Bath & North East Somerset Council

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Clinical Commissioning Group

How can we support people who are experiencing acute mental health crisis and prevent people's needs from escalating to this point?

Workshop engagement report
June 2018

In June 2018, we held a workshop and evening drop-in event to give people an opportunity to share their views on how we can support people who are experiencing acute mental health crisis and prevent people's needs from escalating to this point.

We invited people who use services, those who care for them, those who deliver the services and the wider public to attend these events, and 19 people attended:

- Six people who use services, carers and members of the public
- Thirteen professionals/providers of mental health services

Summary

Attendees were given an overview of the community mental health services review, including a summary of the scope of the services that are being considered within the programme, as well as information about what people have told us works well and what people would like to see change.

A sub-group focusing specifically on mental health crisis were asked to consider a number of questions:

1. What is crisis?
2. What are the challenges in relation to current provision and what are the gaps?
3. How do we address the challenges and gaps around current provision?
4. What would a future model of care look like?
5. What examples of good practice are available to us, how could we learn from these?

What people told us

What is Crisis?

Anyone can have a mental health crisis. There are many causes of a mental health crisis and a person does not need to have a severe mental health problem to have a crisis.

A person is mentally healthy if "that person is in a state of well-being in which that individual recognises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community." (World Health Organisation definition of Mental Health).

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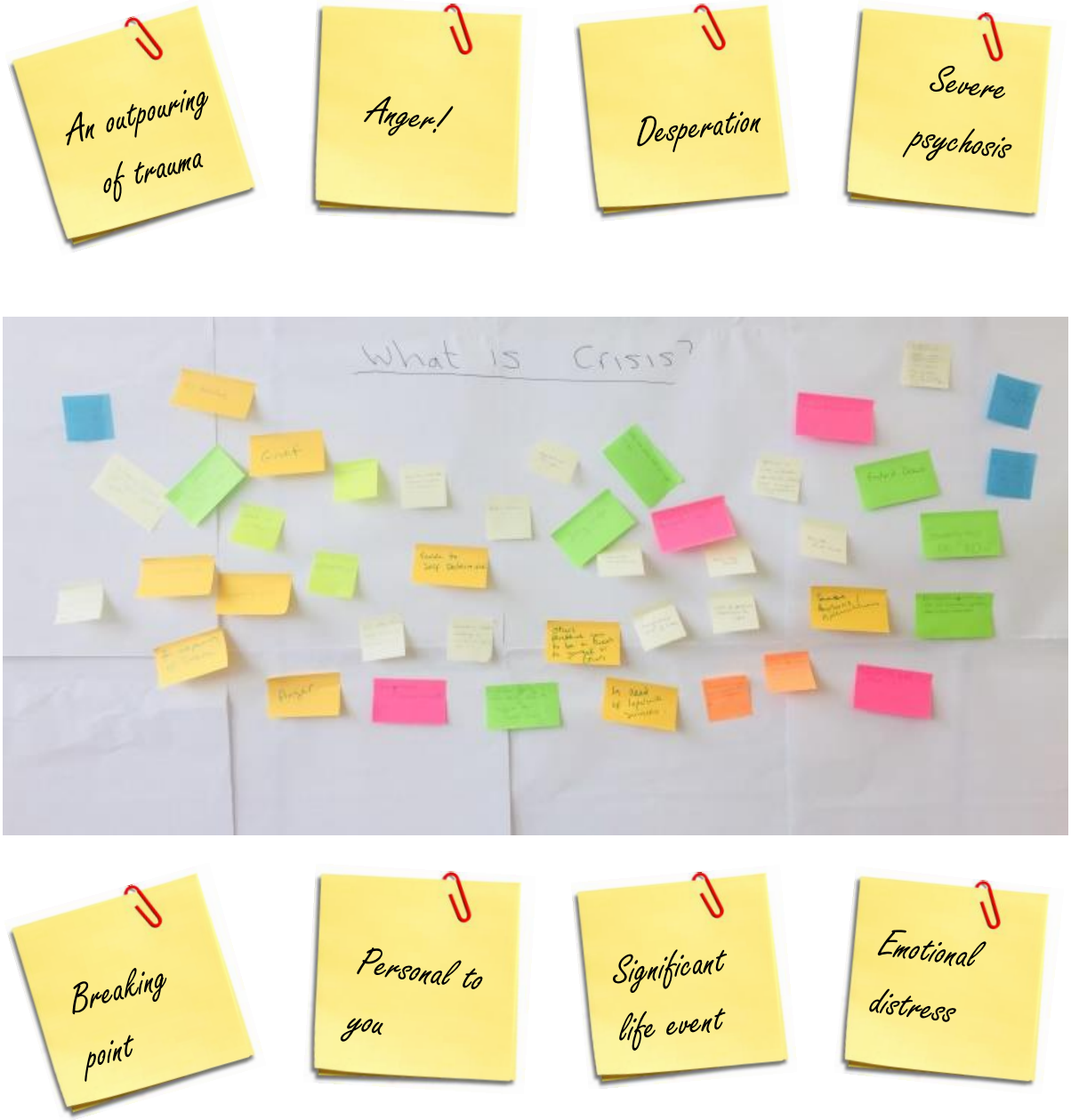
A person has a mental health crisis when they are in a state of mind in which they are unable to cope with, and adjust to, the recurrent stresses of everyday living in a functional, safe way.

We asked people attending the workshop what crisis meant to them. Here are some of the things that people told us:



We currently have a number of services in Bath and North East Somerset that support people who are in, or near to, crisis. These include:

Service	Description
Wellbeing House	A retreat for people experiencing mental and emotional distress, currently operating Monday to Friday.
Supported Living (reablement)	Providing up to 10 weeks, focused support, which can be spread throughout the year. The service provides practical support to prevent escalation of mental health needs.
Wellbeing Services	There are a large range of services available including support groups, the Wellbeing College and creative groups. that offer support and strategies to people in order to build confidence, gain and maintain independence, help reduce social isolation and so engage with the community. These not only can prevent people's mental health escalation they can support their recovery.
Social Prescribing	Social prescribing enables care professionals to refer people to a range of local, non-clinical services that will help prevent escalation of mental health issues.
Supported Housing and Floating Support	Offering emotional and practical support to people in their own homes or in supported accommodation.
Peer Mentoring	Services where people who have lived experience of mental health issues are trained to support people with mental health needs. This is currently offered to individuals who have received a service from the local mental health trust.
Primary Care Liaison Services	This is a short-term support service to help people with mental health difficulties to move forward and get on with their lives. Primary care liaison nurses operate alongside family doctors; they are specialist and experienced mental health practitioners who have the knowledge and skills to decide if someone will benefit from short-term involvement with their team.
Community Intensive Team	Teams consisting of experienced mental health staff, who offer assessment and home treatment for people aged over 16 years experiencing a mental health crisis, as an alternative to hospital admission.

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1. **What are the challenges in relation to current provision at the <u>point of crisis</u> and what are the gaps?**

People not meeting criteria for services - issues escalate.

Inconsistent quality of care and care planning.

Services not collaborating and inconsistent relationship between police and services.

Lack of resources in emergency departments and lack of expertise in urgent care.

Clinical settings can be intimidating, unhelpful environments which can hinder recovery.

2. **How do we address the challenges and gaps around current provision and what would a future model of care at the <u>point of crisis</u> look like?**

Transition: Improved transition services from children and young people to adult services - building resilience and skills - preparation into adulthood

Local: Local 'place of safety'

Continuum: Review of Psychological Therapies post-IAPT - ensure continuum along pathway, capturing and responding to changes

Single Point of Contact: 'Wellbeing Hub' - single point of contact

Digital App or Crisis Card

Training: Packages for carers to increase knowledge of signs/symptoms etc.

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3. **What are the challenges in relation to current provision at pre-crisis or recovery and what are the gaps?**

- Majority of services are 9-5 on weekdays
- Lack of knowledge about services that are available locally
- Lack of training for carers to support recognition and management of signs/symptoms
- Breakdown in collaborative working

4. **How do we address the challenges and gaps around current provision and what would a future model of care at pre-crisis or recovery look like?**

- Flexible: Range of 'out of hours' services, evening safe space, friendly bench, Community Connectors (Frome model), Crisis Line, 7 day services
- Comprehensive training packages for carers and businesses - identifying and managing signs/symptoms
- Interconnectivity, pathway linked to job retention and housing support - inter-connectivity of services and prevention measures
- Data: Detailed mapping of services in single location in different formats (reviewed and revised)
- Improved pre-crisis planning: Development of resilience and self-awareness techniques - empowering individuals
- Peer Mentors
- Advocacy
- Whole Schools Approach
- Signposting: re-think signposting in its current form

5. What examples of good practice are available to us and how could we learn from these?

People told us about lots of existing schemes and services across the country that we could learn from, including:

- SOBAR – Nottingham
- Commorado's – Blackpool
- The Pod – Coventry
- Norway Prevention Model
- Friendly Bench
- Aldershot and York Safe Haven Models
- Frome Model – Community Connectors

Actions and next steps

Here are the key actions that will feed into the community mental health services review as a result of this engagement:

Flexible	•Network of "safe places/quite area/meeting points" for people with mental health needs to be collated. •Wellbeing House – proposal currently being drafted by CURO to explore seven day a week operating. This will consider expanded weekend activities. •Review of York and Aldershot model. •North Somerset Crash Pad offer to be explored.
Training	•Training offer and strategy for staff and carers to be developed. Needs to consider signposting. •Domestic violence training strategy hierarchy model to be reviewed as potential framework that could be replicated in mental health.
Interconnectivity and Data	•Improve communication and collaboration across the sector. •Interconnectivity of providers ensuring that all practitioners and carers are listened to, to be followed up through Collaborative Workstream. •Data mapping of services to be picked up in Care Co-Ordination project.
Planning	•Proposal for advocacy service for carers and people who use services at times of crisis to be developed.
Signposting	•Moving to a whole systems approach for the individual. Whilst sign-posting is a statutory requirement, hand-offs need to be minimised. Learnings from incorrect referrals should be reflected within the Collaborative Pact.