Mental Health Measure extends access to advocacy to all those in mental health hospitals.

which people can choose, such as crisis houses and services provided by specialist providers in BME communities.

- Commission advocacy from BME groups, including to help facilitate joint crisis planning.
- Value and support organisations that use innovative approaches to working with risk, such as Dial House in Leeds and the Maytree in London.

### A shared approach to healing and recovery

- Ensure that commissioned services use different staff groups appropriately and that this includes peer workers and support staff.
- Facilitate a co-ordinated approach at local level to providing readily accessible, well publicised local information about what services are available, and targeted promotion to communities and groups.

## Recommendations for providers of professional education and training

### Humanity

- Ensure that the importance of human interaction between staff and the people they are working with is emphasised in training and education and that it is applied to the acute and crisis context.
- Involve people with lived experience of acute care in the design and delivery of mental health education and training; for example, as partners in defining learning objectives, designing courses, authoring materials and presenting.
- Re-evaluate how professional boundaries are described and taught, so that professionals are confident to be themselves with the people they are caring for while retaining their professionalism.

- Recruit candidates to professional courses on the basis of their values and personal qualities as well as their skills.
- Attract the best candidates by marketing mental health professions as the important and interesting vocations they are.
- Ensure that care professionals are supported and equipped to talk with people about safety, self-harm and suicide.

### Choice and control

- Include joint crisis planning and shared decision-making in professional education and training so that all professionals who are responsible for clinical decisions and care planning in an acute context are equipped to use this approach.

### A shared approach to healing and recovery

- Build on existing progress made through New Ways of Working to encourage leadership in different professional groups and effective team-working that includes peer workers and carers, and respects self-direction by the person whose care it is.

## Recommendations for Government and the NHS Commissioning Board

### Humanity

- Re-evaluate the use of control and restraint procedures, and end the use of face-down restraint, as is already recommended but not mandatory in Wales.
- In England establish standards for training in a respect-based approach to preventing and managing violent or disturbed behaviour.
- Fund evaluation of emerging models for reducing restraint such as Respect and incorporate findings into national guidance.

### Commissioning for people's needs

- Ensure that guidance on commissioning and provision supports all the recommendations to commissioners and local health boards (see p.44).
- Build the original Delivering Race Equality goals into commissioning guidance, in particular around reducing and eliminating ethnic inequalities in service experience and outcomes, improving satisfaction and outcomes for BME groups and providing culturally competent services.
- Provide full entitlement to free secondary healthcare for all refused asylum seekers until the point at which they return to their country of origin.

### Choice and control

- Include reduction of coercive care in the measurement of outcomes, as an indicator relating to positive experience of care, with particular reference to ethnic inequalities.
- Ensure that monitoring of the Mental Health Act use includes length of stay and ethnicity and other equality elements.
- Allow choice of mental health clinician. In England, build this into the NHS Constitution, as part of the extension of choice to mental health.
- Provide a strong steer in favour of innovative practice and harm minimisation approaches to working with people who self-harm.
- The Department of Health should develop an equivalent entitlement to the entitlement included in the Mental Health (Wales) Measure of direct access to secondary mental health services for people who have already been service users (implementation in Wales is due by October 2012).

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# Members of the inquiry panel

## **Paul Grey – Chair**

A pastor and social entrepreneur, Paul's experiences within the mental health system have given him first-hand knowledge of the issues that are relevant to service users today. He is a co-founder of I and I (Inspire and Influence) National black service user movement and his innovative ideas ensure that people's lives are transformed by age-old principles like love, joy and peace.

## **Helen Bennett**

Helen is currently the Divisional Nurse for Mental Health at Cardiff & Vale University Health Board and chairs the All Wales Senior Nurse Advisory Group for Mental Health. She has a keen interest in law and ethics, and service user rights, and in her extensive NHS career has been instrumental in bringing about improvements in the quality of care and in legal rights.

## **Jayasree Kalathil**

Jayasree is a researcher and writer and a former user of mental health services. She leads Survivor Research, an online collective of individuals interested in promoting user-led perspectives from marginalised communities in the understanding of mental health issues. Jayasree is currently a co-chair of the Social Perspectives Network and the editor of *Open Mind*.

## **Martyn Cooper**

Martyn heads the Advocacy and Rights-Based Services department at City & Hackney Mind which has services in both acute and forensic hospitals. His academic background is in psychology and counselling and he previously worked on acute wards, in mental health supported housing and as a mental health advocate on acute and forensic mental health wards and in the community.

## **Rachel Perkins**

Rachel was formerly Director of Quality Assurance and User Experience at South West London and St. George's Mental Health NHS Trust. Her background is in clinical psychology and she is also a long-term user of mental health services. She has pioneered UK developments in accessing employment and education. In 2010 she was awarded an OBE and voted Mind Champion of the Year, and as the chair of Equality 2025 she currently advises the Government on issues affecting disabled people and on equality in mental health.

## **Sashi Sashidharan**

Sashi set up one of the first Home Treatment services teams in the country and was instrumental in the national development of Home Treatment. He has long been actively involved in research, service reform and campaigns to improve community mental health services and eliminate ethnic inequalities in mental health services. He led the development of the first national BME mental health strategy in England and is now a consultant psychiatrist in Scotland.

One of the hearings was chaired by journalist and former mental health nurse Nina Lakhani.

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We're Mind, the mental health charity for England and Wales. We believe no one should have to face a mental health problem alone. We're here for you. Today. Now. Whether you're stressed, depressed or in crisis. We'll listen, give support and advice and fight your corner. And we'll push for a better deal and respect for everyone experiencing a mental health problem.

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