

Right here right now



People's experiences of help, care and support during a mental health crisis

Summary

JUNE 2015

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can



CQC supports the Time to Change **Get the Picture** campaign to change the way mental health stories are illustrated in the media. Images from the campaign are used throughout the report.

www.time-to-change.org.uk/getthepicture

Contents

Foreword from Paul Lelliott	2
Foreword from Lucy Seren	3
Background	4
What we found	8
Help, care and support in the community	9
Going to A&E	10
Experiences of being detained	11



Forewords

Dr Paul Lelliott

Deputy Chief Inspector of Hospitals
(Mental Health)



Public attitudes to mental ill health are shifting. There is growing recognition and acceptance that it can affect anybody and that experiencing mental ill health does not and cannot stop you from working and participating fully in our society. It is now also widely accepted that people with mental illness have the same right to high-quality care as people with physical ill health.

Our review explored the lived experience of people during a mental health crisis and the response they received when they reached out to services for help and support. It paints a picture of variation and inconsistency in the quality of care given and while some of the evidence it draws on is new, some of the key messages are not.

If there is a reason to be confident then it may be found in the Crisis Care Concordat. Launched in February 2014, it focuses on how services respond to help people with mental illness at the time of their greatest need. It has been a remarkable initiative.

With the momentum built by the Concordat, it is now the time for health and care leaders to act decisively. They need to tackle the long-standing issues that result in the most vulnerable people in society being abandoned at a time of crisis. Organisations must look carefully at when, where and why a person in crisis comes into contact with a local service and how they can work collaboratively to challenge unacceptable responses.

The report flags up some beacons of good practice and innovation; such as the pilot street triage services that divert people with mental illness from the criminal justice system to the help that they need. However, it also shows that services across England still vary greatly in their ability to provide a timely and high-quality response to people experiencing a mental health crisis. It demonstrates that too many people in this situation are unable to access the help they need, when they need it, and are dissatisfied with the help they have been given.

The report highlights some key lessons for the wider system, including commissioning services to meet local need, and the different agencies involved in crisis care taking a more joined-up approach. Local Crisis Care Concordat Groups have a major role in making sure that pathways for crisis care provide the right care to people in crisis, when they need it.

It also points the way forward for CQC. As set out in our business plan for 2015/16, *Shaping the Future*, the way we operate contributes to the way health and social care is, and needs to be, changing. We want to more actively look at the quality of care not just in a provider, but also across pathways.

Thanks to the work of this review, we are now far better placed to inspect the health and social care services that interact with people experiencing a mental health crisis, to understand what good looks like and to encourage services to improve.

When crisis care works well

“The care that I received during my crisis was amazing. My care coordinator responded appropriately and helpfully in calling the crisis and home treatment team who I was already known to having had several crises over the last few years.

They saw me within the expected time frame and were able to offer me the help and support I needed. The day after I saw them I knew I could not remain in my own home so some friends offered for me stay with them. When I rang the crisis team to say this would be happening and would they be able to support me there, the immediate answer was yes and that is what they did.”



Lucy Seren

Expert by Experience

As with the findings of this report, my experiences of care when I have been in crisis have been very mixed. Sometimes I have received the help I need to get better. At other times I most definitely have not.

I am fortunate that I have great support from my GP and community psychiatric nurse (CPN). My CPN in particular is great as she knows me and knows when I need extra help or am able to manage on my own. I have also found that, on the whole, staff in my local liaison psychiatry service are responsive to my needs.

However, this is not the case across all specialist mental health services. As other people who have experienced a crisis have described in the report, of all the services that I have come into contact with, I have found that the response of the crisis teams to be the least helpful. I often feel that they don't have enough resources as they are keen to get people 'off their books' as quickly as possible. On occasion, I have not felt listened to and felt that I have been discharged too early.

Like many others, when I have experienced a crisis I have often ended up going to A&E as I don't feel that I have anywhere else to turn. I've never used the crisis helpline in my local area as I've only heard bad things about it, like being put through to a call centre, being cut-off after 20 minutes or just being referred to A&E in the first place.

How people speak to me and treat me when I have a crisis has a big impact. On the whole, the staff in A&E have been kind and treated me with respect. But sometimes when I have gone there for help I have often felt sidelined, and that people with physical health needs have been given priority over me. Being able to access the help you need when you need it and being treated with respect and compassion are so important during a crisis.

I welcome this report and the recommendations CQC has made. Commissioners need to listen to the people in their local areas to make sure that they are providing the right services, with kind and compassionate staff, and that are open at the times people experiencing a crisis need them the most.

Background

Attitudes to mental health are changing fast. In the last four years it is estimated that two million people have developed a more positive attitude towards mental illness.

However, there is still a long way to go until a person experiencing a mental health crisis receives the same response as someone with a physical health emergency.

In February 2014, the Coalition Government announced the launch of a new agreement called the Crisis Care Concordat. This is a challenge to those responsible for commissioning, providing and delivering the services to commit to a set of core principles around crisis care, to make sure that people get the help they need when they are having a mental health crisis. The Concordat has been signed by more than 25 national bodies, including CQC.

As part of our commitment, we agreed to review the quality, safety and effectiveness of care provided to those experiencing a mental health crisis. Throughout we have put people at the heart of the issue and sought to understand whether people were being offered the right care, at the right time, and if they were being given the information they needed, as well as what they felt about the attitudes of those providing help, care and support.

Our findings show that there are clear variations in the help, care and support available to people in crisis and that a person's experience depends not only on where they live, but what part of the system they come into contact with.

We found many examples of good crisis care, but our work has also shown that far too many people in crisis have poor experiences due to service responses that fail to meet their needs and lack basic respect, warmth and compassion. This is unsafe, unfair and completely unacceptable.

The consequences of poor crisis care

“My GP initially referred me to the early intervention in psychosis team which didn’t help since they weren’t the right team for me. I eventually went to A&E since I became suicidal and tried to kill myself...”



“It was approximately seven hours before I got crisis support and that was only a call not a visit, which would have been more useful. As my crisis worsened I took a small overdose as I was not coping or getting any immediate help.”

“My GP listened and did not judge me, he believed what I was saying and agreed I needed help.”

We asked people to share their experiences with us. What they told us presents a challenge for everyone responsible for ensuring people in crisis receive the best possible help, care and support. Commissioners, providers and those delivering services must all recognise the role they have to play in providing the right kind of services and making sure that they are accessible at the times when people need them.

There is a distinct gap between people’s perceptions of how they are treated by staff working in accident and emergency (A&E) departments and specialist mental health services compared to other services. We asked people whether they felt listened to and taken seriously, whether they were treated with warmth and compassion and if they felt judged. Fewer than four in 10 respondents gave a positive response about their experience in A&E for any of these statements. Those coming into contact with specialist mental health services were only slightly more positive.

In comparison GP, ambulances and the police were all perceived as being more successful in providing caring and empathetic responses to people in crisis. It may be less of a surprise that volunteers and charities received the most positive responses from those who come into contact with them but the gap between the voluntary and statutory sectors is substantial (table 1). Irrespective of location or which services people came into contact with, 56% (449 people) told us that the care they received helped to resolve their crisis or was partially helpful, but 42% (339 people) said it did not help (figure 1). A health and care system where over four in 10 respondents feel their crisis was not resolved raises serious questions about the fairness and safety of service responses.

This variation is unfair. The principle of parity of esteem between mental and physical healthcare is built into the NHS Mandate. Providers must recognise that the risks from emotional harm are just as real, and potentially life-threatening, as those from a physical injury. Feedback from our call for evidence highlights poor staff attitudes to injuries caused by self-harm. These attitudes cannot be tolerated and show that work is still needed to embed parity of esteem across organisations.

This report makes an important contribution to the conversation around crisis care at a national and local level. It gives a strong evidence-base for recommendations to local Concordat groups, and identifies a series of areas where we encourage commissioners, providers and services to make improvements.

Table 1

Individual survey: I received help in a timely way, felt listened to, treated with compassion and not judged

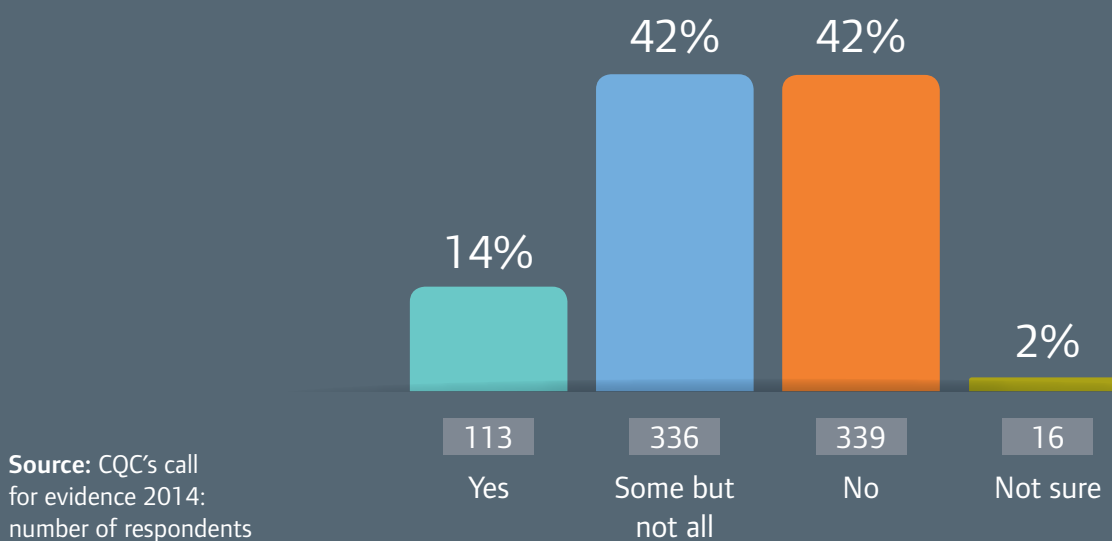
Local Service	I felt...				Average number of respondents
	I received the help I needed in a timely way	My concerns were taken seriously and listened to	I was treated with warmth and compassion	I was not judged for what I had done or how I felt	
Volunteers or a charity	74%	86%	88%	84%	97
GP	52%	64%	65%	66%	538
Telephone helpline	50%	62%	63%	64%	112
NHS ambulance	63%	61%	63%	53%	156
Police (encountered in a public place)	65%	54%		50%	104
Crisis resolution home treatment team	41%	44%	46%	47%	317
Community mental health team	38%	48%	52%	54%	431
Accident and emergency	35%	37%	34%	33%	316

Source: CQC’s call for evidence 2014: number of respondents



Figure 1

Individual survey: Do you feel that the care you received provided the right response and helped to resolve your mental health crisis?



Source: CQC’s call for evidence 2014: number of respondents

What we found

Overall, we found that:

- The quality of care experienced by a person in crisis varied depending on where they lived and when they sought help.
- Many people have experienced problems in accessing help at the time they need it and in getting the right help when they have a mental health crisis. We found this reflected in:
 - The attitudes of staff towards people when they were in crisis. For example, staff judging people in crisis, not treating them with respect or compassion, or not taking the time to listen to carers' concerns.
 - The accessibility and availability of care at all times. This includes people being able to access the service they need at any time of day and night.
 - The quality of services that are offered, and their responsiveness to people's needs. For example, whether services are following evidence-based models of good practice and are set-up to meet the needs of their local population.
 - The implications for safety, particularly in risks associated with self-harm. For example, making sure that people are treated quickly and compassionately to prevent the crisis from getting worse or prevent them from hurting themselves or others.
- Across the country local services are developing innovative approaches to the challenge of providing a high-quality response to people in crisis. More can be achieved where these innovations work in partnership and services are integrated around the needs of the person in crisis.



Help, care and support in the community

“I wouldn't have gone through so much pain if I had known what to do about my illness and who to go to, where I could get support. Maybe then I could have stayed in work.”

Many people with a mental health condition will be seen mainly by their GP and will only have limited, if any, contact with more specialist mental health services. We know that, at any given time, an average of one in four patients of a full time GP requires treatment for a mental health condition. To put this into context, there were nearly three million adults on local GP registers for depression in 2013/14, and nearly 500,000 people on GP registers for a serious mental illness.

It is positive that the majority of people said they felt that their GP listened to them, and treated them with compassion. However, almost one in four said they did not feel they could get help they needed. GPs have a vital role in identifying mental health issues. When they do not feel they can provide the required care they must refer people to specialist services, such as talking therapies.

In 2013/14, over one and a half million people were in contact with NHS trusts providing specialist mental health services, the vast majority of who were supported by community-based mental health teams. The role of these teams is to support people with more complex mental health problems, and help those at risk from a crisis to stay well. Making sure that people feel involved in their care, and that they know who to contact in a crisis is essential.

While 57% of people who responded to the 2014 Community Mental Health Survey felt as involved as they wanted to be in their care planning, it is clear that there is significant room for improvement with a substantial minority (6%) feeling they were not involved at all. In addition, 23% said that they had

not agreed the care they received. Over three in 10 (32%) people also said that they were unsure who to contact in a crisis.

Problems have been identified with Crisis Resolution Home Treatment Teams, with teams struggling to offer an adequate home treatment function. In particular, lack of frequent visits, inconsistency of staff and lack of support was a major frustration of people who use services.

One person told us:

“Perhaps the worst thing is all the different faces you meet. I wish they could adjust their rotas to minimise this, as seeing fewer people would be easier.”

While ideally a crisis will be managed to prevent it from escalating, we recognise that there are times when a person will need to be admitted to hospital. However, accessing inpatient beds when they are needed is becoming increasingly difficult. This can lead to the person being placed a long way from home, which can in turn make a crisis worse. Local commissioners need to make sure that the services they are commissioning are able to meet the needs of people in crisis in their local area. This includes services that can intervene early and prevent crises from happening, as well as making sure that there is a bed available locally when someone needs to be admitted to hospital.

Going to A&E

Around 5% of all A&E attendances are recorded as relating to mental health problems. There are many reasons why people go to accident and emergency (A&E) at a time of crisis. For example due to self-harm, referral from a GP or because they feel that there is nowhere else to go.

“I feel that GPs dismissed my concerns and my experiences and made me feel that I could not turn to them.”

Not being able to access the right help at the right time is unsafe and unacceptable. This can cause a crisis to escalate, leading to greater mental distress or physical harm.

We found that the rate of people admitted to acute hospital via A&E for a mental health condition varied across the country. In 2012/13, over 4,000 people had attended A&E multiple times (on average at least once a month) in the five years before being admitted. The rate and frequency of attendance at A&E is likely to be a sign that local services are not working well together and that people are not getting the specialist help they need.

The Crisis Care Concordat is clear that people experiencing a mental health crisis should have access to the help and support they need 24 hours

Figure 2

Peak hours for acute admission via A&E



Source: HSCIC Hospital Episode Statistics

a day, seven days a week. This is crucial to achieving parity with physical health care. Except for people with dementia, most people with a mental health condition are admitted to hospital via A&E in the evenings (outside of 9am and 5pm). In particular, the peak hours for self-harm admissions are between 11pm and 5am when it accounts for 6% of all people admitted via A&E (figure 2). This may indicate that there are problems with other services providing support out of hours, so that people turn to A&E for help because other support is not available.

Key national and local organisations have signed up to the commitments in the Crisis Care Concordat. Our findings challenge those organisations to look at whether they are delivering their commitments and doing enough for people who experience a mental health crisis. There is no silver bullet, but it is clear that some systems and organisations are already meeting the needs of people in crisis. By learning from those organisations, we can secure a programme of continuous improvement.

We found that access to, and the quality of, services after 5pm was not good enough. Commissioners and providers should make sure that they have the most appropriate services with the staff that have the right skills working at the times when people with mental health needs are more likely to access them. To address this, many acute hospitals have introduced liaison psychiatry teams. These teams provide patients who are in distress in hospital with assessment and short-term care, and link with the follow-up support they need. They are designed to help bridge the gap between mental and physical health care, and enable organisations to deliver a more joined-up approach. However, findings from a national survey by the Royal College of Psychiatrists have deemed that many liaison psychiatry services are not good enough and were providing an inadequate response to people who need their service.

At a time when the NHS is under financial pressure, it is vital that commissioners take an active role in commissioning adequate and effective liaison psychiatry services across acute settings that deliver value for money, alongside improving outcomes for people who come into contact with them.

Experiences of being detained

People don't choose when or where to have a crisis. As a result, the police, in particular, frequently find themselves involved in responding to people in mental health crisis. For example, they may be called to attend someone acting in a way that may be a danger to themselves and others. In these situations, the police have the power to detain the person under section 136 of the Mental Health Act. In 2013/14, this power was used by the police over 24,000 times.

We carried out some experimental analysis on the use of section 136. The analysis suggested that there were wide variations across the country in how often people were admitted to hospital after being subject to the power. We also found that just under 13% of section 136 detentions in 2012/13 were of people who had been detained under the Act in the last 90 days. Repeated use of section 136 for the same person may be a sign that people are not receiving appropriate support from local services after being discharged from hospital. NHS trusts that provide mental health services should make sure that people receive the support they need after they have been assessed or, if admitted, once discharged from hospital to prevent further crises.

Feedback from people who came into contact with the police showed the service in a more positive light than many of the specialist mental health services. It is encouraging that a professional working outside of specialist services can get it right and this should act as a challenge to those working in the health service to do the same.

"[I had] brilliant support from the police who gave me good advice and agencies to contact."

To make sure that people have access to the right support from the beginning of the detention, a number of local authority areas are piloting street triage schemes. In these schemes, mental health nurses accompany officers to incidents where police believe people need immediate mental health support. Nurses assess and intervene where needed to make sure that people receive the most

appropriate help. Initial results are positive with pilots appearing to show a substantial reduction in the use of section 136.

People should receive transport quickly and that is appropriate to their needs. Ambulance trusts have implemented a voluntary target of responding to requests from police within 30 minutes, and data from the first three-quarters of 2014 shows that most trusts met this target on over two-thirds of requests.

However, on arrival at the health-based place of safety people are often being turned away or forced to wait for long periods because they are already full or there are staffing problems. This is neither fair nor acceptable. We would not expect someone with a broken leg to be turned away from A&E or to have to wait in police custody until they could be seen by a health professional.

In 2013, only 44% of the places of safety that returned information said that their assessment room was never inaccessible because it was already occupied. While there has been a significant reduction in the use of police custody as a place of safety for people in crisis, in some areas we found that there were still problems with people under 18 being able to access a suitable place of safety. In 2013/14, 31% of people under 18 who were detained were taken into police custody.

We welcome Home Secretary Theresa May's announcement, in May 2015, of £15 million for the delivery of health-based places of safety so that no-one ends up in a police cell due to a lack of suitable alternatives.

Once in a place of safety, most services are conducting assessments under the Mental Health Act within three hours of arrival. Where we found delays, the most common reason was a lack of specialist mental health (section 12) doctors or approved mental health practitioners (AMHPs).

Local authorities are reminded that they are responsible for ensuring that there are enough AMHPs to meet local need.

Conclusions and recommendations

Our findings suggest a health and care landscape that is struggling to provide the appropriate levels and quality of responses and support across the system. We looked at three different pathways of care and at the services with which people in crisis most often come into contact and found poor experiences and considerable variation across England at almost every point in the process.

Local providers and commissioners have to ask serious questions about whether the services they provide are safe. It is not just about making sure that people are physically safe, it is about preventing unnecessary mental distress to people when they are vulnerable. The level of variation also presents a challenge about whether services are fair, and whether people are receiving unacceptable responses because of where they live or when they try to access it.

There is also cause for optimism as through our review we have found some examples of very good practice. However, there is still too much variation across the country, and even variation within the same local authority areas. The Crisis Care Concordat has called on the different agencies that help people in crisis to

work together to provide a better, more joined-up approach to mental health care. To this end, we have outlined a number of specific recommendations that we expect primary care teams, acute trusts and those involved in section 136 detentions to action.

When asked for their view on the quality of services, our findings point to people in crisis having a much more positive experience of voluntary sector services compared with services provided by the statutory health sector. This should act as a challenge to providers who must take responsibility for making sure staff have the appropriate skills to meet the needs of people in crisis. Commissioners should look towards the role the voluntary sector could play in providing local area responses to people in crisis.

We urge local providers and commissioners to recognise the issues relating to individual pathways and that only they, working in partnership with those who use and deliver services, are in a position to understand how this might impact on their local area and the solutions necessary to resolve them.

We recommend that representatives of local Crisis Care Concordat groups:

- Ensure that all ways into crisis care are focused on providing accessible and available help, care and support for all those who require it at the time they need it.
- Hold commissioners to account for commissioning crisis services that deliver a quality of care based on evidence-based good practice and that is in line with the Concordat key principles.
- Engage with local, regional and national partners to make sure that innovative approaches to improving the experiences of those in crisis are shared within, and across, local areas.



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