healthwatch
Nottingham

Insight

Experiences and views on seeking support during a mental health crisis: Engagement activity report

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Commissioned by

NHS
Nottingham City
Clinical Commissioning Group

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1. Introduction

In March 2016 Healthwatch Nottinghamshire and Healthwatch Nottingham were commissioned by Nottingham City NHS Clinical Commissioning Group, on behalf of the Nottingham/shire Crisis Concordat Partnership Board to deliver engagement activity to support the development of a local action plan in response to the national Crisis Care Concordat. The engagement objective was to target five specified groups to improve understanding of the issues faced by these groups in accessing mental health crisis services. The groups were:

- Black and minority ethnic (BME) communities (including asylum seekers and refugees)
- Students
- Carers of people with a mental health illness
- Veterans/ex-military personnel
- People who are homeless or at risk of homelessness

1.1. Crisis Services in Nottinghamshire

There are three main services that provide specialist crisis support:

- Crisis Resolution and Home Treatment Teams (CRHT) are based geographically to cover Nottinghamshire County and Nottingham City. They provide a 24 hour, seven day crisis resolution service that offers assessments to people with significant mental illness who would otherwise be admitted to hospital. This includes short-term home treatment in order to minimise the risk of a patient being admitted to hospital and providing support to achieve recovery from crisis at home. The team is made up of a range of healthcare professionals including: doctors, nurses, occupational therapists, support workers and non-medical prescribers. They aim to discharge service users to the most appropriate services to meet their needs within six weeks of referral. They also help service users to leave hospital sooner by providing intensive support in their own home.
- In South Nottinghamshire and for Nottingham City residents there is also a Crisis House, which offers an alternative to inpatient care. The service offers holistic treatment and support for up to 7 days.
- Inpatient care is also available, which can be accessed through a voluntary admission but also through a compulsory section. This is delivered at services including Highbury Hospital, Millbrook Unit at Kings Mill Hospital and Ward B2 of Bassetlaw District Hospital.

All of these crisis services provide 'acute care', short term treatment before discharging them into other appropriate services.

People can access these crisis services by the following ways:

- self-referral if they have been involved with adult mental health services in the last six months (direct)
- being referred by their GP or another mental health professional (indirect)

1.2. Our approach

We wanted to get a deep understanding of the situations that those from within the specified groups were in and if this was influencing their experiences of seeking urgent and emergency support during a mental health crisis. The main focus of our engagement was therefore on talking to people from within these five groups face to face or over the

telephone where this was not possible. To identify and engage with people our main approach was to work with community groups and organisations across Nottingham City and Nottinghamshire County. We asked to attend their facilities, groups or services in person to talk with people face to face during our visit but also offered them some information about our project which they could distribute to their service users or members. This included a link to an online survey or hard copy surveys which enabled people to identify to take part in a more detailed conversation, at a time and date convenient to them.

Through this combination of approaches we were able to gather detailed experiences a total of 269 people. Some of these people fell into more than one of the five specified groups and were able to provide experiences from two perspectives, for example, we spoke to some people from a BME background who were also carers of someone with a mental health illness. The total numbers engaged applicable to each group were:

- 73 people who were from a black and minority ethnic community, including 10 asylum seekers and refugees.
- 55 students studying at the University of Nottingham or Nottingham Trent University
- 83 carers of people with a mental health illness
- 21 veterans/ex-military personnel
- 37 people who are homeless or at risk of homelessness

Some of these interviews were with service managers who we interviewed as a proxy to gathering experiences from their service users where direct access was proving problematic.

Experiences were gathered through semi-structured interviews undertaken by members of our project team. Participation in interviews was on a voluntary basis and patients were informed that they could withdraw from the interview at any point. Before interviews were conducted individuals were fully informed about the project and gave consent for their interview to be recorded. Where consent for recording was not provided written notes were taken during the interview.

We also felt it was important to explore experiences of seeking urgent and emergency help during a mental health crisis from people who did not fall into any of the five specified groups. To do this we circulated the survey to contacts on the mailing list of both Healthwatch organisations, and through other organisations and groups supporting people who may have experienced mental health illness. We took hard copies of this survey to all engagement activities we were undertaking during the period of evidence gathering asking people to either complete them at the time of contact or providing freepost envelopes so that they could return completed forms to us after the event. Engagement activities took place between April – July 2016.

Experiences already held on the Healthwatch database were also subject to secondary analysis.

Across all of these approaches the experiences of 484 people across Nottingham City and Nottinghamshire County were included in this project.

1.3. Our project team

Our project team included members of staff from both local Healthwatch who were supported by a cohort of volunteers from the city and members of the volunteer Healthwatch Nottinghamshire team of Authorised Enter and View Representatives. All members of the team were DBS checked and took part in a project orientation session. This

session provided an opportunity for them to fully understand the rationale for the project and familiarise themselves with the data collection tools including the interview schedules and digital voice recorders. We wanted staff and volunteers to be as prepared as possible for undertaking their role in the project.

Across the project a total of 21 people were involved in interviewing local people, facilitating or attending activities to promote the project and secure engagement opportunities.

1.4. Data analysis and reporting

All interview recordings were transcribed verbatim. These transcripts, written notes taken during the interviews, responses from the quantitative survey and experiences taken were uploaded into NVIVO qualitative data analysis software package. All were coded to identify key aspects of their experiences and views related to the project objectives.

This report is based on analysis of this coding and presents findings for each of the five specified groups along with findings for those engaged who did not fall into any of these groups. A summary of the key findings and a set of conclusions and recommendations based on this evidence is presented to inform the development of the local action plan.

2. Summary of findings

Every group we spoke to would seek urgent and emergency support from their GP during a mental health crisis episode (43%; 198 people) but a number of barriers were identified which have and could prevent this. A lack of awareness of how and where to get urgent and emergency support and the stigma associated with mental health illness were more likely to be identified as barriers in the specified groups compared to the wider population. Additional specific barriers were also key for specific groups:

- Language and cultural issues were barriers for those from a BME community;

- Alcohol and substance misuse for both veterans/ex-military personnel and people who are homeless or at risk of homelessness;

- The symptoms of the crisis episode itself were significant barriers for both veterans/ex-military personnel and homeless people.

People were in contact with services prior to any crisis episode but they still went to crisis because of a number of factors. Where people talked about their experiences of contact with services prior to their crisis it was mostly negative. People often talked about:

- **Long waiting times** which were most frequently identified and talked about issue. This was a source of frustration for many with some people identifying that as a consequence they were not getting better and there was the potential for them to reach crisis point as a result.

- **The criteria for accessing specialist mental health or psychological support services**, which resulted in them not receiving the support they felt they needed.

- Feeling that their **mental health issues or illness were dismissed** by the service staff. This left people feeling like they were without any support for their issues, with two people specifically identifying how their experience had been detrimental to their mental health status, leading one person to take an overdose.

- Problems around **communication between services** in the home town of the student and services in Nottinghamshire.

Long waiting times were particularly difficult for people from the BME communities and veterans/ex-military personnel, who felt that they had experienced a traumatic event and didn't know what to do whilst waiting for help and support. Some people in the student community also reflected that their studies were negatively impacted by having to wait to receive help and support.

Where people did access crisis services, this was done indirectly through GP, A & E and the police and directly through the crisis phone line. People's experiences were mostly negative and this was due to a number of factors:

- Waiting times in A & E and no support plan on discharge and lack of compassion and poor communication demonstrated by staff. This was specifically referenced as adding to an already stressful situation and being detrimental to the mental health of the person needing care and support:

> [Waiting was] difficult, but she was trying to get out and go places and so on. I had to keep calming her down.
>
> Unfortunately, a nine hour wait in a small side room in A&E with security guards at the door with talk of being transferred to Manchester, did nothing to improve matters.

- Lack of onward referral (access through the police).
- Poor quality advice, referral to other services, e.g. accident and emergency department and NHS 111 and lack of access, e.g. no one answering the crisis phone line.

> They told me to drink milk and put lavender oil on.
>
> They have not given him any sound advice over the phone just recently.
>
> The advice and support varied from "just keep taking the tablets" to "well what do you normally do" when my son was threatening suicide.

Positive comments made reference to:

- Short waiting times and kind and compassionate staff (A & E)
- Waiting times and referral to emergency services (GP)
- Referrals for a mental health assessment (police)
- Helpful advice given (crisis phone line)

The experiences of mental health crisis services is variable. Where people shared details about their experiences of crisis services, these were mostly negative, though there were some references to positive experiences.

Experiences of the Crisis Resolution Home Treatment team
Negative experiences made reference to how their ongoing crisis and mental health state was not considered sufficiently by the team in the context of their responses and actions stating that they felt some staff lacked compassion and dismissed their problems:

> There were also a lot of very unhelpful, dismissive and rude individuals who appeared to know very little about mental health.
>
> Also I don't think that all the staff have appropriate training and understanding of autism and mental health (as a combination) or of things like flashbacks and dissociation.

Some individuals also felt that the quality of advice poor (or lack of advice) and was of no help to them. Others commented on the frequency of contact, where people felt that they either weren't seen for as long as they wanted, or that contact was inconsistent but no explanation was given for this. Other negative experiences made reference to a lack of immediate support available from the crisis team, resulting in feelings of frustration.

The positive experiences made reference to short waiting times and the supportive care provided by staff members who attended during an estimated six hour period of support. The outcome of which was securing further support through an inpatient facility. Other positive experiences made reference to the frequency with which the patient was seen, and also commented on the quality of advice given and the way that crisis staff communicated:

> I'd say on one occasion I rang them up and they told me what to do. They were very calming and were very calm and they were very good and made some suggestions of what to do. So that was good.

Experiences of inpatient care

Wards where people stayed included Millbrook Mental Health Unit and wards at Highbury Hospital. Negative experiences made reference to a lack of beds in the inpatient services, and having to travel to locations far from their residence. This was distressing:

> There was no bed in Nottingham... but they're trying to get a bed for me somewhere close by I don't really have to go far because of my kids, I would have loved to have seen my kids...they couldn't get a bed in Nottingham but there was no beds so they had to move me... ...I was a bit upset and things like that because *[the hospital bed]* a long way to Nottingham, but I didn't know how long I was going to go for.

One person made reference to how they felt the inpatient service was unsafe for the person they cared for as they that he had been attacked by another patient while sedated.

Positive experiences made reference to the effectives of the service, and stated that they felt supported. Staff communication was also praised by some who described how they had frequent interactions with staff which demonstrated compassion. This support was effective and achieved a positive outcome:

> She'd [member of staff] make sure she turned up for all his ward reviews, even if she was on her day off she came in for one of his ward reviews and she really... She made his point and made sure that he got the care that he needed.

Others identified that the atmosphere of the ward was central to the positive experience of the service.

Experiences of Crisis Houses

Haven House was often mentioned when people talked about their experience. Negative comments made reference to the service being unprepared to deal with the physical needs of service users:

> I also think they have got a problem with their physical healthcare because I had to go to NEMS at one o'clock in the morning to get some steroids because they didn't have doctor on call to get me a prescription...I had a virus and couldn't breathe so one of the patients had to take me in the car.

Other negative experiences made reference to the facilities being dirty and having to wait to access the service due to a lack of beds. The outcome of having to wait for a bed was

people feeling worse because they were not getting the support that they needed.

Where people spoke about the positive aspects of Haven House, the atmosphere and activities that were available was referenced. One person told us that the service had helped them get better.

Issues around discharge related to a lack of preparation. People often commented on how they felt that they were not adequately prepared for their discharge because they were not told about the discharge process and any support that would be in place for them. This made reference to staff communications and changes in members of staff. We were often told that people were being discharged without care plans being put in place, or that where a care plan was in place, this was not followed. In some cases this led to further episodes of self-harm. The discharge process was more problematic for the specialist communities that we engaged with because of the context surrounding them:

> They come back out and they're high and dry again. Someone they knew before sees them and says come on have a drink with me and then here we go again…You get them out here, unless you get stable accommodation with help out here they go back to it, cos that's all they've got.

Where people talked positively about the discharge experience, this made reference to the follow-up care that was put in place.

3. Conclusions and recommendations

Conclusion 1:

Some people aren't getting the help and support that they need when they need it to prevent the escalation of a crisis episode or to access crisis services. Our evidence has highlighted that accessing services is problematic across all communities and that services need to be tailored to overcome the specific barriers identified, if specified communities are to be better supported. We know that often GPs are the first point of contact for people if they are having a mental health crisis but this does not always mean that this prevents escalation of the crisis, nor does it ensure referral to the crisis service. Our evidence shows that some GPs in Nottingham and Nottinghamshire do not always have the knowledge to be able to refer to the correct service, nor always did they appear to understand exactly what the local arrangements are for people seeking support and help for their mental health.

Our evidence also identified that the eligibility criteria for access to this service were often a barrier to people getting help at the right time, before the crisis became serious. For example, people with alcohol and substance misuse problems were negatively affected as they were not seen by the crisis service when they were under the influence of drink or drugs, yet this was often when a crisis would occur. We also found that a barrier to accessing the service was (not surprisingly), the nature of the crisis episode itself, where people told us that the nature of being in crisis made it difficult or impossible to access help at that point. Our evidence shows that people felt that if they tried to access help before the crisis became serious, they might be told that it was not serious *enough* for them to receive help.

Recommendation 1
Ensure greater promotion of services and sources of support so that people are aware of where they can seek help before they reach crisis. This would be most successful if undertaken through community venues and groups where members of our five specified communities already attend. People also suggested that this should be done alongside an education campaign to help overcome the stigma associated with mental health illness in these communities. For example, students felt that this would be most successful if executed through social media platforms like Facebook and Twitter which are often used by students. Insofar as it is to GPs that people will normally turn for information, it is not clear whether GPs have the most up-to-date information about pathways for referral and information about services available to support people after crisis or upon discharge.

Recommendation 2
Review the eligibility criteria that are in place for people to gain access to crisis services and include additional support for people who have alcohol and substance misuse problems. This recommendation follows our finding that people who have alcohol and substance misuse problems must have these addressed *before* they are eligible to receive support for their mental health condition. This raises an issue around inequality as it means that potentially, some individuals are being excluded from any help for their mental health crisis altogether. In addition, if there is a requirement that the crisis must be serious before help is available, there is no opportunity for *prevention* of escalation of crisis, only a response when the crisis has occurred. We proposed that treatment for alcohol and substance misuse is included in the treatment provided by the crisis team.

Recommendation 3
Provide mental health support through locations attended by the community. Students felt that having low level psychological support available through their university would be helpful. This suggestion would take into account the context of students, particularly those living away from home that may need to access these services. For those who are homeless or at risk of homelessness, this was suggested as a means of providing some form of drop-in support at places where those who are homeless or at risk of homelessness already attend or are aware of. In addition, the crisis service could signpost people to other services that might be able to help them if they feel that, having assessed the individual, they do not think the individual is in crisis. This would involve establishing closer working relationships and communication between third sector support groups and statutory services.

Conclusion 2:

When people are discharged from the crisis services, they do not always recover and may experience further crises. Recovering from crisis is difficult and our evidence suggests that people are suffering from multiple crises situations and so more work needs to be done to prevent the escalation of future crises episodes and break the cycle of crises to promote and sustain long term recovery. Our evidence shows that people from the five specified communities will often return to situations of social isolation, alcohol and drug misuse, stigma and so on. These may be the triggers that contributed to the initial crisis episode.

Recommendation 4
Implement an open-ended follow-up programme with service users that includes a "step down" service that addresses the specific needs of the community. For example, people from BME communities felt that having peer support in this way would be reassuring and increase their confidence in the services and the help that could be provided. Supported housing could provide homeless people with the help they need to overcome and prevent the escalation of future crises episodes e.g. additional support following discharge from in-patient care and a phased transition back into the community. This may also help overcome issues related to social isolation and alcohol dependence which were identified as barriers to accessing services which could either prevent people getting to the point of crisis or support them through a crisis.

Conclusion 3:

The majority of the people we spoke to with a previous experience of crisis services had not had a positive experience. Across all of the five categories we engaged with, we found evidence that people's experience of services were largely negative. Such evidence is difficult to measure in terms of overall significance but nor can people's accounts of feeling 'dismissed' or treated 'without compassion' be disregarded. Further, there was evidence from some of the people we spoke to that the suggestions for 'self-care' made by the Crisis Services were not always felt to be appropriate in relation to the situation that the person using the service was in.

Recommendation 5

Further work on the quality of crisis services is undertaken. We feel that there were several comments made to us about the people's negative experience. This justifies a further and more detailed evaluation of the nature of the advice given to people in a crisis, both in terms of the manner in which advice is given and the evidence base for the effectiveness of the suggestions for self-care that appear to be made (listening to music, taking a bath etc).

Conclusion 4:

Arrangements made when patients are discharged from patient care are not always perceived as satisfactory. Where people had been admitted for inpatient care following a crisis, the majority reported that arrangements made on discharge were not always satisfactory and that a majority of people felt that they were not offered the on-going support that they felt they needed or were adequately prepared for discharge before it took place. This links to Recommendation 4 above.

Recommendation 6

Further work on discharge arrangements is undertaken. On the evidence given it would not be possible to say that this is a widespread problem but the evidence is strong enough for us to recommend that a review of discharge arrangements in a sample of discharges be undertaken, to ascertain whether or not the support plans put in place are satisfactory and lead to the outcomes people should expect. This should include ensuring that the person's GP is fully appraised of these arrangements and that the care plan is shared with the individual and his/her carer where there is one.

Recommendation 7:

The Crisis Resolution Home Treatment team should consider ways in which staff can avoid having to ask the service user to tell her/his 'story' more than once. We were told that there was a 'lack of consistency' for users of the service and this was linked to the requirement to re-tell their details and history to a 'new' staff member. People did not always know how often the visits would be or how long they would continue for. If Care plans were co-produced and shared with the user/carer, such concerns would be reduced, if not eliminated. Carer's assessments should be offered as routine.

4. Findings from Black and Minority Ethnic (BME) communities (including asylum seekers and refugees)

This section details the findings from 74 experiences. This includes:
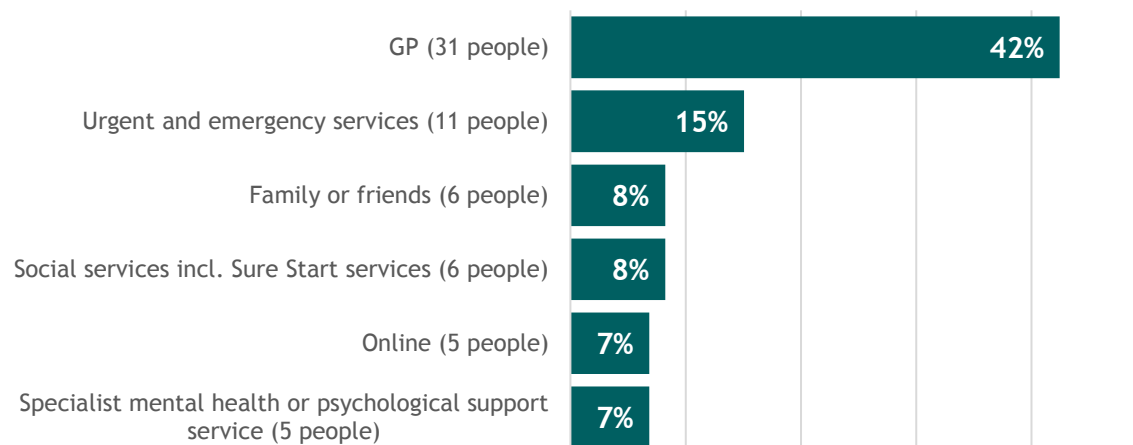
- 53 experiences and views collected through the quantitative survey
- 21 semi structured interviews

The demographic profile of the people reporting these experiences can be found in appendix 1.

4.1. Accessing urgent and emergency help during a crisis

People were asked to identify where they would access urgent and emergency help if they or someone they care for experienced a mental health crisis in the future. The top five most frequently identified sources are illustrated in figure 1 which shows that people were most likely to identify their GP as a source of urgent and emergency support. When asked why, people were most likely to state that this was because they saw their GP as the access point for other services, either through referrals or information and signposting. The only other reason identified by multiple people was because they had no knowledge of other sources of support.

Figure 1 Top five sources of help and support if needed

Source	Percentage
GP (31 people)	42%
Urgent and emergency services (11 people)	15%
Family or friends (6 people)	8%
Social services incl. Sure Start services (6 people)	8%
Online (5 people)	7%
Specialist mental health or psychological support service (5 people)	7%

Source: BME community (74 people)

It is also interesting to note that:

- Four people from the BME communities we engaged identified that they did not know where they would access urgent and emergency support if needed.

- Five people would actively choose not to seek urgent and emergency support if they were to experience a mental health crisis in the future. Where people identified a reason for this, it was most likely to be due to previous negative experiences of seeking support.

4.1.1. Barriers to accessing support

People were also asked to identify if anything had or would stop them from seeking urgent and emergency help and support for a mental health crisis in the future. 15 people (21%) stated that nothing would stop them accessing support, but of those who did identify a barrier this was most frequently because of:

- **Lack of information and awareness about services:** Almost a quarter (23%; 17 people) of the BME communities we spoke to made reference to this being something which would stop them accessing urgent and emergency support if needed in the future. As a result some of these people felt that there would be no-one who could help in a crisis situation or that they had or would access support from their family and friends.

- **Stigma:** Over a fifth (21%; 15 people) of all the BME people we engaged made reference to the stigma associated with mental health and being embarrassed to admit they had a problem. For example:

> I did not access any service as I did not want to be seen as that 'strong woman' who was vulnerable and lost control. I did not want to be stigmatised.

This was related to another barrier around confidentiality of services which led to people identifying that they may therefore look to deal with a future crisis themselves. Two people specifically made reference to how their status as an asylum seeker was a source of stigma and a status which prevented access to health services.

- **Home nation cultural influence:** 12 people (16%) referenced the home nation cultural influence as a potential barrier for accessing future help and support during a crisis situation. This meant people wanted to deal with their issues themselves, something which was also referenced in relation to a cultural influence amongst their community. This was often talked about alongside the stigma attached to mental health issues, identifying that this also originated from their home nation.

> ...over there you don't have special help, if you have a problem that's your headache, find a way to sort it out yourself. If you want to kill yourself go and kill yourself, they don't care, so you'll find a way to solve your problem, that's just it...Because that's how it happens in my country.

- **Language:** This barrier was identified by 12 people (16%) and was also related to the issue of confidentiality when translators, particularly family members, are required to facilitate access to services. People worried about not being able to communicate with services and convey their issues sufficiently to access the support needed.

- **Previous negative experience:** This barrier was discussed by 12 people (16%) and was referenced alongside comments related to accessing support from secondary mental health services and the long waiting times often involved.

4.2. Experiences of seeking urgent help and support

Of the 74 experiences collected, over a quarter (27%; 20 experiences) identified that they had been through what they thought was a crisis experience.

4.2.1. Contact and involvement with services before their crisis

Where people talked about support they had received from NHS services prior to their crisis experience, they were most likely to have been in contact with a specialist mental health or psychological support service.

- The majority were involved with secondary mental health services such as Psychiatrists or Community Psychiatric Nurses.

- Others had been referred through to a shorter term talking therapy including for example those provided through Let's Talk Well-being and Trent PTS.

- A smaller number of people had been in contact with their GP, referencing medications and referrals to further support.

Where people talked about their experiences of contact with service prior to their crisis it was mostly negative. Long waiting times were the most frequently identified and talked about issue. This was a source of frustration for many with some people identifying that as a consequence they were not getting better and there was the potential for them to reach crisis point as a result. For example:

> One time they referred me to rape crisis. I waited, waited for no appointments, no space, no space. GP will refer you but they will tell you no space you have to wait three months, four months, five months, it's a knock-on…Doesn't get fixed.
>
> I don't know why, you have to wait for six/eight months before you can be answered. Between that time you don't know what would happen to you. You don't know if one of these days you just wake up and you say, no, I'm going to give up…So if something like that goes on and on and on and on, I know one day I just break down and I just kill myself.

This was particularly referenced by the refugees and asylum seekers we spoke to, with over half of these identifying that they had come to this country having witnessed and or experienced trauma in their home nation. They were also dealing with being away from their families. This was specifically identified as being responsible at least in part for the mental health issues they felt they were now experiencing.

> Sometimes when I remember that in my head it's a trigger. I feel sick, I feel scared and you know.
>
> I always feel that there is somebody who is going to bang, you know, break into my home and do whatever with me, kill me…

Another issue identified by multiple people was the criteria for accessing specialist mental health or psychological support services, which resulted in them not receiving the support they felt they needed.

> I know like three psychologists actually refused me because they feel like my situation is too big for them to handle, which I feel like it makes me feel like I am going through a lot. Even if it's a little help, and it's temporary, could do a lot, but it could not help me.
>
> They tell you talking down at you like you're fine and then they give you that form to fill in where sometimes everything that you feel can't be written in just a form because they ask you those questions there, but what if I feel a certain way but I can't express it… and if you didn't get up to the score that you're meant to get they're going to tell you no, you don't really need it.

Four people commented on how they had not been in contact with any services before their crisis episode. When talking about this they commented on this being due to the cultural influence from their home nation and the stigma attached to mental health.

4.2.2. Experiences of accessing urgent and emergency support during a crisis

Where people from the BME community had accessed help and support during a crisis, they were most likely to have done this through accident and emergency, the NHS 111 service or a GP referral.   Where details were provided of accessing support through these routes, negative comments outnumbered positive comments by around three to one. All positive experiences made referenced how further support had been secured.

Where negative experiences were identified the opposite was true, further support from specialist services was not offered or secured. This did not meet the patient and or carer expectations, and there some indications that this experience was detrimental to their mental health.

When people from the BME community talked about accessing crisis services directly through the crisis phone lines there were three negative issues identified compared to one positive reference about how the experience had helped them in the immediate situation:

> I think that day it was enough, you know, to see me through the week and that evening and to prevent any more thoughts coming into my head about doing something silly and that sort of thing, so it sort of helped, definitely, yeah. It definitely helped.

Two people made reference to not being able to access urgent and emergency support through the phone call.

4.2.3. Experiences of support provided by specialist crisis services

Three people from the BME community that we talked to had received a visit from the Crisis Resolution Home Treatment team. Two identified their experience as negative and one positive. Both of the negative experiences made reference to how they felt their ongoing crisis and mental health status was not considered sufficiently by the team in the context of their responses and actions, leading to safety concerns for the patient and potentially others:

> We can see the signs of his illness, but when nurses come to the house he hides his real behaviour and can be charming. After, he refuses to take tablets and becomes more aggressive and violent. The problem is convincing everyone he is ill...
>
> When we rang the crisis team, people came out and he wouldn't let them in and he wouldn't let me out and they could see the situation was, you know, something needed to be done but they said their hands were tied until something more urgent happened. So they said they couldn't do anything until maybe if the police had been called or something had happened.

The positive experience made reference to how the team arrived at their home around one hour after referral and the supportive care provided by the two staff members who attended during an estimated six hour period of support. The outcome of which was securing further support through an inpatient facility.

Four people had experience of inpatient care to support them through their crisis, with all of these being placed at Highbury Hospital. However, one of these people told us about having to travel to London after a two night stay to secure a longer term inpatient bed as there were no appropriate beds available in Nottingham at the time of their crisis, something which they found distressing.

> There was no bed in Nottingham... but they're trying to get a bed for me somewhere close by I don't really have to go far because of my kids, I would have loved to have seen my kids...they couldn't get a bed in Nottingham but there was no beds so they had to move me... ...I was a bit upset and things like that because *[the hospital bed]* was a long wait to Nottingham, but I didn't know how long I was going to go for.

Three of the four people staying at Highbury had positive experiences. Two praised the service for the effectiveness of their support and the outcomes achieved:

> We could see the changes in him and then from the person that went in to the person that came out, he was like chalk and cheese. The person that came out, it was our brother again. So he was in a good place, medication was as it should be and we could see the effects of that and they were positive.
>
> It was very good support to me.

Staff communication was also praised by two people, who had frequent interactions with staff which demonstrated compassion. Another person identified that the atmosphere of the ward was central to the positive experience of the service.

4.3. Meeting the support needs of BME communities during a mental health crisis

We asked people to identify if they thought there was anything services could do better to ensure that people from BME communities received the care and support they needed during a mental health crisis. The following emerged as key themes as to how this groups needs could be better met:

● **Greater promotion of services and sources of support.** It was identified that this would be most successful if undertaken through community venues and groups where people from black and minority ethnicities already attend. Particularly venues which reflect and mirror the cultural influences of their home nation such as churches. People also suggested that this should be done alongside an education campaign to help overcome the stigma associated with mental health illness in these communities.

● **Peer support could be beneficial in helping support people to access services and provide support following discharge from crisis services.** People from black and minority ethnicities and particularly refugees and asylum seekers felt that having peer support in this way would be reassuring and increase their confidence in the services and the help that could be provided. For example,

> I think the best, for me, it would be being able to speak to people who are in the same situation or have gone through the same problems like me because I believe it's always good to share the experience and if you've been in the shoes, obviously, you have better understanding.

It was felt that this would help to prevent the escalation of crises episodes by supporting access to services before the point of crisis and promote recovery following a crisis, particularly after discharge from inpatient care.

5. Findings from carers of people with mental health illness

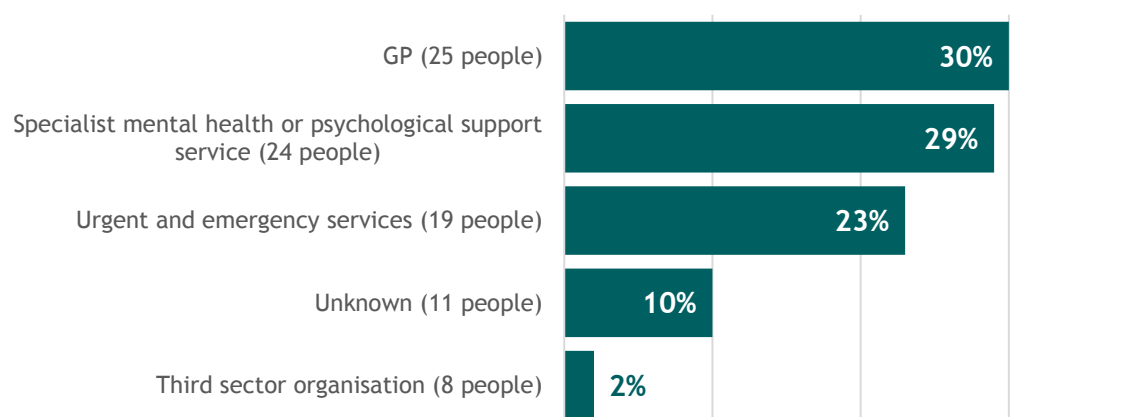This section details the findings from 83 experiences. This includes:

- 57 experiences and views collected through the quantitative survey
- 5 experiences reported to Healthwatch in the last three years
- 21 semi structured interviews

The demographic profile of those we engaged can be found in appendix 2.

5.1. Accessing urgent and emergency help during a crisis

People were asked to identify where they would access urgent and emergency help if they or someone they care for experienced a mental health crisis in the future. All carers we engaged stated that they would look to access urgent and emergency support and the most frequently identified sources of this support are illustrated in figure 2. This shows that carers were most likely to identify their GP as a source of urgent and emergency support. When asked why, they were most likely to state this was because they saw their GP as the access point for other services either through referrals or information and signposting. They also stated this was because of previous positive experiences with their GP. Two people told us that they wouldn't know where else to go.

Figure 2 Top five sources of help and support if needed

Source	Percentage
GP (25 people)	30%
Specialist mental health or psychological support service (24 people)	29%
Urgent and emergency services (19 people)	23%
Unknown (11 people)	10%
Third sector organisation (8 people)	2%

Source: Carer community (83 people)

Figure 2 also shows that there were 11 carers who did not know where they would access urgent and emergency support if needed.

5.1.1. Barriers to accessing help and support during a crisis

Carers were also asked to identify if they thought there would be anything that would stop them from seeking urgent and emergency help and support for a mental health crisis in the future; 57 provided a response. There were 15 people (26%) who stated that nothing would stop them seeking access to support, but of those who did identify a barrier this was most frequently:

- **Previous negative experience:** Over a quarter (26%; 15 people) of the carers we spoke to referenced this barrier alongside comments relating to additional stress for them as a carer and a lack of involvement in care provided. People also spoke about a lack of

convenience in accessing the service, and referenced previous negative experience relating to premature discharge, staff communication and not getting help when they felt they needed it:

> Because the person I care for had attempted suicides and the last time we called the crisis team he relayed a story to them and he (staff) said "well you didn't do it so therefore you're not at risk." That's not the type of information I expect to get from the county crisis team.

Lack of awareness or information: 15 carers (26%) made reference to not knowing how and where to access urgent and emergency support as being something that would present a barrier if they needed this support in the future. As a result some of these people felt that there was no one who could help in a crisis situation.

> It's just, I think these services, nobody knows they're there until they're in that situation where they need them and then sometimes they don't access them until it's too late.

Service capacity: 8 people (14%) referenced the lack of service capacity as a potential barrier for accessing future help and support during a crisis situation. People felt that understaffing, poor management and inadequate funding resulted in a service that did not have positive outcomes for the patient or themselves.

5.2. Experiences of seeking urgent help and support

Of the 83 experiences collected, over two thirds (70%; 58 experiences) identified that they cared for someone who had been through what they thought was a crisis experience.

5.2.1. Contact and involvement with services before their crisis

Where people talked about support that they and the person they care for had received from NHS services prior to the crisis episode, they were equally likely to have been in contact with specialist mental health or psychological support services or their GP. One person told us that the person they care for had not been in contact with any NHS services prior to the crisis experience.

Where people talked about their experiences of these services it was mostly negative. The most frequently talked about aspect of their experience was feeling as though their issues were being dismissed. This was a source of worry for the carers and they felt that the person they cared for was not getting the help they needed that could prevent the escalation of a crisis episode. For example,

> He (GP) actually, he seriously did nothing. You know. She (the person I care for) sat down and she wrote a letter of the way she felt and how she was and everything and he just went "oh it's nice to get a letter every now and again", and that's all he bloody well said, honestly.

The effectiveness of prior services was also referenced negatively, and the impact this had was that people felt that there was nothing that anyone could do to help with their mental health condition.

Another issue identified by multiple people was long waiting times. This was a source of desperation for many, with some people identifying that the person they cared for would become more ill and there was the potential for them to reach a crisis point as a result.

> …it can be three or four months and I keep saying to them, well what the hell do you think he's doing in the mean time? They just don't respond.
>
> We'd been to the GP when we thought he was beginning to get quite ill and they had referred him to a drug service in town, but then that took a while to kick in and actually then he became more ill and it ended up with the crisis team and then Early Intervention and Psychosis team.

People also made reference to the diagnosis and assessment process undertaken by the services they were in contact with prior to the crisis episode. Carers talked about missed opportunities for correctly diagnosing the mental health illness, with two going on to explain how they felt this led to a crisis episode:

> …at the same time it was a missed opportunity again of early identification, I suppose, that was the key thing. We went to the GP with real concerns about her health and it didn't seem to be, they didn't seem to want to manage it in-house.
>
> …she [doctor] missed possibility of diagnosis of bi-polar despite the fact that my wife had kept quite copious journals explaining times when she could have been a bit high and times when she thought she was a bit low. Kept receiving medication for depression, depression, depression, but as you may know, if you just keep medicating a bi-polar person for depression, you can go up at the top and the antidepressants can actually push you there and that's what we believe happened, what led to a manic episode.

Where people spoke positively about support that they had received from the NHS prior to a crisis experience the communication of the staff with them as the carer, and the regular contact they had with the patient were referenced as being beneficial in helping to identify the need for additional support before a crisis situation develops. Another person told us that this contact had helped them cope better with their situation.

5.2.2. Experiences of accessing urgent and emergency support during a crisis

38 carers had experience of seeking urgent and emergency help during a crisis. They were most like to have been done through indirect routes (31 carers; 82%):

- accident and emergency departments (18 carers; 47% of those who had sought help)
- through the police or 999 (14 carers; 37%)
- via a GP referral (5 carers; 13%)
- by a referral from another medical professional (5 carers; 13%)

Where details were provided about of accessing support through these routes, 14 negative comments were made, compared to 10 positive comments. The positive comments referenced waiting times, assessment and discharge with a support plan in place and referral either for mental health assessment or to emergency services.

Where negative experiences were identified, this was due to a lack of mental health support provided during their experience or the process through which a referral for ongoing specialist support was made. This was highlighted where people attempted to access the crisis service through accident and emergency departments and GPs.

Waiting times at accident and emergency departments were specifically referenced by three carers as adding to the stress of the situation for them as carers and being detrimental to the mental well-being of the person they care for who was experiencing the crisis episode. For example,

> [Waiting was] difficult, but she was trying to get out and go places and so on. I had to keep calming her down.
>
> Unfortunately, a nine hour wait in a small side room in A&E with security guards at the door with talk of being transferred to Manchester, did nothing to improve matters.

Twelve people told us that they had accessed crisis services directly through the crisis phone line, and there were seven negative issues identified compared to one positive reference. The latter commented on the helpful advice they received. The negative comments made reference to poor quality advice, for example,

> They told me to drink milk and put lavender oil on.
>
> They have not given him any sound advice over the phone just recently.
>
> The advice and support varied from "just keep taking the tablets" to "well what do you normally do" when my son was threatening suicide.

Two people specifically made reference to the crisis line advising them to call or use other services, including NHS 111 or accident and emergency departments, as means of accessing support during their crisis episode.

Three people made reference to calling the crisis phone line but not having their call answered, two specifically talked about this happening after hours.

5.2.3. Experiences of support provided by specialist crisis services

Experiences of the Crisis Resolution Home Treatment team
33 talked about their experience of a visit from the Crisis Resolution Home Treatment team, with 23 providing overall negative experiences compared to 10 who provided overall positive experiences.

The most common negative theme was around the frequency of contact, where people felt that they either weren't seen for as long as they wanted, or that contact was inconsistent but no explanation was given for this. For example,

> They also were very inconsistent with appointments. They came out every day for two weeks when we had his first episode of [attempted] suicide, then after that they started drip feeding him down, to the point it got, later on, after a couple of months, where it was just a once a week or once a fortnight, without any consistent pattern.

Other negative experiences made reference to a lack of immediate support available from the crisis team. This resulted in feelings of frustration for the carers we spoke to, who felt that the needs of the person they cared for were not being met:

> When we rang the crisis team, people came out and he wouldn't let them in and he wouldn't let me out and they could see the situation was, you know. Something needed to be done but they said their hands were tied until something more urgent happened. So they said they couldn't do anything until maybe if the police had been called or something had happened, then they could do something and it just seemed a shame that everybody seemed to be waiting for something to happen before they could act.

Other negative comments referenced staff, particularly poor communication. This described problems around being able to speak with relevant staff from the crisis team. When people did manage to speak with staff, a lack of compassion was commented on, as this was not supportive to the carer. For example:

> The person in the afternoon was quite dismissive. The one in the evening was better. I rang a couple of days later to let them know where she [the person I care for] was, how she was, and to thank them. The person had no interest, no compassion (I was very shaken by my friend's action and state), and pretty much put the phone down on me.

The positive experiences made reference to the frequency with which the patient was seen, and also commented on the quality of advice given and the way that crisis staff communicated. For example,

> I'd say on one occasion I rang them up and they told me what to do. They were very calming and were very calm and they were very good and made some suggestions of what to do. So that was good.

The effectiveness of the care received was referenced with people describing positive outcomes.

Experiences of Haven House crisis service
Three people had experience of Haven House. Negative comments made reference to the service being unprepared to deal with the physical needed of service users:

> I also think they have got a problem with their physical healthcare because I had to go to NEMS at one o'clock in the morning to get some steroids because they didn't have doctor on call to get me a prescription...I had a virus and couldn't breathe so one of the patients had to take me in the car.

Other negative experiences made reference to the facilities being dirty and having to wait to access the service due to a lack of beds. The outcome of having to wait for a bed was people feeling worse because they were not getting the support that they needed.

Where people spoke about the positive aspects of Haven House, the atmosphere and activities that were available was referenced. One person told us that the service had helped them get better.

Experiences of inpatient care

Twelve people had experience of inpatient care to support them through their crisis, with:

- 8 people placed in Highbury Hospital;
- 3 people placed in Millbrook;
- 1 person placed in Queens Medical Centre (Ward A42).

Four people made reference to there being a lack of beds available in inpatient services. The outcome of this was carers being left to deal with difficult situations and having to take on additional responsibilities to ensure the person they care for received the support that they needed:

> I mean they were almost hot bedding. They said to me you can take him home on leave but he's still under section but have him at home, because we haven't got any beds. So he was here with me and I had to take him into the ward a couple of times a week.

Other negative experiences made reference to a lack of involvement of the family in supporting the service user, a lack of treatment options with a reliance on medication over talking therapies and the perception that some members of staff were disinterested and lacked compassion. One person made reference to how they felt the inpatient service was unsafe for the person they cared for as they that he had been attacked by another patient while sedated.

Where people talked about positive experiences, references were made to staff being sympathetic, understanding and taking time to build relationships with the patient and the carer. This support was effective and achieved a positive outcome:

> She'd [member of staff] make sure she turned up for all his ward reviews, even if she was on her day off she came in for one of his ward reviews and she really... She made his point and made sure that he got the care that he needed.

We asked people about their experience of being discharged from crisis services. Negative comments outweighed positive comments by around four to one. We were most often told that the person was discharged too early and that there was no continuity in follow up services. This specifically made reference to changes in members of staff and often services not communicating with each other. One person told us that the lack of consistency in staff was so poor and detrimental to the person they cared for, that they decided to pay for private care:

> The key for me is the lack of consistency and the consultants as well, she [person I care for] is on her third consultant psychiatrist so it is … Now, what we did which I think is interesting, out of despair really, I paid privately and we found a very good counsellor.

We were also told that people were discharged without having a care plan in place or that where a care plan was in place, this was not implemented. In some cases people told us that this led to further episodes of self-harm. Two people told us that they had to initiate the development and implementation of a care plan for the person they cared for. Three people also told us that they had never been given the crisis phone number at discharge, nor did they know that this service was available.

Where people talked positively about the discharge experience, this made reference to the follow-up care that was put in place.

5.3. Meeting the support needs of carers during a mental health crisis

We asked people to identify if they thought there was anything services could do better to ensure that carers received the care and support they needed during a mental health crisis. The following emerged as key themes as to how this groups' needs could be better met:

- **Better communication between mental health services and carers and more carer involvement.** This was suggested because often carers felt as though they needed reassurance that the person they care for would be getting the support and care that they needed. Carers we spoke to also felt that they wanted to be better informed about what was happening to enable them to provide better support to the person they care for. People who were caring for adults told us that often decisions about care were made without input from them, and this was a source of frustration:

> And the argument I always have is, "You've excluded me from her care. You've excluded me when she has a relapse but when she's being discharged you write to me."

- **More support for carers and the families of people experiencing a mental health crisis.** We were told that caring for someone experiencing a mental health crisis can affect the carers' own mental health. Words like "isolated" and "frustrated" were often used to describe how people felt. Unpaid caring responsibilities combined, for some people, with employment can put strain on an individual and we were told that carers often are concerned about themselves. People talked about this in reference to being able to fulfil their caring responsibilities and were concerned about what would happen if they became unwell.

6. Findings from those who are homeless or are at risk of homelessness

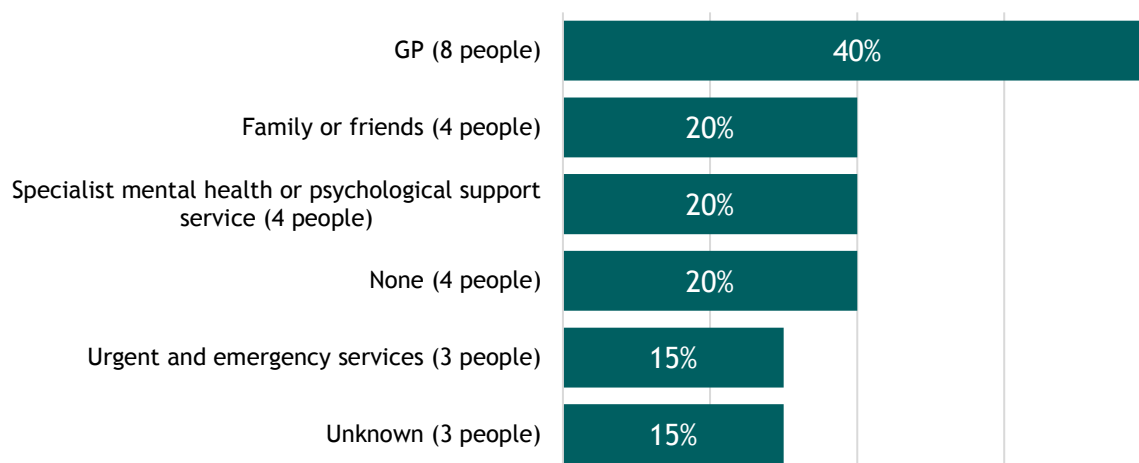This section details findings from 37 people engaged through the following:

- 6 experiences and views collected through the quantitative survey
- 1 focus group involving five people
- 24 semi-structured interviews, including 3 interviews engaging 5 service providers supporting people who are homeless or are at risk of homelessness

The demographic profile of the people reporting these experiences can be found in appendix 3.

6.1. Accessing urgent and emergency help during a crisis

People were asked to identify where they would access urgent and emergency help if they or someone they care for experienced a mental health crisis in the future. The top five most frequently identified sources are illustrated in figure 3 which shows that people were most likely to identify their GP as a source of urgent and emergency support. Where reasons were provided this was because the GP is seen as a primary contact for accessing other services.

Figure 3 Top five sources of help and support if needed

Source	Percentage
GP (8 people)	40%
Family or friends (4 people)	20%
Specialist mental health or psychological support service (4 people)	20%
None (4 people)	20%
Urgent and emergency services (3 people)	15%
Unknown (3 people)	15%

Source: 20 people responding to this question

For those people who identified that they would not seek urgent or emergency support, two identified that the reason for this was a lack of knowledge or awareness of how or where to get this help.

6.1.1. Barriers to accessing help and support during a crisis

People were also asked to identify if anything had or would stop them from seeking urgent and emergency help and support for a mental health crisis in the future. Three people identified that there would be no barrier to seeking urgent and emergency support during a mental health crisis. For those who did identify barriers, this was most frequently:

- **The crisis episode itself:** Six people (30%) made reference to how the symptoms of their mental health illness would prevent them from accessing help and support during a crisis. This was either because their illness would mean they could not attend GP

appointments needed to access specialist services or because their illness prevented them from recognising the need to seek help and support. This was linked to the chaotic lives often led by those who are homeless or at risk of homelessness.

🌱 **A lack of awareness or information:** This was identified by six people (30%), including some of the service providers we interviewed. They were unaware of how or where to access support for acute mental health problems.

🌱 **GP processes:** Five people (25%) identified that people who are homeless or are at risk of homelessness are often not registered with a GP practice and so this presents as a barrier for seeking help and support before or during a mental health crisis episode. In addition to this, two people also noted how the processes for booking appointments present a barrier to those who do not have mobile phones or not being able to see a GP of choice for a same day appointment.

🌱 **Previous negative experiences:** Five people (25%) specifically commented on how previous attempts at seeking help and support from NHS services would prevent them from accessing urgent and emergency help during a crisis episode. The majority of these experiences related to accessing help from GPs, and related to no support being provided or a lack of compassion and understanding from staff, for example,

> Previous doctor experience 'waste of space'. How can a doctor be a doctor if got no compassion?
>
> Wouldn't go to doctors, previous bad experiences - pushed away from the doctors 'told to go back and get a job' made feel frustrated and so got fed up.
>
> You say you've got to go back to your doctors and they'll say that's a waste of time…because every time they've done that in the past it never gets anywhere. They just think, what's the point?

🌱 **Alcohol and substance misuse:** Four service provider interviews (20%) made reference to this preventing access through a need for abstinence from alcohol before the specialist crisis teams could undertake an assessment, waiting times to access dual diagnosis teams and through people being placed into alcohol and substance misuse programmes which do not address their mental health needs.

6.2. Experiences of seeking urgent help and support

Of the 37 people engaged almost half (43%; 16 people) identified that they had supported someone who was homeless or at risk of homelessness through a mental health crisis episode or that they had personal experience of this.

6.2.1. Contact and involvement with services before their crisis

Where people talked about being engaged with NHS services prior to their crisis episode they were most likely to talk about seeing their GP (7 people). Three people had been in contact with some form of specialist mental health or psychological support service, two specifically making reference to Community Psychiatric Nurses.

The experiences reported were almost exclusively negative. The most talked about aspect was how people felt that their mental health issues or illness was dismissed by the service staff. This left people feeling like they were without any support for their issues, with two

people specifically identifying how their experience had been detrimental to their mental health status, leading one person to take an overdose.

> I knew I was on the verge of a suicide attempt, I walked into my GP in tears very distraught. The receptionist refused to let me see anyone saying I could come back in the evening for a sit and wait appointment! I went home and within 2 hours had taken an overdose.

6.2.2. Experiences of accessing urgent and emergency support during a crisis

The homeless people we spoke to were most likely to have accessed urgent and emergency support during a crisis through accident and emergency departments. Seven people talked about their experiences of accessing support in this way, six of these were negative experiences, one was positive. The main issue people faced related to discharge or release from accident and emergency, with three people specifically identifying that no mental health support or follow up had been put in place or initiated, for example,

> I was taken to QMC where they kept me overnight. I saw the psychiatrist who asked me if I would do it again, (not why or showing any interest in my problems) when I said no she released me from hospital, there was no back up or support.
>
> A lot of those people could be discharged to the streets, to no fixed abode...they have nowhere to go, no services to go to, there's no help for them.

There was a feeling that discharge happens too soon without sufficient assessment of their mental health issues. Service providers felt that this, in combination with a lack of support upon discharge, was not promoting recovery either in the short term or the long term. This created a 'revolving door' situation with patients experiencing future crisis episodes and returning to the accident and emergency departments.

The positive experience talked about how their experience of accident and emergency was characterised by kind and compassionate staff and quick access to specialist crisis team.

Experiences of accessing specialist services through other indirect routes were mostly positive:

- **999 access** – One person reported their experience as positive due to the care and compassion demonstrated by the person answering the phone, and the quick response of the ambulance crew. They indicated that this has been effective in preventing their crisis episode from escalating.

- **GP access** – Four people identified that they had sought urgent and emergency support through their GP. Three people talked about this being positive, referencing a referral to specialist crisis team. The negative experience was the opposite with a referral to crisis teams denied.

- **Direct police access** – Two people talked about going to or calling the police directly in an attempt to get support during a crisis episode. These experiences were both identified as negative due to the lack of an onward referral to specialist crisis services.

Only three people identified that they had sought help and support directly through the crisis phone lines. Two of these experiences were given by service providers who identified that although the person they were supporting was known to crisis services they were told that no support could be provided:

> I rang them up and they took ages to phone back and when they did they were like again, saying he's been before, we know about him, we can't really do anything…He was talking about taking his own life, about harming other people…
>
> And often, I've had clients who were known to them…they've actually told me to call A+E because of the crisis.

Another service user identified that crisis line had not referred them onto the treatment team as their depression was not seen as being severe enough. They went on to seek support through the NHS 111 service.

6.2.3. Experiences of support provided by specialist crisis services

Experiences of the Crisis Resolution Home Treatment team
Seven people identified that they or the people they support had received urgent and emergency support from the Crisis Resolution Home Treatment teams. One person described a positive experience with frequent contact from the team who had been helping them to manage their medication more effectively and recover from their crisis episode.

Six people discussed negative experiences of the home treatment team. The most talked about issue was the staff who came to visit them, and this not always being the same person. This resulted in patients having to retell their story to different members of staff which caused them additional anxiety and stress:

> So you have to get through that awkwardness of revealing yourself to a stranger every single time, instead of getting comfy with one. And for mental health that's the worst, because for somebody that's got like a physical problem, that might not be a problem seeing a different doctor, but for someone who's got mental health – anxiety – they're literally telling you to go and cause yourself anxiety to stop anxiety. That's what they're doing, basically.

Staff were also referenced with regards to the compassion and understanding they demonstrated. Two people commented on how they felt the staff didn't demonstrate the principles of person centred care and were going through a 'process' of assessing whether someone met their criteria.

Service providers we talked to felt that the service delivered by the treatment team didn't always accommodate the chaotic lifestyles of people who were homeless. It was acknowledged that the treatment team have attended community venues to see and assess homeless people, but the appointment times could be problematic. This reflects the access barrier previously identified in that the crisis episode itself and the chaotic lifestyle can often prevent homeless people from attending appointments.

These negative experiences led two people who had personally experienced this service to specifically identify that the home treatment teams were not helpful and did not support a long term recovery from their crisis episode.

Experiences of inpatient care

Seven people identified that they had received inpatient care as a result of their crisis episode; there were six negative experiences reported compared to one positive experience.

The most frequently identified theme of the negative experiences was the discharge from inpatient care. Three people talked how they felt discharge happened too early before they were ready to cope with the chaotic lifestyle that homeless people or those at risk of homelessness often lead. For example,

> From my experience, the care is good but however I think the discharge process is very quick and the people are not ready to be discharged at that point. They kind of need longer to stay in hospital and be monitored …long enough to be independent, take your medication 4 times a day type of thing.
>
> They come back out and they're high and dry again. Someone they knew before sees them and says come on have a drink with me and then here we go again…You get them out here, unless you get stable accommodation with help out here they go back to it, cos that's all they've got.

There were also two people who commented on how they felt there were not adequately prepared for their discharged due to a lack of communication from staff in terms of explaining why they were being discharged and providing information on the discharge process and any support that would be offered. Whilst two people commented on the support put in place for them following discharge, there were three people who stated the opposite. They were unaware of any support being offered for them upon their discharge from inpatient care. Two people identified that although support had been organised they were unable to access this due to long waiting times or it was unhelpful due to the frequency of contact.

6.3. Meeting the support needs of those who are homeless or are at risk of homelessness during a mental health crisis

We asked people to identify if they thought there was anything services could do better to ensure that people who are homeless or at risk of homelessness received the care and support they needed during a mental health crisis. The following emerged as key themes as to how this groups needs could be better met:

- **Provide mental health and urgent and emergency crisis support through community venues and groups.** This was suggested as a means of providing some form of drop-in support at places where those who are homeless or at risk of homelessness already attend or are aware of. Drop in support was identified as overcoming the barriers associated with chaotic lifestyles and crisis episodes. Using established venues would help attendance as people would have established relationships and trust in the people running the venue and/or group.

- **Residential support could provide homeless people with the help they need to overcome and prevent the escalation of future crises episodes.** This was discussed as a means of providing additional support following discharge from inpatient care and a phased transition back into the community. It was also identified that this could help overcome issues related to social isolation and alcohol dependence which were identified as barriers to accessing services which could either prevent people getting to the point of crisis or support them through a crisis.

● **Closer working relationships and communication between third sector support groups and statutory services.** All of the service providers we spoke to felt they could play a more valuable role in supporting homeless people if they could directly refer them into specialist crisis services and had better communication with services around the care and support they were receiving during a crisis episode. This could support both recovery from, and prevention of mental health crisis episodes by identifying and addressing the barriers that are preventing them accessing help they need when they need it.

7. Findings from students living or studying away from their hometown

This section details the findings from 55 experiences collected through:
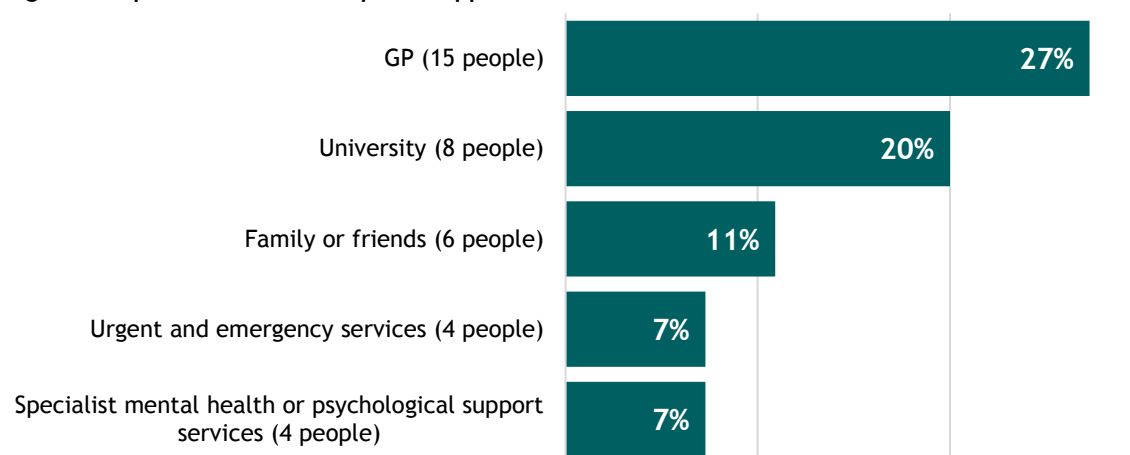
- 45 experiences and views collected through the quantitative survey
- 10 semi structured interviews, including one interview engaging two university mental health advisors.

The demographic profile of those we engaged can be found in appendix 4.

7.1.   Accessing urgent and emergency help during a crisis

People were asked to identify where they would access urgent and emergency help if they or someone they care for experienced a mental health crisis in the future. The top five most frequently identified sources are illustrated in figure 4. This shows that people were most likely to identify their GP as a source of urgent and emergency support. When asked why, people were most likely to state this was because they felt their GP could assess the severity of their condition and prescribe medication to help. Prior positive experiences with their GP were also mentioned with people specifically identifying their GP as supportive and understanding.

Figure 4 Top five sources of help and support if needed

Source	Percentage
GP (15 people)	27%
University (8 people)	20%
Family or friends (6 people)	11%
Urgent and emergency services (4 people)	7%
Specialist mental health or psychological support services (4 people)	7%

Source: Student community (55 people)

It is also interesting to note that:

- Three people from the student communities we engaged with identified that they did not know where they would access urgent and emergency support if needed.
- Three people would actively choose not to seek urgent and emergency support if they were to experience a mental health crisis in the future. One person told us that the reason for this was that they would not know where to seek help. Two people told us that they would try and resolve the problem themselves.

7.1.1.   Barriers to accessing help and support during a crisis

People were also asked to identify if anything had or would stop them stop seeking urgent or emergency help and support for a mental health crisis in the future; 40 people provided

a response. 11 people (28%) stated that nothing would stop them from accessing support, but of those who did identify a barrier this was most frequently:

Lack of information and awareness about services: Just over a fifth (23%; 9 people) of the student community we spoke to made reference to this being something which would stop them accessing urgent and emergency support if needed in the future. Some people told us that there was no information available to them if they needed help in the future. Two people told us that they were unsure about what help they were eligible to have as an international student.

Stigma: 8 people (20%) of those students providing a response talked about the stigma associated with mental health illness and being embarrassed to admit that they had a problem. For example,

> I never did [seek urgent or emergency help] because I was scared I would be wasting time, that I wasn't worthy of that kind of help, at all, that I'd be judged because of the scars on my arms or for misusing NHS resources and time. In retrospect, there were probably at least two occasions when I should have gone but was too scared to.

One person specifically made reference to how seeking help for a mental health condition may specifically result in being 'labelled' and may affect them longer-term, particularly when they seek work.

Previous negative experience: This barrier was discussed by 5 people (13%) and was discussed alongside the poor quality of advice given by the specialist crisis service and not always being able to see the same member of staff.

7.2.   Experiences of seeking urgent help and support

Of the 55 experiences collected, almost half (42%; 23 people) identified that they had been through what they thought was a crisis experience.

7.2.1.   Contact and involvement with services before their crisis

Where people talked about support they had received from NHS services prior to their crisis experience:

The majority were involved with their GP.

A smaller number of people had been referred to a shorter term talking therapy, for example, Let's Talk Wellbeing, or said that they were under the care of a psychologist (though it was not clear what service they worked for).

Where people talked about their experiences of contact with services prior to their crisis, it was mostly negative. Difficulties in getting an appointment with a GP was often cited and the delay that was caused meant that the help people needed was delayed.

> They may have periods of time where everything's shiny and new, but quite often the difficulties creep back and even where they're seeking services, often they will begin that journey here through the GP and then there's a delay and then they go home for the holidays.

Two more people highlighted problems around communication between services in the home town of the student and services in Nottinghamshire. This poor communication was a source of concern as it meant that access to care may be delayed, and that there was potential for them to reach crisis point as a result:

> Then they [student] don't answer any letters because all the letters go to the wrong place, then they're seen as not being compliant with any support that's being offered so the timing and the understanding of the context is absolutely crucial.

Positive experiences of contact and involvement with services before a crisis episode made reference to the GP that was seen. People commented on being signposted to other organisations that would be able to help them, and this was viewed as helpful. The attitude and care provided by the GP was also commented on:

> I did see the GP a lot and there were a couple of GPs there who were really helpful and they're trying to do all that they could.
>
> I had very good GP who is very active in trying to find any option to help.

One person told us that they had not been in contact with any services before their crisis episode. This was due to the sudden onset of the crisis episode.

7.2.2. Experiences of accessing urgent and emergency support during a crisis

Where people from the student community had accessed help and support during a crisis, they were most likely to have done this through indirect routes. Seven people talked about accessing support through accident and emergency departments, all of them discussed negative experiences. The main issues with their experiences related to the compassion and communication skills demonstrated by staff, which led to students feeling like their issues were being dismissed.

> Went to A+E at QMC experiencing suicidal and self-harm thoughts and physical pain symptoms and was told 'if you had overdosed or something we'd be able to offer treatment' and was immediately discharged.
>
> ...the doctors weren't [nice], they were very, it was like, you have done it before you will do it again. One said "you have ruined your looks" so not appropriate. Would never say that to someone who had had a motorbike accident.

Another theme of these experiences related to discharge. Students talked about being sent home very quickly with no mental health support being put in place.

Four people had sought urgent and emergency support via a GP referral and all of these talked about this experience in a negative way. The common theme was a lack of NHS mental health support being provided, with two people identifying that GPs were referring students back to mental health support services provided by the university.

Experiences of accessing specialist services through other indirect routes were mostly negative. One person provided negative experiences of accessing support through 999 due to long waiting times, and another person referenced a bad experience of accessing support through the police but provided no additional details of this experience.

Three people talked about and provided examples of seeking support directly from the specialist crisis services through their dedicated phone line. All of these experiences were negative, with all three talking about the unhelpful advice they felt they had been offered. For example,

> …because the things they'd suggest (especially those on the phone), were utterly ridiculous and, the overwhelming majority of the time, things that ANYONE with any degree of ability to think for themselves- no matter how impaired- would already have tried. Examples include, taking a shower, watching a film or listening to music to distract oneself (something I spent the majority of my time spent in my flat doing ANYWAY), going for a walk (something I also spent the majority of time doing), drinking herbal tea (I drank so much chamomile tea at that point in my life that I could get through a box of 80 bags in less than a month) and of course telling me to go to A&E nearly every time regardless of the fact I was not always suicidal
>
> Crisis said have a warm bath and a drink…if a warm bath and drink was going to solve it I wouldn't be on the phone. Felt that I hadn't been taken seriously, advice was wildly out of line with the situation.

Students felt that this showed a lack of compassion from the staff and made them feel as if their issues had been dismissed.

7.2.3. Experiences of support provided by specialist crisis services

Experiences of the Crisis Resolution Home Treatment team
Five people from the student community that we talked to had received a visit from the Crisis Resolution Home Treatment team. All experiences were identified as negative, although there were some positive features described. Four experiences made reference to the staff that were encountered, and how they lacked understanding about mental health conditions:

> There were also a lot of very unhelpful, dismissive and rude individuals who appeared to know very little about mental health.
>
> Also I don't think that all the staff have appropriate training and understanding of autism and mental health (as a combination) or of things like flashbacks and dissociation.

Three people made reference to poor communication and the extent that they were listened to. Two people specifically commented on how they felt the poor communication skills demonstrated by the team could or had been a risk to their safety.

There were also two examples provided of when staff had not turned up to visit people as planned, with this not being communicated to patients properly beforehand.

Staff were also referenced with regards to it often being different members of staff attending home visits. This meant that details of their crisis and mental health status and history having to be repeated which was a source of additional anxiety. For example,

> Seeing different people all the time and repeating the same thing over and over is also incredibly difficult when you are already really low on resources and just need some security and consistency.

The positive experiences of the Crisis Resolution Home Treatment team made reference to feeling listened to by staff and that the interactions were helpful to them. One experience made reference to how they were seen for the first time on the same day that the referral was made. The outcome of which was being supported through an inpatient facility.

Experiences of Haven House crisis service

Three people had experience of the Crisis House to support them through their crisis. These were positive experiences, identifying in general terms that their stay had been 'brilliant' or 'helpful'. One person told us that they felt supported, and said that they would seek a referral there if they experienced a crisis again.

Experiences of inpatient care

One person had experience of inpatient care to support them through their crisis, and was placed at Ward B2 (Bassetlaw Hospital). This person told us that they were placed here as there was no space in their home town of Mansfield. They felt that their overall experience of the inpatient service was negative and made reference to their mental health issues being dismissed, not receiving information about what was happening to them and also longs waits to see a consultant.

> And in that 10 minutes he saw me he decided I wasn't even depressed it was all just stress and that was honestly one of the most devastating things was to be told that this huge breakdown I had was an overreaction to something. I was only stressed, that if I managed to handle my stress I would stop being traumatised or you know…

One person had experience of Health Based Places of Safety, which was mixed in sentiment as it mentioned both negative and positive features of the staff that they saw. They told us that they felt most of the staff were quite negative, however they spoke positively of staff that were happy to listen to them.

We asked people about their experience of being discharged from crisis services and this was a negative experience for all. We were most often told that the person was discharged too early, and for two people this led to another crisis episode. Three people made reference to poor contact from the Crisis Home Treatment Team highlighting problems with waiting times and a lack of communication from the service. One issue that was highlighted was that students may be discharged to an inappropriate location, such as halls of residence or a shared student house, where responsibility for that person was assumed on other students:

> Sometimes it has occurred that a student's been an inpatient discharged home to their flat with a kind of, almost an expectation their flatmates will keep an eye on them. These flatmates may be 18.

7.3.   Meeting the support needs of students during a mental health crisis

We asked people to identify if they thought there was anything services could do better to ensure that students received the care and support they needed during a mental health crisis. The following emerged as key themes as to how the needs of this group could be met:

- **Greater promotion of services and sources of support.** It was identified that this would be most successful if executed through social media platforms like Facebook and Twitter which are often used by students.

- **NHS support being available through university based treatment.** Students felt that having low level psychological support available in this way would be helpful. This suggestion would take into account the context of students, particularly those living away from home that may need to access these services. The service would be bespoke and take into account the pressures that students are under:

> I think the other thing is I do honestly think there is a need for greater thinking and consideration of the context of student living. So they're in the most risky age group, we already know that, the vast majority of them obviously.

Having a service based at the university may also be more convenient for students and may overcome a barrier to seek support in the first place.

8. Findings from veterans/ex-military personnel

This section details the findings from 21 experiences collected through the following:

- 13 experiences and views collected through the quantitative survey
- 8 semi structured interviews, including one with a provider of a third sector service supporting veterans/ex-military personnel

The demographic profile of those we engaged can be found in appendix 5.

8.1. Accessing urgent and emergency help during a crisis

People were asked to identify where they would access urgent and emergency medical help if they or someone they care for experienced a mental health crisis in the future. The top sources identified by more than one person are illustrated in figure 5 which shows that people were most likely to identify their GP as a source of accessing urgent and emergency support. When asked why people were most likely to state this was because they had a good relationship with their GP, had previous positive experience relating to physical illness and saw their GP as an access point to other services.

Figure 5 Sources of help and support identified by more than one person

GP (12 people)	60%
Urgent and emergency services (6 people)	30%
Unknown (3 people)	15%
None (2 people)	10%
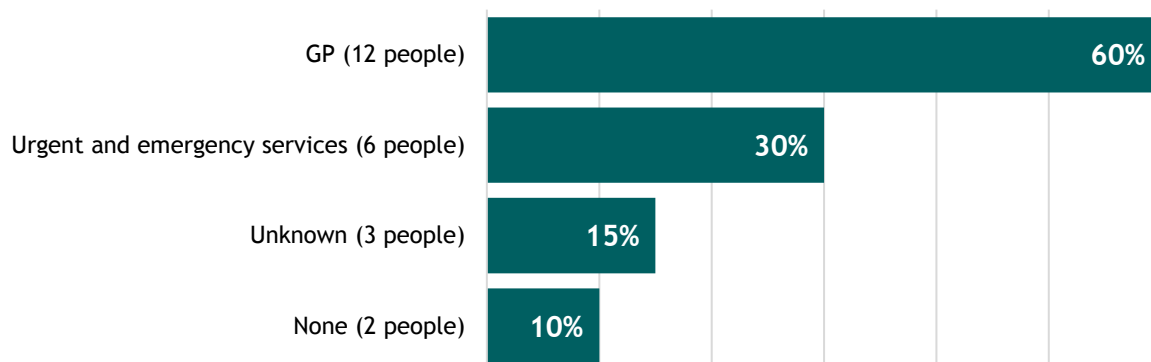
Source: 20 people responding to this question

Two people would actively choose not to seek urgent and emergency support if they were to experience a mental health crisis in the future. Where people identified a reason for this, it was most likely to be because they would use other members of the veteran/ex-military community to resolve any problems.

8.1.1. Barriers to accessing help and support during a crisis

People were also asked to identify if anything had or would stop them from seeking urgent and emergency help and support for a mental health crisis in the future; 19 people provided a response. Eight people (42%) stated that nothing would stop them accessing support, but of those who did identify a barrier, this was most frequently:

- **Stigma:** One third (37%; 7 people) of the veterans/ex-military personnel we engaged made reference to the stigma associated with mental health illness and poor health more generally. This was identified as being specifically related to their previous service in the armed forces. For example:

> In the early days I was a bit 'oh, I spent 10 years in the grenadier guards, I guarded the Queen, I'm macho, I'm not asking for help, because a coward asks for help.
>
> From personal experience, if you went sick or report sick at any of the services, it's looked down on. And again, people I work with, ex-service men and people I've worked with in the past very, very rarely go off sick. They'll come to work when they're dying, some of them. It's just sort of loyalty, it's what you have to do in the forces. And you carry on doing that in civilian life.

The crisis episode itself: Five people (24%) made reference to how the symptoms of their mental health illness would prevent them from accessing help and support during a crisis. This was either because their illness would mean they could not attend GP appointments needed to access specialist services or because their illness prevented them from being able to recognise the need to seek help and support. This was linked to the social isolation faced by some veterans/ex-military personnel.

Lack of awareness or information: Almost one fifth (19%; 4 people) of the community that we spoke to made reference to not knowing how or where to seek support as being something that would stop them accessing urgent or emergency help for a mental health crisis in the future.

8.2. Experiences of seeking urgent help and support

Of the 21 experiences collected, 3 people (14%) identified that they had been through what they thought was a crisis experience.

8.2.1. Contact and involvement with services before their crisis

Where people talked about the support they had received from NHS services prior to their crisis experience they were most likely to have been in contact with a specialist mental health service. One person had been in contact with their GP.

Where people talked about their experiences of contact with a service prior to their crisis, all of these were negative. Issues with staff communication was the most frequently identified aspect of experiences. This was linked to perceptions about the effectiveness of treatment and a feeling that their issues were being dismissed. This was a source of frustration and upset, with some people identifying that there was potential for them to reach breaking point as a result:

> I went, and because I'd got no confidence, I'd got no self-esteem, you know, because you think they're the professionals, they should know and everything and the way he was talking to me was like I was a piece of dirt. And I said, "Well what am I going to do about my antidepressants then?" He said, "Well, I'm not going to give you a repeat prescription. What I want you to do is, I want you to go home, sit down, make yourself a cup of tea and over the weekend work out how long you want to be ill for." …I went home, thank God I had the internet because how I didn't kill myself God only knows.

8.2.2. Experiences of accessing urgent and emergency support during a crisis

Two people talked about accessing urgent and emergency support during a crisis through accident and emergency departments. One person did not provide any details of this experience and the other believed that experiences of accessing support through this route were negative due to the waiting times that were involved. This was seen as exacerbating the stigma veterans/ex-military personnel attach to seeking help for mental health illness due in part to the influence of the military service history.

> Most of the time they turn round and walk out. Quite often there's arguments and most of the time they walk out. You have guys coming back from Queen's walking 5, 6, 10 miles to get home, because they're so angry and frustrated.

One person talked about their experiences of accessing help and support directly from specialist crisis services through their dedicated phone line. Their experience was mixed, with an initially positive outcome from the phone call but a lack of further support from the home treatment team:

> So, I can always remember, it was a Saturday morning, I phoned them up and I said look, I'm not feeling very good...Anyway, he sat on the phone for about half an hour and he managed to get me calmed down and that were it. And it were like, OK, go and see your GP on Monday.

Their GP subsequently complained about the lack of follow up and secured a referral to the home treatment team the same afternoon.

8.2.3. Experiences of support provided by specialist crisis services

Two veterans/ex-military people we talked to discussed experiences of the Crisis Resolution Home Treatment team. These were both negative experiences and made reference to issues with accessibility and therefore a lack of immediate support available. Both talked about issues related to waiting times to see someone from the team, stating that initial contact doesn't always happen quickly, and one person detailing their experience of having to chase the team on numerous occasions when promised phone calls were not received.

One person also commented on the effectiveness of the service, stating that they had been aware of veterans/ex-military personnel being involved with them on several occasions yet not receiving any help. On some occasions help and support had not been provided due to the involvement of alcohol misuse:

> And there's two or three times when I've actually been on the phone to the Crisis Team and having arguments over it...'well we can't help him because he's drinking'

8.3. Meeting the support needs of veterans/ex-military personnel during a mental health crisis

We asked people to identify if they thought there was anything services could do better to ensure that veterans/ex-military personnel received the care and support they needed during a mental health crisis. The following emerged as key themes as to how this groups needs could be better met:

- **Identification of veteran/ex-military status in medical records.** It was suggested that this information would make medical professionals aware of the personal circumstances of an individual. This would act as an indicator of the person's history and may reduce unnecessary discussion about this.

- **Greater promotion of services and sources of support.** It was identified that this would be most successful if undertaken through community venues and groups where veterans/ex-military personnel already attend. People suggested that this should be done alongside armed forces organisations to help overcome the stigma associated with mental health illness in these communities to encourage people to seek help if and when they need it.

- **Closer working relationships and communication between third sector support groups and statutory services.** People that we spoke to felt that signposting and referral from other agencies could be beneficial in supporting veterans/ex-military personnel. It was suggested that a hub specifically for this community would be helpful, where different organisations could work together to support people who are experiencing a mental health crisis.

9. Findings from the wider population

This section details the findings from 215 experiences. This includes:
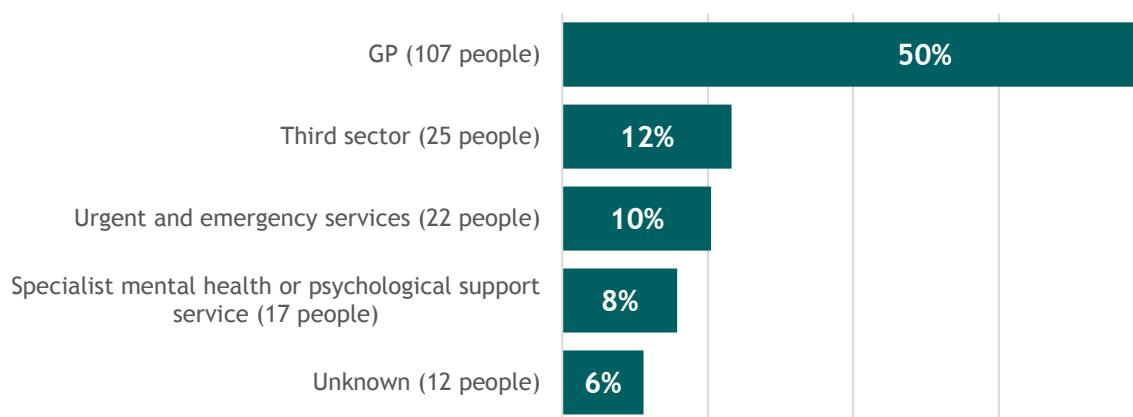
- 170 experiences and views collected through the quantitative survey

- 38 experiences reported to Healthwatch in the last three years

- 7 semi-structured interviews

The demographic profile of the people reporting these experiences can be found in appendix 6.

9.1. Accessing urgent and emergency help during a crisis

People were asked to identify where they would access urgent and emergency help if they or someone they care for experienced a mental health crisis in the future. The top five most frequently identified sources are illustrated in figure 6 which shows that people were most likely to identify their GP as a source of urgent and emergency support.

Figure 6 Top five sources of help and support if needed

GP (107 people)	50%
Third sector (25 people)	12%
Urgent and emergency services (22 people)	10%
Specialist mental health or psychological support service (17 people)	8%
Unknown (12 people)	6%

Source: 213 people responding to this question

When asked why people were most likely to access support through their GP, the top three most reported reasons were:

- they saw their GP as the access point for other services either through direct referrals or information and signposting (52% of all given reasons made reference to this)

- they had no other knowledge of where to go for support during a crisis (16% of all given reasons made reference to this)

- they felt the GP was best placed to provide support as they knew them already (9% of all given reasons made reference to this)

People identifying the third sector as their source of support talked about having no other knowledge of where they would access support or that they felt the staff working within this sector would have more understanding of the situation. For example,

> I would probably get in touch with one of the mental health charities. They are more confidential. I think the people who work there have a more personal approach.

9.1.1. Barriers to accessing support

People were also asked to identify if anything had or would stop them from seeking urgent and emergency help and support for a mental health crisis in the future. Of those who provided a response the most frequent response was that there would be no barrier, people indicated that they would look to seek urgent and emergency support in that situation (29%; 41 people).

For those who did identify barriers, this was most frequently:

- **A lack of funding for and capacity within mental health services:** Almost a quarter (24%; 33 people) identified barriers related to their perception of how mental health services are funded and therefore the capacity within them. This led to a third of these people identifying fears that support may not be immediately available if needed. Some of these fears were a result of previous experiences, others were a perception. For example,

> …they are not readily available when in crisis, you need something immediate to step in and this hasn't always been the case for me personally.
>
> Suspect there could be delay. Would be worried that services would not have staff to respond.

- **Previous negative experiences:** a fifth (19%; 27 people) commented on how their previous experiences of seeking help and support would stop them attempting to do the same in the future. The majority of these were from people who experienced mental health illness and or had been in a crisis before, and through these comments equal reference was made to how they felt there was a **lack of care and support** offered or available to them, the **effectiveness of any care and support** which was offered and the **poor communication and compassion** demonstrated by staff. For example,

> Because when I have tried in the past and no one answers the phone.
>
> No support from any NHS service apart from medication. Ended up self-referring to a charity.
>
> [Previous experience of care]…has just made me feel worse and the worrying thing is that I'm not sure I will ever go back but what do I do when I need urgent care? It frightens me that I will kill myself.
>
> Poor response from previous contact with services i.e. others not understanding your concerns and being abrupt and judgemental.

- **A lack of awareness or information:** This emerged as barrier to seeking urgent and emergency help and support during a mental health crisis for 18% (24 people) of those who responded to this question. People are unaware of what services are available to support people with mental health issues and how to access them which led to responses such as, *"Do not know where help is"* and *"Not knowing who they are or where to go."*

- **The accessibility of services:** Nine people (7%) specifically stated that either a lack of an out of hours or a 24 hour service or services which were not accessible due to location would stop them from seeking urgent or emergency help during a mental health crisis.

- **The support packages/treatments available:** Eight people (6%) felt the only options available if they needed help would not be appropriate for them. This was related to previous negative experiences of seeking support.

9.2. Experiences of seeking urgent help and support during a crisis

Almost half (49%; 109 people) of the people engaged identified that they had experienced some form of mental health crisis.

9.2.1. Contact and involvement with services before their crisis

When people talked about being in contact with NHS services prior to any crisis experience they were equally likely to talk about contact with a GP and or some form of specialist mental health service.

Negative issues were identified more frequently than positive experiences, with one of the main issues being access to services. There were examples provided of where people had been delayed in accessing specialist mental health and well-being services. This was due to having to push for referrals from GPs, long waiting times (including one person still waiting 18 months after a referral). There were three examples of where people had not been able to access services due to their criteria for treatment:

> My Doctor referred me to a therapist…after my first visit before the session had even got started I was told that the therapy they had in mind was unsuitable and I was referred back to my doctors.
>
> Despite my GP referring me to mental health services my questionnaire scores were not within the 'acceptable' parameters.
>
> At one point I did get referred to Highbury Hospital but the person I met with said that because I was dressed and didn't have unkempt hair etc. I was well enough.

Where treatment and support had been received people most frequently made reference to poor communication of the staff providing the care. People reported feeling like staff were dismissing their mental health issues, or didn't take them as seriously as physical health issues.

Six people made reference to how these negative experiences had a negative effect on their mental health and well-being. Some people talked about how their mental health had generally deteriorated as a consequence and others talked about experiencing a crisis which they directly linked to their negative experience of trying to seek help. For example,

> The help I have received over ten years has gone down dramatically over the years to the point where I have virtually no input from mental health services but my needs haven't changed, this is not recognised. It has a bad impact on my general mental health.
>
> ...all help I had been getting had stopped due to the cuts. With not enough support and other things I relapsed I reached crisis point and made an attempt on my life.

9.2.2. Experiences of accessing urgent and emergency support during a crisis

Where people had sought urgent and emergency support during their crisis they were most likely to have done this indirectly, through accident and emergency departments. Staff were the most talked about aspect of people's accident and emergency experiences, and negative comments were twice as likely as positive comments. Those reporting negative experience talked about accident and emergency staff lacking compassion and understanding of the mental health crisis episode they were experiencing. Poor communication was referenced and people felt that their issues were being dismissed, particularly by doctors. This was detrimental to people's mental health status, for example:

> I know that I self-harm and can understand the judgement that professionals make but I was treated really coldly and in an uncaring way. It just compounds the thoughts that I have that I am dirty, stupid and disgusting. No one cared that I was upset, cold, in pain and alone and I got the impression that they think if they treat me like that I won't do it again but unfortunately mental health doesn't work like that and I don't have a lot of control.

Positive experiences made reference to the opposite, nursing staff were specifically identified as being compassionate and caring. For example,

> When I got there the nurse recognised me and said how well I have been doing and she had noticed that I haven't been for a while. She was very caring and supportive.

Waiting times to be seen at accident and emergency were another central theme to negative experiences. People reported that their crisis episode made the hours of waiting difficult and two people commented on how the waiting in combination with their mental state meant that they had or had thought about walking out of the department before being seen.

Access to specialist mental health support through the department was variable. There were two examples of where specialist mental health support had been provided but four people made reference to how this specialist mental health support was lacking whilst they were in the department or as follow-up upon their discharge. For example,

> Another friend went to A and E because she was suicidal but she was just sat down and watched, no mental health specialist came to see her.
>
> Disgusting lack of care from the mental health team. Said they were unable to visit me whilst I was on a ward recovering from a suicide attempt as they were busy. Discharged with no mental health follow up.

Two people made specific reference to how their negative experiences of seeking urgent and emergency help for a crisis through accident and emergency departments had not helped to prevent them from experiencing a subsequent crisis episode.

11 people talked about accessing urgent help and support through the GP, and where details were provided experiences were predominantly negative. There was no key theme amongst these experiences but two people felt that there issues were dismissed by GPs who did not have a full understanding of mental health issues and individual people reported having to proactively request a referral to the crisis team. Two positive experiences reported mentioned the staff and their understanding of the patient and their need for immediate support during the crisis episode.

Individual people reported attempting to access urgent and emergency support through ambulance and police services. The former was a positive experience which ensured the person got the help they needed to prevent their episode escalating.

> …they was there within five minutes or something, maybe a little bit longer, but they was there and they could see that I was struggling so as far as ambulance services go, and people like I was speaking to on the phone that night, he more or less saved me from killing myself because I was very, this close to ending it, and just the way he was with me on the phone, he'll never know what he's done.

The experience of the police was more negative with people reporting a lack of compassion and no onward referral to crisis services.

Accessing support directly through the crisis team phone lines

There were 26 people who identified that they had called the crisis phone lines to access support from specialist crisis services directly. Negative comments outnumbered positive comments by three to one. Almost two thirds of these people (65%; 17 people) commented on how when calling the crisis phone lines they were unable to secure any urgent or emergency help and support for their crisis episode. This was due to the following:

- **Unanswered phone calls or no return phone calls.** 12 people commented on how they had not received a return phone call from the crisis team to arrange their home visit or that when they had called it had not been answered. For example,

- **The time of access or criteria for access.** Three people talked about not being offered help and support due to the time of their call, particularly if this was outside of normal working hours.

> …then said that it was too late to send anyone out to see her as it was after 8.30 on a Friday night.
>
> I was told by the crisis team when I rang to say I was suicidal "What do you want us to do it's a Bank Holiday".
>
> Crisis team usually offer limited telephone support out of hours.

Two other people were told that they did not fit the criteria for accessing the support that could be offered as they were no longer self-harming or that there were other people worse than them.

The staff answering the phone were the second most talked about aspect of people's experiences of the crisis team phone lines. Nine people commented on poor communication skills and how they felt staff demonstrated a lack of compassion and understanding of their mental health issues.

> In need of support she phoned the Crisis team. A male member of staff answered her call. She told the man that she was feeling suicidal and needed help. He laughed at her and said ' just think about all the third world children who have to live up trees and have nothing to eat and they are still smiling'. The patient was taken aback by this and told him that the voices in her head kept telling her to kill herself. The man then said to her that if she didn't want to be resuscitated she could go to the GP and sign a form. The patient hung up.
>
> ...called the mental health crisis number and was told 'oh it's you again! If you were really going to kill yourself you would have done so already'.

This was related to the quality of advice they felt they were given, with distraction activities and taking 'hot baths' specifically referenced as being of little value to people during a crisis episode, or something which they had previously tried.

Three people talked about the consequences of this being to exacerbate their crisis episode generally, or more specifically identifying that they had gone on to self-harm following their experience of the crisis phone line.

> I was told team would call within 24 hours. I went all through the weekend, no call. Then Monday afternoon they called and asked if I was ok and said someone would be out to see me by the end of the day. This did not happen. When I called I was told that they had an emergency and someone would be out the next day. Never had a call back, never came out, but definitely made the situation feel a hell lot worse.
>
> Difficult to get any help at all when ringing the crisis team. Also, some of the comments I have received from them when ringing to say I am in a crisis are very unhelpful and actually make me feel worse. I rarely ring them any more as if they make me feel worse or can't help me I feel more suicidal therefore it is actually a risk to ring them.

Other people talked about how their experiences meant that they had subsequently sought help through accident and emergency departments.

9.2.3. Experiences of support provided by specialist crisis services

Experiences of the Crisis Resolution Home Treatment teams
There were 27 people from the wider community who indicated that they had accessed the Crisis Resolution Home Treatment team, and 21 provided further details of this experience. There were equal positive and negative experiences reported; 11 people reported overall negative experiences, 10 people reported positive experiences overall.

The most talked about aspect of negative experiences of the Crisis Resolution Home Treatment teams was the lack of compassion and understanding of the staff who visited them. People felt that they were not listened to or that the staff were unsympathetic to

the symptoms and cause of the crisis episode. This made feel people as if their issues were being dismissed. For example,

> I was told by one of the nurses when I expressed feelings of fear and flashbacks when I see and hear people arguing that "*It's normal for people to argue, it's going to happen*".
>
> I felt I was not heard or listened to... what I did share was dismissed.

Six people talked about issues related to the capacity of the service. Three of these people specifically made reference to how they felt the service was stretched and could not meet the demands placed upon them. A further three people talked about how long they had to wait before seeing someone from the team, including one example of someone waiting three days for a visit. For example,

> I didn't feel very safe, I felt very impulsive behaviour and he [GP] felt I needed some support. But often I feel I've needed it in the moment and even though they do come the next day...with my condition it's very intense and then it can change just really quick, so I felt like I needed the support right then or even to just speak to somebody.

As a result of these negative experiences eight people talked about how this affected them in terms of their mental health status. Half of these people made reference to going on to suffer from another crisis episode, one person specifically identified that they went on to self-harm, another identified that they took and overdose and two made general reference to how their mental health deteriorated or that the experience had been detrimental to their well-being. For example,

> I felt so angered that I kicked her out of my flat, which the anger led onto me self-harming and smashing things in my flat.
>
> They basically told me I did not know what I was talking about and I should just not worry about what might happen and discharged me as I was no longer depressed... I was correct and my mood did indeed deteriorate again some months later.

Conversely, positive experiences identified generally how the team had been helpful, or more specifically how they had helped to ease the crisis episode by calming people down. Where people identified why this was they commented on the staff, their communication skills and compassion, and the frequency with which they visited.

> When they did visit they were very pleasant, and I found that just being seen helped calm me, as I knew I was not alone. I had about four visits over a few weeks, which helped a lot.
>
> They came to my house and gave me as much time as I needed to discuss my issues and provided an immediate prescription. The follow up visits were excellent allowing me to talk through the issues and they continued to visit until the immediate crisis was over.

Experiences of inpatient care

There were 12 people who identified that they had experienced inpatient care as a result of their crisis episode. There were three times more negative experiences reported than positive experiences.

Negative experiences were most likely to talk about the staff delivering their care at the inpatient facility. Over half (7 people; 58%) of those who had inpatient care referenced how they had experienced poor staff communication skills and a lack of compassion, which affected the quality of care they received. For example,

> Being an inpatient most of the staff did not have time to even talk to me.
>
> I was shouted at, treated like a child and felt unsupported.

The opposite was reported in positive experiences, which also had staff as the main talking point. However, in these experiences people used words such as 'good' and 'helpful' to describe the staff. This led three people to specifically attribute an improvement in their mental health status to the staff they worked with during their inpatient stay. For example,

> The staff there are fantastic, took real good care of me and I was soon better.

The other main negative issue identified with inpatient care was a lack of beds. Five people commented on how they had needed to be admitted but that there was a lack of acute mental health bed available in Nottingham. Two people referenced how beds had been sought or found far away from home or out of the area entirely:

> There have been various times when the mental health professionals have thought I needed to be admitted as an inpatient only for them to try and get me a bed (sometimes trying as far away as Harrogate) only to be unable to find me one?
>
> Usually no acute mental health beds available, sometimes had to travel to Bassetlaw area.

Experiences of Haven House crisis service

Six people talked about their experiences of Haven House, the short stay crisis service. Four of these experiences were positive, and two were negative.

There were two key themes to positive experiences. The service was praised by four people for its staff who were identified as being understanding, caring and supportive. Three people specifically identified how the service had been effective support for them during their crisis episode. For example,

> Good aspects are that it is a place you can go to build resilience and break patterns of behaviour. There is plenty of time for self-reflection and support to try to think things through yourself. It can be very empowering.
>
> This place I've never felt so at ease and they've gave me confidence as well. They've made me feel confident.

There were no key themes to negative experiences, but people talked about the duration of the stay being too short to achieve recovery, staff who weren't very attentive or approachable and issues related to the conduct of other residents.

9.3. Meeting the support needs of the wider population during a mental health crisis

We asked people to identify if they thought there was anything services could do better to ensure that people receive the care and support they needed during a mental health crisis. There was little consensus in the suggestions put forward but the following were identified by more than one person:

- **Peer support could be beneficial in inpatient facilities.** People talked about how having someone who understands you as being helpful in promoting recovery from a crisis episode.

- **Services are needed to match the spectrum of what people consider to be a crisis episode.**

> Yeah, there could be something between crisis team and your GP to kind of support you.
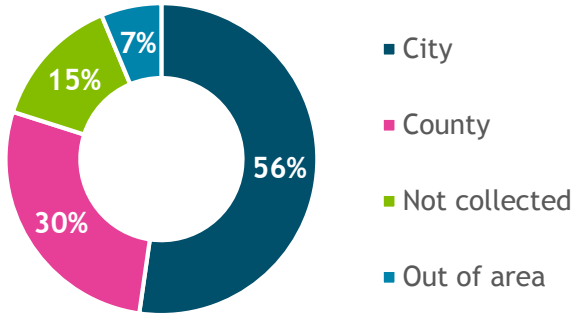>
> it just seemed to be like I was in crisis, then judged not to be in crisis, so like, you know, you're alright until you get to crisis again and for me that puts everybody under pressure, it puts the crisis team under pressure because then they've got to judge phases of crisis, is this person to crisis, is this person middle crisis, or of the lower crisis? It's that thing of like they've got to judge, but I think it needs to be sort of like on more of a spectrum…

Drop in centres in central, community based venues were suggested as a means of providing this support and could also provide an extended period of follow up to help promote and sustain recovery once people are discharged from acute crisis services.

Appendix 1. Demographic profile: BME community

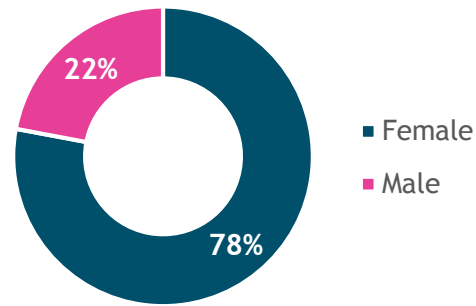**Total number of community: 74** (NOTE: Responses were not compulsory)

Locality

- City 56%
- County 30%
- Not collected 15%
- Out of area 7%

Source: 74 people

Gender

- Female 78%
- Male 22%

Source: 68 people

Ethnicity

Ethnic background of respondents	Count	%
Black/Black British: African	12	16%
White: Any other white background	12	16%
Asian/Asian British: Indian	7	9%
Not collected	6	8%
Asian/Asian British: Pakistani	5	7%
Black/Black British: Any other Black/African/Caribbean background	5	7%
White: Unspecified	5	7%
Asian/Asian British: Chinese	4	5%
Black/Black British: Caribbean	3	4%
Other: Arab	3	4%
Asian/Asian British: Unspecified	2	3%
Black/Black British: Unspecified	2	3%
Mixed: Any other Mixed background	2	3%
Mixed: White and Black Caribbean	2	3%
Any other Black/African/Caribbean background	1	1%
Asian/Asian British: Any other Asian background	1	1%
Asian/Asian British: Bangladeshi	1	1%
Other: Unspecified	1	1%

Source: 74 people

Age

- 70-79 years (2 people) 3%
- 60-69 years (6 people) 9%
- 50-59 years (9 people) 13%
- 40-49 years (11 people) 16%
- 30-39 years (19 people) 28%
- 25-29 years (7 people) 10%
- 20-24 years (10 people) 15%
- 15-19 years (3 people) 4%
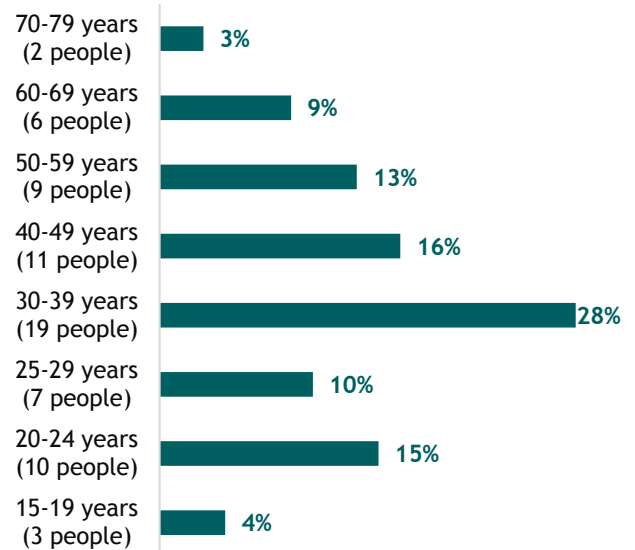
Source: 67 people

Sexual Orientation

- Bi-sexual
- Gay
- Heterosexual/straight 93%
- Other
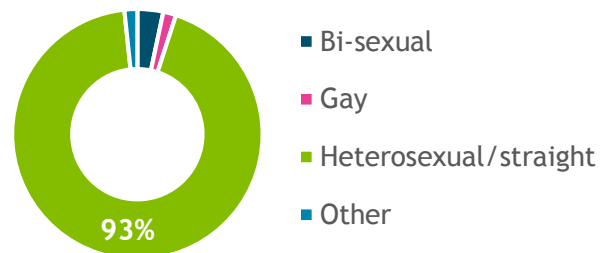
Source: 60 people

Religion

Religion of respondents	Count	%
Christianity	34	46%
Not collected	11	15%
Islam	10	14%
No religion or belief	8	11%
Hinduism	4	5%
Muslim	2	3%
Atheism	2	3%
Buddhism	1	1%
Other	1	1%
Sikh	1	1%

Source: 74 people

Disability

Do you consider yourself to have a disability?	Count	%
No	37	50%
Not collected	26	35%
Yes I am limited a little	9	12%
Yes I am limited a lot	2	3%

Source: 74 people

Disabilities identified by respondents:

- Mental health condition (9 people): 38%
- Long term illness/physical condition (7 people): 29%
- Visual impairment (4 people): 17%
- Other (4 people): 17%
- Physical or mobility impairment (2 people): 8%
- Learning or intellectual impairment (2 people): 8%
- Hearing impairment (1 people): 4%
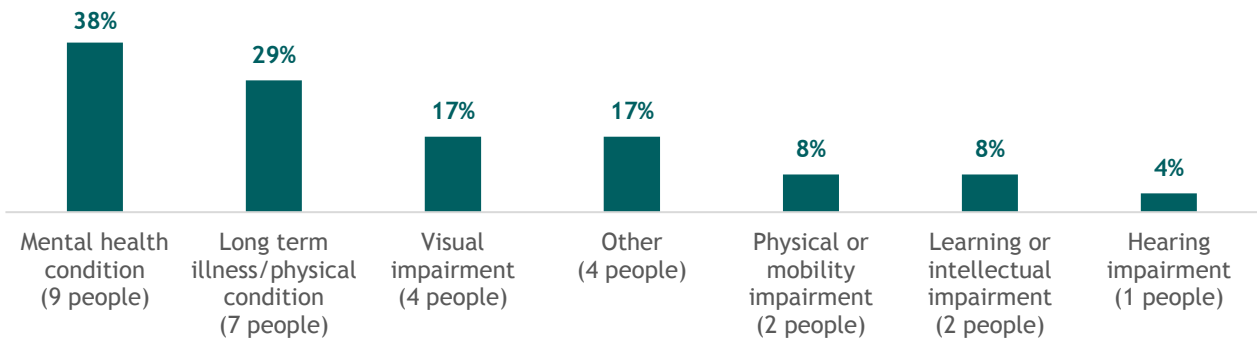
Source: 24 people (Note: some people identified as having more than one disability)

Unpaid caring responsibilities

11 people (15%) told us that they had unpaid caring responsibilities.

Pregnancy/birth in the last 12 months

4 people (5%) told us that they had been pregnant or given birth in the last 12 months

Language

Of the **36 people** who told us that their main preferred language, **28 people (78%)** told us this was **English. 8 people (12%)** told it was **another language**:

- Arabic
- Greek
- Polish

Other languages that people could speak, read or write included:

- Arabic
- Bengali
- French
- Greek
- Malay
- Mandarin
- Polish
- Punjabi
- Russian
- Urdu

We asked how well people could speak, read and write English:

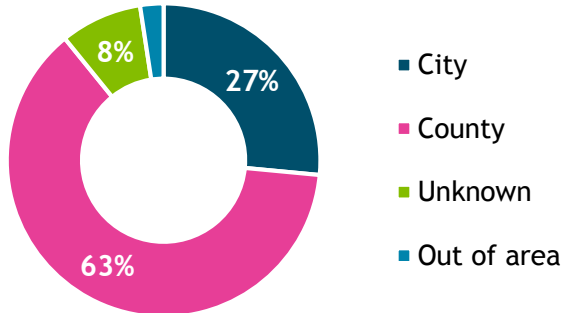|	Not at all	Not well	Well	Very well	Not collected
Speak English	0%	5%	11%	35%	49%
Read English	0%	5%	9%	35%	50%
Write English	0%	5%	12%	32%	50%

Source: 74 people

Appendix 2. Demographic profile: Carers

Total number of community: 83 (NOTE: Responses were not compulsory)
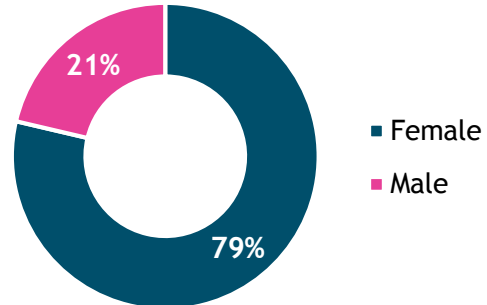
Locality

- City — 27%
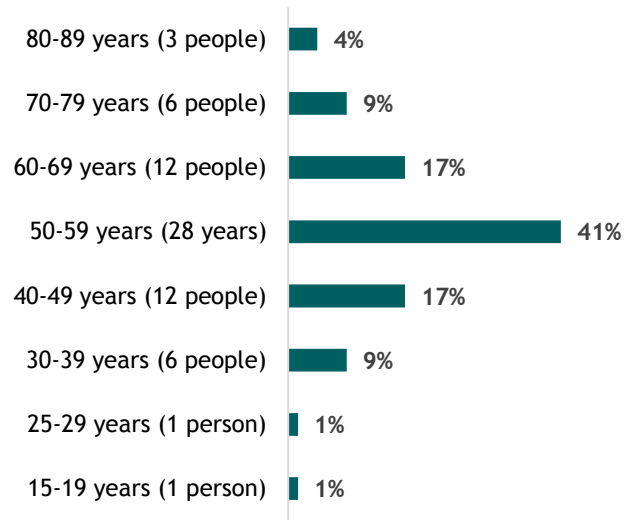- County — 63%
- Unknown — 8%
- Out of area

Source: 74 people

Gender

- Female — 79%
- Male — 21%

Source: 68 people

Ethnicity

Ethnic background of respondents	Count	%
White: English/Welsh/Scottish/Northern Irish	44	53%
White: Not specified	23	28%
Not collected	9	11%
Black/Black British: Caribbean	3	4%
Asian/Asian British: Pakistani	1	1%
Black/Black British: Not specified	1	1%
White: Any other White background	1	1%
White: Irish	1	1%

Source: 83 people

Age

- 80-89 years (3 people) — 4%
- 70-79 years (6 people) — 9%
- 60-69 years (12 people) — 17%
- 50-59 years (28 years) — 41%
- 40-49 years (12 people) — 17%
- 30-39 years (6 people) — 9%
- 25-29 years (1 person) — 1%
- 15-19 years (1 person) — 1%

Source: 69 people

Sexual Orientation

- Bi-sexual
- Heterosexual/straight — 92%
- Lesbian — 5%
- Other
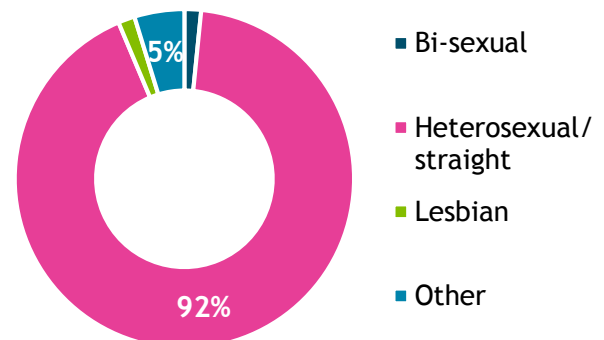
Source: 63 people

Religion

Religion of respondents	Count	%
Christianity	36	43%
No religion or belief	24	29%
Not collected	13	16%
Other	5	6%
Atheism	3	4%
Islam	1	1%
Judaism	1	1%

Source: 83 people

Disability

Do you consider yourself to have a disability?	Count	%
Not collected	40	48%
No	20	24%
Yes I am limited a little	16	19%
Yes I am limited a lot	7	8%

Source: 83 people

Disabilities identified by respondents:

	42%	29%	21%	13%	8%	8%	8%

Long term illness/physical condition (16 people) — 42%
Mental health condition (11 people) — 29%
Physical or mobility impairment (8 people) — 21%
Hearing impairment (5 people) — 13%
Visual impairment (3 people) — 8%
Learning or intellectual impairment (3 people) — 8%
Other (3 people) — 8%
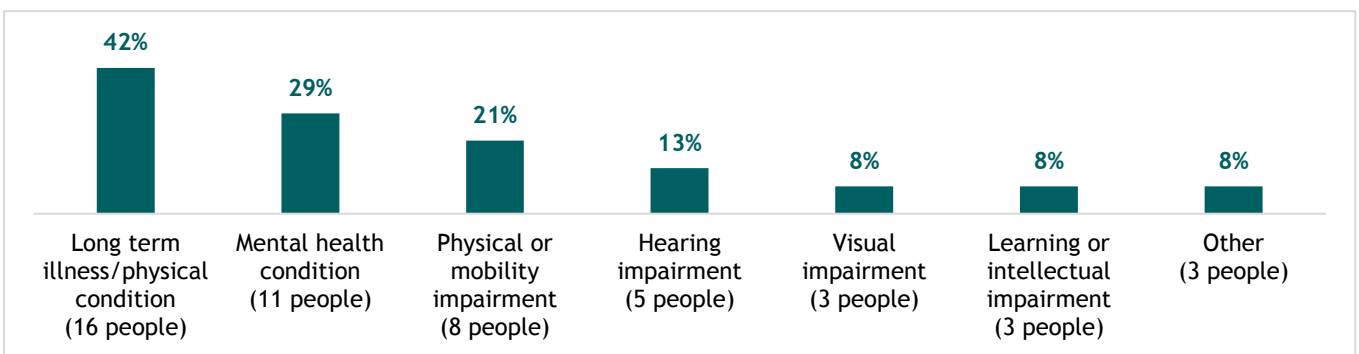
Source: 38 people (Note: some people identified as having more than one disability.)

Unpaid caring responsibilities

48 people (58%) told us that they had unpaid caring responsibilities.

Pregnancy/birth in the last 12 months

1 person (1%) told us that they had been pregnant or given birth in the last 12 months

Language

Of the **39 people** who told us that their main preferred language, **all of them (100%)** told us this was **English**.

Other languages that people could speak, read or write included:

- French
- German
- Welsh
- Spanish
- Greek
- Hebrew
- Italian

Of the 6 people who answered rated how well they could speak, read and write English, all of them rated "very well".

We asked how well people could speak, read and write English:

	Not at all	Not well	Well	Very well	Not collected
Speak English	0%	5%	11%	35%	49%
Read English	0%	5%	9%	35%	50%
Write English	0%	5%	12%	32%	50%

Source: 83 people

Appendix 3. Demographic profile: Homeless/People at risk of homelessness

Total number of community: 37 (NOTE: Responses were not compulsory)

Locality

- County
- City
- Unknown

14%

84%
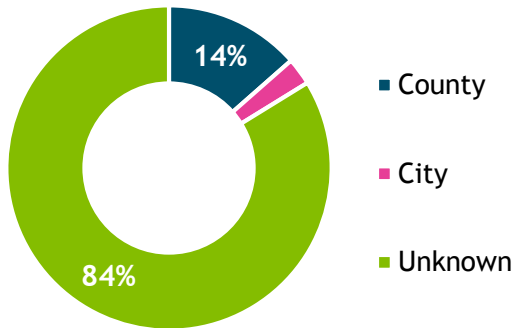
Source: 37 people

Gender

- Female
- Male

11%

89%
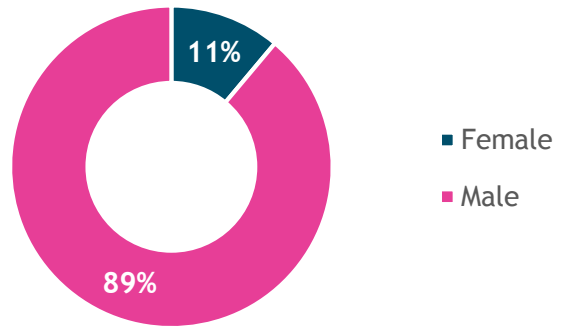
Source: 9 people

Ethnicity

Ethnic background of respondents	Count	%
Not collected	28	76%
White: English/Welsh/Scottish/Northern Irish	8	30%
White: Irish	1	3%

Source: 37 people

Age

50-59 years (2 people)	25%
40-49 years (1 person)	13%
30-39 years (2 people)	25%
25-29 years (1 person)	13%
20-24 years (2 people)	25%

Source: 8 people

Sexual Orientation

- Heterosexual /straight
- Not collected

22%

78%
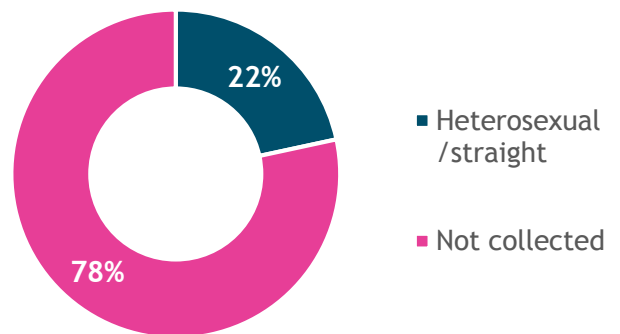
Source: 37 people

Religion

Religion of respondents	Count	%
No religion or belief	32	86%
Christianity	4	11%
Not collected	1	3%

Source: 37 people

Disability

Do you consider yourself to have a disability?	Count	%
Not collected	33	89%
No	3	8%
Yes I am limited a little	1	3%
Yes I am limited a lot	0	0%

Source: 37 people

Disabilities identified by respondents:

33% Physical or mobility impairment (2 people)
33% Long term illness/physical health condition (2 people)
33% Mental health condition (2 people)
17% Hearing impairment (1 person)
17% Other (1 person)
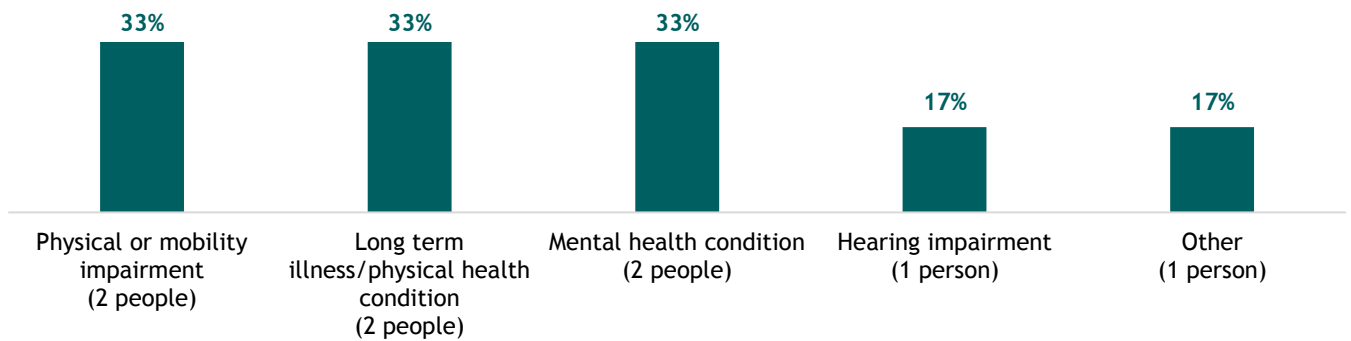
Source: 6 people (Note: some people identified as having more than one disability.)

Unpaid caring responsibilities

0% (0 people) told us that they had unpaid caring responsibilities.

Pregnancy/birth in the last 12 months

0% (0 people) told us that they had been pregnant or given birth in the last 12 months

Language

Of the **4 people** who told us that their main preferred language, all of them (100%) told us this was **English.**

Of the **1 person** who rated how well they could speak, read and write English, they told us that they could speak English very well, read English well and write English not very well.
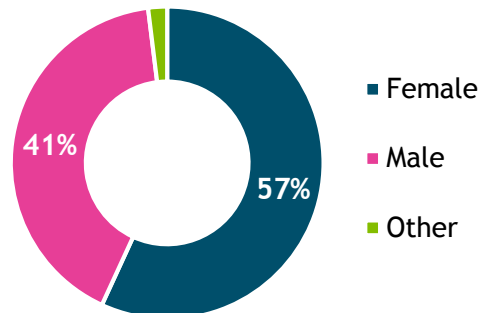
Appendix 4. Demographic profile: Student community

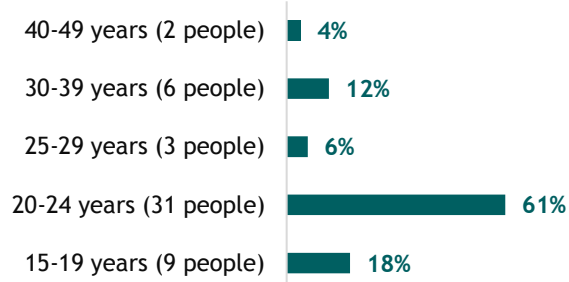**Total number of community: 55** (NOTE: Responses were not compulsory)

Locality

- City
- County
- Unknown
- Out of area

56%
20%
15%
9%
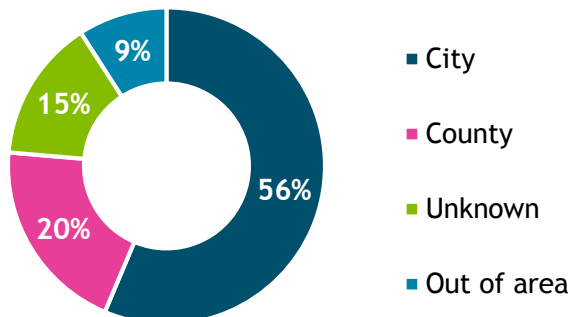
Source: 55 people

Gender

- Female
- Male
- Other

57%
41%

Source: 51 people

Ethnicity

Ethnic background of respondents	Count	%
White: English/Welsh/Scottish/Northern Irish	16	29%
White: Not specified	13	24%
Black/Black British: African	6	11%
Not collected	5	9%
Asian/Asian British: Chinese	3	5%
Other: Arab	3	5%
White: Any other white background	3	5%
Asian/Asian British: Pakistani	2	4%
Asian/Asian British	1	2%
Asian/Asian British: Bangladeshi	1	2%
Mixed: White and Asian	1	2%
Mixed: White and Black Caribbean	1	2%

Source: 55 people

Age

- 40-49 years (2 people) — 4%
- 30-39 years (6 people) — 12%
- 25-29 years (3 people) — 6%
- 20-24 years (31 people) — 61%
- 15-19 years (9 people) — 18%

Source: 51 people

Sexual Orientation

- Bi-sexual
- Heterosexual/straight
- Lesbian
- Other

10%
78%
8%
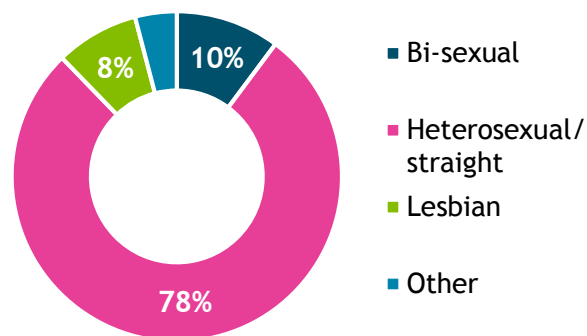
Source: 37 people

Religion

Religion of respondents	Count	%
Christianity	18	33%
No religion or belief	15	27%
Islam	7	13%
Not collected	6	11%
Atheism	3	5%
Other	3	5%
Buddhism	2	4%
Muslim	1	2%

Source: 55 people

Disability

Do you consider yourself to have a disability?	Count	%
No	27	49%
Not collected	20	36%
Yes I am limited a little	5	9%
Yes I am limited a lot	3	5%

Source: 55 people

Disabilities identified by respondents:
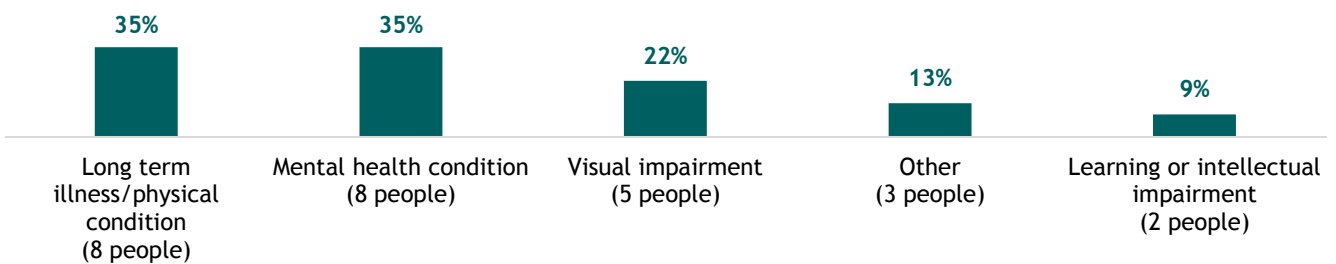
Source: 23 people (Note: some people identified as having more than one disability)

Unpaid caring responsibilities

3 people (5%) told us that they had unpaid caring responsibilities.

Pregnancy/birth in the last 12 months

2 people (4%) told us that they had been pregnant or given birth in the last 12 months

Language

Of the **44 people** who told us that their main preferred language, **38 people (86%)** told us this was **English. 6 people (14%)** told it was **another language**:

- Arabic
- Greek
- Lithuanian
- Polish

Other languages that people could speak, read or write included:

- Arabic
- French
- Greek
- Russian
- Bengali
- Lithuanian
- Maltese
- Spanish
- Dutch
- German
- Mandarin
- Urdu
- Spanish
- Slovak
- Malay
- Yoruba
- Catalan
- Czech
- Polish

Of the **6 people** who answered rated how well they could speak, read and write English, **all of them rated "very well".**
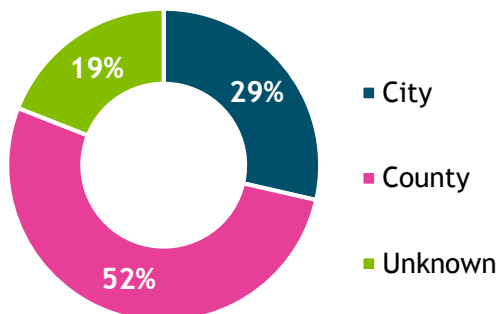
We asked how well people could speak, read and write English:

	Not at all	Not well	Well	Very well	Not collected
Speak English	0%	5%	9%	65%	20%
Read English	2%	2%	9%	65%	22%
Write English	0%	4%	13%	62%	22%

Source: 55 people

Appendix 5. Demographic profile: Veterans/Ex-military personnel

Total number of community: 55 (NOTE: Responses were not compulsory)

Locality

- City 29%
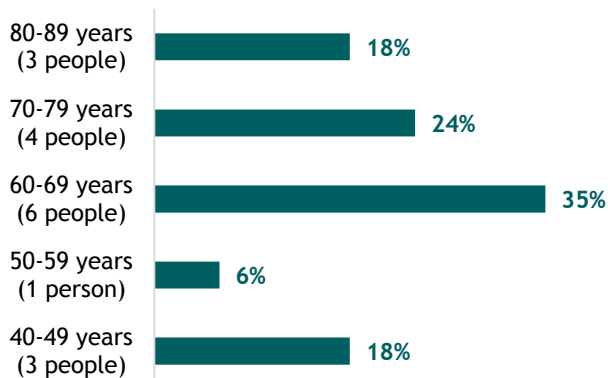- County 52%
- Unknown 19%

Source: 21 people

Gender

- Female 22%
- Male 78%
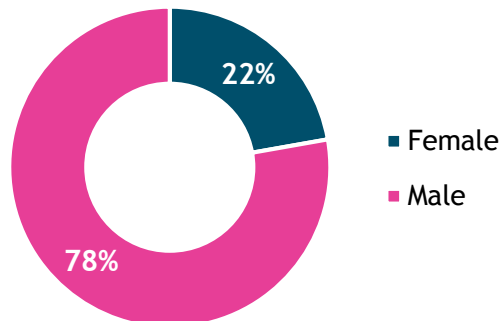
Source: 18 people

Ethnicity

Ethnic background of respondents	Count	%
White: English/Welsh/Scottish/Northern Irish	14	67%
Did not disclose	6	29%
Mixed: Unknown	1	5%

Source: 21 people

Age

- 80-89 years (3 people) 18%
- 70-79 years (4 people) 24%
- 60-69 years (6 people) 35%
- 50-59 years (1 person) 6%
- 40-49 years (3 people) 18%

Source: 17 people

Sexual Orientation

- Bi-sexual 8%
- Heterosexual/ straight 92%
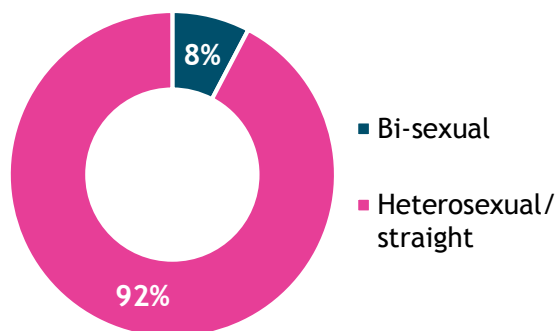
Source: 13 people

Religion

Religion of respondents	Count	%
Christianity	11	52%
Not collected	8	38%
Agnostic	1	5%
Other	1	5%

Source: 21 people

Disability

Religion of respondents	Count	%
Not collected	12	57%
No	4	19%
Yes I am limited a little	3	14%
Yes I am limited a lot	2	10%

Source: 21 people

Disabilities identified by respondents:

64%	27%	18%	18%	9%
Hearing impairment (7 people)	Physical or mobility impairment (3 people)	Long term illness/physical health condition (2 people)	Mental health condition (2 people)	Visual impairment (1 person)
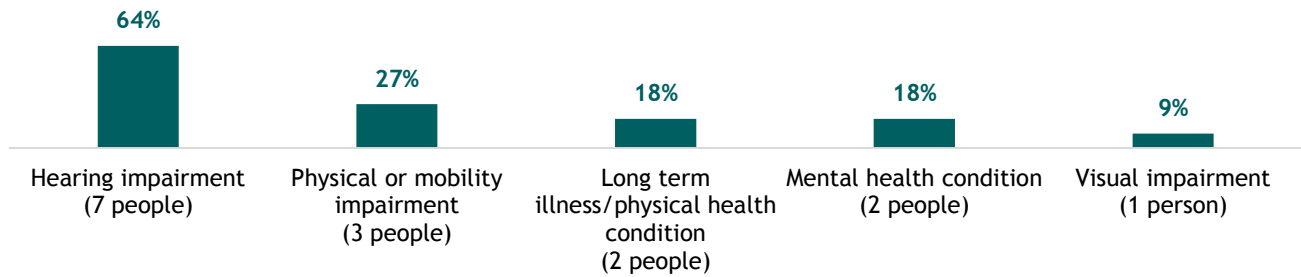
Source: 11 people (Note: some people identified as having more than one disability)

Unpaid caring responsibilities

4 people (27%) told us that they had unpaid caring responsibilities.

Pregnancy/birth in the last 12 months

0 people (0%) told us that they had been pregnant or given birth in the last 12 months

Language

Of the **6 people** who told us their main or preferred language, **all of them** told us that this was English.

Other languages that people could speak, read, or write included:

- Arabic
- Greek
- Lithuanian
- Polish

Of the **6 people** who answered rated how well they could speak, read and write English, **all of them rated "very well".**
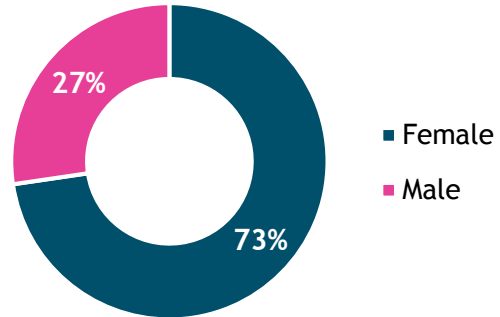
Appendix 6. Demographic profile: Wider population

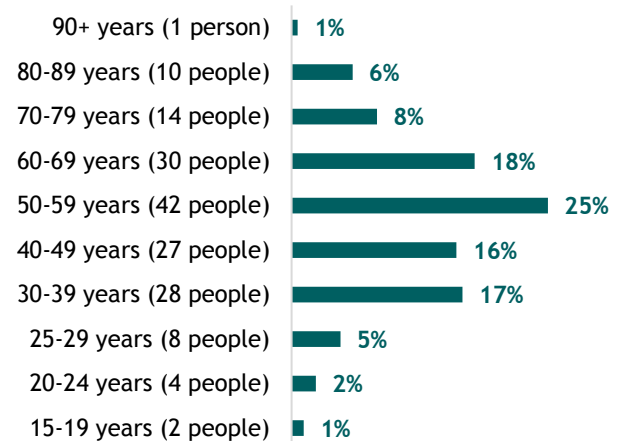**Total number of community: 215** (NOTE: Responses were not compulsory)

Locality

- County — 55%
- City — 23%
- Unknown — 19%
- Out of area
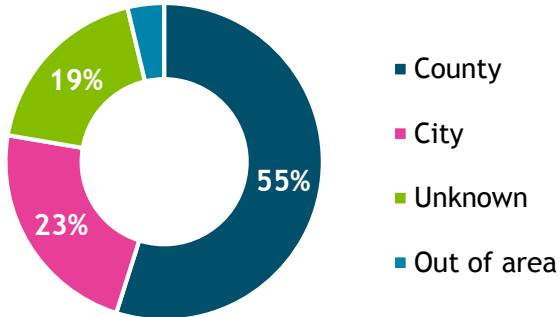
Source: 215 people

Gender

- Female — 73%
- Male — 27%

Source: 183 people

Ethnicity

Ethnic background of respondents	Count	%
White: English/Welsh/Scottish/Northern Irish	105	49%
White: Not specified	62	29%
Not collected	42	20%

Source: 215 people

Age

- 90+ years (1 person) — 1%
- 80-89 years (10 people) — 6%
- 70-79 years (14 people) — 8%
- 60-69 years (30 people) — 18%
- 50-59 years (42 people) — 25%
- 40-49 years (27 people) — 16%
- 30-39 years (28 people) — 17%
- 25-29 years (8 people) — 5%
- 20-24 years (4 people) — 2%
- 15-19 years (2 people) — 1%

Source: 17 people

Sexual Orientation

- Bi-sexual
- Gay
- Heterosexual/Straight — 88%
- Lesbian
- Other
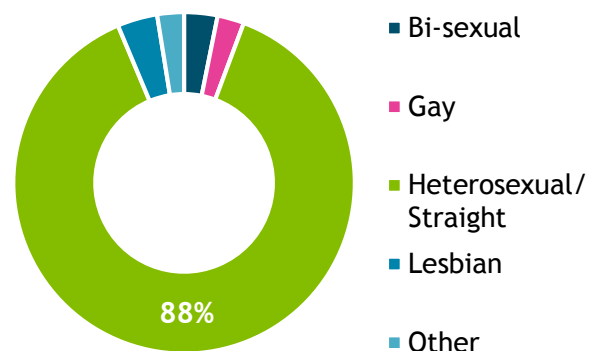
Source: 13 people

Religion

Religion of respondents	Count	%
Christianity	78	36%
No religion or belief	62	29%
Not collected	60	28%
Atheism	6	3%
Other	6	3%
Buddhism	2	1%
Judaism	1	0%

Source: 215 people

Disability

Religion of respondents	Count	%
Not collected	96	45%
No	63	29%
Yes I am limited a little	29	13%
Yes I am limited a lot	27	13%

Source: 215 people

Disabilities identified by respondents:

- Mental health condition (65 people): 54%
- Long term illness/physical condition (35 people): 29%
- Hearing impairment (17 people): 14%
- Physical or mobility impairment (17 people): 14%
- Visual impairment (11 people): 9%
- Learning or intellectual impairment (6 people): 5%
- Other (4 people): 3%
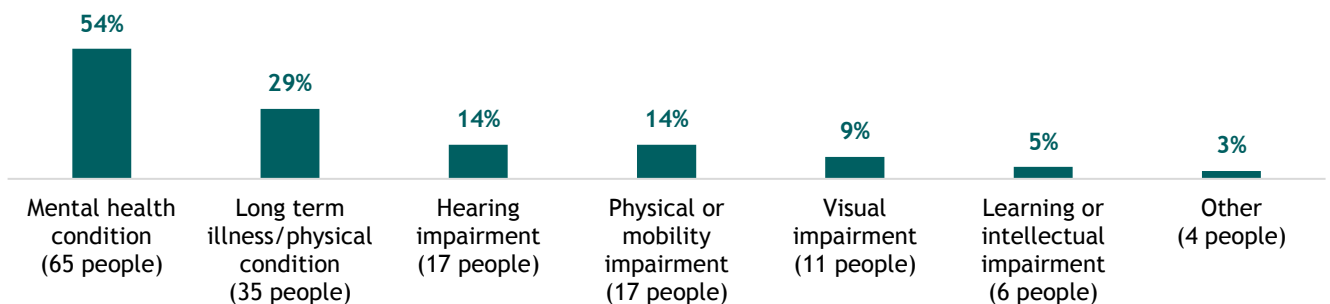
Source: 120 people (Note: some people identified as having more than one disability)

Unpaid caring responsibilities

26 people (12%) told us that they had unpaid caring responsibilities.

Pregnancy/birth in the last 12 months

2 people (1%) told us that they had been pregnant or given birth in the last 12 months.

Language

Of the **135 people** who told us that their main preferred language, **134 people (99%)** told us this was **English. 1 person (1%)** told us it was Polish.

Other languages that people could speak, read, or write included:

- French
- German
- Greek
- Italian
- Polish

We asked how well people could speak, read and write English:

	Not at all	Not well	Well	Very well	Not collected
Speak English	0%	0%	3%	53%	44%
Read English	0%	2%	2%	51%	45%
Write English	0%	2%	3%	51%	45%

Source: 215 people